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TOOL TUTORIAL

Communication Tools to Support Advance Care Planning and Hospital Care During the COVID-19 Pandemic: A Design Process

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The COVID-19 pandemic has exposed the medical and social vulnerability of an unprecedented number of people. Consequently, there has never been a more important time for clinicians to engage patients in advance care planning (ACP) discussions about their goals, values, and preferences in the event of critical illness. An evidence-based communication tool—the Serious Illness Conversation Guide—was adapted to address COVID-related ACP challenges using a user-centered design process: convening relevant experts to propose initial guide adaptations; soliciting feedback from key clinical stakeholders from multiple disciplines and geographic regions; and iteratively testing language with patient actors. With feedback focused on sharing risk about COVID-19–related critical illness, recommendations for treatment decisions, and use of person-centered language, the team also developed conversation guides for inpatient and outpatient use. These tools consist of open-ended questions to elicit perception of risk, goals, and care preferences in the event of critical illness, and language to convey prognostic uncertainty. To support use of these tools, publicly available implementation materials were also developed for clinicians to effectively engage high-risk patients and overcome challenges related to the changed communication context, including video demonstrations, telehealth communication tips, and step-by-step approaches to identifying high-risk patients and documenting conversation findings in the electronic health record. Well-designed communication tools and implementation strategies can equip clinicians to foster connection with patients and promote shared decision making. Although not an antidote to this crisis, such high-quality ACP may be one of the most powerful tools we have to prevent or ameliorate suffering due to COVID-19.

The COVID-19 pandemic has exposed the medical and social vulnerability of an unprecedented number of people in the United States and globally. Rapidly evolving epidemiologic and prognostic information about the coronavirus has heightened uncertainty about its potential effect on individuals, creating a need for high-quality communication between clinicians, patients, and families. A sense of urgency has emerged for clinical communication about risk or prognosis related to COVID-19 and elicitation of patients' personal values and priorities to guide current or future medical decisions (advance care planning [ACP]).^{1–4}

Although patients and clinicians are having ACP conversations on an unprecedented scale, doing so involves negotiating an evolving and complex care environment: patients alone in rooms without family or visitors, conversations occurring via phone or digital technologies, clinicians working tirelessly to care for patients while also fearing for their own safety, and amplification of preexisting systemic inequities and disparities. These realities lead to moral in-

jury, collective trauma, and distress for patients, families, and clinicians.

ACP can improve patient well-being, experience, and quality of care by aligning care with what matters most to patients and avoiding burdensome and unwanted treatments at the end of life.^{5–11} Given the speed with which the virus is spreading, uncertainty about its short- and long-term consequences, and the disproportionate negative impact on specific populations (for example, older adults, patients with underlying medical conditions, and persons of color),¹² we face an enormous volume of patients who would benefit from empathic ACP conversations with their clinical teams.

Unfortunately, health systems often struggle to reliably deliver such communication to patients who would benefit. On average, fewer than one third of patients with serious illness have these conversations or do so too late in the course of illness (for example, the last weeks of life) to make a difference.^{13–17} In addition, when discussions do occur, inconsistent and inaccessible documentation of patients' preferences may result in medical errors characterized by patients receiving treatments that poorly reflect their known goals and wishes.^{18,19} This urgent need for high-quality, well-documented ACP conversations during

Development and Design Process

Assemble a team	The team met regularly to create and refine the prototypes, incorporate feedback, resolve tensions, and finalize the content of the guides.
Agree to guiding principles	We paused to articulate (and agree to) a set of guiding values and principles, informed by best practices in serious illness communication.
Adapt SICG to develop a prototype	Based on our knowledge of COVID-19, we created an initial prototype and identified a diverse group of expert and end-user reviewers.
Obtain expert and end-user feedback	We received feedback on the language and structure from 18 stakeholders (for example, caregiver advocate; interprofessional clinicians across specialties).
Incorporate user experience	Several clinicians used the guides with patients and provided feedback; we made final adjustments based on simulated encounters with patient actors.
Prep for evaluation and dissemination	We developed videos, supportive implementation resources, and an evaluation and dissemination plan.

