COLORADO
Department of Public Health & Environment

Palliative Care in Colorado: Trends, Gaps, and Opportunities to Improve Care

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Executive Summary

This is the third statewide survey of all palliative care providers in Colorado. The goal of this survey was to measure growth in palliative care and to identify opportunities to improve care for Coloradans suffering from serious illness. All 95 Colorado hospitals, 76 hospices, and known community-based palliative care providers were contacted in 2019 and participated in a brief phone survey. The total number of palliative care providers continues to incrementally increase (from 31 in 2007 to 58 in 2018), predominately among hospice providers. The total number of patients and consults continues to grow exponentially (from 3,241 patients in 2008 to 16,131 patients in 2020, and from 12,640 consults in 2008 to 62,989 consults in 2020). There has been relatively little increase in the number of hospitals offering palliative care services since 2013 (26 hospitals in 2013, 28 hospitals in 2020), though the hospitals that do provide palliative care services more than doubled the number of patients served. While there was only a small (8%) increase in the number of hospitals providing palliative care, there was a 52% increase in the number of hospices providing palliative care. For the first time, palliative care providers outside of the hospital or hospice setting have been identified in Colorado. One alternative site program was robust, and two of the emerging providers hold great potential to deliver palliative care.

The number one challenge noted by all palliative care programs was the need for reimbursement to support the interdisciplinary teams that are the hallmark of high-quality palliative care. 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, chaplains, pharmacists, and other members of the palliative care team. Since most of the interdisciplinary team cannot bill for services, additional dollars to support those staff must come from other sources. Limitations in reimbursement have had a chilling effect on what services can be offered and to which patients. In large part, reimbursement drives the structure and availability of palliative care teams and the amount of care provided in both hospital and hospice settings. This challenge has been a barrier to the expansion of palliative care for years.

Another challenge noted by all palliative care teams was the lack of education for both physicians and the community about the role of palliative care. For cyclical diseases such as chronic obstructive pulmonary disease or congestive heart failure, there are years of peaks and valleys before the patient is truly considered to be at the end of life. Palliative care can be beneficial throughout these patients' lives early in diagnosis, rather than just in the end stages, and it is in this interim role that palliative care is under-researched and underutilized. All of the palliative programs surveyed reported receiving primarily late-stage patients but were working to improve upstream referral and care provision. The lack of understanding of what palliative care is and when it is appropriate is a chronic issue that has impacted the delivery of care for years.

The top recommendations from this study include: 1) additional funding mechanisms for palliative care; 2) ongoing statewide education, networking, and mentoring; and 3) development of consistent palliative care data collection and reporting tools.

Summary of Colorado Palliative Care Studies: 2008, 2013, and 2020

Palliative Care Providers	2008 Study (2007 data)	2013 Study (2012 data)	2020 Study (2018 data)
Hospitals	20 providers 2,184 pts 8,518 consults	26 providers 3,143 pts 12,257 consults	28 providers 8,694 pts 34,883 consults
Hospices	11 providers 1,057 pts 4,122 consults	19 providers 1,118 pts 4,362 consults	29 providers 5,296 pts 19,752 consults
Others	0 providers	0 providers	1 provider 2,141 pts 8,350 consults
Total	31 providers 3,241 pts 12,640 consults	45 providers 4,261 pts 16,619 consults	58 providers 16,131 pts 62,989 consults

Background

In 2008, the Colorado Center for Hospice & Palliative Care (COCHPC) commissioned a survey from Hospice Analytics to evaluate the prevalence of palliative care provision in the state of Colorado. That survey used structured 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, the Center for Improving Value in Health Care (CIVHC) contracted with Hospice Analytics to replicate the 2008 study to identify trends and changes in palliative care services across the state. The 2013 survey was specifically designed to evaluate the location and mechanisms of palliative care service provision 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:

- Where are palliative care services being provided across the state?
- Are facilities providing services using team-based approaches for care or a single provider?
- What kinds of facilities are offering palliative care?
- Is palliative care reimbursed by insurers or do facilities see it as a part of doing business?

Late in 2019, the Colorado Department of Public Health and Environment, Colorado Department of Health Care Policy and Financing, and the American Cancer Society, Cancer Action Network came together and contracted with Hospice Analytics to replicate the 2013 study. The questions for the structured interviews for the most recent study are included in Appendix 1.

All 95 Colorado hospitals and 76 Colorado hospices completed the palliative care phone survey. New facilities identified as palliative providers in 2018 include nine non-hospital, non-hospice facilities.

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.

Survey Methodology

From October 2019 through January 2020, Hospice Analytics contacted all Colorado hospitals and hospices to conduct a structured phone survey of palliative care services provided in calendar year 2018 (Appendix 1). Phone surveys took 20-30 minutes on average to complete. The survey used the definition of palliative care adopted into the Colorado 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)

All 95 hospitals in Colorado and 76 Colorado hospices were contacted at their primary administrative and billing site and were asked to include data from satellite offices in their answers. 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. Based on conversations with those providers, nine other non-hospital and non-hospice providers were identified and contacted about their provision of palliative care. Fourteen total providers were designated as Emerging Providers. Most Emerging Providers were missing at least one element from the Colorado definition of palliative care and did not provide any consults in 2018, but had either started providing services or were planning on providing services in 2019. (Note: In 2013, eight hospices would have met the 2018 criteria for Emerging Provider. These hospices have been removed from the comparison data in this paper for consistency.)

Providers were asked to report both the number of palliative care patients and the number of palliative care consults. This differed from previous versions of the survey where providers were either asked about the number of palliative care patients (2008), or the number of palliative care consults (2013), but not both[1].

[1] The 2008 report is based on calendar year 2007 data; the 2013 report is based on calendar year 2012 data; the 2020 report is based on calendar year 2018 data.

Only seven providers reported the numbers of both patients and consults, including one hospital, five hospices, and one other provider. These seven providers averaged 3.9 consults per patient—in line with the published national average of 3.2 consults per patient[2]. This ratio was applied to palliative care providers missing either patient or consult numbers to provide a consistent estimate of palliative care services across Colorado facilities. This average was also applied across all three studies to provide comparative estimates over time.

Findings

Overall, there have been slight shifts in palliative care provision since 2013. Hospitals still provide the largest percentage of consults, and though the overall number of consults has increased, hospitals now provide 49% of consults across the state compared to 72% in 2013. Hospice-based palliative care now accounts for 36% of consults, compared to 27% in 2013, and other providers accounted for 15% of consults in 2020, compared to zero in 2013.

There has been a similar change in the distribution of providers. In 2013, hospitals employed 58% of the palliative care providers in the state, and hospice employed the remaining 42%. In 2020, 48% of providers were employed by hospitals, and fully half of palliative care providers worked in hospice. The remaining provider was employed by a non-hospital, non-hospice provider.

This means that hospital providers, on average, each give 967 consults per year, with a total of 239 patients per provider. Hospice providers, on average, each give 681 consults per year, with a total of 183 patients per provider.

Percentage change for these measures over time is provided below in Table 1: Growth in Palliative Care Providers, Patients Served, and Consults Performed.

[2] The 3.9 consults / patients found in this study is consistent with 3.2 visits / patients reported by Maggie Rogers and Rachael Heitner of CAPC in "A Decade of Data: Findings and Insights from the National Palliative Care Registry"; 2018; slide 19; https://registry.capc.org/wp-content/uploads/2019/07/Decade_of_Data_July2018.pdf.

Figure 1: Percentage of Palliative Care Facilities, Patients, and Consults by Facility Type, 2020

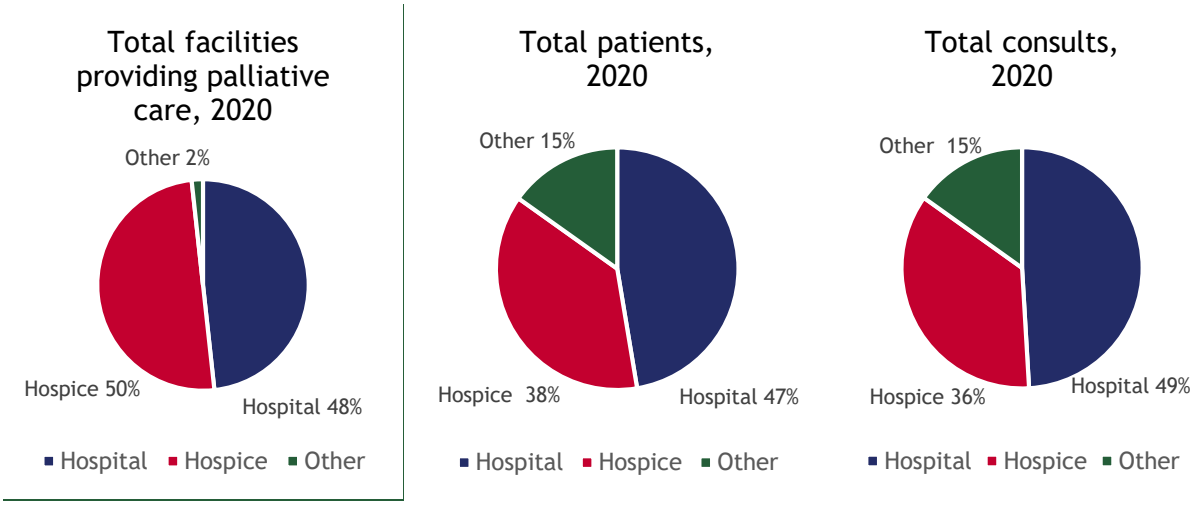


Table 1: Growth in Facilities Providing Palliative Care, Patients Served, and Consults Performed

Facilities with Palliative Care	Growth 2008-2013	Growth 2013-2020	Growth 2008-2020
Hospitals - Providers	30%	8%	40%
Patients	44%	177%	298%
Consults	44%	185%	310%
Hospices - Providers	73%	53%	164%
Patients	6%	374%	401%
Consults	6%	353%	379%
Others - Providers	NA	NA	NA
Patients			
Consults			
Total - Providers	45%	29%	87%
Patients	31%	279%	398%
Consults	31%	279%	398%

Hospital based palliative care

It appears that there has been relatively little increase in the number of hospitals offering palliative care services since 2013 (26 hospitals in 2013, 28 hospitals in 2020), though the hospitals that do provide palliative care services more than doubled the number of patients served.

