Implementing Smoke-Free Property Policy in the Hospital Setting

Sunnybrook
HEALTH SCIENCES CENTRE

Implementing Smoke Free Property Policy:

A key aspect of tobacco control is the reduction of exposure to second hand smoke, generally by the creation of smoke free policies. The rationale for implementing a smoke-free hospital campus comes largely from the belief that smoke-free facilities project a healthy image in the community, protect smoke-sensitive patients, encourage smoking cessation, save on cleaning and maintenance costs and improve productivity, although little has been published to support these beliefs (Williams, Hafner, Morton, et al., 2009).

In 2005, the government of Ontario passed the Smoke Free Ontario Act. This legislation forms the basis a comprehensive public policy to reduce smoking related illness. The Act essentially bans smoking in public places such as hospitals, schools, restaurants and bars, and restricts the display of tobacco products. The Act does not, however, entirely ban smoking from hospital grounds.

In Ontario, hospitals that implement completely smoke free policies exceed the requirements of the Smoke Free Ontario Act. Such hospitals promote healthier and safer workplaces for their employees, give a consistent message to their patients about reducing the adverse effects of smoking and providing real opportunities for smoking cessation, and show leadership in their communities by promoting healthy public policy. The Cancer Prevention Program at the Odette Cancer Centre played a leadership role in the creation of a campus-wide smoke free policy at Sunnybrook Health Sciences Centre in 2007. This is a growing trend; close to 50% of U.S. hospitals currently have smoke-free policies in place (Williams et al., 2009), and the benefits and challenges have been well described (Shipley; Pell; Felix, 2008) The program has further extended its leadership role by recently investigating the feasibility of a completely smoke- free Toronto Central LHIN. The following toolkit has been created based on the feedback gathered during this project, it is hoped to provide useful resources for the implementation of smoke-free property policies.

The Role of Smoke- Free Hospitals

According to the Ministry of Health and Long Term Care, all hospitals in Ontario are affected by the Smoke –Free Ontario Act. On May 31, 2006, this act banned smoking in enclosed workplaces and enclosed public places in Ontario. This action was taken so that workers were protected workers from the hazards of second-hand smoke. Smoking is prohibited in any enclosed public place or enclosed workplace, in accordance with section 9(1) of the Smoke-Free Ontario Act. A hospital is considered both an enclosed workplace and an enclosed public place under the act.

Furthermore, hospitals entrances and exits, as defined by the above mentioned act, are smoke-free within a 9 meter radius. This "9 meter rule" applies as defined by the Public Hospitals Act, the Private Hospitals Act, or a psychiatric facility as defined in the Mental Hospitals Act. In addition the sale of tobacco is prohibited in the above facilities.

Smoke- free hospital properties do not provide a smoking shelter outdoors. Rather, as outlined in this toolkit, smoke- free property policies should present a well rounded approach to tobacco control. In order to be effective they should include a number of best practices for patients and staff. A thorough approach to tobacco control should also include linkage to community resources, effective policy enforcement and organizational communication. For more information on the Smoke-Free Ontario Act please click here or visit: http://www.mhp.gov.on.ca/English/health/smoke_free/default.asp

Getting Started: Creating Your Smoke-Free Property Policy

Creating policies in the hospital setting can be an intimidating process, however with the right action plan; you may find your way to building not only an effective policy, but also a group of people committed to making your hospital a healthy smoke- free environment. The following resources may be useful as you move forward and put your ideas into action.

Business Case for Smoke- Free Work Place

Creating a business case for smoke- free property policy and smoke-free programs in the hospital setting can be a challenge. You can make an effective business case by relating the facts and figures in understandable terms. In the appendix of this toolkit, you will find a particularly useful "Return on Investment Calculator" www.businesscaseroi.org , this calculator will help you estimate the expected savings associated with implementing smoke-free programs at your hospital. The Return on Investment (ROI) calculator was created by America's Health Insurance Plans and the Centre for Health Research in the USA. The original research and translation was supported by an unrestricted educational grant, where the findings of the research indicated, that investments in smoking cessation save money even in the short term. This study validates that evidence-based programs can improve the health of smokers who quit and economically benefit health care budgets.

Even though smoking cessation offers long term benefits, there has been a lack of published data concerning the short term clinical and economic payback. If you are looking for local resources on the Return on Investment for smoking cessation programs, please consult with the Ottawa Model for Smoking Cessation. (Information in the appendix).

