



QUALITY UPDATE

Health care quality issues for Minnesota's health care leaders

Fall 2012

Health Policy Affects Lives

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

During this election year, I am reminded of the importance of good policy making, based on research, data, and real life experiences. Stratis Health's work is often focused on patients and populations that are not necessarily mainstream and are often vulnerable or underserved in terms of health care—including seniors, rural residents, and cultural communities. These people and communities are affected by the policies and programs that our elected officials enact.

The demographics of Minnesota are changing rapidly. With the Baby Boomers now reaching age 65 and becoming eligible for Medicare, we will see our senior population explode. Currently, our health care system is not well suited to respond to these patients' needs, with far fewer geriatricians available than the population will need, for example. And our rural communities are disproportionately older, as well as have more chronic disease, bringing real challenges to delivering effective, high quality, efficient health care to our rural areas.

In addition, while many outside of Minnesota think only of our state's traditional Scandinavian and German heritage, Minnesota's racial and cultural picture is changing rapidly as well, especially as we continue to attract immigrants and refugees. The largest and fastest growing cultural communities in Minnesota are Hispanics and Latinos, Asian and Pacific Islanders, and African and African Ameri-



cans. The need for cultural awareness and cultural competence among health care clinicians and organizations is imperative to being patient-centered.

Stratis Health's work sits at the intersection of research, policy, and practice. We are driving attention to these rapidly changing demographics and needs, developing and implementing resources and initiatives, based on evidence based best practices, to support high quality health care, and using our experiences to inform health care policy. We are leading the way in increasing cultural awareness and competence through our Culture Care Connection online resource center and related projects, in supporting rural health care providers to participate in the care delivery and payment innovations happening as a result of federal and state legislation, and improving care for seniors through our work as the Medicare QIO (Quality Improvement Organization) for Minnesota.

Policy making may seem like a distant concept, but it affects lives. Federal

THIS ISSUE

Geriatricians and the Care of Our Aging Population 2

Health IT's Role in a Changing Reimbursement Landscape 3

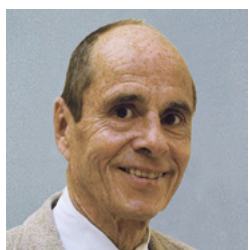
Large Scale Impact to Prepare for the Coming Alzheimer's Epidemic 4

Diabetes: Creating a Common Agenda for Collective Impact 6

Medicare reimbursement policy is driving action to reduce hospital readmissions—and Stratis Health has worked as a RARE Campaign partner to help Minnesota hospitals successfully decrease avoidable readmissions by 13 percent so far since the launch of the campaign last year. For one patient, this means having a physician make a home visit to coordinate his medications prescribed by numerous doctors and to provide the patient with education and self-management skills, resulting in a drop from 30 hospitalizations in a year to remaining out of the hospital for six months and counting.

To quote Minnesota's own Hubert Humphrey, "It was once said that the moral test of government is how that government treats those who are in the dawn of life, the children; those who are in the twilight of life, the elderly; and those who are in the shadows of life, the sick, the needy and the handicapped." We look forward to Stratis Health's expertise and experience continuing to inform policies and improve care for Minnesotans most in need. ☺

Geriatricians and the Care of Our Aging Population



Perspective from
Michael Spilane, Stratis Health Board member and Jane Pederson, Stratis Health medical affairs director

Jane Pederson, MD, MS, is director of medical affairs at Stratis Health and is a practicing geriatrician for Allina Senior Care Transitions.

Michael Spilane, MD, is a member of the Stratis Health Board of Directors. He is co-head of the Division of Geriatrics in the HealthPartners Medical Group, and is a faculty member for the Division of Geriatrics in the Department of Internal Medicine at the University of Minnesota Medical School.

Many in the health care profession are concerned about how we will provide quality care to the 72 million Baby Boomers aging into the senior population over the next 20 years. The American Geriatrics Society suggests we need an additional 9,600 certified geriatricians to care for our current population of about 12 million older Americans.

Practicing geriatricians, Michael Spilane, Stratis Health Board member and Jane Pederson, Stratis Health medical affairs director, discuss the role of geriatricians in care delivery as the U.S. population ages.