In fact, though the number of hospitals offering palliative care services increased slightly, the percentage of programs with a physician or nurse certified in Hospice and Palliative Medicine dropped from 85% to 75% since 2013. Despite the drop in certified staffing, there was a slight increase in the number of programs offering access 24/7 to palliative care services. The number of hospital-based programs providing 24/7 palliative care services increased from two hospitals (8%

of all programs) to five hospitals (18% of all programs). Hospital-based programs had an average of five FTE providing services of some kind; the most frequently reported disciplines included MD and APRN. Most programs used a multi-disciplinary team, typically consisting of a physician, advance practice nurse or RN, social worker, and chaplain. Therapy services were least used by hospitals with physical therapy, occupational therapy, alternative therapy (music, art, pets), and psychologists available at fewer than three hospitals each.

Table 2: Hospital Palliative Care Team Composition

Discipline (at least 1 partial FTE)	Providers with this Discipline	Mean FTE / Provider
Physician	16/28 (57%)	1.04
Physician Assistant	4/28 (14%)	0.13
Advanced Practice Nurse / Nurse Practitioner	19/28 (68%)	1.50
Nurse	15/28 (54%)	0.57
Social Worker	19/28 (68%)	0.84
Chaplain	16/28 (57%)	0.41
Pharmacist	4/28 (14%)	0.05
Psychologist / Counselor	3/28 (11%)	0.08
Physical Therapy	1/28 (4%)	0.01
Occupational Therapy	1/28 (4%)	0.01
Dietitian	2/28 (7%)	0.01
Volunteers	1/28 (4%)	0.11
Office Manager / Administrative Assistant	6/28 (21%)	0.16
Other (music therapist; therapy dog)	2/28 (7%)	0.07

Virtually all palliative care teams reported providing the following services: pain and symptom management, patient and family meetings that included clarification of goals of care, and advance care planning discussions often with completion of advance directive documents. Nearly all palliative care teams also reported using the Medical Durable Power of Attorney (MDPOA) and Medical Orders for Scope of Treatment (MOST).

Hospital Palliative Care Program Finances

Approximately half of the hospital palliative care teams reported adequate financial resources for their current operation, an increase from previous years. However, a frequently cited challenge was the lack of resources for increased service provision or increased staff.

Half of the hospital programs were able to bill for their services through a public or private insurance provider or through direct patient billing, most typically for provider time and symptom codes. The other half of the hospitals did not bill for services, but saw the palliative care program as a part of doing business and providing appropriate care.

Table 3: Hospital Palliative Care Metrics

Metrics	2008	2013	2020
Number of hospitals surveyed	84	98	95
Number (%) of hospitals providing palliative care services	20 (24%)	26 (27%)	28 (29%)
Number of hospital palliative care patients per year			
Sum	2,184	3,143	6,694
Mean patients per hospital	109	121	239
Range	3 - 720	13 - 462	3 - 1,633
Number of hospital palliative care consults per year			
Sum	8,518	12,257	27,083
Mean consults per hospital	426	471	967
Range	12 - 2,808	50 - 1,800	10 - 6,369

Hospice-based palliative care

There has been a significant increase in the number of hospices offering palliative care, from just 19 in 2013 to 29 in 2020—a jump of more than 50%. The number of patients served and, likewise, the number of consults increased by more than 350%. This dramatic increase in service provision may help explain the lack of uptake in hospital settings. The number of providers in these settings with certifications in Hospice and Palliative Medicine dropped to just over half, compared to 74% in 2013.

Seven of the hospices noted that they share staff between hospice and palliative care programs. Given the co-location of the care, it is likely that this is a common practice in hospice-based palliative care programs. Compared to 2013, there was a three-fold increase in the number of hospices providing care around the clock (five hospices in 2013 [26%] versus 15 hospices in 2020 [52%]). Hospice teams frequently used interdisciplinary teams with an average of just under 4.5 FTE per program. Most frequently, hospice teams included a physician, advance practice nurse, a social worker, and a chaplain; palliative care physicians spent less time with patients in the hospice setting, as reflected by the lower average FTE per facility. Occupational and physical therapy were not offered at any facilities, and no hospice indicated the presence of a pharmacist as part of the care team. Only one hospice reported having a psychologist available.

Table 4: Hospice Palliative Care Team Composition

Discipline (at least 1 partial FTE)	Providers with this Discipline	Mean FTE / Provider
Physician	16/29 (55%)	0.35
Physician Assistant	1/29 (3%)	0.04
Advanced Practice Nurse / Nurse Practitioner	18/29 (62%)	1.39
Nurse	15/29 (52%)	0.66
Social Worker	20/29 (69%)	0.60
Chaplain	13/29 (45%)	0.16
Psychologist / Counselor	1/29 (3%)	0.14
Certified Nurse Assistant	3/29 (10%)	0.07
Volunteers	2/29 (7%)	0.62
Office Manager / Administrative Assistant	4/29 (14%)	0.38
Other (Respiratory Therapist)	1/29 (3%)	0.02

Nearly all palliative care teams reported providing the following services: pain and symptom management, patient and family meetings that included clarification of goals of care, and advance care planning discussions often with completion of advance directive documents. Nearly all palliative care teams also reported using Medical Durable Power of Attorney (MDPOA) and Medical Orders for Scope of Treatment (MOST).

Approximately half of the hospice-based palliative care patients are discharged to hospice. The remaining half are discharged to self-care, the hospital, or die while on palliative care.

Hospice Palliative Care Program Finances

Approximately half of the hospice programs were able to bill for their services through a public or private insurance provider or through direct patient billing—most typically for provider time and symptom code—and reported receiving adequate financial support. It is unclear how the remaining hospices pay for palliative care services. The palliative care program may be seen as a part of doing business and providing appropriate care, may be funded through philanthropy, or some other combination. The most frequently reported challenge was a lack of staff.

Table 5: Hospice Palliative Care Metrics

Metrics	2008	2013	2020
Number of hospices surveyed	49	52	76
Number (%) of hospices providing palliative care services	11 (22%)	19* (37%)	29 (38%)
Number of hospice palliative care patients per year			
Sum	1,057	1,118	5,296
Mean patients per provider	96	41	183
Range	14 - 412	1 - 521	2 - 1,308
Number of hospice palliative care consults per year			
Sum	4,122	4,362	19,752
Mean consults per provider	375	162	239
Range	55 - 1,607	3 - 2,032	8 - 5,100

**The 2013 report included 8 hospices that reported providing palliative care, but had no consults. These Emerging Providers have been removed from this report to align with the 2020 methodology.*

Palliative care in non-hospital, non-hospice settings

2020 was the first year with non-hospital, non-hospice palliative care facilities. Based on conversations with hospital and hospice palliative care providers, nine programs were believed to provide palliative care in one of these alternative settings. Six of these programs did not provide palliative care in accordance with the Colorado state definition and were not included in this study. Two of these nine met some, but not all, of the elements of the state's definition and so were classified as emerging palliative care providers and are also not included in this report. Only one of the nine met the state definition of a palliative care provider.

The one alternative setting provider that met the state definition requirements reported having one physician or a nurse certified in Hospice and Palliative Medicine. The facility provided services around the clock, seven days a week, and was staffed by almost 20 FTE. The interdisciplinary team included physicians, nurses, social workers, and pharmacists.

Table 6: Alternative Site Palliative Care Team Composition

Discipline (at least 1 partial FTE)	Providers with this Discipline	Mean FTE / Provider
Physician	1/1 (100%)	4.0
Nurse	1/1 (100%)	7.0
Social Worker	1/1 (100%)	6.5
Pharmacist	1/1 (100%)	2.0

The alternative site palliative care provider reported providing the following services: discussing and clarifying goals of care, pain and symptom management, family meetings, and discussion of advance directives. For advance care planning, palliative care teams reported using both the Medical Durable Power of Attorney (MDPOA) and the Medical Orders for Scope of Treatment (MOST).

It is unclear how palliative care services are financed at the alternative site provider. We anticipate more detail will be available in the next iteration of this survey.

Table 7: Alternative Site Palliative Care Program Metrics

Metrics	2008	2013	2020
Number of palliative care programs surveyed	0	0	9
Number (%) providing palliative care services	0	0	1 (11%)
Number of palliative care patients per year			2,141
Number of palliative care consults per year			8,350

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. In fact, one of the major challenges noted by both hospital and hospice programs was the need for the financial resources to support additional interdisciplinary staff to the team. Since most of the interdisciplinary team cannot bill for services, additional dollars to support those staff must come from other sources.