If creating a "business case" for a smoke-free property policy is your first challenge, you may find it effective to utilize the following work place facts and figures from Toronto Public Health. Smoking costs the Ontario economy $2.6 billion in productivity losses each year (Ministry of Health and Long-Term Care, 2005). Return on investment (ROI) provides an excellent incentive for Employee Assistance Program (EAP) providers and their clients to implement wellness programs. Poor employee health results in increased absenteeism, higher health insurance claims, and therefore costs, and a higher number of workplace accidents (The Conference Board of Canada, 2006).

Total annual cost for employer, per smoking employee:

1997	$2,565
2006	$3,396

Employee Absenteeism

Smokers are absent from work two additional days/year compared with their non-smoking colleagues (Statistics Canada, 2004). Costs associated with these extra absences are covered by employers through paid sick leave.
The average cost for two days of absence per smoking employee:

1997 $93

2006 $323

(The Conference Board of Canada, 2006)

Employee Productivity

Employees may have to travel farther now to reach the place where they are permitted to smoke, e. g. leaving work grounds. Smokers are suspected of taking two smoking breaks per day, averaging 15-20 minutes each, that are not formally allowed by employers.

The annual cost of lost productivity per smoking employee:

1997 $2,175

2006 $3,053
(The Conference Board of Canada, 2006)

Incentive for Smoking Cessation Programs

On-site smoking cessation programs make it easier to implement smoke-free workplaces and increase the benefits for employees and employers.

20 studies of worksite smoking cessation programs found an average quit rate after 12 months of 13%, much higher than the national average among all smokers of 2.5% (U. S., 1990 data). Quit rates were even higher for heavy smokers.

Cessation programs are relatively low-cost and are highly cost-effective (Safework Program of the International Labour Organization, 2002).

Payback for the workplace comes in the form of:
Fewer insurance and workers compensation claims
Less absenteeism
A decrease in accidents
Reduced staff turnover and the retention of valued staff, which means reduced recruitment, training and induction costs
Improved staff attitudes towards the organization and higher staff morale
A more receptive climate for, and ability to cope with, workplace changes
Enhanced business reputation and customer loyalty
(Health Communication Unit, 2004)

Impact on Hospital Admissions and Return on Investment for Hospitals

In the appendix of this toolkit you will find several documents and resources related to the return on investment for smoking cessation programs in the hospital.

Creating a Smoke-Free Property Policy

As you begin to plan the details of how you will implement a smoke- free property policy, it is wise to ensure that key stakeholders are involved in the planning phase of your work. Once you have secured "buy in" from senior management, it is time to move on to forming a "task force". This may work best if your senior management representative invites participation of representatives of different employee groups. Administrators, physicians, nurses, patient care managers, security representatives, as well as, facility managers and individuals responsible for property planning should be present. The members who will make up your task force will depend on the structure and size of your hospital, this group should be similar to other groups that have been used to work on policy issues in the past. The following may be helpful to provide an outline for not only developing a task force, but also to set an agenda for your work together. (See appendix for examples of task force structure).

Policy Planning Task Force

Policy planning task forces are often made up of key representatives from each hospital program. For example, if your hospital is a large organization with multiple campus locations, it would be important to have representation from each area. Representation from each major area of hospital administration is also a critical component of creating a task force. For example it is helpful to engage human resources, public affairs, facilities management, and occupational health. (See sample task force list).

Policy Statement

Creating a policy statement in the beginning can help to clarify the goal for smoke-free property policy task force. It is important to state that Senior Leadership Team (SLT) and Integrated Management have endorsed implementing a smoke- free property policy and that this policy will go beyond rules outlined by the Smoke Free Ontario Act. Some smoke-free property policy groups have been established as a time-limited work group to develop the implementation plan to achieve this objective; however, it may be wise to continue with this group beyond implementation in order to work on sustainability.

Reporting relationship and communication

Successful task forces often report to the hospital senior leadership team. Messages regarding changes to existing policy and tobacco control initiatives should ideally be communicated through this senior leadership team as well. How these messages are communicated will affect how the messages are received by the target audience. Successful messages are often up-beat and include positive events and or activities for employees, patients and the community. (For examples see the communication tools in the appendix of this toolkit).

Objectives

It is important to breakdown and list the items that need to be accomplished by the policy task force. The following items may be used to guide the objectives of your groups work together.

