2015 Value Report

LETTER FROM THE PRESIDENT

Bruce Flareau, MD
President, BayCare Physician Partners

2015 was a year of growth, change and continued maturation as BayCare Physician Partners Clinically Integrated Network (BPP CIN), our commercial insurance entity, completed its third full year of operations. We also went live as a Medicare-approved Accountable Care Organization. Collectively, these side-by-side organizations increased our covered lives to over 168,000 and our operations achieved positive cash flow. In addition, we consistently met or exceeded quality targets with payers and doubled our eligibility pool to $1 million, with physicians earning 60 percent of those incentive payments.

Because of strong physician engagement and improved sophistication in business intelligence and care management activities, we achieved these additional successes:

- Doubled our care management expertise and volume of activity
- Added a full-time pharmacist
- Developed advanced-care disease management protocols
- Deployed cutting-edge care management technology in cooperation with Cerner Corporation and Advocate Health System
- Implemented new reporting systems that enabled more real-time and actionable data reporting
- Increased network expectations around physician engagement and citizenship

There is no doubt our physicians and their meaningful engagement in change management and care delivery led to these successes. I thank them for their dedication and hard work, especially in a year characterized by substantial change in a variety of directions.

In 2015, ICD-10 conversions disrupted billing and coding activities throughout the country. Also, we successfully lobbied on behalf of our physicians for changes to legislation that created the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). This legislation resolved long-standing issues with the sustainable growth rate (SGR) formula, implemented in the Balanced Budget Act of 1997, averting a 21 percent reduction in payments to physicians. It also created the Merit-based Incentive Payment System (MIPS) and Alternative Payment Models, which begin to consolidate a host of programs and reporting obligations (PQRS, Meaningful Use, etc.) into a single reporting and payment structure. We believe this new system is correct in making reporting requirements less burdensome and more aligned across governmental agencies.

In the midst of these changes, we increased our expectations around network physician engagement and citizenship, developing new online training materials and instituting meeting attendance

requirements and other criteria used to determine the threshold for incentive awards. About 200 physicians chose to withdraw, but we gained 125 new physicians who joined the network in 2015.

In addition to increasing our network expectations, we focused on enhancements for physician practices that helped create more timely, patient-centered, high-value care. We implemented new data reporting systems that enable more real-time, actionable data to reach physicians faster than ever. We also continued to evolve our care management programs and deployed a state-of-the-art customer relationship management system.

We took a hard look at patient access to primary care and conducted a market study to establish baseline. It became apparent that, from a patient's perspective, we have a long way to go to create timely access to primary care. To help close this gap, we began efforts to deploy on-demand virtual visits and utilize BayCare's Urgent Care centers as emergency department alternatives. We also continued to help physician practices with throughput enhancements, and we recruited primary care providers and advanced care practitioners into our network.

There is growth of consumerism in our industry as patients' out-of-pocket expenses increase and their expectations for access to care are unmet. We will continue to mature our ability to deliver timely services, which is essential to our strategy to meet this growing trend in consumerism.

In summary, 2015 was a very productive year. We made high-quality, high-value care available to patients by empowering physicians with better systems, better intelligence and more resources.

Sincerely,

Bruce Flareau, MD
President, BayCare Physician Partners

2015 YEAR IN REVIEW

KEY WINS

CLINICALLY INTEGRATED NETWORK

In its third full year of operation, BayCare Physician Partners Clinically Integrated Network (BPP CIN) continues to grow and generate shared savings.

Contracted Payor	Lives
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
TOTAL	126,796

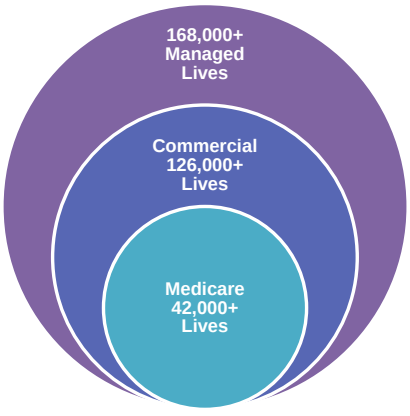
Performance Year	Shared Savings
2013	$2.1 M
2014	$2 M

ACCOUNTABLE CARE ORGANIZATION

In January 2015, BayCare Physician Partners Accountable Care Organization (BPP ACO) began operation as a Medicare Shared Savings Program with approximately 42,000 Medicare beneficiaries and 1,140 participating providers. ACO designation will further develop our capabilities with value-based reimbursement models. It also will expand our overall proficiency at supporting physicians on population health management.

