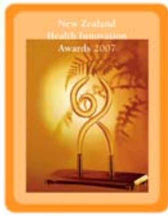


2007 New Zealand Health Innovation Awards
Excellence in Primary Health Care Category

ASC

Asian Smokefree Communities Pilot

A culture specific and appropriate approach that combines both smokefree promotion and smoking cessation in a family-oriented setting

아시안
금연
커뮤니티

亞裔社群
無煙推廣行
動

ASIAN
Smokefree
Communities

ASC is here to support you and your family to be smokefree!

ASC – a collaborative project of ARPHS, Harbour PHO and Waitemata DHB's Asian Health Support Services

Asian Health Support Services

2007 New Zealand Health Innovation Awards

Expression of Interest Form

Please complete this form electronically and return to the New Zealand Business Excellence Foundation by email to: hia@nzbef.co.nz

Expressions of Interest close at 5.00pm Friday 26 January 2007.

The Expression of Interest form will register your interest in applying for the New Zealand Health Innovation Awards. Twenty one applicants will be selected as finalists for the next stage of the process. All entrants will be notified in writing by Friday 16 February 2007 of the status of their entry. Finalists will be provided with more detailed application forms to complete.

For more **information**, please contact the New Zealand Business Excellence Foundation: hia@nzbef.co.nz or 09 489 8791.

Legal Name:	Asian Smokefree Communities
Trading Name:	As above
Name of Highest Ranking Official in Organisation:	Susan Turner
Email address:	STurner@harbourpho.co.nz
Address:	PO Box 302-163, North Harbour, Auckland 1330
Phone number:	09 415 1091
Name of Primary Contact Person:	Janice van Mil
Email address:	JVanMil@harbourpho.co.nz
Address:	PO Box 302-163, North Harbour, Auckland 1330
Phone Number:	09 448 0470; 0275 415759
Name of Alternative Contact Person:	Janet Chen
Email Address:	JanetChen@adhb.govt.nz
Address:	Private Bag 92605 Symonds Street, Auckland
Phone Number:	09 623 4600 x 27193

Please identify which award category you are applying for:
☐ Excellence in Quality Improvement ☑ Excellence in Primary Health Care ☑ Excellence in Prevention (injury or health promotion) ☐ Excellence in Rehabilitation (injury or long-term condition management)

- ☐ Excellence in Treatment
- ☑ Innovation
- ☐ Process Improvement

What is the title of your entry? (no more than 10 words)
A Big ASC – For You and Your Family

For the following questions, please keep your answers to no more than 250 words each. Please try to use the maximum amount of words to enable us to assess your EOI effectively.

Q1. Provide details about your organisation/group/business including a summary of your vision, purpose/mission, values and the key health care products or services provided. This information helps the evaluation panel to understand the environment within which the entry operates.

The Asian Smokefree Communities (ASC) Pilot Service is a tripartite collaborative partnership between Auckland Regional Public Health Service (ARPHS), Harbour Primary Health Organisation (HPHO) and Waitemata District Health Board's Asian Health Support Service (AHSS) and Health Gain team – it is the first of its kind in New Zealand, involving primary health, secondary health and public health.

This innovation of a language and culture specific service that combines smokefree promotion and smoking cessation in a family-oriented community setting is also the first of its kind in New Zealand.

It is aimed not only at reducing the exposure to second-hand smoke and increasing the effectiveness of smoking cessation in the Asian population of the Waitemata District, but also in improving Asian people's access to health services and in reducing health inequalities.

Launched on 28 April 2006, the service provides free service for Asian peoples who:

- Smoke or have a smoker in the family
- Wish to live smokefree – work, home, car
- Live on the North Shore and/or enrolled with Harbour PHO doctors

The services offered include:

- Assisting clients and families to create a smokefree environment
- Supporting for smokers to go smokefree through quit smoking advice, nicotine replacement therapy, counselling, phone support, home visits and resource information

ASC was judged the winner of the oral presentation category in the Waitemata District Health Board's Annual Clinical Quality Awards on 17 November 2006.

Q2. Describe your entry: why there is a need for it and who it is intended for.
The key drivers that support and led to the development of the ASC Pilot Service include the following: a) Waitemata District Health Board's Strategic Plan 2005-10 identifies Tobacco Control as a priority population health activity for the prevention of cardiovascular disease in the district b) Waitemata District Health Board's Health Gain & Service Improvement Priorities require WDHB to address health inequalities as a priority area and create health services that are accessible, culturally appropriate and safe to meet the healthcare needs of the population, including Asian people, migrants and refugees. c) A stocktake of available cessation services and a gap analysis for the district conducted by the Waitemata District Health Board's Health Gain Team identified subgroups within the Asian population with particularly high smoking prevalence rates, and a lack of specific cessation or smokefree promotion services. The research involved consultation with ARPHS Asian Public Health and WDHB Asian Health Support Service, and confirmed that language difficulties and cultural differences are known barriers to accessing existing smoking cessation and other services for many Asian people in the district (Whittaker R, Thompson C, 2005). d) The growing Waitemata Distrcit Health Board's Asian population - Asian peoples are the fastest growing ethnic community in New Zealand, particularly in the Auckland region. According to the 2001 Census, Asian people in WDHB make up 9.4% of the total population. This figure has since increased to 14.8% (Census 2006).

Q3. Who were the key individuals or organisations involved in the development and implementation of your entry. What role did each one play?
All 3 collaboration partners are represented in the ASC Steering Group who is responsible for all aspects of the project - from funding commitments to planning, implementation and evaluation as well as project management and governance. The three organisations provided a combined one-off funding to commence the 12-month pilot service development project from 1 March 2006. 25% of the overall funding was specifically used for the development and production of culture-specific resources (flyers, booklets, banners, drink bottles, magnets, stress balls, stickers, pamphlets, etc). 60% of the funding was for engaging two part-time Asian coordinators while 15% was allocated for the cost of service promotion, translation of resources and the provision of interpreters to support smokefree and smoking cessation interventions and to support the evaluation process. Key linkages have since been forged with regional and national smokefree promotion and smoking cessation providers as well as the Asian communities (in particular the Chinese and Korean communities). The Steering Group is also responsible for issues

relating to sustainability of the project and is exploring means of expanding the service across the Waitemata district and beyond.

Q4. Explain the extent to which the entry has had a positive effect on a health service, product or system and/or improved patient care. Please provide data where possible..

The following tables and graphs demonstrate the success of the Asian Smokefree Communities Pilot – 83% in creating smokefree environments and 83% in smoking cessation. In comparison, the National Quitline success at 6 months with full intervention is 30% and 15% without full intervention. “Full intervention means “having received and redeemed at least one quit exchange card, spoken to a Quit Advisor at least twice and read some Quitline’s quit resources” (www.quit.org.nz).