1. To develop a "Smoke Free Environment" policy to be approved by senior leadership.
2. To create an input solicitation tool and obtain stakeholder input (see example ion appendix)
3. To identify and recommend solutions to perceived barriers to creating a smoke free environment on all hospital property.
4. To identify staff supports that should be put in place
5. To identify patient supports that should be put in place
6. To identify community resources that can be utilized for patients, staff, volunteers and community members.
7. To create a communication plan
8. To develop a budget for the implementation of a smoke free environment
9. To recommend a lead for implementation

Creating a time line

As with planning in any other area, it is extremely important to develop a timeline in order to guide your objectives. The following items should be part of a timeline; however, you may chose to use the suggested items as a guide.

1. Planning:
2. Official Notice of Change:
3. Implementation Actions:
4. Effective Date:

Smoke-Free Supports for Patients

Staff Training

An essential component of patient support is staff training. According to the Centre for Addiction and Mental Health (2006), another important part of the smoke free process is ensuring that staff are trained on the identification and treatment of nicotine withdrawal – including the use of NRT. At CAMH, a core group of "champions" were trained before going smoke free. Nursing Representatives were recruited from units across the centre and trained on the use of NRT in working with clients who smoked. These champions acted as resources to the staff on their units when the centre went smoke free. After going smoke- free this group of champions developed in to a practice group which meets on a monthly basis to discuss policy related issues as well as keep abreast and current regarding smoking cessation/reduction literature, practices, guidelines, etc. Unit specific trainings about the Medical Directive for NRT were also provided upon request before going smoke free.

The above example from CAMH gives an excellent description of planning for your smoke-free property policy. Champion training can be provided through various groups within Ontario. Many online learning modules exist to make training in this area especially accessible. (Please see the staff training area in the appendix of this toolkit for further information on accessing training for staff members at your hospital.)

Smoking Cessation Programs for Patients

A number of patient programs for smoking cessation exist in Ontario, the key to choosing and planning a patient program for smoking cessation at your hospital, is ensuring that you chose the model that is a good fit. There is no "right" way to plan a patient smoking cessation program, because each hospital has unique characteristics and needs that are a reflection of various factors. Below is a list of commonly used patient programs for smoking cessation, in some cases programs have been combined and in some cases different programs are used for various areas within the same hospital.

The Ottawa Model for Smoking Cessation

Since 2002, the University of Ottawa Heart Institute (UOHI) has had in place an institutional program that systematically identifies, treats, and provides long-term follow up to hospitalized smokers, known as the Ottawa Model for Smoking Cessation (OMSC) www.theottawamodel.ca .

The principle goal of the OMSC is to reach a greater number of tobacco users with effective, evidence-based tobacco-dependence treatments delivered by health professionals. The program includes three main components:

1. Identify and document smoking status on admission;
2. Provide cessation advice and pharmacotherapy; and,
3. Provide long-term follow-up support.

(For more information on the Ottawa Model for Smoking Cessation, please see the patient program section of this toolkit.)

The Canadian Cancer Society Smokers' Helpline & Fax Referral Program

The Canadian Cancer Society's Smokers Helpline (SHL) **Fax referral program** is available for use in outpatient and inpatient hospital programs. Instead of giving patients the Smokers' Helpline number and hoping that they call, the fax referral program will call the patient at home, if the patient provides written consent.

The Canadian Cancer Society's Smokers' Helpline is a free, confidential telephone service you can call for easy access to a trained Quit Specialist. We can help you develop a structured "Quit Plan", answer your questions about quitting, and refer you to services in your community. (For more information on the Canadian Cancer Society's Smoking Cessation Programs, please see the patient program section of this toolkit.)

Smoke-Free Supports for Staff

Employees may qualify for smoking cessation aid coverage through employee benefits:
For most benefit divisions at Hospitals, smoking cessation coverage is available, limited to a lifetime maximum of $300 (there are a small number without such coverage). In a limited number of cases, coverage is limited to Nicoderm patch only. It may be helpful to investigate the benefits available at your hospital and share them with staff members in a staff newsletter or have them posted in occupational health.

Smoking Cessation assistance may also be available through your hospital's employee assistance program. For example Shepell. FGI's program offers Smoking Cessation Counselling as a Health & Wellness resource. Extra support is available with Shepell·fgi's two options in smoking cessation.

Smoking Cessation Aids should be available for purchase at Hospitals

Smoking cessation aids such as nicotine replacement therapy should be available at your hospital pharmacy. It is advisable to have a variety of products available such as the nicotine patch, gum, inhaler, and lozenges are available.

