



Building a Successful Physician-Led ACO

How to Thrive in a Brave New World

Forward

Defining an ACO: An
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Physician practices now lead more accountable care organizations (ACOs) than hospitals and health systems do. Many physician practices are participating in and creating ACOs to achieve the Triple Aim developed by the Centers for Medicare and Medicaid Services (CMS): improving population health and the patient experience and managing costs.

What Are The Results?

- HealthCare Partners Physician Group, one of the nation's largest operators of medical groups and physician networks, partnered with Anthem Blue Cross to create an ACO providing care to 55,000 patients that has resulted in improved clinical metrics and \$4.7M in savings in just six months
- Coastal Carolina Quality Care, Inc.'s ACO used actionable data to drive improvements in quality—Costs declining by 19 percent, or \$2,635 per patient, for beneficiaries who are dually eligible for Medicare and Medicaid

Ready to drive success with your own ACO? In this eBook, you will learn:

- The nature and types of physician-led ACOs
- The current state of ACO development as it exists today
- The core components of a successful ACO
- Strategies to drive your own ACO into a model of enhanced, efficient and profitable care

CHAPTER 1

Defining an ACO:

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Defining an ACO: An Overview of the Physician-Led Accountable Care Model

“Accountable Care Organizations

(ACOs) are groups of doctors, hospitals, and other health care providers, who come together voluntarily to give coordinated high quality care to their Medicare patients.

When an ACO succeeds in both delivering high-quality care and spending health care dollars more wisely, it will share in the savings it achieves for the Medicare program.”

Centers for Medicare and Medicaid Services
www.cms.gov

- 21 out of 29 successful first year ACOs were physician-led
- Medicare is the largest ACO-oriented program right now—but that’s likely to change
- Medicare makes it very clear that ACOs are provider-led structures. They have to include primary care physicians—non-negotiable—and providers have to make the majority of the governance bodies. The ACO has to have its own board and its own governance structure so even if it was started by a hospital or integrated delivery system, it has to have a separate board and that board has to be physician-led.

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The ACO model enables providers to assume risk for total cost of care, empowering them to share in cost savings.



Provider-Led Organization

Primary care physicians are mandatory; other specialties and providers (e.g., hospitals, post-acute care facilities) are included as necessary.



Quality- and Value-based Payment Incentives

Reimbursement may be capitated, but is more typically traditional fee-for-service; participants are rewarded for reducing total population cost over a defined time period.



Sophisticated Performance Measurement

Rigorous quality and cost reporting requirements require more than a basic information structure.

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Most organizations today in the pre-fee-for-value world are focused on individual encounters. ACOs focus on the patient's health in its entirety, regardless of who is providing care. To be cost effective, this means driving effective care from the hospital to the ambulatory clinic, and from the clinic to the patient's home.

Medicare defines a Triple Aim for a Physician-Led ACO:

- Improve the health of populations
- Improve the patient experience
- Manage costs

To accomplish these goals, three pillars are necessary to support a successful ACO:

- Improved clinical outcomes
- Improved financial outcomes
- Improved operational outcomes



IMPROVE
POPULATION HEALTH



IMPROVE PATIENT
EXPERIENCE



MANAGE COSTS

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According to KLAS

research, study participants from medical groups went beyond the relative safety of Medicare's Shared Savings Program and took on the more substantial risk inherent in Medicare Advantage and commercial-payer agreements—more than any other type of ACO.

Erik Bermudez, "Physician ACOs 2014: Variations on the Accountable Care Theme," (March, 2014) www.KLASresearch.org

When forming an ACO, governance is the key differentiator between physician-led organizations large and small. As you move from an IDN toward an association, the level of structure diminishes.

Typical ACO structures include:

Hospital/IDN

This will have the most structure, with physicians as employees that align with the corporate strategy. But the ACO will still have an independent board with a majority of physicians serving on the board.

Medical Groups

A medical group functions similar to an IDN, but without the hospital. It is centrally managed as a rule and often employs physicians directly.

Partnerships

In partnership ACOs, physician groups work closely with one or more local hospitals. Governance is shared equally, and physicians are often employed by the partnership.

Associations

With an association ACO, independent physicians form a voluntary membership beneath a single organizing entity. This is the most decentralized form of an ACO. Associations are sometimes administered by third parties such as a Managed Services Organization.

