

Dental Practice Interest Card

[POSTCARD BACK]

Do you have Internet access in your office?

Yes _____ No _____

Do YOU access the Internet from your office at least once a week?

Yes _____ No _____

Would you be interested in participating in this project?

Yes, very interested _____ Yes, somewhat interested _____ No _____

How many years have you been in practice? _____

Thank you so much for your participation in this survey; please return via US mail.

[POSTCARD FRONT -- RETURN ADDRESS]

Andrea H. Mathews, RDH, BS
1530 3rd Avenue South
SDB 111
Birmingham, AL 35294-0007

BASELINE PRACTICE SURVEY

ORAL CANCER PREVENTION PROJECT

We appreciate your participation in the Oral Cancer Prevention Project. An important part of the project is the completion of this survey about your practice. The information provided is confidential and the results will be reported only as statistical summaries, with no personal identifiers.

Name of person completing survey: _____ Today's Date: _____

Your position: _____

Do the dentist(s) in this practice also practice at other settings?

_____yes _____no

PART 1: PATIENT DEMOGRAPHICS

For each of the following, please estimate the percentage of patients in this practice. (If you do not know exact percentages, please provide your BEST GUESS.)

1a. Approximately what percentage of the patients in this practice are ... ?
[please check that the total adds to approximately 100%]

Children & Teenagers (1 to 18 years)	about _____%
Young adults (19 to 44 years)	about _____%
Middle aged adults (45 to 64 years)	about _____%
Elderly (65 or older)	about _____%
	[Adds to about 100%]

1b. Approximately what percentage of the patients in this practice are..?
[please check that the total adds to approximately 100%]

White, not of Hispanic origin	about _____%
White, of Hispanic origin	about _____%
Black or African-American, not of Hispanic origin	about _____%
Black or African-American, of Hispanic origin	about _____%
American Indian	about _____%
Asian or Pacific Islander	about _____%
Other, please specify _____	about _____%
	[Adds to about 100%]

1c. Approximately what percentage of the patients in this practice are ...?
[please check that the total adds to approximately 100%]

Covered by private insurance that pays for some or all dental care	about _____%
Covered by a public program that pays for some or all dental care	about _____%
Not covered by any third party and pay their own bills	about _____%
Not covered by any third party and receive free care or for a fee that is substantially reduced	about _____% [Adds to about 100%]

PART 2: ABOUT THIS PRACTICE

2a. Check one of the following that best describes this practice during the past 12 months?

- _____ 1. Too busy to treat all people requesting appointments
- _____ 2. Provided care to all who requested appointments, but the practice was overburdened
- _____ 3. Provided care to all who requested appointments, and the practice was not overburdened
- _____ 4. Not busy enough - the practice could have treated more patient

2b. On approximately what percent of patients are the following services provided at some time while they are patients in this practice?

(If you do not know exact percentages, please provide your BEST GUESS.)

- _____ % of patients get: Diet counseling
- _____ % of patients get: Tobacco counseling
- _____ % of patients get: Alcohol moderation and/or cessation counseling
- _____ % of patients get: Blood pressure screening
- _____ % of patients get: Oral cancer screening examination
- _____ % of patients get: Oral hygiene instruction
- _____ % of patients get: In-office fluoride application
- _____ % of patients get: Fluoride gel/rinse prescribed or recommended for home use
- _____ % of patients get: Patient education from written pamphlets
- _____ % of patients get: Patient education from videos or slides
- _____ % of patients get: Intraoral photographs taken (conventional, non-video photography)
- _____ % of patients get: Intraoral video images taken (usually done with fiberoptic)
- _____ % of patients get: Oral CDx Brush Biopsy for early detection of oral cancer
- _____ % of patients get: Surgical Biopsy
- _____ % of patients get: In-office whitening (usually done with carbamide peroxide)
- _____ % of patients get: At-home whitening (usually done with carbamide peroxide)

PART 3: USE OF COMPUTERS IN THIS OFFICE

3a. How many computers with Internet access does this practice have? _____

3b. What type of Internet access do you have at this practice? (check all that apply):

- High-speed internet or phone access (DSL or Cable)
 Dial-up (requires user to key-in phone number for access)
 Other, please specify _____

3c. Indicate in what ways this dental practice uses the computer (check all that apply):