Community Support for Staff Members:

The Canadian Cancer Society Smokers Helpline
Employees and their friends or family can get free help from a quit smoking specialist. The Canadian Cancer Society **Smokers Helpline** can provide individuals with an opportunity to speak one-on-one with someone who understands what you're going through. The Smokers Helpline is available in **100 languages**. Their Quit Specialists can help you with: making a quit plan that works for you, coping with cravings, information on quitting methods, withdrawal symptoms, managing stress and available services and resources. Call them toll-free at 1.877.513.5333

The Smokers Helpline is also available online at: http://www.smokershelpline.ca

The Centre for Addiction and Mental Health (CAMH) has a Nicotine Dependence Clinic:

This clinic offers service to smokers and tobacco users who want to quit or reduce their tobacco use. Clients assessed through General Assessment and can self refer.
Contact: (416) 535-8501 ext. 7400 to book an assessment.

Enforcement of Smoke-Free Policies

Smoke-free property policies exceed the requirements of the Smoke- Free Ontario Act. Smoke – Free property policies ban smoking from all spaces within hospital property. It is up to individual hospitals to create policies and security measures which will therefore enforce the smoke- free property policy rules.

Enforcement by public health units will only enforce the Smoke-Free Ontario Act (as per page 4 of this toolkit). According to the Ministry of Health Promotion, local public health units will carry out inspections and investigate complaints in hospitals in order to enforce the smoke free Ontario act.

There is no maximum corporate fine listed in the SFOA for contravention of this section of the Act, meaning the fine amount would be left up to a justice of the peace, in accordance with general statutory requirements. An individual could be subject to a maximum fine of $5,000.

For more information, please contact your local public health unit. You may also obtain information by calling toll-free:
INFO line 1-866-396-1760

Smoke-Free Policy Communication Tools

Smoke-free property policies can be communicated by health care providers and health care administrators. As health care providers, we can offer sincere non judgmental advice about becoming smoke-free. As health care administrators, we can advise our patients, staff and community members that our hospital is a safe smoke- free property. How the message about your smoke-free property is communicated will affect how the message is received by the target audience. Successful messages are often up-beat and include positive events and or activities for employees, patients and the community.

A number of communication tolls can be helpful in spreading messages about smoke-free policies, resources, and programs. In the appendix for this section you will find numerous samples which may be helpful for communication with:
Employees (email and notices)
Volunteers (emails and letters)
Community & Public (signs and notices)
Contractors (letters and signs).

Links

RNAO Resource Information

http://tobaccofreernao.ca/

Smoke-Free Ontario for hospitals

http://www.mhp.gov.on.ca/en/smoke-free/factsheets/hospitals.pdf

Ontario Tobacco Research Unit Training Information

http://www.otru.org/training.html

Ottawa Model for Smoking Cessation Information

http://www.ottawamodel.ca

Canadian Cancer Society's Smokers Helpline

http://www.smokershelpline.ca/

Center for Addiction and Mental Health Nicotine Dependence Clinic Information

http://www.camh.net/About_CAMH/Guide_to_CAMH/Addiction_Programs/Addiction_Medicine_Service/guide_nicotine_dependence.html

CAN-ADDAPT information

http://www.can-adaptt.net/

TEACH Training Enhancement in Applied Cessation Counseling and Health

http://www.teachproject.ca/about.htm

Appendices

Return on Investment Calculator Information

Sample Terms of Reference for Smoke-Free Policy Planning Group

Sample Smoke- Free Meeting Agenda

Sample Questionnaire/Environmental Scan Outline

Sample Smoke- Free Policy Communication Tools

Return on Investment Calculator Information

Frequently Asked Questions (FAQs)

This page provides a short list of questions and responses that visitors may have about the Business Case for Smoking Cessation and the ROI Calculator. We welcome additional questions and comments from users. You can email us at roi-team@kpchr.org

Q: Who is the audience for the Business Case Website?

A: Primarily health insurance plans. The information presented and the ROI Calculator assumes health insurance plans incur the costs of the cessation programs (except for member co-pays). Employers, purchasers, and health benefits managers can use the results to gain insights into the financial costs and benefits of cessation.

Q: How do I use this site to make the business case for cessation?