If a facility is using a team-based approach to palliative care, the funding for those additional members must come from other sources. Some use grant dollars to support palliative care, but most simply absorb the costs as operating costs. 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

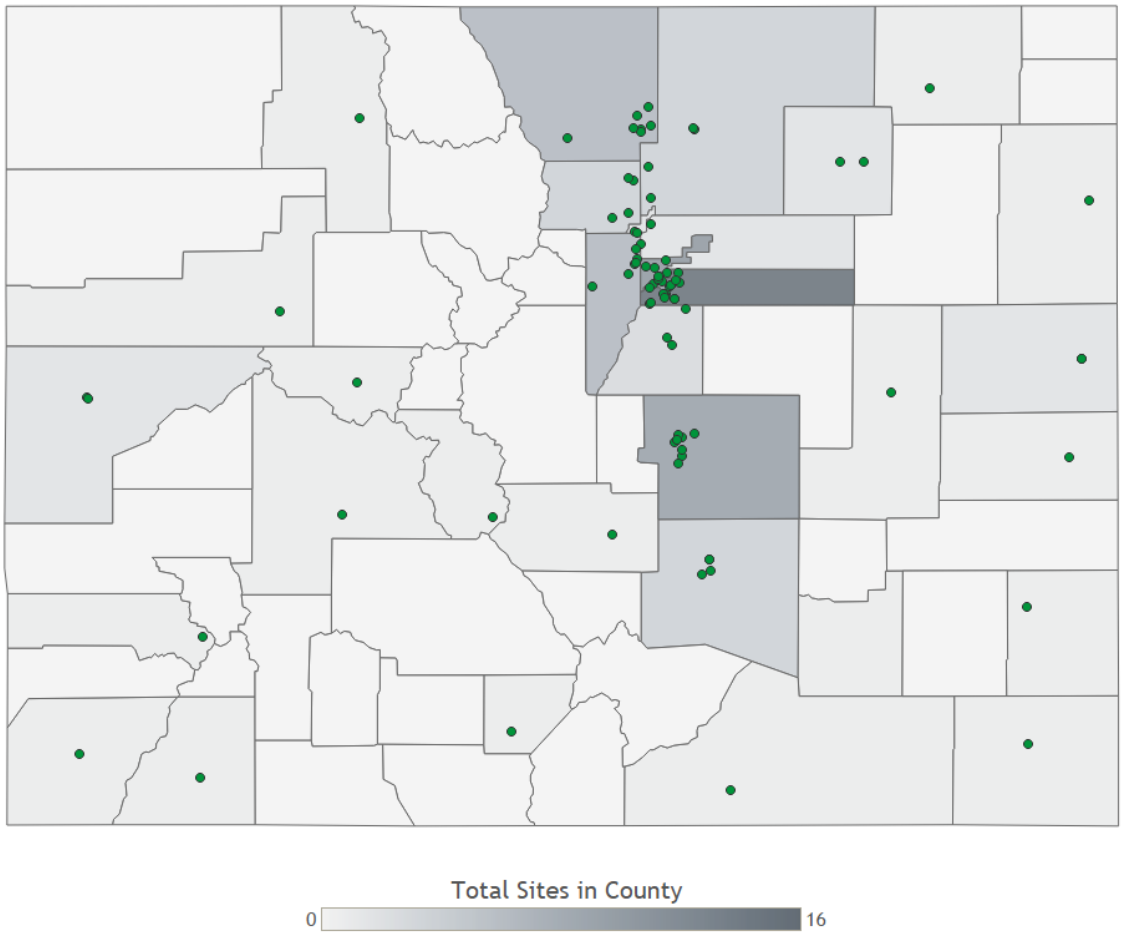
that not only did the number of hospice-based consults rise dramatically from 2013 to 2018, but there was also a significant increase in hospital consults, and the emergence of a new kind of palliative care provider unconnected to either hospice or hospitals. This points to the possibility that palliative 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, increased patient and family satisfaction, etc.).

The other challenge noted by all palliative care teams is the lack of education for both physicians and the community about the role of palliative care. Lack of understanding of palliative care is a chronic issue that has plagued palliative care for years. There have been community-sponsored efforts to support widespread education campaigns, but these efforts require financial and personnel resources that are hard to come by. Moreover, these campaign designs are generally targeted at the general public; there is an additional need for provider-specific education that will be difficult to impossible to address through community efforts and will require collaboration with medical schools, hospitals, and continuing education providers.

Conclusions

Palliative care provision continues to increase in Colorado. The number of people receiving palliative care services has been increasing rapidly, which is a positive step toward better health, lower costs, and higher quality of care across the state. Yet, while the number of patients and consults is growing, the number of actual programs is not keeping pace. 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 leaders in the field are investing more in providing palliative care, there have been few new facilities that recognize the benefit and are developing programs of their own. Looking at the map of all palliative care providers (i.e., hospice, hospital, and the alternative site) in the state map below, the distribution of access to palliative care is disproportionate, with extensive availability on the Front Range and little to no availability elsewhere in the state. An interactive map is available at https://www.civhc.org/programs-and-services/palliative-care/palliative-care-in-colorado/.

Figure 2: Map of Palliative Care Programs in Colorado



Palliative Care Facilities and Care Team Composition

While hospital-based providers currently serve more patients, hospice-based palliative care providers are growing faster and will likely match or exceed hospital-based service provision soon. Between 2013 and 2020, hospital-based palliative care provision increased more than 100%, while hospice-based palliative care increased more than 350%. Despite these increases in the number of patients served and the number of consults, there was only an 8% increase in the number of hospitals providing palliative care, while there was a 52% increase in the number of hospices providing palliative care.

Growth in the number of facilities providing palliative care has slowed. In 2013, Colorado had a 45% increase in the number of facilities providing palliative care (from 31 to 45 total). From 2013 to 2020, Colorado had a 27% increase in the number of facilities providing palliative care (from 45 to 57 total), but the vast majority of that increase was in hospice-based providers. In fact, there were only two additional hospital-based providers that emerged between 2013 and 2020.

For the first time, palliative care providers outside of the hospital or hospice setting have been identified in Colorado. The one alternative site program surveyed was robust, and the two emerging providers hold great potential to deliver palliative care.

There are currently three accrediting organizations offering certificates in palliative care: The Joint Commission, Community Health Accreditation Partner, and Accreditation Commission for Health Care. One hospital and three hospice-based programs were certified by at least one of these organizations; however, certification was mentioned as a short-range goal by many organizations.

The top diagnoses in both hospital and hospice-based programs were:

- **Cancer Diagnoses.**
- **Cardiac Diagnoses** – most often congestive heart failure (CHF).
- **Respiratory Diagnoses** – most often chronic obstructive pulmonary disease (COPD).
- **Dementia Diagnoses.**
- **Neuromuscular Diseases** – most often Parkinson's disease and amyotrophic lateral sclerosis (ALS).

All programs reported receiving primarily late-stage patients and were working to improve upstream referral and care provision.

Overall, palliative care in all settings was primarily provided by interdisciplinary teams, and the majority of the teams used non-dedicated personnel to provide services. Hospital-based teams used more diverse teams with a larger physician presence, likely due to the available resources in a hospital environment. Hospice-based teams were more dependent on nurses (RN, NP, and APN) with a reduced use of physicians, and a less diverse team overall. Much of this is likely due to dependence on limited reimbursable services for sustainability.

Rural Community-Based Non-Palliative Care Program

In the course of conducting this survey, Tri-County Health Network – Palliative Support Services was identified as a non-traditional program that was developed to meet the needs of their specific community. While the program does not technically meet the state parameters for palliative care provision, it is a program well-suited for its specific community. A summary of the conversation with this interesting program is in Appendix 2. This creative solution to meeting community needs may be able to inspire other unique community-based palliative care models across both urban and rural Colorado communities.

Pediatric Palliative Care Patients

For the first time, this survey asked programs about pediatric palliative care provision. Data shows there is a chronic shortage of available pediatric palliative care, due to both a shortage of appropriately trained providers and the low reimbursement rates. In 2020, two hospitals provided pediatric palliative care; both were pediatric specialty hospitals. Seven hospices provided pediatric palliative services with a patient count of 1 to 40.

Finances and Billing

Billing for palliative care services is limited and quite complicated. There are no billing codes specific to palliative care reimbursement and there is no Medicare palliative care benefit that is separate from the Medicare Hospice Benefit. However, physicians, physician assistants, and advanced practice nurses can bill Medicare, Medicaid, and some commercial insurance companies for patient care and for advance care planning. Social workers may be able to bill for advance care planning through their facility, but not for the other services associated with the care they provide. It is widely recognized that the most effective palliative care teams are widely interdisciplinary, but there is no mechanism to bill for the services provided by chaplains, nurses, and other vital members of the interdisciplinary team. Because of this lack of reimbursement mechanisms, all palliative care programs must rely on philanthropy, donations, financial support from their affiliated hospice or hospital, or some combination of funding sources.

There are a few codes that can be used for tracking palliative care services and for reimbursement of advance care planning through Medicare. The ICD-10 code for Palliative Care Encounter (Z51.5) replaced the ICD-9 code (V66.7). This code has no associated payment, but was intended to be used to track palliative care services and potentially be used for reimbursement in the future. Approximately 50% of the programs reported using the code, though there were few programs that were consistent with the coding.

Starting in January 2016, Medicare began reimbursing for advance care planning discussions using CPT 99497 and 99498. Only half of the palliative care programs reported using these codes, and again, use was inconsistent. Only a few programs reported regular use of this code for reimbursement of advance care planning discussions. It is unclear why this code is not used more regularly for reimbursement. It may be an opportunity for increased provider education.

