PARTNERS *In Our Future 2017*

BayCare
Physician Partners

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Bruce Flareau

LETTER FROM OUR PRESIDENT

BayCare Physician Partners Clinically Integrated Network (BPP CIN) and BayCare Physician Partners Accountable Care Organization (BPP ACO) continue to move further down the road of transitioning from fee-for-service to value-based care. In 2017, with our maturing infrastructure and expanding care coordination services, we were able to successfully manage a medical spend of over $1 billion covering 168,000 patient lives. Toward the end of the year, BPP ACO gained approval to take on nearly $70 million of additional downside risk as a Medicare Shared Savings Track 3 ACO starting in 2018. These wins were significant steps in our evolution and are necessary to ensure our ongoing success.

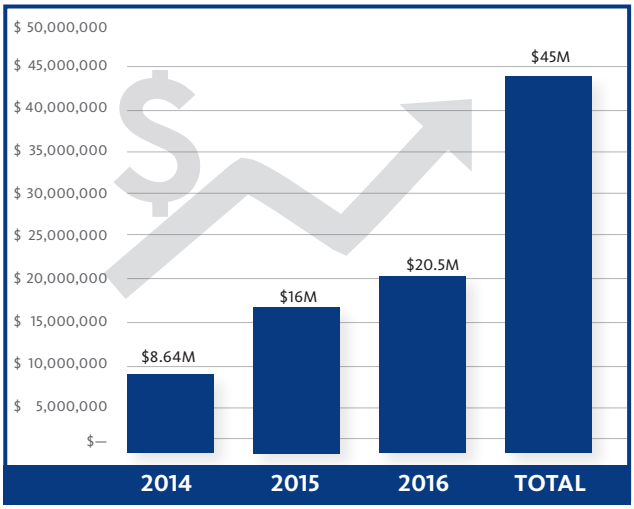
CLINICAL EXCELLENCE

Quality performance for both organizations continued to increase in 2017. BPP CIN met all of the contractually-obligated performance goals and BPP ACO achieved a 98.3 percent quality score with five publicly reported metrics attaining top-decile performance. Our ability to manage our population using data analytics helped our providers and our internal teams focus their efforts on gaps in care and guide our patients through the care continuum. We truly raised the bar on quality and brought value to those we serve.

CARE COORDINATION

Our Enterprise Care Coordination Office finished its second year of operation. The team grew to over 110 care coordinators, social workers, pharmacists and others who support our patients at various points along the care continuum. In 2017, our Care Coordination Office was assessed by an industry expert, Lumeris, and deemed "Highly Effective." As targeted care coordination programs continued to expand and technology improve, our ability to track and coordinate the care for our patient population has improved. This year we had a patient engagement score of 65 percent and saw a record low readmission rate of 9 percent for engaged patients.

Figure 1



From 2014-2016, BayCare Physician Partners has saved $45M in medical and pharmacy spend for its partners.

BENDING THE COST CURVE

BPP CIN and BPP ACO continued to have success in bending the cost curve year-over-year, generating savings for each of our payor partners. While health care costs continued to rise, our organizations saved $45 million in medical and pharmacy spend for our payor partners (see Figure 1). This was achieved through expanding our information technology infrastructure, implementing care coordination programs and dedicated providers proactively coordinating care.

Through hard work and meaningful engagement to BPP CIN and BPP ACO performance goals, our providers are the key to greater success. Continued focus on strategic and deliberate execution of action items tailored to help our providers be successful in improving clinical quality and reducing unnecessary utilization will be the key to successfully moving further down the risk continuum.

Bruce Flareau
President, BayCare Physician Partners

2017 Year In Review

WITH **$20 MILLION** SAVINGS TO PAYORS IN 2016

ONLY **18%** OF ACOs

generated shared savings in 2015 and 2016 Performance Years

400%

Provider shared savings distributions from 2015

168,000+
Patient lives

5.4% SAVINGS GENERATED **by chronic kidney disease program representing $7.2M in cost reduction**

15% Provider engagement score increase from 2016

1,800+
Providers across both networks

All contracted performance goals met

5 Publicly reported top-decile metrics

2-3%

Bent cost curve year-over-year generating savings with each of our payor partners

Increase in Screenings from 2016 results:

Breast cancer — **6% HIGHER**

Colorectal cancer — **5% HIGHER**

Diabetes — **3% HIGHER**

And

Generic drug usage — **2% HIGHER**

$1 BILLION

Annual medical spend responsibility

2,000+

Provider performance meetings held to review quality and efficiency metrics

★★★★

4.3

STAR RATING

Medicare Advantage

Decrease in Utilization from 2016 results:

- ED utilization — **21% LOWER**
- 30 day readmission rate — **3% LOWER**
- Heart failure admits — **39% LOWER**

KEY INGREDIENTS TO OUR SUCCESS

As BayCare Physician Partners (BPP) continues to move down the risk continuum and toward a fully integrated population health model, we will continue to focus our efforts around the four main support pillars that will move us from fee-for-service to value-based care.

