Statera Health

NEWS

Spring 2017 News and updates for members of Statera Health

Highlights from this issue:

Welcome to our first newsletter

Donavon Wewers, MD
Chairman of the Board

Marc Miller, MBA, FACHE, FACMPE
Chief Executive Officer

Welcome to the inaugural edition of the official newsletter of Statera Health. On behalf of the Statera Health Board of Directors and the Executive Staff we first want to thank you for your participation in 2016 as members of our Clinically Integrated Network (CIN), known as "Statera Health". We have chosen the model of CIN because it is the approved model of the Federal Trade Commission and the Department of Justice, and it is what we are doing as a network of physicians and hospitals, to better integrate and coordinate the care that we provide to our patients and employers, and for the community.

Together we are managing this Clinically Integrated Network organization as "…an active and ongoing program to evaluate and modify practice patterns by a network's physician participants and create a high degree of interdependence and cooperation among the Physicians [and hospital] "to control costs, ensure quality* and improve outcomes." We had a very successful year with our SAMC health plan partner in 2016, but we still have much to learn and to do as we move forward in 2017 with additional Employer Health Plans and Payors.

* (The Federal Trade Commission and Department of Justice definition of a Clinically Integrated Network organization)

Board of Directors and Executive Staff

Once again this year we are pleased to have the following Physicians and Executives serving on the Statera Board of Directors:

Donavon Wewers, MD
Chairman, Primary Care Physician

William Beckett, MD
Specialist Physician

Edwin Morriss, MD
Primary Care Physician

James A. Robeson Jr., MD
Primary Care Physician

Sam Tarwater, MD
Specialist Physician

Rick Sutton, FACHE
SAMC CEO

Derek Miller, FACHE
SAMC CFO

Charles Harkness, MD
SAMC CMO

Dr. Bruce Wozow
HCHCA Board Member

Bob Theune
HCHCA Board Member

Marc J. Miller, MBA, FACHE, FACMPE – *CEO*

Walter Young, MD
Chief Medical Officer

Jayne Sikes
Lead Data Analyst

Jan Largess, BSN
Director, Care Management

An important part of a CIN is the involvement of physicians in both the governance and the direction setting for the organization. While the Board addresses the governance, it is the committees and their work that get the direction. The committees that have been established include:

- Physician Participation Committee
- Contracting, Payer Relations, and Finance Committee
- Clinical Integration and Quality Improvement Committee

If any of these committees are of interest to you or you would like more information, please contact Kristie Covington in the Statera Health Office on the 3rd floor of the Doctors Building on the campus of Southeast Alabama Medical Center, or call Kristie at 334-712-3143.

We look forward success again in 2017, and the following is an update on the current status of our CIN organization. Sincerely,

Donavon Wewers, MD–*Chairman, Statera Health Board of Directors*

Marc J. Miller, MBA, FACHE, FACMPE, *Chief Executive Officer*

Physician Participation Committee (Membership)

Sam Tarwater, MD, *Chairman*

As of April, 2017, Statera now has almost 200 members covering Primary Care Physicians and an array of Specialties. Of course, Statera will continue to welcome new members going forward. We are currently in the enrollment period for our 2017 membership drive. We offered 100% incentives until March 31, 2017. The membership fee of $500 will cover the 2017 membership dues. Partial incentives are still available throughout the year.

Sam Tarwater, MD

As of the writing of this newsletter, our current membership drive has resulted in commitments from approximately 30 physicians representing Pulmonology, Endocrinology, General Surgery, Cardiovascular Surgery, Anesthesia, Orthopedic Surgery, Medical Oncology, Radiology and others.

Our marketing and communications efforts have resulted in a new look which you can see in our newsletter, as well as our physician pocket cards, our membership folders, and other educational materials.

The following are members of our Physician Participation Committee:

- Sam Tarwater, MD–*Chairman*
- Charles Harkness, MD–*Board Member*
- Clint T. Wade, MD–*Anesthesia*
- Scott Burrow, MD–*Emergency Medicine*
- J. Ryan Connor, MD–*Internal Medicine*
- Ravi Nallamothu, MD–*Hospitalist*
- Praful Patel, MD–*OB/GYN*
- Walter Young, MD–*Medical Director*

Clinical Integration and Quality Committee

James A. Robeson Jr., MD, *Chairman*

2016 Quality Initiatives

A key component of a CIN is engaging its physician members in programs that can lead to improvements in value (cost reduction and quality improvement) for its population of patients. Beginning in 2016, Statera completed its first twelve-month performance improvement contract with Southeast Alabama Medical Center employees and their family members as its customers. As a result, we are happy to report that an audit by an independent third party organization concluded that Statera and SAMC saved $634,000 in Health Plan costs for the year. The quality initiatives that were launched (resulting in these substantial savings) included:

James A. Robeson Jr, MD

- **Diabetes**
- **Generic Drugs**
- **ED Avoidable Admissions**

Due to the success of the 2016 Quality Initiatives, we will be repeating some of these same initiatives in 2017.