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ACO TYPE	STRATEGY	RISK/PAYER	DATA COLLECTED
 HOSPITAL/IDN	Primary care network owned and directed by health system	Medicare ACO, some commercial	Equally claims and clinical
 MEDICAL GROUP	Centrally managed/ owned practices with shared IT	Medicare Advantage, Commercial, Medicare ACO	Equally claims and clinical
 PARTNERSHIP	Alliance between hospital and affiliated medical group	Medicare ACO, Medicare Advantage, Commercial	Mostly clinical
 ASSOCIATION	Voluntary alliance of independent practices supported by coordinating entity	Medicare ACO, some commercial	Mostly claims

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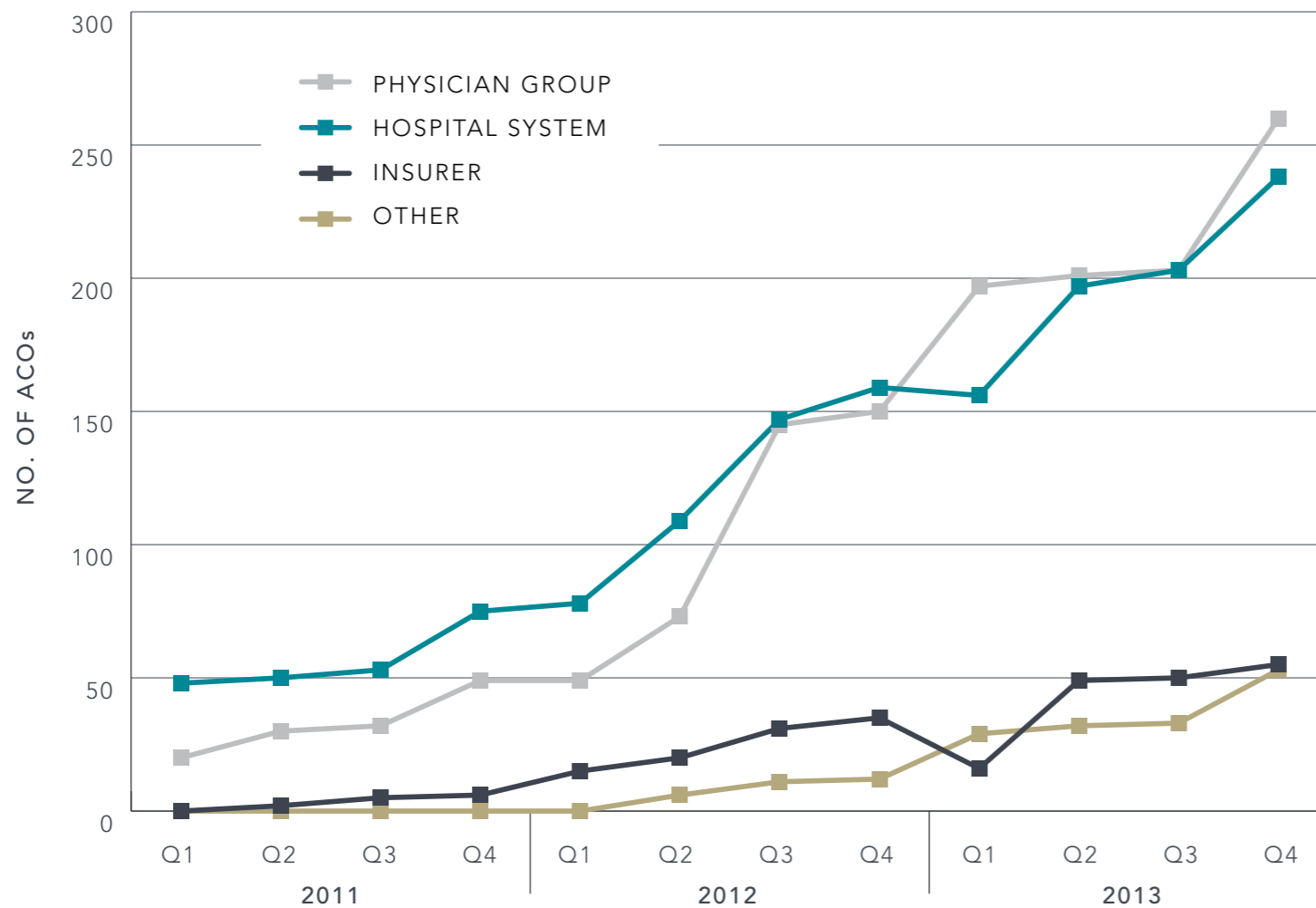
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ACO Formation by Type: 2011-2013