PHYSICIANS

Our population health approach requires all healthcare providers in the network to be fully aligned with the goals and expectations within our model. Frequent education on a variety of topics is critical. Physicians understand clinical care, however, concepts such as hierarchical condition categories, minimum savings rate, attribution, etc. were not taught in medical school. 2017 brought large advancements to our educational offerings for our providers to help them navigate the changing health care environment.

CARE COORDINATION

A coordinated and systemic approach to care coordination is more crucial than ever as BPP takes on more financial risk amid the shift toward value-based care. In 2017, we continued to implement our vision for a redesigned care coordination program. We believe that care coordination requires cross continuum collaboration enhanced by patient-centric technology for seamless patient transitions across the care continuum. We strengthened our post-acute care strategy by creating a network of preferred skilled nursing facilities (SNF), allowing us to apply for, and subsequently receive, approval for the Medicare three-day SNF waiver. This will allow BPP ACO to admit patients directly to a SNF without a qualifying three-midnight inpatient stay. This will also add the ability to directly admit to a SNF from an emergency room or a community setting.

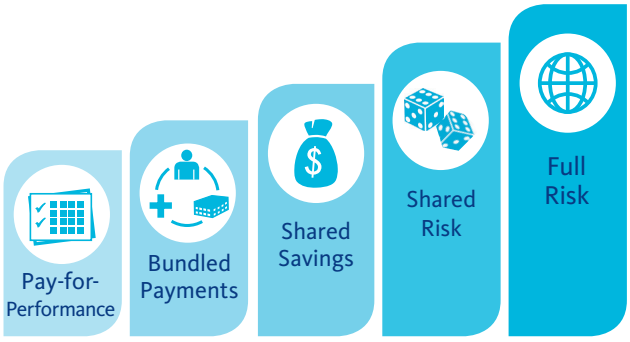
BUSINESS INTELLIGENCE

It's important to engage physicians with actionable performance data to help them identify opportunities to improve patient care. BPP continues to invest in real-time physician dashboards that provide actionable patient data which allows physicians to compare their performance against national and network standards.

CONTRACTS

The shift toward increased collaboration, outcome-based payment and new benefit design is driving innovation in the relationship between payors and providers.

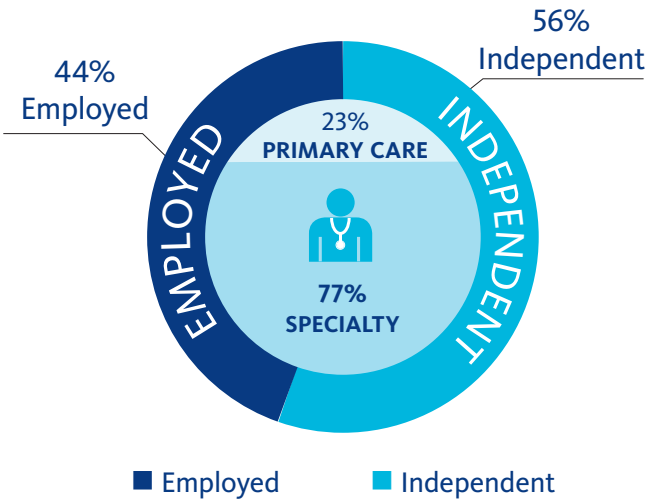
BPP has a variety of value-based contracting strategies to ensure a diversified portfolio that allows BPP to take on incremental downside risk.



Our six payor partners across 10 products have varying contract terms focused on goals to increase quality, reduce medical costs, improve patient outcomes and share in risk. In 2017, we introduced our first BPP CIN downside risk contract furthering our ability to adapt to evolving payment and delivery system models.

PHYSICIANS

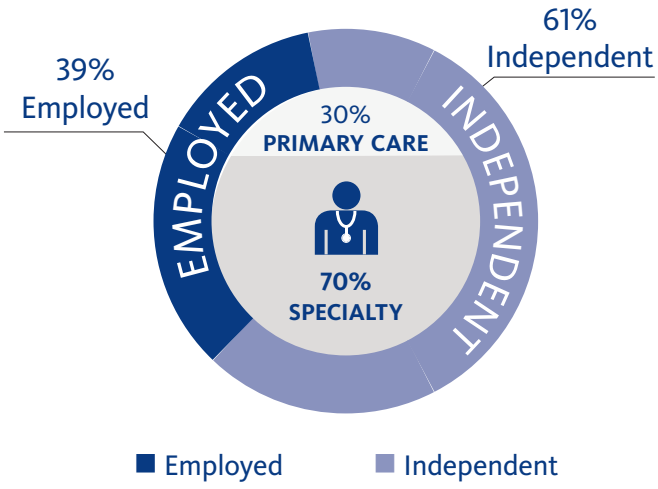
BPP ACO PHYSICIANS
1,475



13 HOSPITALS

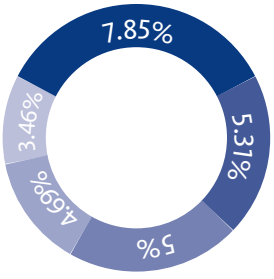
8 PREFERRED SNFs

BPP CIN PHYSICIANS
1,313



TOP FIVE SPECIALTIES

- Cardiovascular Disease
- Gastroenterology
- Diagnostic Radiology
- Orthopaedic Surgery
- Pulmonary Disease



PHYSICIAN ENGAGEMENT

In 2017, the BayCare Physician Partners Provider Relations Specialists (PRS) Team expanded to accommodate the growing responsibilities of managing over 1,800 providers. The PRS team builds and maintains collaborative, engaging relationships with our providers, develops meaningful education, delivers customer service and focuses on provider data integrity in order to improve the health and wellness of our community through promoting quality, low-cost care.

