

# Palliative Care in Colorado



May 2015

**Trends, Gaps and  
Opportunities to  
Improve Care for  
Coloradans**



CENTER FOR IMPROVING  
**VALUE** IN HEALTH CARE

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### Acknowledgements

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- Colorado Health Foundation
- Palliative Care Task Force
- Hospice Analytics
- Colorado Hospitals and Hospices



Palliative care is specialized medical care for people with serious illnesses. This type of care is focused on providing patients with relief from the symptoms, pain and stress of serious illness, whatever the diagnosis. The goal is to improve the quality of life for both the patient and the family. Palliative care is provided by a team of physicians, nurses and other specialists who work with a patient's other health care providers to provide an extra layer of support. Palliative care is appropriate at any age and at any stage in a serious illness and can be provided together with curative treatment.

### Colorado Standards for Hospitals and Health Facilities, Chapter 2 – General Licensure Standards (6 CCR 1011-1 Chap 02)

The misconception that palliative care is the same as hospice care has made palliative care a sensitive and often avoided subject with many people - patients and providers alike. In reality, while palliative care can include hospice care, it is much broader than immediate end of life care and can be incredibly helpful to anyone suffering with a severe or life-limiting illness. As a result of the confusion between hospice and palliative care, palliative care services are often unavailable and underutilized.

Palliative care has long been identified as a prime area of opportunity to improve patient and family satisfaction, care and lower health care costs. While many agree that palliative care needs improvement, challenges in addressing the needs exist due to discrepancies in the definition of palliative care and the services provided.

This report summarizes a survey conducted in 2013 by Hospice Analytics to evaluate palliative care services across Colorado and measure trends in palliative care compared to an initial 2008 benchmark survey. Specifically, the survey was designed to identify where, how, and to whom services are being provided, and to identify barriers to expanding palliative care services.

#### RESEARCH QUESTIONS

- Where are palliative care services being provided across the state?
- Are facilities providing services using team-based approaches for care or a single provider?
- Are all patients being offered palliative care services or just a specific sub-set of patients?
- Is palliative care reimbursed by insurers or do facilities see it as a cost of doing business?

The overall goal of the survey was to develop a clearer picture of palliative care services across the state in order to identify gaps and ultimately address challenges and barriers that are preventing Coloradans from receiving the best possible care. While every question about palliative care cannot be answered with the results of a single survey, the findings provide key insights into palliative care in Colorado:

- Hospitals continue to be the primary source of palliative care across the state
- Hospital-based palliative care consults increased by more than 400 percent from 2008-2013
- Hospice-based palliative care consults increased by more than 200 percent from 2008-2013
- Reimbursement continues to be a concern and creates a substantial barrier to expanded service from all providers
- Access to palliative care is disproportionately centered in the metro Denver area, leaving more rural residents without a source of care

#### KEY FINDINGS

- Hospitals are primary source of palliative care
- Palliative care visits have increased since 2008
- Barriers include lack of reimbursement and cultural misconceptions
- Rural areas lacking in palliative care services

Despite significant increases in the number of palliative care consults being given around the state, reimbursement and cultural misperceptions continue to create barriers to more widespread implementation. In fact, since this survey was conducted, several hospice-based palliative care programs have shut their doors because of a lack of sustainable reimbursement and a lack of patient demand for the service.

Survey results indicate that Colorado has significant opportunities to improve access to palliative care services across the state. The lack of knowledge about when to initiate palliative care, inconsistent understanding about what palliative care is and should be, and inadequate financial reimbursement for the provision of services are preventing thousands of patients, families and caregivers from gaining better health and higher quality care.

More research and changes in policy and reimbursement structure needs to occur at the local and national level to improve access to effective palliative care services. To that end, CIVHC is working with several partners to analyze claims information from the Colorado All Payer Claims Database to identify the impact palliative care services have on utilization of services and costs. Results of the analysis may be utilized to encourage reimbursement by demonstrating a return on investment. In addition, recent federal funding opportunities to advance the science of palliative care may indicate the beginning of a cultural priority change and may indicate increased awareness of the benefits of palliative care.

## BACKGROUND



When the Center for Improving Value in Health Care (CIVHC) was established in 2008, health care organizations and stakeholders across the state came together to determine focus areas that would have the biggest potential impact on Coloradans. Palliative care was identified as a one of the most direct ways to advance the Triple Aim goals of better health, better care and lower costs. Effective and timely provision of palliative care improves the quality of care for

patients, improves patient and family satisfaction and decreases the total cost of care.

### PALLIATIVE CARE

- Is NOT the same as hospice care
- Provided to alleviate pain, symptoms and stress related to severe illnesses
- Improves quality of life, patient and family satisfaction and decreases costs

The misconception that palliative care is the same as hospice care has made palliative care a sensitive and often avoided subject with many people - patients and

providers alike. In reality, while palliative care can include hospice care, it is much broader than immediate end of life care and can be incredibly helpful to anyone suffering with a severe or life-limiting illness. As a result of the confusion between hospice and palliative care, palliative care services are often unavailable and underutilized.

In 2010, CIVHC and the Colorado Department for Health Care Policy and Financing (HCPF) established a palliative care task force to examine the provision of palliative care in Colorado and determine next steps to promote its use. Over the next years, the task force built a set of eight recommendations and began working to move each of them forward. The recommendations addressed such issues as: education and culture change, policy and regulation development, increasing the number of patients receiving palliative care across the state, improving reimbursement, and several more.

In order to evaluate the state of palliative care in Colorado and what progress had been made over the years, CIVHC used a 2008 survey from the Colorado Center for Hospice & Palliative Care (COCHPC) as a baseline. In that survey, COCHPC conducted phone surveys with Colorado hospitals and hospices to better understand where palliative care services were being provided in the state, the number of palliative care consults performed, and to describe the composition of teams providing palliative care.

In 2013, CIVHC contracted with Hospice Analytics to replicate and expand the 2008 study to identify trends and changes in palliative care services across the state. The 2013 survey was specifically designed to evaluate the where and how palliative care services are being provided across the state and measure the growth in palliative care since the initial 2008 benchmark

survey. In addition, the survey sought to identify how palliative care services were being paid for. The 2013 survey identified answers to the following broad questions.

## RESEARCH QUESTIONS

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## SURVEY METHODOLOGY



From March through August of 2013, Hospice Analytics contacted Colorado hospitals and hospices to conduct a phone survey on palliative care using a structured set of questions (see Appendix A). On average, the surveys took 20-30 minutes to complete. The final survey question, “Outside of your program and local hospitals and hospices, who else in your community provides palliative care services?” was intended to identify any palliative care providers in Colorado outside of hospitals and hospices. The survey used the definition of palliative care adopted into the state standards for hospitals and health facilities:

Palliative care is specialized medical care for people with serious illnesses. This type of care is focused on providing patients with relief from the symptoms, pain and stress of serious illness, whatever the diagnosis. The goal is to improve quality of life for both the patient and the family. Palliative care is provided by a team of physicians, nurses, and other specialists who work with a patient’s other health care providers to provide an extra layer of support. Palliative care is appropriate at any age and at any stage in a serious illness and can be provided together with curative treatment.

