



**Stony Brook Medicine**

**OFFICE OF CONTINUING MEDICAL EDUCATION  
STONY BROOK UNIVERSITY  
SCHOOL OF MEDICINE**

*Performance Improvement Activity  
For physicians improving their practice of  
tobacco control.*



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The School of Medicine, State University of New York at Stony Brook, is accredited by the Accreditation Council for Continuing Medical Education to sponsor continuing medical education for physicians.

The School of Medicine, State University of New York at Stony Brook designates this activity for a maximum of 20 *AMA PRA Category 1 Credits*<sup>™</sup>. Physicians should only claim credit commensurate with the extent of their participation in the activity.

**PERFORMANCE IMPROVEMENT (PI) CME DOCUMENTATION FORM**

Name of Participant: \_\_\_\_\_  
(please print)

Phone: \_\_\_\_\_  
E-mail Address: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_  
City, State, Zip

Proposed Start Date for PI CME: \_\_\_\_\_

Signature: \_\_\_\_\_

Focus of PI Activity: Tobacco control

**Section I - PI Activity Planning**

1. Purpose of PI activity (e.g. identifying a question in practice)

Specify the objectives of your PI activity in terms of knowledge, competence and/or performance in practice.

*My goal is to demonstrate both increased competence and practice performance in tobacco control (through chart review) to achieve the following objectives:*

*Systematically (ask) identify all patients visiting my office who smoke.*

*Advise all who smoke to quit.*

*Assess the patient's willingness to quit.*

*Assist patients in their efforts to quit.*

*Arrange or schedule a close follow-up of those attempting to quit.*

2. What is your anticipated timeline?

a) Specify below the number of weeks or months you anticipate taking to conduct each PI stage you intend to complete (the 3 stages are described on the procedure cover page and in subsequent pages of form):

<u>Stage</u>	<u>Length of Time</u>
A. Current performance assessment	_____
B. Application of PI to patient care	_____
C. Evaluation of PI effort	_____

b) Please sign the disclosure form that is located at the end of this PI form.

**To obtain approval to begin the PI process as a Category 1 CME activity, please send a copy of both the signed disclosure form and this page with a check for \$50 made payable to Office of Continuing Medical Education and mail to:**

**Office of Continuing Medical Education  
HSC, Level 2 Room 142  
Stony Brook, NY 11794-8222**

**FOR CME USE ONLY**

Further information needed?  No  Yes, specify \_\_\_\_\_  
Approved \_\_\_\_\_ Date \_\_\_\_\_

**PERFORMANCE IMPROVEMENT (PI) CME DOCUMENTATION FORM**

**Name of Participant:** \_\_\_\_\_ **Date Completion of Stage A:** \_\_\_\_\_

**Focus of PI Activity:** Tobacco control

**Section II - Needs Assessment**

**Stage A. Evidence of learning from current practice performance assessment**

1. What performance measures are you using for your current practice assessment?

*Pre and post intervention assessment of chart documentation of: tobacco status (smoker or non-smoker) asked on last visit and for smokers, documentation that advice to quit was recorded as well as documentation that assessment of readiness to quit, assist/arrange quit attempt was recorded.*

2. Specify the data source(s) you will examine in your practice assessment, e.g., chart reviews, and attach a sample of any data collection form used.

*A retrospective review of charts of all patients 18 years of age or older who visited the office during a typical week(s) up to a minimum of 60 charts will be performed using the attached audit form. The attached Stage A evaluation will also be completed to learn from my current practice performance assessment.*

3. Describe the outcome of the measurement of your own performance in practice and/or append any data sheets to this form:

*See attached completed evaluation and the summary chart audit form*

**Signature:** \_\_\_\_\_

# Tobacco Control Chart Review

Physician Name: \_\_\_\_\_

Baseline       Post Intervention

Chart	Tobacco Status Documented on the Last Visit (asked)		Does Patient Use Tobacco?		Advice to Quit Recorded		Assess Readiness to Quit		Assist/Arrange Quit Attempt Recorded*	
	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
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Comments

\*Include Phamocotheraapy, Quitline referral, counseling, self-help materials, follow-up support

System to identify tobacco use: check one  
 \_\_\_\_\_ Sticker                      \_\_\_\_\_ Progress Note  
 \_\_\_\_\_ EMR                             \_\_\_\_\_ Other (specify) \_\_\_\_\_  
 \_\_\_\_\_ Stamp

