Using Community Health Information to Improve Care and Health

November 16, 2016
The Affordable Care Act

Better Health ... Better Care ... Lower Costs
IRS Issues Final Rule Providing Guidance For Charitable Hospitals

Last week, the Treasury Department’s Internal Revenue Service issued a final rule that provides guidance regarding the requirements for charitable hospital organizations added by Affordable Care Act of 2010. The regulations will affect charitable hospital organizations. The rule is effective Tuesday, Dec. 29. A copy is at http://www.gpo.gov/fdsys/pkg/FR-2014-12-29/pdf/2014-30256.pdf.

COMMENT
Approximately 30 percent of the rule is community health needs identified through the CHNA. Section 501(r) (4) requires a hospital organization to establish a written financial assistance policy and a written policy relating to emergency medical care.

Section 501(r)(5) requires a hospital organization to not use gross charges and to limit amounts charged for emergency or other medically necessary care provided to individuals eligible for assistance under the organization’s FAP (FAP, eligible individuals).
Meet Compliance or Improve?
Health Spending and Life Expectancy by Country

Low Cost-Long life
- Japan
- Italy
- Spain
- United Kingdom
- Belgium
- Germany
- Austria
- Canada
- France

High Cost-Long Life
- Switzerland
- Norway
- Sweden
- Australia

Low Cost-Short Life
- Missouri

High Cost-Short Life
- United States

Health Expenditures Per Capita, Est. 2014 World Bank

Health Expenditures Per Capita for Missouri is based on 2009 KFF data
Population Health Improvement
What is Population Health?

• The health outcomes of a group of individuals, including the distribution of such outcomes within the group. (Kindig, Stoddard, 2003)

• Health outcomes for a group of individuals whom share at least one characteristic that influences their individual and collective health.
**Nuanced Terminology**

- Population health connotes health care delivery system involvement
  - Population health *improvement*
    - Primary care
    - Prevention
  - Population health *management*
    - The business of care delivery and population management
    - Finance
    - Chronic disease management
- Public health connotes government agency and actor involvement
How to Comply: CHNA Guidance

1. Define the community
2. Identify partners
3. Gather available data
4. Seek community perspective
5. Aggregate data
6. Analyze and prioritize
7. Document and disseminate
8. Adopt and implement a plan to address issues
CAUTION: Conserve Energy

Commit to Three

- Stakeholders/partners
- Secondary data sources
- Formats for primary survey
- At-risk population groups
- Routes to disseminate findings
- Priorities to address
- Strategies for each priority
- Three indicators per priority
- Three-year plan

Keep in Mind:
The hard work begins with implementation.
Know Your Community
Health Equity

“The most important five-digit number I need to predict your health status and well-being is your ZIP code, bar none … not your cholesterol level, or your blood pressure, or your age.”

David Nash, M.D., Jefferson College of Population Health, Dean
Actual Causes of Premature Death


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**Figure 1.** Determinants of Health and Their Contribution to Premature Death.
Adapted from McGinnis et al.¹⁰
Social Determinants of Health Status and Outcomes


National Academies Press, Institute of Medicine Conceptual Framework
Population Health Management
## Pay for Quality Timeline

<table>
<thead>
<tr>
<th>Reporting Program</th>
<th>FY 05</th>
<th>FY 06</th>
<th>FY 07</th>
<th>FY 08</th>
<th>FY 09</th>
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<td>End-Stage Renal Disease PPS</td>
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<td>Home Health PPS (9 States)</td>
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- **Penalty based on data submission**
- **Penalty / bonus based on data results**
- **Proposed**
## Acute Inpatient PPS VBP Priority Weighting

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<tr>
<th>Federal Fiscal Year</th>
<th>2013</th>
<th>2014</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
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<td>Percent of Program Contribution</td>
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<td>1.25%</td>
<td>1.50%</td>
<td>1.75%</td>
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<td>Efficiency and Cost Reduction</td>
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<td>20%</td>
<td>25%</td>
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Destination: Start with the End in Mind


