

QUALITY UPDATE

Health care quality
issues for Minnesota's
health care leaders
May 2022



The "Next Normal:" Emerging Issues and Mega Lessons from the Pandemic

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



A crisis is a terrible thing to waste. I've been repeating this mantra over the past two years, as our worlds and work have been upended in so many ways. If we don't learn from what we have experienced and emerge smarter and better, then shame on us for having missed an opportunity. We at Stratis Health are continuing to ask ourselves, in what ways can we be smarter and better to create our "next normal"?

Thus, the theme for this issue of *Quality Update* is the Next Normal: Emerging Issues and Mega Lessons from the Pandemic. I am highlighting a few ways we are learning and

shaping the next normal and encourage you to read the issue in its entirety. It is rich with ideas to courageously plan for what is next.

Become resilient in our organizational practices and cultures.

Organizational resilience is the capacity to recover quickly from difficulties with as little disruption as possible. The factors needed to create resilience in an organization are individuals, teams, leadership, and resources. For Stratis Health, we are smarter and better by adopting new methods in support of these factors and an expanded approach to organizational change

THIS ISSUE

Lessons from the Pandemic: What we've Learned, What's Changed, and What Still Needs to Change 3

Dr. David Satin shares his thoughts on how the convergence of the pandemic and the murder of George Floyd exposed health disparities, creating a remarkable teachable moment.

Solving Health Care and Health Equity Challenges Together Across the Full Continuum of Care 5

We challenged Stratis Health colleagues from across the health care continuum to share responses to pressing questions about pandemic lessons learned and hopes for the future.

Exploring the Relationship Between Staff Capacity and Quality in Rural Health Care 7

Meeting evolving patient care needs amid rapidly growing staff shortages while remaining committed to quality measurement, reporting, and improvement requires innovation and resilience.

Stratis Health News 9

New Board and staff members,
Building Healthier Communities

and improvement; namely, the adoption of implementation science. We have added this to our work, expertise, and skill set, recognizing that quality improvement science

(The "Next Normal:"... continued on page 2)

The “Next Normal:” Emerging Issues and Mega Lessons from the Pandemic

(Continued)



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

and methods are valuable for certain issues and problems, but do not help with bringing to scale proven and promising practices. The past two years have demonstrated how necessary rapid innovation and adoption are — there is urgency in the next normal. Using implementation science is already helping us accelerate the adoption and spread of proven and promising practices, such as Pathways HUBs community care coordination models and solutions for sharing social needs referrals between health care and community.

Put equity and health equity at the center of what we do and how we do it.

Author Roxanne Gay published a column in the *New York Times* in May 2020, early in the pandemic and just after George Floyd’s murder. Her words are profound and are still with me:

“Eventually, doctors will find a coronavirus vaccine, but Black people will continue to wait, despite the futility of hope, for a cure for racism. We will live with the knowledge that a hashtag is not a vaccine for white supremacy. We live with the knowledge that, still, no one is coming to save us. The rest of the world yearns to get back to normal. For Black people, normal is the very thing from which we yearn to be free.”

What a powerful statement about the fallacy of wishing for things to return to normal. Instead, the next normal must include a sharply focused health equity lens. As a white woman, working with health equity involves deep self-reflection and learning, feeling vulnerable, understanding how my patterns and processes have been complicit, and practicing new modes of shared accountability and decision-making that lift those who have been marginalized due to race, culture, gender identity, disability, age, and more. As we create the next normal in Stratis Health’s work, we are recognizing caregiving is a social determinant of health, we are mitigating against the risk of the digital divide becoming the next equity divide, we know that harm reduction is essential, and we are building bridges between health care and community. I draw your attention to the five [Building Healthier Communities](#) grant awards Stratis Health made in April to Minnesota organizations and projects working at the local level to empower LGBTQ+ youth, to improve chronic disease care for urban American Indians, to use douglas to address Black maternal mortality and morbidity, and more.

Lead with kindness and compassion.

People are hurting, health care workers are stressed and leaving the field in unprecedented numbers,

mental and behavioral health issues abound, and politics and the media are divisive. The recent lawsuit brought against a nurse at Vanderbilt University Medical Center for a medication error is reverberating throughout health care organizations, running counter to the efforts over decades to support [Just Culture](#), a foundation for balanced accountability and patient safety, as well as gains made in transparency and candor with patients and families.