PRIMARY CARE PHYSICIAN ENGAGEMENT

One of the largest initiatives in 2017 was the development of a Primary Care Physician (PCP) Pod Network. The Pods grouped primary care physicians into physician-led organized collaborative units to create a forum to engage with one another and learn best practices for managing risk and improving quality of care. In order to ensure meaningful engagement of all PCPs, we implemented a pilot with four PCP Pods. Pilot participants benefited with increased access to beneficial resources and peer collaboration resulting in increased quality measure compliance scores and physician satisfaction.

Pod attendance has been tied to citizenship requirements, which will ensure adequate participation and physician engagement. Meetings in this collaborative setting will be crucial to providing ongoing education to our physicians to prepare them for additional and increased downside risk arrangements.

SPECIALIST ENGAGEMENT

Providing meaningful data to specialists continued to evolve in 2017. With the use of a new population health risk management tool, the BPP team has been able to create dashboards that enable conversations with specialists around cost, efficiency and appropriate coding. Specialties with high attribution were the focus in 2017: Cardiology, Gastroenterology, Orthopedics, Pulmonology and Urology.

EDUCATION AND COMMUNICATION

Clinical Documentation Improvement Initiative

As BPP continues to take on more downside risk, it is important that we educate our providers on risk adjustment methodologies being used today and how to improve their documentation to gain a more accurate picture of each of their patient's risk. Physicians and other health care providers are

typically not trained to develop proper documentation skills in medical school and residency; therefore, it is necessary for our team to compensate for this lack of training by instituting educational programs, tools and support that align health care providers with proper documentation practices and remove barriers to achieving Clinical Documentation Improvement (CDI). Providing this support to our providers increases our ability as an organization to accurately capture patient diagnosis, which translates into better patient care, accurate patient risk profiles and the ability to maximize reimbursement on value-based payment models, both in the ambulatory and inpatient settings. This year, we provided over 15 general awareness sessions on risk adjustment methodology and

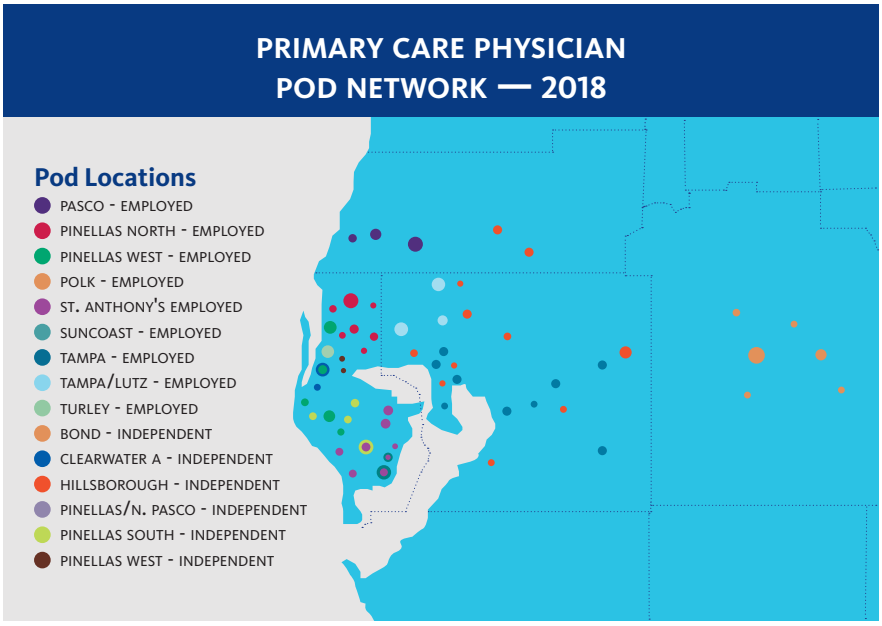
appropriate clinical documentation that all PCPs were required to attend. These sessions were led by a physician, which enhanced our physician-to-physician outreach. In addition to general awareness sessions, we completed over 1600 chart audits to identify potential areas for improvement. The audits highlighted the need for specific education around certain chronic conditions. In response to this, we provided five group training sessions focused on these key areas. All sessions were taped and placed on the Member Resource Center to ensure all physicians had the opportunity to watch at their convenience. In depth physician-to-physician coaching sessions were provided to physicians that were interested in learning more to provide a detailed look into their charts and opportunities for improvement.

Enhanced Communication

New for the year, physician members and their staff were invited to attend monthly "Open Mic" sessions (online educational webinars), focused on a relevant topic that would help with patient care in their offices. The educational aspects of these open forums focused on topics that needed additional clarification around Clinical Documentation Improvement initiatives to reinforce the messages presented in our Educational Outreach. These sessions were recorded and are now part of the resource materials on the BPP Member Resource Center for members to access at their convenience.

