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COVID-19 Content

What If I Get Seriously Ill? A Virtual Workshop for Advance Care Planning During COVID-19



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Abstract

The coronavirus disease 2019 has brought public attention to questions regarding the type of care individuals would want to receive in the event of becoming suddenly critically ill. Advance care planning (ACP) is one way to help individuals and families address these questions. However, social distancing, stay-at-home orders, and hospital visitor restrictions have raised new barriers to facilitating these conversations. Here, we describe the implementation and evaluation of a novel, public-facing, and two-part virtual ACP workshop. Participants were recruited through electronic communication, and evaluations were collected through surveys administered after each part of the workshop. We found that using a virtual format allowed us to reach a large and geographically diverse audience. Participants were likely to recommend the workshop to friends and family. There was no change in ACP engagement between the postsession surveys between the first and second parts of the workshop. *J Pain Symptom Manage* 2020;60:e21–e24. © 2020 American Academy of Hospice and Palliative Medicine. Published by Elsevier Inc. All rights reserved.

Key Words

COVID-19, webinar, advance care planning, virtual workshops

Background

The coronavirus disease 2019 (COVID-19) has placed a new spotlight on human mortality and has focused national attention on questions about wishes for being hospitalized, transferring to the intensive care unit, and receiving mechanical ventilation in the event of becoming seriously ill.

Advance care planning (ACP) is one way to respond to the public's questions and concerns about becoming critically ill from COVID-19, and it has been noted as a critical component in the response to the pandemic.¹

Getting patients and families to participate in ACP has historically been challenging.² Now, social distancing, stay-at-home orders, hospital visitor restrictions, and a transition to telemedicine have made communication more challenging and require novel

methods for providing guidance to patients, families, and the public.

Here, we present a novel format for a public-facing two-part virtual ACP workshop and a practical paradigm for promoting ACP discussions during a pandemic.

Intervention

The two-part virtual ACP workshop was developed at Stanford Health Care, a suburban and academic health system in northern California affiliated with Stanford University. The workshops were supported through a partnership between the clinical Section of Palliative Medicine and the Department of Patient Experience.

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A two-part workshop, as opposed to a single educational intervention, was chosen based on findings that successful ACP interventions provide multiple interactions over time.³ Content was modeled after an in-person two-part ACP workshop that demonstrated improved advance directive (AD) completion.⁴

The first part of the workshop (Part 1 [P1]) was a webinar consisting of a lecture-style presentation and question and answer (Q&A) session. Content included defining ACP, providing a framework for considering one's health status, values, and how those values inform health care decisions. Considerations for COVID-19 were discussed, including overall and intensive care unit-based case fatality rates based on data available at the time.^{5,6} Finally, a four-step process to start ACP was recommended including talking with your doctor, considering what matters most, assigning a health care proxy, and completing an AD.

The second part of the workshop (Part 2 [P2]) consisted of a small group discussion and Q&A session. Each follow-up workshop was limited to 30 participants. In these sessions, presenters reviewed commonly used terms in ACP and demonstrated how he and/or she would think through completing an AD using the PREPARE for Your Care AD.⁷ A recording of P1 and the slides for both P1 and P2 can be found at <http://med.stanford.edu/palliative-care/COVID19.html>.

To recruit participants, we used electronic mail (e-mail) announcements in both a university-wide daily newsletter and our hospital's daily COVID-19 e-mail. We tweeted about the event through the palliative care department and the health system's health library. The event was posted on electronic calendars for the university, hospital, and hospital employee wellness program. Participants were also recruited through several local religious organizations. Finally, 5768 patients who receive primary care at our institution received an invitation through the electronic

patient portal. Participants in P2 were recruited from the e-mail addresses of participants in P1.

Measures

Participation in the workshops was tracked by monitoring the number of accounts logged in to each session. Postsession surveys were e-mailed after each session through Qualtrics (Qualtrics, Provo, UT). Surveys asked participants their age, race, ethnicity, and gender along with the likelihood of recommending the session to a friend or a family member. Participants were also invited to provide qualitative feedback by responding to the following prompts: *the best part of this event was* and *this event could be improved in the future by*. ACP engagement was measured using a validated four-item ACP engagement survey, which assesses readiness to participate in various ACP actions on a five-point Likert scale (1 = I have never thought of it, 2 = I have thought about it, but I am not ready to do it, 3 = I am thinking about doing it in the next six months, 4 = I am definitely planning to do it in the next 30 days, and 5 = I have already done it).⁸ We calculated a mean score for each ACP action using the five-point Likert scale, and we calculated an overall mean ACP engagement score by averaging the scores across all ACP actions. We used two-tailed t-tests to compare means.

