ASaP+
Brief Intervention and Care Planning

Patient's Medical Home Guide to ASaP+

Alberta Health Services

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ALBERTA MEDICAL ASSOCIATION

ACTT Accelerating Change Transformation Team

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Overview

Alberta Screening and Prevention Plus (ASaP+) is a co-designed initiative of the Accelerating Change Transformation Team (ACTT) and the Alberta Cancer Prevention Legacy Fund (ACPLF). Building on the success of Alberta Screening and Prevention (ASaP) in Primary Care Networks (PCNs) across Alberta, ASaP+ uses a multifaceted approach that provides primary care teams with a comprehensive guide and resources to enable them to support patients wishing to take action on modifiable factors. With ASaP+, primary care teams have tools and strategies to address, document and follow-up on modifiable factors, and help patients make positive health changes.

ASaP+ has been designed to allow providers to guide their own practice and to support continuous quality improvement efforts in prevention, screening and follow-up care. The *Patient's Medical Home Guide to ASaP+* was designed for use by all primary care teams interested in integrating health promotion into healthcare services for patients. Additional resources to support implementation of ASaP+ in primary care clinics are provided on the ACTT website, and include:

- Evidence based recommendations, rationales and supplemental references for each modifiable factor.
- Resources for care teams to help guide discussions that empower patients to take action on identified modifiable factors.
- Tools including the brief ASaP+ Health Checklist and the Goals and Action Plan section of the Care Plan template.
- A list of self-management resources and community programs for patients.
- EMR tip sheets to document key data elements to enable ongoing quality improvement work in clinics.
- Collaborative care planning and shared decision making.
- A "whole person" approach that addresses what is important to the patient.

Improved outcomes happen when multidisciplinary teams partner with patients as a shared responsibility to enhance and promote proactive and preventive care.

Section 1: The ASaP+ Opportunity

1.1 Background

Research indicates about 4 in every 10 cancers in Alberta are caused by factors that we can change. That's about 6,100 cancer cases that we could prevent each year, if we work together.[1,2,3] Tobacco use, alcohol use, physical inactivity and low vegetable and fruit intake are four modifiable factors associated with increased risk of cancer and other health conditions including dementia, cardiovascular disease and stroke.

Primary care is an ideal setting for identifying patients at risk for cancer and chronic disease who could benefit from interventions targeting modifiable factors. Primary care providers are typically the first and continuing point of contact for access to healthcare services, support and care and have a significant impact on their patients' modifiable factors and preventative activities.

1.2 About ASaP+

The Accelerating Change Transformation Team (ACTT) and Alberta Health Services (AHS) – Alberta Cancer Prevention Legacy Fund (ACPLF) have partnered to create a suite of materials that support the implementation of screening and brief intervention for modifiable factors in primary care. Alberta Screening and Prevention Plus (ASaP+) builds on the success of Alberta Screening and Prevention (ASaP) in Primary Care Networks (PCNs) across Alberta by introducing evidence-informed flexible processes to address modifiable factors with patients, and provide ongoing support to make positive health changes.

It is understood that most primary care providers[4] already incorporate modifiable factor discussions into their interactions with patients. Results from the 2015 Alberta Community Health Survey[5] indicate that of people aged 18-79 years of age:

- 84% have a personal family doctor and of those who have a family doctor, about 90% visited their doctor in the past year.
- Of the respondents who saw their doctor and discussed physical activity, about 60% decided to make a change and 80% of them felt supported to make the change.
- Of those who saw a doctor and discussed their eating habits, 74% decided to make a change and 86% of them felt supported to make the change.

ASaP+ supports this by systematically identifying and engaging patients proactively, thereby reducing the potential for major health issues in the future. With ASaP+, primary care teams have tools and strategies to address, document and follow-up on modifiable factors, and help patients make positive health changes.

[1] All data provided by ComPARe Study (prevent.cancer.ca)
[2] Brenner, D. R., Friedenreich, C. M., Ruan, Y., Poirier, A. E., Walter, S. D., King, W. D., . . . De, P. (2019). The burden of cancer attributable to modifiable factors in Canada: Methods overview. *Preventive Medicine*, 3-8.
[3] Poirier, A. E., Ruan, Y., Volesky, K. D., King, W. D., O'Sullivan, D. E., Gogna, P., . . . ComPARe Study Team. (2019). The current and future burden of cancer attributable to modifiable risk factors in Canada: Summary of results. *Preventive Medicine, 122*, 140-147.
[4] The term 'primary care providers' includes primary care physicians and nurse practitioners.
[5] 2015-2016—Alberta Community Health Survey (ACHS).

Specifically, ASaP+:

- Invites providers to engage with patients in conversations about making positive health changes.
- Provides strategies for clinics to *identify* modifiable factors, *prepare and plan* with patients to address what is important to them, and *manage* ongoing engagement in their own health.
- Develops common processes within practices for EMR documentation and self-directed planning tools focused on modifiable factors.
- Provides strategies to improve linkages between clinics and community resources, featuring warm handoffs between the primary care team and community services.
- Engages patients in their own care planning.

1.3 Modifiable Factors Included in ASaP+

The modifiable factors included in ASaP+ are: tobacco use, alcohol use, physical inactivity, and low vegetable and fruit intake.

