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UNITÉ DE RECHERCHE SUR LE TABAC DE L'ONTARIO

Generating knowledge for public health

Tobacco Cessation Practices and Services in Central West Ontario: 2013, 2015 and 2017 Survey Results

Knowledge and Evaluation Support Project

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Executive Summary

Tobacco cessation interventions by healthcare providers have been shown to significantly increase cessation rates. Evidence-based clinical practice guidelines have been developed to support the delivery of tobacco cessation interventions by a variety of healthcare providers. In particular, these guidelines recommend the use of the 5As model for tobacco cessation intervention (Ask, Advise, Assess, Assist and Arrange) to maximize the likelihood of successful quitting for tobacco users.

The Central West Tobacco Control Area Network (CW TCAN), in partnership with the Ontario Tobacco Research Unit (OTRU), conducted surveys of public health and healthcare organizations who are members of local Tobacco Cessation Communities of Practice (CoP) in 2013, 2015 and 2017. The aim was to explore the state of tobacco cessation practices and services in CoP organizations across the CW TCAN. The surveys aimed to assist the TCAN in assessing the progress toward achieving its 2013-2017 Regional Action Plan's outcome of decreasing gaps in tobacco cessation interventions in the region.

Key Findings

Key findings are centred on a) an organizations' capacity to provide tobacco cessation services, b) implementation of the 5As approach to tobacco cessation, and c) sustaining tobacco cessation services.

Organizations' Capacity to Provide Tobacco Cessation Services

- Three-quarters (74.1%) of organizations had an implementation plan in place for the adoption of tobacco cessation interventions in 2017, up from 68.0% in 2013
- Organizations reported increased support from senior management (84.2% in 2013 vs. 87.1% in 2017), increased presence of a dedicated staff lead for implementing tobacco cessation services (76.3% in 2013 vs. 82.4% in 2017) and increased availability of resources necessary to *implement* tobacco cessation services (80.5% in 2013 vs. 85.7% in 2017)

- The use of billing codes for tobacco cessation services increased (28.6% in 2013 vs. 37.4% in 2017), as did the availability of prompts or reminders for billing (57.4% in 2013 vs. 62.1% in 2017) and the presence of a chart reminder system (43.4% in 2013 vs. 52.9% in 2017)
- In 2017, fewer organizations reported being members of other CoPs or Champion networks (i.e., beyond the seven cessation CoPs currently in place in the CW TCAN region) compared to 2013 (67.5% in 2013 vs. 56.5% in 2017). In 2017, the most frequently reported CoPs were TEACH (n=32), RNAO (n=18), and OMSC (n=3)
- Over 90% of staff attended a few or more trainings in tobacco cessation interventions in both 2013 (94.8%) and 2017 (94.2%)
- In 2013, half of the organizations who completed the survey (52.0%) reported having (or were in the process of implementing) evaluation processes and/or performance metrics. In 2017, this increased to 62.4% of organizations who reported having (or were in the process of implementing) evaluation processes
- In 2017, a majority of hospital settings who completed the survey indicated having cessation medication on formulary (92.3%, similar to 92.9% reported in 2013). Among all organizations, a substantial proportion had medical directives in place (58.8%, up from 40.8% in 2013), while less than a quarter reported using order sets for cessation medications (22.9% in 2017, down from 29.0% in 2013)

Implementation of the 5As Approach to Tobacco Cessation

- A standardized Ask question is the most commonly adopted intervention question among organizations, with a similar proportion observed from 2013 to 2017 in those that have integrated or were in the process of integrating Ask questions (85.5% of organizations in 2013 vs. 85.9% in 2017)
- Patients are increasingly being asked about tobacco use by staff in all areas of an organization (34.2% in 2013 vs. 47.1% in 2017) vs. only in specific programs/areas
- The majority of organizations have designated staff members who implement Ask, Advise and Assess related activities. In 2017, however, there was an increase in all staff who implemented these activities over that reported in 2013 (Ask: 29% in 2013 vs. 42.9% in 2017; Advise: 27% in 2013 vs. 35.4% in 2017; Assess: 14.9% in 2013 vs.

23.5% in 2017)

- In 2017, a substantial proportion of organizations reported Asking patients about tobacco use at intake/admission (48.2%) or at every visit (23.5%)
- In 2013, 2015 and 2017, tobacco cessation services were most often provided by nurses, physicians, nurse practitioners, and pharmacists
- In 2017, the vast majority of organizations reported providing brief contact interventions (92.9%), relatively unchanged from 2013 (94.8%). In 2017, intensive tobacco cessation interventions were provided by 82.4% of organizations, an increase over that reported in 2013 (76.3%)
- In 2017, seven activities were implemented by 90% or more of the organizations who provide intense smoking cessation services including distributing handouts (quit plan), assisting patient/client to create and maintain a quit plan, reviewing past quit experiences, providing information and teaching on stop smoking medications, assisting the patient/client to identify social supports, identifying triggers and brainstorming coping strategies, and providing NRT or partnering with existing initiatives for free NRT. In 2013, only distributing handouts (quit plan) and reviewing past quit experiences exceeded 90% implementation
- Four activities implemented as part of the Arrange stage showed a pattern of significant growth from 2013 to 2017 including: internal referral or follow up by staff within an organization (64.9% in 2013 vs. 69.4% in 2017), referral to local cessation services (36.4% in 2013 vs. 56.5% in 2017), referral to SHL (Fax Referral Partner; 26% in 2013 vs. 34.1% in 2017), and referral to PHU Quit Smoking Clinic (23.4% in 2013 vs. 36.5% in 2017)

Sustaining Tobacco Cessation Services

- In 2013, nearly half of organizations (49.3%) reported not having a formal policy in place to support the implementation of the 5As. More organizations reported not having a formal policy in place to support the implementation of the 5As in 2017 (58.8%)
- In 2013, 74.0% of organizations reported having secured or being in the process of securing resources necessary to sustain tobacco cessation services. This value rose to 77.6% in 2017. Key resources reported in 2017 included dedicated staff, staff time,

materials, and funding

- In 2017, most organizations did not conduct documentation audits to assess staff performance of tobacco dependence intervention services (61.5%), up from 2013 (56.6%)
- In 2017, organizations increased the presence of several activities to ensure staff engagement in tobacco cessation including addressing barriers with staff on a regular basis (40.3% in 2013 vs. 45.9% in 2017) and providing new staff with training and orientation to the 5As model (31.2% in 2013 vs. 47.1% in 2017)
- Over the period 2013 to 2017, there was a decrease in the number of organizations identifying barriers to implementing and sustaining the provision of tobacco cessation services. The barriers that were reduced included: more pressing concerns with clients, lack of knowledge and training in tobacco cessation among staff, lack of staff to deliver cessation services and lack of administrative support. Two barriers that increased over this period included: lack of staff time and more pressing concerns with workload

Overall, many improvements were noted between 2013 and 2017 among the CW TCAN Tobacco Cessation CoP member organizations, particularly in their capacity to provide smoking cessation and integration of evidence-based cessation approaches, such as the 5As, into daily practice. These findings also point to the need to focus future efforts on addressing barriers and areas with little or no progress. Such efforts have the potential to facilitate system-level and organizational changes and adoption of evidence-based tobacco cessation interventions.

Background

The inclusion of healthcare providers in the provision of tobacco cessation interventions is effective at promoting successful quits. Meta-analysis of randomized control trials revealed that tobacco cessation interventions by physicians significantly increase cessation rates, as do treatments delivered by other health care providers such as nurses, dentists, dental hygienists, and pharmacists.[1] Greater efficacy is achieved if interventions involve a team approach (e.g. physician and nurse versus physician only).[2,3,4] Furthermore, healthcare providers are perceived by the public as credible sources of health information and have contact with an estimated 75% of smokers each year.[5] Thus, efficacy of the tobacco cessation intervention, perceived credibility of healthcare providers' advice and their access to tobacco users put them in a unique position to offer tobacco cessation interventions, provide information on cessation aids, and assist tobacco users to quit.

Clinical practice guidelines recommend providing a minimal tobacco cessation intervention following the "5As" protocol: Ask patients whether they smoke, Advise them to quit, Assess readiness to quit, Assist with quitting, and Arrange follow-up.[1] The 5As model (Ask-Advise-Assess-Assist-Arrange) is considered the gold standard for a healthcare provider's intervention because it provides a plan for maximizing the likelihood of successful quitting for tobacco users.[1] The model has been recognized in Canada and internationally. In particular, the Canadian Action Network for the Advancement, Dissemination and Adoption of Practice-Informed Tobacco Treatment (CAN-ADAPTT) guidelines for smoking cessation call for adoption of the 5As approach into healthcare providers' daily practice.[6] The CAN-ADAPTT guidelines are intended for use by Canadian healthcare providers in diverse clinical and/or treatment settings, and they contain both clinical and population level approaches to tobacco cessation, as well as for specific populations.

Widespread dissemination of clinical practice guidelines is necessary to increase healthcare providers' awareness and knowledge of evidence-based cessation interventions. However, awareness and knowledge of clinical-practice guidelines is insufficient for routine application of interventions by healthcare providers.[7,8] As recognized by the Expert Panel of the US Public

Health Service clinical guideline for treating tobacco use and dependence, organizational or system-level changes are critical to ensure that evidence-based cessation interventions are fully used by healthcare professionals in their daily practice.[1]

System-level changes refer to policies and practices designed to establish the identification of smokers and incorporate the provision of evidence-based cessation interventions as a routine part of standard patient care. These system-level policies or practices include implementing procedures for identifying and documenting tobacco users, prompting providers to intervene, providing education, resources and feedback to healthcare providers to support interventions with patients, evaluating performance, and promoting hospital-based cessation policies.[1] A substantial amount of literature demonstrates that training health professionals is associated with positive changes in their practice behaviour.[9,10] There is also growing evidence that supportive systems or policies—such as establishment of a tobacco-user identification system, provider education, and reminder systems—can increase rates of delivering evidence-based interventions.[11,12]

One of the key priorities of the Central West Tobacco Control Area Network (CW TCAN) is enhancement of tobacco-cessation services and practices in the Central West Ontario region. In 2008, the CW TCAN established a Cessation Sub-committee which assumed responsibilities for needs identification, planning and implementation of tobacco cessation related programming and training in the region. The Cessation Sub-committee is represented by Public Health Nurses and Health Promoters from local public health units (PHUs), as well as the CW TCAN Coordinator and a Senior Coordinator from Smokers' Helpline.

Since 2008, the Cessation Sub-Committee has been working with a broad spectrum of stakeholders to increase the priority of tobacco cessation interventions within the healthcare system. This process led to establishment of Tobacco Cessation Communities of Practice (CoP) across the region. Cessation CoPs serve as a forum for building capacity among local public health and healthcare organizations to enhance their cessation efforts and support system changes for tobacco cessation interventions. Cessation CoPs provide opportunities for local knowledge transfer about trainings, models of care, available cessation resources (e.g. nicotine replacement therapy) and system-wide cessation programming (e.g., the Ottawa Model for

Smoking Cessation[i]). The work of cessation CoPs is guided by the Ontario Public Health Standards for Chronic Disease Prevention and the Smoke-Free Ontario Strategy: Public Health Unit Tobacco Control Program Guidelines. There are seven cessation CoPs across the CW region. The number of member organizations across all CoPs has increased over time, from 113 in 2013 to 137 in 2017.

To explore the state of tobacco cessation practices and services in the CW region, a survey of member organizations participating in the seven CoPs was conducted in 2013, with follow-up surveys administered in 2015 and 2017. All three surveys were conducted in partnership with the Ontario Tobacco Research Unit (OTRU), under the frame of OTRU's Knowledge, Evaluation and Support project. The purpose of these surveys was to assist the CW TCAN in assessing the progress toward achieving its 2013-2017 Regional Action Plan's outcome of decreasing gaps in the provision of tobacco cessation interventions in the region.

[i] A brief description of the Ottawa Model for Smoking Cessation is provided in Appendix A.

Methods

Data Collection

Data collection occurred over three periods. The 2013 survey was conducted from June to July, the 2015 survey was conducted from March to June, and the 2017 survey was conducted from March to June. All three surveys targeted organizations that were members of the Central West TCAN Tobacco Cessation CoPs.

The surveys were administered with the use of an online survey tool (Key Survey in 2013 and 2015, REDCap in 2017). Unique survey links were generated for all eligible organizations. To ensure a high response rate, a representative from each CoP aided data collection by arranging and conducting interviews in person or by phone with healthcare providers representing the eligible organizations.

Survey Instrument

The 2013, 2015 and 2017 survey questionnaires were designed collaboratively by the CW TCAN and OTRU. The surveys asked a range of questions on various issues including: organizational capacity and resources to deliver the 5As (Ask, Advise, Assess, Assist, and Arrange) tobacco cessation services, the current state of implementing each of the 5As components in daily practice, types of tobacco cessation services currently in place in the organization, types of healthcare providers engaged in delivering tobacco cessation services, policies and resources in place to sustain tobacco cessation services, and challenges in implementing and sustaining services and policies. Each survey was designed to take between 20 to 30 minutes to complete. To view the individual survey questionnaires, please refer to Appendices B-D.

