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# HFMA California Fall Conference

## Optimizing the Performance of Hospital-Affiliated Physician Networks

Presented by:

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**ECG**

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# Agenda

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*The purpose of today's presentation is to review the keys to financial and operational success for employed-physician entities and to apply those principles in a discussion of the medical foundation model.*

- I. Employment Drivers and What Has Changed
- II. Keys to Physician Employment Success
- III. Medical Foundation Model
- IV. ValleyCare Health System Case Study
- V. Panel Discussion

# I. Employment Drivers and What Has Changed

# Industry publications have chronicled the return of physician employment over the past 5 years.

**Physician's News**  
**DIGEST**  
February 2009

"The boomerang effect: Hospital Employment of Physicians Coming Back Around"

September 2008  
Robert Wood Johnson Foundation

"The Decline of the Voluntary Medical Staff Model"

**Modern Healthcare**

January 2005

"Hospitals revisit old strategy: Buying doc practices"

**AMA**  
AMERICAN  
MEDICAL  
ASSOCIATION

"Economy sends physicians to hospitals for help"

December 2008

MANAGED  
**Care**  
MAGAZINE

"Many Changes in Store as Physicians Become Employees"

July 2008

Puget Sound  
**BUSINESS JOURNAL**  
Business Leaders Get It.

October 2005

"Docs quit independent practices to join hospitals"

**HealthLeaders**

January 2006

"The 'Hire' Road: Physician Employment Makes a Comeback"

**hfma**

healthcare financial management association

November 2006

"physician employment: this time around, give finance a leading role"

# What is different from previous employment trends?

## Characteristics of 1990s Physician Employment Trend

- Focus on primary care.
- Large, guaranteed compensation contracts.
- Driven by managed care.
- Failure to create effective practice management structures.
- Large acquisition costs.
- Large financial losses (i.e., greater than \$100,000 per physician).

## Characteristics of Current Physician Employment Trend

- Focus on specialists.
- Incentive compensation plans that include productivity and quality metrics.
- Driven by the need for strategic alignment and clinical integration.
- Emergence of hospital competence/expertise in managing physicians.
- Acquisition costs limited to hard assets.
- Employment of specialties that cannot generate sufficient revenue to afford market compensation rates (e.g., hospitalists, other “-ists,” cardiology).
- Sustainable financial losses (i.e., \$20,000 to \$40,000).

## The modern physician has different values than previous generations of physicians.

*Is the modern physician different from past generations?*

<b>“What Is Important to You in a Practice?”</b>	<b>Percentage Very Important</b>
<b>Family/Personal Time</b>	<b>69%</b>
Adequate Support Staff and Services	41%
Long-Term Income Potential	39%
<b>Practice Income</b>	<b>37%</b>
Health Insurance Coverage	34%
Flexible Scheduling	33%
No or Very Limited On-Call	28%
Adequate Patient Volume	28%
<b>Opportunity to Advance Professionally</b>	<b>27%</b>

Source: 2006 AAMC Survey of Physicians Under 50.

# Hospitals are smarter about employing physicians than in the 1990s.






*Between the lessons learned from past experience and changes in the market, hospitals are smarter about physician employment today.*

- **No Purchase of Goodwill** – Hospitals are only buying hard assets at their appraised value.
- **No Practice Purchase Bidding Wars** – There are seldom bidding wars for physician practices, which historically inflated practice prices.
- **No Long-Term Employment Contracts** – These can lock hospitals into unprofitable contracts for extended periods of time.
- **No High Guaranteed Salaries** – High guaranteed salaries weaken productivity incentives and can be very costly for hospitals.
- **Connection Between Productivity and Compensation** – A significant amount (at least 50%) of physician compensation should be productivity-based.
- **Financial Engineering to Obtain the Highest and Best Reimbursement** – Provider-based billing opportunities can significantly enhance revenue from employed physicians.

## **II. Keys to Physician Employment Success**

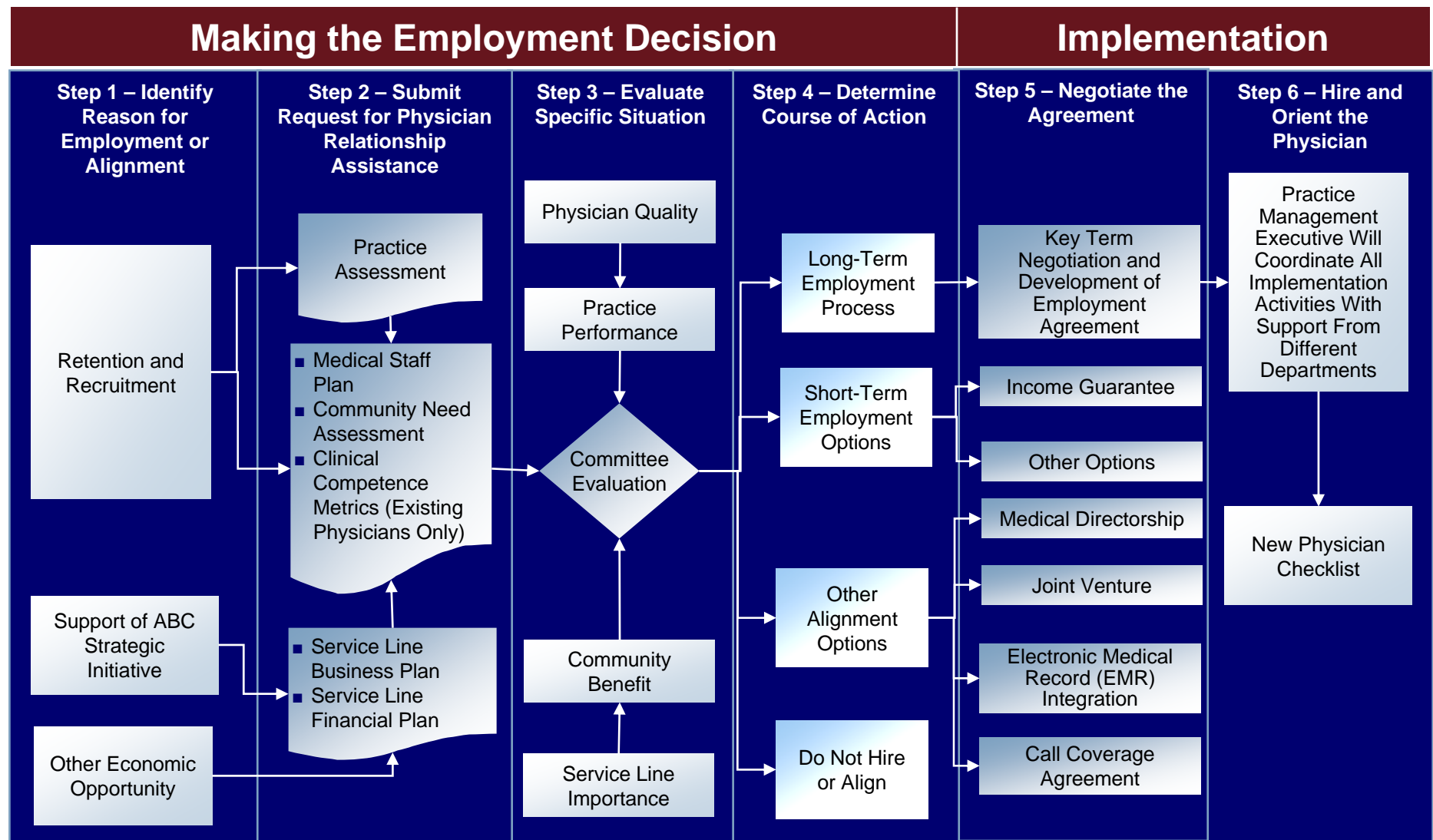
# Paying close attention to five areas will greatly improve your success in employing physicians.

