PANEL

• Dr. Sophia Papadakis, Program Director, Ottawa Heart Institute

• Dr. Colleen Webster, Family Practitioner, Kingston Family Health Team

• Chantal Rioux, Nurse Practitioner, Monfort Academic Family Health Team
Smoking Cessation

The single, most powerful preventive intervention in clinical practice.

Bar none.

Tobacco-related illness is a leading cost driver of health care spending. In Champlain, tobacco use is responsible for 66,784 hospital bed days per year and $132 million in direct health care spending per year.
What is Nudging?

Any method used to “steer” a group/individual toward a specific choice in a way that still leaves them in control.
Large scale “nudging” has already been used effectively in the battle against tobacco use.
Examples:

• Stopping direct advertising of tobacco
• Reducing visibility of tobacco products where sold
• Including prominent negative imaging on cigarette packaging
• Restricting the locations where cigarettes can be consumed
• Public education campaigns about risks of smoking
Examples:

- Increasing the costs associated with purchasing cigarettes

- Restricting the sale of tobacco directly to minors through legislation

- Increasing accessibility of products aimed at assisting those trying to quit smoking (nicotine patch, gum)

- Disallowing false claims about cigarettes
The ultimate goal of nudging:

• To make the desired “target” action the most attractive and easiest one for the group/individual to CHOOSE by removing as many barriers, and providing as many incentives, as possible
How can nudging be applied on a smaller scale, to defined clinical populations?
Approaches that DON’T work

• Being judgmental or condescending
• Obvious scare tactics
• Telling patients what to do
• Minimizing the patient’s concerns
• Inconsistent messaging to patients
• Making assumptions
• Benign neglect/doing nothing

Nudging: Smoking Cessation
Approaches that DO work

• Straightforward, direct advice aimed to reduce real risks for the individual

• Consistent, concise messaging delivered by all team members, to all target pts.

• Acknowledging pt. concerns and addressing them realistically

• Offering assistance in the change process in a timely fashion, when the pt. is ready
Approaches that DO work

• An established protocol and support process involving multiple providers working together with the pt.

• Involving/educating all team members so everyone feels ownership and confidence

• Clearly defined roles for all providers, with simple, efficient practice tools
Approaches that DO work

• Regular performance feedback on the intervention, enabling changes needed to improve/continue success

• Reducing barriers to patient access to the intervention, and any supports they may need (ie: medication)

• Offering choice to the patient whenever possible
THE OTTAWA MODEL FOR SMOKING CESSATION

Nudging’ Toward a Culture of Wellness
Conference Board of Canada May 7 2014

Sophia Papadakis, Ph.D., MHA
Program Director, Primary Care Smoking Cessation,
Division of Prevention and Rehabilitation, University of Ottawa Heart Institute
Associate Professor, Faculty of Medicine, University of Ottawa
A Real World Example

The Ottawa Model for Smoking Cessation
OMSC PRIMARY CARE NETWORK

62 Partner FHTs, FHNs, CHCs
147 Clinics in 11 LHINS
646 MDs
132 NPs
272 RNs
30 Pharmacists

Serving:
~720,000 rostered patients
~150,000 smokers
1.8 million visits/year
PREVALENCE OF SMOKING IN ONTARIO FHTS
(N=42,020, 28 FHTs)

20.3% Patients Reported Tobacco Use
Range was 13-39%
74% of Smokers intend to quit

43% will attempt to quit \(^1\)

4-7% will be successful \(^2\)\(^-\)\(^3\)
Increase Odds of Success with Quitting

**Behavioural Intervention x Pharmacotherapy**

<table>
<thead>
<tr>
<th>No medication or placebo</th>
<th>No behavioural treatment</th>
<th>Brief Intervention</th>
<th>Longer advice, multiple sessions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Control condition (CC)</td>
<td>2 x CC</td>
<td>3 x CC</td>
<td></td>
</tr>
<tr>
<td>Medication</td>
<td>2 x CC</td>
<td>4 x CC</td>
<td>6 x CC</td>
</tr>
</tbody>
</table>