What can leaders do amidst all of this? As workforces and workplaces evolve, as hybrid and remote work become part of the next normal, we are learning and adjusting to new modes and forms of connection. Those who will succeed are those who lead with kindness, compassion, and awareness that none of us knows what someone else is living or experiencing. Creating safe, harmonious, efficient, and effective work environments is an essential safety net in these turbulent times. I participated in an intense leadership program over the course of 2018-2019 and have found myself reflecting on one of my most powerful take-aways from that experience — extending oneself in an openhearted way for the sake of another is core to any relationship. Working with others stretches us to understand, respect, support, and have compassion for one another. I hope kindness and compassion are the new currency of leadership in our next normal.

You’ll read more in this issue about the “next normal” — from Stratis Health Board member Dr. David Satin, from some of our key leadership partners in Minnesota as they share their lessons learned with an eye to the future, and from our Stratis Health staff who are exploring the relationship between staff capacity and quality in rural health care. ○

Lessons from the Pandemic: What we've Learned, What's Changed, and What Still Needs to Change



David Satin, M.D.
 University of Minnesota
 Assistant Professor, Department
 of Family Medicine and
 Community Health and
 Stratis Health Board Member

The convergence of the pandemic and the murder of George Floyd exposed health disparities, creating a remarkable teachable moment. If, in the best of times, we were unable to get our act together, surely, we shouldn't have been surprised when disparities were exacerbated in the worst of times. With inequities on display, now is the time to build structures that are more equitable to sustain our people, our communities, and our society — in good and bad times. I've been asked to share my perspective as a physician on what we've learned, what's changed, and what needs to change.

What we've learned

- The unprecedented scientific collaboration in vaccine development and deployment can inform needed revolutions in many areas of health care. While we can't speed up the laws of nature (i.e., what's happening in a petri dish), we can make vast improvements in care quality and efficiency by implementing flexible, lean solutions that solve for human-made limitations such as unnecessary time-intensive administrative steps.
- People are non-fungible. Hospital staff cannot meet the same patient needs as family and friends. When patients couldn't have visitors in the hospital, it was often disastrous for them, their loved ones, and health care teams. Working as a doctor in the hospital during a pandemic without the support of patient families heightened my appreciation of the irreplaceable role they play in caring for their loved ones. Social and emotional support isn't just the "fluffy stuff." I saw firsthand how patients who were isolated from their loved ones did not recover as fully or as quickly as I expected.

The [Minnesota Alliance for Patient Safety \(MAPS\)](#), a subsidiary of Stratis Health, promotes meaningful patient and family engagement and collaboration across all care settings

"People of color are at higher risk for COVID-19 infection, hospitalization, and death compared to their white counterparts. In fact, American Indian and Alaska Native, Hispanic, and Black people were roughly twice as likely as white people to die from COVID-19, [according to the CDC.](#)"

- Minnesota became the epicenter of the largest worldwide protest in history. We were already living in a powder keg, ignited by a state of pandemic lockdown and enormous disparities in wealth, education, and health running along racial lines. Community members may not know all the statistics, but the explosion of pent-up emotion is evidence that they feel deeply today's injustices and inequality. There are large numbers of people from all walks of life who want to make things better and lessen disparities, but we don't share a common language or a plan about how to do that.
- Having earned an "A" for vaccine discovery, we are barely passing the test of social cohesion. The trifecta of miscommunication, misunderstanding, and mistrust meant we couldn't cooperate to adhere to the simple precautions of masking, social distancing, and getting vaccinated. This was an expression of society calling for payment of a longstanding and growing debt of trust in our institutions. We spent decades making the incremental and costly mistakes of government scandals, lack of investment in education, and unchecked health and wealth disparities. We must improve on how we communicate and improve equity opportunities as a health care industry and as public health organizations.
- Because older Americans generally are not integrated into our youth-worshipping society, we learned how vulnerable, with respect to COVID-19, they can be. The United Nations notes that "solidarity among generations is fundamental to an intergenerational society that values and demonstrates reciprocity between generations." We learned, far too late, what infrastructure and social commitment are needed to protect our elders.

