A Primary Care Provider's Perspective

FAQs

Alberta Screening & Prevention Program

1. **Why develop panel – isn't that a lot of work? Is this like the PDI panel?**
   The panel is not an 'end,' it is a 'means.' It allows us to understand who is responsible for screening for any given patient. Participation in the ASaP program does not expect this answer for every patient at once and can take a staged approach. Participation does require providers to have a process for building and keeping this information current.
   Typically this is a reception/booking question. Studies tell us that for a typical family practice 85% of patients will book an appointment within an 18-month time frame.

2. **What if I discover that my panel is too large/too small?**
   The ASaP program is not focused on determining whether your panel is too large or too small. If this is a concern for you, the Practice Facilitator working with your practice will be able to direct you to optional resources or programs to consider.

3. **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.

4. **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.

5. **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.

6. **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.

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In addition, the program seeks to have standardized measures across PCNs 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.

7. **Can I participate but not measure?**
   Without measuring you will have no idea whether any changes you implemented resulted in any improvement. Think about the diagnostic measures you rely on in your day-to-day work to make decisions. The process you will engage in through the ASaP program requires the same kind of logic. A baseline assessment will provide an assessment of your current state. Ongoing measurement will monitor the status of the changes and guide future decision-making. In short, participation without measuring would create more questions than answers for you. You and your team will have no way of understanding if the effort had the desired impact or disservice to you and the members of your improvement team.

8. **Can we participate if we don't have an EMR?**
   Absolutely. The screening and prevention processes you and your team members will design and implement will be what works for you in whatever documentation system you use. Some strategies for enhancing your screening offers are easier or more challenging depending on the system being used. Your Improvement Facilitator will work with you to identify the best strategies for your context. NOTE: A community of practice will be made available to you to share experiences and to gather ideas from others who will be participating in ASaP.

9. **I am a primary care provider and I want to participate, but my PCN has not provided us with any information regarding this program.**
   We'd be happy to answer any questions you have about ASaP. Please contact us directly at asap@albertadoctors.org or call 780.482.0319 or toll free at 1.866.505.3302.

10. **Where do we get started once we have committed to participate?**
    Once your Primary Care Organization (PCN/FCC) is enrolled, someone from your Primary Care Organization will contact you to complete a registration package and discuss next steps. Initially, they will work with you and the members of your team to assess your baseline status. Together you will explore topics such as:

    - Panel awareness – do you know who your patients are? What is your current process for documenting and maintaining your patient panel list?
    - Screening process – what are your current processes?

11. **What screens are on the list?**
    The list of clinical maneuvers, supported through this program, is being finalized. Primary care providers and team members will be provided the option to select from the list of clinical maneuvers, which will include: cardiovascular (i.e. blood pressure, lipids, glucose, etc), cancer

(i.e., mammography, pap, colorectal, etc), and common risk factors (i.e., alcohol, exercise, tobacco use, etc.)

12. **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 common, evidence based screening maneuvers is available. The reference list of evidence reviewed by the ASaP scientific committee can be found here. A table of practical implementation tips has been developed to support your improvement activities.

13. **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 (i.e., 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.

14. **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. For practices or PCNs who have enhanced measurement systems, you may still participate in ASaP.

15. **Can you assist us with our EMRs?**
    Yes. The ASaP program has 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 PCNs and practices.

16. **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.

17. **"Doesn't the College (CPSA) frown upon calling your patients for appointments? I thought we were not allowed to do that."**
    We understand your concern and you are not the first physician to mention this. 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."