



# QUALITY UPDATE

Health care quality issues for Minnesota's health care leaders

Spring 2013

## Innovating the Future of Health Care

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

Innovation is a word we are hearing a lot in health care today. What do we really mean by it and what are we seeing in Minnesota?

According to Webster's, innovation is "the introduction of something new; or a new idea, method, or device."

We are in the midst of a big national push for innovation in health care, led by the CMS Innovation Center, which was established by the Affordable Care Act in 2010. Congress created the Innovation Center for the purpose of testing innovative payment and service delivery models to reduce program expenditures while preserving or enhancing the quality of care for individuals who receive Medicare, Medicaid, or Children's Health Insurance Program (CHIP) benefits.

Minnesota has been successful in garnering federal funding flowing out of the CMS Innovation Center. Minnesota has two of the 100 Innovation Advisors across the country, three of the 32 Pioneer ACOs, and a community care transitions program; and is one of eight states leading Multi-Payer Advanced Primary Care Demonstration projects. Eight different Innovation Challenge Grants are led by or being implemented in Minnesota. And most recently, Minnesota was selected as one of six states for the ambitious large-scale model testing awards of the new State Innovation Model from CMS. There are more, too many to enumerate here.



In addition, when the stimulus package passed in 2009, which included the HITECH Act, Minnesota was successful in receiving a Beacon project—one of only 15 across the country—along with an HIT Regional Extension Center, which Stratis Health is co-leading, along with funding for workforce training and health information exchange. These resources and programs are helping to keep Minnesota on the cutting edge of using technology to drive innovation in health care and improve quality and safety. A groundbreaking example is the Southeast Minnesota Beacon Project's efforts to enable health information exchange between primary care clinics and school nurses for kids with asthma.

Few other states have achieved this level and combination of funding for innovation. Clearly, Minnesota has good reason to claim status as a leader in health care innovation. We should be proud that so

## THIS ISSUE

**Biomedical and Health Informatics Needed to Support the Triple Aim 2**

**Reducing Readmissions for Minnesota - exceeding goal 3**

**Minnesota's Innovation Model 4**

**Hospital Value-based Purchasing 7**

many of our health care delivery provider organizations and systems, our state agencies, our health plans, and many community stakeholders are leading the way. We are moving fast to introduce new ideas, and it is an exciting time of experimentation and change. The rapid pace of innovation and change is reflected in our language—phrases such as "accountable care organizations", "bending the cost curve", and the "Triple Aim" are routinely part of health care conversations today. Not so long ago, they were not part of our vernacular.

However, the true tests will be over time, as we see what impacts these innovations will have and whether they can be sustained. Our ability—in care delivery, as payers, and as policymakers—to discern the changes that can have positive and lasting impact on the health of the population, the experience of care, and costs will be the measure on which future generations will look back and judge this era of experimentation and innovation. I am hopeful, but at the same time, recognize the hard work and new thinking that this necessitates...we're up for the challenge! ○

## Biomedical and Health Informatics Needed to Support the Triple Aim



Perspective from  
**Connie Delaney**  
Stratis Health Board member

### The Triple Aim

- ♦ Improve patient experience of care, including quality and satisfaction
- ♦ Improve the health of populations
- ♦ Reduce per capita cost of health care

**Connie Delaney, PhD, RN, FAAN, FACMI**, is a member of the Stratis Health Board of Directors. Dr. Delaney is dean of the School of Nursing at the University of Minnesota, where she also is director of Biomedical Health Informatics. She is a nationally recognized Health Information Technology (HIT) policy expert.

**OUR COMMUNITIES ARE BIRTHING STRATEGIES** to achieve the Triple Aim, which require health care leaders to foster learning health systems and extensively use biomedical and health informatics (BMHI).

Learning health care systems are intentionally re-designed to generate and apply the best evidence/knowledge for the collaborative health care choices of each patient and provider. They drive discovery as a natural outgrowth of patient care and ensure innovation, quality, safety, and value in health care.

BMHI fosters capturing clinical information for the electronic health record (EHR); using data to measure and improve quality, safety, and costs ensuring real-time access to knowledge, and engaging and empowering patients and families/other caregivers as vital members of the continuously learning care team. It applies principles of computer and information science to advance life sciences research, health professions education, public health, and patient care.

