End-of-life care presents special challenges to patients, health professionals, families and friends. It is particularly important to “be there”, and to maintain strong communication ties during this difficult phase of life. Hospice providers are finding that they can enhance care through the use of telehealth services. Often, these communications links can be critical to easing the pain of a patient, obtaining the advice of a nurse or physician at a difficult moment, or allowing a patient to speak with and be comforted by a distant friend or relative.

Hospice provides services to patients facing a life limiting illness, particularly emphasizing palliative care and symptom relief. Hospice caregivers offer emotional, spiritual, and practical support, such as respite care, based on the patient’s desires and family’s needs. While hospice has been around in some form since the fourth century, people still find it difficult to understand that hospice is a philosophically based concept of care, and not a specific place where care is given. Hospice prides itself on its affirmation of life and treating dying as a normal process of living. It is estimated that in the United States, hospice cares for approximately 400,000 patients each year, with more than 25,000 professionals and nearly 100,000 volunteers providing over more than five million hours of support and care to people in their communities.

Communication is particularly important in end-of-life care. The ability to monitor a patient, assist in pain management, and keep everyone on the hospice team and in the family informed, presents some huge challenges. Hospices are figuring out how to integrate modern communications and monitoring services in such a way as to enhance the dignity and comfort of the patient, many of whom have returned to their homes.

Telehospice provides many benefits to the patients, their families, and providers as well as to home health agencies. It can:

• Increase contact with providers, resulting in more timely interventions which are crucial for pain management;

• Provide physiological tracking tools, e.g., monitoring ECG, pulse, and blood pressure, to give the provider and caregivers important and timely data about the patient’s status;

• Teach caregivers how to provide comfort measures through audio and video resources or distance learning for longer-term volunteer caregivers;
• Pre-program infusion pumps to deliver pain medication, reducing both pain and anxiety for the patient and their caregivers;

• Provide reminders about when to take pills, or provide education on what to do with the medicine;

• Deliver medical directives from doctors using video technologies;

• Integrate information across the care management team so that it only needs to be entered once, and can be viewed by everyone on web-based programs, thus allowing more time to be spent on actual patient care and interaction, and less time on paperwork;

• Provide better staff planning so that understaffing, which can lead to mistakes, is minimized; and,

• Partner less experienced caregivers, or those providers who are new to hospice and palliative care, with those who have more experience.

A joint study done by Michigan State University and University of Kansas Medical Center, allowed researchers to examine the benefits of telehospice by putting videophone equipment in both rural and urban hospice homes. The research was primarily focused on five themes:

1) Access/utilization;
2) Patient and provider perceptions;
3) Delivery of services;
4) Outcomes (pain efficacy, cost, types of services delivered via telehospice); and
5) Educational programming.

The study found that rural patients in particular, benefited from telehospice. The providers were still the main obstacle between the patients and the use of telehospice, with only a handful of the nurses feeling fully comfortable with the technology. However, the research showed that both patients and caregivers are eager to learn more about telehospice.

These technologies are useful in more ways than in just coordinating care and monitoring pain management.

The Michigan State/Kansas Medical Center study also discovered added benefits in terms of the human dimension at end-of-life care. Participants were able to connect with distant family members in far away states such as Alaska, Hawaii, Florida, New Mexico, Arizona, and North Carolina, as well as throughout Michigan. This application provided an immeasurable enhancement to quality end-of-life care for these dying patients.

Perhaps the best illustration is the example of a forty-year-old woman with a five-year-old daughter located some seventy-five miles away. Prior to installation of the telehospice equipment, they were only able to visit every two weeks. The equipment was installed on the daughter’s sixth birthday. They were able to share presents that day, and continued to share stories and homework every day for the final two weeks leading up to the mother’s death. As she said, “You have no idea what you have given to me.”

Bringing hospice into the future and improving end-of-life care means incorporating all forms of care – technology, nurse, caregiver, family, and patient – into the hospice culture in a way that works for everyone.

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