Value Improvement Recognition Program

In addition to our success in reducing costs, the SAMC agreement looks to Statera Health to demonstrate effective process management of Specialty-based value improvement projects. These come under the umbrella of the "Value Improvement Recognition

Program." In 2016, Physician members were successful with a number of these projects, and physicians received a recognition award of $500 or more based on the level of financial success. The successful specialty-based value improvement programs in 2016 included:

- **Lower Back Pain–Radiologists**
- **Gastroenterologist Initiative**
- **OB/Gyn Initiative**

Due to the success of the 2016 Value Improvement Recognition Programs, we are offering this opportunity again in 2017 to Specialty Physicians, and those programs will be finalized very soon.

2017 Statera/SAMC/UMR Joint Operating Committees

Beginning with 2017, Statera Health, SAMC, and UMR have formed two (2) significant "Joint Operating Committees". The first JOC is the "Quality and Care Management Committee" designed to increase the quality of care provided to the members of SAMC Health Plan. The second JOC is the "Data Analysis Committee" designed to identify unnecessary health plan costs, and develop a plan to resolve these issues.

The following are members of our Clinical Integration and Quality Committee:

- James A. Robeson Jr., MD *Chairman*
- Charles Harkness, MD *Board Member*
- Jonathan Scott, MD *OB/GYN*
- Travis Rutland, MD *Gastroenterology*
- William Beckett, MD *Radiology*
- Vernon Pruitt, MD *Anesthesia*
- Walter Young, MD *Medical Director*
- William Hundley, MD *Internal Medicine*
- Niel Rasmussen, MD *Family Medicine*

Contracting/Payor Relations and Finance Committee

Donavon Wewers, MD–*Chairman Contracting and Payor Committee*

Edwin Morriss, MD–*Chairman Finance Committee*

Donavon Wewers, MD

Edwin Morriss, MD

The Contracting/Payor Relations and Finance Committees have been very busy this past year. The committees successfully completed the Health Plan agreement with SAMC, and have signed another agreement with SAMC for 2017. In addition, the reward payments for 2016 were distributed in January, 2017, and as of March, 2017 we are in our third month of our 2017 agreement.

Due to the success we have had with our partnership with the Southeast Alabama Medical Center Health Plan, the Contracting committee is pursuing our next partnership with another large self-insured employer in Dothan.

Also, the committee is pursuing both a "Medicare Advantage Agreement" and a "Commercial Value-based Agreement" with the appropriate qualified payors.

On the Finance Committee side, Jayne Sikes, our lead data analyst has successfully developed the "Cost/Utilitzation Report" and the other "drill-down" reports necessary for the Finance committee to study unnecessary health plan utilization and costs, and is coordinating with the Quality Improvement Committee to resolve a number of issues and opportunities identified.

Again, an important part of a CIN is the involvement of physicians in both the governance and the direction setting for the organization, which includes these committees. If you are interested in being a part of a committee or would like more information, **please contact Kristie Covington in the Statera Health office at 334-712-3143.**

Contracting/Payor and Finance Committee:

- Donavon Wewers, MD–Chairman Contracting/Payor Committee
- Edwin Morriss, MD–Chairman Finance Committee
- Derek Miller, FACHE–Secretary/Treasurer
- Guy Middleton, MD–OB/GYN
- Craig Nordhues, MD–Anesthesia
- Bob Theune, Board Member
- Walter Young, MD–Medical Director

Educational Field Trip

Any worthwhile endeavor has an educational component and the Statera staff is no exception. In February, the Statera staff visited Brookwood Baptist Health in Birmingham at the invitation of Scott Fenn, their Chief Integration Officer. Mr. Fenn leads Brookwood's Clinical Integration and Accountable Care Organizations and over the past seven years, he has created an ideal environment for balancing healthcare quality and cost. With the wholehearted support of the Health System Leadership and Physicians at Brookwood Baptist, Mr. Fenn's organization has been very successful. In fact, they are the most successful and advanced Clinical Integration Organization in the state of Alabama. Statera is grateful for the opportunity to meet with Mr. Fenn and his staff to take our Leadership, Care Management, and Administration processes to the next level to ensure Statera's future success.

