Value Based Purchasing

Presented by Vicki Olson (50-minute Webinar) [01-25-2012]

Vicki Olson: Welcome to the Value Based Purchasing presentation.

Our objectives for today is to talk about the value-based purchasing program and a defined terminology, which is confusing relating to value-based purchasing and then introduce the new value-based purchasing worksheets Stratis Health is generating. They were actually developed by another quality improvement organization, Qualis Health, but they've generously shared that with us so we're implementing that. You should have received those in your quality net secure box last week, and we want to go over that so you know how to interpret those.

There are lots of different words, so one of my objectives is so that you understand what some of the terminology related to value-based purchasing means by the end of this presentation.

What is it about the hospital value-based purchasing program?

It's important to see the hospital because there are other value-based purchasing programs for other healthcare organizations and entities. It is an incentive program in this case, for PPS hospitals. So it's hospitals that are paid under the perspective payment system. It doesn't apply to critical access hospitals. There are also other hospitals that don't operate under the in-patient perspective payment system that it would not apply to.

The idea that they withhold 1% of the base DRG payments, so come next October they'll be taking that 1% to hold and what's given back to the hospital is based on their performance on specified measures.

What is the background related to this?

The concept is to get more accountability in the healthcare system, plus this is coming from the Accountable Care Act that buyers should hold the providers of healthcare accountable for both cost and quality. CMS really looks at this as a way to reward better value outcomes and innovations and not be focused on volume. As we all know, when you focus on volume healthcare providers are getting paid for doing more which isn’t necessarily in the best interest of the patients in terms of keeping costs down.

Where did it come from?

Originally, the whole paper reporting started this off. In the webinar you can see a graph of measures which you are all probably familiar with of how those have climbed over the years. It started with 10 in fiscal year 2005 and now we’re up to 55 in 2014, so it came down a little because of the topped out measures, the retired measures and suspended measures for this year.
Ultimately, the goal is when meaningful use kicks in that there’ll be more things electronically to reduce that burden of the reporting piece. So the focus has been on reporting and for PPS hospitals who are giving their annual payment update and could have 2% of their payment at risk if they don’t report in a timely and accurate way, you could see these are the PPS hospitals in the United States and these are the ones who received the full payment update.

These are the ones that didn’t or are not participating and over time there are few compared to the number of PPS hospitals. Just to orient us to the critical access hospitals, this is a graph of those critical access hospitals who are not paid by the perspective payment system, but are still collecting measures in many cases.

**When they’ve done studies and looked at, what is the impact of paper reporting and has it made a difference?**

Indeed it has. There has been a significant increase in the outcome measures and success that people have had in providing care and meeting those standards of care by participating in the in-patient quality reporting program. Ultimately the goal is to take the bell shape curve and not just get more people on one side, but really move the entire curve. The goal is to be able to do those system changes to really make a difference.

Now, just a bit of history…there is a lot of paper performance and all these different things in terms of Congress interest and reports to Congress, the IOM reports, all of those have recommendations in terms of paper performance. There were quite a few different demonstration projects and those projects also show they did make a difference in terms of outcome.

There are many various initiatives and some of you might be familiar with the third one, the hospitals inaudible conditions where based on whether something is present on admission, you would not get payment any longer for those statements like pressure ulcers and things like that.

**Where did the hospital’s value-based purchasing program come from?**

It came from the Affordable Care Act. It’s an incentive, currently built on the in-patient quality reporting measures and could include outpatient in future iteration. Really looking at that as the next step in providing quality care and looking at that driver of not looking at volume but really of the quality of care and as we said, 1% as being withheld.

Doing this last year there were three rules and this is part of what I think made it confusing as there was an initial value-based purchasing rule that was released on April 29, 2011. There were changes made to that throughout the year so when the in-patient rule came out in August, that had some changes and then there were quite a few changes that came out in the outpatient rules, so the value-based purchasing rule is in all three of those. You have to track it throughout the year to understand what the current date is.

So my visits already started, which you are probably all familiar with so the baseline is dated from three reporting quarters, so they landed on using a nine months period for both the baseline and performance period. The baseline starts July 1, 2009 and the performance period inaudible so it started last July and ends this March and that will be taken into effective for all patient discharges starting next October. So the CMS fiscal year starts in October every year and that’s the 2013 fiscal year.

