Enablers and Barriers to Using the Serious Illness Conversation Guide: A Quality Improvement Initiative with BC Cancer Clinicians

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Introduction

In 2016, the British Columbia Centre for Palliative Care (BCCPC) created the Serious Illness Conversation (SIC) Initiative (Beddard-Huber et al., 2020). This initiative adapted Ariadne Labs' Program to the healthcare system in British Columbia (BC), supporting the integration of the Serious Illness Conversation Guide (SICG) into the routine care of seriously ill patients. The SICG is an evidence-based conversation tool designed for clinicians who lack specialty-level palliative care training to have more and better SICs using a structured approach. This approach covers topics such as the patient's understanding of their illness and their decision-making preferences, prognostic information, patient goals, fears, and sources of strength (Lakin et al., 2017). Early, high-quality conversations using the SICG were associated with substantial benefits such as reduced patient anxiety and depression (Bernacki et al., 2019; Paladino et al., 2020).

Since the initiative started, over 2300 BC clinicians have taken an SIC workshop and over 250 BC facilitators have been trained to deliver SIC workshops. After training, 95% of clinicians agreed or strongly agreed that the training was effective, enhanced knowledge, and would recommend the workshop to others. However, with only 61% of clinicians using the guide in clinical practice after 3 months, more research is needed to identify the barriers and enablers of using the SICG in practice (Beddard-Huber et al., 2020). Previously, a few barriers to using the SICG in BC were identified such as documentation, using the SICG with patients/families from culturally and linguistically diverse backgrounds, giving prognosis, and engaging in SIC when not the patient's regular care provider (Beddard-Huber et al., 2020). A better understanding of the barriers and enablers to implementing the Serious Illness Conversation Program into a clinical setting is needed.

Purpose

The purpose of this Quality Improvement Initiative pilot at BC Cancer was to further identify barriers and enablers of using the SICG in BC since the implementation of the SIC initiative in 2016, as well as to elicit suggestions on how to improve implementation.

Methods

Staff members who had received training either through the Early Symptom Indicators for Cancer Care Screening Program (EPICC) or a previous Serious Illness Conversation (SIC) Clinician Workshop were surveyed by email in November 2021 about their experience in having Serious Illness Conversations with patients in a BC Cancer clinical setting. The survey was divided into five sections to better understand whether the clinician used the guide after training, and if they did, what their clinical experience in using the guide was, their perceived patient experience and perceived impact on the patient and their family and other contextual factors of the guide.

Clinical settings were identified as Regional Cancer Centres located in Prince George, Abbotsford, Victoria, Surrey, Kelowna and Vancouver as well as Community Oncology Network sites.

Subsequent to the survey interviews were conducted with clinicians who indicated a willingness to be interviewed. The telephone interviews were held on Zoom and recorded with the clinician's consent for accuracy. Duration of each interview was approximately 20 minutes. The interview was designed to elicit the clinician's views on implementation of the SICG into practice, sustainability, and program expansion. Interviews were transcribed verbatim and key themes were extracted.

Survey Results

177 staff members received the survey and 36 (20%) responded, including nurses, physicians, and allied health professionals within radiation therapy, systemic therapy, and pain and symptom management programs. See Table 1 for additional demographic details. Just less than half did not use the SICG after taking the training. Of those responding who used at least part of it, 71% used it 10 times or less. (Table 1). No clinician experienced decreased satisfaction with their role in patient care after using the SICG, with 86% of clinicians finding it helped them understand their patient's values and goals of care and 43% of clinicians experienced at least slightly reduced anxiety about having these discussions. None of the clinicians thought that using the SICG made their patient's emotional state worse. However, only 46% agreed that the SICG can be done in an appropriate amount of time with 32% of clinicians experiencing difficulty addressing prognosis and 32% experiencing difficulty introducing the conversation (Table 2a and 2b).

In addition to insufficient time, other top reasons identified to not have SICs included not having a clear plan to integrate SIC into their work schedule, lack of documentation space in the electronic health record (EHR) and uncertainty about the right time to have the conversation (Table 3a and 3b). Other notable comments included feelings of being overwhelmed: "We are asked more tasks, with less support, less time, less room to do it" and the need for refresher courses: "There needs to be a review of this information. I had actually forgotten about the resource".

