

Appendix A. Methods

Search Strategies for Published Literature

Table A-1. Guiding Question 1 PubMed search strategy

#	String
1	"framework"[Title/Abstract]
2	"theory"[Title/Abstract]
3	"theory of change"[Title/Abstract]
4	"logistical framework"[Title/Abstract]
5	"log frame"[Title/Abstract]
6	#1 OR #2 OR #3 OR #4 OR #5
7	"medical oncology"[MeSH Terms]
8	"Early Detection of Cancer"[MeSH Terms]
9	"biomarkers, tumor"[MeSH Terms]
10	"Cancer Care Facilities"[MeSH Terms]
11	"oncology service, hospital"[MeSH Terms]
12	"Cancer Screening"[Title/Abstract]
13	"Cancer Early Detection"[Title/Abstract]
14	"Early Diagnosis of Cancer"[Title/Abstract]
15	"cancer early diagnos**"[Title/Abstract]
16	"tumor biomarker**"[Title/Abstract]
17	"biologic tumor marker**"[Title/Abstract]
18	"cancer biomarker**"[Title/Abstract]
19	"cancer care facilit**"[Title/Abstract]
20	"cancer hospital**"[Title/Abstract]
21	"hospital oncology service**"[Title/Abstract]
22	"cancer care unit**"[Title/Abstract]
23	"medical oncology"[Title/Abstract]
24	"cancer care delivery"[Title/Abstract]
25	#7 OR #8 OR #9 OR #10 OR #11 OR #12 OR #13 OR #14 OR #15 OR #16 OR #17 OR #18 OR #19 OR #20 OR #21 OR #22 OR #23 OR #24
26	2010/01/01:3000/12/31[Date - Publication]
27	"English"[Language]
28	"animals"[MeSH Terms]
29	"humans"[MeSH Terms]
30	(#26 AND #27) NOT (#28 NOT #29)
31	#6 AND #25 AND #30

Table A-2. Guiding Question 2 and Guiding Question 3 PubMed search strategy

#	String
1	"Organizational Culture"[MeSH Terms]
2	"Organizational Characteristics"[Title/Abstract]
3	"organizational innovation"[MeSH Terms]
4	"Leadership"[MeSH Terms]
5	"organization and administration"[MeSH Terms:noexp]
6	"knowledge management"[MeSH Terms]
7	"crew resource management, healthcare"[MeSH Terms]
8	"Health Workforce"[MeSH Terms]
9	"efficiency, organizational"[MeSH Terms]
10	"quality assurance, health care"[MeSH Terms:noexp]
11	"Health Resources"[MeSH Terms]
12	"Organization structure"[Title/Abstract]
13	"Organizational structure"[Title/Abstract]
14	"Structural characteristics"[Title/Abstract]

#	String
15	"Organization context"[Title/Abstract]
16	"Organizational context"[Title/Abstract]
17	"Organization climate"[Title/Abstract]
18	"Organizational climate"[Title/Abstract]
19	"Care coordination"[Title/Abstract]
20	"Organization design"[Title/Abstract]
21	"Organizational design"[Title/Abstract]
22	"Organization learning"[Title/Abstract]
23	"Organizational learning"[Title/Abstract]
24	"Organizational change"[Title/Abstract]
25	"Organization change"[Title/Abstract]
26	"Teamwork"[Title/Abstract]
27	"team work"[Title/Abstract]
28	"Team processes"[Title/Abstract]
29	"Team norms"[Title/Abstract]
30	"Team performance"[Title/Abstract]
31	("Team"[Title/Abstract] AND "coordination"[Title/Abstract])
32	("Team"[Title/Abstract] AND "communication"[Title/Abstract])
33	"organizational performance"[Title/Abstract]
34	"organization performance"[Title/Abstract]
35	"Program Evaluation"[MeSH Terms]
36	"Program Evaluation"[MeSH Terms]
37	"care delivery"[Title/Abstract]
38	"decision making, organizational"[MeSH Terms]
39	"Efficiency"[MeSH Terms]
40	"Health Facility Administration"[MeSH Terms]
41	"Hospital Administration"[MeSH Terms]
42	"Institutional Management Teams"[MeSH Terms]
43	"Management Information Systems"[MeSH Terms]
44	"Military Health Services"[MeSH Terms]
45	"models, organizational"[MeSH Terms]
46	"Multi-Institutional Systems"[MeSH Terms]
47	"Organizational Affiliation"[MeSH Terms]
48	"ownership"[MeSH Terms]
49	"Employee Incentive Plans"[MeSH Terms]
50	"Leadership"[MeSH Terms]
51	"Management Quality Circles"[MeSH Terms]
52	"personnel administration, hospital"[MeSH Terms]
53	"Personnel Delegation"[MeSH Terms]
54	"Personnel Downsizing"[MeSH Terms]
55	"Personnel Loyalty"[MeSH Terms]
56	"Personnel Selection"[MeSH Terms]
57	"Personnel Staffing and Scheduling"[MeSH Terms]
58	"Personnel Turnover"[MeSH Terms]
59	"Physician Incentive Plans"[MeSH Terms]
60	"Staff Development"[MeSH Terms]
61	"Work Engagement"[MeSH Terms]
62	"Workplace"[MeSH Terms]
63	"Strategic Planning"[MeSH Terms]
64	"Professional Practice"[MeSH Terms]
65	"Community-Institutional Relations"[MeSH Terms]
66	"Hospital-Patient Relations"[MeSH Terms]
67	"Hospital-Physician Relations"[MeSH Terms]
68	"Interdepartmental Relations"[MeSH Terms]
69	"Interinstitutional Relations"[MeSH Terms]
70	"Patient Satisfaction"[MeSH Terms]
71	"Risk Management"[MeSH Terms:noexp]
72	"shared governance, nursing"[MeSH Terms]

#	String
73	"Total Quality Management"[MeSH Terms]
74	"alert fatigue, health personnel"[MeSH Terms]
75	"benchmarking"[MeSH Terms]
76	"medical audit"[MeSH Terms]
77	"Nursing Audit"[MeSH Terms]
78	"near miss, healthcare"[MeSH Terms]
79	"Potentially Inappropriate Medication List"[MeSH Terms]
80	"Total Quality Management"[MeSH Terms]
81	"accreditation"[MeSH Terms]
82	"Pharmacy and Therapeutics Committee"[MeSH Terms]
83	"Public Reporting of Healthcare Data"[MeSH Terms]
84	"quality management"[Title/Abstract]
85	"Healthcare Quality Assurance"[Title/Abstract]
86	"Administration and Organization"[Title/Abstract]
87	#1 OR #2 OR #3 OR #4 OR #5 OR #6 OR #7 OR #8 OR #9 OR #10 OR #11 OR #12 OR #13 OR #14 OR #15 OR #16 OR #17 OR #18 OR #19 OR #20 OR #21 OR #22 OR #23 OR #24 OR #25 OR #26 OR #27 OR #28 OR #29 OR #30 OR #31 OR #32 OR #33 OR #34 OR #35 OR #36 OR #37 OR #38 OR #39 OR #40 OR #41 OR #42 OR #43 OR #44 OR #45 OR #46 OR #47 OR #48 OR #49 OR #50 OR #51 OR #52 OR #53 OR #54 OR #55 OR #56 OR #57 OR #58 OR #59 OR #60 OR #61 OR #62 OR #63 OR #64 OR #65 OR #66 OR #67 OR #68 OR #69 OR #70 OR #71 OR #72 OR #73 OR #74 OR #75 OR #76 OR #77 OR #78 OR #79 OR #80 OR #81 OR #82 OR #83 OR #84 OR #85 OR #86
88	"medical oncology"[MeSH Terms]
89	"Early Detection of Cancer"[MeSH Terms]
90	"biomarkers, tumor"[MeSH Terms]
91	"Cancer Care Facilities"[MeSH Terms]
92	"oncology service, hospital"[MeSH Terms]
93	"Cancer Screening"[Title/Abstract]
94	"Cancer Early Detection"[Title/Abstract]
95	"Early Diagnosis of Cancer"[Title/Abstract]
96	"cancer early diagnos*"[Title/Abstract]
97	"tumor biomarker*"[Title/Abstract]
98	"biologic tumor marker*"[Title/Abstract]
99	"cancer biomarker*"[Title/Abstract]
100	"cancer care facilit*"[Title/Abstract]
101	"cancer hospital*"[Title/Abstract]
102	"hospital oncology service*"[Title/Abstract]
103	"cancer care unit*"[Title/Abstract]
104	"medical oncology"[Title/Abstract]
105	"cancer care delivery"[Title/Abstract]
106	#88 OR #89 OR #90 OR #91 OR #92 OR #93 OR #94 OR #95 OR #96 OR #97 OR #98 OR #99 OR #100 OR #101 OR #102 OR #103 OR #104 OR #105
107	2010/01/01:3000/12/31[Date - Publication]
108	"English"[Language]
109	"animals"[MeSH Terms]
110	"humans"[MeSH Terms]
111	(#107 AND #108) NOT (#109 NOT #110)
112	"review"[Publication Type]
113	"guideline"[Publication Type]
114	"practice guideline"[Publication Type]
115	"literature-review"[Title]
116	"systematic-review"[Publication Type]
117	"meta-analysis"[Publication Type]
118	"systematic-review"[Title]
119	"systematic-literature-review"[Title]
120	"scoping-review"[Title]
121	"cochrane-review"[Title]
122	"meta-analysis"[Title]
123	"meta-analysis"[Title]
124	"address"[Publication Type]

#	String
125	"autobiography"[Publication Type]
126	"bibliography"[Publication Type]
127	"biography"[Publication Type]
128	"comment"[Publication Type]
129	"dictionary"[Publication Type]
130	"directory"[Publication Type]
131	"lecture"[Publication Type]
132	"legal case"[Publication Type]
133	"legislation"[Publication Type]
134	"news"[Publication Type]
135	"newspaper article"[Publication Type]
136	"patient education handout"[Publication Type]
137	"periodical index"[Publication Type]
138	#112 OR #113 OR #114 OR #115 OR #116 OR #117 OR #118 OR #119 OR #120 OR #121 OR #122 OR #123 OR #124 OR #125 OR #126 OR #127 OR #128 OR #129 OR #130 OR #131 OR #132 OR #133 OR #134 OR #135 OR #136 OR #137
139	#87 AND #106 AND #111 NOT #138

Table A-3. Guiding Question 1 CINAHL and PsycInfo search strategy

#	CINAHL/Psycinfo
1	TI("framework" OR "theory" OR "theory of change" OR "logistical framework" OR "log frame")
2	AB("framework" OR "theory" OR "theory of change" OR "logistical framework" OR "log frame")
3	#1 OR #2
4	MM("medical oncology" OR "Early Detection of Cancer" OR "biomarkers, tumor" OR "Cancer Care Facilities" OR "oncology service, hospital")
5	TI("Cancer Screening" OR "Cancer Early Detection" OR "Early Diagnosis of Cancer" OR "cancer early diagnos*" OR "tumor biomarker*" OR "biologic tumor marker*" OR "cancer biomarker*" OR "cancer care facilit*" OR "cancer hospital*" OR "hospital oncology service*" OR "cancer care unit*" OR "medical oncology" OR "cancer care delivery")
6	AB("Cancer Screening" OR "Cancer Early Detection" OR "Early Diagnosis of Cancer" OR "cancer early diagnos*" OR "tumor biomarker*" OR "biologic tumor marker*" OR "cancer biomarker*" OR "cancer care facilit*" OR "cancer hospital*" OR "hospital oncology service*" OR "cancer care unit*" OR "medical oncology" OR "cancer care delivery")
7	#4 OR #5 OR #6
8	LA(English)
9	MM (Animals NOT human)
10	#6 NOT #7
11	#3 AND #7 AND #10
12	Date limit 2010 - present

Table A-4. Guiding Question 2 and Guiding Question 3 CINAHL and PsycInfo search strategy

#	CINAHL/Psycinfo
1	MM("Leadership" OR "knowledge management" OR "crew resource management, healthcare" OR "Health Workforce" OR "efficiency, organizational" OR "Health Resources" OR "Program Evaluation" OR "Program Evaluation" OR "decision making, organizational" OR "Efficiency" OR "Health Facility Administration" OR "Hospital Administration" OR "Institutional Management Teams" OR "Management Information Systems" OR "Military Health Services" OR "models, organizational" OR "Multi-Institutional Systems" OR "Organizational Affiliation" OR "ownership" OR "Employee Incentive Plans" OR "Leadership" OR "Management Quality Circles" OR "personnel administration, hospital" OR "Personnel Delegation" OR "Personnel Downsizing" OR "Personnel Loyalty" OR "Personnel Selection" OR "Personnel Staffing and Scheduling" OR "Personnel Turnover" OR "Physician Incentive Plans" OR "Staff Development" OR "Work Engagement" OR "Workplace" OR "Strategic Planning" OR "Professional Practice" OR "Community-Institutional Relations" OR "Hospital-Patient Relations" OR "Hospital-Physician Relations" OR "Interdepartmental Relations" OR "Interinstitutional Relations" OR "Patient Satisfaction" OR "shared governance, nursing" OR "Total Quality Management" OR "alert fatigue, health personnel" OR "benchmarking" OR "medical audit" OR "Nursing Audit" OR "near miss, healthcare" OR "Potentially Inappropriate Medication List" OR "Total Quality Management" OR "accreditation" OR "Pharmacy and Therapeutics Committee" OR "Public Reporting of Healthcare Data" OR "organization and administration" OR "quality assurance, health care" OR "Risk Management")
2	TI("Organizational Characteristics" OR "Organization structure" OR "Organizational structure" OR "Structural characteristics" OR "Organization context" OR "Organizational context" OR "Organization climate" OR "Organizational climate" OR "Care coordination" OR "Organization design" OR "Organizational design" OR "Organization learning" OR "Organizational learning" OR "Organizational change" OR "Organization change" OR "Teamwork" OR "team work" OR "Team processes" OR "Team norms" OR "Team performance" OR ("Team" AND "coordination") OR ("Team" AND "communication") OR "organizational performance" OR "organization performance" OR "care delivery" OR "quality management" OR "Healthcare Quality Assurance" OR "Administration and Organization")
3	AB("Organizational Characteristics" OR "Organization structure" OR "Organizational structure" OR "Structural characteristics" OR "Organization context" OR "Organizational context" OR "Organization climate" OR "Organizational climate" OR "Care coordination" OR "Organization design" OR "Organizational design" OR "Organization learning" OR "Organizational learning" OR "Organizational change" OR "Organization change" OR "Teamwork" OR "team work" OR "Team processes" OR "Team norms" OR "Team performance" OR ("Team" AND "coordination") OR ("Team" AND "communication") OR "organizational performance" OR "organization performance" OR "care delivery" OR "quality management" OR "Healthcare Quality Assurance" OR "Administration and Organization")
4	#1 OR #2 OR #3
5	MM("medical oncology" OR "Early Detection of Cancer" OR "biomarkers, tumor" OR "Cancer Care Facilities" OR "oncology service, hospital")
6	TI("Cancer Screening" OR "Cancer Early Detection" OR "Early Diagnosis of Cancer" OR "cancer early diagnos*" OR "tumor biomarker*" OR "biologic tumor marker*" OR "cancer biomarker*" OR "cancer care facilit*" OR "cancer hospital*" OR "hospital oncology service*" OR "cancer care unit*" OR "medical oncology" OR "cancer care delivery")
7	AB("Cancer Screening" OR "Cancer Early Detection" OR "Early Diagnosis of Cancer" OR "cancer early diagnos*" OR "tumor biomarker*" OR "biologic tumor marker*" OR "cancer biomarker*" OR "cancer care facilit*" OR "cancer hospital*" OR "hospital oncology service*" OR "cancer care unit*" OR "medical oncology" OR "cancer care delivery")
8	#5 OR #6 OR #7
9	LA(English)
10	MM (Animals NOT human)
10	#9 NOT #10
11	#4 AND #8 AND #11
12	Date limit 2010 - present
13	PT("review" OR "guideline" OR "practice guideline" OR "systematic-review" OR "meta-analysis" OR "address" OR "autobiography" OR "bibliography" OR "biography" OR "comment" OR "dictionary" OR "directory" OR "lecture" OR "legal case" OR "legislation" OR "news" OR "newspaper article" OR "patient education handout" OR "periodical index")

#	CINAHL/Psycinfo
14	TI("systematic-review" OR "systematic-literature-review" OR "scoping-review" OR "cochrane-review" OR "meta-analysis" OR "meta-analysis" OR "literature-review")
15	#13 OR #14
16	#12 NOT #15

Table A-5. Guiding Question 1 SCOPUS search strategy

#	SCOPUS
1	TITLE-ABS-KEY ("framework" OR "theory" OR "theory of change" OR "logistical framework" OR "log frame")
2	TITLE-ABS-KEY ("Cancer Screening" OR "Cancer Early Detection" OR "Early Diagnosis of Cancer" OR "cancer early diagnos*" OR "tumor biomarker*" OR "biologic tumor marker*" OR "cancer biomarker*" OR "cancer care facilit*" OR "cancer hospital*" OR "hospital oncology service*" OR "cancer care unit*" OR "medical oncology" OR "cancer care delivery")
3	#1 AND #2
4	LANGUAGE(English)
5	#1 AND #2 AND #4
7	Date limit 2010 - present

Table A-6. Guiding Question 2 and Guiding Question 3 SCOPUS search strategy

#	SCOPUS
1	TITLE-ABS-KEY ("Organizational Characteristics" OR "Organization structure" OR "Organizational structure" OR "Structural characteristics" OR "Organization context" OR "Organizational context" OR "Organization climate" OR "Organizational climate" OR "Care coordination" OR "Organization design" OR "Organizational design" OR "Organization learning" OR "Organizational learning" OR "Organizational change" OR "Organization change" OR "Teamwork" OR "team work" OR "Team processes" OR "Team norms" OR "Team performance" OR ("Team" AND "coordination") OR ("Team" AND "communication") OR "organizational performance" OR "organization performance" OR "care delivery" OR "quality management" OR "Healthcare Quality Assurance" OR "Administration and Organization")
2	TITLE-ABS-KEY ("Cancer Screening" OR "Cancer Early Detection" OR "Early Diagnosis of Cancer" OR "cancer early diagnos*" OR "tumor biomarker*" OR "biologic tumor marker*" OR "cancer biomarker*" OR "cancer care facilit*" OR "cancer hospital*" OR "hospital oncology service*" OR "cancer care unit*" OR "medical oncology" OR "cancer care delivery")
3	#1 AND #2
4	LANGUAGE(English)
5	#1 AND #2 AND #4
	PT("review" OR "guideline" OR "practice guideline" OR "systematic-review" OR "meta-analysis" OR "address" OR "autobiography" OR "bibliography" OR "biography" OR "comment" OR "dictionary" OR "directory" OR "lecture" OR "legal case" OR "legislation" OR "news" OR "newspaper article" OR "patient education handout" OR "periodical index")
	TITLE("systematic-review" OR "systematic-literature-review" OR "scoping-review" OR "cochrane-review" OR "meta-analysis" OR "meta-analysis" OR "literature-review")
	#13 OR #14
	#12 NOT #15
6	Date limit 2010 - present

Table A-7. Guiding Question 1 Cochrane search strategy

#	Cochrane
1	TI("framework" OR "theory" OR "theory of change" OR "logistical framework" OR "log frame")
2	AB("framework" OR "theory" OR "theory of change" OR "logistical framework" OR "log frame")
3	#1 OR #2
4	"medical oncology"[MeSH Terms]
5	"Early Detection of Cancer"[MeSH Terms]
6	"biomarkers, tumor"[MeSH Terms]
7	"Cancer Care Facilities"[MeSH Terms]
8	"oncology service, hospital"[MeSH Terms]