Figure 1: Shown here is the development and design process to create the COVID-19 Conversation Guides for Outpatient and Inpatient Care.

the COVID-19 pandemic calls for rapid mobilization of innovative and flexible approaches to ensure that patients and families receive care aligned with their values and preferences.

Numerous interventions exist to close the quality gap, including clinician training programs and communication tools.^{7,8,20–23} Our team has spent the last nine years designing, testing, and scaling one evidence-based program, which is centered on our Serious Illness Conversation Guide (SICG, or guide).^{1,24} This guide was developed with iterative input from interdisciplinary clinicians from a variety of specialties, as well as patients. Studies of program implementation demonstrate more, earlier, and better conversations; positive patient and clinician experiences; improvements in patient anxiety and depression; and lower health care expenses at the end of life.^{7,8,25–28} We adapted the SICG to meet the unique communication needs of patients, families, and clinicians during the time of COVID-19. We employed a user-centered design approach to tool development. The process addressed the whole user experience, driven and refined by user-centered evaluation and grounded in an explicit understanding of users, tasks, and environments. This article describes the tool development strategy, the themes that emerged from stakeholder engagement, and the two communication guides that resulted from this process, which clinicians have put to immediate use in the inpatient and outpatient clinical settings.

TOOL DEVELOPMENT

We sought to identify the unique challenges of communication for patients, families, and clinicians during the

COVID-19 pandemic and how they might be addressed using adaptations of existing tools. For that reason, we engaged in a user-centered design approach that balanced the need for rigor and structure with expediency. Over a three-week period in March and April 2020, we employed the following steps (Figure 1):

1. We assembled a team of eight individuals composed of the chief medical officer of Ariadne Labs and the former vice president for Population Health and Quality for Baystate Health [E.B.]; physicians with expertise in palliative care and significant experience creating evidence-based ACP tools and clinician training programs [J.P., E.K.F., J.J.S.]; the director of Implementation of Ariadne Labs and a nurse leader and quality improvement expert [S.G.]; a health care delivery expert and hospitalist physician [N.M.]; a physician in family medicine and health care disparities expert [S.M.]; and a project manager [N.D.]. Team members are based in Boston, a COVID-19 “hotspot” during the period of tool development.
2. We identified guiding principles for the development of the adapted communication tools based on best practices in ACP conversations and person-centered communication techniques.^{1,20,29–31}
3. We elicited feedback from an external review panel ($N=18$) that consisted of experts in ACP and end users of the communication tools, including caregiver and disabilities advocate and interprofessional clinicians (physicians, nurses, social workers) in primary care, family medicine, palliative care, nephrology, ethics, hospitalist medicine, emergency medicine, and psychiatry. Several

