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SC Communities Unite Group Interviews Fall 2021

Report

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Executive Summary

Introduction

In fall 2021 evaluation team members from the Center for Applied Research and Evaluation (CARE) conducted a series of group interviews with SC Communities Unite to Increase CRC Screening staff and stakeholders to understand project progress to-date, lessons learned, and suggestions for improvements going forward.

Methods

CARE interviewed six Year 1 Learning Collaborative participants in September 2021, four American Cancer Society (ACS) staff in October 2021, five Colorectal Cancer Prevention Network (CCPN) staff in November 2021, and seven members of the CCPN advisory council in January 2022. Interviews were loosely structured based on an interview guide. The four group interviews were conducted virtually via Zoom; interviews were recorded and CARE staff took notes. Themes were drawn from note-based analysis.

Results

INTERVIEW 1: YEAR 1 LEARNING COLLABORATIVE PARTICIPANTS

Six Learning Collaborative participants representing six clinics participated in the group interview. The purpose of the group interview was to understand their experience of the learning collaborative process. Conversation focused heavily on a) participants' expectations of the process prior, b) the most helpful parts of the learning collaborative so far, and c) current and anticipated barriers to colorectal cancer screening. Below are the major takeaways from this conversation:

- Clinics came into the project openminded with little to no expectations
- Clinics find having newfound structure and standardization in their screening process valuable
- Clinics appreciated carving out dedicated time to study their processes
- Clinics found the Learning Collaborative most helpful when working 1:1 with Lisa to unpack their processes; clinics found it most challenging to implement the PDSA cycles to improve these processes
- Clinics expect to continue facing the challenges of staffing and improving their FIT return rates

A table of themes, sub-themes, and examples can be found in the Appendix.

INTERVIEW 2: AMERICAN CANCER SOCIETY STAFF

Four ACS staff who either oversee the project or provide technical assistance to clinics participated in the group interview. The purpose of this interview was to understand a) the historical context of ACS's role providing technical assistance to clinics, b) staff perspectives of the technical assistance provided to Year 1 clinics to-date, c) lessons learned and next steps for Year 2. Below are the major takeaways from this conversation:

- ACS participated in and led Learning Collaboratives in the past and, also have a history of providing Evidence Based Intervention (EBI) technical assistance (TA)
- ACS adapted past experiences to meet criteria for current CDC grant. For example: Now the focus is on quality improvement (QI) instead of EBI implementation and they are incorporating peer-to-peer sharing in addition to individual TA
- The ACS team noticed clinics have struggled with PDSA cycles and think they could help clinics focus on making small tweaks in the process going forward
- The ACS team feels clinics struggle the most with finding time and capacity to implement the PDSA cycles
- Over the next year, ACS plans on "Beefing up" the PDSA content and making processes improvements like including the bootcamp examples in Lucid Chart

INTERVIEW 3: COLORECTAL CANCER PREVENTION NETWORK STAFF

Five CCPN staff who either oversee the project or provide technical assistance to clinics participated in the group interview. The purpose of this interview was to understand a) the context of the grant, b) staff perspectives of the progress made in Year 1, and c) staff's hopes for Year 2. Below are the major takeaways from this conversation:

- CCPN has previous experience collaborating with ACS and providing TA; however, the scope of this project is broader and more intensive (e.g., requires more rigorous evaluation, provides more consistent TA, follows a QI process)
- CCPN used lessons learned from past 5 years to reframe collaboration with clinics as "what can we do for them" instead of treating them like contract employees
- Things went well in Year 1 considering COVID-19; the team had to provide some extra grace to clinics but the clinics all showed up and were able to stick with it
- The most valuable lesson learned from Year 1 was "flexibility"
- There have been hiccups that the team has worked through using QI internally (e.g., budget cuts, participation in Learning Collaborative meetings) and ultimately the model has been a win
- CCPN has big goals for year 2 and are excited to dive deep into CRCS completion rates, to explore with clinics the workflow for positive tests, and to guide clinics through processes they've never looked at before

INTERVIEW 4: CCPN ADVISORY COUNCIL MEMBERS

Seven CCPN advisory council members participated in a group interview in January 2022. The purpose of the interview was to assess the advisory council's perceptions of the CCPN's CDC-funded colorectal cancer screening project and to better understand the relationship between the advisory council and the project. Below are some take-aways from the group interview:

- The advisory council is made up of clinical care providers, colorectal cancer advocates, and folks lending their expertise on cancer prevention from community-based organizations and higher education.
- The advisory council provides 1) input and expertise on coordinating clinical care for the populations and regions of the state in need, 2) expertise and time advocating for policy change in the state legislature, and 3) input on CCPN's projects when needed
- The perceived benefits of membership include data sharing and staying "in the know" about cancer screening projects
- The advisory council thinks that CCPN's CDC-funded colorectal cancer screening project is going well and had no requests for a change in structure or group dynamics

Conclusion

The SC Communities Unite to Increase CRC Screening challenged CCPN and ACS to provide technical assistance and learning collaboratives in new ways. However, both organizations were able to draw from their past experiences and incorporate previous lessons learned. Year 1 was deemed a success by CCPN, ACS, and the clinics- especially considering the challenges of COVID-19. Staff and stakeholders agree that time and clinic staff capacity remain the biggest challenges to project implementation. In Year 2, clinics expect staffing and FIT return rates to be a challenge. ACS is looking forward to enhancing PDSA TA and making small improvements to their TA process. CCPN is looking forward to diving deeper into CRC screening rates and positive test result processes with clinics.

Interview 1: Year 1 Learning Collaborative Participants			
Category	**Theme**	**Sub Themes**	**Examples and/or quote**
Expectations	No expectations	No expectations because this kind of project was new for the health system	
		No expectations because they wanted to be openminded about the process	No expectations but been 'pleasantly surprised'; looking at the data closer made them realize they've been doing things incorrectly
			Wanted to have low expectations so as not to be disappointed (this is not based on prior disappointment)
Biggest takeaway: Clinics came into the project openminded with little-to-no expectations.			
Benefits	Improvements in clinic processes	Pausing in a busy to day to incorporate new processes	"It has forced us to very routinely take that pause and have conversations and talk to doctors in their busy day, to not move mountains but to take small progress."
		Improving documentation	EMR is not the easiest to navigate, people might put data and numbers in some places and other people are putting it in other places; providers did not realize it was not being documented correctly
		More structure in the process	5/11 said process was previously "haphazard"
			Structure to the process is the most important thing gained through this experience
			Standardization across clinics
			Having 1 person in charge of process
	Overcoming barriers	Champions in clinics	Having champions in clinics to snowball efforts
	Progress towards screening goals	Made everyone more aware of what they needed to do to make improvements	Champions had to work harder because screening visits went down since covid visits were going up and taking time away from other types of visits
			Making sure everyone on the team understood the tools for quality improvement. Using those tools to understand whether what is being done is 'value added'
Biggest takeaway: Clinics find having structure and standardization valuable			

The TA process	Most beneficial part of the TA	Slowing down, mapping process out "from top to bottom"	"Forced us to look at exactly how are we getting these patients in to get screened"
		1:1 sessions between Lisa and clinics	More beneficial than group sessions
		Lisa's "dialing in" with them has helped them take the pause necessary to initiate processes.	Lisa's probing the clinics to dig deeper helped them realize variation across clinics.
	Hardest part of TA	Fishbone	Most had prior experience with fishbone but found this experience more helpful
		Swim lanes	Had trouble "wrapping head around" the diagram
		PDSA	"because I was the only one doing it"; the more people you have figuring these things out the easier
			Having to actually change systems in clinics
			Specifically PDSA cycles for getting FIT kits back
			Having the staffing to actually implement
		Being probed to go deeper and deeper into the process (also most beneficial part, see above)	
Biggest takeaway: Clinics found it most helpful when working 1:1 with Lisa to unpack their processes; clinics found it most challenging to implement the PDSA cycles to improve these processes.			

Looking to the future	Challenges	STAFFING	Having staffing to see patients
			Staff to implement PDSA cycles
		Mindset shifts on screening methods	Old providers are old school and want to use colonoscopy which used to be Gold Standard versus FIT testing, never refer for FIT; other provider prefers Cologuard
	Goals	FIT return rate	Improving the process for when patients leave the office; can they possibly mail the FIT kits in?
	Suggestion	More “asynchronous” touchpoints like surveys	A small clinic with few employees finds it difficult to get the clinic-level staff on group calls because they are all needed in the clinic
Biggest takeaway: Clinics expect to continue facing the challenge of staffing and improving their FIT return rates.			