- Clinical Integration
- Transactions/Network Development
- Accountable Care Organization
- System-Wide Care Management Restructuring
- Physician Enterprise Restructure
- Clinical Co-Management
- Physician Relationship/Leadership Development
- Hospital Case Management Improvement
- Patient-Centered Medical Home
- Bundled Payment
- Reduce Re-Admissions
- Hospitalist and Hospital-Based Physicians
- Patient Safety and Throughput
- Fee-For-Value
- Fee-For-Volume

Source: The Camden Group
<table>
<thead>
<tr>
<th>Engaged Partners</th>
<th>Business Intelligence and Knowledge Management</th>
<th>Care Transformation</th>
<th>Financial Alignment</th>
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<td>Leadership</td>
<td>Segmented populations</td>
<td>High reliability</td>
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<td>Physicians</td>
<td>Outcomes-based quality</td>
<td>Bundled care protocols</td>
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<td>Data analytics</td>
<td>Care transitions</td>
<td>Narrow networks</td>
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<td>Consumers</td>
<td>Physicians and clinics</td>
<td>Complex patient management</td>
<td>ACOs</td>
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<td>Community partners</td>
<td>Community health</td>
<td>Health equity</td>
<td>Medical homes</td>
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<td>Policy actors</td>
<td>Workforce</td>
<td>Preventive health</td>
<td>Medicaid Advantage</td>
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<td>Stakeholders</td>
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<td>Resilient communities</td>
<td>Self-insured products</td>
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<td>Collaboratives</td>
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</tbody>
</table>
Measure and Improve

Quality

Cost

Segment the Population – Risk Stratification

Well

At Risk

Chronically Ill

Complex

Health and Care Continuum

Prevention

Screen

Risk Reduction

Chronic Care Mgmt.

Complex Care Mgmt.

Business Intelligence

Health status

Claims

Clinical

Quality

Cost

Identify the Population

FFS with Attribution

Risk Contract with Enrollment

Adapted from: Silverstein, B. (2015) Authentic Population Health Management, Presentation to Mid-America Coalition on Health Care
Strategy
Better Health, Better Care, Lower Costs

Health Across the Lifespan

Standardized Yet Individualized
Community Health

Socioeconomic (e.g., Racial, Income Inequities)

Safety (e.g., Homicide Rate, Motor Vehicle Crash Death Rate)

Health Behaviors (e.g., Smoking, Obesity, Binge Drinking)

Health Care Access (e.g., Primary Care, Clinics)

Safety and Resiliency

Hospital Utilization

Preventable Hospitalizations (e.g., Diabetes, Asthma)

Readmissions (e.g., CHF, COPD)

Service Lines

Health Care Access (e.g., Primary Care, Clinics)

Other Factors ...

COMMON GOALS

BETTER HEALTH...BETTER CARE...LOWER COSTS
COMMUNITY HEALTH HOSPITAL UTILIZATION

COMMON GOALS

CONTRIBUTE
• Advocate
• Awareness
• Donate
• Champion

SOCIAL ISSUES

ALIGN
• Hotspot services
• Expand primary care
• Continuum of care services

PATIENT-BASED SERVICES

INNOVATE
• Partner
• SME expertise
• Facilitate
• Develop
• Implement
• Evaluate

POPULATION-BASED STRATEGIES

BETTER HEALTH...BETTER CARE...LOWER COSTS
Contribute
Coordinate
Cooperate
Collaborate
Partnerships

EXTERNAL STAKEHOLDERS

Patients/Consumers
Public Schools, Daycare
Insurance and Payers
Chamber of Commerce
Local Colleges and Technical Schools
Surgical Centers, Dialysis
YMCA
Retail Health and Pharmacy

Citizens
Missouri Chapters – Cancer, Diabetes, Heart, Lung
Business – Banking, Realtors
Local Agencies – Health, Social Services
Elected Officials
University Extension, Library
Faith Community
Networks and Partnerships

