ASaP Frequently Asked Questions

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1. What has changed in 2022? Why were the changes made?

The updated ASaP Maneuvers Menu for Adults continues to strike a balance between the evidence and what is practical and achievable within a primary care setting – *i.e., focus on addressing the most important maneuvers, for most of the people (general, low/normal risk population), most of the time.*

Highlights:

- Change age of initial mammography screening for women from 50 years old to 45 years old. See table below.

Maneuver	What's New?	Why the Change?
Mammography	Recommend screening women starting at age 45 (formerly 50 years of age)	There is a new Alberta breast cancer screening guideline, hosted by AHS' Screening for Life that now recommends starting screening at 45 (previously 50). The TOP Guideline has been retired. More information. **How to implement the change:** Clinics can use their discretion to determine when or if to change their breast cancer screening approaches. Primary care clinics making this change can modify their EMR alerts accordingly. There is no expectation for the change to take place immediately. AHS have communicated that implementation may take some time, including adding the 45-49 age group to targeted screening invitation letters. However, they have notified radiology clinics that they can accept people 45-49 immediately without a special requisition.
Pap test	Simplified wording	Previously the Pap test recommendation included optional screening for age 21-24 and had a 'do not screen' recommendation for age 18-20. Based on user feedback and expert opinion, this was simplified to focus on who *should* get screened.

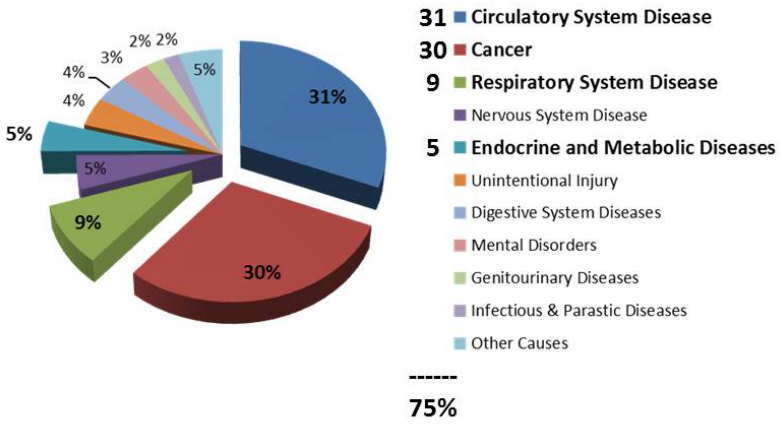
Like all of the ASaP maneuvers, the recommended ages and intervals are suitable for the general adult population (*i.e.,* low/normal risk population). The approach for individual patients will vary and is at the physician's/provider's clinical discretion. For each maneuver, the physician/provider should offer care as appropriate.

2. Originally, how were the ASaP maneuvers selected? Why these maneuvers and not others?

The maneuvers were selected by a Scientific Advisory Committee. The committee was comprised of academics and non-academics. The committee met on a regular basis to review and discuss the maneuvers, the guideline evidence and recommend changes based on maneuver selection criteria, emerging or current evidence and their own experience in practice. The process for decision making

utilized by the Scientific Advisory (SA) Committee involved synthesizing the evidence in the Alberta context and utilizing a consensus process to determine the most important maneuvers for most of the people (general population) most of the time that was practical and achievable within a primary care setting. As illustrated below, the selected ASaP screening maneuvers represent approximately 75 % of the leading causes of mortality (Source: OECD).

The selected ASaP screening maneuvers represent ≅75 % of the leading causes of mortality



"Place the big rocks first"

There is a principle in process improvement to focus on the 20% of the tasks that create 80% of the work. This is not because the remaining 80% of the tasks are not important. It is simply that dealing with the metaphorical "rocks" in an efficient way leaves more capacity for the other chores.

The ASaP maneuvers menu focuses on the biggest rocks in screening and prevention. The intent is to address the most important screening interventions, for most people, most of the time. The objective is to have a process where the system and supports around the provider (Physician and Nurse Practitioner) does as much of the "heavy lifting" as possible. This is to enable the provider to have the time to focus on the individual needs and exceptions for those patients with special concerns

"Most important" means that the menu concentrates on diseases where the evidence suggests the provider can have the most impact. The menu is based on the best-available guidelines reviewed today to ensure currency and applicability to the Alberta context.

