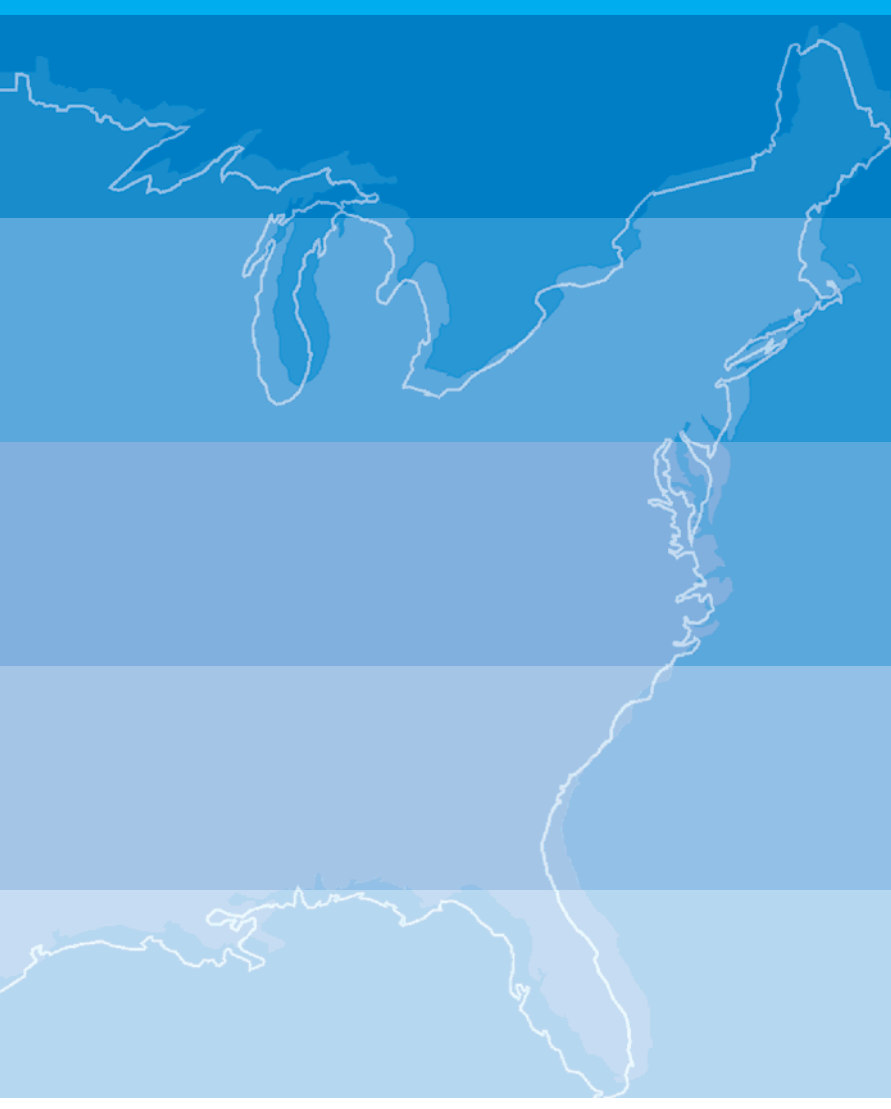
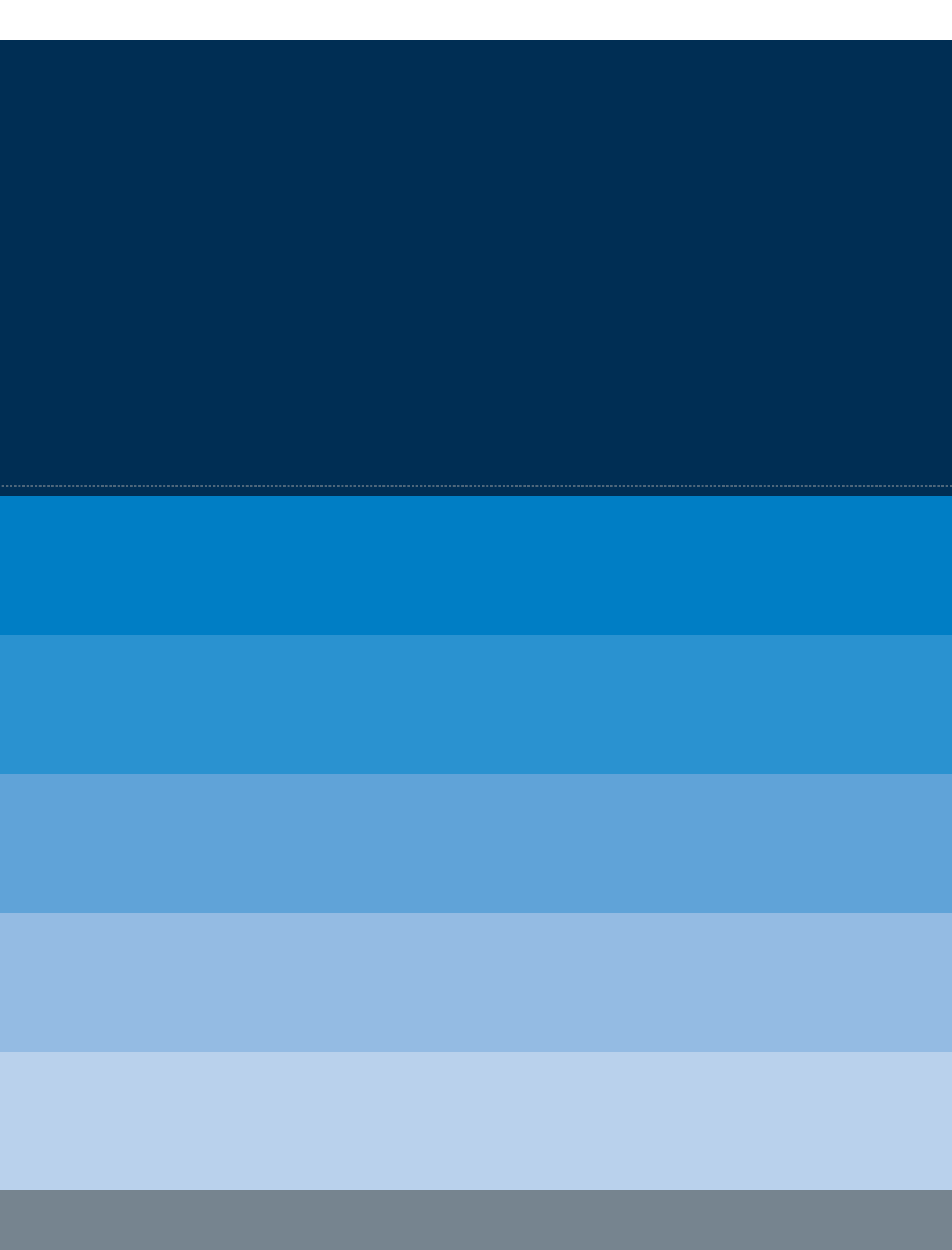




**AMERICA'S CARE OF SERIOUS ILLNESS:**  
A State-by-State Report Card on Access  
to Palliative Care in Our Nation's Hospitals



**A**  
**B**  
**C**  
**D**  
**F**



## Preface

This report is the result of extensive collaboration between the Center to Advance Palliative Care (CAPC) and the National Palliative Care Research Center (NPCRC).

Our work was undertaken in an effort to understand the prevalence of, and hence access to, hospital palliative care programs in the United States. To contribute to the understanding of the care currently available to seriously ill patients, we developed a framework that measures and indicates patterns among states.

The research draws on the clinical and operational expertise of leaders in the field of palliative care. The research team was led by R. Sean Morrison, MD, Director of the National Palliative Care Research Center. Jessica Dietrich, Director of Research for the Center to Advance Palliative Care, Benjamin Goldsmith, BS, a Doris Duke Clinical Research Fellow at Mount Sinai School of Medicine, and Qingling Du, MS, Senior Research Analyst at Mount Sinai School of Medicine, provided invaluable contributions to the data analysis contained in this report.

We would like to acknowledge our funders, without whose support we could not have conducted this study: Aetna Foundation, Brookdale Foundation, the Emily Davie and Joseph S. Kornfeld Foundation, JEHT Foundation, the John A. Hartford Foundation, the Olive Branch Foundation, the Robert Wood Johnson Foundation and the United Hospital Fund. CAPC and NPCRC work independently of any pharmaceutical company support and are funded solely by a consortium of foundations.

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September 2008

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Support for this project was made possible by grants from Aetna Foundation, Brookdale Foundation, the Emily Davie and Joseph S. Kornfeld Foundation, JEHT Foundation, the John A. Hartford Foundation, the Olive Branch Foundation, the Robert Wood Johnson Foundation and the United Hospital Fund.

The major findings in this report are drawn from research described in "Variability in access to hospital palliative care in the United States" (*Journal of Palliative Medicine*, October 2008). Data were obtained primarily from the AHA Annual Survey Database™ for fiscal year 2006. Additional data for *America's Care of Serious Illness* were obtained from the American Academy of Hospice and Palliative Medicine, National Board for Certification of Hospice and Palliative Nurses, Dartmouth Atlas, the American Medical Association and the Centers for Disease Control and Prevention.

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## A PALLIATIVE CARE STORY: AN ESSAY BY GAIL SHEEHY



*The following is excerpted from an e-mail Sheehy sent to friends in July 2008. Reproduced by permission from the author. © 2008 by Gail Sheehy.*

It is said that people die the way they live. Knowing Clay as you do, you will probably not be surprised by the story I want to share with you. In the past week, as he approaches the final deadline of his life, Clay's life force returned with gusto.

