



# QUALITY UPDATE

Health care quality issues for Minnesota's health care leaders

Fall 2010

## Quality Remains at the Core of Health Care During Uncertain Times

Jennifer P. Lundblad, PhD, MBA  
President and CEO, Stratis Health

THE many and varied changes in health care in recent years—including transparency and public reporting, pay for performance and value-based purchasing, health system redesign, and health information technology—can be both exciting and confusing. These changes have converged in the passage of federal legislation in the HITECH Act (2009) and the Affordable Care Act (2010). Just when we were starting to make sense of these many converging forces of health reform, we experience a mid-term election that may dramatically change the political landscape.

The good news from my perspective is that the quality, financing, and delivery system redesign called for in federal and state legislation are not the components being called into question in terms of legal authority or repeal efforts, and appear to be moving forward. We are in uncertain but exciting times in health care quality, and Minnesota has emerged as a leader in testing and experimenting with new approaches to improve quality and value.

Stratis Health is in the thick of this work...

- As a Medicare QIO, we are now working under the leadership of Don Berwick, MD, as the new CMS administrator, focusing on the “Triple Aim”—better care for individuals, better health for populations, and reducing per capita costs.



- As a federally designated health information technology Regional Extension Center, a part of Key Health Alliance, we are immersed in helping providers to realize the potential of electronic health records to improve quality and efficiency.
- And as a nonprofit organization committed to our community, we are engaged in collaborative efforts in Minnesota on rural palliative care, shared decision making, patient safety, cultural competence, and more.

I've become fond of describing Stratis Health's work in three concentric circles. The inner circle reflects the traditional and current core of our work—improving clinical care and outcomes. In the middle circle, we know that health care is largely delivered in teams within organizations, such that organizational change has become a critical area of focus for Stratis Health, reflected in our efforts to support health care providers in leadership, teamwork, culture, and technology. The outer, most encompassing circle is community—

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a recognition in our work that health care cannot continue to be viewed in silos, that we must look not only across the continuum of health care, but across the community, to achieve sustainable quality.

The articles in this issue of Quality Update reflect our current efforts related to the Triple Aim and our growing work in the public health arena, where we are helping to bridge the medical model with the community. You'll learn about the challenges of inpatient versus outpatient hospitalization as a microcosm of health reform challenges—the intersection of clinical decision making, payment and reimbursement, patient centeredness, and care transitions.

Thank you for your continued leadership in quality, and your ongoing support and engagement with Stratis Health in these exciting but uncertain times. ○

## The Role of Public Health in Maintaining a Strong Health System



Perspective from  
**Huda Farah,**  
Stratis Health Board member

An effective system of health must be a collaborative effort between stakeholders and levels of government that promotes the delivery and sustainability of quality health care.

**Huda Farah, MSc,** is a member of the Stratis Health Board of Directors. She is a researcher in public health, educator, cultural competence trainer, mentor, coach, and leader in public health and early childhood education.

**WHILE PUBLIC HEALTH MAY BE CONSIDERED A SILENT PARTNER IN IMPROVING THE QUALITY OF HEALTH** and the environments in which we live, it is an integral part of the operation of a comprehensive health care system.

An effective public health system surpasses the realm of health providers and insurers by implementing standards of quality that protect conditions such as the water we drink, the food we eat, and the air we breathe, which ultimately work in a downstream capacity by supporting individuals in their quest to make healthier choices. A public health system at all levels—federal, state, county or city—outlines the framework necessary for facilitating the conditions that lead to the creation of healthy communities.

In Minnesota, the primary objective of the Minnesota Department of Health, the state's primary government health agency, as stated in its mission statement, is "protecting, maintaining, and improving the health of all Minnesotans." To achieve this impressive and arduous goal, there must be an underlying system of governing, guiding policies, and partnerships in place.

We have groups in the general population which are considered more vulnerable in terms of achieving optimal health outcomes—the elderly, ethnic minorities, and individuals with special needs. A robust public health system ensures that these groups have equitable access to a good health service and education system. It develops surveillance systems that collect data which identify critical community needs and areas requiring research and evaluation, which assist in developing appropriate programs.

Equitable access also is achieved by raising awareness among stakeholders of the preventive provisions of good health.

