Revenue Cycle Optimization:
Employed Physician Networks

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Presenters

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- Physician Strategy Development
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- Management Infrastructure and Administrative Leadership
- Revenue Cycle
- Physician Leadership Development

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Objectives

1. Learn key questions to ask about your employed provider network's professional services revenue cycle.
2. Learn how the answers to these key questions will help you optimize your revenue cycle.
3. Learn from the mistakes of others—learn what not to do with your physician revenue cycle function.

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Revenue Cycle

Vital Reports:

1. Schedule utilization & no show rate
2. Denial reason report
3. Registration errors & POS collections
4. Delinquent charges
5. Days in AR & AR aging
6. Claim denial rate

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Revenue Cycle: Key Questions

KEY QUESTIONS TO ASK TO OPTIMIZE EFFECTIVENESS

- Without increasing volume, can we increase collections per contact (i.e., per patient, per wRVU)?
    - What is our current fee schedule? Are we charging enough?
    - Are we documenting and coding effectively? (Note, also a compliance concern)
    - Are providers signing off on charts in a timely manner?
    - Are we managing denials (i.e., limiting first pass denials and working others)?
    - What is our charge capture rate? Are we missing products and services?
    - What are our commercial payer contract rates? Are we charging enough?
    - Are we collecting co-payments at each opportunity?
    - What do our adjustments look like? Are they appropriate or are we just writing off services?
- Are our providers credentialed and onboarded correctly and timely?
- Are we taking steps to mitigate the impact of no-shows?
- Are providers and staff utilizing our IT system effectively, are they trained appropriately, and is it optimized for efficiency?
- What is our current payer mix? Is it a limiting factor?
- Do we have enough and the correct staff?
- Do we communicate back to the front desk regarding mistakes and denial reasons, so we aren't making the same mistakes over and over?
- How to we measure, monitor, and report these metrics in dashboards to the management staff?

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HSG Revenue Cycle Review Process

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Revenue Cycle: Key Data Points

Data Element	Timeframe
General Data	
1. Contact info for all key contacts as well as responsible party for each data set: a. Name b. Title c. Email Address d. Phone Number	
Provider and Practice Data	
2. A table containing the following data for each Practice provider: a. Provider Name b. Provider NPI c. Provider taxonomy code d. Practice Name/Location e. Provider Type (NP, MD, PA, etc.) f. Specialty and subspecialty focus g. FTE (.2, .5, .9, 1.0, etc. and defining clinical and administrative, if applicable) h. Hire Date i. Termination/departure date (if no longer with group)	Include any provider with group in last 2 years
3. For each practice location a. Practice Name b. Address c. Name of EMR & PM system(s) utilized d. List of participating health plans e. Complete list of services provided at the location (i.e., professional services, PT, x-ray, etc.) f. Revenue allocated to the P&L by service type (i.e., professional revenue, PT, x-ray, etc.) g. Total charges (gross professional revenue) by payer h. Charge lag time by provider i. A/R Aging Summary (i.e., current, 31 to 60, 61 to 90, 91 to 120, 121+) j. A/R Balance k. Claim denial rate by provider l. Adjustments by adjustment type	For profit loss statements and charges by payer: current fiscal year-to-date and two most recently completed fiscal years. For A/R show end of current fiscal year to date.

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Revenue Cycle: Key Data Points

Data Element	Timeframe
4. CPT detail report containing the following by rendering provider: a. Rendering provider name b. CPT code c. Modifiers d. Number of units e. Total personally-performed wRVUs f. Total charges g. Total adjustments h. Total payments	Current fiscal year-to-date and two most recently completed fiscal years
5. For each non-provider staff member, please define: a. Practice name, location, or department (CBO, admin, etc.) i. *Please list the revenue cycle team assigned to work Practice A/R* b. Job title c. FTE or average hours per week (i.e., 1.0 FTE or 40 hours per week) d. Hire date e. Pay rate f. Total pay (Current fiscal year-to-date and two most recently completed fiscal years)	Current roster
6. Practice charge master/fee schedule	Current
7. Top 20 CPT codes in terms of volume with top 5 commercial payer rates by CPT code	Current
8. Practice Access Metrics (i.e., how many appointment slots are unfilled, no-show rates, time to 3rd next available appointment, and other unnamed measures utilized by Practice by practice and location)	Most recent

