wednesday webinar

PRESENTED BY PALMETTO CARE CONNECTIONS

Benefits of Telehealth in Palliative Care

Wednesday, July 28, 11am-12pm EST

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This webinar is being recorded.

The webinar recording and presentation will be available after the webinar.

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Telehealth in Palliative Care

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Objectives Part 1

- Brief introduction to Palliative Medicine
- Review the state of the palliative care workforce and expected future challenges
- Discuss how telehealth might help overcome these challenges, and other possible benefits
- A brief review of the literature; what the data shows about telehealth benefits in hospice and palliative medicine

Palliative Care Definition

A **medical specialty** that focuses on the relief of the pain, symptoms and stress of serious illness.

The goal is to improve quality of life (for patients and their families)

Palliative care is appropriate at ***any*** point in an illness and can be provided at the same time as curative treatment.

An extra layer of support for the patient with serious and complicated illness (support care team as well)

- Symptom assessment and relief
- Family-patient-care team communication
- Future planning
- Works with your doctors
- Multiple types of care providers (physicians, nurses, chaplains, social workers)

Palliative Care – Overcoming an Identity Problem

Palliative care is not about giving up!

Palliative care IS NOT hospice (though it can lead to hospice care)

Palliative Care Improves:

- Quality of life and the quality of how people are *living*
- Communication about personal choice that helps align treatment with values to deliver person-centered and goal-concordant care
- Quality of care that reduces need for acute, high-cost hospital/ER/ICU utilization

What Palliative Care Offers

Relieve:

- Symptoms, distress (emotional, spiritual, practical) and uncertainty

Communication:

- What to expect, treatments that match patient and family goals

Coordinate

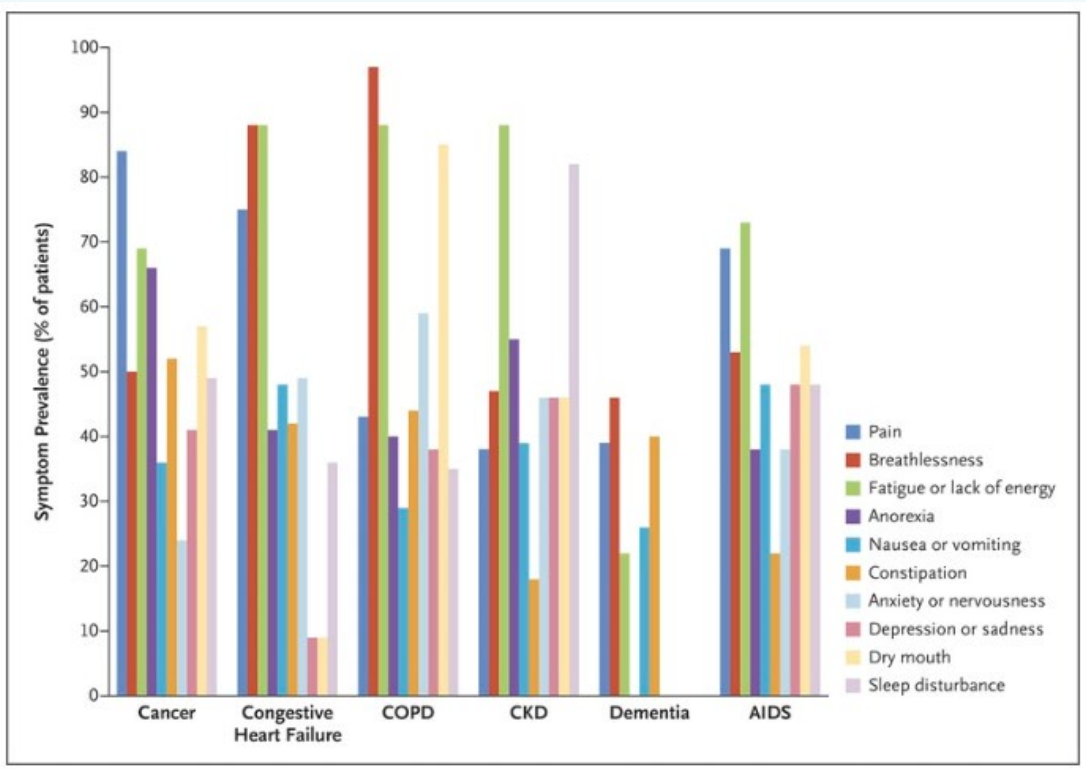
- Medical and practical needs across settings

Improve Outcomes for Families

Caregivers for patients receiving palliative care

- Better quality of life
- Experience less regret
- Improvements in physical and mental health

Wright AA et al, JAMA. 2008;300(14):1665-1673 and JCO Sept 2010



Palliative Care for the Seriously Ill

Amy S. Kelley, M.D., M.S.H.S., and R. Sean Morrison, M.D.

August 20, 2015
N Engl J Med 2015; 373:747-755
DOI: 10.1056/NEJMra1404684

Conversation About End of Life

Difficult, but important in making sure care is appropriate to patients hopes and goals

Talking about something doesn't make it happen

Over 85% percent of patients think it is appropriate for their doctors to talk to them about resuscitation