- Social capital — mutual interest and potential benefit from coordination and cooperation
  - **Access** to information
  - Ability to yield **influence**
  - Credibility through association — **power**

- Linkages
  - Binding ties — strong, high levels of trust
    - Health care systems
  - Bonding ties — respect and mutual reciprocity
    - Mutual Aid Agreement system
  - Belonging ties — shared membership and identity
    - Coalitions
  - Bridges between networks are often through loose networks with belonging ties
Community Health Issues

Opioids and Diabetes
Substance Abuse: Opioid Crisis

- Since 1999
  - Consumption, prescriptions, overdoses and deaths all have increased approximately 300 percent

- 2013
  - 46,000 overdose deaths
    - More than motor vehicle accidents
    - 50 percent from opioids and heroin

The opioid crisis is a significant public health issue in the United States. Since 1999, there has been a dramatic increase in opioid consumption, prescriptions, and deaths related to opioid use. In 2013, there were 46,000 overdose deaths, more than motor vehicle accidents. The crisis has affected various demographics, including the middle-aged white population, with the highest rate of opioid-related mortality among rural settings. The absence of such a registry limits efforts to address the issue.

The National Opioid Epidemic

Across the U.S., the consumption of opioid analgesics increased by 26 percent between 1999 and 2013. This rate of use was paralleled by chronic nonmedical use of opioids resulting in death. Since 2000, deaths from prescription drugs have surpassed those of cocaine and heroin combined.

MHA BOARD OF TRUSTEES APPROVED POLICY
Effective November 2013

OPIOID USE IN MISSOURI: Emergency Room Strategy for Reduced Misuse and Abuse

BACKGROUND

The fastest growing drug problem across the U.S. and Missouri is the misuse and abuse of opioid-based pain relievers. Throughout this last two decades, the rise in prescriptions, use and abuse of prescription-based opioids has increased at an alarming rate. The U.S. Department of Justice Drug Enforcement Administration recently announced that deaths from drug overdoses are the leading cause of death from injury and leads to motor vehicle accidents.

The rate of overdose deaths increased by 10 percent per year from 2000 to 2006, setting an aggravated rate of 14 deaths per 100,000, then increasing to a rate of 21.1 deaths per 100,000 in 2013. Among the patient population, non-Hispanic white men age 35 to 64 years in rural settings have the highest rate of opioid-related mortality although important steps do not indicate such a gender disparity.

FIGURE 1: Rate of Hospital Inpatient and ED Visits, and Cumulative Percent Change in Missouri, 2005-2014

Source: Hospital Inpatient Data, State of Missouri Uniform Data System and MyCare Missouri Provider Portal.
Opioid Reduction Initiative
Alarming Trends in Missouri Hospital Utilization for Opioid Overuse

Panel 1: Rates of Hospital Inpatient and ED Visits for Opioid Overuse by Region, 2005 Compared to 2014 and Cumulative Percent Change

Sources: Hospital Industry Data Institute FY 2005 and FY 2014 Missouri Inpatient and Outpatient Hospital Discharge Databases and U.S. Census Bureau 2005 and 2014 Population Estimates Program. The regions depicted in these maps are Missouri Workforce Investment Areas.
White House Fact Sheets — State Specific

Drug Poisoning Death Rate per 100,000, by County, 2010-2014

Source: CDC NVSS Multiple Cause of Death File, 2010-2014

https://www.whitehouse.gov/factsheets-prescription-opioid-abuse-and-heroin-use
Multi-Faceted Approach

• Analysis
  ➢ Low back pain
  ➢ Dental pain

• Guidance
  ➢ Emergency department prescribing guidelines
  ➢ CDC chronic pain guidelines

• Education
  ➢ Patient education materials
  ➢ Quarterly programming and resources

• Policy
  ➢ Advocate for a prescription drug monitoring program
  ➢ Seek solutions through self-regulation
OPIOID USE IN MISSOURI: Strategy for Reduced Misuse

MARCH 2016

OPIOIDS: A POPULATION HEALTH DILEMMA

Opioid Use and Overdose

As health care providers are challenged to address patient care issues at a population health level, much work has focused on reducing patient harm. Missouri hospitals have addressed many patient safety issues and reduced harm across clinical topics throughout the last several years. One key issue has been in the area of adverse drug events, with particular emphasis on managing outcomes for patients receiving opioids as part of a treatment plan.