Not that it ever flagged for long. In the past year, he has astonished every doctor and nurse who predicted "It won't be long now." Last summer, after three months in a rehab unit in Riverdale, Clay revived from near-drowning in double pneumonia and worked with physical therapists twice a day until he could circle the floor twice on a walker at about the speed he used to reach while sprinting across town for an important lunch date. He was able to come home last September.

In January, pneumonia returned. We were sent to the emergency room by his primary care doctor for yet another CT scan. After waiting 8 hours for the test, the doctors had gone home and he was under imminent threat of being admitted by default. I threw a little hissy fit. The CT was done, but the radiologists had left so no one could read it. A sympathetic resident finally produced some results. They sounded foreign. It was a scan taken 9 months before.

I wheeled Clay out of the ER with the IV needles still in his arms, and we congratulated ourselves on a jailbreak. We had spent more than a year frantically circling around the revolving door of acute care, from gridlocked ER's to repeated hospital admissions, where, nonetheless, each time one is treated as a tabula rasa, one's body parts segmented like cheese cubes on an hors d'oeuvres tray with each one assigned to a different specialist and Medicare code, then on to a rehab facility and back around the revolving door again. Until we discovered palliative care. A doctor insisted on making a house call. Honest to God.

It was Dr. Sean Morrison, who leads the Palliative Care team at Mt. Sinai hospital. He took over Clay's care last January. The mission of palliative care is to keep a senior out of the hospital and give back some control to people over a stage in life that is uncontrollable. Dr. Morrison sat with Clay and me for an hour, at our home, and we had the first full and frank conversation about Clay's ideas on how he wanted to play out the end of life. He wanted to remain at home, under only maintenance care by aides, and get out and see and taste the world whenever he could.

He was always up for rolling over to Lincoln Center for a rehearsal at the Philharmonic, or helping to swing himself into the car and heading downtown for a show at the New Museum, or the opening of Byron Dobell's art show, or out to Bridgehampton to have Thanksgiving with Bina and Walter Bernard. He insisted upon climbing icy outdoor stairs, with help, to be present for our grandson's first piano recital. . . .

Monday, June 17, Dr. Morrison made a home visit. He told Clay that he recommended that the tube feedings be suspended because the nutrition that had nourished him for the past nine years was not being absorbed and was causing him to choke. Clay nodded assent. His body was beginning to shut down.

Clay asked, "How long?"

"It won't be long. A week to a month."

Clay did not look surprised. The doctor took me aside in the next room. We spoke in hushed tones. Clay's voice pierced through the half-open door. He wanted his wishes heard: "Don't abandon me."

An urgent inspiration possessed me. “Do you want to do one great thing, darling?” He nodded vigorously. “How about we go out and hear some jazz?” The light flared again in his eyes. *Tonight?* He shook his head up and down. I said, “Let’s see who’s playing at Dizzy’s Club Coca Cola!” The show started in two hours.

He pulled up from his hospital bed and picked out a linen jacket and deep blue shirt and a suede cap. I touched up his face with tinted sunscreen and wheeled him in front of the full-length mirror. “How’s that for handsome?” He looked pleasantly surprised to see a picture of normalcy.

Dizzy’s was the quintessence of New York . . . seductive cocktail tables set beneath a window wall with a bigger-than-Trump vista across Central Park to the frosted layer cake condos of Fifth Ave. The aides and I ordered exotic drinks. Clay took a sip . . . the first taste in his mouth in years.

Clay sat tall and straight in his wheelchair and for the next hour and a half drank in the music as his sustenance. His attention locked on Mike Melvoin, the jazz pianist whose trio it was. . . . Melvoin voiced the philosophy behind his original compositions. “There’s a lot of pessimism and feelings of futility out there . . . it’s the job of music to dispel those feelings. This is a little song called ‘Life Is What You Make It.’” Up-tempo drums kick-started a piece with strong major chords and a restless backbeat. . . . Clay’s fingers drummed on the table . . . he was a drummer as a boy.

Between two aides, myself, and a cooperative driver, we cantilevered Clay out of the car service and back up to the apartment and into bed shortly before midnight. He was not the least tired. He wanted to talk. He gripped my hands and said clearly, with gusto, “It was a wonderful evening.”

*Gail Sheehy is a journalist and the bestselling author of fifteen books, including Passages (1976) and Sex and the Seasoned Woman (2006). Her husband, Clay Felker, founding editor of New York magazine and a proponent of the New Journalism of the 1960s, died on July 1, 2008.*



## 2

## CARING FOR SERIOUS ILLNESS

**Quality and the Role of Palliative Care**

In 2008, some ninety million Americans are living with serious and life-threatening illness, and this number is expected to more than double over the next twenty-five years with the aging of the baby boomers.<sup>1</sup> Despite the highest per-person spending on health care in the world, more than 50 percent of caregivers of Americans hospitalized with a life-threatening illness report suboptimal care,<sup>2</sup> and more than 30 percent of families lose most or all of their savings in caring for a loved one with a serious illness.<sup>3</sup> Of the 1.5 million Americans who die of chronic illness each year, more than 70 percent are admitted to a hospital during the last six months of life.<sup>4</sup> Recent studies examining the experience of being hospitalized with a serious illness in the United States have reported the following:

- > *1 in 4 patients report inadequate treatment of pain and shortness of breath.*<sup>5</sup>
- > *1 in 3 families report inadequate emotional support.*<sup>6</sup>
- > *1 in 3 patients report that they receive no education on how to treat their pain and other symptoms following a hospital stay.*<sup>7</sup>
- > *1 in 3 patients are not provided with arrangements for follow-up care after hospital discharge.*<sup>8</sup>

- 1 The Dartmouth Institute for Health Policy and Clinical Practice. The Dartmouth Atlas of Health Care Web site. [www.dartmouthatlas.org](http://www.dartmouthatlas.org). Accessed July 14, 2008.
- 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 Covinsky KE, Goldman L, Cook E, et al. The impact of serious illness on patients' families. *JAMA*. 1994 Dec 21;272(23):1839–44.
- 4 Dartmouth Atlas of Health Care.
- 5 Teno et al. Family perspectives.
- 6 Ibid.
- 7 The Commonwealth Fund. Care coordination. *Quality Matters*. 2007 May/June;24.
- 8 Ibid.

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Palliative care provides relief of pain and other debilitating symptoms, intensive physician-patient-family communication and rigorous coordination of care. The ultimate goal is to improve quality of care for patients and their families.

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To help address these shortcomings, hospitals have begun to establish palliative care programs. In the last five years alone the number of palliative care programs has more than doubled in response to the increasing numbers and needs of Americans living with serious, complex and chronic illnesses and the realities of the care responsibilities faced by their families. Hospital palliative care programs have been shown to reduce symptoms, improve doctor-patient-family communication and satisfaction with care, and enhance the efficiency and effectiveness of hospital services.

While the numbers of palliative care programs in hospitals are increasing overall in the United States, they must be accessible at the local level. The Center to Advance Palliative Care and the National Palliative Care Research Center developed a framework to measure and identify patterns of patient access to palliative care. This report examines geographic variation at the state level in order to help the public and policymakers increase utilization of these services.

### The Quality Imperative

Data from studies such as those cited above about the quality of American health care have prompted multiple calls for change. In 2001 the Institute of Medicine (IOM) undertook an investigation of health care quality and published its findings in a 360-page study by nineteen experts entitled *Crossing the Quality Chasm: A New Health System for the 21st Century*. The report was a stunning indictment of our health care industry and called for fundamental change in the way health care is delivered. As stated in the report's executive summary, "the care delivered is not, essentially, the care we should receive. . . . Health care today harms too frequently and routinely fails to deliver its potential benefits. . . . Quality problems are everywhere . . . [and] between the health care we have and the care we could have lies not just a gap, but a chasm."<sup>9</sup>

What, then, can be done to ensure that Americans receive the quality of health care they deserve? The IOM identified six specific aims for improvement. Health care needs to be:

**Safe:** *avoiding injuries to patients from the care that is intended to help them.*

<sup>9</sup> Institute of Medicine. *Crossing the Quality Chasm: A New Health System for the 21st Century*. Washington, DC: National Academy Press; 2001.

**Effective:** *providing services based on scientific knowledge to all who could benefit, and refraining from providing services to those not likely to benefit.*

**Patient-centered:** *providing care that is respectful of and responsive to individual patient preferences, needs and values, and ensuring that patient values guide all clinical decisions.*

**Timely:** *reducing waits and sometimes harmful delays for both those who receive and those who give care.*

**Efficient:** *avoiding waste, including waste of equipment, supplies, ideas and energy.*

**Equitable:** *providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location and socioeconomic status.*

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The Report Card Web site can be found at [www.capc.org/reportcard](http://www.capc.org/reportcard).

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## Hospital Palliative Care Programs Bridge the Quality Chasm

Hospital palliative care programs are one solution to improving the quality of health care in hospitals for our most seriously ill and vulnerable patients. Although the reasons for inadequate care of the seriously ill are many, most stem from a medical culture that is focused on curing individual diseases and a health care system that is designed to reimburse disease-specific care.

The needs of seriously ill patients cannot be met by medical specialists (such as cardiologists, oncologists, pulmonologists) who focus only on treating or improving their organ of expertise, function as independent consultants rather than as members of a care team, lack the training and knowledge to adequately coordinate care and view symptoms and suffering as important only in guiding them in diagnosis. Nor can these needs be met by a reimbursement system that fails to adequately cover the combination of life-prolonging treatments, treatment of symptoms or rehabilitation and support for family caregivers. Patients with serious and life-threatening illness typically live with multiple disease processes (such as advanced heart and lung disease, diabetes, arthritis, cancer), multiple symptoms (pain, nausea, shortness of breath, fatigue, sleep disorders), caregiving requirements (assistance with feeding, bathing, toileting, walking) and complicated transition planning (rehabilitation, visiting-nurse

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Patients with serious and life-threatening illness typically live with multiple diseases, symptoms and caregiving requirements and have complex transition planning needs.

