

**CLINICAL TRACK**

# Connecting Care, Comfort, and Compassion: The Role of Palliative Care



Introduction by:  
**Ramona Midkiff**  
Palmetto Care Connections

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**Christina McDaniel, DNP, MSN, RN**  
MUSC Health

**REGENCY BALLROOM G**

# Connecting Care, Comfort, and Compassion

## The Role of Telehealth in Palliative Care

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Expanding Access, Preserving Compassion, and Demonstrating Value

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

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# Learning Objectives

What participants should be able to do after this session

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- 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



A photograph of a dog, possibly a Weimaraner, wearing a black hood that covers its ears and the back of its head. The dog is looking upwards and to the left with a somber expression. It is holding a silver handgun in its mouth. The background is a mottled, dark green and blue texture.

# HOW OTHERS SEE US IN PALLIATIVE CARE



**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                                                                                                                                                                                                                                                                                                     |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"><li>• Can be provided at any stage of a life-limiting illness</li><li>• For patients who may be seeking curative treatment in addition to symptom management</li><li>• Care teams typically work in hospital and ambulatory settings</li><li>• Costs are paid by Medicare, Medicaid, and private insurance</li></ul> | <ul style="list-style-type: none"><li>• Provided near the end of life</li><li>• For patients with a prognosis of six months or less who are not seeking curative treatment</li><li>• Care delivered where the patient calls home</li><li>• Costs are paid by Medicare, Medicaid, and private insurance</li></ul> |

# Why This Conversation Matters Now

The clinical need is growing while specialty access remains uneven

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- 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

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- 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

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- 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

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- 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

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- 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

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- 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

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- 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

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- 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

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**C**

Clarify who is present and what everyone understands

**E**

Engage the local care team

**O**

Orient to the purpose of the visit

**C**

Close the loop on decisions

**N**

Name difficulty without rushing

**T**

Translate into an actionable care plan

**N**

Navigate goals, values, and tradeoffs

# Common Concerns About Virtual Palliative Care

Anticipate and address barriers directly

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- 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

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**1,227**

consults ordered

**851**

consults completed

**69%**

completion rate

**376**

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

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1,169

patients in 2024 dataset

73.6

mean age

72%

Medicare coverage

52% / 47%

White / Black

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

# Key Performance Indicators

Moving from activity to measurable impact

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**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

## Mean overall LOS



## Mean days from consult to discharge



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

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**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

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## 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

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- 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

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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

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## 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

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- 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

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- 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

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- 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.