The measures that are included are also on your value-based purchasing worksheets that you have, which may be easier to read.
Basically, it’s two AMI measures, one heart failure measure, two pneumonia measures and five skip measures in the process of care domain which will be 70% of the weight of the total score. Then there are eight measures related to the patient experience of care domain, essentially that each surveys. So nurse and doctor communication, death responsiveness, pain management, medication, cleanliness, quietness and discharge an overall hospital rating.

**How does it work?**

A hospital participates, it first needs to be a PPS hospital, publicly reports their inpatient measures and then each of those measures...12 process of care measures, 8 HCAPHS measures with each of those scored of zero to ten. Then those measures are grouped into the domain, so for this fiscal year it would be the clinical process of care and the patient experience of care, and those domains are scored and then they get rated.

The 70 and 30% is determined by the rule that rating and they can change that, but that’s for fiscal year 2013. Then that incentive payment is then calculated on that total performance score and the hospital gets money back based on that score and then obviously all the hospitals are working on improving that, because the buyer will change from year to year because it’s based on the benchmark and that is a national indication of what top deciles, it’s actually the mean of the top deciles so it’s like 95% is where the benchmarks are being set.

That will change as everyone improves. That’s at a high level of how the purchasing program works.

**Why do I care?**

Obviously, part of it is because it’s the right thing to do. The measures are to get you started in clinical quality and trying to provide the right care to every single patient every time. Then the obvious now incentive is adding the monetary piece in terms of it, has a huge impact to hospitals. So giving that 1% withheld overall in the nation, that’s $850 million that’s being withheld and then that goes all back to the hospitals but, depending on your performance it can be less or more than 1%, so it has a huge differentiator than between hospitals.

As you’re competing in the marketplace it can have impact in terms of your successes and organization.

**How do you know if your hospital is eligible?**

First as we mentioned, your hospital needs to be paid through that perspective payment system. So critical access hospitals, this doesn’t apply to children’s hospitals, VA hospitals, Psyche hospitals, cancer hospitals or long-term acute care facilities because they aren’t paid under that system.

The hospital also needs to have at least 10 cases for a measure, so when I talked about those 12 measures in the clinical process of care and the HCAPHS, they have to have at least 10 measures in that. If they don’t for the AMI measures then you would not qualify for that measure and you need to have at least four measures and if there are less then you wouldn’t be eligible for this program.

**Guest:** Ten in a year or ten in a quarter?

**Vicki Olson:** That’s 10 in the performance period, which in this case its that nine month period that would determine that.

For the experience of care domain you need to have at least 100 HCAPHS surveys in that performance period, otherwise you wouldn’t be eligible.
You will end up getting reports perhaps, because CMS is still committed to improvement and giving you some feedback on that but it won't relate to the whole incentive process. Here’s a visual of that is that for each measure, and we have 12 measures, its looked at how many patients you have that qualify for that particular measure. If you have at least four of the measures or you do have 10 or more patients, then you would qualify.

So, if you’re eligible for it, how do I know how well I will perform on it? We’re going to talk a little today about the Stratis Health worksheet. They are just worksheets that use different performance periods so they aren’t an exact science but at least its giving you some feedback about it and it lists out the benchmarks so you can compare yourself.

CMS is also rolling out a report. We are encouraging people to join the CMS call in December and I know many of you signed up for that call to be able to learn about that. Unfortunately, they cancelled it and put it on hold but it is coming. The plan is January or February and since we’re reaching the end of January I’m assuming in the next month or so we’ll receive more feedback because they’ll be scheduling that call.

On that call we’ll go over reports that you will be receiving through your quality net inbox that will give you an estimate, and they actually have a little bit of a payment estimate that’s part of those reports, at least the drafts that I’ve seen.

The calculation for the incentive payment will be determined but not until after the reporting period is over, because the idea is they’re giving that $850 million back, but they have to know how people perform before they can figure out how to divvy it up, because they are responsible for giving it all back to hospitals. Who gets it will be determined on the performance reporting.

So technically there’s no way to know in advance what amount you’ll receive. The estimated amount of the hospitals incentive payment will be shared through quality net account, 60 days prior to October by rule and the exact amount will be shared on November 1, 2012.