Source: Leavitt Partners



ACO Distinction: Defining the Types of ACOs

ACO Needs

Regardless of the governance structure on an ACO, the needs remains the same:



DATA SHARING



RISK STRATIFICATION



CARE MANAGEMENT



REFERRAL MANAGEMENT



REPORTING & PATIENT ENGAGEMENT

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When Medicare first announced its intentions for its Pioneer ACO and Medicare Shared Savings Plan (MSSP) programs, accountable care was seen as a huge undertaking requiring the coordinated participation of providers across a full continuum of care. IDNs seemed the ideal participants. With networks of providers already in place and access to the capital needed to support technology and culture change, IDNs could exert control and thus take on risk.

Physician groups adopted a different point of view, however, recognizing the pivotal role that primary care providers play in managing patient relationships and behavior on the front line. Within two years, physician-led ACOs outnumbered hospital-led efforts. By the end of 2013, physician initiatives—including MSSPs, commercial-payer agreements, and other at-risk arrangements—accounted for 260 out of 606 ACOs, according to Leavitt Partners.

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In order to track the evolution of ACO development, IDC Health Insights developed an ACO maturity model to evaluate where healthcare organizations currently stand. It's helpful to understand these phases to get an overall sense of the current state of ACO.

The phases include:

Ad Hoc

Initiatives in the Ad Hoc phase are typically pilot projects or proofs of concept. There are some changes in reimbursement to encourage and reward providers for meeting or exceeding performance goals. There is no risk sharing, just rewards for performance. Any specialized analytics are manual. While there are metrics for performance, there is no routine mechanism to report these metrics, making it challenging for providers to be successful. The goal of the Ad Hoc stage is to get some experience with managing a set of quality metrics without any downside risk.

Opportunistic

Reactive accountable care occurs in the Opportunistic phase. Healthcare organizations respond when accountable care programs are offered by an external third party, but they do not initiate programs on their own. Upside risk gets introduced into reimbursement. Funding for programs comes from individual practices or departments. Data is available through existing reports, as well as standard reports developed to track performance measures on a routine basis. Information is shared with clinicians, and strategies are developed to improve performance. The goals of the Opportunistic stage are to gain experience about accountable care requirements and determine how successfully the organization can meet those requirements.

Repeatable

The Repeatable phase recognizes the ability to duplicate accountable care programs as a growth strategy for organizations. Healthcare organizations accept both upside and downside risk, and care management becomes more proactive. Data is critical at this phase and new data sources are introduced such as unstructured clinical data. One of the objectives of the Repeatable phase is the creation of the 360-degree view of the patient. Clinical interoperability is achieved, and a cloud platform is deployed to further support information sharing and faster deployment of applications. Accountable care staff have incentives based on outcome targets and goals. Repeatable goals are to create common processes and programs across an enterprise and improve infrastructure to support accountable care.

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Managed

In this phase, a formal staffed and funded management structure now exists. The composition of Provider networks is driven by performance metrics as well as coverage and geography. Financial management and program evaluation are the primary focus in the Managed phase. Performance metrics are formalized across the enterprise, although individual sites have the ability to create their own metrics. Technology investments for population health management (analytics, workflow and patient engagement) are consolidated on a single platform or are fully integrated. Clinical best practices for care management and hospital transitioning are identified and deployed across the enterprise. The goal during the Managed phase is to standardize and operationalize best practices, results from outcome studies, structure and governance, and performance measurement.

Optimized

Now exists an enterprise-wide culture of proactive coordinated care and the acceptance of upside and downside risk in the Optimized phase. Organizations will have 50–65% of their revenue from risk-based contracts at this stage. Investments include advanced analytics and technology to support large volumes and varieties of data. Much of the work at this stage is about optimizing people, processes and technology. To that end, both infrastructure and applications will be evaluated and, where necessary, tuned or replaced. Staffing as well as processes will be complete and standardized. Evaluations for process efficiency and for best-fit will occur. Goals include cultural adoption for proactive coordinated care as well as attaining a highly efficient organization to meet the objectives of the Triple Aim.

