StratisHealth

QUALITY UPDATE

Health care quality issues for Minnesota's health care leaders

Spring 2012

Making National Priorities Local

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President and CEO, Stratis Health

Over the past year, I've had the opportunity to spend more time than usual in Washington, DC, meeting and talking with national health care policy and program leaders. I've come away with a deeper understanding of how important local implementation of national health care quality priorities is to achieving sustainable improvement.

While quality standards are national, the way states and communities address and achieve quality does indeed differ, reflecting the unique local health care environment.

Stratis Health has long served federal agencies in implementing national priorities at a local level. We currently play this role in two significant ways in Minnesota—first, as the long-lasting and successful Medicare Quality Improvement Organization (QIO) for Minnesota, one of 53 such state-based programs in the country, and more recently, as the health information technology (HIT) regional extension center for Minnesota and North Dakota, one of 62 such extension centers.

Minnesota's Quality Improvement Organization

As Minnesota's Medicare QIO, Stratis Health serves as an independent, locally integrated field team for the Centers for Medicare & Medicaid Services (CMS) to help implement the National Quality Strategy and federal health reform efforts.

The QIO Program is dedicated to improving health quality at the community level.

In implementing the program in Minnesota, we support and convene providers, practitioners, and patients in statewide learning and action networks to build and share knowledge, spread best practices, and achieve rapid, wide-scale improvement. One example is the Collaborative Healthcare-Associated Infection Network (CHAIN) partnership to develop and carry out effective approaches for reducing healthcare-associated infections in Minnesota. CHAIN was formed in 2011 by Stratis Health, the Minnesota Chapter of the Association for Professionals in Infection Control and Epidemiology, Minnesota Department of Health, and the Minnesota Hospital Association.

Regional Extension and Assistance Center for HIT (REACH)

In partnership with the College of St. Scholastica and the National Rural Health Resource Center, Stratis Health leads the REACH program. The concept of an extension center has its origins in agricultural extension centers out of land grant institutions such as the University of Minnesota—the epitome of local implementation.

REACH helps providers implement and effectively use electronic health records (EHR) to improve patient safety and the quality of care—achieving meaningful use. Since 2010, we have worked with nearly 4,500 primary care clinicians, of whom 3,540 are now able to do e-prescribing and quality measure reporting through their EHR. Many are on their way to meaningful use. With the emphasis on rural and underserved providers, REACH clients include 120 rural health clinics and 21 Federally Qualified Health Centers. In addition, we are working with 104 rural and critical access hospitals, of which 33 to date are able to do computerized physician order entry and quality measure reporting.

Stratis Health is uniquely positioned to effectively and efficiently drive the national goals in Minnesota, which is increasingly important in a rapidly changing federal health care landscape. We take pride in being good stewards of public funds, and in aligning national priorities with local needs and interests.

THIS ISSUE

Community Paramedics: Here, There (and soon) Everywhere

Perspective from
Gary Wingrove
Stratis Health Board member

For the last eight years a movement has been quietly growing internationally, led locally in Minnesota. The movement supports the use of existing health care providers under their existing scope of practice to use their skill set in nontraditional roles. The movement is called community paramedicine.

The concept behind community paramedicine is to use EMS (emergency medical services) providers to perform a number of social service, public health, primary care, and post-discharge functions. A traditional paramedic uses the skill of giving shots to administer drugs like Valium; a community paramedic uses the skill of giving shots to do immunizations. A traditional paramedic uses the skill of infusion therapy to mix and administer drugs like Dopamine; a community paramedic uses the skill of mixing and administering drugs to provide antibiotic drips. A traditional paramedic uses assessment skills to determine which protocol to use to get a patient through the next 30 minutes, a community paramedic uses advanced assessment skills to have a conversation with a primary care provider about how a patient's care plan might be adjusted to work better for the next 30 days.

Skill	Traditional Paramedic	Community Paramedic
Giving shots	Administer drugs like Valium	Administer immunizations
Infusion therapy/ mixing and administering drugs	Mix and administer drugs like Dopamine	Provide antibiotic drips
Assessment skills	Determine which protocol to use to get a patient through the next 30 minutes	Have a conversation with a primary care provider about how a patient's care plan might be adjusted to work better for the next 30 days

The third version of a college curriculum for community paramedicine is about to be released by the North Central EMS Institute in St. Cloud, Minnesota. About 80 colleges in eight countries have version 2 and will receive version 3 upon release. Last year, the Minnesota Legislature passed a law which established the country's first regulation of this new profession. This year, they added the services to payment under Medicaid.