This does not take away hope

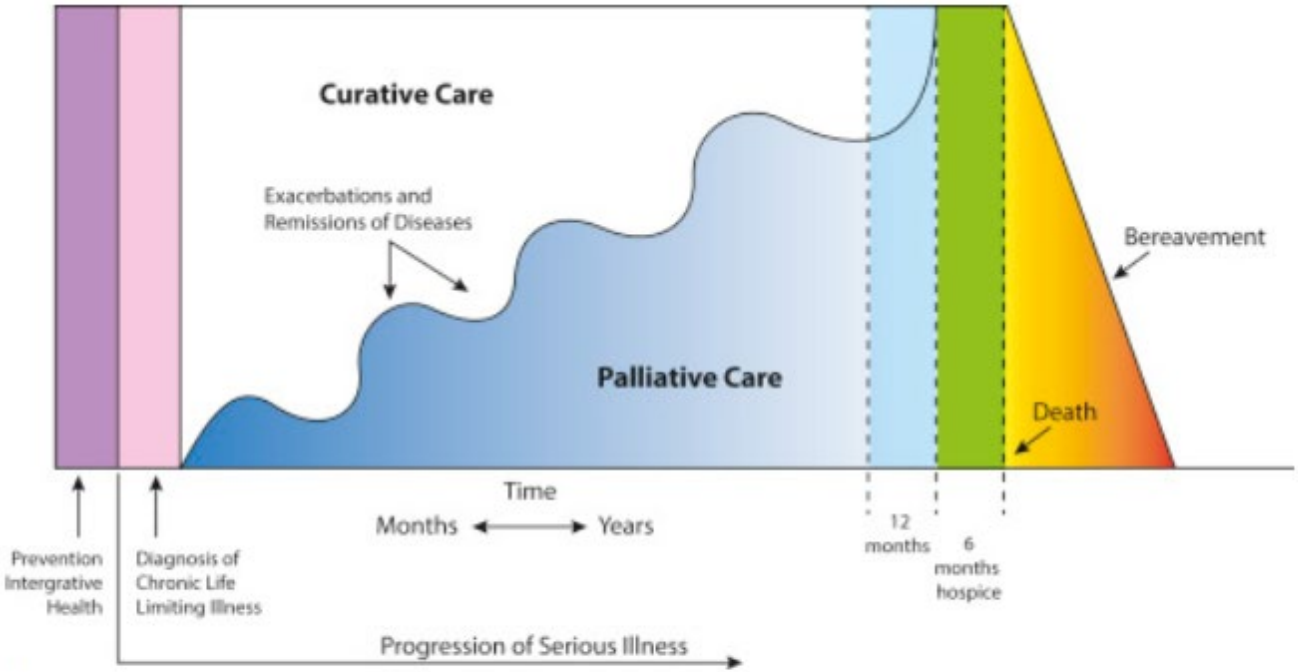


Fig. 1

Continuum of care model for patients with serious illness.

(*Adapted from* Lynn J, Adamson DM. Living well at the end of life: adapting health care to serious chronic illness in old age. Santa Monica: RAND; 2003; with permission.)


IMPROVES QUALITY OF LIFE AND SYMPTOM BURDEN
Quality of Life
Symptom Burden
Reduces symptom distress by
66%
with improvements lasting months after initial consultation[3]
DRIVES HIGH SATISFACTION AND POSITIVE PATIENT EXPERIENCES
93%
of people who received palliative care are likely to recommend it to others[2]
REDUCES AVOIDABLE SPENDING AND UTILIZATION IN ALL SETTINGS
48% readmissions
28% cost/day
INPATIENT[3,4]
50% admissions
35% ED visits
OUTPATIENT[5]
43% hospital/ ED transfers
SKILLED NURSING[6]
36% total costs
HOME-BASED[7]
Center to Advance Palliative Care™
capc
Learn more at capc.org

CAPC State by State Report Card 2019

- 72% of Hospitals with >50 beds report having a palliative care presence (This number was 7% in 2001)
- Geography matters
  - 90% of hospitals with palliative care programs are in urban areas
  - 17% of rural hospitals with greater than 50 beds report having PC programs
- Hospitals fewer than 50 beds make up about 2/3 of the nation's hospitals, but only account for 1.2 million admissions (4% of total nationwide admissions)
  - Most of these are in rural areas
  - Small volume means many rural hospitals have a hard time supporting a PC program

Population Health of the United States (CAPC report cont.)

- 12 million adults are living with serious illness (e.g. cancer, dementia, heart disease, kidney disease)

- By 2035:
  - 78 million people in the US will be over the age of 65
  - 81% of these adults will be living with multiple chronic conditions
  - This will be the first time this number eclipses the number of women between the ages of 18-55 (important as this is the traditional caregiver workforce)

- Of patients 85 years or older, 1/3 will have dementia

In short, the need for palliative medicine will continue to grow into the near future

Estimate of Current Hospice and Palliative Medicine Physician Workforce Shortage

Dale Lupu PhD, American Academy of Hospice and Palliative Medicine Workforce Task Force

2010 estimation of the need for HPM physicians

-at the time approx. 4400 palliative medicine physicians

Demand: hypothetical demand using exemplar hospices, academic center model, and CAPC staffing recommendations (only looking at hospice and hospital settings)

CAPC staffing recommendation at the time – one physician FTE for every 250 staffed beds in a hospital, exemplar institution in the range of one physician FTE per 150 beds

Conclusion: A shortage of FTE between 1700-3300, equating to 6000 – 18000 physician shortage (depending on how much time physician devoted to HPM)

At the time did not include estimations of outpatient palliative care needs

Future of the Palliative Care Workforce: Preview to an Impending Crisis

Kamal et al. American Journal of Medicine, 130:2. 2017

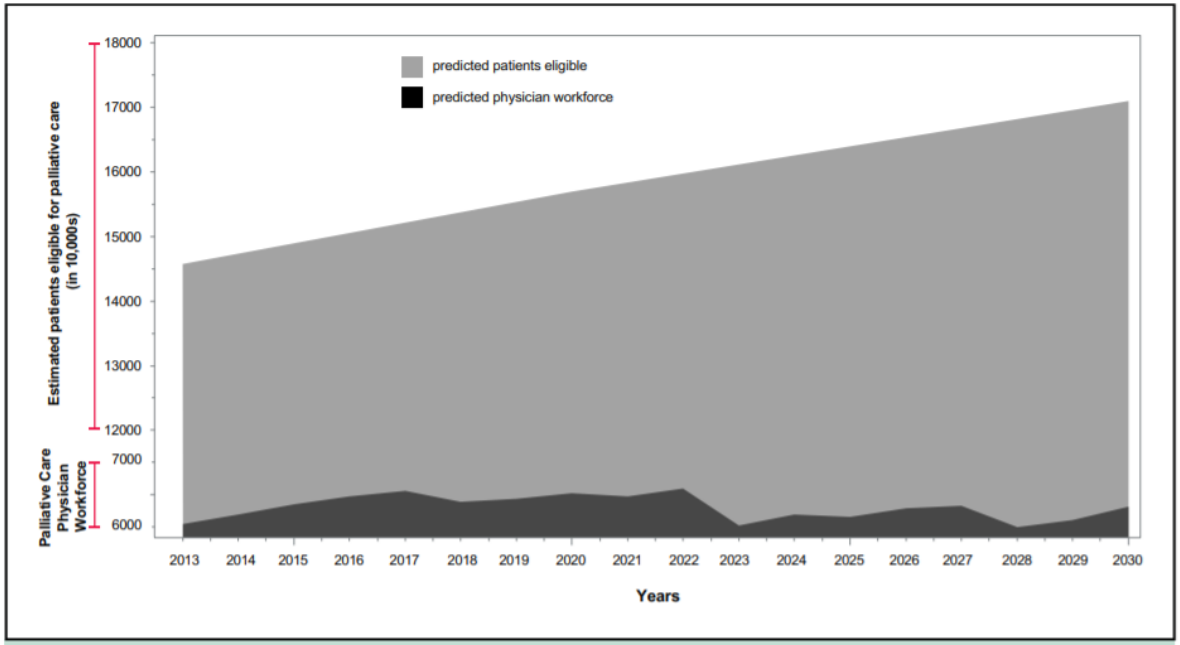


Figure Projected changes in palliative care physician workforce and seriously ill patients eligible for services.

The Growing Demand for Hospice and Palliative Medicine Physicians: Will the Supply Keep Up?