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Revenue Cycle: Production

Specialty	FY17 wRVUs	FY17 wRVU %tile	FY18 wRVUs	FY18 wRVU %tile	FY19 wRVUs	FY19 wRVU %tile	FY20 wRVUs	FY20 wRVU %tile
Orthopedic Surgery: Foot and Ankle					5,060	14	1,974	13
Orthopedic Surgery: General	9,914	65	9,145	58	7,629	41	2,673	44
	7,984	44	7,815	43	7,574	40	2,709	45
	8,295	47	6,577	28	6,853	32	2,672	44
	5,712	24	5,392	16	6,569	27	2,704	45
Orthopedic Surgery: Hand					3,720	90	2,570	29
Orthopedic Surgery: Spine	5,363	14	5,109	14	5,412	14	1,943	18
Orthopedic Surgery: Sports Medicine	15,089	89	13,809	85	12,870	81	3,786	71
	7,177	31	7,918	38	8,608	46	2,569	35
PA: Orthopedic (Surgical)	3,246	66	2,808	57	2,585	53	980	59
	2,522	52	2,084	45	2,204	46	898	54
			1,138	25	2,510	52	1,107	67
			755	35	1,796	39	806	50
	78	0	11	0	26	0	17	0
Physiatry (Physical Medicine and Rehabilitation)	3,152	17	3,373	20	2,769	13	944	13

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Revenue Cycle: Rates and per Unit Metrics

	FY19 Actual	FY 19 MGMA %tile Rank	FY20 Actual	FY20 MGMA %tile Rank	MGMA Median
Gross Collection Rate	37%	45th	36%	44th	38%
Net Collection Rate	86%	23rd	83%	20th	94%

	FY19 Actual	FY 19 MGMA %tile Rank	FY20 Actual[1]	FY20 MGMA %tile Rank	MGMA Median
Collections per Provider	$347,493	26th	$390,341	33rd	$501,914
Collections per wRVU	$62.49	13th	$62.23	12th	$78.81

	FY20 Actual	MGMA %tile Rank	MGMA Median
Days in AR	41.89	23rd	56.61
Percent of AR > 90 days	29%	41st	34%

	FY20 Actual	MGMA %tile Rank	MGMA Median
Charge Lag[2]	7.10	70th	3.00
First Pass Denial Rate	4.10%	18th	9.00%

2: Time between date of service and claim drop date to payer

The 2 primary denial reasons are "Missing Claim Information" followed by "Eligibility/Registration"

