

QUALITY UPDATE

Health care quality
issues for health
care leaders
Fall 2022



Optimizing Rural Health Assets in America

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



Improving rural health is a long-standing organizational priority for Stratis Health, and I am excited to focus this issue of *Quality Update* on rural health in conjunction with National Rural Health Day on November 17, 2022.

In recent years, Stratis Health has sharpened its focus on building bridges between health care and community. Nowhere is that able to be realized better than in rural America. While it is true that rural health care is hampered by challenges related to access and services that have been exacerbated more recently by workforce shortages, it is equally true that there are plentiful assets in rural communities that can be leveraged to improve health.

Rural health care and community organizations are often nimble in decision making and action, have a clearly defined service area and patient population, are known entities to each other with a base of working relationships, and are interested and willing to engage in proactive collaboration with rural peers. Rural health care and community organizations are resilient — they are accustomed to doing more with less and making it work.

We have been designing our rural health improvement efforts for decades to make the most of the assets in rural, viewing community as our unit of action. Our [rural community-based palliative care program](#) has been bringing rural

THIS ISSUE

Strengthening Inter-governmental Tribal-State Relationships Enables All To Thrive 3

Showcasing Rural Health Care Equity and Quality Assets 6

Reframing Rural Health: Community Vitality and Resilience 8

Stratis Health News 10



health care and other organizations together since 2008 in a community capacity building model which enables each unique rural community to design care for those with serious or advanced illness based on the assets available in that community. Since 2013, our RQITA (Rural Quality Improvement Technical Assistance) program has worked locally to improve care offered by the nation's 1,300+ rural critical access hospitals through supporting sustainable change, which includes community partners. Our PATH (Partnership to Advance Tribal Health) considers the 24 Indian Health Service hospital "communities" across the country as the reservations on which each of them is based, supporting their adoption of culture

(Optimizing Rural... continued on page 2)

Optimizing Rural Health Assets in America

(Continued)



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change and continuous improvement. All of these (and many more) help amplify the assets in rural to overcome the deficits.

I can't reflect on rural health without raising the policy and program perspective. We provide expert insight and resources to federal policymakers regarding rural health policy, through our Minnesota Congressional delegation and my service as a member of the [RUPRI](#) (Rural Policy Research Institute) Health Panel. We also respond to federal Notices of Proposed Rulemaking and Requests for Information, offering comments about how proposed regulations will positively or adversely affect rural health based on our in-the-field experiences. Yet, due to the complexities of policymaking and the multiple competing interests being balanced, rural often ends up at a disadvantage. For example, we are learning that participation in the long-awaited Centers for Medicare and Medicaid Innovation (CCMI)



[CHART](#) (Community Health Access and Rural Transformation) program is uncertain for some communities. This, after an investment in the application and community engagement process, and years of planning with supportive funding. It is complex for rural sites and leaders to move forward because the design of the program is not practical from multiple perspectives, despite being specifically developed for rural. This is a signal that we have much to do to bring the understanding and appreciation of what rural health care is to the fore of policy and program planning.

We remain optimistic because of the assets in rural, and I hope the content of this issue gives our readers a shared sense of optimism. Stratis Health Board member Patina Park reflects on how strengthening inter-governmental tribal-state relationships enables all to thrive. Our Stratis Health rural health team shares the efforts they are leading, working from the construct that you cannot have quality without equity. The model they share in this issue has proven to help rural health care organizations take action and showcase rural health care equity and quality assets through two case studies. The interview with

Brock Slabach and Peggy Wheeler illuminates community vitality and resilience.

Rural health and health care will carry on and continue to evolve, learning and applying lessons from the pandemic and public health emergency, and adapting to changing regulations and policies. Stratis Health sees and supports tremendous innovation and change in rural health. Telehealth requirements continue to change, and we have seen rural use of telehealth transition from primarily offering access to specialty care not available in rural into a preferred mode by some patients to see their local primary care or family practice clinician and care team. The new Rural Emergency Hospital status — the first new rural Medicare provider type since the late 1990s — will enable some critical access hospitals to discontinue their low volume inpatient care to focus on providing the rural emergency safety net for their community.