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-  Be disciplined about how you arrive at the employment decision.
-  Invest in the basics.
-  Continually assess revenue opportunities.
-  Manage physician practice expenses.
-  Develop part-time provider policies.

# #1 – Assess Employment Decisions

**Too often, hospitals rush the employment decision to meet a perceived crisis. You can still use business discipline and rigor and make timely decisions.**



# The political implications of an employed structure must be actively addressed.

*It is critical to address political issues in the development of an employed-physician structure, because it will be viewed as a competitive threat to other physicians, health systems, and payors.*

- Hospital and health system boards often have trouble understanding the economics of employed structures, including foundations, seeing only the investment but not the return.
- There is real power in creating an employed structure, and that power often produces fearful and negative reactions in those physicians not in the hospital-affiliated medical group.
- The market will likely react to this development, with other health providers becoming more aggressive in recruiting and payors resisting increases in contract terms.
- Hospitals need to take steps to minimize the alienation of the medical staff members who wish to remain independent and who will continue to serve as productive partners with the hospital in years to come.

# Obtaining input from the independent medical staff is critical in employment decisions.

*Many hospitals have developed advisory committees and/or instituted policies for obtaining input from independent physicians regarding employment decisions.*

## Committee Responsibilities

- Facilitating the development and review of community need and other detailed analyses regarding the employment of specific physicians.
- Utilizing a standard decision-making process for physician employment and other economic relationships, and making recommendations to the administration and board regarding these decisions.
- Communicating with the medical staff regarding the decision-making process.

*There is no panacea for eliminating political opposition to an employed structure – some independent physicians will always have opposition. However, you can take steps to reduce opposition and demonstrate that an employment structure is necessary for hospitals to maintain viability.*

## **#2 – Invest in the Basics**

# Successful hospitals have developed basic infrastructure and reporting tools for their employed physicians.

## Financial Indicators

- Trended EBITDA.
- Profit/loss per physician.
- Downstream ancillary contribution.

## Quality Infrastructure

- E-prescribing capability.
- HEDIS metrics.
- Patient satisfaction evaluations.

## Physician Compensation Philosophy

- Incentive-driven.
- Standard methodology.
- Limit guarantees to the first 12 to 18 months.
- Eliminate/limit special deals.

## Governance and Operations

- Practice management infrastructure separate from, but integrated with, hospital.
- EMR, implemented or planned.
- Forum for physician input (advisory councils, operating committee, etc.).

## **#3 – Continually Assess Revenue Opportunities**

## Billing designation can have a significant revenue impact that must be weighed against strategic considerations.

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- Several clinic billing designations offer compelling reimbursement advantages but have significant licensing, operational, and/or organizational restrictions that may limit their appeal.
  - » ***Provider-Based Clinic (PBC)*** – Clinic operated as a department of the hospital that qualifies for enhanced Medicare reimbursement due to reimbursement for technical fees.
  - » ***Rural Health Clinic (RHC)*** – Primary care-based clinics operating in nonurban areas that qualify for cost-based reimbursement.
  - » ***Federally Qualified Health Center (FQHC)*** – Primary care-based clinics operating in medically underserved areas (MUAs) that qualify for cost-based reimbursement.
- Prior to converting to any of these billing designations, an assessment of the financial impact should be conducted to determine whether operational and strategic challenges are worth the effort.