When asked about the financial information of the program, the vast majority of both hospital and hospice palliative care programs expressed interest in having more financial information in order to better understand the financial impact of their services and improve patient decision-making autonomy. One of the long-standing questions in palliative care is how to capture the value of the service to support increased and more consistent reimbursement. Most providers we spoke to were unsure of the financial metrics of their services. Some respondents reported financial information was not communicated at all levels of the organization.

Despite the challenges of access to financial data, some hospital-based services were able to identify cost-savings associated with palliative care services. Several hospitals reported approximately $700 per patient day savings for inpatient palliative care services. Two hospitals reported palliative care services ranging in savings from $200,000 to $4.5 million annually. It is unclear what methods were used to arrive at these cost-saving numbers.

Survey Challenges

There were three important challenges identified in the course of the 2020 Colorado Palliative Care Survey. First was the lack of a statewide directory to guide individuals to the appropriate contact at each program or facility. Second, most palliative care providers collect information on

the number of patients served or the number of consults provided; very few collected both numbers. There is a need for a standardized, consistent data reporting tool for Colorado palliative care programs so information can be collected, reported, and consistently compared over time. Finally, there continues to be confusion about what the term "palliative care" means, even among providers, and no program referred to the state definition when discussing their program offerings.

Recommendations

Reimbursement

The number one challenge noted by all palliative care programs was the need for reimbursement to support the interdisciplinary teams that are the hallmark of high-quality palliative care. This is a challenge that has been a barrier to the expansion of palliative care for years. While physician and some nurse time can be reimbursed, many of the services provided in palliative care are delivered by other professionals who still cannot bill directly for their services. The 2016 addition of the Medicare codes for Advance Care Planning was a step in the right direction, but we are still seeing only occasional use in half of the palliative care programs in the state.

Results indicate that, in large part, reimbursement drives the structure and availability of palliative care teams and the amount of care provided in both hospital and hospice settings. Hospice palliative care has larger numbers of dedicated physicians and strong administrative staff support, but has less diversity in the total available care team 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 private and public 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 offer a palliative care benefit and generally do not reimburse for services apart from physician time. Colorado Medicaid does offer palliative care services to children who qualify for its Home and Community-Based Services (HCBS) Waiver. 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. If palliative care is to remain a holistic and interdisciplinary approach to care, then funding must be advanced for non-medical team members as well.

Historically, there has been little uptake 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. The need for additional financial

information was highlighted by most of the programs in this survey, indicating a strong need for increased organizational transparency of the mechanisms for financing palliative care services.

While there has been some research into the physical benefits that can accrue from palliative care, most published research still does not 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. The Center to Advance Palliative Care has demonstrated a cost benefit to palliative care services in the Medicare population, but palliative services are still not covered by traditional Medicare benefits (some Medicare Advantage plans have started to cover certain palliative services). 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. For cyclical diseases such as chronic obstructive pulmonary disease or congestive heart failure, there are years of peaks and valleys before the patient is truly considered to be at the end of life. Palliative care can be beneficial throughout these patients' lives post-diagnosis, rather than just in the end stages, and it is in this interim role that palliative care is under-researched.

Geographic Limitations

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.

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. This misperception is present among policymakers and the general public, but is also present and especially harmful in the physician and provider populations. There is little understanding of palliative care as the larger whole and hospice care as a specific sub-set of palliative care. Additionally, even for those who understand what palliative care is, there is a need to increase understanding of when it is appropriate. For many years, palliative care providers have been working to move care upstream, earlier in the disease process, where they can provide valuable services to patients and families. The persistent belief that palliative care is solely appropriate at end of life many times delays referrals to palliative care until just before hospice. 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. There is no one sector creating barriers to expanded care—the barriers come from all directions and it will require significant cultural change to break those barriers down.

Increased efforts at education could be addressed through state-supported convenings and conferences. Expanding existing conferences or creating larger events would offer an opportunity

for a broad curriculum to meet the needs of providers, researchers, patients, and others. Additional opportunities for education could include:

- A statewide media campaign aimed at patients, caregivers, and health care professionals to increase public awareness of what palliative care is and when it is appropriate.
- Increased engagement from membership organizations to promote education of physicians and other providers about the benefits and appropriate timing of palliative care.
- Inclusion of palliative care in a more significant way in the medical educational curriculum at the University of Colorado School of Medicine. Colorado is already a leader in training palliative care specialists and this role could be further embraced.
- A statewide mentorship program to facilitate peer learning and the exchange of best practices across the state.
- Community-based innovations like that through the Tri-County Health Network demonstrate what solutions can exist with an informed and engaged community. Examples like this also demonstrate potential ways to increase access to palliative care in the most underserved rural and mountain parts of Colorado.

There are multiple organizations in Colorado, such as the Center for Improving Value in Health Care or the Home Care and Hospice Association of Colorado that have a long-standing presence in the area from a policy, data, and convening perspective that could be used to support expanded education and understanding across the state.

For years, there have been efforts across the nation to try to find ways to change the cultural perceptions of palliative care, but it continues to be a significant barrier to expanded 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 Gunderson Health System in La Crosse, Wisconsin, and a similar effort in Madison, Wisconsin, from the Wisconsin Medical Society, work to tackle one piece of the palliative care conundrum at a time from the patient and the provider perspectives. It is possible that the results of these efforts are driving the increased patients accessing palliative care, but more work must be done.

Practice Standards

Policy

Standardized data collection and reporting of national measures and metrics is critical to determining the value and impact of quality palliative care. The Center to Advance Palliative Care, the American Academy of Hospice and Palliative Care, the National Palliative Care Research Center, and others have come together to develop the Palliative Care Quality Collaborative (PCQC). PCQC is an excellent resource for high-quality palliative care survey tools and is recommended by the National Hospice and Palliative Care Organization. National adoption of some of these tools as standard reporting mechanisms will contribute to consistent measurement

and reporting of palliative care use and outcomes, and will support educational opportunities across the care spectrum. In order to demonstrate efficacy, palliative care providers must focus on quality measures, transparency, and integrating palliative care into all aspects of the health care system.

State Policy

State Legislation

In 2019, Colorado passed legislation (SB19-073) in support of an advance directive registry system. While the registry is still in development, this is a strong indication that the state is increasingly valuing advance care planning and advance directives—critical components of any strong palliative care program.

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 illnesses and comorbidities. The lack of knowledge about the appropriate time and circumstances 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 is 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.

Palliative care is growing rapidly in Colorado. This study has confirmed the growing number of hospital-based and hospice-based palliative care services, as well as the emergence of non-traditional palliative care programs that are finding innovative ways to serve their communities. Additionally, the number of patients and consults that take place each year has been steadily increasing for more than 12 years. There are strong indications of movement in the right direction, but there is much work left to do if palliative care is going to become a standard of care for life-limiting, chronic disease.

Appendix 1

Prevalence of Palliative Care in Colorado

2019 CDPHE Palliative Care Telephone Survey 2019-20

1) Date _____Provider name, respondent name and contact information.
2) Do you have a Palliative Care Program in place (separate from the Medicare Hospice Benefit)?
   a) If no, why not, do you plan to establish one?
   b) To whom do you refer patients for this type of care?

   --If NO, stop here—

3) Name of Palliative Care Program
   a) Name and discipline of Director
   b) Contact information of primary contact
4) When was your first Palliative Care Program patient served? (If program was established prior to last survey in 2013, confirm date.)
5) Please describe the organization of your Palliative Care Program:
   a) Please describe where your program fits into your organizational structure.
   b) What clinical disciplines participate in the program (e.g., physician, PA, NP, RN, social work, chaplain, aide, volunteers, pharmacist, dietitian, etc.), and how many FTEs are represented by each?
   c) How many of your staff members are certified in Hospice & Palliative Medicine (including: Physician, RN, APN, CNA, SW, Chaplain, Counselor, Pediatric Nurse)?
   d) What are the locations of care and percentages in each (e.g., inpatient consultation service, outpatient clinic, home care)?
   e) Is your program available 24/7/365?
   f) Is your Palliative Care Program certified by Joint Commission (hospitals and hospices), CHAP (hospices and community-based providers), ACHC (hospices) or DNV GL (hospitals)? If not, when do you plan to, or are you considering it?
6) Please describe your Palliative Care Program patient services:
   a) How many patients received palliative care services in 2018? And/or how many consults were done in 2018?
   b) What are the top 3 services provided to patients (e.g., goals of care, bereavement, symptom management, family meetings, ADs, etc.)?
   c) On average, how long are patients on your palliative care service (e.g., number of consults / patient; number of days, etc.)?
   d) Advance Care Planning:
      i) What ACP tools do you initiate most frequently (MDPOA, Living Will, MOST, etc.)?
      ii) When patients enter your program, which ACP tools have they already completed?
      iii) What disciplines are routinely having ACP conversations / completing forms?
      iv) Is MOST being used, and if so, how often?
   e) What conditions / diagnoses does your Palliative Care Program most frequently see?
   f) Where do most of your patient referrals come from?
      i) For Hospitals: oncology, intensive care, emergency department, etc.
      ii) For Hospices: internal medicine, oncology, family practice, etc.
   g) What percentage of your patients are discharged to the following locations: deceased, hospice, home / self-care, nursing home, ALF, and other?
   h) How many pediatric patients did you serve in 2018? Do your pediatric clinicians have specialty training? (Pediatrics <=18 years old.)

i) Does your program use telehealth (yes/no)?

