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Online Supplementary Material

Shaw EK, Ohman-Strickland PA, Piasecki A, et al. Effects of facilitated team meetings and learning collaboratives on colorectal cancer screening rates in primary care practices: a cluster randomized trial. *Ann Fam Med*. 2013;11(3):220-228.

http://www.annfammed.org/content/11/3/220

Supplemental Appendix 2. P10: Moderate to Strong Implementation With Dramatic Drop in CRC Screening Rates

This practice had moderate to strong QI implementation characteristics but saw a dramatic decrease in CRC screening rates, from 71% (preintervention) to 33% (postintervention). This practice was a community-based health center that provided primary care services to the poor and medically underserved population in an urban area. The practice had 3 clinicians (20 practice members total) and had several outreach programs, including ones that targeted child immunizations and HIV infection counseling.

This practice held 8 RAP meetings and had a consistent team of 6 members. As evidence of their strong communication, in an early RAP meeting, the team decided on a plan to distribute all ideas, decisions, or action plans to the entire practice for input and feedback. The team took a democratic decision-making approach: they brainstormed a list of areas for improvement, which was then distributed to all practice members for a vote on what to focus on first. The top choice was to address 'chaos' in the practice, which was articulated as various kinds of interruptions, trying to address multiple patient problems in a single 15-minute visit, and confusion or miscommunication that occurred among support staff. There was some evidence that the lead physician was not in favor of focusing on these issues but did not obstruct the dialogue. Although subsequent RAP meetings entailed team discussion on their communication and working relationship issues, they simultaneously worked on implementing other plans to improve work flow at the front office and update an unused flow sheet and mammogram referral sheet. During the intervention time frame, the team spent little time working directly on anything CRC related.

As with each practice, the role of the facilitator shaped their change process. Facilitating what were often tense, difficult conversations during RAP around communication problems and poor relational dynamics meshed well with the strengths of the facilitator. Yet, the facilitator struggled with figuring out (in real time) how to effectively balance the clinical goal of improving CRC screening rates with the process goal of tailoring the intervention to the perceived needs of the practice and allowing them to determine their QI focus. In this case, the timing of the first learning collaborative (near the middle of the intervention timeframe) helped to redirect this team's attention on CRC screening as their subsequent RAP meetings included more-pointed CRC screening discussions.

At the 12-month follow-up visit, the practice had been experiencing various externally derived challenges, as well as physician and staff losses. After the intervention time period, the practice did not continue RAP meetings or work on the plans that were raised during SCOPE. Some members noted that time constraints were a big challenge that worked against keeping the momentum going to continue their QI efforts. Although the practice did not continue with the SCOPE QI approach, there was evidence that the practice kept CRC screening as a priority. Key stakeholders in the practice, however, indicated that they sought to improve their use of colonoscopies even though it was very difficult for their patient population to get screened for colon cancer other than via FOBT. In fact, their use of FOBT decreased from 70% (baseline) to 31% (12-month follow-up), while their use of colonoscopy increased from 25% (baseline) to 46% (12-month follow-up).

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It is plausible that the intervention had an unintended effect on the practice's screening rates. For example, if key practice stakeholders concluded that their current method of screening was less desirable than colonoscopy, based on their interpretation of messages received during the intervention, it may have contributed to the observed results. With a shift from a test done annually to 1 done every 10 years (colonoscopy), there may have been insufficient time in our follow-up period for the practice to demonstrate positive increases in their overall screening rate. Interestingly, by the 24-month follow-up, their overall CRC screening rate increased from 33% to 52%, with 87% of these being screened via colonoscopy, and most patients having had both colonoscopy and FOBT.

CRC = colorectal cancer; FOBT = fecal occult blood test; HIV = human immunodeficiency virus; RAP = reflective adaptive process; QI = quality improvement.

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