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services, care coordination) that can be met only by specialized teams of health care providers. The absence of team-supported, coordinated care for the seriously ill results in health care that is often unsafe, ineffective, untimely, inefficient, inequitable and rarely patient-centered.

Palliative care is a relatively new medical specialty that was developed in response to the aforementioned inadequacies and is devoted to improving care for seriously ill patients and their families. Hospital palliative care teams are designed to provide comprehensive symptom management, intensive communication and a level of coordination of care that addresses the episodic and long-term nature of serious, chronic illness. Unlike hospice, patients do not need to be terminally ill to access and benefit from hospital palliative care programs. Palliative care may be provided at any time during a patient's illness—from the time of diagnosis and at the same time as curative or other life-prolonging treatments. In this respect, hospital palliative care programs are directly addressing the “quality chasm.”

***Hospital palliative care programs are safe and effective.***

Well-managed physical and psychological symptoms and improved communication—the domains of palliative care—form the foundation for safe and effective health care and increase patient and family satisfaction. Through a whole-person approach that includes a specific focus on pain and other distressing symptoms, identification of the patient's goals of care and direct involvement of the patient's family and health care providers, palliative care programs have been shown to:

***Reduce high levels of suffering among patients with serious or life-threatening illness at any age and at all stages of disease.*** *Studies of palliative care programs demonstrate considerable reductions in pain and other symptoms.*

***Address the emotional and practical needs of caregivers.*** *Palliative care programs have been shown to improve the ability of families to appropriately care for and feel confident in caring for patients with serious illness.*

***Improve communication among patients, families and health care providers.*** *Studies have shown that palliative care teams result in better identification of goals of care, better understanding of disease and treatment options and improved communication between health care providers.*

***Hospital palliative care programs are timely and efficient.***

Well-managed physical and psychological symptoms, improved communication around goals of care and desired treatments and skilled medical transition management from hospital to home—the key domains of palliative care—result in highly timely and efficient health care as well as improved patient and family satisfaction. According to a new analysis, hospital palliative care programs are associated with significant cost savings by providing the right care, to the right patients, at the right time. The study, “Cost savings associated with United States hospital palliative care consultation programs,” conducted by the Center to Advance Palliative Care (CAPC) and the National Palliative Care Research Center (NPCRC) and reported in the *Archives of Internal Medicine* (September 8, 2008), found that hospital palliative care programs resulted in a \$1.3 million reduction in hospital expenditures annually for a typical 300-bed hospital. In summary, palliative care programs:

***Facilitate transitions between hospitals and other care settings such that patients are safely looked after in the setting of their choice.***

*These transitions reduce unnecessary and unwanted stays in intensive care units and hospitals.*

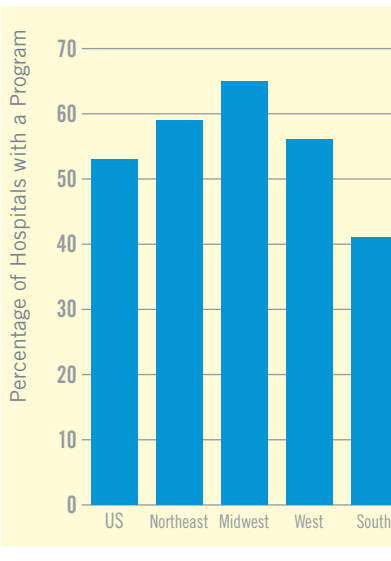
***Ensure that the care provided by hospitals to patients with serious and life-threatening illness is of the very highest quality and consistent with patients' values and goals.***

***Reduce unnecessary and wasteful hospital expenditures.***

***Hospital palliative care programs are patient-centered.***

By working in collaboration with patients and families to establish realistic treatment goals and matching medical treatments to those goals, hospital palliative care programs provide the epitome of patient-centered care. Palliative care professionals employ a unique and new approach to patient care: goal-centered care. Traditionally, doctors generate a list of medical problems—typically based upon organ systems and diseases—and approach the “problem list” as a puzzle to be solved. Although effective for single disease states, this approach falls apart in the setting of multiple disease processes, complicated emotional and spiritual distress and acute caregiver needs. In New

## Prevalence of Hospitals with Palliative Care



York City, the average person with a serious and life-threatening illness is receiving care from twelve different physicians, with no single individual coordinating care.<sup>10</sup>

In contrast, palliative care teams begin by interviewing patients about their goals for care, the symptoms and other issues that bother them and the needs of their families. By starting with the patients' needs and goals, palliative care teams ensure that the care patients receive addresses their needs and is driven by their agenda, not that of the physician. Furthermore, and perhaps most importantly, such an approach ensures that the person is viewed in his or her entirety, not as a collection of organs and systems. By following this approach, palliative care programs have been shown to:

***Reduce unwanted, unnecessary and painful interventions.***

*By establishing patients' care goals and focusing on what are important and achievable outcomes for medical treatment, palliative care programs ensure that patients receive the most effective and timely treatments and that their valuable time and energy is not spent undergoing burdensome tests and procedures that will not lead to improvements or changes in care.*

***Enhance the ability of patients' families to cope with and care for a loved one with serious illness.*** *By identifying family needs, fears and knowledge gaps, palliative care programs have been shown to improve a family's feelings of self-efficacy in the setting of a loved one's serious illness.*

***Improve patient and family satisfaction with care.*** *Surveys of patients cared for by hospital palliative care teams routinely reveal very high patient and family satisfaction—among the highest rates observed in hospitalized patients.*

## The Equity Gap

National recognition of the importance of palliative care in the continuum of health care has spurred rapid growth of palliative care services in hospitals. In 2008, the Center to Advance Palliative Care (CAPC) and the National Palliative Care Research Center (NPCRC) released a comprehensive report on the growth and prevalence of hospital palliative care programs. The good news is that the

<sup>10</sup> Dartmouth Atlas of Health Care.

CAPC/NPCRC research demonstrates a steady yearly increase in the number of hospitals in the United States reporting a palliative care program. The percentage of hospitals with 50 or more beds reporting a palliative care program almost doubled from 2000 (24 percent) to 2006 (53 percent)—an overall increase of 97 percent. The bad news is that despite this growth, millions of Americans with serious illness still do not yet have access to palliative care before they are eligible for hospice.

Availability varies considerably by region and state. This report examines adequacy of patient access to palliative care in hospitals at the state level and the availability of palliative care programs at our nation's medical school teaching hospitals. The report provides recommendations to patients and families, the health care community, medical schools and teaching hospitals and elected officials and policymakers to close the demonstrated "equity gap" and complete the palliative care bridge across the quality chasm. Data from this report are drawn primarily from a study performed by senior author R. Sean Morrison and colleagues.<sup>11</sup>

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Across the nation, 53 percent of hospitals with 50 or more beds reported a hospital palliative care program in 2006.

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<sup>11</sup> Goldsmith BA, Dietrich J, Du Q, Morrison RS. Variability in access to hospital palliative care in the United States. *J Palliat Med.* 2008 Oct;11(8)(in press).



## A NATIONAL AND STATE-BY-STATE REVIEW AND REPORT CARD

# 3

### AHA Began Tracking Palliative Care in 2000

The American Hospital Association (AHA) first started tracking data for hospital palliative care programs in 2000, using its Annual Survey Database™. The results of the initial AHA queries on hospital palliative care were reported by CAPC in 2001<sup>1</sup> and again in 2005<sup>2</sup> in the *Journal of Palliative Medicine*.

### Public Attention in 2002

Last Acts®, a national coalition whose aim was to improve care at the end of life, published its state-by-state analysis of end-of-life care in November 2002. *Means to a Better End: A Report on Dying in America Today* was the first study to address access to palliative care. The report's overall consensus was that America was doing a mediocre job of providing palliative care for its people most in need.

Access to palliative care in the hospital setting was one of several key indicators in the 2002 national report. In the chapter "Hospitals Reporting Palliative Care Programs, 2000," few states made the grade: no states earned A or B grades, only two rated a C (District of Columbia and Vermont), ten received D grades, and the remaining thirty-nine states received an F.

When the 2002 report was released, however, palliative care was not the norm in hospital settings. The good news is that today's reality is different. Many

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Since a 2002 report, only three states have not improved: Oklahoma, Alabama and Mississippi.

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<sup>1</sup> Pan CX, Morrison RS, Meier DE, Natale DK, et al. How prevalent are hospital-based palliative care programs? Status report and future directions. *J Palliat Med*. 2001 Sept;4(3):315–24.

<sup>2</sup> Morrison RS, Maroney-Galin C, Kralovec PD, Meier DE. The growth of palliative care programs in United States hospitals. *J Palliat Med*. 2005 Dec;8(6):1127–34.

more hospitals have palliative care programs, and palliative care is no longer provided only to those at the end of life. The present study, *America's Care of Serious Illness: A State-by-State Report Card on Access to Palliative Care in Our Nation's Hospitals*, is the first comprehensive, state-by-state evaluation of hospital palliative care since the seminal 2002 report.

### Report Card 2008 Reveals Progress and Gaps

After eight years of rapid growth in United States hospital palliative care programs, this report was undertaken in an effort to add to the literature on health care quality for seriously ill patients. The study focuses on geographic variations in access to hospital palliative care. Specifically, we examine:

1. Patient access to palliative care services in hospitals
2. Patient access to board-certified palliative medicine physicians
3. Medical student access to clinical training in palliative medicine
4. Physician access to specialty-level training in palliative medicine

Hospitals containing fifty or more beds are the primary focus of the report card. Hospitals with fewer than fifty beds see only a small number of patients with serious and life-threatening illness and are unlikely to be able to support the model of hospital palliative care (a consultation team consisting of a physician, nurse and social worker) that has been shown to lead to improved patient, family and health care system outcomes. Also excluded from the study are rehabilitation hospitals; psychiatric hospitals; subacute and chronic care facilities; eye, ear, nose and throat hospitals; pediatric hospitals; hospitals under federal control; hospitals located outside the fifty states and District of Columbia; and hospitals that did not respond to the annual American Hospital Association (AHA) survey.