Due to the wide range of topics examined, a given survey was sometimes completed by a group of healthcare providers knowledgeable about cessation activities in their organization and sometimes by individual respondents.

Survey Population

For each survey year, CW TCAN supplied OTRU with a list of all CoP member organizations. The

number of member organizations in the Tobacco Cessation CoPs, and therefore invited to complete the survey, increased from 113 organizations in 2013 to 137 organization in 2017 (Table 1). Only organizations that reported providing direct tobacco dependence interventions were eligible to be included in the analysis of this report. Response rates for all three surveys ranged from 62% to 69% (Table 1).

Table 1: Survey Response Rate, 2013, 2015 and 2017

Indicator	2013	2015	2017
Number of organizations invited to the survey (final sampling frame)	113	129	137
Number of organizations who completed the survey (sample size, *n*)	82	96	88
Number of eligible[a] organizations included in the analysis	77	89	85
Response rate, %	68.1	69.0	62.0

[a] CoP member organizations who reported that they provide direct smoking cessation services

The CoPs vary in size, with Niagara and Waterloo-Wellington CoPs having the largest number of member organizations and therefore the majority of the overall response to the three surveys (Table 2).

Table 2: Number of Organizations Completing the Survey, by CoP, 2013, 2015 and 2017

	2013		2015		2017	
CoPs	**%**	**n**	**%**	**n**	**%**	**n**
Brant	7.8	6	9.0	8	4.7	4
Haldimand-Norfolk	1.3	1	5.6	5	5.9	5
Halton	13.0	10	14.6	13	15.3	13
Hamilton	14.3	11	12.4	11	16.5	14
Niagara	31.2	24	28.1	25	31.8	27
Waterloo- Wellington	27.3	21	23.6	21	21.2	18
Dufferin	2.6	2	3.4	3	3.5	3
Member of more than one CoP:						
All CoPs	1.3	1	--	--	--	--
Waterloo-Wellington & Dufferin	1.3	1	1.1	1	--	--
Brant & Hamilton	--	--	1.1	1	--	--
Haldimand-Norfolk & Niagara	--	--	1.1	1	1.2	1
Total	**100**	**77**	**100**	**89**	**100**	**85**

Various types of organizations completed the survey (Table 3). For the purpose of select analysis, they were collapsed into four categories: hospitals, primary-care settings, other healthcare settings and public health departments, and other settings.

Table 3: Number of Organizations Completing the Survey, by Organization Type, 2013, 2015 and 2017

	2013		2015		2017	
	%	n	%	n	%	n
Group 1: Hospitals	18.2	14	20.2	18	15.3	13
Group 2: Primary care settings						
Family Health Team	24.7	19	20.2	18	23.5	20
Community Health Centre	9.1	7	9.0	8	9.4	8
Aboriginal Health Access Centers	2.6	2	1.1	1	1.2	1
Nurse Practitioner-Led Clinics	1.3	1	--	--	--	--
Group 3: Healthcare settings and public health						
Dental Clinic	9.1	7	6.7	6	3.5	3
Mental Health and Addiction	3.9	3	4.5	4	4.7	4
Pharmacy	2.6	2	7.9	7	11.8	10
Physicians	--	--	--	--	1.2	1
Public Health Department	7.8	6	9.0	8	11.8	10
Group 4: Other settings[a]	20.8	16	21.4	19	17.7	15
Total	**100**	**77**	**100**	**89**	**100**	**85**

[a] Other settings included: chiropractor and physiotherapy clinic, community outreach program, home care, laser therapy, medical clinic-academic setting, natural care clinic, not-for-profit, post-secondary institutes, regional cancer centre, residential treatment facility and workplace.

Analysis

All three surveys were conducted with all known CoP organizations providing cessation services. As a result, we obtained population (census) data from these CoPs for the populations that they serve. Frequencies were computed for each survey question across all three surveys. Given these data were considered to be population (census) level, differences in frequencies across surveys (for any given question) were considered significant. Whether or not a difference is meaningful, is an open debate (e.g., 52% vs. 54% engagement may be different but not meaningfully so).

Some survey questions allowed respondents to provide their own responses by selecting the

option "other." These responses were either re-coded into one of the existing question's response options (if both responses shared the same concept) or a new response was created (if different from the main question's responses).

Limitations

The use of various survey methods (in-person, telephone and online) may have affected the responses obtained from the organizations. In addition, healthcare providers' busy schedules and vacation time may have affected the completion rate across the CoPs, particularly in 2013 when the survey was conducted in June and July.

The surveys targeted healthcare organizations that were members of the Central West Tobacco Cessation CoPs. With response rates ranging from 62% to 69%, it is not known if non-respondents would have answered these surveys in a similar way.

All data included in this report is self-reported and cannot be verified to ensure that the organizations were not over or under-reporting the provision of tobacco cessation services and related capacity, policies and resources.

Results

1. Capacity to Provide Tobacco Cessation Services

The following section reports on various aspects of organizational capacity to provide tobacco cessation services.

Collection of Background Evidence and Examples of Tobacco Cessation Delivery Models

The vast majority of organizations reported gathering background evidence and examples of tobacco dependence intervention service delivery models (86.8% in 2013, 87.4% in 2015 and 94.1% in 2017; Table 4). No significant differences were found in the responses to the question by type of organization.

Table 4: Organizations Reporting on Gathering Background Evidence and Example of Tobacco Cessation Delivery Models, 2013, 2015 and 2017

	2013		2015		2017	
	%	n	%	n	%	n
Yes	86.8	66	87.4	76	94.1	80
In the process	--	--	1.2	1	1.2	1
No	13.2	10	11.5	10	4.7	4

Training in Tobacco Cessation Intervention

Over 90% of organizations reported that a few or more staff had attended trainings in tobacco cessation interventions (94.8% in 2013, 94.4% in 2015 and 94.2% in 2017; Table 5).

Table 5: Proportion of Staff Who Attended Trainings on Tobacco Cessation Interventions, 2013, 2015 and 2017

	2013		2015		2017	
	%	n	%	n	%	n
All or most of them	27.3	21	22.5	20	24.7	21
Half of them	11.7	9	6.7	6	7.1	6
A few of them	55.8	43	65.2	58	62.4	53
None	2.6	2	1.1	1	4.7	4
Don't know	2.6	2	4.5	4	1.2	1

Membership in Other Communities of Practice or Champions Networks (Beyond the CW Communities of Practice)

Half to two-thirds of the organizations reported being members of other CoPs or Champions networks (i.e., beyond the seven cessation CoPs in the CW TCAN; Table 6).

Table 6: Organizations' Membership in Other CoPs or Champions Networks, 2013, 2015 and 2017

	2013		2015		2017	
	%	n	%	n	%	n
Yes	67.5	52	69.7	62	56.5	48
No	26.0	20	19.1	17	28.2	24
Don't know	6.5	5	11.2	10	15.3	13

In 2013, organizations most frequently reported being members of the Training Enhancement in Applied Cessation Counselling and Health (TEACH) program (n=43) and the Registered Nurses Association of Ontario (RNAO) Smoking Cessation Champions Network (n=22). In 2015, organizations most frequently reported being members of TEACH (n=45), RNAO (n=25), the Smoking Treatment for Ontario Patients (STOP) study (n=4), and Ottawa Model for Smoking Cessation (OMSC; n=3). In 2017, organizations most frequently reported being members of TEACH (n=32), RNAO (n=18) and OMSC (OMSC; n=3). [ii]

Presence of Implementation Plans for the Adoption of Tobacco

[ii] A brief description of the TEACH, RNAO, STOP and OMSC programs is provided in Appendix A.

Cessation Interventions

In both 2013 and 2015, about two-thirds of the organizations surveyed (68.0% and 66.3%, respectively) reported having implementation plans in place to support the adoption of tobacco cessation interventions (Table 7). The proportion of organizations with an implementation plan in place increased to 74.1% in 2017.

Table 7: Presence of Implementation Plans for the Adoption of Tobacco Cessation Interventions, 2013, 2015 and 2017

	2013		2015		2017	
	%	n	%	n	%	n
Yes	68.0	51	66.3	59	74.1	63
In the process	16.0	12	13.5	12	11.8	10
Not at all	13.3	10	16.9	15	11.8	10
Don't know	2.7	2	3.4	3	2.4	2

Presence of Evaluation Processes and/or Performance Metrics

In 2013, half of the organizations who completed the survey (52.0%) had or were in the process of putting an evaluation processes and/or performance metrics in place (Table 8). In 2015 and 2017, about two-thirds of organizations reported having or were in the process of putting an evaluation process and/or performance metrics in place (66.3% and 62.4%, respectively).

Table 8: Presence of Evaluation Processes and/or Performance Metrics Among Organizations, 2013, 2015 and 2017

	2013		2015		2017	
	%	n	%	n	%	n
Yes	30.7	23	47.2	42	50.6	43
In the process	21.3	16	19.1	17	11.8	10
Not at all	45.3	34	28.1	25	32.9	28
Don't know	2.7	2	5.6	5	4.7	4

Senior Leadership Support/Buy-in

In all three survey years, the vast majority of organizations reported that they obtained support and buy-in from senior management (84.2% in 2013, 87.4% in 2015 and 87.1% in 2017; Table 9).

Table 9: Senior Leadership Support/Buy-in Among Organizations, 2013, 2015 and 2017

	2013		2015		2017	
	%	n	%	n	%	n
Yes	84.2	64	87.4	76	87.1	74
In the process	10.5	8	3.5	3	4.7	4
Not at all	5.3	4	9.2	8	3.5	3
Don't know	--	--	--	--	4.7	4

Resources to Implement Cessation Services

In 2013, 9.1% of organizations reported that they had "not at all" secured resources necessary to implement tobacco cessation services, whereas this figure was 5.6% in 2015 and 8.3% in 2017 (Table 10).

Table 10: Availability of Resources to Implement Tobacco Cessation Services, 2013, 2015 and 2017

	2013		2015		2017	
	%	n	%	n	%	n
Yes	80.5	62	86.5	77	85.7	72
In the process	10.4	8	7.9	7	4.8	4
Not at all	9.1	7	5.6	5	8.3	7
Don't know	--	--	--	--	1.2	1

Staff and time dedicated to tobacco dependence interventions were the top two reported resources secured by organization across all three survey years (Table 11).

Table 11: Specific Resources Secured to Implement Tobacco Cessation Services, 2013, 2015 and 2017

	2013		2015		2017	
	%[a]	n	%[a]	n	%[a]	n
Staff (dedicated to complete task)	88.6	62	86.9	73	90.8	69
Time (dedicated to tobacco dependence Interventions)	77.1	54	78.6	66	82.9	63
Materials: books, software	71.4	50	70.2	59	48.7	37
Financial (dedicated funding for tobacco dependence Interventions)	47.1	33	50.0	42	48.7	37
Committee for tobacco dependence Interventions	28.6	20	22.6	19	11.8	9
Other[b]	5.2	4	4.8	4	4.0	3

[a] Percentages do not add up to 100% as the survey participants could check more than one answer
[b] Other written text responses included: free NRT (not through STOP), COPD machine and other committees where smoking is incorporated in the mandate.

Note: Table sorted in descending order according to 2017 survey responses.

Among organizations who reported financial resources as a specific resource secured for implementation of tobacco cessation services, the key source of this support was the STOP program (n=15 in 2013, n=22 in 2015 and n=17 in 2017).

Presence of a Designated Staff Lead for Tobacco Cessation Services

In 2013, three-quarters (76.3%) of organizations had a designated staff lead for tobacco cessation services (Table 12). This rose to 86.5% in 2015 and decreased slightly to 82.4% in 2017.

Table 12: Presence of a Designated Staff Lead for Implementing Tobacco Cessation Services, 2013, 2015 and 2017

	2013		2015		2017	
	%	n	%	n	%	n
Yes	76.3	58	86.5	77	82.4	70
In the process	7.9	6	3.4	3	3.5	3
Not at all	11.8	9	7.9	7	11.8	10
Don't know	4.0	3	2.3	2	2.4	2

Partnership with PHUs and Smokers' Helpline

In 2017, 7 in 10 organizations (or 67.1%) reported having partnerships with their local PHUs and

Smokers' Helpline[iii] for training and/or consultation (Table 13), down from what was reported in 2015 (80.7%) and 2013 (77.6%).

Table 13: Partnership with Local PHU and Smokers' Helpline for Training and/or Consultation Needs, 2013, 2015 and 2017

	2013		2015		2017	
	%	n	%	n	%	n
Yes	77.6	59	80.7	71	67.1	57
Local PHU staff	--	--	26.1	23	22.4	19
SHL staff	--	--	1.1	1	1.2	1
Both PHU and SHL staff	--	--	53.4	47	43.5	37
No	21.1	16	19.3	17	32.9	28
Don't know	1.3	1	--	--	--	--

Presence of a Dedicated Champions Committee

In 2017, the proportion of organizations having a dedicated Champions Committee in place to support the implementation and sustainability of tobacco cessation services (31.8%) decreased compared to 39.3% in 2015 and 34.2% in 2013 (Table 14). Of the organizations surveyed in 2017, the following had a Champions Committee in place: public health departments (70%, n=7), hospitals (54%, n=7), Family Health Team (45%, n=9), mental health and addiction (25%, n=1), Community Health Centres (13%, n=1) and pharmacies (10%, n=1).

