Raw Transcript: Do This Not That _ Scott Ransom Full Video

SPEAKERS
Harjot Singh, M.D., Scott Ransom, D.O.

Harjot Singh 00:16
Hey healthcare leaders do you want to learn how this hospital system saves more than $100 million and forget about alienating they did this while improving physician engagement. Do we have an exciting program for you and I will introduce you to the hero of this whole story. This is a healthcare leadership Insider. This is Dr. Harjot Singh from HarjotSinghmd.com. And this is part of our special series “Do This, Not That for Physician Retention, Recruitment and Well Being”.
This is a very hot topic for healthcare leaders. It is directly related to physician engagement, turnover, effort at work, and burnout, especially essentially like the very existence of every healthcare workplace.

We have an expert Dr. Scott Ransom, who is my co-author on this mega project that comes once in 20 years, and then becomes the authority on the topic, the twin books, Strategy, and Tactics, cover pretty much everything there is to know about physician engagement, and my chapter from the book is free for you to download. Now, Dr. Ransom is a Physician Leader with very long experience. He is an obstetrician turned leadership advisor who has helped healthcare systems transformation on six continents. And that's true for big hospital systems in countries throughout the world, more than 40 countries at this point. Rarely do you get to hear from a person like him. He is the past President of American College of physician executives and a fellow of the American College of Healthcare. Healthcare Executives is truly a leader of physician leaders. And his chapter in the book is about Supply Chain Issues. A very deep chapter that usually isn't even thought about when we talk about physician engagement and physician leadership. So let's talk to him. Hi, welcome.

Scott Ransom 02:29
Well, good afternoon.

Harjot Singh 02:33
By the way, Do you want to say anything about yourself before we start?

Scott Ransom 02:38
I'm Scott ransom. Yes. As I mentioned, I am an obstetrician-gynecologist turned healthcare executive. Early in my career, I was a Chief Quality Officer of an eight Hospital Health System. I was a professor at the University of Michigan for a pretty long time. And then I was President of one of the medical schools in Texas for seven years, all before going into consulting about nine years ago, worked with somewhere

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around 200 healthcare organizations across the planet, including almost every market, a major market, at least in the United States. So it's really great to be here today.

Harjot Singh 03:13
Tell us about your chapter in the book and tell us why your writing would appeal to a healthcare leader seeking engagement from their doctors.

Scott Ransom 03:22
Well, you know, I worked with Carson Dye, the editor of the entire series on what are some of the sections that should be included. And this was just about the time COVID was starting. And you know, I realized that supply chain purchase services really need to be included for a couple of reasons.
One is to try to figure out how to improve quality. The second is, reducing costs, which will happen before COVID. But the third thing was actually accessing the right supplies. This was an era when gloves were in short supply and that sort of thing. So there were a lot of good reasons. I think that this chapter was included in this very big manuscript of different topics for healthcare executives.

Harjot Singh 04:08
So tell us, I am excited to hear that story, of how you helped save the system 100 million dollars in supply chains in less than two years.

Scott Ransom 04:19
Yeah. So this was a very large health system. And we had talked to them and did a preliminary analysis, and we showed up with more than $100 million, there's almost a $289 million opportunity.

Harjot Singh 04:31
$289 million.

Scott Ransom 04:35
What we identified as possible. And the client, frankly, didn't quite know what to do with that information. And we agreed to work with them to kind of start plugging along at identifying both savings as well as cost opportunity. So these were all in the areas of clinical preference items, physician preference items, everything from the classic knees and hips and cardiac game. plants to other things, labor and delivery packs and other things. So we really went off in the first year and identified where its worst, the low hanging fruit, what are the areas that we really cannot attack? Because they identified a lot of money is one thing. Getting the realization is definitely another. So that's really how we started.

Harjot Singh 05:22
Well, but here's the thing. Usually, whenever a high-priced item is like this, anybody even tries to touch it. There are lots of barriers to how to cut costs there. What are typically the problems that a leader is gonna hit, when they're gonna try to approach let's say, an orthopedic surgeon or a cardiologist about this?