Table 1: Effects of pharmacotherapy and behavioural counselling on smoking cessation outcomes

Provider Performance Across Clinics

Smoking Cessation in Primary Care
MAKE IT EASIER
- DELIVER MORE EVIDENCE BASED TREATMENT
- TO MORE PATIENTS
THE MODEL
THE 3As: ASK, ADVISE, ACT

ASK
Include tobacco use question as one of the patient’s vital signs

ADVISE
Provide strong, personalized, non-judgmental advice to quit with offer of support

ACT
For Patient who is READY TO QUIT:
QUIT PLAN VISIT
• Strategic counselling
• Pharmacotherapy
• Follow-up for 2-6 months

For Patient who is NOT READY TO QUIT:
• Reduce to quit
Tobacco use is the 5th Vital Sign
- Integrated into routine care
- System for Documenting
Strategic Advice & Offer of Support

- Unambiguous & Non Judgmental
- Assess Readiness - Are you willing to work with me to set a quit date in the next month?”
Support for 2-6 months
- Personalized Quit Plan
- Medication
- Telephone/Email Follow-up
Review

Strategies to increase the delivery of smoking cessation treatments in primary care settings: A systematic review and meta-analysis

Sophia Papadakis a,b,*, Paul McDonald a, Kerri-Anne Mullen b, Robert Reid a,b, Kimberly Skulsky b, Andrew Pipe b

a Department of Health Studies and Gerontology, Faculty of Applied Health Sciences, University of Waterloo, 200 University Ave. West, Waterloo, Ontario, Canada
b Mauro Prevention and Rehabilitation Centre, University of Ottawa Heart Institute, 40 Ruskin Street, Ottawa, Ontario, Canada

ARTICLE INFO

Available online 17 June 2010

Keywords:
Smoking cessation
Primary health care
Physicians
Family practice
Prevention

ABSTRACT

Objectives. A systematic review and meta-analysis was conducted to evaluate evidence-based strategies for increasing the delivery of smoking cessation treatments in primary care clinics.

Methods. The review included studies published before January 1, 2009. The pooled odds ratio (OR) was calculated for intervention group versus control group for practitioner performance for “5As” (Ask, Advise, Assess, Assist and Arrange) delivery and smoking abstinence. Multi-component interventions were defined as interventions which combined two or more intervention strategies.

Results. Thirty-seven trials met eligibility criteria. Evidence from multiple large-scale trials was found to support the efficacy of multi-component interventions in increasing “5As” delivery. The pooled OR for multi-component interventions compared to control was 1.79 [95% CI 1.6–2.1] for “ask”, 1.6 [95% CI 1.4–1.8] for “advise”, 1.3 [95% CI 1.2–1.4] for “assess” (quit date) and 5.5 [95% CI 2.8–14.2] for “assist” (prescribe medications). Evidence was also found to support the value of practice-level interventions in increasing 5As delivery. Adjunct counseling [OR 1.7; 95% CI 1.3–2.0] and multi-component interventions [OR 2.2; 95% CI 1.7–2.8] were found to significantly increase smoking abstinence.

Conclusion. Multi-component interventions improve smoking outcomes in primary care settings. Future trials should attempt to isolate which components of multi-component interventions are required to optimize cost-effectiveness.

Crown Copyright © 2010 Published by Elsevier Inc. All rights reserved.
## 10 Best Practices for Smoking Cessation in Primary Care

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Clinic task force formed</td>
</tr>
<tr>
<td>2.</td>
<td>Clinic tobacco control protocol developed</td>
</tr>
<tr>
<td>3.</td>
<td>Tobacco use queried and documented for all clinic patients (at least every 90 days)</td>
</tr>
<tr>
<td>4.</td>
<td>Training tobacco dependence treatment offered to health care providers in last year</td>
</tr>
<tr>
<td>5.</td>
<td>Dedicated staff to provide tobacco dependence treatment</td>
</tr>
<tr>
<td>6.</td>
<td>Self-help materials readily available to patients, family members, and staff</td>
</tr>
<tr>
<td>7.</td>
<td>a. MD Flag functional</td>
</tr>
<tr>
<td></td>
<td>b. EMR supports in place (consult form etc)</td>
</tr>
<tr>
<td>8.</td>
<td>Process to follow-up tobacco users for at least one month after clinic visit in place</td>
</tr>
<tr>
<td>9.</td>
<td>Process to evaluate quality or program implementation in place</td>
</tr>
<tr>
<td>10.</td>
<td>Process to provide feedback to clinicians about performance in place</td>
</tr>
</tbody>
</table>
Provider performance in Ask, Advice, Act
Pre-and-Post Implementation of OMSC on day of visit