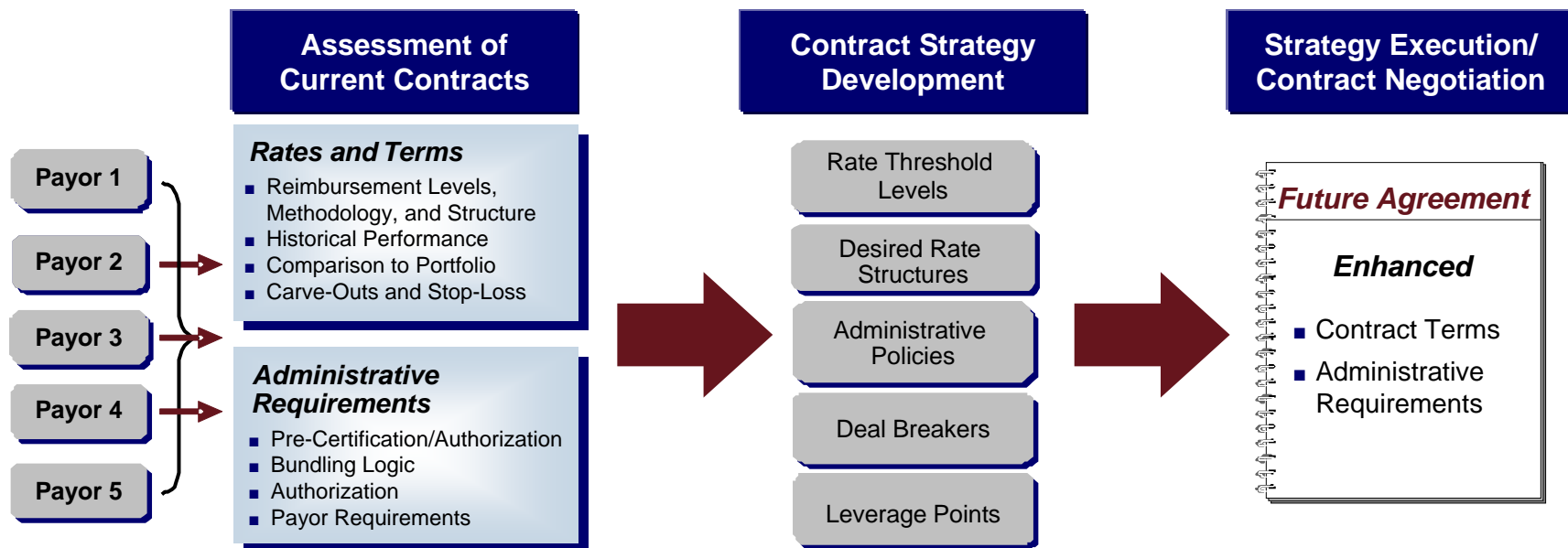
# The four interrelated pieces of managing the revenue cycle must be working well to optimize performance.

	<u>Registration</u>	<u>Charge Capture</u>	<u>Billing/Collections</u>	<u>Contract Management</u>
Activities	<ul style="list-style-type: none"> <li>■ Preregistration</li> <li>■ Entry Priority</li> <li>■ Insurance Verification/Eligibility</li> <li>■ Pre-Certification/Physical Referrals</li> <li>■ Scheduling</li> <li>■ Patient Education</li> <li>■ Financial Counseling</li> </ul>	<ul style="list-style-type: none"> <li>■ Chart Assembly</li> <li>■ Timely Coding</li> <li>■ Accurate Diagnosis Assignment</li> <li>■ Utilization Management</li> <li>■ Electronic Record Entry</li> <li>■ Charge Batch Preparation</li> <li>■ Physician Education</li> </ul>	<ul style="list-style-type: none"> <li>■ Charge Posting</li> <li>■ Claim Processing</li> <li>■ Payment Posting</li> <li>■ Denials Management</li> <li>■ Open Account Resolution</li> </ul>	<ul style="list-style-type: none"> <li>■ Contract Analysis</li> <li>■ Reimbursement Variance</li> <li>■ Underpayment Report</li> <li>■ Payment Appeals</li> <li>■ Contract Modeling</li> <li>■ Contract Negotiations</li> </ul>
Metrics	<ul style="list-style-type: none"> <li>■ Pre-Certification Rate</li> <li>■ Cash/Co-Pay Collection Rate</li> <li>■ Scheduling Error Rates</li> <li>■ Insurance Verification Lag Time</li> </ul>	<ul style="list-style-type: none"> <li>■ Days in Medical Records</li> <li>■ Total Unbilled Charges</li> <li>■ Coding Errors</li> <li>■ Charge Capture Rate</li> </ul>	<ul style="list-style-type: none"> <li>■ Data Entry Lag Time</li> <li>■ Electronic Claim Rejections</li> <li>■ Days in A/R</li> <li>■ Aged Balances</li> <li>■ A/R Greater Than 90 Days</li> <li>■ Write-Off Policy Adherence</li> </ul>	<ul style="list-style-type: none"> <li>■ Contractual Adjustment Rates</li> <li>■ Contract Performance</li> <li>■ Bad Debt Write-Offs</li> <li>■ Denial Rates</li> <li>■ Payor Mix</li> </ul>

***Internal and external benchmarks should be used to set targets for improved performance, as well as gauge appropriate staffing levels for each function.***

# Hospitals often fail to perform due diligence on their physician contracts, leaving significant dollars on the table.

**Commercial contracts are key levers for improving the bottom line. Negotiating small changes in financial and administrative terms can translate into significant margin gains.**

