The Transformer: the UW Medicine Podcast
Episode 1, Part 2: Acronym Bingo

Opening Soundbite: Taking too monolithic a view of things like transformation really undermine the nuance that impacts patients.

[Musical intro]

Josh: Greetings and welcome back to The Transformer: the UW Medicine Care Transformation podcast. I'm your host, Josh Kerns. In our inaugural episode, we talked a lot about all of the factors that led us to where we are now, facing big changes in reimbursements, movement from fee-for-service to pay-for-performance, or value-based care, and all of the other factors driving these changes. So, in this episode, we're again joined by two of the leaders of the UW Medicine way and the care transformation effort, Dr. Dave Flum, the Associate Chief Medical Officer for UW Medicine and Dr. Josh Liao, the Associate Medical Director of Contracting and Value-Based Care. We'll talk to the docs about just what exactly is the UW Medicine way, what it means to all of you, and why the future's actually much brighter, especially once we all better understand the who, what, whys and hows of care transformation. You know all this can seem pretty overwhelming at first but as I've researched care transformation for this podcast, I found a lot of this is really actually pretty straightforward and it makes a whole lot of sense once you get past the hodgepodge of policies and alphabet soup of acronyms. Yeah, I'm a fan of illiteration, so sue me. Oh, wait a minute, you're all doctors, never mind. Anyway, we thought it'd be fun to start off this episode with a little different approach to unscrambling some of the mystery surrounding care transformation. So, in this episode, we begin with a little game we dubbed "Acronym Bingo."

Alright, we're gonna play a quick game here, "Acronym Bingo."

Dave: I will tell you what doctors think and Josh will translate what it actually is. [laughter]

Josh: OK, first one, MACRA.

Dave: OK. Docs think MACRA is the latest torture that Congress is going to impose on them. And it's sometimes in the future and it's not going to bother them really. What's the reality, Josh?

Dr. Josh: The reality is MACRA is a way to move engagement in what we're calling value and transformation, from single digit percentages in the country, up into the majority of doctors.

Dave: What does it stand for?

Dr. Josh: It stands for the Medicare Access and CHIP Reauthorization Act of 2015. Here are a couple pieces: it is separate from the ACA, aka Obamacare. It's completely separate. It did other things. It reauthorized CHIP, as the name suggests. It also fixed the SGR, the sustainable growth rate problem that many clinicians will know about. But as part of that, and in attendant to what we're talking about here, it tries to take value-based transformation and put it into clinics and practices and hospitals around the country, not just for those 2 to 3 percent of doctors who are really engaged to do that already.

Josh: 50 points for Dr. Josh.

Dave: And the reality check for docs, what they need to know about, is that it is fundamentally changing the way Medicare, which is about 40, 35 percent of our book business is going to pay us, and so succeeding in MACRA, which means making sure we standardize care, get back to value-based care of the sort we just described, is key for us all to maintain our bottom line.

Josh: All right, next question for our contestants: MIPS.

Dave: MIPS. I think most docs think that's some kind of like smallpox-ish kinda illness [laughter], like he's got the MIPS.

Dr. Josh: That's right. You report to the CDC. That's right. [laughter] MIPS stands for the merit based incentive payments system. It is actually part of MACRA. It's one of the two tracks within MACRA and it's kind of, within MACRA, physicians and practices and hospitals have kind of a pick your adventure within two or three tracks. And that's one of the three.

Josh: Okay.

Dave: And MIPS, we are currently participating in MIPS, I want to be clear about that. We are submitting data to Medicare to help us meet the requirements and that may be part of the reason why we get a little bit of a benefit in the reimbursement we get from Medicare.

Josh: Next question: QPP.

Dave: That is something that my teenage daughter texts me [laughter] when she…I don't know, what does QPP stand for, Josh?

Dr. Josh: Yeah, I think it's like what iPhones auto-correct to when you try to type quick or something. Quality payment program. These are all related. MACRA enabled QPP. MIPS is one of the tracks within QPP. It's the same thing we're talking about. So just to be clear, number one, we as UW Medicine are in QPP because we are in MIPS and we are subject to MACRA. So we're in it. Number two, the things that Dave just mentioned about the benefits, in terms of reimbursement and the impact on our book of business for Medicare, that is driven by QPP. QPP touches other things that we are not involved in. So it's a bigger scope than MIPS but very related.