#	Cochrane
9	TI("Cancer Screening" OR "Cancer Early Detection" OR "Early Diagnosis of Cancer" OR "cancer early diagnos*" OR "tumor biomarker*" OR "biologic tumor marker*" OR "cancer biomarker*" OR "cancer care facilit*" OR "cancer hospital*" OR "hospital oncology service*" OR "cancer care unit*" OR "medical oncology" OR "cancer care delivery")
10	AB("Cancer Screening" OR "Cancer Early Detection" OR "Early Diagnosis of Cancer" OR "cancer early diagnos*" OR "tumor biomarker*" OR "biologic tumor marker*" OR "cancer biomarker*" OR "cancer care facilit*" OR "cancer hospital*" OR "hospital oncology service*" OR "cancer care unit*" OR "medical oncology" OR "cancer care delivery")
11	#4 OR #5 OR #6 OR #7 OR #8 OR #9 OR #10
12	#1 AND #2
13	LG(English)
14	"animals"[MeSH Terms]
15	"humans"[MeSH Terms]
16	#13 NOT (#14 NOT #15)
17	
18	Date limit 2010 - present

Table A-8. Guiding Question 2 and Guiding Question 3 Cochrane search strategy

#	Cochrane
1	AB("Organizational Characteristics" OR #"Organization structure" OR #"Organizational structure" OR #"Structural characteristics" OR #"Organization context" OR #"Organizational context" OR #"Organization climate" OR #"Organizational climate" OR #"Care coordination" OR #"Organization design" OR #"Organizational design" OR #"Organization learning" OR #"Organizational learning" OR #"Organizational change" OR #"Organization change" OR #"Teamwork" OR #"team work" OR #"Team processes" OR #"Team norms" OR #"Team performance" OR #("Team" AND "coordination") OR #("Team" AND "communication") OR #"organizational performance" OR #"organization performance" OR #"care delivery" OR #"quality management" OR #"Healthcare Quality Assurance" OR #"Administration and Organization")
2	TI("Organizational Characteristics" OR #"Organization structure" OR #"Organizational structure" OR #"Structural characteristics" OR #"Organization context" OR #"Organizational context" OR #"Organization climate" OR #"Organizational climate" OR #"Care coordination" OR #"Organization design" OR #"Organizational design" OR #"Organization learning" OR #"Organizational learning" OR #"Organizational change" OR #"Organization change" OR #"Teamwork" OR #"team work" OR #"Team processes" OR #"Team norms" OR #"Team performance" OR #("Team" AND "coordination") OR #("Team" AND "communication") OR #"organizational performance" OR #"organization performance" OR #"care delivery" OR #"quality management" OR #"Healthcare Quality Assurance" OR #"Administration and Organization")
3	#1 OR #2
4	MeSH descriptor: [Organizational Culture] explode all trees
5	MeSH descriptor: [organizational innovation] explode all trees
6	MeSH descriptor: [Leadership] explode all trees
7	MeSH descriptor: [knowledge management] explode all trees
8	MeSH descriptor: [crew resource management, healthcare] explode all trees
9	MeSH descriptor: [Health Workforce] explode all trees
10	MeSH descriptor: [efficiency, organizational] explode all trees
11	MeSH descriptor: [Health Resources] explode all trees
12	MeSH descriptor: [Program Evaluation] explode all trees
13	MeSH descriptor: [decision making, organizational] explode all trees
14	MeSH descriptor: [Efficiency] explode all trees
15	MeSH descriptor: [Health Facility Administration] explode all trees
16	MeSH descriptor: [Hospital Administration] explode all trees
17	MeSH descriptor: [Institutional Management Teams] explode all trees
18	MeSH descriptor: [Management Information Systems] explode all trees
19	MeSH descriptor: [Military Health Services] explode all trees
20	MeSH descriptor: [models, organizational] explode all trees
21	MeSH descriptor: [Multi-Institutional Systems] explode all trees
22	MeSH descriptor: [Organizational Affiliation] explode all trees
23	MeSH descriptor: [ownership] explode all trees
24	MeSH descriptor: [Employee Incentive Plans] explode all trees
25	MeSH descriptor: [Management Quality Circles] explode all trees

#	Cochrane
26	MeSH descriptor: [personnel administration, hospital] explode all trees
27	MeSH descriptor: [Personnel Delegation] explode all trees
28	MeSH descriptor: [Personnel Downsizing] explode all trees
29	MeSH descriptor: [Personnel Loyalty] explode all trees
30	MeSH descriptor: [Personnel Selection] explode all trees
31	MeSH descriptor: [Personnel Staffing and Scheduling] explode all trees
32	MeSH descriptor: [Personnel Turnover] explode all trees
33	MeSH descriptor: [Physician Incentive Plans] explode all trees
34	MeSH descriptor: [Staff Development] explode all trees
35	MeSH descriptor: [Work Engagement] explode all trees
36	MeSH descriptor: [Workplace] explode all trees
37	MeSH descriptor: [Strategic Planning] explode all trees
38	MeSH descriptor: [Professional Practice] explode all trees
39	MeSH descriptor: [Community-Institutional Relations] explode all trees
40	MeSH descriptor: [Hospital-Patient Relations] explode all trees
41	MeSH descriptor: [Hospital-Physician Relations] explode all trees
42	MeSH descriptor: [Interdepartmental Relations] explode all trees
43	MeSH descriptor: [Interinstitutional Relations] explode all trees
44	MeSH descriptor: [Patient Satisfaction] explode all trees
45	MeSH descriptor: [shared governance, nursing] explode all trees
46	MeSH descriptor: [Total Quality Management] explode all trees
47	MeSH descriptor: [alert fatigue, health personnel] explode all trees
48	MeSH descriptor: [benchmarking] explode all trees
49	MeSH descriptor: [medical audit] explode all trees
50	MeSH descriptor: [Nursing Audit] explode all trees
51	MeSH descriptor: [near miss, healthcare] explode all trees
52	MeSH descriptor: [Potentially Inappropriate Medication List] explode all trees
53	MeSH descriptor: [accreditation] explode all trees
54	MeSH descriptor: [Pharmacy and Therapeutics Committee] explode all trees
55	MeSH descriptor: [Public Reporting of Healthcare Data] explode all trees
56	MeSH descriptor: [organization and administration] do not explode all trees
57	MeSH descriptor: [quality assurance, health care] do not explode all trees
58	MeSH descriptor: [Risk Management] do not explode all trees
59	#4 OR #5 OR #6 OR #7 OR #8 OR #9 OR #10 OR #11 OR #12 OR #13 OR #14 OR #15 OR #16 OR #17 OR #18 OR #19 OR #20 OR #21 OR #22 OR #23 OR #24 OR #25 OR #26 OR #27 OR #28 OR #29 OR #30 OR #31 OR #32 OR #33 OR #34 OR #35 OR #36 OR #37 OR #38 OR #39 OR #40 OR #41 OR #42 OR #43 OR #44 OR #45 OR #46 OR #47 OR #48 OR #49 OR #50 OR #51 OR #52 OR #53 OR #54 OR #55 OR #56 OR #57 OR #58
60	#3 AND #59
61	"medical oncology"[MeSH Terms]
62	"Early Detection of Cancer"[MeSH Terms]
63	"biomarkers, tumor"[MeSH Terms]
64	"Cancer Care Facilities"[MeSH Terms]
65	"oncology service, hospital"[MeSH Terms]
66	TI("Cancer Screening" OR "Cancer Early Detection" OR "Early Diagnosis of Cancer" OR "cancer early diagnos*" OR "tumor biomarker*" OR "biologic tumor marker*" OR "cancer biomarker*" OR "cancer care facilit*" OR "cancer hospital*" OR "hospital oncology service*" OR "cancer care unit*" OR "medical oncology" OR "cancer care delivery")
67	AB("Cancer Screening" OR "Cancer Early Detection" OR "Early Diagnosis of Cancer" OR "cancer early diagnos*" OR "tumor biomarker*" OR "biologic tumor marker*" OR "cancer biomarker*" OR "cancer care facilit*" OR "cancer hospital*" OR "hospital oncology service*" OR "cancer care unit*" OR "medical oncology" OR "cancer care delivery")
68	#60 OR #61 OR #62 OR #63 OR #64 OR #65 OR #66 OR #67
69	LG(English)
70	"animals"[MeSH Terms]
71	"humans"[MeSH Terms]
72	#69 NOT (#70 NOT #71)
73	#3 AND #59 AND #72
74	Date limit 2010 - present

Appendix B. List of Excluded Studies

Guiding Question 1 Excluded Articles

Excluded from Literature Search

1. .A value framework for cancer screening. *Annals of Internal Medicine*. 2015;162(10):NA-NA. doi: 10.7326/P15-9023. PMID: 109828061. - **Does not describe/propose a framework with organizational characteristics**
2. Allen JD, Shelton RC, Kephart L, et al. Examining the external validity of the CRUZA study, a randomized trial to promote implementation of evidence-based cancer control programs by faith-based organizations. *Transl Behav Med*. 2020 Feb 3;10(1):213-22. doi: 10.1093/tbm/iby099. PMID: 30496532. - **Framework is not used in a cancer care context**
3. Angelis A, Kanavos P. Critique of the American Society of Clinical Oncology Value Assessment Framework for Cancer Treatments: Putting Methodologic Robustness First. *J Clin Oncol*. 2016 Aug 20;34(24):2935-6. doi: 10.1200/jco.2015.64.9673. PMID: 27298421. - **Does not describe/propose a framework with organizational characteristics**
4. ASCO Drafts Value Framework to Assist Patient-Physician Conversations. *ASCO Connection*. 2015;6(5):26-7. PMID: 110468456. - **Does not describe/propose a framework with organizational characteristics**
5. Ben-Aharon O, Goldstein DA. Improving on Tail-of-the-Curve Evaluation With the American Society of Clinical Oncology Value Framework-Reply. *JAMA Oncol*. 2018 Oct 1;4(10):1438-9. doi: 10.1001/jamaoncol.2018.3295. PMID: 30128500. - **No original data (opinion, descriptive data, letters, editorial, commentary)**
6. Bertagnolli M, Tabernero J. Value assessment frameworks in oncology: Championing concordance through shared standards. *Annals of Oncology*. 2019;30(4):505-6. doi: 10.1093/annonc/mdz057. - **Does not describe/propose a framework with organizational characteristics**
7. Bilodeau K, Tremblay D. How oncology teams can be patient-centred? opportunities for theoretical improvement through an empirical examination. *Health Expect*. 2019 Apr;22(2):235-44. doi: 10.1111/hex.12847. PMID: 30411450. - **Study focuses on a single NCI framework domain/subdomain**
8. Blayney DW. Measuring and improving quality of care in an academic medical center. *J Oncol Pract*. 2013 May;9(3):138-41. doi: 10.1200/jop.2013.000991. PMID: 23942492. - **Does not describe/propose a framework with organizational characteristics**
9. Carney TJ, Weaver M, McDaniel AM, et al. Organizational factors influencing the use of clinical decision support for improving cancer screening within community health centers. *International Journal of Healthcare Information Systems and Informatics*. 2014;9(1):1-29. doi: 10.4018/ijhisi.2014010101. - **Study focuses on a single NCI framework domain/subdomain**

10. Chera BS, Mazur L, Buchanan I, et al. Improving Patient Safety in Clinical Oncology: Applying Lessons From Normal Accident Theory. *JAMA Oncol.* 2015 Oct;1(7):958-64. doi: 10.1001/jamaoncol.2015.0891. PMID: 26182183. - **Study focuses on a single NCI framework domain/subdomain**
11. Cherny NI, de Vries EGE. Improving on Tail-of-the-Curve Evaluation With the American Society of Clinical Oncology Value Framework. *JAMA Oncol.* 2018 Oct 1;4(10):1437. doi: 10.1001/jamaoncol.2018.3264. PMID: 30128567. - **No original data (opinion, descriptive data, letters, editorial, commentary)**
12. Clauser SB, Taplin SH, Foster MK, et al. Multilevel intervention research: lessons learned and pathways forward. *J Natl Cancer Inst Monogr.* 2012 May;2012(44):127-33. doi: 10.1093/jncimonographs/lgs019. PMID: 22623606. - **No original data (opinion, descriptive data, letters, editorial, commentary)**
13. Cuaron JJ, Gillespie EF, Gomez DR, et al. From Orientation to Onboarding: A Survey-Based Departmental Improvement Program for New Radiation Oncology Faculty Physicians. *JCO Oncol Pract.* 2020 Apr;16(4):e395-e404. doi: 10.1200/jop.19.00641. PMID: 32048921. - **Does not describe/propose a framework with organizational characteristics**
14. Del Paggio JC, Cheng S, Booth CM, et al. Reliability of Oncology Value Framework Outputs: Concordance Between Independent Research Groups. *JNCI Cancer Spectr.* 2018 Jul;2(3):pky050. doi: 10.1093/jncics/pky050. PMID: 31360865. - **Does not describe/propose a framework with organizational characteristics**
15. DiMartino LD, Birken SA, Hanson LC, et al. The influence of formal and informal policies and practices on health care innovation implementation: A mixed-methods analysis. *Health Care Manage Rev.* 2018 Jul/Sep;43(3):249-60. doi: 10.1097/hmr.000000000000193. PMID: 29533270. - **Does not address KQ1 but relevant to KQ2-4**
16. Eddy D. David Eddy created the Archimedes model to predict and analyze care. *Health Affairs.* 2012;31(11):2451-2. doi: 10.1377/hlthaff.2012.1063. - **Does not describe/propose a framework with organizational characteristics**
17. Evans SB, Cain D, Kapur A, et al. Why Smart Oncology Clinicians do Dumb Things: A Review of Cognitive Bias in Radiation Oncology. *Pract Radiat Oncol.* 2019 Jul-Aug;9(4):e347-e55. doi: 10.1016/j.prro.2019.03.001. PMID: 30905730. - **Does not describe/propose a framework with organizational characteristics**
18. Fernandez ME, Walker TJ, Weiner BJ, et al. Developing measures to assess constructs from the Inner Setting domain of the Consolidated Framework for Implementation Research. *Implement Sci.* 2018 Mar 27;13(1):52. doi: 10.1186/s13012-018-0736-7. PMID: 29587804. - **Does not address KQ1 but relevant to KQ2-4**
19. Ganz PA, Levit LA. Charting a new course for the delivery of high-quality cancer care. *Journal of Clinical Oncology.* 2013;31(36):4485-7. doi: 10.1200/JCO.2013.53.7993. - **Does not describe/propose a framework with organizational characteristics**

20. Ganz PA. Institute of Medicine report on delivery of high-quality cancer care. *Journal of Oncology Practice*. 2014;10(3):193-5. doi: 10.1200/JOP.2013.001369. - **Does not describe/propose a framework with organizational characteristics**
21. Graystone R. The Value of Magnet® Recognition for Specialty Hospitals. *J Nurs Adm*. 2019 Jun;49(6):289-90. doi: 10.1097/nna.0000000000000753. PMID: 31135634. - **Does not describe/propose a framework with organizational characteristics**
22. Ha H, Kang JH, Kim DY, et al. The value measurement of emerging therapeutics in renal cell carcinoma: ASCO value framework and ESMO-MCBS. *BMC Health Services Research*. 2022;22(1)doi: 10.1186/s12913-022-08279-6. - **Does not describe/propose a framework with organizational characteristics**
23. Hack TF, Carlson L, Butler L, et al. Facilitating the implementation of empirically valid interventions in psychosocial oncology and supportive care. *Support Care Cancer*. 2011 Aug;19(8):1097-105. doi: 10.1007/s00520-011-1159-z. PMID: 21494781. - **Does not describe/propose a framework with organizational characteristics**
24. Hlávka JP, Lin PJ, Neumann PJ. Outcome measures for oncology alternative payment models: Practical considerations and recommendations. *American Journal of Managed Care*. 2019;25(12):E403-E9. - **Study focuses on a single NCI framework domain/subdomain**
25. Hoos A, Britten CM, Huber C, et al. A methodological framework to enhance the clinical success of cancer immunotherapy. *Nat Biotechnol*. 2011 Oct 13;29(10):867-70. doi: 10.1038/nbt.2000. PMID: 21997622. - **Does not describe/propose a framework with organizational characteristics**
26. Jacobs SR, Weiner BJ, Reeve BB, et al. Determining the predictors of innovation implementation in healthcare: a quantitative analysis of implementation effectiveness. *BMC Health Serv Res*. 2015 Jan 22;15:6. doi: 10.1186/s12913-014-0657-3. PMID: 25608564. - **Does not describe/propose a framework with organizational characteristics**
27. Jansen JP. Relevance of American Society of Clinical Oncology Value Framework Will Be Improved if It Is Based on Network Meta-Analyses. *J Clin Oncol*. 2017 Apr 1;35(10):1131-2. doi: 10.1200/jco.2016.69.4612. PMID: 28165901. - **No original data (opinion, descriptive data, letters, editorial, commentary)**
28. Jazieh AR, McClure JS, Carlson RW. Implementation Framework for NCCN Guidelines. *J Natl Compr Canc Netw*. 2017 Oct;15(10):1180-5. doi: 10.6004/jnccn.2017.7020. PMID: 28982742. - **Does not describe/propose a framework with organizational characteristics**
29. Kraft S, Carayon P, Weiss J, et al. A simple framework for complex system improvement. *Am J Med Qual*. 2015 May;30(3):223-31. doi: 10.1177/1062860614530184. PMID: 24723664. - **Study focuses on a single NCI framework domain/subdomain**
30. Lam TK, Spitz M, Schully SD, et al. "Drivers" of translational cancer epidemiology in the 21st century: Needs and opportunities. *Cancer Epidemiology Biomarkers and*

Prevention. 2013;22(2):181-8. doi: 10.1158/1055-9965.EPI-12-1262. - **No original data (opinion, descriptive data, letters, editorial, commentary)**

31. Lamort-Bouché M, Sarnin P, Kok G, et al. Interventions developed with the Intervention Mapping protocol in the field of cancer: A systematic review. *Psychooncology*. 2018 Apr;27(4):1138-49. doi: 10.1002/pon.4611. PMID: 29247578. - **Does not describe/propose a framework with organizational characteristics**
32. Leeman J, Baquero B, Bender M, et al. Advancing the use of organization theory in implementation science. *Prev Med*. 2019 Dec;129s:105832. doi: 10.1016/j.ypmed.2019.105832. PMID: 31521385. – **Foundational framework included in the Integrated Framework**
33. Leeman J, Birken SA, Powell BJ, et al. Beyond "implementation strategies": classifying the full range of strategies used in implementation science and practice. *Implement Sci*. 2017 Nov 3;12(1):125. doi: 10.1186/s13012-017-0657-x. PMID: 29100551. - **Does not describe/propose a framework with organizational characteristics**
34. Liang H, Tao L, Ford EW, et al. The patient-centered oncology care on health care utilization and cost: A systematic review and meta-analysis. *Health Care Manage Rev*. 2020 Oct/Dec;45(4):364-76. doi: 10.1097/hmr.0000000000000226. PMID: 30335617. - **Does not describe/propose a framework with organizational characteristics**
35. Luke J, Mirkin J, Bach P. Improving Quality and Addressing the Rising Costs of Cancer Care: Two Birds, One Stone. *Journal of Oncology Practice*. 2011;7(6):402-4. doi: 10.1200/JOP.2011.000419. PMID: 104486714. -**Study focuses on a single NCI framework domain/subdomain**
36. Mandelblatt JS, Ramsey SD, Lieu TA, et al. Evaluating Frameworks That Provide Value Measures for Health Care Interventions. *Value Health*. 2017 Feb;20(2):185-92. doi: 10.1016/j.jval.2016.11.013. PMID: 28237193.- **Does not describe/propose a framework with organizational characteristics**
37. McNiff KK, Jacobson JO. Aiming for ideal care: a proposed framework for cancer quality improvement. *J Oncol Pract*. 2014 Nov;10(6):339-44. doi: 10.1200/jop.2014.001305. PMID: 25398953. - **Study focuses on a single NCI framework domain/subdomain**
38. Modica C, Bay C, Lewis JH, et al. Applying the Value Transformation Framework in Federally Qualified Health Centers to Increase Clinical Measures Performance. *Journal for Healthcare Quality*. 2022;44(4):185-93. doi: 10.1097/JHQ.0000000000000340. - **Does not describe/propose a framework with organizational characteristics (different Value Transformation Framework article included)**
39. Newman-Toker DE. A unified conceptual model for diagnostic errors: Underdiagnosis, overdiagnosis, and misdiagnosis. *Diagnosis*. 2014;1(1):43-8. doi: 10.1515/dx-2013-0027. - **Does not describe/propose a framework with organizational characteristics**
40. Osarogiagbon RU. Achieving better quality of lung cancer care. *Lung Cancer: A Practical Approach to Evidence-Based Clinical Evaluation and Management*. 2018:167-82. - **Study focuses on a single NCI framework domain/subdomain**
41. Page RD, Newcomer LN, Sprandio JD, et al. The patient-centered medical home in oncology: from concept to reality. *Am Soc Clin Oncol Educ Book*. 2015:e82-9. doi:

10.14694/EdBook_AM.2015.35.e82. PMID: 25993243. - **Study focuses on a single NCI framework domain/subdomain**

42. Pirl WF, Greer JA, Gregorio SW, et al. Framework for planning the delivery of psychosocial oncology services: An American psychosocial oncology society task force report. *Psychooncology*. 2020 Dec;29(12):1982-7. doi: 10.1002/pon.5409. PMID: 32390322. - **Does not describe/propose a framework with organizational characteristics**
43. Raney L, McManaman J, Elsaid M, et al. Multisite quality improvement initiative to repair incomplete electronic medical record documentation as one of many causes of provider burnout. *JCO Oncology Practice*. 2020;16(11):E1412-E6. doi: 10.1200/OP.20.00294. - **Study focuses on a single NCI framework domain/subdomain**
44. Rapkin BD, Weiss ES, Lounsbury DW, et al. Using the interactive systems framework to support a quality improvement approach to dissemination of evidence-based strategies to promote early detection of breast cancer: planning a comprehensive dynamic trial. *Am J Community Psychol*. 2012 Dec;50(3-4):497-517. doi: 10.1007/s10464-012-9518-6. PMID: 22618023. - **Does not describe/propose a framework with organizational characteristics (different Interactive Systems Framework article included)**
45. Reyna VF, Nelson WL, Han PK, et al. Decision making and cancer. *Am Psychol*. 2015 Feb-Mar;70(2):105-18. doi: 10.1037/a0036834. PMID: 25730718. - **Study focuses on a single NCI framework domain/subdomain**
46. Schilsky RL, Michels DL, Kearbey AH, et al. Building a rapid learning health care system for oncology: the regulatory framework of CancerLinQ. *J Clin Oncol*. 2014 Aug 1;32(22):2373-9. doi: 10.1200/jco.2014.56.2124. PMID: 24912897. - **Does not describe/propose a framework with organizational characteristics**
47. Schnipper LE, Davidson NE, Wollins DS, et al. Updating the American Society of Clinical Oncology Value Framework: Revisions and Reflections in Response to Comments Received. *J Clin Oncol*. 2016 Aug 20;34(24):2925-34. doi: 10.1200/jco.2016.68.2518. PMID: 27247218. - **Does not describe/propose a framework with organizational characteristics**
48. Schnipper LE, Schilsky RL. Converging on the value of value frameworks. *Journal of Clinical Oncology*. 2017;35(24):2732-4. doi: 10.1200/JCO.2017.73.5704. - **No original data (opinion, descriptive data, letters, editorial, commentary)**
49. Senier L, McBride CM, Ramsey AT, et al. Blending Insights from Implementation Science and the Social Sciences to Mitigate Inequities in Screening for Hereditary Cancer Syndromes. *Int J Environ Res Public Health*. 2019 Oct 15;16(20)doi: 10.3390/ijerph16203899. PMID: 31618814. - **Other: Article focuses on frameworks related to implementation sciences; the framework proposed draws upon CFIR, which is included as a foundational framework in the Integrated Framework**
50. Seymour EK, De Souza JA, Fendrick AM. Incorporating value-based care into oncology. *Cancer Journal (United States)*. 2020;26(4):311-22. doi: 10.1097/PPO.0000000000000459. - **Does not describe/propose a framework with organizational characteristics**

51. Shelby M, Malloch K, Shellenberger T, et al. Addressing Falls Among Older Oncology Patients Through Complexity Science. *Nurs Adm Q.* 2019 Jul/Sep;43(3):280-8. doi: 10.1097/naq.0000000000000360. PMID: 31162348. - **Does not describe/propose a framework with organizational characteristics**
52. Sisk BA, Schulz GL, Kaye EC, et al. Clinicians' Perspectives on the Functions of Communication in Pediatric Oncology. *J Palliat Med.* 2021 Sep;24(10):1545-9. doi: 10.1089/jpm.2021.0090. PMID: 34255562. - **Study focuses on a single NCI framework domain/subdomain**
53. Socinski MA, Boehmer LM. A Framework for Defining High-Quality Care for Patients with NSCLC. *Oncology Issues.* 2021;36(6):62-8. doi: 10.1080/10463356.2021.1979879. - **Does not describe/propose a framework with organizational characteristics**
54. Spinks TE, Ganz PA, Sledge GW, et al. Delivering high-quality cancer care: The critical role of quality measurement. *Healthcare.* 2014;2(1):53-62. doi: 10.1016/j.hjdsi.2013.11.003. - **Does not describe/propose a framework with organizational characteristics**
55. Sprandio JD. Oncology patient-centered medical home. *American Journal of Managed Care.* 2012;18(SPECIAL ISSUE). - **Study focuses on a single NCI framework domain/subdomain**
56. Stange KC, Breslau ES, Dietrich AJ, et al. State-of-the-art and future directions in multilevel interventions across the cancer control continuum. 2012. - **Does not describe/propose a framework with organizational characteristics**
57. Subramanian R, Schorr K. Musings on value frameworks in cancer. *Journal of Comparative Effectiveness Research.* 2016;5(5):437-9. doi: 10.2217/cer-2016-0041. - **Does not describe/propose a framework with organizational characteristics**
58. Tappenden P, Chilcott J, Brennan A, et al. Whole disease modeling to inform resource allocation decisions in cancer: A methodological framework. *Value in Health.* 2012;15(8):1127-36. doi: 10.1016/j.jval.2012.07.008. - **Does not describe/propose a framework with organizational characteristics**
59. Teal R, Bergmire DM, Johnston M, et al. Implementing community-based provider participation in research: an empirical study. *Implement Sci.* 2012 May 8;7:41. doi: 10.1186/1748-5908-7-41. PMID: 22568935. - **Other: Article considers organizational factors that influence implementation/utilization of community-based provider participation in research (CBPPR)**
60. Tonges M, McCann M, Strickler J. Translating caring theory across the continuum from inpatient to ambulatory care. *J Nurs Adm.* 2014 Jun;44(6):326-32. doi: 10.1097/nna.0000000000000077. PMID: 24835143. - **Does not describe/propose a framework with organizational characteristics**
61. Tugwell P, Knottnerus JA, Idzerda L. Definitions and framework for knowledge translation to continue to evolve. *Journal of Clinical Epidemiology.* 2011;64(1):1-2. doi: 10.1016/j.jclinepi.2010.11.001. - **Does not describe/propose a framework with organizational characteristics**

62. Umaretiya PJ, Vinci RJ, Bona K. A Structural Racism Framework to Guide Health Equity Interventions in Pediatric Oncology. *Pediatrics*. 2022 May 1;149(5)doi: 10.1542/peds.2021-054634. PMID: 35490282. - **Does not describe/propose a framework with organizational characteristics**
63. Verhoeven DC, Chollette V, Lazzara EH, et al. The Anatomy and Physiology of Teaming in Cancer Care Delivery: A Conceptual Framework. *J Natl Cancer Inst*. 2021 Apr 6;113(4):360-70. doi: 10.1093/jnci/djaa166. PMID: 33107915. - **Study focuses on a single NCI framework domain/subdomain**
64. Verma AA, Razak F, Detsky AS. Understanding choice: Why physicians should learn prospect theory. *JAMA*. 2014;311(6):571-2. doi: 10.1001/jama.2013.285245. - **Study focuses on a single NCI framework domain/subdomain**
65. Vivot A, Créquit P, Porcher R. Improving on Tail-of-the-Curve Evaluation With the American Society of Clinical Oncology Value Framework. *JAMA Oncol*. 2018 Oct 1;4(10):1437-8. doi: 10.1001/jamaoncol.2018.3289. PMID: 30128475. - **No original data (opinion, descriptive data, letters, editorial, commentary)**
66. Walker TJ, Brandt HM, Wandersman A, et al. Development of a comprehensive measure of organizational readiness (motivation × capacity) for implementation: a study protocol. *Implement Sci Commun*. 2020 Nov 11;1(1):103. doi: 10.1186/s43058-020-00088-4. PMID: 33292840. -**Other: Included primary source**
67. Weaver SJ, Verhoeven DC, Castro KM, et al. Thematic Analysis of Organizational Characteristics in NCI Community Oncology Research Program Cancer Care Delivery Research. *JNCI Cancer Spectr*. 2022 Mar 2;6(2)doi: 10.1093/jncics/pkac008. PMID: 35603839. -**Other: Included in foundational framework**
68. Weaver SJ, Verhoeven DC, Castro KM, et al. Thematic Analysis of Organizational Characteristics in NCI Community Oncology Research Program Cancer Care Delivery Research. *JNCI Cancer Spectrum*. 2022;6(2)doi: 10.1093/jncics/pkac008. -**Other: Article already referenced in report**
69. Weiner BJ, Belden CM, Bergmire DM, et al. The meaning and measurement of implementation climate. *Implementation Science*. 2011;6(1)doi: 10.1186/1748-5908-6-78. - **Study focuses on a single NCI framework domain/subdomain**
70. Weiner BJ, Lewis MA, Clauser SB, et al. In search of synergy: Strategies for combining interventions at multiple levels. 2012. - **Does not describe/propose a framework with organizational characteristics**
71. Wheeler JCW, Keogh L, Sierra MA, et al. Heterogeneity in how women value risk-stratified breast screening. *Genetics in Medicine*. 2022;24(1):146-56. doi: 10.1016/j.gim.2021.09.002. - **Does not describe/propose a framework with organizational characteristics**
72. Zoellner J, Porter K, Thatcher E, et al. A Multilevel Approach to Understand the Context and Potential Solutions for Low Colorectal Cancer (CRC) Screening Rates in Rural Appalachia Clinics. *J Rural Health*. 2021 Jun;37(3):585-601. doi: 10.1111/jrh.12522. PMID: 33026682. - **Does not describe/propose a framework with organizational characteristics**

73. Zubkoff L, Dionne-Odom JN, Pisu M, et al. Developing a "toolkit" to measure implementation of concurrent palliative care in rural community cancer centers. *Palliat Support Care*. 2018 Feb;16(1):60-72. doi: 10.1017/s1478951517000323. PMID: 28566103. - **Does not describe/propose a framework with organizational characteristics**

Excluded Studies From Additional Search

1. 2020-2023 Value Assessment Framework Institute for Clinical and Economic Review. 2020. https://icer.org/wp-content/uploads/2020/10/ICER_2020_2023_VAF_102220.pdf- **Does not meet eligibility criteria**
2. Abt Associates. First Annual Report from the Evaluation of the Oncology Care Model: Baseline Period (Contract #HHSM-500-2014-00026I T0003) Centers for Medicare and Medicaid Services. Baltimore, MD: 2018. <https://downloads.cms.gov/files/cmmti/ocm-baselinerreport.pdf>-**Does not meet eligibility criteria**
3. Alonso-Coello P, Schünemann HJ, Moberg J, et al. [GRADE Evidence to Decision (EtD) frameworks: a systematic and transparent approach to making well informed healthcare choices. 1: Introduction]. *Gac Sanit*. 2018 Mar-Apr;32(2):166.e1-.e10. doi: 10.1016/j.gaceta.2017.02.010. PMID: 28822594. -**Does not meet eligibility criteria**
4. Andersen RM. Revisiting the behavioral model and access to medical care: does it matter? *J Health Soc Behav*. 1995 Mar;36(1):1-10. PMID: 7738325. -**Included as foundational framework**
5. Arksey H, O'Malley L. Scoping studies: towards a methodological framework. *International Journal of Social Research Methodology*. 2003;8:19-32. -**Does not meet eligibility criteria**
6. Berwick DM, Nolan TW, Whittington J. The triple aim: care, health, and cost. *Health Aff (Millwood)*. 2008 May-Jun;27(3):759-69. doi: 10.1377/hlthaff.27.3.759. PMID: 18474969. -**Does not meet eligibility criteria**
7. Bodenheimer T, Sinsky C. From triple to quadruple aim: care of the patient requires care of the provider. *Ann Fam Med*. 2014 Nov-Dec;12(6):573-6. doi: 10.1370/afm.1713. PMID: 25384822. -**Does not meet eligibility criteria**
8. Boyer C, Selby M, Scherrer JR, et al. The Health On the Net Code of Conduct for medical and health Websites. *Comput Biol Med*. 1998 Sep;28(5):603-10. doi: 10.1016/s0010-4825(98)00037-7. PMID: 9861515. -**Does not meet eligibility criteria**
9. Charns MP, Young GJ, Radwin LE. Organization Design and Coordination. Burns, Bradley & Weiner, Shortell and Kaluzny's Health Care Management: Organizational Theory and Behavior. 7 ed.: Delmar; 2019:57-81. -**Does not meet eligibility criteria**
10. Damschroder LJ, Aron DC, Keith RE, et al. Fostering implementation of health services research findings into practice: a consolidated framework for advancing implementation science. *Implement Sci*. 2009 Aug 7;4:50. doi: 10.1186/1748-5908-4-50. PMID: 19664226. -**Included as foundational framework**
11. Donabedian A. Evaluating the quality of medical care. *The Milbank Memorial Fund Quarterly*. 1966;44(3):166-206. -**Included as foundational framework**

12. Framework for program evaluation in public health. MMWR Recomm Rep. 1999 Sep 17;48(Rr-11):1-40. PMID: 10499397. **-Does not meet eligibility criteria**
13. Gantner-Bär M, Meier F, Kolominsky-Rabas P, et al. Prospective Assessment of an innovative test for prostate cancer screening using the VITA process model framework. Stud Health Technol Inform. 2014;205:236-40. PMID: 25160181. **-Does not meet eligibility criteria**
14. Glasgow RE, Vogt TM, Boles SM. Evaluating the public health impact of health promotion interventions: the RE-AIM framework. Am J Public Health. 1999 Sep;89(9):1322-7. doi: 10.2105/ajph.89.9.1322. PMID: 10474547. **-Does not meet eligibility criteria**
15. Graystone R. The 2019 Magnet® Application Manual: Nursing Excellence Standards Evolving With Practice. J Nurs Adm. 2017 Nov;47(11):527-8. doi: 10.1097/nna.0000000000000547. PMID: 29065067. **-Does not meet eligibility criteria**
16. Hovland C, Janis I, Kelley H. Communication and persuasion. New Haven, CT: Yale University Press; 1953. **-Does not meet eligibility criteria**
17. Kilo CM. A framework for collaborative improvement: lessons from the Institute for Healthcare Improvement's Breakthrough Series. Qual Manag Health Care. 1998 Sep;6(4):1-13. doi: 10.1097/00019514-199806040-00001. PMID: 10339040. **-Does not meet eligibility criteria**
18. Klein KJ, Sorra JS. The Challenge of Innovation Implementation. The Academy of Management Review. 1996;21(4):1055-80. **-Does not meet eligibility criteria**
19. Kotter JP. Leading change: why transformation efforts fail. Harv Bus Rev. 1995;7(2):59-67. **-Does not meet eligibility criteria**
20. Leeman J, Baquero B, Bender M, et al. Advancing the use of organization theory in implementation science. Prev Med. 2019 Dec;129s:105832. doi: 10.1016/j.ypmed.2019.105832. PMID: 31521385. **-Included as foundational framework**
21. Michie S, Johnston M, Abraham C, et al. Making psychological theory useful for implementing evidence based practice: a consensus approach. Qual Saf Health Care. 2005 Feb;14(1):26-33. doi: 10.1136/qshc.2004.011155. PMID: 15692000. **-Does not meet eligibility criteria**
22. Piña IL, Cohen PD, Larson DB, et al. A framework for describing health care delivery organizations and systems. Am J Public Health. 2015 Apr;105(4):670-9. doi: 10.2105/ajph.2014.301926. PMID: 24922130. **-Included as foundational framework**
23. Proctor E, Silmere H, Raghavan R, et al. Outcomes for implementation research: conceptual distinctions, measurement challenges, and research agenda. Adm Policy Ment Health. 2011 Mar;38(2):65-76. doi: 10.1007/s10488-010-0319-7. PMID: 20957426. **-Does not meet eligibility criteria**
24. Shirey MR. Lewin's Theory of Planned Change as a strategic resource. J Nurs Adm. 2013 Feb;43(2):69-72. doi: 10.1097/NNA.0b013e31827f20a9. PMID: 23343723. **-Does not meet eligibility criteria**

25. Yano EM. The role of organizational research in implementing evidence-based practice: QUERI Series. Implement Sci. 2008 May 29;3:29. doi: 10.1186/1748-5908-3-29. PMID: 18510749. **-Included as foundational framework**

Guiding Question 2 and Guiding Question 3 Excluded Articles

1. Abdulla A, Schell KR, Schell MC. Comparing the Evolution of Risk Culture in Radiation Oncology, Aviation, and Nuclear Power. J Patient Saf. 2020 Dec;16(4):e352-e8. doi: 10.1097/pts.0000000000000560. PMID: 30608909. **- Does not address delivery of cancer care (screening, diagnosis, or treatment)**
2. Adamson L, Beldham-Collins R, Sykes J, et al. Evaluating incident learning systems and safety culture in two radiation oncology departments. J Med Radiat Sci. 2022 Jun;69(2):208-17. doi: 10.1002/jmrs.563. PMID: 34882982. **- The stated objectives of the article do not include anything about examining how organizational characteristics are related to the delivery of cancer care**
3. Akhtar A, Sosa E, Castro S, et al. A Lung Cancer Screening Education Program Impacts both Referral Rates and Provider and Medical Assistant Knowledge at Two Federally Qualified Health Centers. Clin Lung Cancer. 2022 Jun;23(4):356-63. doi: 10.1016/j.clcc.2021.12.002. PMID: 34991968. **- The stated objectives of the article do not include anything about examining how organizational characteristics are related to the delivery of cancer care**
4. Allen CG, Cotter MM, Smith RA, et al. Successes and challenges of implementing a lung cancer screening program in federally qualified health centers: a qualitative analysis using the Consolidated Framework for Implementation Research. Transl Behav Med. 2021 May 25;11(5):1088-98. doi: 10.1093/tbm/ibaa121. PMID: 33289828. **- Does not include any clearly defined measure of organizational characteristics**
5. Allen JD, Shelton RC, Kephart L, et al. Organizational characteristics conducive to the implementation of health programs among Latino churches. Implement Sci Commun. 2020;1:62. doi: 10.1186/s43058-020-00052-2. PMID: 32885217. **- The stated objectives of the article do not include anything about examining how organizational characteristics are related to the delivery of cancer care**
6. Allicock M, Johnson LS, Leone L, et al. Promoting fruit and vegetable consumption among members of black churches, Michigan and North Carolina, 2008-2010. Prev Chronic Dis. 2013;10:E33. doi: 10.5888/pcd10.120161. PMID: 23489638. **- The stated objectives of the article do not include anything about examining how organizational characteristics are related to the delivery of cancer care**
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Appendix C. Results

Guiding Question 2 and 3 Included Articles

Implementation of Improvement Projects and Barriers to Implementation

1. Brooks K, Polverento M, Houdeshell-Putt L, et al. Observing Provider Utilization of Electronic Health Records to Improve Clinical Quality Metrics. *Perspect Health Inf Manag.* 2022 Winter;19(1):10. PMID: 35440927.
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Workload/Workflow Design/Work Performance

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Organizational Reactions to Environmental Forces

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Psychological States/Traits of Providers and Provider Groups

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Key Informant (KI) Call Discussion and Themes

Question 1: Do you have any questions or concerns about the preliminary literature search strategy and methods described in the protocol?