Colorado Standards for Hospitals and Health Facilities,  
Chapter 2 – General Licensure Standards (6 CCR 1011-1 Chap 02)

Hospitals were asked three additional questions about palliative care to try to identify sources of variation in reporting:

- Do you use the V66.7 secondary billing code for palliative care? If so, how many times did you use it in the past year?
- Is your hospital registered with the Center for Advancing Palliative Care’s (CAPC) Get Palliative Care Initiative?
- Does your hospital participate in the American Hospital Association Survey or CAPC’s Palliative Care Report Card?

All 99 Colorado hospitals and 52 Colorado hospices completed the palliative care phone survey. No other palliative care providers were identified outside of those facility types in either 2008 or 2013.

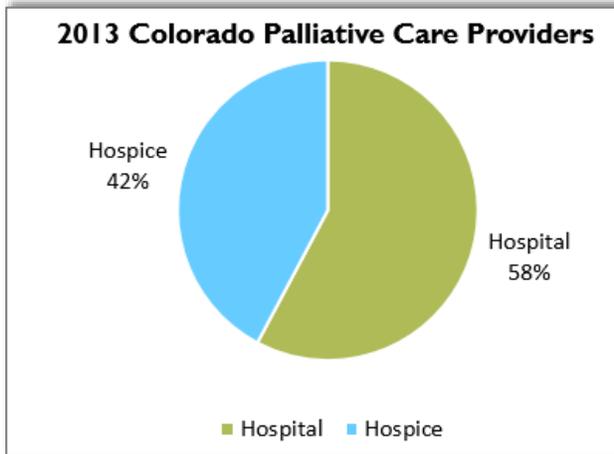
Note: Facilities were asked to self-identify the most appropriate person to answer the survey questions; therefore, answers may be subject to variation based on who was participating in the interview and how terminology was interpreted.

# FINDINGS

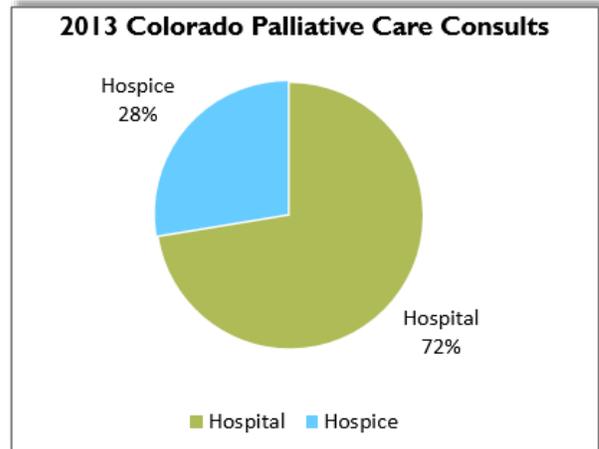


Of the palliative care services provided in 2013, the majority (58 percent) occurred in a hospital-based setting compared to 42 percent in a hospice. Seventy-two percent of the total palliative care consults in 2013 were provided in a hospital rather than hospice-based setting.

**FIGURE 1: PERCENTAGE OF TOTAL PROVIDERS BY FACILITY**



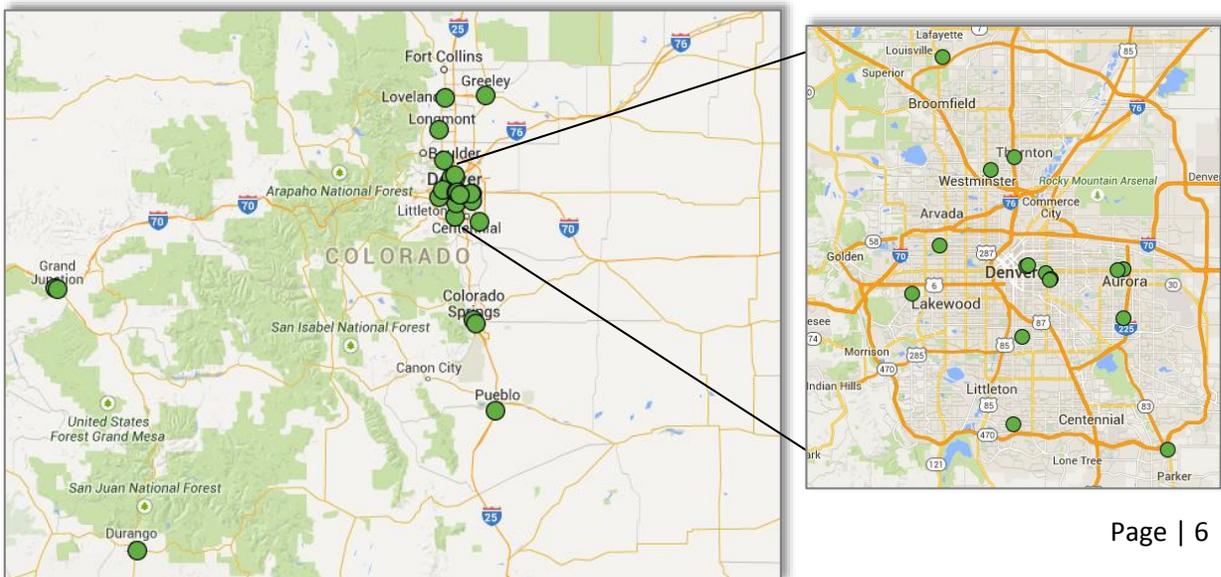
**FIGURE 2: 2013 PERCENTAGE OF CONSULTS BY FACILITY**



## Hospital-based Palliative Care Results

Though there appears to be a slight increase in the number of hospitals providing palliative care (26 of 99 in 2013 compared to 21 of 84 hospitals in 2008), this is most likely due to a more comprehensive survey of hospitals rather than an actual increase in providers, indicating little to no real growth in the number of hospitals providing palliative care. Appendix B contains a directory of hospitals providing palliative care with contact information and data on number of consults in 2008 and 2013.

**FIGURE 3: 2013 MAP - COLORADO HOSPITALS PROVIDING PALLIATIVE CARE**



The map above illustrates the distribution of hospital-based palliative care services across Colorado. Hospitals providing palliative care are clustered in metropolitan areas, primarily along the I-25 corridor. Only one rural county (La Plata) has local access to hospital-based palliative care services.

Although the number of hospital facilities providing palliative care did not change significantly in the five years between surveys, there was more than a four-fold increase in the number of palliative care consults provided (11,443 in 2013 compared to 2,148 in 2008). Currently there is no information to help explain the dramatic increase in the number of consults per year with a simultaneous lack of growth in the development of new palliative care programs. In fact, the continued shortage of reimbursement for palliative care provision is, if anything, a disincentive to increasing services. However, individual programs have reported dramatic improvements in their patient population when appropriate palliative care is available and feel that the service is critical, regardless of the reimbursement levels. With that in mind, facilities may find that the positive impact on patients outweighs the cost of providing palliative care and increasing access to programs may be a way of improving care overall. These programs may also be seeing cost savings through palliative care-related improvements such as shorter length of stay, or reduced readmissions and ED utilization over time.