Outpatient and Inpatient Conversation Guides

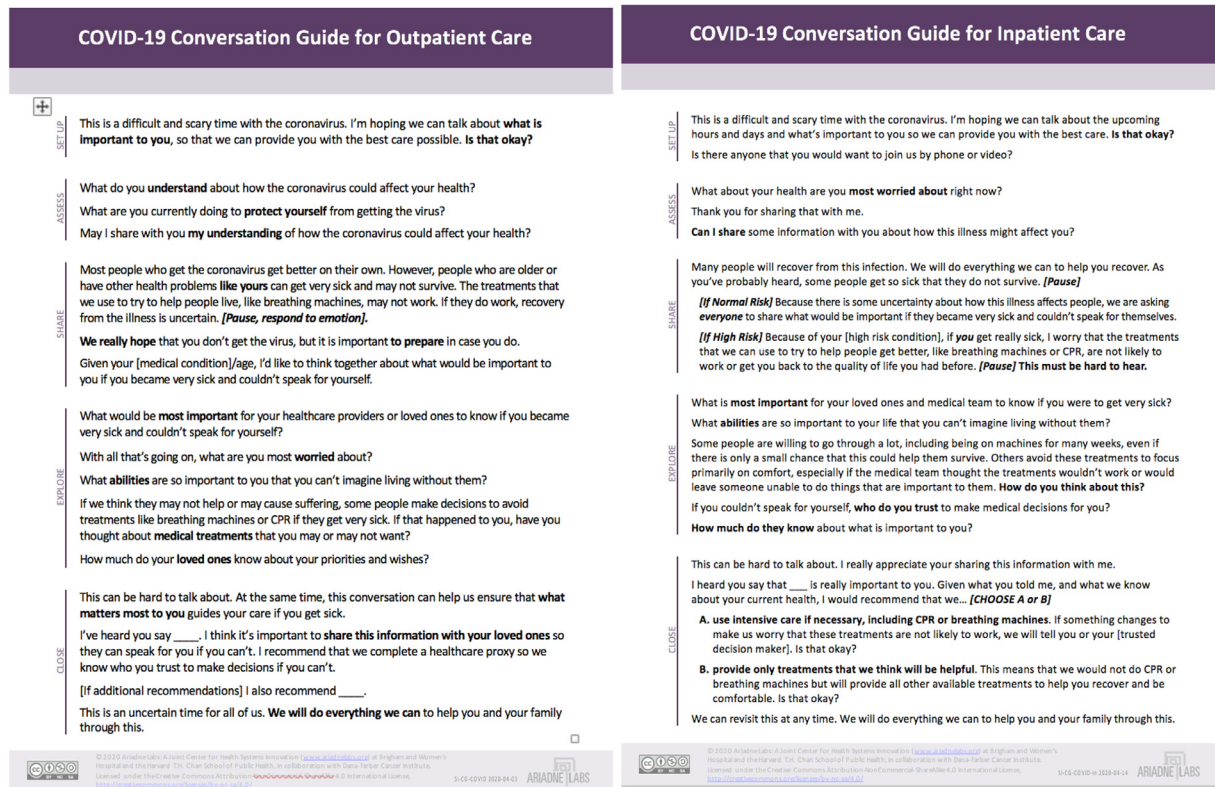


Figure 2: Shown here are the COVID-19 outpatient and inpatient conversation guides.

of these reviewers based their feedback on use of the tool with actual patients in their clinical practices. These individuals came from health care organizations in different geographic locations, including Philadelphia; Palo Alto, California; Atlanta; and Boston.

4. We incorporated input from end-user experience in which clinicians used the communication tools with patients or families. We also tested and refined the tools in simulated encounters with patient actors.

Throughout this process, the design team held regular meetings to create and iterate the prototypes, incorporate feedback, resolve tensions, and finalize design changes.

TOOL DESCRIPTION

This process resulted in two conversation guides and supportive materials, accessible through the Ariadne Labs Serious Illness Care Program COVID-19 Response website (Figure 2). The COVID-19 Conversation Guide for Outpatient Care equips clinicians to proactively reach out to patients in the community with underlying health conditions who are at higher risk of serious complications should they contract COVID-19.³² The tool supports clinicians to ask patients about protective measures, share risk related to COVID-19, elicit what would be important to patients should they become critically ill, invite patients to identify

a trusted decision maker, and create a care plan based on patient priorities and preferences. The COVID-19 Conversation Guide for Inpatient Care equips clinicians to have ACP conversations with patients admitted to the hospital with confirmed or suspected COVID-19 (or their families). The tool invites patients to identify a trusted decision maker; emphasizes patients' values, priorities, and preferences so clinicians can honor them; and informs decision making about life-sustaining treatments.

The design team agreed to adhere to guiding principles to develop the tools, including (1) conversations retain the purpose of ensuring that care plans and treatment decisions align with what matters most to patients; (2) the language and content include high-quality communication techniques and hew closely to the evidence-based structure and flow of the SICG, which is psychologically informed to create safety and build trust; and (3) the tool is concise (one page), is adaptable, and uses simple and relatable language. Based on these guiding principles, the team created prototypes of the outpatient and inpatient guides that retained the structure of the original SICG, including setting up the conversation; assessing patients' worries and current understanding of their illness; sharing information about what may be ahead; exploring values, priorities, and preferences; and closing the conversation by making a recommendation and reaffirming commitment to care.^{24,33}

Sidebar 1**Sharing information about risk from COVID-19 in the outpatient setting:**

Most people who get the coronavirus get better on their own. However, people who are older or have other health problems **like yours** can get very sick and may not survive. The treatments that we use to try to help people live, like breathing machines, may not work. If they do work, recovery from the illness is uncertain. **[Pause, respond to emotion].**

We really hope that you don't get the virus, but it is important **to prepare** in case you do.