Scott Ransom 05:45

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Yeah, there are an awful lot of things to engage those physicians versus identifying the opportunity, is there a quality opportunity? In my experience, as a physician, you should always start with quality if it is going to improve the patient's condition.
As we all know, most doctors are doing what they're trained in residency, and some may evolve through some kind of a representative that kind of teaches them to do this product or that product, but many don't. So they want to do the right thing, but they often don't know how to do the right thing. So we identified where are the opportunities. This required a lot of analysis, trying to identify what is the most cost-effective kind of opportunities by-product for various types of the patient population, one hip does not fit all patients. So we have to figure out what number of hips are required to really optimize that patient engagement.

So first, is analytics. Really getting to the evidence? What is the most cost-effective?
Second, is really identifying what are the areas of the best opportunity? What are those areas in that we can actually meaningfully improve quality while maintaining or reducing cost? Of course, wouldn't be a great thing. So we really worked on that. And that wasn't all of the opportunity. But it was definitely a significant portion of the opportunity.
And then third, once we identified that, and kind of worked for doctors, as well as areas that at least, you know, don't improve quality but can reduce cost. But we all know that changing physician behavior & changing physician preferences was hard. So then we went off to attack, okay, we worked with individual hospital leaders, this large health system had multiple hospitals, we worked with Chief Medical Officer and by department, the chair as well as whomever that kind of thought leader was, that wasn't necessarily a leadership position. But we always know there's that guy that's been in the trenches for a long time, though, respect, really wanted to make sure we had the senior, both formal and informal leaders on board with what we wanted to do. That often changed what we actually did do, because not all of them agreed, of course, which means we weren't necessarily super experts in every one of these areas, but they were.
But in all cases, through the analysis, the literature working with them closely, this was not a one-meeting kind of timeframe, we came up with what we believe is best practice. So that was the next step.
And then the next step was engaging in the broader physician population. That's where we did have one on one meetings where possible. And also group meetings with whole departments.
As we all know, many doctors don't show up to group meetings for department meetings and that sort of thing. So we had to go where they were at the timeframe that they were available, and really get things going. And then lastly, I mentioned this, we wanted to introduce it as part of the systems in the operating room, both what do we order? Because if we don't have certain products, well, you're not gonna be able to use those products that require the physician leaders on board for that. Second is what about the clinical protocols, the pathways, how are we going to actually make sure that this particular hit is for that type, the right type of patient. So we did that with various products across heart, across neuro, the process of orthopedic surgery, and then some of the other nonspecific physician preference items like labor and delivery packs. We found one hospital had 30 different ways they wrapped labor and delivery packs. I am an obstetrician, I am a pretty good expert on that. We don't need 30 different ways to do it. That actually is a very costly thing for most hospitals to figure out how to manage 30 different ways of doing something. We got it down to two ways depending on what it was and then added certain things as doctors needed.

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Harjot Singh 09:47

Well, I think that what's most impressive to me in reading your writing was, how respectful and compassionate you and the leaders were with the doctors in the process, realizing where they were meeting them where they were, like you said, physically meeting them, but also psychologically meeting where the doctor was. So usually, if I hear a story like this, I am bound to hear that the doctors were alienated. Whereas what you did engage the doctors, it. That, to me, is the most impressive part of the whole story. So can you speak about engagement as a tool in this process?

Scott Ransom 10:37

Okay. So we did not expect to get all doctors on board as we moved forward. So we actually in some of the hospitals only got a fraction of the doctors on board in the first pass, so I'll pick on one hospital, we are going to third of the doctors who support the approach that we wanted to go down, we implemented that with only the third of the doctors that was, then we collect the data. And we try to identify the third of the doctors that use the pathway, what happened with the quality of patients, what happened to cost, and any other impact. So that was a really, really big deal. And then we share that information. So it didn't take very long with this particular hospital's pretty busy orthopedic area, to really share that data with the broader group. Okay, after we shared data, it still didn't get everybody, but we had more people. So this was an incremental thing, frankly, over three years. And even after three years, only about 80% of the doctors across the system were on board, but boy that was an impact.