Lupu D et al. Journal of Pain and Symptom Management 2018 55:4

- Evidence suggests despite robust growth, palliative care continues to have significant unmet needs
  - 2016 Study – Palliative care reaches 3.4% of hospital patients
  - 2014 Study – 13.8% of ICU admissions meet criteria for palliative care involvement
  - 2014 Study – one third of hospitalized cancer patients would benefit from PC involvement
- Growth in fellowship programs continues
  - 2010 – 141 physician enrolled in HPM accredited fellowship, in 2016 it was 325
  - Fellowship programs grew from 73 in 2010, to 115 in 2015
- On average, there are 13.5 HPM specialist per 100,000 persons over the age of 65, though distribution is highly variable

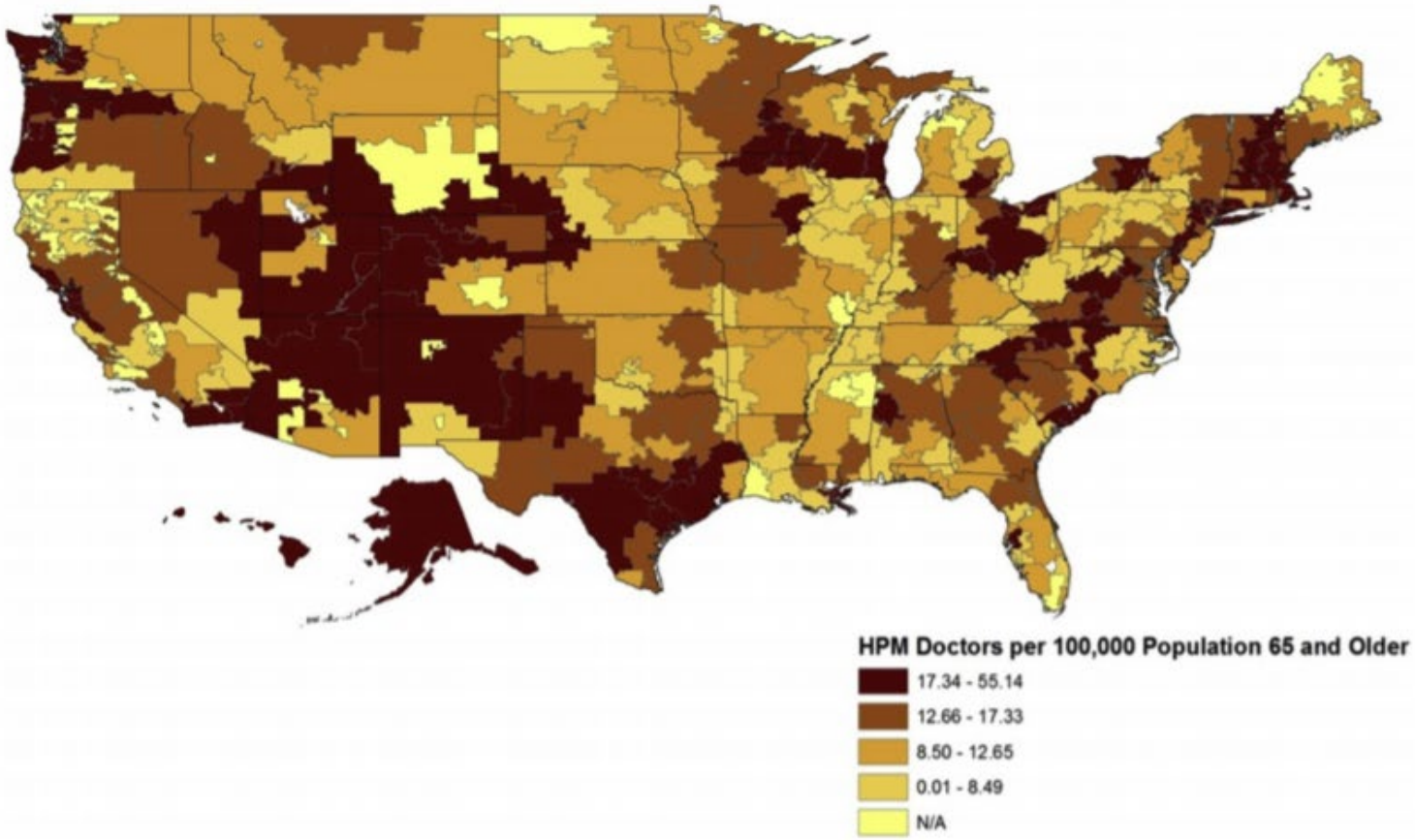


Fig. 1. Ratio of hospice and palliative medicine physicians to older population. HPM, hospice and palliative medicine; N/A, not applicable.

The Growing Demand for Hospice and Palliative Medicine Physicians: Will the Supply Keep Up?

