The Transformer: the UW Medicine Podcast
Episode 9: Palliative Care: Navigating Serious Illness

Opening Soundbite: For me being a good palliative care physician is being able to come in to one of the most difficult and distressing times that a patient and their family is going to experience and to try to help that awful experience be a little less awful.

[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 episode we'll touch on a specialty of which I've had firsthand experience and it means so much to me and we'll learn how important collaborative and empathetic care is in helping our patients and their families find understanding and empowerment in dealing with serious illness and end of life situations.

Josh: Doctors welcome. It's a real pleasure to have you here for such an important topic and first and foremost let's just go around the table and go ahead and introduce yourselves.

Rashmi: Sure, I’m Dr. Rashmi Sharma a palliative care physician based at the University of Washington Medical Center and I also do health services research around disparities in palliative care.

Jim: And I'm Dr. Jim Fausto. I’m the medical director of palliative care for UW Medicine.

Randy: Randy Curtis and I am the director of the Cambia Palliative Care Center of Excellence at UW Medicine.

Paula: I'm Dr. Paula Houston. I am the director of health care equity for UW Medicine.

Josh: Dr. Sharma, let's start with you. When we talk about palliative care I think in terms of the very end of life and my mother for example had cancer, she went into hospice, passed away and it was only in the last week that we really experienced that care but I understand that it is far more complex and involves so many more considerations and factors and much broader spectrum than people commonly believe.

Rashmi: Yeah exactly, I think that really is a common misconception. So palliative care is specialized medical care for patients with serious illness. And it really focuses on quality of life providing symptom management and then support for communication and decision making needs and we're thinking about how to provide the best care for patients but also how to support family members in what is a really difficult and can be a really distressing time.

Josh: In terms of this doctor, as a as a specialty, as an area that you all specialize in, is that's something relatively new, a new discipline and I would assume a growing discipline to integrate with all of the various practices of medicine?

Jim: Yes absolutely. I think you know it became an official board certification in 2008 that people could be certified as a hospice and palliative medicine physician but it's built on work that's been going on for 30 or 40 years essentially with interested parties. And I think another important element to raise is because of the subspecialty we see a greater emphasis among non specialists in improving their palliative care skills. And so that's a mission that we want everyone to have some basic level of skills when it pertains to meeting the needs of palliative care. And I think that the fact that we've become a codified specialty, we've enhanced everyone's ability to do this work as well.

Josh: The University of Washington, University of Washington School of Medicine, I understand you're somewhat at the forefront of this in developing this specialty and looking at how do we educate not only existing providers but students as well and helping to really create this entire area of practice.

Randy: You know palliative care came to UW Medicine in the early 2000s. We started our first palliative care service and the way that palliative care started at UW Medicine was with individual inpatient consult services at each of the hospitals. And in 2012 we developed this center which is now called the Cambia Palliative Care Center of Excellence to really bring together these individual services at each of the hospitals as well as the critical mass of people across UW Medicine and the University of Washington who are interested in palliative care research as well as palliative care education and really bringing them together under one umbrella and being able to collaborate with each other and work across hospitals as well as across departments and schools within the University of Washington.

Josh: What does that look like evolving a practice? This is, I mean, I understand it in all practices of medicine there's constant evolution but something where you're essentially, there isn't a manual from before…you are having to create this and work with existing systems, especially in UW Medicine, multiple systems, multiple practices, multiple clinicians of different eras, et cetera. How do you create this entire ecosystem, if you will?

Jim: It takes a village of people to do it and it requires a lot of work and a lot of buy-in. I think one of the exciting parts of palliative care but challenging parts is that we cut across cultural norms, spiritual norms, social norms. And each time you try to grow the service you have to re-norm what is acceptable and okay in various other departments, other divisions and other medical specialties and so it's a lot of work and leading by example and delivering on on sort of promises you're going to provide as far as excellent patient care and then a lot of coalition building.

Josh: You mentioned something interesting, the notion of excellent patient care and the entire UW Medicine system is undergoing care transformation, something this podcast has been focused on for a year and a half now. How do you fit palliative care in, developing a new system at the same time that the entire system is trying to change all of these old ways of doing business?