Josh: You still have three lifelines, too Josh, we haven't used any of them, the phone a friend. WTF. I'm just kidding. [laughter] All right. Last one, for the grand prize: VBI.

Dave: I've never heard of it. VBI, Josh, it's all you.

Dr. Josh: So VBI stands for value-based initiatives and this is, it goes back to what we were talking about, it's a perfect capstone to the point we're talking about, where things like MACRA, MIPS, QPP, we didn't even talk about ACOs, EOCs, HIQRs, that kind of thing

Dave: Now you're just showing off.

Josh: What a geek. [laughter]

Dr. Josh: Those are all public policymaker acronyms and programs. VBI is kind of a catch-all term that private policymakers, aka CEOs, health systems, department chairs, division chiefs, they use to then implement those things. So you change how things are paid for. But then someone has to say well this is how we're going to organize docs, put them in a room, redesign pathways. That is the catch term for that kind of activity. And so it looks different from hospital to hospital, organization to organization. But that's the general notion of it.

Josh: Dr. Josh, you are the winner of Acronym Bingo.

Dr. Josh: Nailed it.

Josh: Congratulations.

Dr. Josh: Thank you, thank you.

Josh: So Dr. Dave, I understand we have extra credit now. [laughter] We've not stumped Josh to date. You have a few more though.

Dave: All right, let me offer a couple more that docs are gonna be hearing about. UW Medicine is part of what's called an Accountable Care Network. It's something we created, in part, to address Boeing’s interest in having a health system that was broader than the Seattle area. We had engaged in a set of relationships with hospitals really across the I-5 corridor, that extend from Skagit all the way down to Olympia, and this network is providing services to Boeing and it's really helped us expand our geographic footprint while trying to deliver increasingly on value. UW Medicine is also going to be creating a clinically integrated network which is the next level in integration between these entities, that is trying to be the premier population health network, which means we're trying to service a large population of patients that extend the whole west coast of Washington state and is more broadly trying to accomplish all that value for larger communities of patients that beyond what you might expect taken care of at UW Medicine clinics and hospitals. So that's the clinically integrated network and the Accountable Care Network. And together they are big part of what UW Medicine's future is going to be about.

Josh: Ok, so we’ve talked a lot about care transformation but we haven’t yet detailed what exactly is the UW Medicine way and the key tenets.

Dave: So we try to make it really boil it down to six areas that the clinicians really needed to focus on because taking too lofty an idea and it sounds overwhelming and it sounds a little bit preachy and even using the term care transformation is not a term I love so much. I think Carlos Pellegrini, our CMO, has taken to using the term the UW Medicine way. 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 and then really make it about the patient and not about the payer or not about other, you know the clinicians, researchers, educational activities, but really make it about the patients. Patients are First and really imbue that in the work we do. And to accomplish the UW Medicine way, we’re or focusing on six areas, and I think the future podcasts are going to elaborate on that, but why don't we just make sure. So there are six areas we think every clinician needs to understand and see their role. The first is around creating reliable excellence, a standardized approach to the way we do care. So there, in our system, we may have 20 surgeons who take out people's gallbladders. I think we can agree there's probably one

good way to take out a gallbladder with lots of variations around that potentially, but you know, like any diagnosis or procedure, we should figure out the best way to do it, the most efficient, effective way to do it and make sure we spread that across all areas of care unless there's a good reason not to have that kind of standardized approach. In some ways, that involves protocols and pathways, sometimes it just means that you and your colleagues get in a room and decide which antibiotics make the most sense for patients or are the highest value and which are lower value that maybe we can avoid. But a massive approach to standardizing the most common diagnoses and procedures, that's thing number one in the journey towards care transformation and it's something that every clinician should understand and I think would warm to that because every doc thinks they do it the best and getting them together with their colleagues allows them to either show that their colleagues how to do it the best or lets them learn what, maybe if you use data, to set you free, well maybe is the real story about whether or not the way you do it is the best.