Table 14: Presence of a Dedicated Champions Committee to Assist with Implementation and Sustainability of Tobacco Dependence Intervention Services, 2013, 2015 and 2017

	2013		2015		2017	
	%	n	%	n	%	n
Yes	34.2	26	39.3	35	31.8	27
No	65.8	50	60.7	54	68.2	58

[iii] A brief description of Smokers' Helpline is provided in Appendix A.

Use of Billing Codes for Tobacco Cessation Services

In 2017, over a third (37.4%) of organizations reported having billing codes for providing tobacco cessation services (Table 15), up from 31.5% in 2015 and 28.6% in 2013. Of the organizations surveyed in 2017, the availability and use of billing codes was reported by pharmacies (80%, n=8), Family Health Teams (79%, n=15), hospitals (15%, n=2), Community Health Centres (13%, n=1), public health departments (10%, n=1), Aboriginal Health Access Centres (100%, n=1), and physicians (100%, n=1).

Table 15: Availability and Use of Billing Codes for Tobacco Cessation Services, 2013, 2015 and 2017

	2013		2015		2017	
	%	n	%	n	%	n
Yes	28.6	22	31.5	28	37.4	31
Yes, but do not use	11.7	9	6.7	6	4.8	4
No, do not have	59.7	46	61.8	55	57.8	48

Among organizations that had incorporated billing codes into a documentation system, 62.1% indicated in 2017 that they had prompts or reminders for billings. This is an increase in reported use of prompts or reminders compared to 40% reported in 2015 and 57.4% reported in 2013 (Table 16).

Table 16: Availability of Prompts or Reminders for Billing, 2013, 2015 and 2017

	2013		2015		2017	
	%	n	%	n	%	n
Yes	57.4	12	40.0	10	62.1	18
No	42.9	9	60.0	15	37.9	11

Presence of a Chart Reminder System

In 2017, 52.9% of organizations reported having a chart reminder system in place to prompt staff to provide tobacco cessation services compared to 58% in 2015 and 43.4% of organizations in 2013 (Table 17).

Table 17: Availability of Chart Reminder System to Prompt Staff to Provide Tobacco Dependence Intervention, 2013, 2015 and 2017

	2013		2015		2017	
	%	n	%	n	%	n
Yes	43.4	33	58.0	51	52.9	45
In the process	11.8	9	12.5	11	8.2	7
No	44.7	34	29.6	26	38.8	33

Availability of Cessation Medication in Hospital Formulary

Over 90% of hospital settings reported having cessation medication available in their formulary since 2013 (92.9% in 2013, 94.4% in 2015 and 92.3% in 2017; Table 18).

Table 18: Availability of Cessation Medication in Hospital Formulary (Hospitals Only), 2013, 2015 and 2017

	2013		2015		2017	
	%	n	%	n	%	n
Yes	92.9	13	94.4	17	92.3	12
No	7.1	1	5.6	1	7.7	1

Availability of a Medical Directive to Dispense Cessation Medication

In 2017, 58.8% of organizations had a medical directive in place to dispense cessation medications, up from 56.8% in 2015 and 40.8% in 2013 (Table 19).

Table 19: Availability of Medical Directives to Dispense Cessation Medication, 2013, 2015 and 2017

	2013		2015		2017	
	%	n	%	n	%	n
Yes	40.8	31	56.8	50	58.8	50
No	39.5	30	23.9	21	11.8	10
N/A	19.7	15	19.3	17	29.4	25

Use of Order Sets for Cessation Medication

In 2013 and 2015, close to a third of surveyed organizations (29.0% and 30.3%, respetively) used order sets for cessation medications (Table 20). The use of order sets decreased to 22.9% in 2017.

Table 20: Availability of Order Sets for NRT, Champix® and Zyban®, 2013, 2015 and 2017

	2013		2015		2017	
	%	n	%	n	%	n
Yes	29.0	22	30.3	27	22.9	19
No	34.2	26	29.2	26	19.3	16
N/A	36.8	28	40.5	36	57.8	48

2. Implementation of the 5As Approach to Tobacco Cessation

Implementation of Ask, Advise, Assess Activities

Table 21 reports on the current state of integrating the Ask, Advise and Assess components into paper and/or electronic documentation systems across organizations. Survey results show that the standardized Ask question is the most commonly adopted intervention question among organizations (integrated or in the process of integration: 85.5% in 2013, 86.4% in 2015 and 85.9% in 2017), followed by Assess (59.2% in 2013, 63.3% in 2015 and 58.8% in 2017) and Advise standardized questions (49.3% in 2013, 58.4% in 2015 and 63.5% in 2017).

Table 21: Integration of Ask, Advise and Assess Components into Documentation System Among Organizations, 2013, 2015 and 2017

	2013		2015		2017	
	%	n	%	n	%	n
Ask						
Yes	75.0	57	77.3	68	81.2	69
In the process	10.5	8	9.1	8	4.7	4
No	14.5	11	13.6	12	14.1	12
Advise						
Yes	40.0	30	47.2	42	55.3	47
In the process	9.3	7	11.2	10	8.2	7
No	50.7	38	41.6	37	36.5	31

	2013		2015		2017	
	%	n	%	n	%	n
Assess						
Yes	48.7	37	59.8	52	51.8	44
In the process	10.5	8	3.5	3	7.1	6
No	40.8	31	36.8	32	41.2	35

Tables 22 to 25 summarize additional details about the current practice of implementing the Ask, Advise and Assist components among organizations.

Compared to 2013, patients are increasingly being Asked about tobacco use by all areas of an organization (34.2% in 2013 vs. 54.6% in 2015 and 47.1% in 2017; Table 22). Likewise, a greater proportion of patients are Advised to quit tobacco by all areas of an organization (29.7% in 2013 vs. 42.4% in 2015 and 43.9% in 2017). The declining Ask and Advise in designated areas appears to be explained by the corresponding increase in patients being Asked and Advised to quit tobacco in all areas of the organization.

Table 22: Areas in Organization Where Ask and Advise Are Implemented, 2013, 2015 and 2017

	2013		2015		2017	
	%	n	%	n	%	n
Are patients Asked about tobacco use in:						
All areas of the organization	34.2	26	54.6	48	47.1	40
Designated area/unit/department	65.8	50	45.5	40	52.9	45
Are patients Advised to quit tobacco in:						
All areas of the organization	29.7	22	42.4	36	43.9	36
Designated area/unit/department	70.3	52	57.7	49	56.1	46

In 2017, the majority of organizations had designated staff members who implement Ask, Advise and Assess related activities (Table 23). However, there was an increase in all staff who implemented these activities over that reported in both 2013 and 2015 (Ask: 29% in 2013, 40.7% in 2015 and 42.9% in 2017; Advise: 27% in 2013, 31.4% in 2015 and 35.4% in 2017; Assess: 14.9% in 2013, 28.7% in 2015 and 23.5% in 2017).

Table 23: Staff Involvement in Implementing Ask, Advise and Assess, 2013, 2015 and 2017

	2013		2015		2017	
	%	n	%	n	%	n
Are patients Asked about tobacco by:						
All staff	29.0	22	40.7	35	42.9	36
Designated staff only	71.1	54	59.3	51	57.1	48
Are patients Advised to quit tobacco by:						
All staff	27.0	20	31.4	27	35.4	29
Designated staff only	73.0	54	68.6	59	64.6	53
Are patients Assessed for readiness to quit by:						
All staff	14.9	11	28.7	25	23.5	19
Designated staff only	85.1	63	71.3	62	76.5	62

As shown in Table 24, less than half of organizations in 2017 reported Asking patients about tobacco use at intake/admission (48.2%), which is down from the 55.1% reported in 2015, but an overall increase from the 39.2% reported in 2013. The proportion of organizations Asking patients about tobacco use at every visit decreased in both 2015 and 2017 compared to 2013 (27% in 2013 vs. 22.5% in 2015 and 23.5% in 2017).

Table 24: Points During Health Visit When Patients Are Asked About Tobacco Use, 2013, 2015 and 2017

	2013		2015		2017	
	%	n	%	n	%	n
At intake/admission or initial visit	39.2	29	55.1	49	48.2	41
At every visit	27.0	20	22.5	20	23.5	20
Only at specific times	33.8	25	22.5	20	28.2	24

In 2017, the vast majority of organizations (87.1%) reported flagging or recording patients' tobacco use status in their charts, unchanged from 2015 (87.2%) and 2013 (86.7%; Table 25).

Table 25: Recording Patient Tobacco Use Status in Charts, 2013, 2015 and 2017

	2013		2015		2017	
	%	n	%	n	%	n
Yes	86.7	65	87.2	75	87.1	74
No	13.3	10	12.8	11	12.9	11

Implementation of Assist Activities

To examine the Assist component, organizations were asked whether their staff provided brief contact (1-3 minutes) or intensive (more than 10 minutes) tobacco cessation interventions as part of their daily practice. Table 26 shows that organizations have provided a consistently high level of brief contact interventions to patients (94.8% in 2013, 93.3% in 2015 and 92.9% in 2017); while the proportion of organizations providing intensive tobacco cessation interventions has increased since 2013 (76.3% in 2013, 82.0% in 2015 and 82.4% in 2017). The majority of organizations provided both brief contact and intensive tobacco cessation interventions (72.4% in 2013, 78.7% in 2015 and 81.2% in 2017).

Table 26: Provision of Brief Contact and Intensive Tobacco Dependence Interventions by Staff, 2013, 2015 and 2017

	2013		2015		2017	
	%	n	%	n	%	n
Brief contact intervention	94.8	73	93.3	83	92.9	79
Intensive tobacco cessation intervention	76.3	58	82.0	73	82.4	70
Both Brief contact intervention and Intensive tobacco cessation intervention	72.4	55	78.7	70	81.2	69

Similar to implementation of the Ask, Advise and Assess activities, most organizations allocated designated staff to provide brief contact and intensive tobacco cessation interventions (Table 27). However, in 2015 and 2017, there was a growth in all staff that provided each of these interventions in comparison to 2013 (Brief contact intervention: 20.6% in 2013, 31.7% in 2015 and 36.4% in 2017; Intensive tobacco cessation intervention: 1.7% in 2013, 6.9% in 2015 and 7.1% in 2017; Table 27).

Table 27: Staff Involvement in Providing Brief Contact and Intensive Tobacco Cessation Interventions (Only Organizations Who Reported Providing Each Intervention), 2013, 2015 and 2017

	2013		2015		2017	
	%	n	%	n	%	n
Brief contact intervention						
All staff	20.6	15	31.7	26	36.4	28
Designated staff only	79.5	58	68.3	56	63.6	49
Intensive tobacco cessation intervention						
All staff	1.7	1	6.9	5	7.1	5
Designated staff only	98.3	57	93.2	68	92.9	65

Results across 2013, 2015 and 2017 reveal that organizations tended to assign various types of healthcare providers to tobacco cessation, with the most common being nurses, physicians, nurse practitioners and pharmacists (Table 28).

Table 28: Types of Healthcare Providers Delivering Tobacco Cessation Services, 2013, 2015 and 2017

	2013		2015		2017	
	%[a]	n	%[a]	n	%[a]	n
Nurses	62.3	48	67.4	60	57.6	49
Physician	54.6	42	44.9	40	54.1	46
Nurse practitioners	45.5	35	46.1	41	42.4	36
Pharmacist	36.4	28	36.0	32	38.8	33
Mental Health/Addiction Counsellors	32.5	25	29.2	26	27.1	23
Social Workers	27.3	21	31.5	28	25.9	22
Respiratory Therapists	18.2	14	20.2	18	18.8	16
Dental Hygienist	14.3	11	19.1	17	16.5	14
Health Promotion Specialists	18.2	14	18.0	16	14.1	12
Dieticians	15.6	12	18.0	16	12.9	11
Dentists	9.1	7	10.1	9	5.9	5
Recreational Therapists or Activity Staff	9.1	7	12.4	11	5.9	5
Physiotherapist	9.1	7	7.9	7	1.2	1
Other[b]	24.7	19	22.5	20	15.3	13

[a] Percentages do not add up to 100% as the survey participants could check more than one answer
[b] Other text responses included: cardiopulmonary technologist, case manager, certified respiratory educator, chiropodist, dental assistants, diabetes educators, intake staff, laser therapist, occupational therapists, outreach workers, peer support counsellors, physician assistant, program coordinator, speech and language pathologist, and students.

Note: Table sorted in descending order according to 2017 survey responses.

Table 29 summarizes more specific tobacco cessation activities implemented as part of the Assist stage among organizations that provide intense cessation interventions. In 2015 and 2017, seven activities were implemented by 90% or more of the organizations providing intense cessation interventions, an increase from the two activities that were implemented by over 90% of organizations providing intense cessation interventions in 2013.