Outcomes

We conducted two initial webinars for P1 and seven follow-up workshops for P2. Five hundred seventy-seven accounts registered for P1, and 413 (71.5%) accounts logged in to participate. From those participants in P1, 91 accounts (22%) participated in P2. Ninety-eight (24%) and 39 (43%) participants

Table 1
ACP Engagement^a

ACP Task	P1	P2	P
	Mean (SD)	Mean (SD)	
Readiness to sign papers naming a medical decisions maker?	N = 98 4.3 (0.9)	N = 39 4.1 (0.9)	0.5
Readiness to talk to medical decision maker about wishes?	N = 98 4.2 (1.0)	N = 39 4.1 (0.9)	0.5
Readiness to talk to MD about wishes?	N = 97 3.4 (1.2)	N = 38 3.2 (1.1)	0.3
Readiness to sign papers about your wishes?	N = 98 4.1 (1.1)	N = 39 3.8 (0.9)	0.3
Overall ACP engagement	N = 97 4.0 (0.8)	N = 38 3.8 (0.7)	0.2

ACP = advance care planning; P1 = Part 1 (initial webinar); P2 = Part 2 (small group discussion); MD = doctor of medicine.

^a1 = I have never thought of it, 2 = I have thought about it, but I am not ready to do it, 3 = I am thinking about doing it in the next six months, 4 = I am definitely planning to do it in the next 30 days, and 5 = I have already done it.

completed a postsession survey after P1 and P2, respectively.

The mean age of survey respondents in P1 was 62.4 years (SD 14.3; median 64; range 24–91). Age was not collected for participants in P2. Race, ethnicity, and gender were similar across P1 and P2. Of the respondents who provided information about race ($n = 86$ in P1 and $n = 35$ in P2), ethnicity ($n = 57$ in P1 and $n = 21$ in P2), and gender ($n = 93$ in P1 and $n = 37$ in P2), most were white (83.7% in P1 and 82.9% in P2), non-Spanish/Hispanic/Latinx/Mexican (91.2% in P1 and 100% in P2), and female (80.6% in P1 and 89.2% in P2).

The mean likelihood to recommend score for P1 was 4.0 (SD 1.4; median 5) and 4.2 (SD 1.4; median 5) for P2. The mean overall ACP engagement score after P1 was 4.0 (SD 0.8) and 3.8 (SD 0.7) after P2 ($P = 0.02$). Based on the individual ACP engagement survey items, mean scores were the highest for readiness to sign papers to name a surrogate medical decision maker (4.3 after P1 and 4.1 after P2) and lowest for readiness to talk to a physician about future health care wishes (3.4 after P1 and 3.2 after P2). There were no differences in ACP engagement between P1 and P2 (Table 1).

There were 83 comments about the best part of the initial webinar. The most frequently mentioned components included having a reminder of the importance of ACP (25%), presentation style of the presenters (22%), the presence of or the specific content discussed in the Q&A (14%), and getting information specific to COVID-19 (11%). There were 41 comments for ways to improve the webinar. The most common comments were wanting more information (32%), wanting more time (10%), and having more presenters to provide different perspectives (10%). Examples of comments are included in Table 2.

There were 34 comments about the best part of the follow-up workshops (P2). Most respondents appreciated hearing one of the presenter’s personal perspective on how she would complete her AD (65%). There were 15 comments for ways to improve that included allowing for more time and requests for additional information on a variety of specific topics.

Conclusions/Lessons Learned

Based on the number of attendees and the positive qualitative comments from our postsession surveys, we found that a virtual two-part ACP workshop was a successful way to engage the public about ACP during COVID-19. Notably, 22% of initial participants deepened their engagement through a follow-up workshop. In addition, our webinar was posted on YouTube and has accrued 718 views during approximately three months. After the turnout for our initial

