The Transformer: the UW Medicine Podcast
Episode 1, Part 1: This All Comes Down to Chickens

Opening Soundbite: For me, this all comes down to chickens. It all comes down to the way people used to get their healthcare paid for.

[Musical intro]

Josh: Greetings and welcome to The Transformer podcast. I'm your host, Josh Kerns. So why this podcast? Well, as you no doubt know, it's a critical time for UW Medicine and all of you – our valued partners -- in creating the "UW Medicine way." What is the UW Medicine way? Simply put, it's a patient-centered, mission-driven environment that's focused on reliable excellence. Wherever you look, the healthcare landscape is shifting. We're all facing changes in reimbursements as well as the movement from fee-for-service to pay-for-performance or value-based care. And then, there's the increased focus on the health of patient populations, not just individuals. Care transformation is essential in enabling all of us to adapt to these changes. Over the coming months, we'll go in-depth and learn how care transformation is driving necessary changes across the entire UW Medicine system to improve our delivery of patient care and provide better outcomes and value. But care transformation can only happen when we all take part. From physicians to clinicians and the frontline workforce, we want you to know what care transformation is really all about. So, in this series, we'll bring you honest and valuable conversations with people across the system, about all the trends and the topics that are central to this work. We're gonna talk about how you can manage this process in your own areas and about some of the great work your colleagues are doing to drive improvements in care delivery. So, with that, let's kick off the series with two of the leaders at the forefront of UW Medicine Care Transformation: Dr. Dave Flum is the Associate Chief Medical Officer for UW Medicine and Dr. Josh Liao is the Associate Medical Director of Contracting and Value-Based Care. So, without further ado, let's get right to Episode 1, Part 1 of The Transformer. We call it "This All Comes Down to the Chickens."

Dave: We are at a great time in American healthcare where we're really asking questions about fundamentally why are we delivering the kind of care we deliver and how do we get more value for patients. How do people who come to the healthcare system get healthier when they leave it and how do we figure out how to use all the dollars that we spend in healthcare more effectively and wisely. And that's what care transformation's actually all about.

Josh: Dr. Josh, can we call you Dr. Josh, first of all?

Dr. Josh: That would be fine. Yes, no problem.

Josh: What is it about this process that brought you to the table that said I want to be a part of this?

Dr. Josh: Well, I think you know, you see patients and I think that's a very fulfilling and engaging experience, but I think most every doctor has a sense of there's something bigger going on and there are other shifts that are happening. And I think that was what really drew me to this work, the chance to not only see patients, take care of the people that I was looking at, touching, talking to, but also think on a higher level about how do we take care of people more broadly in populations. And I think doing both of those is really compelling to me personally.

Josh: As we kick off this series, I think it's very important that the listeners, because everybody has a stake in this, this is not a passive exercise here. Why you two, what are the roles you actually have in this process. And I know a lot of people will be asking, well, who are these guys, what are their qualifications. And let's start with you Dr. Flum. What brought you to the table for care transformation, and for those who don't know you, what is your experience that leads you to this point and gives you the expertise to tackle this problem?

Dave: So, I'm a general surgeon. I've been at the UW Medical Center for almost 18 years. And as a surgeon here, I've totally enjoyed taking care of one patient at a time. I have great colleagues and we do, I think, amazing work at the Medical Center, at Harborview, at Northwest, at Valley. Each of us takes care of one patient at a time and that's a tremendous privilege. And all my colleagues know that there's great joy that comes from that. But, as Josh mentioned, we are all part of a system and trying to figure out how to make that system work better for our patients and make it easier to do the right things for our patients, that's really something that I think docs have an obligation to do and, actually, I think we're uniquely qualified for it . Along the way, my research has been focusing on how to use data to drive systems to perform better. A big part of that is understanding why there's so much variability in the care that we deliver. You know, I take out somebody's gallbladder and I do it very differently than one of my colleagues and we may have different outcomes. But, unless you use data to understand differences, you miss the opportunity to improve the kind of care we deliver. And that experience with gallbladder surgery parallels any of my colleagues' experience, with the management of blood pressure, or depression, or fill in the diagnosis or treatment you do as a clinician. There is phenomenal variability. Understanding how data can assess that variability and then how we can build programs to make it so there's less variability, so that our patients do better, that is what I like to think is the special sauce of creating care transformation at UW Medicine.