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IDC Health Insights' Accountable Care Maturity Model

Overview of Maturity Stages

	AD HOC	OPPORTUNISTIC	REPEATABLE	MANAGED	OPTIMIZED
KEY CHARACTERISTICS	<ul style="list-style-type: none"> Pilot projects (e.g., fee for service with quality bonus) No risk sharing 	<ul style="list-style-type: none"> Limited upside risk sharing Reactive accountable care Unbudgeted funding 	<ul style="list-style-type: none"> Upside and downside risk sharing Proactive care coordination Proactive initiated accountable care Budgeted and funded 	<ul style="list-style-type: none"> Management, budget, staff in place Best practices emerge Program evaluation initiated 	<ul style="list-style-type: none"> Enterprise-wide upside and downside risk Culture of proactive, coordinated care
GOALS	<ul style="list-style-type: none"> Test the waters Get experience 	<ul style="list-style-type: none"> Evaluate financial viability of accountable care 	<ul style="list-style-type: none"> Replicate programs across multiple sites to achieve scale 	<ul style="list-style-type: none"> Improve performance Operationalize and standardize 	<ul style="list-style-type: none"> Adopt a new culture
OUTCOMES	<ul style="list-style-type: none"> Identify the required components for accountable care 	<ul style="list-style-type: none"> Evaluate experience and financial sustainability 	<ul style="list-style-type: none"> Growth of accountable care across the enterprise Reduced clinical variation 	<ul style="list-style-type: none"> Evaluate all aspects of the accountable care programs 	<ul style="list-style-type: none"> Adopt proactive, coordinated care across the enterprise

Source: IDC Health Insights, 2013

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As it stands right now, almost every organization is in the early stages of the IDC scale. The reality is that regardless of where an organization is currently with their ACO transition, they are going to have to go much further with their organizational structure. Healthcare organizations need to upgrade both technology and governance so they can take on more risk and truly be successful with Accountable Care.

ACOs are primarily driven by Medicare at the moment, but that will evolve over time with commercial-driven ACO offerings on a much wider scale.

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ACO Fundamentals: Tools to Thrive

The foundation of any ACO solution is the core system. You need a core system that effectively collects the data you need to drive decision support, while effectively engaging both clinicians and patients.

The overall goal is to reach the patients with the highest clinical need as well as the highest cost patients. You need to be able to coordinate not only episodic care, but the entire continuum of care.

The essentials for a core system that deliver robust accountable care include:



Care Coordination and Communication

- Connecting providers and practices across the healthcare system
- Patient engagement
- Reducing communication errors
- Lowering admission costs



Secure Data Acquisition

- MSSP requires ACOs to report on 33 quality metrics
- Access and compile data from disparate sources



Data Analytics for Population Health

- Payment tied to improvement of patients' well-being
- Tools to measure care, create patient risk profiles, analyze trends
- Analytic capabilities to create performance management strategies

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Care Coordination and Communication

By connecting providers and institutions across the healthcare system, care coordination is central to the success of an ACO. An effective care coordination strategy includes a focus on effective health information exchange (HIE) among participating providers. The benefits of HIE and data integration include increasing patient engagement, reducing communication errors, and lowering administration costs.



Secure Data Acquisition

The MSSP final rule requires ACOs to report on 33 quality metrics. Therefore, ACOs must leverage the use of electronic health records (EHRs) and HIEs to access and compile data from disparate sources, from hospital systems, physician systems, and data from CMS, to name a few.



Data Analytics for Population-Health

The payment method of an ACO is tied to the improvement of the ACO patients' well-being. Health IT provides tools to measure care, create patient risk profiles, and analyze trends. ACOs need to build effective analytic capabilities to create performance management strategies to stray from healthcare costs that can be prevented.

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Components for Effective Population Health Management

KLAS research identified four components* critical for effective population health management—functionality healthcare organizations must consider when selecting their solutions partner.