TABLE 1: SUMMARY OF HOSPITAL PALLIATIVE CARE SERVICES

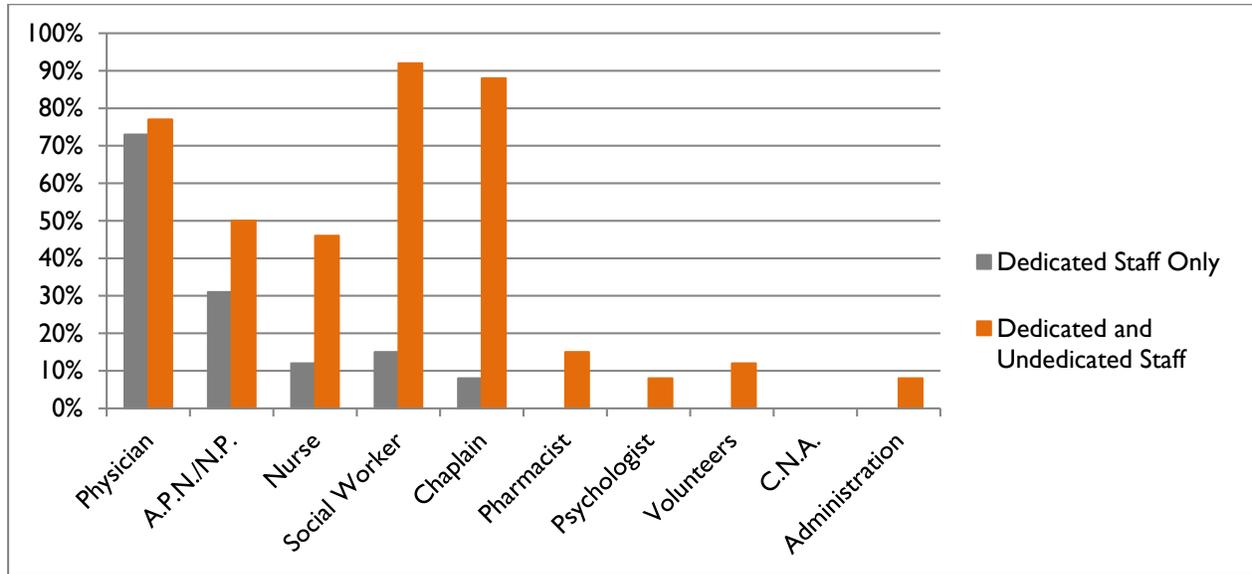
<b>Hospital Palliative Care Services</b>	<b>2008</b>	<b>2013</b>
Number of Hospitals Surveyed	84	99
Number (%) of Hospitals Providing PC Services	21 (25%)	26 (26%)
<b>Palliative Care Consults /Year</b>		
Total	2,184	11,443
Average	146	545
Range	3-720	50-1,800

### ***Hospital Team Composition***

The composition of the palliative care team is an important part of the delivery of palliative care. Many facilities provide palliative care via a single, part-time doctor or nurse, while others use a dedicated full-time team including physicians, nurses, social workers and chaplains, among others.

The graph below does not reflect how much time each employee spent in palliative care (i.e. full time equivalent hours) so the exact palliative care staffing model across facilities is unclear. For the purposes of these questions, “dedicated staff” was defined as staff whose sole responsibility was to provide palliative care services while “undedicated staff” was defined as those whose responsibilities are split between palliative care and another specialty or department.

FIGURE 4: HOSPITAL PALLIATIVE CARE TEAM COMPOSITION



### Staff Certification

The percent of hospitals reporting having at least one physician or a nurse with Hospice and Palliative Medicine certification from the American Academy of Hospice and Palliative Medicine or the National Board for Certification of Hospice and Palliative Nurses doubled from 43 percent in 2008 to 85 percent in 2013. There's no clear explanation regarding the reason for the surge in certification, but it is a trend that is mirrored nationally. The New York-based Center to Advance of Palliative Care has identified a steady increase in palliative care provision and certification through their national survey and feels that the trend can be at least partially explained by improved familiarity with palliative care and the increased data and studies to support the benefits of the service. Palliative care as a field is relatively new and some of the increases could be due to simple dissemination of the concept.

### Types and Availability of Services

One of the most significant additions to the 2013 survey was questions regarding the specifics of the palliative services being provided.

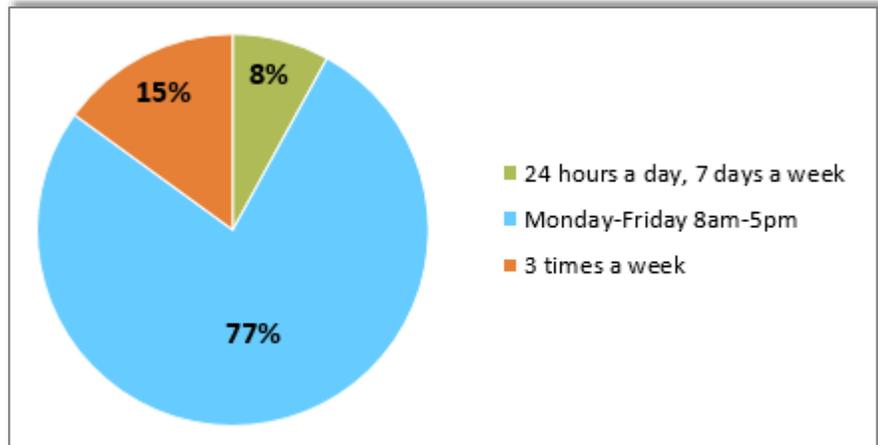
Nearly all palliative care teams reported providing the following services:

- Discussion and clarification of goals of care
- Symptom management
- Facilitation of family meetings
- Discussion of advance directives

Access to bereavement services for the family and care givers is considered a critical part of comprehensive palliative care and is included in the state definitions and regulations. Because of service limitations, most facilities referred families to local hospices for bereavement services rather than provide the services on location.

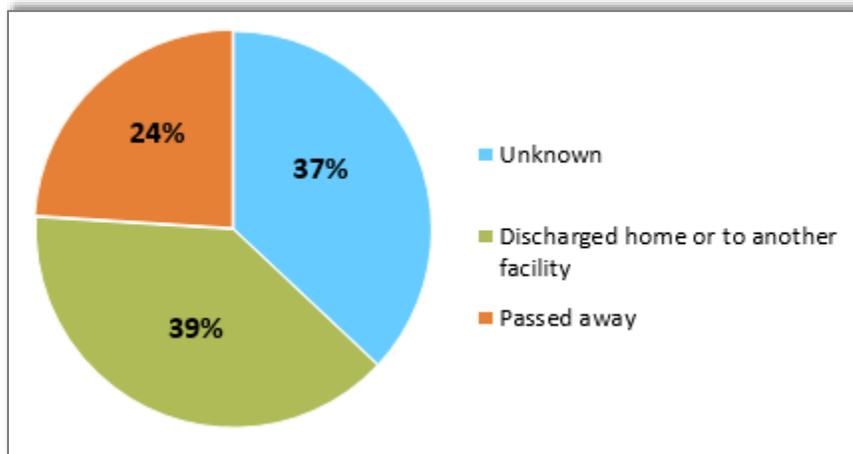
The availability of palliative care varied widely among hospitals. Eight percent reported palliative care services available around the clock, seven days a week. The majority (77 percent) of the hospital palliative care programs had services available Monday through Friday and 15 percent had services available just three days a week.