Jim: Yeah. So I think there are our technical solutions we've tried and will continue to work on around care transformation, like screening and screening tools. That is an element of Care Transformation. I think there's another body of work that we're doing within palliative care which is putting the patient and their preferences at the center of what care and how care is driven, especially in the setting of uncertainty that is transformative in and of itself, to make sure that the algorithm of care is actually built around what the patient would like and prefer given the choices before them and I think as we do that as sub-specialists and as we teach that to others and as primary palliative care techniques, that is transforming care into something that I think patients and families have asked for for years.

Josh: And Dr. Sharma, as a follow to that, the notion of the best care, the right care at the right time and in the right place, I know that there is as a layperson, the preconception that a lot of times Do No Harm extends to we're going to keep somebody on life support well beyond maybe their own wishes or perhaps their understanding and all of that. So when we talk about value based care as well, is that a part of the conversation, is figuring out when is the, what are the options and then what is the proper option so that we're not just continuing care for the sake of continuing care, delivering again the value based care, to the patient, but also what's best for the system.

Rashmi: Yeah, I think in terms of how we can provide care that is in line with what's most important to people and their families in a way that also provides value based care for the system, is kind of a natural fit for palliative care. So I think a lot of people unfortunately receive very aggressive non-beneficial care at the end of life because they aren't aware of other options or conversations haven't taken place to really understand what's important to them. And so I think that's the fundamental addition that palliative care brings that can really help us advance on this journey of how do you have a more system level approach to value based care.

Josh: Well speaking of system level then, if I go to Northwest [Hospital] versus Valley [Medical Center] versus UWMC, how similar, how common are the experiences now? How has your worked helped to standardize, if you will, the practice of palliative care?

Randy: Yeah, we've really focused at the center around educating all clinicians around palliative care. Jim mentioned primary and specialty palliative care. The center is very much focused on improving both of those things, so not not just building the specialty palliative care services and making sure they're available to patients who need them as well as their families, but also training all clinicians to have these kinds of conversations with their patients. And I really believe that it's the combination of those two approaches that it's going to make the most progress for the health care system. And I would say we've made progress that we've seen, I've seen over the last 25 years that I've been doing this, I've seen a lot of improvement in the basic primary care primary palliative care skills of clinicians across our system as well as the growth of the specialty palliative care services.

Josh: What is, I'm just curious, what is it that brought each of you to palliative care as your area of expertise? We chatted, Dr. Sharma and I talked about this before we started the interview, I'm just I'm fascinated by it. I mean, again, I'm gonna go back to my mother very quickly. I found those people that provided palliative care to be almost angelic. The compassion, the level of empathy, which is not always necessarily what we've come to experience with with some physicians who are more, just clinical, not to denigrate them in the least, but it is more clinical versus you have to be far more, it seems like, openly empathetic with your patients.

Rashmi: Yeah, so I can recall sitting in a conference room in the Harborview MICU [Medical Intensive Care Unit] with an Asian-American family and watching this attending do a masterful job of communicating in a way that was so compassionate and so supportive and I thought, you know, that's the kind of care that I want to be able to provide. I want to have that masterful level of expertise in communication at a point where people are at their most vulnerable. And so for me, being a good palliative care physician is being able to come into one of the most difficult and distressing times that a patient and their family is going to experience and to try to help that awful experience be a little less awful, by showing compassion and empathy and providing really good care.

Josh: Doctor?

Jim: You know, a lot of people believe that hospice and palliative care are the same thing but they're not. There are overlapping features but I spent a year between undergraduate and medical school volunteering with a hospice agency that provided end of life care and a home that people would move into. And that really built my understanding of an interdisciplinary team and the interdisciplinary approach taking care of people in hospice who were at the end of life but in palliative care who are seriously ill. And I think that model of looking at the whole person and having a cadre of interdisciplinary folks deliver this care is what sold me. And then I think I fortunately had some aptitude for it too which has allowed me to continue to do this work and excel at times.

Josh: And, Doctor?