Although BPP ACO has its own board of directors, it operates in a side-by-side relationship with BPP CIN to minimize operational redundancies, maximize efficiencies, improve quality, and effectively manage cost and utilization rates of our patient population.

Contracted Payor	Lives
Medicare (CMS)	**42, 126**



CARE COORDINATION PROGRAM

BayCare Physician Partners' Care Coordination team continues to grow.

- Team expanded from 6 to 10 care coordinators
- 834 transition of care calls completed
- 333 case management referrals
- 122 disease management referrals
- 348 face-to-face meetings with providers
- 3 new physician-focused programs launched
- 5 new patient-focused programs launched

PHARMACY INITIATIVES

BayCare Physician Partners hired a pharmacist to educate providers and patients on the appropriate utilization of medications.

- High-risk population diabetes education
- Diabetes Medication Control Program
- Clinical standards developed for use of biologics and oncology protocols
- Physician education on high-risk medications and possible alternatives

PHYSICIAN ENGAGEMENT

In addition to the BPP CIN physician dashboards rolled out in 2014, the team has added a new risk, efficiency and cost solution to produce detailed BPP ACO physician dashboards. The BPP ACO physician dashboards provide physicians with patient and performance data that can help manage the clinical and financial risk associated with value-based contracts.

POPULATION HEALTH

Two new technology applications were rolled out in late 2015. *HealtheCare* for care management and *HealtheRegistrie*s for quality reporting enable better management of our patient population. To date, 6,306 cases have been opened in the *HealtheCare* application by care coordinators across BayCare Health System and BayCare Physician Partners.

FOCUS AREAS

CARE COORDINATION

Care Coordination is the back bone of a strong network. With the addition of the Accountable Care Organization, BayCare Physician Partners evolved and grew its care management model to provide focused outreach and appropriate interventions for our expanding patient population. To manage such a large population, our team utilizes a variety of resources and tools to work with both physicians and patients. Physicians benefit from both one-to-one interaction with their patients and from the care coordination team's help identifying opportunities that may improve patient outcomes.

Engaging both providers and patients continues to improve patient outcomes, increase patient access and lower the cost of care.

PHYSICIAN-FOCUSED CARE COORDINATION PROGRAMS

DEDICATED CARE COORDINATION PROGRAM

The Dedicated Care Coordination Program was developed this year to foster a closer relationship with participating physicians. This program assigns dedicated care coordinators to participating physicians in order to develop a working relationship in the care of their patient population. The dedicated care coordinators review patient charts and recent hospitalizations, identify gaps in care and highlight deficiencies in documentation that can be addressed in upcoming patient visits. Five dedicated care coordinators are now supporting a total of 30 practices and 63 providers.

APPROPRIATE DOCUMENTATION EDUCATION

BayCare Physician Partners is committed to ongoing education for our participating physicians on everything from patient care to in-office work flows. This year we launched a campaign to help physicians understand the importance of appropriate documentation of patients' diagnoses and capturing quality data. Accurate documentation helps identify the resources that can be utilized to meet the needs of their patients.

BayCare Physician Partners developed resources and tools to facilitate appropriate documentation for diabetes and its complications. Diabetes is prevalent in our patient population and through chart audits the team was able to determine that comorbidities such as diabetic neuropathy, retinopathy and nephropathy were not consistently documented. The resources and tools developed by BayCare Physician Partners help to reinforce the importance of adequately capturing specificity and providing supporting documentation within a patient's chart. This campaign also provided much-needed support to physicians on the transition from ICD-9 to ICD-10.

DIABETES MEDICATION CONTROL PROGRAM

The new BayCare Physician Partners pharmacist identified a need to improve management of uncontrolled diabetic patients' A1c. A physician outreach program was developed to alert physicians of patients under their care that:

- Use two or more oral or one combination medication
- Are not on any injectable diabetic product
- Have an A1c greater than 8

Physicians were then provided with information on how to adjust medications to improve A1c control. Over the course of the year, 69 patients met the established criteria and 20 of them have improved their A1c to less than or equal to 8. This is an overall 29% decrease.