Teams = 29, n=3,384

*Proportion of patients (%)*

- **Ask**
  - Pre: 51.6
  - Post: 70.7
  - Increase: 19%, p<0.001

- **Advise**
  - Pre: 39.9
  - Post: 62.5
  - Increase: 23%, p<0.001

- **Act**
  - Pre: 32.5
  - Post: 53.4
  - Increase: 21%, p<0.001

*Evidenced-based tobacco treatment*
‘NUDGING’

ACTIVATING A DESIRED BEHAVIOUR
BOOSTING SELF-CONTROL
PATIENTS
Nudges – Patient

• Tobacco Use Survey
• HP Advise and Offer Support
• Follow-up Check-ins – Telephone or Email
• Cues in Enviro.
• Access to Cost-Free Medication
Tobacco Use Survey

- Time saver
- Identify smokers
- Assess readiness
- Counselling prompts
  - Smoking history
  - Barriers/motivators

PLEASE COMPLETE THE FOLLOWING QUESTIONS:

1. Have you used any form of tobacco in the past 6-months?
2. Have you used any form of tobacco in the past 7 days?
3. What form of tobacco do you currently use?
4. How many years in total have you been smoking?
5. How many cigarettes do you usually smoke per day?
6. How soon after you wake up do you smoke your first cigarette?
7. How many quit attempts (lasting >24 hours) have you made in the past year?
8. Do others smoke in your home?
9. Which of the following best describes your feelings about smoking right now?
10. On a scale from 1-5, how important is it to you to quit smoking?
11. On a scale from 1-5, how confident are you that you can quit smoking?
12. What are your reasons for wanting to quit smoking?
13. What concerns, if any, do you have about quitting smoking?
14. Have you previously used quit smoking medications?
15. Does your drug benefit plan cover quit smoking medications?
16. Are you presently receiving follow-up telephone calls from the Quit Smoking Program?
17. How many caffeinated drinks (e.g., coffee, tea, pop) do you consume per day?

THANK YOU. Please return this survey to the clinic receptionist.
The Opportunity....

Health Providers Advice Important Motivator for Cessation (30-40% boost in motivation)¹

Brief opportunistic smoking cessation interventions: a systematic review and meta-analysis to compare advice to quit and offer of assistance

Paul Aveyard¹,*, Rachna Begh¹, Amanda Parsons¹, Robert West²

*Addiction

In a direct comparison, offering assistance generated more quit attempts than giving advice to quit on medical grounds (RR 1.69, 95%CI 1.24 to 2.31 for behavioural support and 1.39, 95%CI 1.25 to 1.54 for offering medication).
SMOKING CESSATION RELAPSE CURVE

Source: Hughes, 1992

% of smokers

<table>
<thead>
<tr>
<th>Time</th>
<th>Relapse</th>
<th>Complete Abstinence</th>
</tr>
</thead>
<tbody>
<tr>
<td>2 days</td>
<td>33</td>
<td>66</td>
</tr>
<tr>
<td>7 days</td>
<td>24</td>
<td>76</td>
</tr>
<tr>
<td>14 days</td>
<td>22</td>
<td>78</td>
</tr>
<tr>
<td>1 month</td>
<td>19</td>
<td>81</td>
</tr>
<tr>
<td>6 months</td>
<td>10</td>
<td>90</td>
</tr>
<tr>
<td>12 months</td>
<td>5</td>
<td>95</td>
</tr>
</tbody>
</table>

