
Since January 2020 Elsevier has created a COVID-19 resource centre with free information in English and Mandarin on the novel coronavirus COVID-19. The COVID-19 resource centre is hosted on Elsevier Connect, the company's public news and information website.

# Commentary on "Remote Advance Care Planning in the Emergency Department During COVID-19 Disaster: Program Development and Initial Evaluation"

**Authors:** Jennifer Lynn White, MD, and Judd E. Hollander, MD, Philadelphia, PA

Novel applications of telehealth exploded during the pandemic.[1] From virtual acute care visits to virtual triage and home visits and telehealth via ambulances, synchronous and asynchronous telehealth etched a permanent place in the emergency care specialty.[2] In this edition of the *Journal of Emergency Nursing (JEN)*, Liberman et al[3] explore a pragmatic telehealth program developed to take the heavy, bedside end-of-life discussion away from the front-line staff and offload it to a trained group of nurses via telehealth. A logic model describing the use of Remote Goals of Care Program (GOC) was developed and implemented.

The emergency department can be loud and crowded and lack the quiet privacy needed to have end-of-life discussions with patients and families. During the COVID-19 pandemic, when visitation policies were restricted, many end-of-life discussions took place via remote platforms.[4] Patients were often scared, alone, and dying of COVID-19 without their closest loved ones to hold their hands at the bedside. Many hospitals had transitioned to a virtual platform to deliver bad news and work through these decisions; however, the authors' GOC program[3] used a bidirectional platform. This was unique in that both the patient and the bedside clinician were remote. Telehealth programs in the emergency department such as remote stroke care and tele-psychiatry are examples of established one-directional programs—the patient is in person in the bricks-and-mortar emergency department, but the provider is remote. These programs spared the provider the exposure risks from being physically present during the visit during the pandemic. The programs that were bidirectional—both the patient/family and the provider were remote—included acute unscheduled visits and platforms that connected families to remote providers.

Pairing both the need for virtual conversations and job continuity for nurses sidelined during the pandemic, this Remote GOC Program[3] offered a sustainable solution to a major gap in care. The program developed a system by which the bedside team could alert the remote palliative care providers to engage the family in end-of-life decisions.[4] These included DNR/DNI, MOLST, health care proxy discussions, and disposition. The Remote GOC Program[3] was created as a joint endeavor between the division of geriatrics and palliative medicine and emergency medicine. "In decanting the responsibility of goals of care discussions from the emergency department to a calmer, remote setting," the authors seized a unique moment in time, a time where the most precious conversations regarding end-of-life care could were transitioned to a group of nurses working remotely. While this was a nurse-driven initiative, it spanned disciplines including social work and the division of palliative care and emergency medicine, fueling the success of this program.

The advantages of such a program include offloading the clinical team from having difficult, often prolonged discussions at the bedside. The nurses conducting the interviews were not on site, allowing protection from COVID-19 exposure and conservation of precious personal protective equipment (PPE).[5] The pandemic created extraordinary emotional and physical stress on bedside care teams. Health care workers struggled to communicate with the patients in full PPE, screaming above the whirl of the PAPR hood and N95 masks. Face shields prevented

Jennifer Lynn White is Director of Clinical Operations - TJUH Emergency Department, Clinical Associate Professor, Department of Emergency Medicine, Sidney Kimmel Medical College of Thomas Jefferson University, Philadelphia, PA. **Twitter:** @jlynnwhite4.

Judd E. Hollander is Senior Vice President of Healthcare Delivery Innovation at Thomas Jefferson University, Philadelphia, PA; and Associate Dean for Strategic Health Initiatives at Sidney Kimmel Medical College at Thomas Jefferson University, Philadelphia, PA.

For correspondence, write: Jennifer Lynn White, MD, Thomas Jefferson University - Center City Campus, 901 Walnut St, Philadelphia, PA 19107; E-mail: jennifer.white2@jefferson.edu

J Emerg Nurs 2022;48:7-9.
0099-1767



https://doi.org/10.1016/j.jen.2021.10.007

not only droplets from spreading but words from traveling, and conversations were strained at best.[6] Caregivers of patients who were not capable of making end-of-life decisions for themselves attempted to connect to next of kin via iPad. The telehealth platform for end-of-life care was born. Considerations on supporting the entire health care workforce included providing work during quarantine, providing offsite work to those health care workers at higher risk of contracting severe COVID-19, and providing a channel to support both the emotional needs of the emergency health care workers at the bedside and the need to work for those sidelined; this program was ideal.

The authors created a logic model for Remote GOC Program,[3] for other institutions to replicate their implementation. The inputs included the key partnership between emergency medicine and palliative care, nurses who were not onsite, the technology to perform the telehealth visits. Outputs include number of referrals into the program, GOC discussions with families, and any changes in code status. Evidence of the anticipated impact of this program after the pandemic will be continued offloading of the cognitive burden of the bedside clinician and providing meaningful work for nurses sidelined from clinical practice.

