Connecting Care, Comfort, and Compassion

The Role of Telehealth in Palliative Care

Expanding Access, Preserving Compassion, and Demonstrating Value

Christina McDaniel, DNP, MSN, RN
System Executive Director of Palliative Care
MUSC Health

ANNUAL TELEHEALTH SUMMIT OF SOUTH CAROLINA
The Power of Connection
August 31, September 1, and September 2, 2026
PALMETTO CARE CONNECTIONS

Acknowledgment

This project was supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under the Medical University of South Carolina Telehealth Center of Excellence cooperative agreement (U66RH31458), which has a total award amount of $4,250,000 for the approved project period. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by HRSA, HHS, or the U.S. Government.

Learning Objectives

What participants should be able to do after this session

- Explain how telehealth is transforming access to palliative care across rural, medically underserved, and home-based settings.
- Discuss strategies for delivering compassionate, patient-centered palliative care through virtual models.
- Examine real-world outcomes and lessons learned from telepalliative care programs that improve quality, experience, and value.

HOW WE SEE OURSELVES IN PALLIATIVE CARE


HOW OTHERS SEE
US IN PALLIATIVE
CARE

Palliative Care: You are a Bridge

Palliative care and **Hospice** are both types of comfort care that aim to **reduce stress** and offer complex **symptom relief** related to a serious illness, and both address **physical, psychosocial, and emotional** relief.

Palliative Care	Hospice Care
• Can be provided at any stage of a life-limiting illness • For patients who may be seeking curative treatment in addition to symptom management • Care teams typically work in hospital and ambulatory settings • Costs are paid by Medicare, Medicaid, and private insurance	• Provided near the end of life • For patients with a prognosis of six months or less who are not seeking curative treatment • Care delivered where the patient calls home • Costs are paid by Medicare, Medicaid, and private insurance

Why This Conversation Matters Now

The clinical need is growing while specialty access remains uneven

- Patients with serious illness are cared for across increasingly diverse settings.
- Specialty palliative care access remains uneven across regional, rural, and smaller hospitals.
- Delayed consultation can limit opportunities for symptom relief, decision support, and goal-concordant care.
- Telehealth creates a pathway for inclusive, scalable specialty support.

Access Gaps in Rural and Medically Underserved Settings

Geography can shape care options for patients with serious illness

- Limited local specialty workforce can delay palliative involvement.
- Travel distance and transportation barriers can increase burden for patients and caregivers.
- Care teams in smaller hospitals may need consultative support for complex communication and symptom needs.
- Hybrid models embedded in local pathways can reduce disruption and support continuity.

Telehealth Is a Care Model, Not Just a Visit Type

The technology is only one component of the model

- Inpatient consultation across regional hospitals.
- Outpatient or home-based support for serious illness needs.
- Virtual family meetings when decision-makers are geographically dispersed.
- Hybrid care models that combine local bedside support with centralized specialty expertise.
- Capacity-building models that strengthen local primary palliative care skills.

How Telehealth Transforms Access

Three access shifts

- Geographic access: specialty expertise can reach patients without transfer or travel.
- Timely access: consults can occur earlier in the hospitalization or illness trajectory.
- Relational access: family members and decision-makers can join from different locations.

MUSC Program Overview

A systemwide telepalliative care model

- Designed to extend specialty palliative care expertise across the MUSC Health enterprise.
- Supports hospitalized patients with serious illness across diverse hospital settings.
- Focuses on quality, efficiency, communication, and goal-concordant decision-making.
- Partners with local care teams rather than replacing bedside clinicians.

Program Structure

Centralized expertise with local integration

- Three palliative-trained Advanced Practice Providers.
- Fourteen Regional Health Network hospitals across four MUSC Health Divisions and affiliated locations.
- Secure virtual consults integrated into local inpatient workflows.
- Emphasis on early inpatient involvement.

Clinical Focus of Telepalliative Consults

The core work of palliative care remains the same

- Symptom management for pain, dyspnea, anxiety, and other distress.
- Goals-of-care discussions to clarify values, prognosis, and treatment options.
- Advance care planning and documentation of preferences.
- Decision support for patients, families, and care teams.
- Alignment of treatment plans with patient values and preferences.

Compassion Through a Screen

Virtual presence has to be intentional

- Start with presence before agenda.
- Confirm privacy and identify everyone in the room and on screen.
- Ask permission before serious conversations.
- Use names, relationships, pauses, and plain language deliberately.
- Engage the bedside team to reinforce physical presence and continuity.
- Close with what was heard, what matters most, and what happens next.

A Practical Framework: CONNECT

A simple communication structure for virtual serious illness conversations

C Clarify who is present and what everyone understands

O Orient to the purpose of the visit

N Name difficulty without rushing

N Navigate goals, values, and tradeoffs

E Engage the local care team

C Close the loop on decisions

T Translate into an actionable care plan

Common Concerns About Virtual Palliative Care

Anticipate and address barriers directly

- Can it feel compassionate? Yes, when presence and communication are deliberate.
- Will technology get in the way? Sometimes, so programs need backup workflows.
- Is it appropriate for serious conversations? Often, especially when it allows key family members to participate.
- Will virtual care worsen access gaps? It can, unless digital access and support are built into the model.