Josh: And, Josh, for you as well, what brought you to the table and a little bit about your background?

Dr. Josh: So in contrast to Dave, I'm a great contrast, whereas he's been here 18 years, I came to UW Medicine in the last year and before this was at University of Pennsylvania in Philadelphia and spent some time on the East Coast. I'm a general internist and I see hospitalized patients, so people who come in for medical conditions that are sick enough to be hospitalized. I find that also to be very engaging work. You know one of the things that's really stuck with me along my path, has been that the plural of story is policy, and so I've really, it echoes just something that we've talked about before, but this idea of seeing that patient one at a time and then zooming out, so what does this mean when you multiply across the thousands of patients any organization takes care of. I think it's a really interesting dynamic. And to that end, outside of my clinical training, I've spent some time, somewhat like Dave, getting health economics, epidemiology, policy research training and, most formally, had a master's in this at the University of Pennsylvania where I worked on things very similar to actually what I think about now. So my research really focuses on payment models and how changing value-based payment models impacts how we deliver care as an organization.

Dave: Josh and I come at this a little bit from opposite ends and I think we come together in the right spot. A lot of my work has been organizing clinicians and clinical communities to come together to own healthcare change because I think if docs don't drive this, then it's

driven by others, including people who sit in the other Washington, that totally dysfunctional Washington. Josh takes a look at the healthcare system from the perspective of policy, from the people who write it. And I like to use that joke if the opposite of pro is con, then the opposite of progress is Congress. [laughter] And that is the space that Josh is living in. But I think understanding both what policy is driving and what clinicians can do to meet that policy head-on, is sort of where the two opportunities come together.

Dr. Josh: And I just want to drive that home by saying that, you know, there have been, people have described, if you look at medicine, modern Western medicine, I think this is a helpful framework for it, you can divide it into three centuries. In the first century of medicine, it was really about the century of the patient. And so what we did as doctors, and we did as researchers, as policymakers, was think about, you know, someone sick, another person sick with the same thing, there's five, 10 people, what's going on here and we would write things called case reports about them and we would study, if I give them this medicine, or if I give them this treatment or this elixir, what would happen. That would be defined the first century of medicine. Then the second century of modern medicine really shifted to what some people call the century of the cell. We looked really inward and we said, let's talk about these enzymes and these proteins and let's pipette things and clone things. And there's been a pivot I think, whether impressed upon us or driven from internally, about a new century and some would call that the century of the system. And I think the century of the system really brings together what Dave is talking about, maybe some progress and some Congress as well, but also really about ownership and leadership from health systems needing this policy that comes from policymakers. I think that's really the fertile ground that we're on. And I do think it's part of that bigger shift away from prior centuries, if I can say it that way.

Josh: One of the things that impresses me about both of you is that you are still in the trenches. I think so many of us have experienced traditional organizations in which somebody becomes a manager, an administrator, etc. and they become detached from the actual trenches, the situation on the ground. And I would think that when it comes to care transformation, that that's critical, because at the end of the day, every single person has to buy in or this doesn't work.

Dave: Yeah, no doubt. I think this comes down from our leadership. Paul Ramsey has really made it the expectation that clinician leaders are going to be first clinicians, and by that inform their leadership. You know, being in the operating room and seeing what is working, what's not, being on the wards as Josh is, it's key to understanding how things are actually working or not. And also lets you see so many opportunities to improve the system. And I think it's really central to both of the work that we do.

Josh: It's kind of interesting, Josh, that we talked about, you talked about the three centuries, the three sort of periods, epochs, if you will, within medicine. And then it comes back to the system in an individual patient, but also the system that you're trying to transform here, not just here at UW Medicine, but I mean really, we're talking about a global transformation here, of a system that has been in place for a long time.

Dr. Josh: If there's one thing, I think it's helpful to dispel, I think it's terms like transformation and policy are not one thing. And so you know, we think about, I think very much in my academic work about policy from Washington D.C., federal policy. But just because a bill is passed doesn't make it so. That thing has to then be transferred over to what I call private policymakers here, Paul Ramsey, the senior leadership, people like Dr.

Flum, and then transfer it to clinicians and their clinical leads, and so I see all of those levels as policy. I think that this idea of policy lives way out there away from us as unhelpful to that, and I would actually make a similar argument about transformation that there is transformation, capital T, but that cascades down to the level of a clinician into clinical groups, into service lines and the things that we live and breathe as doctors.