I'll leave you with the reminder that rural is not a smaller version of urban. It comes with a unique set of challenges and opportunities. Understanding and taking action with the rural context in mind can result in tremendous positive impacts. ○

Strengthening Inter-governmental Tribal-State Relationships Enables All To Thrive



Patina Park, JD
Executive Director,
Tribal State Relations Office
of Governor Tim Walz and
Lieutenant Governor
Peggy Flanagan and
Stratis Health Board Member

Minnesota is taking the steps to strengthen the tribal-state government-to-government relationship in ways that show great promise for improving the health and well-being of native people in Minnesota. Serving as a direct link between the state's tribal nations and communities has given me insight into the work still needed to actualize our goal of tribal-state relationships built on respect, understanding, and sovereignty.

Background: Improving communications and joint problem solving

Minnesota is home to 11 federally recognized tribal nations — four Dakota and seven Ojibwe. In 2019, within months of taking office, Governor Tim Walz signed an executive order, [“Affirming the Government to Government Relationship Between the State of Minnesota and Minnesota Tribal Nations: Providing for Consultation, Coordination, and Cooperation.”](#)

This executive order was subsequently codified and signed into law on July 1, 2021. Minnesota Statute 10.65 recognizes the government-to-government relationship with the 11 tribal nations, and obligates the State of Minnesota to consult with the tribes on issues that have a direct impact on them or native people.

Since taking office, the Governor and Lt. Governor have prioritized improving and building relationships with the tribal nations. Elevating tribal-state relations within the Governor's office matters because it makes the priority clear to the tribes and others. It also fosters meaningful relationships that facilitate better understanding between state and tribal governments, leading to informed decision making. Opening more opportunities for collaboration and partnership helps establish mutually respectful and beneficial relationships. These relationships not only better meet the needs of Minnesota's tribal nations, but tribal communities nationwide.

“I want Minnesota to be the national model of who's getting it right when it comes to working in partnership with tribes. We are taking steps toward actualizing our goal of tribal-state relationships built on respect, understanding, and honoring treaty rights and tribal sovereignty.”

*Minnesota Lieutenant Governor
Peggy Flanagan*

COVID-19 Emergency Response Plan

The COVID-19 pandemic and emergency response tested the foundation of tribal-state relations in ways no one could've imagined. The Governor's office began having daily solution-focused conversations with the tribal leaders right away to address challenges as they appeared during the state and tribal governments' response. This was an unprecedented event and was critically important to partner to protect the health of tribal communities in the face of COVID-19. Because health disparities within tribal communities increase the risk of serious illness, there was a keen sense of urgency about ensuring tribal communities were included in crisis response planning.

Replacing siloed discussions with integrated action plans, the Minnesota Department of Health (MDH) created specific reports for each of the tribal nations to highlight COVID-19 infection and inoculation rates within their community and the counties surrounding the tribes. These reports helped tribal nations make decisions on their individual responses to the COVID-19 crisis. American Indians and Alaska Natives were experiencing disproportionate rates of hospitalization and death due to COVID-19, so sharing accurate, timely information about COVID-19 is essential.

Ultimately, some of the highest immunization rates occurred where the tribes were located because through access to federal and state vaccines and testing resources, they provided testing and immunizations not just to their tribal members but extended to their

(Strengthening Inter-governmental... continued from page 3)



Billboard featuring Dr. Arne Vainio, an enrolled member of the Mille Lacs Band of Ojibwe and a family physician with Fond du Lac Human Services in Cloquet, MN. Dr. Vainio's quote emphasizes the importance of community in Indigenous culture.

employees and the broader non-tribal community businesses sooner than the state and I do not believe there were any COVID-19 "explosions" as a result. The tribes implemented stringent safety protocols that kept visitors and staff safe through a targeted and carefully executed joint response.

Responding to Health Care Realities of Native People

American Indian and Alaska Native people have long experienced [lower health status](#) when compared with other Americans. Lower life expectancy and the disproportionate disease burden often exist because of multigenerational trauma, inadequate education, disproportionate poverty, discrimination in the delivery of health services, lack of access to timely health care services, and overall systemic racism.