- Patient education Email Order supplies
 Electronic dental record Personal use Scheduling
 Drug reference database Decision support systems Billing
 Other, please specify _____

PART 4: CHARACTERISTICS OF PROVIDERS

Please provide the following information on all providers (dentists, hygienists, dental assistants) at this practice:

Dentist(s) First Name	Dentist(s) Last Name	Office and/or Home Email(s)	Years at this practice
Hygienist(s) First Name	Hygienist(s) Last Name	Office and/or Home Email(s)	Years at this practice
Dental Assistant(s) First Name	Last Name	Office and/or Home Email(s)	Years at this practice
Please complete the following for the OTHER PROVIDERS at this practice			
First Name	Last Name	Office and/or Home Email(s)	Years at this practice

Thank you. Please return the completed survey in the enclosed, addressed envelope within one week of receiving materials. If you have any questions regarding the questionnaire, please call: Andrea Mathews, UAB School of Dentistry, 205-934-2578.

Dear Patient,

Your dentist is taking part in a study about preventing oral cancer. You are being asked to fill out the other side of this card to help us learn more about what happens during a dental visit.

Answering the questions is voluntary and all your answers will be kept confidential. Nobody from the dental office will see your answers.

We will be contacting some patients from this practice for a brief phone survey. If you are willing to be called, please give us your name and phone number. For taking part in the phone survey you will be mailed a \$10 gift card.

If you decide not to give us your name, we hope you will still answer the questions on this card.

THANK YOU FOR HELPING US! ☺

For questions about this project, please call
Jessica Williams at 205-996-4957.

As you leave, please place your completed card in the survey box.

Before you answer these questions, please read the other side. →

What is your age? _____

Are you: Male ___ or Female ___

Do You Now:	YES, every day	YES, some days	NO
Eat five servings of fruits or vegetables a day?			
Smoke cigarettes, cigars, or use smokeless tobacco?			
Drink Alcohol?			
During your dental visit TODAY did anyone:	YES	NO	
Ask you if you eat five servings of fruits or vegetables daily?			
Ask you if you smoke cigarettes, cigars, or use smokeless tobacco?			
Ask you if you drink alcohol?			
During your dental visit TODAY did anyone:	YES	NO (or does not apply)	
Advise you to eat five servings of fruits or vegetables daily?			
Advise you to quit tobacco?			
Advise you to cut down or quit alcohol?			

If you are willing to be called for phone survey, and receive a \$10 gift card, please give us:

Your Name: _____ Phone (area code first) _____

Best day(s) to call you _____ Best time of day: _____ (am / pm)

Before Survey, insert Dr. name on pages 1, 3, and 7.

Oral Cancer Prevention Project Patient Telephone Interview

Hello, may I speak with Mr./Mrs. _____. *Wait for response.*

This is _____ calling from the University of Alabama School of Dentistry. How are you today? *Wait for response.*

Your dentist, Dr _____ is participating in a study that looks at preventing oral cancer. I am calling about the post card survey you filled out at the office about six months ago that gave us permission to call you. I would like to ask you a few questions that will take about 10 minutes and you will receive a \$10 gift card for your time. Can I tell you a little more about this project?

- **IF NO:** Is there a better time to call?
 - **If YES, TIME:** _____
 - If NO, That is fine and I thank you for talking with me.
- IF YES:** Great. PROCEED.

All information you provide will be confidential, you will not be identified by name and none of your information will be given to your dentist. Your participation in this interview is voluntary and if you decide not to participate; it will not affect you or your care in any way.

- **[For every 20th call, add the following:** *Would you be willing to let us audiotape this interview for quality purposes? IF YES, turn on recorder, IF NO, tell person you will not record and proceed.]*

Are you willing to participate in the phone survey?

- IF NO:** That is fine and I thank you for talking with me.
- IF YES:** Great, is this a good time for us to talk?
 - If NO: Is there a better time to call? TIME _____
 - **If YES:** If there are any questions you do not wish to answer, please let me know. There are no right or wrong answers to these questions - just answer the best you can.

A1. Do you smoke cigarettes, cigars, or use smokeless tobacco (dip, chew or snuff) now?^{2 *DK/NS}

- YES
 - A1a. *IF YES:* Do you smoke (or use tobacco products) every day or some days?
 - YES, every day
 - YES, some days
- NO
 - A1b. *IF NO: Interview asks:* Have you ever smoked cigarettes, cigars, or used smokeless tobacco?^{11 added cigars and smokeless}
 - YES-** PROCEED WITH SURVEY
 - NO-** END SURVEY and take the person's information to SEND A GIFT CARD
- DON'T KNOW/NOT SURE
- REFUSED

Now I am going to ask you a question about each type of tobacco.