Recent Hospital Industry Data Institute analysis of opioid use in Missouri hospitals throughout the last decade indicates the following:

- Opioid misuse has increased significantly in Missouri throughout the last 10 years, particularly among white males younger than the age of 30 and the uninsured.

- Hospital utilization for opioid overdose in Missouri increased 137 percent between 2005 and 2014 (Figure 1).

- Rates and trends in hospital admissions for primary non-hospital opioid-related emergency department visits and hospital admissions in Missouri from 2005 to 2014 can be categorized into three common themes: withdrawal symptomology, poisoning, and mental health-associated disorders.

Figure 1: Rate of Hospital Inpatient and ED Visits, and Cumulative Percent Change in Missouri, 2005-2014

What are the best ways TO GET RID OF OPIOIDS?

Managing Your Pain After Surgery

Our emergency department has changed the way we prescribe opioids.

If you come to the emergency department today for help with your pain, we are happy to help.

We might suggest that you take medication that is either an opioid or a non-opioid. Non-opioids are medications like aspirin or Tylenol. Most non-opioids do not need a prescription.

Opioids are strong pain medications that require a prescription and are taken for a very short time. Opioids work well to reduce certain types of pain. We want to keep you safe if you take them. There are risks of taking opioids that can lead to drug addiction, drug overdose, and possibly death.

What do you need to know?

If you take too many opioids or for too long, you might misuse or even abuse them. To avoid this, we will talk about the following questions that patients usually have.

1. How will we decide if you need an opioid or not?
   - First, we will try to learn how bad your pain is. If we know your level of pain, we can decide what we know about pain medicine to pick the best way to help.

2. What if you've had the pain for more than one day?
   - We may contact your other health care provider(s) to decide the best way to help.

3. How long will we tell you to take the opioid?
   - If we prescribe you an opioid, you will take it for a short time. Usually, three days or less. A doctor will decide how long you take the opioid.
   - You might have pain when the opioid runs out. If you do, please tell your primary care provider or doctor. If you don't have a doctor, we would be glad to help you find one that is right for you!

4. How will you know how to take the opioid correctly?
   - We can show you how to take your medication the right way at the right time. Plus, we will show you how to store it and how to get rid of it when it is no longer needed.

Please note that we will not write a prescription for an opioid that you may have lost or that was destroyed.
Assessment: Adoption of ED Prescribing Guidelines

Data: MHA Member Survey, June 2016
PDMP Assessment

- Policy and advocacy
- Regulations
- Technology
- Financing start-up, integration and maintenance
- Feasibility
- Provider willingness
The Impact of Diabetes — People

United States

- 29.1 million Americans have been diagnosed with diabetes
- 1.4 million new cases each year
- Pre-diabetes

Missouri

- 446,063 Missourians diagnosed with diabetes (9.6 per 100)
- 329,901 Missourians are estimated to be pre-diabetic (7.1 per 100)

Source: DHSS 2016; ProPublica June 2016; 2012 data; CDC BRFSS data
The Impact of Diabetes — Costs

- Health care spending per capita for people
  - $16,021 with diabetes
  - $4,396 without diabetes
- One in 10 U.S. health care dollars is spent on diabetes care
- Estimated Missouri burden = $5.1 billion direct costs

Source: DHSS 2016; ProPublica June 2016; 2012 data; CDC BRFSS data
Prevention and Action

CDC Prediabetes Screening Test

**COULD YOU HAVE PREDIABETES?**
Prediabetes means your blood glucose (sugar) is higher than normal, but not yet diabetes. Diabetes is a serious disease that can cause heart attack, stroke, blindness, kidney failure, or loss of feet or legs. Type 2 diabetes can be delayed or prevented in people with prediabetes through effective lifestyle programs. Take the first step. Find out your risk for prediabetes.