Tobacco Use:

- Tobacco use is included in ASaP.
- Tobacco use is the single greatest risk factor for the development of cancer[6] (i.e., lung, esophagus, colorectal, and bladder) and other chronic diseases[7] (i.e., COPD, diabetes and asthma), and is the leading preventable cause of premature death in Canada.[8]

Alcohol Use:

- Alcohol use was originally included in ASaP, but was removed in 2016 due to the lack of "evidence of corresponding improvement in alcohol-related morbidity and mortality" resulting from brief intervention on alcohol intake.[9,10] Due to more recent evidence, alcohol use has been included in ASaP+.
- There is strong evidence that alcohol use is involved in the development of several cancers[11,12] in addition to being a factor contributing to other chronic diseases.[13]

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[6] Poirier, A. E., Ruan, Y., Volesky, K. D., King, W. D., O'Sullivan, D. E., Gogna, P., . . . ComPARe Study Team. (2019). The current and future burden of cancer attributable to modifiable risk factors in Canada: Summary of results. *Preventive Medicine, 122*, 140-147.

[7] Global Burden of Disease 2015 Tobacco Collaborators. (2015). Smoking prevalence and attributable diease burden in 195 countries and territories, 1990-2015: a systematic analysis from the Global Burden of Disease Study 2015. *The Lancet*, 1885-1906.

[8] Public Health Agency of Canada. (2013). *Chronic Disease Risk Factor Atlas.* Public Health Agency of Canada. Retrieved from https://www.canada.ca/en/public-health/services/chronic-diseases/risk-factor-atlas.html

[9] Alberta College of Family Physicians. (2015, March 16). *https://gomainpro.ca/wp-content/uploads/tools-for-practice/1426518561_tfpalcoholscreeningandinterventionsfv2.pdf.* Retrieved from Toward Optimized Practice:https://gomainpro.ca/wp-content/uploads/tools-for-practice/1426518561_tfpalcoholscreeningandinterventionsfv2.pdf

[10] Elzerbi, C., Donoghue, K., & Drummond, C. (2015). A comparison of the efficacy of brief interventions to reduce hazardous and harmful alcohol consumption between European and non-European countries: a systematic review and meta-analysis of randomized controlled trials. *Addiction*, 1082-91

[11] Boffetta & Hashibe 2006. Alcohol and cancer. *The Lancet*. 7(2); 149-56

[12] Praud et al 2016. Cancer incidence and mortality attributable to alcohol consumption. *International Journal of Cancer*. 138; 13801387

[13] Bell, S., Daskalopoulou M, et al. (2017) Association between clinically recorded alcohol consumption and initial presentation of 12 cardiovascular diseases: population-based cohort study using linked health records. *BMJ*; 356; j909

- Screening and brief intervention for alcohol in primary care settings is effective in reducing alcohol use.[14,15,16,17]

Physical Inactivity:

- Exercise/Physical Activity is included in ASaP.
- Physical inactivity is an important risk factor for the development of certain types of cancer[18,19,20,21] (i.e., colon, breast, endometrial, kidney, bladder, esophageal, and stomach) and other chronic diseases (i.e., coronary heart disease, type 2 diabetes, osteoporosis and dementia).[22,23,24]

Low Vegetable and Fruit Intake:

- Vegetable and fruit intake is not included in ASaP, it is a new addition for ASaP+.
- Insufficient vegetable and fruit intake is a risk factor for the development of several types of cancer (i.e., esophagus, oral cavity/pharynx, stomach, larynx)[25,26,27,28,29] and other chronic diseases (i.e., obesity, diabetes, and CVD).[30]

More detailed evidence for each modifiable factor is provided in the 'Recommendation, Rationale and Supplemental References' documents (on the ACTT website).

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[14] Elzerbi, C., Donoghue, K., & Drummond, C. (2015). A comparison of the efficacy of brief interventions to reduce hazardous and harmful alcohol consumption between European and non-European countries: a systematic review and meta-analysis of randomized controlled trials. *Addiction*, 1082-91

[15] Moyer, A., & Finney, J. W. (2015). Brief interventions for alcohol misuse. *CMAJ*, 502-06.

[16] Jonas , et al. (2012). Behavioural Counseling After Screening for Alcohol Misuse in Primary Care: A Systematic Review and Meta-analysis for the U.S. Preventive Services Task Force. *Annals of Internal Medicine*, 645-652

[17] Carvalho, A. F., Heilig, M., Perez, A., Probst, C., & Rehm, J. (2019). Alcohol use disorders. *The Lancet*, 781-92

[18] 2018 Physical Activity Guidelines Advisory Committee. (2018). *2018 Physical Activity Guidelines Advisory Committee Scientific Report.* Retrieved February 3, 2020, from Office of Disease Prevention and Health Promotion: https://health.gov/paguidelines/second-edition/report/

[19] Patel, A. V., et al. (2019). American College of Sports Medicine Roundtable Report on Physical Activity, Sedentary Behavior, and Cancer Prevention and Control. *Medicine & Science in Sports & Exercise*, 2391-2402.