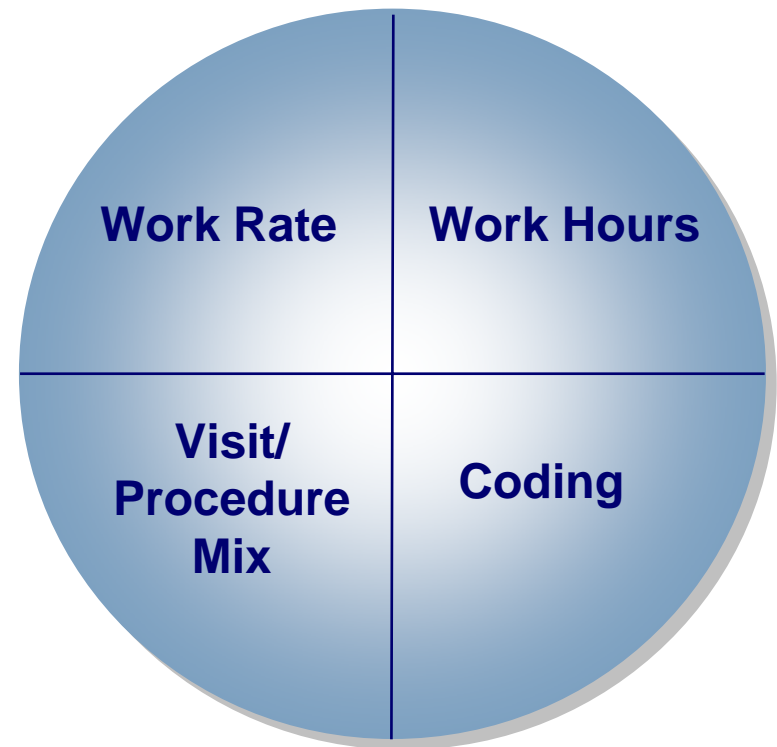


- Assessing how contracted rates compare across health plans and to the regional and national market will inform negotiation priorities.
- Understanding health plan payment methodologies and complex adjudication rules is critical to the success of rate negotiations.
- Hospitals should develop a contracting strategy and action plan to achieve desired outcomes.

# Physician productivity – and your group’s revenue – is driven by coding and service mix as well as work effort.

- Most hospital-employed groups have developed incentive-driven compensation plans with a focus on productivity.
- Often, however, these groups do not have robust tools for evaluating group and individual performance and identifying revenue opportunities that are the result of:
  - » Visit/procedure mix differences.
  - » Coding improvements.

## Physician Productivity Components

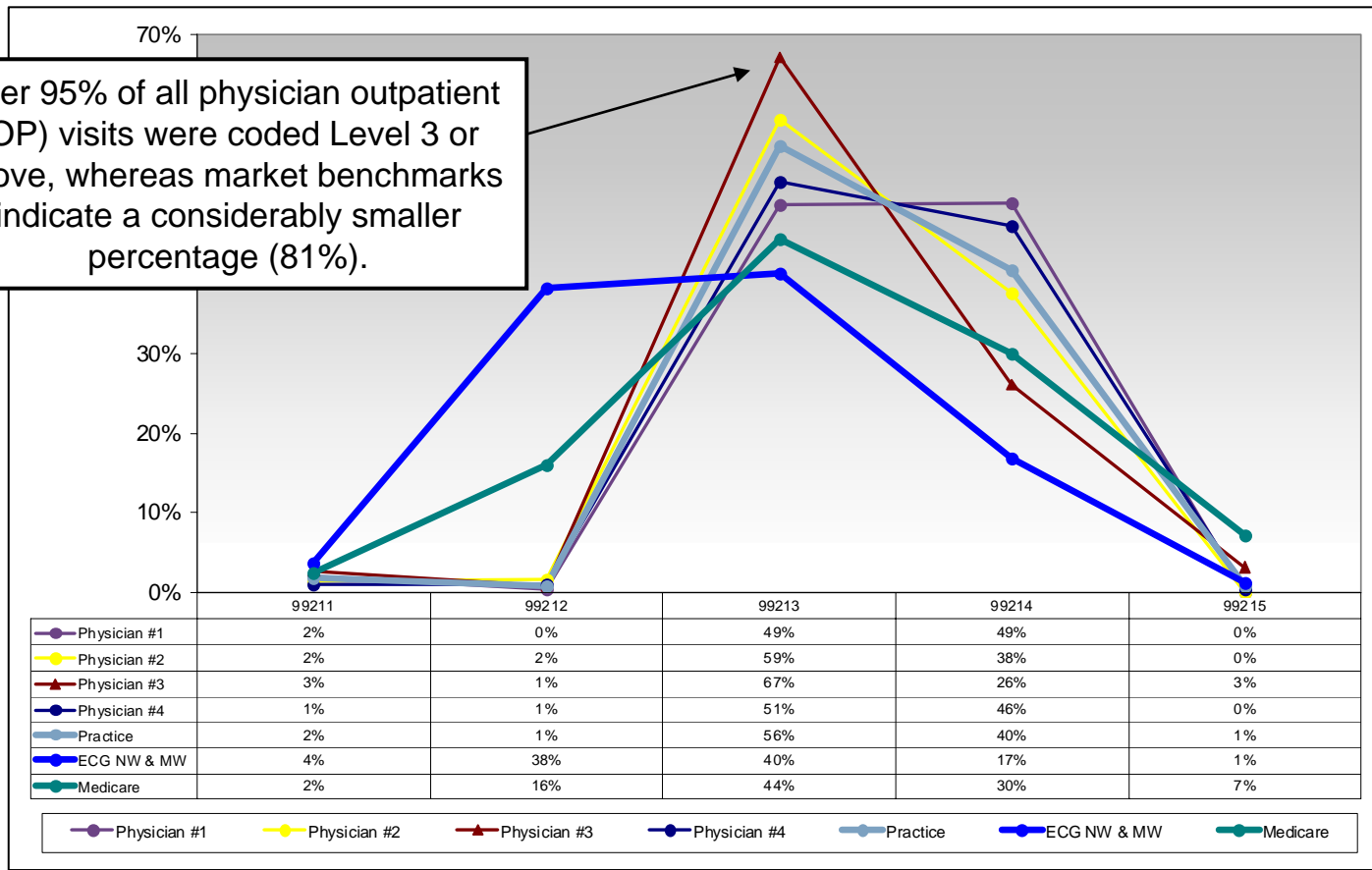


# Regularly performing E&M coding profiles can have an immediate impact on performance.

*Evaluating CPT codes by physician helps to identify the variations in coding and documentation patterns that ultimately drive productivity variability.*

## Established Patient E&M CPT Code Profile by Physician

Over 95% of all physician outpatient (OP) visits were coded Level 3 or above, whereas market benchmarks indicate a considerably smaller percentage (81%).



