Basic Tobacco Intervention Skills
Registration Form

Native Communities

HealthCare PARTNERSHIP
Transforming Lives with Evidence-Based Practices
University of Arizona HealthCare Partnership
www.HealthCarePartnership.org

Name _____ Degree _____ Today's Date _____/_____/_____

Employer _____ Job Title _____

Are you a health or human service professional? ☐ Yes ■ No

What type(s) of patients/clients do you work with and what percentage of each type?

☐ Medicare Patients_____ % ☐ Managed Care Patients _____% ☐ Indian Health Service Patients _____%
☐ Uninsured Patients _____ % ☐ VA Patients _____% ☐ Private Patients_____%
☐ Other *(please specify)* _____ _____%

What tobacco dependence treatment practices currently exist in your healthcare system?

If yes, which one? _____ Tribal affiliation _____

Background Information

Total years of education completed *(circle one)* (9) (10) (11) (12) (13) (14) (15) (16) (17) (18+)
High School College Post-Graduate

Major/area(s) of specialization: _____

List education, special training, licenses, or certifications in substance abuse or behavioral health: _____

How long have you worked in tobacco control? _____ years _____ months ☐ less than 1 month

Purpose for registering for this program: _____

Languages in which you are fluent: _____

Contact Information

Home Address _____
City _____ State _____ Zip _____

County _____
(_____) Home Telephone _____
(_____) Cell Phone _____

Work Address _____
City _____ State _____ Zip _____

County _____
(_____) Work Telephone _____
(_____) Fax Number _____

Email Address _____

Demographic Information

Race/Ethnicity *(please specify)*

☐ American Indian/Alaska Native _____
☐ Asian _____
☐ Black/African American _____
☐ Hispanic/Latino _____
☐ Multiethnic _____
☐ Native Hawaiian or other Pacific Islander _____
☐ White _____
☐ Other _____

Gender: Female ☐ Male ☐ Date of Birth: _____/_____/_____

Do you require Continuing Education Credits to renew your professional license?

☐ Yes ■ No

If yes, what profession? _____ Signature _____

Official Use ONLY

Instructor: _____

Instructor Initials: _____

THE UNIVERSITY OF ARIZONA.

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Confidence Self-Assessment

The following statements address competencies related to assisting people who are tobacco dependent to abstain from tobacco use. **Please indicate your level of confidence in addressing these issues by circling the most appropriate number.**

	Definitely Not Confident	Not Confident	Undecided	Confident	Definitely Confident
1. I can screen for and assess tobacco use	1	2	3	4	5
2. I can accurately assess my clients' motivation to quit	1	2	3	4	5
3. I can perform a brief intervention for tobacco cessation	1	2	3	4	5
4. I can explore issues related to smoking and quitting, even with someone NOT INTERESTED in quitting	1	2	3	4	5
5. I can accurately assess the dependence level of my clients	1	2	3	4	5
6. I can effectively use patient education materials for tobacco cessation	1	2	3	4	5
7. I can provide clients with accurate information regarding the health benefits of quitting	1	2	3	4	5
8. I can personalize the benefits of quitting with each individual client	1	2	3	4	5
9. I can create office protocols to support tobacco cessation	1	2	3	4	5
10. I can provide clients with simple advice and instructions about nicotine replacement therapy	1	2	3	4	5
11. I can describe first-line pharmacotherapies for tobacco cessation	1	2	3	4	5
12. I can help clients develop a personalized plan for quitting	1	2	3	4	5
13. I can help clients identify community resources to help them quit	1	2	3	4	5
14. I can arrange for appropriate follow-up for my clients	1	2	3	4	5

Knowledge Self-Assessment

The following questions are designed to assess your level of knowledge about tobacco issues before completing the Basic Tobacco Intervention Skills for Native Communities certification. Your answers on these questions do not count for a grade. **Please circle the one response that provides the best answer.**

1. Tobacco use should be brought up with the patient/client:
   - a. whenever the patient is presenting with a tobacco-related problem because he or she will be more motivated to quit
   - b. at every visit
   - c. only during general check-up visits when the patient is more likely to be focused on lifestyle issues
   - d. only every few months, so that the patient does not feel that he or she is being "nagged" about quitting
   - e. only by the physician