A2 Do you currently smoke cigarettes (smoked even 1 puff in the last 7 days)?⁸

- YES
- NO
- DON'T KNOW/NOT SURE
- REFUSED

A3. Do you currently smoke cigars (smoked even 1 puff in the last 7 days)?⁸ Adapted to fit cigars

- YES
- NO
- DON'T KNOW/NOT SURE
- REFUSED

A4. Do you currently use chewing tobacco or snuff (took even 1 dip in the last 7 days)?⁸

- YES
- NO
- DON'T KNOW/NOT SURE
- REFUSED

IF A2 or A3 or A4 is YES, PROCEED TO PAGE 3

ELSE,

IF A2=NO, PROCEED TO PAGE 5

ELSE,

IF A3=NO, PROCEED TO PAGE 5

ELSE,

IF A4=NO, PROCEED TO PAGE 5

ELSE,

PROCEED TO PAGE 7

BRANCH 1- QUESTION B ON THIS PAGE ARE FOR PATIENTS WHO CURRENTLY SMOKE

B1. Since the time that you completed the survey in Dr. _____ office, how many times have you made a serious attempt to quit smoking? (A serious quit attempt is 24 hours or more without smoking) ^{8 adapted to say Dr's office *DK/NS R}

- None
- 1 time
- 2 times
- 3 times
- More than 3 times
- DON'T KNOW/NOT SURE
- REFUSED

B2. Are you seriously thinking of quitting tobacco? ^{6 * DK/NS R}

- YES, within the NEXT 30 DAYS
- YES, within the NEXT 6 MONTHS
- NO, not thinking of quitting
- DON'T KNOW/NOT SURE
- REFUSED

IF MORE THAN 1 IN A2-A4 ARE YES, PROCEED TO ALL CATEGORIES THAT APPLY
IF A2 IS YES, PROCEED TO "IF CIGARETTES"
IF A3 IS YES, PROCEED TO "IF CIGARS"
IF A4 IS YES, PROCEED TO "IF SMOKELESS TOBACCO"

IF CIGARETTES:

B3a1. How soon after you wake up do you smoke your first cigarette? ^{1 * DK/NS R}

- 0-5 min
- 6-30 min
- 31-60 min
- After 60 min
- DON'T KNOW/NOT SURE
- REFUSED

B3a2. How many cigarettes per day do you smoke? ^{1 * DK/NS R}

- | | |
|--|-------------------|
| <input type="checkbox"/> 10 or less | PROCEED TO PAGE 7 |
| <input type="checkbox"/> 11 to 20 | PROCEED TO PAGE 7 |
| <input type="checkbox"/> 21 to 30 | PROCEED TO PAGE 7 |
| <input type="checkbox"/> 31 or more | PROCEED TO PAGE 7 |
| <input type="checkbox"/> DON'T KNOW/NOT SURE | PROCEED TO PAGE 7 |
| <input type="checkbox"/> REFUSED | PROCEED TO PAGE 7 |

IF CIGARS:

B3b. In a typical week, how many days do you smoke cigars? ^{Made symmetrical to B3c}

- 0 PROCEED TO PAGE 7
- 1 PROCEED TO PAGE 7
- 2 PROCEED TO PAGE 7
- 3 PROCEED TO PAGE 7
- 4 PROCEED TO PAGE 7
- 5 PROCEED TO PAGE 7
- 6 PROCEED TO PAGE 7
- 7 PROCEED TO PAGE 7
- Don't Know/Not Sure PROCEED TO PAGE 7
- Refused PROCEED TO PAGE 7

IF SMOKELESS TOBACCO:

B3c. In a typical week, how many days do you use chewing tobacco or snuff? ^{8 *DK/NS R}

- 0 PROCEED TO PAGE 7
- 1 PROCEED TO PAGE 7
- 2 PROCEED TO PAGE 7
- 3 PROCEED TO PAGE 7
- 4 PROCEED TO PAGE 7
- 5 PROCEED TO PAGE 7
- 6 PROCEED TO PAGE 7
- 7 PROCEED TO PAGE 7
- Don't Know/Not Sure PROCEED TO PAGE 7
- Refused PROCEED TO PAGE 7

PROCEED TO PAGE 7

**BRANCH 2- QUESTION C ON THIS PAGE ARE FOR PATIENTS WHO
DO NOT CURRENTLY USE TOBACCO**

Congratulations on quitting smoking!

