with newly established palliative care programs and those that closed programs between 2013 and 2016.

Methods. We linked the American Hospital Association Annual Survey to the National Palliative Care Registry for 2013 and 2016. We categorized hospitals as newly establishing a palliative care program, closing a program, or no change. We used 3 multivariate logistic regressions to identify factors associated with each category.

Results. Nationally, the proportion of hospitals with 50 or more beds with a palliative care program increased from 67% in 2013 to 78% in 2016. A total of 278 hospitals established palliative care programs and 61 hospitals closed programs during this period. The proportion of for-profit hospitals with palliative care increased from 23% to 45% compared with nonprofit hospital increase from 78% to 88%. Hospitals with new vs established programs were more likely to be smaller (AOR 8.41, 95% CI 5.49-12.89 for 50-149 vs >300 beds; AOR 3.75, 95% CI 2.43-5.79 for 150-300 vs >300 beds), for-profit (AOR 7.45, 95% CI 4.95-11.19), sole community providers (AOR 3.36, 95% CI 1.97-5.73), and in the South Atlantic. Hospitals that closed palliative care programs had similar characteristics to hospitals that newly established programs.

Conclusion. Palliative care program implementation is volatile among for-profit and smaller hospitals and varies by region. The impact of these changes on access to palliative care remains a critical area for future research.

Implications for Research, Policy, or Practice. Understanding longitudinal patterns in palliative care program implementation and closure will enable development of technical assistance and resources to maximize access to palliative care.

Development of a Social Work-Led Primary Palliative Care Model in Hospital Medicine (FR481C)

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Objectives
- Describe what is involved in an embedded primary palliative care program.
- Describe how an embedded primary palliative care program model can improve patient outcomes.

Original Research Background. Due to palliative clinician workforce shortages and the growing number of patients with serious illness in need of palliative care, innovative primary palliative care models are essential to meet this population's needs using the existing resources.

Research Objectives. To increase palliative care delivery, enhance appropriate hospice referral and decrease readmissions of seriously ill patients admitted to the hospitalist service.

Methods. To meet unmet palliative care needs of patients admitted to the hospitalist service at Mount Sinai Medical Center, a social worker-led embedded primary palliative care model was developed. The social worker facilitated goals of care discussions, delivery of prognosis, discharge planning, and completion of advance directive documentation.

Results. In 2017, 184 patients received a primary palliative care consultation; those patients seen had an average age of 70 years, 43% were female and the median Karnofsky performance status of 40%, as compared to 20% for those seen by specialty palliative care. Overall, 51% of the patients seen met palliative care solid tumor oncology trigger criteria, 20% were triaged from the specialty palliative care team and 15% were direct referrals from hospitalists. Of those evaluated, 5% had documented goals of care in the electronic medical record before the consultation and 92% after the consultation. The hospice referral rate was 25% and the specialty palliative care referral rate was 25%. Reasons for referral to specialty palliative care were transfer to the palliative care unit (51%) and complex symptom management (49%). Of those who received the consultation, 30-day readmission rate was 5.3%, as compared to those who did not (16%).

Conclusion. Patients seen by the social worker-led primary palliative care team were more functional, suggesting they were seen earlier in their disease course, and had fewer readmissions.

Implications for Research, Policy, or Practice. Primary Palliative Care Models broaden the reach of Palliative Care to patients who are seriously ill.

Promoting Resilience in Stress Management (PRISM): A Prevention Model for Palliative Care (FR481D)

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