ASTHMA MANAGEMENT PROGRAM

In its second year of operation, the Asthma Management Program continues to identify patients who chronically over-utilize short-acting rescue inhalers and works with them to get their disease more effectively under control. This year 147 patients were identified as over-utilizers. Care coordinators worked with 96 individual physicians and successfully referred 15 patients to asthma management programs. The other participants continue to be monitored as adjustments are made to care plans.

PATIENT-FOCUSED CARE COORDINATION PROGRAMS

HOME CONNECTION PROGRAM

The BPP ACO Home Connection Program is a home management program launched this year that addresses chronic condition management for patients with Chronic Obstructive Pulmonary Disease (COPD) and Congestive Heart Failure (CHF). Patients with these chronic conditions are at an increased risk of complications and re-hospitalizations. The goal is to help the patient return to maximum functioning and to provide all services possible to help them stay at home. There are two tracks in the program:

Track 1: Proactive Patient Management - Proactive engagement with patients identified as high-risk, including patients referred by participating physicians.

Track 2: Reactive Patient Management – Patients seen within 24 hours of discharge from an acute care facility by BayCare HomeCare.

Both program tracks offer home health interventions to ensure a patient's continued health. The following are key components of the program offerings:

- Energy conservation and relaxation techniques
- Personal contact for urgent needs - 24/7 RN
- Red Flag training and response plans
- Medication self-management
- Emergency medication "rescue kits"
- Disease management and education
- Physical therapy and psycho-social evaluations

BY THE NUMBERS (as of 12/31/15)	
Patient Enrollment – track 1	34
Average visits per patient	5
Average calls per patient	3

Since the program started, 15 patients in the track 1 proactive group have used rescue kits and avoided emergency room visits and hospitalizations.

POST-HOSPITALIZATION STABILIZATION PROGRAM

As an extension to the BPP ACO Home Connection Program, BayCare Physician Partners developed an initiative focused on post-hospitalization transitions for patients discharged from an acute care facility. The initial focus is on all patients with a diagnosis of COPD, CHF or Diabetes Mellitus. Licensed ARNPs will work with these patients and serve as care providers and navigators during the critical post-hospitalization period. The ARNPs will also work closely with the patient's primary care physician and specialists to achieve seamless coordinated care.

DIABETES EDUCATION PROGRAM

BayCare Physician Partners staff developed an educational presentation that provided an overview of preventive health care services available to BayCare enrolled beneficiaries with diabetes. The team also provided attendees with the opportunity to take a diabetes screening questionnaire to identify their risk level for developing Type 2 diabetes. More than 350 team members were reached over the course of the year.

COLORECTAL PROGRAM

Care coordinators identified 2,230 BayCare team members over the age of 50 who had not received a colorectal screening within the recommended time frame. Stool screening kits were sent to all individuals and over 153 fecal occult blood tests were returned and analyzed. Four of these were positive for blood in the stool and three individuals had multiple polyps, often a precursor of cancer.

DIABETES MANAGEMENT PROGRAM

The Free Diabetic Supply Program completed its first year of operation. The program continues to provide 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 self-manage their disease. There are 66 patients successfully enrolled in the program who are eligible to receive free diabetic supplies. Participation continues to grow as awareness of the program increases.

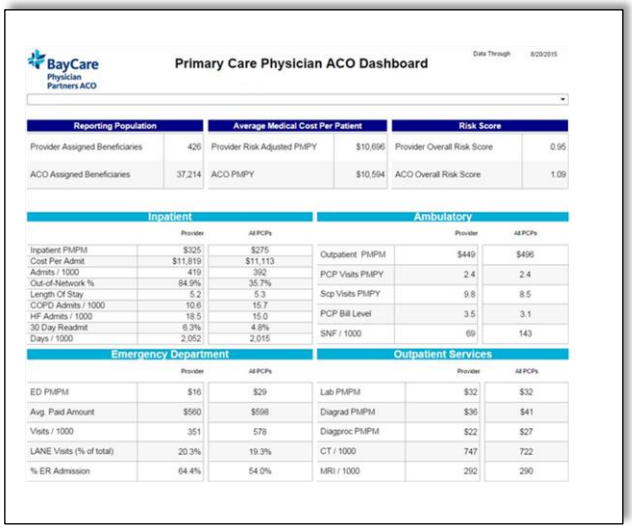
MAMMOGRAPHY OUTREACH PROGRAM

Care coordination identified 1,500 female team members and beneficiaries above the age of 50 who had not had a mammogram in over two years. Letters were sent out to these individuals and over 200 responded by having an exam performed within several months after the letter. No significant abnormalities were found.