Additional progress toward the protection of the health and safety of communities and individuals is made by identifying priorities for health improvement, and by engaging multiple sectors in taking action to strengthen policies while improving

practices based on the best available data and knowledge.

A high quality public health system is one that is continuously evolving to improve quality, safety of patients, and the efficiency and cost of health care service delivery. Two great examples are the Medical Home initiative and Health Information Exchange. Both are great vehicles for exchanging, internally and externally in a secure manner, critical information for diagnosis and treatment of patients across clinics, hospitals, nursing homes, mental health facilities, and home health agencies.

An effective system of health must be a collaborative effort between stakeholders and various levels of government agencies in promoting the delivery and sustainability of quality health care.

In discussing public health, we must recognize the role of medicine in addressing the health problems of individuals. In the clinical setting, individuals are offered diagnoses of diseases and the treatment or relief of pain, and consequently the ability to function better in daily life. But without a strong public health system promoting preventive health care and implementing standards of quality that protect individuals, the larger system of health cannot operate at its optimum level of efficiency, nor can it be sustainable.

With the building of a sustainable, high-quality public system, we face foreseeable challenges, including funding for investment in infrastructure and the continuing cultivation of human capital and leadership. With the increasing costs of health care and ever-shrinking state budgets, the stakes for the creation of strong productive collaborations and partnerships for cohesive systems of care are even higher. Health care in the U.S. is said to depend upon an interactive health care system founded on principles of public health, which underscores patient safety and equitable access to quality health care for all parties. ○

# Balancing Clinical Care, Cost, and Patient Centeredness

## Hospital outpatient observation reflects the challenges of health reform

**IN AN EFFORT TO BALANCE CARE AND COST, MEDICARE'S BILLING RULES FOR OUTPATIENT OBSERVATION CREATED A RIDDLE.** What do hospitals do with a patient too sick to leave but too well to be admitted to inpatient status? For many hospitals and patients, solving this riddle has been a source of confusion and consternation. Solving the riddle may provide clues to implementing health reform.

The need for health reform is indisputable—medical costs in the U.S. have risen disproportionately to other costs and are out of alignment with other countries. Medicare, as a payor funded by tax payer dollars, seeks ways to control costs while ensuring quality patient care. In 1996, it implemented outpatient observation as a billing status for patients that did not need full hospital care. This allowed Medicare to reimburse hospitals at a lower rate for providing less intensive service. Good in theory perhaps, but challenging in implementation.

The use of observation stay has increased as hospitals gain a better understanding of how to evaluate and code for level of care. Along with the increased use of observation stay, the health care community has seen its challenges come to light.

### Determining a patient's status is challenging

Whether patients can be admitted to inpatient status or should be placed in observation is determined by the severity of their illness or the level of intensity in the services they need.

"The guidance for inpatient medical necessity is continually changing," said Joe Schindler, Minnesota Hospital Association. "It can be frustrating for physicians to navigate complex documentation requirements for patients who clearly need to be monitored, but don't meet Medicare's inpatient admission criteria."

Hospitals act conservatively, erring on the side of patient safety. Patients receive the care they need, regardless of the billing determination about status. "The good news is that patient care is placed ahead of all the bureaucracy," Schindler added.

### Communicating complex information to patients is challenging

Patients are confused when what looked and felt like an inpatient hospital stay didn't count as an inpatient hospital stay for their Medicare coverage. The financial impact is significant when Medicare does not fully cover medications, the time in the hospital, or nursing home costs following the hospital stay.

Hospitals are only required to inform patients of outpatient status if their status changed from inpatient to outpatient or if previously covered observation services are being reduced or terminated. But, when hospitals haven't clearly communicated a person's outpatient status, patients and their families have been shocked to learn their medical expenses are not being covered by Medicare as expected.

### Collaborating to understand and overcome challenges

"We were hearing about problems with outpatient stay from Medicare beneficiaries," said Betsy Jeppesen of Stratis Health. "We were hearing about it from nursing homes and from hospitals."

Recognizing the extent of the problem, Minnesota stakeholders came together to discuss and work on the challenges around observation.

"Navigating Medicare is difficult," said Cheryl Hennen, Minnesota Office of Ombudsman for Long-Term Care. "We wanted to bring understanding and a focus to the problem."