FIGURE 5: AVAILABILITY OF HOSPITAL-BASED PALLIATIVE CARE SERVICES



Questions regarding availability were not asked in the 2008 survey, so unfortunately there is no benchmark for comparison over time. Based on the qualitative feedback from hospitals, the relatively low number of hospitals providing 24 hour palliative care is likely due to a combination of a lack of staff dedicated staff and the challenges of paying for such extensive services with limited reimbursement.

FIGURE 6: DISPOSITION OF HOSPITAL-BASED PALLIATIVE CARE PATIENTS

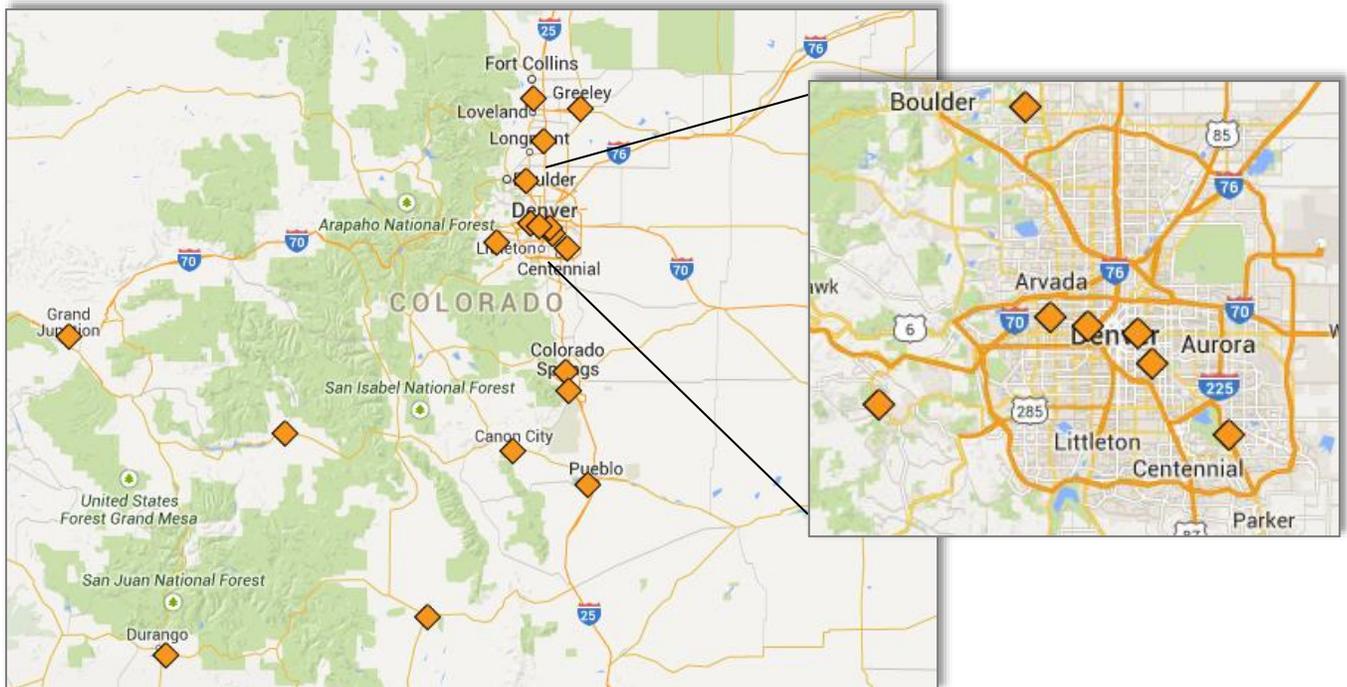


Hospitals tracked the disposition of 63 percent of their palliative care patients. Of those, 61 percent were discharged to their homes or to another facility, such as long term care or an in-patient hospice provider and 39 percent of the hospital palliative care patients deceased before discharge.

## Hospice-based Palliative Care Results

Between 2008 and 2013, the percent of hospice providers offering palliative care increased from 23 percent to 36 percent of the 53 Colorado hospices. Appendix C provides a list of palliative care hospice facilities including information on the number of consultations provided in 2008 and 2013 and contact information. The map illustrates the distribution of palliative care hospice services across the state. Although services are more concentrated in metropolitan areas, there is more access to hospice-based palliative care in rural areas compared to hospital-based services. Though access is very limited, there are five rural counties with hospice-based palliative care, including La Plata, Alamosa, Otero, Fremont and Gunnison counties.

FIGURE 7: 2013 MAP - COLORADO HOSPICES PROVIDING PALLIATIVE CARE



The number of hospice providers appears to increase from 48 to 53 providers between 2008 and 2013, though there is no indication as to whether the increase is due to actual growth in the number of providers or a more complete survey. The number of palliative care consults provided by those facilities increased more than 400 percent from 1,057 in 2008 to 4,632 in 2013—far outpacing the growth in the number of hospices providing the service. Though the growth is impressive, it is important to note that almost half of the 2013 consults were provided by a single facility. Even without the contribution of this facility, hospice-based palliative care consults more than doubled between 2008 and 2013.

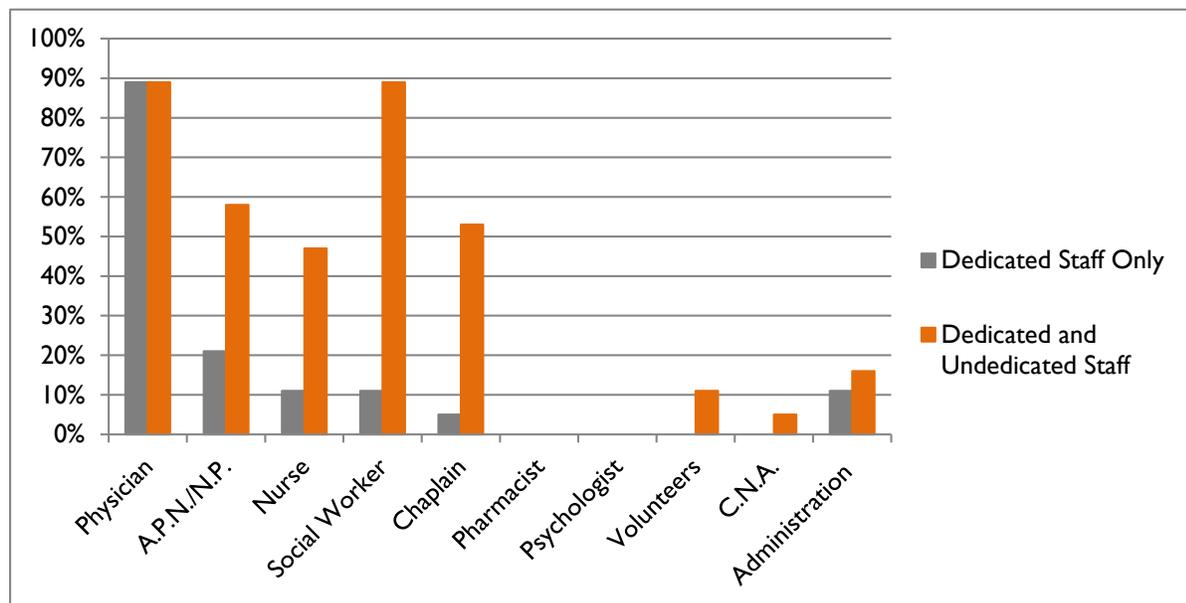
TABLE 2: SUMMARY OF HOSPICE PALLIATIVE CARE SERVICES

