The Transformer: the UW Medicine Podcast
Episode 10: What's Value-Based Care, Anyway?

Opening Soundbite: Yeah, I mean I think ideally we're trying to get the patients to a place where they're feeling more empowered about their own healthcare and their feeling that when they are receiving health care services they're getting better value for that care so that they're feeling like they're getting the quality of care that they need, the access to care that they need, but at an appropriate cost.

[Musical interlude begins playing]

Josh Kerns: Greetings and welcome to another edition of The Transformer: the UW Medicine Care Transformation podcast. I'm your host Josh Kerns. And in this, our tenth episode, we reflect on our journey toward value-based care, improving quality of care and patient outcomes at a lower cost. Welcome to both of you. Fitting that you're here on our tenth episode of The Transformer as we've come full circle back to where we started very early on in this series on care transformation. First of all, just introduce yourselves for our audience, who you are and what you do.

Cynthia: I'm Cynthia Dold and I'm the associate vice president for clinical operations for UW Medicine

DC: And, DC Dugdale, internal medicine doctor, and I work as the medical director for value-based care for UW as well.

Josh: Let's start there. Going back to the very beginning, we started this all on the premise of value-based care and care transformation. Take us back. Value-based care, what is it? Why does it matter?

DC: Well, what it is is care that's delivered in which the outcome of the care has some bearing on how much you get paid for it. Clinicians are always interested in the outcome, of course, but the idea that the payment is tied to that is fundamental to the definition of value-based care.

Cynthia: Yeah, we're seeing value-based care be more and more common in terms of what the payers are wanting to reimburse for. So, health care systems like ourselves are having to build more muscle around the ability to deliver this type of care.

DC: And from a patient's standpoint, they may think of it even a little bit moreso, because they have costs themselves that go beyond payment from insurers. So, although we may portray it as a construct that comes from payers, it really is applicable to the patients as well.

Josh: Well, let's talk about the payer. Who is it that actually controls the purse strings? Because I would guess that even within your system, people that do this for a living, healthcare in some form, don't actually understand. Maybe all of the different constituencies here, and how the money actually flows. So, first and foremost, what are we talking about in this cohort of value-based care covered lives? And then how does that actually work here?

[00:02:46] Sure, well a payer could be an entity that is self-insured and provides benefits to their employees, like a large company such as Microsoft or Boeing. A payer could be an

organization that reimburses claims for health services, such as an insurer like Premera or Regence. Or it could be a government body, such as the Health Care Authority, that is also reimbursing for healthcare services. So, a payer can come in different forms, but at the end of the day, it's really about reimbursing for healthcare services.

DC: And for patients who don't have health insurance, they're the payer. And so the category for that it is called self-pay. As health plans have evolved, I think most people know that the patient's share of the cost has gone up through what are called copayments, co-insurances and deductibles. This is terminology that most people that have health insurance will run across. And that has somewhat changed the dynamic to where patients really are more at the table around the cost discussions.

Josh: Culturally, that's been a big change in our country. And we still see it. Why should I have to pay more? It seems like we set up, I hate to use the word, but an entitlement, that our healthcare should cost very little to nothing and that's a different dynamic now, isn't it? That we're still having to get the patients on board with.

Cynthia: Yeah, I mean, I think ideally we're trying to get the patients to a place where they're feeling more empowered about their own healthcare and their feeling that when they are receiving healthcare services they're getting better value for that care so that they're feeling like they're getting the quality of care that they need, the access to care that they need, but at an appropriate cost.

Josh: How much of this is driven by or was driven originally by the employers coming to you, the Boeings, for example, and saying, you know what, we cannot continue to pay X percentage increase, therefore you will change.Or were you already, was UW Medicine, your industry looking to change at the same time that employers, for example, payers began to say you need to change the way this business is running.

Cynthia: I think it's fair to say that Boeing was really first at the table in the state of Washington to want to innovate in this space and so they put out an RFP a year back and UW Medicine was excited to respond to that and to start to move in the direction of value-based care and so saw the opportunity for what it was and won that opportunity to provide care to these employees. And so we've been doing that since 2013. So I think it's been a great partnership.

Josh: And then culturally, when you look, you started 2013 a novel concept, if you will. How has it evolved since then? Are we seeing more and more adoption and where are you at this point, DC?