Given your [medical condition]/age, I'd like to think together about what would be important to you if you became very sick and couldn't speak for yourself.

Sharing information about risk from COVID-19 in the inpatient setting:

Many people will recover from this infection. We will do everything we can to help you recover. As you've probably heard, some people get so sick that they do not survive. **[Pause]**

[If Normal Risk] Because there is some uncertainty about how this illness affects people, we are asking **everyone** to share what would be important if they became very sick and couldn't speak for themselves.

[If High Risk] Because of your [high risk condition], if **you** get really sick, I worry that the treatments that we can use to try to help people get better, like breathing machines or CPR, are not likely to work or get you back to the quality of life you had before. **[Pause]**
This must be hard to hear.

RESULTS AND LESSONS

We received feedback from expert reviewers on the initial prototypes in response to structured questions that assessed the language of the guides for clarity and simplicity and the utility and clinical relevance of its elements, based in some cases on their use of the guides with patients. We analyzed this feedback to identify key themes.

Theme 1: Communicating Uncertainty Around COVID-19–Related Risk and Prognosis

Reviewers emphasized the importance of acknowledging uncertainty when sharing information about risks related to COVID-19 infection. Patients with underlying conditions are at higher risk of poor outcomes, but many patients recover from the infection. Yet even young and healthy people are known to get very sick quickly and die from the virus. This reality creates the need to normalize ACP conversations such that they reach a broader population of patients.

Questions also arose about how comprehensive to be with regard to sharing information. For example, several reviewers felt that high-risk patients, even those who do not have the infection, need to know that they have a higher risk of developing acute respiratory distress syndrome (ARDS) should they become critically ill from COVID-19, which carries a poor prognosis.^{32,34,35} For hospitalized patients with underlying conditions, several reviewers felt that specific information about the experience of being on a ventilator for COVID-ARDS should be shared, such as a potentially long ventilator and ICU course and a potentially high likelihood of dying and/or experiencing post-acute disability.

Given the themes raised, we based our adaptations on the following principles and evidence (Sidebar 1): (1) patients and families often want information about the future of their health, even if it is uncertain^{36–38}; (2) sharing too much information (including too many medical details),

too little information, or vague information may increase patient anxiety and may not be helpful in making decisions^{39,40}; and (3) sharing information with compassionate language builds trust and helps manage anxiety when receiving difficult news.^{41–44}

Theme 2: Recommendations About Care Planning and Life-Sustaining Treatment Decisions

First, the speed with which some patients get critically ill created a sense of urgency around making decisions about cardiopulmonary resuscitation (CPR) or ventilation. For the outpatient guide, for example, several reviewers recommended including a prompt to complete a form with the patient (for example, Physician Orders for Life-Sustaining Treatment⁴⁵) or to document a code status. Others felt inclusion of these elements on the outpatient tool reflected a rush to life-or-death decisions for patients in the community who do not currently have the virus and may not be ready to make such decisions. Several reviewers also expressed worries that the looming threat of crisis standards of care (for example, ventilator shortages and the need for resource allocation)^{46–48} would steer these conversations to overemphasize life-sustaining treatment preferences as the main focus of the discussion.

Second, important considerations arose about systemic inequities and cultural diversity as related to decision making, including disparities in end-of-life care for persons of color.^{49–53} Given understandable mistrust in the health care system experienced by marginalized communities, which affects experiences with ACP,⁵⁴ language or intention that could reflect a bias toward denying life-sustaining treatments can violate trust. This is particularly important right now, given that racial and ethnic minorities are already disproportionately hospitalized and dying from the infection.^{12,55}

Third, ensuring that patients were asked about involvement of their loved ones in these conversations and decisions emerged as a priority in both inpatient and

Sidebar 2**Making a recommendation in the outpatient setting:**

This can be hard to talk about. At the same time, this conversation can help us ensure that **what matters most to you** guides your care if you get sick.