2017 marked the first year in which BPP published 12 monthly newsletters for BPP CIN and BPP ACO providers, office staff and other stakeholders. These newsletters have become the main mode of consistent communication for new and useful information to our members. Topics include pharmacy programs, care coordination initiatives, industry specific changes and updates, as well as clinical best practices.

In 2018, the PCP Pods will be expanding to all participating PCPs in both BPP CIN and BPP ACO. There will be 15 Pods, each led by a community PCP, having 10-30 physicians per Pod.



CARE COORDINATION

Care Coordination saw many changes in 2017 as the focus on clinical quality and process improvement matured. The continuous care coordination team continued to grow in size in order to fully execute their clinical programs and interventions. The 110 member team and 13 clinical programs are organized into four divisions (see pyramid to right).

New in 2017, the Enterprise Care Coordination Office expanded its reach into the community by collaborating with local partners such as Publix, Uber, Merck, and Tobacco Free Florida to provide wrap around supporting care coordination services. BayCare has an agreement with Publix to be its exclusive healthcare partner at all of their stores within four Tampa Bay counties.

65%
Patient Engagement Rate

97%
Calls Made Within 48 Hours of Discharge

8,844
Completed Provider Pre-VIsit Planning

9%
Hospital Readmission Rate

36,000
Transition of Care Patients Touched

Our Programs	Description
Transition of Care Calls	All discharges, regardless of inpatient facility, receive scheduled calls from a multidisciplinary team to aid in post-discharge planning, reduction of hospital readmission, medication adherence and timely follow-up care.
ED & Unengaged Utilization Management	Engage with ED over-utilizers to educate them on appropriate usage and smart alternative choices (Urgent Care, Telehealth). Also engage with those who don't identify with a PCP to make recommendations.
Disease Management	Disease-specific phone consultations using certified health coaches and nurses. Designed to help with chronic conditions, such as diabetes or certain types of heart disease. Education and resources are offered to support optimal health of patients who are currently being treated for chronic conditions. Members receive case management and can attend workshops on how to live with their condition with confidence.
Complex Care Coordination	Program tailored to meet the needs of individuals who have high healthcare utilization patterns and whose complex physical, behavioral and social needs are not adequately met through traditional care coordination programs. This typically is the patient cohort that represents 1-2% of the population, however utilizes the majority of the healthcare costs.
Chronic Kidney Disease Program	Program designed to combine big data analytics with a provider-friendly approach to treat patients suffering from chronic kidney disease (CKD) and end-stage renal disease (ESRD). Collaborative coordination between PCPs, Nephrologists and patients.
Health Coach	Program to help patients gain the knowledge, skills, tools and confidence to become active participants in their care so that they can reach their self-identified health goals. Program targets weight loss, tobacco cessation and diabetes.
Hospital to Home	Nurse practitioners see recently discharged patients in their home to provide needed medical care while they await transition back to their primary care physician. They are monitored for early decompensation in their condition and medication reconciliation is completed to help ensure safe transition from hospital to home.
eSNF Consult	Members in SNFs can be consulted via telemedicine to avoid ED visits and hospitalization for low-acuity issues.
Pharmacy Medication Therapy Management	Pharmacists provide medication therapy coordination services to address drug and non-drug therapy, as well as lifestyle modifications. The goal is to empower patients to manage their disease and medications, and thereby reduce health care costs and improve quality of life of patients.
Gaps in Care	Central team uses EMR and claims data to identify patients who have gaps in care. Outreach is made to patients and providers to close the gaps which impact HEDIS compliance measures. Outreach focused on educating patients to take action. Our team proactively schedules appointments with the patient's physician to facilitate needed care.
Free Diabetic Supply	Program provides free diabetic supplies to BayCare team members who complete appropriate diabetes wellness exams and trainings. The goal of the program is to increase patients' ability to successfully live with their disease.
Provider 1:1 Coaching	Dedicated team that works with Provider offices in care delivery redesign. Provide physicians with patient and performance data that can help manage the clinical and financial risk associated with value-based contracts.
Wellness Information Sessions	General education sessions on wellness, living with chronic conditions and preventative health.