(Lessons from the Pandemic... continued on page 4)

(Lessons from the Pandemic... continued from page 3)

What has changed

- The pandemic was (and is) terrible, but it accelerated innovation that is bridging the technical and financial “digital divide.” Payment and regulatory policy changes quickly normalized video and phone visits. Yet, this also called attention to internet deserts in ways that may continue to shape and improve how health care is delivered in a post-pandemic world.
- In response to the numerous protestors injured and treated during the George Floyd protests, an interdisciplinary U of MN team began developing a shared common language of “less-lethal” vs. “non-lethal” weapons. Inaccurate language has the power to perpetuate injustice and conceal violence. Fact-based conversations about weaponry heighten awareness and change responses: Rubber bullets are not made of soft rubber, “beanbag” rounds fired as projectiles packed with metal pellets are not akin to backyard cornhole games, and tear gas discounts the severity of symptoms caused by its chemical agents. These munitions can and have caused severe and permanent injury. Similarly, “social determinants of health” can be more accurately described as “socio-political determinants of health” as they did not evolve without specific policies passed by specific legislatures.

What needs to change

- Among the most important lessons learned about how we can accelerate progress toward achieving health equity is how urgently we need “good faith cultural brokers.” We desperately need people and organizations who can coax us out of our political, racial, ethnic, and cultural silos to de-politicize the topic of health care quality and safety. The goal is to have change-focused dialog using a shared common language about what we’re aiming for and how we can work together to get there. The ability to disagree with someone’s view without hating them is a skill we can all cultivate. On a societal scale, trusted community-industry partnerships can be a key to advancing community health — among other social goods.
- One of the things I teach medical students is that health equity work doesn’t always sound like health equity work. It requires technical and adaptive change that might never mention “race,” “equity,” or “justice.” For example, technical (and traditional) performance-based measurement programs do not account for socio-political determinants of health. Current risk adjustment methodologies do not sufficiently account for clinically and socially complex patients. As performance outcomes in the lowest-income neighborhoods do not measure up to those in wealthy neighborhoods, P4P (pay for performance)

“For me, the pandemic has **three Rs**. We need a **renaissance** in our public health programs. We need a **robust** primary health care system that’s at the center of our health care system. And we need **resilient** populations more able to withstand health shocks and health threats.”

Tom Frieden, M.D., AMA Chief Experience Officer, from “[Lessons from the Pandemic](#)”

rewards go to clinics and health systems serving the affluent. We’re living in a “reverse Robin Hood” system with elements of structural inequality baked in, worsening disparities. It’s time to more accurately capture and reward neighborhood clinic contributions for clinical patient outcomes. By adjusting P4P for patients, individual, and neighborhood socio-political determinants of health, we can ultimately decrease health disparities. “Risk-adjustment within performance-based incentive programs” sounds far from the work of health equity, but that’s exactly what it can be. The events of the past two years have revealed many technical projects that can, and ought to, improve health equity.

- We need better public health infrastructure. The U.S. has almost the inverse investment of every other developed nation; we invest heavily in disease care and minimally in public health. One of the keys is education across the board. If we, as a community, don’t see the value in public health and do not have trust in public institutions, we won’t fund it. We must overtly demonstrate and promote the value of public health.

Stratis Health’s work in consulting and implementation science contributes to driving positive change in public health. There has never been a more important time to be agile and flexible in responding to what is before us. The pandemic offered a master class in designing systems to deal with new problems that kept coming faster and faster. Teams that survived, and even thrived, during the pandemic were the ones that were flexible and resilient. Every week we had new information about COVID-19 — and sometimes it was the opposite of what we knew the previous week. Adaptability and the ability to rapidly implement new systems will continue to be critical and may become the standard of how we work in the future. ○

Solving health care and health equity challenges together as we work across the full continuum of care and community services



“During this pandemic, the most vulnerable have been the hardest hit ... We must increase our resilience. We must...take an integrated approach to health, hunger, climate, and equity crises — no one is safe from COVID-19 until everyone is safe.”

*Volkan Bozkır,
President of the United Nations General Assembly*

As Stratis Health contemplated this issue of *Quality Update* focused on the “next normal,” it was a timely opportunity to reach out to the leaders of our professional and trade associations, state agencies, and quality partners in Minnesota. While Stratis Health works to improve health and health care nationally, Minnesota is our home state and is often a leader in quality, innovation, and collaboration. We challenged our colleagues to share responses to two questions in 75 words or less. They rose beautifully to the challenge with thoughtful reflection and strategic insight.