# #4 – Manage Physician Practice Expenses

## Overhead rates typically run about 60% of revenue in multispecialty practices (lower in specialty practices).

*Multiple operating statistics should be used to evaluate practice performance – and they should trend in the same direction.*

Key Operating Expenses
Staff Salaries
Staff Benefits
Clinical Supplies
Administrative Supplies
Purchased/Professional Services
Professional Liability Insurance
Rent
Information Technology



Key Operating Statistics	Multispecialty Median Benchmark <sup>1</sup>
Operating Cost per Physician FTE	\$400,000 to \$475,000
Operating Cost as Percentage of Revenue	60% to 62%
Operating Cost per Square Foot	\$200 to \$215
Operating Cost per TRVU	\$55 to \$60

<sup>1</sup> Source: MGMA benchmarks for multispecialty practices and ECG Management Consultants, Inc., experience.

# Similar to hospital operations, clinic staffing costs represent the majority of costs in a physician practice.

*The staffing analysis provides the requisite information to assist physician practices in “rightsizing” for optimal performance.*

## Staffing Analysis

- Job descriptions.
- Staff turnover rates.
- Division of labor.

## Staffing per Physician FTE

- Clinical staff (RNs, LPNs, MAs).
- Nonclinical support staff (medical records, receptionists, schedulers).
- Back-office staff (billing, other administrative).

Staffing Category	Staff per Physician FTE	MGMA Median	Variance
Front-Office Support Staff	1.25	1.56	(0.31)
Clinical Support Staff	2.00	1.57	0.43
Business-Office Support Staff	0.75	1.09	(0.34)
Ancillary Support Staff	0.50	0.67	0.17
<b>Total</b>	<b>4.50</b>	<b>4.75</b>	<b>(0.25)</b>

NOTE: Benchmark medians are independent of each other and will not sum to total.

***In hospital-employed physician practices, wage rates and benefits levels tend to represent greater opportunity than staffing levels.***

# #5 – Develop Part-Time Provider Policies

# Hospitals need to minimize the impact of part-time physicians on overhead ...

*The percentage of all physicians practicing part-time increased from 13% to 19% from 2005 to 2007.<sup>1</sup> We expect that the percentage of part-timers will continue to increase.*

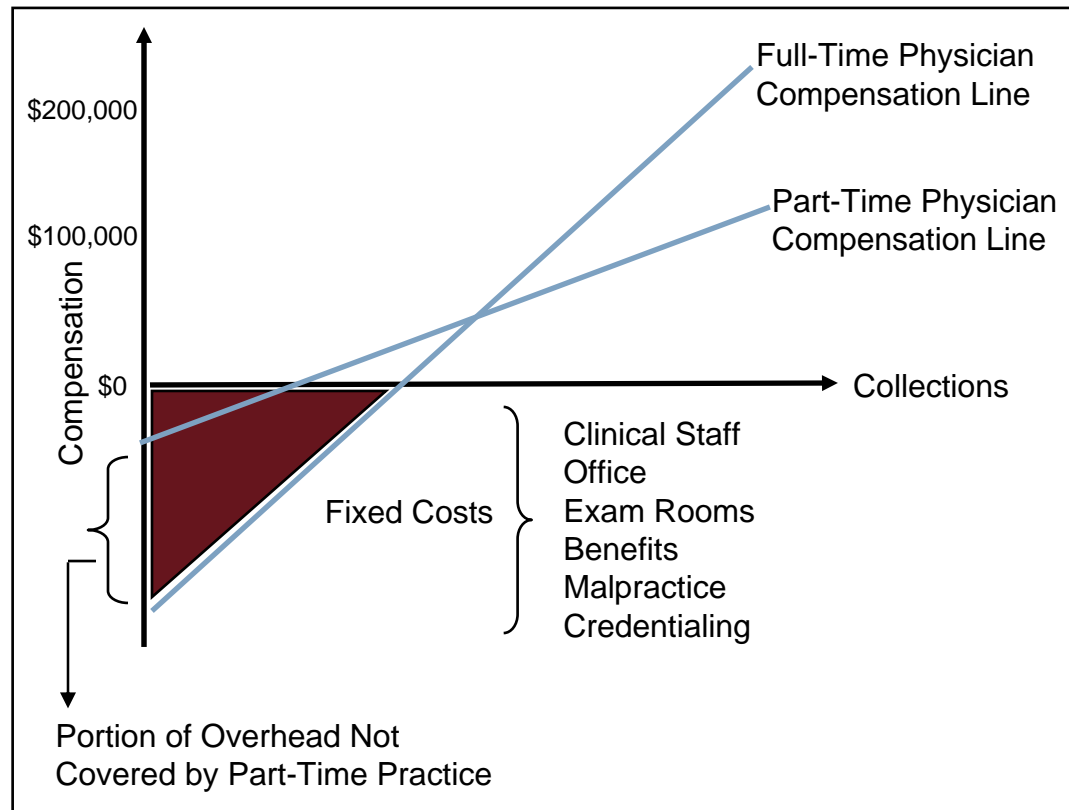
- Part-time physicians are a reality in today's marketplace. In order to be competitive in recruiting, hospital practices need to offer flexible work arrangements.
- However, if policies around part-time practices are not well defined, or the benefits of part-time outweigh full-time, then a practice will end up attracting more part-time physicians.
- There are several keys to managing part-time practices:
  - » Set clear work standards for part-time physicians.
  - » Create standard definitions for clinical FTE.
  - » Ensure that your compensation plan appropriately recognizes the cost of being part-time.
  - » Prorate benefits by part-time status.
  - » Develop a practice share policy.

<sup>1</sup> Source: Cejka Search, Inc./AMGA 2007 Retention Survey.

... which is best achieved through developing shared practices and related policies.

### The Economics of Part-Time Practice

(for illustrative purposes)



### Characteristics of Successful Shared Practices

- Work alternating or complementary schedules.
- Share clinical staff, office space, and exam rooms.
- May share a patient panel.
- Are often required to take a full complement of call.
- Allowed to pool production for purposes of reaching higher levels of compensation in a tiered system.