A: You can make an effective business case for smoking cessation by understanding the issues, having ROI estimates for your population, and being ready to describe in lay terms how these estimates were generated. We hope this site allows you to accomplish these tasks. You can become familiar with the issues by reading the information provided on this and other linked websites. You can use the ROI Calculator to estimate the likely costs and benefits of smoking cessation programs for your population. The methodology page provides a lay description of how the model works and the source of the input data. This information should enable you to calculate ROI for your population and validate the estimates for key decision makers.

Q: What do you mean when you say the ROI Calculator uses a cohort approach? Why is this important?

A: It means the model assesses the future experiences of a defined population of smokers who we assume are given access to cessation services at the start of the assessment period. This approach allows us to simulate the impact of the program on a specific group of individuals, without having to control for the effects on health care utilization of smokers who enroll in future years. For simplicity, we assumed the programs last only one year.

Q: How does the ROI Calculator differ from other models?

A: The ROI Calculator is the first tool to use electronic medical record data over several years that include time-dependent measures for smoking status, disease diagnoses, and plan eligibility (disenrollment). This innovation allowed us to account for the impact of disease diagnoses on quitting, and the role of smoking status and disease diagnoses on the likelihood of leaving the plan. We were also able to use actual expenditure data to project the future expenditures of smokers who quit as a result of a cessation program. Most smokers who participate in programs are healthy and have low average costs compared to former smokers and recent self-quitters. Self-quitters have high average costs because many quit due to an adverse health event. As long as program quitters remain healthy (i.e., no smoking-related disease diagnosis), their costs remain low. If they relapse or have a disease diagnosis, they return to a usual care probability and cost profile.

Q: The model allows users to change some inputs. What if I want to change the distribution of heavy and light smokers, smoking-related disease rates, or other data to better reflect my population?

A: Please contact the ROI Team at roi-team@kpchr.org if you are interested in conducting more detailed analyses. The ROI Calculator is a simplified version of a much more extensive model that allows for the modification of any input.

Q: Why do the medical care and productivity savings vary over time?

A: The medical care and productivity savings vary because of several factors. Medical expenditure savings are zero in year one by design. We conservatively assumed that cessation program quitters would not change their health status in the first year. In years 2 and 3, medical expenditure savings increase because new quitters who remain healthy avoid the high average expenditures of new self-quitters. In years 4 and 5, the beneficial effects of quitting in year 1 begin to dissipate from the combined effects of higher disenrollment rates, relapse, and continuing risk for smoking-related disease.

In future years, productivity savings are affected by smoking relapse and plan disenrollment (we do not include productivity savings for disenrolled members). Savings are also affected by cessation in the usual care condition because some program participants would have quit on their own in future years.

Q: Why are the ROI estimates lower for employers and higher for health insurance plans when member co-pays are assumed?

A: We assume co-payments reduce program participation by half, to about 5% from 10% of current smokers. Fewer participants mean fewer quitters, which lowers productivity savings for employers. For health insurance plans, smokers who now reject the full program regimen are added to the number receiving brief physician advice to quit. Since the difference in costs between the full regimen and brief advice is proportionally greater than the difference in quit rates, the net ROI increases for the plan.

Q: Disenrollment rates are a significant concern for health insurance plans considering a smoking cessation programs. How does the model account for disenrollment?

A: Plan disenrollment is a key feature of the ROI Calculator. Disenrollment varied substantially for smokers and new quitters in the population we analyzed. Disenrollment declined with age, income, and poor health. For the ROI analysis, the model calculates cessation program participation and quit rates prior to estimating disenrollment and other outcomes in the first year.

Q: I'm interested in assessing and eliminating population disparities. Can I do analyses on specific population subgroups?

A: The ROI Calculator does not directly support analyses on population subgroups. However, you can do analyses of subgroups by adjusting the population numbers, smoking prevalence, and disenrollment rates to fit the group of interest. For additional help, contact us at roi-team@kpchr.org.

Q: What's the difference between the probability of a smoking-related disease (SRD) diagnosis in the model and incidence estimates available from medical records?

A: The ROI Calculator uses diagnosis data for smoking-related cancers, cardiovascular diseases, and chronic lung diseases to determine the probability that an individual had at least one smoking-related disease diagnosis during the year. Medical record data may show disease incidence (counts) at medical encounters for the membership as a whole or for individuals. Individuals or groups of individuals may have more than one incidence in a year. Users wishing to compare the model assumptions with their own member data will need to identify members who have at least one SRD diagnosis during the year compared to members with no SRD diagnosis.

Q: The ROI Calculator uses separate data for ages 18-34, 35-64, and 65 and over. These age groups are very wide. Why were they used?