Josh: And that's the whole point of this series that we're launching here and we're going to talk in detail about a number of those elements. But one of the things that jumped out when the three of us got together and had a chance to talk about this before, was that it's important to understand where we've come from and how we've gotten to this place because I as a patient, as a lay person, as a consumer, if you will, look at a system and I just, my rates are going up, I can't see the doctor I want to see. The system is, in my mind, so screwed up in so many ways, and that's my uneducated perspective on that. And you both said that it's really important to look back and for all of us to understand where have we come from and how did we get to where we're at today before we look forward and talk about how we're going to change this.

Dave: Yeah, how did we get here, right? That's the question. For me, this all comes down to chickens. It all comes down to the way people used to get their healthcare paid for. About 100 years ago, doctors didn't really offer that much to patients. Hospitals were a place you went, actually, when you were going to go die. And the way, if a doctor was going to offer you something, maybe put stitches in your leg, the way you'd pay for it, is by you bring him a chicken and the chicken would be a direct value in response to value that you got. There was no question about value-based care. You got a chicken's worth of care. And that worked. It really worked well for a large part of the century. In the 1940s, we started introducing insurance companies, in part to respond to some wage control that was going on around the time of World War II. And all of a sudden, it became a benefit as part of work to have insurance, and as soon as you introduce insurance companies, there's a third party that's paying for care and it sets up lots of weird dynamics. Imagine, if when you went to buy a car, there was a third party that was going to be paying for that car. Well, you'd make very different decisions about what kind of car you were going to buy if somebody else was going to pay for it. If they were going to pay for the replacement of your car, you might treat your car differently. You might maintain it less or you might buy a car that was a like the fastest moving car or you can imagine and maybe not the car that was the most fuel efficient, if somebody else was paying for the fuel in your car. Introducing a third party payer into this mix of healthcare took that chicken totally out of it. And all of a sudden, value got totally upended. It didn't really even matter then, until the 60s, when the government became the ultimate third party payer with Medicare. And all of a sudden, it was a big fat checkbook for doctors to ask for checks to be written out of. And then, we started seeing the rise of all this new technology and medication and sophisticated interventions, like transplants, where all of a sudden it really became an issue. Like when there was not a lot of healthcare to pay for, it didn't matter who was paying for it. A chicken's worth or something even bigger than that, but all of a sudden, with the explosion in the opportunities to spend money, that big checkbook of Medicare or the third party payer insurance companies, became a really disruptive activity. And we got to the point we are now, where 18 percent of the gross domestic product is being accounted for for healthcare. Something that's almost double other industrialized nations, and a lot of people questioning the value of the care that we deliver. And I think it's disrupting this effect of the third party. Getting back to the idea of a chicken's were worth of care, that is what is at the core of what's going on here now, driven in part by Congress, but also driven by large employers who have been paying for healthcare for a long time and are finally asking the question, how do I get more chicken's worth of care out of the

price tag of the insurance we're paying for.

Dr. Josh: I think it's important for all of us, including clinicians and physicians, to realize that there are forces at play that are, call it transformation, the UW way, that are bigger than us and there are many of them, we've highlighted a number today but I see two major ones, and it's conditional on one thing that we have to agree on, and that thing is, do we think that healthcare, paying for healthcare in a fixed predictable way to ensure against a potentially very large and costly and unpredictable cost down the road with health problems and illness, if that's an appropriate thing, we have to look towards the two biggest insurers in this country. Insurer number one are employers, so places like Amazon, Boeing, Walmart, Lowe's. The second is the government. So it's Medicare, CMS and Medicaid. And so those two groups, because of mounting pressures for them, have implemented changes that impact us as well. So certainly things that we do and that we want to sprint towards, but there are things that they're doing that impact us as well. And I'll highlight two, one on each side. So from Medicare's perspective, the government has realized that in any budget, things are fixed and so more money we spend on healthcare, the less money we spend on things like public works, schools, roads, that type of thing, and so reining in healthcare costs has that implication. And so a lot of the policy that we're seeing comes from that. That's number one. On the employer side, you know if you were to tell a manager, I have something that may make up almost 20 to 25 percent of your costs, when you think about compensation, and what goes into wings and widgets and wrenches and computers, and you could intervene to reduce that cost and cut it in half. Most managers at most private companies would say, let's do that, and I think there's a growing recognition that healthcare is one of those things. And so, somewhere between the employers realizing this is a cost that we can right-size, and the government realizing that we need to leave funding for other things that are important in this country, and all the things that cascade from that, those are forces that are driving organizations like UW Medicine but certainly not just us, all around the country, to do the things we're talking about. And I think that's really important. That we didn't generate that, but they impact us significantly.