C1. About how long has it been since you last smoked cigarettes/cigars or used tobacco regularly?²

Interviewer: Ask the question, then confirm their answer by reading the choice. Choices from 5,
choice "past 3-6 months" added

- EARLIER TODAY
- Not TODAY but sometime during the PAST 7 DAYS
- Not during the PAST 7 DAYS but sometime during the PAST 30 DAYS
- Not during the PAST 30 DAYS but sometime during the PAST 3 MONTHS
- Not during the PAST 3 MONTHS but sometime during the PAST 6 MONTHS
- Not during the PAST 6 MONTHS but sometime during the PAST YEAR
- 1 to 4 YEARS AGO
- 5 OR MORE YEARS AGO
- DON'T KNOW/NOT SURE
- REFUSED

C2. When you quit using tobacco, did you use the nicotine patch, gum, or any other medication to help you quit?

10, Added if yes part.

- YES

If yes, Which did you use?

C2a. Nicotine Patch

C2b. Nicotine Gum

C2c. Medication _____

- NO
- DON'T KNOW/NOT SURE
- REFUSED

C3. When you quit using tobacco, did you use quit-lines or websites to help? ^{*DK/NS R}

Interviewer: Check all that apply.

- QUITLINE
- WEBSITE
- OTHER _____
- NONE OF THE ABOVE
- DON'T KNOW/NOT SURE
- REFUSED

C4. When you were using tobacco, what type of tobacco products did you use? ^{*DK/NS R O}

Interviewer: If patient reports multiple products, check all that apply.

- CIGARETTES
- CIGARS
- CHEW, DIP, OR SNUFF
- OTHER _____
- NONE OF THE ABOVE
- DON'T KNOW/NOT SURE
- REFUSED

IF C4 “CIGARETTES” IS CHECKED, PROCEED TO “IF CIGARETTES”

IF C4 “CIGARS” IS CHECKED, PROCEED TO “IF CIGARS”

IF C4 “CHEW, DIP, OR SNUFF” IS CHECKED, PROCEED TO “IF SMOKELESS TOBACCO”

**IF C4 “OTHER, NONE OF THE ABOVE, DON’T KNOW/NOT SURE, OR REFUSED ARE CHECKED,
PROCEED TO PAGE 7**

**IF MORE THAN ONE CATEGORY IS CHECKED FOR C4, PROCEED TO ALL CATEGORIES THAT
APPLY**

IF CIGARETTES:

C4a. When you did smoke, how many cigarettes per day did you smoke?^{1 * DK/NS R}

- | | |
|--|-------------------|
| <input type="checkbox"/> 10 or less | PROCEED TO PAGE 7 |
| <input type="checkbox"/> 11 to 20 | PROCEED TO PAGE 7 |
| <input type="checkbox"/> 21 to 30 | PROCEED TO PAGE 7 |
| <input type="checkbox"/> 31 or more | PROCEED TO PAGE 7 |
| <input type="checkbox"/> DON’T KNOW/NOT SURE | PROCEED TO PAGE 7 |
| <input type="checkbox"/> REFUSED | PROCEED TO PAGE 7 |

IF CIGARS:

C4b. In a typical week, how many days did you smoke cigars?^{8 Adapted to fit cigars and be past tense *DK/NS R}

- | | |
|--|-------------------|
| <input type="checkbox"/> 0 | PROCEED TO PAGE 7 |
| <input type="checkbox"/> 1 | PROCEED TO PAGE 7 |
| <input type="checkbox"/> 2 | PROCEED TO PAGE 7 |
| <input type="checkbox"/> 3 | PROCEED TO PAGE 7 |
| <input type="checkbox"/> 4 | PROCEED TO PAGE 7 |
| <input type="checkbox"/> 5 | PROCEED TO PAGE 7 |
| <input type="checkbox"/> 6 | PROCEED TO PAGE 7 |
| <input type="checkbox"/> 7 | PROCEED TO PAGE 7 |
| <input type="checkbox"/> Don’t Know/Not Sure | PROCEED TO PAGE 7 |
| <input type="checkbox"/> Refused | PROCEED TO PAGE 7 |

