The Transformer: the UW Medicine Podcast
Episode 4: Where the Rubber Meets the Road

Opening Soundbite: This is not business as usual. This is not what we've done in the past. We can't do that. If we continue to do that, then we're going to be significantly constrained in in delivering the care that we all aspire to deliver. So this is different than what we've done in the past.

[Musical interlude]

Josh: Greetings and welcome to another edition of The Transformer: the UW Medicine Care Transformation podcast. I'm your host Josh Kerns. And, in our previous episodes, we've talked a lot about the hows and whys of care transformation, focusing on things like standardized pathways, value-based care, improved outcomes and the other critical components of the UW Medicine way. Underscoring all that, though, is the reality that at the end of the day, there are a number of significant factors driving the need for change whether any of us like it or not. The list is a long one. You've got lower reimbursements, changes in commercial coverage, increasing costs, federal and state funding cuts, a new era of competition and so on and so on. So, we're calling this episode, "Where the Rubber Meets the Road." We're gonna open up the books, have some frank financial talk with the goal of us all better understanding the challenges but also the opportunities that lie ahead. And it's all about why we all have a huge stake in making the care transformation effort successful. I promise though, it won't be nearly as painful as it sounds.

Gentlemen, first of all, welcome, such an important conversation today. Because really, at the end of the day, without firm financial footing, none of what we have talked about in this care transformation effort or the institution itself can function. And Dr. Dean, let's start with you. Introduce yourself, tell us what you do and your role in this initiative.

Larry: Larry Dean. I'm an interventional cardiologist here by training but my involvement in this is the physician lead for the process we're going to be talking about. A little bit of background. I moved here the first time many years ago and then came back here in 2000 around the interest that we had at that time of building a cardiovascular service line. So most of my work in the last almost 20 years has been around that.

Josh: And what brings you to the care transformation initiative, financial improvement. Taking a look at this versus just hearts.

Larry: Well a larger interest. You know, when I got here, UW Medicine did not exist. It now does exist. So there's this notion of we're a system I think was intriguing. Many of the physicians and others will be listening to this have been involved in some of these efforts in the past but it's been kind of one particular practice, one particular hospital. The thing that intrigued me about this is it's not just about these single practices, not about a single hospital, it's about the system and trying to do something with the system

level from a standpoint of the products and to some extent the services that we deliver across the systems. So that was the intriguing part of this to me.

Josh: And Erik.

Erik: Hello everyone. Erik Walerius here. I'm the Chief Supply Chain Officer for UW Medicine. I've been in my role for just shy of four years. Prior to that I was up at Northwest Hospital for seven years in a variety of leadership role capacities. So my responsibility is obviously overseeing the supply chain for UW Medicine. Our team works very closely with Dr. Dean and the Clinical Product and Smart Innovation work. But another big area of focus is our non-clinical products and purchased services work. And so, as Dr. Dean touched on, us coming together as UW Medicine as a system is really yielding a lot of opportunities to standardize and identify all the different things that we purchase and services that we have, from whether that's HVAC maintenance or security to freight to various clinical purchase services that support our clinicians. No surprise. We have four hospitals and medical centers. And oftentimes we have four different ways that we approach things, so our focus is how do we standardize that and how do we do that in obviously the best interest of UW Medicine.

Josh: In layman's terms, I'm just thinking about, SKUs, like if this was retail. Just for a hospital, I mean are we talking thousands and thousands of individual things that are purchased here?

Erik: Absolutely. We have an item master that is in excess of 60,000 items. You know you can slice that multiple ways of what ones that we actually used in the last 12 months. That cuts in more than half. But you look at again the overall spend of UW Medicine, and you know, north of 900 million for products and purchase services. You can see that there is a lot of variation and a lot of opportunity for us to identify what is in the best interest from a system lens that obviously supports our clinicians and patient care.

Josh: You can't just go to Amazon Prime?

Erik: Funny that you say that because we recently launched a Amazon program, a partnership with Amazon, to identify what we call our tail spend. So there's all these one-off vendors that we will order one or two things with throughout the year. We've identified that going to a marketplace such as Amazon, people are familiar with that experience that that actually drives some significant cost savings by making them more efficient for the end users but also for us to be able to track and manage that type of spend.