Lupu D et al. Journal of Pain and Symptom Management 2018 55:4

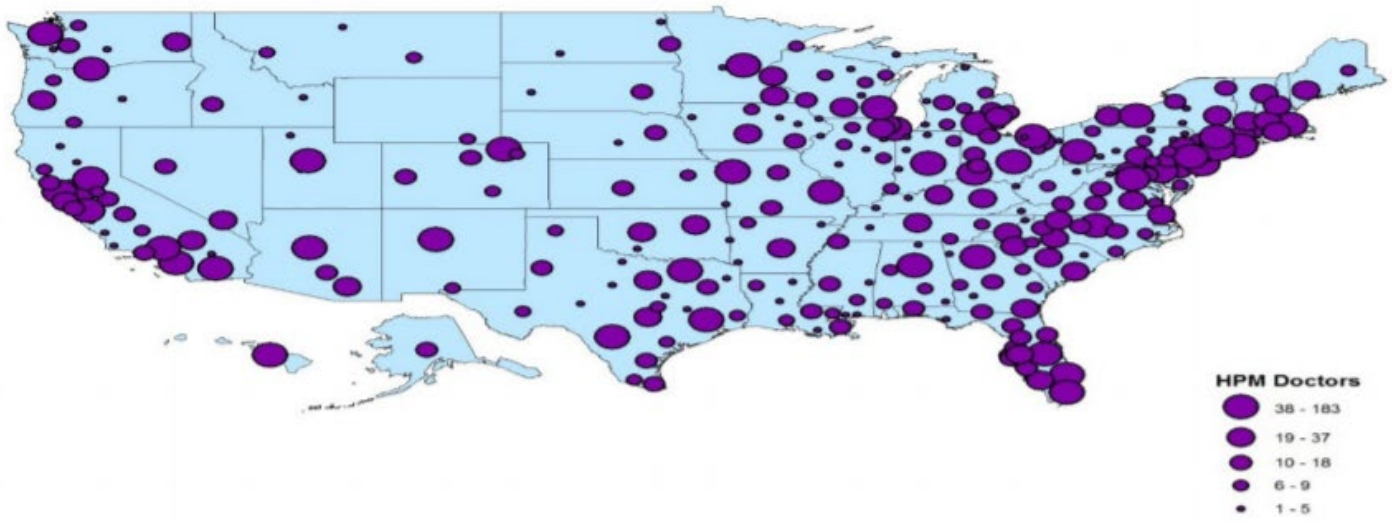
Table 1

Total Projected HPM Physician Need and Supply by Scenario

	Year					
Supply and Need Assumptions	2015	2020	2025	2030	2035	2040
Total supply						
Steady state: 325/yr	6391	6944	7342	7629	7856	8100
Growth: 30 additional/yr	6391	7324	8724	10,618	12,663	14,661
Rapid growth: 50 additional/yr	6391	7578	9645	12,612	15,867	19,034
Total need						
Need 1: current national average	6391	7470	8592	9713	10,177	10,640
Need 2: current Quartile 3	6914	9610	11,053	12,496	13,092	13,688
Need 3: 20/100,000 (San Diego)	8053	11,194	12,874	14,555	15,249	15,944
Need 4: 30/100,000 (Contra Costa)	12,080	16,791	19,311	21,832	22,874	23,916

HPM = hospice and palliative medicine.

Exhibit 10. Number of Active HPM Physicians by Hospital Referral Region



Data on HPM physicians from AMA Masterfile, January 2016. Placed in HRRs by ZIP code of practice. The dots are placed in the geographic center of the HRR, which may be slightly different from the actual physical location.

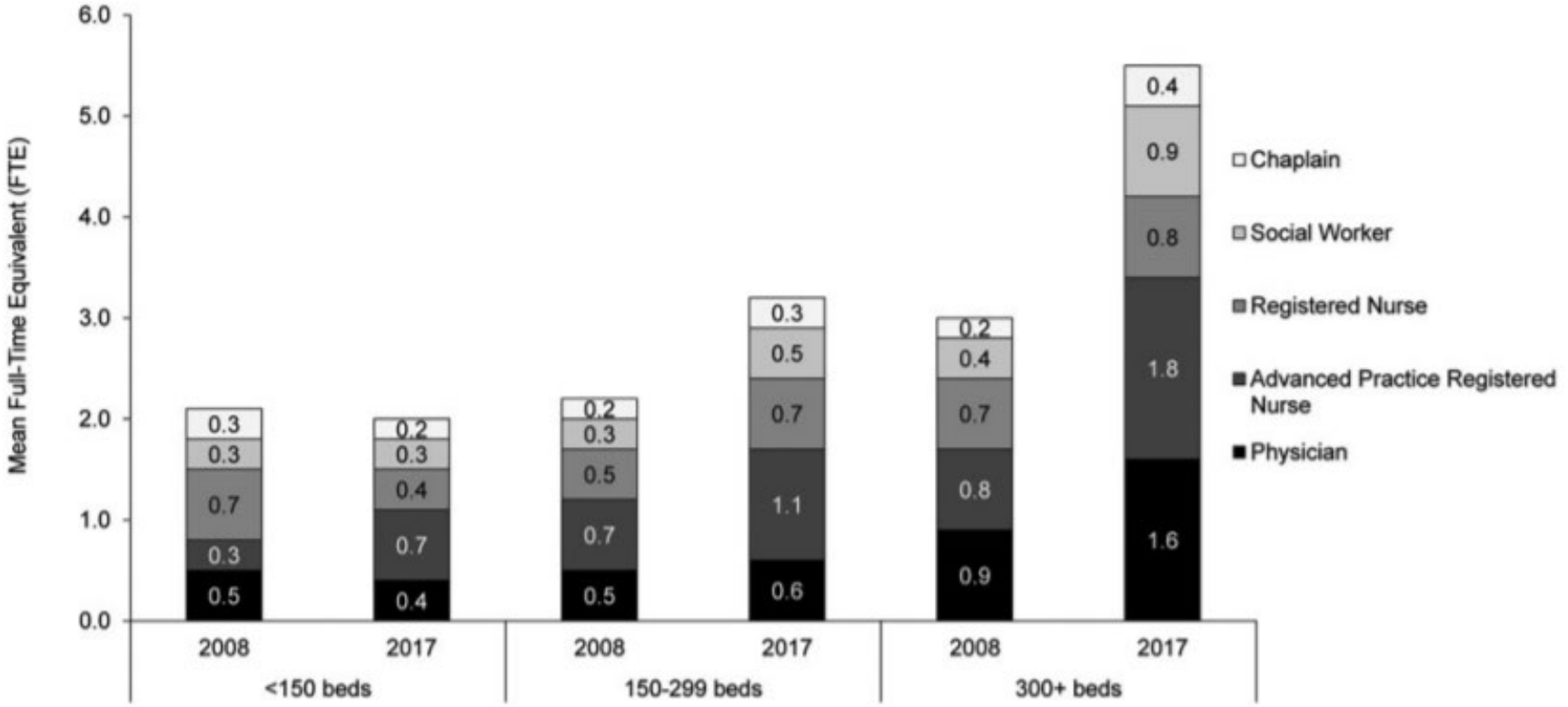


FIG. 3. Changes in palliative care team composition by hospital size, 2008–2017 (adult palliative care programs).

Figure 1. Percentage of Hospitals with a Palliative Care Program by Geographic Type

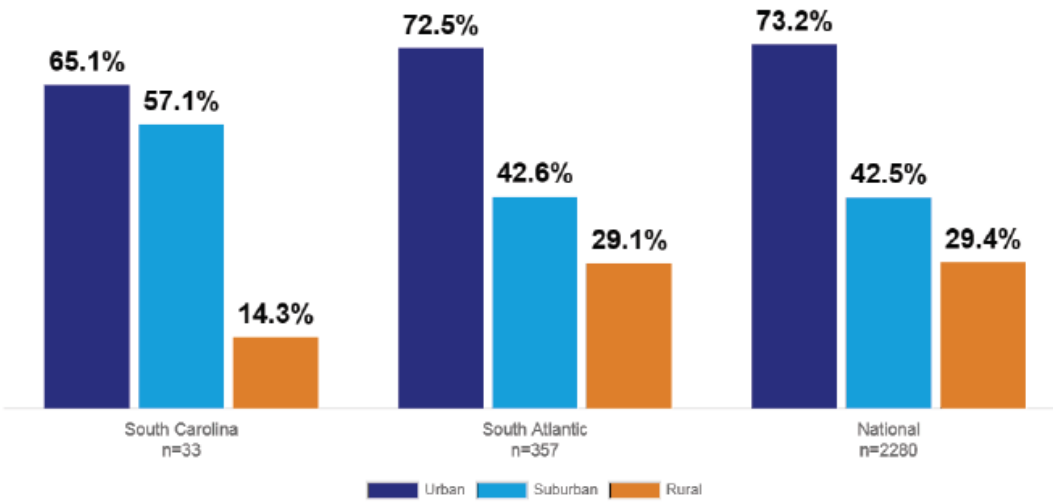
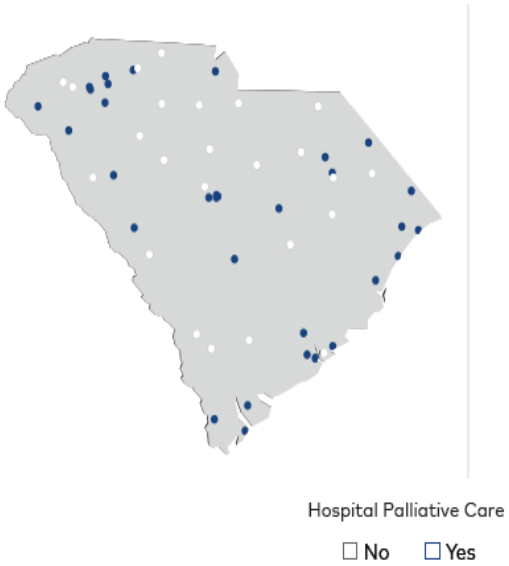