1. *What are the most important lessons learned for your organization in the past two years when it comes to improving health for patients/ residents/ clients your members serve?*

2. *What is your one hope as we look to the future for your peers or members regarding their ability to collaborate and innovate to improve health?*

Our responders represent health care organizations across the continuum of care, from clinicians to leaders of community-based organizations. While the pandemic was devastating, leaders universally recognized that the crisis sparked innovation and opportunity, new forms of connectedness and collaboration, and drove home the point that relationships matter. A common theme is that, by learning over the past two years to rally as a cross-sector statewide approach focused on providing high-quality, compassionate care and supporting services, we began breaking down operational silos. The interdependence of public and private systems and organizations was undeniable.

When one link in the chain is weak or broken, the impact is significant. Long-term care facilities not being able to accept hospital discharges due to staffing shortages is a stark case in point. Another example is the too-high cost of “lean” and “efficient” health care that led to great risk for health care workers when there was no PPE inventory.

Public health and the needs of our culturally, racially, and ethnically diverse citizens, once largely invisible, are now top of mind. The idea that we must focus deliberately on health equity is clear. Transparent communication with those that health care organizations, community-based organizations, and clinicians and care teams serve — counties, tribes, health plans, providers, community members, and organizations — is essential in delivering responsive care.

“When a trusted CHC doctor tells a patient, ‘I care deeply about you and your health and I want you to take this safe and effective vaccine so you don’t die from this very-real disease,’ it can shut down fear and uncertainty.”

Minnesota Public Health Leader

(Solving health care... continued on page 6)

(Lessons from the Pandemic... continued from page 5)

“Being lonely, like other forms of stress, increases the risk of emotional disorders like depression, anxiety, and substance use disorder. Less obviously, it also puts people at risk of physical ailments...like heart disease, cancer, stroke, hypertension, dementia, and premature death.”

*“How Loneliness is Damaging our Health”
The New York Times, April 20, 2022*

The pandemic affirmed that patient trust is at the core of the Community Health Center (CHC) model. Low-income and BIPOC (Black, Indigenous, and People of Color) communities turned to their CHC for life-saving primary care and COVID-19 services. Organizations became even more nimble, engaging with patients to redesign operations and health interventions that more effectively meet their needs. CHCs and others providing direct patient care have a deep obligation to influence basic, essential care such as COVID-19 immunizations when public disinformation runs deep.

In addition to health disparities coming to the fore, so, too, did the “loneliness epidemic.” The pandemic presented opportunities to discover alternative ways to provide services to older adults and caregivers. Things like virtual medical appointments, curbside meal pick-up and delivery, and providing classes and other social interaction opportunities online, need to continue past the pandemic.

Finally, the pandemic drove home the fact that having consistent, manageable systems to track performance is more important than ever to understand and recover from disruption. Worsening health care staffing shortages mean we need comprehensive — but simplified — electronic health records and other tools that do not take precious time away from patient care.

As leaders look to the future, there is hope that we don't lose the sense of urgency prompted by the pandemic. We often default to thinking that change takes a long time, but the pandemic reminds us that large-scale change can happen quickly.

The pandemic response required and generated incredible innovation and collaboration, which was sometimes uncomfortable and difficult. Building upon that and moving forward will help us withstand the exodus of exhausted and demoralized doctors, nurses, and others providing direct and indirect patient care. Rapid advancements in telehealth and accompanying legislation will be a key factor in managing workforce shortages, which will require significant training and education for health care professionals and consumers. The pandemic also illuminated the need to re-examine and update policy and regulatory requirements through a person-centered health equity lens.

Elevating the importance of primary care is key to building back better. This requires aggressive payment reform, changes to education financing, and restrictions on lobbying by those who do not have patient health and well-being at the top of the priority list. We need to create new primary care models centered on social drivers of health and community input to improve health and be more tightly linked to public health.

At Stratis Health, we are grateful for our broad and deep network. We should all be proud of Minnesota's history of health care quality, innovation, and collaboration. As the landscape evolves, the hope is that our spirit of collaboration and inclusion will grow even stronger. Prioritizing patient safety and quality improvement work when staff levels are strained will require highly creative solutions, identifying non-traditional partners, and bringing forward lessons learned to shape the next normal.