Let's move now into the Stratis Health Value-Based Purchasing Worksheet. A little feedback on why we decided to switch to these reports is because previously we were putting out the hospital profile reports every quarter and what we’re doing is eliminating both and we’re stopping those because there is actually a CMS report that provides all that data anyway.

So, when the hospital profile reports from Stratis Health started that, the report from CMS didn’t exist but now it does and you’re giving most of that information through the CMS report. So we’re comfortable that we can stop that. The only information that won’t be on the CMS reports is your appropriate care measure.

Now, we have to get approval from you to share that with MHAA every year, but we’re currently in the process of going through that consent process. Once we have that we’ll be uploading, so we’ll still continue to give you the appropriate care measure but that will be through a separate report.

The CMS report has the core measures and also has other information on it as well, so if you’re not using this report…The Hospital Quality Alliance, Improving Character Information… please look it over because it not only has the core measure information but the mortality re-admission, the ARC indicators and HCAPHS is on there too.

**Guest:** Where do we find that report?

**Vicki Olson:** You should be getting it through your quality net inbox. If for some reason you’ve missed it, we save them so you can contact us and we can help you figure that out and Mary would be the contact.
Guest: Do you have a certain time that comes out?

Vicki Olson: It is quarterly. I haven’t really tracked exactly what their relation; do you know Robyn, up to the quarter? It is older data and that’s the only downside is it’s not the same.

Robyn: It should be coming out in January.

Guest: There was that…what a lot of things are delay is…

Guest: Will the timeline stay the same, like before there was quarterly?

Vicki Olson: With the CMS reports those are quarterly data, so that’s really coming from your submission and when it goes to the hospital to compare and that kind of focus of it. You will, even though there are these reports, as we go through the value-based purchasing reports that we are providing you, that will be more current data and it does still have what your rates are for the core measures. That way you’ll have both to look at.

Guest: Is this report available …?

Vicki Olson: Yes. We did check that out and this report, for anybody who’s reporting this information they get this information.

Here’s what the value-based purchasing worksheet looks like. You actually have three copies in your handouts and we obviously didn’t provide hospital specific data here, so the pages you have, have to do with what our rates are for all Minnesota hospitals. We have done this worksheet, even though the value-based purchasing program doesn’t relate to critical access hospitals, we have done this for critical access hospitals so you’d have this information.

The first page is all hospitals and the second looks like its just PPS hospitals and then the third page is critical access hospitals. As you can see it compares that. This is an example so I’ll go through this, but the information that was uploaded last week is your hospital specific data. If you go to your quality net account you should be able to see that, if you haven’t pulled it up already.

How do you interpret this information?

I’m going to give you a little background and then we can talk specifically about this report, but you’ll see on your report on the right hand side, its broken into the clinical processes of care on the top and the HCAPHS survey dimensions is on the bottom. If you go to the clinical process of you’ll see on the second to last column there’s a benchmark in the threshold, so I’m going to explain the concept of that benchmark and threshold with the slide at this point.

These numbers first, are determined nationally. This isn’t Minnesota-specific it’s national data and the benchmark is determined by the 50th percentile. So in looking at how all hospitals that are part of the PPS, how did they perform? The threshold is at 50% and the benchmark then is the mean of the top decile, which is about 95%.

You can see from this there’s a range and if you look at the measures that are involved, you can see in the slide that people have been working at these, so they’re pretty high, most being above 90% in terms of even the threshold. I think most of the benchmarks end up close to 100%. Those are considered to be the thresholds and benchmarks.

In order to determine the number of points, so there’s a total of 10 points per measure, so there are two ways that a hospital can get points.
It can either be by meeting the benchmark, so if you’re at 100% for a particular measure, that where the benchmark is 100% such as the second AMI measure, then you would get 10 points. The achievement is based on the benchmark. You can also get from zero to ten points for achievement. If its below the threshold that 50th percentile then you’ll receive a zero, but there’s a gradation between the 50th percentile and the benchmark that you might get up to five points, depending on where your particular ratings are in that.

1. One way you can get the 10 points is through achievements, which is based on a benchmark.

2. The other is improvement, where you’re really comparing yourself to yourself and showing that you’ve improved.

So, if you look at your baseline data in the first nine month period and then look at, in the performance period how you’d rate, if you do better than you get points for that. Therefore, you get zero to nine points based on how you do from your original score to your current score. That’s two ways that you can get points.