Figure 2. Availability of Hospital Palliative Care in South Carolina



Palliative Medicine Workforce Challenges - Conclusions

- Palliative medicine continues to be recognized as vital, and fellowship training has grown significantly over the past 20 years
- There remains a large unmet need for palliative care throughout the continuum of care
- As the population ages, the palliative need may outpace the supply of physicians (and providers) even with continued growth
- Palliative physician workforce remains highly concentrated in urban areas, leading to high rural unmet needs
- Most rural hospitals remain without a palliative provider, leaving seriously ill patients without access that others have

The Practical Benefits of Telehealth in Hospice and Palliative Medicine

- When used to its potential, telehealth can improve access to healthcare
  - Expand access when geographical limitations exists
  - Expand access in off hour care
  - Specific to palliative population, avoid burdensome trips to physical locations
- Improved access can lead to improved quality of care and less acute care needs
- Cost efficiencies- Telehealth can reduce the cost of care and increases efficiency through timely access to providers
- Telehealth models can allow a concentrated workforce to expand their reach
- Can allow exemplar organizations that can support a program provide care to areas that are in need

Telehealth and Hospice

- A Systematic Review of the Evidence Base for Tele hospice – Oliver et al. 2012
  - A review conducted between 2000 and 2010, inclusion criteria yielded 26 articles, near 11,000 patients included.
  - Findings categorized to 6 themes: use, provider attitudes, patient/family attitudes, clinical outcomes, readiness, and cost

- Findings:
  - Various technologies used (telephone, videophone, computers, tablets), all were found useful
  - Provider attitudes positive in regard to perceived usefulness and ease
  - 15% of articles evaluated patient/family attitude – majority of patients reported technology as useful and helpful
  - Only three studies looked at outcomes (patient symptom, caregiver quality of life, perception on pain medication usage) – no study large enough to be conclusive

Telehealth and Hospice (cont.)

- Oliver et al Conclusions:
  - Though limited, a strong base for tele hospice has emerged and established a foundation for the field
  - Tele hospice technologies hold promise to be useful and important tools for the future delivery of hospice care
  - Several technologies may be of use, interest levels very high, and there are potential clinical outcomes and cost benefits

"If tele hospice is to live up to the promises found in these initial studies, then increased focus needs to be made in the building of evidence to identify the clinical benefits of tele hospice programs and its associated cost savings"

Systematic Review of Tele hospice Telemedicine and e-Health

Cameron P and Munyon K. Telemedicine and e-Health 2020

- A look at the 10 years since the review conducted by Oliver et al, using the exact same methodology
  - 13 studies included, N total of 1905 (most patients, some providers)
- Results:
  - High comfort level with technology and willingness to use/recommend use from patients/families and providers
  - Patients perceived tele hospice as a beneficial part of pain management
  - Improved ability to contact care team provided more comfort to family
  - Rural settings (children's hospice) – decreased travel time, maintained link with hospice team
- Limitations:
  - Outcome results still limited and present the greatest need in future research

Video consultations in palliative care: A systematic integrative review - Introduction

Jess et al. Palliative Medicine 2019 Vol33(8) 942-958

Goal to appraise the evidence of video-based technology and palliative care visits

39 articles included: mix-methods (14), qualitative (10), quantitative (10), case series (5) and one RCT

2345 patients, 549 relatives, 252 health care professionals and 1631 video consultations

Studies from multiple countries (USA, Australia, Canada, UK, Netherlands, Brazil, Japan)

27 studies used video consultations to supplement in person care

8 studies compared video with in-person care

3 studies investigated video visits as the only palliative care intervention

Platforms for video diverse, all but one study provided patients with devices

Video consultations in palliative care: A systematic integrative review - Results

Jess et al. Palliative Medicine 2019 Vol33(8) 942-958

- Video technology feasible, allowed family presence, and could be used to enhance communication and symptom treatment
- Majority of studies focused on seriously ill cancer patients
- Economic impact – low grade evidence; few studies
  - Cost savings present when video technology replaced in person care in rural setting, allowing home visit instead of in person clinic or in person home visit
- Patients, family members and providers experience was perceived as positive
- The ability to have several participants present at the same time can contribute to effective and inclusive communication
- Technology (phone, tablets, computer platforms) were very acceptable to all parties, and while technology barriers existed, platforms were generally feasible and user friendly

The Covid19 Transformation of Care

- Reinventing Palliative Care Delivery in the Era of Covid-19: How Telemedicine Can Support End of Life Care
  - Ritchey KC, Foy A, McArdel E, Gruenewald DA.Am J Hosp Palliat Care. 2020 Nov;37(11):992-997. doi: 10.1177/1049909120948235
- Feasibility and Acceptability of Inpatient Palliative Care E-Family Meetings During COVID-19 Pandemic
  - Joanne G. Kuntz, MD, Dio Kavalieratos, PhD, Gregory J. Esper, MD, MBA, Noble Ogbu Jr., MS, Julie Mitchell, DO, Cameron M. Ellis, MD, and Tammie Quest, MD. Journal of Pain and Symptom Management. 2020. https://doi.org/10.1016/j.jpainsymman.2020.06.001
- Telemedicine in the Time of Coronavirus
  - Brook Calton 1, Nauzley Abedini 2, Michael Fratkin. J Pain Symptom Manage . 2020 Jul;60(1):e12-e14. doi: 10.1016/j.jpainsymman.2020.03.019. Epub 2020 Mar 31
- Rapidd Implementation of Inpatient Tele palliative Medicine Consultations During COVID-19 Pandemic
  - Humphries et al. Journal of Pain and Symptom Management. 2020 https://doi.org/10.1016/j.jpainsymman.2020.04.001
- Can Video Consultations Replace Face to Face Interviews? Palliative Medicine and the Covid19 Pandemic: A Rapid Review
  - Sutherland AE, et al. BMJ Supportive & Palliative Care 2020;10:271–275. doi:10.1136/bmjspcare-2020-002326