I've heard you say _____. I think it's important to **share this information with your loved ones** so they can speak for you if you can't. I recommend that we complete a healthcare proxy so we know who you trust to make decisions if you can't.

[If additional recommendations] I also recommend _____.

This is an uncertain time for all of us. **We will do everything we can** to help you and your family through this.

Making a recommendation in the inpatient setting:

This can be hard to talk about. I really appreciate your sharing this information with me.

I heard you say that ____ is really important to you. Given what you told me, and what we know about your current health, I would recommend that we . . . **[CHOOSE A or B]**

A. use intensive care if necessary, including CPR or breathing machines. If something changes to make us worry that these treatments are not likely to work, we will tell you or your [trusted decision maker]. Is that okay?

B. provide only treatments that we think will be helpful. This means that we would not do CPR or breathing machines but will provide all other available treatments to help you recover and be comfortable. Is that okay?

We can revisit this at any time. **We will do everything we can** to help you and your family.

outpatient conversations. Conversations that are not communicated with friends and family can trigger conflict and add additional burdens if they are caught off guard by unexpected treatment decisions.^{56,57}

Given the issues raised, we based our adaptations on the following principles and best practices (Sidebar 2): (1) the content of the recommendation should provide opportunities for customization and should be neutral so as not to reflect bias; (2) for decision making in the context of life-sustaining treatments in the inpatient setting, clinicians should make a recommendation for or against the use of CPR or ventilation that incorporates patients' priorities as well as the medical situation and then check in with the patient about that recommendation^{58,59}; and (3) we explicitly included language within the structure of both guides to ask patients to identify a trusted decision maker and explore how much that individual knows about their wishes.

Theme 3: Using Caring, Person-Centered Language

Although specific concerns and questions arose about sharing information and making decisions, reviewers also drew attention to the importance of ensuring high-quality communication strategies throughout the flow of the discussion. These strategies build connection during difficult conversations, manage anxiety and respond to patients' emotions, and keep the focus on what matters most to patients.^{1,42,58,60,61} Therefore, we maintained communication techniques from our original SICG and adapted them to fit the needs of COVID-19 (Table 1).

How to Use the COVID-19 Communication Tools

In both the outpatient and inpatient settings, several reviewers had the opportunity to use the guides with patients, after which clinicians brought up the current context of ACP in the time of COVID-19. Adapted from these clinical

encounters, Table 2 provides examples of conversations with patients and families, using COVID-19 communication tools.

Hospital safety policies, including the use of personal protective equipment, and social distancing measures (including quarantine), can affect ACP conversations by requiring sensitive conversations to be conducted via telemedicine.⁶² In-person empathic techniques to build connection and rapport, such as facial expressions or therapeutic touch, are difficult to replicate or replace. Reviewers also raised the challenges of having discussions with families by phone, at times with interpreters, particularly without an opportunity to meet the family members face-to-face beforehand.

These realities require clinicians to be both empathic and efficient in ACP communication while being even more mindful of their language. To respond to these observations, we tested the conversation tools in simulated encounters using video encounters with two patient actors. These formed the basis of the publicly available video demonstrations of both the outpatient and inpatient guides. The Web-based encounters helped to demonstrate that high-quality, compassionate communication can occur during difficult circumstances and informed changes to the guides that enhanced the empathic approaches.

Given this context, engaging a patient or family in a successful conversation about values, goals, and preferences during the time of COVID-19 requires implementation guidance and a series of workflow processes before, during, and after the discussion. Table 3 describes examples of these steps and tips for frontline clinicians to use the guides as part of a clinical workflow.