Table 29: Tobacco Cessation Activities Implemented as Part of the Assist Stage, 2013, 2015 and 2017

	2013		2015		2017	
	%[a]	n	%[a]	n	%[a]	n
Identify triggers and brainstorm coping strategies	86.2	50	91.8	67	95.7	67
Assist the patient/client to identify social supports	86.2	50	90.4	66	94.3	66
Assist patient/client to create and maintain a quit plan	89.7	52	91.8	67	92.9	65
Review past quit experiences	91.4	53	93.2	68	92.9	65
Provide information and teaching on stop smoking medications	86.2	50	94.5	69	91.4	64
Provide nicotine replacement therapy or partner with existing initiatives for free NRT	75.9	44	94.5	69	91.4	64
Distribute handout(s) - quit plan	91.4	53	90.4	66	90.0	63
Discuss alcohol and drug use	82.8	48	84.9	62	88.6	62
Create patient/client self-help packages for distribution (e.g. quit kit)	67.2	39	63.0	46	41.4	29
Discuss protecting non-smokers, especially pregnant women, from SHS	--	--	74.0	54	--	--
Other[b]	15.5	9	6.8	5	2.9	2

[a] Percentages do not add up to 100% as the survey participants could check more than one answer

[b] Other text responses included: acupuncture, discuss caffeine intake, group programs, handing out Smokers' Helpline and Journey to Quit resources, individual counselling, mobile apps for distraction and Tobacco Addiction Recovery Program (TARP).

Note: Table sorted in descending order according to 2017 survey responses.

Implementation of Arrange Activities

Organizations were asked to specify activities related to the Arrange stage of tobacco cessation intervention. From 2013 to 2015, there was growth in five activities (internal referral/follow-up, referral to primary care physician, referral to local cessation services, SHL Fax referral, and referral to PHU Quit Smoking Clinic; Table 30); while in 2017 organizations increased their engagement in only one activity (refer to PHU Quit Smoking Clinic).

Table 30: Tobacco Cessation Activities Implemented as Part of Arrange Stage, 2013, 2015 and 2017

	2013		2015		2017	
	%[a]	n	%[a]	n	%[a]	n
Internal referral to or follow up by staff within your organization	64.9	50	74.2	66	69.4	59
Refer to local cessation services	36.4	28	59.6	53	56.5	48
Refer to PHU Quit Smoking Clinic	23.4	18	31.5	28	36.5	31
Smokers' Helpline referral (Fax Referral Partner)	26.0	20	36.0	32	34.1	29
Smokers' Helpline referral (Quit Connection)	53.3	41	47.2	42	34.1	29
Refer to primary care physician (discharge note)	44.2	34	52.8	47	21.2	18
Refer to community pharmacist (script)	35.1	27	31.5	28	17.7	15
Other[b]	13.0	10	12.4	11	4.7	4

[a] Percentages do not add up to 100% as the survey participants could check more than one answer
[b] Other text responses included: automated telephone follow-up through Ottawa Model for Smoking Cessation, providing Smokers' Helpline phone number/card, refer to Crush the Crave mobile App, refer to MATCH study, refer to STOP on the Road workshops, refer to Tobacco Addiction Recovery Program (TARP) and refer youth tobacco users to school nurse.

Note: Table sorted in descending order according to 2017 survey responses.

3. Sustaining Tobacco Cessation Services

Adoption of Policies to Support the Implementation of Tobacco Cessation Services

In 2013, only 33.3% of organizations reported having a formal policy in place to support the implementation of the 5As tobacco cessation services (Table 31). This increased to 45.5% adoption in 2015, however decreased to 35.3% adoption in 2017.

Table 31: Adoption of a Policy to Support the Implementation of Tobacco Cessation Services, 2013, 2015 and 2017

	2013		2015		2017	
	%	n	%	n	%	n
Yes	33.3	25	45.5	40	35.3	30
In the process of adoption	17.3	13	13.6	12	5.9	5
No	49.3	37	40.9	36	58.8	50

In 2013, half of organizations surveyed (52.1%) indicated that they had adopted a smoke-free grounds policy (Table 32). The adoption of smoke-free grounds policies among surveyed organizations steadily increased in 2015 (55.1%) and 2017 (68.2%).

Table 32: Adoption of a Smoke-Free Grounds Policy, 2013, 2015 and 2017

	2013		2015		2017	
	%	n	%	n	%	n
Yes	52.1	37	55.1	49	68.2	58
In the process of adoption	12.7	9	7.9	7	1.2	1
No	35.2	25	37.1	33	30.6	26

In 2015, 14.8% of organizations had a formal policy in place that encouraged health practitioners to provide brief interventions aimed to protect non-smokers, especially children and pregnant women, from SHS (Table 33). This increased to 19.1% in 2017.

Table 33: Formal Policy that Encouraged Health Practitioners to Provide Brief Interventions Aimed at Nonsmokers, Especially Children and Pregnant Women, 2015 and 2017

	2015		2017	
	%	n	%	n
Yes	14.8	13	19.1	16
No	85.2	75	81.0	68

Resources to Sustain Tobacco Cessation Services

In 2017, three-quarters of the organizations surveyed (77.6%) reported having secured or were in the process of securing resources necessary to sustain tobacco cessation services (Table 34), which was similar to what was reported in 2015 (79.8%) yet higher than what was reported in 2013 (74.0%). The most common resources specified by respondents were staff and time dedicated to tobacco dependence interventions (Table 35).

Table 34: Availability of Resources to Sustain Tobacco Cessation Services, 2013, 2015 and 2017

	2013		2015		2017	
	%	n	%	n	%	n
Yes	68.8	53	76.4	68	68.2	58
In the process	5.2	4	3.4	3	9.4	8
Not at all	26.0	20	20.2	18	22.4	19

Table 35: Specific Resources to Sustain Tobacco Cessation Services, 2013, 2015 and 2017

	2013		2015		2017	
	%[a]	n	%[a]	n	%[a]	n
Staff (dedicated to complete task)	87.7	50	91.6	65	95.5	63
Time (dedicated to tobacco dependence Interventions)	77.2	44	83.1	59	86.4	57
Financial (dedicated funding for tobacco dependence Interventions)	40.4	23	52.1	37	53.0	35
Materials: books, software	63.2	36	57.8	41	40.9	27
Committee for tobacco dependence Interventions	24.6	14	22.5	16	15.2	10

[a] Percentages do not add up to 100% as the survey participants could check more than one answer.

Note: Table sorted in descending order according to 2017 survey responses.

In all three survey years, the STOP program was the most common source of dedicated funds for tobacco dependence interventions among the organizations surveyed (n=7 in 2013, n=13 in 2015 and n=18 in 2017).

Practice of Ordering Tobacco Cessation Materials

The majority of organizations in CW have ordered tobacco cessation materials from third-party organizations (Table 36). The number of organizations ordering from SHL increased from 85.5% in 2013 to 89.8% in 2015, but decreased to 77.4% in 2017 (data were not available for You Can Make It Happen in 2015 and 2017).

Table 36: Practice of Ordering Tobacco Cessation Materials by Organizations, 2013, 2015 and 2017

Sources of Materials	2013		2015		2017	
	%	n	%	n	%	n
You Can Make it Happen	68.4	52	--	--	--	--
Smokers' Helpline (SHL)	85.5	65	89.8	79	77.4	65

In 2017, 36.5% of organizations surveyed were a fax referral partner with Smokers' Helpline, similar to what was reported in 2015 (35.2%), but an overall increase compared to 2013 (29.0%).

Use of Promotional Materials

In 2017, 75.3% of organizations reported using "You Can Make it Happen" posters or other 5As promotional materials in practice settings, which is down slightly from what was reported in 2015 and 2013 (both 78.7%; Table 37).

Table 37: Use of "You Can Make it Happen" Posters or Other 5As Promotional Materials in Practice Setting 2013, 2015 and 2017

	2013		2015		2017	
	%	n	%	n	%	n
Yes	78.7	59	78.7	70	75.3	64
No	18.7	14	18.0	16	22.4	19
Don't know	2.7	2	3.4	3	2.4	2

In 2017, the following You Can Make It Happen or other 5As promotion materials were used:

- Quit plan tip sheet (76.6%)
- Posters (67.2%)
- 5As laminated cards (59.4%)
- YouCanMakeItHappen.ca (53.1%)
- Pens (48.4%)
- Post it notes (35.9%)
- Folders (29.7%)
- Other (4.7%) including RNAO Tobacco Free in 123 and ads placed on television screens in waiting room

In 2017, the following resources were used specifically to reach patients/clients that use tobacco:

- Posters (65.6%)
- Door Decal (54.7%)
- Table top stand (53.1%)
- Tangle (32.8%)

- Button (23.4%)
- Water bottle (6.3%)
- Other (3.1%) including T-shirts and First Week Challenge tear-offs
- Video (1.6%)

Electronic samples of these materials are available on YouCanMakeItHappen.ca.

Frequency of Documentation Audits

Since 2013, the majority of organizations reported that they did not conduct documentation audits to assess staff performance of tobacco cessation services (56.6% in 2013, 65.5% in 2015 and 61.5% in 2017).

Sustaining Staff Engagement in Tobacco Cessation

Table 38 summarizes key activities that organizations implement to ensure that clinical staff support tobacco cessation services. In 2015 and 2017, two activities were implemented by close to half of all organizations: a) regularly addressing barriers with staff, and b) providing new staff with training and orientation to the 5A model. This was an increase over what was reported in 2013.

Table 38: Activities to Ensure that Clinical Staff Support Tobacco Cessation Services, 2013, 2015 and 2017

	2013		2015		2017	
	%[a]	n	%[a]	n	%[a]	n
Providing new staff with training and orientation to the 5A model	31.2	24	47.2	42	47.1	40
Regularly addressing barriers with staff	40.3	31	42.7	38	45.9	39
Annual staff in-service training on applying and documenting the 5As as well as accomplishments to date	20.8	16	21.4	19	18.8	16
Lunch and Learns/ongoing training for staff	7.8	6	11.2	10	9.4	8
Other[b]	3.9	3	10.1	9	9.4	8

[a] Percentages do not add up to 100% as the survey participants could check more than one answer
[b] Other text responses included: circulating articles, updated information and professional guidelines to staff; addressing tobacco cessation services periodically with staff; reminders in all the treatment rooms; review of medical history and 5A assessment data; and support offered to staff to quit smoking.
Note: Table sorted in descending order according to 2017 survey responses.

Barriers to Implementing and Sustaining Tobacco Cessation Services

Organizations identified a number of barriers to implementing tobacco cessation services within daily practice (Table 39). Several barriers were identified as being less of a concern in 2017 compared to 2013 (see Table), with two barriers in particular identified as more of a concern: lack of staff time and more pressing concerns with workload. The most often cited barriers included: more pressing concerns with clients, lack of staff time to provide cessation support, more pressing concerns with workload, lack of staff knowledge and training in tobacco cessation and lack of staff to deliver cessation services. Since 2013, the proportion of organizations that identified no barriers to implementing tobacco cessation services within daily practice steadily increased (14.3% in 2013 to 14.6% in 2015 to 20.0% in 2017).

Table 39: Barriers to Implementing Tobacco Cessation Services, 2013, 2015 and 2017

	2013		2015		2017	
	%[a]	n	%[a]	n	%[a]	n
Lack of staff time	44.2	34	55.1	49	55.3	47
More pressing concerns with clients	59.7	46	48.3	43	51.8	44
More pressing concerns with workload	45.5	35	41.6	37	51.8	44
Lack of knowledge/training in tobacco cessation among staff	37.7	29	30.3	27	27.1	23
Lack of staff to deliver cessation services	29.9	23	29.2	26	25.9	22
Lack of administrative support	19.5	15	18.0	16	14.1	12
Tobacco cessation is not a priority issue in the organization	14.3	11	13.5	12	12.9	11
Lack of reimbursement for service	13.0	10	14.6	13	11.8	10
Patients not interested in discussing tobacco use or quitting	2.6	2	42.7	38	1.2	1
No barriers	14.3	11	14.6	13	20.0	17
Other[b]	11.7	9	5.6	5	8.2	7

[a] Percentages do not add up to 100% as the survey participants could check more than one answer

[b] Other text responses include: barriers to documenting the intervention, lack of accountability, lack of childcare for patients to come for services, lack of client transportation, lack of communication, lack of policy, lack of reinforcement to remind staff, limited to offering cessation services only to rostered patients, limited support for pregnant participants to receive free NRT, staff not comfortable delivering smoking cessation and the reliance on internal referrals for smoking cessation services.

Note: Table sorted in descending order according to 2017 survey responses.

As Table 40 indicates, organizations identify the same key barriers to sustaining tobacco cessation services as they do for implementing tobacco cessation services (see Table 39); albeit, there appears to be less of a reduction in the sustaining barriers over the period 2013 to 2017 in comparison to the implementing barriers reported in Table 39.