Josh: And then on the other side of the coin, we were talking one of the biggest areas of expenditure, obviously, is in pharmacology in all of the myriad medications and Steve that's your department. Introduce yourself and tell us your role here.

Steve: Yes. Thank you. My name is Steve Fjalka. I'm the director of pharmacy for Harborview Medical Center. I've been with UW Medicine for over 30 plus years and most of that time in various leadership positions across pharmacy at several of the different sites. I've been fortunate in my role to work with pharmacy leadership and pharmacy staff as well as providers, nursing and other clinical healthcare providers that work to really manage, you know as you mentioned, a very expensive resource and I don't think everyone realizes the cost the medications and the expense that the institutions maintain with this valuable resource. And you know it is our job to manage these medications across, making sure that we're getting the best value for our dollar as well as get the outcomes that we all and our providers expect to receive. So we're managing those FIT initiatives across and we're involving each of our organizations as well as pharmacy staff and those outside of pharmacy on these initiatives.

Josh: And you just mentioned FIT. For those maybe who don't know the acronym, Financial Improvement and Transformation. And why is this, I think we need to set the stage, first and foremost, which is why is this so critical, why is the financial portion of this really a cornerstone of wherever we go from here? Maybe just set the stage for us a little bit, doctor.

Larry: So, a great question. I think that, I don't like the word burning platform, but we have a financial imperative here which we've never had like this before. And so as we look at UW Medicine, this financial imperative that we're faced with, we have to solve and we're being given the opportunity to solve it. And I think that's a great position to be in because then we can go forward and come up with the things that we think will solve this problem rather than someone else telling us how to solve the problem. So I think we have this imperative to improve our financial performance and we need to be innovative about this and one of the things that sort of brings that up is this whole process I mentioned a moment ago, and that is we're not talking about UWMC, we're not talking about Harborview, we're talking about UW Medicine. So we have an opportunity to do something different than what we've done before rather than, again, back to single hospitals or single service lines or single services, we have an opportunity to do this in a larger format. And I think that's the innovative part of this quite frankly, is that we, UW Medicine, has never really approached it this way.

Josh: And you alluded to something before which is you're a clinician, you're a doctor, you are a colleague of everybody who's listening, this is not just some faceless, nameless bureaucrat up at the top instituting something for profit. This is for the health of the system and ultimately so you can continue to deliver the best care possible but within this new world now.

Larry: I think that's absolutely correct. And I think that is, again, a different way of doing this, a different way of looking at it. The physicians and clinicians are going to be intimately involved in this process rather than having one physician potentially or no physicians in the process. This is an opportunity for us to have a significant amount of physician involvement because, at the end of the day, as you point out, what drives the cost of the care that we deliver, pharmaceuticals, supply chain, whatever, happens to

be, that's physician driven. We're the people who are making those decisions about how to care for patients and we want to look at that from the standpoint of a value proposition. In other words, we don't want to impact quality unless we obviously want to maintain that or improve that. But at the same time, there's enough variation in the system. So I think Erik was pointing out a moment ago, there are some opportunities here and we need to do this as a system so that we can have more of an impact and more of a consistent direction in the future.

Josh: So how do you. You mentioned, we talked a little bit before, Erik, trying to standardize things. Why is it so critical to get everything on one path. If I'm at Northwest, for example, or if I'm at Valley, well I've always used this for surgery or this. Why should I have to change?

Erik: A variety of reasons I'd say, echoing Dr. Dean here. Having identified, you know, a preferred vendor or preferred method certainly minimizes variation from our clinicians and all the support staff to understand all the different various tools and equipment that is needed. So if we can drive some standardization, that certainly provides a lot better and more efficient experience for our clinicians from my opinion, but also it helps us leverage purchasing power. So, us aggregating our volume, we're able to go out to market and get that much better pricing with our vendors as opposed to having fragmented or you know multiple vendors that dilute what we're able to go out and leverage from a purchasing standpoint. So really, it's multiple facets or avenues that allow, you know, the value of having standardization. Our priority and our focus that we ensure that we don't lose sight of is really three things. Obviously, as Dr. Dean echoed, patient safety is truly paramount for us. And so, what are we doing to ensure that all our purchases align and is in the best interest to support our clinicians to ensure high patient safety. Obviously quality is another area. So you have multiple products, multiple variations. Again, it's that much harder to manage, you have that much more inventory you need to be stocking and then also obviously cost effectiveness. So those three areas to ensure that we're addressing all of those and really have, to Dr. Dean's point, our clinicians be the driving factor and the voice of that. Supply chain is a partner in that. But we have only minimal clinical input and, obviously, experience so we are looking for our physician and clinical and nursing leaders to really drive what is in the best interests of our patient. We're there as a partner to help facilitate and, obviously, identify from a data perspective, where there's opportunity, but really have our clinicians make those decisions.