Next Steps

Given the speed with which coronavirus spreads, strategies are needed to ensure access to high-quality communica-

Table 1. COVID-19 Outpatient and Inpatient Conversation Guides Incorporate High-Quality Communication Techniques

Technique	Examples from the Conversation Guides
Asking permission: These uncertain times with coronavirus can create a sense of powerlessness and loss of control. Building rapport early in the conversation by naming this shared experience and asking patients' permission to proceed before moving forward with the conversation enables patients to maintain control over the discussion.	This is a difficult and scary time with the coronavirus. I'm hoping we can talk about what is important to you , so that we can provide you with the best care possible. Is that okay?
Normalizing the conversation: Given the unpredictable nature of COVID-19, normalizing these conversations creates safety for the patient and/or family to think about hard topics.	Because there is some uncertainty about how this illness affects people, we are asking everyone to share what would be important if they became very sick and couldn't speak for themselves.
Sharing information with compassionate language and responding to emotion: When sharing difficult news, "hope/prepare" and/or "hope/worry" language aligns with patients and expresses compassion. ⁴⁴ Pausing after sharing difficult information to allow silence and respond to emotions enables patients to process their feelings. Both guides include a statement that invites patients to share their worries, as well as prompts clinicians to pause after sharing information to expect emotion and respond to it. ²⁰	Because of your [high risk condition], if you get really sick, I worry that the treatments that we can use to help people get better, like breathing machines or CPR, are not likely to work or get you back to the quality of life you had before. [Pause] This must be hard to hear.
Maintaining open-ended questions about what's important to patients: Patients have varying priorities, different things that bring their lives meaning, and diverse views about what might be acceptable or unacceptable in terms of quality of life, all of which influence decisions about care. ^{1,63,70–72} We maintained open-ended questions to empower patients to share their voice so that priorities remain at the forefront of care plans and decisions.	What is most important for your loved ones and medical team to know if you were to get very sick? With all that's going on, what are you most worried about? What abilities are so important to your life that you can't imagine living without them?
Reaffirming commitment to care: It is imperative that clinicians continue to use communication techniques to build trusting relationships with patients and families. ³¹ Expressions that affirm nonabandonment ⁷³ and commitment to doing everything they can to care for the patient are particularly needed during this crisis.	We will do everything we can to help you and your family.

tion about patients' values and preferences at all clinical touchpoints. One such strategy involves proactive ACP with community-dwelling and hospitalized people at high risk of COVID-19 complications. Such communication can enhance connection and relationships with isolated patients, identify potential and addressable threats to their health and well-being, and prepare people for difficult decisions by eliciting and documenting information about what matters most in a crisis.^{26,50,59,63,64}

Whether it occurs in the community setting or in the hospital, effective communication before an acute crisis is a way to ensure that patients receive treatments that align with their preferences. This may reduce suffering and improve experience for patients and families, reduce moral distress for clinicians (which has been linked to burnout), and guide appropriate use of health care resources.^{6,10,13,59,65–68} The COVID-19 pandemic creates an opportunity to shift the standard of care from reactive to proactive ACP communication. In this case, the absence of conversations with patients about values and preferences over the illness trajectory is considered a medical error, with attendant negative consequences for patients, families, and clinicians.

The tools described herein can be easily disseminated and paired with virtual training options, accessible elec-

tronic health record templates,^{3,7} and technical support by experts (such as palliative care specialists) to improve implementation.⁴⁸ However, use of structured communication guides is not without risk, including misinterpretation about conversation intent, such as conserving health care resources. That said, a guide may be the best way to ensure that conversations like these focus on more than just life-sustaining treatments, as is typical.

To date, we have disseminated the COVID-19 conversation guides via webinars, virtual workshops, and online educational sessions to health systems that are implementing the Serious Illness Care Program in partnership with Ariadne Labs as part of an implementation collaborative or online community of practice.⁶⁹ Using surveys and key informant interviews, we plan to evaluate the COVID-19 communication tools by assessing usability, acceptability, and experience from the perspective of patients, families, and clinicians; tracking the strategies that leaders and quality improvement specialists are using to implement the tools in their settings; and identifying key drivers and facilitators of ACP communication during COVID-19 across diverse health systems. Results from this evaluation will allow us to aid health systems and clinicians in implementing high-quality communication during (and