Recommended changes to future surveys: Clinician workplace and role demographics need to be made clearer in future surveys to help identify gaps in structural support on a regional basis. When addressing cultural diversity, it would be beneficial to ask if a translator was required (yes/no) and then ask does having a translator increase or decrease the difficulty (yes/no) and/or change the interpretation (yes/no).

Interview results

5 allied health clinicians who had completed the survey volunteered to be interviewed, including social workers, dietitians, and pharmacists Interviews were conducted from December 2021 to January 2022 over Zoom by 2 members of the BC Center for Palliative Care SIC Program. The identified barriers, enablers, and recommendations were organized into themes and described below.

      Barriers to using the SICG

Time: Most clinicians interviewed felt that there was not enough time to follow the SICG in its entirety and some allied health professionals were not regularly scheduled to work in a setting where these conversations are most likely to occur, hindering time for follow up with other members of the team or the patient.

Lack of interdisciplinary team approach to care: Allied health such as dietitians and pharmacists were not confident that they are adequately supporting physicians and other clinicians with SICs. They felt that there was a lack of opportunities to have SICs and that SIC training was not geared towards allied health, especially with prognostic discussions.

Lack of structural support: Documentation was a barrier with some allied health clinicians not being able to access the EHR of certain clinics. Other structural barriers included the lack of comfortable spaces for SICs and not having all team members working in the same vicinity i.e., building and being physically separated from the rest of the team.

Patient factors: Some patients did not want to follow linear discussions outlined in the SICG. Other patients were not fully engaged as SICs were happening.

Comfort level with material: Some clinicians felt that they knew how to have good SICs without using the SICG or took the workshop as a learning experience to incorporate the SICG into their own SIC process without using the SICG directly. Some allied health practitioners were not comfortable with discussing prognosis unless it had previously been discussed by another practitioner.

Enablers of using the SICG

Interdisciplinary care: A few examples of interdisciplinary care that facilitated SICs were described in the interviews. A pharmacist prepared the patient for SICs during medication reconciliation and pre-physician appointments. Dietitians reinforced previous messaging by other clinicians after their SICs. Counselors used physician and nursing notes/referrals to guide SICs.

Suggested changes for future SIC Program implementations

Models of Care: The need for an interprofessional team approach to identify patients who would benefit from an SIC, prepare the patient for the conversation, have the conversation and document it appropriately was highlighted. The nurse or allied health professional could help to arrange SICs. The need for champions, either a nurse, social worker, dietitian, or pharmacist, to follow new patients alongside physicians and/or nurse practitioners to encourage SICs and to build on them from appointment to appointment was emphasized, reflective of a multi-visit format. Also, within a multi-visit format, follow-up discussions could be scheduled with physicians and nurses after SICs to ensure patients understand their situation. This may help to address time barriers as well as patient barriers such as lack of buy-in.

Physical spaces that are less clinic-like could be implemented to provide a more comfortable space for SICs. Other suggestions included ensuring that members of the

interdisciplinary team are working in close proximity to each other and have an available directory of clinicians who have taken the SIC training.

Training: Increasing the time allocated for training to allow for more interprofessional discussion related to role clarity during role play and offering quick refresher courses regularly were suggested. Offering discussion groups for like-minded people to talk about how the SIC training applies to their patient population and tailor teaching to their health care profession was also suggested.

Technology: Videoconferencing would be preferable to phone calls for SICs to allow for a visual interpretation of emotional responses. EHRs should be modified to ensure all staff can access notes. Dictation software could also be used to speed up documentation.

Recommended changes to future interviews: The use of open-ended questions was useful in eliciting information about the use of the guide. Questions geared more to how to improve the interdisciplinary team approach may be useful in helping to manage clinic flow. A question asking about what their ideal Model of Care would be may elicit new concepts arising from their experience.