### What Are the Key Predictors of Access to Palliative Care?

This report presents the most accurate estimates to date of the prevalence of hospital palliative care programs in the United States. As in other aspects of our health care system, we found wide geographic variation in access to palliative

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This report is based upon “Variability in access to hospital palliative care in the United States,” a study published in the *Journal of Palliative Medicine* in October 2008.

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care services. Factors predicting presence of a hospital palliative care program have not changed markedly since our last growth report in 2005.<sup>3</sup> The overall prevalence of hospital palliative care programs in hospitals with fifty or more beds was 53 percent. Large hospitals (those with three hundred or more beds) are much more likely to report a program (75 percent). A minority of public hospitals (41 percent), for-profit hospitals (20 percent), and sole community provider hospitals (29 percent) reported a program.

**Overall, mid-size hospitals (50–300 beds) reporting a palliative care program were more likely to be:**

- > *An American College of Surgery–approved cancer program hospital*
- > *Affiliated with a hospice*
- > *Located in areas in which college graduates composed more than 70 percent of the surrounding population*
- > *Not-for-profit*

**Large hospitals (over 300 beds) reporting a palliative care program were more likely to be:**

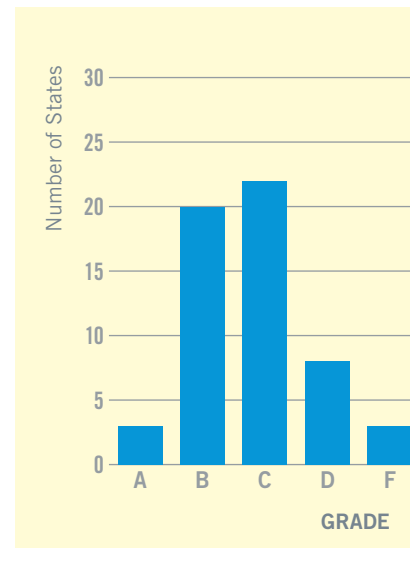
- > *Affiliated with a hospice*
- > *Not-for-profit*
- > *Affiliated with a medical school*

**How Does the Nation Fare?**

Findings today demonstrate improvement since 2002. Table 1 in the Appendix presents the state-by-state findings of hospitals evaluated in this study—hospitals with fifty or more total beds (public, not-for-profit, for-profit and sole community provider hospitals). Table 1 also shows the prevalence of palliative care programs among larger hospitals with three hundred or more beds and small hospitals with fewer than fifty beds.

While hospital palliative care programs are becoming increasingly prevalent in the United States, there is considerable variation from state to state.

Distribution of State Grades



<sup>3</sup> Ibid.

## Which States Make the Grade?

Despite robust growth in palliative care program prevalence in hospitals, there is much need for improvement if we are to adequately care for our sickest patients. Overall, our nation receives a grade of C. Almost half of the fifty states receive a “good” grade of either an A or B. However, almost 40 percent of states need significant improvement (C). More than 20 percent receive nonpassing grades of D and F. Only three states receive a grade of A.

### Top performers (programs in 81 to 100% of hospitals):

#### States receiving an A grade

Vermont (100%)  
Montana (88%)  
New Hampshire (85%)

### On their way (programs in 61 to 80% of hospitals):

#### States receiving a B grade

District of Columbia (80%)  
South Dakota (78%)  
Minnesota (75%)  
Missouri (73%)  
New Jersey (72%)  
Oregon (72%)  
Iowa (70%)  
Maine (69%)  
Michigan (69%)  
North Carolina (69%)  
Ohio (68%)  
Colorado (67%)  
Maryland (67%)  
North Dakota (67%)  
West Virginia (67%)  
Washington (65%)  
Wisconsin (64%)  
Virginia (63%)  
Kansas (61%)

### States in the middle (programs in 41 to 60% of hospitals):

#### States receiving a C grade

Alaska (60%)  
Delaware (60%)  
Rhode Island (60%)

Illinois (58%)  
New York (58%)  
California (56%)  
Idaho (56%)  
Nebraska (56%)  
Utah (56%)  
Connecticut (54%)  
Indiana (54%)  
Pennsylvania (54%)  
Arizona (50%)  
Massachusetts (50%)  
Florida (49%)  
Hawaii (45%)  
Tennessee (45%)  
Arkansas (41%)

### States that need significant improvement (programs in 21 to 40% of hospitals):

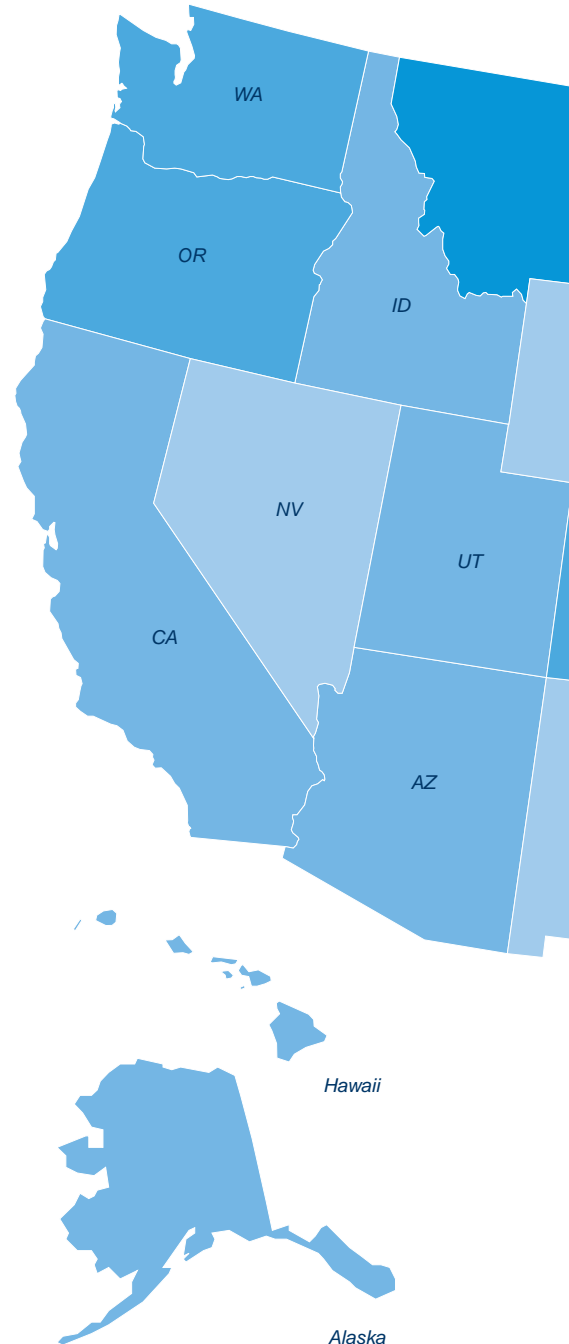
#### States receiving a D grade

Georgia (38%)  
Kentucky (37%)  
New Mexico (33%)  
Texas (33%)  
South Carolina (30%)  
Louisiana (27%)  
Wyoming (25%)  
Nevada (23%)

### States with little or no access (programs in 0 to 20% of hospitals):

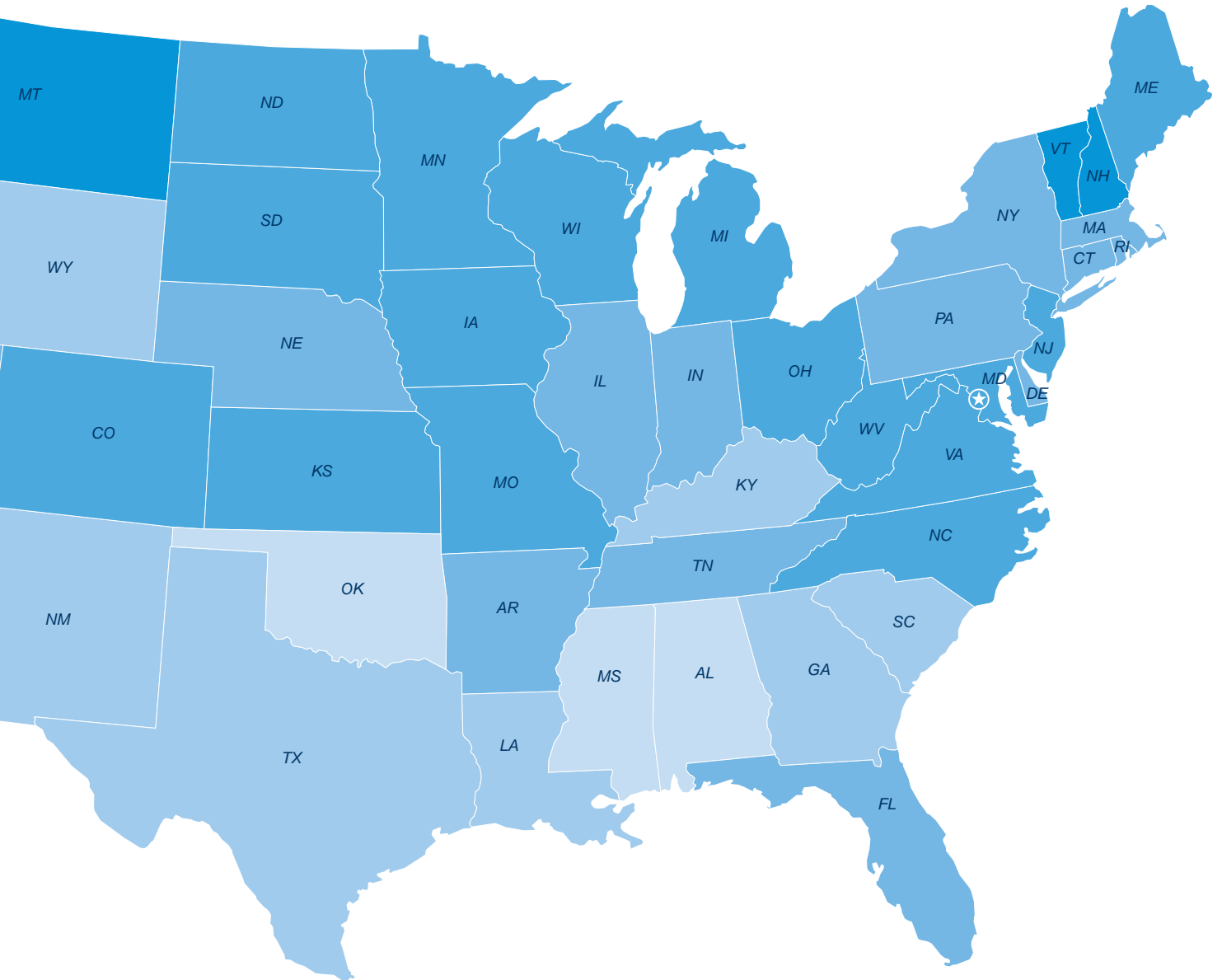
#### States receiving an F grade

Oklahoma (19%)  
Alabama (16%)  
Mississippi (10%)