Table 2. Clinical Cases**COVID-19 Outpatient Conversation Guide****“Alice”**

- A 76-year-old woman with diabetes, hypertension, asthma, and well-managed schizophrenia with full decision-making capacity. She has confirmed coronavirus with five days of fever and intermittent wheezing and is managing at home.
- The conversation occurs via telemedicine with her daughter and family medicine physician.
- During the discussion, the family medicine physician learns that staying home and “feeling like herself” are most important to her. She fears going to the hospital because of visitor restrictions and doesn’t want to be alone. Her best-case scenario is being managed at home. She did say that she would go to the hospital if needed to get more supportive care. Her sister died on a ventilator, and she does not want to be intubated or resuscitated under any circumstances.
- Recommendation: Increase home services, which included a safety check, pulse oximetry, and supplemental oxygen; code status updated in the electronic health record to DNR/DNI, and the discussion was documented in an advance care planning module in the EHR.

“Derek”

- A 48-year-old man with advanced sarcoma on third-line chemotherapy. He lives at home with his wife and two teenage sons. He does not have any symptoms or exposures to coronavirus.
- Derek had a conversation with his oncology nurse practitioner via telemedicine.
- During the conversation, they discussed protective measures to prevent infection, given his compromised immune system and underlying cancer. He had a lot of questions about COVID-19 and its effects on his cancer treatment plan, which were his primary concerns. He was very anxious during the conversation and said that “anything besides living was not OK” when asked what was important to him. He didn’t want to think about what would be important if he were to get very sick. His oncology nurse practitioner responded to emotion and answered his questions. She did not discuss the patient’s values or preferences should he become sick with COVID-19.
- Recommendation: Connect with a social worker for a behavioral health visit; schedule their next oncology check-in within one week.

COVID-19 Inpatient Conversation Guide**“Angela”**

- An 86-year-old frail elderly woman with dementia and heart failure requiring full-time care. She lives in a skilled nursing facility.
- Admitted to the hospital with fever, labored breathing (RR = 30) on 6L nasal canula, and delirium. Coronavirus positive. Patient’s daughter is her surrogate decision-maker.
- The conversation occurs by phone with the patient’s daughter, Anne, and the hospitalist.
- During the conversation when asked about worries, Anne expressed anger about her perceptions of the lack of communication in the nursing home. She was worried about her mother’s care. The hospitalist acknowledged her frustrations and assured her that her mother would be given the best care possible. When asked about what is important, Anne shared that her mother’s quality of life before the admission was declining for months and that it was most important that her mother not suffer and that she be well taken care of.
- Recommendation: Given the patient’s underlying conditions and the daughter’s wishes, the hospitalist recommended intensive comfort measures and best supportive care, which would not include the use of CPR or ventilation. The patient’s daughter agreed. They arranged a video call so she could see her mother.

“Allan”

- A 69-year-old male with advanced COPD (2L home oxygen, multiple admissions for COPD exacerbation), congestive heart failure, insulin-dependent diabetes, chronic kidney disease. The patient lives alone.
- He is admitted with COVID-19. A conversation occurred with his hospitalist on day 2.
- During the conversation, Allan shared his strong faith and belief that God would help him get through this. He said that it is important for him to be able to go to church and continue all of the activities they do when he recovers. He had never thought about life-sustaining treatments and wasn’t ready to discuss it.
- Recommendation: Given the patient’s goal and lack of readiness to discuss specifics of life-sustaining treatments, the hospitalist recommended the standard of care—that they would use resuscitation and ventilation if he got sicker and also continue best supportive care to help him recover. The patient agreed.
- On hospital day 6, Allan developed worsening hypoxemia, dyspnea, and acute kidney injury. The hospitalist revisited the discussion. Allan was scared and tearful. He said that he wanted to live and also shared worries that he wouldn’t be able to get out of the hospital. He asked to see his pastor. The hospitalist responded to the patient’s emotion and set up a video call with the pastor.
- Recommendation: Given what’s important to the patient and worries that his underlying condition put him at higher risk of a prolonged ventilator course, the patient, his pastor, and the hospitalist agreed to a trial of intubation if needed and to revisit that decision if there was a worry that the treatments were not going to work. The patient also identified the pastor as his health care proxy. The hospitalist documented the code status, the proxy, and the discussion in the ACP template.