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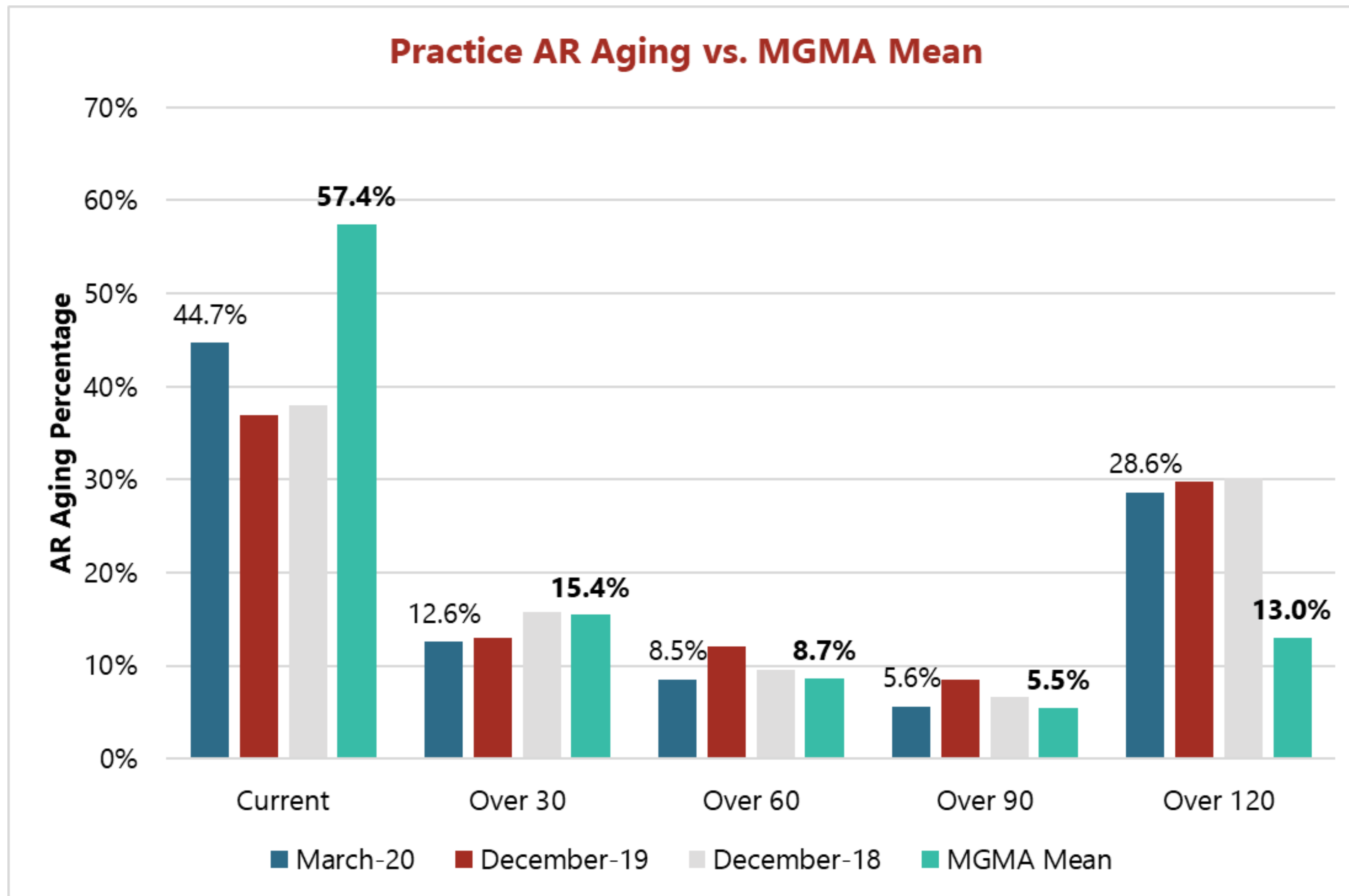
Revenue Cycle: AR Aging



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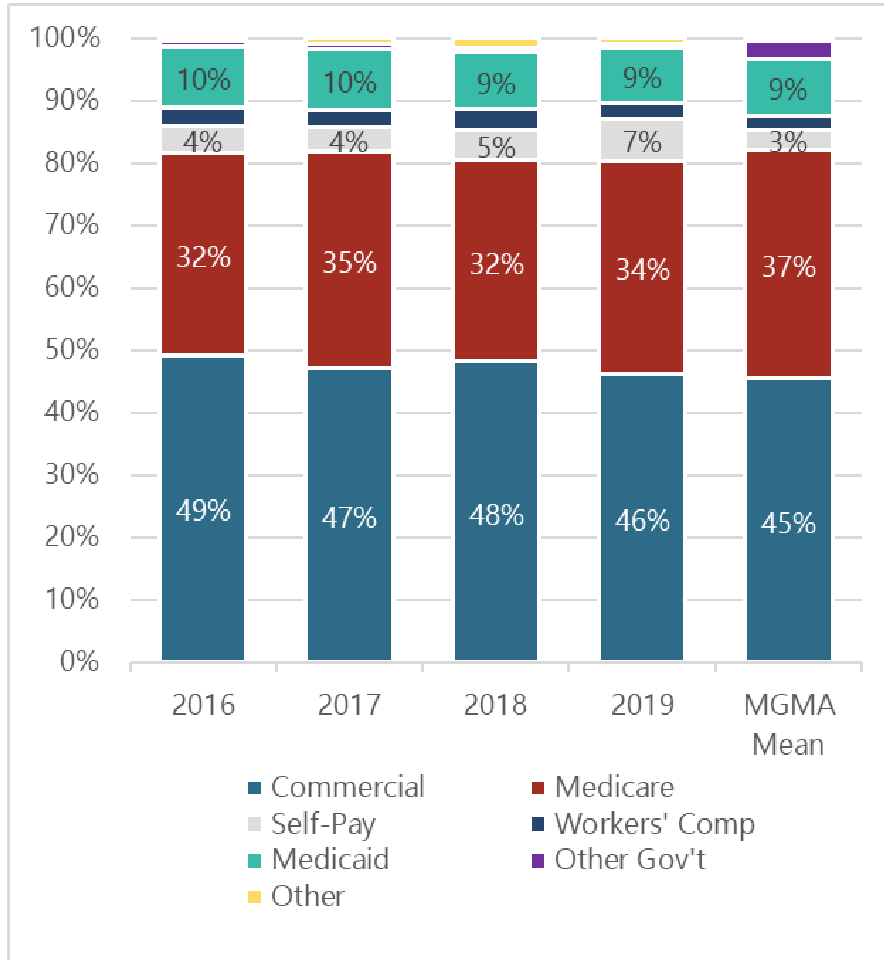
Revenue Cycle: Payer Mix



