A Primary Care Organization's Perspective

FAQs

Alberta Screening & Prevention Program

1. What is practice facilitation/improvement facilitation?

Practice facilitation draws similarities to a personal trainer who offers a customized development plan, knowledge of training techniques, personal motivation skills, and activity structure to help you achieve your personal fitness goals. In improvement work it is a person who applies process change concepts, improvement methodologies, and team optimization to assist the clinical providers achieve their desired goals.

Studies have shown practice facilitation to be 2.76 times more effective at implementing evidence-based guidelines. Click here to see the evidence.

2. 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 learnings from the new screening processes may inform the delivery of treatment options in the future.

3. Why are we doing chart review samples and not measuring the entire panel?

Although measuring improvements of screening for the entire panel is the desired goal very few practices have developed a consistent process to do so. A valuable starting point is to sample the selected patient groups for increase screening offers.
In addition, the program seeks to have standardized measures across PCN's in order to summarize across all participants, including paper based and EMR practices.

As the quality of data input will define the value of a report from an EMR, determining the offers of screening via a trained reviewer who can use his/her discretion is a more sensitive approach to understanding screening performance. The reviewer's experience may also lead to suggestions on how to standardize the use of various data fields such that more meaningful EMR screening related reports can be generated in the future.

Ultimately, primary care organizations and primary care providers will be encouraged and supported to move towards an electronic method of measuring offers of screening service for the entire panel. However, at this time, chart reviews will be an important element of participation.

4. Will the size of a provider's panel or the current FTE he/she works affect the number of charts that will need to be sampled?

The number of records sampled in the ASaP program is between 10 and 30. The recommended number of charts to review is 20. The ASaP program chart review methodology is designed to provide enough feedback that participants can be confident that their improvement efforts can be detected.

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5. **What screens are on the list?**
   Currently there are 11 screening maneuvers on the maneuver menu. These maneuvers were reviewed by a scientific review committee with strong primary care representation and were chosen based on their value for patients, strength of evidence and ability to easily measure improvements in practice.

6. **Will you be providing us a list of the evidence /summary of the evidence for common screening maneuvers? What about practical implementation tips?**
   Yes. A list of the evidence reviewed by the ASaP scientific committee has been made available and can be located here. A table of practical implementation tips has been developed for Improvement Facilitators.

7. **We already do this - why would we want to participate?**
   Data shows physicians excel at screening their patients during focused screening visits, however, a challenge exists in that a substantial portion of patients (greater than one third) do not "self-present" for such opportunities. Although the improvements made through this program will benefit each provider's panel of attached patients, particular emphasis will be placed on those who do not typically 'self-present" for screening care. Everyone starts at a different place, yet all will have access to resources and Improvement Facilitation to support improvement. These resources can also be leveraged in the future for primary care priorities.

8. **We have measurement/evaluation systems in place already how might this align with the work we are already doing?**
   The ASaP program focuses on the offer of screens made to the right patients at the right interval. PCNs with other measurement systems can still participate in ASaP.

9. **Is there funding for the facilitators?**
   ACTT cannot offer monetary compensation for participation in this program However; we will provide training, support and the necessary tools/resources to your primary care organization (PCO) staff to complete this work and to create capacity for participation in additional quality improvement in the future if desired. Dedication of PCO staff to hone facilitation and process improvement skills with providers and teams serviced by PCOs will not only improve the care they offer their patient's, it's an investment into a skill set that will support your future quality improvement priorities.

10. **Can you assist us with our EMRs?**
    Yes. The ASaP program has developed resources to assist clinics with optimizing their EMR's. In addition to the developed resources the ASaP program has EMR KT resources to provide consultation support to PCOs.

11. **How many Practice Facilitators will we need? How much of their time should we allocate?**
    The total time required by an Practice Facilitator to implement the ASaP program in a practice will be highly variable based on several factors - e.g., readiness of the practice

to implement change, size and complexity of the practices, and the number and types of changes required to be made at the practice level. Implementing ASaP changes as a step towards Patients Medical Home implementation suggests a ratio of 1 IF to 5 clinics.

12. **We participated in Health Screen in Act10n, how is this different?**
In Health Screen in Act10n, providers were supported with a checklist of screening maneuvers to reduce errors of omission during a screening encounter. TOP found that statistically significant improvements could be made through the use of a checklist when the purpose of an encounter is for screening or health maintenance. Unlike Health Screen in Act10n, ASaP will focus on improving screening performance for patients who do not present for screening or health maintenance.

13. **How many days of training will there be? Where will the training be? What are the training dates?**
There will be a total of four days of face-to-face training sessions. The four days of training is divided into two days separated by two weeks. ASaP will strive to deliver local training, but minimum participant size will apply. All known training dates and locations will be available on the website: https://actt.albertadoctors.org/events/

14. **What qualities/skills should a practice facilitator have?**
Practice facilitators should have competency in three broad areas: skills in quality improvement methods, ability to generate and use data to drive improvement, and facilitative, interpersonal, and project management skills. These skills will be enhanced through participation in ASaP. The qualities that should be considered in selecting an improvement facilitator include:
    - Able to work autonomously and stay objectively focused on the identified process needs of the practice (not focused solely on developing and maintaining relationships with staff members)
    - Able to understand and work towards long-term goals, given that facilitators are not likely to experience immediate, day-to-day signs of improvement
    - Resilient and flexible (for example, facilitators often travel long distances only to find that a meeting has been cancelled due to a clinical emergency)
    - Able to build confidence and capacity within the practice, rather than keep the dependence focused on themselves
    - Able to apply adult teaching principles and transfer skills and knowledge
    - Ability to understand the importance of valid data and can explain data to others in a meaningful manner.

15. **A patient has not seen the primary care provider in three years is there really a relationship? Do you keep them on the list even though you cannot reach them multiple times?**
Whether there is a relationship between the provider and the patient after three years is really determined by the provider and patient. However, from a practical perspective, after several attempts to reach out to patients to offer screening and prevention you may decide not to pursue the patient any further. This process will be explored during participation in ASaP.