Three different models of community paramedicine are described in literature. The substitution model, used in the UK, Australia, and Canada, involves using community paramedics to do functions that used to be performed by other health care providers that no longer exist in a community. In Australia and Canada, community paramedics operate emergency rooms where there are no physicians or mid-level providers.

Primary health care is the second model. There are programs in the U.S. organized to attack issues such as hospital readmission, including the RARE Campaign being co-led by Stratis Health. An economist's evaluation of a Colorado program has identified that every community paramedic deployed to address hospital readmission and reduce nursing home admission can produce downstream health care cost savings of $1.7 million annually.

The third model is community coordination. This model is being used in San Francisco to get the homeless population into the right service the first time, and in Fort Worth to decrease the 9-1-1 calls by "system abusers." The ambulance service in Fort Worth has reduced emergency department hours by 14,000 per year by taking just 21 abusers to health care providers other than the emergency room.

Community paramedicine has been successful where it has addressed local health care service gaps. It has been unsuccessful where it has tried to compete with existing resources. The single best key to success is by adding value, not by duplication.

Community paramedics may be coming to a community near you. Embrace the collaboration models. Help them be part of the solution to our nation's health care cost battle and enhance patient care along the way.

Every community paramedic deployed to address hospital readmission and reduce nursing home admission can produce downstream health care cost savings of $1.7 million annually.

Gary Wingrove, is a member of the Stratis Health Board of Directors. He represents Gold Cross/Mayo Clinic Transport out of Rochester, Minnesota. He is president of the national Center for Leadership, Innovation and Research in EMS, and he cofounded the first international EMS anonymous patient safety reporting system.

Report Summarizes Medicare Data for Minnesota

The Stratis Health *Profile of Medicare in Minnesota* gathers in one place information and resources about the Medicare program in the state. It provides a picture of who is receiving medical services through Medicare, what the 65 and older population in Minnesota looks like, health status and quality of care information, and information on the major types of Medicare health care providers in Minnesota.

This report on Minnesota's Medicare services, beneficiaries, and providers is a high-level overview for health care provider organizations, health care professionals, Medicare consumers, advocates, researchers, and others interested in Medicare in Minnesota.

Information for the report comes from a variety of sources, starting with Medicare enrollment and claims data available to Stratis Health through our work as the Medicare Quality Improvement Organization (QIO) serving Minnesota.

Excerpts from the report include:

- Medicare enrollment in Minnesota parallels overall enrollment in the U.S., at 15 percent of the population, or a total of 789,263 Medicare beneficiaries in Minnesota.
- In Minnesota, 44.4 percent of Medicare beneficiaries are enrolled in Medicare Advantage programs, substantially higher than the national average of 25.6 percent. Minnesota's high level of Medicare managed care has a number of implications for the state.
- While 30 percent of the state's total population lives in rural Minnesota, 41 percent of Medicare beneficiaries age 65 and older live in rural areas.

As Minnesota's Medicare QIO, Stratis Health has access to Medicare enrollment and claims data for fee-for-service Medicare beneficiaries in Minnesota, as well as statewide rates and information available through the Centers for Medicare & Medicaid Services (CMS).

www.stratishealth.org/documents/MedicareProfile

Looking at the numbers: Race and Age of Minnesota Medicare Beneficiaries

The majority of Medicare beneficiaries in Minnesota are White (94.3 percent). Although the number of beneficiaries representing racial and ethnic minorities in Minnesota is small, it is increasing. Younger Medicare beneficiaries are more likely to be non-White than older beneficiaries, with 39.7 percent of non-White beneficiaries under age 65. Approximately 13.0 percent of White Medicare beneficiaries are younger than age 65. These statistics indicate the Medicare population in Minnesota will continue to become more diverse in the future.

From the *Profile of Medicare in Minnesota,* Stratis Health, April 2012. www.stratishealth.org/documents/MedicareProfile

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.