With the changing demographics, what impact are you seeing on care/care delivery in your practices? How does this impact quality of care?

JP: The average age of my patients in nursing homes and assisted living facilities is in the high 80s, with some patients in their late 90s. It will be interesting to see what the expectations of the baby boomers will be having grown up in a high-tech world and representing a generation that comes from a more diverse ethnic background.

MS: A doubling of the number of older Americans in the next 20 years is going to have enormous impact on all aspects of our society. How we deal with this problem is going to severely test the ingenuity of politicians and health care leaders.

How have you seen your practice change over the years?

MS: When I began my practice as a geriatrician 35 years ago, there were no geriatric nurse practitioners, or very few of them. Today, I couldn't accomplish my work without teaming with an advance practice nurse.

JP: With more services available today to help people stay in their own homes, those moving into nursing homes and assisted living settings are requiring much more support than 20 years ago. There is a much higher percentage of patients who have dementia as their primary diagnosis.

I feel I need to be more aware of community resources and have a good relationship not just with the patient but also with their family or caregivers.

Is the mismatch between the growing number of seniors and the number and availability of geriatricians a concern?

JP: Yes, if our model of care stays as it is. The unique needs of older adults are not always recognized by physicians who do not specialize in that area. And they are not familiar with the many regulations required for nursing homes.

MS: I am far less concerned about the relative scarcity of board certified geriatricians than I am about the number of general primary care physicians who have the desire, knowledge, and skills necessary to care for older adults.

While much of the practice of geriatric medicine is similar to the practice of internal medicine or family medicine, much is also different. Learning the difference and building skill and competence in caring for the older of the old demands that a physician be primarily, if not exclusively, involved with patients in this age group and not have just a small number of them in his or her practice.

What is the impact of the rapidly changing payment and care delivery on seniors and your practice?

MS: Changes in payment and in the mechanisms for delivering care are desperately needed, but like a huge freighter at sea, changing course takes time. Next year, we won't see much change. In 10 years, hopefully we'll see a lot.

JP: If geriatricians can manage the chronic health and social needs of the older population, ACOs (Accountable Care Organizations) will fare better overall from a cost and quality perspective. Without a change in reimbursement, geriatric care likely will remain a money loser because the time needed to care for a patient's social and functional needs is not reimbursed.

MS: To adequately care for a greatly increasing elderly population with critical needs, many more innovative, cost-effective solutions will be required—solutions like medical homes and bundling of services, as well as transformed reimbursement and geriatric education for health care professionals across disciplines. ○

Health IT's Role in a Changing Reimbursement Landscape

Health information technology (HIT) has become an essential tool in the new care reimbursement models which reward value over volume. Value Based Purchasing, Total Cost of Care, Health Care Homes, and Accountable Care Organizations (ACO) all require new uses of data for health care organizations to succeed in the value driven world.

New models of care have expanded the use of population data beyond external reporting for performance ranking. The payment structure of the Health Care Home model now incents providers to use disease registries to target improvement opportunities for patients with specific conditions, such as asthma, diabetes, and heart failure.

For the 89 Medicare ACOs across the country, HIT plays a critical role in supporting their goals to improve care quality and reduce costs through:

- Quality reporting
- Clinical information exchange
- Medical management across the continuum of care
- Member engagement
- Predictive modeling
- Managing financial risk¹

"Health IT is a platform and a tool to help us begin to innovate models of care," said Raymond Gensinger, chief medical information officer, Fairview Health Services, one of Minnesota's three Pioneer ACOs, among 32 across the country.

Medicare provides ACOs with all claims data for their assigned fee-for-service patients. They can now see care these patients receive outside their own walls. By amassing all forms of patient information through a data warehouse, ACOs are analyzing data in new, more complex ways, including risk stratification and predictive analytics.

"Risk stratification, predictive analytics, population disease registries, proactive treatment, chronic disease management—this is exiting, cutting edge stuff," commented Gregg Teeter, lead analytics advisor at Park Nicollet Health Services, another Minnesota Pioneer ACO.