Harjot Singh 11:41

Yes, you describe step by step by step. And not just this one example, this example is almost like an epitome of a lifetime of work, how it can be done. And what are all these steps that you took? What is the most important one?

Scott Ransom 12:05

Well, I think being persistent, sharing data, and being compassionate, as you mentioned, don't expect all doctors to come on board. You think about Rogers's kind of diffusion of information, you're not going to get those laggards, I call that, okay, there's going to be a few that are going to be very easy to get on board. They may be even the ones who want to lead this effort. As an outsider, just an obstetrician, what do I know about orthopedics or cardiology, or neurosurgery? Not much. But I do know enough to do the analysis and work with experts to figure out what the most appropriate way is for the patients, and particularly the easiest fruit. Are those areas that actually do meaningfully improve quality? There's no question. Now what we talked about here on the various joints and things we also applied to use biosimilars and other pharmaceuticals, because that was a similar type of a process, looking at what are the big expensive products or the products that have caused harm. I mentioned one of my favorites, there's just low-hanging fruit all over the place. For example IV Acetaminophen At that time, it's just you know, on the order of seven, eight years ago, we did this particular project. That is very, very expensive. There are lots of better cheaper options than IV acetaminophens, I'm very proud to say I have helped get IV, acetaminophen off of many different formularies. That's not necessarily the first thing you do. But it really is an example of one that can save an awful lot of money and frankly improve quality because of just the other much better options for pain medicine, and pain management. Also, the biosimilar's last big cost there for these and more items, what are the best options, and frequently the data is not super transparent nor understood to really appreciate this practice that is in this other product.

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Harjot Singh 14:03
One of the best things in this chapter, to me, and I'm a visual learner was how you teach, how to present data to doctors, and how to tell it like a story, but also use visual tools, which can be summarized on just one page. And I want to share, this is like a treat. I want to share a diagram that you show, you see how this can only come from a place of deep strategy, in which you're going to say, Oh, I as a healthcare leader have to communicate to doctors in a language that doctors will understand. I want to share this diagram and I would like Dr. Ransom to talk about this diagram. This is from your chapter. And this is an example of what a healthcare leader can do to make one diagram look how rich this thing is. to document some. Explain, please.

Scott Ransom 15:03
Yeah. So this actually transitioned into another component of our strategy. And that is, how do we work with vendors to get a better deal for your products? Okay, so this was more of a cost-oriented kind of opportunity. But what we did is we identified what are the best products. And then we also went to different vendors where they were equivalent, and said, Hey, are you able to give us a price per product reduction in favor of better volume for that particular company, as many people know, the companies, the vendors, their profit is more dependent on the volume than the actual price, they can frequently not always, but frequently give you a price break in return to a greater volume, because the margins are so very high per product. What we ended up doing here is we really narrowed down the various vendor opportunities that we could even carry on that particular formulary, the inventory. And this allowed us to be able to negotiate with vendors to get a better price deal number one, that also, we obviously were picking the better lower cost or the same kind of items that did result in a pretty significant cost reduction, as you see here. This actually improved quality. There's no question this improved quality, not all the products were better, but there were none that were worse. Yes, that was a really important component of what we did here.

Harjot Singh 16:38
And what's very impressive is that three things are happening in that diagram at the same time. One is cost cutting, second is quality improvement. Third is physician engagement because you're talking to a physician and their language in the way the things they can understand. And they can keep it in front of them. And remember that's what's really happening. So it's not being done to harm a physician, it's not being obviously done to harm a patient. So, by the way, what inspired you to write this chapter?

Scott Ransom 17:14
Well, after talking with Carson Dye the editor, we thought this was going to be an important component, both because of supply and that work, huge opportunities right now, to improve quality and reduce costs in the area of supplies, but also to provide a guide of ways to do any number of physician engagement activities. This necessarily is not only applied to supplies, this can be applied to certain kinds of procedures. And when you do things, how many procedures should you do? And for what patient? So this particular chapter was both primarily around supplies, what are the opportunities, and how we approach them. But secondly, it was really about how do you engage physicians for any number of things that you would like to engage physicians for.