Source: Hughes 1992
Patients receive 5+ automated telephone calls
7 days before quit date
3, 14, 30; every month x 6 months
REAL TIME PROMPTS FOR CLIENT INTERACTION & SUPPORT

Smoking Cessation Program Management 3.0

Search Options
- Patient ID
- First Name
- Last Name
- Phone #

Discharge Date
- From
- To

Search
Exit

<table>
<thead>
<tr>
<th>Patient ID</th>
<th>First Name</th>
<th>Last Name</th>
<th>Discharge Date</th>
<th>Profile</th>
<th>Day 3</th>
<th>Day 14</th>
<th>Day 30</th>
<th>Month 2</th>
<th>Month 3</th>
<th>Month 4</th>
<th>Month 5</th>
<th>Month 6</th>
</tr>
</thead>
<tbody>
<tr>
<td>TELASK</td>
<td>Rick</td>
<td>Tech</td>
<td>Jan 22 2009</td>
<td>Ready</td>
<td>Active</td>
<td>Active</td>
<td>Active</td>
<td>Active</td>
<td>Active</td>
<td>Active</td>
<td>Active</td>
<td>Active</td>
</tr>
<tr>
<td>CONFERENCE</td>
<td>Peter</td>
<td>Trial</td>
<td>Jan 22 2009</td>
<td>Ready</td>
<td>Smoke Free</td>
<td>Active</td>
<td>Active</td>
<td>Active</td>
<td>Active</td>
<td>Active</td>
<td>Active</td>
<td></td>
</tr>
<tr>
<td>ID21</td>
<td>Susie</td>
<td>Blank</td>
<td>Jan 01 2009</td>
<td>Not Ready</td>
<td>Ready</td>
<td>Ready</td>
<td>CalBack</td>
<td>Active</td>
<td>Active</td>
<td>Active</td>
<td>Active</td>
<td></td>
</tr>
<tr>
<td>TESTER8</td>
<td>James</td>
<td>Nobody</td>
<td>Nov 26 2007</td>
<td>Ready</td>
<td>UnReach</td>
<td>Ready</td>
<td>Smoke Free</td>
<td>Resch-AnsM</td>
<td>Active</td>
<td>Active</td>
<td>Active</td>
<td></td>
</tr>
</tbody>
</table>
PROVIDERS
Nudges – Providers

• Clinic Protocol
  – Embed 3As in workflow
  – Clearly Defined Professional Roles

• Provider Tools
  – Real Time Reminders (in Office and EMR)
  – Rapid Documentation with Structure to prompt
IVR SYSTEM REPORTS

Clinic Summary

**Total patients = 19 (as of Sept 21/10)**

<table>
<thead>
<tr>
<th></th>
<th>Follow-up</th>
<th>No Follow-up</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Patients</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of Patients</td>
<td>19 (100.0%)</td>
<td>0 (0.0%)</td>
<td>19 (100.0%)</td>
</tr>
<tr>
<td>Readiness to Quit</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Recently Quit</td>
<td>1 (5.3%)</td>
<td>0 (0.0%)</td>
<td>1 (5.3%)</td>
</tr>
<tr>
<td>Ready to Quit</td>
<td>18 (94.7%)</td>
<td>0 (0.0%)</td>
<td>18 (94.7%)</td>
</tr>
<tr>
<td>Not Ready to Quit</td>
<td>0 (0.0%)</td>
<td>0 (0.0%)</td>
<td>0 (0.0%)</td>
</tr>
</tbody>
</table>

**SUMMARY OF OUTCOMES**

**READY TO QUIT**

<table>
<thead>
<tr>
<th>Day</th>
<th>Number of Patients</th>
<th>Smoke Free</th>
<th>Quit Rate (%)</th>
<th>Patients Reached</th>
<th>Smoke Free</th>
<th>Quit Rate (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>30</td>
<td>7</td>
<td>4</td>
<td>57.1%</td>
<td>5</td>
<td>4</td>
<td>80.0%</td>
</tr>
<tr>
<td>60</td>
<td>3</td>
<td>3</td>
<td>100.0%</td>
<td>3</td>
<td>3</td>
<td>100.0%</td>
</tr>
<tr>
<td>90</td>
<td>N/A</td>
<td>N/A</td>
<td>(N/A)</td>
<td>N/A</td>
<td>N/A</td>
<td>(N/A)</td>
</tr>
<tr>
<td>180</td>
<td>N/A</td>
<td>N/A</td>
<td>(N/A)</td>
<td>N/A</td>
<td>N/A</td>
<td>(N/A)</td>
</tr>
</tbody>
</table>