Josh: So it is very much a team effort. You're not just going to come in and tell Dr. Dean, sorry, you have to do it this way.

Erik: I think that that's certainly safe to say. I am not a physician and I'm going to defer to Dr. Dean and his colleagues to determine what is in the best interest of our patients. Another area I'm really excited about is the various committees that have been stood up and are working to address what is in the best interest of UW Medicine from a system lens. So again, that's not non-clinicians making those decisions. Those are key clinical leaders from our across our system that are making those decisions. And so those

voices are being heard and so they then are deciding what should be done from a standardization standpoint based off, obviously, their clinical expertise.

Josh: Steve, I understand obviously when it comes to purchasing hard goods whether it's tubing or whatever it might be, I.V. bags, some variation but when it comes to pharmacy, I know in the case you and I were talking about a treatment I had several years ago, there was nothing else on the market at the time, so I would think you have a bigger challenge in that you don't have as much choice when it comes to a lot of different medications, for example.

Steve: That's correct, at least initially, you know when they're the first on the market, there isn't a lot of options that we have. So in that case, we have to make sure we're using often an expensive resource with some rules or guidelines that, you know, we just don't open the door that all populations, for example, would get this new treatment; that we set guidelines and put forth those guidelines that are agreed upon by the pharmacy and the clinical providers in nursing and everyone to get the best outcomes, again, for our patients and be most effective. You know, again, it's just like always having different options to treat as Dr. Dean mentioned. It's also been a philosophy that the newest, the latest and the greatest and most expensive is the best product out there. That isn't always true and so we need to make sure that we do our homework, working with the clinical staff and the clinical teams, looking at the research that's out there and looking at our peers to see what they've done and their experiences, to kind of make the best decisions to efficiently use our resources, and again, to get the outcomes that we expect to see.

Erik: And, Steve, you raise a good point that I want to echo, is certainly a mantra that we have in supply chain. It's not always the cheapest product. It may be a product or a service that arguably is a little bit more expensive, but if that gets the outcomes that our clinicians are needing, and obviously is in the best interests of our patient, that in the long term is obviously providing the efficiencies, cost savings for UW Medicine.

Steve: Correct. You know as you mentioned, we also have to look at kind of the big picture. Sometimes an expensive medication while it really looks to be very expensive on the budget, may get the patient out two days earlier, which is, you know, in part when we're looking at the overall cost of healthcare for our patients.

Larry: Or may produce a better outcome as well. You know that brings up this notion that we're also going to be looking at going forward and as part of the part of the group that I'll be working with, and that is this notion of smart innovation, similar kind of concept. You know the latest and greatest tool to take care of patients and in some instances might be the best way to approach that; better outcomes, more efficiencies, better throughput by doing that, but it may just be the next thing on the block that may not really add value, at least when it first appears on the market. Sometimes we need to let that market mature before we make those decisions. So, there's going to be a process that's going to be put in place to look at some of those potentials as well,

because that's another area of significant expense to the to the system. And I think we need to be looking at that in a much more ongoing fashion, forward-looking way.

Erik: And also from a patient experience. Imagine, to your point Steve, that if a patient can be out two days earlier, you know for many patients, obviously, they don't want to be at one of our hospitals. They're sick, they need help, they want to get home. And so if there is a service or a product that can allow them to leave that much earlier, you can imagine what that is for their experience.