*Erik Bermudez, "Physician ACOs 2014: Variations on the Accountable Care Theme," (March, 2014), www.KLASresearch.org



Data Aggregation

Combining patient data from disparate sources



Risk Stratification

Segmenting populations to prioritize interventions



Care Coordination

Directing care providers' efforts



Patient Outreach

Engaging patients in their care, aggregate patient data, stratify risk, coordinate care and engage patients

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Data Sharing and Connectivity

Provides the ability to collect and aggregate patient data from a variety of sources and then normalize it in preparation for analysis.

- Allscripts supports this with dbMotion™, transitions of care, analytics portal, registries and third party HIEs

Risk Stratification

Provides the ability to analyze patient data to highlight gaps in care and opportunities for improvement. Some risk stratification includes statistical models that produce risk scores and predict utilization.

- Allscripts supports this with cohorts, gaps in care, predictive modeling, care director, population health analytics

Care Management

Provides the ability to guide care managers with patient data and workflows that prioritize patient outreach efforts.

- Allscripts supports this with Allscripts Care Management™ and Allscripts Care Director™

Referral Management

Provides the ability to coordinate transitions of care.

- Allscripts supports this with Allscripts Care Management™ and Allscripts Care Director™

Patient Engagement

Provides the ability to drive patient behavior with automated tools for reminders, surveys, education and so forth.

- Allscripts supports this with Allscripts FollowMyHealth® patient portal

Reporting

Provides the ability to measure and report quality and cost performance that helps guide ACO participants and meets government and payer requirements.

- Allscripts supports this with cloud-based reporting

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An effective core system must be able to capture two kinds of data: retrospective and perspective. Retrospective data is the information already available. However, perspective data give you the ability to leverage data in the core EHR and the community to provide clinical decision support. Examine labs, look at the holistic picture around the patient from the community, look at regional variations in medication sensitivity, look at Genomex—this is just a sample of what you should be able to do. The result is a more specialized treatment plan for the patient to drive clinical outcomes with the least amount of cost.

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Care Coordination	Cohort Management	Patient & Caregiver Relationship Management	Clinician Engagement	Financial Management	Reporting	Knowledge Management
Access real time health insurance coverage	Identify cohort from within entire patient population	Basic information services	User-friendly, timely and actionable Clinical Decision Support (CDS)	Administrative simplification for operations	Retrieve data specific to measures	User-friendly, timely and actionable Clinical Decision Support (CDS)
Establish payer relationships	Monitor individual patients	Administrative simplification for patients	Standard clinical assessment tools	Normalized and integrated data	Store quality metric data	Personalize patient-specific information
Establish provider relationships	Clinical Decision Support (CDS)	Patient educational services	Well-defined care teams	Health assessment of entire patient population	Calculate quality measures	Create and share clinical knowledge
Share clinical data during transitions of care	Patient engagement within cohort	Patient communication	Communication with organization	Patient attribution algorithms	Report quality metrics for internal use	Create and share process improvement knowledge
Identify best setting for care	Engage preferred providers and clinicians in care teams	Patient engagement in care	Communication external to organization	Performance reports	Report measures to external designated entities	Support comparative effectiveness research
Identify social and community supports	Shared care management plan	Patient assumption of care responsibilities	Administrative simplification for providers	Risk-sharing analytics	Report data required for syndromic surveillance	
Manage referrals	Interventions	Monitor patient goals and outcomes	Usability of HIT	Payer contract management	Public Health reporting	
Patient-centric medication management	Follow up	Patient experience of care surveys	Comprehensive educational systems for clinicians	Provider contract management	Registry reporting	
Clinical information reconciliation	Monitor cohort		Community-based resources	Cost accounting	Report resource consumption for internal use	
			Public Health information	Reimbursement system for other than fee service	Report adverse events to Patient Safety Organization	
			Research protocol information	Billing for revenue outside of risk contracts		
				Financial management for patients		