# Tobacco Control Chart Review

Physician Name: \_\_\_\_\_

Baseline       Post Intervention

Chart	Tobacco Status Documented on the Last Visit (asked)		Does Patient Use Tobacco?		Advice to Quit Recorded		Assess Readiness to Quit		Assist/Arrange Quit Attempt Recorded*		Comments
	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	
31											
32											
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Total Count											

\*Include Phamocotheraapy, Quitline referral, counseling, self-help materials, follow-up support

System to identify tobacco use: check one

- Sticker                       Progress Note
- EMR                            Other (specify) \_\_\_\_\_
- Stamp

# Tobacco Control Evaluation Self-Report of Baseline Practices

## Stage A

### Learning from current practice performance assessment.

1. Do you screen ALL patients for tobacco use?  Yes  No
  
2. What percentage (approximately) of your patients do you routinely provide the following tobacco cessation activities?
  - A. Ask all your patients at every visit about tobacco use \_\_\_\_\_%
  - B. Advise (tobacco users) to quit \_\_\_\_\_%
  - C. Assess (tobacco users) willingness to quit \_\_\_\_\_%
  - D. Assist (tobacco users) in developing a quit plan \_\_\_\_\_%
  - E. Arrange for follow-up contact (for tobacco users) \_\_\_\_\_%
  
3. Is tobacco use incorporated into collection and recording of vital signs?  Yes  No  
\_\_\_\_\_
  
4. If tobacco use and dependence is not a part of your vital sign screening, how do you document Patient's tobacco use? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
  
5. Are ALL patients identified as tobacco users advised to quit?  Yes  No  
If no, then under what conditions are they not to be advised? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
  
6. Are you aware of the referral resources available to help you assist your patients in quitting smoking?  Yes  No

**Stage A continued**

7. What resources have you found to be most effective/useful? \_\_\_\_\_

\_\_\_\_\_

8. What resources have you found to be least helpful/useful? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

9. Describe your follow-up on tobacco use at subsequent visits \_\_\_\_\_

\_\_\_\_\_

10. What are the barriers in treating patients for tobacco dependence (circle all that apply)?

A. Not reimbursed by third party payers

E. Inadequate training

B. Not necessary/not needed

F. Not cost-effective

C. Unsubstantiated by research

G Patient not willing/motivated

D. Takes too much time

H. Other health issues take priority during a visit

I. Other (specify) \_\_\_\_\_

11. Do you feel your current interventions for tobacco use were effective? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

12. How would you describe your (& staff) educational needs? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Name** \_\_\_\_\_  
(please print)

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

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 STONY BROOK SCHOOL OF MEDICINE/HEALTH SCIENCES CENTER  
 STATE UNIVERSITY OF NEW YORK AT STONY BROOK

**PERFORMANCE IMPROVEMENT (PI) CME DOCUMENTATION FORM**

**Name of Participant:** \_\_\_\_\_ **Date Completion of Stage B:** \_\_\_\_\_

**Focus of PI Activity:** Tobacco control

**Section III - Participating in/initiating an intervention/educational activity to alter your knowledge, competence or performance and integrate what is learned into patient care.**

**Stage B. Evidence of learning from the application of PI to patient care**

1. Describe the intervention that you implemented based on the performance measures you selected in Stage A. Specify and attach a copy of any tracking tools, (e.g., flow sheets) utilized:

*Tobacco status was recorded as a vital sign in the chart. For smokers, the attached flow sheet was inserted in the chart and the action taken was recorded on this sheet. The attached Stage B evaluation was also completed to demonstrate learning from the application of performance improvement to patient care.*

2. Did you obtain guidance on the appropriate parameters for applying an intervention and assessing performance change that is specific to the performance measure and your patient base (e.g. how many patients with a given condition, seen for how long, will produce a valid assessment)? The OCME can provide assistance if needed.

