HSG | Assessing and Reducing Losses in Employed Physician Networks

We build high-performing physician networks so health systems can address complex changes with confidence.

About HSG

Headquarters: Louisville, KY
Formed: 1999
Client Base: 95% Non-Profit Hospitals & Health Systems
Focus: Hospital Physician Network Strategy & Execution

HSG builds high performing physician networks so health systems can address complex changes with confidence.

Strategy

- Health System Strategic Planning
- Physician Alignment Strategy
- Employed Group Strategy
- Referral Capture Improvement
- Creating Shared Vision
- Service Line Strategy
- Service Line Co-Management
- Physician Manpower Plans
- Affiliation Strategy

Physician Network Optimization

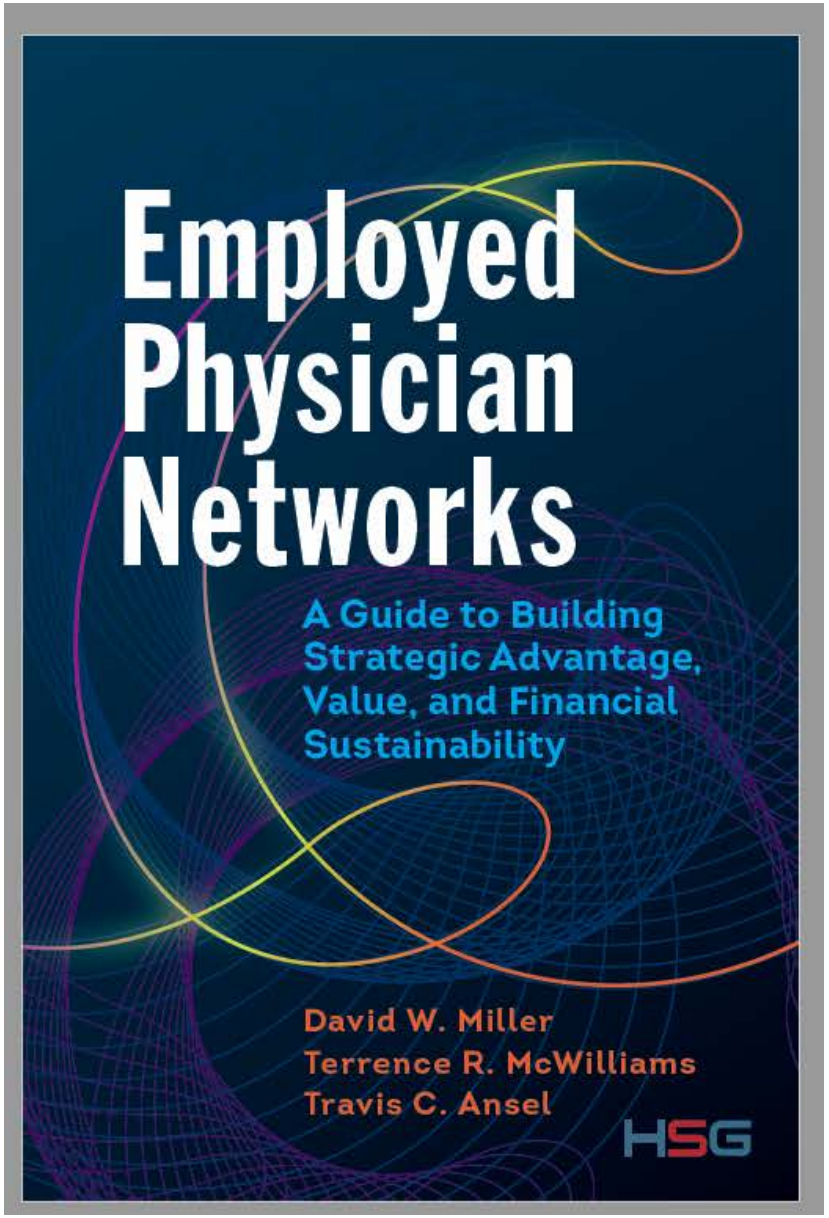
- Network Performance Improvement
- Network Advisory
- Provider Productivity Systems
- Network Revenue Cycle
- Physician Compensation Planning
- Practice Acquisitions
- Fair Market Value Opinions
- Interim Management

Value-Based Care

- Clinical Assessment
- Clinical Integration Strategy
- Practice Transformation
- ACO Development
- ACO Optimization
- Direct Contracting

How We Accelerate the Evolution of Employed Networks

NOVICE	GROWTH MODE	OPERATIONAL CHAOS	STRATEGIC FOCUS	VALUE PHASE	HIGH-PERFORMING
Physician Alignment Strategy	Management Infrastructure	Network Performance Improvement	Shared Vision / Culture	Early Risk Contracting (ACO, Direct Contracting, Bundled Payments)	Leverage Network in Marketplace
Define Compensation Principles	Physician Leadership Development	Revenue Cycle and Productivity Systems	Network Strategic Plan, Integrated with System Plan	Optimize Physician Engagement in Performance Improvement	Full Risk Contracting
Interim Management	Acquisition and FMVs	Physician Advisory Council Enhancement	Clinical Practice Transformation / Population Health	Quality and Patient Experience Focus Across Continuum	Manage Populations
Executive Search	IT Strategy	Enhance Management Infrastructure	Quality / MACRA / Patients' Experience	Brand Enhancement	Provider of Choice
		Referral Capture / Network Integrity	Aligned Compensation Incentives		


Employed Physician Networks
A Guide to Building Strategic Advantage, Value, and Financial Sustainability
David W. Miller
Terrence R. McWilliams
Travis C. Ansel
HSG

Network Performance Improvement

HSG's Philosophy on Assisting Health Systems with Employed Network Challenges

Build Awareness and Consensus. Perform a thorough assessment of the network; work with client to create understanding at the administration and provider-level of "here's where we are" and "here's the challenges we must overcome".

Key Actions:

- Comprehensive assessment of network – practices, revenue cycle, providers, resources, management, org structure, Physician Advisory Council
- Interview administration, providers and practice management leaders
- Engage executives and practice leaders about results
- Engage providers (at large) about results
- Build consensus on what changes need to occur, why, and how we will measure progress and success

HSG Network Assessment
Phase One Goals

OVERALL GOAL: Promote Financial Sustainability. Position leadership and board members to understand the hospital's ability to bend subsidy growth curve as growth of the network continues. Identify areas of clear inefficiency or areas where further exploration and questions are warranted. Define opportunities.

1. **Identify Opportunities to Optimize Practice Performance.** Evaluate the data related to the operational performance of each practice and identify areas for improvement.
2. **Identify Opportunities to Optimize Network-Level Management Structure.** Evaluate the management structure given network size and strategy and how it interacts with operational performance of the network and identify areas for improvement.
3. **Identify Key Initiatives for Implementation.** Given the network's current position, identify areas that need to be addressed to support the network's success. This can include compensation model redesign, quality programs, clinical transformation initiatives, etc.