Race and Age of Minnesota Medicare Beneficiaries

	<18	18-64	65-74	75-84	85+	Total	Percent Total	State Population Percent
White	11	96,612	335,510	210,116	102,037	744,286 (94.3%)	94.3%	83.1%
Black	*	9,592	5,637	2,565	764	18,558 (2.4%)	2.4%	5.2%
Asian	*	2,048	3,711	1,981	825	8,565 (1.1%)	(1.1%)	4.0%
Other	*	2,015	4,014	1,310	252	7,591 (1.0%)	(1.0%)	2.4%
Native American	*	2,314	2,172	973	225	5,684 (0.7%)	(0.7%)	1.1%
Hispanic	*	962	797	406	126	2,291 (0.7%)	(0.7%)	4.7%
Unknown	19	626	1,157	193	287	2,282 (0.7%)	(0.7%)	
Total	30	114,169	352,998	217,544	104,516	789,263		
Percent total	0.004%	14.5%	44.7%	27.6%	13.2%	--		

Sources: Medicare Enrollment Database (2010), state population data 2010 Census, http://quickfacts.census.gov/qfd/states/27000.html

*Too small to report

Medication Therapy Management

The pharmacist's growing role in quality care

Patients often manage a fluctuating rainbow of medications to control their complex health conditions. For chronic diseases, medications are often the first line of treatment. This is true for 88 percent of chronic diseases managed at Park Nicollet. Because medications play such a strong role in patient care, six out of seven of its scorecard measures address effective medication use.

Efforts are increasing nationally to provide medication therapy management (MTM) in caring for high-risk, high-cost, complex patients. MTM services can range from:

- Review of all of a patient's prescriptions, over-the-counter medications, and herbal supplements
- In-depth medication education for patients
- Collaboration between the patient, physician, and other health care providers, including a pharmacist, to develop and achieve optimal goals for medications

Progress in adopting methods of medication management has increased dramatically in the last two years, and we stand poised for rapid adoption, according to Todd Sorensen, University of Minnesota College of Pharmacy.

Evolution of MTM

MTM is most developed in integrated health systems, with Fairview Health Services, HealthPartners, and Kaiser Permanente among the leaders. Within their closed systems, integrated health plans could see they were not getting good value out of medication use, and patients were not achieving desired outcomes.

A 10 year retrospective study at Fairview shows that 85 percent of patients had at least one drug therapy problem and 29 percent of patients had five or more drug therapy problems, such as a dosage too low. Their return on investment for MTM was $1.29 per $1 in MTM costs.[1]

Broad financial support for MTM services began when it was included as a benefit for Medicare Part D and Minnesota Medicaid in 2006. Health systems continue to expand their offerings.

"We've seen success internally with medication therapy management for our fully insured members," said Dan Rehrauer, HealthPartners. When a fully insured, high risk, MTM eligible group was compared to a self-insured control group without an MTM benefit, they had a lower total cost of care. Most of that cost reduction was due to lower hospitalization and emergency room visits in the fully insured group.

> "I can simplify things for the patient so their adherence will be better and their outcomes improve."

This success has led HealthPartners to expand its coverage for MTM. In one employer pilot related to diabetes care, patients participating in MTM showed great improvement in diabetes outcomes that has been maintained over four years when compared to those choosing not participate. The employer has seen accelerated savings. In the first year of the program, it spent more than $2 for every $1 saved. By the fourth year, $8.8 was saved for every dollar spent.

National priorities

The U.S. Department of Health and Human Services is further promoting medication management and the integration of evidence-based clinical pharmacy services into patient care through:

- Patient Safety and Clinical Pharmacy Services Collaborative (PSPC)
- Medicare QIO program
- Medicare Star Rating measures for health plans

The PSPC, led by the Health Resources and Services Administration, is providing resources and coordination to support the integration of evidence-based clinical pharmacy services into patient care.

Through the 185 teams now in the collaborative, pharmacists, physicians, nurses and health care administrators all come together to achieve MTM.

The most important aspect is leadership and vision at the executive level and in the pharmacy area, according to Sorensen, who is faculty for PSPC. The teams experiencing the best progress are those collecting and reporting data.

As Minnesota's Medicare QIO, Stratis Health is helping Park Nicollet with data collection and reporting to support its involvement in PSPC. It also is advancing MTM to improve drug safety, reduce adverse drug events, and prevent avoidable hospital readmissions. Medication management is one of the five key areas for reducing avoidable hospital readmissions in the RARE Campaign.