Yes  No

**Signature:** \_\_\_\_\_



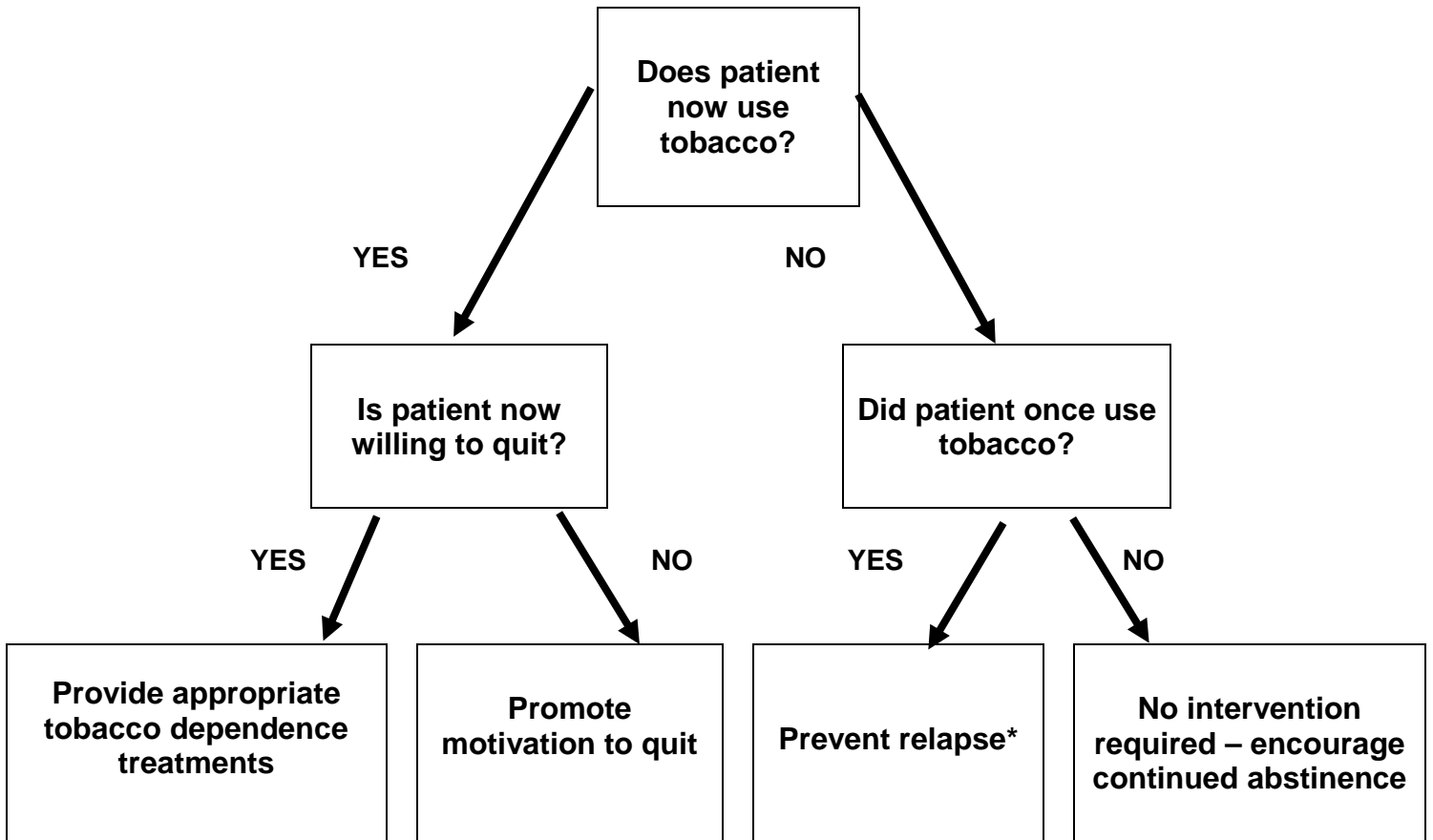
**SAMPLE STAMP OR STICKER FOR MEDICAL RECORDS**

<b>VITAL SIGNS</b>		
Blood Pressure:	_____	
Pulse:	_____	Weight: _____
Temperature:	_____	
Respiratory Rate:	_____	
Tobacco Use:	Current Fomer	Never
	(circle one)	

Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_

### ***Tobacco Control tracking form***



\*Relapse prevention interventions are not necessary in the case of the adult who has not used tobacco for many years.

***Action Taken:***

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## The 5-Steps (5As) for Smoking Cessation\*

- Step 1.     **Ask** – systematically identify all patients who smoke.  
(“Vital sign” stamp that includes smoking status.)
  