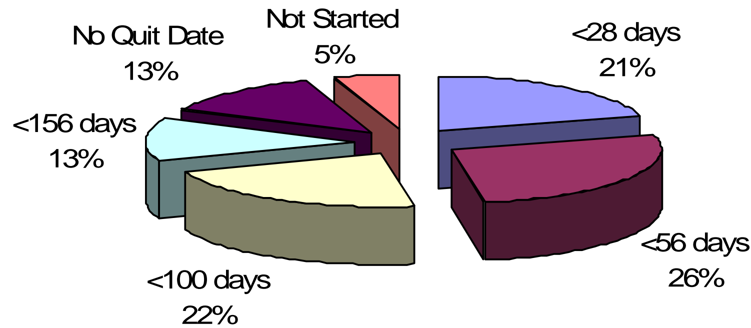
Creating Smokefree Environments	**No. of clients complied**	**Total No. of households /clients**	**Success Rate %**
Level 1 Smokefree success (after 7 days)	49	59	83%
Level 2 Smokefree success (after 2 months)	39	59	66%

Note:
* = total number of all households/invidividuals in the programme
* = total number of all households/invidividuals in the programme for 2 months

Smoking Cessation Success	**No of clients quit**	**Number of clients**	**%**
Level 1: Quit Success (no cigs past 7 days)	71	85	83%

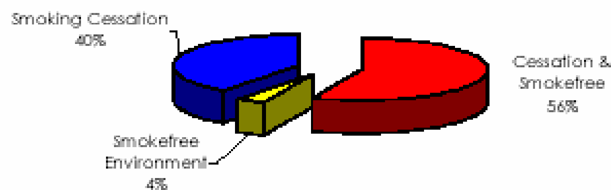
<u>Number of Clients: in the programme by time period</u>

- 16 of clients <28 days in the programme
- 21 clients >28<56 days in the programme
- 17 clients >56<100 days in the programme
- 10 clients >100<156 days in the programme
- 10 new clients have not set quit date
- 4 new clients – waiting to be seen



Number of Client Contacts

- Client contacts = 636
- 40 appointments pending
- 68% appointments were made over the phone
- 14% at client's home
- 8% at workplace
- 7% at HPHO clinic
- DNA rate = 5 (0.84%) out of 595 appointments
- Cancelled rate = 4 (0.67%)



Service and Health Promotion

The majority of referrals are self-referrals – indicating that Asian communities are in support of this initiative. Service and health promotion efforts have entailed the use of the service launch, media articles, mail-out, GP promotion; health awareness events; flyers, website, radio, TV, coordinators' promotion efforts, etc.

Declaration:

My organisation is not under investigation by any statutory body (for example ACC, NZ Police, Health and Disability Commissioner, or Ministry of Health)

Have you entered or won any other awards with this entry (for statistical purposes only)?
No

To ensure excellence in the management of the Health Innovation Awards the event owners will contract an external supplier to undertake an evaluation of the HIA. You may be contacted as part of the evaluation.

I give me permission to be contacted ☑
I do not want to be contacted ☐

2007 New Zealand Health Innovation Awards

Application Form – Excellence in Primary Health Care category

	Office Use Only
Applicant ID Number:	

Legal Name:	Asian Smokefree Communities
Trading Name:	Harbour Primary Health Organisation
Name of Highest Ranking Official:	Susan Turner
Highest Ranking Official Email Address:	sturner@harbourpho.co.nz
Highest Ranking Official Postal Address:	P O Box 302-163, North Harbour Postal Centre, Ak 0751
Name of Primary Contact Person:	Janice van Mil
Primary Contact Person Email Address:	jvanmil@harbourpho.co.nz
Primary Contact Person Phone Number:	09 415 1091; 0275 415 759
Name of Alternative Contact Person:	Lis Cowling
Alternative Contact Person Email Address:	lcowling@harbourpho.co.nz
Alternative Contact Person Phone Number:	09 415 1091; 0275 502 400
Award Category:	Excellence in Primary Health Care

Release Statement and Signature of the Highest-Ranking Official

I state and attest that:

- I have reviewed the information provided by my organisation in this application
- I understand that members of the Panel of Evaluators and Judges will review this application
- Should my entry require a site visit by the evaluators, we agree to host the site visit and to facilitate an open and unbiased examination
- I have read the term and conditions, as laid out in the Guide for Finalists, of entering the Health Innovation Awards and agree to participate as outlined

To the best of my knowledge:

- No untrue statement of a material fact is contained in this application
- No omission of a material fact that I am legally permitted to disclose and that affects my organisation's ethical and legal practices has been made. This includes, but is not limited to, sanctions and ethical breaches
- Neither the initiative nor the project team (in their capacity as contributors to this process improvement) are under investigation by any statutory body (ACC, NZ Police, Health and Disability Commissioner or MoH)

Name:	Susan Turner	Date:	19 April 2007
Title:	Chief Executive Officer	Signature:	

Q1.1 PROVIDE A BRIEF DESCRIPTION OF WHAT THE INITIATIVE IS

The Asian Smokefree Communities (ASC) pilot is a language and culture specific service that combines smokefree promotion and smoking cessation in a family-oriented community based setting.

The ASC service was launched on 28 April 2006.
It provides a free home visiting service for Asian peoples who:

- Smoke or have a smoker in the family
- Wish to live smokefree – work, home, car
- Live on the North Shore and/or enrolled with Harbour PHO doctors

ASC services include:

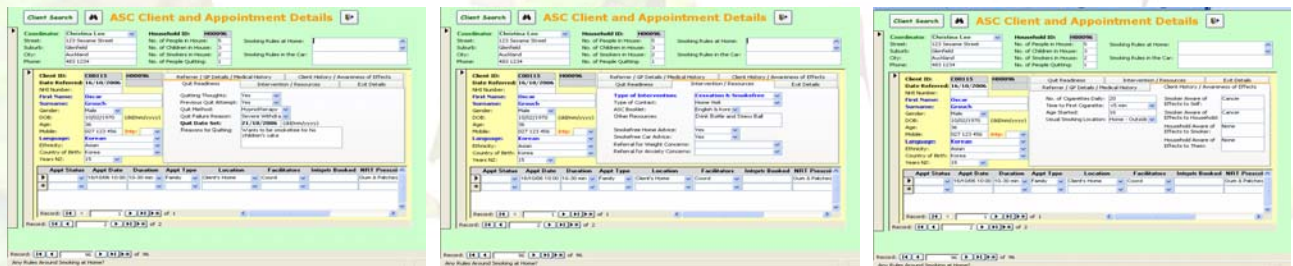
a) Assisting clients and families to create a smokefree environment
b) Supporting smokers to go smokefree through quit smoking advice, nicotine replacement therapy, counselling, phone support, home visits and resource information

Aims of the pilot project were to:

1. Reduce exposure to second-hand smoke in the Asian population
2. Reduce smoking in the Asian population
3. Reduce health inequalities by improving Asian peoples' access to smokefree and cessation services

"The Big ASC" won first place in the oral presentation category of the Waitemata District Health Board's Annual Clinical Quality Awards on 17 November 2006, six months after the rollout of its services.