The Ombudsman's Office is working with stakeholders and partners to develop a standard information sheet to help patients understand observation status and its implications.

This summer, the Centers for Medicare & Medicaid Services held forums to hear from the public, providers, and advocacy groups. It is evaluating the recently reported impact to

Medicare patient benefits and to providers, and considering whether changes to observation rules are needed.

### Learning from observation status

Health reform will require us to better communicate with patients, sharing the right information, at the right time, in a manner patients can understand.

Health reform requires that we look for efficiencies in systems to keep down costs. Managing patient care outside of hospital walls is becoming more important.

Health reform is requiring better documentation of diagnoses and treatments, not only for billing accuracy but to enhance care delivery and support population health. Electronic health records are becoming more essential to support care quality, assist with data reporting and analysis, and aid in accurate and appropriate billing.

From the experience of outpatient observation, we know health reform won't be easy. We can expect more challenges from unintended consequences as we try to find the right value equation for balancing clinical decision making, payment and reimbursement, and patient centeredness.

We also believe that stakeholders in Minnesota's health care system are well poised to work together on these challenges. ○



# Quality Improvement in Public Health

Public health agencies in Minnesota are embracing quality improvement as they prepare for the voluntary national accreditation program for public health departments, to launch in 2011. The goal of accreditation is to improve and protect the health of every community by advancing the quality and performance of public health departments.

“Improving health department performance may be the best way to improve the health of the population,” said William Riley, chair of the Public Health Accreditation Board and associate dean of the University of Minnesota School of Public Health. “We have this tremendous opportunity with accreditation right now.”

Accreditation is bringing a focus to standards of practice, starting with performance and capacity measures that will provide greater consistency across public health agencies. The process measures ensure that the key components are in place to impact health outcomes. Before agencies can register to apply for accreditation, they need to have a:

- Comprehensive health assessment
- Strategic plan
- Comprehensive health improvement plan

Readiness for accreditation across the country varies. According to Riley, “Some agencies have processes in place and are ready to go. Others have some of the pieces, and others have a long way to go.”

“As more agencies are able to meet the standards and measures, I think they’ll bump up the measures so that all are improving,” said Kim McCoy, Minnesota Department of Health (MDH), Office of Performance Improvement.

Public health agencies in Minnesota are well ahead of other states. The state already requires local health departments to complete a community health assessment every five years. Minnesota agencies have been evaluating their accreditation readiness and receiving guidance from MDH.

## 10 Essential Public Health Services

The Essential Public Health Services (1994) describe public health activities that should be undertaken in all communities.

1. Monitor health status to identify and solve community health problems.
2. Diagnose and investigate health problems and health hazards in the community.
3. Inform, educate, and empower people about health issues.
4. Mobilize community partnerships and action to identify and solve health problems.
5. Develop policies and plans that support individual and community health efforts.
6. Enforce laws and regulations that protect health and ensure safety.
7. Link people to needed personal health services and assure the provision of health care when otherwise unavailable.
8. Assure competent public and personal health care workforce.
9. Evaluate effectiveness, accessibility, and quality of personal and population-based health services.
10. Research for new insights and innovative solutions to health problems.

Having national standards and measures will allow public health agencies to stay focused on priority issues and not need to change priorities with each newly appointed commissioner. They can reduce the likelihood that priorities will fluctuate on the essential health services, like surveillance and health promotion.

## Quality Improvement

Unlike for some accreditation programs, quality improvement is an integral part of the public health accreditation process.

“Many accreditation processes are basically about dotting the “i’s” and crossing the “t’s”, mostly focused on record keeping,” said Riley. Public health accreditation is based on a philosophy of comparing performance against standards. In areas where agencies are not meeting standards, accreditation requires that they use continuous quality improvement practices.

Minnesota is one of 16 states participating in a multi-state collaborative, funded by the Robert Wood Johnson Foundation, to build quality improvement capacity in public health agencies across the country and prepare state and local health departments for accreditation. In Minnesota, MDH has been providing resources, tools, technical assistance, and training on quality improvement techniques to the state and local public health departments. Stratix Health has shared with this group its knowledge and experience in building a culture of quality improvement.

