THE ONTARIO TOBACCO RESEARCH UNIT
UNITÉ DE RECHERCHE SUR LE TABAC DE L'ONTARIO
Generating knowledge for public health

EVALUATION NEWS

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Evaluation of the STOP Program with Community Health Centres and Addiction Agencies

Background

The STOP program is a province-wide initiative coordinated by the Centre for Addiction and Mental Health (CAMH), which uses the existing health care infrastructure, such as Community Health Centres (CHCs) and Addiction Agencies (AAs), to provide free nicotine replacement therapy (NRT) and cessation counselling to patients interested in quitting smoking. As of March 2014, a total of 51 CHCs and 19 AAs are implementing the STOP program and have provided NRT and counselling services to over 6,000 smokers in Ontario.

Both CHCs and AAs participating in the STOP program are able to choose from various program delivery models that suit their specific capacity or interest. Organizations can offer support to patients by providing:

- One-on-one counselling and up to 26 weeks of NRT (individual model)
- One day group counselling session and a 5-week kit of NRT (group model)
- A combination of both individual and group counselling (combination model)

The STOP program requires practitioners to be trained in smoking cessation in order to participate in the program. Training and knowledge exchange opportunities include:

- TEACH 3-day Core Course and/or 2-day Specialty Courses
- One six-hour Fundamentals of Tobacco Interventions workshop
- Monthly webinars on various topics related to smoking cessation

Evaluation Approach

The Ontario Tobacco Research Unit conducted two separate formative evaluations of the STOP program. The evaluation with CHCs started in April 2012 and was completed in January 2014. The evaluation with AAs started a year later in June 2013; it will continue until March 2015.

The overall purpose of the formative evaluations was to examine the program implementation process to provide ongoing feedback to the STOP program team and participating CHCs and AAs, and inform further improvements and adjustments to the program.

To this end, the evaluations focused on program implementation to:

- Validate that program activities were implemented as planned
- Explore variations in program delivery among CHCs and AAs
- Examine program effects on patients' smoking behaviour and smoking cessation practices at CHCs and AAs

Evaluation Methods

The formative evaluations used a mixed – quantitative and qualitative – method approach to examining the implementation of the STOP program. The key sources of data for the evaluations were:

- Cases studies
- Analysis of program administrative data (e.g. patient enrolment)
- Baseline and follow-up surveys of all participating CHCs and AAs

Five CHCs were selected as case studies for in-depth assessment of the program implementation, outputs, and outcomes. Currently, three AAs have been selected as case studies. Two more organizations will be selected in 2014. Evaluation activities for each case study CHC and AA involve the following:

- An initial interview and a series of follow-up and brief/check-in interviews with health practitioners assigned to the program
- Interviews with managers
- In-depth interviews with patients
- Analysis of patient surveys at baseline, three-, six-, and 12-month follow-up

Key Findings

These key findings describe the current state of program implementation at CHCs and AAs as well as its initial effects on patients' smoking behaviour. Due to the ongoing nature of the STOP program, the evaluation findings are relevant only for the period of program implementation during which the formative evaluation was conducted.

Smoking Cessation Services and Practices at CHCs and AAs

Community Health Centres: Participation in the STOP program has affected the smoking cessation practice at CHCs. As well as enhancing smoking cessation services through the provision of free NRT and intensive counselling to smokers, there has been an increase in the following since the launch of the program: the priority of providing smoking cessation services within the organization, the number of CHC

practitioners trained in smoking cessation, the allocation of staff and resources for smoking cessation, support and buy-in from physicians and CHC management.

Addiction Agencies: Most AAs were offering some form of smoking cessation services prior to STOP program; however, the frequency and consistency with which these services were offered varied. Nevertheless, at the time of enrolment into the STOP program, the majority of AAs considered smoking cessation to be either a high or moderate priority relative to other health concerns that these organizations were dealing within their daily practice. Since the launch of the program, AAs have experienced an increase in support from management and co-workers, which has helped to address the burden of program administration and has increased patient referrals to the program.

Smoking Cessation Capacity at CHCs and AAs

CHC and AA health practitioners assigned to the STOP program had some prior knowledge of and experience with smoking cessation interventions. The STOP program appears to have improved their capacity in smoking cessation; many of them reported that formal training and knowledge exchange opportunities through program teleconferences and webinars provided by the CAMH program team have been very helpful. Meanwhile, new gaps in knowledge among practitioners have been identified as the STOP program evolves. In particular, practitioners pointed to the need for more advanced training in motivational interviewing and treating patients with complex issues, such as mental health and comorbidities.