Larry: I suspect this has been studied someplace, but physicians are not the best at change. And so when you start talking about changing practice of something they've done for many, many years, it's difficult for everyone, but certainly clinicians, in particular. So the thing that I think will help with this is the fact that this is not me telling them how to do this, it's not supply chain telling them how to do this. This is their colleagues looking at this, so this is going to be a physician-led effort, along with the other efforts we were talking about a moment ago, so clinicians will have input into this and we're going to use evidence-base to look at this. So if the evidence is there to support maintaining what we're doing, then that's great. If the evidence is not there or if we want to bring in a new product, the evidence is not there at that point, then we're going to have a mature conversation about that. But it's going to be physician-led, clinician-led to make those decisions.

Josh: And Steve, you, for example, going back to, because it speaks to a lot of experience that a lot of patients have, I mean, you have your hands, at least one hand tied behind your back, because insurers dictate so much of what is covered, especially in pharmacy. How do you deal with that variable there, because you can't tell an insurer what to cover, what they can't cover. You're working almost with this whole separate world of change that's going on out there.

Steve: Yes, that's very true, especially in the outpatient environment where you go and your insurance, you know, tells you that you can't use Aniprazol, you have to use their product. And so that does add a certain amount of complexity to the decisions we make. You know, that being said, not everything is a blockbuster drug and there's many different medications out there. So we have a Pharmacy Therapeutics Committee across UW Medicine currently that looks at how we use utilize our medications, making sure that we have the most cost-effective, the most safe products on formulary. We have certain admission populations, we need to make sure we have the appropriate medications to serve those patients available. And before we make those available, we want to make sure they go through a thorough review that involves a multidisciplinary group looking at kind of the research behind that, the cost of those medications, any adverse drug reports, and so we look at the whole safety profile, all the cost and effectiveness of that medication to that committee. An example would be ace inhibitor or ARBs where we worked with a different clinical team and our P&T committee to come with our preferred items, especially when they're in the hospitals, you know we have a preferred list, makes it like you say, a little bit more challenging when they go outpatient and the insurance dictates what they could have. And we do our best to meet those

challenges. But allowing us to make that standardization across P&T committee allows us to use our tools as well through our electronic medical record and ordering system to set up templates so that kind of help the provider and their ordering process to drive out that we get to that standardization across. So you have different order templates that are built with the preferred items or we may have a specific alert for a high cost item that will lead them to specific things that need to be done or patients that need to be followed. There are certain conditions that have to be met in order to use that item. And I think one of the things that's been new that we hope to continue to see and see more of, is we used to kind of work within our own silos; pharmacy would work within our group, providers would have their decisions and now when we work through our care pathways and our care plans, and so forth, you know we have pharmacy, providers, nursing, materials, OR, everybody's at the table to kind of come up with the best plan because they all have different experiences and different you know skills and knowledge base that kinda go into the best care and most efficient care plan for that patient would be.

Larry: One of the things I think that's important for the people listening to this podcast to understand is, this is not just Larry Dean's committee. There is a structure here as well. And so one of the things they're going to start hearing about, if they haven't already heard about, this sort of these core groups, the structure here is sort of multi-tier, multilayered. It ultimately reports up to the FIT group so that there is consistency and direction around the work that we'll be doing. But the physicians that will be involved really in making a number of these decisions, are on these individual core groups. And those core groups, there are various core groups. There is one for surgery, there is one for orthopedics, there's one for spine, there's one for cardiology, cardiovascular surgery. There are several of them and they are by and large physician-led. There's one that's nursing-led because of a historical committee that we would try and use that structure. That committee is going to be reviewing this information. So the other thing that's unique about this effort here, not only is it a system-wide effort, we also have some national benchmarks here which we really never had before. We've done some of this work, I've done some of this work before, we used our own internal sources to try to figure out what the best price was for example, on a particular product. But we didn't have those national benchmarks and we're working with our consultants. We have national benchmarks. We know what these companies are paying for the same product at another institution, another academic institution on the west coast. So we had that information, so we are, with that information, we have a much better position to try to work with these vendors to get the best price we can get. And that is a unique thing that we've not done before. And, as I said a moment ago, we're not doing this just one hospital, we're doing this across the system, so we're trying to make decisions across the system with respect to this new knowledge that we will have that core group, that we talked about a moment ago, then does report up to an oversight committee, which I chair that oversight committee, will have physicians on it that come from those core groups. But at the end of the day, it's not the oversight committee. It's not the core group. It's actually the people down at the operational day in and day out patient care that have got to be involved in this as well and we're going to use the structures that we currently have, if they exist, within the different entities to really make sure that we make

decisions they can actually implement if there's an issue about the decision that's made, that there's an appeals process so that we can we can listen to the people who will be in the trenches, so to speak, to people delivering the daily care to make sure that our decisions are well-informed.