DC: Well, certainly within our system, the number of patients whose health insurance is designed around value has gone up and up and up and it's now I would say the majority of patients have some component of value in how the payment works. As a nation, the same is true. And so, although our relationship with a payer, with an employer directly, a direct-to-employee relationship in 2013 was really quite I think uncommon, it's become more common and the relationship that we have with insurers around payment for value has certainly become much more common across the country, probably exceeding the degree to which it's present in our market.

Josh: It's amazing to see the amount of brainpower and work and how much it takes to change this entire world, if you will. What are the goals at the end of the day? What do you

look at as we want to accomplish A. B and C? Because, I take it, it's not just simply we want to see a lower bottom line next year, that it's got to be far more holistic.

DC: Well, I would say that everyone is interested in creating health, actually, and so medical care has some influence on overall health. But it probably actually isn't the most influential piece of it. So when you think about creating health, it's important to go beyond the medical care system. Our world, of course, is what we can do on the medical care system, that's our particular expertise and domain. In order to do that, we've embarked on many different programs that we believe, or can prove, will improve the health of patients.

Cynthia: Overall, again, it's really about making sure that we're getting care to patients in the right way, providing the right types of healthcare services at the right time, and making sure that we're demonstrating our results around that. So, more transparency around the type of care that's being given, when it's given, so that all individuals, healthcare organizations, providers involved, feel like we're on the journey together. I see a long journey of alignment that needs to play itself out. You know I think we have a shorter term and longer term goals that are in play here, but at the end of the day, this feels like a journey that is iterating itself and hopefully is feeling better to patients, feeling better to providers. Because I feel, it does feel like we are moving in the right direction, but I'd say the destination feels afar to me, but DC, I don't know if you have other thoughts.

DC: Well, I don't think that we can say that there's a given destination, that when we've arrived there, all of sudden all the work ceases. It's hard for me to envision a world in which there wouldn't always be a continual quest for improvement. If you were to think of, but I think it's a good exercise, to try to articulate you know, how would you feel, or what would you call, the job is kind of done. And I think that the best answer to that is that the health of individuals and the health of populations, collective individuals, would be as good as it could be. That's not very quantitative or specific, but that's ultimately what we're trying to accomplish. And for individual practitioners, I think most individual practitioners would say something along those lines. The question of whether spending a thousand dollars or two thousand dollars or ten thousand dollars, how does that change a person's health status? And how much more do you get if you spend 10 versus 2? That's the sort of thing that the health systems and people who buy healthcare are trying to work out. And there's pretty good reason to believe that some of the dollars that are spent don't get that much extra health and therefore probably shouldn't be spent, but figuring out what those are in the moment, and then making decisions that steers away from them, that's actually what we're trying to do. And each step may be a relatively simple step, but it is a complex system.

Josh: When we talk about milestones along the way, the measures or categories of value, what are some of those things that you look at on this journey to measure your progress?

DC: Some of the things that have been used as measurements and we do use them that are totally logical. So, for example, if you have a patient who needs a given health service, can it be delivered in a hospital or can it be delivered outside of a hospital? It's almost always less expensive outside of a hospital. Is the result as good? If you can do it as well outside of the hospital inside the hospital, people would say, well do it outside the hospital. So, hospitalization and number of admissions per year and number of days that people spend in the hospital per year at a population level is an example of a measure that's been around for quite some time. That's part of what we look at as we work to improve the health of the population and the public. There is not, however, a magic number. I can't say that we should have 50 hospital admission days per thousand per year. That would be

quite a low number. But I can't say that that's the destination. So it becomes more a matter of trying to continuously improve on where we are. In the setting of some other things, like diabetes or blood pressure control, can be a little bit more precise, and so we have quality measures for those sorts of conditions and for other conditions that have a higher degree of precision. And then we have a better sense of what the ultimate goal could be, a little bit more precise ultimate goal. So it varies somewhat based on how we're assessing things as to whether we can articulate that.

[Musical Interlude]

Josh: So what do our partners say about this process? We spoke with Dr. Emily Transue, the associate medical director of clinical quality and care transformation for the Washington State Health Care Authority. She shared with us the critical quality measures that are most important to them and their constituents.

Emily: There's always a challenge in measuring quality since there's really an infinite number of things that are part of quality of care, but you have to pick concrete and pretty concise set to represent that. We have 15 measures in our Accountable Care contract with UW Medicine and those represent a number of components of quality. We have some screening and prevention, some on chronic disease management, including diabetes and depression, and then patient experience, including how well doctors communicate. So, we've really tried to pick out important issues with a lot of impact and then represent different parts of the care continuum within the measures that we choose.

