

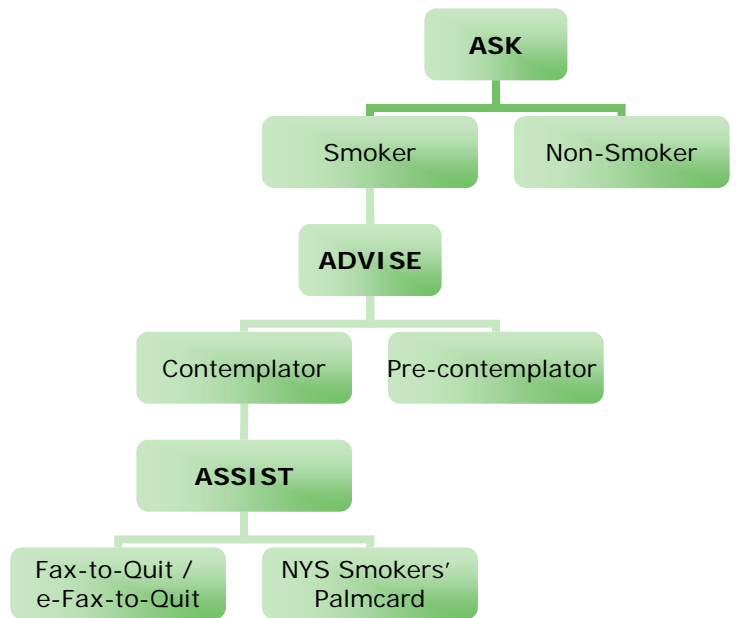


N E W S L E T T E R

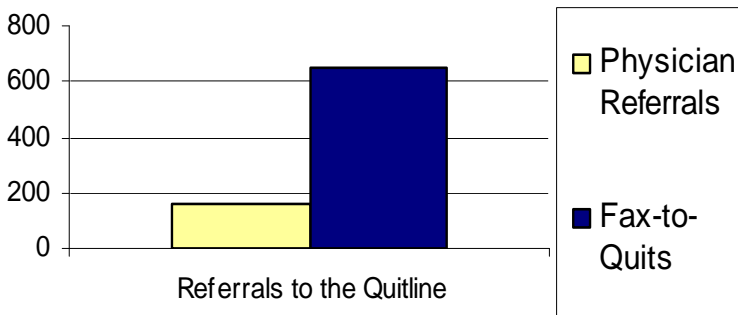
IS YOUR PRACTICE MEETING THE STANDARD OF CARE?

- ✓We ASK every patient at every visit about tobacco use.
- ✓We document this data in the patient record.
- ✓We consistently ADVISE identified tobacco users with a strong, personalized statement.
- ✓We ASSESS each patient's readiness to quit using tobacco.
- ✓We ASSIST patients by giving information on tobacco treatment options, including referrals to the NYS Smokers' Quitline.
- ✓We record interventions in the patient record and ARRANGE for follow-up.

USE THE 3-A's WITH EVERY PATIENT AT EVERY VISIT – YOUR PATIENTS ARE LISTENING



2008-2009 GRATCC referrals to the Quitline



The Fax-to-Quit and the Physician Referral are excellent ways to help connect your patients with effective, evidenced-based treatments. Be sure to remind your patients to say they were referred by your office.

DON'T BE SILENT ABOUT SMOKING

TalkToYourPatients.org

DEMONSTRATE YOUR COMMITMENT TO TALK TO YOUR PATIENTS ABOUT SMOKING – **COMPLETE AND RETURN** THE STANDARD OF CARE ON THE BACK OF THIS NEWSLETTER.

STANDARD OF CARE: TREATING TOBACCO USE AND DEPENDENCE

Name of Organization: _____

Provider: _____ Date: _____

Purpose:

To develop and implement a sustained change in methodology to the patient care system related to treating tobacco use and dependence.

Scope:

All patients will be screened for tobacco use at every visit. Patients identified as current tobacco users will be advised to quit, will be offered education and counseling on tobacco use cessation and pharmacotherapy. Such education and counseling, may be provided by:

1. A health care professional during the office visit;
2. Referral /faxed referral to the New York State Smokers' Quitline;
3. The provision of educational/self help materials.

For each patient visit, the patient record will clearly indicate that the patient was asked about tobacco use, was advised to quit, and was offered assistance in quitting.

Procedure:

1. At all visits; initial and subsequent, patients will be asked to self-report tobacco use.
2. Patient report is documented in the vital signs section (may use sticker or stamp), progress notes, or EMR by the nurse or medical assistant who documents other vital sign data.
3. Providers will deliver a strong, personalized advice statement to identified tobacco users; assess the patient's readiness to quit; and offer assistance by giving information on tobacco dependence treatment options, including pharmacotherapy and referral to other programs. The patient record will reflect the provider's interventions and plan for follow-up.

Please return to GRATCC
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mail PO Box 278969 Rochester NY 14627