Telehealth to Extend Palliative Care Access to Rural Care Settings

Introduction

The 2024 Serious Illness Scorecard found that only 35% of rural hospitals report having a palliative care program. At the same time, as telehealth continues to be become standard practice, new opportunities to deliver palliative care to rural patients and families is emerging. A growing body of literature suggests that delivery of palliative care services via telehealth is not only feasible[i] and maintains high patient experience scores,[ii] but also results in better outcomes, such as:

- → Reductions in pain intensity and pain interference[iii]
- → Improvements in quality of life[iv]
- → Reductions in caregiver burden[v]
- → Reductions in hospitalization from long-term and community settings[vi,vii,viii]
- → Some evidence that palliative telehealth has an impact on survival[ix]

In addition to these positive patient and caregiver outcomes – found in both adult and pediatric populations[x] – telepalliative care also brings benefits to the palliative care team, such as enhanced ability to incorporate family members in conversations, and improvements in team efficiency.[xi]

Much of this literature has focused on palliative telehealth delivered to community settings, but there is an equally compelling case to be made for palliative care consultations delivered to inpatients and emergency departments. In August 2024, CAPC hosted a listening session with leading palliative care programs that have leveraged flexibilities in telehealth delivery and payment to extend their reach into rural hospitals that would otherwise not have access to any palliative care specialists. **Participants were unanimous in their support of this model, sharing that benefits included reductions in unwanted transfers to tertiary settings and building primary palliative care capacity in rural hospitals**. Their enthusiasm for the model remained unanimous even if the consultation was a "one-and-done," because the single consultations had long-term impacts on the patient and family experience. In one program, roughly two-thirds of tertiary transfers were avoided,[xii] consistent with patient goals, benefiting the patient, the caregiver, employers, payers, and the tertiary hospital.

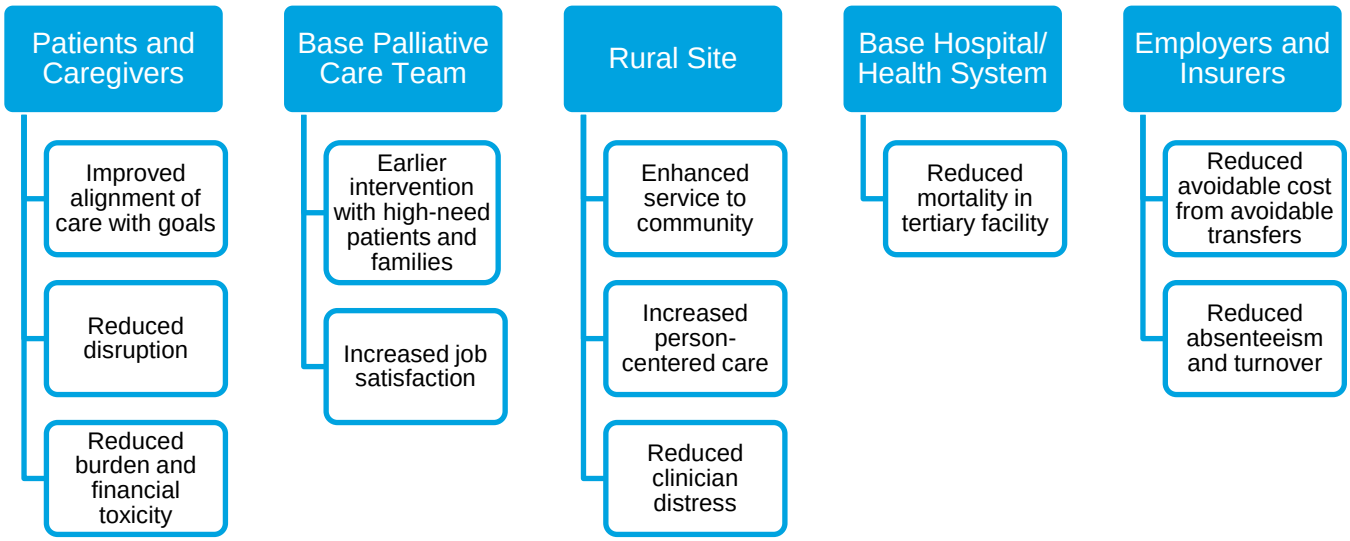
Table 1 summarizes key features of innovative programs that use telehealth to extend palliative care access to rural facilities. The discussion that follows highlights benefits, facilitators, and barriers to palliative care consultative services to rural care settings via telehealth.

Table 1 – Key Features of TelePalliative Care Consult Programs to Rural Hospitals and Emergency Departments

Program/Location	Inpatient TelePalliative Consult Service (UPMC)	Tele Palliative Care Services (MUSC)	TelePC (Providence)
Status	Active	Active	Sunset
Recipient Sites	6 in-system hospitals (ICUs, general medical wards) and 3 EDs	14 in-system hospitals, including 2 rehab hospitals. In acute care, spend more time in general med/surg, with about 20% in ICU	2 Critical Access Hospitals (CAHs)
Palliative Care Team	1.0 FTE advanced practice provider	3.0 FTE advanced practice provider Interest in adding part time social worker and chaplain	Physician, nurse and social worker • Physician 0.1 FTE • Social Worker 0.25 FTE
Patient Criteria	Inclusion: • Inpatient: by referral • ED: pre-admission by referral Exclusion: • None	• Physician referral from partner site	By referral
Services	• Goals of care discussions • Pain and symptom management • Psychosocial support • Referral for community services	• Goals of care discussions • Pain and symptom review (cannot prescribe without FTF in South Carolina)	• Goals of care discussions
Hours	M-F, 8:30am-4:00pm	M-F, 9:00am-5:00pm Interest in expanding to 24/7 to better meet ED need	M-F, 9:00am-5:00pm