A: We recognize that the age groups in the ROI Calculator are wide and that smokers in the early and late years of each age group may be quite different. The age groups simplified the web calculations, and calculation time. The age groups also reflect the known differences in relative risks for smoking-related diseases (a key model component). Smokers aged 18-34 have low overall disease risks. As smokers age, excess risks compared to never smokers increase substantially for smoking-related cancers and chronic respiratory diseases. However, the risk of heart attack and stroke are highest among smokers age 35-64 and fall substantially after age 65.

Q: The ROI Calculator requires I select a state or region. What does this do?

A:When you select a state or census region, the model automatically loads the adult smoking rate data, by age group and sex, for the state or region. Many insurance plans and employers will not know the smoking rate in their population, and many plans and employers may operate in multiple states. These estimates are not perfect, but provide a reasonable starting point.

The model also adjusts the medical expenditure data for regional variations in the annual cost of family insurance. The medical cost adjustment is based on four census regions (West, South, Midwest, and Northeast).

Q: Does the model include productivity losses from disability and premature death from smoking?

A: No, thus the model likely understates the productivity savings from interventions that prevent future smoking-related disease diagnoses.

Q: The ROI Calculator does not include measures of household income and race-ethnicity. What are the impacts of these measures and why were they not included?

A: Initial analyses were conducted using electronic medical records that did not include information on race-ethnicity, which was unavailable. We did not include income in the ROI Calculator because other plans were not likely to have these data, and initial analyses using geo-coded household incomes indicated that accounting for income did not change the model conclusions. Income did affect the probability and expenditure estimates consistent with other studies. However, there was no change within high, middle, and low-income classes in the relative relationships for the probability and expenditure data for current smokers, new quitters, former smoker, and never smokers. In addition, income was not a predictor of smoking-related disease diagnoses after correcting for other factors. Over time, we will expand the capabilities of the ROI Calculator, including income and race-ethnicity.

Q: The ROI Calculator does not distribute the costs of the cessation programs among health insurance plans, payors, and employers. How do I distribute program costs among these stakeholders?

A: The ROI Calculator displays total intervention costs and the number of participants for each intervention. Costs can be manually distributed among health insurance plans, employers, and payors. Separate ROI estimates can then be calculated using the medical expenditure and productivity savings data in the ROI Calculator.

Sample Smoke Free Planning Group
Terms of Reference

POLICY STATEMENT:

Senior Leadership Team (SLT) and Integrated Management Committee (IMC) have endorsed implementing a smoke free environment on all Sunnybrook Campuses (Bayview and Wellesley). The Smoke Free Planning Group has been established as a time-limited work group to develop the implementation plan to achieve this objective.

REPORTING RELATIONSHIP:

The Smoke Free Planning Group reports to Senior Leadership Team

MEMBERSHIP:

- Director of Ops. Long-Term & Veterans
- Manager, Cancer Program
- Manager, Holland Centre
- Patient Care Manager, Mental Health
- Manager, OH&S
- Manager, Human Resources
- Manager, Physical Facilities
- Representative, Public Affairs
- CEO, Chair

OBJECTIVES:

10. To develop a "Smoke Free Environment" policy for SLT approval
11. To create an input solicitation tool and obtain stakeholder input
12. To identify and recommend solutions to perceived barriers to creating a smoke free environment on all Sunnybrook campuses & patient populations
13. To identify staff supports that should be put in place
14. To create a communication plan
15. To develop a budget for the implementation of a smoke free environment
16. To recommend a lead for implementation

TIME TABLE:

Planning: June – September/06
Official Notice of Change: October/06 (or earlier)
Implementation Actions: October/06 – March/07
Effective Date: April/07 (Cancer Prevention Week)
(approved by Smoke Free Planning Group 2006-07-12)

Sample Smoke Free Planning Group

Meeting Agenda and Notes

Date

Agenda:

1. Background and Introductions
2. Review and approval of Terms of Reference
3. General discussion on topic
4. Identify leads for Objectives
5. Establish meeting schedule

Meeting Notes:

1. No Action required from Agenda item #1

2. **Terms of Reference** were reviewed and accepted with a few minor changes (final Terms of Reference will be circulated):
   a. ##### to replace #### as member
   b. ##### to replace #### as member (#### is on maternity leave)
   c. Additional Objective "To develop a smoke free policy"