Josh: How do you begin to actually implement that then? I take it this isn't it, I don't hear a switch flipping and all of a sudden tomorrow, ok, we're doing it this way now and this is moving the tanker, not the speedboat, right?

Larry: This is a huge institution and trying to communicate to everyone about this is complicated and difficult. But I think we need to have the message, continuous message, about what we're trying to do while we're doing it and what we're going to do in the future. Change is difficult. Change is particularly difficult when you're dealing with a system as large as we are. So we've got to communicate this, we've got to be communicating directionally. We can't just be telling people what we're going to do. We have to be able to listen to people as well. Knowing who their representatives are on these various committees so they can reach out to those people to give feedback, I think it's going to be really important to make sure we get to where we need to be.

Josh: Erik, from your perspective on the supply chain side, how do you implement these new processes, all this change? How do you begin to incorporate your myriad institutions, all of these different things? Again, going back to flipping the switch, I take it this is no, we're building a big new database and one day I'm going to turn it on and everything's different. That it has to be somewhat systematic and piece by piece by piece.

Erik: Absolutely. It's not overnight. And this work we've been doing, obviously, for many years, and we've had physician engagement, but not to this level. This is truly unprecedented. And something that really excites me, the level of enthusiasm and engagement and urgency from our physicians, recognizing that we need to do things differently. We need to do things more efficiently and obviously do that in the lens of what's best for our patients. So that that doesn't happen overnight. The work, you know, behind the scenes, to make sure that this data is accurate and is presented in a transparent and thoughtful manner. Our physicians and clinical leaders, obviously, their time is very expensive and this committee work implies that they're not at the bedside or in the operating room or in various procedural areas, so I can assure you that our supply chain team takes that time very seriously and hours and hours of prep work go into each meeting to ensure that this is done as efficiently as possible. The data is correct and if it is challenged, which we certainly welcome, we are in a position where we can articulate how these conclusions have been made and have supporting detail available if indeed various physicians or nurses want to get, you know, so quote unquote, into the weeds. We are prepared to do that. So again, that does not happen overnight and there is a team behind each one of these committees and each one of these efforts to ensure we do this as efficiently and accurately as possible.

Josh: Steve, I'd take it on the pharmacy side, change is something that's been a constant in your field throughout your entire career. Does that make it any easier from a pharmacological standpoint because you're constantly dealing with new developments, new techniques, new products, changes in reimbursement, etc., etc. Or are you facing all of the same challenges that the rest of the system is facing there?

Steve: I would just suggest that change is hard for everyone. And while we've been dealing with this for years, as Erik has said, we're still trying to implement change. But the big difference I think now is we have partners across not just UW Medicine but across different disciplines. And that makes it a little bit easier. I think also having kind of a group understanding of the situation, I was very impressed with the number of my staff that have actually watched the video from Lisa Brandenburg and Dr. Pellegrini and their kind of new understanding of where we are financially. And I think that really helps as you're trying to work with your staff and outside your department on making those kind of changes. And while I think, last count we have over 20 or so different pharmacy or not just pharmacy, but medication-related FIT initiatives, staff are coming forward with new ideas, new thoughts to kind of drive out that waste and increase our standardization and kind of look at different ways that they could kind of help with the FIT initiative and I think that really helps as we try to make these changes across.

Larry: This is a multi-year effort. This is not a one-and-done. We are doing this differently than what we've done in the past and to a certain extent we're learning how best to do that. The initial involvement process is not one-and-done. This needs to become part of our culture going forward because the stresses on healthcare reimbursement, the cost of what we're doing here, it's just become something that's, for lack of a better term, the UW way, the UW Medicine way. We've got to change what we do here. This is, again, not just one approach and one time at this. It’s gotta be what we do going forward.