This represents work done by the Accountable Care Workgroup of the ONC HIT Policy Committee in collaboration with CCHIT: Charles Kennedy, Chair, Aetna/WellPoint, Inc.; Grace Terrell, Co-Chair, Cornerstone Health Care, P.A.;Shaun Alfreds,Member, HealthInfoNet Hal Baker, Member, Wellspan; Karen Bell, Member, CCHIT; Craig Brammer, Member, HealthBridge; Scott Gottlieb, Member, American Enterprise Institute; Heather Jelonek, Member, John C. Lincoln Accountable Care Organization; Joe Kimura, Member, Atrius Health Irene Koch, Member, Brooklyn Health Information Exchange (BHIX); Eun-Shim Nahm, Member, University of Maryland School of Nursing; Frank Ross, Member, Cumberland Center for Healthcare Innovation; Samuel Van Norman,Member, Park Nicollet Health Services Federal; H. Westley Clark, Ex Officio, SAMHSA/HHS; Akaki Lekivili, Ex Officio, CDC; Mai Pham, Ex Officio, CMMI; John Pilotte, Ex Officio, Centers for Medicare & Medicaid Services; Alex Baker, Staff Lead, ONC; Kelly Cronin,Staff Lead, ONC

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We've outlined the components of how to successfully transition to an accountable care model. Now it's time to get to work!

Allscripts can put you on the right road to ACO. Here's how:

- **Connecting the community**—We have the ability to collect, aggregate and connect patient data from a variety of sources and then normalize it in preparation for analysis.
- **Stratifying patient populations and assessing risk**—We have the ability to analyze patient data to highlight gaps in care and opportunities for improvement. Some risk stratification includes statistical models that produce risk scores and predict utilization.
- **Coordinating care to improve outcomes**—We have the ability to guide care managers with patient data and workflows that prioritize patient outreach efforts.
- **Engaging patients in a meaningful way**—We have the ability to drive patient behavior with automated tools for reminders, surveys and education.
- **Managing referrals**—We have the ability to coordinate transitions of care.
- **Financial, operational and clinical reporting**—We have the ability to measure the report quality and cost performance that helps guide ACO participants and meets government and payer requirements.

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Allscripts proven strategy for value-based care:

- Support and enable existing EHR clients to scale across communities of care and ensure they are realizing full functionality of their systems—and that starts at the core.
- Connect those clients with other communities of care—this is where our philosophy of an Open architecture enables us to connect with multiple partners and systems.
- Community Health Platform fueled by dbMotion and FollowMyHealth. This further connects the continuum of care delivery with a single source of truth—one patient record, accessible by everyone, including the patient.

This is how we achieve true population health management, the goal of every ACO.

Allscripts ACO services strength:

- **Allscripts Adoption Accelerator**—Ensures high physician adoption and meaningful utilization, accelerates time to value and optimizes end-user performance.
- **Allscripts Speed to Value**—Incorporates highly structured and staged content for new and existing clients. Current state assessment and project management tools speed informed decision making while gap analysis of data assets identifies opportunities for continual outcomes improvement. The Speed to Value implementation methodology is designed to deliver the following content:
 - Pre-built foundation inclusive of a pre-configured database, Allscripts prescriptive workflows and embedded clinical content
 - Client-customizable content, configured to promote clinician adoption and site specific workflows
 - Meaningful Use (MU) Reporting Toolset

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Allscripts delivers:

- Allscripts continues to touch more clinicians than any other solutions provider in the industry with more than 180,000 physicians, 45,000 practices, 2,500 hospitals and 13,000 post-acute facilities utilizing our solutions. In 2013 alone, we gained 800 new clients.
- Allscripts portfolio includes complete clinical, financial and operational solutions
- Allscripts is #2 in meaningful use attestations to date. We have also implemented cloud-based reporting for MU moving forward. With the evolving requirements and standards, this will allow us to properly support our clients continue to achieve MU
- Allscripts is highly scalable to support large, growing organizations with flexibility that allows employed and affiliated physicians to configure workflows to their preferences. We have solutions for a 1-physician practice, as well as a 1,000-physician practice.
- More than 1,000 peer reviewed Care Guides provide the fastest, safest and most accurate diagnosis, documentation, ordering, prescribing and patient education available for dozens of specialties
- Q1 2014 bookings totaled \$223 million, an all-time Allscripts record for the first quarter and an increase of 26 percent compared with Allscripts' Q1 2013 bookings

180,000 physicians

100,000 prescribing physicians

45,000 physician practices

2,500 hospitals

13,000 post-acute facilities

40,000 clinicians in patients' homes every day

8.4 million referrals managed through our solutions each year

1 million patients using FollowMyHealth patient portal

800 new clients in 2013

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Being “Open” is Critical to Making an ACO Work