Process With Client

1. Survey of Stakeholders
2. Data Request
3. Benchmarking at Practice Level
4. Benchmarking at Network Level
5. Definition of Opportunities in each Practice
6. Definition of Opportunities for the Network
7. Developing a Plan of Action
   A. Resources required
   B. Management ownership
   C. Timeline
8. Implementation
9. Re-assessment

Survey of Stakeholders

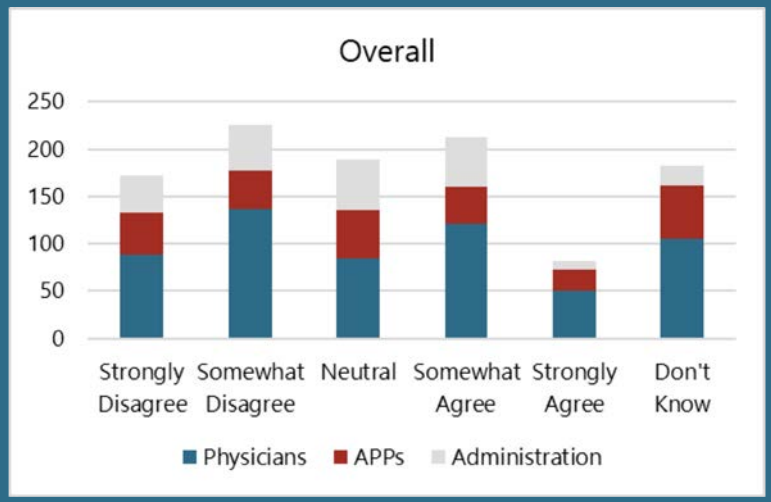
Challenges

Generic Medical Center (GMC) has experienced rapid growth in its employed provider network, growing from 20 to 80+ providers in a short time span.

This growth has fueled operational, managerial, and financial challenges that management recognizes must be addressed in short order. These challenges include:

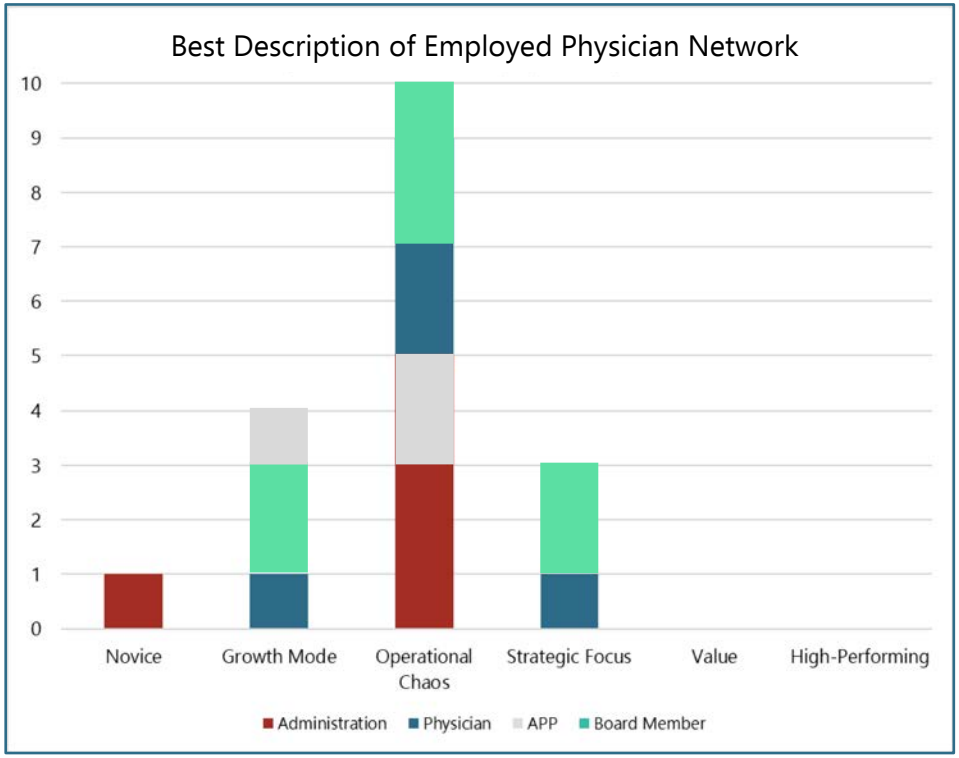
- **Financial Performance.** Growing subsidies, estimated at $12.6m/year
- **Revenue Cycle.** Ambulatory billing done out of hospital billing office; questions about whether sufficient resources and focus exist on Ambulatory
- **Management Resources.** Questions about whether the right people are in the right roles, and whether sufficient bandwidth exists.
- **Compensation.** Mixture of models exist, all providing different incentives
- **Provider Engagement.** Providers perceived as "focused on their practice" and having little concept of the network.
- **Impact of EMR.** Recent implementation of new Ambulatory EMR product causing operational, revenue cycle issues

HSG Physician Network Evaluation Survey



- Wide band of responses indicates there is little agreement on the network's challenges
- Could indicate actual disagreement
- Often indicates a lack of presentation and discussion of management data to draw a conclusion from

Operational Chaos



Most Chosen Response:

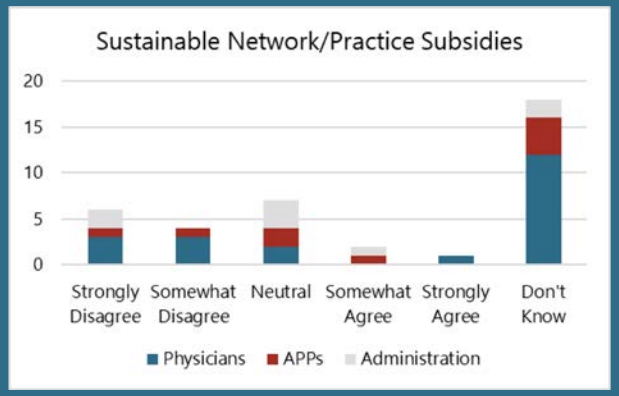
"Our network has grown rapidly and is now experiencing operational challenges as a result of that growth. Our network is experiencing increasing practice subsidies that must be addressed. Hospital leadership is sensing the need to control the group's growth and limit employment offers to manage the losses of the group."