- Some of the literature out there is about what should be done, not what has been done. There are a number of white papers about lessons learned or more of what needs to be done, that hasn't been as tested
- Should consider articles on service lines, which include empirical articles. One Key Informant found eight variations of service lines, by the degree of which they put people together. Terms are not used consistently.
- On the 2010 publication cutoff, the introduction of the Affordable Care Act (ACA) is important, but also should think about the pandemic. Particularly the shift in healthcare during and around the pandemic and this could be a separate/called out issue. Additional changes have been made in the past two and a half years, and should be considered within the framework, as the pandemic is also going to be important in helping to define organizational culture and structures.
- Current publications are more on what should have been done, not so much on what has been done and tested due to the short timeframe since the pandemic started.
 - Examples: Increase in telemedicine and reimbursement, expansion of remote working and roles like nurse navigation, staffing mix, and how much the changes in staffing have played a role in patient outcomes.
 - These could go toward future research needs.

Question 2: Which governmental / nongovernmental organizations are most likely to have relevant reports that we might not find in the peer-reviewed literature? Are there key reports not listed in Table 1?

- Relational Coordination Analytics
- National Coalition for Cancer Survivorship (NCCS) shared link to survey: <https://canceradvocacy.org/2022-state-of-cancer-survivorship-survey/>
- Accreditation agencies report metrics on measurements of cancer centers that matter to cancer centers: Commission on Cancer, National Cancer Database, Association of Community Cancer Centers, National Accreditation Program for Breast Centers
- Quinte Health Care (QHC): can see what they use for measurements especially for screening, but also for cancer care.
- Sometimes people use the term “integrated care” rather than care coordination or coordination care. Example: Sarah Singer developed a survey on patient perspectives of integrated care.
- The Center for Medicare and Medicaid Innovation: Models of care delivery.
- Center for Qualitative Inquiry (C4QI): <http://www.c4qi.net/>
- Alliance of Dedicated Cancer Centers (ADCC): www.adcc.org

- American Society of Clinical Oncology (ASCO) pilot project: <https://old-prod.asco.org/news-initiatives/policy-news-analysis/new-certification-pilot-focuses-patient-centered-cancer-care>
- ASCO has a pilot project entitled Patient-Centered Cancer Care that is a collaboration with the Community Oncology Alliance and contains elements of the Oncology Medical Home
- Assistant Secretary for Planning and Evaluation (ASPE)
- Commonwealth
- Robert Wood Johnson Foundation
- National Institute for Health Care Management
- Medical Group Management Association surveys
- Health Care Systems Research Network

Question 3: What specific frameworks, models or theories (other than the draft integrated framework) do you suggest we review that describe how organizational characteristics may influence cancer care (screening, diagnosis, or treatment) or health care delivery in general?

- Organization Theory for Implementation Science (OTIS)
- Continuum framework
- Way of classifying organization designs, that takes into account traditional organizational structure where people are grouped by profession and discipline and adding coordinating structures, until the ninth alternative, which is completely reorganizing into institutes and centers, where all of the staff providing care for patients with cancer including all the way across the cancer care continuum are members of the Institute/Center.
- This work is difficult because the unit of analysis is the organization and getting enough organizations for a good empirical study is a challenge.
- Reach, Effectiveness, Adoption, Implementation, Maintenance (RE-AIM) framework
- Triple Aim
- Quadruple Aim
- Consolidated Framework for Implementation Research

Question 4: Do you foresee any difficulties in using the draft integrated framework to guide our approach to answering the Key Questions?

- When categorizing the characteristics, or resources and delivery, it gets to this concept of what the unit of analysis are in these frameworks, and how is it defined? It gets more complicated in getting a representation as this isn't defined. Secondly, how do the frameworks consider the temporal factors? Structural and temporal complexity are important factors. These challenges could be highlighted in future research needs

- Organizations don't operate in vacuums. An example is an organization as a corporate entity, but their cancer care facility is an amalgamation of two separate entities. What is the unit of analysis and how do they relate to one another?
- The ownership models are difficult to prioritize. Historically it has been academic vs community, but now community can include academic-like roles. So, what is important about being academic? ASCO defined it as having fellowship program or connected to medical school, but this also has many grey areas. Some of the practices are traditional others are not. It's a very dynamic field.
- Even just regional differences are very different, is the framework tested for regional differences as well?
- Some frameworks are easy to understand and not complex. More complex ones are harder to implement, if it gets too complex it gets overwhelming for the user. There needs to be a balance between completeness of the framework and complexity.

Question 5: Do you foresee any challenges with our inclusion/exclusion criteria for our literature search and selection?

- Might be hard to find studies that are generalizable to a whole population of cancer patients, but I think these types of resources impact a patient's cancer screening/diagnosis, etc. and therefore, their outcome.

Other Comments

- These are opportunities to think of new questions, hope it forces investigators to consider things in areas not directly related to organizations, but which have huge implications for organizations. What are we attributing to individuals that is actually related to things that are totally beyond individual control?

Table C-1. Grey literature search results

Source Title (Link)	Type of Grey Literature Type of Information	General Summary Information	Measurement of Organizational Characteristics	Measurements/Variables	Measurement Instrument
<p>Delivering High-Quality Cancer Care: Charting a New Course for a System in Crisis¹</p> <p>(https://www.ncbi.nlm.nih.gov/books/NBK202150/)</p>	<p>Book</p> <p>Descriptive Summary of Concepts</p>	<p>Table 2 in Chapter 7 provides a summary of the advantages and disadvantages of various measures used in assessing the quality of cancer care.</p>	<p>NA</p>	<p>(1) Structure: Measures the settings in which clinicians deliver health care, including material resources, human resources, and organizational structure (e.g., types of services available, qualifications of clinicians, and staffing hierarchies)</p> <p>(2) Process: Measures the delivery of care in defined circumstances (e.g., screening the general population, psychosocial evaluations of all newly diagnosed patients, care planning before starting chemotherapy)</p> <p>(3) Clinical Outcome: Measures personal health and functional status as a consequence of contact with the health care system (e.g., survival, success of treatment)</p> <p>(4) Patient-Reported Outcome: Measures patients' perceived physical, mental, and social well-being based on information that comes directly from the patient (e.g., quality of life, time to return to normal activity, symptom burden)</p> <p>(5) Patients' Perspective on Care: Measures patients' satisfaction with the health care they received</p> <p>(6) Cost: Measures the resources required for the health care system to deliver care and the economic impact on patients, their families, and governmental and private payers</p> <p>(7) Efficiency: Measures the time, effort, or cost to produce a specific output in the health care system (e.g., time to initiate therapy after diagnosis, coordination of care)</p> <p>(8) Cross-Cutting: Measures issues that cross cancer or disease types (e.g., patient safety, care coordination, equity, and patients' perspective on care)</p> <p>(9) Disease-Specific: Measures issues within a specific cancer type (e.g., clinicians' concordance with clinical practice guidelines for breast, prostate, and colon cancer)</p>	<p>N/A</p>

Source Title (Link)	Type of Grey Literature Type of Information	General Summary Information	Measurement of Organizational Characteristics	Measurements/Variables	Measurement Instrument
<p>Transforming Cancer Care and the Role of Payment Reform: Lessons from the New Mexico Cancer Center²</p> <p>(https://www.brookings.edu/wp-content/uploads/2016/06/Oncology-Case-Study-August-2014-FINAL-WEB.pdf)</p>	<p>Report</p> <p>Descriptive Summary of Concepts</p>	<p>The report describes innovations in care delivery and includes a list of structural, process, and outcome measures that the New Mexico Cancer Center uses to promote clinical actions that improve the quality of cancer care.</p>	<p>NA</p>	<p>Structural Measures: (1) extended hours, (2) number of same day appointment slots available, (3) EHR downtime, (4) pulls of data from EHR into other systems, and (5) missing records and incomplete data.</p> <p>Process Measures: (1) compliance reports of triage for symptom management pathways, (2) treatment dashboards for adherence to clinical pathways, (3) number of extended hours visits per month, (4) number of calls triaged per month, (5) number of calls triaged per month, (6) number of triage pathways used, and (7) percentage of patients staged within one month of diagnosis.</p> <p>Outcome Measures: (1) patient satisfaction survey (see next): (1A) getting an appointment and starting treatment for a condition that needed care right away, (2) emergency department utilization, (3) real-time comparative effectiveness research of clinical pathways (see next): (3A) percentage of patients completing regimen on time, and (3B) percentage of patients who accessed required auxiliary pathways (nausea, diarrhea, etc.)</p>	<p>NA</p>

Source Title (Link)	Type of Grey Literature Type of Information	General Summary Information	Measurement of Organizational Characteristics	Measurements/Variables	Measurement Instrument
<p>American Society of Clinical Oncology – State of Cancer Care³</p> <p>(https://ascopubs.org/pb-assets/pdfs/2018-SOCCA-Census-Article-Infographic-Web-1650552446517.pdf)</p>	<p>Issue or Data Brief</p> <p>Data Brief</p>	<p>The American Society of Clinical Oncology – State of Cancer Care issue briefs identified potential barriers to providing oncology care in the United States. The major concerns by practices relate to payer pressures, including prior authorizations and denials and appeals for coverage. Other environmental pressures reported by practices are competitive pressures, concerns around staffing shortages, electronic health records, and increasing costs.</p>	<p>NA</p>	<p>(1) Prior authorizations, (2) coverage denials/appeals, (3) competitive pressures, (4) staffing issues, (5) electronic health records, and (6) increasing costs.</p>	<p>NA</p>

Source Title (Link)	Type of Grey Literature Type of Information	General Summary Information	Measurement of Organizational Characteristics	Measurements/Variables	Measurement Instrument
<p>AHRQ's Comparative Health System Performance (CHSP) Initiative⁴</p> <p>(https://www.ahrq.gov/sites/default/files/wysiwyg/chsp/compendium/2018-Compendium-TechDoc-update.pdf)</p>	<p>Technical documentation</p> <p>Descriptive Summary of Concepts</p>	<p>This is a website providing information on AHRQ's comparative health system performance compendium. It provides health-system level aggregated data on structural features of provider organizations.</p>	<p>NA</p>	<p>(1) Number of hospitals in systems, (2) Number of general acute care hospitals in systems, (3) Number of total physicians, (4) Number of primary care physicians, (5) Number of nurse practitioners, (6) Number of physician assistants, (7) Number of medical groups, (8) Multistate system, (9) Number of beds in systems, (10) Number of discharges in systems, (11) Number of residents in systems, (12) System offers any insurance product, (13) System offers an MA product, (14) System offers a Medicaid managed care product, (15) System offers a Health Insurance Marketplace product, (16) List of MA contracts offered by the system, (17) Total enrollment across all MA contracts owned by the system, (18) System participates in a Medicare APM, (19) Number of system-affiliated physicians participating in a Medicare ACO, (20) Number of system-affiliated physicians participating in a Medicare primary care transformation model, (21) Number of system-affiliated nursing home</p>	<p>NA</p>
<p>Oncology Care Model Evaluation Reports⁵</p> <p>(https://innovation.cms.gov/data-and-reports/2022/ocmar4-eval-payment-impacts-app)</p>	<p>Technical documentation</p> <p>Descriptive Summary of Concepts</p>	<p>These reports used multilevel sociodemographic and market-supply characteristics variables – beneficiary, practice, and market-levels - as control variables in their analyses.</p>	<p>NA</p>	<p>(1) CMS program alignment, (2) Beneficiary clinical characteristics, (3) Practice organization and affiliations, (4) Practice size and volume, (5) Practice specialty type, (6) Market size, (7) Market demographics, (8) Market exposure to Medicare Alternative Payment Models, (9) Market provider supply, (10) Market health services utilization</p>	<p>NA</p>

ACO = Accountable Care Organization; AHRQ = Agency for Healthcare Research and Quality; APM = Alternative Payment Model; CHSP = Comparative Health System Performance; CMS = Centers for Medicare & Medicaid Services; EHR = electronic health record; MA = Medicare Advantage; NA = not available or not applicable

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Appendix D. Evidence Tables

Evidence Table D-1. Approaches to measure organizational context and process characteristics for cancer screening (Guiding Question 2)

Theme	Author, year	Study design	Approach to measurement	Organizational characteristics measured	Brief summary of the pertinent findings
Impact of training, training types, workforce capacity assessments	Shaw, 2012 ¹	Cross-sectional	Interview with primary care practice team-members, using template approach to code transcribed data for themes and patterns.	Team-based reflections' effect on quality improvement	Organizational reflection promoted buy-in, motivation, and feelings of inspiration; Process reflection enhanced team problem solving and change management; Relational reflection enhanced discussions of Relational dynamics necessary to implement desired QI changes
Implementation of improvement projects and barriers to implementation	Beuhler, 2021 ²	Mixed-Methods	Used surveys developed as part of a quality indicator project to identify barriers faced by imaging administrators and LCS coordinators.	Support, barriers, and motivation as it relates to lung cancer screening implementation	Of the 76 sites contacted, only eight sites, which are different from the eight highlighted herein, reported that they did not face any barriers to screening, identified a gap between support and resources given to the CT imaging sites and motivation and commitment from the local LCS leaders.
	Brooks, 2022 ³	Retrospective Cohort	The Michigan Office of Health Information Technology provided summary data on all eligible MD and DO physicians who participated in its Medicaid MU program. Also utilized the Michigan Medicaid data warehouse.	12 CQMs - for preventive care, cancer screening and chronic illness; providers performance	Improvements in quality of infant well-child visits (mean difference = 10.2) and colorectal cancer screening (mean difference = 8.0 percent) were observed. Found no change or slight decreases for the other selected measures.

Theme	Author, year	Study design	Approach to measurement	Organizational characteristics measured	Brief summary of the pertinent findings
	Bucho-Gonzalez, 2021 ⁴	Prospective Cohort	In Phase 1, community sites were randomized to either tailored navigation from trained navigators or control. All participants reaching Phase II were navigated to complete their CRC screening; Staff hours for all study staff were tracked by activity using an Outlook® calendar-based tracking system.	The Phase 1 outcome was attendance at a clinic visit; screening competition; unit costs	The largest component of startup costs (32% of total) was community site recruitment. Implementation costs per class attendee were higher in the navigation group (\$1084) than control (\$798). But costs per participant who made a clinic appointment (\$3573 versus \$6292) and per participant who completed screening (\$4083 versus \$7640) were lower in the navigation group
	Carlin, 2015 ⁵	Retrospective cohort	Utilized commercial insurance and Medicaid data for enrollees and the Johns Hopkins ACG system to capture prior-year health status. Demographic data was captured from US Census Bureau data.	Screening rates, inpatient admissions, ACS admissions, readmissions, emergency department visits.	Moving a clinic system into a vertically integrated delivery system resulted in limited increases in quality of care indicators.
	Dwyer, 2022 ⁶	Prospective Cohort	Utilized the Practical, Robust Implementation and Sustainability Model (PRISM) model and the Patient Navigation Sustainability Assessment Tool for Preventive Cancer Screening (PNSAT).	PNSAT Scores; facilitators and barriers to implementation and sustainability of patient Colorado Cancer Screening Program (CCSP)(i.e., patient navigation)	The domains most frequently targeted for improvement in the sustainability plans were Workflow Integration (8 clinics), Communication, Planning, and Implementation (8 clinics), and Funding Stability (5 clinics).
	Frederman, 2014 ⁷	Retrospective Cohort	Consulted with leadership from the departments of radiology and information technology, and sections of primary care, pulmonary, cardiothoracic surgery, and oncology, an electronic clinical reminder was created.	Patients eligible for lung cancer screening; patients who received lung cancer screening with low-dose computed tomography (CT)	During the study period, 1082 patients (76.4%) who agreed to screening had completed the low-dose CT. Of the 1082 patients who underwent low-dose CT, initial screening CT results were abnormal in 689 (63.7%) and normal in only 393 (36.3%)

Theme	Author, year	Study design	Approach to measurement	Organizational characteristics measured	Brief summary of the pertinent findings
	Frosch, 2011 ⁸	Feasibility Study	Qualitative field notes and ethnographic field methods.	Staff/physicians practices and work-flow	Practices that were better able to integrate the project had adequate clinic infrastructure, a relatively well-matched patient pool, and positive work and patient care environments.
	Kegler, 2018 ⁹	Semi-structured Interviews	Semi-structured interviews with key informants using a codebook developed based on the CFIR constructs, and used quarterly reports to ACS through an online tracking tool.	CFIR construct, used NVivo 10 to generate a report that included all text coded for each construct from all transcripts within each site; Completed a cross-case analysis to identify CFIR constructs that demonstrated salience in implementing EBPs across sites; screening targets and the actual number of patients screened	Of the five CFIR domains, constructs within four CFIR domains (inner setting, outer setting, individual characteristics and process domains) were particularly salient in discussions of implementation while constructs within one CFIR domain (characteristics of the intervention) were not.
	Mader, 2016 ¹⁰	Prospective Cohort	Physicians, nurses, and other care providers at each practice received a continuing medical education-accredited academic detailing session (ADS) presented by a primary care physician with expertise in cancer prevention recommendations.	Changes in screening rates, practice staff attitudes and experiences, readiness for transformation	Average screening rates for breast cancer increased by 13% (p<.001), and rates for colorectal cancer increased by 5.6% (p<001). Practices implemented a mix of electronic health record data cleaning workflows, provider audits and feedback, reminder systems streamlining, and patient education and outreach interventions.
	Murphy, 2022 ¹¹	Retrospective cohort	Used Maryland Medicaid administrative claims data.	Cancer screening measures: receipt of pap smear, mammography, colonoscopy, sigmoidoscopy, or fecal occult blood test	Maryland Medicaid behavioral health home (BHH) enrollment associated with increased screening for cervical and breast cancer but not for colorectal cancer

Theme	Author, year	Study design	Approach to measurement	Organizational characteristics measured	Brief summary of the pertinent findings
	Rauscher, 2020 ¹²	Secondary Data Analysis	Data submitted by facilities across the state of Illinois for screening mammograms performed in 2006, 2009, 2010, 2011 and 2013; Calculated the proportion of facilities meeting each specific benchmark by time point and examined trends in these proportions.	Trends for meeting benchmarks by Breast Imaging Center of Excellence (BICOE) status, Recall Rate, Biopsy recommendation rate, cancers from abnormal screen (PPV1), cancer from biopsied (PPV3), Cancer detection rate, Proportion minimal, Proportion early stage, Timely follow-up imaging, Timely biopsy, Not lost at imaging, Not lost at biopsy, Known minimal status, Known stage at diagnosis.	The number of facilities able to show that they met specific benchmarks increased with length of participation for many but not all measures. Trends towards meeting more benchmarks were apparent for cancer detection, timely imaging, not lost at biopsy, known minimal status (p<0.01 for all), and proportion of screen-detected cancers that were minimal and early stage (p<0.001 for both).
	Shih, 2011 ¹³	Retrospective Cohort	Practices were recruited by phone, and signed a letter of consent allowing independent medical reviewers to conduct EHR-based patient chart abstraction.	Quality measures for breast cancer screening and smoking-cessation intervention	More than half of the practices increased their patients' blood pressure control, recorded BMI, breast cancer screening, and HbA1c screening by 5 percentage points.
	Weiner, 2017 ¹⁴	Pre-Post	Practice facilitator worked with clinic staff to select and implement policies and procedures from a tool kit developed by the National Colorectal Cancer Roundtable. Data collected through semi-structured interviews.	Recommendation for CRC screening; facilitators of and barriers to implementing office systems changes using the tool kit (implementation policies and practices); satisfaction with the amount and quality of support provided by the practice facilitators (implementation support); and the extent to which systematic CRC screening was expected, supported, and rewarded (implementation climate)	Overall, the percentage of eligible patients who received a documented recommendation for CRC screening increased from 15% preintervention to 29% postintervention (p < .001). Nonwhite patients were significantly more likely to receive a recommendation during the preintervention period (22% vs 12%, p< .001),
	Yabroff, 2011 ¹⁵	Retrospective cohort	Used data from the 2006–2007 National Survey of Primary Care Physicians' Recommendations and Practices for Breast, Cervical, Colorectal, and Lung Cancer Screening.	Clinical information systems strategy, delivery system design strategy, decision support strategy, physician and practice characteristics	Few physicians report using a comprehensive set of strategies to support cancer screening

Theme	Author, year	Study design	Approach to measurement	Organizational characteristics measured	Brief summary of the pertinent findings
Leadership	Mejia, 2022 ¹⁶	Cross-sectional	53 key informants were interviewed to discuss perceptions of adoption of screening and referral practices across 15 community health centers. Interview topics informed by the CFIR framework.	Factors associated with feasibility and potential facilitators and barriers of a new evidence based comprehensive primary care and community health-based program aiming to delivery of Lung Cancer Screening and Tobacco Cessation (LCS-TC)	Three major themes representing facilitators and barriers were identified: (1) Allocation of resources and services coverage (2) need for a collaborative process to engage stakeholders and identify champions (3) stakeholders need different types of evidence to support implementation.
New roles or team composition	Sinclair, 2019 ¹⁷	Cross-sectional	Medical chart data was collected from the Amity Medical Group for pharmacist integrated and non-pharmacist integrated cohorts.	The impact of a pharmacist embedded within a primary care practice on quality measures of the Merit-Based Incentive Payment System	Colorectal cancer screening (55% of pharmacist cohort vs. 28% of non-pharmacist cohort)
Participation in total care delivery models	Angelotti, 2015 ¹⁸	Continuous quality improvement data collection, 24-month, no control	Data from quarterly narrative reports submitted by hospitals and residency programs were used to assess achievement of outcomes. A resident survey was created and included questions regarding residents knowledge and attitudes toward PCMH, quality measurement, and team-based care.	Number of sites achieving high-level PCMH recognition under NCQA's 2011 standards; Improvements in resident continuity; implementation and improvement in at least one care coordination and integration project chosen from a predetermined list: care transitions, culturally competent care, Improved access and coordination between primary and specialty care, care coordination and integration project composites	All sites enhanced resident education using PCMH principles through patient empanelment, development of quality dashboards, and transforming resident scheduling and training. Clinical quality outcomes showed improvement across the demonstration, including better performance on colorectal and breast cancer screening rates (rate increases of 13%, $p < .001$, and 11%, $p < .011$, respectively).
	Fifield, 2013 ¹⁹	RCT	Intervention received a tailored practice redesign support. Facilitators engaged physicians and staff on-site in a series of activities to implement the PCMH model.	PCMH participation; qualitative assessment of the amount of practice redesign, received by practices revealed that most practices (78%); received the maximum amount, while the other 22%, received some or very little support	Compared to control physicians, intervention physicians significantly improved quality indicator breast cancer screening over 3 years (intervention +3.5 percentage points, control -0.4 percentage points, $p=0.03$).