The Centers for Medicare & Medicaid Services is planning to include MTM as a Star Rating measure for health plans for 2014. It will measure completion rate for comprehensive medication reviews.

Pharmacist as part of the care team

Health care is realizing that a team-based approach can be effective in caring for patients with complex needs.

Patients in Park Nicollet's Accountable Care Organization (ACO) may have three to four members on their care team. "We all have various strengths which we

Jennifer Morgan, PharmD, medication management specialist, Suellen Hansen, RN, care coordinator, and Tim Rajtora, MD, clinical practice director, are part of Park Nicollet's staff working on medication therapy management.

bring together on behalf of the patient," said Molly J. Ekstrand, pharmacist in medication management at Park Nicollet. For patients in the ACO, clinicians and team members have a care conference to look at the patient panels and discuss what the patients need.

Pharmacists may engage a patient in a conversation about medications. "I can suggest dose adjustments to reduce side effects or improve clinical outcomes. Maybe I can't eliminate the number of medications they take on a daily basis. But maybe I can simplify things for the patient so their adherence will be better and their outcomes improve," shared Ekstrand.

Park Nicollet has three sites using medication management through its ACO Health Care Home model and is expanding to eight in July. "As more patients become aware of medication management, they want the service," said Ekstrand. After seeing a patient last fall for an MTM consult, she received a call from him asking her to see his mother also.

"When interprofessional teams come together they realize that medication management is specialized," said Sorensen. Pharmacists are becoming an increasingly important member of a patient's care team.

For years, pharmacists have been stepping forward to offer their medication knowledge and expertise to improve patient care. Sorensen said, "We're beginning to see a shift with pharmacists being invited into the improvement work." Pharmacists have become more involved in patient care, electronic health record system development, and building systems of medication use.

To support MTM, pharmacists also are taking on limited prescribing roles, driven by protocols through collaborative practice agreements with physicians. For conditions such as diabetes, pharmacists might initiate insulin or adjust oral hypoglycemics based on A1C levels. This role also can help with the shortage of primary care physicians.

What lies ahead

Because medication therapy management is a breakthrough innovation, system supports lag behind.

The fee-for-service (FFS) model makes it difficult to justify a pharmacist's salary for MTM. The Accountable Care Act is supporting a shift. With less focus on specific physician work, health systems are incented by the shared savings approach to bring MTM in-house.

HealthPartners has expanded its coverage of MTM to all of its product lines. HealthPartners will pay for the process of the MTM visit—paying for the pharmacist's time and expertise—whether changes are made to drug therapy or not. This change places the health plan among the leaders in supporting this service.

"MTM is still very much in its infancy," said Rehrauer. By offering MTM across its member population, HealthPartners hopes to spur growth of the provider network which will in turn improve access to the service.

To date, there's been less success in the community pharmacies because it's harder to track impact, according to Sorensen. When talking with pharmacists outside a health system, Ekstrand suggests they try to engage the clinic leadership about the role of medication management in the clinic's initiatives. Are there any pay for performance goals? Are you affiliated with a hospital working on care transitions and medication management, like in the RARE Campaign? If you can decrease readmissions by five percent a year, you will pay for a pharmacist's salary, she said.

"We cannot be measured on the number of procedures and how often we see a patient. We need to start looking at quality and outcomes," commented Ekstrand.

Health care is working with varying definitions of MTM and needs a consistent practice model. While the pharmacy profession shifted to a PharmD degree in 1990, many of today's pharmacists still have limited experience in clinical care.

Minnesota Medicaid laid the groundwork for the state when it decided to pay for advanced MTM. Rehrauer contends Minnesota is lucky to have a lot of people who want to provide comprehensive medication therapy management. "Once you get outside the state, it's tough to find."

1. Medication Therapy Management: 10 Years of Experience in a Large Health Care System, Journal of Managed Care Pharmacy, April 2010.

RARE Reducing Avoidable Readmissions Effectively

Improving Care Transitions - 1,915 readmissions avoided

Hospitals participating in the RARE (Reducing Avoidable Readmissions Effectively) Campaign are making progress toward preventing 4,000 avoidable readmissions by Dec. 31, 2012, based on the Potentially Preventable Readmissions (PPR) data for the last two quarters of 2011 from the Minnesota Hospital Association (MHA). Results show a reduction of 1,915 readmissions—representing patients sleeping 7,660 more nights in their own beds.* To date, 80 Minnesota hospitals accounting for more than 80 percent of the state's readmissions are participating in the campaign.