## **III. Medical Foundation Model**

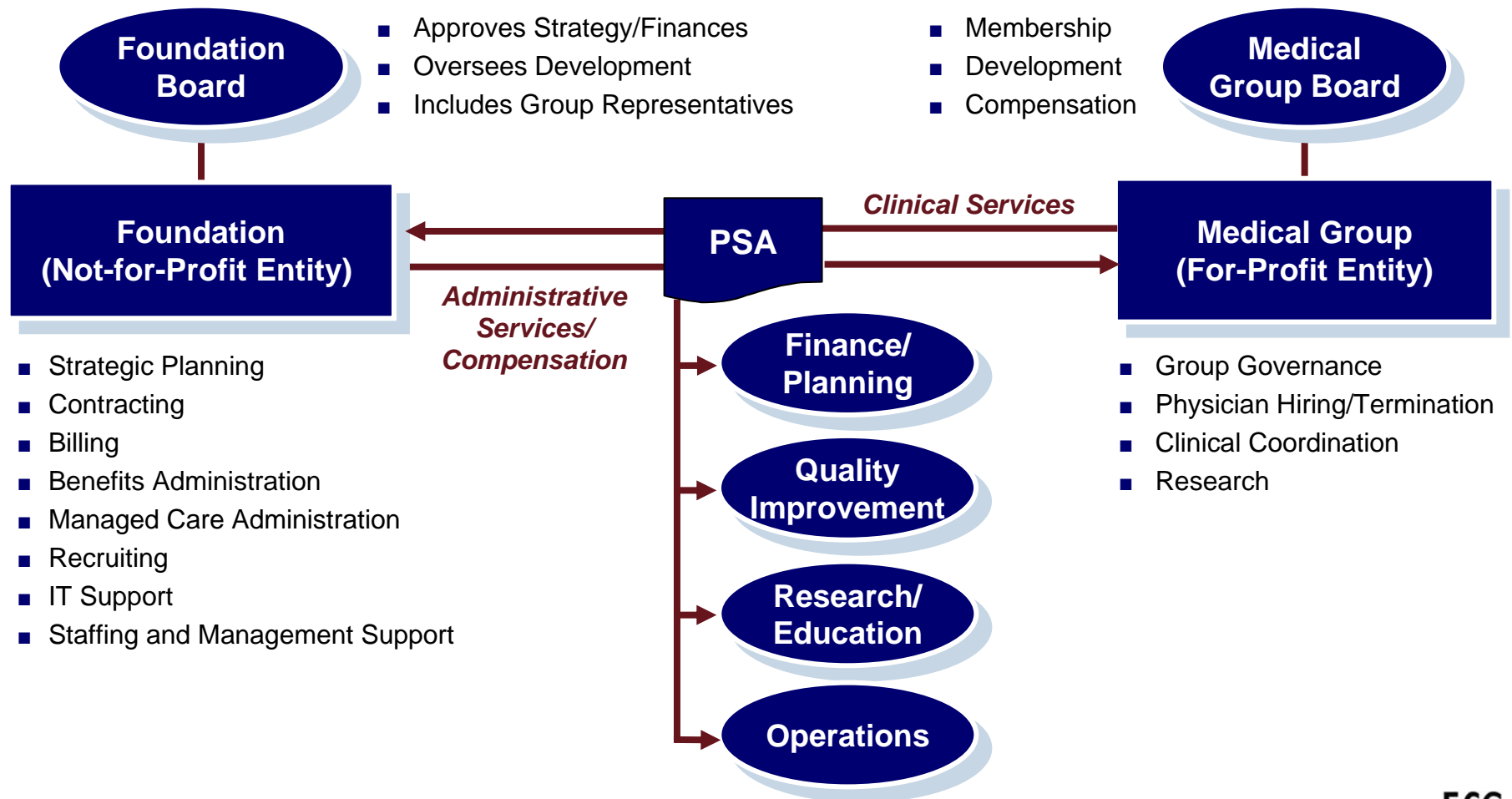
# The medical foundation model is the physician employment vehicle for California.

*The medical foundation model is a unique model utilized by California providers due to the state's complicated corporate practice of medicine statute, which prohibits hospital employment of physicians.*

- A California medical foundation is a not-for-profit healthcare entity (exempt from federal income taxation) that provides ambulatory care to its patients who remain less than 24 hours.
- It does not employ physicians, rather it contracts with them to provide professional services to foundation patients (usually a foundation contracts with a medical group).
- Foundations can also be “risk-bearing organizations,” meaning that they can accept capitation and arrange for the provision of healthcare services to their patients.
- In California, a medical foundation is required to perform medical research and educational services for its patients.
- In other states, many hospitals and physicians have begun to emulate the medical foundation structure, often referred to outside of California as a “PSA structure.”

# The foundation provides the administrative infrastructure for the medical group.

*Under the foundation model, a group or groups of physicians are linked to the hospital-sponsored foundation through a PSA.*



## **IV. ValleyCare Health System Case Study**

# About ValleyCare Health System

*ValleyCare Health System is a medium-sized not-for-profit healthcare system that competes directly with several large health systems in its service area.*










## Key Characteristics

- Two campuses:
  - » Pleasanton (focus of inpatient services and ED).
  - » Livermore (OP surgery, physician offices, urgent care).
- 212 licensed beds, 177 staffed.
- Approximately \$200 million in annual net revenue.
- Approximately 42,000 inpatient bed days.
- Major competitors include Kaiser Permanente, Sutter Health, and John Muir Health.