Top 6 Commercial Payers

#	Payer	Charges
1.)	BCBS	$13,000,000.00
	MEDICARE	$9,900,000.00
2.)	STATE HEALTH PLAN	$2,400,000.00
3.)	UNITED HEALTHCARE	$2,200,000.00
	Self Pay	$2,100,000.00
	MEDICAID NC	$1,500,000.00
	UNITED HEALTHCARE MEDICARE ADV	$1,430,000.00
	HUMANA MEDICARE ADV	$1,400,000.00
4.)	UMR	$1,100,000.00
5.)	CIGNA	$1,000,000.00
6.)	MEDCOST	$827,000.00

#	Payer	Payments
	MEDICARE	$4,500,000.00
1.)	BCBS	$4,400,000.00
2.)	STATE HEALTH PLAN	$830,000.00
	UNITED HEALTHCARE MEDICARE ADV	$728,000.00
	HUMANA MEDICARE ADV	$634,000.00
	MEDICAID NC	$622,000.00
3.)	UNITED HEALTHCARE	$572,000.00
4.)	MEDCOST	$348,000.00
5.)	UMR	$305,000.00
	UNITED HEALTHCARE SHP MEDICARE AD	$288,000.00
6.)	CIGNA	$284,000.00

#	Payer	Quantity
	MEDICARE	131,000.00
1.)	BCBS	94,000.00
	UNITED HEALTHCARE MEDICARE ADV	25,000.00
2.)	STATE HEALTH PLAN	22,000.00
	HUMANA MEDICARE ADV	17,000.00
	MEDICAID NC	16,000.00
	Self Pay	12,400.00
3.)	UNITED HEALTHCARE	12,000.00
	UNITED HEALTHCARE SHP MEDICARE AD	9,000.00
	BCBS MEDICARE ADV	8,200.00
4.)	UMR	5,700.00
5.)	CIGNA	5,200.00
6.)	MEDCOST	4,800.00

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Revenue Cycle: Charge Master

Type	Recommended %
Surgical	250%
Evaluation and Management/Medicine	160%
X-Ray	160%