Hospice Palliative Care Services	2008	2013
Number of Hospices Surveyed	48	53
Number (%) of Hospices Providing PC Services	11 (23%)	19 (36%)
Palliative Care Consults / Year		
Total	1,057	4,362
Average	106	230
Range	14-412	3-2,032

### Hospice Team Composition

The composition of the hospice palliative care team has remained static over the past several years. In 2013, 74 percent of hospices reported having at least one physician or nurse certified in Hospice and Palliative Care Medicine, compared to 73 percent in 2008.

FIGURE 8: 2013 HOSPICE PALLIATIVE CARE STAFF COMPOSITION



Hospice palliative care team composition differs from hospital palliative care teams in several ways. Hospice palliative care has a higher percentage of dedicated physicians and strong administrative staff support, but has less diversity in the total available care team (dedicated and undedicated) compared to the care teams for hospital-based palliative care. From the survey feedback collected, it is likely that the decreased variety of staff is due to billing challenges and fewer resources overall compared to hospitals. Only 75 percent of hospice-based programs bill for their palliative care services, and of those that do, billing is primarily for physician services through Medicare Part B reimbursement. Limited billing for palliative care services in a hospice

setting is due to a number of factors, not limited to challenges in coding, limited authorized services, staffing and a smaller operational fund with less room for flexibility.

### **Types and Availability of Services**

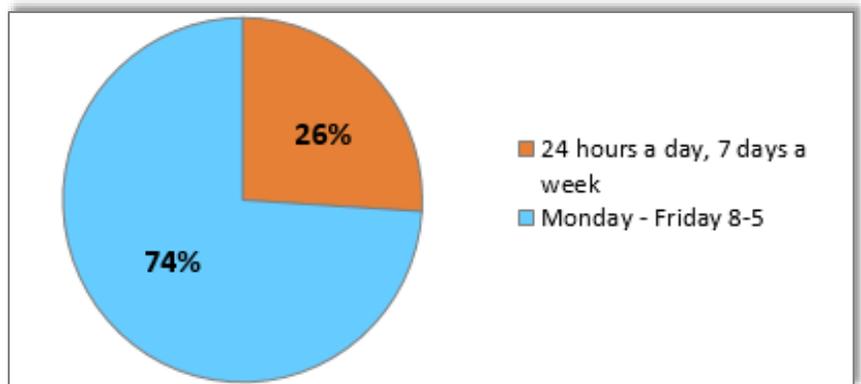
All hospice-based palliative care teams reported providing the following services:

- Discussion and clarification of goals of care
- Symptom management
- Facilitation of family meetings
- Discussion of advance directives

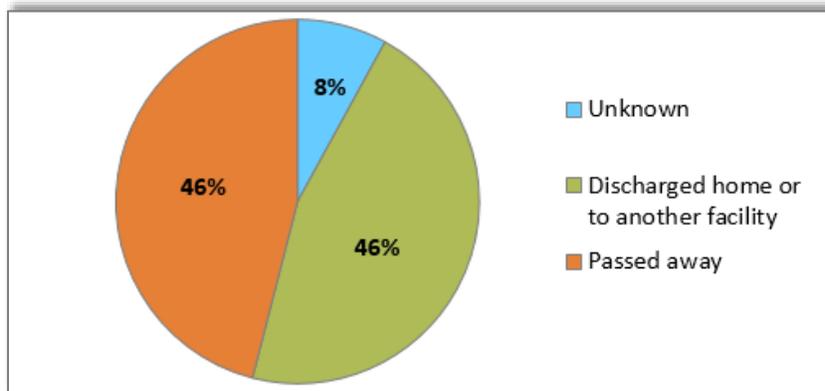
Hospice based palliative care programs also generally provided bereavement services to families and loved ones.

The disposition of palliative care patients in a hospice setting was tracked much more closely than in hospital settings. Across Colorado, hospice settings could account for the disposition of 92 percent of their palliative care patients. Of that 92 percent, half were discharged to home or another facility and half passed away prior to discharge.

**FIGURE 9: 2013 AVAILABILITY OF HOSPICE-BASED PALLIATIVE CARE**



**FIGURE 10: POST-PALLIATIVE CARE PATIENT DISPOSITION - HOSPICE**



Hospice-based services were generally more available to patients than hospital-based palliative care. The round-the-clock nature of hospice services results in a robust infrastructure designed to provide full support and services 24 hours a day. Because of the decreased reliance on an 8-5

schedule, hospice settings are more able to provide more constant palliative care services. Many hospices depend in great part on alternative delivery methods such as telephonic and remote care that allow patients to access care at any point without having to leave their homes or have a live-in nurse. These adaptations support the provision of care at any time of day or night. Additionally, hospices tend to be smaller than the majority of Colorado hospitals, giving them some additional flexibility and adaptability of schedules.

## Challenges

The majority of hospital palliative care programs reported having strong administrative support for their programs, though both hospitals and hospices reported widespread financial challenges and most expressed a need to add staff. Financial reimbursement for palliative care continues to be a significant concern for all palliative care providers. Facilities can receive reimbursement for physician or nurse time as a standard visit, but there is little to no reimbursement mechanism to support social workers, pharmacists, chaplains and other members of a palliative care team. If a facility is utilizing a team-based approach to palliative care, the funding for those additional members has to come from other sources. Some use grant dollars to support palliative care, but most simply absorb the costs as operating costs. Interestingly, only half of the programs surveyed billed insurance companies for their palliative care services, primarily for physician or nurse practitioner time – the others were among those that considered palliative care costs as part of their operating budget or used grants to support the work.

With the challenges in reimbursement, it is surprising that the number of hospital-based consults rose so dramatically, and hospice consults also increased from 2008 to 2013. This again points to the possibility that palliative care provision is having a widespread impact on quality of care and patient well-being and is paying for itself in other ways (through reduced readmissions and ED utilization, etc.).