ACOs are starting to learn more about their populations and leverage that information to identify the most promising interventions.

"The role of HIT is to turn data into actionable lists of high risk patients and reach out to them to engage before they peak and encounter an acute situation," said Teeter.

Predictive modeling in action

Teeter and his colleagues in health sciences research at the Park Nicollet Institute partnered to develop a model to predict which patients currently in the hospital are likely to be readmitted within 30 days.

For each hospitalized patient, a probability score for readmission is generated based on a regression model that looks at comorbidity, prior utilization, and demographic variables. Patients are determined to be at

high, medium, or low-risk for readmission. High risk patients are flagged in the EHR and care coordinators provide them with more intensive follow up.

Looking ahead

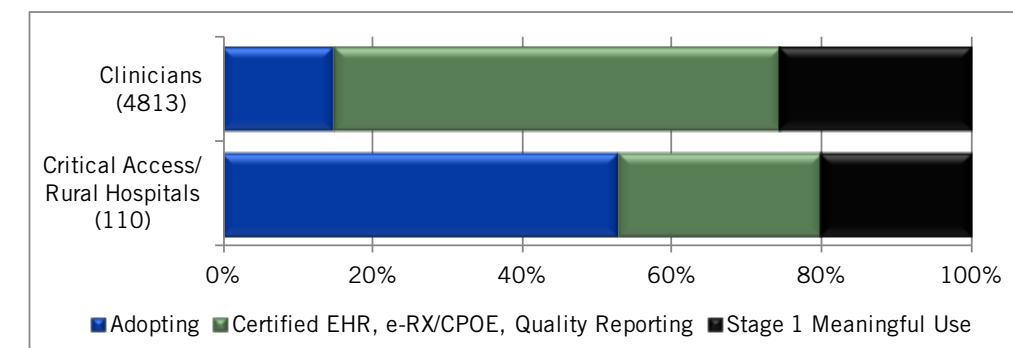
Health reform and the Affordable Care Act are incenting leaders to innovate and are pulling all health care organizations toward value-based care.

If ACOs can successfully move away from the fee-for-service model, they can use the value driven approach with commercial payors and talk about contracting in a new way that incents health and wellness.

Federal meaningful use requirements are propelling the use of electronic health record (EHR) systems at all clinics and hospitals. Providers must meet objectives for quality reporting, lists of patients by specific conditions to use for quality improvement, and information exchange across settings. Effectively using this EHR functionality for care management will begin to prepare health care organizations to participate in value based care models. ○

1. Health Information Requirements for Accountable Care. Computer Sciences Corporation, 2010.

REACH Client Progress Toward Meaningful Use



Data through September 2012, e-RX: electronic prescribing, CPOE: computerized physician order entry

As of September 2012, 22 hospitals and 1,231 clinicians in Minnesota and North Dakota working with the Regional Extension Assistance Center for HIT (REACH) have attested to meaningful use of their electronic health record systems. As a partner in Key Health Alliance, Stratis Health co-leads REACH along with the National Rural Health Resource Center, and The College of St. Scholastica. www.khaREACH.org

Large Scale Impact Needed for Communities to Prepare for Coming Alzheimer's Epidemic

ACT on Alzheimer's is preparing Minnesota for the budgetary, social, and personal impacts of the disease

The numbers can't be ignored: one in eight people over 65 have Alzheimer's and nearly 50 percent of people over 85 have the disease. With the coming age wave, Alzheimer's will reach epidemic proportions—125,000 Minnesotans are expected to have the disease by 2025.

People are joining forces through the state-wide collaboration ACT on Alzheimer's, formerly Prepare Minnesota for Alzheimer's, to prepare Minnesota for the budgetary, social, and personal impacts of Alzheimer's disease and related dementias.

The ACT on Alzheimer's coalition took root following the January 2011 report released by the state-mandated workgroup that identified the future needs of Minnesota with respect to Alzheimer's and recommendations on how to address those needs.

"People from the workgroup were concerned that nothing had changed," said Olivia Mastry, who facilitated the Alzheimer's workgroup. "We asked, 'What can we do to make the recommendations a reality?'"