Here's what HSG usually associates with Operational Chaos (not necessarily specific to GMC):

- Recent, rapid growth in employed providers
- Recent, even more rapid growth in employed subsidies
- Sense that finances are not sustainable, but not seeing a path out of where we are
- Lack of management resources - management being used to do "everything" - recruitment, contract renewal/negotiation, leaving local practice leadership to fend for selves; gaps in communication.
- Wide variation in practice operations
- Revenue cycle not formalized - gaps in communication with practice administration
- Coding variation, particularly under coding
- Referrals leaking out of network
- Variety of compensation models - hard to measure effectiveness of compensation strategy or to provide right incentives at network level
- Providers retaining "autonomy" in a negative way
- Lack of provider engagement/leadership - no formal roles or roles not being utilized properly
- No defined vision/culture
- EMR wreaking havoc / not enough resources to support

Takeaway: This is where you should expect to be, but we have to have a plan to get out. No silver bullets, just more hard work.

Financial Performance

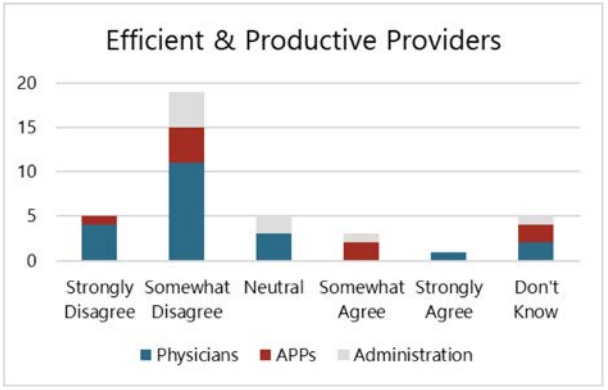


The subsidies generated by our employed physician network are sustainable for the organization.

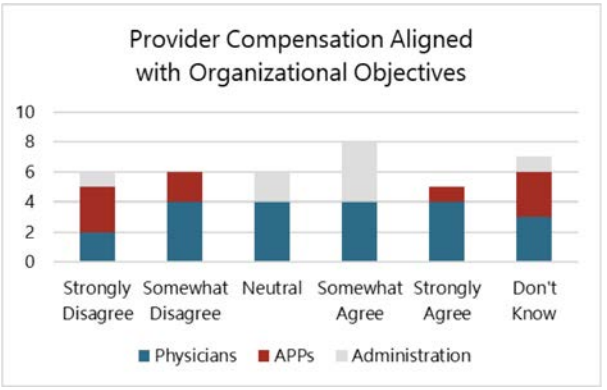
GMC Network – Annualized 2018 Performance

Metric	Actual[1]	Benchmark Based on MGMA Median Performance[2]
Gross Charges	$50.4M	$52.1M
Net Revenue	$22.2M	$23.2M
Total Expenses	$34.8M	$32.2M
Net Income (Loss)	**($12.6M)**	**($9.0M)**