7) Please describe financial aspects of your Palliative Care Program:
   a) Does your program have adequate financial support from your organization? Please describe.
   b) Who do you bill for palliative care services (e.g., Medicare, Medicaid, commercial payers, patients, etc.)?
   c) How do you bill for palliative care services (e.g., by physician, APN, hospital, ICD-10 symptom codes, billing by time)?
   d) Do you use the ICD10 Z51.5 code (encounter for palliative care; ICD9 V66.7) in your billing? (The Z-code is used for tracking purposes through claims but is not a reimbursement mechanism – yet.)
   e) Do you bill for ACP discussions (CPT 99497 and 99498)?
   f) What percentage of your program expenses are paid for by direct care billing?
   g) Are statistics collected / reported on?
      i) For Hospitals: cost savings / cost avoidance? If so, approximately how much is saved per year?
      ii) For Hospices: hospital readmission rates, etc.? If so, approximately what is the savings?
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, completing advance directives, cost savings, hospice referrals, quality measures, etc.)?
   b) What kinds of quality projects / performance improvement projects does your Palliative Care Program participate in?
   c) 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.)?
   d) What percentage of time are your meeting with patients vs. caregivers vs. patients along with their caregivers?
9) Please describe your Palliative Care Program's greatest challenges.
10) Outside of local hospitals and hospices, are there any other palliative care providers in your area?
11) May we have your permission to share your contact information (name of organization, location, setting (i.e., hospital, community, clinic), and telephone number) with CAPC?
12) For hospitals only:
   a) Please describe the relationship between your Palliative Care Program and local hospices.
   b) What kinds of situations / diagnoses automatically trigger a palliative care consult (including whether patients are near end of life, including early and late stage patients)?

Appendix 2

Rural Community-Based
Non-Palliative Care Program
Tri-County Health Network (TCHN)

238 E Colorado Ave., Telluride, CO 81435
Program name: Palliative Support Services
dsi@tchnetwork.org; www.tchnetwork.org:
Main: 970-708-7096

Phone interview and supplemented with information from TCHN website.

Tri-County Health Network

TCHN is a vertical network of providers committed to improving the quality and coordination of health in the tri-county area by increasing access to health care and health services at lower costs. Palliative Support Services is one of several programs offered through the network.

MISSION

Tri-County Health Network is a nonprofit organization committed to improving the overall health and quality of health care in the [Telluride] rural region by identifying, developing, and operating programs and initiatives that will reform the health care delivery system and payment methodology in rural communities while providing solutions to critical health care needs and health disparities.

Network Members

There are eight members in the TCHN, which include *The Telluride Foundation, four local health clinics/facilities, Montrose Memorial Hospital, one pediatric physician/provider practice clinic, and one mental health clinic.

Funding

TCHN has benefitted from funding from 23 local and national providers including The Telluride Foundation, The US Department of Health and Human Services, CDPHE, The Colorado Trust and CMS.

PALLIATIVE SUPPORT SERVICES

History

Palliative Support Services (PSS) is one of many programs of the Tri-County Health Network. There was a hospice in the area several years ago, but it disbanded due to the challenges of providing services in a rural area. This left people facing the end of life without support. So, the Telluride Regional Medical Center approached TCHN about formalizing a volunteer program to serve the non-clinical needs of the dying. In 2010, a 501(c)3 was established with The Telluride Foundation and in 2016 the Palliative Support Service program was launched within the TCHN. It is one of many programs offered within several counties through the TCHN. However, the Palliative Support Services program only serves San Miguel County.

Program Features

The program is called Palliative Support Services, but it is not a palliative care provider. It provides no clinical or medical services. It considers itself a "wrap-around support" program for any client with any illness, injury or post-surgical health and/or support need and who is also at risk of having to leave his/her home. They internally refer to their program as "Public Health Lite." They pride themselves on being strong collaborators with community members and agencies and they work together to find ways to serve clients in need. The funding comes primarily from the town and county governments, as well as those agencies listed above. Community members also contribute through fundraising activities.

Two Programs within Palliative Support Services

1. Supporting Visiting Nurses: Palliative Support Services program is aimed at supporting the visiting nurses. Two RNs who are employed with local health care providers are contracted to also work with Pasco Home Health Care (HHC). Due to limitations in funding, the Pasco HHC can only pay the RNs for mileage and travel time one way to the patients' homes. Because this is a rural community, travel areas are large. TCHN raises funds in order to provide one-way mileage reimbursement and travel time pay one-way for the nurses. In 2019, the Palliative Support Services program within TCHN supported the two Pasco nurses in visiting two traditional home health patients and two more patients needing a palliative approach to nursing care. Additionally, PSS provides dressing supplies and other medical supplies. It also maintains a DME lending closet, so patients can borrow wheelchairs, hospital beds, walkers, etc. The process for PSS to get involved with patients starts with Pasco HHC. The medical provider calls Pasco HHC with the patient referral. The RN assigned calls TCHN to request one-way mileage and travel time reimbursement and any medical supplies/equipment needed. TCHN sends an "Options Counselor" (with contractual help from Area Agency on Aging) to the patient's home to evaluate what non-medical needs are present. The needs are then addressed through the contracts, networks, and affiliations of the TCHN.

2. Assisting Clients in the Community: The second program within Palliative Support Services is the volunteer component. It is aimed at assisting clients with non-medical needs. Volunteers are recruited and trained to provide respite as well as friendly visits to clients in need. A volunteer might shovel the snow, or run the vacuum, go to the post office to pick up mail or bring meals to a client. Many of the clients do not have nearby family and without such support, are at risk of having to leave their home. Currently there are 22 support volunteers. They may see a client daily for a couple of weeks after surgery, for example, and then visits may occur every week for a while. The clients may or may not be simultaneously receiving visiting nurse visits. In 2019, PSS provided volunteer visits to 10 clients. PSS works with HopeWest (a hospice and palliative care agency) in Grand Junction, Colorado, to provide training for the support volunteers. PSS volunteers are taught about client communications and support, HIPAA regulations, etc. They also learn about serious illness and dying, even though that is not the focus of the PSS volunteer support program.

Questions Asked

1. Do you see children in the PSS program?
   We have not seen children.

2. Do you use telehealth in the PSS program?
   We work with providers from the Front Range of Colorado who provide mental/behavioral health counseling using telehealth technology.

3. What is your greatest challenge in the PSS program?

a. The two RNs through Pasco HHC sometimes see patients who do have serious illness and need palliative nursing care. When that happens, we call that "palliative care" and want to track those cases as distinct and separate from traditional home health patients. It is a challenge to get the referring providers to order "palliative care" rather than just traditional home health care services. This nursing "palliative care" is different from the Palliative Support Services through TCHN described above.
b. We have 22 volunteers and not enough clients to keep volunteers active and engaged!

4. May we share this information as well as your contact information with others?
   Yes, you may share it all with anyone who wants it.

Appendix 3

2020 Directory of Colorado Palliative Care Providers

2020 Colorado Hospital Palliative Care Providers

Sorted by 2018 Number of Palliative Care Consults

Provider Type	Provider Contact Information (Year Palliative Care Program Established)	Palliative Care Patients (bold = estimate)	Palliative Care Consults (bold = estimate)
Hospital	**Centura Penrose St. Francis (2007)** 2222 North Nevada Avenue Colorado Springs, CO 80907 Carolyn April MD PhD Medical Director Palliative Care E: carolynapril@centura.org P1: 719-776-7148 C: 781-366-5164	2007= 230 2012= ***197*** 2018= 2,000	2007= ***897*** 2012= 770 2018= ***7,800***
Hospital	**UCH University of Colorado Anschutz Hospital (2005)** 12605 East 16th Avenue Aurora, CO 80045 Jeanie Youngwerth MD Director Palliative Care Service E: jean.youngwerth@cuanschutz.edu P1: 720-848-8530 C: 303-618-9489	2007= 284 2012= ***141*** 2018= 1,633	2007= ***1,108*** 2012= 550 2018= ***6,369***
Hospital	**UCH Memorial Hospital Central (2004)** 1400 East Boulder Street Colorado Springs, CO 80909 John Himberger NP Program Coordinator E: john.himberger@uchealth.org P1: 719-365-2567	2007= 425 2012= ***166*** 2018= 1,347	2007= ***1,658*** 2012= 648 2018= ***5,253***
Hospital	**UCH Medical Center of the Rockies (2008)** 2500 Rocky Mountain Avenue Loveland, CO 80538 Lisabeth Paradise NP E: lisabeth.paradise@uchealth.org P1: 970-495-8369	2007= 0 2012= 0 2018= ***499***	2007= 0 2012= 0 2018= 1,947
Hospital	**Children's Hospital Anschutz (1999)** 13123 East 16th Avenue Aurora, CO 80045 Jenny Raybin E: jennifer.raybin@childrenscolorado.org P1: 303-204-0912	2007= 0 2012= ***158*** 2018= 211	2007= 0 2012= 618 2018= 1,800