"Outdated Census definitions and poor data quality have led to a misunderstanding about the size and significance of the rural Native American population. In an era of data-driven decision-making and increased demands for efficiency and impact, small and rural native communities are often left behind."

From ["Twice Invisible: Understanding Rural Native America"](#)

Primary challenges across the U.S. health care system further reduce access to care for American Indian and Alaska Native people. For example, most rural communities face a worrisome and increasing shortage of medical personnel. This is even more severe in tribal communities, especially those in remote reservation locations. Not exactly rural – they're a nation unto themselves.

I was drawn to serving as a Stratis Health Board member for its longstanding commitment to improving care for American Indian and Alaska Native people. In its health improvement work, Stratis Health does not shy away from addressing health care inequities that are largely due to historical and ongoing structural and social determinants.

For example, the [Partnership to Advance Tribal Health](#) (PATH), funded by the Centers for Medicare & Medicaid Services (CMS), is a strategic partnership of organizations committed to improving health care for American Indians. Stratis Health, [Comagine Health](#), and [Mountain-Pacific Quality Health](#) collaboratively lead this work which is focused on supporting 24 Indian Health Services (IHS) hospitals across the country. The goal is to improve health care quality and address the unique health care issues of the populations IHS hospitals serve by implementing best practices and providing performance improvement training and coaching.

Looking to the Future

Social drivers, primary care, preventive care, care for chronic conditions, mental health services, and IHS hospital care, are indivisible. Serving the continuum of health care needs for native people in rural communities has the potential to transform the legacy of Native American disparities.

One of the biggest challenges in Indian country is that tribes are limited by bureaucracy preventing them from being fully sovereign. Fortunately, tribal-state relations continue to improve. To continue building those relationships and confronting disparities, we need to keep providing education and raising awareness of what will influence the health and well-being of tribal nations.

There is a need for:

- Enhancing data to distinguish American Indian and Alaska Native people on and off reservations to better target care needs and increase funding to close gaps.
- Building greater respect for and access to [traditional healers and healing practices](#).

(Strengthening Inter-governmental... continued on page 5)

(Strengthening Inter-governmental... continued from page 4)



- Developing a dependable funding structure to allow for traditional healers and ceremonies to be brought into health care.
- Providing separate health improvement strategies for urban native people (about 70% of AIAN people) and those living in rural reservation settings.
- Simplifying efforts required to apply for funding and deliver on reporting.
- Achieving increasing levels of [food sovereignty](#).
- Improving patient anonymity in tribal services health care delivery settings.
- Elevating visibility of the IHS mission to raise the physical, mental, social, and spiritual health of American Indians and Alaska natives.
- Expanding the depth and breadth of rural health assets in Minnesota and beyond.
- Accelerating the dismantling of the imperialism, colonialism, and capitalism that have informed our current health care system (e.g., we can instantly come up with billions for war, but don't prioritize health care, safe and suitable housing, nutrition, etc.).

Learn More:

- [PATH Resources](#)
- [Social and Economic Factors: American Indian Health Status in Minnesota](#) (a 30-year retrospective from MDH)
- [One Minnesota Council on Inclusion and Equity](#)
- [MN Indian Affairs Council Indigenous Native American Healing Traditions](#)

Accelerating COVID-19 Vaccine Administration in Tribal Communities

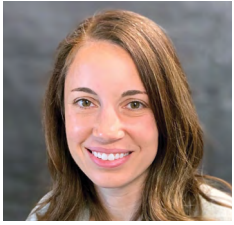
The Leech Lake Band of Ojibwe became among the first tribal nations in the country to receive the COVID-19 vaccine as initial doses were administered on December 14, 2020. From January through April, the Health agencies in the Leech Lake Nation collaborated to develop and implement a mass immunization model to increase access to COVID-19 vaccines for rural Minnesotans.