IF SMOKELESS TOBACCO:

C4c. In a typical week, how many days did you use chewing tobacco or snuff?^{8 Adapted to be past tense*DK/NS R}

- | | |
|--|-------------------|
| <input type="checkbox"/> 0 | PROCEED TO PAGE 7 |
| <input type="checkbox"/> 1 | PROCEED TO PAGE 7 |
| <input type="checkbox"/> 2 | PROCEED TO PAGE 7 |
| <input type="checkbox"/> 3 | PROCEED TO PAGE 7 |
| <input type="checkbox"/> 4 | PROCEED TO PAGE 7 |
| <input type="checkbox"/> 5 | PROCEED TO PAGE 7 |
| <input type="checkbox"/> 6 | PROCEED TO PAGE 7 |
| <input type="checkbox"/> 7 | PROCEED TO PAGE 7 |
| <input type="checkbox"/> Don’t Know/Not Sure | PROCEED TO PAGE 7 |
| <input type="checkbox"/> Refused | PROCEED TO PAGE 7 |

PROCEED TO PAGE 7

ALL PARTICIPANTS- BOTH BRANCHES- QUESTION D

Have you used a tobacco quitline or website for help in quitting smoking?^{team *DK/NS/R}

Interviewer: Check all that apply.

- QUITLINE
- WEBSITE
- OTHER _____
- NONE OF THE ABOVE
- DON'T KNOW/NOT SURE
- REFUSED

D1. Did your dentist, hygienist, or dental assistant give you written materials about your tobacco use?⁷

YES

➡ If YES, D1a. did you:

- Not read them
- Read parts of the materials
- Read all of the materials once
- Read them more than once

➡ D1b. How helpful did you find them?

- Not at all helpful
- Somewhat helpful
- Very helpful
- Does not apply

- NO
- DON'T KNOW/NOT SURE
- REFUSED

D2. During your last dental visit, did anyone advise you to quit using tobacco?^{From Baseline DTC Postcard, adapted to fit last visit}

YES

➡ If YES, D2a. How would you rate the helpfulness of Dr. _____ and staff in helping you to consider quitting tobacco? Would you say they were...? ^{*DK/NS R}

- Not at all helpful
- Somewhat helpful
- Very helpful
- Does not apply
- DON'T KNOW/NOT SURE
- REFUSED

- NO
- DON'T KNOW/NOT SURE
- REFUSED

D3. In the past 6 months, has a medical doctor advised you to quit using tobacco products?^{*DK/NS R}

- YES
- NO
- DON'T KNOW/NOT SURE
- REFUSED

D4. Do you live with others who smoke or chew tobacco?^{*DK/NS R}

- YES
- NO
- DON'T KNOW/NOT SURE
- REFUSED

I'm going to ask you a few questions about your opinion on tobacco. Please let me know how strongly you agree or disagree with the following:

D5. Tobacco use puts you at risk for health problems. ^{Team}

- STRONGLY AGREE
- AGREE
- NEUTRAL
- DISAGREE
- STRONGLY DISAGREE
- DON'T KNOW/NOT SURE
- REFUSED

D6. Tobacco use puts you at risk for **oral** health problems. ^{Team}

- STRONGLY AGREE
- AGREE
- NEUTRAL
- DISAGREE
- STRONGLY DISAGREE
- DON'T KNOW/NOT SURE
- REFUSED

D7. Dentists should talk to patients about tobacco use. ^{Team}

- STRONGLY AGREE
- AGREE
- NEUTRAL
- DISAGREE
- STRONGLY DISAGREE
- DON'T KNOW/NOT SURE
- REFUSED

D8. INTERVIEWER: Indicate SEX of Respondent. ³

- MALE
- FEMALE

D9. What is your age (today) in years? ^{* DK/NS R}

- ____=NUMBER OF YEARS
- DON'T KNOW/NOT SURE
- REFUSED

D10. About how old were you when you first started using tobacco products on a daily or weekly basis (cigars, non-smokeless)? ^{2 * DK/NS R}