Discussion

In general, the SIC initiative was well received by BC Cancer clinicians. Clinicians interviewed were appreciative of the training as many found it helpful and 43% experienced reduced anxiety when having a SIC after the training (Table 2b). However, the full SICG had a low uptake among clinicians. None of the clinicians interviewed and only 26% of clinicians surveyed had used the SICG in its entirety. This is consistent with previous studies using the SICG in BC (Beddard-Huber et al., 2021)**.** Although we previously found that 61% of clinicians were using the Guide in clinical practice after 3 months (Beddard-Huber et al., 2020), it was not asked if the Guide was used in full or in part. Only 21% of BCC clinicians surveyed experienced difficulty using the SICG with patients/families from culturally and linguistically diverse backgrounds, suggesting that this previously identified barrier has been addressed (Beddard-Huber et al., 2020). Other barriers identified as well as possible solutions found in the literature are discussed below.

Time

In practice, one contributor to the low uptake of the SICG is its time-consuming nature relative to the clinician's schedule. Lack of time is cited as a major barrier through the interviews and survey responses. This is also consistent with other groups that have implemented the SICG (Hafid et al., 2021; Littell et al., 2019; Mandel et al., 2017; Pasricha et al., 2020; Photopoulos, 2019; Pottash et al., 2020). Possible solutions suggested for the time barrier in BC were to conduct the SIC over multiple visits with good collaboration amongst clinicians. This allows the SIC to happen over time without the pressure of addressing all the topics in the SICG in one sitting. This also allows different clinicians to build upon previous conversations. These thoughts were also suggested in another interview of clinicians in Ontario (Hafid et al., 2021). Another solution was to have a SIC champion, a dedicated staff member who would facilitate SICs by preparing and supporting the patient and their family as well as managing the logistics. This suggested solution was effective in another setting where many clinicians felt that it was

essential to use the SICG (Lagrotteria et al., 2021). This would also address the issue of the logistics of integrating SICs into the workflow that many clinicians face (Photopoulos, 2019). In addition, using dictation software for allied health could reduce time spent on documentation.

Timing, i.e., when to have the conversation, was also identified as a barrier to having earlier conversations. Mandel et al. identified strategies to overcome this barrier within nephrology by using the Surprise Question and other tools such as the Cohen 6 Month Mortality Predictor to identify who would benefit from a Serious Illness Conversation. Having standardized defined intervals of when the SIC should occur throughout the disease trajectory was another suggestion that would provide guidance to clinicians as to the timing of when to have the SIC.

Lack of an Interdisciplinary Team Approach to Care

Engaging in SICs when not the patient's regular care provider was a previously identified barrier (Bernacki et al., 2015; Beddard et al., 2021) and remains an issue, with 40% of clinicians surveyed citing a lack of established relationships with the patients as a difficulty with SICs. (Table 3a). 70% of BCC clinicians surveyed had difficulty integrating SIC conversations into their work and many were uncertain about the right time to have the conversation and how to address prognosis. During the interviews, allied health professionals mentioned that they were not able to complete the SICG due to scope of practice limitations with prognostication and were not certain how to best support the physicians. Role clarity such as who discusses prognosis and who identifies appropriate patients for SICs were barriers that others have also identified (Hafid et al., 2021).

Suggestions on how to improve an interdisciplinary team approach to SICs were identified by BCC clinicians and examples were given. Having an allied healthcare professional such as a pharmacist prepare patients for SICs by offering hand-outs (i.e., pre-visit letter) and asking who they wish to have at the visit (e.g., family member) before the patient has an SIC with a physician were two of the suggestions. This could occur at scheduled medication reconciliation discussions. Better access to documentation regarding the SIC was emphasized to allow healthcare professionals, such as counselors and dietitians, to use the extant SIC notes and referrals to play a key role building upon the previous SIC and reinforce the previous messaging. Those who build upon the work of others found it easier to re-introduce the conversation and the prognosis. Engaging team members was an effective way of implementing the SICG in other groups (Lagrotteria et al., 2021).

Suggestions to improve the interdisciplinary team approach to care also included having members of the interdisciplinary team working in close proximity, offering follow-up discussions after the SICs, profession-specific role play for allied health during SIC workshops, and follow up discussion groups specific to a profession's patient population.

