

Better Help for Smokers to Quit targets need evaluation and integration with community-based services

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The Ministry of Health introduced the Better Help for Smokers to Quit targets in 2009. The current goal is for 95% of hospitalised smokers to receive quit advice during their stay. This target has been largely achieved, with all DHBs reporting over 93% of smokers being identified and given advice in the 2015/2016 third quarter. However, there has been very little evaluation of the wider impact of the Better Help for Smokers to Quit targets, such as the effect of the targets on the proportion of smokers trying to and succeeding in quitting during or after hospital admission.

We found only two small studies which investigated the impact of the Better Help to Quit targets. The first, in Hutt Hospital, was about the impact of training at the time of introduction of the targets on prescriptions of nicotine replacement therapy (NRT).¹ This study found that house surgeons significantly increased rates of prescription of NRT after the training. The second was a small study (31 patients) in Dunedin Hospital, which found the ABC approach was well received by patients, and had a quit attempt rate of 39% post-discharge.² These findings are difficult to interpret due to small numbers and lack of comparison groups.²

We examined the effects of the target in Hutt Hospital.³ Due to a limited time frame of five weeks, our study is best understood as a pilot study which could be reproduced on a larger scale in the future. The study included three components. Firstly, all patients identified as smokers over a two-week period were invited to complete a survey assessing their experience of smoking cessation advice. Secondly, we carried out in-depth

interviews with five of these patients.

Thirdly, we interviewed nine key informants involved in smoking support and target implementation; seven at Hutt hospital and one each in the local community and at the national level. The research was approved by the Department of Public Health under the Category B process for low-risk research administered by the University of Otago Human Ethics Committee.

Of the 34 patients in the survey, 22 (65%) had been offered smoking cessation advice at the time they were surveyed. Of these, 23 (68%) had been offered NRT. Māori and heavier smokers were more likely to report receiving advice, though the differences were not statistically significant. Those who had been offered advice were more likely to have improved motivation to quit since admission than those who had not, and this advice was largely acceptable.

The five patient interviews supported the finding that the advice given was acceptable to patients, although numbers were too small to produce conclusive data. There was one concerning case of a mental health patient who had started smoking during a prolonged admission to hospital, but more investigation is needed to identify whether this is an isolated occurrence.

Key informant interviews revealed mixed views on the targets. Hospital admission was considered an important opportunity to help smokers to quit, and interviewees reported that the targets had created greater awareness of the importance and effectiveness of brief smoking-cessation advice among health professionals, and greater impetus and accountability in delivering

that advice in the hospital. However, some interviewees noted that the targets may have sacrificed quality for quantity, with the risk that implementation becomes a 'checkbox' exercise. Some also noted that there was inadequate resourcing to support their implementation, and that the targets are a process measure, not an outcome like quitting or NRT prescription.

Several of the key informants noted that there was a disconnect between hospital and community-based services, with no follow-up of smokers outside of the hospital and inadequate referral pathways to community-based providers or Quitline. For example, the Aukati Kaipapa Maori community-based smoking cessation service representative was concerned about their lack of referrals from the Hutt Hospital. A literature review suggested that hospital-based quit smoking interventions are only effective when they are linked to ongoing cessation support in the community,⁴ so this is a clear area for improvement. We were impressed to

discover during the local dissemination of our findings an initiative at Hutt Hospital in which an automated electronic referral to Quitline services occurred for all smokers attending the emergency department.

This study is one of the first attempts to evaluate the Better Help to Quit targets. Our research was limited by a short time frame and small numbers of subjects. We were also not able to follow-up patients after discharge from hospital. However, the study has highlighted the need for a robust, outcomes-based evaluation of the impact of the targets within and outside the hospital setting.

We recommend that the patient survey be repeated over a longer time-frame and with follow-up of patients outside of hospital. We also suggest that the Ministry of Health should be identifying best practice and practice innovations in smoking-cessation support within hospitals and its integration with cessation support following discharge, and facilitating the wider implementation or further research into such approaches as appropriate.

Competing interests:

Nil.

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<http://www.nzma.org.nz/journal/read-the-journal/all-issues/2010-2019/2017/vol-130-no-1449-27-january-2017/7147>

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