Although formal quality improvement techniques are new to public health, continuous quality improvement is proven from decades of application in other industries. It’s well recognized as a means to improve quality and decrease deficiencies.

Local public health directors are supportive of performance improvement. “It’s an expectation of our elected officials, and an expectation of our residents that we will be improving our performance,” said Karen Zeleznak, public health administrator for the City of Bloomington.

## Collaboration is Central to Public Health

Public health has to work with other organizations to successfully carry out its work. Collaborating and engaging with the community to identify and solve health problems is a theme in the accreditation standards.

“The ultimate goal is improving community health.”

Public health works with school partners, faith organizations, and other community organizations. Data from hospitals and clinics, such as rates for immunizations and health conditions, provide the basis for public health to develop community health assessments and improvement plans. And, the medical community refers patients to public health services, such as high risk new moms and babies, and children with developmental delays, asthma, or autism.

“We work together to build synergy around health issues,” said Zeleznak.

## Plans in Action

Using their community assessments and data, public health agencies execute plans in support of short term and long term goals. But, funding for the work remains a challenge and agencies rely heavily on grant funding to carry out their work.

“About 70 percent of our budget is grant funded and those dollars are usually very targeted,” Zeleznak noted.

Among other sources, Bloomington Public Health tapped into Statewide Health Improvement Program funding to foster and promote two new farmers markets, working to eliminate access barriers for minority populations and people with disabilities. SHIP is part of a larger statewide health care reform effort intended to improve the overall function of the health care system and reduce health care costs.

It also participated in Stratis Health’s cultural competence initiative, funded by UCare. Completing the Culturally and Linguistically Appropriate Services assessment and following up on the gap analysis developed by Stratis Health, the agency developed a strategic plan to improve its staff’s cultural competence.

No one is losing sight of the purpose for the standards and measures, assessments, and plans. Zeleznak noted, “The ultimate goal is improving community health.” ○

# BUILDING HEALTHIER COMMUNITIES

Stratis Health awarded its Building Healthier Communities award to two new recipients.

Lakewood Health System will use its \$15,000 award to work across care teams and community stakeholders in the Staples area to train on and embed the use of Physician Orders for Life Sustaining Treatment (POLST), physician orders used to translate a patient’s wishes into specific actions for treatment.

The Minnesota Shared Decision Making Collaborative was awarded \$10,000 to enable its Patient and Community Engagement Workgroup to conduct patient/community focus groups, and to plan for a media outreach campaign that will promote a common understanding of shared decision-making for patients and the community. Shared decision-making is an approach that aims for clinicians and patients to partner in making treatment decisions for complex medical decisions when the best therapeutic option is unclear.

“These two projects are natural extensions of Stratis Health’s strong support of patient-centered care,” said Dale Thompson, Stratis Health board chair and president and CEO of Benedictine Health System. “POLST and shared decision-making, at their core, are about putting the patient first.”

Lakewood Health System was one of 10 communities that participated in the Minnesota Rural Palliative Care Initiative led by Stratis Health to develop or expand their palliative care services. As its palliative care services have matured, staff identified the need for coordinating care across counties and services, including emergency medical services and implementing the POLST form in their community.

The Shared Decision Making Collaborative’s goal is to enhance effective shared medical decision making between patients and their clinicians by studying and implementing methods to assure that medical decisions are well informed by the best available evidence and are consistent with patient preferences.

As a nonprofit organization, Stratis Health is committed to being a responsible and engaged community member. The Building Healthier Communities award supports initiatives that can help grow an appreciation for the culture of health care quality and patient safety in Minnesota.

Nominations for the award are made by Stratis Health Board or staff members. Awards must align with Stratis Health’s mission and vision, advance Stratis Health’s work and relationships, benefit the community, and focus on Minnesota.

