

Key Messages



Why this program?

Toward Optimized Practice's (TOP) data shows physicians do an outstanding job of screening individual patients during focused screening visits. The challenge is about one-third of patients simply do not "self-present."

What is the program?

The ASaP program is focused on supporting primary care providers and team members to offer a screening and prevention bundle to all their patients through enhanced opportunistic and planned outreach methods, targeting patients who do not present for screening care.

How will this occur?

Toward Optimized Practice offers training, tools and resources to primary care organizations (e.g., primary care networks and family care clinics) to support the screening and prevention improvements through the use of improvement facilitators and EMR resources.

Primary care providers and team members are supported with the development of customized processes and EMR optimization to improve offers of screening prevention.

What does the program offer primary care providers and team members?

- support to develop customized processes within clinics and/or primary care organizations to optimize screening and prevention activities for patients, focusing on those who do not typically present for screening
- assistance to develop, understand, and use lists of patients (i.e., patient panel)
- opportunity to enhance the role of team members, electronic medical records (EMRs) and primary care organizations to support screening and prevention
- provision of improvement tools for primary care providers, team members and organizations
- strategies to address competing demands for time by "bundling" screening and prevention care (e.g., cardiovascular, cancer and other chronic diseases)
- support to develop "practical methods" that work within the time constraints of a busy practice
- provision of confidential screening and prevention performance feedback reports

What does the program offer primary care organizations?

- practical, evidence based approach to support clinics with implementation of elements of the **Patient's Medical Home**
- development of skills in practice facilitation that can be applied to other primary care projects
- provision of reports with results that are measurable, standardized across primary care organizations and suitable for demonstrating the aggregate benefit of these organizations (as suggested by the Auditor General of Alberta)
- support to maximize investments in EMRs and patient panels
- support to improve integration and effectiveness of all members of the primary care team
- access to quality improvement resources through the Institute for Healthcare Improvement (IHI.org)

What will be expected of participants?

Primary care providers and team members will:

- with support, begin to develop sustainable processes to identify and maintain lists of patient information to guide clinical management approaches
- work closely with their improvement facilitators to locally select and implement changes to maximize screening and prevention
- provide access to identified primary care network staff to conduct confidential chart reviews.
- commit to regular improvement team meetings during the change period

Primary care organizations will:

- be invited to identify improvement facilitators who will be provided with the resources and mentorship to support clinics and primary care organizations implementing this initiative
- participate in planning and implementation activities to locally select changes to maximize screening and prevention methods and results
- participate in planning and implementation activities to support emerging communities of practice in facilitation and EMR use
- coordinate and deliver, with support, physician recruitment events
- identify staff members who will receive resources, tools and methods to conduct standardized chart reviews

How does this benefit Albertans?

This program benefits Albertans by:

- standardizing screening and prevention care for all Albertans wherever they live
- improving rates of screening and early detection of significant health issues
- harmonizing messages received from healthcare providers across the healthcare system

What are the next steps?

- Contact your PCN to learn more about local ASaP support that may already be available to you (e.g., an improvement facilitator)
- please direct inquiries regarding the program and expressions of interest to engage in this work to Mark Watt, TOP Delivery Team Lead - top@topalbertadoctors.org or **1.866.505.3302**.