- ____=NUMBER OF YEARS
- DON'T KNOW/NOT SURE
- REFUSED

- D11. What is the highest grade or year of school you completed? (*Interviewer: Do not ask the categories, but fill in appropriate category*)³ *DK/NS R
- NEVER ATTENDED SCHOOL or ONLY ATTENDED KINDERGARTEN
 - Grades 1 through 8 (ELEMENTARY)
 - Grades 9 through 11 (SOME HIGH SCHOOL)
 - Grade 12 or GED (HIGH SCHOOL GRADUATE)
 - College 1 year to 3 years (SOME COLLEGE OR TECHNICAL SCHOOL)
 - College 4 years or more (COLLEGE GRADUATE)
 - DON'T KNOW/NOT SURE
 - REFUSED

- D12. Do you consider yourself to be Hispanic or Latino, that is a person of Mexican, Puerto Rican, Cuban, South or Central American, or other Spanish culture or origin regardless of race?⁹ *DK/NS R
- Hispanic or Latino
 - Not Hispanic or Latino
 - Don't Know/Not Sure
 - Refused

- D13. What RACE do you consider yourself to be? (*Select one or more of the following*)⁹ reordered choices and added Other, and DK/NS R
- Black or African American
 - White
 - Asian
 - American Indian or Alaska Native
 - Native Hawaiian or Other Pacific Islander
 - Other: (specify) _____
 - Don't Know/ Not Sure
 - Refused

- D14. Would you say that in general, your health is:³
- EXCELLENT
 - VERY GOOD
 - GOOD
 - FAIR
 - POOR
 - DON'T KNOW/NOT SURE
 - REFUSED

This completes the survey. If it's okay, let me get your address so I can send you a gift card. Do you have a Wal-Mart in the area? If no, ask if a K-Mart is in the area. Note which store's card to send. Ask for the person's name and address. [To be saved in separate file for tracking completed survey address list]

Thank you so much for completing this phone survey. Your input is very helpful to our study on Oral Cancer Prevention. If you have any questions, please call Heather Coley at 205-934-9421.

References

¹Fagerstrom Questionnaire to Determine Level of Nicotine Addiction, adaption of original

²modification of Behavioral Risk Factor Surveillance System, BRFSS Historical Questions, 2003

³ Behavioral Risk Factor Surveillance System, BRFSS Historical Questions, 2003

⁴ National Health and Nutrition Examination Survey (NHANES)

⁵ National Youth Tobacco Survey (NYTS), adaptation to delete a response category and add 2 categories

- ⁶ Cancer Prevention Research Center, Smoking: Stage of Change
<http://www.uri.edu/research/cprc/Measures/Smoking11.htm>, adapted to say tobacco instead of smoking and deletion of Stage of Change descriptors (Precont, etc.)
- ⁷ Judith Gordon from the 6-week Smoker Survey
- ⁸ Judith Gordon from the Baseline Tobacco Use Survey
- ⁹ NIH guidelines but based on question from a PHS Personal Information on Principal Investigator /Program Director example offered by the NIH. <http://grants.nih.gov/grants/funding/phs398/personal.doc>
- ¹⁰ ATS, Adult Tobacco Survey 2003
- ¹¹ Monitoring the Future- University of Michigan
- *DK/NS R O means Don't know/not sure, refused, and other were added by DTC to this question

DENTAL PRACTICE FINAL SURVEY

Dentist Survey
Oral Cancer Prevention Project Phase 3

This section of the survey is to be completed by the dentist. It will only take about 3-5 minutes to complete. The information provided is confidential and the results will be reported only as statistical summaries, with no personal or practice identifiers. We appreciate your participation as it is critical to the success of this project.

Please answer how much the Oral Cancer Prevention Project has influenced you to do each of the following actions by marking on the scale from 1 -5 with 1 meaning “Not Influenced at All” and 5 meaning “Very Much Influenced.”