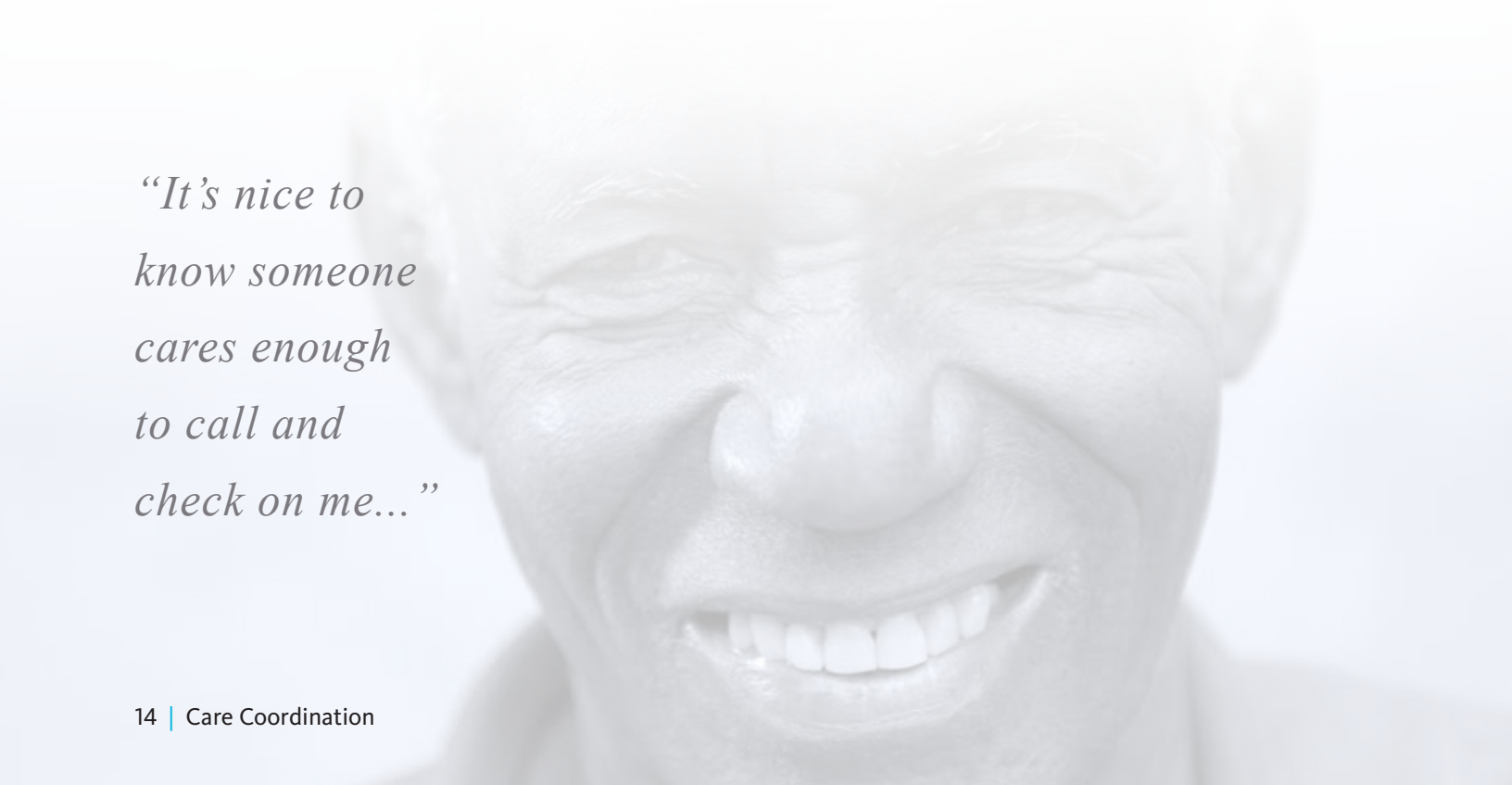
PROGRAM HIGHLIGHTS

TRANSITION OF CARE

The Transition of Care team (TOC) continues to provide phone outreach to patients within 48 hours post-hospital discharge for 30 days to ensure a seamless transition from hospital to home for optimal recovery and readmission prevention. All BPP ACO and BPP CIN lives are offered this service. In total, the TOC team made over 36,000 calls, with 97 percent of patients contacted within 48 hours of discharge. This had a large impact on reducing readmissions and lowering ED utilization rates.

The TOC team is structured into pods, which align with BayCare hospitals for enhanced collaboration across all care coordination programs and between inpatient and ambulatory settings. The pods consist of RN's, LPNs, social workers, case coordination assistants, and medical assistants to reduce barriers to post-acute care and increase patient success at home. Interventions include assistance with symptom management, medications, home health care, follow-up appointments, and Skilled Nursing Facility (SNF) monitoring and follow-up.

In addition to the TOC team, we implemented an automated transition of care call program that makes educational phone calls to patients discharged home from a BayCare hospital. The team then provides follow-up to patients based on flags for readmission prevention— 46,682 patients received at least one transition call, and 48 percent of patients contacted had a flag necessitating follow-up from the TOC team. The follow-up addresses: medication issues, follow-up appointments, physical symptoms, weight monitoring, behavioral symptoms, discharge instructions and new issues.



"It's nice to know someone cares enough to call and check on me..."

CHRONIC KIDNEY DISEASE PROGRAM

BPP partnered with Healthmap Solutions to deliver better outcomes to patients with chronic kidney disease (CKD) and end-stage renal disease (ESRD). The program combines powerful big data analytics with evidence-based clinical best practices to improve the lives of patients facing serious kidney disease. We are able to provide a custom care plan that is based on each individual patient's needs, which resulted in significantly improved health outcomes.

In 2017, we had 176 primary care physicians and nephrologists participating in the program and 7,115 enrolled patients. As a result, we have reduced ED visits by more than 9 percent and we have reduced admissions by 6 percent, thus improving outcomes and the quality of life for patients while reducing overall health care costs.

CONTINUOUS CARE COORDINATION

In June of 2017, the expanded Disease Management Program was introduced to patients identified with Congestive Heart Failure (CHF), Diabetes and Coronary Artery Disease (CAD). The disease management team is composed of registered nurses, pharmacists, and licensed clinical social workers who work together to educate patients regarding disease state, symptom management, and medications. They empower the patient for better personal outcomes, and improved quality of life. The program had over 500 patients under care and saw a 10 percent decrease in medical spend and an 11 percent reduction in ED utilization.