[20] World Cancer Research Fund network. (2018). *Diet, nutrition, physical activity and cancer: A global perspective.* World Cancer Research Fund International. Retrieved from https://www.wcrf.org/dietandcancer/recommendations/be-physically-active

[21] Friedenreich, C. M., Barberio, A., Pader, J., AE, P., & Ruan, Y. e. (2019). Estimates of the current and future burden of cancer attributable to lack of physical activity in Canada. *Preventive Medicine*, 65-72

[22] 2018 Physical Activity Guidelines Advisory Committee. (2018). *2018 Physical Activity Guidelines Advisory Committee Scientific Report.* Retrieved February 3, 2020, from Office of Disease Prevention and Health Promotion: https://health.gov/paguidelines/second-edition/report/

[23] Lee, I.-M., Shiroma, E. J., Lobelo, F., Puska, P., Blair, S. N., & Katzmarzyk, P. T. (2012). Effect of physical inactivity on major non-communicable diseases worldwide: an analysis of burden of disease and life expectancy. *The Lancet*, 219-229.

[24] Livingston, G., et al. (2017). Dementia prevention, intervention, and care. *The Lancet*, 2673-2734

[25] Aune, D., et al. (2017). Fruit and vegetable intake and the risk of cardiovascular disease, total cancer and all-cause mortality – a systematic review and dose-response meta-analysis of prospective studies. *International Journal of Epidemiology*, 1029-1056.

[26] IARC Working Group. (2003). *IARC Handbooks of cancer prevention: volume 8 'Fruit and Vegetable'.* IARC

[27] Kushi, L. H., et al. (2012). American Cancer Society Guidelines on nutrition and physical activity for cancer prevention: reducing the risk of cancer with healthy food choices and physical activity. *CA: A Cancer Journal for Clinicians*, 30-67.

[28] Leenders, M., et al. (2013). Fruit and vegetable consumption and mortality: European prospective investigation into cancer and nutrition. *American Journal of Epidemiology*, 590-602.

[29] Royal Australian College of General Practitioners (RACGP). (2015). *Smoking, nutrition, alcohol, physical activity (SNAP): A population health guide to behavioural risk factors in general practice, 2nd ed.* Retrieved from THe Royal Australian College of General Practitioners: https://www.racgp.org.au/FSDEDEV/media/documents/Clinical%20Resources/Guidelines/SNAP-guideline.pdf

[30] IARC Working Group. (2003). *IARC Handbooks of cancer prevention: volume 8 'Fruit and Vegetable'.* IARC

1.4 ASaP+ Language Considerations

People First Language

The ASaP+ guide is based on the best practice of using ‘people-first’ language. ‘People with obesity’, ‘people who use tobacco’, ‘people with diabetes’, rather than ‘the obese’, ‘smokers’, or ‘diabetics’. People-first language does not define people by a medical condition and supports patient-centred approaches to working with patients to address modifiable factors that may be impacting their health.

Modifiable Factors

The ASaP+ guide uses the term ‘modifiable factors’ rather than ‘lifestyle factors’ to refer to the health behaviours (tobacco use, alcohol use, physical inactivity and low vegetable and fruit intake) that can impact a patient’s health. Lifestyle is a common term, widely prevalent in clinical practice guidelines, health promotion and self-management resources and programs. For many patients, this term is not problematic. However, for some people, the term lifestyle implies these behaviours are a choice the patient makes. Feelings of blame, shame, and other emotions can interfere with the patient’s willingness and comfort in addressing these factors with their provider and healthcare team.

Tobacco use, alcohol use, physical inactivity, and low vegetable and fruit intake are influenced by a variety of factors including social, medical, genetic, physical environments and some factors under the control of the individual. For example, nicotine addiction is now best viewed as a relapsing, chronic medical condition. Most people begin using tobacco at a young age with no intention of becoming addicted to nicotine. The majority of patients who use tobacco want to quit and may have tried to quit many times.

The goal of the ASaP+ guide is to assist providers and primary care teams in developing proactive, systematic approaches to support patients in making changes in these modifiable factors. It is important to recognize that all of these factors are complex and progress may be cyclical with opportunities to learn from setbacks – these are not simple ‘on – off’ behaviour changes. ASaP+ supports a patient-centred incremental approach to supporting patients’ progress towards positive health changes.

Physical Activity vs Exercise

Experts who promote physical activity and the reduction of sedentary behaviour have learned that some people equate ‘exercise’ with routine workouts in a gym or recreation facility. ‘Physical activity’ includes a variety of indoor and outdoor physical pursuits. The more options for enjoyment, the greater likelihood the activity will be maintained long enough to experience health benefits, a further incentive to become or keep active.

The Power of Language

An ACTT Consultant who worked for many years in the pharmaceutical industry shared a powerful story about a time when she interacted with a person who identified as a smoker.

Many people who use tobacco have expressed that it is very challenging to quit and that setbacks are normal. The consultant found it helpful to explain that it is common for tobacco users to relapse and that it often takes 5-7 attempts to quit before they permanently succeed. She went on to state that, "it's not about being weak, it's not about willpower and it's not about lifestyle choice". When it was described in that way, the patient started crying, expressing that he was so relieved to hear that it was a 'legitimate relapsing chronic condition'. It was a powerful way to explain his struggles and he realized that he did not need to feel blame or shame following his multiple attempts to quit smoking. He was comforted that the medical community was there to support him.