The pitfalls of this type of program are typical of many telehealth programs, with a few unique challenges. Families may not have access to the technology needed to conduct the telehealth interview. This lack of access is more prevalent in lower socioeconomic and rural areas.[7] These types of technology barriers may be more profound during a very intense end-of-life discussion compared with a virtual visit for an uncomplicated self-limited medical condition. Glitches in Wi-Fi or software may be extremely intrusive in these sensitive moments. There may also be conflicting advice given to the patient's family by a telehealth nurse who is not the patient's primary in-person bedside nurse. Would the weight given to the information provided to make such difficult decisions be watered down by the nurse being remote? There is something profound about the bedside clinician giving advice regarding advanced directives with the patient in front of them. Would a virtual approach convey the same meaning?

Health care providers, including nurses, are often sidelined from clinical care secondary to injury, illness, exposure, or, recently, COVID-19 quarantine.[8] This unique GOC program[3] paired the nurses who were not able to work clinically to participate in a valuable program. The use of nursing in telehealth has expanded rapidly over the past 5 years. A gap still exists around telenursing and disaster care. This application of telehealth as an avenue for emergency nurses to use their specialized skillsets begins to fill this gap. The telehealth platform for nursing seemed counterintuitive at first, with the goals of bedside nursing to be truly a hands on specialty. There was a delayed launch of the specific telehealth nursing applications.[8] The potential for delivering nursing care such as patient history, triage, individualized patient education, postdischarge counseling, and care coordination is enormous.

Nurse-led telehealth initiatives during the pandemic provided a platform for virtual care that limited infection exposures and physical demands and allowed flexibility to work from home. The pandemic disproportionately affected working parents, who had to manage their jobs, their own psychological stressors, and children who were learning at home during lockdown. The use of telehealth to mitigate the occupational psycho-social stressors during the pandemic can be stretched to postpandemic times.[9] Health care is not only complicated, it has now become draining, leading to high rates of burnout and dissatisfaction. Allowing nurses to intermittently perform their duties from home is one possible solution, for some nurses, some of the time.[10] The Remote GOC Program[3] manuscript provides important feasibility evidence that remotely working nurses can engage patients in end-of-life discussions. During staff shortages, remote nurses can potentially help perform the admission intake for patients boarding the emergency department; they may be able to provide more continuous visual monitoring or patient surveillance care when staffing levels cannot be maintained. Remote nurses might be engaged to have more comprehensive discharge planning meetings with patients and their families. The pandemic taught us that you can be an emergency nurse but do not need to be in an emergency department to deliver specialty care. It is about the skill set and not the location. The paper by Liberman et al[3] illustrates that very nicely. Through their discussion about end of life, they have breathed new life into how we care for patients.

## REFERENCES

1. Hollander JE, Carr BG. Virtually perfect? Telemedicine for Covid-19. *N Engl J Med*. 2020;382(18):1679-1681. https://doi.org/10.1056/NEJMp2003539
2. Pierce BS, Perrin PB, Dow AW, Dautovich ND, Rybarczyk BD, Mishra VK. Changes in physician telemedicine use during COVID-19: effects of practice setting, demographics, training, and organizational policies. *Int J Environ Res Public Health*. 2021;18(19):9963. https://doi.org/10.3390/ijerph18199963
3. Liberman T, Roofeh R, Chin J, et al. Remote advanced care planning the emergency department during COVID-19 disaster: program development and initial evaluation. *J Emerg Nurs*. 2022;48(1):22-31. https://doi.org/10.1016/j.jen.2021.09.006
4. Selman LE, Sowden R, Borgstrom E. 'Saying goodbye' during the COVID-19 pandemic: a document analysis of online newspapers with

implications for end of life care. *Palliat Med*. 2021;35(7):1277-1287. https://doi.org/10.1177/02692163211017023

5. Adams JG, Walls RM. Supporting the health care workforce during the COVID-19 global epidemic. *JAMA*. 2020;323(15):1439-1440. https://doi.org/10.1001/jama.2020.3972
6. Boran M, Boran OF, Korukcu O, Ozkaya M. The psychological resilience and perceived stress of the frontline heroes in the pandemic in Turkey: a descriptive study of the COVID-19 outbreak-mutations-normalization triad. *Jpn J Nurs Sci*. 2021:e12442. https://doi.org/10.1111/jjns.12442
7. Schoen JC, Russi CS, Laack TA. Addressing barriers to telemedicine use in rural emergency medicine: leveraging in situ simulation. *Telemed JE Health*. Published online April 19, 2021. https://doi.org/10.1089/tmj.2021.0026
8. Fowler SB, Rosado CA, Jones J, Ashworth S, Adams D. Novel use of a nurse-led telemedicine team in acute stroke: a retrospective review of the impact on a regional health care system. *J Emerg Nurs*. 2019;45(3):242-248. https://doi.org/10.1016/j.jen.2018.07.026
9. Delaney RK, Locke A, Pershing ML, et al. Experiences of a health system's faculty, staff, and trainees' career development, work culture, and childcare needs during the COVID-19 pandemic. *JAMA Netw Open*. 2021;4(4): e213997. https://doi.org/10.1001/jamanetworkopen.2021.3997
10. Castner J, Bell SA, Hetland B, Der-Martirosian C, Castner M, Joshi AU. National estimates of workplace telehealth use among emergency nurses and all registered nurses in the United States. *J Emerg Nurs*. 2022;48(1):45-56. https://doi.org/10.1016/j.jen.2021.07.001