What does Open mean? It means care is coordinated across every setting: from the physician’s office to the hospital to post-acute settings and beyond. We collaborate openly with industry partners and clients because Open is not only our platform—it’s how we build better solutions. Our Open strategy enables clients and vendors to customize on top of our software which delivers improved clinical and financial outcomes. We connect clients and patient to our community network with the right information at the right time. And the results are clear:

- Clients turn data into actionable insights and improved patient outcomes with our open APIs
- 74% raised compliance in diabetic medication therapy – University Hospital, TX
- 89% reduced medication errors – DeKalb Medical, GA
- 83.6% reduced patient fall rates – Cape Canaveral Hospital, FL

Key Strength with Financials for ACOs

Seven years ago we started Sunrise Financials and that has built even more value into what we can offer ACOs. As the ACO model continues to develop, different types of financial systems are going to be required, particularly systems that are able to bundle payments across encounters, whether they are ambulatory or acute or post-acute. It’s why we’re positioning our financial offerings for the future.

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“**Allscripts has developed** what we believe could be a compelling population health vision for its next generation of solutions...we believe this patient-centric vision for population health could be very attractive to providers, allowing Allscripts to capture its share of what we estimate could be a ~\$60 billion long term opportunity.”

CITI Research – May 2013

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Proven Success: Real-World Success and Outcomes

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See for yourself the value of Allscripts capabilities in helping our clients make accountable care a successful reality. Just look at what we have achieved for our clients:

Coastal Carolina Quality Care, Inc

Overview

Multi-specialty physician group practice with 11 clinics and includes 50 providers. Their ACO serves more than 11,000 attributed Medicare beneficiaries, who account for approximately 30% of CCHC's patient population and 40-50% of the organization's revenue.

ACO Initiatives

- EHR-based data infrastructure
- Advanced reporting package
- Clinician-specific performance reporting
- Suite of point-of-care tools

Allscripts Solutions

- Allscripts TouchWorks® EHR
- Allscripts Clinical Quality Solutions™ (CQS)
- FollowMyHealth®

ACO Results

- ED utilization trended 10 to 15% lower in fiscal year 2013
- Hospital admissions trended 10 to 15% lower in fiscal year 2013 according to internal data, with only one month seeing a modest increase
- Many more diabetic patients have achieved control of their blood sugar. The population with HgbA1c levels greater than nine fell from more than 20% to 8.3% (for the entire CCHC population, not just the ACO patients)
- Costs dropped by 19% (\$2,635 per patient) for beneficiaries who are dually eligible for Medicare and Medicaid
- A positive by-product of the CCHC efforts was helping the local hospital move off the penalty list under Medicare's Hospital Readmissions Reduction Program

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Mercy Health System

Overview

Non-profit community healthcare organization that serves residents of southern Maine through two hospitals, primary care practices, four express care practices and 15 specialty locations.

ACO Initiatives

- Enhance core system to improve data access
- Deploy comprehensive ACO metrics and reporting
- Increase adaptability to changing regulatory requirements
- Open architecture for seamless integration
- Overall simplified operations

“It was remarkable to partner with Allscripts to develop 24 ACO metrics and reporting for outcomes in literally 90 days.”

Judi Hawkes, Vice President Physician Practices
Mercy Health System

Allscripts Solutions

- Allscripts TouchWorks® EHR
- Allscripts Practice Management™
- TouchWorks® EHR Reporting
- FollowMyHealth®
- Allscripts Remote+
- Allscripts Clinical Quality Solution™
- Allscripts Prenatal™
- Allscripts Wand™
- Hosted Revenue Cycle
- Management Services

ACO Results

- Developed 24 clinical ACO metric reports in three months
- Reporting helped achieve 90% HbA1c compliance rate for diabetic patients
- Improved patient safety through increased falls risk screening for patients over 65
- Received \$1.35 million in incentives from Meaningful Use, PQRS and e-prescribing
- Attained PCMH level 2 certification in eight sites

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Brown & Toland Physicians

“**As healthcare continues**

to become more integrated and coordinated, it's critical to have a partner like Allscripts, whose technology is open and flexible enough to gather and relay information from virtually anywhere...With this information at hand, we can deploy solutions that make it easier for our doctors to practice medicine, and improve the health of our patients.”

Richard Fish, CEO, Brown & Toland Physicians

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