Josh: You know, I find it interesting that there’s so much variability, so this whole notion of standardization and reliable excellence makes perfect sense. What’s next?

Dave: The second is getting clinicians to think beyond the patient in front of them. This is really something that is a change in the way docs have to think. We are trained in medical school and then in residency to take care of the patient in front of us. The notion of thinking about patients who are not in front of us, the patients maybe who don't come in but whom we’re responsible for, populations of patients who have different experiences in healthcare than the patient in front of you, let’s say patients who are in marginalized groups socially or economically based on race or ethnicity. Thinking beyond the patient in front of you makes you really broaden your horizon. In primary care, that's meant that docs need to understand the panel of patients that they take care of and who they're responsible for. The best example I can give is, you start a patient on an antidepressant when they have depression. You need to see that patient back to understand if their depression is improving. If they don't make a follow up appointment, you can't just assume that they're okay. You can't rely on just taking care of the patient in front of you. You need a system to help think of the whole population. That's the second area, populations beyond patients. The third is really actualizing the medical home. The idea that every patient we take care of needs a home where all their healthcare needs can be met and really building that capacity is something we've been working on.

Josh: Now one area I’m really focused on Dr. Dave, is the whole notion of using data rather than just an opinion to come up with the best way to provide value-based care.

Dave: The fourth area is using data to help really drive us. I've mentioned data a couple of times. But having kind of insight about the care you’re delivering, back to those gallbladder surgeons, so that they can understand how much variation is there in the way the gallbladder surgery they do is playing out. The patient with depression…understanding how my patients who I treat for depression, how they look at six months and whether or not they're all improving or whether or not I can improve their remission rates for depression. That is better use of data. The fifth is shifting our focus beyond sick care, the kind of care that all docs are trained to do and that the healthcare system typically pays for, you know, I'm sick I go to the doctor, I get fixed. Shifting that to be about we call it healthy care, either prevention or helping people stay out of the hospital through palliative care or care after patients leave hospitals. That's a shift from sick care to healthy care.

Josh: Alright, so that’s five. And then what’s number six?

Dave: And then the last is trying to embrace smart innovation. The idea that not all technology is smart or adds value. Trying to be part of figuring out what new innovation is helpful to us. We think every doctor can find some activity in those six focus areas that for them could represent their role in healthcare transformation. It gets beyond the lofty idea of we should change or Congress is telling us to change, to really emphasize their role in either standardizing the way things are done, thinking about populations, thinking about the importance of a medical home, using data on their practice to drive performance improvement, moving beyond sick care, and thinking about how to embrace new technology. That is the UW Medicine way towards care transformation. And I think it's leading us to exactly where we need to go to deliver better value for both the employers and Congress, but more importantly, for our patients. And that's what this is all about.

Josh: If I were to look at a timeline, we began the care transformation process somewhere, and then we looked down the line. Is there an endgame to this or is this going to be now a continuum that goes on, based on what you have begun? That never ends because, theoretically, you're always evolving much as you would in any other industry, technology, etc.

Dr. Josh: Yeah, a couple of thoughts. I really like the way Dave mentioned the UW way because I think care transformation inherently connotes like something is transforming and then it's transformed, past tense. And I think that if we assume that there's going to be new technology and new trainees coming in and new ways that we deliver care and changes that we all know that occur on a higher level in society and with insurers and with Congress, I think it's going to be a continuous process to some degree. The other thing I'll highlight that Dave also mentioned is that, you know, I think taking too monolithic a view of things like transformation really undermine the nuance that impacts patients, not nuance for nuance's purpose. And I think a lot of docs and clinicians can appreciate this. Dave mentioned vulnerable populations. When we say things like paying for volume is not good, what sits underneath that but is not called out explicitly and I'll do it now, is that for some , in some place, in some circumstances, that's wasteful. And we probably shouldn't do that. But for other people and other populations in other settings and other situations, they don't get enough of it. And we see that a lot. And since we've used the joint replacements condition as an example, we know for example, that there are huge racial disparities and that racial minorities and ethnic minorities do not get joint replacement at the rate at other patients do. So to say that we need to stamp out variation and reduce and curb the volume is true at a high level, but it misses that finer point. And so I think how do different organizations and clinics and doctors, how do we continue to deliver the UW way here locally, and how do people around the country do that in a way that respects that nuance. I don't think that there's, you know, December 15th on this year, we'll get there. I don't think it should be that way because we face different patients in different markets in different communities. So there is a continuous process. I think taking too high and too lofty a view, it misses that really important nuance that matters to patients.

