Cancer Screening Learning Collaborative – Evaluation Report

July 2022

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Alliance for Healthier Communities
Alliance pour des communautés en santé

Introduction

The Learning Collaborative (LC) is a short-term learning system that brings together peers from multiple organizations to seek improvement in a focused topic area, with guidance from a coach or practice facilitator. This approach was developed by the Institute for Health Information (IHI)'s Collaborative Model for Achieving Breakthrough Improvement.

The Alliance for Healthier Communities planned and implemented its first LC in 2021, with teams participating from ten Community Health Centres and three Aboriginal Health Access Centres. The first objective of this collaborative was to build quality improvement (QI) knowledge and skills among participating teams. The second objective was to improve cancer screening rates impacted by the COVID-19 backlog by applying QI theory, tools and resources.

Evaluation of this LC was embedded throughout to answer two key questions:

1. Was the learning collaborative implemented as intended?
2. Did the learning collaborative meet its intended objectives?

This report relays a summary of key findings, a description of how the LC was implemented, and detailed results of our evaluation. It also highlights recommendations shared by participating teams and adopted to improve ongoing and future LCs.

Summary of key findings

Key Finding #1: QI Coaches supported teams on their QI journey

All survey respondents reported receiving the support they needed throughout the LC process. Those we interviewed commented on the benefit of having an external person supporting their QI journey. This helped keep their teams on track and encouraged ongoing progress towards their QI milestones.

Here's how one interviewee described the LC:

> *"An intimate QI working group with an external accountability partner"*
> *– LC participant*

Key Finding #2: Teams developed their QI knowledge and skills

Data from the post-capstone survey revealed that for **93%** of respondents, the learning sessions had improved their knowledge of QI; **81%** said they had applied the

knowledge and tools presented during the learning sessions. However, interviews revealed that those with no or limited QI experience sometimes felt overwhelmed by the amount of content being shared. They suggested it would be helpful to receive reading materials prior to learning sessions.

> *"I've done a lot of individual QI things. This by far was the best I've ever done because of the tools and resources available as well as the coach's support. "*
> *– LC participant*

Key Finding #3: Preliminary results indicate improvements in cancer screening rates

Throughout the LC, teams monitored their progress by using a run chart to track changes in their cancer screening rates. These charts were annotated to track key events that could help explain any change in screening rates. These included the implementation of change ideas, such as adding reminders to the Electronic Medical Record (EMR) system, or unforeseen circumstances, such as the hiring of new staff.

All teams worked at their own pace and experienced priority shifts throughout the duration of the LC. Between September 2021 and April 2022, most teams saw their cancer screening rates improve. Many teams are continuing to develop and test change ideas in order to improve even further.

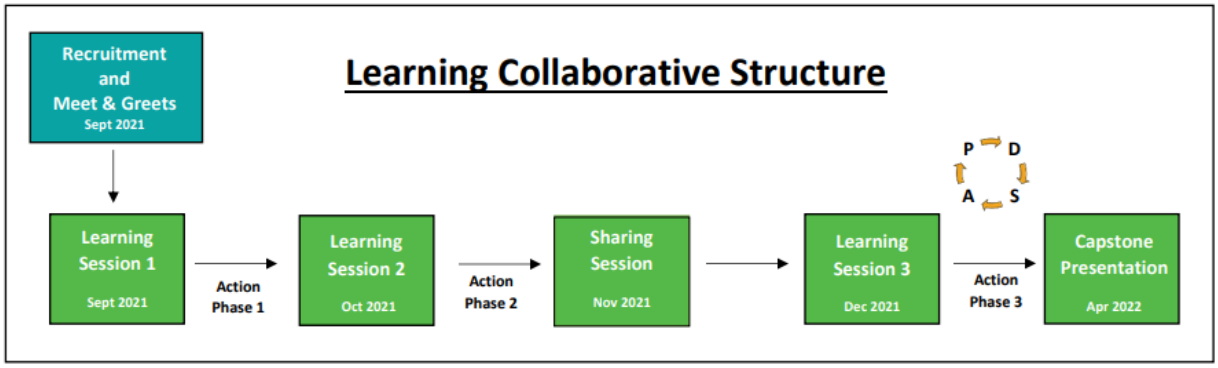
Concluding remarks

Overall, our results suggest that the LC was implemented successfully. It facilitated the learning of QI theory and tools, and centres saw improvement in their cancer screening rates. As the LC was implemented to help move the Alliance and its member centres towards a learning health system, we hope teams continue to use the skills and knowledge gained in other QI work.