DASHBOARDS, PHYSICIAN ENGAGEMENT AND CITIZENSHIP

PHYSICIAN DASHBOARDS

BPP CIN initiated the use of physician dashboards last year to provide participating physicians with individual performance data that could identify opportunities for improvement. In addition to the BPP CIN dashboards, the team added a new risk, efficiency and cost solution to develop BPP ACO physician dashboards.


BayCare Physician Partners ACO

Primary Care Physician ACO Dashboard

Data Through 8/20/2015

Reporting Population		Average Medical Cost Per Patient		Risk Score	
Provider Assigned Beneficiaries	426	Provider Risk Adjusted PMPY	$10,696	Provider Overall Risk Score	0.95
ACO Assigned Beneficiaries	37,214	ACO PMPY	$10,594	ACO Overall Risk Score	1.09

Inpatient	Provider	All PCPs
Inpatient PMPM	$325	$275
Cost Per Admit	$11,819	$11,113
Admits / 1000	419	392
Out-of-Network %	84.9%	35.7%
Length Of Stay	5.2	5.3
COPD Admits / 1000	10.6	15.7
HF Admits / 1000	18.5	15.0
30 Day Readmit	6.3%	4.9%
Days / 1000	2,052	2,015

Ambulatory	Provider	All PCPs
Outpatient PMPM	$449	$496
PCP Visits PMPY	2.4	2.4
Scp Visits PMPY	9.8	8.5
PCP Bill Level	3.5	3.1
SNF / 1000	69	143

Emergency Department	Provider	All PCPs
ED PMPM	$16	$29
Avg. Paid Amount	$560	$598
Visits / 1000	351	578
LANE Visits (% of total)	20.3%	19.3%
% ER Admission	64.4%	54.0%

Outpatient Services	Provider	All PCPs
Lab PMPM	$32	$32
Diagrad PMPM	$36	$41
Diagproc PMPM	$22	$27
CT / 1000	747	722
MRI / 1000	292	290

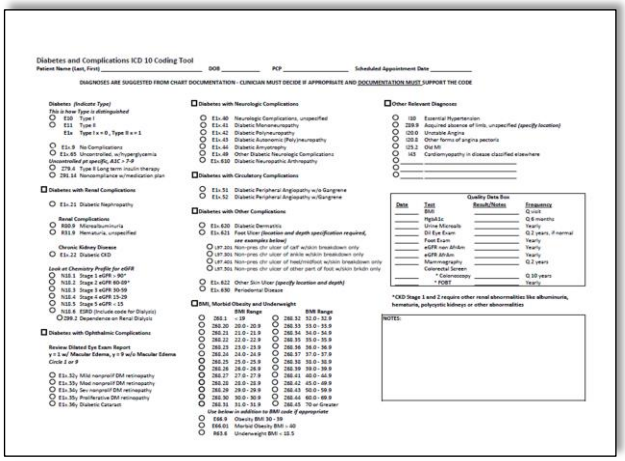
This tool aggregates monthly claims from CMS, which are then analyzed by powerful data analytics technology. This creates dashboards using risk adjustment tools, predictive models, multiple attribution methodologies, and sophisticated statistical analyses.

The BPP ACO physician dashboards provide physicians with patient and performance data that can help manage the clinical and financial risk associated with value-based contracts. It is critical that we use this data to help identify trends and areas that could improve our overall efficiency and costs.

While the content is dense, it is meant to be a directional view into the provider's overall performance. Good data drives good decision-making, but too much information can become a distraction. BPP ACOs developed a phased approach to provide participating providers with actionable data in a user-friendly format.