- Step 2.     **Advise** – strongly advise all who smoke to quit.  
(Tailor the advice towards the patients’ clinical situation.)
  
- Step 3.     **Assess** – assess the patient’s willingness to quit.  
(Ask every patient if he or she is willing to attempt to quit. If the patient is not ready, then provide motivational intervention to promote future attempts.)
  
- Step 4.     **Assist** – assist patients in their efforts to quit.  
(Pharmacotherapy and counseling.)
  
- Step 5.     **Arrange** – schedule a close follow-up.  
(Follow-ups should occur around the date that the patient ceases smoking.)

\*Adapted from the Agency for Health Care Policy and Research (13), with permission from *JAMA*. 1996;275:1270-1280. Copyright 1996, American Medical Association

# Tobacco Control Evaluation

## Post implementation of Intervention

### Stage B

#### Learning from the application of PI to patient care.

1. When did you begin implementation of the flow sheet in your practice? \_\_\_\_\_

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**ASK** Are all patients screened for tobacco use?  Yes  No

Is there a standardized method for documentation of tobacco use and dependence screening in every chart?

**ADVISE** Are all tobacco users advised to quit?  Yes  No

**ASSESS** Do you routinely evaluate your patients' willingness to quit smoking?  Yes  No

**ASSIST** Do you routinely prescribe pharmacotherapy for patients who are ready to quit smoking?  Yes  No

What referral resources have you utilized to assist in your patients' quit attempts?

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**ARRANGE** Do you follow-up with patients at subsequent visits? (Regarding tobacco use.)  Yes  No

2. Did you face any challenges implementing the flow sheet and/or Clinical Practice Guidelines? If so, what were they and how did you overcome the challenges?

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**Stage B continued**

3. How have your patients who smoke reacted to the change in your approach? \_\_\_\_\_

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5. Please provide one example of an effective intervention, which motivated a patient to make a quit attempt:

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**Name** \_\_\_\_\_  
(please print)

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

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STATE UNIVERSITY OF NEW YORK AT STONY BROOK

**PERFORMANCE IMPROVEMENT (PI) CME DOCUMENTATION FORM**

**Name of Participant:** \_\_\_\_\_ **Date Completion of Stage C:** \_\_\_\_\_

**Focus of PI Activity:** Tobacco control

**Section IV - Evaluating your own performance improvement effort as a part of the performance improvement activity.**

**Stage C. Evidence of learning from the evaluation of the PI effort**

1. After re-evaluating and reflecting on your performance in practice (Stage B), by comparing it to the assessment done in Stage A, summarize below any practice, process and/or outcome changes that resulted from conducting the PI activity and attach to this form any data spreadsheets comparing pre to post intervention:

*See attached post-intervention chart audit and completion of the Stage C Evaluation*

**Signature:** \_\_\_\_\_



# Tobacco Control Chart Review

Physician Name: \_\_\_\_\_

Baseline  Post Intervention

Chart	Tobacco Status Documented on the Last Visit (asked)		Does Patient Use Tobacco?		Advice to Quit Recorded		Assess Readiness to Quit		Assist/Arrange Quit Attempt Recorded*	
	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
31										
32										
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<b>Total Count</b>										

Comments

\*Include Phamocotheraapy, Quitline referral, counseling, self-help materials, follow-up support

System to identify tobacco use: check one  
 \_\_\_\_\_ Sticker                      \_\_\_\_\_ Progress Note  
 \_\_\_\_\_ EMR                              \_\_\_\_\_ Other (specify) \_\_\_\_\_  
 \_\_\_\_\_ Stamp



# Tobacco Control Evaluation Self-Report of Post Intervention Practices

## Stage C

### Learning from the evaluation of the PI effort.

1. When did you first begin working with the PI project (completed Stage A)? \_\_\_\_\_
2. When did you submit the first set of data to the OCME (completed Stage B)? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
3. Do you screen ALL patients for tobacco use?  Yes  No
4. What percentage (approximately) of your patients do you routinely provide the following tobacco cessation activities?
  - A. Ask all your patients at every visit about tobacco use \_\_\_\_\_%
  - B. Advise (tobacco users) to quit \_\_\_\_\_%
  - C. Assess (tobacco users) willingness to quit \_\_\_\_\_%
  - D. Assist (tobacco users) in developing a quit plan \_\_\_\_\_%
  - E. Arrange for follow-up contact (for tobacco users) \_\_\_\_\_%
5. Is tobacco use incorporated into collection and recording of vital signs?  Yes  No  
\_\_\_\_\_
6. If tobacco use and dependence is not a part of your vital sign screening, how do you document patient's tobacco use? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
7. Are ALL patients identified as tobacco users advised to quit?  Yes  No  
If no, then under what conditions are they not to be advised? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Stage C continued**