While both organizations traditionally provide care to eligible Native Americans, the collective team provided vaccinations to anyone who needed a dose. The team's plan to provide vaccinations to all regardless of demographics was approved by the Indian Health Service and tribal leadership.

Of the vaccines administered, 57% of those self-identified as non-Native American. Additionally, 70% of the community's elders were vaccinated before it was a national goal and 70% of Cass Lake Indian Health Service's user population was vaccinated before President Joe Biden's July 4 goal.

The Cass Lake IHS and Leech Lake Band of Ojibwe Health Division teams are considered one of the state's best and fastest vaccine administration teams. Their vaccination model is now considered a best practice and has garnered the attention of federal, state, and private sector partners nationwide. ○

Showcasing Rural Health Care Equity and Quality Assets



Sarah Brinkman,
Program Manager



Carrie Howard,
Program Manager



Karla Weng, Senior
Program Manager

There is a consensus that quality is an essential part of the value equation. While quality performance is often measured in the aggregate, the goal of quality is to ensure the right care to the right patient every time — which means quality cannot be achieved unless care is equitable.

Equity is at the heart of Stratis Health’s rural-focused quality work. Enhancing the ability of rural health care professionals to measure, improve, and demonstrate care quality helps ensure all patients have access to needed care.

Rural communities face many challenges, but the strength of collaboration among rural individuals and organizations can be an opportunity to improve care continuity and coordination and implement strategies that help build healthy communities. A key takeaway from the [2022 National Rural Health Resource Center’s Rural Health Equity and Quality Summit](#) is the idea of leveraging the power of rural relationships and community to identify and address those things that are impeding the ability of all people to be their healthy best. Rural communities are well suited to create processes that foster collaboration and coordination

There is no Quality Without Equity

Quality (Institute of Medicine)

“The degree to which health care services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.”

Equity (Centers for Disease Control and Prevention)

“Health equity is achieved when every person has the opportunity to attain their full health potential and no one is disadvantaged from achieving this potential because of social position or other socially determined circumstances.”

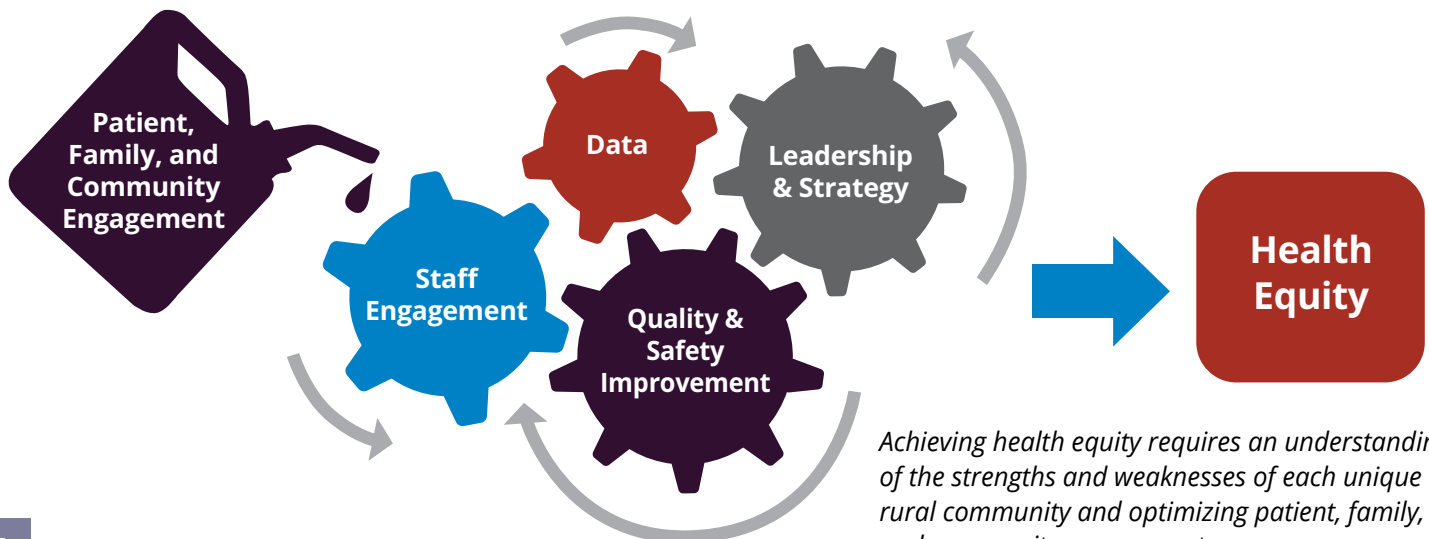
across care settings and community-based organizations. Similarly, rural health care organizations can leverage their community focus and size to get their boards fully engaged in and supportive of health equity work.