HOSPITAL TO HOME

Covering 12 hospitals, our Advanced Registered Nurse Practitioners (ARNP) partnered with 558 Medicare patients with a COPD or CHF diagnosis. These patients saw an 18 percent reduction in hospital readmissions. The team of ARNPs had over 3,000 touch points with these patients and their families.

PREVENTATIVE INITIATIVES

The Check-Change-Control blood pressure monitoring program with the American Heart Association provides education and care coordination. In 2017, we had 437 participants with 43 percent of the particpants showning improvement in their blood pressure since their first blood pressure reading.

EDUCATION

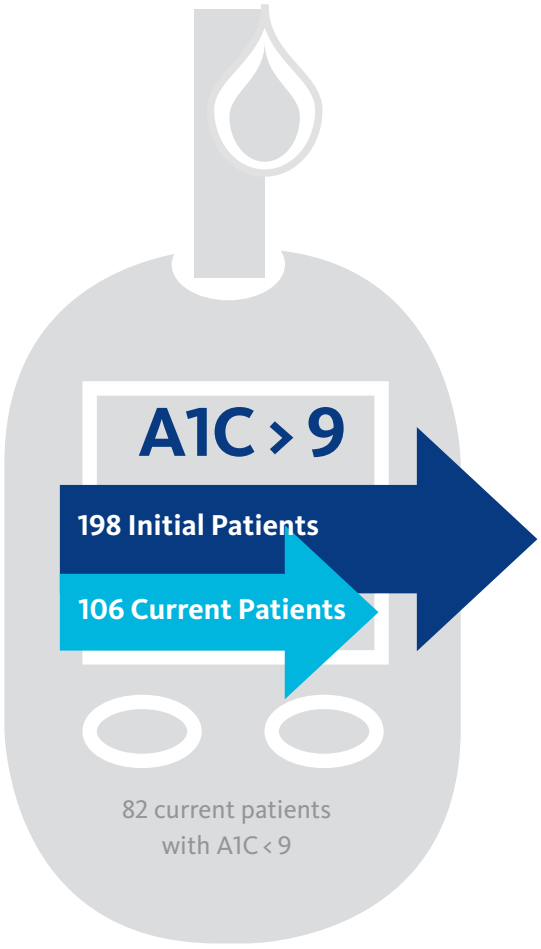
We invested in a robust educational strategy utilizing not only virtual education avenues, but also community partners (Merck, Tobacco Free Florida) and our own internal resources (physician and pharmacy trainings) to provide training and education in topics relevant to care coordination, helping to ensure that our staff has current information and the necessary foundation they need to be experts in their area.

DIABETES PROGRAM

The Pharmacy Program continues to add value to our patients and providers. Education to the providers focuses on the importance of completing a medication reconciliation on each patient encounter. The education stresses patient safety and improved quality of care for patients.

The pharmacists engaged 198 patients that had an A1C > 9. These patients were contacted and offered a medication review, education and assistance with obtaining their medication. We saw a 41 percent decrease in patients with an A1C > 9.

The Pharmacy program works with the Disease Management team to provide participating patients with medication reviews and ongoing support. They also provide outreach and support to patients who had diabetes without Coronary Artery Disease (CAD) that had a higher than average cost per member per month. Patients were offered a complete medication review, medication education, disease state education and assistance in obtaining medications.



BUSINESS INTELLIGENCE

Business Intelligence efforts were focused in six key areas to further mature the infrastructure needed to manage the health and risk of our growing patient population. We continue to invest and strengthen our analytics and reporting capabilities in each of these areas. Significant resources were spent on developing predictive modeling/risk stratification and drill-down analytics by provider, location and date. Using this level of analytics has given our providers and staff the information they need to develop and implement targeted programs and interventions based on our population's needs.

Care Coordination (HealtheCare)

- Patient population segmentation
- Comprehensive care plans and assessments
- Transitions in care

Quality & Care Gaps (HealtheRegistries)

- Increase disease registries
- Build wellness registries

Analytics

- Predictive modeling
- Create operational dashboard to drive decisions

Patient Engagement

- TeleHealth offering
- Partnership with Publix to offer blood pressure readings

Wellness

- Annual Wellness Visit checklists
- Events and workshop reporting

Risk Adjustment

- Clinical documentation improvement support
- Reporting on insights and opportunities

BayCare Health System's arrangement with Publix and the BayCare Anywhere initiative has extended our care coordination responsibilities. Our Care Coordination team will provide the wrap around services to support these system initiatives. Technology innovations both helped add additional proactive patient coordination and technology-enabled convenience to engage patients and providers.

PARTNERSHIP WITH PUBLIX

Our Population Health Information Technology team worked together with the Enterprise Care Coordination Office to implement a partnership formed with Publix, which allows patients enrolled in any of our Disease Management Programs to use the higi stations that reside in Publix pharmacies to measure important health indicators such as pulse, heart rate, BMI (body mass index) and blood pressure.