Randy: I became interested in palliative care in medical school. I was in medical school in the late 80s in Baltimore at Johns Hopkins and HIV had just really hit that city and we were taking care of a lot of young men at that time who were dying in the hospital. And I just remember seeing in providing this care, which I thought was really sub-optimal substandard care, not supporting these patients and their families. And then occasionally I'd see it go exceedingly well. And I think this can go well. And yet so often doesn't. I became very interested in what makes it go well and how can we have that be the average experience not the unique experience

Josh: And Dr. Houston? He mentioned treating patients with HIV but this seems to fall directly in line with your efforts overall with providing equity, equitable care for all which would extend. It seems like it only makes sense that equity is an important part of this medical practice as well as all of the other ones that you're engaged with at University of Washington Medicine.

Paula: Absolutely. I mean we have talked about our blueprint before that was developed going on three years ago now with the three focuses under our care transformation: wanting to be a leader in decreasing health inequities and ultimately decreasing health disparities, so focusing on having our workforce decrease implicit bias, increase their cultural humility and recruiting a more diverse workforce. How we engage our communities as our partners in care is our second objective and then the third one is around our clinical quality improvements and that's where this area comes in. So we're looking at individual populations and individual issues within those populations to focus on the care being equitable for them so that they have the opportunity to have the best health outcome. So this group of people in palliative care has also asked us to come in and talk about, OK, what are the equity, diversity, inclusion issues that they should be thinking about. As was mentioned, there are lots of different cultural issues around end of life care and we want to make sure that we have staff and clinicians that understand the history of racialized medicine and how that might then affect the care that they are providing.

Josh: And Dr. Sharma, Dr. Houston referenced the cultural differences, you made the allusion to it as well…I would think that when it comes to end of life, that it is even more complex, because not only do we each have our own personal, but then we have cultural, religious, et cetera, so you have so many different strata that you have to navigate for each person, it's not all of these people want to deal with death in this way.

Rashmi: Yeah, I think that's exactly right. So it's so difficult to have these conversations when you speak the same language and share similar values and beliefs. And so when you bring in issues around cross-cultural communication, different religious perspectives, you're just amplifying the complexity and the difficulties of this conversation. And so we try so hard to be sensitive in the way that we're talking with every patient and family that we see. But if you add in issues around you know a family-centered, decision-making style, so families where they want to withhold certain information from the patient, for example, you have to be especially sensitive in how you navigate that situation in a way that still maintains trust, doesn't cause additional distress, and actually facilitates the building of a plan that's in line with those values and goals.

Josh: And perhaps for Dr. Houston or the others, as a follow to that, I take it you also have to be very conscious of your staffing, of how do you build teams that are in place so that you actually have the right person for the particular conversation, for the particularly difficult conversation when it when the time comes.

Paula: Well exactly. I mean that's why we want to make sure that we have a diverse staff that is representative of a lot of the patients that we are caring for. We want to make sure that staff understand their own identities and how that their identities and their experiences are coming into the care setting and are influencing how they might be treating and caring for patients. That's why we talk a lot about implicit bias and what microaggressions are, that with all good intentions, they are often committing in the care setting, and so we are working on disrupting all of that so that we can make sure that we have a complete and inclusive environment where our patients are having the best experience possible.

Josh: And doctor, in terms of your approach with Cambia, with the project, how do you integrate all of that? How is it that you make sure that you are accomplishing what you need to accomplish, the goals that you have set to make sure you're providing that most equitable care?

Randy: You know we've been very interested at the Cambia Palliative Care Center of Excellence in developing quality metrics that allow us to measure the quality of care that we're providing over time and so we have developed some metrics for UW Medicine that look at the utilization of care at the end of life, assessment of pain and other symptoms, communication around goals of care and are measuring those over time. We've found that over the last 10 years or so we've seen some pretty significant improvements in the care that we're providing. More communication, more advanced directives and advance care planning. We're also seeing less intensive care at the end of life for patients with life limiting illnesses. We know that many patients would prefer to die at home and yet most die in the hospital. But we're seeing gradual improvements over time in those metrics and that's one of the ways that we're looking at both the work that we've done as well as the work that we have yet to do. We've also looked at issues around equity across this care as well. We've looked at the UW Medicine system over a five year period and looked specifically intensive care at the end of life and what we've found is as many others have across the U.S., that there are important differences by race and ethnicity in the intensity of care at the end of life. Individuals who are white, non-Hispanic receive lower intensity of care at the end of life which we know is more in line with what most people would want. Minorities in our system receive higher intensity of care as is true elsewhere as well. And we've also looked at whether some of that is driven by education and by income and by access to health care and some of it is. But a lot of it is actually driven by race and ethnicity and that gets to the fact that culture drives a lot of what we want at the end of life. And so some of these differences are not disparities, but in fact some patients may actually prefer more aggressive care at the end of life. But we also have some evidence that there are also disparities in the way that we talk with patients and their families. And that we really need to find ways to address those disparities.