Provider Type	Provider Contact Information (Year Palliative Care Program Established)	Palliative Care Patients (bold = estimate)	Palliative Care Consults (bold = estimate)
Hospital	**Centura St. Anthony Hospital (2003)** 11600 West 2nd Place Lakewood, CO 80228 Chester Dreiman MD Medical Director E: chesterdreiman@centura.org P1: 720-321-1590 C: 303-501-2195	2007= 112 2012= ***215*** 2018= ***372***	2007= ***437*** 2012= 840 2018= 1,450
Hospital	**Saint Joseph Hospital (2003)** 1375 East 19th Avenue Denver, CO 80218 Brittany Fuentes Lead Social Worker E: brittany.fuentes@sclhealth.org P1: 303-746-9197 C: 303-532-6586	2007= 720 2012= ***326*** 2018= ***358***	2007= ***2,808*** 2012= 1,272 2018= 1,397
Hospital	**VA Eastern Colorado HealthCare System (2003)** 13701 East Mississippi Avenue; Ste. 200 Aurora, CO 80012 Cari Levy MD Director Palliative Care E: cari.levy@va.gov P1: 303-907-7132 P2: 720-857-2814	2007= 0 2012= ***192*** 2018= ***333***	2007= 0 2012= 750 2018= 1,300
Hospital	**Centura Porter Adventist Hospital (2000)** 2525 South Downing Street Denver, CO 80210 Rachel Sabolish NP E: rachelsabolish@centura.org P1: 303-778-5699	2007= 0 2012= 0 2018= ***238***	2007= 0 2012= 0 2018= 928
Hospital	**Centura Littleton Adventist Hospital (2007)** 7700 South Broadway Littleton, CO 80122 Jamie Benton MSW Palliative Care Coordinator E: jamiebenton@centura.org P1: 303-738-2605	2007= 0 2012= 0 2018= 232	2007= 0 2012= 0 2018= ***905***
Hospital	**Medical Center of Aurora (2008)** 1501 South Potomac Street Aurora, CO 80012 Todd Hultman NP Palliative Care Manager E: todd.hultman@healthonecares.com P1: 303-944-9500 C: 781-572-2459	2007= 0 2012= ***105*** 2018= ***175***	2007= 0 2012= 410 2018= 684

Provider Type	Provider Contact Information (Year Palliative Care Program Established)	Palliative Care Patients (bold = estimate)	Palliative Care Consults (bold = estimate)
Hospital	**St. Mary's Hospital and Medical Center (2012)** 2635 North 7th Street Grand Junction, CO 81502 Bryan Newman Chaplain Director Palliative Care E: bryan.newman@sclhealth.org P1: 970-298-2288	2007= 0 2012= ***52*** 2018= ***165***	2007= 0 2012= 203 2018= 642
Hospital	**Centura Parker Adventist Hospital (2012)** 9395 Crown Crest Boulevard Parker, CO 80138 Yuki Asakura CNS Team member E: yukiasakura@centura.org P1: 303-269-2452 C: 720-217-9819	2007= 0 2012= 0 2018= ***162***	2007= 0 2012= 0 2018= 633
Hospital	**Lutheran Medical Center Hospital (2010)** 3210 Lutheran Parkway Wheat Ridge, CO 80033 Sonya Neumann RN Senior Executive Director - Post Acute Services E: sonya.neumann@sclhealth.org P1: 303-425-8000 C: 719-648-4442	2007= 0 2012= ***32*** 2018= ***162***	2007= 0 2012= 123 2018= 630
Hospital	**Centura Longmont United Hospital (2012)** 1950 Mountain View Avenue Longmont, CO 80501 Katherine Atherton-Wood NP Palliative Care Coordinator E: katherineatherton-wood@centura.org P1: 303-485-4391	2007= 0 2012= ***26*** 2018= ***158***	2007= 0 2012= 100 2018= 618
Hospital	**Centura St. Anthony's North Health Campus (2007)** 14300 Orchard Parkway Westminster, CO 80023 Natalie Rodden MD Medical Director E: natalierodden@centura.org P1: 720-627-0036	2007= 80 2012= ***96*** 2018= ***154***	2007= ***312*** 2012= 373 2018= 600
Hospital	**Foothills Hospital (formerly Boulder Community Hospital) (2003)** 4747 Arapahoe Avenue Boulder, CO 80303 Sharna Ill Chaplain Palliative Care Manager E: sill@bch.org P1: 303-415-7543 C: 303-990-1370	2007= 100 2012= ***41*** 2018= ***118***	2007= ***390*** 2012= 160 2018= 462

Provider Type	Provider Contact Information (Year Palliative Care Program Established)	Palliative Care Patients (bold = estimate)	Palliative Care Consults (bold = estimate)
Hospital	**Northern Colorado Medical Center (2011)** 1801 16th Street Greeley, CO 80631 Sondra (Sonny) Miles MD E: sondra.miles@bannerhealth.com P1: 970-810-4288 C: 661-860-6357	2007= 0 2012= ***462*** 2018= ***117***	2007= 0 2012= 1,800 2018= 455
Hospital	**Presbyterian St. Luke's Medical Center (2006)** 1719 East 19th Avenue Denver, CO 80218 Todd Hultman NP Palliative Care Manager E: todd.hultman@healthonecares.com P1: 303-944-9500 C: 781-572-2459	2007= 10 2012= ***75*** 2018= ***96***	2007= ***39*** 2012= 293 2018= 374
Hospital	**Rocky Mountain Hospital for Children (2018)** 1719 East 19th Avenue Denver, CO 80218 Kristanne Korsgaard RN E: kristanne.korsgaard@healthonecares.com	2007= 0 2012= 0 2018= 90	2007= 0 2012= 0 2018= ***351***
Hospital	**North Suburban Medical Center (2005)** 9191 Grant Street Thornton, CO 80229 Carol Barrett RN Director Case Management E: carol.barrett@healthonecares.com P1: 303-450-3551 C: 303-349-0656	2007= 0 2012= ***41*** 2018= ***51***	2007= 0 2012= 158 2018= 200
Hospital	**Valley View Hospital (2017)** 1906 Blake Avenue Glenwood Springs, CO 81601 Liz Shugart NP Palliative Care Coordinator E: elizabeth.belanger-shugart@vvh.org P1: 970-945-6535 P2: 734-330-7913	2007= 0 2012= 0 2018= ***19***	2007= 0 2012= 0 2018= 75
Hospital	**Aspen Valley Hospital (NA)** 401 Castle Creek Road Aspen, CO 81611 Julie Jenkins RN Case Management / Utilization Review E: jjenkins@aspenhospital.org P1: 970-544-1147 P2: 970-544-1366	2007= 0 2012= 0 2018= ***3***	2007= 0 2012= 0 2018= 10

Provider Type	Provider Contact Information (Year Palliative Care Program Established)	Palliative Care Patients (bold = estimate)	Palliative Care Consults (bold = estimate)
Hospital	**Centura Mercy Regional Medical Center (2011)** 1010 Three Springs Boulevard Durango, CO 81301 Tina Gallegos RN Director E: tinagallegos@centura.org P1: 970-764-3534	2007= 0 2012= ***83*** 2018= 0	2007= 0 2012= 325 2018= 0
Hospital	**Good Samaritan Medical Center (2007)** 200 Exempla Circle Lafayette, CO 80026 Danielle (Dani) Andrade RN Director Care Management E: danielle.andrade@sclhealth.org P1: 303-689-5236 C: 307-421-9315	2007= 0 2012= ***208*** 2018= 0	2007= 0 2012= 810 2018= 0
Hospital	**Sky Ridge Medical Center (2017)** 10101 Ridgegate Parkway Lone Tree, CO 80124 Mark Speckman NP E: mark.speckman@healthonecares.com P1: 303-263-3647	2007= 3 2012= 0 2018= 0	2007= ***12*** 2012= 0 2018= 0
Hospital	**Swedish Medical Center (2016)** 501 East Hampden Avenue Englewood, CO 80113 Jennifer Davis NP Hospice & Palliative Care Coordinator E: jennifer.davis@healthonecares.com P1: 303-788-4475	2007= 70 2012= 0 2018= 0	2007= ***273*** 2012= 0 2018= 0
Hospital	**VA Western Colorado HealthCare System (2009)** 2121 North Avenue Grand Junction, CO 81501 Mary Jo Hughes RN Hospice & Palliative Care Program Manager E: mary.hughes5@va.gov P1: 970-242-0731 x2737	2007= 0 2012= ***209*** 2018= 0	2007= 0 2012= 814 2018= 0

Provider Type	Provider Contact Information (Year Palliative Care Program Established)	Palliative Care Patients (bold = estimate)	Palliative Care Consults (bold = estimate)
Hospital - palliative care emerging	**Centura Castle Rock Adventist Hospital (2019)** 2350 Meadows Boulevard Castle Rock, CO 80109 Jamie Benton MSW Palliative Care Coordinator E: jamiebenton@centura.org P1: 303-738-2605	2007= 0 2012= 0 2018= 0	2007= 0 2012= 0 2018= 0
Hospital - palliative care emerging	**Denver Health (2011)** 777 Bannock Street Denver, CO 80204 Diana (DiDi) Mancini MD Chief of Palliative Care E: diana.mancini@dhha.org P1: 303-436-6000 C: 303-570-6440	2007= 0 2012= 0 2018= 0	2007= 0 2012= 0 2018= 0
Hospital - palliative care emerging	**National Jewish Health (2010)** 1400 Jackson Street Denver, CO 80206 Bronwyn Long CNS E: longb@njhealth.org P1: 303-475-2841 P2: 303-270-2392	2007= 0 2012= ***67*** 2018= 0	2007= 0 2012= 260 2018= 0
Hospital - palliative care emerging	**ParkView Medical Center (2017)** 400 West 16th Street Pueblo, CO 81003 Barbara Brown E: barbara_brown@parkviewmc.com P1: 719-595-7704	2007= 0 2012= 0 2018= 0	2007= 0 2012= 0 2018= 0

**Palliative care programs were considered "emerging" for the purposes of this survey if any of the following factors existed:

1. Entity unable to capture patients served or consults;
2. Entity unable to respond to the survey in the requested timeline;
3. Entity did not see patients during the captured timeframe; or
4. Entity did not meet the state's regulatory definition of palliative care.

