



America's Care of Serious Illness

2015 STATE-BY-STATE **REPORT CARD** ON ACCESS
TO PALLIATIVE CARE IN OUR NATION'S HOSPITALS

Alabama

Alaska

Arizona

Arkansas

California

Colorado

Connecticut

Delaware

Florida

Georgia

Hawaii

Idaho

Illinois

Indiana

Iowa

Kansas

Kentucky

Louisiana

Maine

Maryland

Massachusetts

Michigan

Minnesota

Mississippi

Missouri

Montana

Nebraska

Nevada

New Hampshire

New Jersey

New Mexico

New York

North Carolina

North Dakota

Ohio

Oklahoma

Oregon

Pennsylvania

Rhode Island

South Carolina

South Dakota

Tennessee

Texas

Utah

Vermont

Virginia

Washington

West Virginia

Wisconsin

Wyoming

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Preface

The *State-by-State Report Card on Access to Palliative Care in Our Nation's Hospitals* provides an analysis of whether seriously ill patients in the United States are receiving equitable access to palliative care services in hospitals. The goal is both to inform and to help the public and policymakers increase the availability of palliative care for the millions of Americans in need.

This report, an update of the 2011 edition, is the result of a collaboration between the Center to Advance Palliative Care (CAPC) and the National Palliative Care Research Center (NPCRC).

The report draws on the expertise of a research team led by R. Sean Morrison, MD, director of the National Palliative Care Research Center, Diane E. Meier, MD, director of the Center to Advance Palliative Care, and Tamara Dumanovsky, PhD, and Maggie Rogers, MPH, of CAPC.

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Introduction: The Case for Palliative Care

Decades of fee-for-service medicine have contributed to a crisis of value: the highest per-capita spending on health care in the world, without better results.

America's health care system is at a watershed moment. Decades of fee-for-service medicine have contributed to a crisis of value: the highest per-capita spending on health care in the world, without better results. Policymakers, payers and providers are now focused on how to achieve quality of care over quantity of services. Patients and families are demanding change.

The need to improve health care quality and reduce cost is urgent. The aging of the baby boomer generation is contributing to a growing population of patients who are living longer with serious and chronic illness. Millions of Americans are living with a serious illness, and the numbers are expected to grow substantially over the next twenty-five years.¹ The rate of growth of current health care expenditures is unsustainable and is perhaps the single greatest threat to the American way of life.

Our sickest and most complex patients are the ones who fall through the cracks in the system. Half of caregivers of Americans hospitalized with a serious illness report less than optimal care.² Multiple studies have shown that seriously ill patients endure untreated and recurrent pain and other symptom crises. They are seldom able to have their needs reliably met in the community, so patients and caregivers resort to 911 calls and emergency department visits, resulting in repeated lengthy hospitalizations. Hospitals are risky places for complex patients—hospital-acquired infections, medical errors, falls, delirium and complications are commonplace. Hospitals are also the costliest setting of care.

A recent report from the Institute of Medicine notes that 5 percent of Medicare beneficiaries account for fully half of Medicare spending.³ A closer look at the "high-cost 5 percent" is instructive. Contrary to popular perception, only 11 percent of the costliest 5 percent are in their last year of life, and even in this small population, many are not predictably dying and do not qualify for hospice care.

Half of the costliest 5 percent have very short-term high costs during the year under analysis, such as a major surgical procedure from which the patient recovers and then his or her costs return to the average. The remaining 40 percent of the costliest 5 percent have persistent high spending year after year because of one or more life-limiting illnesses, often accompanied by chronic debilitating conditions such as dementia, frailty or functional dependency. These patients—the seriously ill—have ongoing acute and long-term care needs from the health care system and are not predictably dying. Patients such as these are using the very costly and high-risk acute-care system of 911 calls, emergency department visits and hospitalizations because all too often, there are no meaningful alternatives. Palliative care offers a solution for this population.

What is palliative care?

Palliative medicine is specialized medical care for people with serious illnesses. It focuses on providing relief from the pain, symptoms and distress of serious illness. It is a team-based approach to care involving specialty-trained doctors, nurses, social workers and other specialists focused on improving quality of life. By determining patients' goals of care through skilled communication, treating distressing symptoms and coordinating care, palliative care teams meet patients' needs and help them avoid unwanted and expensive crisis care. Unlike hospice care, palliative care can be provided *at the same time* as curative treatments; it is appropriate at any age and at any stage of a serious illness.

Palliative care is quality care.

The underpinnings of high-quality and effective health care are expert attention to physical and psychological symptoms and communication and coordination. All too often, this is not what seriously ill patients get.

- 1 Dartmouth Institute for Health Policy and Clinical Practice. The Dartmouth Atlas of Health Care website, www.dartmouthatlas.org. Accessed May 26, 2015.
- 2 Teno JM, Clarridge BR, Casey V, et al. Family perspectives on end-of-life care at the last place of care. *JAMA*. 2004 Jan 7;291(1):88–93.
- 3 Institute of Medicine. *Dying in America: Improving Quality and Honoring Individual Preferences Near the End of Life*. Washington, DC: The National Academies Press, 2014.

Unlike hospice care, palliative care can be provided *at the same time* as disease-directed treatments; it is appropriate at any age and at any stage of a serious illness.

Typically, doctors approach medical problems with discrete organ systems and diseases in silos; their specialties determine which part of the patient they will treat. Although it is effective for single disease states, this approach falls apart when a patient has multiple illnesses and conditions interacting with each other. Seriously ill patients can find themselves with many specialist physicians, with no one coordinating their care. Families are brought to the breaking point by their inability to protect their loved ones from our modern health care system.

Palliative care teams begin by learning about a patient's priorities, symptoms and other problems—perhaps social, emotional or spiritual—and then work to ensure that the care they provide is aligned and coordinated with the needs of that patient as a whole person.

Studies have demonstrated that palliative care produces significant improvements in clinical outcomes. These include relief from pain and symptoms, less anxiety and depression, and improved quality of life for patients and their families. Patients feel supported by ongoing discussion of their greatest concerns and hopes, and are relieved to have help with difficult decision making and with knowing what to expect and how to handle it. Family caregivers feel supported and more satisfied with the care they are able to provide. In small studies among cancer, COPD and hospice patients, palliative care has been shown to contribute to significantly better survival rates.

Quality care is cost-effective care.

By establishing patients' priorities and achievable goals for care through skilled communication, palliative care teams meet patients' needs and help them avoid crises. Studies have demonstrated that such high-quality patient-centered care substantially reduces hospital costs—the largest driver of health care spending. This has the potential to save hospitals and the larger health system millions of dollars per year.

A landmark study found that patients at eight diverse U.S. hospitals who received palliative care incurred significantly lower hospital

costs than a matched group receiving “usual care.” The study found that palliative care consultation was associated with a reduction in direct hospital costs of almost \$1,700 per admission for patients discharged alive and of almost \$5,000 per admission for patients who died. For an average 400-bed hospital containing an interdisciplinary palliative care team seeing 500 patients a year, these figures could translate into net savings of \$1.3 million a year.⁴

Palliative medicine is coming of age.

Palliative medicine has become the fastest-growing medical specialty in the United States, as payers, providers and policymakers have recognized its potential to improve quality and, as a direct result of improved quality, reduce costs. Almost 90 percent of large U.S. hospitals (300 beds or more) now have a palliative care program.

Much more is needed. Millions of Americans with serious illness do not yet have access to palliative care from the point of diagnosis throughout the course of an illness. Availability is highly variable by region and by state. Even in those hospitals that report palliative care services, only a small fraction of the patients that could benefit receive palliative care. Many programs remain too understaffed and underresourced to reach all the patients in need.

Health care reform centers on how best to support high-quality patient-centered care that reduces the need for costly crisis care in hospitals. There is little room for disagreement about whether palliative care achieves these goals. This Report Card examines variations in access to hospital palliative care services at the state level to help the public and policymakers increase the availability of palliative care for all Americans in need.

The next phase of growth requires integration of palliative care into the community—nursing homes, assisted living facilities, physician office practices and home care. Without reliable and quality palliative care support in the community, patients and families will continue to resort to 911 calls, emergency departments and hospitals when the next crisis strikes.

4 Morrison RS, Penrod JD, Cassel JB, et al. Cost savings associated with US hospital palliative care consultation programs. *Arch Intern Med.* 2008 Sep 8;168(16):1783–90. doi:10.1001/archinte.168.16.1783.