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Harjot Singh 18:00
You know, with your experience, tell us a few other resources or books or places, you would like an aspiring physician leader to know.

Scott Ransom 18:14
So, you know, I think this particular book that was shared a bit ago, is excellent. It is intended to be comprehensive, on a number of different topics for physicians to really engage their physicians, and nurse practitioners, and physician assistants. The same tools really can engage nurses, which are often very, very important for clinical other clinical preference items that aren't necessarily Doctor driven. Okay, which is an awful lot. So I think that's an excellent resource. Second, there are older works. I mean, I wrote a book on enhancing physician performance in 2001. We've gotten to be a lot more advanced now over the last 20 years, of course, but there are a lot of other older products there. Third, there's a lot of information out there in the nonphysician press on how you change behavior on any number of things, not just specific positions, looking even just the graph of Rogers's diffusion of information. We know there are some innovators that are going to jump on things quickly. We also know there are some laggards that probably I'll never get there. Well, you said information. I mean, if it takes a third of the doctors to get on board for something, do that smile about it's all good, you're successful, you got a third, and then maybe in a few months, you can get 50% and 60% Move on. So I think some of the literature on behavior leadership can be really, really very, very helpful.

Harjot Singh 19:44
If you were to speak to a young doctor, and you had to give them advice. And then you know, we talked about leadership, but anything is a fair game. What would you say? How can they be better Doctors? For a better leader or a better human, what would you say?

Scott Ransom 20:05
It's a great question. I mean, the first, I've really, you know, I talked to new Doctors all the time, even people in high school that think they want to be a doctor. The first thing I want to lead with is, you know, follow your passion. If you have a passion for something, you know, I had a passion for obstetrics, I didn't even know what obstetrics was when I went to medical school. But there was a doctor that really kind of taught me the way and it was like explosions of goodness that came up with me, but whether it be orthopedic surgery, or whatever, so the specialty is really, really important. I would say the same thing about going into various leadership positions. You need a passion, going into physician executive leadership is not a place to retire to. Now, in the good old days, I guess if you want to say call their good old days, in the 70s, 80s, and 90s, it was not uncommon for the president of medical staff or chief of medical staff was the only doctor candidate that was on the senior team. There was the good old Dr. Welby, that was really a good guy that wanted only work half the time or a quarter of his time days out. I think today's physician executive really needs to have a full commitment, because they're passionate about it, not because of care for patients or anything like that. That's the worst doctor to go into the physician executive world. I think this person is really passionate, and really thinks being a physician executive is going to provide the opportunity for a bigger impact for improving quality of care across a lot more patients are reducing costs, which, frankly, is a quality measure. Because we know that hospitals across the country, at least a third of the hospitals in the United States right now are losing a lot of money. And we are losing a lot of money. You can't survive that long sustainability challenge. Well,

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if you can't be there, that's a quality problem for many, many years. So helping both on the classic clinical quality or patient satisfaction, together with what I think is a quality metric of cost is a really big deal and can have an enormous impact. But I would only do it if you have passion for it.

Harjot Singh 22:09
So what do you do now? And why did you choose to do this?

Scott Ransom 22:14
So when I was in business school in the late 90s, I was already a vice president of medical affairs and was very, very excited about continuing that journey. I had the opportunity to apply to a variety of things, I was offered a job at a consulting firm, like a lot of top MBA programs consulting as a preferred career. I really considered it back in 1997. But it was a boss that convinced me to say no, you're going to stick with me, we'll do great things together. And someday you're going to be a consultant and he advised me. He knew my kids, and he advised me to wait till my kids were grown up and didn't care about most homes or not. I went into consulting when my youngest was a junior in high school. And frankly, she didn't care. And so this was a long dream to go into consulting. Way back before I even went into consulting the last nine and a half years, it's been exciting, the opportunity to work with lots of different places and big things, little things. I've worked with seven of the top 10 US News hospitals, I think six of the top 10 children's hospitals work with places you've never heard of before, there are tiny places that are on this near to the stock exchange that is huge. It's been really exciting. For me, this has been a passion. I don't know how much longer I'm going to be doing it. But for the time I've done it, it's been a learning experience like none other. And I believe going from being a doctor one on one I've had an impact. Being a physician executive at a hospital and a professor, I hit impact. But going into consulting actually provided the opportunity to go to broader impact, working with lots of hospitals, not one hospital, lots of hospitals, and lots of health systems, insurance companies, really to provide that bigger impact across a bigger population. So that's how I kind of see Mike,