Implementing the Learning Collaborative

The first step in implementing this LC was the **selection of a key topic of interest**. This was done in collaboration with Alliance member centres and the Equity, Performance, Improvement, and Change (EPIC) committee, and it took into account emerging evidence and data trends that indicated the existence of a backlog. The second step was developing a formal structure for the LC. This structure is presented in Figure 1.

Figure 1: Learning collaborative structure



Once a topic was developed, member centres were **recruited** through various channels of communication, including news bulletins and mass emails. After centres expressed interest, **meet & greets** were held between each team and their assigned QI coach. In these one-hour meetings, a short introductory presentation clarified what would be involved in the LC. The makeup of teams varied across centres; however, all teams had a QI lead and a combination of healthcare providers, a data management coordinator and administrative staff.

As seen in Figure 1, the meet & greets were followed by **three learning sessions**, in which teams developed their QI knowledge and skills. Each learning session was followed by an **action phase**, during which the teams worked through and applied the QI knowledge and skills they had gained. In the third action phase, teams focused specifically on tests of change, using **Plan, Do, Study, Act (PDSA) cycles** to implement, test, and refine process changes that were intended to lead to improvement.

The **sharing session** and **capstone event** were opportunities for all participating centres to come together to celebrate and share their progress, lessons learned, and key resources they had developed or used.

As they progressed through these sessions and phases, each team was **supported by an assigned QI coach**, who attended team meetings and provided feedback and support where needed.

Evaluation

The evaluation of this LC employed both developmental and implementation approaches, which included the following data collection methods:

Surveys were disseminated to LC members after each learning session* and were used for ongoing improvement. A final survey was shared after the capstone presentation and was completed by 20 participants (27% response rate).

Interviews were conducted with all four QI coaches to evaluate and improve the processes involved in the planning and implementation of future LCs. Interviews were also conducted with four participants from three LC teams to expand on survey feedback. Based on participation, teams were categorized as *very engaged* and *minimally engaged*. An attempt was made to include teams from both categories in order to better gauge what worked well and identify areas for improvement.

Team-based run charts (outcome measure): All participating teams created monthly run charts to monitor their cancer screening rates over time. These charts were created using EMR data and compiled by the QI coaches each month. Some teams took their data from the Alliance's Business Intelligence Reporting Tool (BIRT), a sector-wide platform that collects and aggregates EMR data. Others took it directly from their EMR using JReports, a third-party reporting tool.

**Please note that the survey data is not presented in this report.*

Results

Was the learning collaborative implemented as intended?

QI Coach Perspective

QI coaches described the meet and greets as an excellent opportunity to start building relationships and get a sense of each team's experience with QI as well as their capacity to participate in the LC. However, they suggested greater clarity was needed on the role of the coach and how teams could utilize them as a resource. Not all teams engaged equally with their coaches, and those who engaged more regularly with their coaches were the most successful. These teams made use of QI skills, methods and tools; tested multiple change ideas; and saw improvements in screening rates. Furthermore, coaches told us that emphasizing the importance of having staff on the team with diverse roles can help ensure that all relevant perspectives are included in discussions.

> *"One major benefit of the collaborative was how diverse staff were brought together and given an equal voice in solving the problem. For example, having admin staff provide their perspective to physicians, nurses and management staff at the centre was crucial in increasing screening rates."*
> *– QI coach*

Coaches felt they facilitated the learning sessions well, but that the amount of content to be covered in each session limited the number of breakout sessions possible. In addition, they told us that having longer action phases would enable teams to spend more time on applying the QI tools and methodologies covered in the learning sessions, as well as testing their change ideas.

LC Participant Perspective

LC participants highlighted that conducting the LC virtually fostered inter-team collaboration. This helped facilitate co-learning and sharing of ideas among participating centres. They also described breakout sessions as extremely helpful in learning how to apply and use QI tools, such as the fishbone diagram.

From our survey data, **83%** of respondents agreed that the sharing session was a useful component of the LC and requested that future LCs include more of them. Interviewees commented that the sharing session allowed teams to learn from others. They were then able to adapt those learnings to their own centres' unique contexts. All

interviewees reported that the sharing session left them feeling validated, knowing other centres had experienced similar issues.