8. Are you aware of the referral resources available to help you assist your patients in quitting smoking?  Yes  No

9. What resources have you found to be most effective/useful? \_\_\_\_\_

\_\_\_\_\_

10. What resources have you found to be least helpful/useful? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

11. Describe your follow-up on tobacco use at subsequent visits \_\_\_\_\_

\_\_\_\_\_

12. How have you used or plan to use the analysis of the performance improvement data to enhance your current tobacco dependence standard of care?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

13. What are your overall impressions of this performance improvement project? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

14. What other improvements can you implement in your practice for patients who use tobacco?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Stage C continued**

15. Describe the feedback you have received from your patients identified as using tobacco, since the implementation of the Clinical Practice Guidelines:

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16. Has the implementation of the Clinical Practice Guidelines improved your treatment of patients who use tobacco?  Yes  No

How so: \_\_\_\_\_

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17. What barriers remain in treating patients for tobacco dependence (circle all that apply)?

- |   |   |
|---|---|
| A. Not reimbursed by third party payers | E. Inadequate training                              |
| B. Not necessary/not needed             | F. Not cost-effective                               |
| C. Unsubstantiated by research          | G. Patients not willing/motivated                   |
| D. Takes too much time                  | H. Other health issues take priority during a visit |
|   | I. Other (specify) _____                            |

**Name** \_\_\_\_\_  
(please print)

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

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School of Medicine – Stony Brook University  
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<b>CME Activity Title:</b> <u>Performance Improvement: Tobacco Control</u>	
Date: _____	
Name: _____	Title: _____
Phone: _____	E-mail: _____

**DISCLOSURE**

YES     NO    Have you (or your spouse/partner) had a personal financial relationship **in the last 12 months** with the manufacturer of the products or services that will be presented in this CME activity (planner) or in your presentation (speaker/author)?

If **NO**, skip to **DECLARATION** section below.    If **YES**, please list your disclosures and resolutions below.

Commercial Interest	Nature of Relevant Financial Relationship
Name of Company	Employee, Grants/Research Support recipient, Board Member, Advisor or Review Panel member, Consultant, Independent Contractor, Stock Shareholder (excluding mutual funds), Speakers' Bureau, Honorarium recipient, Royalty recipient, Holder of Intellectual Property Rights, or Other (specify)
1.	
2.	
3.	
4.	
5.	

**RESOLUTION OF CONFLICT OF INTEREST**

Presenter/Authors

- I will support my presentation and clinical recommendations with the "best available evidence" from the medical literature.
- I will refrain from making recommendations, regarding products or services, e.g., limit presentation to pathophysiology, diagnosis, and/or research findings.
- I will recommend an alternative presenter for this topic for the planning committee's consideration.
- I will submit my talk in advance to allow for adequate peer review.
- I will or have divested myself of this financial relationship.

Planners

- To the best of my ability, I will ensure that any speakers or content I suggest is independent of commercial bias.
- I will excuse myself from planning activity content in which I have a conflict of interest.

**DECLARATION**

I will uphold academic standards to ensure balance, independence, objectivity, and scientific rigor in my role in the planning, development or presentation of this CME activity. In addition, I agree to comply with the requirements to protect health information under the Health Insurance Portability & Accountability Act of 1996. **(HIPAA)**

Signature \_\_\_\_\_ Date \_\_\_\_\_

Additional information may be requested to resolve any conflict of interest. All identified conflicts of interest will be resolved, and disclosure will be made to activity participants.

**Please return completed form to:    Dorothy S. Lane, MD, Associate Dean for CME, School of Medicine, HSC, Level 2, Room 142  
Stony Brook University, Stony Brook, New York 11794-8222. Fax Number 631-444-2202**

**Office of Continuing Medical Education  
School of Medicine – Stony Brook University**

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*And*

- If the product he/she will be discussing is not labeled for the use under discussion or that the product is still investigational.

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