RESOURCES DEVELOPED FOR ASC – MAGNETS, BROCHURES, STICKERS, DATABASE (SEE SNAPSHOTS)



SERVICE LAUNCH 28 APRIL 2007
ATTENDED BY COMMUNITY ELDERS, MAYOR GEORGE WOOD, WDHB BOARD MEMBERS, CEOS

Q1.2 WHAT WERE THE KEY OBJECTIVES FOR THE INITIATIVE? DESCRIBE WHERE POSSIBLE, HOW THEY ALIGN TO APPROPRIATE NATIONAL, REGIONAL OR LOCAL HEALTH PRIORITIES.

Key objectives of the pilot project were:

1) *To increase the number of smokefree cars/home environments in Asian families*
2) *To increase the effectiveness of quit attempts in Asians who smoke*
3) *To ascertain the appropriateness of the ASC service model for smokefree promotion and smoking cessation for the Asian population*

Rationale for ASC and service alignments - local, regional and national alignments:

LOCAL	
WDHB's District Strategic Plan 2005-10	• Tobacco Control identified as priority population health activity for the prevention of cardiovascular disease in the district • Reducing Inequalities as priority to create health services that are accessible, culturally appropriate and safe to meet the healthcare needs of the population, including Asian people, migrants and refugees
Gap Analysis Report entitled, "Establishment of Comprehensive Co-ordinated Smoking Cessation Services in Waitemata District" (Whittaker & Thompson, 2005)	• Asian people are the fastest growing population in the WDHB (census 2001). • Based on the 1996 Census smoking rate and the 2001 Census figures, it was estimated that there were 3,500-4000 Asian smokers out of 65,000-90,000 smokers in the Waitemata district • Specific cessation or smokefree promotion services for Asian people were not available even though cardiovascular disease and smoking are major health issues • Language difficulties and cultural differences are known barriers to accessing existing mainstream smoking cessation services.
REGIONAL	
Asian Public Health Project Report (MoH, 2003):	Recommendations include: ▪ Reducing language and cultural barriers through the provision of interpreters, recruitment of more Asian health professionals, development of more culturally-sensitive services, enhancing mainstream services, targeting of resources and ensuring that service development involves Asian communities through partnerships and other mechanisms ▪ Improving access to health services by Asian communities
NATIONAL	
New Zealand Health Action Plan (MoH, 2001)	o Smoking is the major cause of lung cancer and a range of other cancers in New Zealand o Smoking and exposure to second-hand smoke are known to cause lung cancer, heart attacks and strokes
New Zealand Cancer Control Strategy (MoH, 2003)	Goals are to reduce the incidence and impact of cancer and to reduce inequalities in health care access.
Primary Health Care Strategy (MoH, 2001)	The role of primary health care services is to focuse on better health for the population and to work actively to reduce health inequalities between different groups.
Clearing the Smoke: A five-year plan for tobacco control in New Zealand 2004–2009 (MoH 2004)	Objectives include: o promote smoking cessation o prevent harm to non-smokers from second-hand smoke o improve infrastructional support and coordination for tobacco control activities

Q1.3 DESCRIBE HOW THE INITIATIVE WAS LED INCLUDING: WHO LED THE INITIATIVE AND HOW THEY:

- **SET AND COMMUNICATED THE VISION AND OBJECTIVES**
- **GAINED COMMITMENT FROM THOSE INVOLVED AND THOSE AFFECTED**
- **ENSURED EFFECTIVE MANAGEMENT OF THE INITIATIVE**

ASC was established as a tripartite collaborative partnership between Auckland Regional Public Health Service (ARPHS), Harbour Primary Health Organisation (HPHO) and Waitemata District Health Board's Asian Health Support Services (AHSS) and Health Gain Team (HGT) – it is the first of its kind in New Zealand, involving primary, secondary and public health.

The project was led by a Steering Group with representatives from WDHB (HGT and AHSS), ARPHS and HPHO:

Janet Chen	*Auckland Regional Public Health Service*
Lis Cowling	*Harbour Primary Health Organisation*
Sue Lim	*Waitemata DHB, Asian Health Support Services*
Kai Hong Tan	*Auckland Regional Public Health Service*
Janice van Mil	*Harbour Primary Health Organisation*
Robyn Whittaker	*Waitemata DHB, Health Gains Team (at the time of the ASC pilot, now Clinical Trials Research Unit, University of Auckland)*

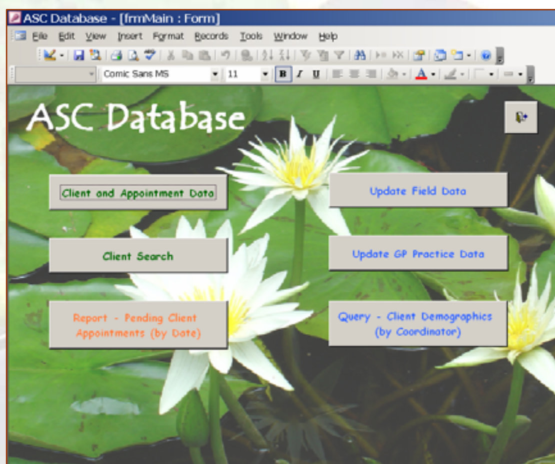
This governance group developed the vision, objectives, management and service development framework (including Terms of Reference), and service model. Health promotion principles were initially applied for the service development, which were subsequently evolved into an 8 Cs framework (explained in more detail under Section 1.4)

The roles of the three organisations were formalised in a multiparty agreement formulated by the Steering Group and signed by the CEOs of all three parties. This signalled commitment from all three organisations.

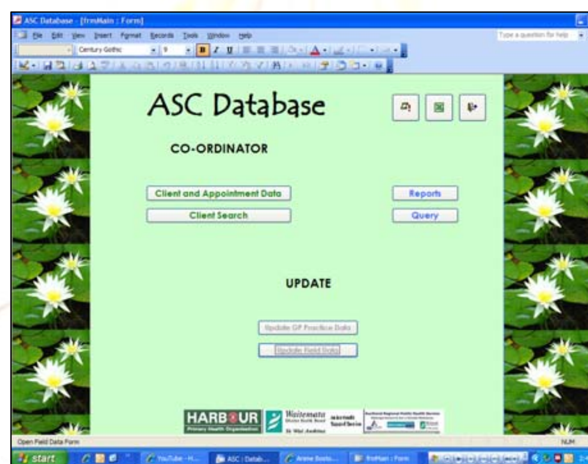
The Steering Group met fortnightly/monthly as required. It was responsible for:

- securing funding
- community consultations
- negotiating Multi-Party Agreement
- developing project plan, monitoring key deliverables, timelines
- resource and database development
- workforce development (recruitment and training)
- service management and promotion
- facilitating information dissemination to key stakeholders
- mitigating risks as identified
- evaluation plan, report and planning for the future

Database Version 1



Database Version 2 *(under construction)*



Q1.4 HOW WERE THE NEEDS AND EXPECTATIONS OF ALL KEY STAKEHOLDERS (BOTH INTERNAL AND EXTERNAL) ESTABLISHED? WHAT WERE THOSE NEEDS AND EXPECTATIONS AND HOW WERE THEY ADDRESSED

The needs and expectations of internal stakeholders were identified and agreed upon at the first Steering Group meeting. The needs and expectations of the external stakeholders were determined via a literature review and community consultations. The findings led to the development of the family-oriented, culture appropriate and language specific model of service.