The health sector is engaged in wide-scale implementation of interoperable health and communications technology and information systems to support clinical care and health information exchange (HIE). The Office of the National Coordinator for Health Information Technology (ONC), part of the U.S. Department of Health and Human Services, is at the forefront of the administration's health IT efforts and is a resource to the entire health system to support the adoption of HIT and the promotion of nationwide HIE to improve health care. ONC's current goals are: 1) patient-focused health care, and 2) population health, with additional attention addressing privacy and security, the interoperability and adoption of systems, and establishing collaborative governance structures.

Minnesota has benefitted from some of the \$788 million dollars used to support ONC Regional Extension Centers that serve local communities to provide on-

the-ground assistance to small practices, medical practices lacking resources to implement and maintain EHRs, and who serve mostly those who lack adequate coverage or medical care. Stratis Health and its partners were instrumental in driving these supports for Minnesota.

ONC advocates for the individual patient voice through the Consumer e-Health Program. This program focuses on empowerment of individuals to improve their health and health care through health IT. The State HIE Cooperative Agreement Program funds states' efforts to rapidly build capacity for exchanging health information across the health care system both within and across states. This program advances regional and state-level health information exchange while moving toward nationwide interoperability. In January 2011, an additional \$16 million was made available to states through ONC's HIE Challenge Grant Program. State grantees are to create and implement up-to-date privacy and security requirements for HIE; coordinate with Medicaid and state public health programs to establish an integrated approach; monitor and track meaningful use HIE capabilities in their state; set strategy to meet gaps in HIE capabilities; and ensure consistency with national standards. These few examples describe some of the resources and knowledge available to us. Minnesota has successfully competed for over \$9 million from this program.

Minnesota continues to be a national leader in helping us to prepare and create a learning health care system, as does Stratis Health. The state shares a commitment to fostering society's healthy adoption of and alliance with communications and information technologies and informatics to foster health. We have invited a conversation, creative practice, and contribution to the evolution of our health care system and accomplishing the Triple Aim. ○

Further reading from IOM: *Digital Infrastructure for the Learning Health System* (2011) and *Best Care at Lower Cost: The Path to Continuously Learning Health Care in America* (2012) at [www.iom.edu/Reports.aspx](http://www.iom.edu/Reports.aspx).



## Reducing Readmissions for Minnesota - campaign participants exceeding goal of 4,000 readmissions

Congratulations to the 83 hospitals participating in the RARE Campaign (Reducing Avoidable Readmissions Effectively) for exceeding the goal of reducing 4,000 avoidable hospital readmissions. The 2012 data shows that participants have collectively prevented 4,570 readmissions between January 1, 2011, and December 31, 2012. In the last quarter of 2012, readmissions were reduced by 17 percent.

Hospitals and their community partners have successfully helped patients in Minnesota spend 18,280 nights of sleep in their own beds and saved an estimated \$45 million in inpatient health care expenditures.\* This success reflects their commitment to better care for patients, innovative improvement, and hard work.

“As Minnesota hospitals and community partners collaborate together in new ways, or for the first time, they are discovering solutions to mend our fragmented care delivery system and, most importantly, they are providing better care,” said Jennifer Lundblad, president and CEO of Stratis Health.

The campaign continues through 2013 with the following goals:

- ✦ By the end of 2013, prevent an additional 2,000 avoidable readmissions for a total of 6,000
- ✦ Continue to reduce the percentage of readmissions to reach and sustain a 20 percent reduction
- ✦ Help Minnesota residents sleep in their own beds 8,000 more nights for a total of 24,000 nights
- ✦ Save an additional estimated \$20 million in health care expenditures for a total of \$60,000

The RARE Campaign, which began in July 2011 and involves 83 hospitals and 93 community partners across Minnesota, is one of the largest coordinated improvement initiatives undertaken by the Minnesota health care community. It is being led by three operating partners: the Institute for Clinical Systems Improvement, the Minnesota Hospital Association, and Stratis Health. Supporting partners include the Minnesota Medical Association, MN Community Measurement and VHA Upper Midwest. The campaign was initiated to address the fact that in Minnesota, nearly one in five Medicare patients is readmitted within 30 days. ○

\* Average length of a hospital stay is 4 days. Estimated \$10,000 inpatient costs per avoided readmission

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

### RARE Campaign: 4,570 Readmissions Prevented to Date



Stratis Health's RARE Campaign team used their pillows to display the campaign's progress of achieving a 17% reduction in avoidable readmissions. While we're resting better at night knowing Minnesotans are receiving better care, by day we continue to support hospitals, community partners, and communities to reduce readmissions.