## Looking at the numbers: hospitals work to improve patient safety

STRATIS HEALTH HAS BEEN WORKING WITH NINE MINNESOTA HOSPITALS TO IMPROVE surgical care by reducing surgical complications. The Surgical Care Improvement Project focuses on preventing complications in four areas that comprise 40 percent of the most common complications after major inpatient surgery: infec-

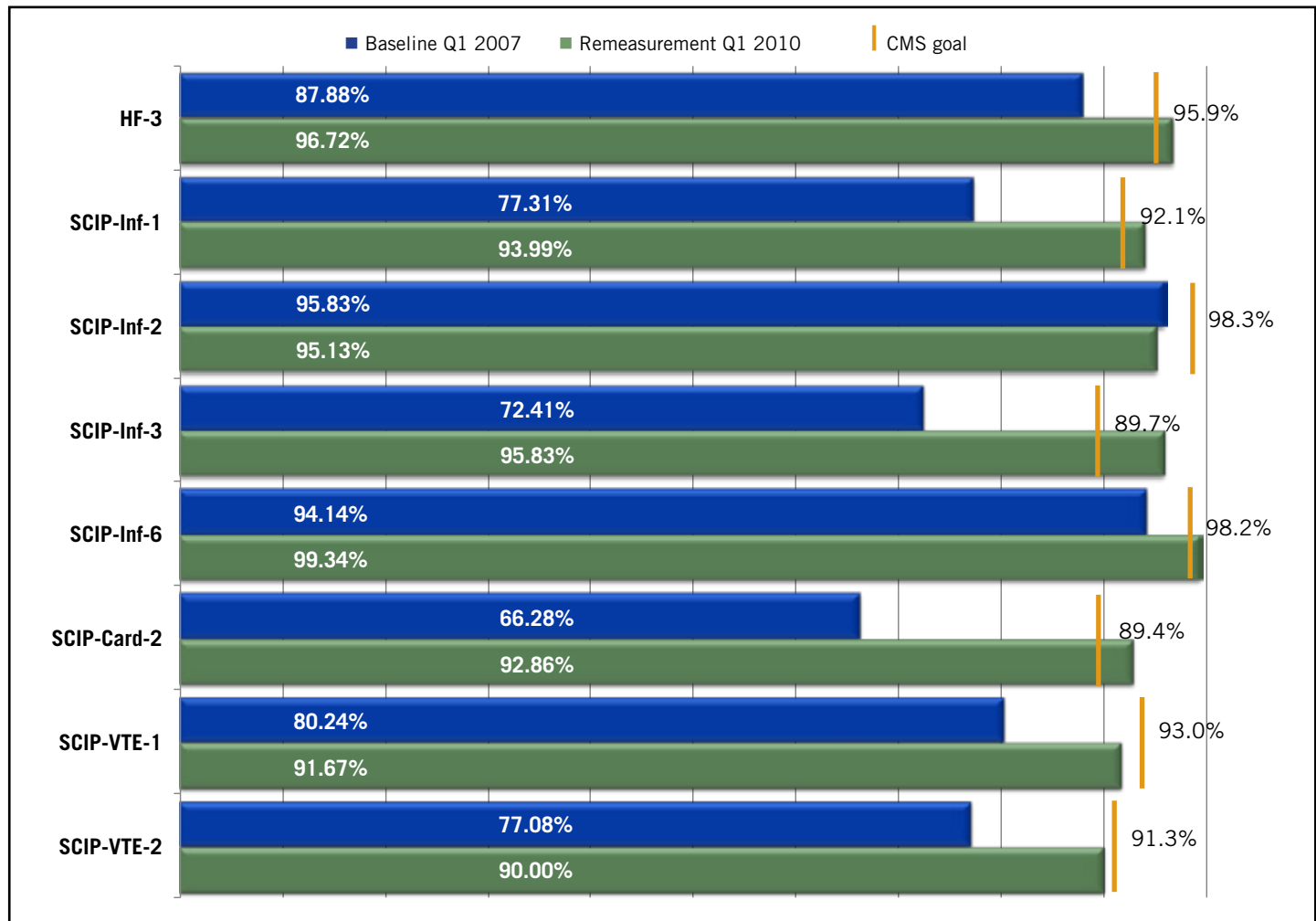
tion, blood clots, and adverse cardiac and respiratory events.

**Results:** Collectively the nine hospitals showed improvement, from baseline to remeasurement, on 7 of 8 measures shown. They exceeded five of the goals—benchmarks based on care levels being achieved by the Minnesota hospitals

performing best on these measures. See the trend graphs online at [www.stratishealth.org/pubs/qualityupdate/f10/hospitals.html](http://www.stratishealth.org/pubs/qualityupdate/f10/hospitals.html).