1.5 The Role of Brief Intervention in Addressing Modifiable Factors

With about 4 in every 10 cancers in Alberta and many other chronic conditions linked to modifiable factors, it is important for primary care providers and their teams to address, document and follow-up on modifiable factors as part of care planning and optimization of patients' health. ASaP+ supports Brief Intervention through use of the 5As (Ask, Advise, Assess, Assist, Arrange) operational framework to encourage patients to adopt positive health changes. Brief Intervention refers to brief face-to-face encounters with a patient; advice may include communicating with the patient about the risk of the modifiable factors, and motivating patients to improve their health. Research evidence supports the effectiveness of screening and offering opportunistic advice during brief interventions in primary care.[31,32,33]

The 5As Framework (Ask, Advise, Assess, Assist, Arrange)

The 5As is an iterative, non-linear process, as illustrated in Figure 1. The approach refers to a key operational framework for the provision of preventive care[34] and was used to guide the development of ASaP+. The 5As framework has been found to be effective in smoking cessation interventions in primary care (e.g., pcnACT Best Practice Algorithm[35]) and in obesity management (the Canadian Obesity Network 5As of Obesity Management™[36]). 5As frameworks have been developed for alcohol use, physical inactivity, and low vegetable and

[31] Stead et al 2013. Physician advice for smoking cessation. *Cochrane Database of Systematic Reviews*

[32] O'Donnell et al 2013. The impact of brief alcohol interventions in primary healthcare: a systematic review of reviews. *Alcohol and Alcoholism*.

[33] Vallis et al 2014. Modified 5As: minimal intervention for obesity counselling in primary care. *Canadian Family Physician*.

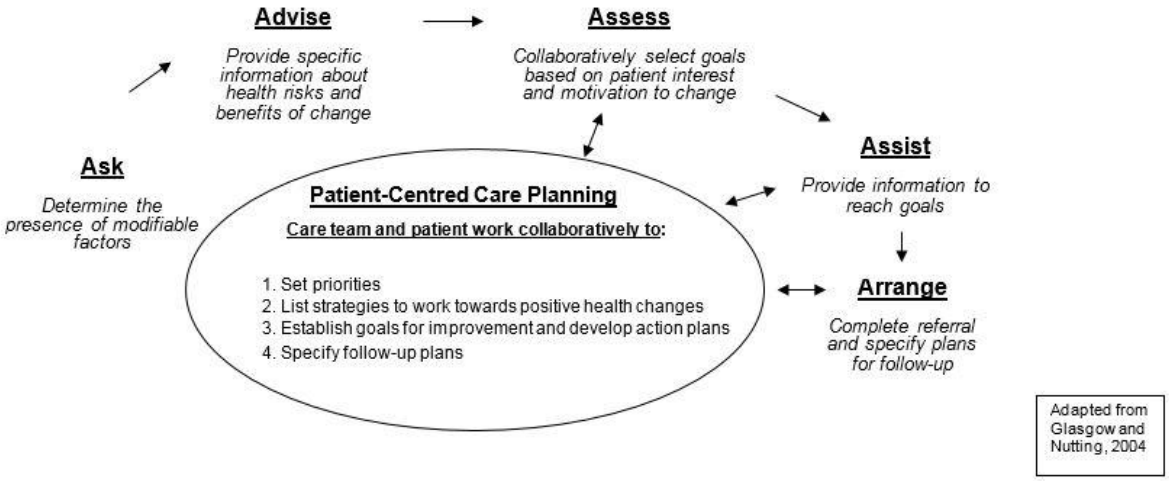
[34] Glasgow & Nutting 2004. Handbook of Primary Care Psychology.

[35] Toward Optimized Practice archive. Accessed online April 10, 2017 at: http://www.topalbertadoctors.org/uploads/122012_Xh2AN8px7BKPMa7Y_144349.pdf

[36] Canadian Obesity Network. 5As of Obesity Management. Accessed online April 10, 2017 at: http://www.obesitynetwork.ca/5As

fruit intake (see ASaP+ Modifiable Factors Best Practices Algorithms on the ACTT website). The pcnACT framework can guide tobacco use conversations, and is included in the ASaP+ Modifiable Factors Best Practices Algorithms document. Gauging a patient's readiness to change is part of the conversation between patients and their healthcare team. If the 5As frameworks are being referred to, readiness conversations will be addressed as part of the 'Assess' step.

Figure 1



1.6 ASaP+ Care Planning Template and the 03.04J Code

The Care Planning Template, developed in partnership with the Patients Collaborating with Teams (PaCT) development project, is a strong enabler of the patient-centred work to document the goals and interventions of providers and patients. ASaP+ leverages the clinic EMR and the Care Planning Template to support the documentation and follow-up elements of the modifiable factors in practice. It is recognized that the Complex Care Plan (CCP, 03.04J code) is a widely and regularly used care plan template in clinic settings. The existing 03.04J template was designed to support specific conditions (Table 1), whereas the PaCT Care Planning Template was designed to expand care planning for broader, single condition, modifiable factor or non-disease specific concerns. Find the Care Planning template in the ASaP+ materials on the ACTT website.

