Central Line
Episode Number: 87
Episode Title: Building your value proposition
Recorded: January 2023

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VOICE OVER:

Welcome to ASA’s Central Line, the official podcast series of the American Society of Anesthesiologists, edited by Dr. Adam Striker.

DR. ADAM STRIKER:

Welcome back to Central Line. I'm Dr. Adam Striker, your host and editor. Today we're going to speak with Dr. Phillip Richardson and Sheena Scott from ASA’s Committee on Practice Management about how anesthesiologists can build our value. Dr. Richardson and Ms. Scott, welcome to the show.

DR. PHILLIP RICHARDSON:

Thank you so much.

MS. SCOTT:

Thanks. It's great to be here.

DR. STRIKER:

Thank you, guys. First, if you don't mind, tell our listeners a little bit about yourselves and your interest in practice management issues.

DR. RICHARDSON:

Sure thing. So this is Philip Richardson. I am in Southern California. I've been in private practice my entire career, over 20 years. Got interested in practice management just simply because I was curious. I wanted to know how reimbursement worked, how the internal structure of my own group worked, how things worked from the payer side of things, and just continually asking questions and being involved a little while I was CEO of my 50 physician anesthesia group in Southern California, which was an honor to to lead and learned a great deal about practice management. Continued to develop and grow was able to be on a couple of boards of some hospitals. And decided that I needed some more business skills. So I went back and got my MBA. And so that was a fun process and able to learn a little bit more and hopefully I have something to offer.

MS. SCOTT:

Yeah, so I have actually come from a different angle. I've been in the practice management side of things for a little over 30 years. I was the lead non physician in a large anesthesia group in Central Florida for about the first 20 of those years. And at that time, I was very active on the national front. I served as the president of the MGMA's Anesthesia Administration Assembly, and then I went on to become chair of the MGMA board and actually led that organization through a merger with its credentialing arm, ACMPE.

So when I finished my term there and thought I was going back to having just one job, our hospital system got a new CEO that came in from a system that had worked with a large national company that provided all of the hospital based services. And he really liked that model and wanted to bring that company in to work with the physicians in our hospital system. And the hospital physicians really didn't want to do that. They really wanted to retain their independence. So we pulled together on very short notice about six different groups--some independent, some hospital employed--in what can probably only be described as a shotgun wedding to create a 300 provider multi-specialty group that provided all of the emergency medicine, radiology and anesthesia services to the largest integrated delivery network in the county where I live in Florida.

So I stayed on with that group for about five years and then left to form my own consulting company in 2018. And since that time, I've worked with medical groups in general, but primarily anesthesia groups, a few emergency medicine, helping them with all kinds of practice management issues.

DR. STRIKER:

Wonderful. Well, let's dive right in. And let me start with Dr. Richardson. Do you mind telling us why it's important for groups to understand how to frame and communicate their value to stakeholders, and also how this helps us advance our care for patients?

DR. RICHARDSON:

Oh, absolutely. It's critical that we're getting our message out of the value that we're bringing to all of our constituents. Be that the C suite, nursing the surgeons. And we really need that elevator pitch just really succinctly communicating the value that we're bringing to folks. Folks commonly just forget that we exist and be in a little black box, but we need to always kind of make that front and center of, this is what we're doing in order to really help get the right information to the right folks so that when these discussions come up, it's front of mind that, oh, yeah, those anesthesiologists, they're really on top of things. They're getting these problems all solved for us, as opposed to simply just quietly working in the background and people forgetting that we're bringing value and making life better for the patients, the surgeons, the nurses, the administrators, the board.

DR. STRIKER:

Well, I want to talk a little bit about how to structure that in a little bit. But Ms. Scott, do you mind talking just a little bit about value propositions? What are they what should they include? And just what do our listeners need to know about them?

