Tobacco Disease Registry Guide

Building tobacco-free families and eliminating children's secondhand smoke exposure through routine screening, assistance, and follow-up

Why create a Tobacco Disease Registry?

- Systematic regular screening, documentation, and follow-up of tobacco use and exposure in the household is important for identifying patients with secondhand smoke exposure and providing families the necessary ongoing support and resources to become 100% tobacco-free.

Maintaining a Tobacco Disease Registry serves as a tool for your practice to improve:

- ✓ Routine documentation of tobacco exposure in patients' electronic health records
- ✓ Record-keeping of high-risk patients
- ✓ Identification of parents/families who will benefit from follow-up regarding tobacco control and assistance
- ✓ Following the 3-Step approach (Ask, Assist, Refer) for families with tobacco exposure at every visit
- ✓ Establishing routine follow- up procedures

Step 1: Screen for tobacco use and exposure

A simple tobacco screener question to ask all families at check-in is:

Does any member of your household use tobacco?

❖ Asking every family about tobacco exposure establishes your concern about the health of the patients and families in your practice. It opens the door to address this major public health hazard and expresses your willingness to prioritize a tobacco-free environment for the benefit of your patients and families.

❖ The next slide includes suggestions for integrating this tobacco screener into your practice.

Screening Methods

Suggestions for screening for tobacco exposure at check-in include:

- Using an electronic device (such as a tablet) to conduct a brief screening survey of every family who checks in for a clinical visit.

- Incorporating the screener question as a component of already existing intake paperwork or questionnaires that parents/families fill out upon checking in.

- Distributing strips of bright colored paper at the front desk that say:

  Please circle one. Does any member of your household use tobacco?

  Yes No

  These paper strips allow for a private exchange of information between the front desk staff and the family.

- For practices that feel comfortable doing so, the front desk staff may verbally ask the screener question to each family checking in.

Before the clinical visit

- At check-in, front desk staff should give every family who screens positive for tobacco exposure in the home the following materials before they see the clinician:
  - ✓ The AAP CEASE Action Sheet
  - ✓ The state Tobacco Quitline Fax-to-Quit enrollment form

- A positive screen is any answer that indicates that a member of the household used tobacco. It is appropriate to provide resources and support to anyone who lives with or cares for the child to reduce secondhand smoke exposure in the child's environment.

AAP CEASE Action Sheet: Step 1

- The AAP CEASE Action Sheet 'Step 1' should be completed by the parent/family member who uses tobacco and brought in to the exam room to review with the clinician.

- Even if the tobacco user is not present at the visit, every family who screens positive should receive the AAP CEASE Action Sheet at the front desk and review it with the clinician during the clinical visit.

Step 2: Collect information and document household tobacco use

- The AAP CEASE Action Sheet 'Step 2' cues the physician to ask key questions and provide the necessary tobacco control resources to help the family become tobacco-free.

- Consistent, routine documentation of tobacco use and exposure as well as services provided is critical. This information will be used to develop your tobacco disease registry. Using key words during electronic record documentation may aid in future queries of your electronic medical records system. As a practice, work together to identify the key words you wish to use.

Step 3: Consider the benefits of having a Tobacco Control Coordinator in your practice

- Work with your office to develop a key contact who can serve as a resource in your practice to help other staff members routinely and effectively address tobacco use with families.
- This person can serve to help coordinate information and follow-up, identify and utilize community linkages and resources for tobacco use cessation, and build relationships with families for whom tobacco is an issue.
- This person can be any staff member who is passionate about helping families live healthier, tobacco-free lives. The Tobacco Control Coordinator is most effective if he/she has the opportunity for regular contact with physicians in the practice in order to reinforce clinical actions that facilitate tobacco control.
- The electronic health record Problem List and detailed Notes in the patient's record can inform the Coordinator's follow-up efforts. This may include phone calls after the family's visit to ask if identified tobacco users received and are using cessation assistance, such as NRT, the Quitline, text messaging services, and/or would like help being set up with any of these resources.

Step 4: Create a meaningful Tobacco Disease Registry report

- The information documented in the patient's electronic medical record can be used to generate a disease registry report. Query your medical records system to identify those patients with identified tobacco use and exposure in the home.

- Suggested fields for the report include names of patients who have tobacco use in their household, clinician name, most recent visit date, and which member of the household uses tobacco. See the "Sample Report" to use a guide.

- Regularly generating this report offers your practice the opportunity to provide each clinician with an up-to-date list of their patients with tobacco exposure in the home. By doing so, clinicians may choose to utilize the Tobacco Control Coordinator for support, or provide direct follow-up with families that would benefit from increased support and resource referral. One way to provide additional support is to schedule a special appointment to address quitting smoking and reducing secondhand smoke exposure.

Sample Report

Clinician Name	Date of Visit	First Name of Child (patient)	Last Name of Child (patient)	Household Tobacco User
Garvey, M.	5/12/2013	Adam	Redburn	Mother
Garvey, M.	5/14/2013	Savannah	Charst	Mother
Garvey, M.	5/14/2013	Elias	Farnsworth	Father
Garvey, M.	5/20/2013	Harvey	Gittly	Patient
Garvey, M.	6/1/2013	Samantha	Armond	Other
Garvey, M.	6/15/2013	Vernonica	Boil	Father
McMillen, C.	5/12/2013	Susan	Kort	Father
McMillen, C.	5/15/2013	Edmond	Riley	Other
McMillen, C.	5/17/2013	Rico	Juanes	Mother
McMillen, C.	5/22/2013	Charley	Pitman	Father, Mother
McMillen, C.	6/18/2013	Amanda	Stateman	Mother
Steiner, P.	5/2/2013	Phillip	Hammond	Father
Steiner, P.	5/4/2013	Ryan	Adams	Other
Steiner, P.	5/10/2013	Chris	Netwood	Father, Mother
Steiner, P.	5/15/2013	Rihanna	Duback	Mother
Steiner, P.	5/17/2013	Alexia	Carvos	Father
Steiner, P.	6/19/2013	Bob	Branhom	Other
Thomas, R.	6/4/2013	Brittany	Stone	Mother
Thomas, R.	6/21/2013	Francis	Lineman	Father, Mother

Incorporating a Tobacco Disease Registry into your practice

Develop a plan for:

- ✓ Who will develop and maintain the Disease Registry
- ✓ Who will serve as the Tobacco Control Coordinator
- ✓ How, and how often, each doctor will receive his/her list of patients with tobacco exposure
- ✓ Routine follow-up procedures

Key Highlights

A Tobacco Disease Registry is used to:

- ✓ Identify families in need of additional support, resources, and follow-up around tobacco cessation and control.
- ✓ Help guarantee you discuss tobacco use and exposure at every visit for households in which tobacco is an issue and yearly for households in which tobacco exposure has not been previously documented.
- ✓ Ensure documentation of tobacco exposure in the household is occurring 100% of the time and follow-up procedures are in place for assisting high risk patients.