Updates & Innovations in Essential Conversations for the Health Care Team

Topic: Facilitators & Barriers of SICP Implementation: A Knowledge Translation Approach

Tuesday, March 5, 2024 12:00pm – 13:00pm PST

AGENDA ITEM	DISCUSSION	
Introduction & Territory Acknowledgment	Facilitators & Barriers of SICP Implementation: A knowledge translation approach Welcome to all participants, and introduction of the presenter, and presentation outline. Participants are notified the session is being recorded.	
Overview Summary Presentation & Discussion	**Presentation Summary** **<u>Presenter:</u> Laura Finkler-Kemeny RN, MSN** Clinical Lead, Serious Illness Communication, BC Centre for Palliative Care **<u>Learning Objectives</u>:** • Define Knowledge Translation. • Identify the role of knowledge translation frameworks in the Serious Illness Conversation Program (SICP). • Use the COM-B Framework to categorize and identify implementation barriers and facilitators. **GROUP DISCUSSION** • What are the barriers to engaging in serious illness conversations? available time, personal apprehension, cultural taboo, cultural confidence, support, relationship, connections, etc. • What facilitates serious illness conversations? advanced care planning helps, mentorship, patient identification processes, confidence building, having a built-in documentation system, interdisciplinary communication, etc. • Knowledge translation: this refers to a set of activities aimed at reducing the gap between knowledge and action and in this case to improve health care. These variety of activities could be in the form of dissemination - which is sharing of information to increase awareness and knowledge.	

	• Examples of implementation people have engaged in include interactive training, engaging local leaders, improving organizational facilities, resources, equipment, etc. • A good framework for implementation is the knowledge to action cycle. See the Resources section to see this framework and its stages towards implementation. • For this session, we are going to focus specifically on identifying barriers and facilitators: This phase is about identifying potential barriers that might limit the uptake of knowledge in a setting. A barrier is anything that's closer to your knowledge from being translated and a facilitator is anything that helps. It is helpful to use different sources to be able to identify these barriers and facilitators. For example, regarding research with the center on implementing the serious illness conversation program, a variety of sources to identify these barriers and facilitators are being used which includes knowledge and experiences from collaborators, stakeholders and partners, future survey that will be administered to clinicians, expert interviews and semi structured interviews as well. • Once barriers are identified and the facilitators in a particular setting, one can systemically understand what is going on and what interventions would be needed to target, address and potentially kind of reduce the barriers and improve the facilitators. • The model is called the COMB model- which suggests that in order for a person's behavior to change, they need to have 3 things in place. ➢ They need to be capable of change. ➢ They need to have the opportunity to change and ➢ They need to be motivated to change. • Capability compromises of knowledge, skills, memories, and habits. This approach is often used in implementation because it encompasses the education side of implementation. • It also requires opportunity and motivation. Opportunity compromises of the environmental context and social influences which includes resources, Leadership, organizational support, culture, etc. • Motivation is about beliefs, capabilities, consequences, roles, goals and intentions, reinforcement. • In serious illness communication, clinicians often identify their own anxiety and fears about death of dying as a barrier to engaging in serious illness conversations. • Participants Identified Barriers to SICP Implementation: ➢ Difficulty in continuing SICs when patients move throughout settings, locations and contexts within the healthcare system particularly towards EOL. Difficulty in communicating across	

	the interdisciplinary care team via documentation systems. This makes the "Re-enforcement" part of SICs complicated. ➢ There is the inability within the system to have a feedback loop in a lot of places where you know definitely that the conversation that was started six months ago resulted in that patient having the end-of-life experience that they wanted because we just lose track of patients by virtue of how busy everybody is and how patients transition from care settings. There need to be a system in place to be able to support reinforcement and follow up. ➢ Another barrier to engaging in serious illness conversation guide is the electronic medical record system- physically having a documentation system that can be seen across disciplines, regions, and care settings. This barrier may also fall in categories of Optimism, Belief about capabilities and goals to want to change practices. ➢ Another barrier; Taking away Hope. We have a participant telling us ultimately the oncologists here are afraid of taking away hope, afraid of being real about death with patients. This quote rings true for all of us to an extent in our work in serious illness communication, and the kind of level of mortality and difficulty and emotions that these conversations kind of inherently bring and often what we see in the literature about serious illness communication is a fear of, taking away hope but what we know from kind of our best evidence and research is that, when supported with training, when done, in the right setting, at the right time with the right amounts of support, It actually reduces patient anxiety often and clinician anxiety as well. But that is a real fear and that's something that we need to support and be mindful about sort of our own personal feelings about hope and I think it is really hard to recognize or to have the insight to recognize that Patients are going to die no matter what we do as individuals and to not hold the deaths of our patients as our responsibility. • BCCPC''s SIC portfolio is continuing onwards with our implementation research and will continue to update our website aners with key findings, takeaways and resources as we move forward.	
Session Materials and Additional Resources	1. Knowledge to Action Cycle and Framework: https://rnao.ca/leading-change-toolkit/knowledge-to-action	**Session Recording** is uploaded on the BCCPC's YouTube page, link:

	2. Assessing Barriers and Facilitators: Using the COM-B model to map out barriers and facilitators to SIC Implementation a. https://implementationsciencecomms.biomedcentral.com/articles/10.1186/s43058-020-00100-x/figures/2 3. Implementation Science and Frameworks 101: https://healthresearchbc.ca/webinar/implementation-science-101-what-works-in-theory-practice-for-clinical-interventions/ a. Informative and useful webinar from Health Research BC, "Implementation Science 101: what works in theory and practice for clinical interventions"	https://www.youtube.com/watch?v=vWh5hr1B5gA
Closing	**SAVE THE DATE:** BC-CPC will be hosting an All Together Symposium October 4th, 2024. This will be an exciting day of workshops, networking and learning with noted community and health care experts in compassionate communities and palliative care. For more information, please visit our website. Visit the BCCPC Palliative Care **ECHO website** to learn about and register for future sessions Subscribe: BC Centre for Palliative Care **YouTube page** Subscribe: BC Centre for Palliative Care **Newsletter**	