Dave: Yeah, let me add one more external force that I think we dismiss it at our own loss, which is patients. I think people hate dealing with the healthcare system. I think especially as healthcare has gotten more complex, as the options for drugs and technologies and interventions has gotten more complex, as the Internet has given us access to more and more information about things that most patients knew nothing about before, I think they want a healthcare system that does a couple of things for it beyond just being there when it has a cut, needs a set of stitches. I think people want a healthcare system that explains the complexity and handles the complexity, that handles evolving technology, that will reach out to them when they need a service rather than waiting for me to get sick and going to the system, that anticipates when I could use some healthcare or healthcare intervention, that wants to check up on me after I get put on that medication for depression to see how I'm doing, and can be more proactive in helping me accomplish better health. And I think, frankly, the typical system of fee-for-service, come to us when you need a gallbladder operation, we'll take out your gallbladder, has really neglected that key aspect of what people want from the healthcare system. A trusted partner that helps me accomplish my healthcare goals, empowers me to make better decisions about my health, and is there for me when I need them. And also there for me when I don't know that I need my healthcare system to be there for me. And I think that driver of what people need and people want and how the healthcare system is really not been that responsive to it in the past, is for me, one of the main motivators to do this work. I mean we talked about payers. Yes, if we can't meet our margin, we can't meet our mission. And payers are a big

component of why we do what we need to do. We've talked about doctors, making sure that they see the positives in all this role, but we don't spend nearly enough time talking about how lousy it is being a person or patient who has to interact with the healthcare system at various times in their lives and has expected more and deserve to expect more, frankly, for 100 years in America, but we are only now starting to get the motivation of the healthcare system to align with what people need. And for me, that's reason enough to come to work every day and do this good work.

Dr. Josh: You mentioned a little bit before about benefits. You know, we've seen wages for most Americans stay relatively flat, but what's not stayed flat is actually health benefits and that's ballooned. And I think that that's popped up over the proverbial horizon, to where a lot of managers are saying, we have to control that cost. I do think there's a shift in how people are thinking about that now. I when I say that, I mean managers and leaders of companies are seeing that health benefit cost rising because that's where really a lot of the growth has been. So, I'm oversimplifying this part of the answer, but to your question about why have we seen, for example, networks get narrower, more restrictions on who you can see, premiums going up, copays going up, it has a lot to do with what Dave said, the setup has led us to a place where the action has been in those benefits, in a way that the costs have increased and so people, people being insurance companies, employers, are leaning on that part of the benefit package to try to control costs. And so I think that cascades down to individuals, like you and me, feeling that in our benefits.

Josh: You know, it’s interesting, so many people and in this discussion out in the mainstream, if you will, everybody looks towards policymakers, towards Congress, for example, which I would argue to look to Congress for anything these days might be a little problematic. And yet, you are the ones who are actually on the frontlines, the medical community, so to me it makes perfect sense. We should be hearing a lot more from you guys and you should be the one setting the policy, not some 80 year old with a lifetime of of great Cadillac care, who's been a senator for 40 plus years. It makes perfect sense to me why we need to start this conversation at this level, at the micro level, but then this needs to become part of the general discourse when it comes to care transformation, not just what are you doing internally with UW Medicine, but collectively as a country.

Dr. Josh: To the point about leaders who are physicians, seeing patients and remaining on the frontlines, we actually did a recent study where we took the top 10 hospitals on the Best Hospitals list of the U.S. News and World Report list, and we surveyed all of their leaders. And it turns out, the vast majority of people, who are doctors and leaders, still see patients. What was really intriguing though, that came out of that study, was that being a leader in this environment is its own, if I can call it this way, a specialty. I just want to counterbalance the point that you mentioned about docs should be involved, we should be creating policies. I completely agree that we need to be engaged. That said, there does need to be focused attention and expertise. Just like Dave has to have it for taking a gallbladder out and I have to have it for taking care of a septic patient. There needs to be somewhere in each organization and some entity, some kind of expertise around this that is extremely and completely engaged with doctors, but sits outside of doctors who are full-time. I feel that is a piece of the solution. So I don't think it's Congress doing everything. That's not true and wouldn't work. But I also think that doctors who are seeing patients full-time coming up with policies, there's limitations to that as well.