"Most of the people" means that the menu focuses on the maneuvers needed by the general population. It doesn't account for individual medical history. Patients with chronic disease and/or cancer for example need to have more specialized care. Secondary screening of this type is critical. Experience suggests that care for patients outside the "norm" is significantly enhanced when the routine care is systematically addressed therefore leaving more capacity for this important specialized care.

"Most of the time" means that the menu addresses patients of "average" risk. For example, women with a family history of breast cancer will need more frequent and earlier mammography. Having a

process that supports the woman's other "routine" needs allows the provider to focus on the area of special concern.

Clinical circumstances and patient populations vary. The reason ASaP is based around a menu and not a set list is to support providers to adapt the tools to the needs of their patients and their clinic capabilities. For best results, providers are encouraged to focus improvement on the "big rocks" as described above. Existing clinical care processes including the patient visit is usually the best tool for dealing with the high value specialized interventions and often less common interventions.

3. What was the process for updating the maneuver menu?

Physician leaders and system partners reviewed the new evidence and guidelines in the Alberta context and used a consensus process to determine whether existing maneuvers should be updated. The reviewers balanced the opportunity costs of time and resources against practicality and evidence of clinical/behavioural benefits.

4. What if a team would like to focus on a screening maneuver that is not on the ASaP menu?

It's possible. The ASaP intervention is about process improvements which can be extended past the ASaP screening maneuvers.

While the ASaP maneuver menu focuses on those supported by the evidence as having the greatest clinical impact, each provider and team must use their discretion to decide what is best for their patients.

5. As a Practice Facilitator, what can I do to support my teams with implementing the updates?

Your facilitation and quality improvement skills will continue to come in handy. Consider the following:

- **BE AVAILABLE TO ANSWER QUESTIONS.** You will be the first point of contact for questions from participants. This FAQ has been developed to support you and you can always reach out to your TOP Improvement Advisor as needed.
- **BUILD AWARENESS & SOCIALIZE THE UPDATES.** Simply knowing and understanding what's new will be the first step for most teams.
- **FACILITATE TEAM PLANNING & DECISION MAKING.** Consider meeting with your teams to discuss the new evidence/updates and help them make a plan outlining how they would like to proceed. Here are a few questions you might want to use to prompt teams during their planning discussions:
    - What are your current processes for the screening maneuvers that will be updated? Do you need to change them?
    - What modifications do you need to consider in your work processes? Clinical decision processes? EMR processes/templates/reminders, etc.?
    - How will you best document the decision and process changes to inform future measurement?
    - Are you leveraging all members of the care team to optimize screening and prevention processes
    - Will you need to update any resources (*e.g.,* posters, handouts, web content, etc.)?

- Are there key messages you can begin to script for staff if patients ask why their screening (e.g., age range) has changed?

TIP: When decisions and process changes are made, we recommend you document them to inform future measurement results.

6. Doesn't the College (CPSA) frown upon calling your patients for appointments?

We understand your concern. Contacting patients to solicit business is very different than contacting patients who are on your patient panel for preventative care. ACTT did contact the CPSA and they indicated "efforts made by physicians to encourage their patients to receive appropriate disease prevention and chronic disease management interventions in a timely manner is considered desirable and in keeping with good medical practice."

7. Why not address screening and treatment gaps simultaneously?

Improvements to both screening and treatment gaps are required to deliver high quality patient care, however, these both are addressed by different clinical processes, which require different strategies. Focusing on screening allows primary care to improve one thing at a time, build on success, and provide 'usual care' to patients currently unscreened. Furthermore, the learning's from the new screening processes may inform the delivery of treatment options in the future.

8. Aren't these my least ill patients?

Possibly. These patients may not have any disease, they may have preventable risk factors, they may have disease without symptoms severe enough to cause the patient to seek care, or they may be presenting for specific issues but not screening. However, improved screening can help with prevention of chronic disease or control of symptoms in the earliest stages, which will have a tremendous impact on health outcomes in the future. Some of these patients may be the seriously ill of tomorrow.