DNR/DNI, do not resuscitate/do not intubate; EHR, electronic health record; RR, respiratory rate; CPR, cardiopulmonary resuscitation; COPD, chronic obstructive pulmonary disease.

Table 3. Implementation Guidance for Outpatient and Inpatient Conversations

Outpatient	Inpatient
<ul style="list-style-type: none"> • Identify a cohort of high-risk patients in the community for proactive outreach. • Schedule the discussion in advance and review the electronic health record (EHR) for evidence of prior discussions and documentation of a health care proxy (HCP). • Decide who on the interdisciplinary team will facilitate the discussion. • Prepare to use the Conversation Guide by reading it aloud and watching the demonstration video. • Review the implementation guide one-pager. • Arrange for interpreter if needed, and review the tool with an interpreter before the conversation. • Use the words as written on the Conversation Guide for the discussion with the patient and/or family. • Document the patient's priorities, preferences, and care plan in the EHR. • Provide the patient with access to any institutional resources on advance care planning. • Record (or confirm) the patient's HCP (if identified). • Enact the care plan and communicate key decisions with other clinicians involved in the patient's care. 	<ul style="list-style-type: none"> • Review census to prioritize patients with whom to have a discussion based on acuity. • Review the EHR for evidence of prior discussion(s) and documented HCP. • Determine the conversation modality and whether the patient has capacity to engage in a serious illness discussion. If not, confirm HCP/family member. • Prepare to use the Conversation Guide by reading it aloud and watching the demonstration video. • Review the implementation guide one-pager. • Arrange for interpreter if needed, and review the tool with an interpreter before the conversation. • Use the words as written on the Conversation Guide for the discussion with the patient and/or family. • Document the conversation, recommendations, and plan in the EHR. • Confirm and document the HCP and contact information. • Record the patient's code status in an accessible location. • Communicate key decisions with other care team members involved in the patient's care (including outpatient primary care provider and specialists).

beyond) the COVID-19 pandemic by improving the tools and enhancing the development of virtual educational sessions and implementation case studies.

Limitations

A rapid design process during a crisis meant that we were unable to include as robust an array of interprofessional and patient feedback as we would have liked. Although we were able to include input from Black physicians—and although the original SICG has undergone formal testing with Black patients⁵⁰—we lacked structured input from patients whose communities are most deeply affected by the pandemic. These include ethnic groups for whom the language we adapted, or the English language in which it was written, may not most sensitively account for their needs. Addressing this in part, that these tools have been translated by native speakers into at least six languages: Spanish, French, Portuguese, Haitian Creole, Cape Verdean Creole, and Vietnamese.

CONCLUSION

Employing a user-centered design process, with feedback from key stakeholders, we adapted an evidence-based structured communication tool, the SICG, to address COVID-related ACP challenges in ambulatory and acute care settings. We plan to follow this effort with attempts to elicit formal feedback from a more diverse set of stakeholders, including Black, Indigenous, and people of color, whose communities have been most deeply affected by the pandemic and whose communication needs and concerns may differ from those who have not been underserved and

marginalized by health care systems and clinicians. Access to well-designed communication tools and supportive implementation strategies during times of high stress can better equip clinicians to innovate, adapt, and improvise in ways that foster connection with patients under difficult circumstances and create space for patients' voices to be heard. Attentive and meaningful communication is not an antidote to this crisis, but it may be one of the most powerful tools we have to spread care, compassion, and healing during this unprecedented time.

Funding. Supported by the Patrick J. McGovern Foundation. The funder did not play a role in the design, execution, or writing of this work.

Acknowledgments. The authors would like to acknowledge Dr. Stephen D. Brown, Director of the Institute for Professionalism and Ethical Practice at Boston Children's Hospital, for his contributions to the video simulations. The authors would also like to acknowledge all of the reviewers who contributed their time and expertise to this project.

Conflicts of Interest. Dr. Mitchell holds equity in See Yourself Health LLC, a digital health platform for diabetes education. She also has delivered workshops on Relationship-Centered Care sponsored by Merck & Co. for which no product promotion is permitted.

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