SELECTED ARTICLES *of* INTEREST

1

Dr. James A. Robeson, Jr. (Chairman of the Clinical Integration and Quality Improvement Committee) submitted the following:

Creating patient-centric clinical integration committees

12:00 AM on July 15, 2013 by Sarah O'Hara

How can you design clinical integration committees to address more complex population needs, not just individual specialty clinical improvement initiatives?

Traditionally, committees are organized around legacy academic and specialty distinctions. These committees provide an important opportunity for physicians from different practices to interact, often for the first time, in a meaningful way. However, this structure provides little chance for providers from different specialties or across ambulatory-inpatient divisions to meet.

Coordination between specialists is increasingly crucial as the average Medicare patient sees seven physicians across four practices. As CI networks move toward population management, many are reorienting clinical decision-making structures around key patient needs.

Memorial Hermann's multidisciplinary oversight models

Since its incorporation in 2008, Memorial Hermann Physician Network (MHMD) has built Clinical Programs Committees (CPCs) to establish performance standards and develop evidence-based order sets. While CPCs were originally organized around traditional single-specialty disciplines (and many remain that way today), MHMD has added new CPCs that address issues cutting across specialty lines, such as palliative care.

To ensure its CPCs remain relevant as CI network strategy and initiatives evolve, MHMD re-examines committee structure and leadership on a regular basis. Once a year, an oversight committee reviews the effectiveness of each CPC's leadership. Twice a year, it reviews the actual structure of the committees to determine if any changes are needed.

Upon review, CPCs can be created, eliminated, or combined. For example, separate Women's Services and Children's CPCs were consolidated into a single Women and Child committee to streamline resource use.

MHMD logoCase study: Six lessons for striking the right balance between investing in infrastructure to manage populations and securing contracts from payers.

MissionPoint's patient condition-focused quality committees

Going a step further, MissionPoint Health Partners has organized its quality infrastructure solely around high-impact patient issues.

The network maintains nine quality committees focused on the highest-volume, highest-cost conditions affecting its patient base. All MissionPoint physicians are required by contract to serve on these committees on a rotating basis, with nearly 20% of physicians serving on a committee at any time.

As committees near completion of stated goals around one high-impact condition, they transition to tackle new but related issues. The next assignment may be a new aspect of the same problem, or a different issue committee members have prior experience in.

The sepsis committee's success at improving inpatient infection control processes, for example, helped them pivot to a new project to control blood utilization.

MissionPoint logoCase study: Build an integrated delivery network focused on population health, and engage physicians and patients to drive cost and quality improvements.

Giving other care team members a place at the table

When designing a more patient-centric clinical improvement oversight structure, CI networks must also improve coordination between physicians and other care providers who may play an increasingly active role in managing the highest-risk patients.

MissionPoint handles this issue by ensuring that quality committees, while led by physicians, also include other care team members.

Social workers, nurses, and health coaches all bring unique perspectives to discussions on how best to improve patient care. In addition, MissionPoint's committees often include inpatient administrators, whose input is critical to ensuring collaboration not just across specialties, but also across care sites.

Advisory Board: https://www.advisory.com/research/care-transformation-center/care-transformation-center-blog/2013/07/ci-multidisciplinary-clinical-decision-making

2

Dr. Donavon Wewers (Co-Chair of the Contracting & Payor Relations and Finance Committee) submitted the following:

3 ways to make 2017 the year of financial-clinical integration

11:40 AM on February 9, 2017 by John Johnston, CPA, MHA

While there is a big question mark around the future of health care reform, hospitals can be sure of one thing: We must prepare to live with further cuts to payment.

In this environment, hospitals must be prepared to undertake more radical efforts to control costs, and many health care finance professionals acknowledge there are major dollars tangled up in clinical care from inappropriate admissions, inefficiencies, and duplicative services.

Executives are beginning to tackle these issues, and initial results reflect the potential for an outsized impact on margins. For example, one health system recently reduced annual operating costs by $12 million in just six months by organizing an initiative focused solely on reducing excess length of stay.