Collective impact

To achieve the system-wide change described in the report's 50 recommendations, the state needed a comprehensive approach. ACT on Alzheimer's is using the collective impact process to provide a disciplined, high performing approach to achieving large-scale social impact. It aligns nonprofits, businesses, and government organizations around established common goals and shared measures, in order to move beyond the isolated impacts each would have working on separate goals.¹

Over 150 stakeholders are working on these five shared goals, each with its own leadership group, intended to drive change:

- Increase early detection of Alzheimer's disease and improve ongoing care and support
- Sustain caregivers information, resources, and in-person support
- Equip communities to be "dementia capable" so that they can support their residents who are touched by the disease
- Raise awareness about Alzheimer's by engaging communities throughout Minnesota
- Identify and invest in promising approaches that bend the cost curve for Alzheimer's and related dementias

ACT on Alzheimer's participants each identified what they were already working on that aligned with the goals. The group determined what it could do in the first 18 to 24 months

and defined a set of success measures across the five goals through 2013.

"We didn't want to ask everyone to do a lot more, we just wanted to organize the work that was already happening," Mastry explained. "We zoned in on key areas to move the dial on the issue."

Early identification

Early identification of Alzheimer's has a dramatic impact on quality of life, not just medical treatment and symptom management. Early diagnosis allows individuals and their families to plan for the future. It can help prevent big catastrophes like car accidents, financial disaster, people who are lost and wandering. Identifying the disease early can cut unnecessary emergency room visits and unnecessary hospital visits. Having a medical diagnosis also opens the door to a number of resources that might not be available otherwise.

Literature suggests that only 50 percent of providers can recognize Alzheimer's when someone comes into a doctor's office and complains of memory problems. With no standardized approach for early identification, ACT on Alzheimer's created a practice algorithm that supports screening, early diagnosis and intervention, and quality care consistent with recommended practices.

"Our bold concept is not to wait until a patient comes in with a memory problem and then give them a screening test," said Michael H. Rosenbloom, MD, clinical director, Center for Dementia and Alzheimer's Care, HealthPartners.

ACT on Alzheimer's is trying to get clinics to use asymptomatic screening as a best practice, starting with clinics in the Twin Cities region. The leadership group also has developed Health Care Home certification requirements and dementia-specific training for inclusion in curricula for health care providers and caregivers.

Bending the cost curve

The direct and indirect costs of Alzheimer's and other dementias including Medicare and Medicaid costs and the indirect cost to business for employees who are caregivers of people with Alzheimer's are estimated at more than \$148 billion annually in the U.S.

Minnesota's Medicaid program pays for the long-term care needs of those who cannot pay for their own care. Growth in the senior population and growth in both health care and long-term care services (including nursing homes and disability services) accounted for approximately 69 percent of the increase in Minnesota's Medicaid costs in recent years. Together, they are one

of the major causes of the state's continuing budget deficits.

ACT on Alzheimer's is looking at how to bend down the cost curve by quantifying the direct and indirect cost of dementia in an economic model, and by identifying interventions that show a return on investment.

Among the evidence based best practices currently available, the coalition identified two promising interventions for Alzheimer's. First, caregiver support has been shown to extend the time a person with Alzheimer's can be cared for at home before being admitted to a nursing home. The Mittelman model showed a delay of nursing home admission by six months.² Second is the transitional care model for at-risk hospitalized elders researched by the University of Pennsylvania. Using the model is expected to decrease readmissions to hospitals and lengthen the time from hospital discharge to return.

"Arming caregivers with information and support networks is a vital step toward reducing the human cost of an Alzheimer's diagnosis," commented Lt. Governor Yvonne Prettner Solon, who is a former caregiver and the Honorary Chair of ACT on Alzheimer's. "Successful, informed, and supported caregivers are happier, more fulfilled, and can help keep loved ones healthier and in their homes longer—something that often keeps families happier and health care costs down for family and state budgets."

The economic model is expected to show savings through these interventions—savings for insurance companies, Medicare, Medical Assistance, and personal resources.