Findings and Analysis: A National and State-by- State Review and Report Card

One-third of U.S. hospitals with fifty or more beds report no palliative care services, and one-third of the states received a grade of C or D.

Access to palliative care depends upon hospital size, location and tax status.

The 2015 *State-by-State Report Card* demonstrates that access to palliative care remains inadequate for millions of Americans living with serious illness, such as cancer, heart disease, kidney disease and dementia, despite continuing growth in the number of U.S. hospitals reporting palliative care programs.

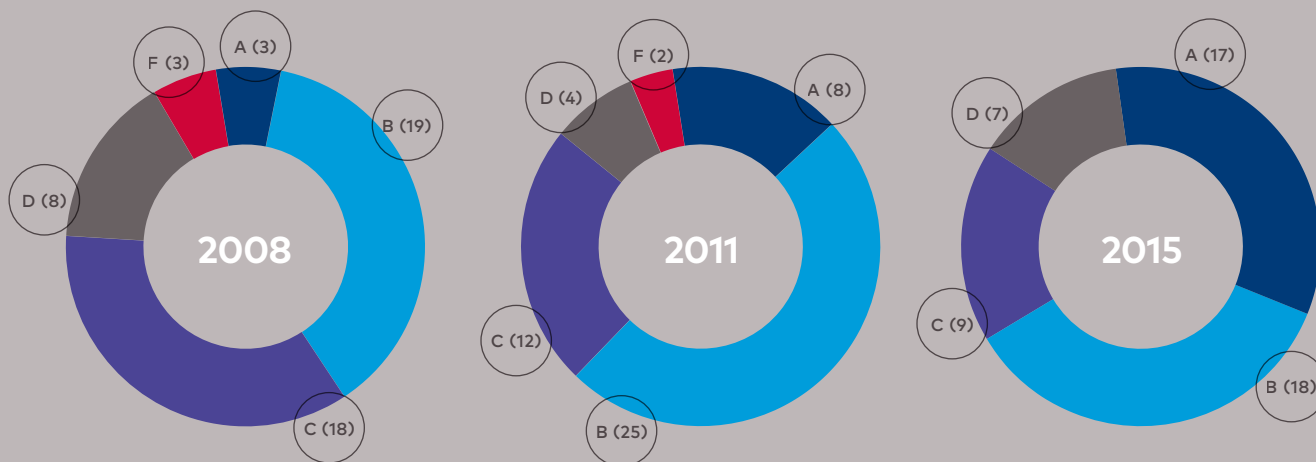
Building on our previous Report Cards of 2008 and 2011, this report tracks the growth of hospital palliative care programs across the fifty states and identifies areas where persistent gaps in access remain. Drawing data from the American Hospital Association (AHA) Annual Survey Database™ from fiscal years 2012 and 2013 and the National Palliative Care Registry™, we examine the prevalence and geographic variation of palliative care in U.S. hospitals. (*Please see page 22 for a complete methodology.*)

The 2015 Report Card shows a continued increase in the number of hospital palliative care teams in the United States: 67 percent of U.S. hospitals with fifty or more beds report palliative care teams, up from 63 percent in 2011 and 53 percent in 2008. The number of states with A grades (defined as more than 80 percent of the state's hospitals reporting a palliative care team) also increased, from 3 percent in 2008 to 17 percent in 2015, and for the first time no state has a grade of F (defined as less than 20 percent of a state's hospitals reporting a palliative care program). Important gaps still remain. One-third of U.S. hospitals with fifty or more beds report no palliative care services, and one-third of the states received a grade of C or D. The overall grade for the United States in 2015 was a B, unchanged from 2011.

Hospital palliative care teams are often overstretched and unable to see every hospitalized patient who could benefit from their services.

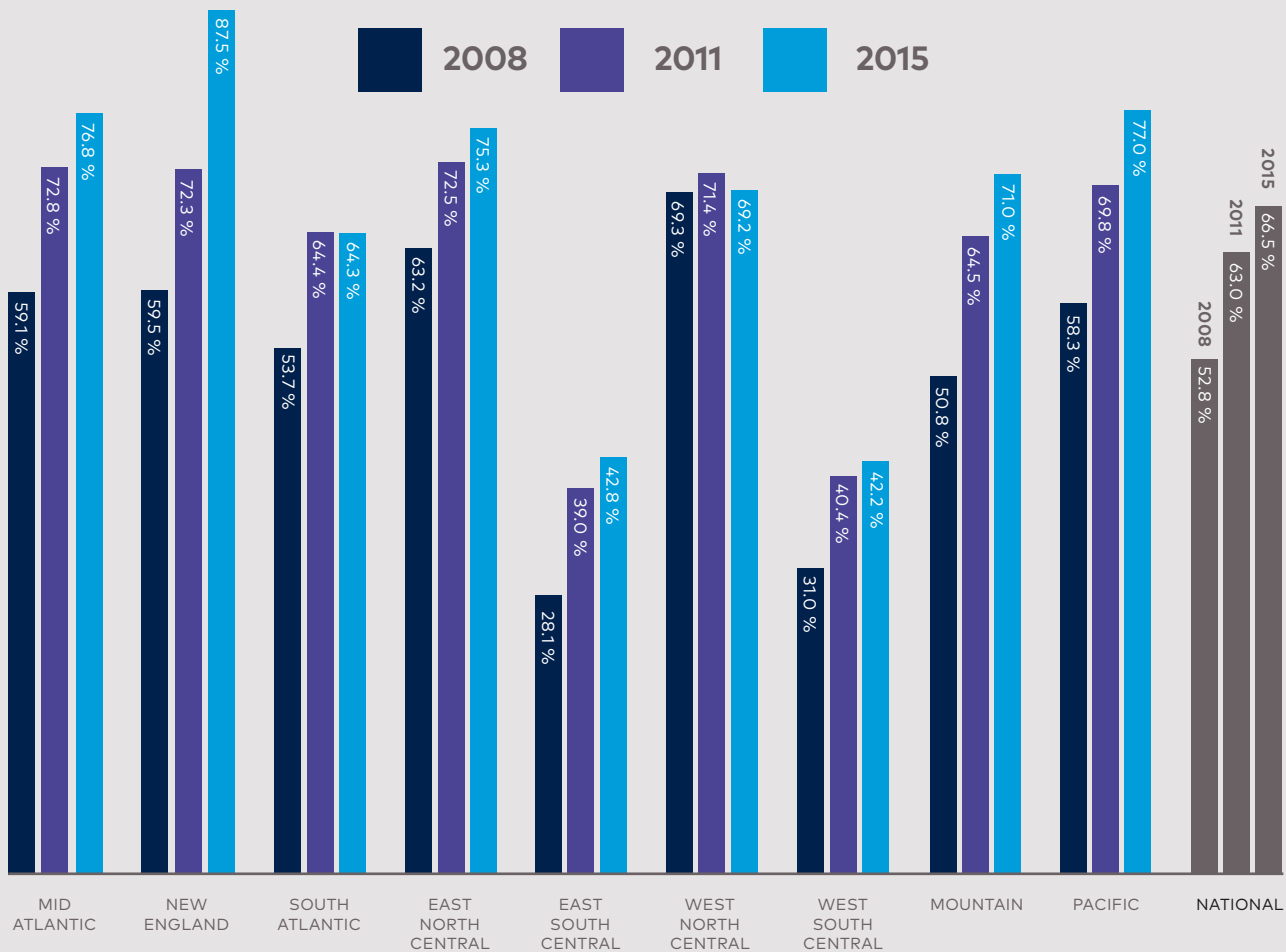
Graph A. Distribution of state grades (2008, 2011, 2015)