Telemedicine as a Tool to Provide Family Conferences and Palliative Care Consultation in Critically Ill Patients at Rural Health Care Institutions

Menon et al. American Journal of Hospice and Palliative Medicine. 2015 32(4) 448-453

- Design: Tertiary Care Center performed telehealth family conferences prior to transfer from rural center
  - Transfer center physician discretion, if inclusion criteria met, offered the intervention, if family/patient and physician agreed, meeting was coordinated
  - Inclusion criteria: metastatic cancer with respiratory or cardiac failure, very advanced age with organ failure, advanced dementia, end stage heart, lung liver disease
- Intervention: an interdisciplinary conference including patient/family, ICU attending at the TCC, palliative team, social worker
- Results: 12 conferences performed, 8 transferred, 4 did not. 7/8 eventually transferred back. 10/12 died within 30 days of the conference
- Findings: tele ICU/palliative consults feasible, “early” consultation may have helped with downstream end of life care decisions.
- 1/3rd of patients – avoided cost of transfer and continued care, avoided psychosocial burden of isolated death

Virtual Interinstitutional Palliative Care Consultation during the COVID-19 Pandemic in NYC

Asprec L. et al. Journal of Palliative Medicine 2021

- Columbia University Irving Medical Center/New York Presbyterian experience
  - First wave of covid, unprecedented demand outpaced the adult PC team's ability
  - Virtual care model developed and utilized
  - Volunteer PC specialists from University of California, UCSF, Stanford, and Dartmouth
- Patients with severe covid, non could communicate, most intubated, sedated. PC specialist conducted consults with family via phone or video modality, exclusively assisting with goals of care
- Retrospective observational cohort
- Primary outcomes: frequency of PC visits and duration of follow-up
  - Secondary outcomes: code status changes, life-sustaining treatment at end of follow-up, withdrawal of LST

Interinstitutional Palliative Care Consultation

- Findings: 34 patients reviewed, median time between admission and consultation was 24 days, 30 patients full code at time of consult, 82% in the ICU receiving 2 forms of life support

- End of consultation findings: 15 patients died, 9 survived to discharge, 10 patients signed off. 198 total tele visits were made, 90% phone, 10% video. Median time following was 11 days, median number of visits per patient was 4.5.

- 15 patients had code status changed, LST were withdrawn in 8 patients

- Conclusions: It was feasible to provide palliative care consultation virtually
- Of deceased patients, code status changed in most, and half had LST withdrawn – suggests that palliative consultation may have guided end of life decision making

Summary

- Across multiple care settings, telehealth can be a platform that can increase access to palliative care
- Tele palliative consultation can enable clinical assessment and support effective communication at a distance
- Video consultation can provide cost savings compared to inpatient or home in person visits
- Overall user experience (both patient and provider) positive and accepting
- Further research is needed:
  - Patient outcome data
  - Cost efficacy
  - How and when video can supplement or replace in person palliative care

Objectives Part 2

- Discuss telehealth background
- Overview of MUSC telehealth program
- Describe inpatient telehealth visits
- Pros and cons of telehealth
- Tips for being successful in telehealth practice

Case Study #1

- 83-year-old male hx lung cancer and COPD. ED with shortness of breath. CT showed spiculated nodule of RLL and severe emphysematous changes to both lungs. Sputum tested + for MRSA. Poor overall prognosis- Had been in hospital 10 days. Palliative consulted for goals of care discussions.
- At initial visit there was no family at bedside.

Case Study

- “I’m very sick-I have no one to blame but myself”
- Empathy and support
- Discussed goals- “I know everyone dies, I just do not want to suffer or be a burden to my family”
- Talked about his support system.
- He was open to exploring hospice care- gave permission to talk to his family
- Felt “pretty good overall” -though feeling short of breath at times especially with movement. Recommended low dose opioids for dyspnea
- Called his wife-she was overwhelmed requested a meeting the following day as their other children were getting in town.

Case Study

- Held family meeting next day through telemonitor.
- Open discussion and recap from the visit day before.
- “Last chapter of his life”
- Family concerns- lack of appetite, dyspnea (improved), grand daughters wedding
- Talked about hospice and what care they could provide
- Family decided that they will rotate and stay with them at home while on hospice care.
- Needed a few days to get the home set up- went home with hospice 2 days later.

Telehealth

- The use of telecommunications and information technologies to share information and provide clinical care, education, public health, and administrative services at a distance.
- Remote delivery of health care using devices with audio an/or video capabilities.
- Culture changing- Banking, shopping, etc.
- Palliative Care (PC) involvement in telehealth has been slower than other specialties
- Limited palliative access and positive palliative telehealth studies have led to an increase in demand

Telehealth Barriers for Palliative Care

- Common misperception that PC cannot provide the same degree of human compassion using remote technology
- Clinician acceptance and readiness to use technology
- Presence of organizational infrastructure that supports adoption
- Lack of funds (Improved by COVID reimbursement.)
- Lack of training
- Mistrust in security of the internet
- Lack of access to internet- 24% of rural Americans report limited access.
- Lack of studies showing specific telehealth outcomes.

- Has been found that telehealth allows for “anonymity” which translates to space for some levels of disclosure that may otherwise be difficult.
- Many professional organizations and clinical guidelines now recognize telehealth palliative care as a valid strategy.

“We now feel it’s cheaper to do surgery via Skype. So, go home and lie down in front of your computer.”

Telehealth

- Has quickly become a mainstay of healthcare (including palliative care) during COVID-19 pandemic. Telehealth has increased exponentially.
- “Many facilities have gone from 40 televists a year to 4,000 in a month”
- ”Rapidly increasing utilization during the Covid-19 pandemic has long-term implications for access to primary and specialty palliative care.”
- In 2007 there were 695 hospice agencies- only 6% were using telehospice
- In a recent survey 90% of hospice/palliative providers reported providing telehealth services.
- More organizations are becoming equipped with telehealth infrastructure
- Telehealth for hospice and palliative care is expected to grow

Commons Reasons for Palliative Consults

- Comprehensive Symptom Assessment
- Symptom management associated with serious illness, such as:
  - Pain
  - Nausea
  - Dyspnea
  - Anxiety & Depression
  - Anorexia
- Discussion of Prognostication
- Goals of Care and Advanced Directives
- Hospice Discussions

MUSC Telehealth Program

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Palliative Telehealth Program

