Alberta Screening and Prevention Plus (ASaP+):
Engaging Primary Care Patients in Addressing Lifestyle Factors

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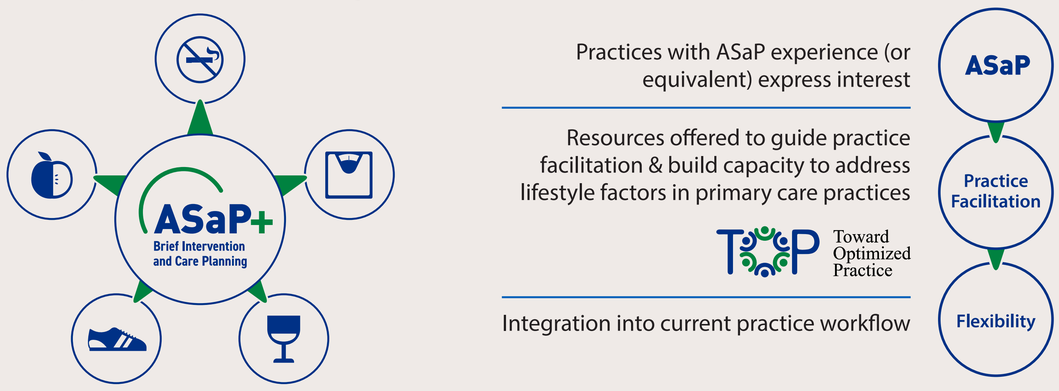
BACKGROUND 1

- Tobacco and alcohol use, physical inactivity, and eating habits are 4 lifestyle factors associated with increased risk of cancer and chronic conditions including dementia, cardiovascular disease and stroke; excess weight is also associated with increased risk of these conditions
- Primary care is an ideal setting to *identify* patients with any of the 4 lifestyle factors or who are interested in weight management/healthy weight support, *offer* to help them reach their goals, and *document and follow-up* on progress towards improving their health
- Evidence supports the effectiveness of screening and brief intervention to initiate lifestyle changes in primary care and motivate patients to improve health
- 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 behavior changes relevant to patient)

WHAT IS ASAP+? 2

- ASaP+ offers a curriculum and resources for primary care teams to support patients with any of the 4 lifestyle factors or weight management/healthy weight
- Toward Optimized Practice (TOP) Improvement Advisors (IAs) train PCN Improvement Facilitators (IFs)
- Evidence-based lifestyle intervention strategies, including HealthChange™ methodology, have been incorporated into the ASaP+ design



DESIGN OF ASAP+ 3

- ASaP+ is designed to support and extend ASaP work
- ASaP+ is a response to, "How can I support my patients who have lifestyle factors they want to work on?"
- The 5As (Ask, Assess, Advise, 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-centered Care Planning

Care team and patient work collaboratively to:

1. Set priorities
2. List strategies to change behaviours
3. Establish goals for improvement and develop action plans
4. Specify follow-up plans

ASK – Determine presence of modifiable lifestyle factors

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

ADVISE – Provide specific information about health risks and benefits of 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

- In 2016, a model care planning process was developed through consultation with physician innovators and the Health Quality Council of Alberta
- The process has 4 main phases: identify, prepare, plan and manage
- ASaP+ supports a broad cross-section of panel patients who have prioritized lifestyle factors and/or healthy weight in their Care Plan

1. Identify	2. Prepare	3. Plan	4. Manage
Define target patient group based on ASaP screen for general patients (plus eating habits/fruits and vegetable intake and alcohol). Identify eligible patients embedded in ASaP screen or combined as part of care planning for patients with complex needs.	Update the EMR patient profile. Team members prepare for patient-centred conversations. Select patient assessment tools &/or resources to guide conversation with patient.	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.	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.

PATIENT INVOLVEMENT IN ASAP+ DESIGN 5

Patient representation on the Care Plan Template Development Group

- Weekly meetings over 5 months
- Significant contributions to the design of the Care Plan Template:
  - Patient-friendly language and focus
  - Patient-centered design
  - Shared decision-making
  - Goals and Action Plan component designed to target goals most relevant and of concern to patient

Focus group (n=6) to review ASaP+ design and resources

- Consensus on importance of preventive conversations occurring regularly with primary care teams

"This is an investment in our health care system… Conversations up front will hopefully steer people in the right direction, and try to keep them healthy and reduce the use of the health care system in the future."

- Patients agreed that the Lifestyle Checklist is helpful start to conversation with providers
- Patients want a certain level of information in their conversations with providers

"I need to know why. Don't just tell me to do. I need to know why I'm doing it… because I'm not gonna buy into it if you don't explain to me why."

- Lifestyle information must be tailored to format that works for individual patient

"There needs to be like a teach-back kind of method to it, that it shouldn't just be a handout that people might have good intentions of reading, but never look at again. But I think it's not really just that didactic portrayal of information."

ASAP+ RESOURCES 6

Improvement Facilitator (IF) Training Curriculum
- Training for Improvement Facilitators on how to implement ASaP+

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

References and Recommendations
- Evidence summary and guidelines/recommendations for each factor
- Deep dive into the evidence base for lifestyle factors and healthy weight, and guidelines or recommendations

5As Framework/Algorithms
- Contains best practice and primary care team options, in addition to evidence highlights
- Provided as part of training package, as example of how to potentially guide conversations

Programs and Resources Quick Referral List
- Provides link to PCN and community-based programs to support patients

Lifestyle Checklist
- Helps start conversation between patients and providers

KEY LESSONS

- Need to work with partners, PCNs, practices and providers to supplement and extend existing programs (ASaP) to help increase uptake in primary care; TOP extended ASaP training to include ASaP+
- Patient-centered (vs. disease-specific) approaches can address the needs of a broad spectrum of patients
- The importance of working closely with patients as partners in planning their care to address, "What is important to you?"

NEXT STEPS

- A formative evaluation will assess the implementation process and outcomes at pilot practices
- Results and recommendations will be used to revise ASaP+ and determine sustainability and feasibility for spread to other Alberta primary care settings

CONTACT INFORMATION

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