AMERICA'S CARE OF SERIOUS ILLNESS:

A State-by-State Report Card on Access to Palliative Care in Our Nation's Hospitals



- A** Top Performers
- B** On Their Way
- C** In the Middle
- D** Need Significant Improvement
- F** Little or No Access

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Our nation receives an overall grade of C.

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### Where You Live Matters

As the Dartmouth Atlas researchers have often pointed out, “geography is destiny.”<sup>4</sup> The same holds true when speaking of access to hospitals offering palliative care, which are influenced by geographic location and regional characteristics. In the Midwest, 65 percent of hospitals with fifty or more beds report a program, compared to only 41 percent in the South. Among institutions in the United States containing between fifty and three hundred total beds, hospitals located in the Northeast and South are significantly less likely to report a palliative care program. If you’re living in a region where there are only small hospitals, your chances of having access to palliative care are extremely limited.

Nationally, state prevalence of palliative care programs in hospitals ranged from 10 percent in Mississippi to 100 percent in Vermont, with a cumulative national average of 53 percent (1,294 out of 2,452 study hospitals). The lowest prevalence rates of hospital palliative care programs were found in Mississippi (10 percent), Alabama (16 percent), Oklahoma (19 percent), Nevada (23 percent) and Wyoming (25 percent). The highest rates were found in Vermont (100 percent), Montana (88 percent), New Hampshire (85 percent), the District of Columbia (80 percent) and South Dakota (78 percent).

Large hospitals constitute 16 percent of all hospitals in states across the country, with a range of 0 percent in Wyoming to 46 percent in New Jersey. Prevalence rates for hospital palliative care programs in large hospitals range from 0 percent (Nevada) to 100 percent in twenty states, with a cumulative national average of 75 percent.

The lowest prevalence rates of hospital palliative care programs in large hospitals were found in Nevada (0 percent), Mississippi (10 percent), Alabama (29 percent), Louisiana (50 percent) and South Carolina (50 percent). The highest prevalence rates in large hospitals were found in twenty states with 100 percent prevalence (see Appendix, Table 1).

The numbers of small hospitals (under fifty beds) vary widely by state—four states (Connecticut, Delaware, New Jersey and Rhode Island) and the District of Columbia do not report any hospitals of this size, whereas in other states, such as Montana and South Dakota, greater than 80 percent are in this

4 The Dartmouth Institute for Health Policy and Clinical Practice. The Dartmouth Atlas of Health Care Web site. [www.dartmouthatlas.org](http://www.dartmouthatlas.org). Accessed July 14, 2008.

category. The national prevalence rate for palliative care programs in small hospitals was 20 percent. The lowest prevalence rates of hospital palliative care programs in small hospitals were found in Louisiana (0 percent), Maryland (0 percent), Nevada (0 percent), New Mexico (0 percent) and Mississippi (5 percent). The highest prevalence rates in small hospitals were found in Vermont (78 percent), Maine (63 percent), New Hampshire (46 percent), New York (38 percent) and Wisconsin (38 percent).

***Underserved populations show disparities in access to palliative care.***

This study reveals important differences in access to hospital palliative care programs across the United States. In addition to notable disparities in geographic availability, we observed strikingly low rates of palliative care programs in public and sole community provider hospitals. Public and sole community provider hospitals often serve as the only option for medical care for the forty-seven million Americans lacking health care coverage and geographically isolated communities, respectively. Thus, our finding that the majority of these institutions lack palliative care services speaks to a disparity in access to comprehensive care for some of America's most vulnerable patient populations. Notably:

- > *Only 41 percent of public hospitals provide their patients access to hospital palliative care.*
- > *Fewer than 30 percent of sole community provider hospitals offer their patients access to hospital palliative care.*

### **Educating Future Doctors in Palliative Care**

Improving access to palliative care for America's patients and families requires that all future physicians receive training in the fundamental principles of palliative care. This training needs to exist not only in the classroom but also in hospitals, where medical students experience the physician mentoring and role modeling at the bedside that is so critical to their professional development. Additionally, physicians who have completed their primary specialty training (e.g., internal medicine, family medicine, surgery) and who want to pursue a career in palliative care need access to specialist-level postgraduate fellowship training programs in this discipline. Fortunately, of the

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Hospitals located in the South are much less likely to report a palliative care program.

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116 allopathic, nonmilitary medical schools affiliated with hospitals that responded to the AHA survey, 98 (85 percent) have alliances with at least one hospital reporting a palliative care program. Three states (Mississippi, Nebraska and Nevada) do not have a medical school that is affiliated with a hospital palliative care program.

Additionally, we found that among private United States medical schools, 38 of 43 (88 percent) are affiliated with at least one hospital palliative care program. Among state-funded medical schools, 60 of 73 (82 percent) are affiliated with at least one hospital palliative care program. Four states do not have a state-financed medical school that is affiliated with a hospital palliative care program: Connecticut, Mississippi, Nebraska and Nevada.

At the time this study was being conducted, the five private medical schools affiliated with hospitals not reporting a palliative care program were: Albany Medical College, Boston University School of Medicine, Meharry Medical College, Tufts University School of Medicine and Yale University School of Medicine. Since completion of this study, Yale has started a palliative care program.

The thirteen state schools not affiliated with a palliative care program are located across twelve states. In twenty-three states and the District of Columbia there exists no postgraduate fellowship training program in palliative care.

***Lack of board-certified palliative medicine physicians is a problem.***

In 2007, only 2,651 United States physicians held board certification in the practice of palliative medicine (1 physician per 31,000 persons living with serious and life-threatening illness, or 1 physician per 560 Medicare deaths). In comparison, there are 16,800 cardiologists (1 per 71 heart attack victims) and 10,000 oncologists (1 per 145 patients newly diagnosed with cancer). The prevalence of board-certified palliative care physicians varies across states; in Hawaii, for example, there is 1 physician per 143 Medicare deaths, while in Mississippi the rate is 1 per 3,112.

The statistics show that the highest rates of board-certified palliative medicine physicians are in Hawaii (1 per 143 Medicare deaths), New Mexico (1 per 235 Medicare deaths), the District of Columbia (1 per 237 Medicare deaths),

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If you're living in a region where there are only small hospitals, your chances of accessing palliative care are extremely limited.

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Colorado (1 per 244 Medicare deaths) and Alaska (1 per 247 Medicare deaths). The lowest rates of board-certified palliative medicine physicians are in Mississippi (1 per 3,112 Medicare deaths), Arkansas (1 per 1,489 Medicare deaths), Idaho (1 per 1,365 Medicare deaths), Nebraska (1 per 1,357 Medicare deaths) and South Dakota (1 per 1,296 Medicare deaths).

Table 2 in the Appendix presents a state-by-state comparison of the number of certified physicians as well as advanced practice nurses and registered nurses relative to Medicare deaths.

### **Implications for Patients and Families in the Last Six Months of Life**

Our data indicate that in states where there is greater access to hospital palliative care programs, patients are less likely to die in the hospital. Our findings show that they experience fewer ICU/CCU admissions in the last six months of life, have fewer ICU/CCU admissions during terminal hospitalizations and spend less time in an ICU/CCU in the last six months of life.<sup>3</sup>

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In states where there is greater access to hospital palliative care, patients are less likely to die in the hospital, are less likely to be admitted to the ICU/CCU in the last six months of life and spend fewer days in the ICU/CCU in the last six months of life.

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<sup>3</sup> The Dartmouth Institute for Health Policy and Clinical Practice. The Dartmouth Atlas of Health Care Web site. [www.dartmouthatlas.org](http://www.dartmouthatlas.org). Accessed July 14, 2008.



## RECOMMENDATIONS FOR ACTION

# 4

### How Can We Improve?

Providing hospital palliative care services to our nation's most seriously ill patients is a critical component of health care. Reliable access to these services, however, will be possible only with changes in the health care environment, health care financing, public policy and strong public awareness of palliative care.

Patients with serious illness need relief from their symptoms and better overall quality of care. To that end, they must be able to access a palliative care program in their local hospital, and medical trainees—our future physicians—must receive training within established hospital palliative care programs. The recommendations below are a call to action to both increase the prevalence of palliative care programs in United States hospitals and maximize access to training in this field in teaching hospitals across the nation.