**NOT READY TO QUIT**

<table>
<thead>
<tr>
<th>Day</th>
<th>Number of Patients</th>
<th>Ready to Quit</th>
<th>Ready Rate (%)</th>
<th>Patients Reached</th>
<th>Ready to Quit</th>
<th>Ready Rate (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>30</td>
<td>0</td>
<td>0</td>
<td>(0.0%)</td>
<td>0</td>
<td>0</td>
<td>(0.0%)</td>
</tr>
<tr>
<td>60</td>
<td>0</td>
<td>0</td>
<td>(0.0%)</td>
<td>0</td>
<td>0</td>
<td>(0.0%)</td>
</tr>
<tr>
<td>90</td>
<td>N/A</td>
<td>N/A</td>
<td>(N/A)</td>
<td>N/A</td>
<td>N/A</td>
<td>(N/A)</td>
</tr>
<tr>
<td>180</td>
<td>N/A</td>
<td>N/A</td>
<td>(N/A)</td>
<td>N/A</td>
<td>N/A</td>
<td>(N/A)</td>
</tr>
</tbody>
</table>

*Includes Smokers Ready to Quit and Not Ready to Quit seen by Clinic Quit Smoking Cessation Counsellor for appointment.

**Definitions:**
- Number of Patients: Number of patients whose call cycle had been completed at a time point (whether reached or not reached) minus those who were not reached.
- Smoke-Free: Number of patients responding "Yes" to "Have you used any form of tobacco in the last 7 days?" minus those who were not reached.
- Quit Rate: Percentage of patients who are smoke-free.
- Ready Rate: Percentage of patients who are ready to quit at a time point.
- Patients Reached: Patients who were reached and responded to the call at the time point.
- Ready to Quit: Patients ready to quit smoking at the next 30 days.
A Fresh New Approach
- Simple, Systematic, Timely
Influencing Change

Implementing the Ottawa Model for Smoking Cessation into a Primary Care Setting

Chantal Rioux, Nurse Practitioner, Monfort Academic Family Health Team
Influencing Change Amongst Colleagues

- Through a partnership initiative with the Ottawa Model for Smoking Cessation that all the providers of the clinic adopted a standardized approach to addressing tobacco use with patients.
The Working Group

- A small group from our clinic was formed to work with the OMSC facilitators- with the aim to plan and implement a tobacco control protocol within the clinic
- Small group included:
  - 2 Allied Health Professionals
  - 1 Administrator
  - 1 Lead Physician
  - 1 Technical Consultant
## The Change

<table>
<thead>
<tr>
<th>Pre</th>
<th>Post</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Random unstructured process of addressing tobacco use with patients</td>
<td>• Taking 30secs of each visit with patients to <strong>ASK</strong> - if they consumed tobacco in the last 7 days</td>
</tr>
<tr>
<td>• Onus on Physicians</td>
<td>• Taking 2 minutes of the clinic visit (when appropriate) to deliver strong personalized <strong>ADVISE</strong> - to quit by the physician/NP</td>
</tr>
<tr>
<td>• Combination of methods for documenting and identifying smokers within the electronic medical record (EMR)</td>
<td></td>
</tr>
<tr>
<td>Pre</td>
<td>Post</td>
</tr>
<tr>
<td>-----</td>
<td>------</td>
</tr>
<tr>
<td>• Counselling and pharmacotherapy offered by physicians within the short clinic visit</td>
<td>• <strong>ASSESS</strong> - the readiness to Quit within the next 30days</td>
</tr>
<tr>
<td></td>
<td>• <strong>ACT and ATTEMPT</strong> - Strategic Counselling, Pharmacotherapy, Follow up – Allied Health Professional (Nurse, NP, Pharmacist)</td>
</tr>
</tbody>
</table>
Incorporating the OMSC into the Electronic Medical Record

- Optimizing the use of our Electronic Medical Record to implement the initiative was the facilitating factor in the success of this initiative.
The Accomplishments

- We adopted a standardized approach applying the 5As through the use of an innovated EMR custom documentation form.