Harjot Singh 24:05
I think you brought up something which is not only a sub-chapter of human development, which is what do you do after you're 23? Like, do you stop growing after that? Or what does the doctor do after they're 33 or 43? And in the life cycle, what happens? Do you start waiting, like you said, waiting to die kind of Dr. Williams, Chief Medical Officer versus somebody who can bring passion to the table? So what have been some of your career highlights? And what insight did you gain from that?

Scott Ransom 24:43
Yeah. So let me kind of divide it into two ways. So the first three careers I have I believe I've had four groups consulting as my fourth career. The first three ironically were seven years. And this is going to tell a little bit about me personally. My first career is at a health system. I got promoted very fast. But every year, a year and a half, I had a new job, which was great. Still saw patients. That's about seven years, I learned a lot. I had an itch, I felt like my learning curve had probably flattened out quite a bit. At the end of the seven years, I had an opportunity to be a professor and do a lot of research and NIH funded and other things. Boy, the first two years, three years, I learned a lot holding, doing NIH grants, and how to write books and other things was definitely a learning curve. But again, around you know, about that seven-year mark, really started kind of leveling off. And I love to learn, I had an opportunity to

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be president. Wow, the first three years were terrifying and exciting. At the same time, I learned more, I had a great team, and I developed a great team. And then we really love a lot of big turnarounds, frankly. And that, again, was a learning curve around the year six or seven, that's when it started flattening out. Now in consulting, I think the learning curve is a lot longer than that because you do so many different things. But especially in the first three years of consulting, how do you consult? What's the process of consulting? How do you advise somebody to do something versus you doing it yourself? That's a learning curve. So I may be more on the flat side of my learning curve, maybe there's a different career path for me in the near future is curve number five. But I know Consulting has been just a learning curve opportunity like none other for across the board, working with people working with doctors worked with nurses working with CEOs, and positions that I frankly, didn't even think I'd ever work with, like real estate. What real estate is a hurricane? Who would have thought Parking important? Well, just about every patient thinks Parking is important. Things aren't necessarily Doctor related directly. But boy, the patient's caring a lot about those things.

Harjot Singh 26:54
Oh, there you go. Dr. Ransom, you have a seven-year itch, and you scratch it. But now what gives you the courage to scratch it? Because many times what a doctor would find is that, oh, I'm very comfortable. Is this going to be too risky? Will I end up you know, being destitute trying to do this? What will happen to my family or my household? What gives you the courage to say, Okay, now, I want to do this, or I need to do this?

Scott Ransom 27:32
I try to follow my passion. And the second part, which is really important, I think for every doctor is networking. You can network in a lot of different ways. Each of my four careers has had a different process to get there. My first one was right out of residency, I knew some folks the job at the place, and I can undo some folks, which was very exciting. They were looking to grow. When I went back to be a professor, frankly, one of the people, the chair of the department that I was, you know, an OBGYN, wrote a chapter one of my books, I had edited a fairly large textbook and you and we didn't know each other really well, but we knew each other. And he knew what I was doing. And he was very motivated, they came to me about the opportunity to kind of lead the Institute and really develop. Third, again, through networking. And this was a one-way, a recruiter call me about being President of a Franklin institution I never even heard of before. Well, he got my name from somebody else that I knew a little bit but not that well. They were looking for a doctor who is board certified, who is NIH funded, who actually had led a turnaround of a healthcare organization or supported. Well, I was one of the only and I think he told me I was the only one that actually had all three of those kinds of components of being a board-certified doctor and an NIH-funded doctor and a turnaround blocker. It's very exciting. And then again, through networking, the consulting kind of came through. So yes, there was a little bit of anxiety, can I do it? We all have insecurities and anxieties about things. But you know, fortunately, my wife has also a physician, she was very patient with me and these various transitions and very supportive. And it's all worked out spectacularly well.