[Musical Interlude]

Cynthia: Yeah, and I would add another area that we are tracking closely is around pharmaceuticals. Making sure we are prescribing appropriate levels of generics as well as trying to make sure that if there are expensive pharmaceuticals that are clinically necessary, that we're doing what we can do to partner with our providers to make sure that we're prescribing the more appropriate alternative. So I think that's just an ongoing opportunity as we work in this phase going forward.

Josh: Speaking of pharmaceuticals, I'm thinking back to my own experience. I had Hepatitis C, was eventually treated successfully on a program that many others were not able to get approval from their payor until they were much further along with their fibrosis score, for example, their viral load. Is it a challenge for you working with these different payers who may have different definitions of what constitutes chronic, what constitutes advanced, whether it is for prescribing of medication or advanced treatments, things like that and how do you work within that?

DC: Well that's a wonderful question and it actually highlights a challenge that we have in this country. And of course this plays out within our system, which is why would a payer invest in helping a patient when the payoff is 10 years in the future and they're no longer responsible for that patient? And that is a real challenging question for many payers because they would prefer to avoid cost as much as possible. And Hepatitis C is a great example of that because certainly as the highly effective treatments of the past 10 years have come online, people have questioned what is the right threshold to use those medications and how does that play out from a payment standpoint if you're a payer? Do you spend that money now or should it be spent later on when it's more clear that the benefit might be higher? As that particular condition has played out, the clinical standard of care has evolved to where pretty much everybody is considered a candidate for curative

therapy now and any modelling that looks at the saving, the future savings, supports that notion. But that wasn't always the case. And even if, even when it does support that, the idea of who's actually paying for it, this is an example of how a fragmented payment system can lead to a kind of perverse decisions. That's not a system that we can solve as a healthcare system. Our role is to try to do the best job we can with the resources we have and provide the highest, ultimately that's the definition of value to our patients both individually and as a population. The payers, when it comes to pharmaceuticals, have a very difficult challenge in that pharmaceuticals are just one type of technology and in general, technology is going to advance and opportunities that were even unthinkable in the not too distant past, will become possible. Deciding which of those technologies ought to be embraced quickly now versus which ones should be embraced partially as more data are available and which ones simply aren't ready for primetime. We have very disorganized systems and it creates challenges for us as we work with the multiplicity of payers and database care.

Josh: So what do you do, how do how do you do that? At this day right now when you're having these conversations every day?

DC: We try to establish clinical standards that we can defend. We try to universally use those to create a UW Medicine way around them and then we try to operationalize them so that the patients who our clinicians have agreed should get treatment X, Y or Z, actually get treatment X, Y or Z. Important to remember that patients have a role in deciding what treatment they get. So I should probably call it recommended treatment rather than treatment. Ultimately there are patients who decline recommended treatments for any number of reasons, totally appropriate to do so. But that's how we do it. We try to set a standard, universalize that standard and then measure our adherence to that standard.

Cynthia: Yeah, I would add that partnerships do come into play here because often data is what's needed and we the healthcare organization don't always have the data we need to see the full picture for the patient. So sometimes that could be in partnering with the employer because they have access to data based on other pharmaceutical contracts they have in terms of how they're managing their pharmaceutical benefit. It could be partnering with outside physicians from our health system or obviously partnering with the physicians within our health system. So data, you know as we've been through this work over the years, one of the key learnings I think from that have been data is just really a conundrum often in terms of having the appropriate data you need in order to make good decisions. And I think it will likely always be the case. But I mean, I think it's been really challenging that we've managed these contracts to make sure we have good data to make decisions from.

DC: And I may be able to elaborate on what Cynthia said even a bit further. The clinician has always known that patients get their care from other clinicians too. And one thing that having relationships with both self-insured employers and insurers has helped us understand better, is what that care looks like. Most patients who are in these arrangements get large amounts of their care from outside of our system. Maybe I should say it this way, the population gets large amounts. Some patients never go outside our system. Some patients often go outside our system. When you add it all up, there's a very large portion of care that occurs outside of our system which we would have quite limited visibility into if we didn't receive information from payers. The electronic health record interoperability has improved a lot so that we can see some of that now that wasn't visible. We don't need payers to show it to us but ultimately payers do provide a more global picture of healthcare utilization than we can get on our own.