"When we finalize this work in early 2013, it will have value not only for the state, but also for others who can implement interventions, like health systems that are trying to manage costs within bundled payments and manage avoidable hospital readmission rates," said Parti Cullen, Care Providers of Minnesota president and CEO.

Community

All of the work of ACT on Alzheimer's is intertwined and will be delivered and embedded across the state through a community engagement process. One of its long-range goals is to have communities act on a more wide-scale basis to embed system changes that foster community readiness for dementia.

Stratis Health, in conjunction with one of the coalition leadership groups, is spearheading the development of the *Dementia Capable*



Some of the 18 members of Act on Alzheimer's Preparing Communities Leadership Group: (front) Cathy Croghan, Caryn McGeary, Lori Petersen, Dawn Simonson. (back) Jayne Hager Dee, Mary Ek, Carol Thelen, and Annette Sandler.

Community Toolkit—a comprehensive toolkit that includes information and resources on how communities can prepare for needs related to dementia, from early identification of the disease to community awareness and readiness. The toolkit provides a structured process to foster convening leaders and influencers, assessing of strengths and gaps, identifying and planning community goals, and acting together.

Currently, five community teams—representing geographic and faith communities—have partnered with ACT on Alzheimer's to pilot the process.

A different process, different future for dementia

The complexity of the issues surrounding Alzheimer's and related dementias requires the wide-reaching approach of the collective impact model to problem solve to achieve large-scale progress. The magnitude of involvement and cooperation through this process is greater than any of the 150 stakeholders has previously experienced.

"It feels like I'm in the middle of a renaissance or revolution," said Rosenbloom. "It seems like we are changing how we look at the disease." ○

1. Channeling Change: Making Collective Impact Work, Stanford Social Innovation Review, January 2012.
2. Mittelman, M.S., Ferris, S.H., Shulman, E., Steinberg, G. & Levin, B. (1996). A family intervention to delay nursing home placement of patients with Alzheimer disease. *Journal of the American Medical Association*, 276, 1725-1731.



Diabetes: Creating a Common Agenda for Collective Impact

Continuing Minnesota’s tradition of working collaboratively to reduce the burden of diabetes in the state, the Minnesota Diabetes Steering Committee, a statewide coalition of nearly 30 organizations led by the Minnesota Department of Health (MDH) for almost three decades, made a bold decision in the fall of 2011 to try a new organizing approach—collective impact—to address the many complex, long-standing issues around diabetes.

While Minnesota has great expertise in diabetes research, diabetes care, and public health approaches and it shows better rates than the nation as a whole, the percentage of adults who have diabetes in Minnesota nearly doubled in the last 20 years. A new full-system approach to address diabetes in the state was needed.

In February 2012, numerous key health care and community leaders, including leadership from Stratis Health, Mayo Clinic, and the Centers for Disease Control and Prevention (CDC), came together to learn about the collective impact process from FSG, the consulting group that developed the model. Collective impact emphasizes a rigorous, disciplined, and multi-organizational/multi-sector effort to tackle social and health care problems in concert.

Stakeholders supported using collective impact—as an approach that spans health care providers, insurers, academic institutions, community organizations, public health agencies, diabetes program funders, and others—to address diabetes. Spurred by an initial investment from MDH to have FSG help the group begin the collective impact process, the stakeholder group has drafted a common agenda, developed a list of needs to be immediately addressed, and defined a vision for the work. With goals to decrease the number of people who develop diabetes and to improve outcomes for those with the disease, the group aims to change the picture of diabetes in Minnesota.

The first phase of the collective impact work showed that Minnesota has a wealth of experience to draw from. In the realm of quality improvement, Stratis Health and the Institute for Clinical Systems Improvement each have led multiple diabetes clinical quality improvement projects over the years, the Aligning Forces for Quality program developed the D5 diabetes measure which is now used across the country, diabetes was the first measure collected and reported by MN Community Measurement, and the Minnesota Quality Summit focused on diabetes. Within health systems, health plans, state government, providers, and the community, Minnesota has strong organizational assets and commitment to diabetes, including world-class diabetes treatment centers, and more recently, the Decade of Discovery partnership between Mayo Clinic and the University of Minnesota.