> *"I really like the sharing sessions. It is interesting to hear how others worked through their difficulties. Some of those ideas may help in our health centre as well."*
> *– LC participant*

The majority of survey respondents **(77%)** reported that their level of engagement with the LC and QI work was *very engaged*. However, interviews revealed that not all members of a team were equally able to participate. Primary care staff had a difficult time attending sessions due to competing priorities such as clinic hours or redeployment for COVID-related work.

All respondents (**100%**) felt they had received the support they needed throughout the LC process. During interviews, coaches were described as invaluable in helping generate constructive discussions between team members, re-framing challenges and providing overall support.

> *"Even though our centre had experience with QI, having the coach's support was a huge advantage."*
> *– LC participant*
>
> *"The most value came from our QI coach attending our team meetings and providing feedback, adding thoughts and redirecting gently as needed. Their input throughout our ongoing generative discussion, troubleshooting and planning was key to the success of our team making forward movement with our process and PDSAs."*
> *– LC participant*

Interviewees also repeatedly described the coaches as external accountability partners and expressed wanting ongoing check-ins with their coaches to help ensure continuation of their QI work.

> *"The way the learning collaborative was set up with learning sessions and QI coaching really helped us to keep on track. It helped our own group to continue working behind the scenes, knowing we would have more touch points and an external person [QI coach] to help keep us accountable. Going through this solidified our need to keep our goals small to keep the work moving forward."*
> *– LC participant*
>
> *"I would love to continue having access to QI coaching no matter what QI project we have on the go. They are amazing and very knowledgeable with the QI work."*
> *– LC participant*

Did the learning collaborative meet its intended objectives?

Objective #1 - Build quality improvement knowledge and skills

Our survey data revealed that for **93%** of respondents, the learning sessions had improved their knowledge of QI, and **81%** reported that they applied the knowledge and tools presented during the learning sessions. Even participants who had done previous QI work expressed that they had learned new approaches and tools.

> "The biggest take home message is the PDSA. So test a small change, evaluate the results whether positive or negative, and make changes.
> Centres often hear a concern from staff and make a big process change without even considering a small test of change."
> - LC participant

However, teams with no or limited QI experience found the amount of material covered in the sessions was a bit overwhelming, especially when they were introduced to the various QI tools and approaches. They felt it would be helpful to have practical examples for each tool and approach discussed. One team suggested receiving reading materials/resources prior to each learning session, so they could be better prepared.

Objective #2 - Improvement in cancer screening rates

QI teams pulled their screening data into monthly run charts, and they annotated any key occurrences to help explain cancer screening rate changes. For example, they might note that a change idea was implemented or a new staff member was hired.

Of the thirteen teams who signed up for the LC, ten participated in all learning and sharing sessions. These teams developed a variety of QI objectives:

- Six teams chose to work on improving all cancer screening rates.
- Three teams chose to focus on improving screening rates for colorectal cancer.
- One team chose to focus on improving screening rates for cervical cancer.

Six of the ten teams who participated through the entire LC saw improvements in their rates. Change ideas that helped improve rates include:

- Identifying clients who were due for screening.
- Stratifying screening rates by race/ethnicity to tailor outreach to those who had never been screened or were overdue.
- Adding reminders in the Electronic Medical Record (EMR).

- Providing quarterly reports on screening performance to providers.
- Creating a client script to educate on the benefits of screening.
- Running and sharing regular lists with providers and office staff.
- Conducting data audits to ensure accuracy of entry.

Overall, most teams saw improvement in their screening rates or began to. This is exemplified in figures 2 and 3, below, which show the progress made by two teams.