# Minnesota's State Innovation Model

## Transforming the health care system through experimentation

Minnesota is one of six states selected by the Centers for Medicare & Medicaid Services (CMS) Innovation Center to receive funding to act a laboratory of innovation to support comprehensive approaches to transform the state's health system through new payment and service delivery models.

The Innovation Center is fostering the testing of new payment and service delivery models that have the potential to lower costs for Medicare, Medicaid, and the Children's Health Insurance Program (CHIP), while maintaining or improving quality of care for program beneficiaries. The goal is to create multi-payer models with a broad mission to raise community health status and reduce long term health risks for beneficiaries of these programs.

The Minnesota Department of Human Services (DHS) and Department of Health (MDH) are jointly

Diane Rydrych, director of the Division of Health Policy, Minnesota Department of Health, and one of the leads for Minnesota's innovation model. The state innovation model will allow Minnesota to take the next steps in testing and spread.

Each participating state developed a State Health Care Innovation Plan with a strategy to use all of the levers available to transform its health care delivery system through multi-payer payment reform and other state-led initiatives.

The work aims to close gaps in the areas of health information technology, secure exchange of health information, quality improvement infrastructure, and workforce capacity for team-based coordinated care.

Minnesota was well positioned to receive the testing award because of all the innovative work being led by the state. The Minnesota Accountable Health Model builds on state reforms already underway, including:

- **Medicaid ACO demonstration (Health Care Delivery System):** DHS has non-fee-for-service payment arrangements with provider groups caring for non-dually eligible populations.
- **Multipayer health care home initiative:** in addition to the regular fee-for-service reimbursement for traditional covered services, Medicare, Medicaid, and some commercial payers are paying participating primary care practices a monthly per-beneficiary fee to cover the cost of providing improved care coordination, enhanced access, patient education, community based support, and other services. The state now has 244 certified health care home clinics.
- **Community care teams:** multidisciplinary teams that partner with primary care offices (certified health care homes), the hospital, and existing health and social service organizations to provide individuals with support for well-coordinated preventive health services and coordinated links to social and economic support services.
- **Statewide Health Improvement Program (SHIP):** a community grant program to create good health for parents, kids, and the whole community by making environmental changes that support decreasing obesity and reducing the number of people who use tobacco or who are exposed to tobacco smoke.

### Closing the gaps in:

- Health information technology
- Secure exchange of health information
- Quality improvement infrastructure
- Workforce capacity for team-based coordinated care

leading Minnesota's \$45.2 million project—called the Minnesota Accountable Health Model—over the next three years. This is the largest award for any of the six testing states,

which also include Arkansas, Maine, Massachusetts, Oregon, and Vermont. A total of over \$250 million was awarded.

CMS is awarding an additional \$50 million to 19 other states to start or support further development and planning of state-based models for multi-payer payment and health care delivery system transformation with the aim of improving health system performance for residents of the participating states.

### Expanding Experimentation

The Innovation Center created the State Innovation Models initiative for states that are prepared for or committed to planning, designing, testing, and supporting new payment and service delivery models in the context of larger health system transformation.

"Minnesota is seen as innovative. We've done an extensive amount of work in electronic health records, quality reporting, quality management, and improvement. And, we also have progressive reform legislation," said

- **E-health initiative:** a public-private collaborative working to accelerate the adoption and use of health information technology.
- **Statewide Quality Reporting and Measurement System (SQRMS):** a standardized set of quality measures for health care providers across the state, with a uniform approach to quality measurement in Minnesota to enhance market transparency and improve health care quality.

Approximately 150 representatives from across the continuum of care, including mental health and long term support and services, attended three stakeholder meetings to contribute ideas to develop the state's plan.

A six-month planning period started in April 2013, with implementation and testing to run October 2013 and through September 2016.

### Core Work

Key components of the three year implementation phase of the project include secure exchange of health information and data analytics including building data warehouse capability for data from DHS, managed care organizations, and Medicaid ACO participating providers. The work will strengthen quality and performance measurement by expanding the current measurement infrastructure to support shared savings models. Workforce development will include integrating new professions into care delivery, such as community health workers, community, paramedics, and doulas. The model will support development of 15 Accountable Communities for Health that build on the Community Care Teams to better integrate health care with behavioral health, long term care supports and services, and social services.

### Risks and Challenges

This experimentation is not without risks. We're already seeing more consolidation within the large integrated systems. Smaller providers are folding into these systems or are being controlled within them.