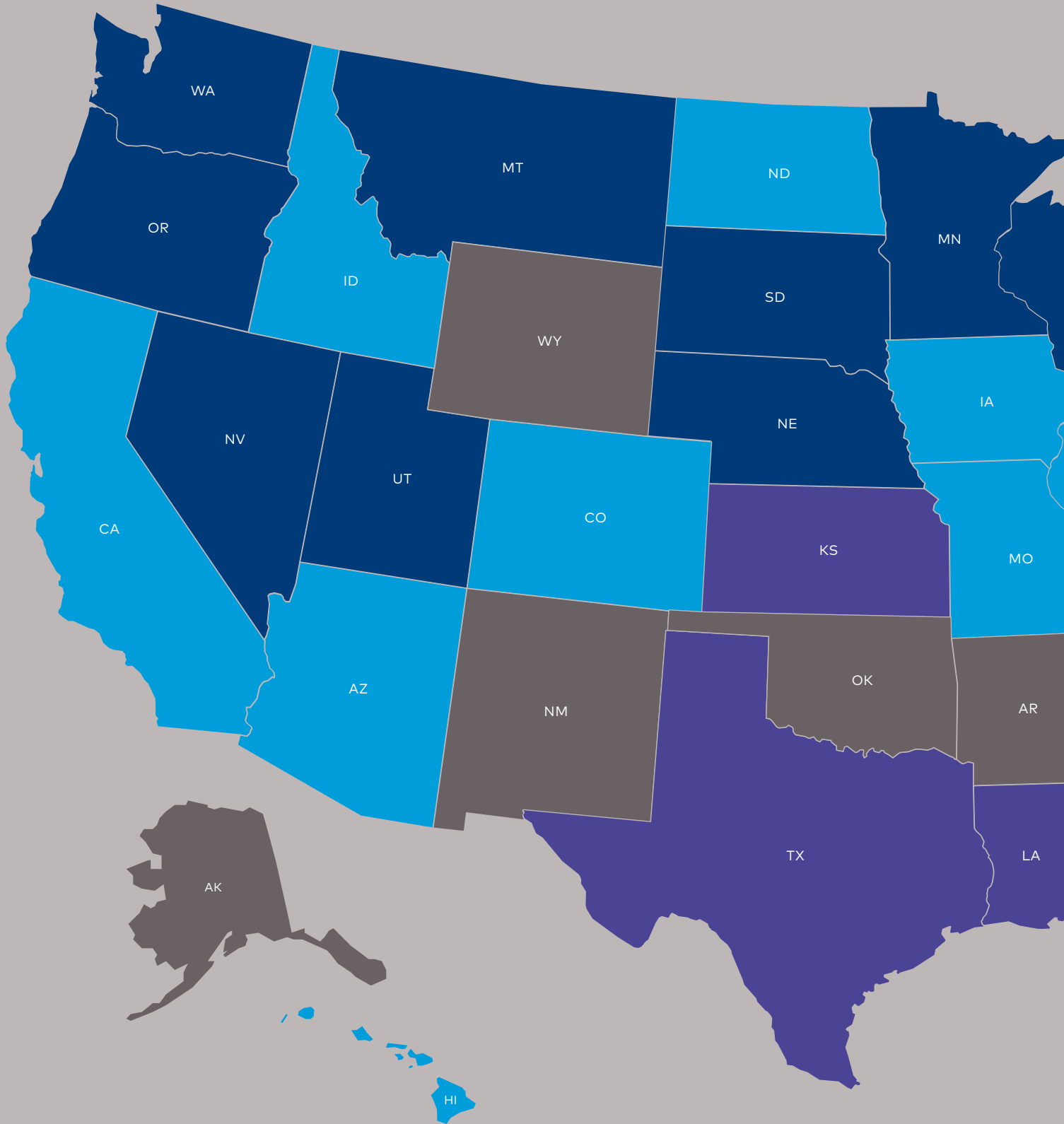
Two-thirds of states have a grade of A or B in 2015.



Graph B. Percent of hospitals with a palliative care program by census region (2008, 2011, 2015)

Most regions continue to see growth in palliative care programs.







Does your state make the grade?*

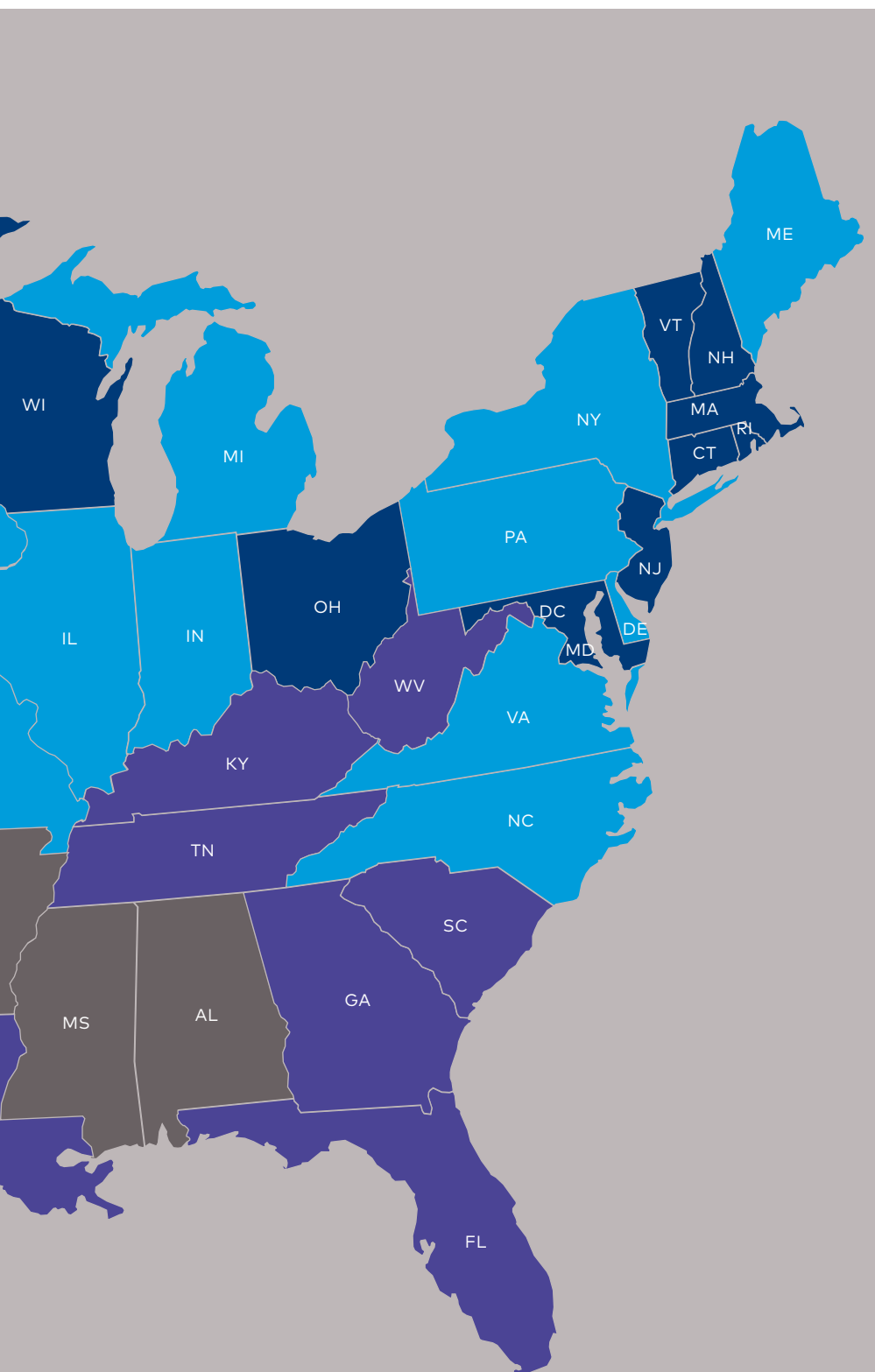
* As reported in 2013 AHA Annual Survey.

If we are to provide high-quality care for our sickest and most vulnerable patients, access to palliative care services must improve in our hospitals and in our communities.

The availability of palliative care services in U.S. hospitals varies widely by region. For example, in the south-central U.S., no state gained an A or B grade and less than one-third of hospitals in Arkansas, Mississippi and Alabama reported a palliative care team. These south-central regions are most in need of improvement.

In contrast, persons in the northeast and mountain regions have almost universal access to hospital palliative care. All hospitals in New Hampshire and Vermont report palliative care programs, as do 89 percent in Rhode Island and 88 percent in Massachusetts. Farther west, Montana, Nevada and Utah earned A grades with hospital palliative care rates of 100 percent, 92 percent and 85 percent, respectively.

Appendix **Table 1** presents detailed results by state, including hospital palliative care prevalence by hospital type (nonprofit, for-profit, and public), sole community providers and larger hospitals (300 beds or more). These data are limited to hospitals with fifty or more beds. **Table 1** also presents prevalence of palliative care programs among small hospitals (fewer than fifty beds) from the 2013 AHA Annual Survey Database™.