Josh: Working, Dr. Sharma, for example, in the hospital and, doctor, looking at analyzing how UW Medicine is doing on this front there. I've been very impressed throughout this process over the last year and a half, the willingness of leaders from the top down to say here's where we fall short. Especially working with Drs. Houston and Dawson when it comes to equity, you know, do you see areas that that the system, have you identified some place of where we need to do better in those areas?

Jim: I think there are sectors of the health care system that are opportunities for improvement. I think we've done a really good job creating sub-specialty palliative care in the hospital setting. I think we've been challenged, like many other health systems nationally, to bring that work to the community and to bring it to patient's homes and to bring it to nursing facilities that might have large populations of the patients we serve or to ambulatory care settings. And so I think, to some end, they're built into that if you think about institutional racism then you know we are only reaching the folks that reach us in the hospital and there are certain privileges that get you there and certain disparities that get you there. And so I think we have a lot of room to grow on that front.

Josh: Dr. Sharma?

Rashmi: Yeah, I think that was part of the reason that we chose to have the theme “Caring for Diverse Populations” for our Pacific Northwest Palliative Care Conference. I think to highlight some of the key issues related to accessing palliative care, unique needs of specific patient populations and how we can better address those needs and some of that as Paula mentioned, comes through understanding some of the historical patterns and kind of theoretical frameworks for equity work, kind of across health care in general. And so I think, you know, that would be an example of the way in which we're trying to increase awareness throughout the health care system of some of these issues so that we can provide more culturally sensitive and equitable palliative care.

Josh: I want to go back to earlier when we talked about standardizing care. What are some of the things that you have implemented for example? I understand there are a screening process for general inpatient hospice. For those listening, maybe highlight some of those areas, some very concrete things that you have done.

Jim: Yes, I think there are a few programs over the years that we've been able to increase the consistency and reliability of access to palliative care for patients in our hospitals. One example is certain patients with advanced heart failure will get something called a ventricular assist device that essentially helps the heart and those patients have great outcomes often but sometimes have complications and we recognize that is a population of seriously ill patients that could benefit from just an automatic palliative care consult. So almost all of the patients at UW Medicine that are evaluated for this device get a consultation from our team to make sure that their advance care planning is in place and they and their loved ones have had thoughtful conversations about this. We in the last year and a half actually implemented or attempted to implement 18 different screening tools to sort of see where could we find patients in need of palliative care and then deliver more palliative care to appropriate populations. A number of those screening tools showed that we have a lot of patients with a lot of serious illness and we don't actually have the staff to meet all those needs and so we need to grow our primary palliative care. One of the tools we used was screening for patients who are near the end of life and thinking about making sure that they and their loved ones are getting access to hospice should that be appropriate in the hospital. And that was one where we showed an almost, a 200 percent increase in the utilization of hospice care at the very end of life for patients that are dying in our hospital for example. So I think we've tried a lot of things. We've, you know, there's a saying, “fail forward.” We tried and failed a lot of things but also found some successes in there. And I think ultimately we are a learning institution and a learning program that's trying to improve continually.

Josh: In a lot of cases, you're actually able to reduce services, reduce costs. So, it actually is better, it ties right back into the notion of value based care and care transformation as well, right?