The "8 Cs" Service Development principles were applied throughout the project to address the needs and expectations of both internal and external stakeholders:

The 8 Cs:

1. **Community engagement approach** *to assist in developing a culturally specific approach*
2. **Collaborative partnership** *between primary health, public health, Asian health and the HGT*
3. **Combination smoking cessation and smokefree promotion:** *package of intervention for clients*
4. **Culturally responsive approach** *including family oriented services with translated resources*
5. **Capacity building** *of the Asian workforce*
6. **Communication support** *for non-English speaking Asian clients with the provision of interpreters*
7. **Community based outreach**: *home visiting, fully subsidized service*
8. **Collecting of client information** *to support monitoring and evaluation to inform future planning*

<table>
<tr><th>Stakeholders</th><th>Needs and expectations</th><th>How were these addressed</th></tr>
<tr><td rowspan="8">Asian Community

Supporting organisations/ agencies (Appendix (ii))</td><td>Language, culture appropriate service</td><td rowspan="3">Culturally responsive approach
Community engagement
Capacity building</td></tr>
<tr><td>Language, culture appropriate information</td></tr>
<tr><td>Community/Family support</td></tr>
<tr><td>Access to service</td><td rowspan="3">Community based outreach</td></tr>
<tr><td>Convenience</td></tr>
<tr><td>Low Cost</td></tr>
<tr><td>Effective intervention</td><td>Combination of smoking cessation and smokefree promotion
Collecting of client information</td></tr>
<tr><td>Support diverse populations</td><td>Communication support</td></tr>
<tr><td>Internal</td><td>Fulfil organisations' obligations to address health inequalities and align with key health strategies
Addressing health inequalities and achieving positive health outcomes for the growing Asian population using an intersectoral approach.</td><td>Collaborative partnership
+ the other 8 Cs as above</td></tr>
</table>

The model of service was developed on the basis of continual local and regional community consultations from initial gap analysis, resource and service development and service delivery.

Local and national smokefree and quit networks e.g. the Health Sponsorship Council, The Quit Group, the National Heart Foundation and other organisations were engaged for funding, resource development and training support.

Q1.5 HOW WERE POTENTIAL SOLUTIONS INVESTIGATED AND ANALYSED AND HOW WAS FEASIBILITY AND THE EXPECTED BENEFITS DETERMINED?

Step 1: ARPHS explored potential solutions through a literature review. AHSS consulted with community leaders through focus groups. HPHO investigated service delivery feasibility and consulted with general practices with larger Asian client numbers.

Step 2: The Steering Group (SG) identified feasibility issues and potential solutions at the commencement of the project {Appendix 1 (i)}

Step 3: The SG determined and weighted the level of expected benefits from various aspects, such as:

- Burden of disease: its impact on population, economic impact and target population
- Health gain: response rate, incremental health gain, anticipated impact, early intervention
- Access: regional equity, geographical equity, timeliness,
- Appropriateness: organisational goals; appropriate setting/level of service; best clinical practice; reduces demand for services; partnerships and collaborations
- Organisational impact: innovation; impact on workload, capacity building

Step 4: The SG identified potential risks using a risk assessment framework to gauge probability and impact and to identify strategy.

Step 5: The SG developed an evaluation plan with clear objectives and measurable outcomes during the service development and implementation phases. It includes specific process and impact measures. Ethical approval was obtained to carry out a formal external evaluation to determine the following benefits from the project:

1. The effectiveness of the ASC service on smoking in cessation clients
2. The effectiveness of the ASC service on exposure to second-hand smoke in homes and cars of clients
3. The acceptability of the ASC service to clients
4. The factors critical to ASC's success or otherwise.

The full and short version of the Evaluation of ASC: Asian Smokefree Communities Pilot, March 2007 is available on the following websites:

Waitemata DHB's Asian Support Services
www.asianhealthservices.co.nz

Asian Health Website
www.asianhealth.govt.nz

Harbour PHO
www.harbourhealth.org.nz

Q2.1 HOW WAS THE INITIATIVE PLANNED? (INCLUDING THE DESIGN, DEVELOPMENT AND IMPLEMENTATION PHASES). INCLUDE INFORMATION ON THE PLANNING PROCESS, KEY MILESTONES, TIMELINES, TESTING, TRAINING AND CHANGE MANAGEMENT

The project is managed, led and governed by the Steering Group. There is no project manager or sponsor. A formal project management approach was applied throughout the project. The following were the key deliverables and timelines at different phases:

Project planning Information

Phase	Key Deliverables	Who	Timeline
Design	**Service Model** Design and agree service model Consult with community groups Consult with general practices	Steering Group (SG) AHSS HPHO Sign off by SG	Mar 06 Mar 06
	ASC resource development Design Smokefree booklet, car stickers, etc) Pre-testing (focus groups with Asian groups) Translation of resources and fact sheets Finalise resource development	ARPHS AHSS AHSS Sign off by SG	Apr 06 Apr 06 Apr 06
	Service Protocols and referral systems Develop service referral forms Consult with GP practices and teams Confirm wrap around services Finalise protocols, processes	HPHO HPHO HPHO Sign off by SG	Apr 06 Apr 06
	Database development Explore existing database options Develop database	SG AHSS	Apr 06 Apr 06
	Workforce development Recruitment of coordinators Orientation and Training of coordinators	ARPHS, HPHO, AHSS and National Heart Foundation	Apr 06 Apr 06
Development	**ASC Guidelines Development** Develop a set of guidelines for measuring smokefree and cessation outcomes	SG	May 06
	Develop support structure for ASC coordinators Ongoing training support Employee Assistance Programme Clinical psychologist support Mentoring support	SG AHSS AHSS HPHO	Apr 06
	Develop support structure for ASC clients HPHO wrap around services – diabetes, respiratory, physical activity, nutrition, clinical psychologist	HPHO	Apr 06
	Service Launch Develop ASC Banners in three languages Invitations of key speakers Venue and catering Media release, articles for mainstream media and ethnic-specific media communicate to Asian networks Flyers to GP practices	SG	28th Apr 06 1st May 06
Implementation	**Service promotion** Community presentations Health awareness days Promotion and publishing articles in ethnic-specific media; (TV, radio, newspapers) and email to Asian networks Flyers to GP practices	AHSS HPHO	Ongoing

Phase	Key Deliverables	Who	Timeline
	Service and staff management Managing staff and service performance which include problem solving for service delivery; client and staff issues Identifying training needs Tracking and reporting client information	HPHO	Ongoing
Evaluation	Develop draft plan for measuring formative, process and impact outcomes Finalise evaluation plan Complete and submit Ethics Application Source funding for evaluation process to start Dec latest Source external evaluator Evaluation	Dr R Whittaker Sign off by SG Dr R Whittaker Dr R Whittaker Dr R Whittaker External evaluator	Apr 06 Jun 06 July 06 Sep 06 Nov 06 Mar 07

Q2.2 How was progress monitored and measured against the plan?