## Recommendations for Patients and Families

### ***If you are living with a serious or life-threatening illness:***

- > *Ask your doctor to refer you to a palliative care specialist.*
- > *Go to the Palliative Care Directory of Hospitals at [getpalliativecare.org](http://getpalliativecare.org) to see which hospitals in your area have a program.*
- > *Let your doctor(s) and family caregivers know that you want palliative care specialists to be a part of your treatment team and care.*
- > *If your hospital does not have a palliative care program, write to your hospital CEO and your state and federal representatives and ask them to ensure that palliative care becomes a core component of your hospital's services.*

## Recommendations for the Health Care Community

### ***If you are a hospital administrator or clinician:***

- > *Implement a palliative care program in your hospital that meets the quality standards published by the National Quality Forum (NQF) in its report A National Framework and Preferred Practices for Palliative and Hospice Care Quality ([www.qualityforum.org/publications/reports/palliative.asp](http://www.qualityforum.org/publications/reports/palliative.asp)). Access comprehensive training tools, including a CAPC crosswalk with NQF preferred practices for palliative care (available at [www.capc.org](http://www.capc.org)).*
- > *Provide comprehensive information about palliative care to your patients. Patients and families often wait for their physician to recommend palliative care services. They don't know when to ask for palliative care, whom to ask or what kinds of services to request.*
- > *Educate your clinical staff in the principles and practices of palliative medicine through continuing medical and nursing education programs.*

## Recommendations for Medical Schools

### ***If you are an administrator or clinician in a medical school:***

- > *Include education in pain and symptom management, communication training (e.g., “breaking bad news,” establishing goals of care, deciding on treatments) and working on an interdisciplinary team in the first and second years of medical school.*
- > *Include mandatory clinical rotations in palliative medicine in the third and fourth years of undergraduate training for all medical students.*

## Recommendations for Teaching Hospitals

### ***If you are an administrator or clinician in a teaching hospital:***

- > *Increase opportunities for medical residents to train on hospital palliative care teams and outpatient hospice programs.*
- > *Increase the number of postgraduate fellowship training programs in palliative care.*

## Recommendations for Elected Officials and Policymakers

Palliative care has become the model for how high-quality, fiscally responsible care can be provided to the sickest, most vulnerable patients and their families, and is emerging as a critical component of health reform. State governments and legislators need to be concerned about how their jurisdictions are performing (based on this report)—and should take action.

### ***If you are a state or federal policymaker, to ensure that your constituents facing serious illness have access to the highest-quality medical care, you should:***

- > *Fund palliative care team training and technical assistance for all hospitals in your state.*
- > *Include palliative care indicators in your state's quality programs for your state health plan and Medicaid programs.*

- > *Ensure the development of palliative care programs in public and sole community provider hospitals, as these hospitals provide care to the underserved and most vulnerable patient populations.*
- > *Promote and pass legislation requiring all hospitals to offer palliative care services as a condition of Medicare and Medicaid reimbursement.*
- > *Promote and pass legislation requiring all state-supported medical schools to have affiliations with hospital palliative care programs.*
- > *Create loan-forgiveness programs for nurses and physicians seeking postgraduate palliative care training.*
- > *Create a statewide resource center for promotion of access to quality palliative care services (see New York Palliative Care Training Act—Public Health Law Article 28 at <http://public.leginfo.state.ny.us/menuf.cgi>).*
- > *Support congressional initiatives that increase National Institutes of Health and Veteran’s Health Administration funding for palliative care research.*
- > *For a state directory of hospital palliative care programs, visit [www.getpalliativecare.org](http://www.getpalliativecare.org).*

## CONCLUSION



### **Equitable Care = Access**

Despite rapid improvements over the last few years, people living with a serious illness still experience significant disparities in their access to a hospital that provides palliative care. Some areas of the United States are better equipped than others to provide such services, and some hospitals are more committed than others to offer palliative care to their patients.

The ultimate goal of palliative care is to improve the overall quality of care for both patients experiencing life-threatening illnesses and their families. To benefit from that goal, however, patients and their caregivers must be able to access these services in their local hospital, and physicians in training must learn from direct exposure to high-quality hospital palliative care programs. Focused efforts by hospital administrations, the health care community and policymakers are required to promote the development of quality palliative care programs in all hospitals, with special attention needed in small, rural, public and for-profit hospitals (see “Recommendations for Action” section of this report). This will result in a more efficient and effective use of hospital resources, and will enhance the quality of care delivered to our nation’s most seriously ill patients and their families.



## APPENDIX: TABLES AND GLOSSARY

# 6

### Grades, Prevalence, Distributions and Terms

Although this report assigned grades to states, regions, and the nation based on the percentage of hospitals (with fifty or more beds) that reported palliative care programs, it may be useful to look more closely at how hospitals of various sizes and types rate. Table 1, “Prevalence and Distribution of Palliative Care in U.S. Hospitals,” lists percentages and raw numbers of hospitals reporting palliative care programs by hospital size and type within each state and region and for the country as a whole.

Table 2, “Prevalence of Palliative Care Health Care Professionals,” lists numbers of physicians, advanced practice nurses and registered nurses who are certified in palliative care. It also shows the numbers of Medicare deaths (overall and in the hospital) per certified palliative care clinician to indicate how the distribution of qualified professionals affects quality of care for our sickest hospitalized patients. These numbers are also listed by state, region and the entire country for comparison.

The Glossary contains some terms used throughout this report, along with others you are likely to encounter in similar publications.

**Table 1** Prevalence and Distribution of Palliative Care in U.S. Hospitals

PERCENT OF HOSPITALS REPORTING A PALLIATIVE CARE PROGRAM							
	Grade	50+ Beds	For-Profit	Public	Sole Community Provider	300+ Beds	< 50 Beds
Illinois	C	58% (58/100)	0% (0/2)	29% (2/7)	13% (1/8)	84% (21/25)	10% (5/51)
Indiana	C	54% (29/54)	55% (6/11)	47% (9/19)	0% (0/1)	64% (7/11)	21% (8/38)
Iowa	B	70% (23/33)	— (0/0)	60% (3/5)	45% (5/11)	100% (5/5)	30% (25/84)
Kansas	B	61% (20/33)	14% (1/7)	43% (3/7)	29% (9/31)	100% (5/5)	14% (13/96)
Michigan	B	69% (57/83)	— (0/0)	13% (1/8)	32% (6/19)	89% (25/28)	35% (14/40)
Minnesota	B	75% (27/36)	— (0/0)	50% (3/6)	50% (4/8)	100% (7/7)	31% (19/62)
Missouri	B	73% (49/67)	33% (4/12)	75% (9/12)	41% (11/27)	88% (15/17)	14% (6/44)
Nebraska	C	56% (10/18)	0% (0/1)	50% (1/2)	38% (3/8)	67% (2/3)	18% (9/50)
North Dakota	B	67% (6/9)	— (0/0)	— (0/0)	44% (4/9)	100% (1/1)	22% (6/27)
Ohio	B	68% (75/110)	100% (3/3)	67% (8/12)	100% (1/1)	86% (25/29)	24% (8/34)
South Dakota	B	78% (7/9)	100% (1/1)	— (0/0)	55% (6/11)	67% (2/3)	17% (7/41)
Wisconsin	B	64% (37/58)	50% (1/2)	— (0/0)	50% (6/12)	100% (8/8)	38% (25/65)
<b>MIDWEST</b>	<b>B</b>	<b>65% (398/610)</b>	<b>41% (16/39)</b>	<b>50% (39/78)</b>	<b>38% (56/146)</b>	<b>87% (123/142)</b>	<b>23% (145/632)</b>
Connecticut	C	54% (14/26)	— (0/0)	0% (0/1)	25% (1/4)	75% (6/8)	— (0/0)
Maine	B	69% (11/16)	— (0/0)	— (0/0)	60% (6/10)	100% (2/2)	63% (12/19)
Massachusetts	C	50% (28/56)	20% (1/5)	67% (2/3)	50% (1/2)	73% (11/15)	33% (3/9)
New Hampshire	A	85% (11/13)	50% (1/2)	— (0/0)	100% (1/1)	100% (1/1)	46% (6/13)
New Jersey	B	72% (41/57)	— (0/0)	100% (1/1)	— (0/0)	88% (23/26)	— (0/0)
New York	C	58% (70/121)	— (0/0)	25% (2/8)	50% (7/14)	77% (30/39)	38% (5/13)
Pennsylvania	C	54% (67/123)	0% (0/9)	— (0/0)	22% (2/9)	77% (24/31)	16% (3/19)
Rhode Island	C	60% (6/10)	— (0/0)	— (0/0)	— (0/0)	100% (2/2)	— (0/0)
Vermont	A	100% (5/5)	— (0/0)	— (0/0)	71% (5/7)	100% (1/1)	78% (7/9)
<b>NORTHEAST</b>	<b>C</b>	<b>59% (253/427)</b>	<b>13% (2/16)</b>	<b>38% (5/13)</b>	<b>49% (23/47)</b>	<b>80% (100/125)</b>	<b>44% (36/82)</b>
Alabama	F	16% (7/44)	0% (0/13)	20% (4/20)	0% (0/5)	29% (2/7)	9% (1/11)
Arkansas	C	41% (17/41)	21% (3/14)	50% (2/4)	26% (5/19)	67% (4/6)	17% (6/35)
Delaware	C	60% (3/5)	— (0/0)	— (0/0)	— (0/0)	100% (2/2)	— (0/0)
District of Columbia	B	80% (4/5)	— (0/0)	— (0/0)	— (0/0)	100% (2/2)	— (0/0)
Florida	C	49% (56/115)	29% (13/45)	65% (13/20)	60% (3/5)	64% (30/47)	31% (4/13)

