



# QUALITY UPDATE

Health care quality issues for Minnesota's health care leaders

Fall 2009

## Building a Reformed Health System that Emphasizes Quality

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President and CEO, Stratis Health

MINNESOTA AND THE NATION ARE UNDERTAKING A NUMBER OF EXCITING EFFORTS that, together, help us move toward a reformed health system that truly emphasizes quality. Our hope at Stratis Health is that these collective efforts signal a shift from health care delivery, measurement, and payment in silos, to more-comprehensive and patient-centered approaches. The shift may be slow and incremental right now, but it gives us a sense of the possibilities and opportunities, both locally and nationally.

Among these efforts we see:

- Momentum, supported by new tools and resources, in responding to a rapidly changing patient population and health care workforce, enabling clinicians and staff to be more culturally aware and competent in serving patients, as well as supporting a more diverse workplace.
- Attention to care planning, including advance directives, such as we've never seen before, which provides the opportunity to help physicians and their patients develop a mutual understanding of values, beliefs, and goals to make health care choices that are right for each patient and their family.
- The use of technology such as electronic health records (EHR), accelerated by new Medicare and Medicaid financial



incentives for achieving "meaningful use" of an EHR, to ensure safe, high quality, and efficient care delivery.

These efforts are highlighted in this issue of Quality Update. Stratis Health is leading the way in these areas, through initiatives such as our new Culture Care Connection Web site, our Minnesota and national rural palliative care projects, our involvement in the Honoring Choices Minnesota program, and our proposal to serve as a federally-designated Health Information Technology Regional Extension Center. We continue to be involved in health reform efforts led by the Minnesota Department of Health, including the state's new quality measurement program and the Health Care Homes work, as well as policy and program efforts to better engage consumers and to assure rural health needs are understood and addressed in local and national health reform.

In the last issue of Quality Update, I offered four questions that serve as our litmus test with regard to reforming health care:

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1. Does an idea or proposal increase access to health care services?
2. Does this idea or proposal reduce disparities in health care?
3. Does this idea or proposal improve health care value?
4. Does this idea or proposal encourage both patients and providers to do the right thing?

These questions continue to guide Stratis Health in the midst of ambiguity and change, and will enable us to stay focused on our mission of leading collaboration and innovation in health care quality and safety, and to serve as a trusted expert in facilitating improvement for people and communities, as we help improve and reform health care. ○

## Why Culture Matters for a Healthier Minnesota

Making better connections with multicultural health plan members and patients.



Perspective from  
**Nancy J. Feldman,**  
Stratis Health Board member

When we say UCare is “health care that starts with you,” we include every single member, no matter his or her race or ethnic background.

**Nancy J. Feldman**, is a member of the Stratis Health Board of Directors. She is president and CEO of UCare, a health plan long known for its work with diverse and underserved populations.

**MANY OF YOU KNOW THE STATISTICS.** The Minnesota State Demographic Center projects the state’s multicultural population to increase from 14 percent in 2005 to 25 percent in 2035. In the Twin Cities metropolitan area, the impact will be even greater, with the non-white population accounting for 35 percent of the population, compared with only 20 percent in 2005.

While Minnesota is consistently ranked as one of the healthiest states in the nation, a deeper look shows that Minnesotans of color lag behind the state’s majority community in health outcomes. New immigrants may not speak or understand English, be accustomed to Western medical practices, or trust our health care system. Health care providers are equally challenged by language and cultural barriers. Ultimately, the breakdown in communication can lead to disparities in health care access and outcomes.

We in the health care community need to make better connections with our multicultural health plan members and patients to find better ways to “speak your language.” It’s incumbent on us to accelerate our efforts to reduce disparities. I believe all health plans and health care providers should make cultural competency a top priority. Indeed, it should be viewed as a core ingredient to our success.

When we say UCare is “health care that starts with you” to our more than 180,000 members, we include every single member, no matter his or her race or ethnic background. Implied in our member-focused promise is that we will strive for a deeper understanding of our members to more effectively meet their health care needs.

For 25 years, UCare has made cultural competency an organization-wide mandate. We have established a Diversity and Cultural Competency Council to oversee these activities. We are proud of our long history of innovation in this area, including:

- Winning the Ellis J. Bonner Community Leadership Award for our Hmong Outreach Program, aimed at bridging

the cultural gap separating the Hmong population and US health care practitioners.