For the overall project, the Steering Group:

- Monitored the project progress against the project plan, milestones and specified deliverables, using a monthly reporting template
- Developed a special database to track service referrals, client information, appointment activity and smokefree and cessation outcomes for Steering Group
- Reviewed service outputs; coordinators' issues and client feedback and made improvements to ensure continuous quality improvements

For the external evaluation process, the Steering Group:

- Developed a work plan for the external evaluator
- Monitored progress of the evaluation process against the work-plan, milestones and deliverables

Q2.3 How was effective communication of the initiative ensured from the planning to implementation stages

Communication Method	Timing	An Effective Way of:
Multi-party Agreement	Start of the project	Agreeing partnership framework, funding, and setting roles and responsibilities, reporting requirements
Minutes	After each Steering Group meeting	Keeping all SG members informed
SG monthly reports	SG meetings after service commenced	Managing service performance and resolving issues
Emails	Dissemination of information Urgent reviewing of documents Urgent decision making required	Disseminating information. Getting documents reviewed. Getting consensus and agreement for meeting deadlines.
ASC Service Reports to management or Board	Monthly	Reporting to respective organisation
General Practitioners Cell meetings and flyers	Initial planning phase Development phase Implementation phase	Consulting at all stages with GPs Promoting the service
Focus group	Initial planning phase Resource development phase	Consulting with community groups to gather feedback, views
Language appropriate materials	Resource development phase	Consulting with community groups who are limited-English or non-English speakers
Ethnic-specific media (including TV, newspapers and radio)	Launch Service promotion - ongoing	Promoting information to ethnic community especially when reaching out to non-English speakers

Communication Method	Timing	An Effective Way of:
Dissemination of information to Asian community leaders via email system	Launch Service promotion – ongoing	Promoting information to ethnic community leaders who have community links to reach to small ethnic minority groups who do not have ethnic-specific media coverage
English, Korean and Chinese translated mailouts	Service promotion - ongoing	Promoting service to the Asian clients of HPHO GP practices and AHSS clients
Presentations and Display booths at various community events	Service promotion - ongoing	Promoting service to the Asian community groups using different venues
Network meetings (Appendix 1 (ii))	Service promotion - regular and ongoing	Promoting service to smokefree and cessation agencies
Regional smokefree coordinators	Regional meetings	Keeping regional smokefree coordinators informed
Mainstream Media - Herald - North Shore Times	Service Launch Service promotion	Promoting information to Asian who may not access ethnic-specific media
Healthlines	Service Launch – June 2006 1st Prize Oral Presentation Winner Article – Nov 2006	Promoting ASC service information to WDHB services /staff who may have Asian friends to refer to ASC

SECTION 3: RESULTS INCLUDING EVALUATION AND IMPROVEMENT

Q3.1 WHAT EVIDENCE (DATA AND/OR INFORMATION) IS THERE THAT SHOWS THAT INITIATIVES HAS BEEN A SUCCESS?

The initiative has successfully achieved its key objectives outlined in Section 1.2.

KEY OBJECTIVE ONE:
To increase the number of smokefree cars /home environments in Asian families.

The analysis of the impact of ASC on smokefree environments was based on the household data-set from the ASC database for the period from 1st May 2006 to 21st December 2006. Eight-seven households received ASC smokefree environments service. Sixteen were not smokefree inside their homes at baseline (18.4%). Almost two-thirds of the households reported smoking in cars at baseline (63.2%).

Smokefree rules in house and car (87 Clients)

Rules in house BEFORE ASC	Yes No Not stated	63 (72.4%) 16 (18.4%) 8 (9.2%)	**Rules in house AFTER ASC**	**All homes (100%) were smokefree after the intervention,** an increase of 18.4% from pre-intervention levels.
Rules in car BEFORE ASC	Yes No Not stated	21 (24.1) 55 (63.2) 11 (12.5)	**Rules in car AFTER ASC**	**All but two households had smokefree cars after the intervention,** an increase of 60.9%.

KEY OBJECTIVE TWO:
To increase the effectiveness of quit attempts in Asians who smoke

135 mainly male migrants, with Korean or Chinese as their first language, and a high level of dependency on tobacco, approached ASC in its first 7 months. Many (27) were out of area and unable to receive service. Nine people used the smokefree environments only option for service.

Results of quit rates (All cessation clients as a denominator): Of the 93 ASC cessation clients who had access to some form of intervention, the self-reported quit rate (continuous abstinence) was 72.0% at one month, and 53.8% at three months. Point prevalence quit rates would have been even higher, as many relapsed clients have since set second quit dates and remained quit for at least one month. These high quit rates (although self-reported and short-term) were supported by the high motivation levels of the clients and coordinators, demonstrated by a particularly low "did not attend" rate and a high level of follow-up contacts.

The 11 people who were "not ready to quit" received varying levels of service. Two set quit dates after 21 November (the cut-off date for the denominator). Two received some visits and phone calls. Seven contacted ASC and then determined with coordinators they were not ready to quit. These "not ready to quit" clients were excluded from the analysis in the second table.

All ASC cessation clients: Self-reported quit rates one month and three months after quit date *using a 7 day point prevalence (complete abstinence for 7 days prior to contact)*

One month post-quit date		
Quit	67	67 (72.0%)
Relapsed Lost to follow up Not ready to quit	14 1 11	26 (28.0)
		93
Three months post-quit date		
Quit	50	50 (53.8%)
Relapsed Lost to follow up Not ready to quit	29 3 11	43 (46.2)
		93

One month post-quit date *Excluding "not ready to quit" (11)*		
Quit	**67**	**67 (81.7%)**
Relapsed Lost to follow up	14 1	15 (18.3%)
		82
Three months post quit date *Excluding "not ready to quit" (11)*		
Quit	**50**	**50 (61.0%)**
Relapsed Lost to follow up	29 3	32 (39%)
		82

Nine of the 29 relapsed clients (31%) had set second quit dates. All of these had been quit for one month or more from their second quit date, and four had been smokefree for 3 months or more, therefore point prevalence quit rates would be higher than the continuous abstinence rates presented here.