Dave: Yeah, and let's not overplay it. I mean docs are not always making the right decisions when it comes to a healthcare system. I mean, in part because they grew up in a system that reimburses and rewards fee-for-service, so the more you do, the more you get

paid. That is actually a component of this healthcare system built on that third-party payer, open checkbook approach. That means that a whole generation of docs has been raised with the idea that the more I do, the more I get paid and the more the system does, the more the system gets paid. Well, that's maybe OK, but it definitely favors specialized care, interventions, sickness care, rather than preventative care, chronic care and wellness. And so docs are not that well suited to make policy the guide to a healthcare system. I think the most amazing thing that's happened and it will be the best thing for the American healthcare system is that the insurance companies and employers have basically said, listen, we're insurance companies and employers, we don't know where the money should exactly be spent in the healthcare system. You're doctors and nurses and therapists, we're going to put the risk over to you. Instead of us being the big checkbook that you keep on writing against, we're going to give you a bundle of money to take care of Mrs. Jones or Mr. Smith for the year or for 90 days after they're diagnosed with a hip problem. We're just going to give you the money that we think it's going to take to take care of that patient. You figure out how much preventative care, how much screening, how much therapy, how much just interventions should happen, and let you figure it out. So what you're hearing there is a little bit of a hybrid. The policies set and the reimbursements, how much it's worth, is being set by the people who pay for it, employers, insurance companies. But all the decision-making about how to spend that money is being driven by the clinicians who are closest to the patients. Ideally, that would be informed by the patients And that has opened up the whole game. Josh is an expert at this thing called bundles. Maybe, Josh, take them through how a bundle is this magical effect on healthcare delivery because I do think it is a revolution in the way healthcare is delivered.

Dr. Josh: Yeah absolutely. And I think, Dave, that the word you used, hybrid, is exactly right. I'll just underscore something that I said earlier, which is that transformation to me is not a dichotomous, yes, no, they, us type of thing. It doesn't work that way and I don't think it's actually shaping up to be that way. And so I think recognizing the hybrid approach is really important. Again, public policymakers can say and legislate what they want. We have to enact it and vice versa. But it's not, at the same time, so in the same way, it's not that they push something down our throats and we have absolutely no say. I think all doctors who make discretionary decisions about the care they give patients know that's not true. At the same time, this idea that all policy is going to go away and transformation's just this notion that's not real, I think that's misinformed as well. It's real and it's happening and I think, to Dave's point, what we're seeing is a hybrid of that. And bundles, or bundle payment, is one area of that and that's something that I spend a lot of my time thinking and studying and focusing on. And Dave put it really well, which is that, essentially, based on the best information that a public policymaker like CMS or Medicare would have. They give, they adjust for things like illness, other conditions, and they give healthcare providers, hospitals, clinics, doctors like us, a sum of money that's bundled. The reason it's called a bundle, is it's fixed. And in that bundle, we provide all the care that we think is necessary. No one polices that. They don't tell us, give this antibiotic, do this type of surgery. We make that decision. But we are held accountable to, not just the costs of that bundle. And by that I mean, if we spend more, we're on the hook for that. If we spend less, we keep the difference. But we're also on the hook for the quality of it. And that's a really key component, because you can imagine, the opposite of fee-for-service where when you do more, you get paid more, is if you do less, you get paid more. If you get a fixed amount and you do less, you keep more of the difference. And so ensuring quality is part and parcel to that. And so bundles have been designed increasingly with that in mind, which is that we'll give you a fixed amount of money, leave the freedom to you, because you know what's best, you know what's right. But you have to hold up the end of the bargain where people aren't having worse outcomes and doing more poorly. And I think that's really part

of the, you know, the secret sauce and the really interesting part of what's happening.