If you look at the two hospitals, the same that originally in the baseline performance had 69% went up to 75% so for this particular measure its saying their threshold was around 65% for the achievement and the benchmark was between 90 and 95%. Then you can see those gradations. From an achievement standpoint it went up four points and for the improvement range, if you look at the baseline rate going up to benchmark and look at the gradation there, it would get three points for improvement.

Whichever is higher is what you get to tape, so in this case it would be better to take the four for achievement, which is where you’ll see on your value-based purchasing worksheet a column on the far right that says attainment, improvement and then points. This worksheet calculates what your attainment points would be, your improvement points would be and then whichever is highest is what your total will be on the right hand side, and it does that calculation for you.

The piece you need to be aware of is when we’re looking at the baseline to your performance is that those performance periods aren’t exactly matching the value-based purchasing. We’re just trying to give you feedback on how you’re doing currently.

So, it’s a little confusing but the outcome is that you end up earning points and you can earn those points either by achieving a benchmark or close to it, somewhere between the threshold and the benchmark, or by improving from your baseline.

The same thing works for the dimensions. There’s a benchmark and threshold and you get the same thing, you either get achievement points or you get improvement points and whichever is greater, you get to take that from the HCAPHS. The HCAPHS have another little caveat and that is consistency points. You can see at the very top the clinical process scores, domain score and the patient experience, all join together for the total performance score.

If you look at the patient experience domain there is base points, consistency points and that’s how you get the patient experience domain score. So if you look at that calculation there are 8 HCAPHS measures. You can get a total of 10 points for each of those, which is a total of 80. Then there’s this idea of consistency points and those consistency points I’ll talk a little more about on the next slide of how they are calculated.

So if you’re above achievement thresholds on all of them. Actually the consistency points takes the lowest one so if you look at your lowest score and if you’re below the floor column you can see those four benchmark and thresholds so it adds this other context of floor.
This floor is used for the consistency points, and that’s kind of the lowest of the low and who did the lowest in the baseline performance. If you look nationally and you see like for the communication with nurses it was 38.98, that was the lowest hospital that was at the zero percentage and that’s how they did on that particular measure. Also, if you’re below any of these floors you’ll get zero consistency points.

If you’re above the thresholds on all of them you’ll get 20 and then you get a range between that, depending on how you perform. The general idea behind it is that you’re looking at your relative distance from the worst performer, so it’s a way to look and incentivize people to do well on all measures and be consistent in terms of your patient experience score.

This is just another one showing we had the clinical process domain score and those were the core measures. The patient experience domain scored and that’s the HCAPHS and you get a total performance score from that. So the clinical process domain score is by earned points and those earned points are either by achievement or improvement and there are a total of 10 per measure.

So if you had 10 cases in all your measures then you could have 120 potential points, so your earned points are divided by those potential points. If you only had four measures that qualified then you’d only have 40 potential points, so your score would be divided by that 40 which means, you should be penalized because you don’t have the number of cases. Therefore, whatever measures you qualify for you’ll get 10 points for each measure and your potential points.

Then on the HCAPHS the earned points added together could be up to 80, so whatever number of points you get for each measure added together and then those 20 consistency points, so if you get all 20 you add those together, if you get zero you get zero or somewhere in between and get a number of consistency points.

Now those two domain scores are then weighted so the clinical process domain scores to 70%, HCAPHS is 30% and you get a total performance score, so you can see where it’s a bit confusing and complicated and that’s the advantage of having the worksheet because those calculations are done behind the scenes and gives you a little more feedback.

So the Stratis Health value-based purchasing worksheet will help you get some feedback and then when the CMS report comes out you’ll also get feedback through that report as well, otherwise it’s hard to figure this out independently.

How can I improve my score?

When the Closed Health I mentioned that we’re using the value-based purchasing worksheet that was here was like Closed Health, another quality improvement organization. When they implemented this and people started getting feedback and knew how to prioritize and where to put their efforts, they made a huge increase so we’re hoping this feedback helps you and helps to strike the priorities in your organizations to give you feedback of where you might improve.

Something else Robyn and I developed that we brought to this core measures meeting where you provided some input into this is some best practice sheets, which you can also find on our website. What we’ve done is taken the core measures and gone one at a time talking about what the name of the measure is, its description and the patient version of the description, but then identified common failure modes and then best practices to address those modes.