## CONCLUSION

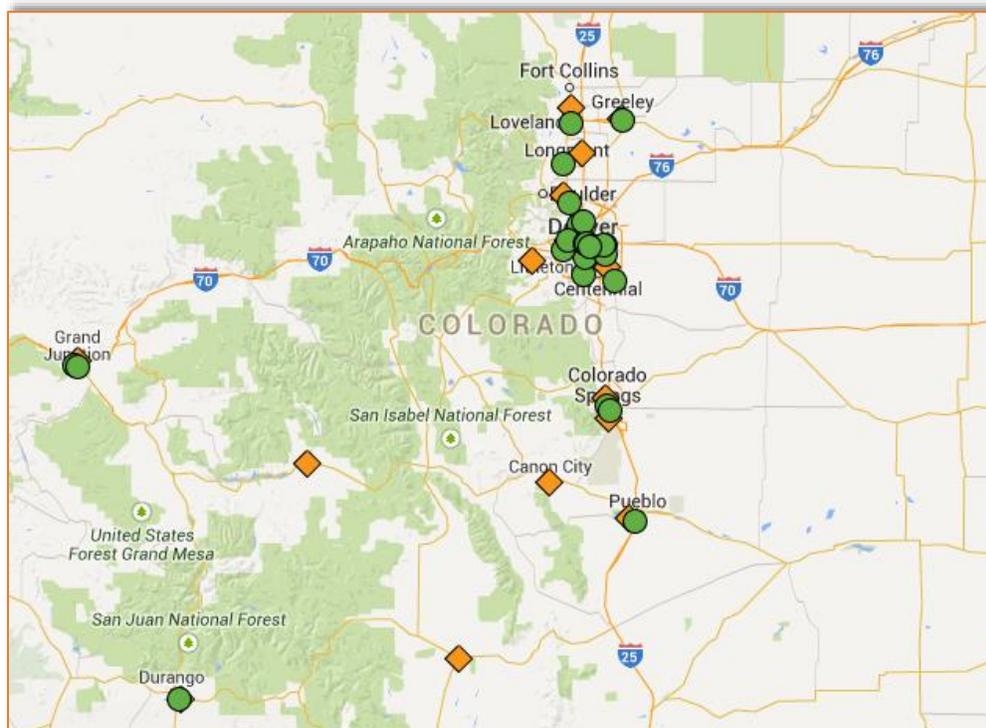


Palliative care provision is growing in Colorado. The number of people receiving palliative care services has been increasing rapidly, which is a positive step towards better health, lower costs and higher quality of care across the state.

Yet, while the number of consults is growing, the number of actual providers is not. The facilities that were providing palliative care in 2008 are still providing it today, and to more people, reaffirming that some providers and facilities are seeing palliative care as a valuable service for patients and families. While these champion facilities are investing more in providing palliative care, there have been few new facilities that recognize the benefit and are developing programs of their own. In fact, in 2014, several of the hospices that were providing palliative care at the time of this survey have eliminated or drastically reduced their palliative care programs due to the costs of maintaining the program and inadequate reimbursement for services.

Looking at the map of all palliative care providers (i.e., both hospice and hospital) in the state below, the distribution of access to palliative care is uneven, with extensive availability on the Front Range and little to no availability elsewhere in the state. Only five of Colorado's 47 rural and frontier counties have any access to palliative care services from a hospital or hospice facility.

FIGURE 11: 2013 MAP PALLIATIVE CARE PROVIDERS      - HOSPICE      - HOSPITAL



## RECOMMENDATIONS



### Reimbursement

Limited growth in the number of providers of palliative care may be due in part to the significant challenges involved with getting adequate reimbursement for palliative care services. It is possible to bill for physician and nurse time to some extent, but a large portion of the services provided in palliative care are delivered by other health care professionals who are currently unable to bill directly for their services.

Results indicate that, in large part, reimbursement drives the structure and availability of palliative care teams and amount of care provided in both hospital and hospice settings. Hospice palliative care has a higher percentage of dedicated physicians and strong administrative staff support, but has less diversity in the total available care team (dedicated and undedicated) compared to the care teams for hospital-based palliative care. It is likely that the decreased variety of staff is due to billing challenges and fewer resources overall compared to hospitals. Many benefit plans do not recognize an independent need for palliative care, and, as a result, do not reimburse for services. Neither Medicare nor Colorado Medicaid recognize an independent palliative care benefit for adults and do not reimburse for substantial services apart from physician time. Colorado Medicaid does have a waiver for a children's palliative care benefit, but the program has received criticism for low reimbursement rates and resulting low physician participation.

Limitations in reimbursement have also had a chilling effect on what services can be offered and to which patients. To be most effective, palliative care should be provided by a multi-disciplinary care team. Lack of standard reimbursement to support a team-based approach has resulted in the development of palliative care programs that are designed around dollars rather than around patients. Hospitals, with their relatively diverse services and funding streams, often have more discretionary resources than hospices, giving hospitals more freedom to allocate unreimbursed staff resources than hospices. In fact, since this survey was originally conducted, more than one hospice in Colorado has dropped their palliative care program because of issues of sustainability.

Addressing the financial concerns related to palliative care is a major problem both here in Colorado and across the nation. There has been little interest in reimbursement for palliative care services from private and public insurers. This hesitation may be due, in part, to the lack of solid evidence demonstrating the health and cost benefits of palliative care. In Colorado, CIVHC and several partners are in the process of analyzing data from the Colorado All Payer Claims Database to determine the impact of palliative care services on utilization and cost. Results of the analysis may be utilized to encourage reimbursement by demonstrating a return on investment.

While there has been some research into the physical benefits that can accrue from palliative care (such as the study finding a survival benefit from palliative care in patients with metastatic non-small-cell-lung-cancer; Temel, 2010), most published research doesn't distinguish palliative care from hospice care and tends to treat palliative care as pre-hospice care for those not ready to qualify for the Medicare hospice benefit. Without distinguishing the bulk of palliative care as a service distinct from hospice, research can fail to capture the value of early palliative care for anyone suffering from a severe illness. Chronic Obstructive Pulmonary Disease (COPD) symptoms, for example, typically have a cyclical nature with many peaks and valleys that last for years before the patient can truly be considered to be at the end of life. Palliative care can be beneficial throughout a COPD patient's entire life, rather than just in the end-stages, and it is in this interim role that palliative care is under-researched.

In response to this gap in data, the National Institute of Nursing Research has helped create a Palliative Care Research Collective at the University of Colorado at Denver and Duke University to support and encourage high quality research on the benefits of palliative care in order to advance the science and understanding of the practice.

## **Cultural Perceptions**

In addition to the lack of research, there is a persistent cultural perception that palliative care is akin to hospice – a last ditch effort to preserve comfort at the end of life when treatment options have been exhausted. There is little understanding of palliative care as the larger whole and hospice care as a specific sub-set of palliative care. While there is a definite role for palliative care at the end of life, the reach of palliative care goes well beyond hospice and end-of-life. The misperception of what palliative care can be is prevalent across the care continuum, from policy-makers to providers and patients. There is no one sector creating barriers to expanded care – the barriers come from all direction and it will require significant cultural change in order to break those barriers down.

There are efforts underway across the country to try to find ways to begin changing the cultural perceptions of palliative care. Some of these efforts focus on the research and data surrounding the practice and aim to change perceptions from an analytical standpoint, hoping that the financial return on investment will drive reimbursement and reimbursement will drive an increase in services. Other efforts, such as Respecting Choices from the Gundersen Health System in La Crosse, WI and a similar effort in Madison, WI from the Wisconsin Medical Society, work to tackle one piece of the palliative care conundrum at a time from the patient and the provider perspective. Advance care planning is one way to start educating providers, patients and families that there are choices available when it comes to the way we receive care and what care we receive. This type of work starts to lift the curtain on the mystery of palliative care and can be used as a first step in changing the way we talk about palliative care.