CPT	Description	Type	Current Fee Amount	Current Medicare Part B PFS	Current % Medicare	Highest Payer	Highest Payer Rate	Highest Payer % of MCR	Recommended Fee	Recommended Fee % of MCR	Recommended Fee % of Highest
10021	Fna W/o Image	Surgical	$ 213	$ 118	181%	BCBS	$ 280	238%	$ 294	250%	105%
10040	Acne Surgery	Surgical	$ 121	$ 85	143%	BCBS	$ 200	236%	$ 212	250%	106%
10060	Drainage Of Skin Abscess	Surgical	$ 167	$ 91	184%	Aetna	$ 200	220%	$ 227	250%	114%
51701	Insert Bladder Catheter	Surgical	$ 68	$ 57	119%	Humana	$ 135	237%	$ 142	250%	105%
51702	Insert Temp Bladder Cath	Surgical	$ 163	$ 73	224%	Humana	$ 173	237%	$ 182	250%	105%
58300	Insert Intrauterine Device	Surgical	$ 185	$ 69	268%	Humana	$ 164	237%	$ 173	250%	105%
64405	N Block Inj, Occipital	Surgical	$ 190	$ 89	213%	Humana	$ 212	238%	$ 223	250%	105%
64430	N Block Inj, Pudendal	Surgical	$ 150	$ 134	112%	Humana	$ 317	237%	$ 334	250%	105%
64435	N Block Inj, Paracervical	Surgical	$ 150	$ 124	121%	Humana	$ 294	237%	$ 310	250%	105%
65205	Remove Foreign Body From Eye	Surgical	$ 113	$ 45	249%	Humana	$ 108	238%	$ 113	250%	105%
69200	Clear Outer Ear Canal	Surgical	$ 130	$ 100	130%	Humana	$ 238	237%	$ 251	250%	105%
69210	Remove Impacted Ear Wax	Surgical	$ 86	$ 42	204%	Humana	$ 100	238%	$ 105	250%	105%
71010	Chest X-Ray	X-Ray	$ 28	$ 22	129%	Humana	$ 33	152%	$ 35	160%	105%
71020	Chest X-Ray	X-Ray	$ 30	$ 29	105%	Humana	$ 44	153%	$ 46	160%	104%
71030	Chest X-Ray	X-Ray	$ 50	$ 42	119%	Humana	$ 64	153%	$ 67	160%	105%
99203	Office/outpatient Visit, New	E&M/Medicine	$ 141	$ 86	163%	BCBS	$ 131	152%	$ 138	160%	105%
99204	Office/outpatient Visit, New	E&M/Medicine	$ 202	$ 134	150%	BCBS	$ 204	152%	$ 215	160%	105%
99205	Office/outpatient Visit, New	E&M/Medicine	$ 288	$ 170	170%	BCBS	$ 258	152%	$ 272	160%	105%
99213	Office/outpatient Visit, Est	E&M/Medicine	$ 80	$ 58	138%	BCBS	$ 88	151%	$ 93	160%	106%
99214	Office/outpatient Visit, Est	E&M/Medicine	$ 116	$ 88	132%	BCBS	$ 133	152%	$ 140	160%	105%
99215	Office/outpatient Visit, Est	E&M/Medicine	$ 186	$ 119	157%	BCBS	$ 180	152%	$ 190	160%	105%
99291	Critical Care, First Hour	E&M/Medicine	$ 290	$ 242	120%	BCBS	$ 368	152%	$ 387	160%	105%
99292	Critical Care, Add'l 30 Min	E&M/Medicine	$ 141	$ 110	129%	BCBS	$ 167	152%	$ 176	160%	105%
99304	Nursing Facility Care, Init	E&M/Medicine	$ 75	$ 77	97%	BCBS	$ 117	152%	$		
99305	Nursing Facility Care, Init	E&M/Medicine	$ 132	$ 108	122%	Aetna	$ 164				
99306	Nursing Facility Care, Init	E&M/Medicine	$ 145	$ 139	105%	BCBS					
99309	Nursing Fac Care, Subseq	E&M/Medicine	$ 90	$ 77	117%						
99310	Nursing Fac Care, Subseq	E&M/Medicine	$ 113	$ 114							
	Nursing Fac Discharge Day	E&M/Medicine	$ 70	$							
		E&M/Medicine	$								

- When was the last time you updated your fee schedule?
- Did you compare it to Medicare as well as your Highest Commercial Payer?
- Is it standardized across specialties?
- Have you added new specialties and services?

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Revenue Cycle: Adjustments by Type

Trans Reason Code	Amount
MEDICARE ADJUSTMENT	-1,196,397.87
Medicaid CMO Adjustment	-426,862.51
Medicare Advantage Adjustment	-408,869.72
Blue Cross Adjustment	-334,706.73
Commercial Insurance Adjustment	-206,971.80
Bad Debt Write-Off	-180,980.94
Uninsured Discount	-169,631.42
Other Adjustment	-149,003.60
MEDICAID ADJUSTMENT	-92,677.71
Non Participating Provider Adjustment	-89,662.17
Other Government Adjustment	-50,686.15
MEDICAL CLEARANCE CONTRACTUAL	-29,408.90
Small Balance Write-Off	-18,680.12
Timely Filing Billing	-17,958.47
Financial Assistance	-13,384.86
Work Comp Adjustment	-10,626.28
Deceased	-7,377.38

Trans Reason Code	Amount
Contractual adjustment	-4,179.51
Timely Filing Front Office	-3,179.83
No Prior Authorization	-3,050.00
Medical Necessity Adjustment	-2,893.00
Late Charge Processing	-2,374.56
Global Adjustment	-1,181.00
EMPLOYEE WORK RELATED INJURY	-420.00
Customer Service Adjustment	-419.70
CHARITY WINDROSE	-387.69
IB Cost Report	-308.34
Self Pay Adjustment	-305.51
ADMINISTRATIVE ADJUSTMENT	-212.00
Contract Adjustment	-208.08
Provider not certified for Proc this DOS	-87.89
Deceased- Medicare	-81.36
SAD Drug Write-Off	-4.99
BAD DEBT RECOVERY	859.05
Bad Debt Reversal	33,273.35
REVERSAL	205,421.31
Grand Total	**-3,183,626.38**