State grade by color:

A >80%

B 61%–80%

C 41%–60%

D 21%–40%

United States Grades by Region

Mountain

Arizona B
Colorado B
Idaho B
Montana A
Nevada A
New Mexico D
Utah A
Wyoming D

Pacific

Alaska D
California B
Hawaii B
Oregon A
Washington A

West South Central

Arkansas D
Louisiana C
Oklahoma D
Texas C

Region grade by color:

A >80%

B 61%–80%

C 41%–60%



West North Central

Iowa B
Kansas C
Minnesota A
Missouri B
Nebraska A
North Dakota B
South Dakota A

New England

Connecticut A
Maine B
Massachusetts A
New Hampshire A
Rhode Island A
Vermont A

East North Central

Illinois B
Indiana B
Michigan B
Ohio A
Wisconsin A

A

B

B

B

Mid Atlantic

New Jersey A
New York B
Pennsylvania B

C

B

South Atlantic

Delaware B
D.C. B
Florida C
Georgia C
Maryland A
North Carolina B
South Carolina C
Virginia B
West Virginia C

East South Central

Alabama D
Kentucky C
Mississippi D
Tennessee C

High-quality patient-centered care substantially reduces hospital costs—the largest driver of health care spending.

According to data from the National Palliative Care Registry™, in hospitals reporting palliative care teams, an average of 3.4 percent of admissions receive palliative care services. Estimates place the need for palliative care between 7.5 and 8.0 percent of hospital admissions. Accordingly, between 1 million and 1.8 million patients admitted to U.S. hospitals each year could benefit from palliative care, but are not receiving it.

Most large hospitals now offer palliative care services.

In 2015, on average 90 percent of U.S. hospitals containing 300 beds or more offer palliative care services. Even in this category of large hospitals, however, where you live matters. For example, in the east and west south-central region, fewer than 75 percent of these large hospitals report palliative care teams (see Table 1).

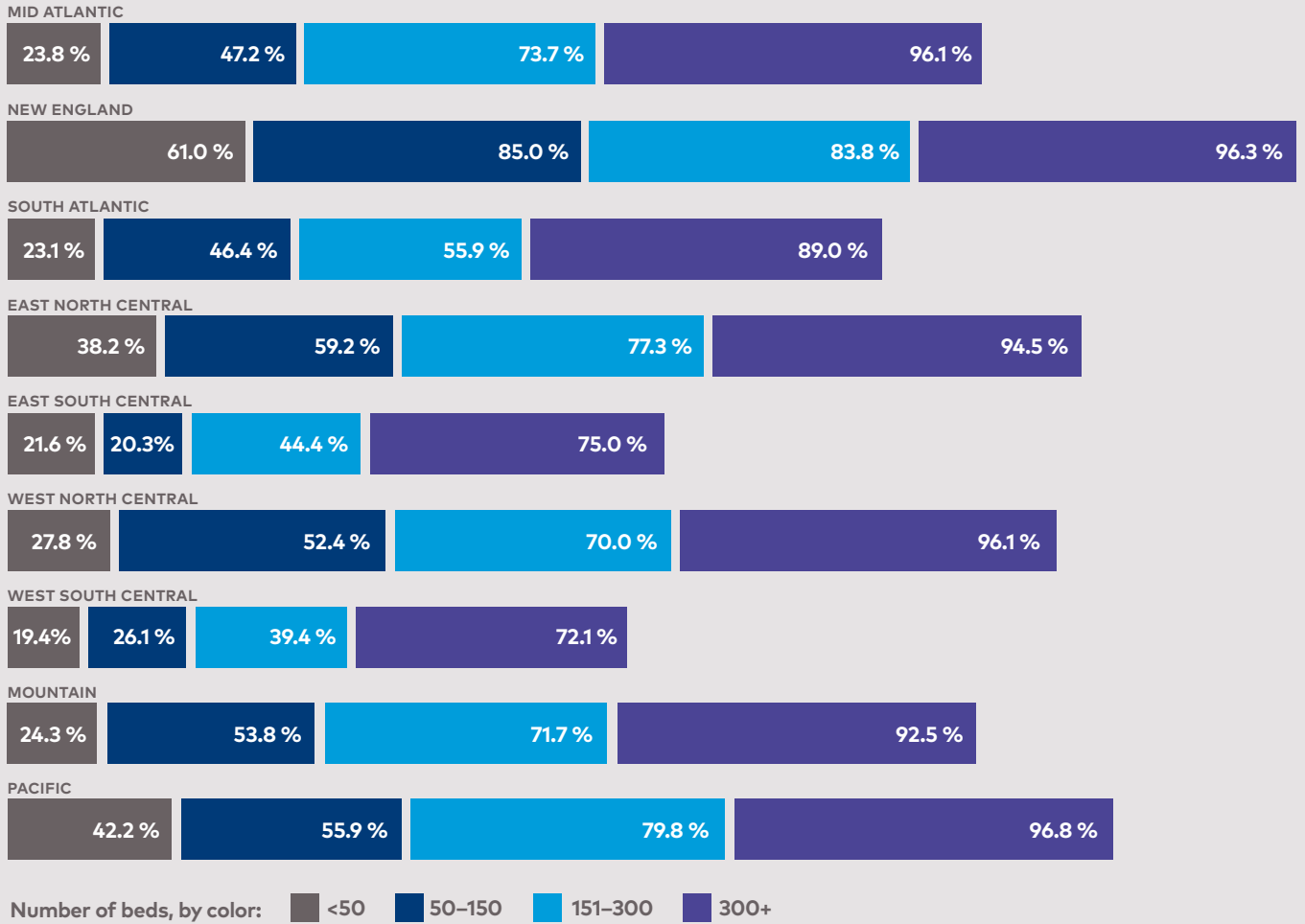
Nationally, hospitals with fewer than fifty beds and sole community provider hospitals are less likely to provide palliative care, with 29 percent and 45 percent of these hospital types, respectively, reporting palliative care teams.

For-profit hospitals report lower rates of palliative care services.

Hospital tax status is the most significant predictor of access to hospital palliative care, after geography and hospital size. For-profit hospitals of any size are less likely to provide palliative care services than nonprofit hospitals. Among hospitals with fifty beds or more, 23 percent of for-profit hospitals reported a palliative care team, in contrast to 78 percent of nonprofit hospitals and 59 percent of public hospitals. In hospitals with 300 beds or more, 54 percent of for-profit hospitals report palliative care teams, compared to 94 percent of nonprofit and 93 percent of public hospitals. In the east and west south-central regions, prevalence of palliative care teams in for-profit hospitals averaged 10 percent and 18 percent, respectively. Reasons for differences in palliative care availability in for-profit as compared to nonprofit and public hospitals are unknown.

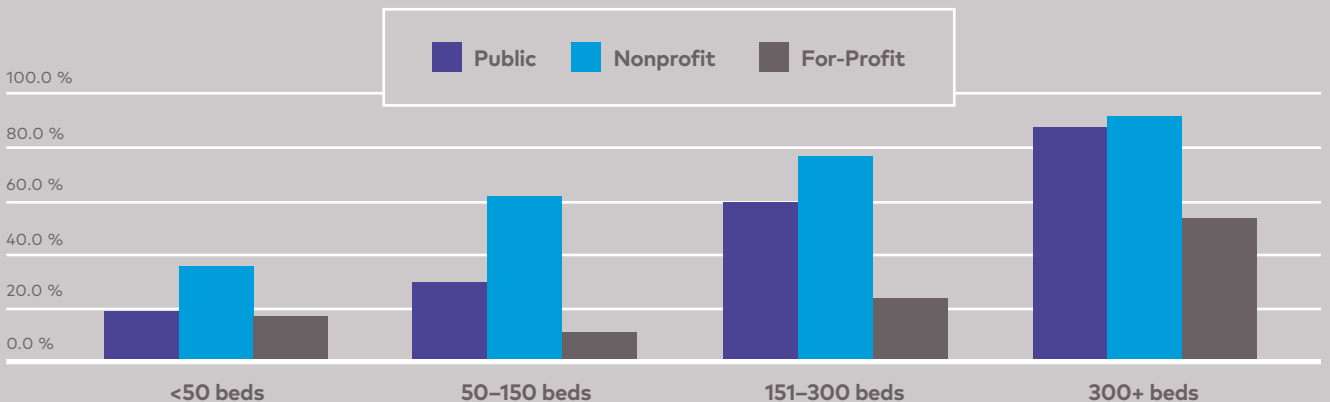
Graph C. Percentage of hospitals with a palliative care program by hospital beds and regions, 2015

Prevalence of palliative care programs increases with hospital size across regions, with some variation.



Graph D. Percentage of hospitals with a palliative care program by hospital ownership and hospital beds, 2015

Lower rates of palliative care program prevalence persist in for-profit hospitals across all hospital sizes.