Themes from hospital organizational assessments

Rolling up the organizational assessments completed by participating hospitals, RARE identified their main gaps as: discharge planning, assessment and measurement, patient education, staff education, IT/electronic health records (EHR), and collaboration and best practice sharing across care settings and disciplines.

In addition to the Operating Partners providing support for these issues through collaboratives and technical assistance, Stratis Health is facilitating discussions with the Minnesota EPIC Users Group about key improvements for how this EHR platform—one that dominates in Minnesota's large hospital market—can better support successful care transitions. The group gave top priority to enabling the EHR to provide patient-friendly discharge documentation about medications and medication-use to the patient and caregiver at time of discharge.

Beyond the hospital walls

At the RARE Action Day in April, Dr. Stephen Jencks, national consultant in health care safety and quality, said hospitals cannot prevent most readmissions on their own. He posed the need to shift measurement from a series of episodes of care at the hospital level to monitoring a patient's overall health from the perspective of the entire health care community, much the way health plans look at their member populations.

Jencks and other presenters shared the perspective that if we want to improve care transitions, providers need to get feedback from the next source of care and from the patient. Communication needs to be both upstream and downstream. "We tend to focus on how the quarterback throws the ball and keep forgetting about the receiver," said Jencks.

The RARE Campaign is working to change that by focusing across the continuum of care. Sixty-nine Community Partners are participating in the campaign, including primary and specialty care providers, nursing homes, home health agencies, health plans, and state health agencies.

* Average length of a hospital stay is 4 days.
The RARE Campaign is lead by three Operating Partners: Stratis Health, MHA, and the Institute for Clinical Systems Improvement.
www.rarereadmissions.org

Building Healthier Communities Awards

Stratis Health provided grant support for four projects through its Building Healthier Communities award, announced in March in conjunction with National Patient Safety Week.

Leech Lake Band of Ojibwe will use its award for a multi-media education campaign and to provide cultural competence training for 50 health care providers who serve Native American consumers.

University of Minnesota School of Nursing will co-create new pre-licensure nursing curriculum focusing on older adults that emphasizes person-centered care, quality, and safety.

Multilingual Health Resources Exchange will use its award toward creating three public service video vignettes about the use of interpreters in the Somali and Latino communities. These videos also will be accessible by smartphones via QR codes.

Minnesota Network of Hospice and Palliative Care will develop an end-of-life curriculum and reference guide for community health and allied health care workers serving the Somali, Latino, and Hmong communities in Minnesota.

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.

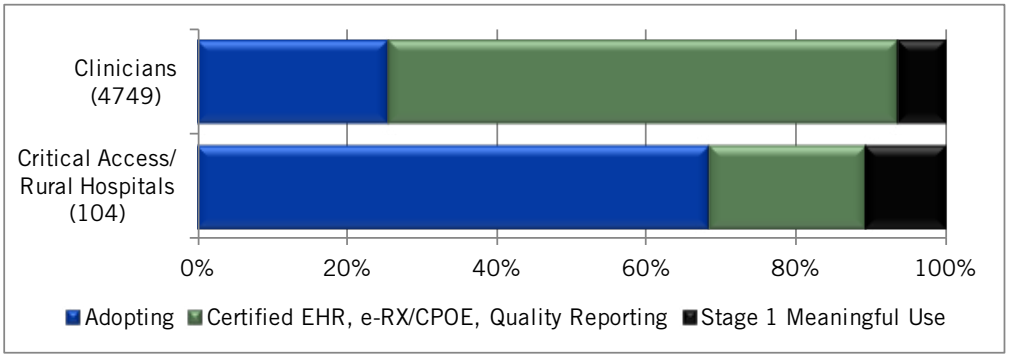
Progress Toward EHR Meaningful Use

Nearly 4,750 clinicians served

Two years into the four year program, the Regional Extension Assistance Center for HIT (REACH) has turned its full attention to working with Minnesota and North Dakota providers to achieve meaningful use of their electronic health record (EHR) systems.

Minnesota and North Dakota providers are directly benefitting from REACH services, including 4,749 clinicians and 104 critical access and rural hospitals. Nationally, more than 130,000 providers are working with regional extension centers.