Josh: As a layperson, my perception is the insurance company, the payers, I've been under both the self-insured employee care as well as through Aetna, Premera, some others. Do you feel like they're in this with you and as you're working with these different groups that you work with specifically that they are making sure that at the end of the day that patients are getting the best care?

Cynthia: I would say that as we've created value-based contracts with two primary employers, Boeing and the Health Care Authority, they are absolutely about making sure their employees are getting good quality of care, good access to care, good coordinated care. So I believe these employers are absolutely wanting to make sure, ultimately their employees, that they're obviously paying for better value of care but that their employees are receiving the highest quality of care possible to them.

DC: I would agree. I mean I've been at many of the tables that Cynthia has been at with those self-insured employers and if there's one thing that they really want us to do is to coordinate the care. They wouldn't presume to kind of micromanage whether a specific piece of care was helpful or not helpful, etc., but they definitely want it to be coordinated and they have that expectation. Frankly, I think they have a right to that expectation, but that doesn't mean it's easy to deliver on. So I would say on that side, I completely agree. On the insurer side, actually, they're every bit as interested in the health of their members too. They don't work for the people who actually pay the insurance premiums, so unlike Boeing, or those folks, work for the company that employs the people that they're covering, that's not how insurance companies work, with the exception of their own employees. But they are actually really quite interested in and repetitively say so and demonstrate this, the health of the people that they insure. I think that they feel like healthcare shouldn't cost as much as it does. They receive a lot of pressure from the people who pay their premiums to to reduce the outlay and they can from there, kind of through their lens, they also get to the coordination question, which is why does somebody get care at a couple of different sites and is there a way to streamline that that would be to everyone's benefit. And of course the answer is not a simple one, but is there a way to simply streamline it. Yes, there ought to be. And that's a big part of what we're trying to do. Everybody's interested in paying less for healthcare but really none of the people I've run across take that as their principal driver and we know it's critical to listen to our partners.

[Musical Interlude]

Josh: Dr. Transue of the HCA told us that coordination is working.

Emily: We've been very impressed at how UW Medicine has worked on really building systems that truly improve care. Things like being able to do outreach when someone hasn't come in for care that they need and also taking every opportunity when someone is in to ensure that quality gaps are closed.

[Musical Interlude]

Josh: I want to switch gears a little bit. When we talk about healthcare, so often behavioral health, mental health is left out of the conversation. How do you integrate that into all of the work you're doing here around value-based care overall?

DC: Well if there's one thing that I think I can attest to, both as a clinician and then as somebody involved in this work at a population level, is that a person's behavioral health

has a pretty big impact on how their overall health goes, has a big impact on how they would rate their health. It has a big impact on how they choose to get healthcare and it has a big impact on how they choose to kind of carry out whatever healthcare has been recommended to them. That's been supported in the research literature for a long time. I think that a real innovation that has its roots within UW Medicine, I wouldn't want to say we're the only place that's done this, but there's a very long tradition in our system and I would give a lot of credit to some very seminal thinkers in the department of psychiatry to quantify what the effect of behavioral health status is on medical care, to quantify a person's behavioral health status so it can be managed in a way that doctors manage other sorts of conditions, and to then set up systems that deal with the situation where a person's care is not going the way it ought to or at least the way it could best go, and then figure out how to intervene on that. So that has culminated in collaborative mental health care in which behavioral health and medical care are unified in ways that, frankly, I don't think has been true in many systems. But our system has been a leader that way and every assessment that we've done has demonstrated that it's an important model shift to approach as an integrated patient-centric sort of situation.

Cynthia: Yeah, I think this area as we think about different ways that UW Medicine differentiates itself from the broader health care system, I really do think this is a really important area where we have a lot of reason to be proud of what we've accomplished. And so as DC's mentioning, when our patients are going to see a primary care provider, for example, in a UW Neighborhood Clinic, they're receiving that collaborative care model, where behavioral health is always front and center in terms of ensuring they're getting access to the appropriate care they need to support their physical health, and at the same time, their mental health. So this is also an area where the employers are actually very interested in ensuring that the work that's been done here at UW Medicine is spreading across our Accountable Care Network, for example, to make sure that our network partners are also implementing these models because they know that is what best care looks like at this point in time and they want to make sure their employees are receiving it. From their standpoint, they want the most productive employee they can to be present at work, getting the job done, they want them to be healthy, both mentally and physically, and so they're looking to make sure models such as these are being implemented.