A Call to Action: Policy Initiatives to Support Palliative Care

Although palliative care is associated with better quality of care and lower costs, access to it is currently limited mostly to hospitals and, for those who are dying soon, hospice.

This Report Card demonstrates continued steady growth in the number of hospital palliative care programs in the United States. Access to palliative care remains uneven, however, and depends upon accidents of geography. Millions of people with serious illness still do not receive the care they need. One-third of hospitals report no palliative care services of any kind, and access to palliative care in community settings (home, nursing home, assisted living) is limited for people who are not hospice eligible (actively dying).

Palliative care is a rapidly growing medical specialty aimed at improving quality of life for people with serious illness and their families. Although palliative care is associated with better quality of care and lower costs, access to it is currently limited mostly to hospitals and, for those who are dying soon, hospice. Making palliative care available to the much larger population of the seriously ill who are receiving care in the community settings where they live, is the single largest opportunity to improve value in the U.S. health care system. Patients and families coping with serious illness want and need access to the quality of life that palliative care provides.

The timing, demand and opportunity to expand access to palliative care are unprecedented. The public and private health care markets are under pressure to provide higher-quality care for the growing number of aging Americans who face serious and chronic disease. The emphasis on coordinated quality care has stimulated interest

Barriers to access remain in three key areas: workforce, research and payment models.

among private insurers and health care networks in solutions that are person- and family-centered and have proven cost effectiveness. Public and private health care payers are moving away from fee-for-service siloed payment systems that confound the ability of hospitals, doctors, nurses and other health care providers to coordinate the care they give their patients. Payment changes based on quality of care are pushing communities and health systems to work together to reorganize how and where care is delivered, to reach patients where they live and not just in the hospital. This new environment has led to widespread recognition by payers, providers and other influential stakeholders that palliative care is an evidence-based practical solution to improving value that can be widely implemented. Key stakeholders, including the Institute of Medicine, have recognized a need for additional training in palliative care for most doctors and nurses based on the value this care provides to patients and their families.

Barriers to palliative care access remain in three key areas: workforce, research and payment models linked to quality measures.

Lawmaker interest in promoting wider patient access to palliative care is growing. Widely supported legislation pending in Congress would facilitate research, professional development and public education in palliative care. In addition, numerous state governments are developing new initiatives and passing supportive legislation.

Federal Policy Recommendations

Interest in expanding access to palliative care is growing. Barriers to palliative care access remain in three key areas: workforce, research and payment models linked to quality measures. Below are recommendations for federal policy actions that could help overcome these barriers.

Workforce

ORGANIZATION TYPE

CONGRESS

PCORI

Patient-Centered Outcomes Research Institute

CMMI

Center for Medicare & Medicaid Innovation

NIH

National Institutes of Health

AHRQ

Agency for Healthcare Research and Quality

CMS

Centers for Medicare & Medicaid Services

recommendation:

Establish palliative care centers that would develop and disseminate curricula relating to palliative care, support the training and retraining of clinicians in palliative care skills, support continuing education and provide students with clinical training in appropriate sites of care.

who should act:

CONGRESS

recommendation:

Establish career incentive awards for palliative care physicians, nurses, social workers and chaplains to foster interest in entering the field of palliative care, and to support clinician educators who can integrate palliative care into medical, nursing school and postgraduate training curricula.

who should act:

CONGRESS

recommendation:

Reform Graduate Medical Education (GME) funding to support residency slots in high-value specialties like palliative care, and explore a GME quality-improvement program to create incentive for skills training in patient-centered communication, team-based care and pain and symptom management for all physicians, regardless of specialty.

who should act:

CONGRESS

rationale

A competent workforce is a prerequisite to delivery of quality palliative care across the health care continuum to the millions of seriously ill patients who could benefit from it.

Large-scale training programs are needed to meet a chronic shortage of palliative care specialists and fill a gap in basic palliative care knowledge and skills among clinicians of all types.

Millions of Americans are living with serious illnesses such as cancer, heart disease, frailty, functional dependency and/or dementia. This number is expected to increase over the next 25 years as the baby boomer generation reaches old age. However, recent data show there is only one palliative care physician for every 1,200 patients living with serious or life-threatening illness.

Historically there has been little focus on palliative care education in medical and nursing schools. The majority of health professionals today have had little to no training in pain and symptom management, skilled communication or helping patients negotiate our health care system.

The need to strengthen the palliative care skills of the health care workforce has never been more urgent. Supportive policy is needed to make training in basic palliative care competencies a requirement for all clinicians.

Research

recommendation:

Support PCORI, NIH and AHRQ research that focuses on symptom relief, communication with those with serious illness, and developing and evaluating models of care delivery. Support the development of innovative palliative care delivery models.

who should act:

PCORI CMMI
NIH AHRQ CONGRESS



rationale

Increased funding for palliative care research is needed to strengthen clinical practice and improve health care delivery that will maximize quality of life for patients and families facing serious and chronic illnesses.

While the growth of the palliative care field has been remarkable in the last 15 years, there is a need to strengthen the knowledge base that supports basic elements of clinical practice in pain and symptom management, communication skills and care coordination for our sickest and most vulnerable patients.

The U.S. Senate Committee on Appropriations, the National Institutes of Health and the Institute of Medicine have called for substantial investments in palliative care research.

Research is needed on the recognition and treatment of pain and other symptoms across all chronic disease categories, including cancer, heart, kidney and liver failure, lung disease, Alzheimer's disease and related dementias. Research is also needed on methods to improve communication about goals of care and treatment options between providers, patients and caregivers, care models that maximize the likelihood that treatment is delivered in line with a patient's wishes, and care models that improve coordination, transitions and caregiver support and increase the likelihood of a patient's remaining at home.

recommendation:

Develop specific program announcements and requests for applications targeted to palliative care research priorities. These studies should include populations with functional and cognitive impairment and frailty. Implementation studies should have a plan for knowledge translation into practice.

who should act:

PCORI CMMI
NIH AHRQ



recommendation:

Develop a Center for Scientific Review (CSR) study section that focuses on serious illness, beyond disease and biology-specific topic areas. Existing study sections that currently review research grant applications related to palliative care should have at least three members with content and methodological expertise in palliative care.

who should act:

NIH AHRQ



Quality and Payment

ORGANIZATION TYPE

CONGRESS

PCORI

Patient-Centered Outcomes Research Institute

CMMI

Center for Medicare & Medicaid Innovation

NIH

National Institutes of Health

AHRQ

Agency for Healthcare Research and Quality

CMS

Centers for Medicare & Medicaid Services

recommendation:

Allocate funding to develop quality measures that address communication, concordance of treatment with patient preferences and goals of care, and care transitions for those with serious illness, multimorbidity and functional and cognitive impairment, and that are applicable across settings for use in new value-based payment models.

who should act:

CMS

CONGRESS

recommendation:

Direct CMS to include palliative care measures in all relevant quality- and value-based programs, such as Medicare-sponsored Accountable Care Organization (ACO) measures, the Five-Star Quality Rating System for Medicare Advantage plans and CMS facility-based quality reporting and incentive programs. Measures should include, where applicable, both process and outcome measures to ensure that facilities have adequate resources in place to care for those with serious illness.

who should act:

CONGRESS

recommendation:

As CMMI is selecting and piloting new care models, ensure that palliative care is a component of care, quality measurement and payment for those with serious illness.

who should act:

CMS

rationale

Promotion of regulatory and accreditation requirements, payment linked to value and availability of valid reliable measures are necessary to redress inconsistencies in access and quality of palliative care services associated with geographic location, health systems and ownership, among other variables.

Recommendations for State Policymakers

- **State leadership should create a multidisciplinary** advisory board and/or task force to conduct a landscape analysis of available palliative care services to determine state capacity and develop appropriate recommendations for improving access to quality palliative care. An advisory board or task force can be created through legislation or by executive order and would coordinate with the state hospice and palliative care association. Conducting a needs assessment and gap analysis is the foundation for strengthening access to palliative care at the state level.
- **State legislatures should direct the appropriate** department to create quality standards for palliative care and insert these into the state's general licensure standards to ensure that palliative care programs operating within the state meet standardized minimum requirements.
- **State legislatures should appropriate funding** to establish palliative care training institutes in their states, ideally within an existing university health system, to develop appropriate curriculum, create requirements for training and provide opportunities for hands-on professional development. The institute should integrate this curriculum into undergraduate and graduate courses in medicine, nursing, social work and chaplaincy. The institute should also provide continuing education for practicing midcareer health care professionals.