3. **General discussion:**
   a. #### to email PDF of (another hospital) documentation to CEO for circulation.
   b. CEO to arrange for a web portal for this group so that minutes and documents can be posted.
   c. A number of key issues were raised to be considered as part of the various plans that will be required:
      i. Definition of "campus" – ***Physical Plan***
      ii. Options for enforcement – ***Physical Plan***
      iii. Timing of messaging to staff/patients – ***Communication Plan***
      iv. How to integrate Phase 1 (requirements of the new legislation) and Phase 2 (smoke-free environment) – ***Communications Plan***
      v. Border input solicitation and stakeholder input – ***Communication Plan***
      vi. Smoking Cessation and Education – ***Human Resource Plan***
      vii. Involvement of various unions and staff (including PCM Group, Operations Committee, Joint OHS Committee) – ***Human Resource Plan*** and ***Communications Plan***
      viii. Involvement of veteran stakeholders – ***LTC/Veteran Plan***
      ix. Involvement of mental health stakeholders – ***Mental Health Plan***
      x. One-time costs for implementation – will be developed as barriers/solutions are identified

4. **Objectives** were reviewed and primary responsibility assigned as follows (with recommendations and integration to come back to the Planning Group):
   a. **Policy** – ####
   b. **Input Solicitation tool** – #### (part of Communication Plan)
   c. Barriers/Solutions **- HR Plan** – #### & ####
   d. **Physical Plan** – ####
   e. **Communication Plan** – ####
   f. **Mental Health Plan** – ####
   g. **LTC/Veteran Plan** – ####
   h. **Staff supports** – #### (part of HR Plan)
   i. **Budget** for Implementation – #### committed to find one-time $ in 2006/07 not to exceed $200K if necessary
   j. **Lead of Implementation** – to be recommended in September 2006

   It was agreed that as the various tasks are addressed others in the hospital will be included (an example was given of Pharmacy participation as relates to smoking cessation).

5. **Meeting Schedule -** Meetings will be scheduled for every 2 weeks (July through end of September) to best accommodate as many members as possible. Meeting Agenda's will be developed based on who will be at any given meeting.

   It was agreed that #### would arrange to have future meeting notes taken, with a focus on decisions and actions from the meeting.

Sample Smoke Free Questionnaire

1. Is your hospital a Smoke-Free environment/property? (i.e. no smoking on hospital property, this is more than the smoke free Ontario legislation of 9 meters from the doorway)

2. If you do not have a policy, would you be open to developing one?

3. Do you have any specific documents or policies pertaining to this and, may we collect a copy?

4. If your hospital is a smoke free property, when did your hospital become a smoke free environment?

5. Does your hospital have a committee, planning task force or individual who has been responsible for smoke-free initiatives?

6. Does your hospital offer smoking cessation programs for patients?

7. Does your hospital offer smoking cessation programs for staff or volunteers?

8. Are smoking cessation aids and counseling covered under your employee health benefits package?

9. How do you enforce the smoke free policy in your hospital?

10. How do you communicate/promote smoke-free policies and initiatives in your hospital?

11. Do you have staff training on tobacco dependence?

12. Do you have patient self help materials available and displayed throughout your hospital or in clinical areas?

13. Do you make appropriate community referrals to places such as CAMH nicotine dependence clinic or the Canadian Cancer Society Smokers Helpline?

Example Smoke-Free Policy Reminder to All Staff

Message sent internally to staff using the hospital's all-staff email communication tool. The purpose of the message was to remind staff that the hospital is a smoke-free facility.

Smoke-Free Policy at **(insert name of Hospital)**

This is a reminder to all staff that **(insert hospital name)** is a smoke-free facility. As a healthcare facility, we strive to assist in the prevention of medical diseases such as lung cancer and chronic pulmonary diseases, asthma and other respiratory conditions that can be caused by smoking and the effects of second-hand smoke.

We are a completely smoke-free facility:

 Smoking is prohibited in all areas of the hospital. This includes the inside of the building in its entirety, exterior grounds, parking garages, vehicles, and bus shelters.

 This policy applies to staff, volunteers, students, visitors and patient populations that are within the boundaries of **(insert hospital name)**.

Example Smoke Free Policy Enforcement Strategy Announcement

Message sent internally to staff to provide them with updated information on the enforcement strategy in relation to the Smoke-Free Policy. The email was sent by the Senior Leader in charge of the initiative.