REACH Client Progress Toward Meaningful Use



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

Current challenges for hospitals and providers

Hospitals and providers face numerous EHR challenges that REACH is striving to help them address. REACH has been working with other regional extension centers to create efficient workflows for providers to assemble the information needed to produce a clinical summary. This information will help clients redesign their workflows.

The greatest challenge for collecting hospital quality measures is that the data collection points are missing from the provider's workflow. REACH is helping hospitals evaluate their workflow and clarifying the measure requirements.

Dr. Paul Kleeberg, REACH clinical director, has been visiting critical access hospitals (CAHs), clinics, and large integrated delivery systems throughout Minnesota and North Dakota to work with their physicians to understand the value in meaningful use and its contribution to improved quality and safety of patient care.

The delay in launching the Medicaid incentive program in Minnesota is impacting very small clinics that purchased EHR technology based on expectations that the Medicaid program would be running in 2011. Without the incentive payments, clinics are unable to pay their EHR vendors. As of January, providers in 43 other states are able to register for Medicaid EHR incentives. REACH is coordinating with the Minnesota Medicaid staff and preparing clinicians to attest to meaningful use as soon as a system is in place.

Looking ahead to Stage 2

The federal government released two health information technology (HIT) proposed rules in February 2012.

The Centers for Medicare & Medicaid Services (CMS) proposed rule for Stage 2 meaningful use outlines the next stage for the EHR Incentive Programs. This rule proposes options for the Stage 1 criteria which will make it simpler for professionals and hospitals to document meaningful use and proposes new criteria for Stage 2 starting in 2014, which will assure greater patient involvement in their care and more robust health information exchange.

The Office of the National Coordinator (ONC) proposed rule defines the standards that all certified HIT must meet starting in 2014. The new certification criteria provides greater flexibility.

In its connector role between providers and the federal government, REACH staff solicited feedback from clients and synthesized it into a formal comment submission for the proposed rules. REACH emphasized how the proposed regulations and changes will affect providers and patients who tend to fall outside of the mainstream health delivery system in Minnesota and North Dakota, in settings such as CAHs, rural health centers, Federally Qualified Health Centers, and community clinics that focus on underserved populations.

Among REACH's submitted concerns, the proposed ONC rule 13 to 18-month timeline will force many vendors to hastily develop software, which may meet certification script requirements without delivering corresponding patient safety or clinical efficiency.

"I was impressed by how much CMS and ONC had listened to the feedback they'd received about Stage 1 and how they used that to craft improvements for Stage 1 and the new criteria for Stage 2 which will advance the interoperability of EHRs and allow for true two-way exchange of patient information across different EHR platforms," noted Kleeberg.

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

STRATIS HEALTH NEWS

Stratis Health named one of the 100 best companies to work for in Minnesota. Minnesota Business Magazine recognized the 100 best companies to work for in Minnesota. The awards recognize small, mid-sized, large, and nonprofit businesses that continue to make an impact and set the standard of excellence for others to follow. The competition salutes Minnesota organizations that are setting the standard for leadership, benefits, best work environment, innovative training programs, and employee happiness.

MHA-Stratis Health Regional Meetings. In conjunction with the Minnesota Hospital Association (MHA), Stratis Health held six regional meetings this spring. These annual meetings focused on the programs and projects that are made available to the hospitals including MHA's Hospital Engagement Network and patient safety roadmaps, Stratis Health's QIO program (quality reporting, infections, adverse drug events, readmissions) and palliative care, and joint programs to include adverse health events, RARE Campaign, and Minnesota Alliance for Patient Safety culture work.

Stratis Health welcomes new staff member. Joining our quality improvement staff, **Kim McCoy, MPH, program manager,** uses her background in collaborative facilitation and public health planning to support quality improvement in areas such as reducing adverse drug events and improving care transitions.

Greg Linden, BSEE, Stratis Health chief information officer, was named chair of the National Rural Broadband for Healthcare Committee.

Michelle Hopkins, MS, Stratis Health research analyst, presented the paper "Deep Dive into the PIM and DDI Data" at the national SAS Global Forum in April.

Karla Weng, MPH, Stratis Health program manager, presented on Stratis Health's Rural Palliative Care at the National Rural Health Association Annual Meeting in April.

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.

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