For further state-level recommendations, please visit <https://www.capc.org/policymakers/overview>

Case Study

Colorado



In 2003, then U.S. senator Ben Nighthorse Campbell set aside a \$500,000 appropriation from the U.S. Department of Health and Human Services for the development of a palliative care institute in Colorado, the Life Quality Institute (LQI). Initially a program of the Denver Hospice, LQI was charged with developing a palliative care curriculum for third-year medical students at the University of Colorado-Denver (UCD) School of Medicine.

By 2008, it had embedded more than forty hours of required palliative care content and clinical experience into the School of Medicine curriculum. LQI and UCD also launched a unique palliative care rotation for forty physician-assistant students per academic year, comprising twenty-four instruction hours and thirty-two clinical hours at sites providing palliative care. LQI then turned its attention to educating practicing midcareer health professionals and the community. Since 2008, LQI has provided more than 200,000 person-hours of palliative care education to thousands of health care professionals, students and community members throughout Colorado.

In 2008, then governor Bill Ritter created the Center for Improving Value in Health Care (CIVHC) by executive order. CIVHC identified palliative care as one of its focus areas and convened a multidisciplinary task force to develop eight recommendations to improve access to high-quality palliative care for all Coloradans. In early 2014 the task force, together with the Colorado Center for Hospice & Palliative Care, successfully included a definition of and standards for palliative care in the state's Hospitals and Health Facilities General Licensure Standards. The standards currently lack an enforcement mechanism, presenting an opportunity for Colorado's task force to take a next step in its work to increase access to palliative care.

Case Study

California

In May 2012, California Governor Jerry Brown established the Let's Get Healthy California Task Force. Diana Dooley, California's Secretary of Health and Human Services, and Don Berwick, MD, cochaired the effort. One of the task force's strategic priorities—Health Across the Lifespan— included palliative care as a key component.

Task force leaders built on the work of long-time palliative care champions such as the California HealthCare Foundation, the Coalition for Compassionate Care of California and the Palliative Care Leadership Center at the University of California, San Francisco (UCSF) to guide their efforts. UC Berkeley's School of Public Health convened the state's health system leaders and conducted analyses to identify opportunities to create more value in health care; among the options identified, palliative care was a clear priority. All these efforts helped increase awareness and understanding of palliative care, turning key decision makers into advocates. In September 2014, California enacted a law requiring the Department of Health Care Services (DHCS) to establish standards and provide technical assistance for Medi-Cal (Medicaid) managed-care plans to ensure delivery of palliative care services. The DHCS is holding multiple stakeholder meetings to create standards, identify resources and develop an implementation plan for the legislation.

Additionally, in an effort to expand the palliative care workforce, California State University launched a statewide Institute for Palliative Care. The institute provides professional development opportunities through online certificate programs for nurses, social workers, chaplains and other health professionals to ensure that they have the skills they need to provide high-quality palliative care. It also integrates palliative care into thirty graduate and undergraduate courses across its seven partner campuses and has educated more than 2,000 community members in its first two years.

Appendix

Data Sources and Methodology

Hospital data: Data on hospital characteristics were obtained from the American Hospital Association (AHA) Annual Survey Database™ for fiscal years 2012 and 2013, and were supplemented with data from the National Palliative Care Registry™. All hospitals identified by AHA as having palliative care programs but not listed in the Registry underwent a call screening and/or web search to verify AHA's reporting. The verification process began using the 2012 AHA data, and was updated and supplemented with the AHA's 2013 data when they became available.

Analyses were limited to nongovernmental, general medical and surgical, cancer and heart hospitals within the fifty states. Where analyses are limited to hospitals with fifty or more beds, the final sample included a total of 2,393 hospitals. Of these, 2,330 completed the AHA survey; this number includes 840 hospitals that participated in the National Palliative Care Registry™. An additional sixty-three hospitals that participated in the Registry but had not submitted data to AHA were also included.

Glossary

Accountable Care Organization (ACO)

Accountable Care Organizations are groups of doctors, hospitals or other health care providers that come together voluntarily to give coordinated high-quality care to their Medicare patients. The goal of such coordinated care is to ensure that patients, especially the chronically ill, get high-quality care while avoiding unnecessary duplication of services and preventing medical errors. When an ACO succeeds in both delivering high-quality care and reducing health care expenditures, it shares in the savings it achieves for the Medicare program.

Hospice

Hospice provides palliative care for terminally ill patients who are no longer seeking curative or life-prolonging treatments and whose life expectancy is six months or less. Hospice is covered by the Medicare hospice benefit and by other payers. It can be delivered at home or in a nursing home, hospital or stand-alone facility.

Hospital categories

For-profit: Run by individuals, partnerships or corporations.

Nonprofit: Run by a charitable organization (including church-operated).

Public: Nonprofit institutions run by a state, county, city, district or other government authority.

Sole community provider (SCP): Hospitals that receive SCP designation by Medicare because they are located more than thirty-five miles from other hospitals, or they are the sole providers of health care services for a region due to limitations in local topography or prolonged severe weather conditions.

Hospitalist

Physician employed by a hospital who specializes in the care of hospitalized patients.

Joint Commission, The

The Joint Commission is the country's oldest and largest standards and accreditation organization in health care. In 2011 The Joint Commission launched a voluntary certification for hospital palliative care programs, developed under the guidance of a national task force of experts in palliative care.

National Consensus Project for Quality Palliative Care (NCP)

The National Consensus Project (NCP) represents an alliance of six leading organizations in palliative care: the American Academy of Hospice and Palliative Medicine (AAHPM), the Center to Advance Palliative Care (CAPC), Hospice & Palliative Nurses Association (HPNA), National Association of Social Workers (NASW), National Hospice and Palliative Care Organization (NHPCO) and the National Palliative Care Research Center (NPCRC).

The guidelines are intended to direct the development and structure of both new and existing palliative care teams, to establish uniform definitions of the essential elements of palliative care and to establish national goals for access to palliative care. They are also intended to promote performance measurement and quality improvement initiatives in palliative care services and to foster continuity of palliative care across settings (including home, hospital, nursing home and hospice). www.nationalconsensusproject.org

National Quality Forum (NQF) Framework

A National Framework and Preferred Practices for Palliative and Hospice Care Quality was released in 2006 and updated in 2012. Practices are defined across the Institute of Medicine's six dimensions of quality: safe, effective, timely, efficient, equitable and patient-centered. The NQF Framework used the clinical practice guidelines of the National Consensus Project for Quality Palliative Care as a starting point for identifying expectations and best practices in palliative care. www.qualityforum.org/topics/palliative_care_and_end-of-life_care.aspx

Palliative care, palliative medicine

Palliative care is specialized medical care for people with serious illnesses. It focuses on giving patients relief from the symptoms and stress of a serious illness no matter what the diagnosis. The goal is to improve quality of life for both the patient and his or her family. Palliative care is provided by a team of palliative care specialists, including doctors, nurses and social workers, who work together with a patient's other physicians to provide an added layer of support. Palliative care is appropriate at any age and at any stage of a serious illness and can be administered *at the same time* as curative treatment.

TABLE 1. Prevalence and Distribution of Palliative Care Programs in U.S Hospitals by State and U.S. Census Region

