**Supplementary Table 2 ERIC Strategies identified in clinical studies (ERIC- Expert Recommendations for Implementing Change)**

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| --- | --- |
| **Strategy** | **ERIC strategies described in papers (for process strategies only, not clinical tools)** |
| **Pre-AVS**Developing technical skill | * Assess for readiness (number of procedures) and identify barriers (e.g. Number of clinicians doing AVS) and facilitators
* Audit and provide feedback (venography examination with skilled clinicians)
* Centralize technical assistance (E.g. one trained person to do AVS)
* Conduct ongoing training
 |
| **Pre-AVS**Patient voice and informed choice | * Assess for readiness (of the patient) and identify barriers and facilitators (to the procedure and surgery if needed)
* Conduct educational meetings (with the patient so they understand the procedure and potential surgical cure)
* Prepare patients/consumers to be active participants (by providing information, support and advice)
 |
| **Pre-AVS**Work-up preparations and decisions | Prepare patients/consumers to be active participants (for participation in changing their drug routine) |
| **Pre-AVS**Protocols (as opposed to guidelines) for AVS | * Capture and share local knowledge (especially between departments and specialties who have different needs)
* Conduct local consensus discussions (to inform the development of the protocol)
* Inform local opinion leaders (within the hospital to ensure a protocol is developed and supported)
* Use advisory boards and workgroups (to develop the protocol)
 |
| **During AVS** Communication and collaboration | Change record systems (the way to do labels and reports) |
| **During AVS** Procedural support | * Provide clinical supervision
* Provide local technical assistance
 |
| **Post AVS** Results interpretation | None identified |