# The Driving Forces for ValleyCare's Foundation Development

*A number of environmental issues, most of which impact providers throughout California, drove the development of the medical foundation at ValleyCare.*

Major Environmental Issues	Details
<b>Structural Inefficiency</b>	 <p>The community was characterized by hundreds of small, independent physician practices with low levels of commercial payor reimbursement and high levels of practice inefficiency.</p>
<b>Competitive Market</b>	 <p>Perhaps the major driving force, other major health systems have a high degree of penetration in the hospital's service area; many established physicians were leaving, and new recruits also expressed a preference for an employment model.</p>
<b>Hospital/Physician Divergence</b>	 <p>While relationships between the hospital and physicians groups were generally amicable, the hospital lacked a physician structure to engage with on key projects related to service line planning, facility improvements, etc.</p>
<b>Community Need Restrictions</b>	 <p>Despite access problems, community need restrictions prevented the hospital from providing financial support to many physicians who were requesting help with recruitment.</p>
<b>Patient Service/Access</b>	 <p>As physicians are located at various sites throughout the community, patients were frequently traveling from one site to another to receive care; many practices were also turning away new Medicare and Medicaid patients.</p>
<b>Access to Capital</b>	 <p>Most physicians lacked the resources necessary to upgrade facilities and technology; infrastructure was lagging relative to key competitors.</p>
<b>IPA Implosion</b>	 <p>The IPA in the hospital's service area went broke, leaving physicians without a viable alignment and contracting structure.</p>

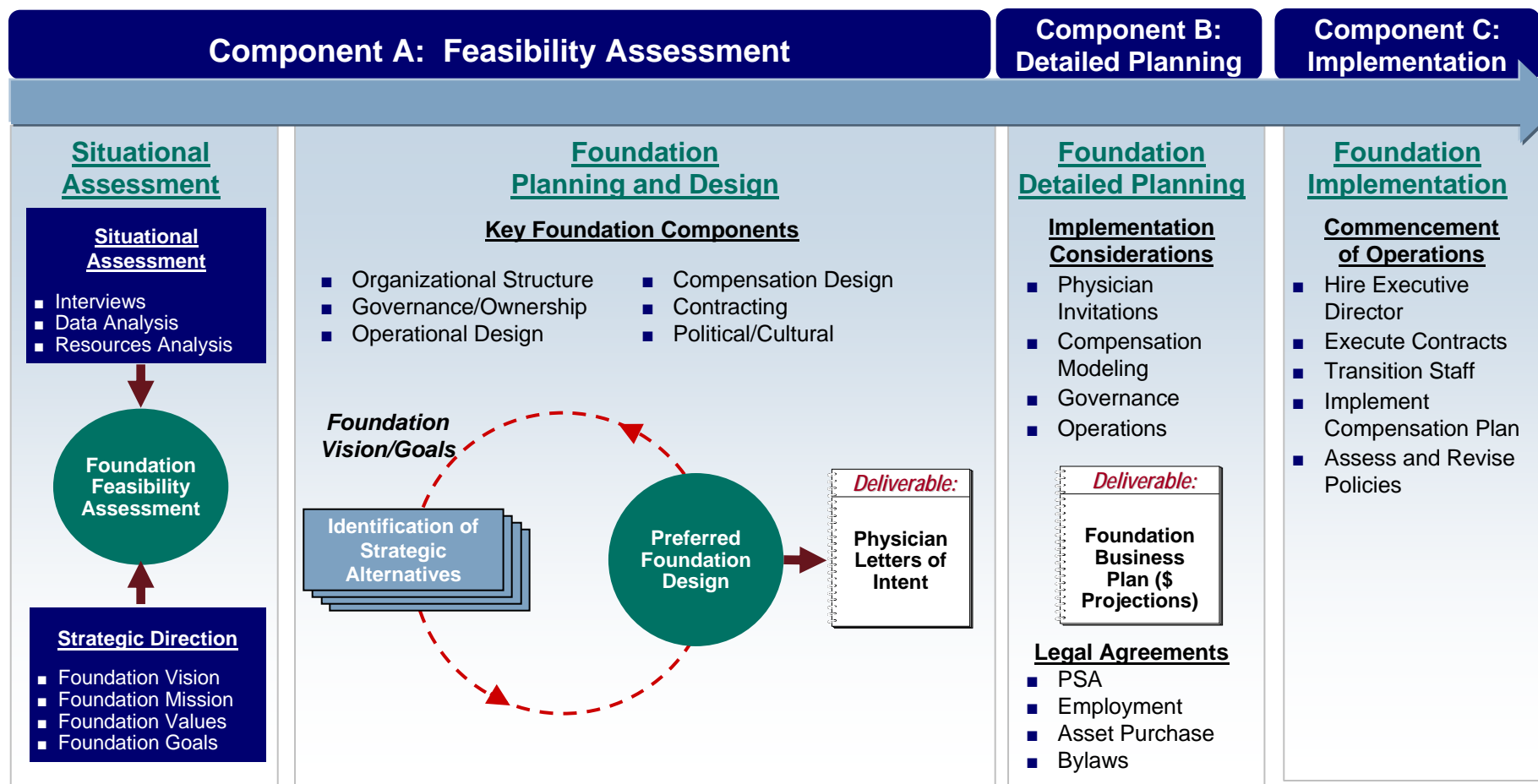
## The Driving Forces for ValleyCare's Foundation Development *(continued)*

***As a result of these factors, the hospital CEO decided to pursue a comprehensive strategy to build a new medical foundation in the community.***

- The CEO engaged in numerous informal conversations with physicians over a series of months to gauge interest and begin building a burning platform for change.
- After these discussions, administration identified a number of potential physician leaders to begin crafting a new medical foundation structure.
- Administration also engaged ECG to work with physicians to facilitate the process.
- The CEO adopted a “hands-off” approach to ensure that the structure development would be physician-driven. However, the CEO and other administrators did participate in many key development meetings and facilitated many private conversations with physicians to ensure their questions were appropriately answered.