Health equity isn’t just about the health care value proposition — it’s about the community. Every person and every public and private organization benefits when everyone in the community has an opportunity to achieve their highest level of health and wellness.

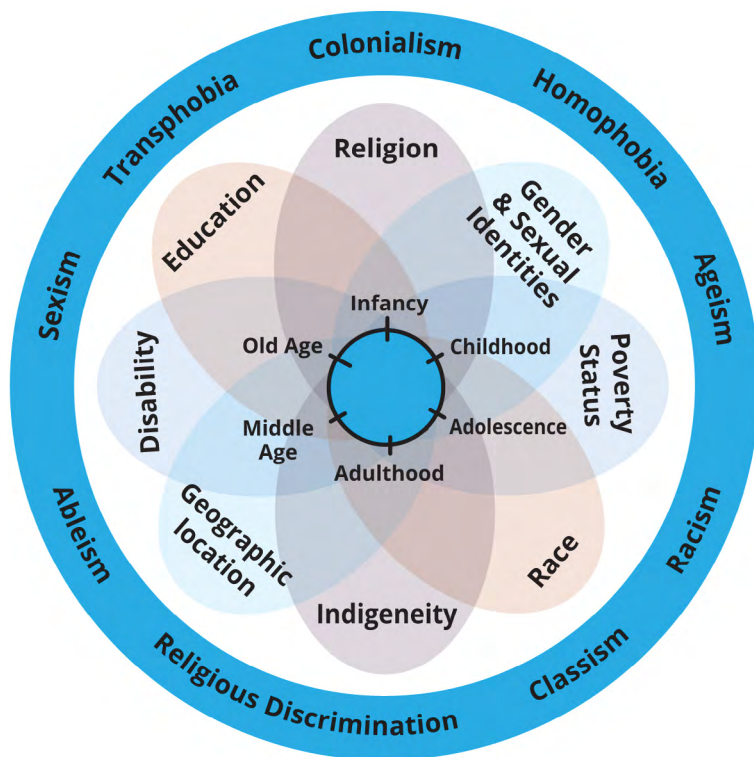
Rural Health Equity and Quality Case Studies

The story of rural health in America often focuses on barriers to access, health care worker shortages, and poor outcomes for communities where persistent poverty, economic disparity, and inequity are prevalent. These issues must be acknowledged; however, positive stories of inspirational problem-solving are also plentiful. Here are two examples. (Continued on page 7)

Health Equity Essential Components



(Showcasing Rural Health Care... continued from page 6)



Intersectionality wheels illustrate how overlapping social identities relate to social structures of racism and oppression.

Accelerating COVID-19 Vaccine Administration in Tribal Communities

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The Multilayered Nature of Health Equity

We cannot talk about health equity in rural without considering intersectionality. We know that people in rural communities tend to be older, sicker, and poorer than in urban areas, and challenges to accessing care can be exacerbated by geographic distance, broadband availability, and lack of public transportation. These risks are further complicated by points of intersectionality. For example, a gay Black older adult may experience the world based on his age, sexuality, gender, and race — a unique experience based on how those identities intersect. Geography adds another layer of intersectionality to the individual experience — what does it mean to be a gay Black older adult in rural America as opposed to suburban or urban America?

Increasing Cancer Screening Among Women

In rural South Carolina, many African American women have limited access to lifesaving medical screenings. The St. James-Santee Family Health Center launched the [Black Corals program](#) to increase breast and cervical cancer screening among women by engaging the community and empowering women to make personal health a priority.