- Creating a cultural competency chapter for our provider manual.
- Integrating the cultural needs of our members into our daily activity, such as providing the Community Family Doula Program to pregnant members from many cultures (Latino, American Indian, African-born, and teens).
- Being a founding partner of the Multilingual Health Resource Exchange, a Web-based clearinghouse of health materials in different languages ([www.health-exchange.net](http://www.health-exchange.net)).
- Funding and collaborating on Stratis Health’s groundbreaking Minnesota online cultural competency learning center for health care practitioners, Culture Care Connection ([www.culturecareconnection.org](http://www.culturecareconnection.org)).
- Providing the UCare Fund and community benefit grants across the state to community, clinic, and research programs designed to reduce disparities in care.

Becoming more culturally competent can be enormously gratifying. Making new connections with our members and patients can be rewarding. Providers experience success when patients fully understand diagnosis or treatment options. By the same token, health plan customer service staff are successful when members who call can truly understand the explanation of how their health care benefits work.

All of us in the health care community share a common goal to improve health outcomes among emerging populations, as well as all populations, in Minnesota. I’m confident we can make it happen ... through the hard work of improving our understanding of these communities and learning new and meaningful ways to communicate with them. I think we’d all agree that an initiative that improves health outcomes is priceless. ○

# Advance Care Planning

## Getting patients ready to have “The Talk”

WITH THE US POPULATION AGING, INCREASING RATES OF CHRONIC DISEASE, AND NEVER KNOWING WHEN YOU MIGHT GET HIT BY A BUS, patients need to have “The Talk” about their end-of-life wishes with their physicians and families.

The Agency for Healthcare Research and Quality has documented the need for more effective advance care planning, from the need for documents that require less interpretation to physicians being unaware that patients had health care directives.

According to a Harvard Medical School study, nearly half of patients with metastasized lung cancer and their doctors did not discuss hospice care within four to seven months of their diagnosis.

Some physicians do not want patients to think that they are not going to survive, even if the reality is that a patient with metastasized lung cancer is not expected to live more than two years. Delaying discussions about end-of-life preferences can increase the difficulty of the discussion as conditions become more critical.

Many primary care physicians facilitate advance care planning with their patients. State support of Health Care Homes in Minnesota should foster increased planning. And, advance care planning is growing in the Twin Cities in part because of Honoring Choices Minnesota, a metro-wide community approach to fostering increased use of advance care planning. Honoring Choices is supported by the East Metro Medical Society and the West Metro Medical Society.

Some Minnesota health care systems are working to formalize systems for initiating advance care planning discussions with aging and palliative care patients. Advance directive discussions are thoughtful and deliberate. They help people examine their values, beliefs, and desires to assist them in

making the choices that are right for them at end of life and to ensure those choices are documented. A University of Pennsylvania School of Medicine study found that people who did not have written directives were twice as likely to change their preferences than those who did. Those who had directives were more likely to maintain consistent wishes for end of life.

### Care preferences, culture, equity

A recent University of Pittsburgh study showed that when people with Medicare were asked about their treatment preferences if diagnosed with a terminal illness, the majority did not prefer life-prolonging measures.

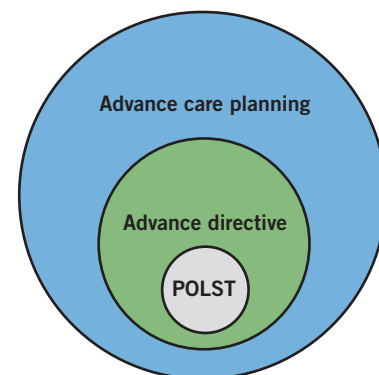
However, the study found a correlation between end-of-life care preferences and race. African Americans and Hispanics were both more likely to opt for intensive end-of-life care. African Americans were twice as likely as whites to say they would want life-prolonging treatments.

Theories for this difference include: belief that the health care system is racially biased, communication barriers, and lack of a regular doctor, which makes end-of-life discussions more difficult within the limited patient-physician relationship.