Table 40: Barriers to Sustaining Tobacco Cessation Services, 2013, 2015 and 2017

	2013		2015		2017	
	%[a]	n	%[a]	n	%[a]	n
More pressing concerns with clients	46.8	36	43.8	39	45.9	39
More pressing concerns with workload	32.5	25	49.4	44	42.4	36
Lack of staff time	35.1	27	43.8	39	41.2	35
Lack of staff to deliver cessation services	28.6	22	30.3	27	23.5	20
Lack of knowledge/training in tobacco cessation among staff	26.0	20	25.8	23	20.0	17
Tobacco cessation is not a priority issue in the organization	13.0	10	14.6	13	12.9	11
Lack of administrative support	20.8	16	20.2	18	10.6	9
Lack of reimbursement for service	14.3	11	9.0	8	9.4	8
No barriers	15.6	12	13.5	12	22.4	19
Other[b]	13.0	10	15.7	14	7.1	6

[a] Percentages do not add up to 100% as the survey participants could check more than one answer
[b] Other text responses include: champion engagement, lack of policy, loss of funding, staff turnover and sustaining the steering committee.

Note: Table sorted in descending order according to 2017 survey responses.

Conclusion

The Central West Tobacco Control Area Network and the Ontario Tobacco Research Unit conducted three surveys (2013, 2015, and 2017) to explore the state of provision of tobacco cessation services across healthcare organizations in the Central West region of the province. The surveys were targeted to organizations that are members of the local Tobacco Cessation Communities of Practice.

In general, organizations are taking steps toward building their capacity in smoking cessation and integrating evidence-based cessation approaches, such as the 5As, into daily practice. Further, many of these steps appear to have increased over the period of 2013 to 2017. Findings demonstrate that organizations continue to advance goals, including increased:

- Availability of resources to implement tobacco cessation services (80.5% in 2013 vs. 85.7% in 2017)
- Increased use of a chart reminder system to prompt staff to provide tobacco dependence interventions (43.4% in 2013 vs. 52.9% in 2017); increased availability of medical directives to dispense cessation medication (40.8% in 2013 vs. 58.8% in 2017)
- Integration of the standardized Advise questions into the documentation system (49.3% in 2013 vs. 63.5% in 2017)
- Frequency of Asking and Advising patients in all areas of the organization with a corresponding increase in the frequency of all staff Asking, Advising and Assessing patients
- Implementation of Arrange activities such as internal referrals (64.9% in 2013 vs. 69.4% in 2017), referrals to local cessation services (36.4% in 2013 vs. 56.5% in 2017), referrals to the SHL via Fax Referrals (26.0% in 2013 vs. 34.1% in 2017), and referrals to the health unit quit smoking clinic (23.4% in 2013 vs. 36.5% in 2017)
- Adoption of a formal policy to support the implementation of the 5As tobacco cessation services (33.3% in 2013 vs. 35.3% in 2017) and smoke-free grounds (52.1% in 2013 vs. 68.2% in 2017)

In other aspects of capacity building and integration of the 5As approach into daily practice,

progress has been stagnant. For instance, there has only been a negligible increase in dedicated funding to implement tobacco cessation services (47.1% in 2013 vs. 48.7% in 2017); and no increase in the availability of cessation medication in hospital formulary (92.9% in 2013 vs. 92.3% in 2017), the integration of the Ask and Assess questions into the documentation system (Ask: 85.5% in 2013 vs. 85.9% in 2017; Assess: 59.2% in 2013 vs. 58.9% in 2017), or the recording of the patient's tobacco use status in the chart (86.7% in 2013 vs. 87.1% in 2017). The use of order sets for cessation medication also decreased (29% in 2013 vs. 22.9% in 2017). Furthermore barriers remain to sustaining tobacco cessation services including: lack of staff time (35.1% in 2013 vs. 41.2% in 2017) and more pressing concerns with workload (32.5% in 2013 vs. 42.4% in 2017).

The limited progress reported in several of these areas may be explained, in part, by stagnant budgetary resources—organizations are doing what they can with the funds they have, but these funds may be inadequate to fully sustain a comprehensive tobacco cessation service. Notwithstanding, progress has been made, which speaks to the resiliency of organizations that participate in Central West Tobacco Cessation Communities of Practice.

These findings point to the need to focus future efforts on addressing barriers and areas with little or no progress. Such efforts have the potential to facilitate system-level and organizational changes and adoption of evidence-based tobacco cessation interventions.

Appendix A: Description of Programs

TEACH (Training Enhancement in Applied Cessation Counselling and Health) is a University of Toronto accredited program for health practitioners. TEACH aims to enhance treatment capacity for tobacco cessation interventions by offering evidence-based, accredited, accessible, and clinically relevant curricula to a broad range of health practitioners (nurses, addiction counsellors, social workers, pharmacists, etc).

The Registered Nurses Association of Ontario (RNAO) Smoking Cessation Champions Network is a network of over 1400 nurses and other health care professionals across Canada. Network members, i.e. Champions, participate in a one-day orientation workshop, designed to provide them with numerous tools and strategies to promote and integrate the RNAO Smoking Cessation Best Practice Guideline recommendations in the organizations. Champions also get access to a variety of cessation resources and supports.

The STOP (Smoking Treatment for Ontario Patients) program is a province-wide initiative coordinated by the Centre for Addiction and Mental Health. The program uses the existing health care infrastructure, such as Family Health Teams, Community Health Centres, to expand support to smokers willing to quit by providing access to free nicotine replacement therapy and cessation counselling.

Smokers' Helpline (SHL) is a free, confidential and province-wide smoking cessation service that provides support to individuals who want to quit, are thinking about quitting, have quit but want support, continue to smoke and do not want to quit, and those who want to help someone else quit smoking. SHL has different channels to deliver cessation support, including over the phone, and by web-based and text messaging services.

University of Ottawa Heart Institute's Ottawa Model for Smoking Cessation (the Ottawa Model) is a clinical smoking cessation program designed to help smokers quit smoking and stay smoke-free. The overall goal of the program is to reach a greater number of tobacco users with effective, evidence-based tobacco dependence treatments delivered by health professionals. This is accomplished by systematically identifying and documenting the smoking status of all

admitted patients, providing evidence-based cessation interventions—including counselling and pharmacotherapy—and conducting follow-up with patients after discharge. Since 2005, the Ottawa Model has been introduced in many hospitals across Ontario and other provinces of Canada. In 2011/12, the program was also launched in a number of Ontario primary health clinics.

Appendix B: 2013 Central West HCP Survey

Dear (name)

On behalf of the Central West TCAN, welcome to this environmental scan survey. The Central West TCAN is inviting health care providers who are members of local Community of Practices to complete an online survey which aims to determine if and how the organizations represented by health care providers are implementing tobacco dependence interventions. Tobacco dependence interventions are any interventions where patient tobacco use is assessed and then an intervention and some sort of follow-up is implemented; you may also know this as the 5As (Ask, Advise, Assess, Assist, Arrange). The data collected across seven Community of Practices of the Central West Tobacco Control Area Network will be aggregated to provide a picture of the current tobacco dependence services in place and areas for improvement in our local community and across the Central West Ontario area.

"You do not have to participate in the scan if you do not want to and you can choose to not respond to any questions or withdraw at any point in time. Completing or not completing the scan will not affect your participation in the Community of Practice. There are no known risks to you or your organization if you choose to participate. Your participation in the scan is voluntary and all answers will be kept confidential. Your name and the name of your organization will not be included in annual reports. Personal information is collected under the authority of the Municipal Freedom of Information and Protection of Privacy Act and will be used to assist Community of Practice facilitator staff to understand the types of tobacco dependence interventions your organization is providing and what supports may be helpful to you and your organization."

This environmental scan survey is conducted in partnership with the Ontario Tobacco Research Unit (OTRU) who is assisting in survey administration and data analysis. Survey data will be collected and stored using a password protected account in Key Survey. OTRU and CW Community of Practice Facilitators and the TCAN Coordinator from the Central West Tobacco Control Area Network will have access to the data. All raw data will be destroyed in 2 years after the last data collection period is complete and the final report is written by December 2014. We intend to complete this scan once a year for the next three years (2012-2014)." Annual summary reports will be e-mailed to participants before the end of each scan year. The scan has been reviewed by the Office of Research and Ethics at Region of Waterloo Public Health and the Brant County Health Unit"

The scan should take about 20-30 minutes to complete.

Do you consent to participate in the scan survey?

1. Yes
2. No

Do you give permission to be contacted in the future to clarify any responses you provide?

1. Yes
2. No

Section A. ABOUT the HCP Organization

What is your name and title? _____

What is the name of your organization? _____

What type of organization do you represent? (Check only one)

1. Hospital
2. Not-for-profit
3. Public Health Department
4. Family Health Team
5. Community Health Centre
6. Physician
7. Pharmacy
8. Community Outreach Program
9. Dental Clinic
10. Long Term Care residential
11. Aboriginal (e.g. Aboriginal Health Centers)
12. Post-Secondary Institute
13. Workplace
14. Nurse Practitioner Led Clinics
15. Other, please specify:_____

O1. Number of sites (optional):_____

O2.Number of clinicians (optional): _____

O3. Number of clinicians providing services (optional):_____

Does your organization <u>provide</u> tobacco dependence intervention services? Tobacco dependence interventions are any interventions where patient tobacco use is assessed and then an intervention and some sort of follow-up is implemented; you may also know this as the 5A's (Ask, Advise, Assess, Assist, Arrange).

1. Yes
2. No

Which CoP is your organization a member of?

1. Brant
2. HN
3. Halton
4. Hamilton
5. Niagara
6. Waterloo- Wellington
7. Dufferin
8. Not a member (Specify PHU jurisdiction) **GO TO Q 7**

Since when has your organization been a CoP Member?

1. 2007
2. 2008
3. 2009
4. 2010
5. 2011
6. 2012
7. 2013
8. 2014

If N/A **(do not provide services directly), go to the end of the survey**

Section B. Preparing to Provide Tobacco Dependence Intervention Services
The following questions will ask about various steps that your organization may have taken in preparation to providing Tobacco Dependence Interventions (TDI) services.

Has your organization gathered background evidence and examples of tobacco dependence intervention service delivery models (i.e. 5 As)? (www.youcanmakeithappen.ca).

1. Yes
2. In the process
3. No
4. Other, specify: _____

What proportion of the staff in your organization attended training(s) on tobacco dependence intervention /control (e.g. TEACH, RNAO, PTCC, OTRU modules)?

1. All of them
2. Most of them
3. Half of them
4. A few of them
5. None
6. Don't know

Is your organization a member of any other Community of Practice/ champions networks (e.g. TEACH, RNAO) that involve health care providers implementing tobacco dependence intervention services (i.e. 5 As)?

1. Yes, please list: _____
2. No

Has your organization developed an implementation plan (e.g. a plan outlining the process of adopting tobacco dependence intervention services as a routine part of standard patient care)?

1. Yes
2. In the process
3. Not at all

Has your organization developed evaluation and/or performance metrics and continuous improvement processes? (e.g. chart audits)

1. Yes
2. In the process
3. Not at all

Has your organization obtained senior leadership support/buy-in?

1. Yes
2. In the process
3. Not at all

Has your organization secured resources to IMPLEMENT tobacco dependence intervention services?

1. Yes
2. In the process
3. Not at all GO TO Q15

Please indicate which resources (check all that apply)

1. Financial (dedicated funding for TDI) List source_____
2. Staff (dedicated to complete task)
3. Time (dedicated to TDI activities)
4. Materials- books, software
5. TDI Committee
6. Other specify: _____

Has your organization designated a staff lead for the tobacco dependence intervention (i.e. 5 As) implementation process?

1. Yes
2. In the process
3. Not at all

Has your organization partnered with your local PHU and Smokers' Helpline staff to provide training and/or consultation for your staff?

1. Yes
2. No

Have you used "You Can Make it Happen" posters or other 5 As promotional materials in your practice setting?

1. Yes
2. No

Does your organization have a dedicated Champions Committee to assist with implementation and sustainability of tobacco dependence intervention services?

1. A Champions Committee may be represented by: senior manager, physician, pharmacy, nursing, other allied health (respiratory therapist, social worker, physiotherapist, etc.), occupational health, public relations, security and IT.
2. Yes
3. No
4. Other, specify:

Does your organization use billing codes for TDI?

1. Yes
2. Yes, but do not use
3. No, do not have

Are prompts or reminders available in all documentation systems for billing (electronic and paper)?

1. Yes
2. No

Is a chart reminder system in place in your organization to prompt staff to provide tobacco dependence intervention?

1. Yes
2. In the process
3. No

Are any tobacco dependence intervention medications (e.g. NRT) available in formulary (only for: *hospital settings*)?

1. Yes
2. No
3. N/A(not a hospital setting)

Does your organization have medical directives to dispense tobacco cessation medication, if needed (e.g. NRT)?

1. Yes
2. No
3. N/A
4. Other, specify: _____

Does your organization have order sets for NRT, Champix and Zyban?