The program is designed to help patients improve their activity level, reduce the risk of future acute events and lessen the physical and emotional effects of their disease. Throughout a patient's enrollment in a disease management program, they can check in at a higi station to measure their vitals each week. This enables our care coordinators to monitor a patient's progress and provide the support they need.

BAYCARE ANYWHERE

2,532 patients utilized our in-house telehealth application which provides virtual provider visits for minor illnesses. This program increased access to care into our system, as well as allowed patients to avoid unnecessary wait times to treat minor and common conditions. This program was a reaction to the increasing need for convenience by our consumers.

NOTIFY

This technology was launched in late 2016, but has really grown over the last year. The technology delivered close to 200,000 provider-specific notifications about inpatient or discharge events at BayCare hospitals. Improving a provider's ability to have real-time information about their patients allows them to make interventions when necessary to improve patient care. The 280 participating providers enrolled in the program, receive notifications via email, text message, or direct secure email, based on their communication preferences.

HEALTHEREGISTRIES

HealtheRegistries is embedded in the providers EMR and offers a registries and scorecard solution that enables BPP to identify, attribute, measure and monitor people and providers at an individual or population level. This software platform allows us to proactively identify gaps in care, recommend targeted interventions and measure provider performance.

HEALTHECARE

Our care coordination software platform enables our care teams to make more informed decisions as it offers a longitudinal record designed to provide clinicians an organized, summary view of a person's health and care story. It allows our care coordinators to coordinate and facilitate health care services across the care continuum.

HealtheRegistries

- **Scorecards** for PCPs and Specialists
- **35** Disease Registries Built
- **Total of 64** Quality Measures
- **3 MILLION** Patient Records
- **21** Chronic Condition and Wellness Registries Built

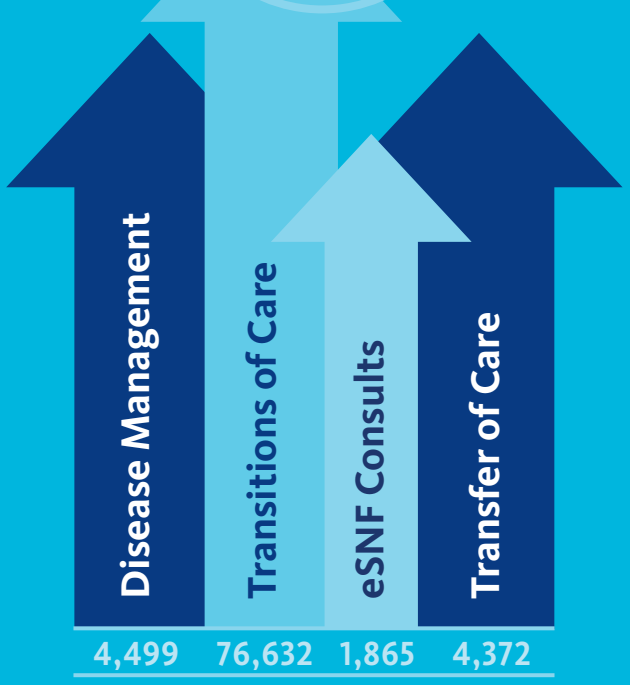
HealtheCare

2.3 CASES
OPENED PER HOUR
ON AVERAGE

94,067+
CASES

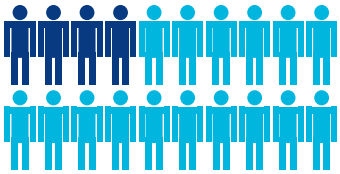
113 CARE
COORDINATORS

11 USE CASES
AND
GROWING...



CONTRACTS

BayCare Employee Plan	35,914
Cigna East Commercial	16,386
Aetna Commercial (Fully Insured)	5,730
Aetna Commercial (Self-Insured)	18,950
Aetna Medicare Advantage	1,663
Blue Cross Commercial (HMO and Non-HMO)	30,130
Blue Cross Medicare Advantage (HMO and PPO)	6,371
United Medicare Advantage	11,652
Medicare Shared Savings Program CMS ACO	42,031



168,827
TOTAL LIVES

QUALITY PERFORMANCE

CLINICALLY INTEGRATED NETWORK

BPP CIN met 37 of the 39 (95 percent) contractual quality performance measures. This was the third year in a row BPP successfully met the required quality performance goals with our payor partners, making BPP CIN eligible to share in cost savings.

Payor Data—
- Exceeded target
- Did not meet target

Metric	Aetna	Aetna Medicare Advantage	Florida Blue	Florida Blue Medicare Advantage	Cigna	United
BMI Assessment				●	●	●
Breast Cancer Screening	●		●	●	●	●
Cholesterol Screening			●	●		
Colorectal Cancer screening	●		●	●	●	●
Diabetes Screening - HbA1C test		●	●		●	●
Diabetes Nephropathy Screening	●				●	●
Diabetes Retinopathy Screening					●	
Diabetes Hemoglobin A1C poor control (>9.0%)	●			●	●	
Diabetic Medication Adherence				●		●
30 Day Readmission Rate	●					
ER Visits per 1,000	●			●		
Generic Dispensing Rate - All Drugs				●		
High Risk Medications				●		
Office Visits per member each calendar year		●				●
Office Visit - Post Acute Care Inpatient Hospital		●				
Post Hospitalization PCP Follow Up Visits				●		
Reduce Avoidable Hospital Admissions		●				
Well-Child 15 Mo - Visits during the first 15 months of life					●	