Table 1

Group A	Group B
Hypertensive Disease (ICD 401)	Mental Health Issues (ICD 290-319)
Diabetes Mellitus (ICD 250)	Obesity (ICD 278)
Chronic Obstructive Pulmonary Disease (ICD 496)	Addictions (ICD 303-304)
Asthma (ICD 493)	Tobacco (ICD 305.1)
Heart Failure (ICD 428)	
Ischaemic Heart Disease (ICD 413-414)	
Chronic Renal Failure (ICD 585)	

The updated Care Planning Template is now much more versatile. This template:

1. Can be used to create a care plan for any patient, for any reason. Single or multiple conditions of any kind can be actively monitored or managed for updates by any member of the Medical Home team.
2. Can be utilized solely for a modifiable factor such as alcohol use (ASaP+).
3. Contains significantly more patient-specific detail in comparison to the Complex Care Plan (CCP).
4. Can be incorporated into the EMR forms the same way as the original CCP. Multiple elements from the charts can auto-populate in the EMR such as; medications, allergies, demographics, etc. reducing the need to re-enter data during follow-up visits.
5. Includes new sections related to social determinants that impact success of goals and interventions.
6. Is not required to be filled out completely every visit. Providers complete the portions of the template that are applicable to that date of service. Gradually and over time, the template creates a “whole person’ picture of each patient, encompassing various aspects of their health.
7. Is a recognized replacement of the traditional CCP template. The Care Planning Template form meets the requirements for the billing of the 03.04J code and has been approved by the Alberta Medical Association. Going forward all patients can have a care plan on a single, multi-use document. Any physicians developing comprehensive care plans for patients meeting 03.04J code criteria can discard the old CCP template and now use the new Care Planning Template exclusively. See the most recent version of the Care Plan Template on the ACTT website.

1.7 ASaP+ and EMR Documentation

EMR guidance for ASaP+ is incorporated into the main EMR guides on the ACTT website as well as linked in the ASaP+ section.

1. TELUS Med Access
2. TELUS PS Suite
3. TELUS Wolf
4. QHR Accuro
5. Microquest Healthquest

- Modifiable factor documentation should be tailored to each EMR, taking into account any previous data collected and documented by providers.
- Documentation of modifiable factors can be entered by any member of the healthcare team. A discussion with the provider is encouraged to determine a standardized approach to documentation.

Configuring Documentation in the EMR

Practices may need to configure drop-down selections when identifying patients who *screen positive* for the 'presence' of any ASaP+ modifiable factor. Most EMRs do not have a list and it must be configured. Please note that these selections will be EMR-specific. See the ASaP+ Measurement Guide on the ACTT website for more information.

Section 2: ASaP+ in Clinical Practice

2.1 How ASaP+ will Impact Clinical Practice

Primary care clinics are extremely busy and increasing the number of things patients are screened for comes with challenges. ASaP+ takes this into consideration and is designed to be phased in slowly and seamlessly with current workflow with minimal impact on workload. Clinics that are implementing ASaP will be able to use the knowledge and QI skills they have gained to move into ASaP+.

ASaP+ is focused on building primary care teams' abilities to address modifiable factors as a key aspect of their ongoing relationship with all patients. It allows practices a great deal of flexibility in implementing the initiative to fit with their culture and unique conditions (e.g. EMR, staffing, composition of team, etc.).

2.2 How ASaP+ will Impact Patient Visits

Teachable moments are naturally-occurring opportunities created through engaged primary care provider-patient interactions and, when taken advantage of, can be used to encourage and/or remind patients to consider or commence positive health change[37].

With careful planning and observation, primary care teams can embed these positive health change conversations during patient visits. For example, an elevated cholesterol finding, a high blood pressure reading, and a family member diagnosed with heart disease all provide excellent opportunities to engage in discussions about modifiable factors and to support patients who might have some desire to make changes. Documenting the conversation in the EMR assists the care team to quickly pick-up where they left off.

2.3 The ASaP+ Process

There are three phases in the ASaP+ process:

- ✓ Identify Phase
- ✓ Prepare and Plan Phase
- ✓ Manage and Follow-up Phase

Identify Phase

The identify phase includes the process of:

- Reviewing the EMR prior to the patient arriving for an appointment:
    - For patients who have screened *positive* in the past for a maneuver using the ASaP+ Health Checklist, their record should indicate the positive screen.
    - The ASaP+ Health Checklist is a simple tool to help identify what might be of most concern to the patient among the modifiable factors included in ASaP+. The checklist can create an opportunity to discuss modifiable factors with the patient.

[37] Flocke et al 2014. A randomized trial to evaluate primary care clinician training to use the Teachable Moment Communication Process for smoking cessation counseling. *Prev Med*, 69:267-73.

Any member of the care team can review the checklist with the patient and inquire as to what is of most concern to them.

- Identifying any modifiable factor flags in the EMR and building reminders into the appointment:
    - Example 1: There is an individual reminder built into the EMR to ask the patient how they are progressing with the "Goals & Action Plan" section of the care plan template that was developed at their previous visit.
    - Example 2: The clinic enters modifiable factors into the appointment or problem list as a reminder for the team to incorporate into clinical discussion.
    - Population-wide reminders can be set for all the patients who have screened positive for a modifiable factor.