From:

Sent:

To

Subject: Enforcement of our Smoke-Free Policy

Dear **(insert hospital name)** Staff,

On **(insert date), (insert hospital name)** took a bold step in implementing a smoke-free environment throughout **(insert hospital name)**. I would like to remind you that our Smoke-Free Policy can be found at **(insert website link to where this information is posted internally for staff).** This policy, which has now been in effect for over two years, applies to everyone on the **(insert hospital name)** grounds, with some smoking provisions for veterans as is required by legislation. Smoking is prohibited in all areas of the hospital including, but not be limited to, the inside of the building in its entirety, exterior grounds, parking garages, vehicles located on our grounds, and bus shelters. **We recognize that this initiative has been a significant change and adjustment for many staff and I would like to take this opportunity to thank the many staff that have respected this policy.**

Unfortunately we have not achieved anywhere near acceptable compliance by staff, visitors and patients with this policy, and in fact we have found violations in areas that are explicitly prohibited by provincial law under the Smoke-Free Ontario Act. Some instances of these infractions have lead to Public Health Officers imposing fines of $300+ for each observed smoking by-law violation. To date, this enforcement and related fines have not been a **(insert hospital name)** initiative, and are instead the result of random inspections conducted by Toronto Public Health officials and payable to the province of Ontario.

It is clear that the time has come to step up the enforcement of our policy in this area. As such, we are implementing a plan to increase the frequency of patrols and deliberate surveillance of our properties for non-compliant smokers effective next week. Our Fire & Security Officers have agreed to follow up on and report incidences of policy and/or by-law violations to the appropriate authorities, including hospital managers and Toronto Public Health officials as applicable. Security Officers will approach smokers on the property with information about our smoking policy and Ontario's law. Violators of either of these will be asked to cease their smoking activities on the property and compliance with our policy will be monitored on an ongoing basis. In the case of staff and contractors, reports will be made to appropriate managers and other authorities for follow up. **I want to thank our Security Team for their willingness to take on this important function.**

I regret that these increased enforcement measures have become necessary, but we see no other alternative as a means to achieving our important objectives in this regard. To avoid any undesirable embarrassment or unpleasant experience related to the increased enforcement, I strongly urge and request everyone's cooperation in complying with our smoking policy and the provincial law. We would much rather count on your cooperation and support than have to engage in what is inherently a more assertive approach.

Thank you in advance for your anticipated co-operation.

0Example 2 Smoke Free Policy Enforcement Strategy Announcement

Message sent internally to staff to provide them with new information on the enforcement strategy in relation to the Smoke-Free Policy. The email was sent by the Senior Leader in charge of the initiative.

From:

Sent:

To:

Subject: IMPORTANT NEW INFORMATION - Enforcement of our Smoke-Free Policy

On **(insert date)** I sent you the email below encouraging you to respect our Smoke-Free Policy and informing you of a new enforcement strategy. I want to thank those many staff that have complied with our Smoke-Free Policy and I want to recognize the personal effort this has taken from those staff. **For others, I want to give you notice of a further enforcement strategy that is being implemented that could have a significant impact on you.**

I recently meet with the City Enforcement Officer assigned to **(insert hospital name)**, and while he can't be here all the time, he has increased his presence on our site. On the day I met with him, he had issued tickets to three of our staff, a number of visitors and an onsite contractor for violations of the provincial by-law. Those tickets cost these individuals $300 each.

Effective **(insert date) (insert hospital name)** will be enhancing the enforcement strategy noted below as follows. Our Security Officers will be issuing Smoking Policy Infractions to individuals that they identify violating our Smoke-Free Policy. A copy of these Infractions will be provided to the individual; a copy will go to their direct report for performance management purposes (disregarding a hospital policy can result in disciplinary action); a copy will go to Human Resources to be included in the individuals employment record; and a copy will be retained by Fire & Security Services. For non-staff, we believe that these Infractions will also help to change behavior as they will identify when the individual was "lucky" that it was our Security Officer rather than the City Enforcement Officer (and a $300 ticket) that noticed them smoking.

It is unfortunate that we need to implement this more assertive enforcement strategy, but regrettably we still have many staff and visitors that are disregarding our hospital policy and the provincial law.
Once again I strongly urge and request everyone's cooperation in complying with our Smoke-Free Policy. I also ask you to respect the fact that our Security Officers have an important and often thankless job to do in the enforcement of this policy, and it is inappropriate behaviour to be discourteous to them when all they have done is to identify a violation of a Hospital Policy.

Thank you,