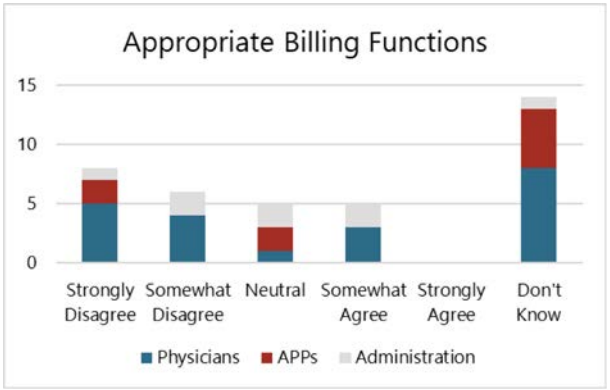
Financial Performance
Possible Drivers



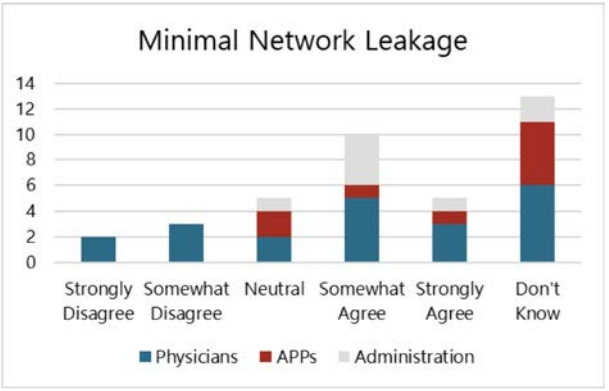
Productivity



Compensation

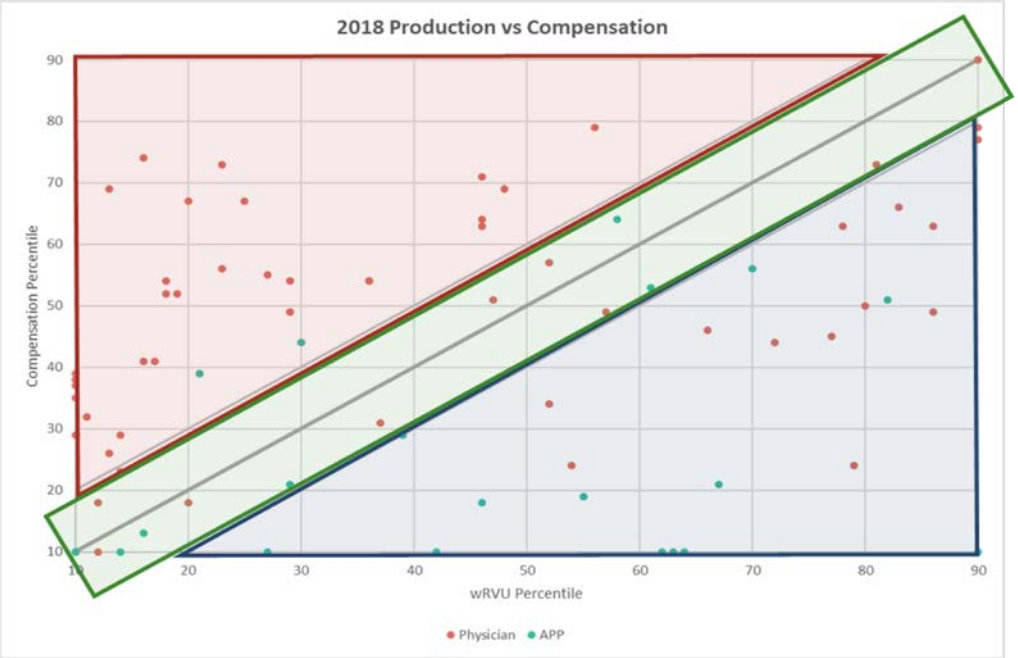


Revenue Cycle



Referral Leakage

Financial Performance
Possible Drivers

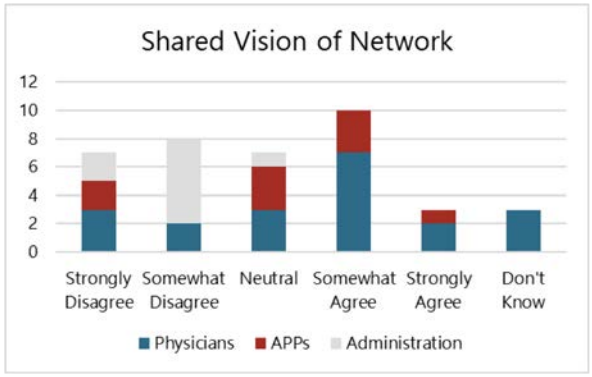


Compensation vs. Productivity Analysis

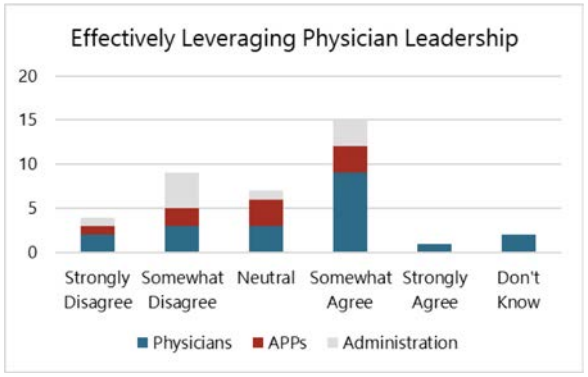
Questions:

1) What incentives do we feel the providers need that they don't currently have?
2) What are barriers to change?

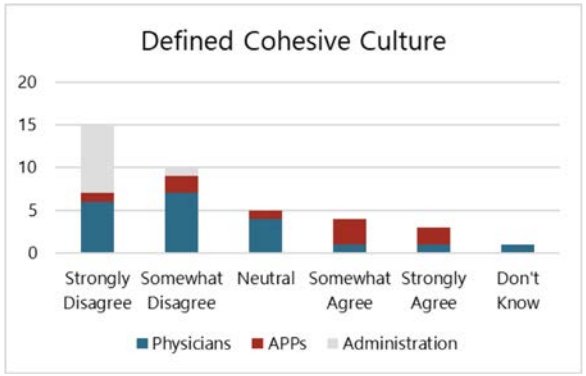
Provider Engagement & Culture



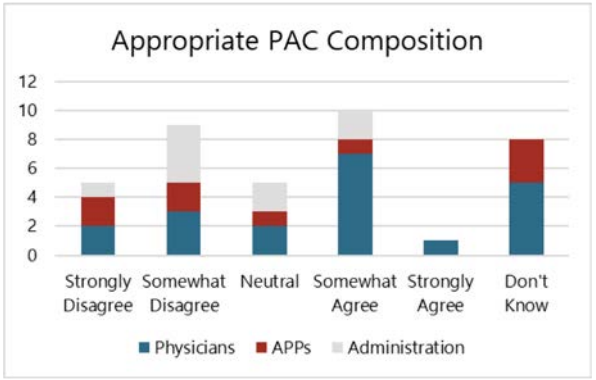
Vision



Leadership



Culture



PLC Composition

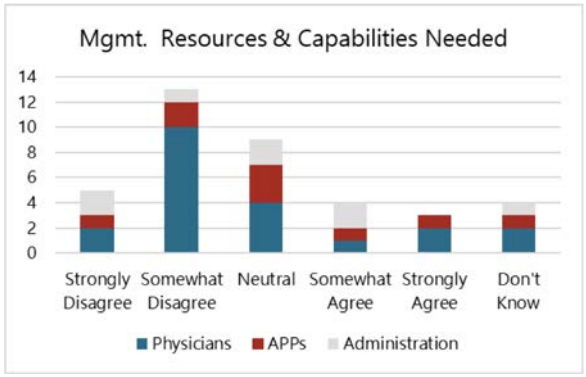
Provider Engagement & Culture

Sample Subcommittee Structure for Executive Council

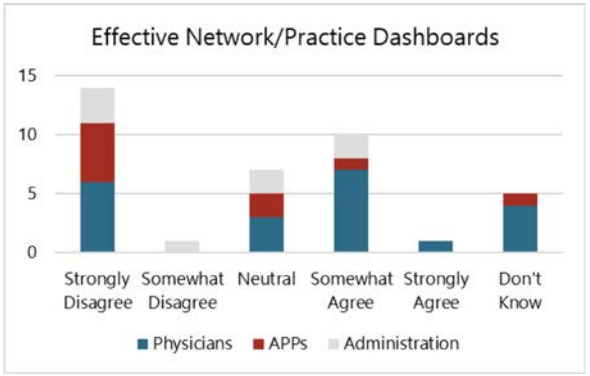
Questions:

- Does charter give the group effective power within the organization?
- Does the overall group feel represented by the Executive Council? Does communication filter down to rest of group?
- Plans to evolve subcommittee structure to promote greater engagement?