As ACOs are being embedded in hospitals and health systems, many are building their own social services supports instead of linking with social services agencies and programs already working in the community.

The state is examining payor coordination to see if health plans and the state can continue moving toward

## Minnesota's Innovation Aims

1. Every patient should receive coordinated, patient-centered primary care. Services are integrated for the whole person, with particular attention to individuals with complex health issues and who need multiple types of care.
2. For Medicare, Medicaid, and other populations, providers participate in accountable care and payment models. Payment is based on quality, patient experience, and cost performance measures.
3. Providers are rewarded for keeping patients healthy and improving quality of care. Financial incentives will be aligned. The state will move away from the current payment system which is riddled with perverse incentives where we reward the volume of treatment rather than best care and healthy outcomes.
4. Population health becomes a focus with providers partnering with community organizations and engaging consumers to integrate medical care, mental/chemical health, community health, public health, social services, schools, and long term supports and services.

aligned payment approaches and data sharing methodologies. "We need to use various policy levers and incentives to move toward broader data sharing and greater accountability for a community-wide perspective on care coordination and health," said Rydrych.

Patients often lack a real voice in their care. They frequently are missing from the conversation on how to reform care systems, and the state is looking for opportunities to bring forward patients' ideas.

Providers are wary about expanded health care home accountability, such as for behavioral health. The accountability is talked about in general terms and planning is underway to determine what this really means.

Lastly, the state has three years to complete this transformational work. That's a short time for the difficult, groundbreaking work planned.

### Rewards

Savings from the model are projected at \$111.1 million over three years, with \$90.3 million in Medicaid savings, \$13.3 million in savings to private payers, and \$7.5 million in Medicare savings. ○

## Building Healthier Communities Awards

Stratis Health provided grant support for two new projects through its Building Healthier Communities award, announced in March. This Stratis Health award supports projects and programs that promote a culture of health care quality and patient safety in Minnesota.

The 2013 award recipients:

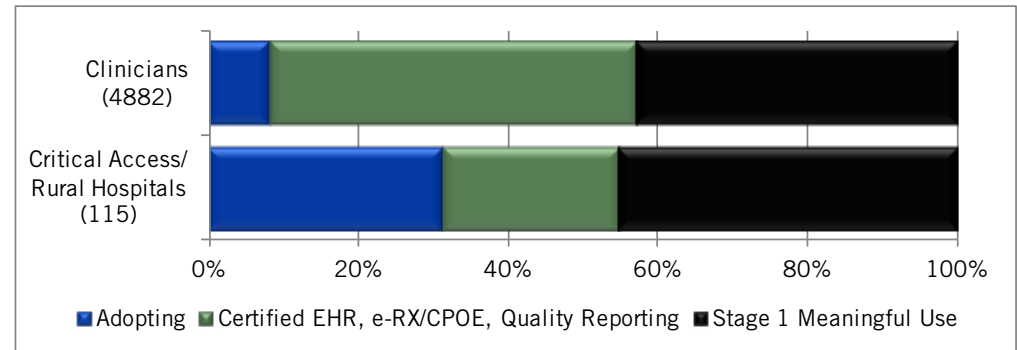
- The Center for Population Health is resurrecting itself as a collaboration of local public health agencies, hospitals, and health systems. It receives \$10,000 of in-kind support for Stratis Health to lead a strategic planning process to define its new work scope. The center aims to improve health in the Twin Cities metropolitan area by identifying unmet community needs, creating opportunities for collaboration, and facilitating alignment with state and federal priorities. By making the best use of time and resources, duplication of efforts will be minimized for improvement planning, community health needs assessment, and data and information sharing.
- The University of Minnesota Center for Spirituality and Healing will use its \$15,000 award to implement integrative therapies and cancer recovery projects to support patients recovering from cancer—a growing and historically underserved population. The projects will assist providers in creating supportive communities that help patients take charge of their post cancer health by integrating therapies and practices to sustain a longer, healthy life.

As a nonprofit organization, Stratis Health is committed to being a responsible and engaged community member. 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 4,900 clinicians served

### REACH Client Progress Toward Meaningful Use



Data through April 2013, e-RX: electronic prescribing, CPOE: computerized physician order entry

Hospitals and clinics in Minnesota and North Dakota being served by the Regional Extension Assistance Center for Health Information Technology (REACH) are making great strides in implementing and achieving meaningful use of their electronic health record systems. REACH is led by Key Health Alliance, a partnership of Stratis Health, the National Rural Health Resource Center, and The College of St. Scholastica.