Randy: Yeah I think that's right. I think that what we find is that if we have conversations with patients and their families about what's happening about their prognosis and support them in thinking through the options, that they have, they often choose less aggressive care at the end of life. They choose to be at home, they choose to have less intensive surgeries or chemotherapies, and so forth, and so improving the quality of care, improving the quality of their lives at the end of life, is also associated with lower intensity care, a lower cost of care. And so it's a very useful way to increase the value of care, if you think of value of care as being quality divided by costs.

Josh: And do you have some very specific metrics that you are working towards, or some goals that you are working towards, that you say, this is where we're trying to get to with the system.

Randy: Working with Jim as the director of palliative care for UW Medicine, as well as the center, we've developed a strategic plan that has three components. The first component is to increase the capacity for primary palliative care across the system primarily through educational programs. We want to build systematic advance care planning programs across the UW Medicine. And then the third is really to build the specialty palliative care access, particularly in the community as Jim mentioned, and into people's homes. And then building on the continuity as well, so that patients can be followed by palliative care in the hospital, after the hospital, as well if they wind up back in the hospital.

Josh: Does this only start at the hospital level or is there a conversation to even be had at the clinic, at the Federal Way clinic [for example], when somebody is now maybe been diagnosed or even beginning a screening process for a potentially serious illness.

Rashmi: Yeah. So I think there's a great opportunity to try and move these conversations to an earlier point in time. I think right now within our system we're very focused on inpatient consultations. And unfortunately that's often in the midst of crisis. So things have really taken a turn for the worse and that's not the best time to be able to have a conversation with someone about what's important when you're in the midst of a crisis. So I think we're definitely trying to think about ways to have these conversations earlier or to support people with decision making before they're in the ICU having to make, you know, an especially difficult decision.

Josh: What is the conversation as you come in for a consult, for example, in the hospital, what does that conversation look like? How do you determine what to talk about, what to say, because I would guess it's a different conversation, again, with every patient, with every different, with every family.

Rashmi: It is a different conversation with every patient and family. We touched a little bit on how issues around culture, for example, religious beliefs, can shape that conversation and how important it is to be sensitive to where someone is coming from when you're having that conversation. And yet I think there's some universal elements to all of these conversations. So eliciting someone's understanding of their illness, trying to understand what's important to them, trying to think about who should be involved in decision making. You know those are all questions that we try and have with every patient and family that we see. It's just the way in which we might phrase something or the way in which we may choose to kind of further explore a topic maybe a little different from conversation to conversation, but those are I think some of the key elements of any palliative care consultation.

Josh: Doctors, how do you approach your work with your colleagues, with the specialists that you engage with every day, oncological, for example, you have an oncologist, you might have had previously a primary care physician, you might have a respiratory specialist, you have the RNs on duty, the PA, perhaps, all of these different people that are coming and going through this Venn diagram, if you will, of humanity, and how do you get everybody at least somewhat on the same page there?

Jim: I think as we become care providers, it’s a privilege in going to serve patients and their loved ones. As our field is largely consultative, when another physician or provider asks me for help, it’s a privilege to show up and provide that help too, so the same kind of humility that I try to walk into a room for patient and family and assess what their needs are, their understanding and what they're hoping for, that similar formula works with our colleagues, because most of the time, they're calling you because they're struggling with something, they're in a place of uncertainty and if you can step into that space, explore understanding, needs, hopes, worries, and then do that with patients and families and bring some unity to the uncertainty, that that's where we succeed. And so that would be how I approach it.

Josh: What about you Dr. Sharma. How do you, again, you're in the hospital, you're interacting with these colleagues on a regular basis, how do you get everybody at least, how do you talk to each other?

Rashmi: I think that's the great thing about being a palliative care clinician that we're constantly thinking about how can you better understand someone else's point of view, perspective, experience, and so as Jim was saying it really is nice to be able to use some of those same communication skills with our colleagues, you know…tell me more about what you're thinking about as you're weighing this question or what you're concerned about with this patient. So, being able to use some of those open ended questions that we use with our patients. I find to be really helpful with our colleagues because at the end of the day we're all on the same side. We're all trying to provide the highest quality care we can to patients and to do the right thing by those patients. And so I think that common goal is there and sometimes people are approaching that common goal with a different perspective and so we're usually able to kind of talk that through.