Consult Volume and Completion

MUSC Health telepalliative care program, Sept 2025 to March 2026

1,227	851	69%	376
consults ordered	consults completed	completion rate	consults cancelled

Cancellation drivers: family unavailable, patient death, discharge

Patient Demographics and Reach

FY 2025 Analytical Cohort for KPI Development: Demographic Characteristics of the MUSC Telepalliative Care Consult Population

1,169	73.6	72%	52% / 47%
patients in 2024 dataset	mean age	Medicare coverage	White / Black

Age range: 29 to 101 | Female: 52% | Other racial group: 1%

Key Performance Indicators

Moving from activity to measurable impact

Days to consult

9.0 mean

Days consult to discharge

6.9 mean

LOS for consult admission

15.9 mean

Time to readmission

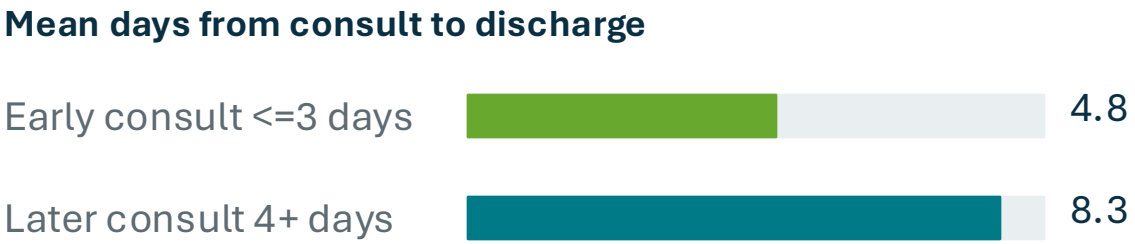
102 mean days

Readmission LOS

4.0 mean

Timing Matters: Early vs Later Consultation

Consult within 3 days of admission compared with day 4 or later



Early consult group: 90% discharged alive | Later consult group: 85% discharged alive

Matched Outcomes: LOS and Estimated Cost

Propensity-score matched groups, N=278 early and N=278 later

10.5 days

lower mean LOS

$27,755

lower general medicine estimated cost

$54,186

lower ICU-associated estimated cost

p<.0001

all three comparisons

Matched mean LOS: 6.3 days early consult vs 16.8 days later consult

Patient, Family, and Provider Experience

Qualitative feedback helps explain why the model matters

Patient and family voices

“The video was perfect solution for those of us out of town to be a part in discussion.”

“Feel very fortunate to have had the service of the palliative consult.”

Provider voices

“Important service for patient care given high acuity and complexity of patients with limited palliative services in the area.”

“An invaluable service. I wish they were available 7 days a week.”

How Telepalliative Care Improves Value

Value is more than cost

- Quality: earlier symptom support, communication, and advance care planning.
- Experience: patients and families can participate across geography.
- inclusivity: specialty support reaches sites without full local palliative staffing.
- Efficiency: earlier involvement may reduce unwanted or non-beneficial interventions.
- Team support: local clinicians gain consultative expertise in complex situations.

Implementation Lessons

What makes programs work

1. **Start with the clinical problem**
2. **Build local relationships**
3. **Standardize core workflows**
4. **Adapt to site context**
5. **Measure what matters**

Barriers and Practical Solutions

Design for predictable challenges

Technology disruptions	Backup workflows and troubleshooting support
Late consults	Triggers, screening criteria, and education
Staff turnover	Repeat training and simple referral guidance
Local skepticism	Champions and experience feedback
Limited data access	Define KPIs early with analytics partners
Sustainability	Connect metrics to access, quality, experience, and value

Ambulatory and Caregiver-Centered Telepalliative Care

Virtual care can extend support beyond hospital walls

- Reduces travel burden for patients with serious illness and limited mobility.
- Allows geographically distant family and caregivers to participate.
- Offers insight into medication access, home supports, caregiving strain, and equipment needs.
- Requires clear escalation pathways when symptoms require in-person evaluation.

What Not to Lose in Virtual Care

The platform must not dilute the discipline

- Do not lose whole-person care.
- Do not lose interdisciplinary collaboration.
- Do not lose spiritual, psychosocial, and caregiver support needs.
- Do not let efficiency replace presence.
- Expanding access should not come at the cost of wider gaps among patients with limited digital access.

Key Takeaways

From access to impact

- Telehealth can extend specialty palliative care across rural, medically underserved, regional, inpatient, and home-based settings.
- Compassionate virtual palliative care requires intentional communication, team integration, privacy, pacing, and presence.
- Early telepalliative care can be measured through meaningful quality, experience, utilization, and value outcomes.
- The MUSC experience demonstrates that systemwide telepalliative care can scale specialty access while supporting goal-concordant care.
- The next frontier is sustainability, inclusivity, interdisciplinary capacity, and earlier identification of patients most likely to benefit.