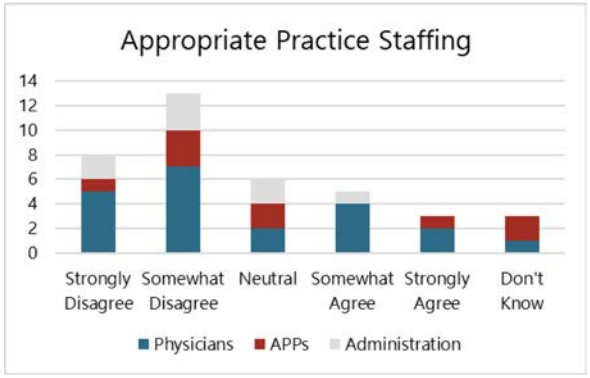
Management Infrastructure



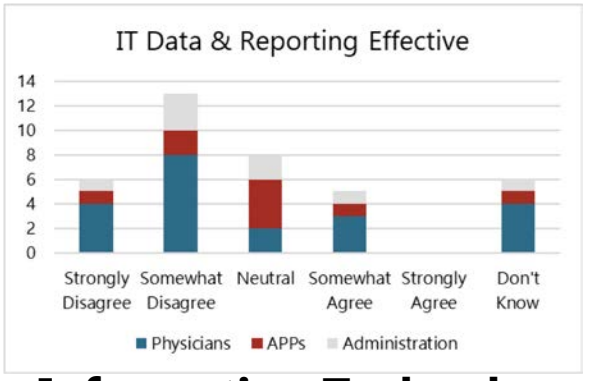
Management Resources



Management Reports



Staffing



Information Technology

Benchmarking

HSG Network Assessment
Sample Practice Benchmark Dashboard

Name of Practice/Rollup:	Sample Data					
Specialty:	Family Medicine					
Benchmark Percentile:	50					
Service Line:	Primary Care					
Metric	**FY 2016**	**FY 2017**		**Variance 2016 to 2017[1]**	**HSG Benchmark**	**Variance from Benchmark**
Operations:						
Physician FTEs	4.2	3.7		(0.6)		
APP FTEs	1.0	2.0		1.0		
Provider FTEs	5.2	5.7		0.4		
Net Income or (Loss) per Provider	($157,982)	($206,423)	🔴	($48,441)	($112,850)	🔴 ($93,573)
Total Operating Cost as % of Net Patient Revenues	64.2%	73.2%	🔴	9.0%	69.3%	🔴 3.9%
Total Provider Cost as % of Net Patient Revenues	67.9%	74.5%	🔴	6.6%	60.6%	🔴 13.9%
Building and Occupancy Expense as % of Net Patient Revenues	7.6%	7.8%	🔴	0.2%	8.5%	🟢 -0.7%
Total Physician Cost per Provider	$271,685	$210,548	🟢	($61,137)	$193,000	🔴 $17,548
Total APP Cost per Provider	$29,877	$39,280	🔴	$9,403	$47,682	🟢 ($8,402)
Total Provider Cost per Provider	$301,562	$249,828	🟢	($51,734)	$239,785	🔴 $10,043
Building and Occupancy Expense per Provider	$34,877	$35,202	🔴	$325	$35,961	🟢 ($759)
Provider Productivity %ile less Compensation %ile	(5.0)	(17.8)	🔴	-12.8	0.0	🔴 -17.8
Average Comp %tile per Physician	73.0	78.0		5.0		
Average Comp %tile per APP	60.0	44.0		(16.0)		
Average Comp %tile per Provider	71.0	74.0		3.0		
Total Support Staff FTEs	11.0	13.2		2.2		
Total Support Staff FTE Cost	$502,317	$617,589		$115,272		
Total Support Staff FTEs per Provider	2.1	2.3		0.2	2.2	🔴 0.1
Total Support Staff FTEs per 10,000 wRVUs	4.8	5.5		0.7	3.9	🔴 1.6
Revenue Cycle:						
Total Net Patient Revenues	$1,905,665	$1,756,984	🔴	($148,681)	$2,758,946	🔴 ($1,001,962)
Days in AR	45.4	43.2	🟢	(2.2)	36.1	🔴 7.1
Adjusted FFS Collection Rate	96.7%	95.4%	🔴	-1.3%	96.9%	🔴 -1.5%
% Commercial Charges	39.5%	40.5%	🟢	1.0%	54.9%	🔴 -14.4%
Total Collections per Provider	$364,372	$310,421	🔴	($53,951)	$494,875	🔴 ($184,454)
Total Collections per wRVU	$84	$74	🔴	($10)	$79	🔴 ($5)
Volume/Throughput:						
Average wRVU %tile per Physician	64.0	58.0	🔴	(6.0)	50.0	🟢 8.0
Average wRVU %tile per APP	75.0	44.8	🔴	(30.2)	50.0	🔴 (5.2)
Average wRVU %tile per Provider	66.0	56.2	🔴	(9.8)	50.0	🟢 6.2
wRVUs Total: Physician(s)	18,254	17,250	🔴	(1,004)	17,970	🔴 (720)
wRVUs Total: APP(s)	4,478	6,584	🟢	2,106	8,616	🔴 (2,032)
wRVUs Total: All Providers	22,732	23,834	🟢	1,102	26,586	🔴 (2,752)
% of Appointments Filled	51.2%	54.2%	🟢	3.0%	95.0%	🔴 -40.8%
No Show Rate (%)	4.7%	4.3%	🟢	-0.4%	6.0%	🟢 -1.7%

Priority for Management Review: High

Variance in Net Income from Benchmark: ($533,366)

Practice Overview:
- Viability of current number of FTEs should be evaluated.

Areas of Concern:
- Provider productivity
- Staffing levels at current productivity
- Mismatch of compensation to production
- Declining Collections per wRVUs
- Increasing overall loss per provider

Opportunities for Improvement*

Building & Occupancy Cost	$0
Provider Compensation	$120,622
Support Staff Cost per 10,000 wRVUs	$178,763
Net Patient Revenue per wRVU	$125,902
wRVU Production	$202,847

**Note: Opportunities for Improvement are potentially not cumulative, depending on metric.*

HSG Network Assessment
Sample Practice Rollup

Practice Name	Ann. 2018 MD FTEs	Ann. 2018 APP FTEs	Ann. 2018 Practice Net Income	NI per Provider	NI/Provider Benchmark	Variance	NI per Physician	NI/Physician Benchmark	Variance
Practice 1	1.5	1.0	$19,536	$7,835	($112,850)	$120,684	$13,024	($170,106)	$183,130
Practice 2	2.6	1.0	($1,082,197)	($303,420)	($189,448)	($113,972)	($421,635)	($197,341)	($224,295)
Practice 3	0.0	0.5	$47,525	$102,055	($112,850)	$214,905	n/a	($170,106)	n/a
Practice 4	0.6	0.0	($244,875)	($419,785)	($195,048)	($224,737)	($419,785)	($248,770)	($171,015)
Practice 5	2.0	0.0	($702,821)	($351,411)	($177,911)	($173,500)	($351,411)	($265,023)	($86,388)
Practice 6	3.8	1.0	($1,444,832)	($304,175)	($177,911)	($126,265)	($385,289)	($265,023)	($120,266)
Practice 7	2.8	1.0	($843,845)	($225,025)	($164,200)	($60,826)	($306,853)	($217,444)	($89,408)
Practice 8	10.0	1.0	($1,897,685)	($172,517)	($67,006)	($105,511)	($189,769)	($71,946)	($117,823)
Practice 9	1.4	0.0	($701,987)	($510,536)	($195,048)	($315,488)	($510,536)	($248,770)	($261,766)
Practice 10	1.0	0.4	($462,596)	($326,538)	($290,786)	($35,753)	($462,596)	($519,997)	$57,401
Practice 11	1.8	1.0	($1,725,996)	($627,635)	($177,911)	($449,724)	($986,283)	($265,023)	($721,261)
Practice 12	4.5	0.0	($2,301,520)	($506,757)	($147,640)	($359,116)	($506,757)	($274,591)	($232,166)
Practice 13	2.2	0.0	($772,775)	($354,484)	($136,381)	($218,103)	($354,484)	($171,848)	($182,636)
Practice 14	3.3	1.4	($887,389)	($188,806)	($120,722)	($68,084)	($268,906)	($205,407)	($63,499)
Practice 15	0.5	2.9	$154,356	$45,399	($112,850)	$158,249	$308,712	($170,106)	$478,818
Practice 16	0.8	2.7	($1,099,381)	($315,474)	($136,381)	($179,093)	($1,465,842)	($171,848)	($1,293,994)
Practice 17	0.0	2.0	($237,316)	($118,658)	($112,850)	($5,808)	n/a	($170,106)	n/a
Practice 18	3.0	2.2	($320,289)	($61,190)	($112,850)	$51,659	($106,763)	($170,106)	$63,343
Practice 19	0.9	0.9	($389,714)	($212,571)	($195,048)	($17,523)	($425,142)	($248,770)	($176,372)
Practice 20	1.0	0.5	($636,317)	($419,971)	($177,911)	($242,060)	($636,317)	($265,023)	($371,295)
Practice 21	2.3	2.3	($1,263,343)	($271,104)	($17,703)	($253,401)	($542,207)	($143,776)	($398,432)
Practice 22	5.6	3.0	($1,965,583)	($229,000)	($96,716)	($132,283)	($352,045)	($145,981)	($206,064)
Grand Total	**51.6**	**24.8**	**($18,759,045)**	**($244,327)**	**($124,995)**	**($119,332)**	**($361,550)**	**($187,740)**	**(173,811)**