Duke Endowment - $1.26 Million

- 3 Year Initiative
  - *Provide scheduled inpatient Palliative Care consults via Telehealth for rural hospitals and patients in South Carolina*
  - *Sept 2020: approved expansion to SNFs and correctional facilities*

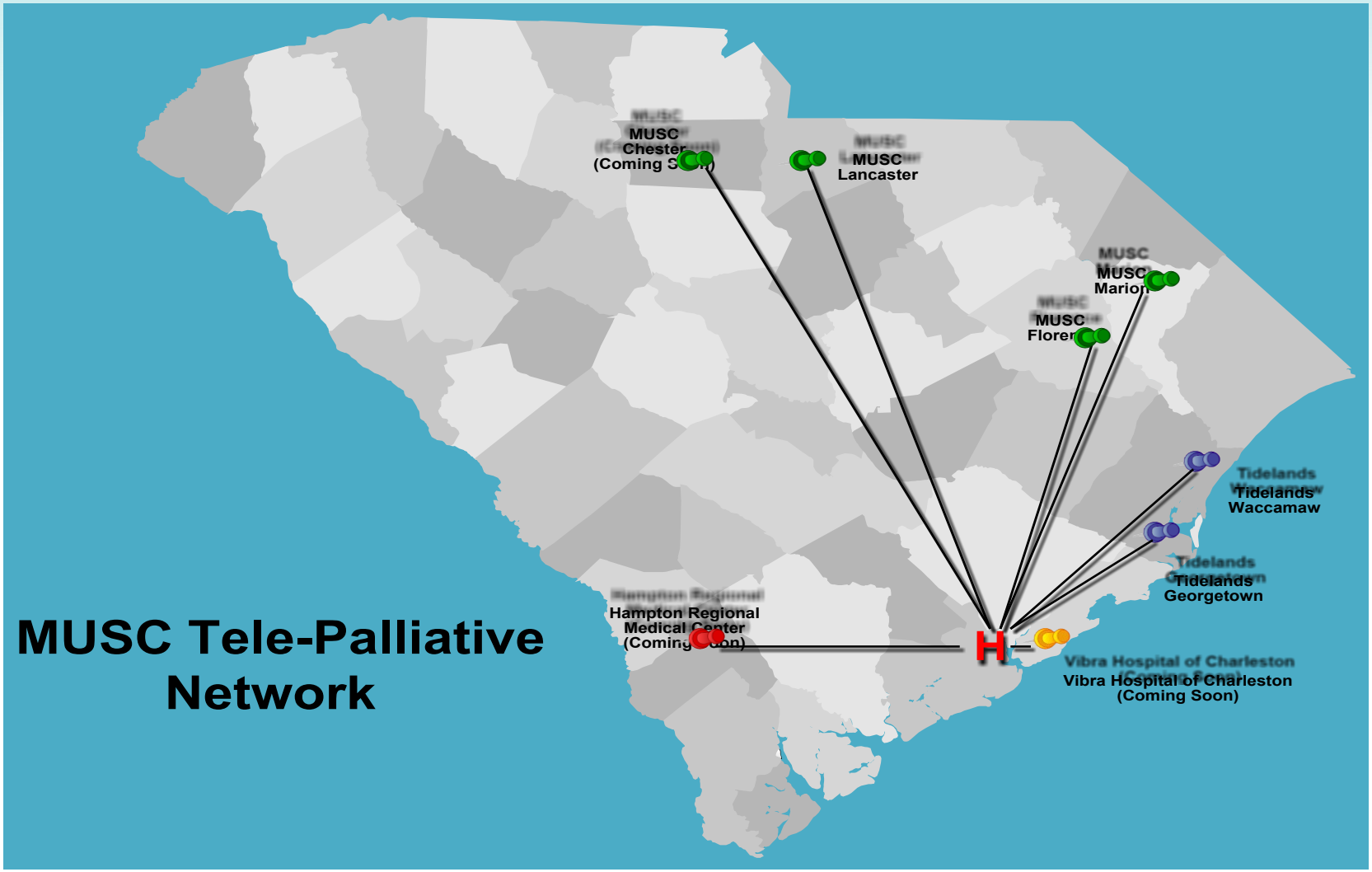
What the Program Offers

- **Provider Training** for care team members on core principles of palliative care so they can partner with us in providing this highly specialized, interdisciplinary care.
- **Ongoing Palliative Education- Quarterly education series**
- **IDT Training** for chaplains and social workers on core principles and practices of palliative care skills.
- **Access** to experienced palliative care providers who can help with pain and symptom management, advanced care planning, and supportive care for your patients.
- **Ongoing collaboration, support, guidance and engagement** with the partner hospital from the Telehealth Team:
  - ✓ Palliative Providers and Team
  - ✓ Clinical Outreach Coordinators
  - ✓ Clinical Service Success Coordinator
  - ✓ Admit Transfer Center (ATC)
  - ✓ Training Coordinator

What the Program Offers

- Scheduled consultations are **available Monday - Friday, 9 am – 5 pm**
- 1 hour appointment blocks
- Same day consults available
- Patients seen by a Palliative APP
- APP will **only provide recommendations**
  - We will not take over as Primary
- Consulting physicians will review consult recommendations in EMR and can call for follow up questions
- Bedside nurses expected to facilitate consults (tele-presenter) and provide pertinent vitals

MUSC Tele-Palliative Network



Inpatient TelePalliative Network

6 Partner Hospitals in South Carolina

MUSC Florence, MUSC Marion, MUSC Lancaster, Vibra Hospital

Tidelands Georgetown & Tidelands Waccamaw

Hospitals Coming Soon

MUSC Chester

Hampton Regional Medical Center

South Carolina Prison System

The Village at Summerville

Our Data FY 2021

Patient Gender	# of Consults	% of Consults
Female	100	49%
Male	105	51%
Total	205	100%

Patient Age	# of Consults	% of consults
18 - 29	3	2%
30-39	1	1%
40-49	14	7%
50-59	21	10%
60-69	50	24%
70-79	59	28%
80-89	41	20%
90-100	16	8%
Total	205	100%

Tele Partner Site	# of Consults	% of consults
MUSC Marion	9	4%
Tidelands Georgetown	8	4%
Tidelands Waccamaw	11	5%
MUSC Florence	177	86%
VIBRA	4	2%
Total	205	100%

Patient COVID Status	# of Consults	% of consults
COVID Positive	64	21%
COVID Negative	141	69%
Total	205	100%

July Data

Patient Gender	# of Consults	% of Consults
Female	21	53%
Male	18	47%
Total	39	100%

Tele Partner Site	# of Consults	% of consults
MUSC Marion	4	10%
Tidelands Georgetown	3	8%
Tidelands Waccamaw	5	12%
MUSC Florence	27	70%
Total	39	100%

Patient Age	# of Consults	% of consults
18 - 29	0	0%
30-39	1	2%
40-49	1	2%
50-59	3	7%
60-69	7	18%
70-79	10	25%
80-89	10	25%
90-100	7	18%
Total	39	100%

Patient COVID Status	# of Consults	% of consults
COVID Positive	0	0%
COVID Negative	39	100%
Total	39	100%

Typical Visit Rundown

- Page from ATC with time of appointment and patient location
- Depending on where the consult is coming from look up the patient in appropriate EMR
- Depending on situation may contact consulting provider
- Always call RN prior to visit to get background and see who all will be in the room
- Introductions- explain palliative care to patient and family.
- Have RN go through a quick report at the bedside. Have them help with physical exam.
- Any concerns they are having? Empathize and check in with how they are coping
- Gather the patient and families understanding of all that is going on
- Ask about their life at home. Understand their values, explore goals.
- Workup and symptoms
- Talk through options.
- Ask permission and then give clinical opinion
- Plan and follow up
- Document and reach out to provider/nurse/case manager if needed.