## Policy

On a policy level, over the past few years the Colorado Center for Hospice and Palliative Care worked with CIVHC and the Life Quality Institute to develop a definition (included in the Executive Summary and Survey Methodology section) and quality standards for incorporation in the Colorado state licensing regulations for hospitals and health care facilities. The definition and standards were adopted in January 2014 and became effective in March 2014. As these standards are enforced they will help to standardize the practice of palliative care and bring consistency to the field. Establishing a minimum level of quality for palliative care provision can only support those that can benefit from the service. Unfortunately, at the time of this writing, there is no enforcement mechanism contemplated for the new regulations. Until funding is available to support their enforcement, the regulations are little more than words on paper.

Access to palliative services is challenging for those in urban Colorado, but they are virtually impossible for rural patients to access. The combination of the lack of reimbursement with provider shortages and resource scarcity in many of our rural areas means that palliative care services are unlikely to be a priority for those providing services. State incentives for the development of programs targeting rural communities may be one way to encourage developing capacity in those underserved areas.

## Summary

Too often the term palliative care is considered synonymous with hospice or end-of-life care, when in reality, it is a supportive service that is designed to help individuals with a large range of serious illness and comorbidities. The lack of knowledge about the appropriate time and situation to initiate palliative care, the inconsistent understanding about what palliative care is and should be, and inadequate financial reimbursement for the provision of services are preventing thousands of patients, families and caregivers from gaining better health and higher quality care. It's not just the recipients of the care who need to be better informed about how to access it – providers also need to be educated regarding what palliative care actually means and what it can do for their patients.

Through combined research, policy, education, payment and practical approaches, palliative care services could be expanded across the Colorado to help improve health and the quality of care while bending the cost curve. CIVHC remains committed to informing those conversations with data and information and convening organizations to move the needle on palliative care services in our state. As mentioned, CIVHC is currently working with partners in the state to use data from the CO APCD to examine both the costs associated with providing palliative care and the cost savings realized from its provision. Armed with this information, CIVHC and our palliative care partners will be able to start making strong arguments for the expansion of palliative care to improve the well-being of Coloradans.

## APPENDIX A: 2013 SURVEY QUESTIONS

### Telephone Survey Questions

1. Provider name and contact information.
2. Palliative care service name and contact information.
3. Do you have a Palliative Care Program in place (separate from the Medicare Hospice Benefit)?
  - a. If no, to whom do you refer patients to for this type of care?
4. When was your Palliative Care Program established, and when was your first patient served?
5. Please describe the organization of your Palliative Care Program:
  - a. Name and discipline of program -\*leadership. What is the reporting structure in your organization for Palliative Care?
  - b. What disciplines participate in the program (e.g., physicians, nurses, social work, chaplain, etc.), and how many FTEs are represented by each?
  - c. How many of your physicians and nurses are Board Certified in Hospice & Palliative Medicine?
  - d. Where are services provided – Inpatient consultation service, outpatient clinic, homecare?
  - e. To whom does your program report to within the organization?
  - f. Is your program available 24/7/365?
  - g. Does your program have Joint Commission Advanced Certification in Palliative Care? If not, are you considering it?
6. Please describe your Palliative Care Program patient services:
  - a. How many patients received palliative care services in 2012?
  - b. What services are provided to patients (e.g., goals of care, bereavement, symptom management, family meetings, ADs, etc.). Is MOST being used, and if so is it being brought in from the outside as well as initiated from the inside? Is the MOST form useful? Any recommended changes?
  - c. What conditions / diagnoses are eligible to receive palliative care consultation and what conditions / diagnoses are most frequently served?
  - d. What services most frequently provide referrals to your program – where are the majority of your patients from (e.g., oncology, intensive care, emergency department, etc.)?
  - e. What percentage of your patients are discharged deceased? To hospice? To outpatient palliative care? Other?
7. Please describe financial aspects of your Palliative Care Program:
  - a. Does your program have both administrative and financial support?

If not, what's missing?

- b. Do you bill for palliative care services? Who bills and who gets billed (e.g., Medicare, Medicaid, commercial payors, etc.)?
  - c. How are palliative care services billed (e.g., by physician, APN, hospital, ICD-9 symptom codes vs. billing by time)?
  - d. Do you use the V66.7 code (encounter for palliative care) in your billing?
  - e. What percentage of your program expenses are paid for by direct care billing?
  - f. Are statistics collected / reported on cost savings / cost avoidance to the hospital? If so, approximately how much is saved per year?
8. Please describe outcome measures for your Palliative Care Program:
- a. What metrics does your program use to track success (e.g., patient satisfaction survey, etc.)?
  - b. Are there annual reviews of your program? Are there quality projects or programs monitoring the effectiveness of your program?
  - c. What percentage of patients have advance directives – both in and outside of your program?
  - d. Where has your program had the greatest impact (e.g., increasing use of advance directives, decreased critical care LOS, cost savings, increased hospice referrals, etc.)?
9. Please describe the relationship between your Palliative Care Program and local hospices:
- a. How many hospices does your program work with / refer to?
  - b. If your program works collaboratively with local hospices, please describe how services are divided between your program and hospice.
10. Outside of your program and local hospitals and hospices, who else in your community provides palliative care services?

## APPENDIX B: 2013 COLORADO HOSPITAL PALLIATIVE CARE PROVIDERS

### Contact Information and Survey Summary



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Sorted by 2013 Number of Palliative Care Consults, v. 10/21/13

Hospital / Provider	City	Palliative Care Contact	2008 Phone Survey # of PC Consults	2013 Phone Survey # of PC Consults	2011 ICD9 V66.7 Encounter w/PC Code; N Codes	2013 Hospital Registered w/CAPC's Get PC	2013 AHA Survey / CAPC PC Report Card
Northern Colorado Medical Center	Greeley	Northern Colorado Palliative Care Program - Robert Fried, Medical Director (970) 352-4121	NA	1,800	Yes, 120	Yes	Yes
Exempla Saint Joseph Hospital	Denver	Exempla St. Joseph Palliative Care Program - Jeff Manuel, MD (303) 746-9197 (303) 548-1697	720	1,272	Yes, 49	Yes	Yes
Centura Health-- St. Mary Corwin Medical Center	Pueblo	St. Mary Corwin Palliative Care Program Durelle Jones, Program Manager (719) 557-5215	100	930	Yes, 60	Yes	No
Centura Health-- St. Anthony Hospital	Lakewood	St. Anthony Palliative Care Program Chester Dreiman, MD - Medical Director (720) 321-7393	112	840	Yes, 147	Yes	Yes
Exempla Good Samaritan Medical Center	Lafayette	Good Samaritan Palliative Care Program Tiffany Malin, Social Worker (303) 689-5253	NA	810	Yes, 43	Yes	Yes
Centura Health-- Penrose-St. Francis Health Services	Colorado Springs	Penrose Hospital (PH) Palliative Care Program - Ginny Davis, Program Manager (719) 776-5746 St. Francis Medical Center (SFMC) Palliative Care Program - Katie Lammi, Program Manager (719) 571-5010	230	770	Yes, 224	Yes	Yes
VA Hospital	Aurora	VA Palliative Care Program - Cari Levy, MD (303) 399-8020	NA	750	No	No	No
Memorial Hospital Central	Colorado Springs	Memorial Hospital Central & North Palliative Care Program - Jim Himberger, Program Manager (719) 365-2567	425	648	Yes, 224	Yes	Yes
Childrens' Hospital	Aurora	Childrens' Palliative Care Program - Brian Greffe, MD, or Nancy King, RN	NA	618	No	Yes	No