PHYSICIAN ENGAGEMENT: DIABETES APPROPRIATE DOCUMENTATION INITIATIVE

BayCare Physician Partners is committed to educating its members on how to accurately code patients' diagnoses and capture quality data. BayCare Physician Partners provided a quick-reference guide to assist with risk scores, star ratings and high-risk drug avoidance for the Medicare population. The tools were intended to more clearly characterize patients by including diagnostic codes on claims for more common chronic conditions. The tools included information on the importance of adequately providing supporting documentation.


Diabetes and Complications ICD 10 Coding Tool

Audits showed that 95-98% of diagnostic coding in the network was only uncomplicated diabetes codes. Twenty-five to 30 percent of Medicare beneficiaries have diabetes, which has numerous complications. Diabetes frequently is accompanied by hypertension, obesity, hyperlipidemia, and heart disease. The importance of addressing and capturing these diagnoses was emphasized. BayCare Physician Partners developed a tool to facilitate more accurate coding for diabetes and its complications. This tool was intended for staff to do pre-visit planning and to capture the relevant information for the clinician to address quality measures and to accurately code the patients' diagnoses. The tools emphasized that for coding there are two components: using appropriate diagnoses and validating diagnoses in the progress note documentation to justify using them as assessments.

CITIZENSHIP REQUIREMENTS

BayCare Physician Partners created "citizenship" criteria that physician members must meet both in BPP CIN and BPP ACO. "Citizenship" is a measure of a physician's commitment to the purpose and visions of BayCare Physician Partners in order to bring value to our patients and payor partners. All citizenship requirements must be met in order to be eligible for any generated shared savings. Physician members who do not meet citizenship requirements are coached and counseled on the expectations of being a network member.

Citizenship requirements will continue to evolve and increase over time. It is imperative that physician members work together and actively pursue opportunities to improve the health of our community in an efficient manner. This is a core component of BayCare Physician Partners' success.

POPULATION HEALTH

As of Jan. 1, 2016, BayCare Physician Partners (BPP CIN and BPP ACO) had just under 169,000 covered lives and was responsible for $1.1 billion of medical spend. In order to manage a population of this size and scope, the network must have a solid technological infrastructure. This will identify targeted interventions to address patient health needs and patient experience needs.

TECHNOLOGY

Since 2014, BayCare Physician Partners has been a key stakeholder in BayCare Health System's implementation of a system-wide population health platform. Our team has been collaborating with BayCare Health System to develop the portfolio of applications that will perform complex care management, quality, utilization and cost management. These advancements provide an unprecedented level of clinical integration and enable improved care delivery across the continuum.

> *"In comparison to other health plan case management systems, HealtheCare is one of the most robust case management solutions that I've worked in to date. It has specific, unique features that I have not previously been exposed to."*
>
> - *Pat Fustino RN, CCM*
> *BPP Care Coordinator*

Much of 2015 has been spent building the solutions, integrating data, piloting and planning for the rollout of these various applications. The principal focus of the project was to enable better management of our patient population through the use of *HealtheCare* for care management and *HealtheRegistries* for quality reporting.

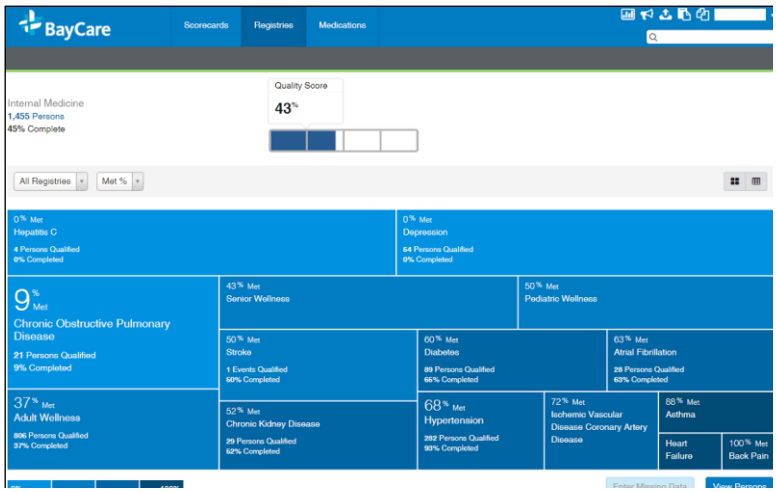
CARE MANAGEMENT (CERNER *HEALTHECARE*)

HealtheCare is a care management program that enables the sharing of clinical data across various care settings and care teams. From its inception, BayCare Physician Partners had a need for a care management solution to improve communication between individuals that are part of the patient's health care experience. This application went live in September 2015. Now, care coordinators can review case statuses, see a list of potential cases to be addressed as identified by a predefined algorithm, and review reminders as set by the care coordinator for follow up with patients, providers and other members of the care team. Access to this depth and breadth of information from BayCare Health System's EMR, along with claims from our payer partners, is arming our care coordinators for success.