Please look these over as ideas of where some of the common failures are for particular measures that you might look at. We’re certainly interested in getting feedback so we can attempt to fix those.
Guest: Is that on your Stratis website?

Vicki Olson: Yes it is. I think as we get more experience and feedback from hospitals we’ll certainly add other failure modes and best practices to these, but this is a place to start or at least to start thinking in your organization what your experience is.

There is data, so if you want to look on the HCAPHS survey site you can do a comparison and see what and where people are. There is also HCAPHS improvement guide on the HRQ site you can go through that’s focused on the health plan, so it says specifically its not for the hospital consumer assessment survey but a lot of the things overlap and it has service-oriented things, so certainly use it to generate ideas or there may be some concrete things you do that are tops on this site.

I think people are feeling because the clinical process measures are so high that there’s lots of room for improvement in the HCAPHS, so I think a lot of other people are focusing on the HCAPHS as an improvement mechanism. We do have a quality reporting and improvement steering committee that’s started up in the last six months, which has representatives from PPS and critical access hospitals, as well as the officer helos and the new sub-state reform folks in the Minnesota Hospital Association.

That group is looking at how we can overall help Minnesota improve because we want to be stars in terms of making sure that we get paid and get the incentives we can get in performing well in terms of quality of care on these measures.

So, we’re here to help and certainly interested in your ideas on how we might do that. Their recommendation is that we help people with the defects analysis tools and process. I think many of you are probably doing this already as you’re looking at where we don’t need a measure, what happened in that case and how we can fill that gap and put some system changes in place to make them.

What we’re encouraging people to do is really formalize that, keep a log of every measure you fail and start looking at where you’ll get the most spend for the buck in terms of where to focus your improvement areas. You’ll see on the top right hand side a chart of looking at where the most areas are where you could make changes.

Looking at units that are very successful, that takes practice and spreading it to other areas, flow charting your processes and looking at when they fail and what the reasons are for that by doing cause analysis processes or, doing a failure mode effect analysis of just proactively looking at what could go wrong in that process that could lead you to not needing this particular clinical standard.

Then obviously in the top left hand corner is getting a team together. I think a lot of hospitals already have core measure teams and people looking at this, but whether you do it by measure and have physician champions, think of your infrastructure of how you’re organizing this in your organization, in order to help the improvement process.

What we’ll be doing at Stratis is to try and provide a log for you, some mechanism where you could be able to attract these from as well as cause analysis tools. I know many of you are doing that with adverse events, so there are skills already in hospitals but whatever we can do to help with that we’re interested in supporting so you can do a defect analysis.

Particularly, when you’re getting this high in terms of the people’s percentage of performance it’s looking at everyone to be able to see where you can improve. So the idea is to track every defect and obviously, the more concurrent your review is the more successful you’ll be in that cause analysis because it will be closer to the situation of when it happened and people will remember what happened.
So as you remember as with your quality improvement focus, when you’re doing the cause analysis stuff you’re really looking at why that happened and it’s usually not clear without the context of the situation. Was staffing bad that day or did something happen in terms of having lots of patient problems that had to be addressed, so it was priority and things got missed or was it a new person who hadn’t been oriented and didn’t realize they were supposed to do something…?

There are many reasons why when you go beyond the people piece that people don’t do things, so it’s a matter of trying to figure out the reason behind why a company didn’t do something and then be able to implement the improvement strategies.

This is just a fun slide to think of things that spread, but it’s a tickler for you to think through. You do have successes and where are you at 100% and what’s the reason for that. Do you have a physician champion that’s unrelenting? Do you have a team in place for certain ones? Do you have units that are successful? Then, looking at your successes and being able to work on spreading those across your organization, whether that’s looking at measure by measure differences or looking at variations within your organization.

So think through how you might spread things because the quicker you can execute that, you still have some time before March 31st so even for this first performance period you have opportunities, but recognize the core measures will be part of fiscal year 2014 and everyone will be working on them, so you can’t stay where you are without recognizing that it won’t impact you in the future.

This is another website WhyNotTheBest.com and you can see there’s a dropdown menu. I picked the surgical care improvement. It has different case studies and also has what our success factors when you look at all the organizations they’ve interviewed and done case studies on. That’s an area for you to look at resources and get ideas for what might be some things for you to focus on, your improvement work.