# The Foundation Development Process

*After preliminary discussions with physicians, a foundation development steering committee was established to determine the key elements of the eventual foundation/medical group relationship. Eventually, the committee evolved into the medical group board.*



# Feasibility Assessment

***The medical foundation physician steering committee committed to a comprehensive process over a period of approximately 6 months to address a series of questions during the feasibility planning process.***

Issue	Questions Addressed by Steering Committee
Governance/Ownership	<ul style="list-style-type: none"> <li>■ How many physicians will participate on the medical foundation board?</li> <li>■ Could the hospital board be utilized as a foundation “mirror” board?</li> <li>■ How large will the medical group board be, and how will board terms be structured?</li> <li>■ What committees will be included on both boards?</li> <li>■ Will entry into the group encompass a buy-in?</li> </ul>
Physician Compensation and Benefits	<ul style="list-style-type: none"> <li>■ What are the key drivers of the foundation physician compensation model, including the types of incentives that will be emphasized?</li> <li>■ How will the physician benefits plan be structured?</li> <li>■ How will potential disparities in current compensation levels (even among specialties) be addressed?</li> <li>■ Will physicians be rewarded for managing their practice expenses under the new model?</li> </ul>
Physician Employment Terms	<ul style="list-style-type: none"> <li>■ What will be contained within physician medical group employment contracts?</li> <li>■ Can the foundation/group/physician terminate the contracts and under what conditions?</li> </ul>
Administration/ Operations	<ul style="list-style-type: none"> <li>■ How will the foundation administrative team be structured?</li> <li>■ How will the team report up to hospital administration?</li> <li>■ How will practices be integrated, especially from an IT perspective?</li> </ul>
Contracting	<ul style="list-style-type: none"> <li>■ How will contracts be assigned, negotiated, and administered?</li> <li>■ Will the contracting structure encompass an aligned IPA?</li> </ul>

# Group Membership Principles

*The physician steering committee was primarily responsible for vetting potential group members, and asked fundamental questions regarding any applicant that related to the underlying principles of building a strong, high-quality, integrated group.*

## Key Group Development Principles

- Facilitate the establishment of an integrated group culture.
- Create a culture that emulates the risks and rewards of private practice.
- Seek the best providers.

## Fundamental Questions to Ask in Assessing Potential Members

- Do they practice high-quality medicine?
- Would they make good business partners?
- Would they contribute to the success of the practice?

*Although this was a physician-driven effort, hospital administration provided a great deal of guidance regarding the physicians to be included in the foundation-aligned group.*

# Group Membership Criteria

*The criteria used to select foundation medical group members in this process were both quantitative and qualitative. Private medical groups do not have to accept all who are interested.*

## Key Quantitative Criteria

- Productivity.
- Practice efficiency (overhead/expense control).
- Compensation.
- Existing practice liabilities (e.g., tail expense, practice liabilities).

## Key Qualitative Criteria

- Clinical quality.
- Patient satisfaction.
- Team player.
- Adaptability.
- Needs of the foundation (e.g., specialty mix).

*One of the key questions for the physician committee was, “Who will initially make these decisions?” With this group, a subset of committed steering committee physicians established these criteria and determined which physicians met them.*

# Medical Foundation Results

*Since its inception approximately 1 year ago, the ValleyCare Medical Foundation has grown in size and sophistication.*

- The foundation has maintained a clinic-without-walls structure since its inception, but it is in the process of building one medical office space with over 10 physicians in one location.
- In addition to facility improvements, the foundation has also invested in EMRs for its physicians; the NextGen system was implemented.
- The foundation has provided a key recruitment tool for the hospital's patient base, and it has addressed many of the challenges faced by the health system.
- Many physicians who were hesitant at first have since joined the foundation-aligned medical group.

# Medical Foundation Results *(continued)*

*Although the foundation represents a large component of the hospital's medical staff, the majority of hospital referrals continue to originate from non-foundation physicians.*



## Voluntary Medical Staff

- “Come and go” medical staff.
- Continues to generate the majority of hospital referrals.
- Slow change process and difficult to engage; nevertheless, hospital continues to recruit to these practices.

## Medical Foundation

- Stronger hospital-physician alignment.
- Ability to engage physicians more effectively.
- Seen as the primary recruitment vehicle of the future.

## Common Pitfalls and Lessons Learned – Structure

*Although some difficulties are unavoidable, careful planning can mitigate common pitfalls in this process.*

- ***Role of Hospital Administration*** – Invest in HR that can manage the operations of a complex multispecialty group.
- ***Compensation*** – Use productivity, and strongly consider a payor-neutral metric such as WRVUs. However, do not assume physicians understand the mechanics of RVUs – educate them thoroughly and frequently.
- ***Founder's Incentive*** – Strongly consider a founder's bonus or (at a minimum) a compensation guarantee to entice physicians to join. Although this is expensive, getting to 40 physicians will be difficult without it.
- ***Investment*** – Plan on a multimillion dollar investment for a 40- to 50- physician foundation. Without this resource commitment, the venture is doomed to fail.
- ***Limit Goodwill Payments*** – Paying for goodwill is expensive and can create huge inequities in physicians joining the foundation. Consider a more uniform founder's bonus instead.

## Common Pitfalls and Lessons Learned – Implementation

*Resist the urge to set unrealistic deadlines.*

- **Timing** – Do not assume you can design, sell, and implement a foundation structure in 6 months. An 18-month timeline is more realistic.
- **Communication** – Do it frequently with both physicians who will be joining the foundation and those who are not interested. Doing so will help quell rumors before they spiral out of control.
- **Get Personal** – From physicians' perspectives, giving up their practices is an intensely personal decision. As such, you will need to develop personal relationships with these physicians so they trust you to look out for them in the long run.
- **Phased Implementation Approach** – Unless you have substantial implementation resources, do not try to implement the entire foundation in 1 day. Consider a phased approach over several months.

## **V. Panel Discussion**

**Mr. Kenneth Jensen, CFO, ValleyCare Health System  
David Bradley, CEO, Marin General Hospital**

## About ECG Management Consultants, Inc.

ECG is a national healthcare consulting firm founded in 1973, which serves physician groups, hospitals, and health systems. We are particularly known for our specialized expertise regarding physician business affairs, hospital/physician relationships, and academic medical centers. Specific areas of expertise include:

- Strategic, business, and financial planning.
- Mergers and acquisitions.
- Operations and interim management.
- Organizational development.
- Physician compensation.
- Information systems.
- Service line and programmatic planning.



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