State	Letter Grade	Grade	Total Programs/ Hospitals	By Hospital Type (≥ 50 beds)			Sole Community Provider (≥50 beds)	>300 beds	<50 beds*
				Nonprofit	For-Profit	Public			
New Jersey	A	91.2	(52/57)	93% (49/53)	67% (2/3)	100% (1/1)	— (0/0)	100% (25/25)	— (0/0)
New York	B	78.1	(107/137)	76% (88/116)	— (0/0)	90% (19/21)	43% (6/14)	97% (62/64)	38% (3/8)
Pennsylvania	B	68.3	(82/120)	75% (79/106)	21% (3/14)	— (0/0)	44% (4/9)	92% (36/39)	15% (2/13)
MID ATLANTIC	B	76.8	(241/314)	79% (216/275)	29% (5/17)	91% (20/22)	43% (10/23)	96% (123/128)	24% (5/21)
Connecticut	A	84.0	(21/25)	83% (19/23)	100% (1/1)	100% (1/1)	100% (1/1)	100% (8/8)	50% (1/2)
Maine	B	78.6	(11/14)	79% (11/14)	— (0/0)	— (0/0)	50% (1/2)	100% (2/2)	67% (10/15)
Massachusetts	A	87.8	(36/41)	89% (31/35)	100% (4/4)	50% (1/2)	100% (1/1)	92% (12/13)	80% (4/5)
New Hampshire	A	100.0	(11/11)	100% (11/11)	— (0/0)	— (0/0)	100% (2/2)	100% (1/1)	64% (7/11)
Rhode Island	A	88.9	(8/9)	89% (8/9)	— (0/0)	— (0/0)	— (0/0)	100% (2/2)	— (0/0)
Vermont	A	100.0	(4/4)	100% (4/4)	— (0/0)	— (0/0)	100% (3/3)	100% (1/1)	38% (3/8)
NEW ENGLAND	A	87.5	(91/104)	88% (84/96)	100% (5/5)	67% (2/3)	89% (8/9)	96% (26/27)	61% (25/41)
Delaware	B	75.0	(3/4)	75% (3/4)	— (0/0)	— (0/0)	— (0/0)	50% (1/2)	— (0/0)
District of Columbia	B	71.4	(5/7)	80% (4/5)	100% (1/1)	0% (0/1)	— (0/0)	80% (4/5)	— (0/0)
Florida	C	58.1	(68/117)	71% (43/61)	19% (7/36)	90% (18/20)	50% (1/2)	84% (38/45)	23% (3/13)
Georgia	C	55.2	(32/58)	66% (27/41)	11% (1/9)	50% (4/8)	14% (1/7)	87% (20/23)	16% (3/19)
Maryland	A	87.5	(35/40)	88% (35/40)	— (0/0)	— (0/0)	— (0/0)	100% (14/14)	67% (2/3)
North Carolina	B	65.3	(47/72)	71% (31/44)	33% (2/6)	64% (14/22)	44% (4/9)	91% (20/22)	16% (3/19)
South Carolina	C	58.1	(25/43)	86% (18/21)	14% (2/14)	63% (5/8)	33% (3/9)	93% (14/15)	33% (3/9)
Virginia	B	76.9	(40/52)	85% (35/41)	25% (2/8)	100% (3/3)	71% (5/7)	94% (15/16)	29% (4/14)
West Virginia	C	55.6	(15/27)	67% (14/21)	25% (1/4)	0% (0/2)	50% (2/4)	100% (4/4)	21% (3/14)
SOUTH ATLANTIC	B	64.3	(270/420)	76% (210/278)	21% (16/78)	69% (44/64)	42% (16/38)	89% (130/146)	23% (21/91)
Illinois	B	72.1	(75/104)	75% (71/95)	40% (2/5)	50% (2/4)	40% (2/5)	100% (30/30)	17% (6/36)
Indiana	B	67.7	(44/65)	79% (34/43)	38% (3/8)	50% (7/14)	50% (2/4)	87% (13/15)	41% (14/34)
Michigan	B	66.7	(48/72)	67% (41/61)	100% (5/5)	33% (2/6)	40% (4/10)	93% (26/28)	24% (7/29)
Ohio	A	82.8	(82/99)	84% (76/90)	100% (2/2)	57% (4/7)	67% (4/6)	96% (27/28)	29% (9/31)
Wisconsin	A	87.7	(50/57)	88% (49/56)	100% (1/1)	— (0/0)	100% (4/4)	88% (7/8)	63% (35/56)
EAST NORTH CENTRAL	B	75.3	(299/397)	79% (271/345)	62% (13/21)	48% (15/31)	55% (16/29)	94% (103/109)	38% (71/186)
Alabama	D	32.0	(16/50)	50% (7/14)	6% (1/16)	40% (8/20)	25% (1/4)	58% (7/12)	15% (3/20)
Kentucky	C	53.1	(26/49)	63% (24/38)	0% (0/7)	50% (2/4)	50% (3/6)	92% (12/13)	25% (6/24)
Mississippi	D	28.9	(13/45)	57% (8/14)	7% (1/15)	25% (4/16)	0% (0/6)	75% (6/8)	4% (1/26)
Tennessee	C	56.0	(28/50)	79% (22/28)	21% (3/14)	38% (3/8)	50% (1/2)	74% (14/19)	50% (9/18)
EAST SOUTH CENTRAL	C	42.8	(83/194)	65% (61/94)	10% (5/52)	35% (17/48)	28% (5/18)	75% (39/52)	22% (19/88)

State	Letter Grade	Grade	Total Programs/ Hospitals	By Hospital Type (≥ 50 beds)			Sole Community Provider (≥50 beds)	>300 beds	<50 beds*
				Nonprofit	For-Profit	Public			
Iowa	B	66.7	(20/30)	72% (18/25)	0% (0/1)	50% (2/4)	50% (3/6)	100% (8/8)	26% (18/69)
Kansas	C	48.5	(16/33)	60% (12/20)	14% (1/7)	50% (3/6)	50% (4/8)	80% (4/5)	24% (17/71)
Minnesota	A	81.6	(31/38)	82% (28/34)	— (0/0)	75% (3/4)	56% (5/9)	100% (11/11)	45% (19/42)
Missouri	B	66.7	(42/63)	79% (33/42)	27% (3/11)	60% (6/10)	40% (6/15)	100% (18/18)	28% (11/40)
Nebraska	A	87.5	(14/16)	87% (13/15)	— (0/0)	100% (1/1)	100% (4/4)	100% (4/4)	9% (2/23)
North Dakota	B	66.7	(4/6)	67% (4/6)	— (0/0)	— (0/0)	50% (1/2)	50% (1/2)	35% (6/17)
South Dakota	A	88.9	(8/9)	88% (7/8)	100% (1/1)	— (0/0)	67% (2/3)	100% (3/3)	27% (6/22)
WEST NORTH CENTRAL	B	69.2	(135/195)	77% (115/150)	25% (5/20)	60% (15/25)	53% (25/47)	96% (49/51)	28% (79/284)
Arkansas	D	31.6	(12/38)	46% (10/22)	8% (1/13)	33% (1/3)	0% (0/11)	75% (6/8)	23% (6/26)
Louisiana	C	55.8	(24/43)	68% (13/19)	38% (3/8)	50% (8/16)	50% (1/2)	83% (10/12)	5% (1/21)
Oklahoma	D	34.9	(15/43)	53% (9/17)	21% (3/14)	25% (3/12)	21% (3/14)	90% (9/10)	27% (11/41)
Texas	C	42.9	(85/198)	64% (55/86)	17% (15/89)	65% (15/23)	27% (4/15)	66% (37/56)	19% (29/154)
WEST SOUTH CENTRAL	C	42.2	(136/322)	60% (87/144)	18% (22/124)	50% (27/54)	19% (8/42)	72% (62/86)	19% (47/242)
Arizona	B	68.4	(26/38)	81% (25/31)	0% (0/5)	50% (1/2)	60% (3/5)	79% (11/14)	25% (3/12)
Colorado	B	75.7	(28/37)	81% (21/26)	71% (5/7)	50% (2/4)	43% (3/7)	100% (11/11)	29% (6/21)
Idaho	B	66.7	(6/9)	80% (4/5)	50% (1/2)	50% (1/2)	33% (1/3)	100% (3/3)	40% (4/10)
Montana	A	100.0	(9/9)	100% (9/9)	— (0/0)	— (0/0)	100% (5/5)	100% (2/2)	26% (7/27)
Nevada	A	91.7	(11/12)	100% (6/6)	80% (4/5)	100% (1/1)	50% (1/2)	100% (4/4)	0% (0/4)
New Mexico	D	35.7	(5/14)	43% (3/7)	20% (1/5)	50% (1/2)	17% (1/6)	100% (2/2)	9% (1/11)
Utah	A	84.6	(11/13)	100% (9/9)	33% (1/3)	100% (1/1)	100% (1/1)	100% (4/4)	33% (4/12)
Wyoming	D	33.3	(2/6)	0% (0/1)	0% (0/1)	50% (2/4)	40% (2/5)	— (0/0)	10% (1/10)
MOUNTAIN	B	71.0	(98/138)	82% (77/94)	43% (12/28)	56% (9/16)	50% (17/34)	93% (37/40)	24% (26/107)
Alaska	D	25.0	(1/4)	33% (1/3)	0% (0/1)	— (0/0)	0% (0/3)	100% (1/1)	43% (3/7)
California	B	74.0	(168/227)	88% (135/154)	17% (6/35)	71% (27/38)	33% (2/6)	96% (71/74)	44% (15/34)
Hawaii	B	70.0	(7/10)	75% (6/8)	— (0/0)	50% (1/2)	67% (2/3)	100% (1/1)	50% (2/4)
Oregon	A	88.9	(24/27)	96% (22/23)	0% (0/2)	100% (2/2)	100% (3/3)	100% (7/7)	45% (13/29)
Washington	A	92.7	(38/41)	100% (30/30)	50% (1/2)	78% (7/9)	80% (4/5)	100% (10/10)	36% (10/28)
PACIFIC	B	77.0	(238/309)	89% (194/218)	18% (7/40)	73% (37/51)	55% (11/20)	97% (90/93)	42% (43/102)
NATIONAL	B	66.5	(1,591/2,393)	78% (1,315/1,694)	23% (90/385)	59% (186/314)	45% (116/260)	90% (659/732)	29% (336/1,162)

*As reported in 2013 AHA Annual Survey.