As of April 30, of the 4,882 priority primary care providers, at approximately 630 clinics:

- 4,477 have implemented electronic health records and are using them for e-prescribing and quality reporting
- 2,094 have achieved meaningful use (43%)

Of the 115 critical access/rural hospitals that REACH is serving:

- 79 have implemented electronic health records and are using them for computerized physician order entry and quality reporting
- 52 have achieved meaningful use (45%)

Meaningful use attainment for Minnesota and North Dakota REACH clients is 14 percent higher than for regional extension center participants nationally. REACH ranks fourth in the nation among extension centers for the number of clients achieving meaningful use—with 100 percent of them reporting being satisfied to highly satisfied with REACH services.

As planned, federal funding for the 62 regional extension centers across the county through the Office of the National Coordinator is ending February 7, 2014.

REACH will continue to provide HIT consulting and education services until the end of the grant, working to move providers and hospitals forward in their HIT use and attainment of meaningful use. Hospitals and clinics are encouraged to take advantage of these free services.

REACH is developing an affordable membership program to continue offering support to clients to ensure Meaningful Use Stage 2 is achieved even after current federal funding has ended. ○

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

## Looking at the numbers: Medicare Hospital Value-Based Purchasing in Minnesota

Hospitals are feeling the first financial impacts of the new Centers for Medicare & Medicaid Services Hospital Value-Based Purchasing (VBP) Program. Collectively, Minnesota hospitals lost \$1,394,175 (-0.01%) when diagnosis-related group (DRG) payment adjustments began with October 1, 2012, discharges.

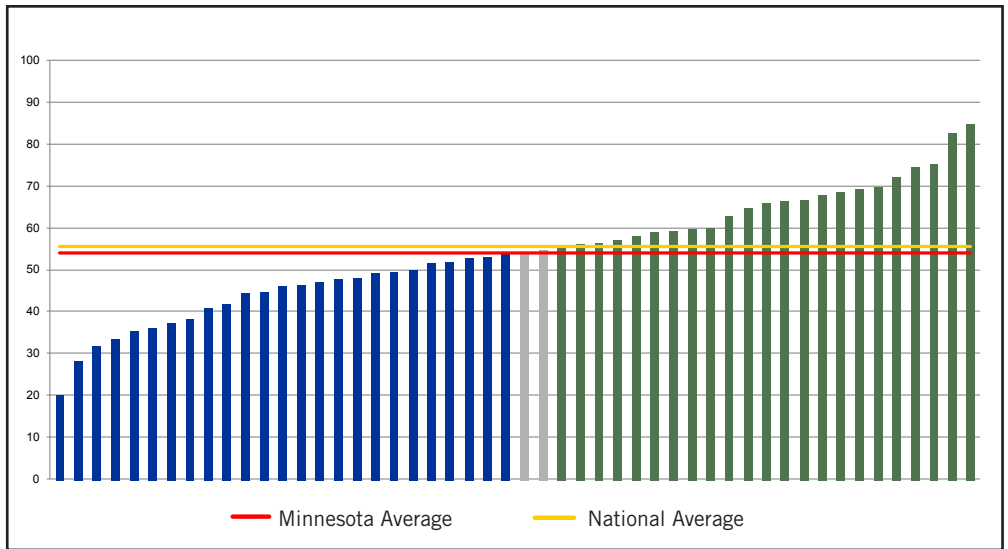
For the first time, approximately 3,500 prospective payment system (PPS) hospitals across the country received incentive payments for inpatient acute care services based on their performance. The VBP program marks an important milestone in CMS’s path toward payment for value of care delivered rather than volume of services provided.

The Patient Protection and Affordable Care Act requires budget neutrality in the VBP program—total incentive payments available to hospitals equal the total base operating DRG payment reduction. The amount to be withheld and redistributed is planned to increase 0.25 percent annually until it reaches 2.0 percent in 2017.