Table 2
Sample Comments From Part 1 and Part 2 of the Workshops

Workshop Part	The best part of the event was
P1	I noted how the presenters used very compassionate, understanding language. Appreciated that it addressed current situation. Questions at end were helpful: good that coordinator selected those with multiple or more general usefulness, rather than giving time to someone with an important but ultra-specific question. I finally got around to completing my advance health directive because of this event. I’d been meaning to but this was just the push I needed. Overall, I thought it was done well and the fact that it was focused around COVID-19 made it very timely. I enjoyed the Q&A because many of the questions were questions I had.
P2	Hearing the presenter talking through the form and vocalizing the different factors that she used to weigh into her decisions, in addition to balancing family situation and spouse preference. I really appreciated the candor and sensitivity that both presenters brought to the sessions. I think it was really helpful to hear someone talk about how they would actually make these personal decision[s] and what they would need to do to feel comfortable making them.
This event could be improved in the future by:	
P1	We want to better understand, in more detail, the long-term consequences of extended intubation and sedation that characterize the treatment of the more severe cases. Please add an attorney to your panel to answer the legal questions about the AHCD form, that was asked during Q&A. For those questions that went unanswered, consider answering them on your website.
P2	Perhaps more discussion and ideas about choosing a decision maker for single people or those who do not feel their family members may be up to playing that role. I’m usually very critical, for example, I barely remember the first seminar presented about the topic, but this particular workshop was very helpful and well done. Maybe there could have been a little discussion about how to make it legal and where to put it once completed, although I notice in the paperwork itself it goes into that a bit.

P1 = Part 1 (initial webinar); COVID-19 = coronavirus disease 2019; Q&A = question and answer; P2 = Part 2 (small group discussion); AHCD = advance health care directive.

webinar, we shared our experience with colleagues at a neighboring institution, and their nearly identical webinar attracted 338 participants.

We found many benefits to using a virtual platform. First, we were able to reach a large and geographically diverse population, with participants from 48 U.S. cities across 16 states. Second, producing the virtual workshops required a smaller administrative effort compared with similar in-person workshops. Third, the virtual platform allowed us to provide educational content during stay-at-home orders. Fourth, easier access through an online workshop may have allowed the attendance of those who would otherwise not be able to attend an in-person event (e.g., homebound

individuals). Fifth, the ability to ask questions anonymously may have provided a unique opportunity for more individuals to ask difficult questions compared with an in-person event.

Despite these benefits, there were challenges to hosting a virtual event. Using electronic methods for recruitment and requiring either phone or computer access likely limited the diversity of participants. The virtual format also limited the ability of presenters to read the room during the presentation, which made determining engagement challenging.

There were several limitations to the evaluation of this intervention. First, our results represent a single institution's efforts and marketing strategy. Our ability to track the number of participants was restricted to the accounts that logged in, which could underrepresent the actual number of participants. Evaluations of ACP engagement were only performed after our interventions, and thus, we do not know if the high levels of ACP readiness among participants can be attributed to our intervention. Because this intervention was public facing, we were unable to track completion of ADs or documentation of ACP in an electronic health record.

Future endeavors could include evaluating participants' ACP engagement both before and after participating in the webinars, tracking participants' completion of ACP documentation or ADs in the electronic medical record, and targeting a more diverse participant population.

In conclusion, a public-facing two-part virtual ACP workshop was able to reach a large and geographically diverse population, and participants found many benefits to participating during the COVID-19 pandemic.

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References

1. Curtis JR, Kross EK, Stapleton RD. The importance of addressing advance care planning and decisions about do-not-resuscitate orders during novel coronavirus 2019 (COVID-19). *JAMA* 2020;323:1771–1772.
2. Yadav KN, Gabler NB, Cooney E, et al. Approximately one in three US adults completes any type of advance directive for end-of-life care. *Health Aff (Millwood)* 2017;36:1244–1251.
3. Risk J, Mohammadi L, Rhee J, Walters L, Ward PR. Barriers, enablers and initiatives for uptake of advance care planning in general practice: a systematic review and critical interpretive synthesis. *BMJ Open* 2019;9:e030275.
4. Rabow MW, McGowan M, Small R, Keyssar R, Rugo HS. Advance care planning in community: an evaluation of a pilot 2-session, nurse-led workshop. *Am J Hosp Palliat Care* 2019;36:143–146.
5. Bhatraju PK, Ghassemieh BJ, Nichols M, et al. Covid-19 in critically ill patients in the Seattle region—case series. *N Engl J Med* 2020;382:2012–2022.
6. Onder G, Rezza G, Brusaferro S. Case-fatality rate and characteristics of patients dying in relation to COVID-19 in Italy. *JAMA* 2020;323:1775–1776.
7. Sudore RL, Schillinger D, Katen MT, et al. Engaging diverse English- and Spanish-speaking older adults in advance care planning: the PREPARE randomized clinical trial. *JAMA Intern Med* 2018;178:1616–1625.
8. Sudore RL, Heyland DK, Barnes DE, et al. Measuring advance care planning: optimizing the advance care planning engagement survey. *J Pain Symptom Manage* 2017;53:669–681.e8.