Structural Support

Many clinicians did not feel supported to engage in SICs. Documentation continues to be a major barrier with 50% of clinicians surveyed citing a lack of dedicated documentation space as a barrier to having SICs. Some allied health workers who were located at a distance from the

clinic building were not able to access the EHR of certain clinics. Other barriers included a lack of comfortable spaces for SICs and forgetting about the SICG as a resource. Mandel et al., 2017, suggested giving the patient the choice of where they would prefer to have the SIC. The SIC, or parts of it, could occur during a treatment (e.g., dialysis) or in a scheduled appointment in a space away from the treatment room.

Other groups have also highlighted the importance of good documentation (Photopoulos, 2019, p. 201) with some finding it helpful to use a template in the EHR (Lagrotteria et al., 2021). Other suggestions would be to ensure all involved in care have access to the EHR and to offer quick refresher courses regularly to those who have already taken the SIC training.

Patient Factors

Some clinicians interviewed found that some patients did not want to have SICs or were not fully engaged as SICs were happening. Other groups have also noted that some patients were reluctant to have SICs (Photopoulos, 2019) or that these conversations caused some distress (Pottash et al., 2020). Currently, some clinicians interviewed overcome this issue by conducting SICs over multiple visits, allowing the patient time to process the information given and to be prepared to continue the SIC. This suggestion was echoed by other groups (Hafid et al., 2021). As some SICs occurred over the telephone due to the COVID-19 pandemic, using videoconferencing software was suggested to increase patient engagement.

Clinician Experience

When interviewing some experienced clinicians working in palliative care, we found that they combined elements of the SICG training such as the patient tested language from the guide with their previous experience, to have quality SICs. This trend was also mentioned with experienced physicians in another study (Pasricha et al., 2020). This suggested lower adoption of the full SICG in those with experience but not necessarily lower quality SICs. This is in line with the goals of the SICG as a tool for those who lack specialty-level palliative care training (Lakin et al., 2017).

Mandel et al, 2017, focusing on nephrology, identified that the attitude of clinicians being overly optimistic about treatment outcomes may hinder an open honest conversation. In other studies, the fear of taking away a patient's hope by having an SIC, along with emotional discomfort of the provider, were also barriers expressed by oncologists (Littell et al, 2019). Strategies to overcome this discomfort include Communication Skills Training embedded in core curriculum and in continuing education. Presenting data related to enhanced patient outcomes and tips on providing empathetic responses may increase clinician confidence in having SICs (Littell et al., 2019).

Model of Care

Key recommendations arising from this Quality Improvement Initiative include the encouragement of an interdisciplinary team approach. This includes engaging all members of the interdisciplinary team to support the identification of a patient who would benefit from an SIC, preparing the patient for the SIC, having the SIC or part of an SIC, documenting the outcome

of the SIC and ongoing follow-up with the patient and their family in relation to their wishes, goals, and preferences. To achieve this model, training should emphasize role clarity within the team, identify champions to be available within a clinic, improve accessibility to the EHR, and provide a workspace where all team members have access to each other.

Limitations

Limitations of this study included a low (20%) survey response rate as well as a low number of clinicians interviewed. The clinicians interviewed only represented allied health with no RNs or MDs interviewed. In addition, only staff members from BCC were invited to be involved, which may not represent the views of clinicians who see patients with other serious illnesses.

Summary

Lack of time, an inadequate interdisciplinary team approach to care, and lack of structural supports were key barriers to having SICs. Clinician reluctance to using a structured format when having a SIC was potentially a barrier to using the full SICG, but not to having SICs themselves.

Key recommendations for future implementation and sustainability of the SIC program arising from this Quality Improvement Initiative include:
- encouraging the use of the SICG in full or in parts
- collaborating on SIC completion with other clinicians
- conducting SIC workshops with more of an emphasis on interdisciplinary care
- having SIC champions available within the clinical setting
- improving accessibility and use of the EHR
- offering refresher courses on SICs to those who have previously attended a SIC Workshop.