**Table 1** Prevalence and Distribution of Palliative Care in U.S. Hospitals *(continued)*

PERCENT OF HOSPITALS REPORTING A PALLIATIVE CARE PROGRAM							
	Grade	50+ Beds	For-Profit	Public	Sole Community Provider	300+ Beds	< 50 Beds
Georgia	D	38% (28/74)	0% (0/15)	42% (8/19)	14% (1/7)	80% (16/20)	17% (5/29)
Kentucky	D	37% (20/54)	13% (1/8)	17% (1/6)	13% (1/8)	69% (9/13)	17% (5/30)
Louisiana	D	27% (13/48)	15% (2/13)	21% (4/19)	0% (0/4)	50% (4/8)	0% (0/21)
Maryland	B	67% (28/42)	100% (1/1)	— (0/0)	— (0/0)	80% (8/10)	0% (0/4)
Mississippi	F	10% (5/48)	0% (0/17)	6% (1/17)	6% (1/16)	10% (1/10)	5% (2/44)
North Carolina	B	69% (55/80)	50% (3/6)	65% (17/26)	30% (3/10)	85% (17/20)	21% (5/24)
Oklahoma	F	19% (8/43)	14% (2/14)	0% (0/8)	4% (1/25)	55% (6/11)	7% (4/55)
South Carolina	D	30% (13/44)	13% (2/16)	27% (3/11)	33% (3/9)	50% (5/10)	7% (1/15)
Tennessee	C	45% (24/53)	24% (4/17)	25% (2/8)	67% (2/3)	75% (12/16)	31% (9/29)
Texas	D	33% (66/203)	14% (12/85)	29% (9/31)	7% (4/56)	60% (32/53)	10% (16/159)
Virginia	B	63% (34/54)	50% (5/10)	67% (2/3)	42% (5/12)	77% (10/13)	33% (3/9)
West Virginia	B	67% (20/30)	50% (3/6)	50% (1/2)	31% (4/13)	100% (4/4)	22% (5/23)
<b>SOUTH</b>	<b>C</b>	41% (401/983)	18% (51/280)	35% (67/194)	17% (33/192)	65% (164/252)	13% (66/501)
Alaska	C	60% (3/5)	100% (1/1)	0% (0/1)	50% (4/8)	100% (1/1)	38% (3/8)
Arizona	C	50% (18/36)	0% (0/6)	50% (1/2)	50% (5/10)	77% (10/13)	20% (1/5)
California	C	56% (127/225)	15% (6/40)	56% (19/34)	37% (10/27)	74% (42/57)	24% (10/42)
Colorado	B	67% (18/27)	83% (5/6)	33% (1/3)	22% (4/18)	89% (8/9)	11% (3/27)
Hawaii	C	45% (5/11)	— (0/0)	50% (1/2)	33% (1/3)	100% (1/1)	25% (1/4)
Idaho	C	56% (5/9)	0% (0/1)	67% (2/3)	0% (0/3)	100% (2/2)	19% (4/21)
Montana	A	88% (7/8)	— (0/0)	— (0/0)	32% (7/22)	100% (1/1)	19% (8/42)
Nevada	D	23% (3/13)	0% (0/6)	0% (0/1)	0% (0/4)	0% (0/3)	0% (0/5)
New Mexico	D	33% (5/15)	0% (0/5)	50% (1/2)	13% (2/16)	100% (2/2)	0% (0/10)
Oregon	B	72% (18/25)	0% (0/2)	100% (2/2)	43% (6/14)	100% (6/6)	28% (9/32)
Utah	C	56% (9/16)	14% (1/7)	100% (1/1)	21% (3/14)	100% (3/3)	21% (3/14)
Washington	B	65% (22/34)	67% (2/3)	30% (3/10)	25% (2/8)	100% (9/9)	18% (5/28)
Wyoming	D	25% (2/8)	0% (0/1)	33% (2/6)	18% (4/22)	— (0/0)	12% (2/17)
<b>WEST</b>	<b>C</b>	56% (242/432)	19% (15/78)	49% (33/67)	28% (48/169)	79% (85/107)	19% (49/255)
<b>NATIONAL</b>	<b>C</b>	53% (1294/2452)	20% (84/413)	41% (144/352)	29% (160/554)	75% (472/626)	20% (296/1470)

**Table 2** Prevalence of Palliative Care Health Care Professionals

	ABHPM-Certified Physicians	Medicare Deaths Per Certified Physician	Medicare Hospital Deaths Per Certified Physician	NBCHPN-Certified Advanced Practice Nurses	Medicare Deaths Per Certified APN	Medicare Hospital Deaths Per Certified APN	NBCHPN-Certified Registered Nurses	Medicare Deaths Per Certified RN	Medicare Hospital Deaths Per Certified RN	Medicare Deaths (2005)	Medicare Deaths Occurring Within a Hospital (2005)
Illinois	101	689	196	12	5,800	1,652	338	206	59	69,602	19,824
Indiana	34	1,142	305	4	9,705	2,592	195	199	53	38,819	10,366
Iowa	26	784	181	2	10,195	2,359	195	105	24	20,389	4,718
Kansas	29	602	149	5	3,490	863	109	160	40	17,448	4,313
Michigan	96	638	165	21	2,915	754	308	199	51	61,218	15,842
Minnesota	58	383	91	13	1,707	405	177	125	30	22,186	5,265
Missouri	40	867	256	3	11,554	3,408	188	184	54	34,662	10,225
Nebraska	8	1,357	347	0	—	—	77	141	36	10,852	2,772
North Dakota	9	480	110	1	4,319	990	12	360	83	4,319	990
Ohio	116	591	149	36	1,903	481	623	110	28	68,501	17,310
South Dakota	4	1,296	299	1	5,185	1,195	7	741	171	5,185	1,195
Wisconsin	61	539	125	11	2,986	694	277	119	28	32,849	7,635
<b>MIDWEST</b>	<b>582</b>	<b>663</b>	<b>173</b>	<b>109</b>	<b>3,542</b>	<b>922</b>	<b>2,506</b>	<b>154</b>	<b>40</b>	<b>386,030</b>	<b>100,456</b>
Connecticut	28	767	237	11	1,953	602	110	195	60	21,481	6,626
Maine	17	566	162	0	—	—	65	148	42	9,630	2,751
Massachusetts	76	428	127	24	1,355	401	238	137	40	32,530	9,631
New Hampshire	20	377	99	5	1,509	394	107	71	18	7,544	1,972
New Jersey	68	718	257	17	2,873	1,029	271	180	65	48,849	17,495
New York	268	343	128	47	1,958	729	531	173	65	92,025	34,259
Pennsylvania	108	700	196	15	5,043	1,412	491	154	43	75,640	21,175
Rhode Island	6	845	246	4	1,267	369	29	175	51	5,068	1,477
Vermont	13	297	77	2	1,930	503	46	84	22	3,859	1,006
<b>NORTHEAST</b>	<b>604</b>	<b>491</b>	<b>160</b>	<b>125</b>	<b>2,373</b>	<b>771</b>	<b>1,888</b>	<b>157</b>	<b>51</b>	<b>296,626</b>	<b>96,393</b>
Alabama	26	1,107	364	2	14,394	4,733	187	154	51	28,787	9,465
Arkansas	13	1,489	477	1	19,363	6,198	70	277	89	19,363	6,198
Delaware	5	1,060	291	2	2,649	726	28	189	52	5,298	1,453
District of Columbia	12	237	77	1	2,840	930	3	947	310	2,840	930
Florida	177	568	144	20	5,030	1,279	1,034	97	25	100,609	25,575

**Table 2** Prevalence of Palliative Care Health Care Professionals (*continued*)

	ABHPM-Certified Physicians	Medicare Deaths Per Certified Physician	Medicare Hospital Deaths Per Certified Physician	NBCHPN-Certified Advanced Practice Nurses	Medicare Deaths Per Certified APN	Medicare Hospital Deaths Per Certified APN	NBCHPN-Certified Registered Nurses	Medicare Deaths Per Certified RN	Medicare Hospital Deaths Per Certified RN	Medicare Deaths (2005)	Medicare Deaths Occurring Within a Hospital (2005)
Georgia	44	925	261	5	8,136	2,295	302	135	38	40,681	11,474
Kentucky	34	771	238	4	6,553	2,024	232	113	35	26,212	8,094
Louisiana	30	832	248	2	12,475	3,718	96	260	77	24,950	7,436
Maryland	56	487	149	13	2,099	643	213	128	39	27,288	8,361
Mississippi	6	3,112	1,085	0	—	—	37	505	176	18,673	6,512
North Carolina	75	656	204	15	3,282	1,021	479	103	32	49,224	15,314
Oklahoma	32	721	208	0	—	—	190	121	35	23,082	6,671
South Carolina	21	1,194	410	4	6,267	2,153	160	157	54	25,067	8,613
Tennessee	42	847	270	9	3,952	1,261	150	237	76	35,570	11,352
Texas	189	512	137	14	6,918	1,847	670	145	39	96,855	25,863
Virginia	69	563	178	14	2,775	880	270	144	46	38,845	12,316
West Virginia	17	792	256	2	6,732	2,176	112	120	39	13,463	4,352
<b>SOUTH</b>	<b>848</b>	<b>680</b>	<b>200</b>	<b>108</b>	<b>5,341</b>	<b>1,574</b>	<b>4,233</b>	<b>136</b>	<b>40</b>	<b>576,807</b>	<b>169,978</b>
Alaska	7	247	65	2	866	227	15	115	30	1,732	454
Arizona	64	333	67	11	1,938	391	350	61	12	21,321	4,300
California	275	370	110	30	3,392	1,010	678	150	45	101,756	30,308
Colorado	57	244	47	8	1,739	334	188	74	14	13,914	2,670
Hawaii	27	143	48	2	1,924	645	34	113	38	3,848	1,289
Idaho	5	1,365	293	0	—	—	43	159	34	6,823	1,467
Montana	9	677	157	1	6,089	1,417	46	132	31	6,089	1,417
Nevada	18	461	124	3	2,767	741	44	189	51	8,302	2,224
New Mexico	34	235	56	2	3,999	958	78	103	25	7,997	1,915
Oregon	45	317	72	5	2,857	645	174	82	19	14,284	3,225
Utah	23	381	66	4	2,188	377	85	103	18	8,753	1,510
Washington	48	574	138	7	3,937	947	188	147	35	27,559	6,626
Wyoming	5	552	137	0	—	—	26	106	26	2,759	686
<b>WEST</b>	<b>617</b>	<b>365</b>	<b>94</b>	<b>75</b>	<b>3,002</b>	<b>775</b>	<b>1,949</b>	<b>116</b>	<b>30</b>	<b>225,137</b>	<b>58,092</b>
<b>NATIONAL</b>	<b>2,651</b>	<b>560</b>	<b>160</b>	<b>417</b>	<b>3,560</b>	<b>1,019</b>	<b>10,576</b>	<b>140</b>	<b>40</b>	<b>1,484,600</b>	<b>424,919</b>

## Glossary

Here are some terms used throughout this report, along with others you are likely to encounter in similar publications.