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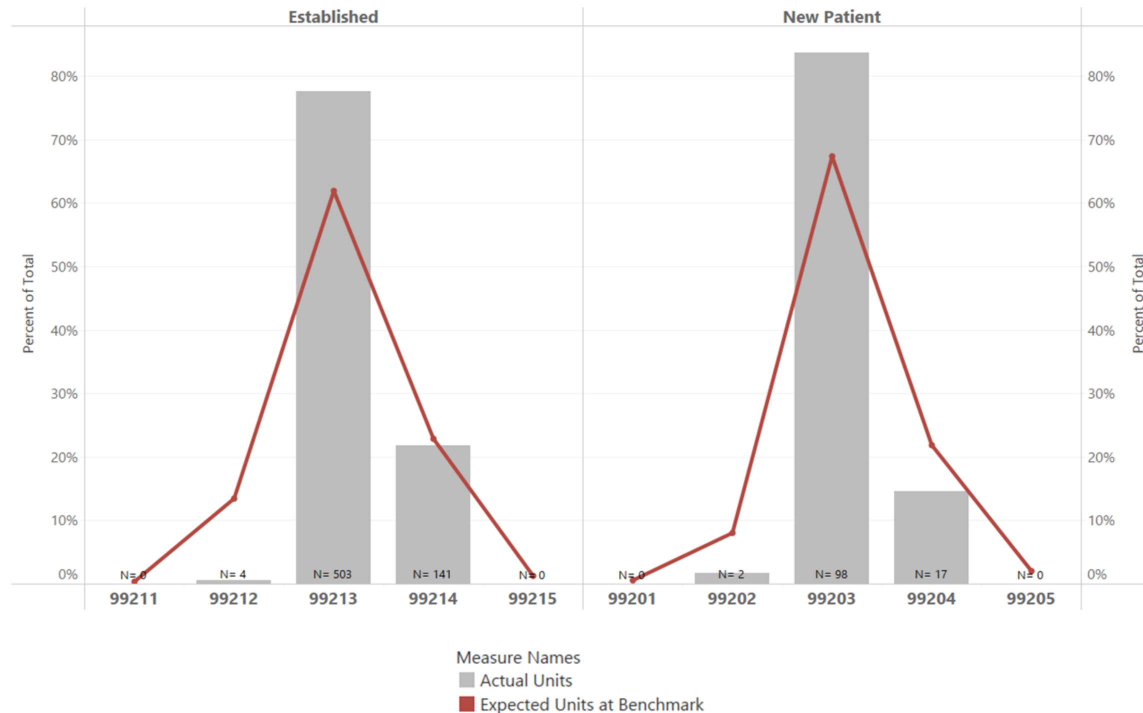
Revenue Cycle: Coding and Documentation



- Do you conduct regular documentation and coding updates for providers and coders?
- Have you completed a network wide coding analysis –
  - Are there opportunities in under coding?
- If there is a discrepancy in coding, what is the process/timeline for correcting?

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Revenue Cycle: Dashboards

- Pick 8-10 relevant metrics that you are confident that you can find a data source of truth
  - Involve IT, Rev Cycle, Operations, Front Office, Providers, etc.
- Review monthly with providers and revenue cycle team
- Don't just "send out"
  - Help managers and team members understand current state and how to improve