2. The highest risk for relapse from nicotine withdrawal is:
   - a. after the first week of being tobacco free
   - b. during the first 24 hours after quitting
   - c. during the first two weeks after quitting
   - d. up to three months after quitting

3. Name the first non-nicotine medication approved for use in treating tobacco dependence:
   - a. Claritin
   - b. Nexatrim
   - c. Nonase
   - d. Valium
   - e. Zyban

4. Name the Five As:
   - a. ask, advise, assess, arrange, act
   - b. ask, advise, admonish, assist, arrange
   - c. ask, advise, assess, assist, arrange
   - d. anticipate, advise, assess, arrange, act
   - e. approach, ask, advise, assist, arrange

The University of Arizona HealthCare Partnership
Tobacco Dependence Treatment Certification Program

Name: _____ **Date**: ____/____/____ **Employer**: _____

Which of the following tobacco control activities are routine procedures within your workplace setting?
(please check all that apply, N/A = Not Applicable)

Yes	No	N/A	ASSESSMENT
☐	☐	☐	1. Ask patients/clients/significant others about current commercial tobacco use at each visit.
☐	☐	☐	2. Ask patients/clients/significant others about past commercial tobacco use at each visit.
☐	☐	☐	3. Ask patients/clients/significant others about the potential of environmental tobacco smoke exposure within their home, workplace, vehicles, etc.
☐	☐	☐	4. Discuss the importance of quitting with patients/clients/family/friends unwilling to quit.
☐	☐	☐	5. Distribute self-help materials to commercial tobacco users on a consistent basis.
☐	☐	☐	6. Other *(please specify)* _____

Yes	No	N/A	TREATMENT
☐	☐	☐	7. Implement the Five A model when conducting tobacco dependence treatment interventions with commercial tobacco users.
☐	☐	☐	8. Help patients/clients who are willing to make quit attempt, set a date and develop a quit plan.
☐	☐	☐	9. Refer patients/clients/family/friends to suitable intensive services to support quit attempt.
☐	☐	☐	10. Refer patients/clients/family/friends to intensive services provided by:_____
☐	☐	☐	11. Provide follow-up support for commercial tobacco users during a quit attempt.
☐	☐	☐	12. Other *(please specify)* _____

Yes	No	N/A	PHARMACOTHERAPY
☐	☐	☐	13. Inform patients/clients about the use of pharmacotherapy for tobacco cessation.
☐	☐	☐	14. Provide no cost or reduced cost medications to assist commercial tobacco users willing to set a quit date: *Check medications available.* ☐ **Nicotine Replacement Therapy (NRT)** ☐ **Bupropion SR (Zyban)** ☐ **Varenicline (Chantix)**
☐	☐	☐	15. Have physician standing orders to provide pharmacotherapy for individuals willing to set a quit date.
☐	☐	☐	16. Other *(please specify)* _____

Yes	No	N/A	DOCUMENTATION & TRACKING
☐	☐	☐	17. Utilize a system *(e.g. vital sign stamps, medical history form, progress note, problem list cover sheet, computerized record system)* to ask patients/clients about current and past commercial tobacco use, along with the incidence of exposure to of environmental tobacco smoke at each visit.
☐	☐	☐	18. Document tobacco prevention/cessation intervention in the patient/client record.
☐	☐	☐	19. Implement the Electronic Health Record to document/track tobacco prevention/cessation interventions.
☐	☐	☐	20. Obtain treatment outcome information and verify abstinence using biochemical validation.
☐	☐	☐	21. Other *(please specify)* _____

Yes	No	N/A	SYSTEM SUPPORT
☐	☐	☐	22. Use billing codes to obtain reimbursement for Tobacco Dependence Treatment services.
☐	☐	☐	23. Provide a setting that has instituted policies and procedures that ensure a tobacco-free campus.
☐	☐	☐	24. Other *(please specify)* _____
☐	☐	☐	25. None