Suggested scripts for starting conversations about modifiable factors:

"Since modifiable factors and health status are strongly related, it is important we talk about these factor(s)"

1. Which factor is of most concern for you?
2. Are there areas where you would like to make improvements?
3. Did you know that making a small change to these modifiable factors could improve your health?

Prepare and Plan Phase

The prepare and plan phase concentrates on interactions that occur when the patient meets with a member of the team or other members of the care team, assessing the patient's understanding of modifiable factors that they've screened positive for, determining readiness to make changes, and providing resources to support the patient's success.

Assessing patient's readiness to change is critical to supporting the patient. Research into smoking cessation and alcohol use has advanced our understanding of the change process, giving us new direction for health promotion and prevention strategies. Current views depict patients as being in a process of change and one approach doesn't necessarily fit all.

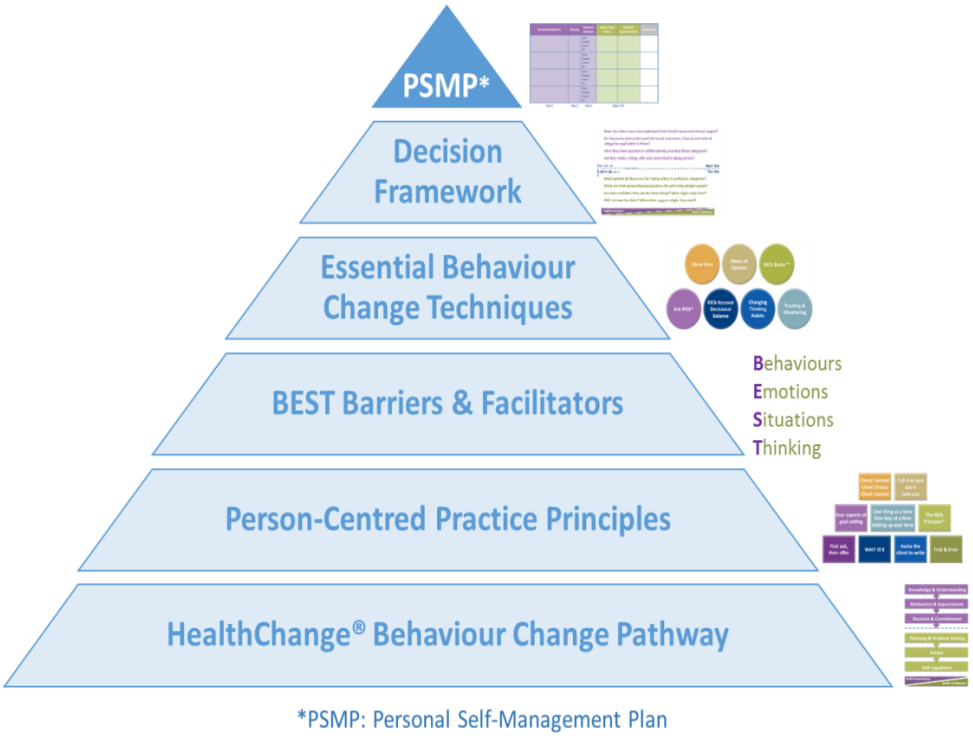
Supporting the Patient with Change Strategies

Changes are hard to make and can be even harder to sustain, but evidence informed programs, such as HealthChange® Methodology, have been shown to help people make sustainable changes in their lives.

ASaP+ encourages healthcare teams to consider attending HealthChange® Methodology training to support them in delivering ASaP+ to their patients. HealthChange® Methodology provides a framework to assist providers in primary care teams to help patients make positive health changes. This overall framework provides a patient-centred structure to a consultation, and ensures that the patient develops sufficient knowledge, understanding and motivation to act on the providers' recommendations.

HealthChange® Methodology provides healthcare providers with a set of techniques to identify and address potential patient barriers to action. It also supports providers to use their existing skill sets, including motivational interviewing, effectively and efficiently.

HealthChange® Methodology promotes shared decision making in a way that balances the clinical duty of care with a patient's right to make fully-informed decisions about their health. The focus is on achieving the best clinical, health and quality of life outcomes possible for each patient, given their unique circumstances.



*PSMP: Personal Self-Management Plan

HealthChange® Methodology is comprised of an integrated suite of tools including a decision support framework to help healthcare providers work more effectively and efficiently with patients.

1. A simple, evidence-informed, *Behaviour Change Pathway*: to help healthcare providers quickly assess patient readiness to take action on recommendations.
2. A set of clearly defined *Person-Centred Practice Principles*: to operationalize person centred care, communication and health literacy support in a way that makes these factors measurable.
3. A functional way of thinking about *Barriers to Action and Facilitators for Change*: to facilitate recognition and understanding of the most common types of barriers for engaging patients in treatment recommendations.
4. A set of *Essential Behaviour Change Techniques*: the minimum set required to identify and address potential barriers to action when they are present.
5. A *10 Step Decision Framework* to guide healthcare providers: Know when and why a patient is unlikely to adhere to recommendations and to apply the appropriate principles and techniques to help them to understand their conditions and treatment options; identify personal motivators; make fully-informed decisions; take action, and self-regulate for improved health and quality of life outcomes over time.