### Allopathic medicine

Also known as “conventional medicine,” the system of medical practice that treats disease by using remedies that produce effects that are different from those produced by the disease under treatment. MDs practice allopathic medicine.

### Hospice care

Care focused on relieving symptoms and supporting terminally ill patients who are no longer seeking curative or life-prolonging treatments and are expected to live for about six months or less. Hospice care provides palliative care, but emphasizes only care, not cure. It is a team-oriented approach to medical care, pain management and emotional and spiritual support. The Medicare hospice benefit is limited to patients with a life expectancy of six months or less.

### Hospital palliative care program

Interdisciplinary medical team focused on symptom management, intensive patient-physician-family communication, clarifying goals of treatment and coordination of care across health care settings.

### Hospital types

*For-profit hospitals* have fifty or more total facility beds and are run by individuals, partnerships or corporations.

*Large hospitals* have three hundred or more facility beds.

*Public hospitals* are not-for-profit institutions run by a state, county, city, joint city-county or hospital district or authority, with fifty or more total facility beds. (In this report, nongovernment, not-for-profit hospitals, such as those run by church-affiliated institutions, were excluded from this category.)

*Small hospitals* have fewer than fifty facility beds.

*Sole community provider (SCP) hospitals* receive special designation by Medicare because they are located more than 35 miles from other hospitals, or they serve as the sole provider of health care services for a region due to limitations in local topography or prolonged severe weather conditions.

**Hospitalist**

Physician who specializes in the care of hospital patients.

**National Consensus Project for Quality Palliative Care (NCP)**

National project that published formal definitions of palliative care in 2004 (*Clinical Practice Guidelines for Quality Palliative Care*). The guidelines were intended to direct the development and structure of both new and existing palliative care programs, establish uniform definitions of the essential elements of palliative care, establish national goals for access to palliative care, promote performance measurement and quality improvement initiatives in palliative care services and foster continuity of palliative care across settings (including home, hospital and hospice). The guidelines are presented within eight defined domains of quality palliative care.

**National Quality Forum (NQF)**

Framework for preferred practices of providing quality palliative care, released in 2006. 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 National Consensus Project for Quality Palliative Care's clinical practice guidelines as a starting point for identifying expectations and best practices in palliative care.

**Palliative care, palliative medicine**

The medical subspecialty focused on relief of the pain and other symptoms of serious illness. The goal of palliative care is to maximize quality of life for both patients and their families. Palliative care can be provided at any point in an illness, often concurrently with curative or life-prolonging treatments.

Palliative care is not the same as hospice care, which focuses on terminally ill patients who are no longer pursuing curative or life-prolonging treatment.

The American Board of Medical Specialties approved palliative medicine as a new physician subspecialty in 2006. Ten specialty groups—anesthesiology; emergency medicine; family medicine; obstetrics and gynecology; internal medicine; pediatrics; physical medicine and rehabilitation; psychiatry and neurology; radiology; and surgery—currently endorse hospice and palliative medicine as a subspecialty of their fields. With this endorsement physicians now have the opportunity to pursue post-graduate subspecialty training in palliative care.

**Palliative care team**

An interdisciplinary medical team that includes physicians, nurses and social workers, and may also include chaplains, massage therapists, pharmacists, nutritionists and others. These teams specialize in the treatment of the pain and other symptoms of serious, complex illness; intensive patient-physician-family communication; clarification of goals of care; and coordination of care across multiple settings.



### **The Center to Advance Palliative Care**

The Center to Advance Palliative Care (CAPC), established in 2000, is a not-for-profit national organization whose purpose is to provide health care professionals with the tools, training and technical assistance necessary to start and sustain successful palliative care programs in hospitals and other health care settings. Our goal is to increase the availability of quality palliative care services for people facing serious, complex illness.

Led by Diane E. Meier, MD, CAPC receives direction and technical assistance from Mount Sinai School of Medicine, New York City. We work with leading consultants and faculty from the fields of health care and business. We also work in close partnership with the National Palliative Care Research Center.

Our work focuses primarily on the operational development of palliative care programs in hospitals, because most seriously ill patients will end up in the hospital at some point in their illness. Hospitals are also the best places to plan for the next phase in the care continuum.

CAPC is supported by funding from Aetna Foundation, Brookdale Foundation, JEHT Foundation, the John A. Hartford Foundation and the Robert Wood Johnson Foundation.

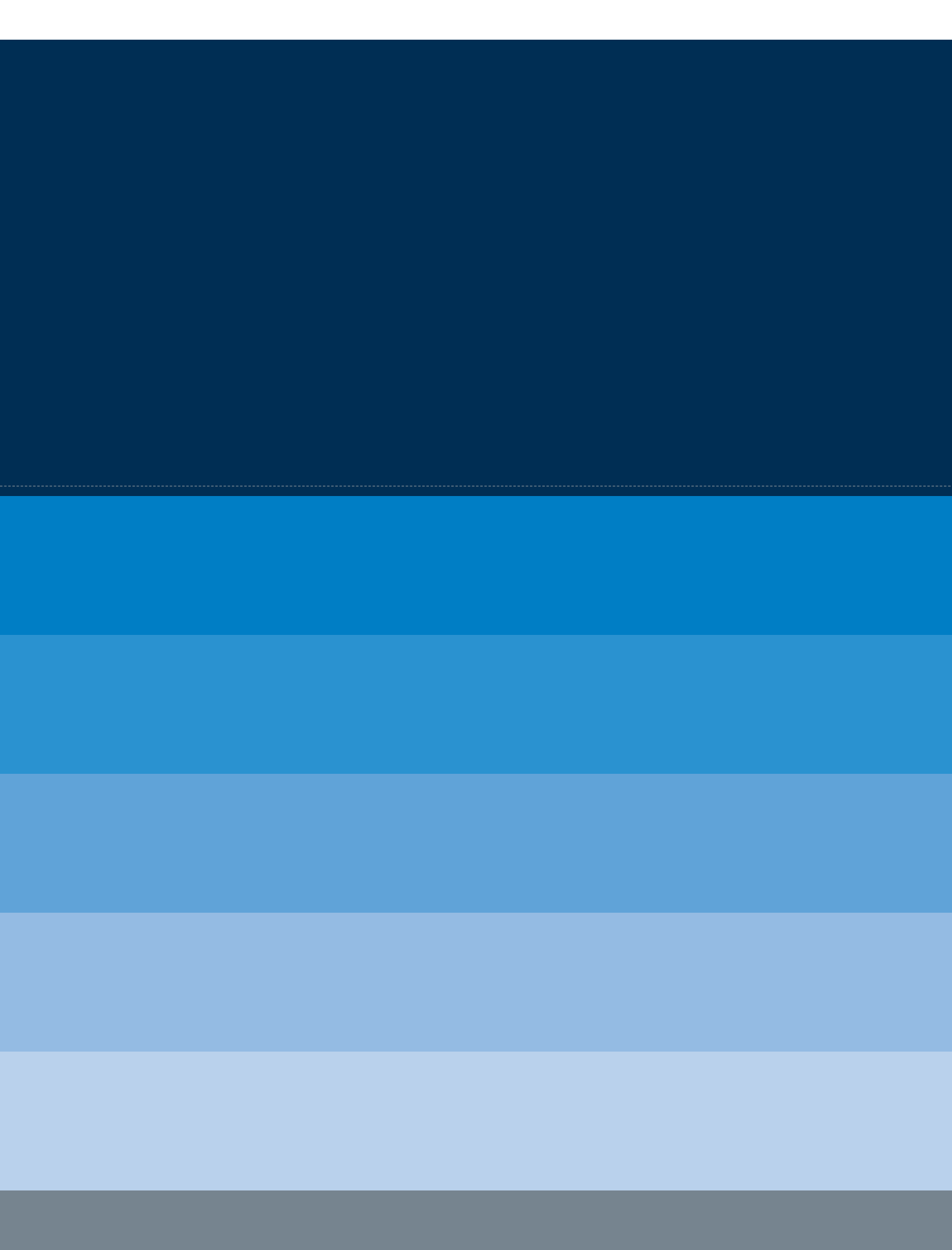


### **The National Palliative Care Research Center**

The mission of the National Palliative Care Research Center (NPCRC), established in 2006, is to improve care for patients with serious illness and address the needs of their families by promoting palliative care research. Specifically, the NPCRC 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 center is led by R. Sean Morrison, MD, and is located in New York City. The NPCRC receives direction and technical assistance from the Mount Sinai School of Medicine. 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 both patients living with serious illness and their families.

The NPCRC is supported by the Brookdale Foundation, the Emily Davie and Joseph S. Kornfeld Foundation, the National Institute on Aging, the Olive Branch Foundation, the Helen and Michael Chiang Foundation and the Levy Foundation and works in partnership with the American Cancer Society.





Center to Advance Palliative Care

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