Figure 2: Cervical cancer screening rates, 2019-2022

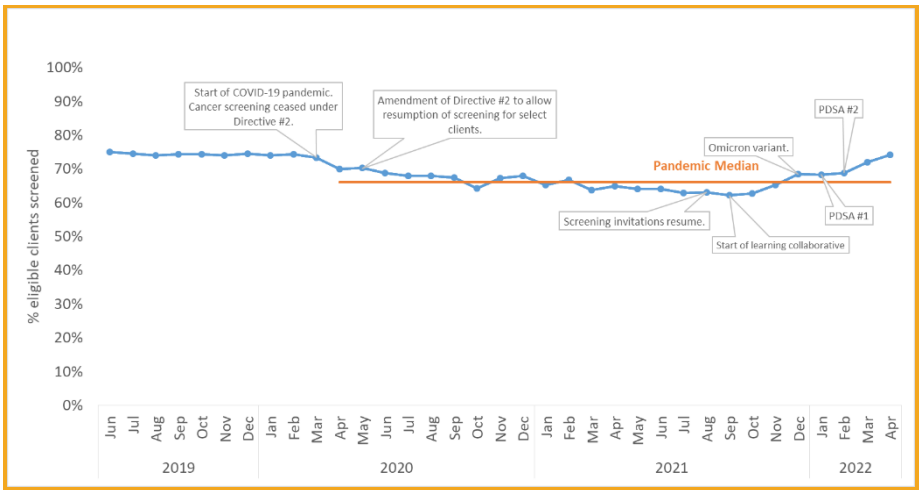
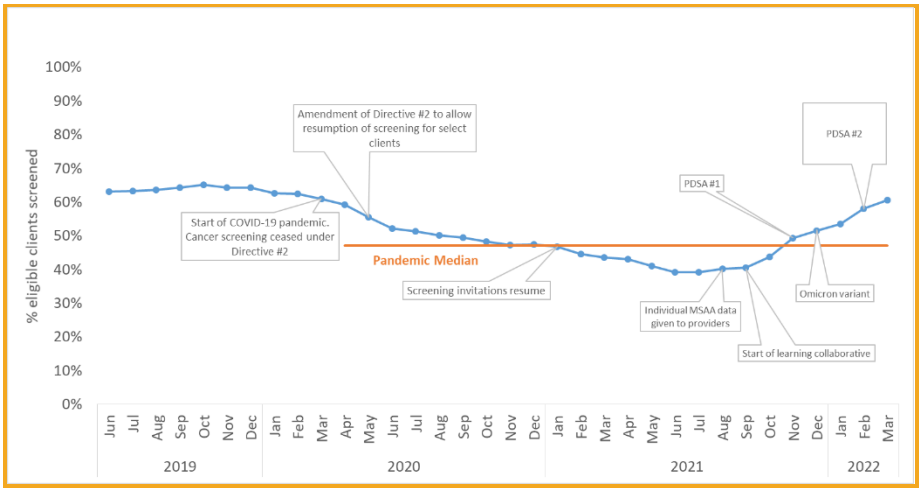


Figure 3: Breast cancer screening rate, 2019-2022



Recommendations

Using the findings from our evaluation, we have incorporated the following recommendations to improve our LCs:

Recommendation	Action
Clarify what's involved when joining the LC.	➔ Recruitment materials now include additional details regarding expectations, who should be on the team, time commitments, and format of the LC.
Encourage teams to engage with their QI coaches.	➔ To encourage engagement, the meet and greet presentation highlights the many benefits of engaging with the QI coach and suggestions on how to do so.
Need for additional data management support.	➔ The Alliance's provincial data management coordinator (DMC) has been included in the planning of the next LC to answer all EMR-related inquiries.
Create space to clarify content covered during learning sessions.	➔ To ensure the teams understand the material presented during learning sessions, QI coaches have been encouraged to gather feedback after each session, and follow up with any additional explanation.
Increase number of sharing sessions.	➔ Additional sharing sessions have been incorporated into the LC structure to further facilitate co-learning and sharing amongst teams.
Increase knowledge of member centres experience with QI.	➔ QI coaches have improved efforts to better understand the QI experience among member centres. This will allow better facilitation of the learning sessions and team meetings.
Increase knowledge of data and measurement.	➔ To ensure teams understand the importance of data in quality improvement, an additional session related to QI measurement has been added prior to the first learning session.
Increase length of the learning collaborative.	➔ Based on the timeline of first learning collaborative, additional time has been added to allow additional time for teams to action the QI knowledge and skills they gain in the learning sessions.

Advice for future Learning Collaborative teams

Below is a summary of advice shared by both QI coaches and LC participants, for teams who participate in future LCs:

- Schedule team meetings well in advance to support moving the work forward.
- Encourage teams to engage with coach regularly and invite them to meetings.
- Have diverse staff on your team to ensure a variety of perspectives are included.
- Keep the scope and your change ideas small and achievable.
- Trust the process. Take it slow, and ensure you've taken sufficient time to determine the root cause before implementing solutions.

Next steps

The second Alliance LC launched in June 2022. We have adapted the model as described above, incorporating changes recommended by teams who participated in the first LC. We will continue to evaluate this and future LCs to support continuous improvement in this program. We are also using what we have learned so far to develop a quick guide to learning collaboratives, to be used across the sector.

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