Women received black coral bracelets that included an insert with a positive message about self-worth and a reminder about breast and cervical cancer screenings. Nurses and case managers traveled to local churches in the counties to hand out bracelets, lead workshops about risks and symptoms of breast and cervical cancers and teach women about early detection.

A media campaign highlighted free exams, including posters at community events and flyers at hair salons. A women’s church group spread the word through walks and cookouts about Black Corals. As more requests for screening appointments and education sessions came in, the health center worked with local restaurants and community partners to provide additional workshop locations. The Medical University of South Carolina provided additional screening locations through its Hollings Cancer Center mobile mammography unit.

Within two years of putting Black Corals into action, the number of women at all four of the health center’s locations getting Pap tests increased by nearly 17%, mammograms increased by 15%, and the number of women who missed scheduled screening appointments dropped from 31% to 19%.

Hear, watch, and read more through [“Telling the Stories of Rural Health in America”](#) from the National Organization of State Offices of Rural Health ([NOSORH](#)) and through the CDC’s [“Rural Health Success Stories.”](#)

Reframing Rural Health: Community Vitality and Resilience



Brock Slabach
Chief Operations
Officer, National
Rural Health
Association



Peggy Wheeler
Vice President,
Rural Healthcare
California Hospital
Association

Everyday conversations about meeting rural health challenges contribute to identifying, replicating, and accelerating successes. Jennifer Lundblad, president and CEO of Stratis Health, welcomed two highly regarded national rural health leaders as podcast guests to share their vision for reframing the focus on rural health. Brock Slabach is chief operations officer at the [National Rural Health Association](#); Peggy Wheeler is the vice president for Rural Healthcare at the [California Hospital Association](#). The following Q&A is an expanded version of the podcast, which can be heard [here](#).

Jennifer: We know that rural communities and rural health have many assets, but it is also commonly described with a deficit-oriented view. Despite the challenges, what gives each of you hope?

Brock: Rural makes up about 80% of the land mass in the U.S. but only about 17% of the population live in these communities, yet we offer vast resources in terms of food and energy production. These critical assets power our nation and much of our rural economy but are often taken for granted. The exchange between urban and rural as we look at how we fund and look at health equity from a geographic perspective is important to how we view the reasons for supporting programming in rural health.

Peggy: I always push back on the deficit-oriented view. Rural is known for and survives on its resilience, which served them well during troubling times that were intensified by the pandemic. They have always done more with less, so were well prepared to respond quickly and attend to what needed to be addressed. They also have the relationships needed to get tough work done — to get essential supplies and resources. Add to that the unparalleled passion of the people who work in rural, and it is unlike anything I've ever experienced.

Jennifer: We talk about the importance of linking rural health care and health equity as if all rural communities are the same when we know they're not. We also know they're not all predominantly white. So, we need to acknowledge that racial diversity in rural communities is variable in different parts of the country. We have communities with longstanding racial diversity, such as in the rural south or near our tribal nations. There are also communities where the demographics are shifting toward an increase in immigrant and refugee populations. Amid this rural diversity, how do we advance the conversation about rural health equity and health improvement and think about united and uniting goals as we do our work?

Brock: Public policy has always treated rural as a smaller version of urban. When you look at the prospective payment system, for example, as a big top-level program on payment for rural hospitals, we see there was no testing or demonstration on whether it would work in a rural community or a low-volume facility. As a result, we saw 400 hospitals close in the late '80s and '90s.

“ When I joined CHA, I was hired to represent the interests of the small and rural hospitals. And to me, that felt like working on the side of the angels. Here are these small hospitals that need to provide the same kinds of quality services in their communities that large hospitals do, but with fewer resources.”

Peggy Wheeler

This is where we need to consider more carefully geographic equity to meet the needs of our rural communities across the U.S. When you go to the Deep South I served as a hospital CEO in rural Mississippi, 70% of the population was African American with pronounced disparities in health care outcomes. When you complicate the lower reimbursement formulas with sicker populations that are older, and typically poorer, it makes the challenge of providing health care services in a rural community that much harder. It takes passion and commitment to bridge those inequities and make the health outcomes equitable among all rural citizens.