Theme	Author, year	Study design	Approach to measurement	Organizational characteristics measured	Brief summary of the pertinent findings
	Fortuna, 2021 ²⁰	Pre-Post	Survey responses for each individual variable were collected with either "Satisfaction" or "Agreement" scales (range of 1 to 10). Composite variables were created for each domain by taking an average of the individual variables within the composite category.	Experiences with PMCH across 5 domains: career, satisfaction, work-life balance, patient care, professional experience, and teamwork	Implementation of the PCMH model did not result in changes in provider, nurse, and staff responses to composite measures of satisfaction (P = 0.45), work-life balance (P = 0.68), teamwork (P = 0.26), patient care (P = 0.62), or professional experience (P = 0.14). Physicians experienced a negative, but mostly nonsignificant, change in all composite measures with implementation of the PCMH model. Quality markers improved for breast cancer screening (53.9% to 77.4%; p< 0.001), and colorectal cancer screening (43.9% to 70.3%; p< 0.001).

Theme	Author, year	Study design	Approach to measurement	Organizational characteristics measured	Brief summary of the pertinent findings
	Friedberg, 2015 ²¹	Pre-Post	Developed a survey instrument to measure practices' structural capabilities, including use of disease management, registries, and electronic health records.	Performance feedback: Quality feedback to PCPs; Utilization or cost feedback to PCPs; monthly or more frequent meetings about quality; monthly or more frequent meetings about utilization; registry use: registry of patients who are overdue for screening services, registry of patients who are overdue for chronic disease services, registry of patients who are out of target range for chronic disease laboratory values, registry of patients at high risk of disease complications or hospitalization; care management: care management for patients at high risk of disease complications or hospitalization, specially-trained non-physician staff who help patients better manage their diabetes; Specially-trained non-physician staff who help patients better manage their asthma; routine assessment of self-management needs of chronically ill patients; referral system for linking patients to community programs; outreach systems to contact patients due for services; other outreach systems; electronic health record capabilities; access: weekend care offered regularly; evening care offered ≥ 2 nights per week; appointments for new patients within 2 weeks.	All pilot practices received recognition as medical homes during the intervention. By intervention year 3, relative to comparison practices, pilot practices had statistically significantly better performance on process measures of breast cancer screening but not colorectal cancer screening

Theme	Author, year	Study design	Approach to measurement	Organizational characteristics measured	Brief summary of the pertinent findings
	Haggstrom, 2012 ²²	Cross-sectional	Self-reporting surveys where several domains were measured with Likert scales.	Six components of the chronic care model: self-management support, clinical decision support, delivery system design, clinical information systems, health care organization, community resources, cancer care process improvement	Implementation of Chronic Care Model (CCM), not solely Health Disparities Cancer Collaborative (HDCC) participation, was associated with cancer care process improvement. Organizational and individual change is challenging among the large, healthy populations. Furthermore, CCM implementation appeared to be the mechanism for improved cancer screening and follow-up in the final models. Establishes pathways from a quality improvement intervention to organizational process changes (chronic care model implementation) to organizational outcomes (improved teamwork) to clinical process changes (breast, cervical, and colorectal cancer screening and follow-up).
	Kern, 2016 ²³	Longitudinal cohort	Obtained data on which physicians received payments through the federal EHR Incentive.	PCMH participation controlled for EHR use; physicians who implemented the PCMH, those who used EHRs but did not implement the PCMH; those who used paper records without the PCMH	There were no significant differences between the PCMH group and the control groups for the 2 measures - breast cancer screening for women, colorectal cancer screening - compared with EHRs and paper records

Theme	Author, year	Study design	Approach to measurement	Organizational characteristics measured	Brief summary of the pertinent findings
	Rosenthal, 2013 ²⁴	Interrupted time series	Used the NCQA recognition audit data to summarize mean and median scores in each domain at baseline and at the end of year 2.	Patient-centered medical home structures and processes used by the NCQA's recognition process from the NCQA; recognition audit; NCQA Physician Practice Connections Standards in 9 areas: access and communication, patient tracking and registry functions, care management, patient self-management support, electronic prescribing, test tracking, referral tracking, performance reporting and improvement, advanced electronic communication	The Chronic Care Sustainability Initiative pilot program was associated with no significant improvements in any of the cancer-related quality measures: colon cancer screening, breast cancer screening, and cervical cancer screening. At the end of the pilot program, all five practices had reached level III status (attaining 75- 100 points). Pilot practices made notable progress in patient self-management support, electronic prescribing, and the tracking of laboratory tests and results. For advanced electronic communication, which includes the ability to message patients through secure e-mail, scores were little changed.
	Rosenthal, 2016 ²⁵	Difference-in-difference analyses	Identified comparison practices in the same geographic region through propensity score matching using the claims data.	PCMH participation	The pilot was associated with increased cervical cancer screening after two (12.5 % increase, p<0.001) and three years (9.0 % increase, p<0.001), but lower rates of colon cancer screening (21.1 % and 18.1%at two and three years, respectively, p<0.001). No changes in breast cancer screening.

Theme	Author, year	Study design	Approach to measurement	Organizational characteristics measured	Brief summary of the pertinent findings
	Schapira, 2016 ²⁶	Cross-sectional	Survey fielded using email with a link to a Web-based survey and mailed versions. The questionnaire content was adapted from the NCI-sponsored National Survey of Primary Care Physicians' Cancer Screening Recommendations and Practices.	PCMH participation, EHR decision support, type of screening performance report (comparative, automated routine or automated follow-up), system for patient reminders (verbal, US mail, patient portal, phone, e-mail, navigator)	Less than half reported EHR decision support for breast (48.8 %) or cervical cancer (46.2 %) screening. A minority received comparative performance reports for breast (26.2 %) or cervical (19.7 %) cancer screening, automated reports of patients overdue for breast (18.7 %) or cervical (16.4 %) cancer screening, or follow-up of abnormal breast (18.1 %) or cervical (17.6 %) cancer screening tests. In multivariate analysis, reported NCQA recognition as a PCMH was associated with greater use of comparative performance reports of guideline adherent breast (OR 3.23, 95 % CI 1.58–6.61) or cervical (OR 2.56, 95 % CI 1.32–4.96) cancer screening and automated reports of patients overdue for breast (OR 2.19, 95 % CI 1.15–41.7) or cervical (OR 2.56, 95 % CI 1.26–5.26) cancer screening.

Theme	Author, year	Study design	Approach to measurement	Organizational characteristics measured	Brief summary of the pertinent findings
	Shi, 2015 ²⁷	Cross-sectional	Utilized the Safety Net Medical Home Scale (SNMHS) evidenced adequate reliability and validity in the development sample	The Safety Net Medical Home Scale (SNMHS) with 52 items across 6 subscales: Access and communication, patient tracking and registry (ability to list patients by clinical characteristics), care management (ability to manage patient care through reminders, education, care coordination), test and referral tracking (ability to monitor from point of order until result is received), quality improvement (ability to systematically collect performance data and improve care), external coordination (ability to refer and receive external updates on patients)	The mixed results highlight the importance of examining relationships between specific PCMH domains and specific clinical quality measures, in addition to analyzing overall PCMH scores which could yield distorted findings. One process measure is cervical cancer screening. Findings showed different directional relationships, with some PCMH domains (care management, test/referral tracking, quality improvement, and external coordination) showing little or no effect on outcome measures of interest. One domain (access/communication) associated with improved outcomes, and one domain (patient tracking/registry) associated with worse outcomes
Structural and resource-related characteristics	Chou, 2015 ²⁸	Cross-sectional	Merged patient level, organizational level, and area level data sources including External Peer Review Program, Primary Care Module of the Clinical Practice Organizational Survey, the VHA Survey of Women Veterans Health Programs and Practices, and US Department of Health and Human Services Area Resource File.	Organizational factors, mammograms and cervical/colorectal screenings	Resource sufficiency led to increased odds of screening. Findings identified organizational processes associated with better performance.
	Collie-Akers, 2012 ²⁹	Cross-sectional	Used a 24-item survey of mammography facilities.	Description of provider characteristics among screening facilities	This survey indicate that the capacity of mammography facilities vary dramatically across many characteristics of capacity.
	Gawron 2021 ³⁰	Cross-sectional	Definitions in Medical Expenditure Panel Survey.	Health Insurance coverage, poverty (annual income by FPL), comorbidities, and provider characteristics	A positive effect of educational efforts and healthcare reform with coverage of screening

Theme	Author, year	Study design	Approach to measurement	Organizational characteristics measured	Brief summary of the pertinent findings
	Onega, 2018 ³¹	Cross-sectional	Utilized a web-based survey completed by 15 primary care practices.	Breast cancer screening percentage	After accounting for woman-level characteristics, the remaining variation in breast cancer screening was largely due to provider and health system variation.
	Smieliauskas, 2014 ³²	Cross-sectional	Combined information from health interview surveys to estimate the numbers of smokers who meet the USPSTF eligibility criteria, and information from administrative datasets to estimate the numbers of radiologists and the numbers of scans they currently interpret in Health Service Areas (HSAs) nationwide.	The prevalence of capacity constraints in the radiologist workforce and resulting potential disparities in access to lung cancer screening	1,023,943 lived in HSAs with increases of at least 5%. HSAs that were rural, with many eligible smokers, and disproportionately Hispanic or low-income, smokers had significantly higher odds of facing capacity constraints.
	So, 2012 ³³	Prospective cohort	Collected data from the VA National Data Systems, linked with Medicare claims data.	Percentage of men at who received prostate specific antigen screening, medical center and patient factors associated with prostate specific antigen screening	Substantial practice variation exists for PSA screening in older men with limited life expectancy across VAs. The high center-specific correlation of screening among men with limited and favorable life expectancies indicates that PSA screening is poorly targeted according to life expectancy.

Theme	Author, year	Study design	Approach to measurement	Organizational characteristics measured	Brief summary of the pertinent findings
Workload/Workflow Design/Work Performance	Davis, 2019 ³⁴	Comparative case study	Collected publicly reported data about coordinated care organizations (CCO) characteristics and CRC screening performance in early 2016. Conducted CRC technical assistance consultation meetings with CCO leadership and quality improvement teams during June and July of 2016. Conducted key informant interviews with a purposive sample of stakeholders from CCOs, primary care clinics, and the state from February 2016 through August 2016.	Establishing relationships and building partnerships; producing and sharing performance data; developing a process and infrastructure to support quality improvement	Findings identified partnership, performance data, and quality improvement infrastructure as critical dimensions.
	Shaw, 2013 ³⁵	RCT	Qualitative data included field notes and audiotaped RAP and learning collaborative meetings. CRC screening rates and physician recommendation for CRC screening were determined by medical record reviews.	CRC Screening rates, Quality Improvement contributing factors (practice, team structure, leadership, engagement, psychological safety, intra-/inter-communication)	Incremental quality indicator interventions can be effective, practice transformation requires enhanced organizational learning and change capacities. The SCOPE model of quality indicators may not be an optimal strategy if short-term guideline concordant numerical gains are the goal.

ACG = Adjusted Clinical Group; ACS = American Cancer Society; ADS = academic detailing session; BHH = behavioral health home; BICOE = Breast Imaging Center of Excellence; BMI = body mass index; CCM = chronic care model; CCO = coordinated care organizations; CCSP = Colorado Cancer Screening Program; CFIR = Consolidated Framework for Implementation Research; CI = confidence interval; CQM = clinical quality measure; CRC = colorectal cancer; CT = computed tomography; DO = Doctor of Osteopathic Medicine; EBP = evidence-based practice; EHR = electronic health record; FPL = federal poverty level; HAS = health services area; HbA1c = glycated hemoglobin; HC = health centers; LCS = lung cancer screening; LCS-TC = Lung Cancer Screening and Tobacco Cessation; MD = Doctor of Medicine; NCI = National Cancer Institute; NCQA = National Committee for Quality Assurance; OR = odds ratio; PCMH = patient-centered medical home; PCP = primary care physician; PNSAT = Patient Navigation Sustainability Assessment Tool for Preventive Cancer Screening; PPV = positive predictive value; PRISM = Practical, Robust Implementation and Sustainability Model; PSA = prostate-specific antigen; QI = quality improvement; RAP = reflective adaptive process; RCT = randomized controlled trial; SCOPE = Supporting Colorectal Cancer Outcomes through Participatory Enhancements; SNMHS = Safety Net Medical Home Scale; USPSTF = United States Preventive Services Task Force; VA = Veterans Administration; VHA = Veterans Health Administration

Evidence Table D-2. Approaches to measure organizational context and process characteristics for cancer diagnosis and treatment (Guiding Question 2)

Theme	Author, year	Study design	Approach to measurement	Organizational characteristics measured	Brief summary of the pertinent findings
Implementation of Improvement Projects and Barriers to Implementation	Patel, 2023 ³⁶	Qualitative	Conducted semi-structured interviews with oncologists, nurses, social workers, medical assistants, and front-desk staff.	Interviews focused on perspectives on: reach, effectiveness, adoption, effectiveness data, flexibility financial implications, implementation, care coordination, evaluation, maintenance, leadership, retention and staffing, and continuous evaluation.	Noted positive shift in perception of advance care planning and symptom management approach. Most participants agreed a combination of top-down and bottom-up approaches was most effective and promoted team-based care.
Leadership	Lawrence, 2012 ³⁷	Cross-sectional	A web-based survey on the practice of quality assurance peer review chart rounds was sent to the chief resident of each institution across the United States.	Departmental demographics, attendance at quality assurance meetings by various disciplines, the thoroughness with which different treatment modalities were peer reviewed, use of advanced technologies within the department, depth of discussion regarding patient's history and staging workup, and frequency with which treatment changes were recommended	Chart rounds led to both minor and major treatment changes. Whereas at the majority of institutions changes were rare (<10% of cases), 39% and 11% of institutions reported that minor and major changes, respectively, were made to more than 10% of cases.

Theme	Author, year	Study design	Approach to measurement	Organizational characteristics measured	Brief summary of the pertinent findings
Organizational reactions to environmental forces	Miller, 2019 ³⁸	Retrospective cohort	National Cancer Database 2015 data were retrospectively reviewed to compare patients treated at CoC centers with and without NAPBC accreditation for compliance on six breast cancer quality measures.	Six breast specific quality measures including: was radiation therapy administered within 1 year, was combination chemotherapy is considered or administered within 4 months, was Tamoxifen or third-generation aromatase inhibitor considered or administered within 1 year, was needle/core biopsy performed, and target rate of 50% eligible patients treated with breast-conserving surgery.	NAPBC centers were twice as likely as non-NAPBC centers to perform at the level expected by the CoC. NAPBC centers achieved significantly higher performance on four of the five quality measures at the patient level and on five of six measures at the facility compared to non-NAPBC centers.
Psychological states/traits of providers and provider groups	Friese, 2021 ³⁹	Cross-sectional	Survey for job satisfaction, safety organizing scale, Nurse-Physician Communication Questionnaire.	Job Satisfaction, Safety Organizing Scale, quality of clinician communication, electronic health record capability	85% reported they were satisfied or very satisfied with their current position. Patient safety and accuracy of clinician communication were positively and significantly associated with job satisfaction.
	Tetzlaff, 2022 ⁴⁰	Cross-sectional	Maslach Burnout Inventory (22 items), Areas of Worklife Survey (18-items).	Measured work life and burnout	The association between workload and burnout was significant with nearly a 100% increase in the odds of burnout associated with a lack of job fit for the workload domain (odds ratio [OR] for burnout 1.99, P< .001).

Theme	Author, year	Study design	Approach to measurement	Organizational characteristics measured	Brief summary of the pertinent findings
Structural/Resource-related characteristics	Ryoo, 2014 ⁴¹	Cross-sectional	Existing quality indicators and guidelines available pertaining to management of NSCLC and SCLC were identified by systematic literature review. Measures were refined after structured discussion and panels. The resulting set of quality indicators were then grouped into domains of Diagnosis and Staging, Treatment, Supportive Care, and End-of-Life Care.	Adherence to 23 quality indicators across four domains (Diagnosis and Staging, Treatment, Supportive Care, End-of-Life Care)	No facility performed consistently well across all domains. Less than 1% performed in the lowest quartile for all. Few facility-level characteristics were associated with care quality. For End-of-Life Care, diagnosis and treatment within the same facility, availability of cancer psychiatry/psychology consultation services, and availability of both inpatient and outpatient palliative care consultation services were associated with better adherence.
Workload/Workflow Design/Work Performance	Dias-Santagata, 2022 ⁴²	Pre-post	Pulled data from laboratory information system, and chart review	Number of tests, average number of tests per order, number of tests by primary site, test results (normal vs abnormal), test recommendation.	Significant increase in requests for gastrointestinal and hepatopancreatobiliary patients, increase in compliance testing recommendations, and increase in the fraction of abnormal results. No indication the rollouts did not negatively affect patient treatments.