On a "per physician" basis, CLIENT is losing $173,811 per physician IN EXCESS of benchmark loss
On a "per provider" basis, CLIENT is losing $119,332 per provider IN EXCESS of benchmark loss

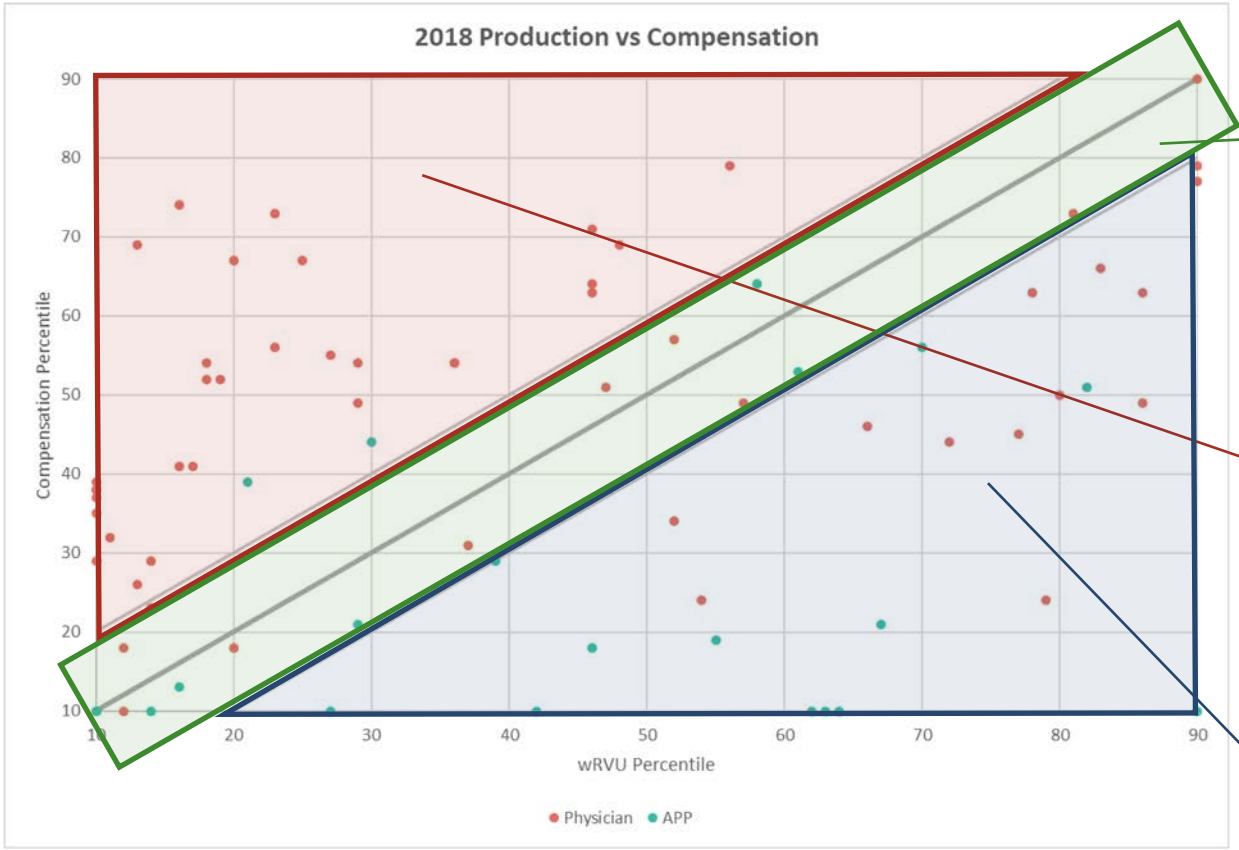
HSG Network Assessment
Sample Practice Summary

Practice	Net Loss In Excess of Benchmark	Provider FTEs	Priority for Management Intervention	Type of Opportunity
Client Internal Medicine 1	($408,486)	2.7	High	Production flat while compensation growing Payer mix appears to be partially an issue, but NPR very low
Client Pediatrics 1	($423,822)	4.0	High	Very productive practice – appears understaffed Building and Occupancy expense severely out of line Improve 3:1 Physician to APP ratio
Client Pediatrics 2	($285,242)	1.0	High	Low Volume not sustainable
Client Family Medicine 1	($633,039)	7.4	Moderate	Growth in providers – utilization very high
Client Internal Medicine 2	($543,173)	7.9	Moderate	Payer Mix Improve 8:0 Physician to APP ratio
Client Internal Medicine 3	($494,198)	5.8	Moderate	Improve 4.8:1 Physician to APP Ratio Building and Occupancy Cost high
Client Family Medicine 2	($416,773)	6.7	Moderate	Practice needs to absorb recent APP growth and ensure incremental volume coming
Client Internal Medicine 4	($369,535)	9.0	Low	Building and Occupancy expense out of line Growth in physicians or APPs needed
Client Family Medicine 3	($338,592)	4.0	Low	Practice looks primed for physician or APP growth given utilization, but payer mix is poor