Josh: I thought it was interesting though, when you were talking before about the process that you have in place here, that there is, you always have the data behind you, you have all of these different constituencies coming together, that you are open to challenge, if you will. And I find that very interesting because in a lot of change initiatives, I've worked a lot in corporate America, you don't get that. It is a top down, this is what we're going to do. There may be data behind the decision making, generally though, not, and through the Smart Innovation process here, it really is a very system-wide collaborative effort here. And you have the data to back it up and you're willing to say, OK ,what do you think. Oh, okay, we'll consider that at least.

Erik: Absolutely. I think what we've recognized, again, is our clinical leaders and various clinicians across UW Medicine, they’re the experts. And so how do we facilitate to get to that finish line and we may have a preconceived notion early on that we think that that is what success looks like or that's the direction we want to head. And we have a physician, you know, participate and say, this is my perspective. This is where I think we need to go and based off of, obviously, the committee or the group, we may end up in a very different place. But I think that's the important part to recognize that it's being done

as a system, it's in a system lens and we have representation and engagement from across UW Medicine making that decision in the best interest, with the data, obviously, to provide the information, to ensure that it's informed.

Josh: And you have some very specific criteria matrixes, if you will, under the Smart Innovation initiative, Dr. Dean, that there are some very specific triggers, there are some very specific. So this is not just some arbitrary decision, oh I think we could maybe save 10 percent, but it really is based, very firmly rooted in fact, if you will.

Larry: Right, I think it's rooted in…

Josh: Science or data, whatever you doctors would use, whatever the term would be. I know there are no true facts in evidence-based medicine.

Larry: So I think, again, this is an academic teaching institution and we're all about evidence and we need to use that evidence as it exists. You know sometimes it doesn't exist, but if it exists and at least it is in a certain direction, we should use not only the evidence within the literature but also the evidence about what these different costs of these different devices and products are. Because that's part of the equation, so to speak. So we need to be more informed about all of this and I think that's what we've been talking about here. This is a different process than what we've gone through before so it will be as informed as we can make it. We have to make these decisions.

Erik: What's also really excited is, obviously, our research component of UW Medicine. So there's many areas that we are focusing in on that. We also participate from a research standpoint. So it's really, you know, us all working together in the partnership from that standpoint to identify and help produce and obviously lead clinical trials and then going back to, again, what is in the best interest for our patients.

Josh: What do you want doctors, others, everybody else working in the system, what should people be doing to actively engage in this process, participate in this process? You're in the elevator with a colleague. What do you tell them? You know, hey, I would suggest you do this, or we'd love to see you do X, Y and Z.

Larry: Well, I think that's where we mentioned earlier and that is that these committees, these core groups, there's representation on those core groups. We obviously can't have all the thousands of physicians and caregivers involved every day in this process with the time constraints. And I'm not sure we would hold such a meeting. So there have to be representatives but those representatives will be known and they should reach out to the people who are representing them if they have concerns or if they have ideas. I mean Steve mentioned a moment ago, we may have an idea but someone else raised their hand and said, hey, look I got a great idea, how do I get that before these groups. And again, we're going to communicate that, we are communicating that. So they'll know who their contacts are and they can bring that forward. So it's bi-directional as I mentioned a moment ago.

Steve: Yeah, I think it's extremely challenging. You know everybody is tapped for resources and extremely, you know healthcare is busy and everybody has a job to do, so it takes some time to take part in all these initiatives. But having that input upfront and having, you know, those discussions and conversations upfront really make it easier because it's very difficult to go back and do things and rework things. So having that input and those ideas so we could set things up appropriately and get that standardization and drive out that waste versus having that input after everything's been put in place and say, oh did you consider this, so I think it's important that we engage as early as we can. You know, again, given that everybody's busy, but it is such an important platform that we all need to work on together and you know we can't keep going back and reworking it.

