Alberta Screening and Prevention Plus (ASaP+)
Supporting patients toward positive health changes

BACKGROUND 1

- Tobacco use, alcohol use, physical inactivity, and low vegetable and fruit intake are four modifiable factors associated with increased risk of cancer and conditions including dementia, cardiovascular disease and stroke
- Primary care is an ideal setting to identify patients with any of the four modifiable factors, offer to help them reach their goals, and document and follow-up on progress toward improving their health
- Evidence supports the effectiveness of screening and offering opportunistic advice during brief interventions in primary care
- ASaP+ and Patients Collaborating with Teams (PaCT)* share a common Care Plan, designed to record the care planning outcome (a process for patients and providers to collaboratively create a plan to achieve health-related goals and behaviour changes relevant to the patient)

WHAT IS ASaP+? 2

- ASaP+ is an extension of the Patient's Medical Home and offers a change package for primary care teams to support patients with any of the four modifiable factors
- Evidence-based behaviour change intervention strategies, including HealthChange™ methodology, have been incorporated into the ASaP+ design

Practices with ASaP experience (or equivalent)

Resources offered to guide practice facilitation & build capacity to address modifiable factors in primary care practices

Integration into current practice workflow

DESIGN of ASaP+ 3

- ASaP+ is designed to enhance and extend ASaP work and further defines how teams can support patients to make positive changes and improve their health
- The 5As (Ask, Advise, Assess, Assist, Arrange) framework, a model for the provision of preventive primary care, was used to guide ASaP+ design and development
- The **Ask** is foundational to ASaP and the implementation of the **Advise, Assist and Arrange** steps is emphasized in ASaP+:

The 5As Framework

Patient-centred Care Planning

Care team and patient work collaboratively to:

1. Set priorities
2. List strategies to work towards positive health changes
3. Establish goals for improvement and develop action plans
4. Specify follow-up plans

ASK – Determine presence of modifiable factors

ADVISE – Provide specific information about health risks and benefits of change

ASSESS – Collaboratively select goals based on patient interest and motivation to change

ASSIST – Provide information to reach goals

ARRANGE – Complete referral and specify plans for follow-up

WHAT DOES THE ASaP+ PROCESS LOOK LIKE IN PRACTICE? 4

- ASaP+ supports a broad cross-section of panel patients who have prioritized modifiable factors in their Care Plan
- In 2016, a model care planning process was developed through consultation with physician innovators and the Health Quality Council of Alberta
- The process has four main phases: identify, prepare, plan and manage

IDENTIFY

Define target patient group based on ASaP screen for general patients (plus vegetable and fruit intake and alcohol use).

Identify eligible patients embedded in ASaP screen or combined as part of care planning for patients with complex needs.

PREPARE

Update the EMR patient profile.

Team members prepare for patient-centred conversations.

Select patient assessment tools &/or resources to guide conversation with patient.

PLAN

Develop shared understanding of what is important to patient.

Based on brief intervention and shared decision-making, complete patient-centred Care Plan.

Create action plan collaboratively, with actions for team and for patient.

Develop follow-up plan.

MANAGE

Share care plan and make appropriate connections with team members.

Refer to PCN or community-based programs or resources.

Follow-up with patient.

Team members and patient together revise plan as needed.

ASaP+ FEEDBACK FROM PROOF OF CONCEPT 5

ASaP+ was implemented by five Proof of Concept PCN practices across Alberta to test over the period of 12 months. Formal evaluation assessed the process and outcomes of ASaP+ and informed recommendations for the ASaP+ Change Package. Clinics participating were located in Edson, Cold Lake, and Calgary (Circle Medical Clinic, Family Health Clinic and Dept. of Family Medicine South Health Campus).

Primary Care Providers and clinic staff indicated value in more detailed patient histories and proactive approaches to prevention:

"these are things we can modify to improve health outcomes"
"ASaP+ provides structure to understand health processes in determining if patient is ready, willing or able to make change. Preventative health helps our patients be healthier and more resilient."

ASaP+ CHANGE PACKAGE 6

Patient's Medical Home Guide to ASaP+
- Training for Practice Facilitators and clinic teams on ASaP+ implementation, including quality improvement and QI materials

Care Plan including Goals and Action Plan
- Steps to collaboratively define problems, set priorities, identify patient-centered goals and associated action plans
- Signed by primary care provider and patient; copy provided to patient

Evidence Summaries
- Evidence base for modifiable factors and accompanying guidelines or recommendations

Best Practice Algorithms
- Contains best practice and primary care team options, in addition to evidence highlights
- Provided as part of change package, as example of how to potentially guide conversations

Program and Resource Quick Referral List
- Provides better links to PCN and community-based programs to support patients

Health Checklist
- Helps start conversation between patients and providers

LEARN MORE:

Visit - actt.albertadoctors.org or contact your AMA Consultant

**PaCT is designed to support primary healthcare providers deliver care for patients with complex health needs through a patient-centred approach*

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