With gratitude to our contributors:
Patti Cullen, President & CEO, Care Providers of Minnesota; Jessica Hausauer, Executive Director, MN Network of Hospital & Palliative Care; Cynthia McDonald, Assistant Commissioner and Minnesota Medicaid Director, Minnesota Department of Human Services; Kathy Messerli, Executive Director, Minnesota Home Care Association; Rahul Koranne, President & CEO, MN Hospital Association; Kate Murray, Program Manager, Long COVID and Post-COVID Conditions, Minnesota Department of Health; Lucas Nesse, President & CEO, MN Council of Health Plans; Jane Pederson, Chief Quality Medical Officer, Stratis Health; Julie Sonier, President & CEO, MN Community Measurement; Jason Swenson, President, Minnesota Association of Area Agencies on Aging; Jonathan Watson, Chief Executive Officer, MN Association of Community Health Centers ○

“Since the start of the pandemic some 60% to 75% of clinicians report symptoms of exhaustion, depression, sleep disorders and PTSD... About 20% of health care workers have quit during this period, and 4 out of 5 of those who remain say staff shortages have affected their ability to work safely and to satisfy patient needs.”

*Victor Dzau, M.D.
President, U.S. National Academy of Medicine*

Exploring the Relationship Between Staff Capacity and Quality in Rural Health Care



Sarah Brinkman, Program Manager, Stratis Health; and a Member of the National Rural Health Association

Rural health care organizations are not new to dealing with staff shortages. Attracting and retaining workforce in rural areas has been a longstanding and continuing challenge. For many rural health care organizations, that challenge has been heightened due to a confluence of issues, including the impact of COVID-19, the great retirement, and stiff competition in the traveling nurse sector. Meeting evolving patient care needs amid growing staff shortages while remaining committed to quality measurement, reporting, and improvement is a significant lift.

Yet, we know that despite the often deficit-focused view used to describe rural health, rural communities have a wealth of assets and have proven time and time again to be innovative and resilient. And so during the April 2022 [Rural Quality Advisory Council](#) (RQAC) meeting, which Stratis Health convenes and facilitates on behalf of the Federal Office of Rural Health Policy, we asked Council

“Love for my community drives me. These are my family, and my friends, and my neighbors. I want to make sure they get the best care possible.”

Ben Power, Barrett Hospital & HealthCare, Dillon, MT

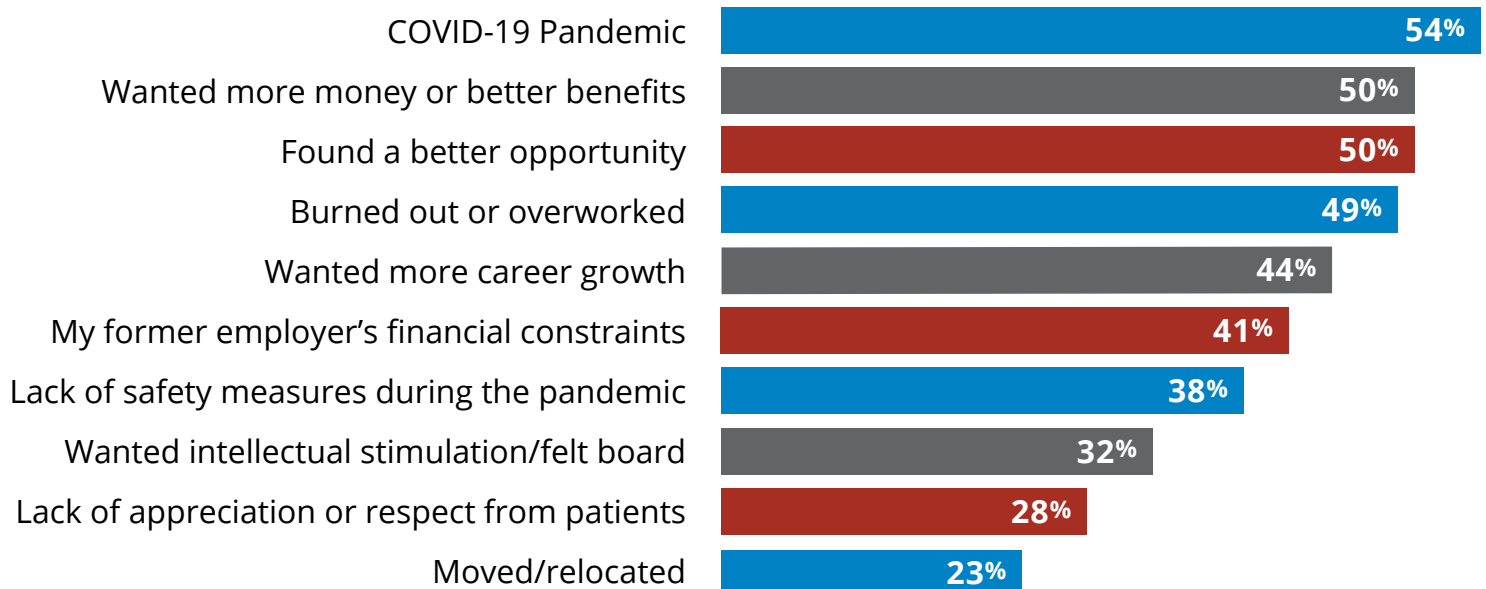
members, who are rural health leaders from across the country, to share their insights from the field on this very topic – exploring the relationship between staff capacity and quality in rural health care organizations.