TABLE 2. Grade by State Detail

State	2015 Report Card				2011 Report Card				2008 Report Card			
	Letter Grade	Grade	Total Programs	Total Hospitals	Letter Grade	Grade	Total Programs	Total Hospitals	Letter Grade	Grade	Total Programs	Total Hospitals
New Jersey	A	91.2	52	57	B	80.4	45	56	B	71.9	41	57
New York	B	78.1	107	137	B	74.6	103	138	C	57.9	70	121
Pennsylvania	B	68.3	82	120	B	66.9	79	118	C	54.5	67	123
MID ATLANTIC	B	76.8	241	314	B	72.8	227	312	C	59.1	178	301
Connecticut	A	84.0	21	25	B	72.0	18	25	C	53.8	14	26
Maine	B	78.6	11	14	B	71.4	10	14	B	68.8	11	16
Massachusetts	A	87.8	36	41	B	66.7	32	48	C	50.0	28	56
New Hampshire	A	100.0	11	11	B	76.9	10	13	A	84.6	11	13
Rhode Island	A	88.9	8	9	A	87.5	7	8	C	60.0	6	10
Vermont	A	100.0	4	4	A	100.0	4	4	A	100.0	5	5
NEW ENGLAND	A	87.5	91	104	B	72.3	81	112	C	59.5	75	126
Delaware	B	75.0	3	4	F	20.0	1	5	C	60.0	3	5
District of Columbia	B	71.4	5	7	A	100.0	6	6	B	80.0	4	5
Florida	C	58.1	68	117	B	61.6	69	112	C	48.7	56	115
Georgia	C	55.2	32	58	C	43.3	29	67	D	37.8	28	74
Maryland	A	87.5	35	40	A	90.2	37	41	B	66.7	28	42
North Carolina	B	65.3	47	72	B	75.3	55	73	B	68.8	55	80
South Carolina	C	58.1	25	43	C	51.2	22	43	D	29.5	13	44
Virginia	B	76.9	40	52	B	78.4	40	51	B	63.0	34	54
West Virginia	C	55.6	15	27	C	55.2	16	29	B	66.7	20	30
SOUTH ATLANTIC	B	64.3	270	420	B	64.4	275	427	C	53.7	241	449
Illinois	B	72.1	75	104	B	67.3	76	113	C	58.0	58	100
Indiana	B	67.7	44	65	B	62.9	39	62	C	53.7	29	54
Michigan	B	66.7	48	72	B	76.5	65	85	B	68.7	57	83
Ohio	A	82.8	82	99	B	79.8	87	109	B	68.2	75	110
Wisconsin	A	87.7	50	57	B	73.7	42	57	B	63.8	37	58
EAST NORTH CENTRAL	B	75.3	299	397	B	72.5	309	426	B	63.2	256	405
Alabama	D	32.0	16	50	D	27.6	16	58	F	15.9	7	44
Kentucky	C	53.1	26	49	C	54.7	29	53	D	37.0	20	54
Mississippi	D	28.9	13	45	F	20.0	9	45	F	10.4	5	48
Tennessee	C	56.0	28	50	C	51.9	28	54	C	45.3	24	53
EAST SOUTH CENTRAL	C	42.8	83	194	D	39.0	82	210	D	28.1	56	199

State	2015 Report Card				2011 Report Card				2008 Report Card			
	Letter Grade	Grade	Total Programs	Total Hospitals	Letter Grade	Grade	Total Programs	Total Hospitals	Letter Grade	Grade	Total Programs	Total Hospitals
Iowa	B	66.7	20	30	B	60.6	20	33	B	69.7	23	33
Kansas	C	48.5	16	33	C	47.1	16	34	B	60.6	20	33
Minnesota	B	81.6	31	38	A	88.6	31	35	B	75.0	27	36
Missouri	B	66.7	42	63	B	75.0	51	68	B	73.1	49	67
Nebraska	A	87.5	14	16	A	92.9	13	14	C	55.6	10	18
North Dakota	B	66.7	4	6	B	66.7	4	6	B	66.7	6	9
South Dakota	A	88.9	8	9	B	77.8	7	9	B	77.8	7	9
WEST NORTH CENTRAL	B	69.2	135	195	B	71.4	142	199	B	69.3	142	205
Arkansas	D	31.6	12	38	D	38.5	15	39	C	41.5	17	41
Louisiana	C	55.8	24	43	C	43.1	22	51	D	27.1	13	48
Oklahoma	D	34.9	15	43	D	30.0	12	40	F	18.6	8	43
Texas	C	42.9	85	198	C	42.1	90	214	D	32.5	66	203
WEST SOUTH CENTRAL	C	42.2	136	322	C	40.4	139	344	D	31.0	104	335
Arizona	B	68.4	26	38	B	69.4	25	36	C	50.0	18	36
Colorado	B	75.7	28	37	B	72.7	24	33	B	66.7	18	27
Idaho	B	66.7	6	9	B	62.5	5	8	C	55.6	5	9
Montana	A	100.0	9	9	B	66.7	6	9	A	87.5	7	8
Nevada	A	91.7	11	12	B	69.2	9	13	D	23.1	3	13
New Mexico	D	35.7	5	14	C	44.4	8	18	D	33.3	5	15
Utah	A	84.6	11	13	C	60.0	9	15	C	56.3	9	16
Wyoming	D	33.3	2	6	C	50.0	3	6	D	25.0	2	8
MOUNTAIN	B	71.0	98	138	B	64.5	89	138	C	50.8	67	132
Alaska	D	25.0	1	4	D	28.6	2	7	C	60.0	3	5
California	B	74.0	168	227	B	67.4	159	236	C	56.4	127	225
Hawaii	B	70.0	7	10	C	58.3	7	12	C	45.5	5	11
Oregon	A	88.9	24	27	A	88.5	23	26	B	72.0	18	25
Washington	A	92.7	38	41	A	82.5	33	40	B	64.7	22	34
PACIFIC	B	77.0	238	309	B	69.8	224	321	C	58.3	175	300
NATIONAL	B	66.5	1,591	2,393	B	63.0	1,568	2,489	C	52.8	1,294	2,452

*As reported in 2013 AHA Annual Survey.

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The Center to Advance Palliative Care

www.capc.org

www.getpalliativecare.org

registry.capc.org

The Center to Advance Palliative Care (CAPC), established in 1999, is a national, member-based organization dedicated to increasing access to quality palliative care for people facing serious illness. CAPC provides hospitals, hospices, payers and other health care organizations with the tools, training, technical assistance and metrics needed to support the successful implementation and integration of palliative care. We work to train frontline clinicians, stimulate new palliative care capacity in all settings and support the long-term sustainability and quality of established services. In addition to supporting clinicians at the bedside, CAPC works with major national health care organizations, policymakers, payers and educators to integrate palliative care as the standard of practice for all seriously ill patients.

Led by Diane E. Meier, MD, CAPC is part of the Icahn School of Medicine at Mount Sinai in New York City. CAPC also works in close collaboration with the National Palliative Care Research Center.

The National Palliative Care Research Center

www.npcrc.org

The mission of the National Palliative Care Research Center (NPCRC) is to improve care for patients with serious illness and address the needs of their families by promotion of palliative care research. The NPCRC, founded in 2005, establishes priorities for palliative care research, develops a new generation of researchers in palliative care and coordinates and supports studies focused on improving care for patients and families living with serious illness.

The NPCRC is led by R. Sean Morrison, MD, and is located in New York City at the Icahn School of Medicine at Mount Sinai. In collaboration with the Center to Advance Palliative Care, the NPCRC works to rapidly translate important research findings into clinical practice in order to improve the care received by patients living with serious illness and their families.