Hospital / Provider	City	Palliative Care Contact	2008 Phone Survey # of PC Consults	2013 Phone Survey # of PC Consults	2011 ICD9 V66.7 Encounter w/PC Code; N Codes	2013 Hospital Registered w/CAPC's Get PC	2013 AHA Survey / CAPC PC Report Card
Association		(720) 777-6787 Centura Health at Home--Butterfly Program - Karen Dolph, (303) 561-5270					
University of Colorado Hospital Anschutz Inpatient	Aurora	University of Colorado Palliative Care Program Harri Brackett (720) 848-0000 Jeanie Youngwerth, MD (720) 848-6799	284	550	Yes, 268	Yes	Yes
Medical Center of Aurora	Aurora	Medical Center of Aurora Palliative Care Program - Kate Norton (303) 873-5795	NA	410	Yes, 225	Yes	Yes
Centura Health--St. Anthony North Hospital	Westminster	St. Anthony North Palliative Care Program - Laurie DeLalio (303) 561-5254	80	373	Yes, 85	Yes	No
Mercy Regional Medical Center (Centura)	Durango	Mercy Palliative Care Program - Dan Keuning (970) 382-2000	NA	325	Yes, 58	Yes	Yes
Presbyterian/St. Luke's Medical Center	Denver	Presbyterian/St. Luke's Palliative Care Program - Mike Murray (303) 839-6458	10	293	Yes, 92	Yes	No
National Jewish Health	Denver	National Jewish Palliative Care Program Bronwyn (Mary) Long, CNS (303) 388-4461	NA	260	No	No	No
St. Mary's Hospital and Medical Center	Grand Junction	St. Mary's Palliative Care Program Norma Pike, Program Administrator (970) 260-4530	NA	203	Yes, 117	No	No
Boulder Community Hospital	Boulder	Boulder Community Hospital Palliative Care Program - Connie Holden, Director Oncology Services, ICU, Medical (720) 854-7340	100	160	Yes, 74	Yes	No
North Suburban Medical Center	Thornton	North Suburban Palliative Care Program Carol Barrett (303) 450-3551	NA	158	Yes, 90	Yes	Yes
Exempla Lutheran Medical Center	Wheat Ridge	Exempla Lutheran Palliative Care Program - Patricia Rodriguez,	NA	123	Yes, 174	Yes	Yes

Hospital / Provider	City	Palliative Care Contact	2008 Phone Survey # of PC Consults	2013 Phone Survey # of PC Consults	2011 ICD9 V66.7 Encounter w/PC Code; N Codes	2013 Hospital Registered w/CAPC's Get PC	2013 AHA Survey / CAPC PC Report Card
		Administrative Coordinator (303) 403-7281					
Longmont United Hospital	Longmont	Longmont Palliative Care Program Adrian Edwards-Goodby, NP & Director of Program (303) 485-4380	NA	100	Yes, 51	Yes	Yes
Rose Medical Center	Denver	Rose Medical Center Palliative Care Program - Diana Manchak (303) 320-7398	30	50	Yes, 73	Yes	Yes



## APPENDIX C: 2013 COLORADO HOSPICE PALLIATIVE CARE PROVIDERS Contact Information and Summary

Sorted by 2013 Number of Palliative Care Consults, v. 10/21/13

Hospice Provider	City	Palliative Care Contact	2008 # of PC Consults	2013 # of PC Consults
Denver Hospice, The	Denver	Optio Health Services (Palliative Care) - Beth Ryan, Director of Optio Health Services(303) 398-6241	140	2,032
Pikes Peak Hospice & Palliative Care	Colorado Springs	Pikes Peak Palliative Care Program - Dan Schroeder or Nat Timmons, MD (719) 633-3400	412	541
Halcyon Hospice & Palliative Care	Mead	Halcyon Hospice & Palliative Care - Kaylee Jennings, Care Coordinator/Social Worker (303) 329-6870	NA	330
Hospice of Mercy-Durango	Durango	Hospice of Mercy Durango - Dan Keuning, Southstate Palliative Care Coordinator/APN(970) 382-2000	NA	320
Peoplefirst Hospice	Denver	Peoplefirst - Hospice John Evans, NP (303) 546-7921	NA	255
Hospice and Palliative Care of Western Colorado of Grand Junction	Grand Junction	Hospice and Palliative Care of Western Colorado Norma Pike (970) 260-4530	176	203
Sangre De Cristo Hospice & Palliative Care	Pueblo	Sangre De Cristo Palliative Care Program - Stewart Francies, VP Resource Development (719) 296-2601	14	135
Exempla Lutheran Hospice At Collier Hospice Center	Wheat Ridge	Exempla Lutheran Hospice at Collier Hospice Center Patricia Rodriguez (Administrative Coordinator for both hospital & home based program) (303) 403-7281	NA	123
Evercare Hospice & Palliative Care of Colorado Springs	Colorado Springs	Evercare Hospice & Palliative Care Program - Ginia Burdick, NP (719) 265-1100	NA	95
Hospicecare of Boulder & Broomfield County Lafayette	Lafayette	True Community Palliative Care Program - Pat Mehnert, VP Clinical Services (303) 449-7740	55	87
Pathways Hospice--Fort Collins	Fort Collins	Pathways Hospice - Heather Steenrod, Administrative Director (970) 292-0882	NA	63
Shalom Hospice	Aurora	Shalom Hospice & Palliative Care - Milissa Barres, Executive Director (303) 766-7600	NA	62
Hospice and Palliative Care of Northern Colorado	Greeley	Hospice and Palliative Care of Northern Colorado Stacy Tull-Leino, Palliative Care RN (970) 352-8487	NA	30

Hospice Provider	City	Palliative Care Contact	2008 # of PC Consults	2013 # of PC Consults
Namaste Hospice	Denver	Namaste Hospice - Jan Bezaidenhout or Lynn Dawson (303) 860-9915	NA	28
Hospice Del Valle	Alamosa	Hospice Del Valle - Laura Lewis (719) 589-9019	15	25
Hospice and Palliative Care of the Gunnison Valley	Gunnison	Hospice and Palliative Care of the Gunnison Valley Pam Brunsell, Administrator (970) 641-4254	20	14
Arkansas Valley Hospice Inc	La Junta	Arkansas Valley Hospice & Palliative Care - Cindy Stone, Patient Care Coordinator (719) 384-8827	NA	11
Mt. Evans Hospice	Evergreen	Mountain Journey Palliative Care Intake Coordinator (individual varies by day) (303) 674-6400	NA	5
Fremont Regional Hospice	Canon City	Fremont Regional Hospice/Palliative Care - Charlene Seaney, Hospice Administrator (719) 275-4315	NA	3