CARE MANAGEMENT (CERNER *HEALTHEREGISTRIES*)

HealtheRegistries is a comprehensive solution that enables providers, staff, care management and quality coordinators to identify care needs of the patients they manage. It allows providers to easily manage their patient population in the areas of wellness, prevention and disease management. This includes the ability to proactively manage patients with chronic diseases such as diabetes by utilizing identification intelligence and automatically calculating when care is needed based on widely recognized, established protocols including PQRS, ACO and/or NQF.

To date, almost all of the clinical quality measures that BPP CIN and BPP ACO are tracking have been incorporated into the *HealtheRegistries* application. This new registry solution gives us the capability to build a separate scorecard (see example, left), which includes a small subset of measures combined with benchmarks that align to shared savings metrics. The solution is available within BayCare Health System's EMR platform, enabling efficient workflows for employed physicians, and also as a web-based application for independent providers on other EMR platforms.



PATIENT EXPERIENCE

BayCare Physician Partners conducted patient surveys in all of its physician offices to measure "Patient Experience." The results showed that 95 percent of surveyed patients stated that their physician "Yes, Definitely" listened to them. Studies show that a better patient experience can contribute to better outcomes and better adherence to medical advice and treatment plans.[1] "Listening" is directly related to a favorable patient experience.

[1] Agency for Healthcare Research and Quality website; *"The Clinical Case for Improving Patient Experience."*

BayCare Physician Partners coached and helped physicians improve their listening skills by sharing best practices on attentive listening and patient engagement. The team also worked with BayCare hospitals to publish Hospital Consumer Assessment of Health Care Providers and Systems (HCAHPS) data and develop interventions to improve the inpatient experience. This year, as part of the citizenship requirements, all physicians were required to complete Patient Experience training. This training gave the physicians and their staffs insight into what gives a patient a better experience in the office setting as well as the hospital setting.

2014 BAYCARE PHYSICIAN PARTNERS CLINICALLY INTEGRATED NETWORK PERFORMANCE

In 2014, BPP CIN monitored performance on 19 quality and efficiency contractual measures that were negotiated with our payer partners. Quality results are determined by the gaps the payers track and the percentage the network is able to close. Efficiency results are based on risk-adjusted, per member per month (PMPM) generated by the payers. In 2014, BPP CIN met all quality targets needed for eligibility to share in any gains. BPP CIN also earned a quality bonus for exceeding Aetna Medicare Advantage quality measures.

The 2014 performance brought BPP CIN $2 million, allowing the network to decrease debt incurred from start-up costs and distribute shared savings payments to participating providers. We increased the shared savings network allocation by 100% over 2013 levels.

2014 Payer Partners

Aetna Commercial (Fully Insured & Self Insured)
Aetna Medicare
Cigna East Commercial
Cigna BayCare
Florida Blue Commercial HMO
Florida Blue Medicare HMP & PPO

Individual Payer Details

FLORIDA BLUE COMMERCIAL

- Attributed membership increased by 12%
- ER utilization was below market average by 8%
- The measured PMPM was 1% lower than the target ($3.44 PMPM savings)
- Met 100 percent of our quality indicators
- Risk score increased by 4%

AETNA

- Generated $117,000 in shared savings
- Met contractual requirements on all quality metrics and exceeded Aetna national average in diabetes testing and breast cancer screening

AETNA MEDICARE ADVANTAGE

- Exceeded quality benchmarks on 5 out of 5 metrics, earning a quality bonus
- Had a medical loss ratio of 84.5%, 2.5% below target
- Had a 5-star rating in access to preventive care, glaucoma testing and breast cancer screening
- Rated 4 stars in colorectal cancer screening, cholesterol screening in diabetes and cardiovascular disease