But achieving meaningful cost savings in the care delivery arena requires tight alignment between finance and clinical teams. Hospitals are beginning to find success in addressing margin improvement through care redesign, yet most have not aligned fully to realize the magnitude of potential savings. With that in mind, here are three priorities that stand out for finance leaders to adopt in 2017:

1. Deal with the trust issues.

Most hospital leaders still hold longstanding biases when it comes to the intersection of care delivery and finances. Many clinicians worry that the mandate to take dollars out of care delivery could jeopardize the quality of care and believe their financial counterparts don't appreciate what it takes to sustain that quality. Likewise, many finance teams continue to interpret pushback from clinicians as a lack of concern for cost pressures or an unwillingness to embrace the data available to measure cost.

It's only natural that different teams come to the table with biases, but leaders must work to ensure those biases do not get in the way of critical margin strategies. Comprehensive care redesign starts with a shared conviction between financial and clinical departments that financial improvement can be attained without compromising safety, quality, or efficiency. To set this baseline, executives can establish a set of boundaries for improvement efforts that both respect and confront biases.

2. Allow clinicians to lead, with accountability to hit the financial target.

Finance leaders are trained to calculate variances and establish savings targets. Every hospital needs to have financial targets and understand where the data point to opportunity. Once those targets are established, however, it is crucial for clinical leadership to design and own the care delivery improvement plan.

This advice does not mean financial leadership should be completely hands-off. The best results are achieved when finance executives both sign off on the initiatives before the clinical teams launch them and conduct a reconciliation of the initiatives against their financial targets.

3. Stay confident with imperfect measures of financial impact.

Earlier, I mentioned a health system that tied $12 million back to avoidable inpatient days. But to be frank, it's not a perfect science when it comes to tracing clinical improvement initiatives back to real dollars.

Most finance executives understand the challenge of trying to map a one-to-one connection between clinical improvement activities and the balance sheet. Even the best cost accounting systems often base savings on average costs at some level. But the most effective leaders see the forest rather than the trees, and they successfully rely on proxy measures based on a wealth of evidence that shows clinical efforts indeed affect the bottom line in a highly meaningful, if not precise, way.

My team partners with hospitals every day to drive savings, and those savings typically are computed based on proxy measures (such as an average savings amount for every excess day that is eliminated). Over time and across many projects in recent years, we have reliably reconciled a measurable impact on the bottom line that is very clos e to the proxy target set.

In 2017, our challenge as industry executives is to continue integrating clinical delivery with financial sustainability. We are close to turning that corner. May this be the year we see a high level of integration become the standard for how clinical and finance leaders guide our hospitals forward.

Advisory Board: https://www.advisory.com/research/financial-leadership-council/at-the-margins/2017/02/sw-financial-clinical-integration

3

Dr. Sam Tarwater (Chair of the Physician Participation Committee) submitted the following:

Clinical integration, demystified

8:23 AM on April 15, 2013 by Michael Koppenheffer

If someone made a "top 10" list for health care strategy jargon, you'd certainly find "clinical integration" there. In fact, Clinical Integration is listed as one of the American Hospital Association's eight "advocacy issues" on its website. According to AHA:

"Clinical integration is needed to facilitate the coordination of patient care across conditions, providers, settings, and time

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in order to achieve care that is safe, timely, effective, efficient, equitable, and patient-focused. To achieve clinical integration we need to promote changes in provider culture, redesign payment methods and incentives, and modernize federal laws."

Hard to argue with—except that when my Advisory Board colleagues talk about clinical integration, they mean something altogether different.

A legal arrangement for provider collaboration

For many who work on the front lines of delivery system reform, clinical integration is not a generic phrase to describe health care professionals working more closely together. It's a specific type of legal arrangement that allows hospitals and physicians to collaborate on improving quality and efficiency, while remaining independent entities.

In a clinical integration organization, physicians collectively invest in IT infrastructure, such as disease registries and clinical performance management systems, as well as funding staff dedicated to performance improvement.

Participating physicians also commit "sweat equity" to improving performance—serving on committees as well as changing their day-to-day clinical practice. And they create explicit plans for how the network will improve care outcomes and efficiency.

In exchange, the physicians can negotiate collectively with insurers for better payment rates (in recognition of their superior quality) or for bonuses based on quality and cost improvements. This collective bargaining would otherwise be illegal, but properly-designed clinical integration arrangements create a "safe harbor" from antitrust rules.