6. A set of skills development, quality assurance and capacity building tools and mechanisms: For frontline staff and organizations to assist, measure and track staff transfer of training into practice and to capture client behaviour change data for reporting against clinical outcomes.

To access training or learn more about HealthChange® Methodology, please access the Primary Health Care Resource Centre or email cdm.provincialeducation@ahs.ca.

Motivational Interviewing

Motivational Interviewing (MI) is a set of interviewing techniques that can be used in conjunction with HealthChange® Methodology. Motivational interviewing is a way of being with a patient, not just a set of techniques for doing counselling[38]. MI can be effective when encouraging patients to consider making positive health changes. It can be used by any member of the care team such as doctors, nurse practitioners, nurses, dietitians, social workers, behavioural therapists, etc.

Key points[39] to consider when using MI are as follows:

- Simply giving patients advice to change is often unrewarding and ineffective.
- MI uses a guiding style to engage with patients, clarify their strengths and aspirations, evoke their own motivations for change, and promote autonomy of decision making.

The way in which you talk with patients can strongly influence their motivation to change. Here are some suggestions of how to enter into a conversation about modifiable factors:

- ✓ Enter the conversation in a non-judgmental way
- ✓ Speak with patients respectfully and work with them as partners in their own health
- ✓ Try to determine if "now" is the right time to have this conversation
- ✓ Determine whether your patient is willing to acknowledge he/she should make positive health changes and if able to commit to making changes
- ✓ Use open-ended questions to guide conversation
- ✓ Acknowledge and applaud where the patient has made efforts to change

You can learn MI in three steps: Practice a guiding rather than directing style; develop strategies to elicit the patient's own motivation to change; and refine your listening skills and respond by encouraging change talk from the patient. MI has been shown to promote behaviour change in various healthcare settings and can improve the provider-patient relationship and the efficiency of the consultation.

[38] Center for Substance Abuse Treatment. Enhancing Motivation for Change in Substance Abuse Treatment. Rockville (MD): Substance Abuse and Mental Health Services Administration (US); 1999. (Treatment Improvement Protocol (TIP) Series, No. 35.) Chapter 3—Motivational Interviewing as a Counseling Style.

[39] Rollnick S et al. 2010. Motivational interviewing *BMJ:* 340 :c1900

Three Core Communication Skills[40]

Asking, listening and informing (or assisting) are three basic but important communication skills in MI.

1. *Ask* the patient: The intent in asking questions is to develop an understanding of the patient's point of view.
2. *Listen* to the patient: Give the patient time to respond to your questions. Listen with the right posture and attitude - your body communicates how much you "care" to the patient. Likewise, it is important to note the patient's body language during positive health change discussions. For example, the patient may "verbally" communicate readiness while their body language communicates otherwise.
3. *Inform or Assist* the patient: How to share knowledge with the patient and assist with goal setting.

Given some patients might agree to care providers' advice despite having no intentions of acting on it, it is key for providers to recognize their potentially perceived position of power and attempt to assess the patient's commitment. For instance, patients often agree to attend a smoking cessation class even though they have no desire to quit smoking or may face barriers to attending a particular program.

In summary, the provider and their care team take care to *Ask, Listen* and *Assist* the patient in making a change in modifiable factors. The "assist" here is very similar to the "assist" in the 5As.

Here are two videos demonstrating a patient and provider engaged in MI:

Evoking Commitment to Change: https://www.youtube.com/watch?v=dm-rJJPCuTE

Role-play Focusing on Engaging: https://www.youtube.com/watch?v=bTRRNWrwRCo

Goals and Action Plan

The Goals and Action Plan is a component of the Care Plan Template. It is a tool that can be used to engage patients in change related to modifiable factors. After the patient has identified what's important to them and where they'd like to start, the patient together with their care team set SMART (**S**pecific, **M**easurable, **A**ttainable, **R**ealistic, **T**imely) goals, and outline specific steps that can help the patient fulfill the goal(s).

- Document and provide a copy of the plan to the patient and incorporate follow-up into future visits. A copy of the plan is kept in the patient's file for clinic record purposes.

[40] Rollnick, S., Miller, W. R., & Butler, C. C. (2008). Motivational Interviewing in Health Care: Helping Patients Change Behavior. New York, NY: The Guilford Press.

- Interested patients can be supported with the ASaP+ Program and Resource Quick Referral List.

Manage and Follow-up Phase

The manage and follow-up phase centers on connecting the patient to the appropriate level of resources/support in order to make positive health change(s), documenting in the EMR the type of support offered, and following up with the patient about their progress at the next appointment.

Support might be in the form of working with the patient to complete the Goals and Action Plan section of the Care Plan Template, meeting with a more appropriate staff member, or referral to a PCN, community, online, or AHS program. ASaP+ is designed to support members of the care team to leverage existing PCN and/or community programs as referral sources for patients wishing to address modifiable factors.

EMR tools that assist in this phase include:

- Individual patient reminders
- Population-wide reminders
- Follow-ups created for the patient
- Other notes, which may include pop-ups for critical information but also notes that remind a team member of a particular action for an individual

EMR Tip: Information recorded in a consistent and searchable location of the EMR helps team members find that information and, when in a searchable location, can be included in a population-wide reminder.