Josh: What are the tools, solutions, improvements, are you looking at as you continue this process here? The different standardized pathways, protocols, streamlining infrastructures?

DC: I think one that you didn't mention would be telehealth and other sorts of care that's delivered outside of the context of a usual sort of medical visit. The technologies to support that has become really quite excellent. And it's a way that everybody wins as long as there's a payment stream to cover the cost of providing the service. That last part has been quite challenging over the past few decades. I think it's moving in the right direction. These value-based arrangements that we have tend to support and encourage that though they haven't gone as far as I would like it to, as I would like to see, but it is moving in the right direction.

Cynthia: Yeah, so I think what this is touching on when we think of telehealth, we're talking about, you know, maybe you're receiving your healthcare services over video, by phone, we've got a model within UW Medicine we call eConsult, where a primary care provider is coordinating on behalf of the patient with a specialist in the hopes that perhaps the patient doesn't need to leave work or their home to have to go see the specialist. It's a great example of what high-value care looks like, where you've gotten great quality care

delivered to the patient at minimal cost. So, you know, these models, this is a really important area of innovation that is iterating itself and is changing rapidly. So this exciting. It also sort of hones in on what the patient's really looking for, which is convenient care. And so when we think about those different ways that the patient is accessing care with different providers and such, I think this is for healthcare systems like our own to have built these models out as robustly as we can, is really critical because you really want to be reaching the patient without them leaving your system and telehealth really offers that opportunity. So I'd say we're doubling down in this space because we know ultimately from an access and convenience standpoint, this is really what the patient needs and wants.

Josh: And that's great that my wife always calls it the genius of and; you can lower costs and actually provide better care and more convenient care whether it's through the clinic, mobile, telehealth and all of that. And I would argue in the work I've done with you the last year and a half along, with other systems, you guys are definitely at the forefront of trying to make this as easy as possible to get whatever care I need, it does not always have to be the standard you gotta go into the office, check in and fill out your form, blah, blah, blah, which would only make this more valuable in the long run.

Cynthia: I think that's right and DC honed in on the care coordination part of this. The public is going to have access to lots of different bells and whistles in terms of this telehealth piece. But at the end of the day, if you're not staying within a health system like UW Medicine, for example, how are you ensuring that care you received from a one-off organization that was done via telehealth is coordinated with your ongoing care going forward and so there's gonna be lots of opportunities I think for patients to take advantage of telehealth, but at the end of the day, that care coordination piece I think is part of what I think we need to further educate patients around, that's helpful for them in terms of their short term and long term health, to have coordinated care across whatever conditions they're facing versus just getting quick care, if that makes sense.

Josh: Right.

Cynthia: It's a journey.

Josh: So we'll those different iterations and the different. Sometimes you are going to need to come from Yakima and go to see your O.B., or in the case of telehealth, which we profiled recently, sometimes you can visit with your O.B. via telehealth. So it's all fabulous. Speaking of conditions, specific conditions, you work, you specialize in diabetes, correct, DC?

DC: Yes.

Josh: And so I know that's one of the areas. What areas do you look at trying to see some actual tangible population health changes? I take it you can't fix everything right away. We're not going to cure cancer, go to the moon, do all of these things in one fell swoop, so where do you start?

DC: Well, so, I would say that the highest priority areas from a population standpoint actually are behavioral health and then some very common but impactful chronic medical conditions. I would list diabetes, list cardiovascular disease, particularly coronary artery disease and cerebral vascular disease, the precursors to heart attacks and strokes and the things that contribute to them, as probably the highest leverage points. Oncology care, cancer care, is super important but most of our population level work there is around

prevention of cancer rather than treatment of the fortunately relatively small portion of the population that gets cancer at any given time. So that's how I would prioritize kind of what has the biggest population impact. I kind of always come back to the behavioral health, I think that optimizing that probably has the biggest payoff. That doesn't mean it's the easiest thing to do. And I do want to mention, just be clear, that under behavioral health, they include things like addiction and dependence, too, so alcohol being the largest, tobacco and alcohol being the two largest from a population standpoint, but other conditions, drug use, opioids and other drugs, having quite high impact as well.

Josh: Do you look at working with the employer, specifically things like EAP programs, substance abuse treatment, mental, things like that, to make sure that's part of the services that you're providing them?