Telehealth Tips

- Telehealth encounters are fundamentally different from the usual experience of face-to-face interactions.
- Takes time and practice to get used to
- Want to establish “genuine presence”
- Match one’s own image size to the patient’s
- Awareness of body language within the frame
- Maintain eye contact
- Dress appropriately- do not multitask
- Create a professional or neutral background
- Speak Slowly and clearly. Use a softer tone using volume to emphasize important words
- Provide information in “bite-sized pieces”
- Avoid interrupting- Wait 2 seconds after the person stops talking before starting
- Allow for silence
- Be yourself

- S.O.L.E.- Face squarely, Open posture, lean forward, and good eye contact

Video Platform

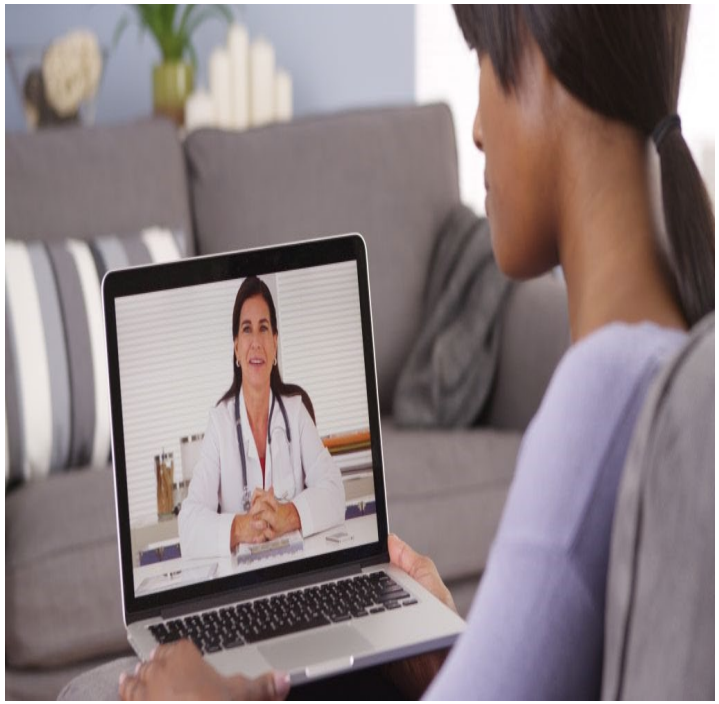
- We use Reach Access for inpatient visits.
- Important to have good quality and **easy usability**
- HIPAA compliance- need a business associate agreement with the vendor- always check with compliance to be sure that platform you are using is valid.
- Need to be ready to troubleshoot.
- Reach is getting an update soon. Building our own palliative specific template now.

Patient

- It is not for everyone. Not one size fits all.
- Issue with “triggers”
- Should assess for patient “fit” for telehealth appointments- are they open to trying.
- If telehealth is being delivered at home- an in person initial visit would be ideal.
- Ensure setting can support the platform and test everything out.
- Could be done concurrently with enrollment and orientation to palliative care program.

Pros of telehealth

- Ease of discussing sensitive or personal problems to the clinician
- Improved patient satisfaction
- Reduced no shows
- No wait time for patients or caregivers
- Avoid traveling (environmental benefits as well)
- Increased access to services for underserved. Especially in rural or low-and middle-income areas
- Sometimes able to see them in their home setting
- Increased efficiency
- Hour block of time where we can have these conversations



Cons for telehealth

- Difficulties gathering accurate information without direct physical exam
- Technological difficulties and lack of connectivity can lead to a patient and clinician frustration
- Cultural and language barriers between patient/caregiver and clinician
- Reviewing/updating other institutions EMR
- Privacy concerns (communal situation)
- Not answering phones
- Attain and maintaining rapport
- **Possible “digital divide” can add to healthcare disparities for patients who do not have access**
- Follow-up issues-inpatient
- Contacting providers at different facilities
- Provider visual and physical fatigue if multiple video visit sessions in one setting.

Increasing Telehealth Acceptability in Palliative care

1- Take time to get to know the patient and family

2- Acknowledge potential awkwardness of telehealth medium

3- Always make introductions with everyone in room or on call

4- Well lit, tidy, clean, private setting

5- Avoid “busy” tightly patterned clothing that could be distracting

6- position camera so that it is at eye level and stable

7- Summarize the visit and discuss next steps including whether and when they need to be seen again

8- Provide time for questions

Future

- Village at Summerville and Mullins Nursing Center- Outpatient setting
- Continue to grow our presence-site visits, education, PLOS meetings.
- Prison system
- Possible peds division

Case Study #2

- 85-year-old hx COPD, Dementia. Recently hospitalized with double pneumonia. Since being home she had been very weak with loss of appetite. She was on home O2 and was being seen by home health. She came back to the hospital and was found to be in septic shock and acute on chronic renal failure. Family had stated that they wanted all interventions done. Was in ICU on levo- Central line inserted. Notes state poor prognosis overall and worry that she may need intubation.
- Palliative consulted for goals of care discussion. Her son was at the bedside.

Case study #2

- Understanding- Knew she was very sick. “she may need to go to rehab after this.”
- Interests/values- independence, home, family, faith
- Our worry- What if she continues to decline?
- Discussed code status
- Goals Discussion- “If it is God’s will that it is your time, then we will let you go peacefully”
- Changed code status to AND- they wished to continue appropriate care
- That night she decompensated- family was present and she died peacefully without intubation or further escalation of care.

Presenter's Perspective

- Have been able to make a real impact
- Beneficial for all involved
- Patients are appreciative
- Always something gained
- Not as daunting as most people think
- Need to be adaptable
- Follow-up visits have been key- not always a "one-and-done"
- One hour period where we give an outsider perspective from a palliative care viewpoint
- Optimize quality of life by anticipating, preventing, and treating suffering
- Coordinate care according to the patient's and family's values and goals.

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