Hospitals often play a role in organizing clinical integration networks; however, the networks are led and operated by physicians.

Why clinical integration matters so much

Today, other than extensive direct physician employment, a clinical integration program is the most effective way to create the incentives, management, and infrastructure for health systems to improve quality and efficiency.

So it's not surprising that clinical integration has surged in popularity in the wake of national health care reform. By late 2012, there were more than 500 clinical integration programs in the U.S., up from a handful just a few years prior.

Advisory Board: https://www.advisory.com/research/care-transformation-center/care-transformation-center-blog/2013/04/clinical-integration-defined

4

Jan Largess, MSN, RN (Care Management Coordinator) submitted the following:

A Day in the Life of Nurse Care Manager Dawn Buckley from the Rhode Island Chronic Care Sustainability Initiative

By NASHP | July 30th, 2014

When South County Internal Medicine joined the Rhode Island Chronic Care Sustainability Initiative (CSI-RI) in 2010, the practice hired a nurse care manager, Dawn Buckley, RN, who has played a key role facilitating significant transformation inspired by the initiative.

"Our entire practice has changed. We've gone from a physician-centric to team- centric model. Our focus on tracking quality measures and setting goals is improving," stated one physician at the six primary care physician (PCP) practices located in southern Rhode Island. "Physician time is better spent, and patients are better prepared for visits."

The Day Begins

Each day quickly brings new challenges for Buckley as she works to best meet the needs of her patients and their family caregivers.

At 8:00 a.m., she logs on to her computer and reviews the list of scheduled appointments to identify patients at risk for complications. The practice recently adopted a risk stratification care management tool that classifies patients into four categories, from no risk to high risk, using color codes. Many patients have not yet been coded, so Buckley works to identify patients with the highest risk for complications. Those patients meet with Buckley for a 15-minute visit before their scheduled PCP visits. She asks questions to understand their situation, reviews medications, and talks with family members and other caregivers. This pre-visit planning helps the physicians better allocate their time with patients.

Buckley then reviews the daily Admission, Discharge, Transfer (ADT) report that South County Hospital emails to the practice each morning. This report lists all patients from South County Internal Medicine who were admitted, discharged, or transferred from the hospital. Because about 70 percent of the practice's patients receive care in this hospital, this report contains a gold mine of data to help Buckley identify patients in need of care management. She also checks CurrentCare–Rhode Island's health information exchange–for ADT activity at other hospitals.

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Regardless of their need for care management, all patients discharged from the hospital are contacted within two business days to review medications and discharge orders—an evidence-based standard adopted by this practice.

She fires off emails to some of the PCPs, sharing information about a recent patient admission. Next, she flags electronic health records to alert physicians who have scheduled office visits today about recent concerns raised by families, caregivers, the Visiting Nurse Services (VNS), and others. She shares her assessments and recommendations regarding some of these concerns with each physician.

The Morning Rush

Patients begin to flow into the practice when the doors open at 9:00 a.m. Buckley starts with several scheduled appointments for "wellness visits" —an annual voluntary checkup for Medicare patients. These patients, often accompanied by their caregivers, bring a completed Health Risk Assessment to the 30-minute appointment.

During the appointments, Buckley reviews changes to the patients' medical health, cognitive and functional status, and social history. She then makes referrals to appropriate patient education resources, including Stanford Chronic Disease Self Management Classes that she conducts, and other community resources, such as transportation and social services. Buckley has trained the practice's two LPNs to also perform these "wellness visits."

After her early appointments, a physician pulls Buckley into an appointment with a patient who has high cholesterol and needs dietary education. Certified as a cardiovascular outpatient educator by the Rhode Island Department of Health, Buckley provides the patient with immediate counseling.

Next, Buckley meets with a diabetic patient. As a certified diabetic outpatient educator, Buckley helps her diabetic patients understand and manage their condition. At this appointment, the patient brings his glucometer and Buckley downloads and discusses his readings—something that rarely happened before South County Internal Medicine became a PCMH. "We didn't have time to deal with meters before Dawn came," one physician notes. Now, more than 100 patients are actively engaged in this aspect of care. Buckley uses motivational interviewing techniques that she learned while taking a Guided Care training offered by CSI-RI to help the patient set new goals. After the visit, Buckley speaks briefly with the physician to relay the patient's progress. This information allows the physician to better focus time spent with the patient. Buckley has also trained the front office staff to remind patients during appointment scheduling to bring in their glucometers, blood pressure logs, and complete Health Risk Assessments, if applicable, so patients are better prepared for their appointments.

