

BEYOND OUR FRONT DOOR: PROMOTING COMMUNITY PARTNERSHIPS TO IMPROVE PATIENT CARE

Introduction

Smoking cessation continues to be the most preventable cause of death and disability, and, therefore, has been a focus in primary care. By going beyond a 5As (ask, advise, act, assist, ask again) approach, the Queen's Family Health Team (QFHT) has developed a comprehensive multidisciplinary approach to smoking cessation. An example of the program's effectiveness has been highlighted by outcome measures indicating comparable performance despite having a higher prevalence of patients with mental health and or substance abuse disorders – a population generally identified as having greater challenges with smoking cessation or reduction.

Program Goals

- Meaningful change to improve health,
- Smoking cessation or reduction interventions tailored to individual patient needs,
- Enhanced effectiveness of smoking cessation interventions with a broader base of support through collaboration with community partners, and
- Resilient and sustainable interventions.

Program Description

- Adopted the Ottawa Model for Smoking Cessation (OMSC) in September 2011.
- Partnered with the Smoking Treatment for Ontario Patient (STOP) program in September 2011 to provide free nicotine replacement therapy to rostered patients.
- Program implementation drew on a variety of skill sets and included the QFHT lead physician, clinic manager, program coordinator, nursing supervisor, pharmacist, social worker and nurses; administrative staff and a data analyst were later added to the team.
- Built upon the 3As (ask, advise, and act) approach and extending it beyond a 5As (ask, advise, act, assist, and ask again) approach, the QFHT began providing more in-depth assessments and treatment, and offered unlimited education sessions to patients.
- Key elements of the program include:
 - Medical directives to improve efficiency and interdisciplinary care,
 - Ongoing collaboration between smoking cessation counselors (social worker and nurses) and other members of the patient's healthcare team (e.g. physicians and residents),
 - Inclusion of family members in the counselling and approach to care, and
 - Incorporation of cognitive behavioural therapy, solution-focused therapy, and adjustment therapy were incorporated along with pharmacotherapy.

Results

- Patients' profile: Following the first year, we identified that a significant proportion (40%) (Table 1) of patients seen had at least one diagnosed mental health or substance abuse disorder.
- Developing relationship with community partners:
 - Smoking cessation counsellors fostered relationships with staff from other community-based agencies, including: Frontenac Community Mental Health Services, Options for Change Addictions and Treatment Program, and Home-Based Housing.
 - With patients' permission, counsellors sought to collaborate with group home support workers, case workers and informed psychiatrists of recommended treatment plans.
- Quit rates: Although with double the prevalence of mental health comorbidities than provincial averages among smoking cessation patients, the QFHT Smoking Cessation Program achieved the OMSC quit rate (52%) in primary care on a 30-day range and were just 7% below the OMSC quit rate on a 60-day range (Figure 1).

Conclusion

Approaches to smoking cessation and reduction require long-term management, particularly in primary care settings.

According to research, people living with mental illness and or substance abuse disorders are more likely to smoke in general, to smoke more cigarettes per day, to be more addicted to tobacco than others, and less successful in making quit attempts., the QFHT's comprehensive multidisciplinary Smoking Cessation Program in partnership with community healthcare services enabled us to commit to a higher level of monitoring and support to our patients for smoking cessation and reduction.

Effective smoking cessation requires modifications and more intensive interventions as our program continues to evolve. Collaborating with various community care providers is instrumental not only for the promotion of smoking cessation or reduction, but also for relapse prevention. Engaging patients, patients' family members and community providers in smoking cessation meets the individual needs of patients. The benefits of this approach are not merely limited to those with mental illness or substance abuse disorders, but can benefit our broader patient population as well.

Sources

Williams, J.M. & Ziedonis, D. (2004). Addressing tobacco among individuals with a mental illness or an addiction. *Addictive Behaviors*, 29, 1067-1083.
Offord, et al (1996). One-Year Prevalence of Psychiatric Disorder in Ontarians 15 to 64 Years of Age. OTRU (Ontario Tobacco Research Unit).

Table 1 Prevalence of mental health comorbidities in QFIT and Ontario

Prevalence of Mental Health Comorbidities	
QFHT	40%
Ontario	20%

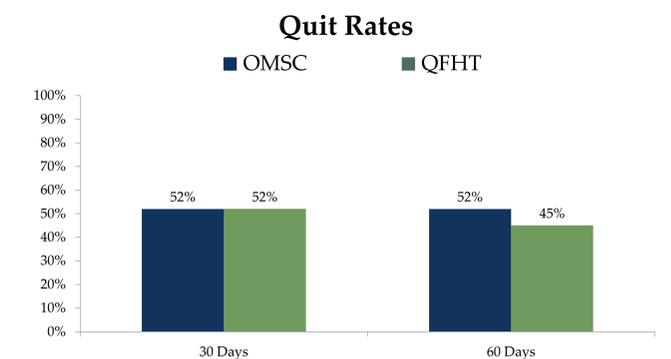


Figure 1. Quit rates on 30-day and 60-day ranges in QFHT and Ontario

AUTHORS

Tracey Beckett, BAsC (Gerontology), BSW, MSW, RSW; Karen Hall-Barber, BSc(Hons), MSc (HQ) Candidate, MD, CCFP;
Danyal Martin, BAH, BEd, MA, MSc (HQ) Candidate