Stratis Health conducted this work as the Medicare Quality Improvement Organization for Minnesota, under contract with the Centers for Medicare & Medicaid Services. CMS goals were set using the ABC Method.

Hospital Patient Safety Measure Rates - Baseline and Q1 2010



**Abbreviation Key**

HF-3	Heart failure patients with left ventricular systolic dysfunction without ACEI and ARB contraindications who are prescribed ACEI/ARB at discharge
SCIP-Inf-1	Prophylactic antibiotic received within 1 hour prior to surgical incision
SCIP-Inf-2	Prophylactic antibiotic selection for surgical patients
SCIP-Inf-3	Prophylactic antibiotics discontinued within 24 hours after surgery end time
SCIP-Inf-6	Surgery patients with appropriate hair removal
SCIP-Card-2	Surgery patients on beta blocker therapy prior to arrival who received a beta blocker during perioperative period
SCIP-VTE-1	Surgery patients with recommended venous thromboembolism prophylaxis ordered
SCIP-VTE-2	Surgery patients who received appropriate venous thromboembolism prophylaxis within 24 hours prior to surgery to 24 hours after surgery

# Status of Meaningful Use

## Implementing electronic health records to improve the quality of care

The federal electronic health record incentive program was finalized in July 2010. As a federal health information technology (HIT) Regional Extension Center, the Regional Extension Assistance Center for HIT (REACH) is working with providers in Minnesota and North Dakota, assisting them in achieving meaningful use.

REACH staff Paul Kleeberg, MD, clinical director, and Sue Severson, program director, discussed the status of meaningful use.

### Where are providers in their journey to meaningful use?

Kleeberg: I'm seeing a complete spectrum. I see small docs and family practices that really like the technology and use it to improve care quality. And, I've met a subspecialist surgeon who declared she'd never use an electronic health record.

Motivations for adoption vary. Some providers see it as a way to improve quality, others see the incentive, while still others see the writing on the wall and believe they will need it to stay in business.

Severson: Health care facilities are extremely practical; they are looking at the nuts and bolts needed to get to meaningful use. Those components will get them started, but we are looking higher, including looking at the National Priority Partnership Goals.

Kleeberg: The greater goal is to leverage health information technology to improve quality, safety, efficiency, and equanimity of care.

So often we take our eye off the ball and look at the dollars or focus on the short term. An effectively utilized record that unifies care across a number of sites so people do not have to re-enter data or duplicate tests and have the information there when a patient shows up at a hospital, will increase quality, increase safety, decrease costs.

Severson: We want meaningful use to be part of an organization's strategic initiative. If a facility is really motivated by incentives, we try to dig into other motivations. If facilities do not set a foundation, getting to stage 2 and 3 of meaningful use will be a steep climb.

### Stage 1 is not enough

Kleeberg: Stage 1 of meaningful use is a low bar. One problem on the problem list and one medication on the medication list is the bare minimum. If providers only meet the minimum, they could record that a patient is a diabetic but miss that the patient has significant vascular complications. That's not quality. Would you willingly give a patient a summary with an incomplete problem list or medication list? As a patient, I consider a complete list along with follow-up instructions to be quality.

Meaningful use criteria are baby steps to bring us to where we want to be. My vision is that one day we will have a system where accessing information is as easy as on the Internet but with significant security protections.

Severson: This is an opportunity to transform care. We are moving into the 21st century with health care. We are moving from this antiquated paper system to an information system that can support the clinical decisions of providers.

### More than an IT project

Kleeberg: Those who see meaningful use as a technological fix think of EHR adoption as an IT project. A vendor can provide you with certified technology, but to use it effectively, you and your staff must be involved in the process. Only then will you get the most out of your invest-



ment, improve the quality of your care, and achieve meaningful use.

Severson: Vendors are saying that they have the capabilities. That's much different than clinics and hospitals being able to use those capabilities. That takes a purposeful approach, one with the right workflows, the right look on screen, and staff who are motivated to enter and extract data because they understand the value to patients.

### Meeting stage 1

Severson: There's so much EHR penetration in Minnesota and North Dakota. Many providers who have an EHR think they already have stage 1 meaningful use accomplished or are well on their way. When we dig into the details, it's much more complicated. We've developed a meaningful use assessment so providers can check how ready they are for meaningful use and work on the areas where they find gaps.