Then for best practices, I just put this one out there for patient rounding and I think it was HCAPHS sets that can be a lot of the focus on how to keep that service and excellent care. This highlights the four P’s so if you do Internet services or have interaction with other quality groups there are lots of good ideas on how you might impact that.

Then the other thing we’re providing you, this was in the letter that went out last week when we introduced the new value-based purchasing worksheets we also introduced this report called Quality Reporting and Improvement. What we’ve done is taken the value-based purchasing measures for these 20 measures and taken information off hospital compare, so this is not confidential data but publicly reported data and it’s a little older because of that. People might have improved since then so you have to take that into consideration.

If you’re interested in seeing how you compare to other organizations this gives you feedback, so I encourage you to look through this. It’s a lengthy document, but it’s organized by measure so if you’re looking at a specific measure you can look at how you rank according to other Minnesota hospitals. If you’re interested in contacting a hospital that’s a high performer and finding out how they did it and have been successful, it also gives you that opportunity to interact and network with your piers in other hospitals throughout Minnesota.

With the steering committee feedback we made some changes in the graph, because we recognized that we included critical access hospitals here because we’re interested in quality, no matter whether you get paid for it or not. We put them all in here and we divided them out, so you’ll see for a particular measure the front page might be hospitals with 25 or more cases and then the back page are hospitals with less than 25 cases.
This way we’re comparing it a little more apples to apples, in terms of low volume in critical access hospitals and all of a sudden your 100% score can go to 50% because you only have 2 patients in a particular quality area. That’s how you read it front to back. Again as I mentioned, this is public data so you could go on hospital computers to figure this out yourself, but we thought we’d help by doing that work for you.

It also has clinical process care measures as well as the HCAPHS, another resource for you in looking at best practices and networking with other hospitals.

**What is the future for value-based purchasing?**

I’ve been talking about fiscal year 2013/2014 measures came out with this outpatient rule in November so we know that too now, so for the following fiscal year the withhold will increase so it’s not just 1% it’s 1.25% and that actually goes up to 2% by fiscal year 2017. Where it gets added in 2014, so the measures that are already part of this are the 20 we’ve talked about those will continue and what’s added are three mortality measures and those also need to have a minimum of 10 cases.

In order to be eligible you would need two of the three mortality measures. The mortality measures as you might remember are the AMI, heart failure and pneumonia currently.

They also add the skip infection as nine and a big focus of adding that one is to help with CAUTI rates, so if all the focus is on infections and doing better on infections and I think that was prednisone or inaudible for adding this one in is because indwelling catheters have been shown to be a inaudible for reducing CAUTI.

There were actually other ones added, so if you’re tracking them the was Medicare spending per beneficiary and the hospital prior to conditions that were originally part of this that were taken out for 2014, so those aren’t part of the 2014 but I think its helpful to track those.

So going to the waving, what happens now with 2014 is they’ve added a domain, so those mortality measures go into the outcome domain. You still continue with the clinical process of care and the patient experience of care, but now we’ve added another domain. When they do add, which I think might come down the pike, the Medicare spending per beneficiary that’s an efficiency domain, so there may be a fourth domain to come eventually.

For fiscal year 2014 there will be three and this is how they are weighted, so you’ll see that the HCAPHS and patient experience of care stays the same at 30%. The clinical practice of care actually goes down from 70% to 45% and then the outcome domain comes in at 25%.

So that is the plan and here’s the timeframe, which is a little different according to domains, but still a nine month period which they aren’t starting until after the 2013 is done which is April 30 and then we move into the baseline for the performance period for fiscal year 2014, so it continues for another nine month period.

As I mentioned, other measures to improve on and tracking is the hospital acquired conditions because even though they put those on hold that gives you potential for 2015. The Medicare spending per beneficiary and re-admission, there’s a separate program on re-admissions penalties for avoidable re-admission. All those are important to be thinking about and recognizing that it takes time to improve, so looking ahead and focusing your efforts will help you.
There will be some HCAPHS as an FYI...they’re looking at three more care transitions that have to do with re-admissions, potentially more questions come in relation to that and some other patient admission items related to emergency room admission and well being.

If you have questions feel free to contact me and I’ll make sure to take care of them as best I can.

That will wrap up our webinar.

If you have questions, please contact Stratis Health, at info@stratishealth.org.