Patient Enrolment

Patient enrolment varies across the case study CHCs and AAs, but in general follows the practice established prior to the STOP program. Patients are enrolled through:

- Referrals from other practitioners and health agencies
- Word-of-mouth
- Advertisements in health care settings

Provision of Free NRT

The lack of no or low cost NRT was overwhelmingly identified by CHCs and AAs as a barrier to the provision or enhancement of smoking cessation support to patients prior to the STOP program. This barrier appears to have been alleviated by the availability of free NRT through the STOP program.

Health practitioners typically dispense one to two weeks of NRT at a time. This practice occurs for several reasons: to monitor any side effects, assess the effectiveness of a particular NRT product for the patient, and to keep patients motivated and accountable. CHCs & AAs dispense more than one to two weeks of NRT at a time in special circumstances (e.g. an intensive work schedule, vacation, etc.).

Counselling

The provision of counselling services varies across the case study CHCs and AAs.
Community Health Centres: Most CHCs under study hold counselling sessions to match the schedule for NRT pick-up. The frequency of counselling sessions is patient-specific and is likely to decrease if patients demonstrate progress in quitting.

Addiction Agencies: One of the case study sites either provides no counselling or short check-ins (1-5minutes) placing the onus on the patient to discuss smoking cessation. The other two case study sites provide counselling (individual and/or group) in a more consistent manner.

Patient Quit Rates

The analysis of patients' follow-up survey data revealed marked variability in the self-reported quit rates across the case study sites.

Community Health Centres: The self-reported 7-day point prevalence abstinence rate ranged from 7% to 18% at 3 months post-enrolment; from 5% to 16% at 6-month follow-up, and from 7% to 12% at 12-month follow-up. Organizational and program related characteristics, such as single vs. multiple program implementation staff, multi-site vs. single site CHC, do not seem to explain the variation in the quit rates as both the CHCs with higher and lower quit rates represent a mix of these characteristics. One plausible explanation for the variation in cessation outcomes could be a difference in health practitioners' level of experience in treating tobacco related issues, with highly experienced practitioners being from CHCs with higher quit rates and less experienced ones from the CHCs with lower quit rates. This difference in the experience may have affected the provision of cessation support to patients and their success with quitting.

Addiction Agencies: The self-reported 7-day point prevalence abstinence rate ranged from 4% to 24% at 3 months post-enrolment; and from 5% to 28% at 6-month follow-up. At the time of data analysis, no 12-month follow-up data was available. Patients' cessation outcomes at one of the case study sites were particularly low. Reasons for low quit rates may include: a younger patient population (therefore less quit experience), a lack of patient follow-up after discharge from residential treatment and a lack of frequent counseling service offered.

Challenges to Program Delivery

Practitioners' time constraints have been a major barrier to program delivery, due in part to practitioners' competing priorities and limited financial and human resources within the organization. These issues combined with the high patient demand for the STOP program appear to have affected other aspects of program implementation, specifically the program administration. Both CHCs and AAs continue to find it

onerous and time consuming to complete the requisite program documentation and keep track of the dispensed NRT.

Adoption of a web-based data collection and management tool currently being coordinated by the CAMH program team is expected to address the burden of program administration. Health practitioners at case study CHCs and AAs seem to welcome the web-based tool as they feel it would increase the program efficiency and lead to more patient interaction time.

Challenges Experienced by Patients

Patients experienced a number of challenges when attempting to quit or cut down on smoking during their participation in the STOP program. Some of these challenges, such as cravings and weight gain, were reported more frequently among quitters than smokers; in contrast, depression, anxiety and stress were more prevalent among smokers. Case study interviews with patients and health practitioners also revealed NRT side effects, boredom, and environmental cues to smoke as barriers to quitting.

The formative evaluation has been closely integrated with program implementation to serve the learning and accountability needs of the STOP program team. Evaluation findings were fed back to the STOP program team on an ongoing basis and allowed the team to make adjustments and modifications in the program over time. The evaluation with CHCs has now finished. More results about the STOP program with AAs will be available in 2015 as the evaluation continues. Further evaluation will track progress in program implementation and examine the program effects on patients' quitting behaviour, health practitioners' capacity to address smoking cessation, and adoption or reinforcement of cessation practices within AAs.

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