CoC = Commission on Cancer; NAPBC = National Accreditation Program for Breast Centers; NSCLC = non-small cell lung cancer; OR = odds ratio; SCLC = small cell lung cancer

Evidence Table D-3. Approaches to measure organizational context and process characteristics for cancer treatment only (Guiding Question 2)

Theme	Author, year	Study design	Approach to measurement	Organizational characteristics measured	Brief summary of the pertinent findings
Financial metrics	O'Neil 2016 ⁴³	Interrupted time series	Utilized administrative data (Medicare FFS fee schedule).	Changes in Medicare fee schedule payment for Minor cystoscopic procedure	Financial incentives in bladder cancer care have unintended and costly consequences in the current FFS environment.
Impact of training, training types, workforce capacity assessments	Trogdon, 2018 ⁴⁴	Retrospective cohort	Used multi-payer claims-based, shared patient network measures to investigate the influence of care coordination on adherence to guidelines, survival, and utilization among colorectal cancer patients.	Adherence to guidelines; consultation with a medical oncologist (stage III), receipt of adjuvant chemotherapy (stage III), and receipt of surveillance colonoscopy posttreatment, 5-year overall survival, number of surveillance radiology studies, any unplanned hospitalization, and any emergency department visit	Team experience is associated with patients' quality of care, survival, and utilization.
Implementation of improvement projects and barriers to implementation	Deraniyagala, 2015 ⁴⁵	Prospective Cohort	Quality and safety team developed an event-reporting system program and utilization of Likert-scale survey.	Number of reported [adverse safety] events; staff opinion on safety culture and effectiveness of event-reporting system	An electronic event-reporting system streamlines quality and safety in a radiation oncology department by increasing reported events and promoting a safety culture
	Lamb, 2013 ⁴⁶	Retrospective Cohort	A survey was used at each clinic site to assess how participants responded to the information reported. Utilized the Dartmouth Atlas Project through the Dartmouth Institute for Health Policy and Clinical Practice to obtain an independent, external measurement of Collaborative performance over time and compare it to areas not participating in the Collaborative.	Screening Preventive Measures for breast, cervical and colorectal cancer	The outcomes demonstrated that public reporting was associated with improvement in health quality and that large physician group practices will engage in improvement efforts in response.

Theme	Author, year	Study design	Approach to measurement	Organizational characteristics measured	Brief summary of the pertinent findings
	Novak, 2016 ⁴⁷	Prospective Cohort	Utilized an incident reporting system to identify the origination and detection points of near-miss errors, and near-miss risk index (NMRI)	Point of [error] origination within each of the broad workflow areas and average NMRI of events	Analysis revealed that the workflow within treatment planning was the most frequent area of event origination (33%); Found that events originating in the simulation process were of higher severity than events originating in other workflow areas.
	Schlueter, 2022 ⁴⁸	longitudinal qualitative case studies	Two sequential rounds of qualitative interviews with key stakeholders in awardee programs, implementation partner organizations, and partner clinics (all FQHCs).	Emerging themes across awardees and clinics: structural characteristics, readiness for implementation, networks/communication, culture, readiness assessments to tailor implementation, funding, clinic champions, leadership support, team-based care, workflow, clinic policies and procedures, and evidence-based interventions and supporting activities.	Themes related to sustainability included the importance of ongoing electronic health record (EHR) support, clinic leadership support, team-based care, and EBI and SA integration with clinic policies, workflows, and procedures.
	Sheetz, 2019 ⁴⁹	Retrospective cohort	Merged data from the American Hospital Association's annual survey on hospital system affiliation with Medicare claims.	Degree of centralization, postoperative complications and death, 30-day mortality	Greater centralization of complex surgery associated with better outcomes

Theme	Author, year	Study design	Approach to measurement	Organizational characteristics measured	Brief summary of the pertinent findings
	Siegel, 2014 ⁵⁰	Retrospective Cohort	Representatives from the 11 oncology sites participating in FIQCC identified quality measures consistent with evidence-, consensus-, and safety-based guidelines that could be abstracted from medical records of breast, colorectal, and non-small cell lung cancer patients; Medical chart reviews were conducted on all patients diagnosed with CRC with a medical oncology appointment in 2006 and 2009.	35 Quality indicators determined by representative oncology experts [represented in table. 2-3]	Significant improvements were noted from 2006 to 2009, with large gains in surgical/pathological QCs (eg, documenting rectal radial margin status, lymphovascular invasion, and the review of ≥ 12 lymph nodes) and medical oncology QCs (documenting planned treatment regimen and providing recommended neoadjuvant regimens). Documentation of perineural invasion and radial margins significantly improved; however, adherence remained low (47% and 71%, respectively). There was significant variability in adherence for some QCs across institutions at follow-up
	Smith, 2019 ⁵¹	Pre-Post	Author defined measures to evaluate the PCR (e.g., access), tracked and extracted data from EHR records, tracked staff hours using Kronos Time Solution System, conducted surveys to determine clinicians/staff experiences and utilized the Physician Worklife Study to assess burnout.	Access (e.g., patient appointments) , Clinical Quality Metrics (colorectal cancer screening) and staffings (staff hours per visit), clinician/staff experiences and burnout	The PCR model is associated with simultaneous improvements in quality, access, and clinician experience, as well as reductions in burnout, while maintaining staffing costs.
	Williams, 2020 ⁵²	Secondary Data Analysis	Electronic survey on the availability of specialty providers, supportive services, and practice characteristics.	Availability of clinical practices/specialties and clinical providers specific for geriatric care	Only a third of community oncology practices have access to a geriatrician within their group and only 5% of community sites have access within the oncology clinic.

Theme	Author, year	Study design	Approach to measurement	Organizational characteristics measured	Brief summary of the pertinent findings
	Yoo, 2018 ⁵³	Retrospective Cohort	Data collected from patient-visits and survey of residents.	Clinic compliance; patient adherence; resident experience	This analysis confirms previous reports that the incorporation of continuity care improves patient compliance. Clinic adherence increased by 9.4% in a large safety-net hospital population with traditionally high rates of no-shows.
New roles or team composition	Rauenzahn, 2017 ⁵⁴	Pre-Post	The ESAS questionnaire was administered by trained medical assistants at each clinic visit, regardless of disease status or prior responses or referrals. The completed ESAS form was reviewed by the provider during each visit to decide if a palliative referral was appropriate based on patient-reported symptom burden.	Quantitatively describe the palliative referral rates and symptom burden in a South Texas cancer center and establish a palliative referral system by implementing the Edmonton Symptom Assessment Scale (ESAS)	Improved referral rates 10-fold (pre: 0.07%, post: 0.8%). Assessment of the ESAS scores suggests that symptom burden remains similarly high from initial to follow-up encounters.
Organizational reactions to environmental forces	Patel 2022 ⁵⁵	Cross-sectional	Thematic analysis guided by Donabedian Quality of Care framework.	Psychological Unmet Needs, Lack of understanding regarding precision medicine and associated costs, undertreated symptoms, financial concerns, trusting relationship with the cancer care team and support from the community	This study identified modifiable health system lung cancer care delivery barriers that contribute to persistent disparities.
Organizational Readiness	Lynch 2021 ⁵⁶	Cross-sectional	Self-developed survey (24-item multiple choice and open-ended questions) was emailed to 567 ambulatory oncology leaders.	Cancer program's reported readiness and 4Ms domains (from the 4M framework): what matters, medication, mentation, mobility	67% of respondents reported that their program could deliver age-friendly cancer care within five years. Respondents less frequently indicated that they employed specific 4Ms elements: medications (41%), mobility (32%), mentation (14%), and what matters (11%).

Theme	Author, year	Study design	Approach to measurement	Organizational characteristics measured	Brief summary of the pertinent findings
Participation in total care delivery models	Blayney, 2012 ⁵⁷	Longitudinal cohort	The measures derived from expert consensus, clinical trial results that test anticancer therapies, and published guidelines. Data collected retrospectively by office personnel using a structured data entry tool.	Measures are grouped into the following 7 modules: core processes, processes specific to a particular cancer type, or disease-specific processes, processes relating to supportive care, including symptom and toxicity management, processes involved in caring for patients at the end of life	For breast and colorectal cancer care, there was a more than 85 percent rate of adherence to quality care processes. For end-of-life care processes, the adherence rate was 73 percent, and for symptom and toxicity management care processes, adherence was 56 percent. In particular, Found variations in care around the fundamental oncologic task of management of cancer pain.
Psychological states/traits of providers and provider groups	Kusano, 2014 ⁵⁸	Cross-sectional	Online survey was administered to the membership of the Society of Chairs of Academic Radiation Oncology Programs (SCAROP). Burnout was measured with the Maslach Burnout Inventory-Human Services Survey (MBI-HSS).	Burnout in chairs of academic radiation oncology departments	The most frequently reported stressors rated as "large" or "extreme" were hospital or department budget deficits, followed by faculty recruitment and retention. The mean MBI-HSS subscale scores of radiation oncology chairs compared favorably with those of chairs of other specialties
Safety and safety culture	Sundaraman 2014 ⁵⁹	Pre-Post	Not specified.	Use of EMR-based CRM program, implementation of Crew Resource Management	Near miss-rates (safety measure) have improved as a result of the CRM implementation.

Theme	Author, year	Study design	Approach to measurement	Organizational characteristics measured	Brief summary of the pertinent findings
	Woodhouse, 2016 ⁶⁰	Pre-Post	Multifaceted approach for each initiative of the SC program using surveys and document review process. Evaluation of Patient Safety Culture based on AHRQ survey's safety grade.	A combination of 6 quality initiatives in a comprehensive safety culture program: implementation of quality and safety culture educational curriculum, hard stop policy to standardize patient safety checks, automated electronic system for peer review, increased leadership oversight through a safety committee, electronic condition reporting system, routine assessment of serious events, evaluation of state-reported medical events	Comprehensive safety culture (SC) program at the University of Pennsylvania increased staff fundamental safety knowledge, enhanced peer review with an electronic system, and special cause variation of SRMEs on control chart analysis.
Structural and resource-related characteristics	Bickell, 2017 ⁶¹	Cross-sectional	Used qualitative comparative analysis from interviews with key informants.	Underuse of breast cancer care, organizational conditions	At safety-net hospitals, underuse of needed cancer therapies is associated with organizational approaches to track and follow-up treatment. Findings provide varying approaches to safety nets to improve cancer care delivery.
	Cha, 2022 ⁶²	Cross-sectional	Retrospective analysis of patient experience survey data for adult patients seen in consultation at two large cancer centers. Five survey questions regarding physician-patient communication and practice experience that were used on both institutions' patient experience surveys were selected for the study to examine the association of patient, practice, and practice related factors and patient experience scores.	Patient-, physician-, and practice-level predictors of patient experience scores in patients undergoing radiation therapy	Physician gender was not associated with any measured patient experience outcomes ($P > 0.40$ for all). Independent predictors of higher score included a wait-time experience classified as "good" compared with "not good" ($q < .001$ for all).

Theme	Author, year	Study design	Approach to measurement	Organizational characteristics measured	Brief summary of the pertinent findings
	Jacobs, 2014 ⁶³	Cross-sectional	The sample is comprised of physicians who responded to the 2011 CCOP Physician Survey.	Physician enrollment in NCI Community Clinical Oncology Program (CCOP)	Physician attitudes and CCOP organizational factors had positive direct effects, but not indirect effects, on physician enrollment of patients.
	Neuss, 2013 ⁶⁴	Retrospective cohort	Reviewed medical records of patients diagnosed with invasive malignancy, including submission of data on core domain module measures.	Improvement of quality scores, adherence to quality indicators	Participation over time was highly correlated with improvement in measured performance. Greater and faster improvement was seen in measures concerning newly introduced clinical information. Some measures showed no change despite opportunity for improvement.
Workload/Workflow Design/Work Performance	Chera, 2014 ⁶⁵	Prospective cohort	Prospective quantitative data were collected in order to assess if the initiative was operating as intended (ie, measuring the process), and/or assess if the initiative was having the desired result (ie, measuring the outcome).	Workload levels for nurses, changes in work flow, treatment rate, rates of rescheduling/replanning, standardized nursing/resident functions, patient wait time, standardizing pre-simulation instructions, overall changes in patient safety culture	Quality improvement initiatives can be successfully implemented in an academic radiation oncology department to yield measurable improvements in operations resulting in improvement in patient safety culture.
	Ignoffo, 2021 ⁶⁶	Cross-sectional	Interview-based surveys were conducted with experienced oncology pharmacists in leadership roles (49-item survey) at 20 organizations balanced by geographic region and type of practice site.	Characteristics and frequency of clinical functions; education of healthcare professionals; anticipated trends of services; characteristic of participating sites (volume, size, academic/nonacademic, payment models)	Anticipated increases in demand for oncology pharmacists strongly suggest the need for more PGY2 oncology residency programs and on-the-job oncology training programs.
	Mazur, 2017 ⁶⁷	Prospective cohort	Assessments were performed in a simulation laboratory that replicated the RT professionals' (radiation oncologists, physicists, dosimetrists) typical working environment. Utilized the NASA-TLX global and individual dimensions scores to review workload.	Workload, procedural compliance and time-to-scenario completion	Simulation-based training may be a tool to improve procedural compliance of RT professionals and to acquire new skills and knowledge to proactively maintain RT professionals' preoccupation with patient safety.

Theme	Author, year	Study design	Approach to measurement	Organizational characteristics measured	Brief summary of the pertinent findings
	Tariq, 2020 ⁶⁸	Cross-sectional	The data were recorded quantitatively noting number, type, severity, and date of errors and incidents. Workload calculated based on patients per staff with rolling averages utilized for 2 week time periods.	Workload measures including patient volumes, physician schedules. Incidence of serious errors	Increases in departmental workload, especially rapid changes, may lead to higher occurrence of errors and incidents in radiation oncology.

AHRQ = Agency for Healthcare Research and Quality; CCOP = Community Clinical Oncology Program; CRC = colorectal cancer; CRM = Crew Resource Management; EBI = evidence-based intervention; EHR = electronic health record; EMR = electronic medical records; ESAS = Edmonton Symptom Assessment Scale; FFS = fee-for-service; FIQCC = Florida Initiative for Quality Cancer Care; FQHC = Federally Qualified Health Center; MBI-HSS = Maslach Burnout Inventory-Human Services Survey; NASA-TLX = NASA Task Load Index; NCI = National Cancer Institute; NMRI = near-miss risk index; PCR = Primary Care Redesign; PGY = post-graduate year; QCI = quality of care indicators; RT = respiratory therapist; SA = supporting activities; SC = safety culture; SCAROP = Society of Chairs of Academic Radiation Oncology Programs; SRME = state-reported medical safety events

Evidence Table D-4. Approaches to measure organizational context and process characteristics for other or more than one cancer care context (Guiding Question 2)

Theme	Author, year	Study design	Approach to measurement	Organizational characteristics measured	Brief summary of the pertinent findings
Financial metrics	Ho 2019 ⁶⁹	Cross-sectional	Identification strategy using administrative data sourced from BCBS TX.	Ownership status of physicians based on their recorded network for reimbursement in the internal data base	Financial integration between physicians and hospitals raises patient spending, but not care quality.
Implementation of improvement projects and barriers to implementation	Carpenter, 2012 ⁷⁰	Longitudinal quasi-experimental study	Used managed care penetration, hospital competition, and clinical trials competition.	Three dependent variables were separately examined as markers of CCOP performance: treatment trial accrual, CP/C trial accrual, and total trial accrual. Independent variables included CCOP characteristics, CCOP-Research Base (RB)1 network characteristics, and environmental characteristics	Results—For total trial accrual and treatment trial accrual, the number of active CCOP physicians and the number of trials were associated with CCOP performance.
	Choa, 2014 ⁷¹	Pre-Post	The Kruskal-Wallis test was used to make comparisons among the 6 month prior to the PIT's hiatus, the 6 months while the team was on hiatus, and the initial 6 months of the WE [workflow enhancement] team and utilized the Gallup Survey.	WE team forms; 'employees committed to quality' score	After the WE team, employee satisfaction and commitment to quality increased as demonstrated by Gallup surveys, suggesting a correlation to the WE team.
	Cole, 2015 ⁷²	Semi-structured Interviews	Developed a semi-structured interview guide based on the Consolidated Framework for Implementation Research (CFIR) model.	The facilitators of and barriers to implementation of the Systems of Support (SOS) intervention	For all tumor types, sites that reached this level increased in six elements: case planning, clinical trials, integration of care coordination, physician engagement, quality improvement, and treatment team integration. Factors that enabled improvement inc

Theme	Author, year	Study design	Approach to measurement	Organizational characteristics measured	Brief summary of the pertinent findings
	Denny, 2014 ⁷³	Prospective Cohort	Teams participated in video conferencing training on the FMEA tool selected.	Ratings for failure's severity, occurrence and detection; Process (consult to treatment, treatment, quality assurance), step in process, failure mode, failure effect	Demonstrated that FMEA can be used across hospitals as a tool for collaboration and action planning (as opposed to being limiting in scope to a single institution application)
	DiMartino, 2018 ⁷⁴	Mixed-Methods Analysis	Gathered qualitative data through in-person interviews with inpatient medical oncology and gynecologic oncology clinicians (attendings, house-staff). Palliative care clinicians interviewed to gain additional insights on implementation context.	Implementation effectiveness, defined as aggregated palliative care consult rates within oncology services from 2010–2016	Briefly, medical oncology employed multiple formal implementation policies and practices to support palliative care consultation, yet most clinicians were unaware of the implementation policies and practices, contributing to a weak implementation climate. In contrast, gynecologic oncology employed one formal implementation policies and practices but also relied on multiple informal implementation policies and practices, which contributed to broader clinician awareness and a strong implementation climate
	Fernandez, 2018 ⁷⁵	Retrospective Cohort	Survey administration was customized, recruitment protocols were tailored based on the CPCRN existing partnerships with FQHCs in each participating state.	Identified constructs of interest and compiled existing measures for those constructs; Generated items for each construct of interest by adapting items from existing measures and developing new items; Pilot-tested and refined the preliminary measures; Conducted a validation study with the refined measures.	Findings suggest that these measures exhibit adequate or good psychometric properties. More specifically, CFAs, inter-item consistencies, and correlation analyses indicated the Inner Setting measures have structural validity, reliability, and discriminant validity.

Theme	Author, year	Study design	Approach to measurement	Organizational characteristics measured	Brief summary of the pertinent findings
	Friedman, 2015 ⁷⁶	Prospective Cohort	Utilized the MDC assessment tool.	Assessment scores - in areas of case planning, physician engagement, treatment team integration, integration of care coordinators, infrastructure, financial, clinical trials, quality improvement and medical records	For all tumor types, sites that reached this level increased in six elements: case planning, clinical trials, integration of care coordination, physician engagement, quality improvement, and treatment team integration. Factors that enabled improvement included increasing organizational support, ensuring appropriate physician participation, increasing patient navigation, increasing participation in national quality initiatives, targeting genetics referrals, engaging primary care providers, and integrating clinical trial staff.
	Jacobs, 2015 ⁷⁷	Cross-sectional Study	Sourced data from the 2011 CCOP Annual Progress Reports, surveys of CCOP physician participants and administrators, and the American Medical Association Physician Masterfile.	Implementation effectiveness	Demonstrated that perceptions of implementation climate have a statistically significant direct effect on implementation effectiveness. Physicians' perceptions of implementation climate also mediated the relationship between organizational implementation policies and practices (IPP) and enrollment ($p < 0.05$)

Theme	Author, year	Study design	Approach to measurement	Organizational characteristics measured	Brief summary of the pertinent findings
	Jhaveri, 2012 ⁷⁸	Secondary Data Analysis	Used a telephone survey to identify integrated urology-RO practices. Geographic information software was used to determine the proximity of integrated urology-RO clinic sites with respect to the state's population. Patient travel time and distance calculated from each integrated urology- RO clinic offering urologic services to the RO treatment facility owned by the integrated practice and to the nearest nonintegrated (independent) RO facility.	Emergence of integrated urology-RO practices, extent of physical integration, and potential effect on patient travel times for radiation therapy; patient travel time and distance from each integrated urology-RO clinic offering urologic services to the RO treatment facility owned by the integrated urology-RO practice; travel time and distance from each integrated urology-RO clinic offering urologic services to the nearest nonintegrated RO clinic	Of 229 urology practices identified, 12 (5%) offered integrated RO services, and 182 (28%) of 640 Texas urologists worked in such practices. Approximately 53% of the state population resides within 10 miles of an integrated urology-RO clinic site.
	Meada, 2015 ⁷⁹	Retrospective Cohort	Conducted an assessment of the 18 safety-net clinics that participated to determine the program's early impact in expanding health care access and improving quality of care in the year following program expansion.	Quality measures for breast and cervical cancer screening among women and smoking-cessation intervention	Performance by the Community Ambassadors was at or near 90% for 2 adult quality measures (weight screening and tobacco use assessment). For breast cancer screenings, however, performance among the Community Ambassadors was much lower (48%).