Kleeberg: We know that providers are facing multiple quality and reporting efforts—ICD-10, Minnesota Health Care Home certification, as well as PQRI and other forms of data submission. These can be easier with an EHR. Providers should look at meaningful use in tandem with other efforts. There can be a great deal of synergy. ☺

Under its current agreement with the Office of the National Coordinator, REACH is able to offer services to providers at deeply discounted rates for contracts initiated before December 31.

[www.khaREACH.org](http://www.khaREACH.org)



# STRATIS HEALTH NEWS



Dale Thompson, Benedictine Health System president and CEO and Stratis Health board chair, and Jennifer Lundblad, Stratis Health president and CEO, honored outgoing board member Nancy Feldman, UCare president and CEO (center).

**Board of directors.** Stratis Health has elected four new officers to its board of directors. **Connie Delaney**, PhD, RN, is dean of the School of Nursing at the University of Minnesota. **Beth Monsrud**, CPA, is senior vice president and chief financial officer of the health plan UCare Minnesota. **Stephen Swensen**, MD, is a radiologist and director of quality at the Mayo Clinic. He also teaches at the Mayo College of Medicine. **Gary Wingrove** is responsible for government affairs and strategic alliances for Gold Cross/Mayo Clinic Medical Transport.

**Stratis Health thanks our outgoing board members** Nancy Feldman, UCare, and Stephen Kopecky, MD, Mayo Clinic, who also served as board president. Each served on the board for nine years.

**Stratis Health staff.** **Jennifer P. Lundblad, president and CEO**, was elected to serve as president elect of the American Health Quality Association. She will serve as president, then immediate past president in subsequent years.

**Deb McKinley, MPH, communications and outreach manager**, was elected to serve as president elect of the Minnesota Health Strategy and Communications Network.

**Vicki Olson, MS, RN, joins Stratis Health as program manager.** She brings over 20 years of experience in health care quality, with certifications in Lean and Six Sigma, to her work at Stratis Health. She manages planning and implementation in the areas of patient safety and quality data reporting with a focus on hospital quality improvement projects.



**Peer reviewed presentations.** **Michelle Hopkins, MS, research analyst**, presented “Improving Drug Safety for Minnesota Elderly” at the Minnesota Pharmacists Association Annual Meeting and “SAS with CLAS: Assessing Adherence to Federal Standards for Culturally and Linguistically Appropriate Services” at the Midwest SAS User Group Conference.

**Paul Kleeberg, MD, REACH clinical director**, will present on how REACH is taking primary care providers across Minnesota and North Dakota from 0 to meaningful use—and beyond, at the Healthcare Information and Management Systems Society national conference in Orlando, Florida, in February.

**Culture Care Connection** won a 2010 Beacon Award for excellence in health care marketing, [www.culturecareconnection.org](http://www.culturecareconnection.org).

**Stratis Health** is a nonprofit organization that leads collaboration and innovation in health care quality and safety, and serves as a trusted expert in facilitating improvement for people and communities.

Stratis Health works toward its mission through initiatives funded by federal and state government contracts, and community and foundation grants, including serving as Minnesota's Medicare Quality Improvement Organization.

**Stratis Health** works with the health care community as a quality improvement expert and clearinghouse, educator and trainer, consultant and supporter, convener and facilitator, and data resource.

Contact us to see how we can assist you with your quality improvement needs. Call 952-854-3306 or 1-877-787-2847 (toll-free), or email us at [info@stratishealth.org](mailto:info@stratishealth.org).

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Jennifer P. Lundblad, PhD, MBA  
*President and CEO*  
[jlundblad@stratishealth.org](mailto:jlundblad@stratishealth.org)

Debra McKinley, MPH, Editor  
*Manager, Communications and Outreach*  
[dmckinley@stratishealth.org](mailto:dmckinley@stratishealth.org)



## Stratis Health

2901 Metro Drive, Suite 400  
Bloomington, MN 55425-1525

952-854-3306 • 952-853-8503 (fax)  
Email: [info@stratishealth.org](mailto:info@stratishealth.org)  
[www.stratishealth.org](http://www.stratishealth.org)