Peggy: When we talk about uniting goals and delivering on health equity, we must go back to foundational elements. Not only are no two rural communities the same, but no two communities are the same.

(Reframing Rural... continued on page 9)

(Exploring the Relationship... continued from page 8)



And when we know that the social determinants of health, where we live, work, learn and play, account for 80% of health outcomes, what we do as medical interventions is only a small portion of health and well-being. We have to turn our attention to those determinants.

Jennifer: How can rural health lead the way in addressing equity for patients, staff, and community?

Peggy: As the saying goes, if you're not at the table, you're on the menu. Rural needs to be actively engaged. If we learned anything from the pandemic, it is that there is an inextricable rural and urban interdependence. We need to continue fostering those kinds of conversations, where we lift up our rural communities and one another. If we don't, urban's going to have an issue and vice versa.

Brock: Rural can also lead the way in being innovation laboratories that are instructional for our urban counterparts. We have the ability with our defined populations to start to look at innovations that could have documented outcomes that do or don't work among specific populations.

Jennifer: What have we learned from the pandemic about how rural healthcare delivery and rural public health and community organizations should be working differently together?

Peggy: One of the outcomes of a very exhausting time is how important collaboration is with community-based partners. I'm against returning to normal. There are so many silver linings and gems that we have learned during an unprecedented time that we need to carry forward. Perhaps the most important thing is that we cannot do this alone and we are not siloed in rural health care delivery. That we do it better, stronger, and serve more members of our community the more we partner with community-based organizations and public health.

Brock: We look at the pandemic as having widened the fractures that existed in our rural communities for quite some time. The virus was beautifully designed to penetrate all the weaknesses of our rural healthcare infrastructure, exploiting the disparities and taking advantage of the many weaknesses in our hospitals, clinics, and the workforce.

The other thing we're observing nationwide is the depletion of our public health infrastructure. We've seen directors of public health agencies in counties and regions across our country ousted from their positions because of their stand on masking or because they're pro-vaccination. Long-standing resources that we've had in rural communities are being depleted and we're losing that store of expertise and professionalism in terms of dealing with not only COVID-19 but future pandemics. We need to pay a lot more attention to our workforce and workforce development.

Peggy: I'll add to what Brock is saying about the workforce. The whole concept of grow your own. Grow your own is going to be even more important, so I will circle that back to relationships and partnerships. We've got great community college systems in the country that we can partner with to help create the pipeline. We know that if you train in rural, you'll likely stay in rural. ○

STRATIS HEALTH NEWS



Jan Malcolm



Ken Johnson

Thank you, Board members!

We are grateful to Jan Malcolm and Ken Johnson as they complete their terms of service on the Stratis Health Board of Directors. Their leadership during uncertain times has been invaluable and we wish them continued success and happiness. Meet all our Board members at stratishealth.org/about-us/stratis-health-board-of-directors/.

Welcome to our Newest Employees

- **Abdirahman Aden**, Business Analyst/
Applications Administrator
- **Sophia Brasil**, Sr. Research Analyst
- **Marleny Garber**, Program Manager
- **Tegan Mosugu**, Communications Director
- **Eddie Napoli**, Recovery Project Coordinator
- **De’Nika Pollard**, Project Specialist
- **Lindsay Roberts**, Sr. Research Analyst

Help us Expand our Community Outreach Committee Member Roster

The COC is a longstanding group of consumers and consumer advocacy and support organizations. Stratis Health convenes the COC quarterly to discuss health care issues that are timely and relevant to older adults. In addition to

Medicare beneficiaries, participants include representatives from organizations representing and supporting older adults, such as AARP Minnesota, the Senior LinkAge Line, the AFL-CIO Retirees Council, and more. We are seeking additional members to represent the diverse interests of older Minnesotans. Please send recommendations to info@stratishealth.org (Add Jenna Kornberg in the subject line).

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.

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

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