Theme	Author, year	Study design	Approach to measurement	Organizational characteristics measured	Brief summary of the pertinent findings
	Mori, 2018 ⁸⁰	Cross-sectional Study	The survey of 26 questions. Questions were grouped into 3 categories: (1) structure, (2) function, and (3) impact.	Structure/function: conference activities and actions, impact: value and barriers of conferences	TBCs had a moderate to significant impact on patient care according to 97% of respondents. All respondents indicated that the meetings enhanced communication among physicians and provided an opportunity for involved specialists and professionals to discuss cases. The most frequently cited barrier to organizing TBCs was determining a common available date and time for attendees (62%)
	Palmer, 2011 ⁸¹	Needs Assessment	Structured face-to-face and telephone in-depth interviews.	Barriers to breast cancer screening in terms of referral procedure, treatment and diagnosis standards, cultural and linguistic competence screening results and breast health education	Overall, screening barriers were common in the safety net system and only a few procedures were in place to help women overcome these barriers.
	Rauscher, 2014 ⁸²	Secondary Data Analysis	Data collected by the Chicago Breast Cancer Quality Consortium. Benchmarks for measures were established by consulting American College of Radiology benchmarks, and through consultation with clinical experts.	Recall rate, not lost at imaging, timely follow-up imaging, biopsy recommendation rate, not lost at biopsy, timely biopsy, cancer if abnormal screen, cancer if biopsied, cancer detection rate, proportion minimal, proportion early stage	The percentage of institutions meeting each benchmark varied from 27% to 83%. Facilities with American College of Surgeons or National Comprehensive Cancer Network designation were more likely to meet benchmarks pertaining to cancer detection and early detection, and Disproportionate Share facilities were less likely to meet benchmarks pertaining to timeliness of care

Theme	Author, year	Study design	Approach to measurement	Organizational characteristics measured	Brief summary of the pertinent findings
	Thaker, 2016 ⁸³	Retrospective Cohort	Obtained medical record data and reviewed patient cases for its overall management plan, radiation management plan, RT technical components, staging documentation and accuracy, evidence of prospective multidisciplinary management, and disease site– specific quality indicators.	Management plan, radiation management plan, RT technical components, staging documentation and accuracy, evidence of prospective multidisciplinary management, disease site and concordance	Of 14% of patients audited, 17% (18 of 104) were deemed non-concordant. Non-concordance rates were lowest in prevalent disease sites, such as breast (16%), colorectal (14%), and lung (12%), whereas rates were highest in lymphoma (50%), brain (44%), and gynecology (27%). Deficiencies included incomplete staging work-up, incorrect target and normal tissue delineation, and nonadherence to accepted dose-volume constraints.
	Tirodkar, 2020 ⁸⁴	Retrospective Cohort	Examined how adoption of the standards varies across a variety of practices and compared practice self-report with external evaluation of implementation.	Self-assessments of implementing standards; standards audit data	Oncology practices showed some progress in their implementation of patient-centered care processes over the course of the pilot program. Systems for tracking and documenting improvement, training for staff and clinicians, leadership support, and alignment of financial incentives are critical to transformation

Theme	Author, year	Study design	Approach to measurement	Organizational characteristics measured	Brief summary of the pertinent findings
Leadership	Tucker, 2022 ⁸⁵	Prospective cohort	Used the Evidence-based Practice (EBP) Knowledge Scale (25 multiple choice and 13 true/false questions), EBP Belief Scale (16 item scale), EBP Competency Scale (24 skills evaluated on 4-point Likert scale), EBP Implementation Scale (18-item frequency scale), and The Organizational Culture and Readiness System-wide Integration of Evidence-based Practice Scale. All scales tested for validity and reliability.	Effects of an evidence-based practice leadership immersion intervention on evidence-based practice attributes: knowledge, beliefs, competencies, implementation self-efficacy, implementation behaviors, and organizational readiness	Demonstrated significant changes in evidence-based practice attributes (except organizational readiness) post-intervention.
Organizational reactions to environmental forces	Fung 2018 ⁸⁶	Cross-sectional	Utilized the ASTRO workforce survey.	Workforce characteristics- age, sex, region, work schedule, race, community type, employer, work setting, technology utilization	Race and gender gaps in the workforce narrowed, but geographic disparities persisted, with ROs gravitating toward suburban and urban locations over rural practices. Workforce shifted from predominantly private practice to more equal balance with academic/university systems.
	Jalali 2020 ⁸⁷	Cross-sectional	Herfindahl-Hirschman Index (HHI), a measure of competition by Hospital Referral Regions, for practices of medical oncologists that billed Medicare in 2015.	Provider Practice Competition in Hospital Referral Regions	OCM was adopted in 114 (37%) of the 306 HRRs. Practices in competitive healthcare markets were more likely to adopt OCM than in non-competitive markets.
	Landercasper 2010 ⁸⁸	Cross-sectional	Not specified.	Implementation of a community breast center	A community breast center can establish a voluntary interdisciplinary quality program, participate in a national quality initiative, improve care in selected categories and have transparency is demonstrated.

Theme	Author, year	Study design	Approach to measurement	Organizational characteristics measured	Brief summary of the pertinent findings
Workload/Workflow Design/Work Performance	Weiner, 2012 ⁸⁹	Cross-sectional	Obtained data on community-based networks of hospitals and physician practices (CCOP) volume of patients with cancer, affiliated physicians, and organizational structure from the progress reports that CCOPs submit to the NCI. Obtained data on CCOP 2010 patient enrollment onto NCI treatment trials and the 2010 treatment trial menu from the NCI CCOP, minority-based CCOP, and research base management system.	Number of open treatment trials with at least one patient enrolled, number of newly diagnosed patients with cancer, number of CCOP-affiliated physicians, and number of CCOP-affiliated hospitals	Two recipes were consistently associated with high levels of patient enrollment onto NCI treatment trials in 2010: having many open treatment trials and many new patients with cancer, and having many open treatment trials and many affiliated hospitals or practices.
	Mesko, 2022 ⁹⁰	Pre-post	Utilized electronic health records used in in-person observations.	Waiting room time, rooming time, wait for physician time, total wait time, visit times.	Patient flow analysis recommendations reduced median cycle time, cumulative waiting time (waiting room and wait for physician time). Also showed reduced >2 hour consult visits. Proportion of visits requiring <1 hour increased.

ASTRO = American Society for Radiation Oncology; BCBS TX = Blue Cross Blue Shield of Texas; CCOP = Community Clinical Oncology Program; CFA = confirmatory factor analysis; CP/C = cancer prevention and control; CPCRN = Cancer Prevention and Control Research Network; EBP = evidence-based practice; FMEA = failure modes and effects analysis; FQHC = Federally Qualified Health Center; HHI = Herfindahl-Hirschman Index; HRR = hospital referral regions; IPP = implementation policies and practices; MDC = multidisciplinary care; NCI = National Cancer Institute; OCM = Oncology Care Model; PIT = process improvement team; RB = research base; RO = radiation oncologist; RT = radiation therapy; SOS = Systems of Support; TBC = Tumor board conferences; WE = workflow enhancement

Evidence Table D-4. Study characteristics of studies exemplifying examination of health care organization context and process characteristics assessing cancer screening (Guiding Question 3)

Author, year	Study aim	Study design	Setting	Population	Organizational level	Number of organizations in the study	Organization ownership
Carlin, 2015 ⁵	"To fill an empirical gap in the literature by examining changes in quality of care measures occurring when multispecialty clinic systems were acquired by hospital-owned, vertically integrated health care delivery systems in the Twin Cities area."	Retrospective cohort	Non-cancer center/General medical center	Patients without cancer: no history of cancer diagnosis Cancer type: Breast cancer, colorectal cancer, cervical cancer	Regional level of integrated delivery system (or multi-institutional system)	3	NR
Chou, 2015 ²⁸	"This study aims to understand the association between organizational factors and adherence to cancer screenings."	Cross-sectional	VA Medical Centers, community-based outpatient clinic	Patients with cancer: history of cancer (even if no current evidence of disease) Cancer type: Breast Cancer, Cervical Cancer & Colorectal Cancer	National level of integrated delivery system or (multi-institutional system)	167	NR
Davis, 2019 ³⁴	"Our study was designed to be hypothesis generating and to suggest promising practices to facilitate effective ACO–clinic partnerships to achieve performance benchmarks for CRC screening."	Comparative case study	Accountable Care Organizations (ACOs)	Patients with cancer: history of cancer (even if no current evidence of disease) Cancer type: Colon and Rectal Cancer	National level of integrated delivery system or (multi-institutional system)	16	NR

Author, year	Study aim	Study design	Setting	Population	Organizational level	Number of organizations in the study	Organization ownership
Haggstrom, 2012 ²²	"[evaluated whether] ... community health centers who participated in the HDCC more likely to implement organizational process changes consistent with the chronic care model (CCM implementation)? As a secondary question, we asked whether community health centers who participated in the HDCC were more likely to report changes in cancer care processes."	Retrospective cohort	Community cancer center	Patients with cancer: history of cancer (even if no current evidence of disease) Cancer type: Breast, Cervical and Colorectal Cancer	National level of integrated delivery system or (multi-institutional system)	40	NR
Murphy, 2022 ¹¹	"This study evaluated the association of the Maryland Medicaid behavioral health home (BHH) integrated care program on cancer screening."	Retrospective cohort	Psychiatric Rehabilitation Programs	Patients with cancer: history of cancer (even if no current evidence of disease) Cancer type: Breast cancer, cervical cancer & colorectal cancer	Individual practice or clinic	Unclear	NR

Author, year	Study aim	Study design	Setting	Population	Organizational level	Number of organizations in the study	Organization ownership
Onega, 2018 ³¹	"Examined the relative effects of these nested levels on four breast cancer screening metrics."	Cross-sectional	Non-cancer center/General medical center	Patients without cancer: no history of cancer diagnosis Cancer type: Breast Cancer	Individual practice or clinic	2	Not-for-profit
Rosenthal, 2013 ²⁴	"To evaluate the effects of the pilot program of a multi-payer patient-centered medical home on health care utilization and quality."	Retrospective cohort	Non-cancer center/General medical center	Patients with cancer: history of cancer (even if no current evidence of disease) Cancer type: Breast, Colon, and Cervical Cancer	National level of integrated delivery system or (multi-institutional system)	5	NR
Shapira, 2016 ²⁶	"To characterize the prevalence and correlates of practice-based systems to support breast and cervical cancer screening, with a focus on the patient centered medical home."	Cross-sectional	Non-hospital based office, hospital-based, community health center	Providers Cancer type: Breast and cervical cancer screening	Individual practice or clinic	133	NR
Shaw, 2013 ³⁵	"The purpose of this study was to evaluate a primary care practice-based quality improvement (QI) intervention aimed at improving colorectal cancer screening rates."	RCT	Academic cancer center	Patients with cancer: history of cancer (even if no current evidence of disease) Cancer type: Colon and Rectal Cancer	Individual practice or clinic	23	NR

Author, year	Study aim	Study design	Setting	Population	Organizational level	Number of organizations in the study	Organization ownership
Shi, 2015 ²⁷	"The current study evaluated the relationship between PCMH model adoption in HCs [as determined by the Safety Net Medical Home Scale (SNMHS)] and clinical performance measures, to determine if adoption of PCMH characteristics is associated with better clinical performance."	Retrospective cohort	Non-cancer center/General medical center	Patients with cancer: history of cancer (even if no current evidence of disease) Cancer type: Cervical	National level of integrated delivery system or (multi-institutional system)	NR	NR
So, 2012 ³³	"To identify medical center characteristics associated with screening in this population."	Prospective cohort	VA medical center	Patients without cancer: no history of cancer diagnosis Cancer type: No prior history; Prostate cancer screening	National level of integrated delivery system or (multi-institutional system)	NR	Government
Yabroff, 2011 ¹⁵	"In this study, we used data from a national survey of PCPs to describe and explore the following: (i) the adoption of multiple systems strategies which may improve cancer screening performance and (ii) whether the use of systems strategies varies for breast, cervical, and CRC screening."	Retrospective cohort	Non-cancer center/General medical center	Patients with cancer: history of cancer (even if no current evidence of disease) Cancer type: Breast, cervical, colorectal, and lung cancer	Individual practice or clinic	NR	NR

ACO = Accountable Care Organizations; BHH = behavioral health home; CCM = chronic care model; CRC = colorectal cancer; HC = health center; HDCC = Health Disparities Cancer Collaborative; NR = not reported; PCMH = patient-centered medical home; PCP = primary care physician; PRP = psychiatric rehabilitation programs; QI = quality improvement; RCT = randomized controlled trial; SNMHS = Safety Net Medical Home Scale; VA = Veterans Administration

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Evidence Table D-6. Organizational characteristics of studies exemplifying measurement and instrumentation assessing cancer screening (Guiding Question 3)

Author, year	Data collection method	Classification of the characteristic as organizational context*	Measurement instrument used [Name, Type, Number of Items]
Carlin, 2015 ⁵	Primary data collection (non-qualitative)	Patient demographics	NR
Carlin, 2015 ⁵	Primary data collection (non-qualitative)	Patient financial status	NR
Carlin, 2015 ⁵	Primary data collection (non-qualitative)	Ownership	NR
Carlin, 2015 ⁵	Primary data collection (non-qualitative)	Payment model and payment program participation	NR
Chou, 2015 ²⁸	Secondary data analysis	Not specified	Primary Care Module of the Clinical Practice Organizational Survey (CPOS), "VHA Survey of Women Veterans Health Programs and Practices" (DVAHS) Type: 7-factor solution, 9-point scale Number of items: NR
Murphy, 2022 ¹¹	Secondary data analysis	Location	NR
Onega, 2018 ³¹	Primary data collection (non-qualitative)	Staffing and skill-mix	NR
Onega, 2018 ³¹	Primary data collection (non-qualitative)	HIT infrastructure	NR
Onega, 2018 ³¹	Primary data collection (non-qualitative)	Patient demographics	NR
Onega, 2018 ³¹	Primary data collection (non-qualitative)	Size and volume	NR
Rosenthal, 2013 ²⁴	Secondary data analysis	Payment model and payment program participation	NCQA Physician Practice Connections Standards assessment Type: NR Number of items: 9
Shapira, 2016 ²⁶	Primary data collection (non-qualitative)	Organization type	NR
Shapira, 2016 ²⁶	Primary data collection (non-qualitative)	Size and volume	NR

Author, year	Data collection method	Classification of the characteristic as organizational context*	Measurement instrument used [Name, Type, Number of Items]
Shapira, 2016 ²⁶	Primary data collection (non-qualitative)	Affiliations	NR
So, 2012 ³³	Primary data collection (non-qualitative)	Patient demographics	NR
So, 2012 ³³	Primary data collection (non-qualitative)	Patient financial status	NR
So, 2012 ³³	Primary data collection (non-qualitative)	Location	NR
So, 2012 ³³	Primary data collection (non-qualitative)	Academic arrangements	NR
So, 2012 ³³	Primary data collection (non-qualitative)	Payment model and payment program participation	NR
So, 2012 ³³	Primary data collection (non-qualitative)	Service comprehensiveness	NR
So, 2012 ³³	Primary data collection (non-qualitative)	Size and volume	NR
So, 2012 ³³	Primary data collection (non-qualitative)	Staffing and skill-mix	NR

*According to the Weaver and Breslau framework⁹¹

CPOS = Clinical Practice Organizational Survey; DVAHS = VHA Survey of Women Veterans Health Programs and Practices; HIT = health information technology; NCQA = National Committee for Quality Assurance; NR = not reported; VHA = Veterans Health Administration

Evidence Table D-7. Organizational processes of studies exemplifying measurement and instrumentation assessing cancer screening (Guiding Question 3)

Author, year	Data collection method	Classification of the characteristic as organizational process*	Study's definition or description of the characteristic	Measurement instrument used [Name, Type, Number of Items]
Carlin, 2015 ⁵	Primary data collection (non-qualitative)	Screening processes	Probability of cancer screening	NR
Chou, 2015 ²⁸	Secondary data analysis	Care management processes	organizational competencies, QI orientation, Utility of computerized patient record system (CPRS) - refer to article for more detail of each category	External Peer Review Program (EPRP), US Department of Health and Human Services Area Resource File (ARF) Type: 7-factor solution, 9-point scale Number of items: NR
Davis, 2019 ³⁴	Interviews	Cross-sector partnerships and multi-level interventions	CCO characteristics and CRC screening performance	Public performance data, transcripts from key informant interviews, and field notes Type: NR Number of items: NR
Haggstrom, 2012 ²²	Survey	Use of QI or other improvement methods (e.g., lean six sigma, etc.)	Chronic Care Model Implementation; teamwork; cancer care process improvement	Survey Type: Likert Scale Number of items: 9
Murphy, 2022 ¹¹	Secondary data analysis	Screening processes	Receipt of cancer screening - determined by procedure and diagnostic codes	Maryland Medicaid administrative claims data Type: NR Number of items: NR
Onega, 2018 ³¹	Primary data collection (non-qualitative)	Screening processes	Breast cancer screening percentages	NR
Rosenthal, 2013 ²⁴	Secondary data analysis	Participation in state or national QI collaboratives	3 preventive care measures— colon, breast, and cervical cancer screening	Administrative claims data; NCQA Physician Practice Connections Standards assessment Type: NR Number of items: 9
Shapira, 2016 ²⁶	Primary data collection (non-qualitative)	Screening processes	Reception of cancer screening reports	NR
Shaw, 2013 ³⁵	Interviews and secondary data analysis	Participation in state or national QI collaboratives	CRC screening rates and physician recommendation for CRC screening	Medical records, MAP field notes, audio-graphed MAP Type: NR Number of items: NR

Author, year	Data collection method	Classification of the characteristic as organizational process*	Study's definition or description of the characteristic	Measurement instrument used [Name, Type, Number of Items]
Shi, 2015 ²⁷	Secondary data analysis	Participation in state or national QI collaboratives	Clinical Performance (% children received vaccine by age 2; % female patients (24-64 who receive 1 pap test in 3yrs; % patients (18-75) diagnoses with diabetes; % patients (18-85) diagnosed with hypertension	HRSA Uniform Data System (UDS); Commonwealth Fund National Survey of Federally Qualified Health Centers Type: Safety Net Medical Home Scale (SNMHS) Number of items:
So, 2012 ³³	Primary data collection (non-qualitative)	Screening processes	Performance on Colorectal Cancer Screening	VA Office of Quality and Performance Type: NR Number of items: NR
Yabroff, 2011 ¹⁵	Secondary data analysis	Care management processes	reported answers related to: system's strategies for patient and physician screening reminders, performance reports of screening rates, electronic medical records, implementation of in-practice guidelines, and use of nurse practitioners/ physician assistants	National Survey of Primary Care Physicians' Recommendations and Practices for Breast, Cervical, Colorectal, and Lung Cancer Screening Type: NR Number of items: NR

*According to the Weaver and Breslau framework⁹¹

ARF = Area Resource File; CCO = coordinated care organizations; CPRS = computerized patient record system; CRC = colorectal cancer; EPRP = External Peer Review Program; HRSA = Health Resources and Services Administration; MAP = multimethod assessment process; NCQA = National Committee for Quality Assurance; NR = not reported; QI = quality improvement; SNMHS = Safety Net Medical Home Scale; UDS = Uniform Data System; VA = Veterans Administration

Evidence Table D-8. Reported outcomes of studies exemplifying examination of healthcare organizational context and process characteristics assessing cancer screening (Guiding Question 3)