Comparative Data for Cessation using Nicotine Replacement Therapy (NRT)
The following national and international studies are used to compare with ASC programme:

- A Cochrane metanalysis of NRT studies, most using 6 month validated continuous abstinence rates or 7 day point prevalence rates, found that 17% of smokers allocated to receive NRT had successfully quit compared to 10% of the control group (The Cochrane Collaboration Review, 2007).
- **The Evaluation of the Quitline NRT Programme (The Quit Group, 2005) measured the quit rate of those who received full intervention. The results showed 30% at 6 months and 18% at 12 months using a 2 day point prevalence (abstinence for 2 days prior to contact)**
- The Evaluation of ASC (2007) measured the quit rate of those who received full intervention. The result showed 82% at one month and 62% at three months. The results for six months and twelve months were not available at the time of this report.

KEY OBJECTIVE THREE:
To ascertain the appropriateness of the ASC service model for smokefree promotion and smoking cessation for the Asian population

Clients were satisfied with factors associated with language and culture, such as talking to coordinators (88.9%) and family involvement in treatment (79.4%). Access barriers were addressed since clients reported high satisfaction levels with their choice of appointment venue (88.9%) and appointment attendance was high (96.5%). The community-focused culturally specific service promotion was successful. Sixty-four percent said they had heard about ASC from family and friends or a community group.

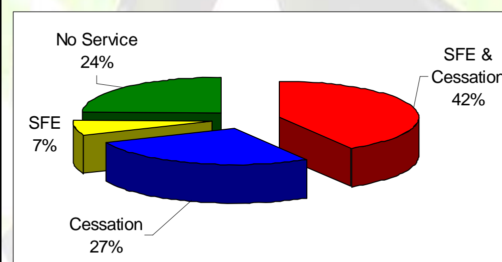
Almost all (92.1 %) clients said they would recommend the ASC service to family or friends

ASC Referrals: Gender and Ethnicity (Total Clients = 135)

Ethnicity	Female	Male	Not stated	Total	% of Total
Korean	13	58		**71**	**52.6%**
Chinese	6	39	4	**49**	**36.3%**
European/other	4	4	1	**9**	**6.7%**
Other Asian		2	1	**3**	**2.2%**
Not stated		2	1	**3**	**2.2%**
Total	**23 (17.1%)**	**105 (77.7%)**	**7 (5.2%)**	**135**	

ASC Referrals: Service and intervention type (Total Clients = 135)

Service: Cessation	SFE and cessation	56		
	Cessation	37	**93**	**68.9%**
Service: Smokefree environments only		9	**9**	**6.7%**
No service	Out of area	27		
	Pending appointment	4		
	Incorrectly referred	1		
	Unable to contact	1	**33**	**24.4%**



ASC cessation clients: Service use (Total appointments = 806)

Appointment type			
Phone, email		561	**561 (69.6%)**
Face-to-face	Individual	196 (83.1%)	**236 (29.2%)**
	Family	37 (15.7%)	
	Group	3 (1.3%)	
	Cancelled	**4**	**9 (1.1%)**
	Did not attend	**5**	

DNA Rate 1.1%

ASC cessation clients: Demographics and health (Total Clients = 93)

Gender	**Male**	**83**	**89.2%**
	Female	10	10.8%
Ethnicity	**Korean**	**49**	**52.7%**
	Chinese	39	41.9%
	European/other	4	4.3%
	Other Asian	1	1.2%

Age	20-29	10	10.8%
	30-39	14	15.1%
	40-49	**37**	**39.8%**
	50 -59	14	15.1%
	60+	7	7.5%
	Not stated	11	11.8%
Years in New Zealand	<1 year	7	7.5%
	1-5 years	**35**	**37.6%**
	6-10 years	22	23.7%
	>10 years	19	20.4%
	Not stated	10	10.8%
Medical conditions	Diabetes	10	10.8%
	Hypertension	6	6.5%
	Hyperlipidaemia	2	2.2%
	Asthma	1	1.1%
	Reflux	1	1.1%
	Sleeping disturbance	1	1.1%
	Nil	35	37.6%
	Not stated	**42**	**45.2%**

ASC cessation clients: Smokers' characteristics (Total Clients = 93)

Age first started smoking	<15	9	9.7%
	16-20	**46**	**49.4%**
	21-25	19	20.4%
	26-30	4	4.3%
	>31	3	3.2%
	Not stated	12	12.9%
Cigarettes per day	1-10	20	21.5%
	11-20	**44**	**47.3%**
	21-30	13	14.0%
	31-40	2	2.2%
	Not stated	14	15.1%
Time to first cigarette	**< 5 minutes**	**52**	**55.9%**
	5-9 minutes	2	2.2%
	10-30 minutes	7	7.5%
	> 30 minutes	20	21.5%
	Not stated	12	12.9%
Reasons for quitting*	**Health**	**72**	**77.4%**
	Family	24	25.8%
	Financial	13	14.0%
	Social	3	3.2%
	Religious	2	2.2%
	Not stated	12	12.9%
Previous quit attempt	**Yes**	**66**	**71.0%**
	No	19	20.4%
	Not stated	8	8.6%
Quit methods tried (self-reported methods)	**Self**	**45**	**48.4%**
	NRT patches and gum	17	18.3%
	NRT inhaler, microtab, other	3	3.2%
	Herbal	3	3.2%
	Not stated/no attempt	27	29.0%

Quit fail reasons (self-reported methods)	Cravings	27	29.0%
	Stress	15	16.1%
	Habit	11	11.8%
	Severe withdrawal	5	5.3%
	Exposure	4	4.3%
	Other	6	6.5%
	Not stated/no attempt	**27**	**29.0%**

Service Activity and Effectiveness Results

The Steering Group has led many activities to generate client referrals, raised the profile of Asian health issues in New Zealand, developed a service model for Asian peoples, and facilitated sharing with all cultures. The activities included media publicity, meetings and promotions with community groups and health professionals, and mail-outs to Asian community members.

ASC promotional activities	
Launch by Mayor of North Shore City and WDHB Board Members	80 attended
Number of health awareness events, expos and mall events	>7
Media activity Media releases Newspaper articles (Chinese and Korean) Weekly article series in Chinese language papers Weekly article series in Korean language papers plus other Chinese and Korean papers and mainstream papers Several eg Chinese World; radio and television; WDHB Asian Health website http://www.asianhealthservices.co.nz/asc.htm	2 2 9+ per paper
E-mails to Asian community leaders Mail-out to AHSS volunteers	>20 80
Mail-outs to WDHB Asian Health Support Services and GP practice Korean and Chinese clients	>2,000
Promotion in restaurants and Asian grocery stores and shops	>10
Community group meetings, seminars	3
Presentations and contacts with health professionals and organisations	>50
First prize WDHB Clinical Quality Awards, 2006	

Referral Source:

All Koreans referred themselves. Chinese people were referring themselves or were referred by others such as their wives or other service users (28.6%). The significant uptake from self referrals reflects on the accessibility of the language and culturally appropriate service, and the huge efforts from community promotion activities.