Cynthia: Yeah, I mean both of the employers that we're currently working with offer their services, so we're not really trying to replace those services. It's really about being complementary to any of those types of services but then because we're actually managing the care of the patients within their populations more along long term or more ongoing, you know we kind of steward that aspect of the care in partnership with whatever existing programs they've got.

Josh: All right. Roadblocks. I take it, this is not a straight line. This is not linear. I keep going back to the journey metaphor, but I take it there are roadblocks, speed bumps, hurdles along the way. What are some of the big ones?

Cynthia: Well, I mean data has been, I've already mentioned, I think data has been a big challenge for us within the employer contracts, just making sure, again, we have good timely data to figure out where the best opportunities to impact are. So, interoperability of data is I think a challenge and I suspect will continue to be, but I'd say there's some incremental improvements in that space

DC: Other roadblocks to optimizing the health of a population, I mean I would include engagement of a population. Not all patients are just kind of sitting around waiting for a healthcare system to embrace them and that's fine, but occasionally that's not necessarily in their best interest. Disseminating clinical innovation that has a high value and doing it quickly and reliably, at least from a health system operations standpoint, is a very large roadblock. I mean it's you might call it a self-generated roadblock because you know maybe we're not as well organized to do that as we could and should be, and so teasing out where those sort of organizational changes could occur and then fixing them is another tactic for reducing the height of some of the roadblocks. It’s generally known in the clinical community that changing the behavior of clinicians, how they take care of pretty much any sort of a situation is difficult and that is that's a big part of the work that I do is trying to figure out how to do that more efficiently.

Josh: Well so what, our audience is primarily internal here within UW Medicine, what do you say to your colleagues to get them on board? Why is it so important for them, what can staff do to make this effort successful over the coming years?

DC: In the years that I've been involved with this, one of the questions that I'm most often asked is, what is the UW Medicine way of doing, and then fill in the blank. And we've come a long way to be able to fill in some of those blanks. But we have a long way to go. It is absolutely correct that patient care plans are individualized, but the tendency away from

trying to articulate a best practice, which should be our default, absent reasons to deviate, that's what I would like to see our workforce engage as universally as possible.

Cynthia: Yeah, I think everybody has a role to play and access, patient experience, you know, providing input into new ways of delivering care, innovations around care. So I think there's lots of different ways people can participate in this process. And it's absolutely an all hands on deck approach. Value-based care is here to stay. And so I think for people to get themselves educated around what it is and what UW Medicine's doing around it, such as this podcast, is great because I think you know sometimes in healthcare, terminology you know it can be confusing and can be challenging to sift through. But I think at the end of the day, for people to listen to podcasts like these and get educated in the space is necessary and helpful.

Josh: So when you guys go home at the end of the day, when you go home today and you're asked how did your day go, how are things going with care transformation, what do you say? How are you feeling about where we're at right now?

Cynthia: Oh, you know I feel like we've accomplished a lot. As DC said, over the last number of years, it's really been a true partnership with employers, with the insurers, with providers. You know it's been fun to be a part of. And I think it's absolutely exciting. You know I had been out of healthcare for a while and one of the reasons I wanted to get back into healthcare directly is because this wave was kind of coming and coming into play and I wanted to be a part of it. And so I think we have a lot to be proud of but we have a lot of work to do.

DC: I've been in health care continuously since the mid 1980s. So the chance to see our system become more patient-centric while at the same time paying attention to how things play at the population level has been really good for us.

Josh: Lastly, is there anything we haven't touched on, anything you want your colleagues to know?

DC: There is an issue that often comes up which is, what is the provider, the care team, the clinical, and frankly, all employees of our health system, what is their work life like and how does this work impact them? How some people have called it the fourth aim of the quadruple aim. And my hope is that as we can articulate the promise of this sort of work that that will energize everybody who works for UW Medicine to participate in the work that they do and help with the innovation. But innovation and change is challenging and I'm certainly aware of that as well.

[Music break]

Josh: Dr. DC Dugdale is the medical director of value-based care. Cynthia Dold, associate vice president for clinical operations, thank you both so much and we look forward to visiting again.

Cynthia: Thank you.

DC: Well thank you very much for your time.

Josh: And that's gonna do it for another episode of The Transformer. I'm Josh Kerns and we'll talk again soon as we explore more of the transformative work you and your UW Medicine colleagues are putting into practice. Thanks so much for listening and take care.