Author, year	Primary Outcome Description	Primary outcome organizational context	Environmental Influence	Secondary outcome organizational context	Secondary outcome organizational context	Environmental Influence
Carlin, 2015 ⁵	Probability of cancer screening	Process	Yes	NR	NR	NR
Chou, 2015 ²⁸	Organizational factors: physical assets, human capital (staff mix), organizational competencies (authority in staff hiring, determining primary care components and processes, communication and cooperation), utilization of computerized patient record system, quality improvement orientation - refer to article for more detail of each category	Organizational characteristics	Yes	Mammograms & cervical/colorectal screenings	Process	Yes
Davis, 2019 ³⁴	1) Establishing relationships and building partnerships 2) Producing and sharing performance data 3) Developing a process and infrastructure to support quality improvement (Figure).	Process	Yes	NR	NR	NR
Haggstrom, 2012 ²²	Chronic Care Implementation; Teamwork	Organizational characteristics	NR	Cancer care process improvement	Process	NR
Murphy, 2022 ¹¹	Cervical, breast and colorectal cancer screening	Organizational characteristics	Yes	NR	NR	NR
Onega, 2018 ³¹	Breast cancer screening percentage	Process	No	NR	NR	NR
Rosenthal, 2013 ²⁴	NCQA Physician Practice Connections–Patient Centered Medical Home level I recognition	Organizational characteristics	NR	Percent of patients who received screening for breast, colon and cervical cancer	Process	NR
Shapira, 2016 ²⁶	Reception of cancer screening reports	Process	Yes	NR	NR	NR
Shaw, 2013 ³⁵	CRC Screening rates	Process	No	Quality Improvement contributing factors (practice, team structure, leadership, engagement, psychological safety, intra-/inter- communication)	Process	No
Shi, 2015 ²⁷	% patients who received cervical cancer screening	Process	NR	NR	NR	NR

Author, year	Primary Outcome Description	Primary outcome organizational context	Environmental Influence	Secondary outcome organizational context	Secondary outcome organizational context	Environmental Influence
So, 2012 ³³	Percentage of men at who received prostate specific antigen screening	Process	Yes	Medical center and patient factors associated with prostate specific antigen screening	Organizational characteristics	Yes
Yabroff, 2011 ¹⁵	Use of comprehensive systems strategies	Process	No	NR	NR	NR

CRC = colorectal cancer; NCQA =; NR = not reported

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Evidence Table D-9. Study characteristics of studies exemplifying examination of health care organization context and process characteristics assessing for cancer diagnosis and treatment (Guiding Question 3)

Author, year	Study aim	Study design	Setting	Population	Organizational level	Number of organizations in the study	Organization ownership
Dias-Santagata, 2022 ⁴²	"Present the results of a clinical pilot to standardize precision oncology workflows."	Before-after	Community cancer center associated with academic cancer center network	Patients with cancer: history of cancer (even if no current evidence of disease) Cancer type: Gastrointestinal cancer	Regional level of integrated delivery system (or multi-institutional system)	Not specified	NR
Miller, 2019 ³⁸	"To determine whether accreditation by the National Accreditation Program for Breast Centers (NAPBC) is associated with improved performance on six breast quality measures pertaining to Adjuvant treatment, needle/core biopsy, and breast conservation therapy rates at Commission on Cancer (CoC) centers."	Retrospective cohort	Academic centers, community cancer programs, other specified cancer programs	Patients with cancer: history of cancer (even if no current evidence of disease) Cancer type: Breast Cancer	Individual practice or clinic	1,308	NR

CoC = Commission on Cancer; NAPBC = National Accreditation Program for Breast Centers; NR = not reported

Evidence Table D-10. Organizational characteristics of studies exemplifying measurement and instrumentation assessing for cancer diagnosis and treatment (Guiding Question 3)

Author, year	Data collection method	Classification of the characteristic as organizational context*	Measurement instrument used [Name, Type, Number of Items]
Miller, 2019 ³⁸	Secondary data analysis	Organization type	NR
Miller, 2019 ³⁸	Secondary data analysis	Size and volume	NR
Miller, 2019 ³⁸	Secondary data analysis	Geographic characteristics	NR
Miller, 2019 ³⁸	Secondary data analysis	Location	NR
Miller, 2019 ³⁸	Secondary data analysis	Patient demographics	NR
Miller, 2019 ³⁸	Secondary data analysis	Patient financial status	NR

NR = not reported

Evidence Table D-11. Organizational processes of studies exemplifying measurement and instrumentation assessing for cancer diagnosis and treatment (Guiding Question 3)

Author, year	Data collection method	Classification of the characteristic as organizational process*	Study's definition or description of the characteristic	Measurement instrument used [Name, Type, Number of Items]
Dias-Santagata, 2022 ⁴²	Primary data collection (non-qualitative)	Use of HIT system	Number of molecular requests submitted to the lab before and after order set roll-out	NR
Dias-Santagata, 2022 ⁴²	Primary data collection (non-qualitative)	Referral processes	Changes in total volume of patients referred to molecular testing	NR
Dias-Santagata, 2022 ⁴²	Primary data collection (non-qualitative)	Clinical decision support	Rates of "abnormal" test results and rates of actionable results of non-recommended tests	NR
Miller, 2019 ³⁸	Secondary data analysis	Use of QI or other improvement methods (e.g., lean six sigma etc.)	Breast-specific quality measures monitored by non-NAPBC and NAPBC centers	NR Type: Quality measure scale Number of items: 6

*according to the Weaver and Breslau framework⁹¹

HIT = health information technology; NAPBC = National Accreditation Program for Breast Centers; NR = not reported; QI = quality improvement

Evidence Table D-12. Reported outcomes of studies exemplifying examination of healthcare organizational context and process characteristics assessing for cancer diagnosis and treatment (Guiding Question 3)

Author, year	Primary Outcome Description	Primary outcome organizational context	Environmental Influence	Secondary Outcome Description	Secondary outcome organizational context	Environmental Influence
Dias-Santagata, 2022 ⁴²	Total number of tests compared before and after roll-out of order set	Process	No	Number of actionable alterations before and after roll-out	Process	No
Miller, 2019 ³⁸	Compliance on six breast cancer quality measures	Process	Yes	NR	NR	NR

NR = not reported

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Evidence Table D-13. Study characteristics of studies exemplifying examination of health care organization context and process characteristics assessing cancer treatment only (Guiding Question 3)

Author, year	Study aim	Study design	Setting	Population	Organizational level	Number of organizations in the study	Organization ownership
Bickell, 2017 ⁶¹	"To identify key organizational approaches associated with underuse of breast cancer care."	Cross-sectional	Non-cancer center/General medical center	Patients with cancer: history of cancer (even if no current evidence of disease) Cancer type: Breast Cancer	Hospital	9	NR
Blayney, 2012 ⁵⁷	"We conducted an initial analysis of medical practice characteristics and of how the practices' adherence to processes was related to valuable patient outcomes."	Retrospective cohort	Outpatient Cancer Center	Patients with cancer: history of cancer (even if no current evidence of disease) Cancer type: Breast Cancer, Colorectal Cancer, Lung Cancer, Non-Hodgkin's Lymphoma	Individual practice or clinic	26	NR
Jacobs, 2014 ⁶³	"To identify physicians' individual characteristics, attitudes, and organizational contextual factors associated with higher enrollment of patients in cancer clinical trials among physician participants in the National Cancer Institute's Community Clinical Oncology Program (CCOP)."	Cross-sectional	Community cancer center	Patients with cancer: history of cancer (even if no current evidence of disease) Cancer type: Not specified	National level of integrated delivery system or (multi-institutional system)	47	NR
Mazur, 2017 ⁶⁷	"The objective of this research was to develop and assess the impact of a simulation-based training intervention on radiation oncology providers' workload and performance during treatment planning and quality assurance (QA) tasks."	Prospective cohort	Academic cancer center	Patients with cancer: history of cancer (even if no current evidence of disease) Cancer type: Sarcoma	Entity within a hospital	1	NR

Author, year	Study aim	Study design	Setting	Population	Organizational level	Number of organizations in the study	Organization ownership
Neuss, 2013 ⁶⁴	"To determine whether QOPI scores showed improvement in measured quality over time and, if change was demonstrated, which factors in either the measures or participants were associated with improvement."	Retrospective cohort	Medical oncology practices	Patients with cancer: history of cancer (even if no current evidence of disease) Cancer type: Not specified	Individual practice or clinic	156	NR
Schlueter, 2022 ⁴⁸	"This study identified factors that facilitated early implementation and sustainability within partner clinics."	Longitudinal qualitative case studies	Colorectal Cancer Control Program (CRCCP) awardees and partner clinics	NR Cancer type: Colon and Rectal Cancer	National level of integrated delivery system or (multi-institutional system)	4	NR
Sheetz, 2019 ⁴⁹	"Evaluated the extent to which existing hospital systems centralize high-risk cancer surgery and whether centralization is associated with short-term clinical outcomes."	Retrospective cohort	Not specified, American Hospital Association survey pool	Patients with cancer: history of cancer (even if no current evidence of disease) Cancer type: Not specified	Regional level of integrated delivery system (or multi-institutional system)	4,390	NR
Tariq, 2020 ⁶⁸	"To evaluate measures of increased departmental workload in relation to the occurrence of physician-related errors and incidents reaching the patient in radiation oncology."	Cross-sectional	Not specified	Providers Cancer type: Not specified	Entity within a hospital	NA	NA
Trogdon, 2018 ⁴⁴	"To estimate the association between provider and team experience and adherence to guidelines, survival, and utilization among colorectal cancer patients in North Carolina."	Retrospective cohort	NR	Patients with cancer: history of cancer (even if no current evidence of disease) Cancer type: Colon and Rectal Cancer	NR	NR	NR

CCOP = Community Clinical Oncology Program; CRCCP = Colorectal Cancer Control Program; NA = not available; NR = not reported; QA = quality assurance; QOPI = Quality Oncology Practice Initiative

Evidence Table D-14. Organizational characteristics of studies exemplifying measurement and instrumentation assessing cancer treatment only (Guiding Question 3)

Author, year	Data collection method	Classification of the characteristic as organizational context*	Measurement instrument used [Name, Type, Number of Items]
Bickell, 2017 ⁶¹	Interviews	Organization type	NR
Jacobs, 2014 ⁶³	Primary data collection (non-qualitative)	Knowledge, attitudes, beliefs of managers, providers, staff about organizational characteristics, policies, or processes	NR
Jacobs, 2014 ⁶³	Primary data collection (non-qualitative)	Service comprehensiveness	NR
Jacobs, 2014 ⁶³	Primary data collection (non-qualitative)	Size and volume	NR
Jacobs, 2014 ⁶³	Primary data collection (non-qualitative)	Organization type	NR
Neuss, 2013 ⁶⁴	Primary data collection (non-qualitative)	Service comprehensiveness	NR
Neuss, 2013 ⁶⁴	Primary data collection (non-qualitative)	Size and volume	NR
Neuss, 2013 ⁶⁴	Primary data collection (non-qualitative)	Affiliations	NR
Neuss, 2013 ⁶⁴	Primary data collection (non-qualitative)	Location	NR
Sheetz, 2019 ⁴⁹	Secondary data analysis	Size and volume	NR
Sheetz, 2019 ⁴⁹	Secondary data analysis	Patient demographics	NR
Sheetz, 2019 ⁴⁹	Secondary data analysis	Organization type	NR
Sheetz, 2019 ⁴⁹	Secondary data analysis	Affiliations	NR
Sheetz, 2019 ⁴⁹	Secondary data analysis	Location	NR
Tariq, 2020 ⁶⁸	Secondary data analysis	Size and volume	Workload determined by hospital patient records and physician scheduling records. Type: NA Number of items: NA

*according to the Weaver and Breslau framework⁹¹

NA = not available; NR = not reported

Evidence Table D-15. Organizational processes of studies exemplifying measurement and instrumentation assessing cancer treatment only (Guiding Question 3)

Author, year	Data collection method	Classification of the characteristic as organizational process*	Study's definition or description of the characteristic	Measurement instrument used [Name, Type, Number of Items]
Bickell, 2017 ⁶¹	Interviews	Care management processes	Cancer care coordination & associated organizational characteristics	Qualitative comparative analysis Type: NR Number of items: 5
Blayney, 2012 ⁵⁷	Primary data collection (non-qualitative)	Care management processes	Module score related to: core processes, processes specific to particular cancer type or disease-specific processes, processes relating to supportive care, and processes involved in end-of-life care	The Quality Oncology Practice Initiative Type: NR Number of items: 52
Jacobs, 2014 ⁶³	Primary data collection (non-qualitative)	Participation in state or national QI collaboratives	Participation in the NCI Community Clinical Oncology Program	NR
Mazur, 2017 ⁶⁷	Assessments/Questionnaires	Provider/Team Training	Scores representing: subjective workload, procedural compliance, time-to-scenario completion, and clinical evaluation	Compliance Assessments, NASA-TLX questionnaire Type: NR Number of items: NR
Neuss, 2013 ⁶⁴	Primary data collection (non-qualitative)	Use of QI or other improvement methods (e.g., lean six sigma etc.)	Quality Oncology Practice Initiative (QOPI)	Quality Oncology Practice Initiative (QOPI) Type: NR Number of items: NR
Schlueter, 2022 ⁴⁸	Interviews	Participation in state or national QI collaboratives	Coding dictionary	Qualitative software Nvivo QSR versions 10.0 and 11.0. Type: NR Number of items: NR
Sheetz, 2019 ⁴⁹	Secondary data analysis	Screening processes	Probability of cancer screening	NR
Trogdon, 2018 ⁴⁴	Secondary data analysis	Care management processes	Guideline-recommended care: consultation with a medical oncologist for stage III patients, initiation of chemotherapy within 120 days of surgery for colon cancer and within 120 days before or after surgery for rectal cancer, and receipt of surveillance colonoscopy within 12 and 18 months of completion of treatment for all patients younger than 80 years	North Carolina Central Cancer Registry, NC Health Professions Data System, and fee-for-service claims (Medicare, Medicaid and privately insured individuals) Type: NR Number of items: NR

*according to the Weaver and Breslau framework⁹¹

NASA-TLX = NASA Task Load Index; NC = North Carolina; NCI = National Cancer Institute; NR = not reported; QI = quality improvement; QOPI = Quality Oncology Practice Initiative; QSR = Qualitative Research Software

Evidence Table D-16. Reported outcomes of studies exemplifying examination of healthcare organizational context and process characteristics assessing cancer treatment only (Guiding Question 3)

Author, year	Primary Outcome Description	Primary outcome organizational context	Environmental Influence	Secondary outcome description	Secondary outcome organizational context	Environmental Influence
Bickell, 2017 ⁶¹	Underuse of breast cancer care	Process	No	Organizational 'Conditions: Information sharing, tracking follow-up, system support, patient-centered culture, flexibility, and whether private practice	Process	No
Blayney, 2012 ⁵⁷	Adherence to quality care processes	Process	No	NR	NR	NR
Jacobs, 2014 ⁶³	Physician enrollment in NCI Community Clinical Oncology Program (CCOP)	Process	No	NR	NR	NR
Mazur, 2017 ⁶⁷	Workload	Process	No	Procedural compliance & time-to-scenario completion	Process	No
Neuss, 2013 ⁶⁴	Improvement of quality scores	Process	No	Adherence to quality indicators	Process	No
Schlueter, 2022 ⁴⁸	Organizational Factors: EHR use, readiness for implementation, leadership support, adoption of team-based approach, integration of evidence-based interventions	Organizational characteristics	No	NR	NR	NR
Sheetz, 2019 ⁴⁹	30-day postoperative complications	NA	Yes	30-day mortality and readmissions	NA	Yes
Tariq, 2020 ⁶⁸	Serious errors reaching the patient requiring appropriate action	Organizational characteristics	Yes	NR	NR	NR
Trogdon, 2018 ⁴⁴	Adherence to guidelines	Process	No	5-year overall survival, number of surveillance radiology studies, any unplanned hospitalization, and any emergency department visit.	Process	No

CCOP = Community Clinical Oncology Program; EHR = electronic health record; NA = not available; NCI = National Cancer Institute; NR = not reported

Evidence Table D-17. Study characteristics of studies exemplifying examination of health care organization context and process characteristics assessing for other or more than one cancer care aspect (Guiding Question 3)

Author, year	Study aim	Study design	Setting	Population	Organizational level	Number of organizations in the study	Organization ownership
Mesko, 2022 ⁹⁰	"The purpose of this study was to identify and address inefficiencies at a high-volume radiation oncology clinic."	Before-after	Community cancer center associated with academic cancer center network	Patients with cancer: History of cancer (even if no current evidence of disease) Cancer type: Gastrointestinal cancer	Hospital	NA	Not-for-profit
Tucker, 2022 ⁸⁵	"Test effects of an evidence-based practice (EBP) leadership immersion intervention on EBP attributes over time among two cohorts of leaders at a national comprehensive cancer center."	Prospective cohort	National comprehensive cancer center	Providers Cancer type: Not specified	Hospital	1	Not-for-profit

EBP = evidence-based practice

Evidence Table D-18. Organizational characteristics of studies exemplifying measurement and instrumentation assessing for other or more than one cancer care aspect (Guiding Question 3)

Author, year	Data collection method	Classification of the characteristic as organizational context*	Measurement instrument used [Name, Type, Number of Items]
Tucker, 2022 ⁸⁵	Primary data collection (non-qualitative)	Knowledge, attitudes, beliefs of managers, providers, staff about organizational characteristics, policies, or processes	Evidence-based Practice (EBP) Knowledge Scale Type: NR Number of items: 38
Tucker, 2022 ⁸⁵	Primary data collection (non-qualitative)	Knowledge, attitudes, beliefs of managers, providers, staff about organizational characteristics, policies, or processes	Evidence-based Practice (EBP) Belief Scale Type: NR Number of items: 16
Tucker, 2022 ⁸⁵	Primary data collection (non-qualitative)	Knowledge, attitudes, beliefs of managers, providers, staff about organizational characteristics, policies, or processes	Evidence-based Practice (EBP) Competency Scale Type: Likert Number of items: 24
Tucker, 2022 ⁸⁵	Primary data collection (non-qualitative)	Knowledge, attitudes, beliefs of managers, providers, staff about organizational characteristics, policies, or processes	Evidence-based Practice (EBP) Implementation Scale Type: NR Number of items: 18
Tucker, 2022 ⁸⁵	Primary data collection (non-qualitative)	Knowledge, attitudes, beliefs of managers, providers, staff about organizational characteristics, policies, or processes	The Organizational Culture and Readiness System-wide Integration of Evidence-based Practice Scale Type: NR Number of items: NR

*According to the Weaver and Breslau framework⁹¹

EBP = evidence-based practice; NR = not reported

Evidence Table D-19. Organizational processes of studies exemplifying measurement and instrumentation assessing for other or more than one cancer care aspect (Guiding Question 3)

Author, year	Data collection method	Classification of the characteristic as organizational process*	Study's definition or description of the characteristic	Measurement instrument used [Name, Type, Number of Items]
Mesko, 2022 ⁹⁰	Primary data collection (non-qualitative)	Use of HIT system	Waiting room times, waiting time for physicians, time in room to arrival of physician, total cycle time	NR
Mesko, 2022 ⁹⁰	Primary data collection (non-qualitative)	Communication	Waiting room times, waiting time for physicians, time in room to arrival of physician, total cycle time	NR
Mesko, 2022 ⁹⁰	Primary data collection (non-qualitative)	Care coordination	Waiting room times, waiting time for physicians, time in room to arrival of physician, total cycle time	NR

*According to the Weaver and Breslau framework⁹¹

HIT = health information technology

Evidence Table D-20. Reported outcomes of studies exemplifying examination of healthcare organizational context and process characteristics assessing for other or more than one cancer care aspect (Guiding Question 3)

Author, year	Primary Outcome Description	Primary outcome organizational context	Environmental Influence	Secondary Outcome Description	Secondary outcome organizational context	Environmental Influence
Mesko, 2022 ⁹⁰	Waiting room times, waiting time for physicians, time in room to arrival of physician, total cycle time	Process	No	NR	NR	NR
Tucker, 2022 ⁸⁵	Evidence-based Practices knowledge, implementation, readiness	Organizational characteristics	No	NR	NR	NR

NR = not reported

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