MS. SCOTT:

So a value proposition is really a clear statement that explains how your group addresses your customers needs. And your customers could be facilities, patients, surgeons, payers perhaps. And it talks about the unique strengths and benefits that your group brings to the table and the way that it benefits your customers. So really, it should provide the direction to be the strategic focus of your organization. And particularly it might include things about, like the depth and strength of your leadership structure, which is certainly something that's very important when you're developing relationships with facilities, to have strong physician leaders who have good relationships with the nursing administrators, with the people in the C-suite, with surgeons, and can really put the best foot forward because they're the face of the group. It might include other things value that you bring to customers for perhaps a strong quality program would be very important to surgeons and to patients and working on patient safety and maybe working with OR leadership to help improve throughput and efficiency and any extra services that you provide that contribute to value. For example, maybe you have very robust pain management program that helps reduce length of stay or you've helped develop a pre admission testing program to help reduce day of surgery cancellations. So there's all these different things that you probably are doing within your hospital, but maybe aren't really communicating them in a value proposition.

So what a value proposition does is bring together all of these benefits that you're providing and really stresses the unique differentiation in value between you and your competitors. So for example, if you're with a group that's been in a hospital for a very long time and you know all the surgeons and they're very comfortable with you and very supportive of you, that's something that the hospital is going to care about. So it's important that something that somebody else coming in from the outside couldn't necessarily bring. So it's taking all of that information, of all the different things that you're doing that bring value to your customers and putting it into a document. And like Philip said, kind of a short elevator pitch that you can constantly be reminding people of what you're doing because anesthesiologists aren't always right out there in the front. And patients, for example, a lot of times aren't as familiar with exactly what an anesthesiologist does. They know that they went to sleep and they woke up comfortably, but they don't necessarily know all the other things that you might be doing. So it's really important to be communicating that value.

DR. STRIKER:

I assume that you think that most groups should have one if they don't already. Is that right?

MS. SCOTT:

Well, I think yes, I do. I think they should do a self-assessment. I see a lot of times if you're going to help somebody respond to an RFP, which is kind of where these two things dovetail together, because if you have to respond to an RFP, they're going to ask you a lot of questions about what your group does, how they have they would handle this, how they would handle that, how they're going to bring value. And so if you've already done a value proposition, A, you might not find yourself in that situation because the hospital might be more familiar with the value that you're bringing. But if you do, you'll be more well prepared to respond to that.

So a lot of times I'll see people who really are doing a lot of elements that are bringing a lot of value to the hospital. Maybe they've helped develop an ERAS program, maybe they've helped with a preadmission testing clinic, but they haven't really put that all together and marketed it in a way so that the hospital really understands what they're doing. And then somebody else comes in with a big shiny, Oh, and we're going to do this. And then you look at it and they're like, you're really doing most of the pieces of that. You just haven't put it together and identified it as such. So by having a value proposition, you are taking all of those elements and putting it into a document that you can share and keep updated and make sure you're continually making everybody aware of the value that you're bringing.

DR. STRIKER:

Well, let's go ahead and talk about those elements. Dr. Richardson, do you mind giving us a little insight on the elements that you think we should be using to build and communicate the value we bring as anesthesiologists, things like leadership, teamwork?

DR. RICHARDSON:

Absolutely. And I think leadership and teamwork are probably the biggest two. I think with leadership really can't be overstated. It's it's building the team and setting the right values and alignment. Great little example was folks were saying, Oh, yeah, everyone's always leaving their scrubs around. Well, as soon as you bring in one of those automated scrub dispensers and you don't get scrubs unless you turn them in, then instantly the changing rooms all clean because the alignment of interest has occurred and things just move so smoothly. And ASA has been great about developing all these leadership opportunities to get educated and learn more skills, which we all need to take more advantage of. And through that, be able to lay the foundation and get the group on the right footing and understand that every person in that group is a leader. They're all the face of the group every time that they're in the operating room, making sure that that case runs smoothly, leading that team through that procedure and keeping the patient safe. And so developing those skills of teamwork, either through team steps, just better communication and developing that, really will facilitate not only just the kind of basic of smooth running of the operating room, which then translates into more efficiency, better patient safety, and then rolls up into being able to roll out those more advanced programs, bringing in complex pain service, really establishing the ERAS program or the next big adventure of opening up the new ASC that the hospital wants. It really starts at that ground level.

DR. STRIKER:

Well so basically we're talking about two separate things. We got the value proposition, which we feel groups should have to succinctly articulate the value that the group is doing. But what you're also suggesting, which I'm sure a lot of people just do without thinking about it too much, but is that we actually walk the walk, we perform the actions, we, on a daily basis, substantiate what we are articulating and the value proposition. We are bringing that value. We're showing up on time. We're doing what we need to for our colleagues. We're doing things that are in the best interest of patients. Is that is that fair to sort of summarize, if you will?