Program/Location	Valley View Hospital-University of Colorado Hospital Collaboration	Washington Rural Pal Care Initiative (State/Grant-funded)
Status	Active	Active
Recipient Sites	1 rural, small hospital	3 cohorts serving 20 communities, including CAHs, community clinics, FQHCs, and other providers
Palliative Care Team	• Physician 1.2 FTE (0.6 FTE inpatient and 0.6 FTE outpatient) • Advanced Practice Provider 0.6 FTE (inpatient) • Chaplain 0.8 FTE (inpatient) • Social Worker 0.2 FTE (outpatient)	Cumulative time est. per month: • Physician 0.4 FTE • Nurse 0.5 FTE • Social Worker 0.5 FTE • Pharmacist 0.1 FTE • Chaplain 0.2 FTE
Patient Criteria	By referral	Standardized screening tool that creates a composite score using: • Degree of illness • Comorbid conditions • Function • Psychosocial factors • Degree of symptom control • Past ED and hospital utilization
Services	• Goals of care discussions • Advance care planning • Psychosocial-spiritual support • Symptom management	Capacity building focus to improve primary palliative care skills across recipient sites. Activities include: • Monthly online education: case consultations and didactic sessions • Office hours and individual consultations
Hours	M-F, 9:00am-5:00pm	Standing monthly times for education and online interdisciplinary case consultation; ad hoc scheduling for individualized consultations

TelePalliative Care in Rural Settings Benefits Multiple Parties



When discussing what drove them to start these programs, the leaders spoke passionately about the benefits to patients and caregivers in particular. Many people with serious illness who show up in rural emergency rooms are in critical condition and unlikely to improve following a transfer to a tertiary hospital; yet without palliative care capabilities, the patient is transferred – often many hours away from their home. And outcomes for these patients are poor, with one study showing that over 50% die following the transfer (14% within 48 hours).[xiii]

When these transfers occur without meaningful discussion of expectations and skilled goals of care conversations, families are put in difficult positions. Some caregivers must pause or terminate employment, and most incur significant travel expenses. Studies suggest that financial hardship is worse for patients and caregivers from rural areas, particularly at the end of life.[xiv] Therefore, the benefits of facilitating palliative care access for seriously ill patients in these settings and their caregivers is clear – more informed decision-making, facilitating more goal-aligned care and reduced financial burden on caregivers.

Beyond patients and caregivers, there were also benefits to clinicians on both sides. Palliative care leaders noted the ability to see patients further upstream, since at least some patients would have been on their consult lists following the transfer. Meanwhile, clinicians at the rural facilities reported a decreased sense of isolation due to the support they received from the palliative care specialists, as well as increased job satisfaction from being able to provide better, person-centered care. In several programs, capacity building among the rural setting's clinicians was an explicit goal.

Third, the hospitals/health systems in which these programs operate benefit greatly from telepalliative care services. For the rural hospital, they are able to offer improved care to the communities they serve, reduce distress experienced by their clinical staff, and maintain patient volumes. The tertiary facility

benefits from a patient-driven reduction in the highest-cost stays,[xv] as well as reductions in mortality. One of the greatest sources for in-hospital mortality rates is transfers from community hospitals; so this work could improve performance on quality measures that can impact hospital ratings and payment.

Benefits also accrue to the payers and employers. Health insurers are able to reduce spending on some air ambulance rides and surgical procedures, while directing a bit more medical spending to local providers. Local employers will experience fewer disruptions in employees' schedules and should experience reduced turnover.

Success Factors

The following factors and strategies set programs up for success:

- → Tailoring the program to the specific needs of the local community/hospital - several programs reported conducting a needs assessment, then designing their services based on the unique needs and resources of each site.
- → Cultivating strong relationships with champions at the rural sites, for instance, the ED director or Chief Nursing Officer to optimize processes. When possible, conducting occasional on-site meetings.
- → Creating effective messaging for the rural team to deliver to patients and caregivers, focusing on clarifying values and goal concordance."
- → Ongoing education; rural sites have turnover so periodic training is needed to sustain skills and processes.
- → Having experienced, competent palliative care specialists, and, if possible, rotating coverage, since it can be difficult for clinicians to sit in front of a computer all day.
- → Starting small and building incrementally - perhaps as a pilot - to demonstrate a successful track record.

Most of the programs operated during standard working hours, and recognized that this was not the best match for providing services to ED patients. Instead, the program leaders suggested maintaining a single shift, but moving it to span the day and evening shifts, stating that "a well-placed 8-hour shift can catch 50% of the need."

Implementation and Scaling Barriers

Participants shared a number of factors that prevented several of them from growing or even maintaining their programs:

- → Creating a financially sustainable model. While fee-for-service billing currently can cover telepalliative care expenses, some consultations take more time, making break-even difficult. While there is a case to be made for potentially significant cost savings,[xvi] value-based payment has not yet supported inpatient or ED palliative care.
- → The heterogeneity of rural sites made developing relationships and setting up systems time-consuming. Many sites had their own cultures and communication preferences; and even within the same health system, not all sites were using the same EHR.

- → Rural health care professionals have little reserve to take on additional work, so the value case needed to be clear for staff.
- → Lack of data and information sharing. Several programs were unable to analyze the impact of their program on clinician outcomes or direct costs. Without data, it is difficult to make the case to support future scaling.

Conclusion

Telehealth can be a valuable tool in expanding access to palliative care, particularly in rural settings where such services are often unavailable. By tailoring programs to local needs and focusing on goals of care, telepalliative care initiatives have enormous benefits for patients, caregivers, health care professionals, hospitals, payers, and employers, particularly from improving goal-aligned care and reducing unnecessary transfers. However, supplemental funding and information exchange remain critical to scaling these programs and ensuring their long-term success.

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