HSG Network Assessment
Sample Rollup of Opportunities

Metric vs. Benchmark or Target	Variance from Benchmark	Potential Causes	HSG Commentary
Net Income (or Loss)	**($18,759,045)**		
Building & Occupancy Cost per Provider	**$839,065**	• Inefficient space usage • Excessive lease rates	• Not a significant issue • Lease rates need to be reviewed • Consolidation should be explored as network grows
Provider Compensation per Provider	**$3,985,144**	• Mismatch between productivity and compensation • Provider Mix	• Some issues likely related to new physicians still ramping up • Mature practices should be evaluated for performance improvement
wRVU Production per Provider	**$7,404,695**	• Practice Volume • Operational Inefficiencies, i.e. Throughput • Staffing Levels • Inefficient APP usage	• Largely unproductive group • Should improve as group ages • A handful of productive practices are understaffed per benchmark – possible growth opportunity
Support Staff per Provider* *Salary only. Total benefit cost for providers and support staff was not available to HSG (benefit cost was not broken out)	**$879,664-1,766,377**	• Severely Low Productivity Below Minimum Threshold for Staffing Levels • Inefficient Staff Usage	• Practice staffing wildly variable • Some practices showing "under"staffing as well – need to look at operations to understand if this is a barrier to increased productivity
Net Patient Revenue per wRVU	**$6,623,291**	• Payer Mix • Payer Rates • Documentation & Coding • In-Office Revenue Cycle • Provider Credentialing	• AR Management an issue • In-office activities must be maximized to ensure revenue cycle is as robust as possible • Credentialing a clear historic issue

HSG Network Assessment
Sample Compensation Alignment



Target Zone:
+/- 10%ile points alignment between compensation and wRVU productivity

Compensation Above Productivity:
Compensation 10+%ile points above wRVU productivity

Productivity Above Compensation:
Productivity 10+%ile points above Compensation

HSG Network Assessment
Results

OVERALL RESULT: Development of a long-term **Implementation Plan** defining the network's path and initiatives that must be accomplished in order for the network to be successful.

Purpose of the Implementation Plan:

- Create a clear path forward for all stakeholders
- Provide guidance to management, provider leadership, and the provider group at large of where and when to prioritize efforts, and what success looks like
- Create mutual accountability between providers, management, and leadership
- Define expected timelines, responsibilities and resources needed
- Achieve desired results

HSG partners with our clients to bring needed resources and counsel for the execution of the Implementation Plan.

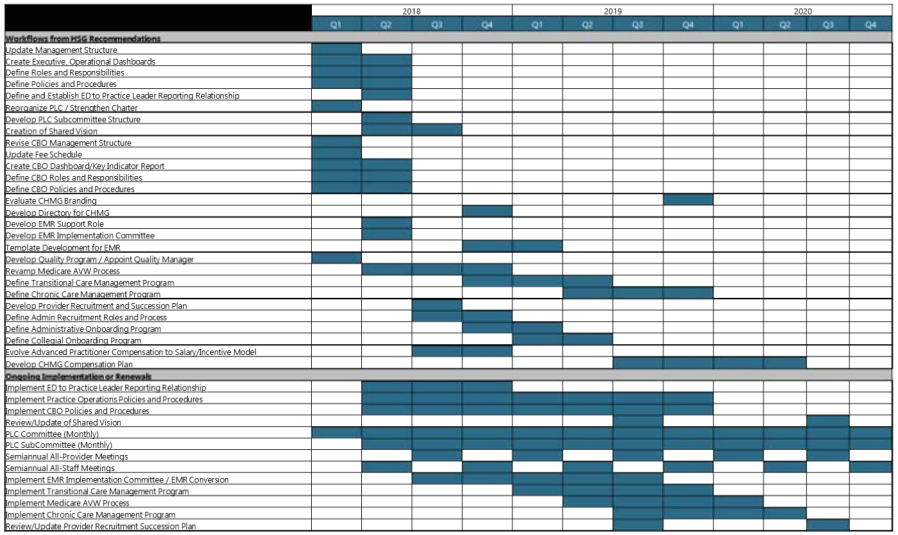
Moving Forward

HSG's Philosophy on Assisting Health Systems with Employed Network Challenges

Build a Playbook – Define a comprehensive implementation plan – the next 24-36 months of key management actions that will address the defined challenges.

Key Components:

- Detailed action plans
- Defined resources needed
- Defined accountabilities
- Workplans for integration into both management and the Executive Council (and subcommittees)
- Ability to integrate into progress management and reporting at board, admin and Executive Council level



Sample 36-Month Implementation Plan Rollup *(Actions and Timing Only)*

Management Resources

- At times, clients tackle the implementation without our assistance

- At times, HSG helps provide management resources
- On-site management to help implement the plan as
  - Executive director
  - Specialty resource, such as revenue cycle
- Management contract to run the network
- Service line focused resources, to coordinate the physicians and a service line growth strategy
- Provides greater **expertise** and greater **speed** of implementation

Case Studies

Case Study - Revenue Per RVU

- Revenue per RVU was well below benchmark
- Root cause of the problem was revenue cycle management
- HSG provided onsite resource to transform the revenue cycle
- Process focus generally
- Added 5 FTEs to the process that was under-resourced
- Quarterly improvement in collections of $1.8 million
- Annualize improvement of over $7 million

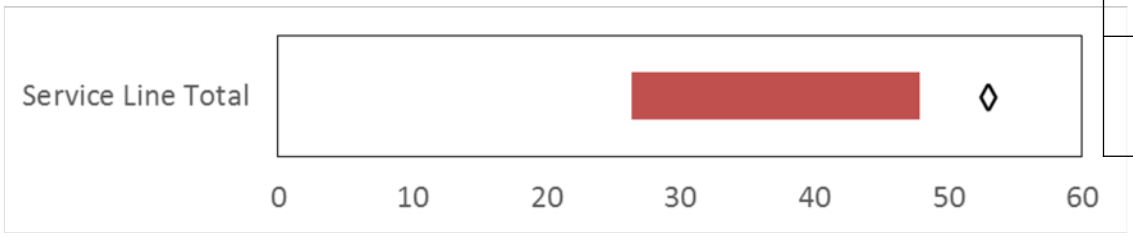
Case Study – Management Infrastructure

- Practices reported to service line with no practice management expertise
- Created centralized infrastructure, including Executive Director, 2 supervisors, and financial analyst
- Push on productivity
  - More common templates
  - Compensation incentives strengthened
  - Increase of 4% 2016 to 2017
- Centralized referral management to retain volume
- Position control/staff productivity
- Move to single EMR
- Losses declined 8% 2017 vs. 2016

Case Study – Support Staffing

- Developed productivity system for use in all practices
- Helped clients create clear expectations and accountability
- Client able to reduce overstaffing across network, as well as increase staffing at some sites