DR. RICHARDSON:

Absolutely. No. I mean, this is a process that we're engaged with every day, with every member of the group. But at the same time, it's kind of like the mission, vision and values of really knowing that the base of the group and keeping everything aligned and then having that leadership succinctly be able to reiterate to the C-suite and in the meetings have reminding everyone what's going on, but also passing that down to the employees so that everyone knows exactly what we're doing, why we're doing it. And it really has to work hand in glove that way, everything we're doing every day, but then also communicating that value up to the decision makers.

DR. STRIKER:

One other piece I want to follow up in this regard is on the demonstration of performance metrics, if you will. Basically, how do we demonstrate excellent performance to our stakeholders?

DR. RICHARDSON:

Well, I have to say data is is the best way to demonstrate that, say that in God we trust, but everyone else brings data. And it really helps everyone see the value of what you're actually doing. And so knowing, what is your post op nausea and vomiting rates? What are your patients satisfaction scores? How are the AQI data that you're collecting compared to other folks? And being able to present that in a succinct way really helps the group in two ways. One, it's communicating to the C-suite and the decision makers all the great work that you're doing. And then two, we all love to think that we're better than average, right? Everyone's always a better than average driver, and we all think that we're the best anesthesiologists. And so having that kind of concrete data and then sharing in a constructive manner, not in a punitive, condemning manner, but in a constructive manner to the rest of the group to say, hey, look, guys, this is where we're at. This is some benchmarks that we should be comparing with. Let's see what other folks are doing and up our game. And so in that way, we're improving ourselves. We're showing to the decision makers that we're great and we're getting better every year. And you really can't do that unless you have some objective data.

DR. STRIKER:

Well, I know your committee has created a compendium of resources to help anesthesiologists with this, and I do have a few questions about that. But before I get to that, if our listeners don't mind staying with us through a short patient safety break.

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DR. KEITH RUSKIN:

Hi this is Dr. Keith Ruskin with the ASA Patient Safety Editorial Board.

Anesthesiologists rely on physiologic monitors, ventilators and other medical equipment to alert them to potentially life-threatening conditions and provide vital life support functions. But alarm fatigue can cause clinicians to ignore alarms. Optimizing your monitor settings will make signals like an electrocardiogram tracing or pulse oximetry more useful and improve the reliability of any alarms. And although conventional wisdom suggests setting alarms as loud as possible to attract attention, reducing the volume for alarms that do not indicate a life-threatening condition can reduce the noise level without jeopardizing alarm responsiveness. If an alarm is activated, verbally acknowledge it and then silence it while addressing the problem that triggered the alarm. These simple changes can help to improve the accuracy of alarms and mitigate the effects of alarm fatigue.

VOICE OVER:

For more information on patient safety, visit asahq.org/patientsafety22.

DR. STRIKER:

Welcome back. Ms. Scott, your committee has created a compendium of resources. They're designed to help groups understand the process of developing value proposition. Do you mind talking a little bit about what's in it?

MS. SCOTT:

Sure. Sure. So the way we structured it, it's ten chapters and each one of the chapters is about 1 to 2 pages and they could be standalone as individual topics. So for example, the chapters we have are: what is a value proposition, the importance of leadership, anesthesiology service contributors to value, demonstrating excellence in anesthesia care, understanding compensation and productivity benchmarking, demonstrating efficiency of the provider workforce, what is an RFP, understanding your customers, legal and contractual issues, and you've been awarded the contract now what. And what we plan to do with each one of those chapters was it's great if you have time to read through the whole thing. It's about, like I said, each one of those chapters is maybe 1 to 2 pages long. And then within the chapter there are a number of hyperlinks to additional resources. If somebody wants to take a deeper dive into a specific area. So, for example, you might start out reading the whole thing. And then if you found yourself needing to figure out how you were going to improve your quality indicators, you might go to the chapter on quality and reread it and look into some of the deeper dive references. So it can be done as individual chapters or it can be done in conjunction.

And that's really our goal was to make it a resource that people can go back and refer to again and again.