The likelihood of a patient-physician discussion about hospice varied with race and ethnicity, according to a Harvard study. Hispanics (43%) and African Americans (49%) were less likely to have discussions than whites (53%) and Asians (59%).

Having a standard of care for physicians to offer patients advance care planning, as they would offer a screening for colorectal cancer, might help decrease disparities in care and increase patient confidence that their wishes will be adhered to.

HealthEast is trying a Hmong facilitator for the planning process, as part of its efforts to ensure that culturally responsive



Honoring Choices Minnesota envisions a three-part process to help ensure that a patient's wishes are honored at end-of-life:

1. Advance care planning: facilitated conversation between a patient and their health care agent
2. Advance directive: patient directed document outlining care preferences
3. POLST: physician's orders used to translate patient's wishes into specific actions for treatment [www.metrodoctors.com](http://www.metrodoctors.com)

components are built into its pilot programs like Honoring Choices Minnesota.

Elizabeth Anderson, HealthEast director of cross cultural services, was surprised when an elderly Hmong man chose to be an organ donor, as Hmong typically do not donate organs at death. He said, “My philosophy is different. I believe it is the right thing to do.” Then added, “Let’s be sure to get this in writing because my family will object.” Anderson said the key is not to assume that a specific patient has the beliefs generally held by the overall culture.

### In support of advance directives

Stratis Health’s quality efforts have long encompassed chronic disease and end-of-life care. As we work with communities to build capacity for palliative care, we’re sharing resources on advance care planning. And, following the hype about “death panels,” our Human Resources staff planned a lunch-and-learn so staff can determine if they are ready to have “The Talk.” ○

# Quality Care for Changing Communities

## Building cultural competence across the state

**HEALTH CARE ORGANIZATIONS ARE HEADING IN DIFFERENT DIRECTIONS WITH CULTURAL COMPETENCE DEPENDING ON THEIR STRENGTHS AND ASSETS,** from health systems with centralized offices driving change initiatives, providing a central point of education for staff, and acting as diversity advocates; to nursing homes starting to build support for their increasingly diverse workforce.



Health care organizations across Minnesota are recognizing the shift in their patient, community, and workforce demographics, and are acting on research that shows disparities in care delivery. Change statewide is being driven community by community, as their demographics change.

In St. Cloud, the 2000 US census showed 7.3 percent residents ages five and older spoke a language other than English at home. In 2006, 21 percent of school children spoke a language other than English at home. Changing demographics prompted CentraCare to hire a cultural competency specialist to expand its diversity efforts.

“Every health care organization needs to be intentional about building a stronger foundation for tackling the health care needs of diverse populations,” said Rosemond Sarpong Owens, health literacy/

cultural competency specialist for CentraCare Health System.

Hospitals and clinics feel they have had more of a burning platform than other settings, moving them sooner to take action toward cultural competence. Even so, hospitals are challenged to meet the cultural and language needs of their patient populations, according to a study by The Joint Commission. Their efforts to address language are more concrete than those to address culture.

Several hospitals and clinics described some of their cross cultural challenges: providers feel uncertain that they are treating the right problem when an ER patient doesn't speak English, the Amish patient who has an advanced health condition because she didn't seek preventive care, staff feeling fearful because they perceive the behavior of ER patients and their families as aggression.

Away from the burning platform, providers face language and culture barriers, patients are unsure how to utilize the health care system, and the workforce is becoming more diverse.

“As we think about who will be working in health care, we need to provide education and training for the growing population of immigrants in Minnesota,” said Donna Zimmerman, vice president of government and community affairs at HealthPartners. “They will be our health care workforce and health care leaders.”

According to American Community Survey 2005 data, 15 percent of US health care workers are foreign born—one in four doctors (physicians and surgeons)

were born abroad, as were 26 percent of nursing and home-care aids.

### Business case

For health systems, the analytics are available to support the business case for cultural competence. A tremendous amount of research is now available, from the Robert Wood Johnson Foundation and others, demonstrating the cost effectiveness of having a solid infrastructure in place to support cultural competence, noted Elizabeth Anderson, director of cross cultural services for HealthEast.

Changing demographics require changing approaches. “I believe that if you do not provide quality language services, you will have more medical errors, more adverse events, and lower patient satisfaction,” said Anderson.