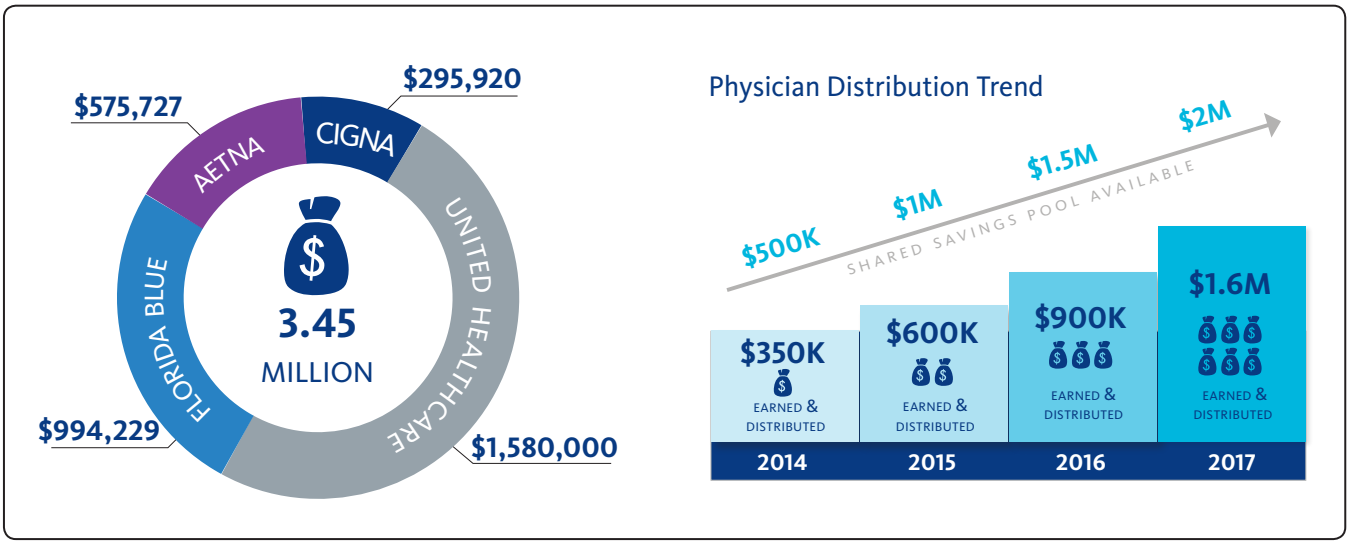
ACCOUNTABLE CARE ORGANIZATION

BPP ACO obtained a quality score of 98.3 percent and had five publicly reported top-decile performance metrics. For non-first year ACOs, this placed us in the top-decile of ACOs for quality performance.

FINANCIAL PERFORMANCE

CLINICALLY INTEGRATED NETWORK

BPP CIN generated approximately $3.45 million in shared savings, of which $2 million were allocated to the physician distribution pool. Since year one of operation, BPP CIN has been able to increase our physician distribution pool by 400 percent.



ACCOUNTABLE CARE ORGANIZATION

For the second year in a row, BPP ACO has achieved its minimum savings target required to generate shared savings in the MSSP Track 1 ACO program. This was an accomplishment only 18 percent of ACOs were able to obtain. BPP ACO generated $9.9 million in savings.

2.3%
% Shared Savings Generated

$9.9 MILLION
Total Shared Savings Generated

$4.82 MILLION
BPP Shared Savings Earned

LOOKING FORWARD

Ethan Chernin

With BPP CIN entering into its sixth year of operation and BPP ACO completing its initial three-year agreement with the Centers of Medicare and Medicaid Services (CMS), we have made substantial progress in developing our physician integration and population health resources and capabilities. Our focus will always be to do what is best for each of our patients and all of the communities we serve.

CMS has set a goal for 90 percent of Medicare payments to come through value-based programs by 2018, and commercial payers are interested in similar approaches. As value-based health care opportunities grow, BPP recognizes that strategies built to thrive in a fee-for-service environment must evolve as health care reimbursement is transformed. BPP will continue to focus on building an integrated, cost-efficient clinical network that is capable of embracing and successfully implementing changes in the way health care is delivered along the care continuum.

With market forces at play, such as changing demographics and consumerism, the advancement in technology and data availability and the increase of government influences, BPP will continue to help providers make the shift from fee-for-service to value-based care. These changes will have a profound impact on our physicians' ability to continue to practice, succeed and thrive. Therefore, it will be imperative for BPP to find ways to provide education, resources and support to add value to its members.

As we begin a new chapter of taking on additional downside risk contracts, we will need to strengthen our integrated care delivery model through the maturation of our care coordination teams, implementation of real-time patient monitoring, expansion of actionable analytics to specialists and the development of a post-acute network to further seamless transition of care.

I look forward to 2018 and beyond.

Ethan Chernin
Vice President & Chief Operating Officer
BayCare Physician Partners

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