Service Utilisation Data:

Cessation clients had an average of 8.7 contacts (of any kind) each.

Employee results:

Employed two smokefree coordinators, one Korean and one Chinese. From the client survey, the ASC coordinators received the most praise. Clients were pleased with being able to communicate with the coordinators freely in their own first language with no cultural barriers.

Christina and Zhoumo (Korean and Chinese Smokefree Coordinators)

Financial results:
The project was managed within the allocated financial contribution.
For the purpose of measuring an average cost in this instance, the following table outlines 7.5 months of successful intervention data (1 May to 21 Dec 06) and using 7.5 month pro-rata expenses to calculate the average cost.

Service expenses (7.5 months) pro-rata cost of: 1 FTE salary, mileage, cell phone, database, and overhead expenses *Excluding establishment costs*	$50,435
ASC Clients who received some form of interventions / services (average 8.7 contacts/per client)	82
(a) Number of successful smokefree home intervention	24
(b) Number of successful smokefree car intervention	62
(c) Number of Quit at one month	67
(d) Number of Quit at three months	50
Average cost of successful intervention (based on number of successful interventions (a) + (b) + (c)	153 ($330 per successful intervention)
Average cost of successful intervention (based on number of successful interventions (a) + (b) + (d)	136 ($371 per successful intervention)

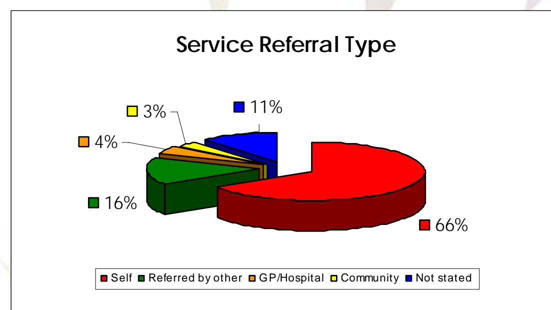
8 Cs Framework
Summary of Achievements

The factors critical to the success of the ASC model were good governance, cultural sensitivity, and community leadership and engagement. Cultural sensitivity and community engagement flowed through ASC from the Steering Group to service promotion and delivery.

The Service Development Framework "8 Cs" were multi-dimensional and allowed people to see how the components of ASC fit together. One of the dimensions was the important meaning of number "8" to Chinese people. **"8" means prosperity**.

1. Community engagement

to assist in developing a culturally specific approach
Self referrals make up the majority of the referrals received showing that the community is behind this initiative. The DNA "Did Not Attend" rate for the 852 appointments was 9 (1.1%). Of those 9 appointments, 4 were cancelled ahead of time.



2. Collaborative partnership

between primary health, public health, Asian health and the health gain team.
The partnership brings to the table different skill sets and resource sharing opportunities.

3. Combination of smoking cessation and smokefree promotion

as a package of intervention for clients
The combination of the interventions was a *unique, efficient,* cost effective way of presenting two synergistic interventions to the client, especially for clients who have difficulty accessing service. The following client story illustrates the points above:

Chinese Woman, aged 55 – Living with five smokers, one of whom was her son, noticed she was coughing and often short of breath from second-hand smoke. She consulted ASC to help her achieve a smokefree environment. Smokefree policy was introduced and after five months of home visits, four of the smokers, including her son, are smokefree, her symptoms have disappeared and her home is now healthier and cleaner.

4. **Culturally responsive**
   approach including family-oriented services with translated resources

5. **Communication support**
   with Asian language speaking staff or interpreters
   Clients considered talking to coordinators in their own language and having family involvement in treatment very useful. Access barriers were also addressed as a result of the provision of interpreters to support 30 Asian languages/dialects. The community-focused culturally specific service promotion was successful.

6. **Community based**
   service and outreach
   The community-based approach has proven to be an effective way of delivering services to Asian migrants who are not familiar with the health system, especially for those with transport difficulties. The home visits allowed coordinators to understand clients' needs more, and provided an opportunity to promote smokefree environments.

7. **Capacity building**
   of the Asian workforce
   The development of the two Asian staff skills and knowledge to perform their role effectively has been proven successful not only from the results, but from the coordinators' perspective.

8. **Collecting of client information**
   to support monitoring and evaluation to inform future planning
   The creation of a database has proven to be an excellent tool for the systematic tracking, reporting and monitoring of information.

Q3.2 How has the initiative been reviewed and improved following implementation?

Steering Group reviewed progress throughout the project implementation phase and made specific changes for continuous quality improvement. The following improvements were made:

- Database modifications:
  - Added additional alerts and prompts to improve client follow-up at specific intervals
  - Added a Fagerstrom score system to ascertain severity of nicotine dependence
  - Improved relapse tracking and added more reports

- Access criteria:
  - Modified the criteria to accept non-Asian clients who lived in same households

- Workforce training: provided client cessation relapse management training for coordinators
- Resource development: incorporated 3 languages into one ASC flyer
- ASC Guidelines: agreed measures for smokefree and cessation success
- Process improvement: Tracking of clients at specific intervals (1 month, 3 months, 6 months, 9 months, 12 months) to measure quit status at these specified times for future evaluation

