OREGON State

**Cessation Program Review Questionnaire**

Survey Date (MM/DD/YY) \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

**Instructions:** Please refer to the attached list of tobacco cessation resources in the state of Oregon (sorted by county). If the contact information shown for your organization needs updating, please fill out the form below completely (even if only one item needs to be changed) and return it to the address below. If nothing needs to be changed, simply check the “No Changes” box and return it to us.

We also would like to keep up to date on the specifics of your cessation program (which we use to refer callers to local resources). Please take a few minutes and complete the attached survey and return it with your contact update.

Your name: Title:

Name of Organization:

Street Address:

City/State/Zip:

**Counties served**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Business Phone: FAX:

E-mail: Web site:

Contact Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Tobacco Cessation Program Name** (e.g. FreshStart):

* No Changes to Contact Information – data is correct

# DESCRIPTION OF SERVICES

1. How frequently do you offer your tobacco cessation program? *(Check all that apply.)*
* Weekly
* On a regularly scheduled basis (e.g. every Thursday night)
* Whenever a group can be formed
* On demand
* Other *(Specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)*

*2.*  Do you conduct an initial assessment of the client’s readiness to quit?

* No
* Yes

***If Yes:***

*2a*. Which of the following are used to evaluate the client’s readiness to quit? *(Check all that apply.)*

* Discussion of health risks of using tobacco
* Discussion of benefits and rewards of quitting tobacco use
* Discussion of motivation to quit using tobacco
* Discussion of confidence to quit using tobacco
* Discussion of willingness to quit at this time
* Discussion of social support
* Discussion of current and past tobacco use
* Other *(Specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)*

*3.* Does your tobacco cessation program use a published curriculum?

* No
* Yes

***If Yes****:*

*3a*. Curriculum name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*3b.*  Is the published curriculum adapted in any way? *(e.g. different number of sessions, in Spanish, adapted for Native Americans, adapted for other special populations, etc.)*

* No
* Yes *(Specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)*
1. Do you use a curriculum of your own design?
* No
* Yes Curriculum name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
1. Which of the following topics does your curriculum address? *(Check all that apply.)*

### Problem solving techniques

* Skills training (such as coping skills)
* Stress management (such as relaxation exercises)
* Basic information on tobacco use and successful quitting strategies
* Encouragement to talk about the quitting process
* Use of self-help materials
* Relapse prevention (how to recognize and avoid relapse)
* Direct contact with a clinician for support
* Social support during program
* Social support outside of program
* Aversive techniques (rapid smoking, rapid puffing, other smoking exposure)
* Other *(Specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)*

1. Which of the following services does your cessation program offer? *(Check all that apply.)*
* Individual face-to-face counseling
* Group counseling
* We initiate telephone calls for client counseling
* We respond to telephone calls for client counseling
* Self-help materials
* Acupuncture
* Hypnosis
* Other *(Specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)*
1. What language(s) are cessation services provided in? *(Check all that apply.)*
* English
* Spanish
* Other *(Specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)*

1. Are your materials published in a language other than English?
* No
* Yes—What language? Spanish Other *(Specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)*
1. Are your materials designed for use with specific audiences? *(Check all that apply.)*
* Ethnic/Multi-cultural groups *(Specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)*
* Pregnant or parenting women
* Youth
* Other *(Specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)*
1. Which of the following self-help materials does your program offer? *(Check all that apply.)*
* Brochures
* Books
* Audio tapes and or Video tapes
* Materials from the internet
* Other *(Specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)*

*10a*. What is the reading level of your printed materials? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PHARMACOLOGICAL THERAPIES**

1. Does your program recommend and/or provide any of the following pharmacological therapies? *(Check only one response per line.)*

Type of therapyProvide Recommend; Neither

 do not provide

1. Nicotine gum
2. Nicotine patch
3. Nicotine inhaler
4. Nicotine nasal spray
5. Bupropion (Zyban)
6. Clonidine (Catapress)
7. Nortriptyline (Aventyl or Pamelor)
8. Non-nicotine herbal remedies
9. Other pharmacological therapies

 *(Specify:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)*

*12.* Do you provide any assistance to your clients to purchase or obtain pharmacological therapies?

 No

 Yes

***If Yes:***

*12a*. How is this assistance dispensed? *(Choose all that apply.)*

 Directly to client (i.e. product is given to client from cessation provider)

 Using a coupon for a specific facility (store, pharmacy, physician)

 Using a coupon for any facility (anywhere the product is sold)

*12b*. What is the cost for this assistance to the client?

 No cost (free to client)

 Discount (client pays part of the cost)

 Varies, depending on the client’s income (e.g. a sliding scale: some clients pay 10%, others pay 75%)

*12c.* Are these resources available to people with tobacco cessation coverage through their health insurance plan?

* No
* Yes

#### DELIVERY OF PRODUCTS AND SERVICES

 *13.* Where are your cessation services delivered? *(Check all that apply.)*

 At the main address (listed on the first page of this survey)

 At offsite locations

*14.* Is childcare available during times when cessation services are offered?

 No

 Yes

 *15.* Is your program offered at a site accessible to people with physical disabilities

(e.g. wheelchair users, etc.)?

 No

 Yes

 *16.*  When are services provided? *(Check all that apply.)*

 Mornings

 Afternoons

 Evenings

 Weekends

*17.* *.* How do people register for your cessation services? *(Check all that apply.)*

 By phone

 In person

 By mail

 By referral from insurance provider

 By email

 Other *(Specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)*

*18.* On average, how many days do people wait to receive cessation services from the time

they first contact you? *(Provide exact number, not a range.)*

Number of days: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 *19.* How long is an average session? *(Provide an exact number, not a range.)*

 Number of minutes\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*20.*  How many sessions are there in your program? *(Provide exact number, not a range.)*

 Number of sessions\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*21.* For each client, what is the average duration of an entire program? *(Record duration in numbers of sessions per period of time, e.g. one session per week for six weeks.)*

 Number of sessions \_\_\_\_\_\_\_\_\_\_\_\_\_ Number of weeks \_\_\_\_\_\_\_\_\_\_\_\_\_

#####  Other *(Specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)*

*22.* Do you charge a fee for your cessation program?

 No

 Yes

***If Yes:***

*22a*. How much do you charge for cessation services? Total cost: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*(If necessary, attach an additional page to describe fee structure in greater detail.)*

##### **PROGRAM OUTCOMES**

*23.* Do you conduct follow-ups with your clients?

 No *(If no****, END*** *survey questionnaire)*

 Yes

***If Yes*:**

*23a*. How do you follow-up with clients? *(Check all that apply.)*

 Telephone contact

 Mail letters or postcards

 Establish appointments for relapse prevention

 Visit prison/shelter or other offsite location

 Other *(Specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)*

*23b*. Do you contact: *(Check only* ***ONE*** *response.)*

 All program participants

 A random sample of program participants

 A selected sample of program participants

 Other *(Specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)*

*23c*. How often do you follow-up? *(Check all that apply.)*

 At 30 days

 At 3 months

 At 6 months

 At 12 months

 Other *(Specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)*

***Thank you for your help keeping our records up to date!***

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| --- | --- |
| **Please return completed form to:** | **Attn. Cherinda Cage****GHC****ANB-1, CHP****Oregon Tobacco Quit Line****12401 E Marginal Way S****Tukwila, WA 98168****(206) 988- 7947****fax #206-988-7878** |