Randy: You know there is an epidemic of burnout amongst clinicians these days and some of that burnout has to do with how hard it is to work with patients who are going through incredibly difficult times and support them to work with their families, to care about people who are really suffering and to try to alleviate that suffering and so I think that palliative care providers throughout our system view their clients, if you will, as including patients and families but also clinicians and many times we do get calls for consults from clinicians who are suffering and who are really struggling and so I think an important part of our job as a palliative care provider is to provide support for those clinicians.

Josh: Dr. Sharma, as a physician, do you find it's difficult for some physicians to even acknowledge fallibility? The end of life is, ultimately, you are trained to save lives, to heal people and when it becomes a fait accompli, your patient is not going to make it, is that a difficult hurdle for some physicians to make to even to go there emotionally or intellectually?

Rashmi: It is really challenging because medical school is training people to save lives, to cure disease. I mean, still in training, despite I think a lot of wonderful work that's being done around communication skills, that's still kind of the take away from medical school. And so it's a big source of moral distress when you feel like all of those skills that you've learned are still not able to help this specific patient live longer. And I think that is a place where we are really able to help support our colleagues, to remind them that in addition to trying to cure disease, we are also trying to alleviate suffering. And we have so much technology at our hands and not all of that technology all of the time is doing good, right, and we need to do no harm as well. And so I think that it continues to be a challenge for many physicians and I think that's a place where in palliative care we're able to try and support our colleagues as they really wrestle with what is, you know, a really difficult place to be.

Josh: Which I would think, Dr., is such a great advantage to have the medical school here, to be able to integrate that into the training process earlier on so that you can affect cultural change way earlier in the process that could then be applied to the medical education system in general nationwide at some point.

Jim: Yeah I think that's absolutely correct. I think A) it helps train future generations. I think the other non-obvious element of a medical school and a center of innovation is that we create new ways to improve and prolong life. We also, by default then, create new ways or different ways of dying and people don't always know how to deal with that. And so having folks that can navigate the uncertainty of different paths that didn't exist 10 years ago is really critical to innovation.

Josh: There's an interesting article that was just published in CNN, which surprisingly still does other news besides politics, but very insightful and in it talked about how difficult it is for a lot of physicians to have these difficult conversations and the subject of the story was a physician at OHSU [Oregon Health & Science University] in late stage cancer and his experience with his own physicians led him to see that there were some great shortcomings and challenges and he's now working with residents and it cited some of the training methods that you have developed up here…VitalTalk and some other things…what kind of training tools are you using? How are you helping your colleagues have these difficult conversations?

Randy: Yeah, these conversations, having difficult conversations with patients with serious illness, is a skill and people can improve in that skill. But like many skills, you can't really learn how to do it unless you get an opportunity to practice. You know, you can't read a book about how to have a serious illness conversation and necessarily pick up that skill. You really need the opportunity to practice to get feedback. We've been using the VitalTalk techniques of having actors and actresses play simulated patients and family members so that trainees and clinicians in practice can have an opportunity to practice these skills, get feedback, try different things, use the opportunity to have a time out and talk about how it's going, use the option to have a rewind and try a conversation in a different way, things that's very hard to do in in in clinical work when you're dealing with real patients and families. But that can be a very wonderful opportunity to work on those skills.

[Musical Interlude]

Josh: We thought it would be helpful for you to hear what one of these VitalTalk trainings sound like. Here's a clip from one of them:

***Doctor*:** So, I have one other thing that I wanted to bring up, that's kind of planning for the future kind of thing. So, you know, at the point when death is really close, you know, have you given any thought to what kind of medical care you would want to have? I know that's a hard one to think about.

Patient: Yeah. I just know one thing and that is, I don't want to die in a hospital. I don't want to leave my home. Can you arrange that?

Doctor: So you want to be at home.

***Patient*:** I do

Doctor: So, you know what, there are some things I can do to help that and help make that happen.

[Musical Interlude]

Josh: Obviously learning this, as Dr. Curtis said, this is a learned skill and not everybody has time to go to a CME [Continuing Medical Education], etc., or wait for the next regional conference to come through a year from now. Where do you suggest your colleagues turn to begin to find some of those resources that can help them in this process?