“There’s probably no better cluster of diabetes assets in the world as in Minnesota,” said Kyle Peterson, managing director at FSG.

Work has moved into the second phase, which includes refining the common agenda, developing a blue print for action, and identifying a group that can take on the backbone or supporting role for the group’s work, a role currently filled by FSG. For collective impact to work and change the picture of diabetes in Minnesota, the initiative is seeking additional partners and support.

“Everyone feels we have the opportunity to come together in a new way, to bring together the wealth of resources we have in this state, and truly align our work,” said Gretchen Taylor, manager of the Diabetes Prevention and Control Program, MDH.

260,000 diagnosed with diabetes
241,000 reporting prediabetes

CDC 2010 data for Minnesotans

Key Conditions of Collective Impact

The collective impact process brings diverse organizations together with a common goal of solving a social problem. All actors involved collaborate in a highly-structured manner to make a true impact on a complex issue.

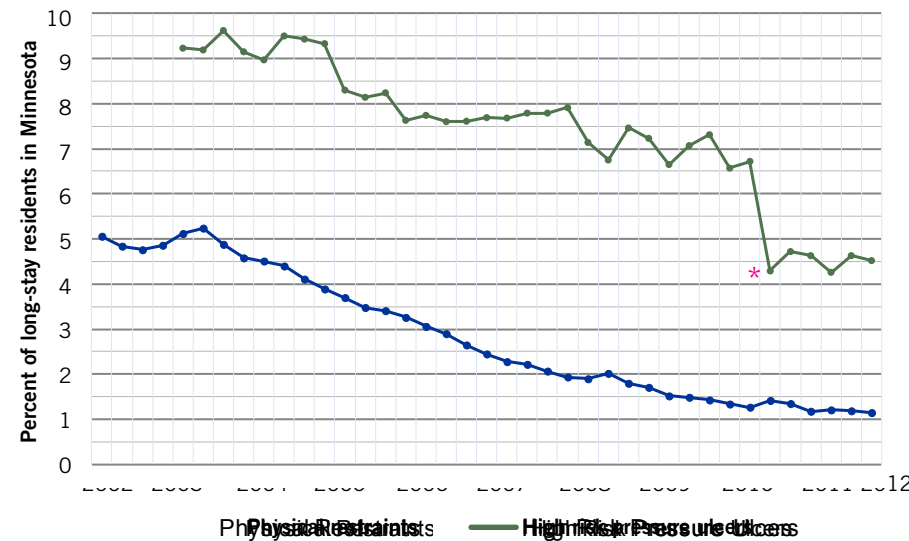
The five key conditions of collective impact, as developed by the consulting group FSG are:

- Alignment of diverse stakeholders around a common agenda
- Shared measurement system
- Continuous communication
- Mutually reinforcing activities
- Backbone support organization

Read more: Channeling Change: Making Collective Impact Work, Stanford Social Innovation Review, January 2012.

Looking at the numbers: progress over the last decade in Minnesota Nursing Home Quality Measures

Minnesota Long-stay Residents Who Were Physically Restrained or Had Pressure Ulcers - Quarter 3, 2002 to Quarter 1, 2012



Minnesota's Quality Measure national performance rankings²

15th Lowest use of physical restraints

5th Lowest incidence of high risk pressure ulcers

* The rate drop for high risk pressure ulcers in Q4 2010 corresponds with the Minimum Data Set (MDS) 3.0 quality measure specification change which eliminated reporting of stage 1 pressure ulcers.

Since the Government Performance and Results Act (GPRA) required all federal agencies to move toward a performance-based, results-oriented government starting in 1999, the Centers for Medicare & Medicaid Services (CMS) has focused on decreasing the use of restraints and pressure ulcers in nursing homes to improve the quality and safety of resident care.