DR. STRIKER:

Since you mentioned RFP, I think that would be interesting to just elaborate a little bit on. Is there anything our listeners need to know when it comes to winning RFPs?

MS. SCOTT:

Sure. And actually the compendium also includes a sample value proposition and a sample RFP. Because a lot of people say, how do I respond to an RFP? They've never seen one. They don't know what type of information is in it. So we do have a sample in there, which is also a great resource. But one of the reasons we combine these two topics, value proposition and RFP, is because there really is a lot of similarity. Like I said earlier, when you're responding to an RFP, essentially what you're doing is putting together and stating your value proposition to the facility that's put out the RFP to explain why you think you would be a better person to get the job and why you think you can do a better job than the other people that they might be asking to respond. So in order to do that, you're really communicating your value proposition. So if that's something that you've done ahead of time and have that ready to go, if the time comes that you have to respond to an RFP, it gives you kind of a leg up and makes it easier for you to get started.

But as far as any advice I would have on responding to an RFP, I think the main thing is to understand that it's a business decision. It's not emotional. People shouldn't take it personally. It's something that facilities have to do from time to time. Sometimes they do it to justify if they're being asked to do a significantly increased financial support. Sometimes they'll do it because they're unhappy with the service. They don't feel that the group is actually delivering the value that they feel that they need, and that could be because the group isn't delivering it or that the group hasn't really communicated what they're doing. So I think the most important thing is to tackle it very unemotionally and businesslike. And, you know, try to get some help. And once you put together your strengths and put together the best offer that you can reasonably live with, try not to worry about how other people are going to respond. Too often people try to guess how others will respond and then they'll they think it's all about the money. And so they'll try to put forth a really lowball offer that's not sustainable or that they're not able to deliver. And that really doesn't serve anybody well. And it could be bad for the group if they end up contractually obligated to deliver services that they can't deliver. And particularly in this tight hiring market, if the rate is too low, they may not be able to deliver the service and that could put the group in breach.

So I think at the end of the day, there are many reasons that hospitals put out RFP and the selection process isn't really always about the money. Quite often it is about having an appropriate value proposition and having that in place and an appropriate leadership structure.

DR. STRIKER: Who is the compendium aimed at? Is it valuable to any physician, regardless of the stage of their career?

DR. RICHARDSON:

Yeah, absolutely. Even though this is really geared towards the leaders of the group and really helping them as they're putting together this RFP or really defining their value proposition, it really is critical for everyone to kind of go through this material and understand the value that the group is bringing to the community. For example, the folks fresh out of residency or fellowship that are joining the group, being able to go through and understand that I need to be bringing value, how am I contributing as an individual to the group to make the group indispensable to the facility, to the nursing staff, to surgeons? And then similarly, someone who is much more senior in their career. It's always good to have a reminder, but also as as the more senior staff go through this and refresh the concept of, look, I need to be bringing value and making myself and the group indispensable Things will come to light and you'll get a little inspiration of like, Oh yeah, remember we did this a while ago and look, we could be doing this and make things better here. So they have a lot of wisdom and insight to bring to advance, maybe some more on the technical side of things of how can we increase our value to our community. So it really is something that everyone should be involved with for the group.

DR. STRIKER:

Well, that was actually going to be my next question was the group involvement. I imagine everybody's got a niche in any group.Everybody's got different aptitudes and different interests. Something like business related issues may not be as appealing to a lot of physicians just because of their background and what they chose to do for their career. Are there groups that tend to have like the the business guru or the business expert and then basically delegate the responsibility of this kind of communication to that one individual? And if that is the case, I imagine that's probably not the best approach. I imagine it's probably better to everybody should be involved at some level, even if you do have that particular person.

DR. RICHARDSON:

Yeah, absolutely. I mean, you can have the leaders, the five or 10% of the group that are much more involved than the other folks, that are going to the meetings and spending a lot of that extra non compensated time building those relationships and being seriously involved. But absolutely, if you don't have everyone in the group committed and engaged and rowing in the same direction, being able to really work on that value proposition and showing it and collecting the data, understand that that data is being collected and being forwarded, you're not going to succeed, right? I mean, you could have a leader who's in the C-suite having lunch with the CEO every day and they've got a great relationship and they're out on the golf course all the time. But if the team isn't following through and and really doing the work to create the value, it's not going to go anywhere. So it really is for everybody.