Historical Hospital – Palliative Care Providers

Provider Type	Provider Contact Information (Year Palliative Care Program Established)	Palliative Care Patients (bold = estimate)	Palliative Care Consults (bold = estimate)
Historical Hospital	**Centura: St. Mary Corwin Medical Center** - Pueblo	2007= 100 2012= ***238*** 2018= 0	2007= ***390*** 2012= 930 2018= 0
Historical Hospital	**HealthONE: Rose Medical Center** - Denver	2007= 30 2012= ***13*** 2018= 0	2007= ***117*** 2012= 50 2018= 0
Historical Hospital	**Montrose Memorial Hospital** - Montrose	2007= 11 2012= 0 2018= 0	2007= ***43*** 2012= 0 2018= 0
Historical Hospital	**Triumph Hospital** - Aurora	2007= 9 2012= 0 2018= 0	2007= ***35*** 2012= 0 2018= 0
Historical Hospital	**Banner: McKee Medical Center** - Loveland	2007= 0 2012= 0 2018= 0	2007= 0 2012= 0 2018= 0
Historical Hospital	**Poudre Valley Hospital** - Fort Collins	2007= 0 2012= 0 2018= 0	2007= 0 2012= 0 2018= 0

2020 Colorado Hospice Palliative Care Providers

Sorted by 2018 Number of Palliative Care Consults

Provider Type	Provider Contact Information (Year Palliative Care Program Established)	Palliative Care Patients (bold = estimate)	Palliative Care Consults (bold = estimate)
Hospice	**Halcyon Hospice & Palliative Care (2009)** 209 Main Street; Ste. B Mead, CO 80542 Lisa Studebaker LCSW Palliative Care Director E: lstudebaker@halcyonhospice.org P1: 303-329-0870 x301 P2: 720-607-4487	2007= 0 2012= ***85*** 2018= ***1,308***	2007= 0 2012= 330 2018= 5,100
Hospice	**The Denver Hospice (2003)** 501 South Cherry Street; #700 Denver, CO 80246 Leilani Smith RN Clinical Manager E: lsmith@care4denver.org P1: 303-321-2929 x6229 C: 720-233-7200	2007= 140 2012= ***521*** 2018= 670	2007= ***546*** 2012= 2,032 2018= ***2,613***
Hospice	**Pathways Hospice & Palliative Care (2003)** 305 Carpenter Road Fort Collins, CO 80525 Kam Berkenkotter RN Clinicial Manager Palliative Care E: kam.berkenkotter@pathways-care.org P1: 970-889-0272	2007= 0 2012= ***16*** 2018= 648	2007= 0 2012= 63 2018= ***2,527***
Hospice	**HopeWest (1997)** 2754 Compass Drive; Ste. 377 Grand Junction, CO 81506 Holly Howell SW Senior Director Community Programs E: hhowell@hopewestco.org P1: 970-683-4902 C: 970-589-6859	2007= 176 2012= ***52*** 2018= 410	2007= ***686*** 2012= 203 2018= ***1,599***
Hospice	**TRU Community Care (2006)** 2594 Trailridge Drive East Lafayette, CO 80026 Michael McHale President & CEO E: michaelmchale@trucare.org P1: 303-449-7740	2007= 55 2012= ***22*** 2018= 403	2007= ***215*** 2012= 87 2018= ***1,572***

Provider Type	Provider Contact Information (Year Palliative Care Program Established)	Palliative Care Patients (bold = estimate)	Palliative Care Consults (bold = estimate)
Hospice	**Sangre de Cristo Hospice & Palliative Care (2007)** 1207 Pueblo Boulevard Way Pueblo, CO 81005 Tarrah Lowry President & CEO E: tarrah.lowry@sangre.org P1: 719-251-8111	2007= 14 2012= ***35*** 2018= 350	2007= ***55*** 2012= 135 2018= ***1,365***
Hospice	**Suncrest Hospice of Colorado (2017)** 5700 South Quebec Street; Ste. 310 Greenwood Village, CO 80111 Ginia Burdick NP E: gburdick@suncrest.com P1: 720-941-5580 P2: 719-434-1773	2007= 0 2012= 0 2018= ***205***	2007= 0 2012= 0 2018= 800
Hospice	**Compassus - Colorado Springs (2008)** 5475 Tech Center Drive; #105 Colorado Springs, CO 80919 Lin Howland MHA Executive Director E: lin.howland@compassus.com P1: 719-226-0091	2007= 0 2012= ***24*** 2018= 261	2007= 0 2012= 95 2018= 696
Hospice	**Lutheran Medical Center Hospice & Palliative Care (2010)** 3210 Lutheran Parkway Wheat Ridge, CO 80033 Sonya Neumann RN Senior Executive Director - Post Acute Services E: sonya.neumann@sclhealth.org P1: 303-425-8000 C: 719-648-4442	2007= 0 2012= ***32*** 2018= ***138***	2007= 0 2012= 123 2018= 537
Hospice	**Namaste Home Health & Hospice (2011)** 6000 East Evans; Ste. 400 Denver, CO 80222 Jackie Zinkgraf Executive Director Hospice and Home Health Care E: jzinkgraf@namaste-health.com P1: 720-532-3686 C: 303-330-3282	2007= 0 2012= ***7*** 2018= 137	2007= 0 2012= 28 2018= ***534***
Hospice	**Agape Hospice & Palliative Care (2006)** 6041 South Syracuse Way; #220 Greenwood Village, CO 80111 Kelly Bastian NP Director Palliative Care E: kbastian@agape-healthcare.com P1: 720-482-1988	2007= 75 2012= 0 2018= 225	2007= ***293*** 2012= 0 2018= 523

Provider Type	Provider Contact Information (Year Palliative Care Program Established)	Palliative Care Patients (bold = estimate)	Palliative Care Consults (bold = estimate)
Hospice	**Bridges Hospice & Palliative Care - Denver (2017)** 3895 Upham Street; Ste. 150 Wheat Ridge, CO 80033 Susanne Anderson RN Administrator E: sanderson@bridgescommunitycare.com P1: 720-900-3505	2007= 0 2012= 0 2018= 121	2007= 0 2012= 0 2018= ***472***
Hospice	**Compassus - Denver (2008)** 2420 West 26th Avenue; Ste. 200 Denver, CO 80211 Kathryn (Kate) Parks Palliative Care Coordinator E: kathryn.parks@compassus.com P1: 720-808-5373	2007= 0 2012= 0 2018= 156	2007= 0 2012= 0 2018= 416
Hospice	**Mt. Evans Hospice & Palliative Care (2012)** 3081 Bergen Peak Drive Evergreen, CO 80439 Keri Jaeger RN Senior Director of Clinical Services E: kjaeger@mtevans.org P1: 303-674-6400	2007= 0 2012= ***1*** 2018= 91	2007= 0 2012= 5 2018= ***355***
Hospice	**Hospice of the Valley (2009)** 1901 Grand Avenue; Ste. 206 Glenwood Springs, CO 81601 Kristen Levey RN E: klevey@hchotv.org P1: 970-930-6008	2007= 0 2012= 0 2018= 45	2007= 0 2012= 0 2018= ***176***
Hospice	**Arkansas Valley Hospice (2012)** 531 Lewis Avenue La Junta, CO 81050 Jennifer Netherton Patient Care Coordinator E: jennifer.netherton@arkvalleyhospice.org P1: 719-384-8827	2007= 0 2012= ***3*** 2018= 33	2007= 0 2012= 11 2018= ***129***
Hospice	**Complete Hospice & Palliative Care of Denver (2017)** 720 South Colorado Boulevard; #1328 Denver, CO 80246 Kevin Goos Executive Director E: kevin@completehospice.com P1: 720-425-3135 C: 720-425-3135	2007= 0 2012= 0 2018= 25	2007= 0 2012= 0 2018= ***98***