Josh: Given that this is a continuum, you mentioned data and metrics, what is success? When you come to work every day, when do you say this was a good day?

Dr. Josh: Success is not at the end of the week, I said I gave this antibiotic five times. That misses the human interaction of seeing a patient. What success is though is when I interact with that patient, I thought not only of the things that I have been trained in medical school to think of, the risks and benefits of that medication or that procedure, or that intervention. But then also, how do I understand this patient in the whole population of

patients that I take care of and are taking care of at UW Medicine. And that to me, if I can step back and say, that that was done, at the end of a day, for me, I consider that a day well spent.

Dave: I'll tell you a win for me. So I was on call this weekend, very busy day in the operating room, and I was doing rounds on a patient who had a bowel obstruction, and I went in the room and I was tired and I was kind of moving through things quickly. And I talked about the next step for the patient's care and the patient said, but I'm on the pathway over there, and pointed on the wall and there was this pathway for the management of bowel obstruction, and was able to really be engaged in their own care and actually correct me and say, actually the next step is this move. And they were totally right. And to me that was the system working to really take care of this patient and not relying on any individual doc or nurse to remember what the right thing to do, but really making sure that the system, because it existed, and that the patients felt empowered that they were part of this whole deal, that to me is a huge win. I was part of creating that bowel obstruction pathway but I had forgotten. And the nice way that the system can work is if it doesn't rely on my memory to work effectively. And that's just one simple example of the way you move from being able to hope a system takes care of you, to the way you trust the system will take care of you, and that's what we're building towards, and every little example like that is another step in the right direction.

Dr. Josh: The thrust of what we're trying to do though is to protect that hybrid that I think Dave was describing, which is that there are things that are not reproducible through policymaking and legislation and financing and insurance companies. That's between you and the patients you take care of. That said, there's room for us to move forward and to do the things we've been talking about. To think about the care we provide, to think about populations, to think about the value of innovation, to think about standardization. That's an opportunity. That's not a turn of phrase, that's a true opportunity. And there are mechanisms like bundle payments and others that create the room for us to do that, but we have to step up and do that. So I think that concern is a thing that can happen in a passive way, but engagement is the thing that requires active motion. And so to that, I would say there are people working on it. We need, and we want, every doc engaged in that. And there's an opportunity here.

Dave: This is a never-ending journey that we're on and it's one that we've been on for quite some time. The exciting part about it I think is that the conversations changed. It's no longer about how do we generate as much revenue as a healthcare system as we might by prescribing those drugs, it's about how do we think about really servicing the population of patients who really are trusting that UW Medicine is going to do the right thing for them. And I think that's the exciting point too because it's changing the whole dynamic of us as a healthcare system. One that's just about providing services to one that's caring for a population and I think that's where UW Medicine is really going to move in the next decade.

[Musical break]

Josh: Dr. Dave Flum, Dr. Josh Liao, thank you both so much. As an end user of UW Medicine, let me just say that this conversation has left me feeling so much more comfortable, confident and optimistic about the future and I love that everything in here says patient-centered, because it's all about me, your humble host, so thank you both.

Dave: Thank you.

Dr. Josh: Thanks for having us.

Josh: That's gonna do it for this edition of The Transformer. And over the coming months, we'll go much more in-depth and learn how care transformation is driving all of the necessary changes across the entire UW Medicine system to improve our delivery of patient care and provide better outcomes and value. We'll hear from more physicians, clinicians, the frontline workforce, everybody who is involved in making care transformation successful. I'm your host, Josh Kerns. Thanks so much for joining us and we look forward to speaking with you again soon on The Transformer: the UW Medicine Care Transformation podcast.

[Musical outro]