**TAKE THE TEST—KNOW YOUR SCORE!**
Answer these seven simple questions. For each "Yes" answer, add the number of points listed. All "No" answers are 0 points.

- Are you a woman who has had a baby weighing more than 9 pounds at birth?
- Do you have a sister or brother with diabetes?
- Do you have a parent with diabetes?
- Find your height on the chart. Do you weigh as much as or more than the weight listed for your height?
- Are you younger than 65 years of age and get little or no exercise in a typical day?
- Are you between 45 and 64 years of age?
- Are you 65 years of age or older?

Add your score and check the back of this page to see what it means.

**AT-RISK WEIGHT CHART**

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<tr>
<th>Height</th>
<th>Weight</th>
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<th>Weight</th>
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<td>5'7&quot;</td>
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<td>6'4&quot;</td>
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**IF YOUR SCORE IS 3 TO 8 POINTS**
This means your risk is probably low for having prediabetes now. Keep your risk low. If you're overweight, lose weight. Be active most days, and don’t use tobacco. Eat low-fat meals with fruits, vegetables, and whole-grain foods. If you have high cholesterol or high blood pressure, talk to your health care provider about your risk for type 2 diabetes.

**IF YOUR SCORE IS 9 OR MORE POINTS**
This means your risk is high for having prediabetes now. Please make an appointment with your health care provider soon.

**HOW CAN I GET TESTED FOR PREDIABETES?**
Individual or group health insurance: See your health care provider. If you don’t have a provider, ask your insurance company about providers who take your insurance. Deductibles and copays may apply.

Medicaid: See your health care provider. If you don’t have a provider, contact a state Medicaid office or contact your local health department.

Medicare: See your health care provider. Medicare will pay the cost of testing if the provider has a reason for testing. If you don’t have a provider, contact your local health department.

No insurance: Contact your local health department for more information about where you could be tested or call your local health clinic.

www.cdc.gov/diabetes
Healthcare Provider

- NEW American Medical Association and CDC: Preventing Type 2 Diabetes - A guide to refer your patients with prediabetes to an evidence-based diabetes prevention program.
- CDC Poster encouraging people to contact a local program
- Information About The Lifestyle Change Program
- Recommendation Form
- Elevator speech
- Healthcare provider testimonial prompts
- Healthcare provider fact sheet
- Content for a mailing insert
- Outreach toolkit
- Talking points
Purpose of the intervention also matters … Diabetes interventions from a population health improvement perspective change over the lifespan.
Reflection
Be Honest in Your Intent

- Is it critical all community activities count toward community benefit?
- Is it efficient and effective to align an issue with an existing patient service line and not consider the issue a community health benefit?
- Is it important that the hospital be the leader?
- Is improvement likely if funding is provided but not personnel? Is it okay to “contribute to a cause?”
- Is participating in a broader community initiative an appropriate role?
Collaboration: Art and Science

- Communities are complex and unique
- Every organization may have different reasons for collaboration – that is okay – but you need a common goal
- Ensure those with authority for resource allocation support the goals and objectives
- Find an inspired champion
- Time is required to build trust and systems
- Measure, evaluate
Five Conditions for Collective Impact

✓ Common agenda
  ➢ Efficacious, comprehensive diabetes care

✓ Shared measurement systems
  ➢ Shared analysis
  ➢ Common metrics

✓ Mutually reinforcing activities
  ➢ Coordination, possible collaboration

✓ Continuous communication and learning
  ➢ Structured approach and process

✓ Backbone support organizations
  ➢ Indirect support

Start ... Now!

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