“We are a nonprofit, but we are a business too. We want to be the first choice for patients, physicians, and employees,” Anderson said. “Paying attention to diverse communities is critical for our long term success.”

For Fairview Health Services, the business case for cultural competence has not been hard to make. Sue Plaster, director of diversity, could easily take their four corporate goals and build corresponding diversity goals:

- ✦ Exceptional patient care ties directly to cultural competence.
- ✦ Exceptional patient and family experience maps to creating a welcoming environment—through signage, accessible translations, and other work.
- ✦ Effective and efficient use of resources maps to supporting workforce diversity to optimize and make the best use of Fairview's talent.
- ✦ Strategic growth requires examining the demographic trends in the community.

Scott Wordelman, president and CEO of Fairview Red Wing Health Services, an affiliate of Fairview Health Services, has a changing workforce and a changing community. He didn't develop a formal business case for cultural competence. "We have a demand for a workforce in the future and we clearly need to meet the health care needs of the community today. But, for me, it's a matter of the heart, not the head."

**"We want quality to be within reach of every single patient."**

### Seeing the community

From her rural clinic, Toni Tebben, site coordinator at CentraCare Long Prairie, suggests that health care leaders need to go into the smaller clinics, into the smaller communities, to see what's happening. "There are patient safety concerns and provider concerns."

Fairview Health Services did just that by encouraging presidents across its care system to participate in a Walk in My Shoes training. The core of the program was to have executives participate in three experiential learning activities with people from diverse backgrounds: a home experience, shadowing an employee within the system, and an experience in the community.

"They recognized that there was a gap between where we were as executives and the paradigm of the workforce and the communities we serve," said Wordelman.

As a result of participating in the program, Wordelman has a heightened sense as a

leader about the need to bring his awareness and influence to the hospital and to community health. Among other actions, he's worked to build relationships with the native Mdewakanton Dakota Prairie Island tribe. Fairview will start providing services to the tribe in January.

### Supporting communities in change

Minnesota's nonprofit structure—churches, charities, and others—is very supportive and welcoming of immigrants and refugees. The support spills over to health and human services that need to care for these populations.

Sarpong Owens believes that health care organizations need to be catalysts for change. They need to help people coming from outside of the US understand and seek out preventive care, and help diverse populations navigate the care system and know how to use the resources available.

Wordelman is hearing increased concern from other health care leaders, and leaders in general, about how to support Red Wing as it moves away from being a sleepy river town. Red Wing is working as a community to create a more welcoming and healthy community.

### Patient-centered care plus

At the core of both patient-centered care and cultural competence is the emphasis on seeing the patient as a unique person. Cultural competence expands patient-centered care to include the need to be attentive to the health beliefs, values, and perspectives of the patient—how the family and community impact the patient's health.

"The key is to provide tools that enable the workforce to provide great care," said Anderson. "We want quality to be within reach of every single patient." ○

## IN BRIEF



### Culture Care Connection—online learning and resource center

Stratis Health recently released Culture Care Connection, a Web site designed to help Minnesota health care providers, staff, administrators, and county agencies offer culturally and linguistically appropriate care to the state's growing multicultural populations in order to reduce health care disparities and achieve improved health care outcomes.

Culture Care Connection provides actionable tools to assist organizations in achieving their goals in relation to cultural competence.

Site highlights include:

**County profiles** of each Minnesota county with key demographic, socioeconomic, and health status data so health care practitioners can learn more about the characteristics of the communities they serve.

**GLAS assessment** to evaluate how well health care organizations meet national cultural and linguistic standards.

**Culture fact sheets** to help health care providers learn more about the background, religious and cultural beliefs, and common health issues of the predominant minority populations in Minnesota, including African American, American Indian, Hispanic/Latino, Hmong, Iraqi, Russian, Somali, and Vietnamese.

The site was created by Stratis Health and funded by a UCare grant, [www.culturecareconnection.org](http://www.culturecareconnection.org).

## Looking at the numbers: providers assess themselves against CLAS standards

STRATIS HEALTH WORKED WITH 23 ADULT PRIMARY CARE CLINICS across Minnesota—both urban and rural—to reduce language and cultural barriers to effective health care by engaging physicians and staff to better understand the changing demographics of their patient base and to build more culturally relevant approaches to care delivery into their practices.