1. Yes
2. No
3. N/A
4. Other, specify: _____

Section C. Implementing 5 As

ASK

Has your organization integrated a standardized ASK question into all admission/intake paper and/or electronic documentation? *E.g. "Have you used any tobacco products in the past 6 months?"*

1. Yes
2. In the process
3. No

Which health professionals in your organization provide tobacco dependence intervention services? (Check all that apply)

1. Physician
2. Nurses
3. Nurse practitioners
4. Respiratory Therapists
5. Mental Health/Addiction Counsellors
6. Social workers
7. Recreational therapists or activity staff
8. Pharmacist
9. Physiotherapist
10. Dental Hygienist
11. Dentists
12. Health Promotion officers
13. Dieticians
14. Other, please specify: _____

Are patients/clients ASKED about tobacco use in:

1. All areas of the organization
2. Designated area/unit/department

Are patients/clients ASKED about tobacco use by:

1. All staff
2. Designated staff only
3. Other, specify: _____

When are patients/clients ASKED about tobacco use:

1. At the intake/admission or initial visit
2. At every visit
3. Only at specific times, specify: _____
4. Other, specify: _____

After patient/client is ASKED about tobacco use, is tobacco status flagged or recorded in patient/client charts?

1. Yes
2. No
3. Other, specify: _____

ADVISE

Has your organization integrated ADVISE statements into documentation?

1. E.g. "As your (insert profession) I am concerned about your (insert health condition). I would advise you to quit smoking in order to improve your health. I can help you if you are interested?"
2. e.g. "Smoking cigarettes affects the way your body uses certain medications. If you were to quit smoking we could significantly reduce your ( ) dose.
3. Yes
4. In the process
5. No

Are patients/clients ADVISED to quit tobacco use in:

1. All areas of the organization
2. Designated area/unit/department

Are patients/clients ADVISED to quit smoking by:

1. All staff
2. Designated staff only
3. Other, specify: _____

ASSESS

1. **Has your organization integrated ASSESS questions into all documentation?** E.g. "Have you thought about quitting in the next 30 days?"
2. Yes
3. In the process
4. No

Are patients/clients ASSESSED for their readiness to quit tobacco use by:

1. All staff
2. Designated staff only
3. Other, specify: _____

ASSIST

The following questions are about tobacco smoking cessation services that your staff may currently be providing to patients/clients

Does your staff provide Brief Contact Intervention (1-3 minutes)?

1. Yes
2. No GO TO Q38

Is Brief Contact Intervention provided by:

1. All staff
2. Designated staff only
3. Other, specify: _____

Does your staff provide intensive tobacco cessation intervention (greater than 10 minutes)?

1. Yes
2. No GO TO Q41, unless you answered yes to 36.

Is intensive tobacco cessation intervention provided by:

1. All staff
2. Designated staff only
3. Other, specify: _____

Please indicate which activities your staff implement as part of the tobacco cessation intervention (check all that apply)

1. Assist patient/client to create and maintain a quit plan
2. Handout(s) - quit plan
3. Review past quit experiences
4. Identify triggers and brainstorm coping strategies
5. Discuss alcohol and drug use
6. Assist the patient/client to identify social supports
7. Provide information and teaching on stop smoking medications
8. Provide nicotine replacement therapy or partner with existing initiatives for free NRT
9. Create patient/client self-help packages for distribution (e.g. quit kit)
10. Other, specify: _____

ARRANGE

41.Do staff at your organization, do any of the following … (check all that apply)?

1. Internal referral to or follow up by staff within your organization
2. Smokers' Helpline referral (Quit Connection)
3. Smokers' Helpline referral (Fax Referral Partner)
4. Refer to Primary care physician (discharge note)
5. Refer to community pharmacist (script)
6. Refer to PHU Quit Smoking Clinic
7. Refer to local cessation services (specify)
8. Other, specify: _____

Section D. SUSTAINING EFFORTS

Does your organization have a formal policy in place to support the implementation of the 5As tobacco dependence intervention services organizational …

1. Yes
2. In the process of adoption
3. No
4. Other, please specify: _____

Does your organization have a Smoke-free grounds policy to support tobacco dependence intervention services?

1. Yes, specify policy here: _____
2. In the process of adoption
3. No
4. Other, specify: _____

Has your organization secured resources to SUSTAIN tobacco dependence intervention services?

1. Yes
2. In the process
3. No GO TO Q46

Please indicate which resources (check all that apply)

1. Financial (dedicated funding for TDI) List source_____
2. Staff (dedicated to complete task)
3. Time (dedicated to TDI activities)
4. Materials- books, software
5. TDI Committee
6. Other specify: _____

Does your organization order You Can Make it Happen materials, as needed?

1. Yes
2. No

Does your organization order Smokers' Helpline materials, as needed?

1. Yes
2. No

How often does your organization conduct documentation audits to assess staff performance of tobacco dependence intervention services?

1. Yearly
2. Quarterly
3. Monthly
4. Not at all
5. Other: specify

Which of the following activities does your organization implement to ensure that all clinical staff support tobacco dependence intervention services? (check all that apply)

1. Providing new staff with training and orientation to the 5A model
2. Annual staff in-service training on applying and documenting the 5As as well as accomplishments to date
3. Regularly addressing barriers with staff
4. Other, specify: _____

Is your organization a fax referral partner with Smokers Help Line?

1. Yes
2. No

What are the barriers to IMPLEMENTING tobacco dependence intervention services (i.e 5 As) within your organization?

1. No identified barriers
2. Lack of staff time
3. Lack of staff to deliver cessation services
4. Lack of knowledge/training in tobacco cessation among staff
5. More pressing concerns with workload
6. More pressing concerns with clients
7. Lack of administrative support
8. Tobacco cessation is not a priority issue in the organization
9. Lack of reimbursement for service
10. Other, specify: _____

What are the barriers to SUSTAINING tobacco dependence intervention service delivery s(i.e 5 As) within your organization?

1. No identified barriers
2. Lack of staff time
3. Lack of staff to deliver cessation services
4. Lack of knowledge/training in tobacco cessation among staff
5. More pressing concerns with workload
6. More pressing concerns with clients
7. Lack of administrative support
8. Tobacco cessation is not a priority issue in the organization
9. Lack of reimbursement for service
10. Other, specify: _____

What has contributed to your organization's ability to provide tobacco dependence intervention services (i.e. 5 As)? Please explain.

Are there any other comments that you would like to add?

END of SURVEY

Appendix C: 2015 Central West HCP Survey

On behalf of the Central West TCAN, welcome to this environmental scan survey. The Central West TCAN is inviting health care providers who are members of local Community of Practices to complete an online survey which aims to determine if and how the organizations represented by health care providers are implementing tobacco dependence interventions. Tobacco dependence interventions are any interventions where patient tobacco use is assessed and then an intervention and some sort of follow-up is implemented; you may also know this as the 5A's (Ask, Advise, Assess, Assist, Arrange).

The data collected across the seven Community of Practices within the Central West Tobacco Control Area Network will be aggregated to provide a picture of the current tobacco dependence services in place and areas for improvement in our local community and across the Central West Ontario area. You do not have to participate in the scan if you do not want to and you can choose to not respond to any questions or withdraw at any point in time. Completing or not completing the scan will not affect your participation in the Community of Practice.

There are no known risks to you or your organization if you choose to participate. Your participation in the scan is voluntary and all answers will be kept confidential. Your name and the name of your organization will not be included in annual reports. Personal information is collected under the authority of the Municipal Freedom of Information and Protection of Privacy Act and will be used to assist Community of Practice facilitator staff to understand the types of tobacco dependence interventions your organization is providing and what supports may be helpful to you and your organization.

This environmental scan survey is conducted in partnership with the Ontario Tobacco Research Unit (OTRU) who is assisting in survey administration and data analysis. Survey data will be collected and stored using a password protected account in Key Survey. OTRU and CW Community of Practice Facilitators and the TCAN Coordinator from the Central West Tobacco Control Area Network will have access to the data. All raw data will be destroyed in 2 years after the last data collection period is complete and the final report is written by July 2015.

We intend to complete this scan biennially (2013, 2015, 2017). Biennial summary reports will be e-mailed to participants before the end of each scan year. The scan has been reviewed by the Office of Research and Ethics at Region of Waterloo Public Health and the Brant County Health Unit. The scan should take about 30 minutes to complete.

2. Do you consent to participate in the scan survey?
    1. Yes Go to Q3
    2. No End
3. Do you give permission to be contacted in the future to clarify any responses with you?
    1. Yes
    2. No

Section A. ABOUT the HCP Organization

5. What is your name and title?
    1. Name:
    2. Title:

6. What is the name of your organization?

7. What type of organization do you represent? (Check only one)
   1. Hospital
   2. Not-for-profit
   3. Public Health Department
   4. Family Health Team
   5. Community Health Centre
   6. Physician
   7. Pharmacy
   8. Community Outreach Program
   9. Dental Clinic
   10. Long Term Care residential
   11. Aboriginal (e.g. Aboriginal Health Centers)
   12. Post-Secondary Institute
   13. Workplace
   14. Nurse Practitioner Led Clinics
   15. Other, please specify:

8. Complete the following:
   1. Number of sites (optional):
   2. Number of clinicians (optional):
   3. Number of clinicians providing services (optional):

9. Does your organization provide tobacco dependence intervention serivces? Tobacco dependence interventions are any interventions where patient tobacco use is assessed and then an intervention and some sort of follow-up is implemented; you may also know this as the 5A's (Ask, Advise, Assess, Assist, Arrange).
   1. Yes Go to Q10
   2. No Go to Q11

10. Which of the following priority populations do you provide tobacco dependence intervention services? Please check all that apply.
   1. Youth and young adults
   2. Aboriginal community
   3. People with mental health diagnosis
   4. People with low socioeconomic status
   5. LGBTTQQ community
   6. New immigrants/refugees
   7. Pregnant women
   8. Other, please specify:

11. Which CoP is your organization a member of?
   1. Brant
   2. HN
   3. Halton
   4. Hamilton
   5. Niagara
   6. Waterloo- Wellington
   7. Dufferin
   8. More than one CoP
   9. Not a member (specify PHU jurisdiction)

Q11.A9 AND Q9.A1 Go to Q14
Q11.A9 AND Q9.A2 Go to End
(Q11.A1 OR Q11.A2 OR Q11.A3 OR Q11.A4 OR Q11.A5 OR Q11.A6 OR Q11.A7) Go to Q13

12. You have indicated "more than one CoP". Please specify which:

13. Since when has your organization been a CoP Member?
1. 2007
2. 2008
3. 2009
4. 2010
5. 2011
6. 2012
7. 2013
8. 2014
9. 2015

14. Section B. Preparing to Provide Tobacco Dependence Intervention (TDI) Services. The following questions will ask about various steps that your organization may have taken in preparation to providing tobacco dependence intervention services.

15. Has your organization gathered background evidence and examples of tobacco dependence intervention service delivery models (i.e., 5 As)? (www.youcanmakeithappen.ca)
1. Yes
2. In the process
3. No
4. Other comments:

16. What proportion of the staff in your organization attended training(s) on tobacco dependence intervention /control (e.g., TEACH, RNAO, PTCC, OTRU modules)?
1. All of them
2. Most of them
3. Half of them
4. A few of them
5. None
6. Don’t know
7. Other comments:

17. Is your organization a member of any other Community of Practice/champions networks (e.g. TEACH, RNAO) that involve health care providers implementing tobacco dependence intervention (i.e., 5 As)?
1. Yes Go to Q18
2. No Go to Q19
3. Don't know Go to Q19
4. Other comments:

18. Please list other Community of Practice/champions networks:

19. Has your organization developed an implementation plan (e.g., a plan outlining the process of adopting tobacco dependence intervention as a routine part of standard patient care)?
1. Yes
2. In the process
3. Not at all
4. Don't know
5. Other comments:

20. Has your organization developed evaluation and/or performance metrics and continuous improvement processes (e.g., chart audits)?
1. Yes
2. In the process
3. Not at all
4. Don't know
5. Other comments:

21. Has your organization obtained senior leadership support/buy-in?
1. Yes
2. In the process
3. Not at all
4. Other comments:

22. Has your organization secured resources to IMPLEMENT tobacco dependence intervention services?
1. Yes Go to Q23
2. In the process Go to Q23
3. Not at all Go to Q25
4. Other comments:

23. Please indicate which resources your organization has secured: (Check all that apply)
1. Financial (dedicated funding for TDI)
2. Staff (dedicated to complete task)
3. Time (dedicated to TDI activities)
4. Materials- books, software
5. TDI Committee
6. Other, please specify:

Q23.A1 Go to Q24
(Q23.A2 OR Q23.A3 OR Q23.A4 OR Q23.A5 OR Q23.A6) Go to Q25

24. You indicated financial (dedicated funding for TDI) resources. Please list the source(s):

25. Has your organization designated a staff lead for the tobacco dependence intervention (i.e., 5 As) implementation process?
1. Yes
2. In the process
3. Not at all
4. Don't know

26. Has your organization partnered with your local PHU or Smokers' Helpline staff to provide training and/or consultation for your staff?

1. Yes, local PHU staff only
2. Yes, Smokers' Helpline staff only
3. Yes, both local PHU and Smokers' Helpline staff
4. No, neither local PHU or Smokers' Helpline staff
5. Other comments:

27. Have you used "You Can Make it Happen" posters or other 5 As promotional materials in your practice setting?

1. Yes Go to Q28
2. No Go to Q31
3. Don't know Go to Q31
4. Other comments:

28. Which of the following "You Can Make it Happen" or other 5As promotional materials have you used? (Check all that apply)

1. Posters
2. Quit plan tip sheet
3. Pens
4. Post it notes
5. 5As laminated cards
6. Folders
7. YouCanMakeItHappen.ca
8. Other, please specify:

29. Which of the following "You Can Make it Happen" materials have you used specifically to reach patients/clients that use tobacco? (Check all that apply) If unsure, go to YouCanMakeItHappen.ca (All HCP resources to view the resources/materials).Inform the CoP member: "I will be mailing you a package of all the YCMIH materials available; they have been refreshed and updated. Please consider using the materials."