Before lunch, Buckley pulls reports for each physician showing the number of patients receiving smoking cessation interventions. South County Internal Medicine is eligible for performance payments from all the payers participating in CSI-RI if the practice meets certain quality targets, including one for tobacco cessation interventions.

The Afternoon Rush

After lunch, Buckley reviews hospital discharge summaries online and begins contacting patients in need of follow-up. She places a call to a recently discharged patient to assess his physical, mental, and functional status. She then places a call to a patient found to have a very high blood glucose level after recently being admitted to the hospital for cancer. Buckley attempts to track down the patient and schedule a follow-up appointment with his PCP.

Buckley moves on to send a mass email notifying male diabetics about a "Men's Night Out"—a chronic disease self-management class that she is facilitating later in the month. Then she answers a call from the VNS asking her advice about managing a patient at home. She consults with a physician regarding this patient. Because of her licensure as an RN, she is able to take verbal orders from the physician to change the patient's medications; enter the orders into the chart;; and call the patient, pharmacy, and the VNS about the changed orders. Buckley has developed a strong working relationship with the VNS and keeps them on speed dial as a valuable resource for many of her patients. Next, a physician pulls her into an exam room to counsel a patient and his family. The patient's health is declining and he has lost 15 pounds since the last visit. "In these moments, patients and families are often the most open to interventions. This opportunity might be lost if the counseling is done days later, over the phone, or by someone not connected with the practice," says Buckley.

At the end of the day, Buckley meets with the front office staff to help her conduct outreach to a list of patients who have not had a primary care visit in over a year. Buckley will be back tomorrow at 7:30 a.m. to meet with practice staff and PCMH practice transformation experts from the CSI-RI project. They will discuss how to improve patient satisfaction and establish a patient advisory group. Buckley is responsible for helping the practice maintain its recognition as a PCMH.

It's been another long day, but Buckley could not imagine a better job. "This is an incredible position and so professionally rewarding. It surpasses my prior experiences working in a hospital," she says. "The opportunity to develop one-on-one relationships with patients, their families, and caregivers has resulted in long-term, meaningful connections that have led to improved health care."

NASHP: http://www.nashp.org/day-life-nurse-care-manager-dawn-buckley-rhode-island-chronic-care-sustainability-initiative/

STATERA SPOTLIGHT

FAIRVIEW CLINIC

Fairview Clinic
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Dothan, AL 36301
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Physicians:
Christopher Miller, MD
J. Ryan Conner, MD
James A. Robeson Jr., MD
Fiona I. Masters, MD
Alexis F. Wood, CRNP
Justin Casey, CRNP

We recently spoke with Jessica Wingate, the administrator at Fairview Clinic, to get an inside view of Fairview Clinic. What we found is that this clinic is a leader of Quality Care in the state of Alabama and in the Wiregrass. Fairview Clinic opened its doors more than 30 years ago to serve patients in the Wiregrass. The physicians at Fairview Clinic specialize in Internal Medicine and Infectious Disease.

The principle which guides the practice is "Quality Care through Service, Education, and Patient Participation". In 2016, Fairview was named "Top Internal Medicine Practice in the State for Quality Care". That is an impressive accomplishment and reflects the desire of these physicians to provide the most current methods of treatments combined with the commitment to see their patients in the clinic as well as in the hospital when they are admitted.

Fairview offers an acute medication dispensary in clinic as an added convenience for their patients. They also offer a full lab (Select Lab approved), ultrasounds, echocardiograms, bone density tests, EKG's, Retinal exams, pre & post spirometry, Holter monitors, and event monitors on-site. This allows patients to make one appointment that covers most of their healthcare needs. Patients at Fairview receive convenient, quality, patient-centered care from a group of dedicated physicians committed to achieving the best outcomes.

STATERA MEMBERS ARE WELCOMED TO SUBMIT ARTICLES FOR THE STATERA NEWSLETTER.

Guidelines for submission:

1. Article must be relevant to Statera Newsletter readers
2. Articles about member practices are welcome
3. Articles will be screened for accuracy and may be edited for space

Did you submit an article and didn't see it in this issue?
Watch for it in future publications from Statera.

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Balancing quality and cost to create healthcare value

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