- Assessed how well they were addressing the 14 national Culturally and Linguistically Appropriate Services (CLAS) standards—baseline and re-measurement
- Conducted training for their physicians, nurses, and office staff
- Customized demographic information for their community/region regarding

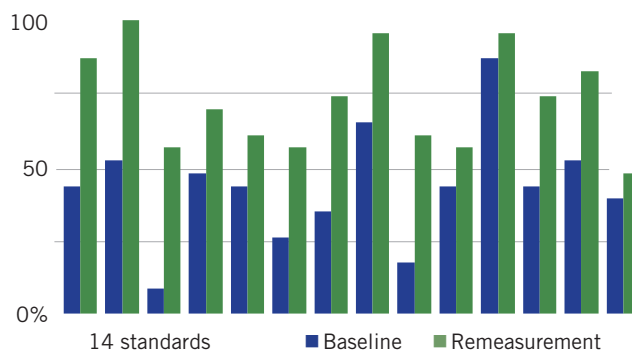
the changing nature of the populations they are and will be serving

- Provided ongoing communication and technical assistance

**Results:** Statistically significant performance improvement on all 14 national CLAS standards, between baseline and re-measurement, by the 23 participating clinics. (CMS Medicare QIO contract 2005-2008)

With support from UCare, we are currently providing technical assistance to another group of clinics and a public

Clinics Meeting or Exceeding CLAS Standards



health agency to help them enhance their culturally competence.

Stratis Health conducts analytical work in support of assessing and improving health care quality and patient safety.

## Expanding Rural Palliative Care Nationally

Rural communities are uniquely positioned to meet the challenges of providing palliative care through collaborative efforts. Stratis Health recently concluded a six-month pilot project that provided technical assistance, for planning and developing palliative care services, to three rural communities:

- Franklin, North Carolina
- Ruleville, Mississippi
- Valley City, North Dakota

Each community team completed an initial needs assessment, attended an in-person capacity building session with education and action planning for palliative care, and participated in formal technical assistance calls, all developed and led by Stratis Health.

All three teams formed a community-based team from multiple care settings and developed an action plan related

to palliative care processes. Two teams focused their efforts on advance directives. The third focused on linkages between agencies that could provide services and on developing a “Care Captain” program with volunteers to support patients with complex care issues.

### Project learnings

A set process and timeline, access to palliative care program development expertise, and external facilitation to help initiate and develop community-based teams are important aspects that can assist in further developing community-based palliative care efforts in rural areas.

On-site community workshops were a key factor in implementing pilot palliative care projects in rural communities.

Rural communities with similar areas of focus can benefit from structured opportunities to connect and share tools and lessons learned in implementation.

An extended time frame, such as one year, may allow teams to further implement their action plans before the project formally ends.

All three teams identified financial support for ongoing efforts related to palliative care services as an ongoing challenge. The lack of reimbursement for interdisciplinary palliative care services will continue to be a concern and barrier for the communities to fully implement team based palliative care. Policy changes for reimbursement of palliative care services, and/or grant funding to help sustain collaborative efforts would be extremely valuable in expanding rural palliative care services through this community-based model.

Find the final report, as well as updates on the Minnesota Rural Palliative Care Initiative, at [www.stratishealth.org/palcare](http://www.stratishealth.org/palcare).

The project was conducted under contract with the National Rural Health Association, funded through the Health Resources and Services Administration, Office of Rural Health Policy.

# HIT Regional Extension Center

## Stimulus dollars funding health information technology adoption

As part of the American Recovery and Reinvestment Act (ARRA) of 2009, Health Information Technology Regional Extension Centers (HITREC) are being developed through cooperative agreements, from the Office of the National Coordinator (ONC) for Health Information Technology.

The Regional Centers are intended to provide education and technical assistance to help primary care providers in selecting, implementing, and achieving meaningful use of certified electronic health record (EHR) technology, as well as the ability to exchange health information with other providers and agencies, with the aim of improving the quality and efficiency of care.

Achieving this goal will enable primary care providers to become eligible for incentive payments for their Medicare/Medicaid patients.