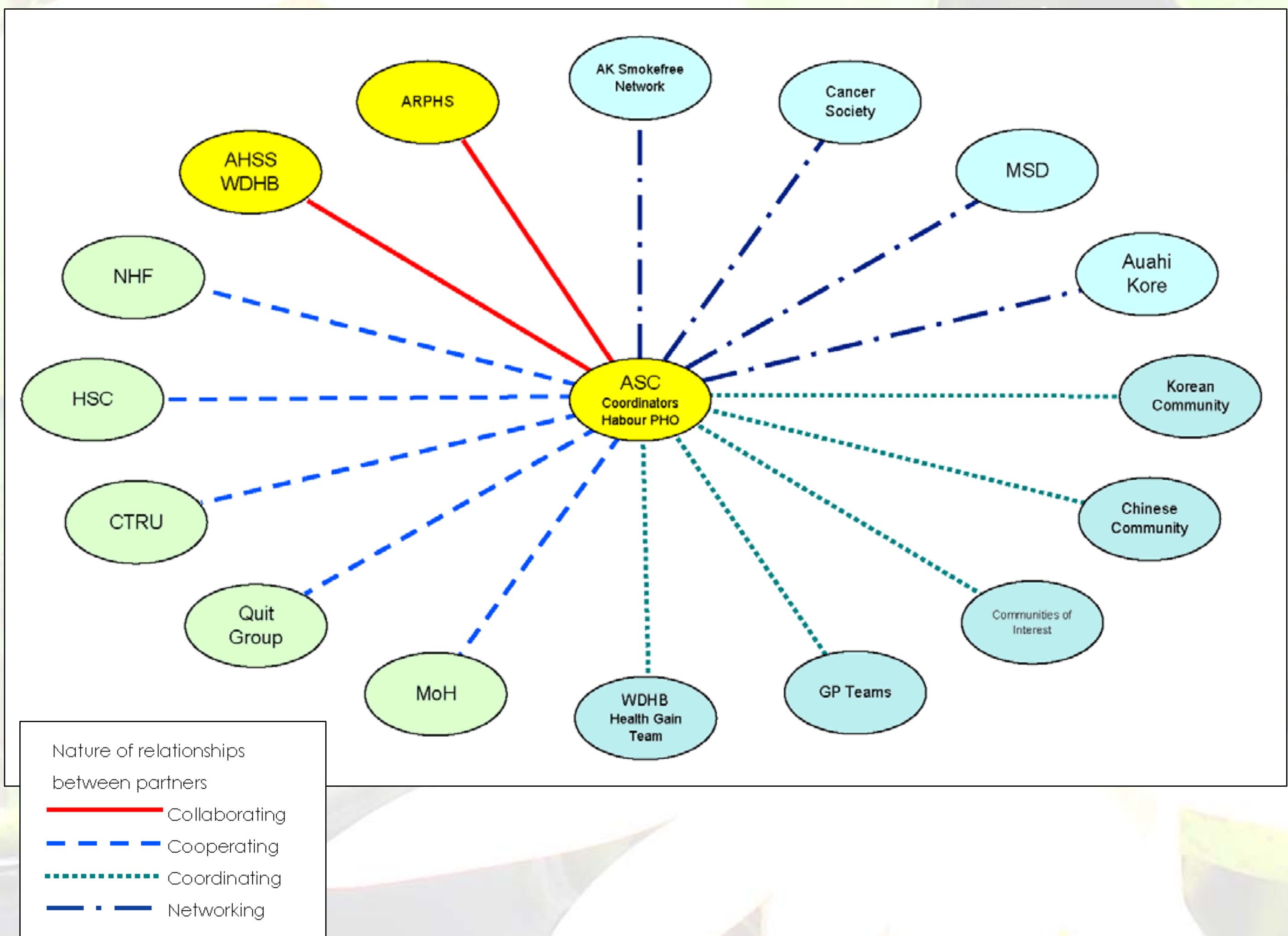
External evaluator reviewed process and impact outcomes. Recommendations include:
- ASC pilot project be continued and expanded
- Standardised follow-up of outcomes
- Evaluation of long-term quit rates at 6 months and 12 months
- Use of ASC model to address needs of Asian smokers and families across New Zealand
  - Workforce development
  - Steering Group to retain governance role
  - Improve database
  - Cultural responsiveness of the service
  - Further translation of resources
  - Consider implementation of Asian language smoking cessation support line
- Use of ASC model for other Asian health issues

Appendix 1

Part (i)
ASC Feasibility and Potential Solutions

Feasibility	Potential solutions identified
Funding and resources	➢ Agree initial funding contribution from each collaborative partner ➢ Identify and source funding and resources eg from Health Sponsorship Council, The Quit Group, National Heart Foundation, etc ➢ Source Funding for Evaluation Plan from MoH ➢ Source sustainable funding from WDHB via the PBMA Business Case Submission process in Oct 2006
Community acceptance of service model and resources development	➢ Consult with the community at key stages of service and resource developments
Partnership framework	➢ Set up formal partnership agreement and framework, with clear roles and responsibilities
Relevant and workable guidelines and processes	➢ Peer review and feedback to assist with development and for continuous quality improvement

Part (ii)
Networking, Cooperation, Collaboration, & Coordination



Glossary and Terms of Abbreviations

Term, Abbreviation or Acronym	Definition or Description
AHSS	Asian Health Support Services
ARPHS	Auckland Regional Public Health Service
ASC	Asian Smokefree Communities
CO	Carbon Monoxide
DNA	Did Not Attend
FTE	Full Time Equivalent
GP	General Practitioner
HGT	Health Gain Team
HPHO	Harbour Primary Health Organisation
Harbour PHO	Harbour Primary Health Organisation
HSC	Health Sponsorship Council
MoH	Ministry of Health
NRT	Nicotine Replacement Therapy
PHO	Primary Health Organisation
SFE	Smokefree Environments
SG	Steering Group
Waitemata DHB	Waitemata District Health Board
WDHB	Waitemata District Health Board

References

Ref #	Ref Detail	Description/Article Name	Authority
1	Ministry of Health, 2000	New Zealand Health Strategy - provides the framework within which DHBs and other health organisations operate and highlights the priorities the Government considers to be most important.	Ministry of Health
2	Ministry of Health, 2001	Primary Health Care Strategy - provides a clear direction for future development of primary health care in improving health outcomes.	Ministry of Health
3	Ministry of Health, 2001	New Zealand Health Strategy DHB Toolkit: Tobacco Control - designed to assist DHBs to implement the New Zealand Health Strategy priority population health objective of reducing smoking (and the harm from second-hand smoke)	Public Health Directorate of the Ministry of Health
4	Statistics New Zealand, 2001 from www.stats.govt.nz	Provides population analysis of the 2001 Census	Statistics New Zealand
5	Ministry of Health, 2003	New Zealand Cancer Control Strategy - the first phase in the development and implementation of a comprehensive and co-ordinated programme to control cancer in New Zealand; it includes purposes, principles and goals to guide existing and future actions to control cancer.	Ministry of Health and the New Zealand Cancer Control Trust
6	Ministry of Health, 2003	Asian Public Health Project Report - comprehensive view of Asian people's public health needs within the Auckland region to assist decision-makers, programme planners, etc to better respond to the increasing public health needs of Asian people.	Ministry of Health (Auckland Public Health Directorate)
7	Whittaker R & Thompson C, 2005	Establishment of Comprehensive Co-ordinated Smoking Cessation Services in Waitemata District – gap analysis and stocktake of smoking cessation services in the Waitemata district	WDHB Cardiovascular Advisory Group
8	The Quit Group, September 2005	Evaluation of the Quitline NRT Programme – multi-method evaluation to determine the Programme's appropriateness, effectiveness and accessibility conducted by BRC Marketing & Social Research	The Quit Group, commissioned by Ministry of Health
9	The Quit Group, November 2005	Economic Evaluation of the Quitline NRT Programme – aimed to establish number of people who quit smoking as a result of The Quit Group's activities (pre- and post-NRT) who would not otherwise have done so, the costs incurred in achieving this and the benefits resulting from smokers quitting.	The Quit Group, commissioned by Ministry of Health
10	Silagy C, Lancaster T, Stead L, Mant D, Fowler G, 2007	Nicotine replacement therapy for smoking cessation (Review) – a review of the effectiveness of nicotine replacement therapy in achieving long-term smoking cessation	The Cochrane Collaboration