BAYCARE EMPLOYEE PLAN

- Generated $782,000 in shared savings

- Exceeded all contractual quality targets, including breast cancer screening, colorectal cancer screening, A1c testing and renal monitoring

CIGNA EAST

- Generated $255,000 in shared savings
- Quality 4 percent above market
- ED visits per 1000 8% below market
- CT imaging per 1000 below market

Key Contractual Performance Measures	Population			
	Commercial		Medicare	
	2014	2015 (Preliminary)	2014	2015 (Preliminary)
Chronic Disease Care				
Diabetes				
Hgb A1c Screening	🟢	🟢	🟢	🟡
Hgb A1c < 9%	🟢	🟡	🟡	🟡
Hgb A1c < 8%	🟢	🟡		
LDL Screening	🟢	🟢	🟢	🟡
Diabetes Eye Exam	🔴	🔴	🔴	🔴
Diabetes Kidney Disease Monitoring	🟢	🟢	🟢	🟡
Cardiovascular Disease				
Cholesterol Screening	🟢	🟢	🟢	🟢
Lipid Lowering Therapy	🟢	🟢	🟢	🟢
Health and Wellness				
Breast Cancer Screening	🟢	🟢	🟢	🟢
Colorectal Cancer Screening	🔴	🔴	🔴	🔴
Annual Office Visit			🟢	🟢
2 office visits / year for CHF, DM or COPD			🟢	🟢
Follow-up visit w/in 30 days of hospitalization			🟢	🟢
Efficiency				
Readmission Rate	🔴	🟡	🟡	🟡
Radiology Utilization	🟡	🟡	🟡	🟢
Generic Drug Utilization	🟢	🟢	🟢	🟢

🔴 Not meeting targets

🟡 Approaching targets

🟢 At or above targets

LOOKING FORWARD

LOOKING AHEAD

As BayCare Physician Partners enters its fourth year of operations as a commercial entity and its second year as a governmentally recognized Accountable Care Organization, we will remain focused on our imperative to deliver high-value care to the patients we serve.

However, we have to recognize that care management and consumerism readiness are key ingredients for our long-term success. Both are dependent on physicians and their offices, which are in varying states of readiness, fundamentally changing the way they interact with patients.

Care management

Care management is a constellation of services targeted at selected patients depending on their health and care needs. For some, it is a simple reminder to get a flu shot. For others, it is advanced care management with high-intensity monitoring and ongoing interventions. We will continue to develop a full menu of service offerings both within and across our practices. It is complex work given the highly matrixed relationships we have with our practices, our patients and our care delivery sites. But, it is essential work and will be increasingly critical to our success. By 2017, we will be in the downside risk business, and targeted care management will be the difference between success and failure.

Consumerism

With rising out-of-pocket expenditures, consumers are becoming more selective about their care. Some forego services altogether, which is not in their overall best interest. Others choose low-cost and sometimes low-quality care because of economic realities. In addition, we have a new generation of Millennials entering the health care space as they age and seek care. Their expectations of immediate care, when and where they want it, are changing how care is -- and will be -- delivered. Many of these individuals have never seen a corded or rotary telephone, an 8-track or cassette tape, and televisions with manual knobs to change the channel. Their tolerance for care the way it has been delivered is nearly non-existent.

Exploring virtual care and creating near immediate, on-demand visit capacity are essential to meeting and exceeding consumer demand. Even in the Medicare world, patients are getting on the Internet, using online services and becoming more informed consumers. So this move toward personal responsibility, engagement and retail-like expectation is surrounding us as caregivers. We will continue to rise to the occasion as we challenge our physicians to expand office hours, create capacity, and virtualize their practices in ways that also assure high-quality, high-value care.

Looking ahead, the future is bright.

At no time in our history have physicians been in a better position to lead the charge around health care reform. Ours is a noble profession and our physicians and providers are highly trained, qualified and

competent experts at what they do. While we become increasingly intrusive into their practices to aid and assist in this transformation, we are, in fact, liberating many to practice care the way they know it should be. This is an exciting time, and I am proud to be part of it.

Bruce Flareau, MD

President, BayCare Physician Partners