D1. How much has the Oral Cancer Prevention Project influenced you to do each of the following?	Not Influenced at All			Very Much Influenced	
	1	2	3	4	5
a) Identify or screen patients for tobacco use by questions in the medical history form	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Identify or screen patients for tobacco use by directly asking them	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) Identify or screen patients for tobacco use by physical exam	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) Document patient tobacco use in the dental record/chart	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e) Advise tobacco users to quit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f) Provide patients with patient education materials related to tobacco use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g) Refer patients to the following resources					
1-800-QUIT-NOW quitline/other quitline numbers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tobacco cessation websites-----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other providers (for tobacco cessation)-----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Quit tobacco programs in the area-----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other (specify)_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h) Help tobacco users set a quit date	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i) Recommend nicotine replacement therapy like the patch or gum	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j) Prescribe medicines to help a tobacco user quit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

D2. What is the biggest barrier in your practice to optimal implementation of tobacco screening and prevention as it relates to oral cancer prevention? (CHECK ONLY ONE BOX)

- My practice is too busy
- I do not have Patient Education Materials
- I can't get reimbursed
- I do not know what to do, or how to do it
- I do not believe it will work
- Other (please specify)_____

We are interested in how the Oral Cancer Prevention Project has met your needs and expectations. The next couple of questions are about your experiences with the Project.

D3. How satisfied were you with the Oral Cancer Prevention Project overall?

- Very Satisfied
- Satisfied
- Neither
- Dissatisfied
- Very Dissatisfied

D4. Would you recommend this project to a colleague?

- Yes, Strongly Recommend
- Yes, Recommend
- No, Would not recommend

Now we would like for you to provide us with information about yourself.

D5. What is your age? _____ years

D6. What is your gender? Male Female

D7. What is your ethnicity? _____

- Caucasian/White
- African American
- Native American
- Asian
- Hispanic
- Other, please specify _____

General Practice Survey

Oral Cancer Prevention Project Phase 3

This section of the survey is to be completed by the dentist or a staff member designated by the dentist. It will only take about 10 minutes to complete. The information provided is confidential and the results will be reported only as statistical summaries, with no personal or practice identifiers. We appreciate your participation as it is critical to the success of this project.

Your Name: _____ Job Title: _____ Today's Date: _____

PRACTICE CHARACTERISTICS

P1. For each of the following, please estimate the percentage of the people who work in this practice, including dentists, hygienists, assistants, and other office staff. (If you do not know exact percentages, please provide your BEST GUESS.)

a) Approximately what percentage of the **people who work in this practice**, including dentists, hygienists assistants, and other office staff are...? [please check that the total adds to approximately 100%]

Male about ____ %

Female about ____ %

[Adds to about 100%]

b) Approximately what percentage of the **people who work in this practice**, including dentists, hygienists, assistants, and other office staff are...? [please check that the total adds to approximately 100%]

Caucasian/White about ____ %

African American about ____ %

Native American about ____ %

Asian about ____ %

Hispanic about ____ %

Other, please specify _____ about ____ %

[Adds to about 100%]

c) Approximately what percentage of the **people who work in this practice**, including dentists, hygienists, assistants, and other office staff are...? [please check that the total adds to approximately 100%]

Tobacco users about ____ %

Non-tobacco users about ____ %

[Adds to about 100%]

Please answer how often you have done each of the following actions in the past 30 days by marking on the scale from 1 -5 with 1 meaning "At No Visits" and 5 meaning "At Every Visit."

TOBACCO

P4. In the past 30 days how often have the following been done with patients who use tobacco?	At No Visits				At Every Visit
	1	2	3	4	5
a) Advised to quit tobacco	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Provided patient education materials related to tobacco use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) Referred to the following resources:					
1-800-QUIT-NOW quitline/other quitline numbers----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tobacco cessation website-----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other providers (for tobacco cessation)-----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Quit tobacco programs in the area-----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other (specify)_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) Evaluated how ready a tobacco user is to quit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

TOBACCO USERS NOT PLANNING TO QUIT

P5. In the past 30 days how often have the following been done with patients who use tobacco and are not planning to quit?	At No Visits				At Every Visit
	1	2	3	4	5
a) Discussed potentially negative consequences of tobacco use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Discussed potential benefits of stopping tobacco use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) Encouraged them to write down their reasons for quitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

TOBACCO USERS PLANNING TO QUIT

P6. In the past 30 days how often have the following been done with patients who use tobacco and are planning to quit?	At No Visits				At Every Visit
	1	2	3	4	5
a) Encouraged them to seek positive support from family and friends	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Advised to remove all triggers for tobacco use (cigarette lighters, ashtrays, pipes) from their home	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) Helped set a quit date	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) Recommended nicotine replacement therapy like the patch or gum	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e) Prescribed medicines to help tobacco user quit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

The survey should be returned in the attached addressed, stamped envelope. If you have any questions about this survey, please call XX XX at XXX-XXX-XXXX.