Rural Quality Advisory Council (RQAC)

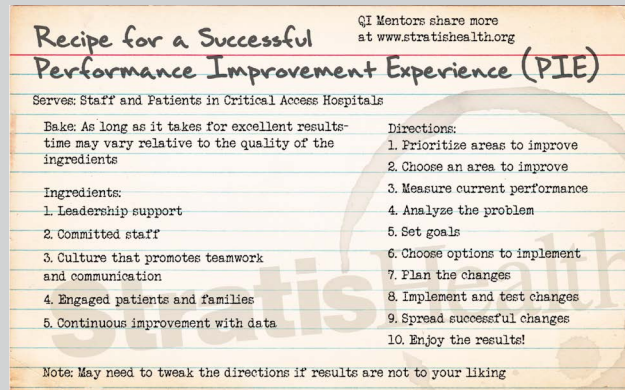
The RQAC is convened by Stratis Health and comprised of diverse rural health quality leaders from across the country. Their work informs the work of Rural Quality Improvement Technical Assistance (RQITA), a program of the Federal Office of Rural Health Policy (FORHP). Through RQITA, Stratis Health provides technical assistance related to quality reporting and improvement to beneficiaries of FORHP quality initiatives across the country such as Medicare Rural Hospital Flexibility (Flex) Programs, critical access hospitals, and other rural providers and grantees.

Pandemic is a Top Reason Medical Workers Were Laid Off or Quit Since Early 2020

Health care workers said the following reasons above are why they quite or were laid off since mid-February 2020



(Exploring the Relationship... continued from page 7)



Hear from Ben Power and Mariah Hesse in the Summer 2020 episode of Quality Time Sharing PIE
[Quality Time: Sharing PIE — The Impact of COVID-19 on Quality Improvement - Stratis Health](#)

Many small rural hospitals were financially unstable and operating with significant staff shortages even before the pandemic. These hospitals have no chance of matching the salaries, signing bonuses, and benefits offered by travel nurse/physician agencies and large health systems. The departure of rural health care professionals and the influx of short-term traveling teams who are not oriented local quality measures and improvement efforts threatens the ability to provide quality care in rural communities.

Find and Focus on the Positives

Council members didn't shy away from sharing the challenges they are facing, including unprecedented rates of staff burnout, increased reliance on agency staffing (which in many cases directly correlates with a decrease in buy-in and understanding of quality measurement improvement), and shuttering of service lines that have declined in volume. And yet, they also shared many heartening examples of how rural health care organizations and their staff are pulling together during this time to optimize their work and attract new staff, including:

- Using interprofessional teams to provide coordinated and efficient care for patients and to extend the reach of each provider.
- Ensuring that all professionals are practicing to the full extent of their training and allowed scope of practice and license.
- Providing in-house mentoring programs which build understanding and commitment to quality, for example, between RNs and LPNs, and between regular staff and agency staff.
- Adding programs to offer mental health and burnout support services and support paid time off.

- Taking advantage of the “next normal” by reengineering clinical workforce and staffing patterns. Examples include helping people from immigrant populations train for careers in health care and promoting remote work in health care and promoting remote work environments for spouses/partners of healthcare workers who re-locate to rural communities and for health care workers not providing physical patient care (e.g., mental health counselors, administrators, supervisors).