Provider Type	Provider Contact Information (Year Palliative Care Program Established)	Palliative Care Patients (bold = estimate)	Palliative Care Consults (bold = estimate)
Hospice	**Berkley Palliative Care & Hospice (2017)** 10697 East Dartmouth Avenue Aurora, CO 80014 Shannon Ratcliff Hospice Director E: sratcliff@berkleyhh.com P1: 303-758-2000 C: 573-979-7158	2007= 0 2012= 0 2018= 19	2007= 0 2012= 0 2018= ***74***
Hospice	**Fremont Regional Hospice (2006)** 1439 Main Street Canon City, CO 81212 Michaelene Jacobs Community Liaison E: michaelene@fremontregionalhospice.com P1: 719-275-4315	2007= 0 2012= ***1*** 2018= 12	2007= 0 2012= 3 2018= ***47***
Hospice	**Divine Hospice & Palliative Care (2017)** 10200 East Girard Avenue; Ste. D140 Denver, CO 80231 Brandy Kendle RN Administrator E: brandy@divinehospice.net P1: 303-357-2540	2007= 0 2012= 0 2018= 10	2007= 0 2012= 0 2018= ***39***
Hospice	**Colorado Palliative Care & Hospice - Colorado Springs (2018)** 5445 Mark Dabling Boulevard; Ste. 205 Colorado Springs, CO 80918 Deana Pinckert RN Clinical Director E: dpinckert@coloradophc.com P1: 719-419-5595 C: 720-795-6236	2007= 0 2012= 0 2018= 9	2007= 0 2012= 0 2018= ***35***
Hospice	**Colorado Palliative Care & Hospice - Denver (2018)** 6551 South Revere Parkway; Ste. 130 Centennial, CO 80111 Joely (Jewlz) Burns Palliative Care Program Manager E: jburns@coloradophc.com P1: 303-727-5709 C: 720-390-1728	2007= 0 2012= 0 2018= 3	2007= 0 2012= 0 2018= ***12***
Hospice	**Hospice Care of the Rockies (2018)** 750 West Hampden Avenue; Ste. 280 Cherry Hills Village, CO 80110 Jan Arnott Executive Director E: jarnott@hospicecareoftherockies.com P1: 303-284-6846	2007= 0 2012= 0 2018= 3	2007= 0 2012= 0 2018= ***12***

Provider Type	Provider Contact Information (Year Palliative Care Program Established)	Palliative Care Patients (bold = estimate)	Palliative Care Consults (bold = estimate)
Hospice	**Mt Rose Health Center Palliative Care & Hospice (2018)** 409 Benedicta Avenue; Ste. A Trinidad, CO 81082 Kathy Bueno RN Director of Nursing E: kbueno@mtrosehealthandhospice.com P1: 719-846-8478	2007= 0 2012= 0 2018= 7	2007= 0 2012= 0 2018= 10
Hospice	**Trailwinds Hospice & Palliative Care (2017)** 75 Manhattan Drive; #208 Boulder, CO 80303 Jenn Thompson RN President & CEO E: jennthompson@trailwindshospice.com P1: 303-442-5683 C: 480-389-7736	2007= 0 2012= 0 2018= 2	2007= 0 2012= 0 2018= ***8***
Hospice	**Lamar Area Hospice Association (NA)** 108 West Olive Street Lamar, CO 81052 Debby Pelley Executive Director E: lamarhospice@gmail.com P1: 719-336-2100 C: 719-688-5517	2007= 0 2012= 0 2018= 5	2007= 0 2012= 0 2018= 5
Hospice	**Colorado VNA Hospice & Palliative Care (1996)** 6750 West 52nd Avenue Arvada, CO 80002 Ann Packer Director Hospice E: packera@vnacolorado.org P1: 303-698-6386	2007= 0 2012= 0 2018= 0	2007= 0 2012= 0 2018= 0
Hospice	**Hospice Del Valle (2003)** 514 Main Street Alamosa, CO 81101 Laura Lewis Executive Director E: llewis@hospicedelvalle.org P1: 719-589-9019	2007= 15 2012= ***6*** 2018= 0	2007= ***59*** 2012= 25 2018= 0
Hospice	**Pikes Peak Hospice & Palliative Care (2003)** 2550 Tenderfoot Hill Street Colorado Springs, CO 80906 Amy Holck Social Worker Director Palliative Care E: aholck@pikespeakhospice.org P1: 719-457-8147 C: 719-641-8313	2007= 412 2012= ***139*** 2018= 0	2007= ***1,607*** 2012= 541 2018= 0

Provider Type	Provider Contact Information (Year Palliative Care Program Established)	Palliative Care Patients (bold = estimate)	Palliative Care Consults (bold = estimate)
Hospice - palliative care emerging	**Abode Hospice & Home Health of Colorado - Colorado Springs (2019)** 5465 Mark Dabling Boulevard Colorado Springs, CO 80918 Christal Ransom-York Community Liaison E: christal.ransomyork@abodehospice.com P1: 719-505-2057	2007= 0 2012= 0 2018= 0	2007= 0 2012= 0 2018= 0
Hospice - palliative care emerging	**Bridges Hospice & Palliative Care - Colorado Springs (2019)** 3895 Upham Street; Ste. 150 Wheat Ridge, CO 80033 Tanya Tysland Administrator E: ttysland@bridgescommunitycare.com P1: 719-596-5001	2007= 0 2012= 0 2018= 0	2007= 0 2012= 0 2018= 0
Hospice - palliative care emerging	**Front Range Hospice & Palliative Care (2016)** 3770 Puritan Way; Ste. E Frederick, CO 80530 Pam Ware Social Worker CEO E: pam.ware@frhospice.com P1: 303-957-3101	2007= 0 2012= 0 2018= 0	2007= 0 2012= 0 2018= 0
Hospice - palliative care emerging	**Frontier Hospice (2012)** 4718 North Elizabeth Street; Ste. A Pueblo, CO 81008 Karla Cordova MSW E: kcordova@frontiercares.com P1: 719-544-5891 x121	2007= 0 2012= 0 2018= 0	2007= 0 2012= 0 2018= 0
Hospice - palliative care emerging	**Hospice of Mercy - Durango (2011)** 175 Mercado Street; Ste. 131 Durango, CO CO Tina Gallegos RN Director E: tinagallegos@centura.org P1: 970-764-3534	2007= 0 2012= ***82*** 2018= 0	2007= 0 2012= 320 2018= 0
Hospice - palliative care emerging	**Interim Healthcare Hospice & Palliative Care (2017)** 1901 North Union Boulevard; Ste. 105 Colorado Springs, CO 80909 Cynthia Ringling RN Owner E: cringling@interimhealthcare.com P1: 719-314-4868 P2: 719-632-9900 x4859	2007= 0 2012= 0 2018= 0	2007= 0 2012= 0 2018= 0

Provider Type	Provider Contact Information (Year Palliative Care Program Established)	Palliative Care Patients (bold = estimate)	Palliative Care Consults (bold = estimate)
Hospice - palliative care emerging	**Mission Healthcare Services (2017)** 12835 East Arapahoe Road; Tower 1; Ste. 400 Centennial, CO 80112 Linda Gaetani RN Hospice Administrator E: l.gaetani@missionhcs.org P1: 303-708-1122	2007= 0 2012= 0 2018= 0	2007= 0 2012= 0 2018= 0
Hospice - palliative care emerging	**Porter Hospice (2007)** 7995 East Prentice Avenue; Ste. 204 Greenwood Village, CO 80111 Crystal Fant Palliative Care Outpatient Coordinator E: crystalfant2@centura.org P1: 303-561-5000 P2: 303-561-5193	2007= 150 2012= 0 2018= 0	2007= ***585*** 2012= 0 2018= 0

**Palliative care programs were considered "emerging" for the purposes of this survey if any of the following factors existed:

1. Entity unable to capture patients served or consults;
2. Entity unable to respond to the survey in the requested timeline;
3. Entity did not see patients during the captured timeframe; or
4. Entity did not meet the state's regulatory definition of palliative care.

Historical Hospice – Palliative Care Providers

Provider Type	Provider Contact Information (Year Palliative Care Program Established)	Palliative Care Patients (bold = estimate)	Palliative Care Consults (bold = estimate)
Historical Hospice	**Kindred Hospice** (formerly Peoplefirst Hospice; Colorado Community Hospice) - Denver	2007= 0 2012= ***65*** 2018= 0	2007= 0 2012= 255 2018= 0
Historical Hospice	**Shalom Hospice** - Aurora	2007= 0 2012= ***16*** 2018= 0	2007= 0 2012= 62 2018= 0
Historical Hospice	**TRU Hospice of Northern Colorado** - Greeley	2007= 0 2012= ***8*** 2018= 0	2007= 0 2012= 30 2018= 0
Historical Hospice	**Gunnison Valley Health Hospice & Palliative Care** - Gunnison	2007= 20 2012= ***4*** 2018= 0	2007= ***78*** 2012= 14 2018= 0
Historical Hospice	**Accentcare Home Health of Mountain Valley** – Loveland	2007= 0 2012= 0 2018= 0	2007= 0 2012= 0 2018= 0

2020 Colorado Other Palliative Care Providers

Sorted by 2018 Number of Palliative Care Consults

Provider Type	Provider Contact Information (Year Palliative Care Program Established)	Palliative Care Patients (bold = estimate)	Palliative Care Consults (bold = estimate)
Other	**Kaiser Permanente Palliative Care Clinics (2005)** Alicia Myers Business Operations Manager / Practice Manager E: alicia.myers@kp.org P1: 720-518-6158 C: 720-518-6158	2007= 0 2012= 0 2018= ***2,141***	2007= 0 2012= 0 2018= 8,350
Other - palliative care emerging	**Aspire Health Care (2019)** 8354 Northfield Boulevard; Bld. G; Ste. 3700 Denver, CO 80238 Alicia Bloom Social Worker VP Partnerships E: abloom@aspirehealthcare.com P1: 303-692-2507 C: 267-514-5603	2007= 0 2012= 0 2018= 0	2007= 0 2012= 0 2018= 0
Other - palliative care emerging	**The Holding Group (2015)** Laurel Tropeano Social Worker Director Research and Education E: laurel@theholdinggroup.org P1: 720-295-1844	2007= 0 2012= 0 2018= 0	2007= 0 2012= 0 2018= 0

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1. Entity unable to capture patients served or consults;
2. Entity unable to respond to the survey in the requested timeline;
3. Entity did not see patients during the captured timeframe; or
4. Entity did not meet the state's regulatory definition of palliative care.