Jim: So I'm going to answer this in three parts. I think for those, if there's learners who are out there listening, residents other fellows, and they want to do palliative care, there is a one year fellowship and that's something that one can pursue, especially if you're in the education stage or you're thinking about a career transition, we've seen a lot of clinicians do that. I think for others, who are working professionals, but want to deepen their skills the Cambia Palliative Care Center of Excellence and UW Medicine, along with the School of Nursing and School of Medicine, have what's called the palliative care training certificate. It's a nine month course that you go through as a cohort. Some of it's web based and some of it's in-person base. And I think that's a wonderful opportunity. And the last resource I'll mention is something called vital Talk.org. I think that's a huge resource, It's free, any clinician can use it. And I would encourage folks out there that just want to deepen their skills or learn more framework, that's another opportunity.

Josh: It's interesting because you obviously have to have metrics, you have to have data that says we're doing better based on X Y and Z, whether it's financial, whether it's number of patient visits to the emergency department, etc. How do you though ultimately quantify the quality of the care you are provided? Is it with families afterwards who say thank you, you made this better? I know that Dr. Sharma and I were talking beforehand, and my experience with palliative care, hospice care, at the end it made a horrible situation so much better. And I am just a huge advocate for it as a result because of that experience and I would say, that is success, even though there's no metric that says my mother lived a better last three days, for example.

Rashmi: I think one of the ways to try and assess that is this idea of goal-concordant care. So, are we providing medical care that is ultimately in line with people's values and goals? And I think that's a challenging concept to measure and to operationalize in the same way that you can look at length of stay and mortality and some of these other metrics. I think if you were going to drill down on something that is really at the heart of what we're trying to achieve, it is that idea of goal-concordant care.

Josh: As we wrap up, Dr. Curtis, looking ahead, where do you go from here? What would you like to see accomplished, both with the center, and personally as this work continues to evolve?

Randy: So, looking ahead, I'm very excited about the opportunity that we have here at the Cambia Palliative Care Center of Excellence to partner with UW Medicine, to really implement palliative care across the continuum. We're, as Jim has said earlier, we're providing high quality consultative palliative care in the hospital now, we've been working on that for the last decade. Where we really need to go next is to then integrate that care with care that's being received in the community. And I think there is a real opportunity to do that to serve the populations that UW Medicine serves, that have serious illness, in a way that extends that care beyond the hospital into the various different settings that patients with serious illness are receiving their care.

Josh: And Dr. Sharma, as you look ahead for your own work, your own goals, how would you like to see that evolve?

Rashmi: So, I think, if I was thinking about the ideal long term goal, it would be that for all the patients that we provide care for, that they can say they feel respected and that they feel heard, that we're able to think about all these issues that we've talked about related to disparities and inequities, and provide care that helps people to feel cared for, and in the context of serious illness, that's helping to make sure that people get care that helps them to achieve their values and goals and promotes quality of life for whatever time it is that they have left.

Josh: And Dr. Fausto, would your goal be that this care, this eventually becomes gold standard, if you will, beyond UW Medicine? That you are really doing work here that can become a standard elsewhere in our communities, the country, generally, have that kind of an impact on medicine in general?

Jim: Yeah, I mean, if you look at the mission and vision of UW Medicine, the University of Washington School of Medicine, it's to improve the health of the public, and part of that mission is teaching others and teaching others what ideally the best care could be and should be. And so, in that way, anyone that comes through our system we hope will carry this work with them and then the models and systems we design here hopefully would be examples for others to adopt, adapt, and provide the patients the communities they serve.

[Music break]

Josh: Well, I must say I am so moved and inspired by this conversation. Thank you all so much for the work you're doing. Dr. Jim Fausto, Dr. Randy Curtis, Dr. Paula Houston and Dr. Rashmi Sharma. Thank you all so much. And for such a thoughtful conversation. And thank you all for listening to another episode of The Transformer. I'm Josh Kerns and we'll talk again soon, exploring more of the transformative work you and your UW Medicine colleagues are putting into practice. Take care.