Harjot Singh 29:17
This is very, very good. And even when you said that earlier on, you didn't know you were going to become an obstetrician and gynecologist and there was a mentor. And here again, the value of

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networking, and finding mentors, who will give the scaffolding to your passion. So you could say, Okay, fine, I'll leap over to this. Now. Is that a fair way to say what you're saying?

Scott Ransom 29:49
Yeah. Yeah, I think there are a lot of different ways to network and the network is bi-directional. People want to know you, you want to know them for a lot of different reasons. I currently meet with about 15 executives, mostly doctors, but some are nondoctors every month for three months. And these are people that I consider it really bi-directional kind of mentor mentees, I may be the mentee at one point, then the mentor the next moment, but we built friendships. But also I have learned because I have the gift of learning from these folks. And I hope to be able to share some of the perspectives that I have. And having these numbers where many are senior, like medical school deans, and CEOs or chief medical officers of big health systems. But I also have two people that are young, you know, one was a brand new chief of staff, 33 years old, we're at a different phase of his career. Another person is actually in graduate school right now. And why do I work with those folks? Well, two reasons.
One is I feel like I can help them. I really don't. I never do this for people I don't like. And secondly, a whole different generation, I can learn a lot. And in fact, I learned more from the two young, younger folks than the more senior folks, because I've been with those guys. I've actually been in their shoes a lot, you know, not that we there's a lot of nuances on how to do things. Don't get me wrong. But the person in graduate school, he's a digital native. I'm very digitally savvy for doctors, but I am not a digital native. He just me every time I am certain. I learned a lot more from him than he learns from me. No question. So it's a privilege. And he's going to do great things in his career. But it's a privilege to learn from these folks and to hopefully share some views that might help them as well.

Harjot Singh 31:38
No, no, I am a big fan of networking. And I like to think that I have never done a job that was ever advertised. Because my mentors in this bidirectional relationship, them helping me and me helping them. And they would create a job for me, they would say, Oh, we have this coming up. And can you want to do this? And that has been so much more exciting than trying to sit down and negotiate with people. How many hours will I be working kind of thing?

Scott Ransom 32:13
Well, that's a great point. You know, I have a pretty good network with recruiters and I have looked at a lot of different jobs over time. Of my four careers, my three careers were 100% through networking. My fourth career, my third career the President role, was kind of networking because it got to the recruiter, and the recruiter ultimately placed me through the process that they had set up. I couldn't tell you how many jobs I've looked at, but it's in the many dozen over my career. Some I've interviewed for and, you know, some I was offered but I said no because it wasn't the right thing. So I'm I got to be a finalist. And I was disappointed in the end. Always, it works out, right? I remember in 2001 or so. I was a finalist-free, kind of large-ish, health system chief medical officer position. And way out on the East Coast. I got to be a finalist, there were two of us who know who the other guy was. Ultimately, they offered the job to him. I thought it was great, that option. But as the recruiter, this was a recruiter lead, he said, you know, the other guy was just perfect. He had, he was more senior than you at that time. I was, you know, in my 30s. This guy was in his mid-50s. He had 20 more years of experience than me. And I need to know the guy through other avenues he didn't even know I was the other candidate. He

was the right guy after I met him a few months ago, or a few months later, he was absolutely the right guy. So, you know, the recruiters are important. Definitely stay with recruiters. But the likelihood of a recruiter placing you is way less than your network to be able to help connect you, especially in earlier jobs.

Harjot Singh 34:04
There you go. Networking is also a form of human engagement. And we're humans helping each other. And it improves the quality of life of doctrine. It improves. You can earn more money by doing that, and of course, you will save them money because then they don't have to go and search for someone like you. They don't have to spend time looking for someone like you And thank you, Dr. Ransom. Thank you very much.

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