Key Health Alliance (KHA)—a partnership of Stratis Health, the Rural Health Resource Center, and The College of St. Scholastica—has submitted a proposal to serve as the Regional Extension Assistance Center for Health Information Technology (REACH) in Minnesota and North Dakota. REACH will have an emphasis in rural practice needs and small urban practices serving medically underserved patients and areas.

“Serving as the REACH will accelerate and expand the work that the three partners in Key Health Alliance are already deeply engaged in,” said Sue Severson, director of Health Information Technology Services at Stratis Health. “We each have successful track records in HIT education, training, and technical assistance—both

on our own and in coordination with many other collaborators.”

Services will be available to providers of all types, sizes, and locations, both with and without an EHR, across the continuum of care. ONC has designated certain primary care providers as “priority primary care providers,” to receive federally subsidized technical assistance. Federally subsidized support is available for primary care practices of 10 or fewer clinicians (i.e., MD, DO, NP, PA).

REACH will help meet national HITREC goals by providing technical assistance services and support to 5,100 priority primary care providers over the next four years, with 3,600 priority primary care providers targeted in the first two years. KHA currently has commitment from 4,628 providers representing 417 practices in Minnesota and North Dakota. Based on the state populations and numbers of providers, REACH will impact more than 2.5 million health care consumers.

The Regional Centers will be established through four-year cooperative agreements, with 50 percent federal funding and 50 percent from participation fees and other grant funding.

In the first two years of the program, technical assistance will be subsidized for priority primary care providers, with approximately 90 percent of the funding for the Regional Center’s services coming from the grant and 10 percent from fees paid by participating providers. For all other providers, and for priority primary care providers after the first two years, there will be a fee scale based on the services needed.

Technical assistance and support from Regional Centers will focus on the following areas:

- Vendor selection and group purchasing
- Implementation and project management
- Practice and workflow redesign
- Functional interoperability and health information exchange (HIE)
- Privacy and security
- Progress toward meaningful use
- Local workforce support

A variety of associations and networks have committed to work with Key Health Alliance in this effort. REACH will coordinate closely with the state agencies and other organizations leading related ARRA efforts, as well as with North Dakota Health Care Review, University of North Dakota Center for Rural Health, and University of Minnesota, in planning and implementing REACH.

“Collectively, Key Health Alliance has served thousands of providers and organizations in HIT over the past five years,” noted Jennifer Lundblad, president and CEO of Stratis Health. “This track record reflects our readiness to be an HIT Regional Center.”

ONC expects to award contracts for the first round of applicants in mid-December. Work is anticipated to start in mid-January 2010 for Regional Centers selected in the first round. ○

# STRATIS HEALTH NEWS

**Patient safety support for rural hospitals and nursing homes.** Stratis Health has received funding to add rural hospitals and nursing homes to our core patient safety Medicare Quality Improvement Organization efforts in Minnesota to improve prevention and treatment of pressure ulcers, or bedsores, and to reduce the use of physical restraints in nursing homes.

## **New Stratis Health board members.**

Stratis Health elected new board of director members. **Huda Farah, MSc**, is a researcher in public health, educator, cultural competency trainer, mentor, coach, and a leader in public health and early childhood education. **Lucinda Jesson, JD**, is an associate professor of law at Hamline University School of Law and director of its new Health Law Institute. **Michael Spilane, MD**, is co-head of the Division of Geriatrics in the HealthPartners Medical Group, and is head of the Division of Geriatrics in the Department of Internal Medicine at the University of Minnesota Medical School.

**Jennifer P. Lundblad, Stratis Health president and CEO**, has been invited to serve as one of six members of the national Rural Policy Research Institute's Health Panel.

**Deb McKinley, MPH, Stratis Health communications and outreach manager**, received the Community Partner Star Award from the University of Minnesota School of Public Health.

## **Stratis Health welcomes new staff members.**

Joining our case review staff, **Terri Janssen, RN, BSN, case review manager**, provides technical expertise in the areas of medical record review and data abstraction and serves as a key contact for beneficiaries, physicians, and providers throughout the medical record review process. She also assists in the administration of the Medicare Helpline and Immediate Appeal Lines.



**Denise White, MA, RN, CPHQ, program manager**, brings her 33 years of experience in health care to managing the planning and implementation of work in the areas of patient safety focusing on hospitals and nursing homes, and to working with health plans on quality improvement projects.



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

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