Over the past 10 years, Minnesota nursing homes have made significant progress in reducing the use of physical restraints, from 5.06 to 1.15 percent (Q3 2002 to Q1 2012), and reducing the incidence of pressure ulcers, from 9.23 to 6.72 percent (Q3 2003 to Q3 2010).¹ Minnesota ranks 15th in the nation for the lowest use of physical restraints and 5th lowest for the incidence of pressure ulcers.²

For more than a decade, nursing homes have benefitted from several national quality initiatives—Advancing Excellence in America’s Nursing Homes, Quality First, the Nursing Home Quality Initiative, the culture change movement, and technical support of the Medicare Quality Improvement Organization (QIO) program. As a Medicare QIO, Stratis Health has worked with Minnesota nursing homes since 2002 providing technical assistance to reduce use of physical restraints and pressure ulcers.

Today, Stratis Health continues to support nursing homes in their work to make improvements. Projects include:

- Providing technical assistance as the Medicare QIO to reduce the use of physical restraints and pressure ulcers.
- Partnering with the Oklahoma Foundation for Medical Quality to assist QIOs nationwide as they support their states’ nursing homes.

- Leading a CMS demonstration project, with the University of Minnesota, to develop and test prototypes of a national Quality Assurance Performance Improvement (QAPI) program for nursing homes.
- Leading a CMS Special Innovation Project to assist post acute care providers in Minnesota—focusing on skilled nursing facilities—to improve quality and coordination of care through the effective use of health information technology.
- Reducing the use of psychotropic medications—a potential chemical restraint—in all settings of care for people with behavioral and psychological symptoms related to dementia, through the Partnership to Improve Dementia Care.

“We are able to apply evidence-based practices and the lessons of individualized care from our decade of success to continued improvement in nursing home resident care,” said Kristi Wergin, Stratis Health program manager. “Nursing homes now use better practices and equipment to prevent pressure ulcers. And instead of using restraints, they are becoming more focused on individualizing resident care by asking questions like ‘Why are residents falling or exhibiting behavioral symptoms?’”

Stratis Health conducts analytical work in support of assessing and improving health care quality and patient safety. This report was produced by Stratis Health in its role as the Medicare Quality Improvement Organization for Minnesota, under contract with CMS.

Data sources:
1. Source: CMS, aggregated data from MDS 2.0 and MDS 3.0.
2. Advancing Excellence in America’s Nursing Homes, latest available national data Q3 2010.

STRATIS HEALTH NEWS



Dale Thompson is honored by Bill Jacott, board chair.

We thank **Dale Thompson, president and CEO of Benedictine Health System**, for his nine years of service on the Stratis Health Board of Directors, including serving as chair in 2010 and 2011.

"I'm proud of the organizational growth that has occurred during my time on the Stratis Health board, and especially appreciate the focus that Stratis Health has taken in long-term care," said Thompson. "This community has developed a high level of trust in Stratis Health. Working with Stratis Health on quality and safety has been a breath of fresh air for long-term care providers."

New Stratis Health board members. Three new members recently were elected to the Stratis Health Board of Directors, with terms effective January 1: Donna Anderson, MPH, is a public health consultant and the former director of the Dakota County Public Health Department for 22 years; Mary Jo Kreitzer, PhD, RN, is founder and director of the Center for Spirituality & Healing; and Craig Svendsen, MD, is chief medical quality officer for the HealthEast Care System.

Stratis Health welcomes new staff members.

Joining our quality improvement staff, **Candy Hanson, program manager**, leads Stratis Health's planning and implementation of the

Centers for Medicare & Medicaid Services' Special Innovation Project: Health Information Technology for Post-Acute Care Providers.

Bruce Johnson, BSN, MA, program manager,



leads the organization's healthcare-acquired infection work, is a key participant in the Minnesota Collaborative Healthcare-Acquired Infection Network (CHAIN), and works with the Minnesota Hospital Association on improving patient safety culture in hospitals.

Erik Zabel, PhD, MPH, epidemiologist, provides leadership and direction for Stratis Health's epidemiologic and analytic work. He brings extensive experience in study design and evaluation, data management, and public health.



Karla Weng, Stratis Health program manager, was elected president-elect of the Minnesota Rural Health Association.

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.

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Quality Update is published twice a year by Stratis Health for Minnesota health care leaders.

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