In fiscal year 2013, approximately 1.0 percent of DRG payments to eligible hospitals were withheld to provide the estimated \$800 million that was allocated to hospitals based on their overall performance. In this first year of the program, the performance score was based on clinical processes of care measures and patient experience of care measures. New measurement components will be added to the performance score each year (table below).

|                                  | Fiscal Year / Score Weighting |      |      |
|----------------------------------|-------------------------------|------|------|
| Total performance score measures | 2013                          | 2014 | 2015 |
| Clinical processes of care       | 70%                           | 45%  | 20%  |
| Patient experience of care       | 30%                           | 30%  | 30%  |
| Outcome                          | —                             | 25%  | 30%  |
| Efficiency                       | —                             | —    | 20%  |

FY 2013 Value-Based Purchasing Total Performance Scores Minnesota Hospitals



Source: Medicare FY 2013 Inpatient Hospital Value-Based Purchasing (VBP) Data

Across the nation, state average VBP changes to Medicare payments ranged from 0.23 percent for Maine to -0.33 percent for District of Columbia. Minnesota ranked 30th for its total performance score among the 50 eligible states for 2013 VBP.<sup>1</sup>

Compared to the nation, collectively Minnesota hospitals are performing slightly lower than average for their total performance scores. Of the 50 Minnesota hospitals eligible for 2013 VBP, 52 percent (26 hospitals) lost money, compared to the national average of 48 percent.

Minnesota is used to being recognized as a leader in health care. This data, with the state’s middle-of-the-pack standing, indicates the rest of the country has been improving hospital quality at a faster rate than Minnesota hospitals. Minnesota hospitals can’t afford to become complacent in their quality improvement efforts.

“I anticipate Minnesota will perform better compared to the rest of the nation once efficiency is included as part of the total performance score, starting in fiscal year 2015,” said Vicki Olson, Stratis Health program manager. “To receive incentive payments, hospital leaders need to be

### In Minnesota:

- Hospitals lost nearly \$1.4M
- 52% of hospitals lost money compared to national average of 48%
- Ranked 30<sup>th</sup> out of 50 states for VBP performance in 2013
- Rural PPS hospitals had slightly better average total performance score than urban hospitals

working to improve their clinical process, patient experience, and mortality measures—with the ultimate aim of improving care.”

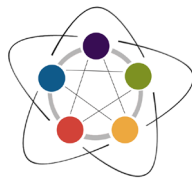
As the Medicare QIO in Minnesota, Stratis Health helps hospitals interpret the VBP scoring system; provides data, analysis and interpretation; and offers actionable assistance and resources so Minnesota hospitals can prioritize and advance their quality improvement efforts. Our nationally acclaimed [fact sheet on hospital VBP](#) is available on the Stratis Health website.

Source:

1. Kaiser Health News, By State: Hospital Quality Bonuses and Penalties Print, December 2012.



# STRATIS HEALTH NEWS



**Dementia Capable Communities Toolkit.** A [new community toolkit](#) is available from ACT on Alzheimer's to help prepare Minnesota for the personal, social, and budgetary impacts of Alzheimer's disease and related dementias. Working in conjunction with the Community Leadership Group of ACT on Alzheimer's, Stratis Health lead development of the toolkit which gives communities a process for coming together and planning how to become dementia capable.

ACT on Alzheimer's is seeking additional communities interested in developing action teams. Contact [info@ACTonALZ.org](mailto:info@ACTonALZ.org).

**Nursing Home Quality Assurance Performance Improvement (QAPI).** In partnership CMS, the University of Minnesota and Stratis Health have developed [QAPI at a Glance: A Step by Step Guide to Implementing Quality Assurance and Performance Improvement \(QAPI\) in Your Nursing Home](#). This resource for nursing homes nationwide provides a comprehensive, structured program to assess the quality of care provided to nursing home residents and to improve the care provided.

**Rural Health Systems Analysis and Technical Assistance (RHSATA) project.** Stratis Health is working in conjunction with the Rural Policy Research Institute (RUPRI) Center for Rural

Health Policy Analysis at the University of Iowa to develop technical assistance tools and resources for rural health care providers and communities across the country that can help improve care coordination, enhance patient outcomes, and lower health care costs.

**Michelle Hopkins, MS, and Deepika Sharma, MHI, Stratis Health research analysts,** received the Quality Leadership Award in January from the national Patient Safety and Clinical Pharmacy Services Collaborative for removing barriers for an organization to expand the delivery of integrated medication management services and/or the refinement of their care delivery system to improve patient safety and medication management. Park Nicollet nominated them for the award.

**Journal of Palliative Medicine,** published "Minnesota Rural Palliative Care Initiative: Building Palliative Care Capacity in Rural Minnesota", an article focusing on Stratis Health's rural palliative care work.

**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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