- We adopted EMR notification mechanism prompting providers to identify and inquire about patient’s smoking status.
Ottawa Model Adopted for PS Suite EMR

Smoking Cessation Consult Form

ASK

Patient's smoking status:
☑ Tobacco use in the last 7 days (active smoker)
☐ Ex-smoker
☐ No tobacco use (never smoked)

Ensure that the Risk field of the patient's chart is up to date.

Does the patient wish to quit in the next 30 days?
☑ Yes
☐ No
☐ Not Appropriate

ADVISE

Refer patient to smoking cessation counsellor?
☑ Yes
☐ No

ASSESS Readiness to Quit

YES

Refer patient to Smoking Cessation Counsellor

☐ Yes
☐ No

NO

Refer patient to Quit Smoking Automated Follow-up Program

Preferred time of call:
☑ 7:30am
☐ 9am-12pm
☐ 1:30pm
☐ 6:00pm

Ottawa Model
Smoking Cessation Consult Form

ASK

Patient's Smoking Status:
- ☑ Tobacco use in the last 7 days (current smoker)
- ☐ Ex-smoker
- ☐ No tobacco use (never smoked)

Ensure that the RISK field of the patient's chart is up to date.

ADVISE

Does the patient wish to quit in the next 30 days?
- ☑ Yes
- ☐ No
- ☐ Not Appropriate

ASSESS

Readiness to Quit

Refer to smoking cessation counsellor?
- ☑ Yes
- ☐ No

FOR SECRETARIAL USE ONLY

☐ Appointment booked
Date: 
Time: 
Provider: 

Setting Reminder

Reminders

- Recherche de sang occulte dans les selles - Fecal occult blood
- Tétanos - Tetanus?

- Remplir: Fumeur - Smoking Cessation Consult
  - WT: 60 Dec 29, 2012
  - BMI: 26.7 Dec 29, 2012
  - BP: never done
  - Last pap: Apr 23, 2012

- Chickenpox...
  - Penicillins -> rash

- E079 - Bill Smoking Cessation Discussion
  - Needs BP Check
  - Tétanos - Tetanus?
Adopting a Tobacco Control Protocol

- Prompting a practice change to a group of colleagues required some understanding of how the proposed changes would impact usual practices.

- Developing a product that would favour buy in.

- Assuring the initiative (OMSC) being promoted has superior benefits to the current practices.
Anticipated Barriers

- The working group was mindful of the impact the initiative may have on usual practices and also on the colleagues natural reluctance to change.

Anticipated factors:
- Account for time constraints
- Following evidence base practices
- Favorable patient outcomes
- Cost effectiveness
- Documentation
- Safety
- Assuring sustainability
- Remuneration
Motivating factors

- Minimal impact on daily practice
- Peer to Peer motivation at CME event
- Sharing the success of the OMSC
- Quality improvement strategy – Ministry Mandates
- Improved Efficiency
- Evidence base initiative
- Provisions of evidence based assessment tools and surveys
- Built in billing system for physicians
- Simple documentation
- Automated booking system
Nudging in Health Care and the Bigger Picture

What else can we do?
What else can we do?

• Make achieving the desired outcome a priority at all levels
• Establish consistent approaches/messaging
• Visibly highlight the benefits of the target action/choice in various settings
• Remove barriers to accessing help
• Make interventions as easy for providers and patients as possible
What else can we do?

- Advocate for needed resources to allow us to provide support effectively

- Lobby government to direct more money toward prevention

- Make the supports for healthy choices more obvious, accessible and affordable than other options
STAY POSITIVE AND REMEMBER THE GOAL
Program Summary