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Revenue Cycle: Dashboards

Metric	2018	2019	Variance[1]	Benchmark (Goal)	Variance[2]
Name of Practice/Rollup:					
Specialty: Family Medicine					
Operations:					
Net Income or (Loss) per Provider	($161,825)	($192,879)	($31,054)	($112,850)	($80,029)
Total Operating Cost as % of Revenue (O/H Rate)	67%	75%	7.5%	69.3%	5.6%
Total Provider Cost as % of Revenue	66%	73%	6.7%	60.6%	12.4%
Building and Occupancy Expense as % of Revenue	12%	13%	0.7%	8.5%	4.6%
Provider Comp Over Productivity (by 10 or greater)	0.0	9.0	9.0	10.00	-1.0
Average Comp %tile per Provider	76.0	65.0	(11.0)	50.0	15.0
Total Support Staff FTEs per Provider	N/A	2.8	N/A	2.9	(0.1)
Total Support Staff FTEs per 10,000 wRVUs	N/A	5.8	N/A	6.3	(0.6)
Total Support Staff Cost as a % of Revenue	N/A	23%	N/A	29.7%	-6.7%
Certification	N/A	CPC+Track 2	N/A		
Revenue Cycle:					
Total Gross Charges	$3,647,594	$3,337,560	($310,034)	$2,800,000	$537,560
Total Professional Collections	$2,197,456	$2,044,647	($152,809)	$1,900,000	$144,647
Days in AR	N/A	20.8	N/A	36.1	(15.2)
Adjusted FFS Collection Rate	97.1%	96.9%	-0.3%	96.9%	-0.1%
% of AR Over 90 Days	N/A	17%	N/A	21.6%	-4.1%
% Commercial Charges	N/A	51%	N/A	54.9%	-3.7%
Total Professional Collections per Provider	$537,275	$416,595	($120,680)	$392,187	$24,408
Total Professional Collections per wRVU	$91	$87	($5)	$83	$3
Volume/Throughput:					
wRVUs Total: Physician(s)	22,741	19,314	(3,427)	19,737	(424)
wRVUs Total: APP(s)	1,319	4,299	2,980	2,872	1,427
Average wRVU %tile per Provider	76.0	56.0	(20.0)	50.0	6.0
wRVUs Total: All Providers	24,060	23,613	(448)	22,609	1,004
% of Appointments Filled	N/A	86%	N/A	95.0%	-8.7%
No Show Rate (%)	N/A	7%	N/A	5.0%	1.5%

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Revenue Cycle: Dashboards

- Deep-dive revenue cycle dashboard items:
  - Volume (Charges and wRVUs) dashboard
    - Charges, patients, and wRVUs by month, by provider
  - Copay collections dashboard
    - Copay collection rate = Appts w Copay Collected / Appts w Copay Due
    - Copay missed = Total copay $ due - Total copay $ collected
  - Denials dashboard
    - First pass denial rate
    - Denials by Reason (i.e., missing claim information, eligibility/registration, not covered, bundled)
  - Charge lag dashboard
    - Total days lag = provider responsibility lag + charge entry lag + charge review lag

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Revenue Cycle: Common Mistakes

- Untimely or incorrect credentialing (i.e., taxonomy errors, promising start date too soon).
- No coding or documentation audits and lack of professional fee coders.
- No coding/documentation feedback or education for providers.
- No CDI team allocated to improve pro fee documentation…usually facility charges only.
- More emphasis and resources allocated to facility charges than professional fee charges.
  - Inappropriate write-off balance amounts for pro fee charges. ($100 denied charge vs $100,000 hospital charge. Pro fee gets written off and never investigated.)
  - Not enough IT resources allocated to pro fee templates, education or updates.
- No provider penalties for delinquent chart completion leading to write-offs for timely filing.
- Lack of monitoring of "third next available appointment" to gauge patient access.
- Administrative time that translates to "time off" versus catching up on incomplete documentation.
- Untrained staff performing charge entry without coding oversight.
- Incorrect or outdated NPI information.
- Lack of up to date coding manuals.
- Not enough staff (front desk and billing office).
- EMR/PMS not optimized for efficient and effective practice use.
- No review of charge master.
- Not enough "policing" of adjustments.
- Not working denials.
- Not communicating reasons for denials and corrective actions needed to front desk (same mistakes repeated over and over).
- Not focusing on copays and point-of-service collections.

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Revenue Cycle – Case Study

Summary

- Employed Physician Medical Group is a not-for-profit healthcare system that employs 140 providers across 19 specialties with locations that span six counties in Ohio.

Challenge

- Medical Group sought to optimize its revenue cycle operations to help address internal structural factors impacting the organization financially. The leadership also was determined to standardize its processes and increase financial accountability and consistency of metrics across its clinics.

Our Approach

- The HSG team evaluated historical data and recommended consistently following revenue cycle indicators, implemented a daily budgeted volumes report, developed a dashboard, reorganized the CBO structure, resolved an insurance denials backlog issue, standardized a fee schedule, and developed a staffing tool.
- Key focus areas of the project included increasing accountability and visibility of metrics across the revenue cycle; therefore, HSG initially provided full-time managerial support to streamline communication and transparency between the CBO and the different practices. The team collaborated to reestablish communication lines between the various points of contact.
- To identify revenue leakage and improve their annual net revenue, HSG streamlined insurance denials by organizing the CBO around the revenue cycle process: Insurance Verification, Coding and Charge Posting, Claims Processing and Payment Posting, Insurance Follow-up and Self-Pay Collections which also included Refunds.. HSG addressed the lack of proper management due to certification by advising all coding and charge entry staff to change their work location to the CBO and start reporting to the Coding and Charge Entry Lead.