Table 1. Clinician survey characteristics and use of SICG

Characteristic	No. (%)
Clinical Discipline	n=34
Physician	4 (12%)
Nurse Practitioner	2 (6%)
Registered Nurse	15 (44%)
Social Worker	5 (14%)
Radiation Therapist	2 (6%)
Pharmacist	2 (6%)
Other	4 (12%)
Location in British Columbia	n=19
Prince George	6 (32%)
Victoria	3 (16%)
Surrey	5 (26%)
Abbotsford	0 (0%)
Kelowna	1 (5%)
Vancouver	4 (21%)
SICG usage	n=31

Yes	8 (26%)
No	15 (48%)
Partial usage	8 (26%)
Frequency of use	n=14
Once	1 (7%)
2-5 times	6 (43%)
5-10 times	3 (21%)
Over 10 times	4 (29%)
Setting of use	n=31
Radiation therapy	4 (13%)
Chemotherapy room	4 (13%)
Ambulatory Care Unit	7 (23%)
Patient and Family Counselling	2 (7%)
In-Patient unit	3 (10%)
Telehealth	6 (19%)
Community care	2 (6%)
Clinic	2 (6%)
other	1(3%)

Table 2a. Clinician survey experience using the SICG

Experience	Strongly agree	Agree	Neutral	Disagree	Strongly disagree	Total
Was easy to use	1 (8%)	7 (59%)	4 (33%)	0	0	12
Helped me understand patient's values and goals of care	1 (7%)	11 (79%)	1 (7%)	0	1 (7%)	14
Allows me to gather important information	1 (7%)	8 (57%)	4 (29%)	0	1 (7%)	14
Provides information that enhances my clinical care of the patient	1 (8%)	8 (61%)	3 (23%)	0	1 (8%)	13
Helps build a trusting clinician-patient relationship	1 (8%)	7 (53%)	4 (31%)	0	1 (8%)	13
Can be done in an appropriate amount of time	0	5 (46%)	4 (36%)	2 (18%)	0	11

Table 2b. Clinician survey experience using the SICG

Experience	No. (%)
Difficulties using Guide with pts/families from culturally and/or linguistically diverse backgrounds	n=14
Yes	3 (21%)
No	10 (72%)
Have done one or more SICs in collaboration with a translator	1 (7%)
Difficulties with sections	n=19
None	2 (10%)
How to address prognosis	6 (32%)
How to introduce conversation	6 (32%)
How to talk about goals and values	4 (21%)
Communicating what I've addressed to others	1 (5%)
Satisfaction with role in patient care	n=14
Greatly increased	1 (7%)
Increased	5 (36%)
Slightly increased	2 (14%)
Neither increased nor decreased	6 (43%)
Slightly decreased	0
Decreased	0
Greatly decreased	0
Anxiety with SIC using the SICG	n=14
Much better	1 (7%)
Better	3 (22%)
Slightly better	2 (14%)
Neither better nor worse	7 (50%)
Slightly worse	1 (7%)
Worse	0
Much worse	0
Patient emotional state after using the SICG	n=14
Much better	0
Better	4 (29%)
Slightly better	4 (29%)
Neither better nor worse	6 (42%)
Slightly worse	0
Worse	0
Much worse	0

Table 3a. Difficulties identified by clinicians surveyed

Difficulty	Strongly agree	Agree	Neutral	Disagree	Strongly disagree	Total
Creating a clear plan to integrate SIC conversations into my work	2 (10%)	12 (60%)	5 (25%)	1 (5%)	0	20
Assessing and integrating previous SIC information into my work	2 (10%)	7 (35%)	6 (30%)	0	0	20
Lack of established relationships with the patients I work with	2 (10%)	6 (30%)	6 (30%)	6 (30%)	0	20
Lack of dedicated documentation space in the Electronic Health Record	4 (20%)	6 (30%)	9 (45%)	1 (5%)	0	20
Getting other health care providers without SIC training to engage in conversations with patients if I start the process	1 (5%)	8 (40%)	9 (45%)	2 (10%)	0	20

Table 3b. Top 3 clinical reasons for not having serious illness conversations among clinicians surveyed

Insufficient time
I'm unsure about the right time to have the conversation
I don't feel prepared to have the conversation

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