In addition to the organizational and community efforts described above, advocating for effective policies to help address rural health workforce and access issues are key, including:

- Removing state and federal barriers to professional practice, where appropriate.
- Changing policy to allow expansions to existing scopes of practice if evidence shows that the health care workers can provide comparable or better care.
- Removing barriers to the use of telehealth to provide access to remote health care providers and patients.
- Utilizing [3RNET, a comprehensive recruitment and retention network focused on rural and underserved communities in all 50 states](#).
- Optimizing technology to help reduce isolation and provide support to the rural health workforce to make working in a rural or remote setting more attractive.
- Working with communities and school systems and using mentoring systems to promote rural health care opportunities to youth.
- Thinking creatively about offering things like low-interest home loans, assistance with student loans, relocation support, practice start-up costs, and daycare assistance to supplement traditional benefits. ○

Fast Facts About Today's Rural Health Workforce

- While only 14% of Americans (about 46 million) live in rural areas, rural communities represent nearly two-thirds of primary care health professional shortage areas (HPSAs) in the country.¹
- Nearly 20% of health care workers quit their job during the pandemic;² among health care workers who kept their jobs during the pandemic, 31% have considered leaving.³
- Each year through 2030, there will be nearly 195,000 vacancies for registered nurses in the U.S.,⁴ with a projected 1.1 million nurses needed to replace retiring nurses in 2022.⁵

STRATIS HEALTH NEWS

We are pleased to welcome incoming Board of Director members Heidi Holste, executive director of the [Minnesota Alliance for Patient Safety \(MAPS\)](#), and Patina Park, director of Tribal State Relations Systems Implementation for the State of Minnesota. We are looking forward to tapping into their wisdom and experience as we continue charting a post-pandemic path. Meet all our Board members at stratishealth.org/about-us/stratis-board-of-directors/.

Stratis Health announced the recipients of its 2022 Building Healthier Community Awards in April in conjunction with National Minority Health Month. Five grant awards totaling \$65,000 were made to Minnesota nonprofit organizations taking action to improve health equity. These awards support initiatives that promote a culture of health care quality, equity, and patient safety in the state. Visit [our website](#) to learn more about the innovative work of Annex Teen Clinic; Gray Matter (Doula Write Thing); Hue-Man Partnership; Native American Community Clinic; and Pillsbury United Communities.

We are growing!

A warm welcome to new staff members Erin Foss, RN, program manager; Senka Hadzic, MPH, program manager; Chastity Hoarde, business development director; and Alona Jarmin, RN, BSN, MSN, program manager.



Heidi Holste



Patina Park

Call for Seniors and Medicare Beneficiaries for Community Outreach Committee!

The COC is a longstanding group of consumer stakeholders Stratis Health convenes each quarter to discuss, learn, and share health care issues that are timely and relevant to seniors and Medicare beneficiaries. In addition to consumers, participants include representatives from organizations representing and supporting seniors. In our ongoing effort to add diversity of thought and lived experience to this group, we are seeking additional seniors and Medicare beneficiary members. Please send recommendations to info@stratishealth.org (Add Jenna Kornberg in the subject line).

References (page 8)

1. https://data.hrsa.gov/tools/shortage_area/hpsa-find
2. <https://www.health.state.mn.us/data/workforce/docs/2022workforcebrief.pdf>
3. <https://morningconsult.com/2021/10/04/health-care-workers-series-part-2-workforce/>
4. <https://www.bls.gov/ooh/healthcare/registered-nurses.htm>
5. <https://nursejournal.org/articles/post-pandemic-nursing-shortage/>

Stratis Health is an independent 501(c)3 nonprofit organization whose mission is to collaborate and innovate to improve health.

Stratis Health delivers data-driven insights, evidence-based interventions, and leading-edge improvement methodologies that inspire organizations and communities to achieve solutions to their most complex health improvement challenges. Visit stratishealth.org to learn more.

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.

Board of Directors

- Jamie Carsello
- Patti Cullen
- Kelly Fluharty
- Renee Frauendienst, chair
- Mark Holder
- Heidi Holste
- Ken Johnson
- Jan Malcolm
- Karen Monsen
- Reuben Moore
- Patina Park
- David Satin
- Ruby Schoen
- John Selstad
- Todd Stivland

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

Jennifer P. Lundblad, PhD, MBA
President and CEO
jlundblad@stratishealth.org

Jean Hanvik, Editor Manager
Communications and Outreach
jhanvik@stratishealth.org



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

952-854-3306 • 952-853-8503 (fax)
Email: info@stratishealth.org
www.stratishealth.org