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Revenue Cycle: Case Study

	Q3	Q4
Quarterly Collections	$15.84 mil	$17.58 mil
Net Collection Rate	90.2%	99.1% (1)
Days in AR	45	40
Denial Percentage	3.33%	2.3%

(1) This rate reflects some "catch-up"; expect 2017 to be 96.5%.

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Summary

- Know what key questions to ask
- Gather the right data
- Diagnose your current state revenue cycle process and identify gaps through analysis and benchmarking
- Do a deeper dive as necessary
- Know the difference between hospital (facility-based) and professional fee revenue cycle, and give professional fee revenue cycle the attention and resources it needs to be successful
- Update your fee schedule/charge master
- Focus on coding and documentation—compliance as well as revenue cycle issue
- Open communication between operations and revenue cycle
- Identify key metrics and measure them using dashboards

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HSG | Questions

Upcoming Webinars

HSG Summer 2020
Employed Physician Networks Webinar Series
Thursdays; Bi-weekly in July and August – 2:00pm EDT

Register Here

Join HSG for our summer 2020 series of four physician network webinars. Live webinars will be hosted bi-weekly by HSG subject matter experts. We have focused webinars on four subjects that have been the core focus of our clients the past few months. All webinars will be live recorded at 2pm ET on the dates identified below.

By registering for the entire series of webinars you will automatically receive all recordings and presentation materials following the live broadcasts, even if unable to attend the live events.

Upcoming Webinars

- **July 23rd** – Employed Physician Networks: A Guide to Building Strategic Advantage, Value, and Financial Sustainability
- **August 13th** – Building Differentiated Service Lines
- **August 27th** – Virtual Health: Optimize Patient Access, Capture, and Retention

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Company **Overview**

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

Headquarters: Louisville, KY

Formed: 1999

Focus: Health Systems and Physician Network Strategy and Execution

Physician Strategy

Driving a common strategic focus with engaged physicians.

Physician Leadership

Identifying and engaging strong physician leaders is integral to the network's development and success.

Performance Improvement

Improving the performance of employed physician networks.

Network Integrity

Leveraging Physician Network Integrity Analytics™ to create and monitor strategies for patient acquisition and retention.

Physician Compensation

Aligning physician compensation with health system and employed network goals.

HSG **Services**

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

Physician Strategy

Healthcare System Strategic Plans

Employed Physician Network Strategy

Growth Strategy

Shared Vision and Culture Development

Physician Manpower Plans

Service Line Strategy

Co-Management

Physician Leadership

Shared Vision and Culture

Physician Burnout

Physician Governance and Leadership

Performance Improvement

Network Performance Improvement

Performance Improvement Implementation

Network Revenue Cycle

Practice Care Model Transformation

Practice Acquisition

Advanced Practice (APP) Utilization

Virtual Health

Network Integrity

Patient Share of Care

Patient Flow

Provider Location and Service Analysis

Market Insights

Physician Compensation

Compensation Plan Design

Fair Market Value and Commercial Reasonableness Opinions

Advanced Practice Provider (APP) Compensation

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17 Years at HSG
20 Years in the Industry

Strengths

- Fair Market Value analysis
- Physician engagement and alignment
- Physician network growth
- Provider incentives and compensation
- Practice performance improvement

Client Accomplishments

- Client expanded the size of its network by 30% over the course of 3 years

PROFESSIONAL EXPERIENCE

Mr. Barker's practice focuses on assisting hospitals and health systems in contractually securing needed clinical/professional services, call coverage, medical direction, and physician leadership through compliant and appropriately aligned financial incentives and compensation programs. Mr. Barker also advises healthcare organizations in physician strategy development, physician network growth and development, service line strategy and expansion and physician practice performance improvement.

EDUCATION

Neal is a member of the American College of Healthcare Executives and a candidate member of the American Society of Appraisers. He holds a Master's Degree in Business Administration with a concentration in Healthcare Administration from the University of Louisville.

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www.HSGadvisors.com

14 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.

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