Dave: So look at the magic of this. Just that single decision from, let's say Boeing. So we, UW Medicine has a relationship with Boeing. Boeing's an innovator. They want to have all of their subcontractors for their planes innovate to get more effective, efficient components, parts, to their planes. Well they kind of view healthcare for their employees the way they view any subcontract. Maybe, you know, when Boeing was trying to make a new wing that was more fuel efficient, they asked the people, the subcontractors who make wings, to go out there and innovate and held them accountable for that innovation. When UW Medicine partnered with Boeing to try to do the same thing in healthcare, that simple shift of saying, hey, instead of us continuing to pay every bill that you send us, why don't we say we're going to give you about as much money as we paid last year for the care that you deliver this year. And we're going to ask you to hold accountable, yourselves, to certain quality measures. You deliver the care that's right, the preventative care, chronic care. The magic of it is that, let's take a procedure like a hip replacement, the second the payer, Boeing or Medicare, says we're going to give you a fixed amount of money for that care, all of a sudden, you have doctors, like Josh and orthopedic surgeons, figuring out what is the absolutely most important stuff we have to do to both reduce costs and improve quality. What supplies do we actually need, what supplies are not, you know, that helpful, they're maybe expensive, they don't add much. What new fancy, gee whiz, innovation is just that, and not actually value-added, and whether or not we should try it on a patient or not, is all of a sudden viewed through a different lens. Once the patient has their procedure, could we agree to how to do it the right way, the same way, get rid of that variability that I was talking about before. And when they leave the hospital, it's not out of sight, out of mind. We now partner with people who take care of patients once they leave a hospital, like skilled nursing facilities, to make sure the care for our patients is optimized there too. So the magic of that shift from, I'll just write a check because I'm a big open checkbook, to I'm going to give you the money for you to do the right thing, for you to be accountable to it, and you have an interest in doing well with that, one because you want to take care of the patients, two because you need to make profit as well or at least have some margin off of the money we pay you. The magic of that, it shifts all of the work of delivering real quality, real value, to the teams, the doctors, the systems, that are closest to it. And I do think that's magic and I think it's going to have a huge impact on the future of healthcare.

Dr. Josh: Yeah, I agree, and I would just add to something that Dave mentioned earlier, which is that the question came about changes in benefits and copays in coverage and networks and you can wrap that up and to say, this is patient or consumer transparency and awareness. And traditionally, not many people who have coverage through their employers have had that. So the idea of saying, hey you know what, you have to pay $40 instead of $20, you can't go to doctor X, you have to go to doctor Z. What it does, is it tethers in the consciousness in the mind of that individual, I should think a little bit about my healthcare. And that engagement you hear in the public discourse about transformation, I would call what Dave and I are talking about now, an analogous transformation. But call it physician or provider engagement where, when now we have to think, gee you know I use this cement for the knee replacement that I use or I get this antibiotic or I use this IV medication, do I really need that. So there's an analogy here. Where patients are thinking about where's the best place to get care in a cost-conscious way for good quality. Docs have to think about it the same way. The mechanisms and the levers we pull for that, you can call it bundle payments, you can call them ACOs. There are many different ways to do it. But to me, that's the kind of fundamental notion that I think Dave is describing that I see. And there's an analog between doctors and patients.

Dave: And they both hate it. [laughter] The patients hate it because they don't like, you know, having a restriction on where to go.

Josh: Sure, we want it all and we want to pay as little as possible for it.

Dave: And I think docs, I mean I'm exaggerating to say they hate it, but you know, this is a who moved my cheese kind of moment. And I think, you know, many docs are seeing it as the positive moment it is, to really make sure, to really have a broader role for clinicians in driving and defining what is quality, what's value. Others see it for the other side of it, which is that somebody is imposing change on me. And it is going to require a new generation of clinicians who see this as an opportunity and really embrace it. And I think one of the most exciting things about working at UW Medicine, one of the reasons I love working here, is that we are a system that takes on innovation and really embraces it. And I think that you're seeing, with the creation of the CMO's office, the notion of clinician-driven innovation is really at the heart of what this is about.

[Musical break]

Josh: Alright, so that's where we've been and where we're at right now but where are we going? Coming up on Part 2 of The Transformer, Drs. Flum and Liao will detail the whys and the hows of the road ahead and we'll unscramble the alphabet soup of acronyms that just dominate the care transformation conversation. Suffice it to say, there are a lot of them.

Dave: You know, how can we take advantage of the brightest minds in healthcare who are working at UW Medicine to offer patients some kind of reliable experience, reliable excellence, that they can expect to have every time they touch our system.

Josh: I'm Josh Kerns. Thanks for listening and we'll talk again soon on the next episode of The Transformer.

[Musical outro]