1. Door decal
2. Posters
3. Video
4. Button
5. Other, please specify:

30. Are there additional promotional materials that you require?

1. Yes
2. No
3. Specific promotional materials you require:

31. Does your organization have a dedicated Champions Committee to assist with implementation and sustainability of tobacco dependence interventions? A Champions Committee may be represented by: senior manager, physician, pharmacy, nursing, other allied health (respiratory therapist, social worker, physiotherapist, etc.), occupational health, public relations, security and IT.

1. Yes
2. No
3. Other comments:

32. Does your organization have billing codes for tobacco dependence intervention services?
    1. Yes Go to Q33
    2. Yes, but do not use Go to Q34
    3. No, do not have Go to Q34
    4. Other comments:

33. Are prompts or reminders available in all documentation systems for billing (electronic and paper)?
    1. Yes
    2. No
    3. Other comments:

34. Is a chart reminder system in place in your organization to prompt staff to provide tobacco dependence intervention?
    1. Yes
    2. In the process
    3. No
    4. Other comments:

35. Are any tobacco dependence intervention medications (e.g., NRT) available in formulary (only for: hospital settings)?
    1. Yes
    2. No
    3. N/A (not a hospital setting)
    4. Other comments:

36. Does your organization have medical directives to dispense tobacco cessation medication, if needed (e.g., NRT)?
    1. Yes
    2. No
    3. N/A
    4. Other comments:

37. Does your organization have order sets for NRT, Champix and Zyban?
    1. Yes
    2. No
    3. N/A
    4. Other comments:

38. Section C. Implementing 5 As

39. ASK

40. Has your organization integrated a standardized ASK question into all admission/intake paper and/or electronic documentation? E.g., "Have you used any tobacco products in the past 6 months?”
    1. Yes
    2. In the process
    3. No
    4. Other comments

41. Which health professionals in your organization provide tobacco dependence intervention? (Check all that apply)
    1. Physician
    2. Nurses
    3. Nurse practitioners
    4. Respiratory Therapists
    5. Mental Health/Addiction Counsellors
    6. Social workers
    7. Recreational therapists or activity staff
    8. Pharmacist
    9. Physiotherapist
    10. Dental Hygienist
    11. Dentists
    12. Health Promotion officers
    13. Dietitians
    14. Other comments:

42. Are patients/clients ASKED about tobacco use in:
    1. All areas of the organization
    2. Designated area/unit/department
    3. Other comments:

43. Are patients/clients ASKED about tobacco use by:
    1. All staff
    2. Designated staff only
    3. Other comments:

44. When are patients/clients ASKED about tobacco use:
    1. At the intake/admission or initial visit Go to Q46
    2. At every visit Go to Q46
    3. Only at specific times Go to Q45
    4. Other comments:

45. You indicated "at specific times". Please specify:

46. After patient/client is ASKED about tobacco use, is tobacco status flagged or recorded in patient/client charts?
    1. Yes
    2. No
    3. Other comments:

47. ADVISE

48. Has your organization integrated ADVISE statements into documentation? E.g., “As your (insert profession) I am concerned about your (insert health condition). I would advise you to quit smoking in order to improve your health. I can help you if you are interested?”E.g., “Smoking cigarettes affects the way your body uses certain medications. If you were to quit smoking we could significantly reduce your (NRT/medication) dose.
    1. Yes
    2. In the process
    3. No
    4. Other comments:

49. Are patients/clients ADVISED to quit tobacco use in:
    1. All areas of the organization
    2. Designated area/unit/department
    3. Other comments:

50. Are patients/clients ADVISED to quit smoking by:
    1. All staff
    2. Designated staff only
    3. Other comments:

51. ASSESS

52. Has your organization integrated ASSESS questions into all documentation? E.g., "Have you thought about quitting in the next 30 days?"
    1. Yes
    2. In the process
    3. No
    4. Other comments:

53. Are patients/clients ASSESSED for their readiness to quit tobacco use by:
    1. All staff
    2. Designated staff only
    3. Other comments:

54. ASSIST

The following questions are about tobacco use cessation services that your staff may currently be providing to patients/clients.

55. Does your staff provide Brief Contact Intervention (1-3 minutes) or 5 As?
    1. Yes Go to Q56
    2. No Go to Q57
    3. Other comments:

56. Is Brief Contact Intervention or 5 As provided by:
    1. All staff
    2. Designated staff only
    3. Other comments:

57. Does your staff provide intensive tobacco cessation intervention (greater than 10 minutes)?
    1. Yes Go to Q58
    2. No Go to Q60
    3. Other comments:

58. Is intensive tobacco cessation intervention provided by:
    1. All staff
    2. Designated staff only
    3. Other comments

59. Please indicate which activities your staff implement as part of tobacco cessation intervention. (Check all that apply)
    1. Assist patient/client to create and maintain a quit plan
    2. Handout(s) - quit plan
    3. Review past quit experiences
    4. Identify triggers and brainstorm coping strategies
    5. Discuss alcohol and drug use
    6. Assist the patient/client to identify social supports
    7. Provide information and teaching on stop smoking medications
    8. Provide nicotine replacement therapy or partner with existing initiatives for free NRT
    9. Create patient/client self-help packages for distribution (e.g. quit kit)
    10. Discuss protecting nonsmokers, especially children and pregnant women, from secondhand smoke
    11. Other comments:

60. ARRANGE

61. Do staff at your organization, do any of the following. (Check all that apply)
    1. Internal referral to or follow up by staff within your organization
    2. Smokers' Helpline referral (Quit Connection)
    3. Smokers' Helpline referral (Fax Referral Partner)
    4. Refer to Primary care physician (discharge note)
    5. Refer to community pharmacist (script)
    6. Refer to PHU Quit Smoking Clinic
    7. Refer to local cessation services
    8. Other comments:

(Q61.A1 OR Q61.A2 OR Q61.A3 OR Q61.A4 OR Q61.A5 OR Q61.A6 OR Q61.A8) and NOT Q61.A7 Go to Q63
Q61.A7 Go to Q62

62. Please specify the local cessation service(s):

63. Section D. SUSTAINING EFFORTS

64. Does your organization have a formal policy in place to support the implementation of the 5As tobacco dependence intervention?
    1. Yes
    2. In the process of adoption
    3. No
    4. Other comments:

65. Does your organization have a smoke-free grounds policy to support tobacco dependence intervention?
    1. Yes Go to Q66
    2. In the process of adoption Go to Q66
    3. No Go to Q67
    4. Other comments:

66. Please specify the policy:

67. Does your organization have a formal policy in place that encourages health practitioners to provide brief interventions that aims to protect nonsmokers, especially children and pregnant women, from secondhand smoke?
1. Yes
2. No
3. Other comments:

68. Has your organization secured resources to SUSTAIN tobacco dependence intervention?
1. Yes Go to Q69
2. In the process Go to Q69
3. No Go to Q71
4. Other comments:

69. Please indicate which resources your organization has secured: (Check all that apply)
1. Financial (dedicated funding for TDI)
2. Staff (dedicated to complete task)
3. Time (dedicated to TDI activities)
4. Materials- books, software
5. TDI Committee
6. Other comments:

Q69.A1 Go to Q70
(Q69.A2 OR Q69.A3 OR Q69.A4 OR Q69.A5 OR Q69.A6) and NOT Q69.A1 Go to Q71

70. You indicated financial (dedicated funding for TDI) resources. Please list the source(s):

71. Does your organization order Smokers' Helpline materials, as needed?
1. Yes
2. No
3. Other comments:

72. Is your organization a fax referral partner with Smokers Helpline?
1. Yes
2. No
3. Don't know
4. Other comments:

73. How often does your organization conduct documentation audits to assess staff performance of tobacco dependence intervention?
1. Yearly
2. Quarterly
3. Monthly
4. Not at all
5. Other comments

74. Which of the following activities does your organization implement to ensure that all clinical staff support tobacco dependence intervention? (Check all that apply)

1. Providing new staff with training and orientation to the 5A model
2. Annual staff in-service training on applying and documenting the 5As as well as accomplishments to date
3. Regularly addressing barriers with staff
4. Other, please specify:

75. What are the barriers to IMPLEMENTING tobacco dependence intervention services (i.e., 5 As) within your organization?

1. No identified barriers
2. Patients/clients are not interested in discussing tobacco use and/or quitting
3. Lack of staff time
4. Lack of staff to deliver cessation services
5. Lack of knowledge/training in tobacco cessation among staff
6. More pressing concerns with workload
7. More pressing concerns with clients
8. Lack of administrative support
9. Tobacco cessation is not a priority issue in the organization
10. Lack of reimbursement for service
11. Other, please specify:

76. What are the barriers to SUSTAINING tobacco dependence intervention services (i.e., 5 As) within your organization?

1. No identified barriers
2. Lack of staff time
3. Lack of staff to deliver cessation services
4. Lack of knowledge/training in tobacco cessation among staff
5. More pressing concerns with workload
6. More pressing concerns with clients
7. Lack of administrative support
8. Tobacco cessation is not a priority issue in the organization
9. Lack of reimbursement for service
10. Other, please specify:

77. Are there any other comments that you would like to add?

The survey is over. Thank you very much for your time. Don't forgot I'm going to be sending you a package of materials by XXX (mail, at our next meeting, etc.).

Please click Submit button below.

Appendix D: 2017 Central West HCP Survey

On behalf of the Central West TCAN, welcome to this environmental scan survey. The Central West TCAN is inviting health care providers who are members of local Community of Practices to complete an online survey which aims to determine if and how the organizations represented by health care providers are implementing tobacco dependence interventions. Tobacco dependence interventions are any interventions where patient tobacco use is assessed and then an intervention and some sort of follow-up is implemented; you may also know this as the 5A's (Ask, Advise, Assess, Assist, Arrange). The data collected across the seven Community of Practices within the Central West Tobacco Control Area Network will be aggregated to provide a picture of the current tobacco dependence services in place and areas for improvement in our local community and across the Central West Ontario area.

You do not have to participate in the scan if you do not want to and you can choose to not respond to any questions or withdraw at any point in time. Completing or not completing the scan will not affect your participation in the Community of Practice. There are no known risks to you or your organization if you choose to participate. Your participation in the scan is voluntary and all answers will be kept confidential. Your name and the name of your organization will not be included in annual reports. Personal information is collected under the authority of the Municipal Freedom of Information and Protection of Privacy Act and will be used to assist Community of Practice facilitator staff to understand the types of tobacco dependence interventions your organization is providing and what supports may be helpful to you and your organization.

This environmental scan survey is conducted in partnership with the Ontario Tobacco Research Unit (OTRU) who is assisting in survey administration and data analysis. Survey data will be collected and stored using a password protected account in Key Survey. OTRU and CW Community of Practice Facilitators and the TCAN Coordinator from the Central West Tobacco Control Area Network will have access to the data. All raw data will be destroyed in 2 years after the last data collection period is complete and the final report is written by July 2017.

Biennial summary reports will be e-mailed to participants before the end of each scan year.

The scan has been reviewed by the Office of Research and Ethics at Region of Waterloo Public Health and the Brant County Health Unit. The scan should take about 30 minutes to complete.

2. Do you consent to participate in the scan survey?
    1. Yes Go to Q3
    2. No End

3. Do you give permission to be contacted in the future to clarify any responses with you?
    1. Yes
    2. No

Section A. About the HCP Organization

5. What is your name and title?
    1. Name:
    2. Title:

6. What is the name of your organization?

7. What type of organization do you represent? (Check only one)
   1. Hospital
   2. Not-for-profit
   3. Public Health Department
   4. Family Health Team
   5. Community Health Centre
   6. Physician
   7. Pharmacy
   8. Community Outreach Program
   9. Dental Clinic
   10. Long Term Care residential
   11. Aboriginal (e.g. Aboriginal Health Centers)
   12. Post-Secondary Institute
   13. Workplace
   14. Nurse Practitioner Led Clinics
   15. Other, please specify:

8. Complete the following:
   1. Number of sites (optional):
   2. Number of clinicians (optional):
   3. Number of clinicians providing services (optional):

9. Does your organization provide tobacco dependence intervention services? Tobacco dependence interventions are any interventions where patient tobacco use is assessed and then an intervention and some sort of follow-up is implemented; you may also know this as the 5A's (Ask, Advise, Assess, Assist, Arrange).
   1. Yes Go to Q10
   2. No Go to Q11

10. Which of the following priority populations do you provide tobacco dependence intervention services? Please check all that apply.
   1. Youth and young adults
   2. Aboriginal community
   3. People with mental health diagnosis
   4. People with low socioeconomic status
   5. LGBTTQQ community
   6. New immigrants/refugees
   7. Pregnant women
   8. Other, please specify:

11. Which CoP is your organization a member of?
   1. Brant
   2. HN
   3. Halton
   4. Hamilton
   5. Niagara
   6. Waterloo- Wellington
   7. Dufferin
   8. More than one CoP
   9. Not a member (specify PHU jurisdiction)

Q11.A9 AND Q9.A1 Go to Q14
Q11.A9 AND Q9.A2 Go to End
(Q11.A1 OR Q11.A2 OR Q11.A3 OR Q11.A4 OR Q11.A5 OR Q11.A6 OR Q11.A7) Go to Q13

12. You have indicated "more than one CoP". Please specify which:

13. Since when has your organization been a CoP Member?
1. 2007
2. 2008
3. 2009
4. 2010
5. 2011
6. 2012
7. 2013
8. 2014
9. 2015
10. 2016
11. 2017

14. Section B. Preparing to Provide Tobacco Dependence Intervention (TDI) Services. The following questions will ask about various steps that your organization may have taken in preparation to providing tobacco dependence intervention services.