MS. SCOTT:

I would also add there's a lot of different kinds of leaders, right? I mean, you have business leaders in the group, you have clinical leaders, you have medical directors that work hand in hand with the nursing staff. So there's a lot of different leadership roles that need to be filled. And it's too much to dump all that on one person or a few people that really everybody needs to kind of participate and step up and help in some way.

DR. STRIKER:

I think evolved groups certainly understand that. It's probably equally understood whether it's an academic or private practice group per say. But preparing our residents or young physicians for these kinds of practice management principles, I imagine there's not a lot in residency programs that address this. And is that the case? And if so, are we really shortchanging young physicians in that regard and not preparing them adequately for what really amounts to an important aspect of of your practice?

DR. RICHARDSON:

No, absolutely. And that's why having the residents and the fellows involved in ADVANCE, getting them out to the meeting to learn a lot of these kind of business concepts, is critical. And I know a lot of the societies are subsidized. We have decreased rates for them and we absolutely tailor information to them to get them on a good level to understand the business of how everything is functioning and flowing. Because without that, I agree with you, it would really hamstring the specialty.

DR. STRIKER:

Excellent. The groups that are maybe more, let's say, academic, their departments that are established there working for the organization, perhaps they're not necessarily looking to win a contract per se. We talk about what that may be subtle differences, if any, are in a group that isn't as maybe private practice based and is established. Talk a little bit about how groups like that fit in here.

MS. SCOTT:

Even if they're not trying to win a contract, they have a job and a role and they want to be putting their best foot forward and making sure that they're delivering the services in a way that the facility wants it and that it's done in a proactive way.

DR. RICHARDSON:

Yeah, absolutely. And so even though you may not be winning a contract for your academic institution, you're still going to be vying for resources. Resources are always going to be limited. And unless you found an institution where resources aren't limited, please let me know. I'd love to be there. And so you have to be showing to the surgeons that, look, we're bringing all this value. Oh, yes. Okay, they're willing to give up a little of their resources so that they can have reliable, high quality anesthesia services. And similarly, conveying that to the dean's office of, look, you've got all these million competing resource needs, and this is why we need a little bit more allocation of that, that limited pie in order to bring greater economic gain back to the institution or facilitating the mission of the institution, be that teaching or something that's not bringing in a lot of dollars.

DR. STRIKER:

Well, one last question before I let you both go. Let's say our listeners do all the right things, prove their value, earn the contract they were aiming at, what do they need to do then? What are some key principles or takeaways in terms of what groups should do as an as the ongoing process?

MS. SCOTT:

I mean, that's really our last chapter is you've won the contract. Now what? And a lot of times it would, especially if you had to go through an RFP to get to it, it's very easy to go, ah, okay, now we can just sit back and rest on our laurels and that's the last thing you need to be doing. When you sign a contract. It's the beginning of the relationship and you really need to make sure if you didn't have a value proposition before that you have one now and that you're continually communicating it and building those relationships so that you find out what the problems are before they actually become problems and you have an opportunity to address them and work with the facilities before it actually becomes a problem. And that really is what a value proposition is all about.

DR. RICHARDSON:

As you said, it is absolutely an ongoing process. I mean, people don't remember what they had for lunch yesterday, let alone all the great work that your group has provided to the institution. And so you have to constantly get out in front and remind the folks of the work that you're doing, remind your own group of the successes that they've had to build that morale and keep everything going. And it's that constant communication and reevaluation.

DR. STRIKER:

Great. I want to thank you both for joining us. Very interesting conversation. I always learn plenty of things in this podcast and I hope our listeners learned a lot too. But more importantly, I hope they check out these resources that are quite valuable.

DR. RICHARDSON:

Thank you so much for having us.

MS. SCOTT:

Yep. Thanks so much for having us. We appreciate the opportunity.

DR. STRIKER:

Thank you both for all the hard work you're doing. Please check out the ASA practice management resources at asahq.org/RFPessentials. And thanks to all our listeners for joining us on this episode of Central Line. We'll be back in a few weeks. And so we hope you will too. Take care.

(SOUNDBITE OF MUSIC)

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