Larry: I think the way I would approach this is that we have an opportunity that, we, the clinicians, have an opportunity that we've not had before, to try to inform a process that, at the end of the day, is going to make UW Medicine a stronger thing and allow UW Medicine to go forward in the future. This imperative, this opportunity is in the laps of the physicians. And again, we've talked a lot about value-based care, quality outcomes, the cost of the services that we provide. This is not business as usual. This is not what we've done in the past. We can't do that. If we continue to do that then we're going to be significantly constrained in in delivering the care that we all aspire to deliver. So this is different than what we've done in the past.

Josh: And you said something really interesting before, which is either we do this or external factors dictate what we have to do. And boy, it sure seems like you'd much rather be the ones driving this than being driven.

Larry: Yes, I think that's critical. We have an opportunity, as I mentioned, to do this right for our patients, but we have to be engaged in this process. We can't stand on the sidelines, I'm using the larger word 'we.' Physicians and clinicians cannot stand on the sidelines and either have this dictated to them, which could happen. They have to participate and it can't be participation by, I just want to keep doing what I'm doing. This is gonna be hard. And we all realize this. This is not easy but our physicians and clinicians have got to be engaged in this process or we won't be successful. And if we're not successful then something else is going to happen that we won't be very happy with, I think.

Erik: And for them to have that voice I think is so important. And I also recognize that it's, you know, some could perceive, which I don't obviously agree with, is that we're picking on our clinicians. Obviously, our spend and the resources to provide patient care is a vast majority of our overall spend but 20 percent of our overall spend for UW Medicine is in what we call our purchased services. And so those are areas, of you know, facilities and I.T., revenue cycle, accounting and finance, office supplies. We're looking across everything, whether that's clinical or non-clinical, across UW Medicine to identify how we can do things more efficiently and obviously in the best interest of improving the patient care and the outcomes and quality for the patients that receive care at UW Medicine.

Josh: I think it's really important to, as we wrap this conversation up, I have come away from each conversation that we've had, each episode of this podcast, feeling actually positive and encouraged that, yes, there is a system-wide review going on, there is change going on, but it is for the better and I think that is a very important message that needs to be left, that there should be tremendous optimism. Yes, the world is changing however, in many ways, it may be different but it could be actually more efficient, better. And at the end of the day, patient care can be improved. Everybody can still have a very satisfying career. This is not the Bataan death march, if you will.

Larry: Right. I think that's critical. The reason, that you asked earlier, why did I get involved in this. The reason I got involved in this is because it's an opportunity. I don't see this as being done to us. I think we have an opportunity to lead this effort. And I think, at the end of the day, there's a lot of enthusiasm, a lot of energy and I think we will be successful. So that's a very positive thing. And I think that's what makes me get up every morning to come to work. I mean, the opportunity to really be involved in something that I think is going to have a meaningful impact on UW Medicine.

Erik: I couldn't agree more. The level of excitement and enthusiasm that we see from our supply chain side has not existed across UW Medicine previously. So, needless to say, that urgency is there. There is research out there that shows for us to get, obviously in the best interest of our patients, is that partnership with our physicians and our clinical leaders so we have that united voice with our vendor community and we don't have our vendors going behind the back doors and trying to have private appointments and know that they can get what they need if they go meet with the surgeons or the physicians that they have established relationships with. We are one and united, you know, across a table with our vendors and delivering that unified message. That is obviously a very powerful one sending to our vendor community.

Steve: You know, a lot of what we've discussed and a lot of the ideas, quite frankly, aren't all new ideas. I think what is new is the work that we're seeing across all of our organizations as well across all our different disciplines. And I think that is very encouraging, to see that everybody is working together on this for a common goal. Again, some of these are ideas that we've identified for a period of time and we just haven't been able to make headway. And now I'm seeing real progress and I think that's very satisfying.

[Musical break]

Josh: Dr. Larry Dean is the medical director of outreach and clinical integration for UW Medicine's Heart Institute. Erik Walerius, the Chief Supply Chain Officer for UW Medicine and Steve Fjalka, director of pharmacy operations for Harborview Medical Center and one of the leads on our cost savings initiative under the chief pharmacy officer. And that's gonna do it for this episode of The Transformer: the UW Medicine Care Transformation podcast. I'm your host and producer, Josh Kerns. And in our next episode, we're going to take a closer look at another key component of the UW Medicine way – population health and population health management. Thanks so much

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