The Importance of Warm Handoffs in the Manage Phase

As part of the manage phase, a warm handoff to resources is desirable when possible:

- A warm handoff approach means going that extra mile to ensure that patients get connected to a service provider who can provide what they want and need.
- A patient may be more willing to sign up for programs and services, such as a smoking cessation group, if there is a warm handoff between the referring clinic, the patient and the team providing the service.
- Handing off patients from one staff member to another promotes continuity of care and helps patients feel secure and clear about what is happening.
- This is a video demonstrating an exemplar warm handoff in a clinic setting: https://www.youtube.com/watch?v=owVzLBaU8tA

The choice of a self-directed vs. supported program/resource should be decided based on the patient's level of confidence about being able to make changes. Care should be taken to adequately assess the patient's level of confidence when deciding on the appropriate level of support.

Warm Handoff Recommendations

- Whenever you need to share information about the patient, do it in person and in front of the patient.
- After the patient's main reason for visiting the clinic has been addressed, use a warm handoff to connect the patient to extended members of the care team, i.e., chronic disease nurse, behavioural health consultant, physiotherapist, etc.
- Warm handoffs can be in the form of a phone call to external programs and services, verbal communication between members of the care team, a faxed referral or introducing the patient to another member of the care team.
- A warm handoff is very effective in connecting patients to external programs/services (including community neighborhood programs, AHS programs, and PCN programs).

Suggestions for Warm Handoff Implementation

According to the Agency for Healthcare Research and Quality (AHRQ)[41], implementation of warm handoffs will depend on a clinic's individual characteristics and current workflow. In some clinics, workflow might need to be adjusted. The following steps are recommended but may be adapted for each clinic's processes:

- Step 1. Obtain buy-in from the care team and, if possible, identify a champion.
    - Staff engagement is important to successful implementation of warm handoffs in clinic workflows.
- Step 2. Design workflows that allow for warm handoffs.
    - Collaborate with providers and the team to integrate warm handoffs into current workflows.
- Step 3. Train team members in warm handoffs and in adjusted workflows.
    - Spread the word across the team about warm handoffs.
- Step 4. Make patients and families aware of warm handoffs.
    - Talk with patients and families about the value of warm handoffs and why they are being used. Answer any questions from patients and families.
- Step 5. Evaluate and refine the process.

[41] Warm Handoff: Intervention. Content last reviewed May 2017. Agency for Healthcare Research and Quality, Rockville, MD. http://www.ahrq.gov/professionals/quality-patient-safety/patient-family-engagement/pfeprimarycare/interventions/warmhandoff.html

- Assess how warm handoffs are being used. Refine the workflow design as the team becomes more comfortable with use and identify and address any barriers to using warm handoffs.

Keep in mind the above are mainly suggestions on how to implement warm handoffs in the clinic setting. Each clinic will determine how best to integrate warm handoffs into their current workflows.

2.4 Connecting Clinics with Communities

Most communities provide important services that can be helpful for patients wishing to make positive health changes. However, opportunities to connect these patients with appropriate services are often missed without strategic planning to weave them into daily practice. Linking your clinic to surrounding community services and programs can address these gaps, but it's not always easy to do. Primary care teams should consider being purposeful and deliberate in their commitment to integrate community programs and services into clinic workflows. The Community Health Center Inc.[42] on Advancing Team-Based Care has put forward a few recommendations for incorporating community-based programs and resources into care of the patients:

1. Recognize staff that have good knowledge of resources in their own community.
2. Designate staff to be responsible for fostering and coordinating community linkages.
3. Investigate community strengths and weaknesses.
4. Develop relationships with key community organizations.
    a. Those providing key patient services
    b. Potential partners in addressing social determinants
5. Use the practice's influence and resources to connect with the local community and work collaboratively to fill gaps.

Leverage your Practice Facilitator to help your clinic develop a more robust resource list that will include local PCN resources or help discover yet untapped community organizations for each modifiable factor.

2.5 Other Factors that can Impact Health Changes

It is important to ensure that while addressing modifiable factors with your patient, you take care to assess your patient's economic capability to support positive health changes. Awareness of community programs and support available to the public will help you support your patient if the topic of income is raised in your conversation.

Make sure you check with your local PCN about program availability in your community for patients requiring economic support. Below are two examples to get you started:

[42] Community Health Center, Inc. (Producer). (2016). Advancing Team-Based Care: Dissolving the walls: Clinic Community Connections [video webinar]. Retrieved from https://vimeo.com/174582556

Good Food Box program (telephone: 403.538.3779)

- Purchase of fresh vegetables and fruits at a low cost
- Check the website for various depot locations throughout Calgary http://www.ckpcalgary.ca/index.php/program-services/good-food-box
- For provincial food resources, go to https://informalberta.ca/public/common/index_ClearSearch.do and search 'food'.

Alberta Income Support

Income Support provides financial assistance to Albertans who do not have the resources to meet their basic needs (food, clothing and shelter). Albertans who are eligible for Income Support also receive:

- Health benefits for themselves and their children
- Help and training to find a job
- Help getting child support payments

How to apply for Income Support: Contact or visit your nearest Alberta Supports or Alberta Works Centre to inquire about applying for Income Support and the Income Support Application Form.