15. Has your organization gathered background evidence and examples of tobacco dependence intervention service delivery models (i.e., 5 As)? (www.youcanmakeithappen.ca)
1. Yes
2. In the process
3. No
4. Other comments:

16. What proportion of the staff in your organization attended training(s) on tobacco dependence intervention /control (e.g., TEACH, RNAO, PTCC, OTRU modules)?
1. All of them
2. Most of them
3. Half of them
4. A few of them
5. None
6. Don’t know
7. Other comments:

17. Is your organization a member of any other Community of Practice/champions networks (e.g. TEACH, RNAO) that involve health care providers implementing tobacco dependence intervention (i.e., 5 As)?
1. Yes Go to Q18
2. No Go to Q19
3. Don't know Go to Q19
4. Other comments:

18. Please list other Community of Practice/champions networks:

19. Has your organization developed an implementation plan (e.g., a plan outlining the process of adopting tobacco dependence intervention as a routine part of standard patient care)?
1. Yes
2. In the process
3. Not at all
4. Don't know
5. Other comments:

20. Has your organization developed evaluation and/or performance metrics and continuous improvement processes (e.g., chart audits)?
1. Yes
2. In the process
3. Not at all
4. Don't know
5. Other comments:

21. Has your organization obtained senior leadership support/buy-in?
1. Yes
2. In the process
3. Not at all
4. Other comments:

22. Has your organization secured resources to IMPLEMENT tobacco dependence intervention services?
1. Yes Go to Q23
2. In the process Go to Q23
3. Not at all Go to Q25
4. Other comments:

23. Please indicate which resources your organization has secured: (Check all that apply)
1. Financial (dedicated funding for TDI)
2. Staff (dedicated to complete task)
3. Time (dedicated to TDI activities)
4. Materials- books, software
5. TDI Committee
6. Other, please specify:

Q23.A1 Go to Q24
(Q23.A2 OR Q23.A3 OR Q23.A4 OR Q23.A5 OR Q23.A6) Go to Q25

24. You indicated financial (dedicated funding for TDI) resources. Please list the source(s):

25. Has your organization designated a staff lead for the tobacco dependence intervention (i.e., 5 As) implementation process?
1. Yes
2. In the process
3. Not at all
4. Don't know

26. Has your organization partnered with your local PHU or Smokers' Helpline staff to provide training and/or consultation for your staff?

1. Yes, local PHU staff only
2. Yes, Smokers' Helpline staff only
3. Yes, both local PHU and Smokers' Helpline staff
4. No, neither local PHU or Smokers' Helpline staff
5. Other comments:

27. Have you used "You Can Make it Happen" posters or other 5 As promotional materials in your practice setting?

1. Yes Go to Q28
2. No Go to Q31
3. Don't know Go to Q31
4. Other comments:

28. Which of the following "You Can Make it Happen" or other 5As promotional materials have you used? (Check all that apply)

1. Posters
2. Quit plan tip sheet
3. Pens
4. Post it notes
5. 5As laminated cards
6. Folders
7. YouCanMakeItHappen.ca
8. Other, please specify:

29. Which of the following "Quitting Smoking? Ask Here. We (Health Care Providers) Can Help" materials have you used specifically to reach patients/clients that use tobacco? (Check all that apply)

1. Door decal
2. Posters
3. Video
4. Button
5. Table top stand
6. Water bottle
7. Tangle
8. Other, please specify:

30. Are there additional promotional materials that you require?

1. Yes
2. No
3. Specific promotional materials you require:

31. Does your organization have a dedicated Champions Committee to assist with implementation and sustainability of tobacco dependence interventions?

A Champions Committee may be represented by: senior manager, physician, pharmacy, nursing, other allied health (respiratory therapist, social worker, physiotherapist, etc.), occupational health, public relations, security and IT.

1. Yes
2. No
3. Other comments:

32. Does your organization have billing codes for tobacco dependence intervention services?
    1. Yes Go to Q33
    2. Yes, but do not use Go to Q34
    3. No, do not have Go to Q34
    4. Other comments:

33. Are prompts or reminders available in all documentation systems for billing (electronic and paper)?
    1. Yes
    2. No
    3. Other comments:

34. Is a chart reminder system in place in your organization to prompt staff to provide tobacco dependence intervention?
    1. Yes
    2. In the process
    3. No
    4. Other comments:

35. Are any tobacco dependence intervention medications (e.g., NRT) available in formulary (only for: hospital settings)?
    1. Yes
    2. No
    3. N/A (not a hospital setting)
    4. Other comments:

36. Does your organization have medical directives to dispense tobacco cessation medication, if needed (e.g., NRT)?
    1. Yes
    2. No
    3. N/A
    4. Other comments:

37. Does your organization have order sets for NRT, Champix and Zyban?
    1. Yes
    2. No
    3. N/A
    4. Other comments:

38. Section C. Implementing 5 As

39. ASK

40. Has your organization integrated a standardized ASK question into all admission/intake paper and/or electronic documentation? E.g., "Have you used any tobacco products in the past 6 months?”
    1. Yes
    2. In the process
    3. No
    4. Other comments

41. Which health professionals in your organization provide tobacco dependence intervention? (Check all that apply)
    1. Physician
    2. Nurses
    3. Nurse practitioners
    4. Respiratory Therapists
    5. Mental Health/Addiction Counsellors
    6. Social workers
    7. Recreational therapists or activity staff
    8. Pharmacist
    9. Physiotherapist
    10. Dental Hygienist
    11. Dentists
    12. Health Promotion officers
    13. Dietitians

42. Are patients/clients ASKED about tobacco use in:
    1. All areas of the organization
    2. Designated area/unit/department
    3. Other comments:

43. Are patients/clients ASKED about tobacco use by:
    1. All staff
    2. Designated staff only
    3. Other comments:

44. When are patients/clients ASKED about tobacco use:
    1. At the intake/admission or initial visit Go to Q46
    2. At every visit Go to Q46
    3. Only at specific times Go to Q45
    4. Other comments:

45. You indicated "at specific times". Please specify:

46. After patient/client is ASKED about tobacco use, is tobacco status flagged or recorded in patient/client charts?
    1. Yes
    2. No
    3. Other comments:

47. ADVISE

48. Has your organization integrated ADVISE statements into documentation? E.g., “As your (insert profession) I am concerned about your (insert health condition). I would advise you to quit smoking in order to improve your health. I can help you if you are interested?” E.g., “Smoking cigarettes affects the way your body uses certain medications. If you were to quit smoking we could significantly reduce your (NRT/medication) dose.

    1. Yes
    2. In the process
    3. No
    4. Other comments:

49. Are patients/clients ADVISED to quit tobacco use in:
    1. All areas of the organization
    2. Designated area/unit/department
    3. Other comments:

50. Are patients/clients ADVISED to quit smoking by:
    1. All staff
    2. Designated staff only
    3. Other comments:

51. ASSESS

52. Has your organization integrated ASSESS questions into all documentation?
E.g., "Have you thought about quitting in the next 30 days?"
    1. Yes
    2. In the process
    3. No
    4. Other comments:

53. Are patients/clients ASSESSED for their readiness to quit tobacco use by:
    1. All staff
    2. Designated staff only
    3. Other comments:

54. ASSIST

The following questions are about tobacco use cessation services that your staff may currently be providing to patients/clients.

55. Does your staff provide Brief Contact Intervention (1-3 minutes) or 5 As?
    1. Yes Go to Q56
    2. No Go to Q57
    3. Other comments:

56. Is Brief Contact Intervention or 5 As provided by:
    1. All staff
    2. Designated staff only
    3. Other comments:

57. Does your staff provide intensive tobacco cessation intervention (greater than 10 minutes)?
    1. Yes Go to Q58
    2. No Go to Q60
    3. Other comments:

58. Is intensive tobacco cessation intervention provided by:
    1. All staff
    2. Designated staff only
    3. Other comments

59. Please indicate which activities your staff implement as part of tobacco cessation intervention. (Check all that apply)
    1. Assist patient/client to create and maintain a quit plan
    2. Handout(s) - quit plan
    3. Review past quit experiences
    4. Identify triggers and brainstorm coping strategies
    5. Discuss alcohol and drug use
    6. Assist the patient/client to identify social supports
    7. Provide information and teaching on stop smoking medications
    8. Provide nicotine replacement therapy or partner with existing initiatives for free NRT
    9. Create patient/client self-help packages for distribution (e.g. quit kit)
    10. Other, please specify:
    11. Other comments:

60. ARRANGE

61. Do staff at your organization, do any of the following. (Check all that apply)
    1. Internal referral to or follow up by staff within your organization
    2. Smokers' Helpline referral (Quit Connection)
    3. Smokers' Helpline referral (Fax Referral Partner)
    4. Refer to Primary care physician (discharge note)
    5. Refer to community pharmacist (script)
    6. Refer to PHU Quit Smoking Clinic
    7. Refer to local cessation services
    8. Other comments:

(Q61.A1 OR Q61.A2 OR Q61.A3 OR Q61.A4 OR Q61.A5 OR Q61.A6 OR Q61.A8) and NOT Q61.A7 Go to Q63
Q61.A7 Go to Q62

62. Please specify the local cessation service(s):

63. Section D. SUSTAINING EFFORTS

64. Does your organization have a formal policy in place to support the implementation of the 5As tobacco dependence intervention?
    1. Yes
    2. In the process of adoption
    3. No
    4. Other comments:

65. Does your organization have a smoke-free grounds policy to support tobacco dependence intervention?
    1. Yes Go to Q66
    2. In the process of adoption Go to Q66
    3. No Go to Q67
    4. Other comments:

66. Please specify the policy:

67. Does your organization have a formal policy in place that encourages health practitioners to provide brief interventions that aims to protect nonsmokers, especially children and pregnant women, from secondhand smoke?
1. Yes
2. No
3. Other comments:

68. Has your organization secured resources to SUSTAIN tobacco dependence intervention?
1. Yes Go to Q69
2. In the process Go to Q69
3. No Go to Q71
4. Other comments:

69. Please indicate which resources your organization has secured: (Check all that apply)
1. Financial (dedicated funding for TDI)
2. Staff (dedicated to complete task)
3. Time (dedicated to TDI activities)
4. Materials- books, software
5. TDI Committee
6. Other comments:

Q69.A1 Go to Q70
(Q69.A2 OR Q69.A3 OR Q69.A4 OR Q69.A5 OR Q69.A6) and NOT Q69.A1 Go to Q71

70. You indicated financial (dedicated funding for TDI) resources. Please list the source(s):

71. Does your organization order Smokers' Helpline materials, as needed?
1. Yes
2. No
3. Other comments:

72. Is your organization a fax referral partner with Smokers Helpline?
1. Yes
2. No
3. Don't know
4. Other comments:

73. How often does your organization conduct documentation audits to assess staff performance of tobacco dependence intervention?
1. Yearly
2. Quarterly
3. Monthly
4. Not at all
5. Other comments

74. Which of the following activities does your organization implement to ensure that all clinical staff support tobacco dependence intervention? (Check all that apply)
1. Providing new staff with training and orientation to the 5A model
2. Annual staff in-service training on applying and documenting the 5As as well as accomplishments to date
3. Regularly addressing barriers with staff
4. Other, please specify:
5. Other comments

75. What are the barriers to IMPLEMENTING tobacco dependence intervention services (i.e., 5 As) within your organization?

1. No identified barriers
2. Lack of staff time
3. Lack of staff to deliver cessation services
4. Lack of knowledge/training in tobacco cessation among staff
5. More pressing concerns with workload
6. More pressing concerns with clients
7. Lack of administrative support
8. Tobacco cessation is not a priority issue in the organization
9. Lack of reimbursement for service
10. Other, please specify:

76. What are the barriers to SUSTAINING tobacco dependence intervention services (i.e., 5 As) within your organization?

1. No identified barriers
2. Lack of staff time
3. Lack of staff to deliver cessation services
4. Lack of knowledge/training in tobacco cessation among staff
5. More pressing concerns with workload
6. More pressing concerns with clients
7. Lack of administrative support
8. Tobacco cessation is not a priority issue in the organization
9. Lack of reimbursement for service
10. Other, please specify:

77. Are there any other comments that you would like to add?

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