Total Service Line Non-Provider Support Staff



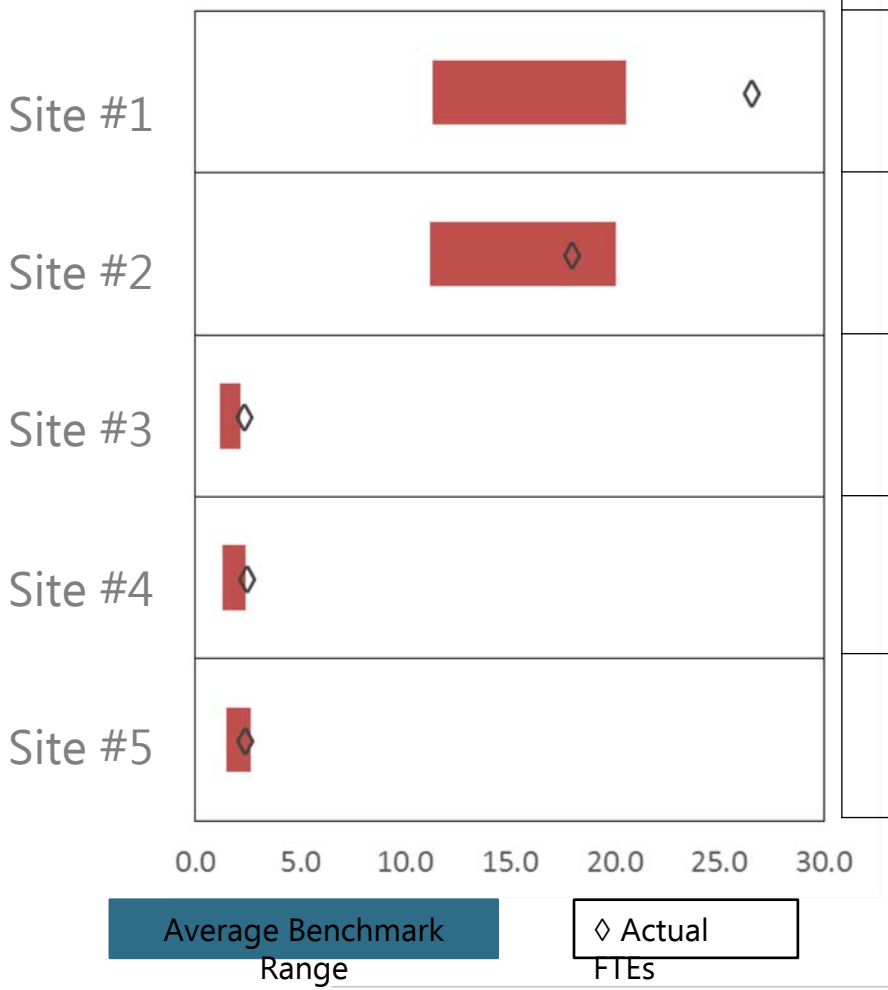
Actual FTEs	Benchmark Range Low	Benchmark Range High
53.4	26.8	48.9

Benchmark Range Determined by Averaging Three Benchmark Sources:

	Top Performing Quartile	Median
*AMGA Per Physician		43.8
**MGMA Per Physician	24.7	45.8
***MGMA Per wRVU	28.9	57.1

*AMGA Medical Group Physician Compensation and Financial Survey: Section X. *Median*
**MGMA Cost Survey: Table 43.4a.
***MGMA Cost Survey: Table 43.9a.
(Totals calculated by multiplying survey ratios by actual number of physicians or wRVUs)

Total Non-Provider Support Staff by Clinic Site



	Actual FTEs	Benchmark Range Low	Benchmark Range High
Site #1	27.5	11.4	20.9
Site #2	18.9	11.4	20.7
Site #3	2.5	1.1	2.2
Site #4	2.5	1.4	2.5
Site #5	2.0	1.5	2.7

Clinic Site Staffing Summary

	Clinical Support Staff			Administrative Support Staff		
	Actual FTEs	Benchmark Range Low	Benchmark Range High	Actual FTEs	Benchmark Range Low	Benchmark Range High
Site #1	2	4.1	9.3	25.5	7.3	11.5
Site #2	2.7	4.1	9.2	16.2	7.3	11.4
Site #3	1.5	0.4	1.0	1.0	0.7	1.2
Site #4	1.3	0.5	1.1	1.2	0.9	1.4
Site #5	0.4	0.5	1.2	1.6	0.9	1.5
Service Line Total	7.9	**9.7**	**21.9**	45.5	**17.0**	**27.1**

- Administrative Support Staff Includes: Clerical & Other Admin, Professional & Administrative, Management & Supervision, Central Scheduling Allocations
- Clinical Support Staff Includes: Technicians and Specialists, Registered Nurses, Licensed Practical Nurses, Aides and Orderlies
- Benchmark Range = Average of AMGA per Physician, MGMA per Physician, & MGMA per wRVU

- Robust "Nurse Navigator" and educational programs would have predicted higher than benchmark clinical support staff
  - Unless classified as administrative due to role

Case Study – Physician Advisory Board

- Built PAC and worked with them initially on shared vision
- Among the role the PAC assumed were
  - Creating physician engagement around network financial performance
  - Creating role for PAC related to compensation systems
  - Took leadership in defining incentives, building incentives around best practices
  - Creating accountability around productivity

Questions

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19 Years at HSG
37 Years in the Industry

Strengths

- Strategic planning
- Physician alignment & engagement
- Critical thinking
- Building physician capabilities needed by health systems for the future

Client Accomplishments

- Client expanded market, growing revenue 8% annually and increasing operating margin by 3%

PROFESSIONAL EXPERIENCE

Mr. Miller's experience as VP of Quality and Managed Care at Norton taught him to value managing variations in care, which only happens with physician collaboration. Those early experience have been repeatedly reinforced by consulting work, and at HSG, we understand the only path to success for hospitals is through strong ties to strong physicians. His practice focuses on strategic planning with a strong focus on physicians, building physician groups that are strategic assets to the health systems.

EDUCATION

David was an executive at Norton Healthcare for 15 years, with leadership roles in Operations, Physician Services, Quality and Managed Care. He holds a Master's in Health Administration from The Ohio State University and a Bachelor's in Management from Virginia Tech.

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12 Years at HSG
23 Years in the Industry

Strengths

- Employed physician network management
- Physician network assessment and optimization
- Physician alignment and engagement
- Network executive recruitment and contracting

Client Accomplishments

- Improved quarterly collections for client's employed physician network by $1.7 million

PROFESSIONAL EXPERIENCE

Mr. Creech's practice focuses on appropriately assessing the needs of employed physician networks, identifying opportunities to enhance the performance and culture of these networks and developing a strategic vision for the future for these networks to become an asset for the organization. His firmly-held belief is that HSG develops partnerships that benefit clients by having consistent advice from advisors who understand the market and knows the key players. He uses the phrase "The HSG Experience" to describe success provided to partner clients.

EDUCATION

Davis was an executive at Jewish Hospital for 7 years with leadership roles in Physician Management, Network Referral and Development. He holds Masters' degrees in Business and Hospital Administration from Xavier University and a Bachelors Degree in Economics and Management from Centre College.