Tobacco Cessation Resources for Cancer Patients and Survivors: Current Landscape and Call to Action

THE GEORGE WASHINGTON UNIVERSITY
WASHINGTON, DC

Presenter:

Dr. Jamie Ostroff, PhD

Psychologist; Chief, Behavioral Sciences Service; Director, Tobacco Treatment Program; Memorial Sloan Kettering Cancer Center

The webinar will begin at 3:00 p.m. Eastern.
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Tap into resources to control cancer

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Jamie Ostroff, PhD
Chief, Behavioral Sciences Service
Director, Tobacco Treatment Program
Memorial Sloan Kettering Cancer Center
www. MSKCC.org

Memorial Sloan Kettering Cancer Center™

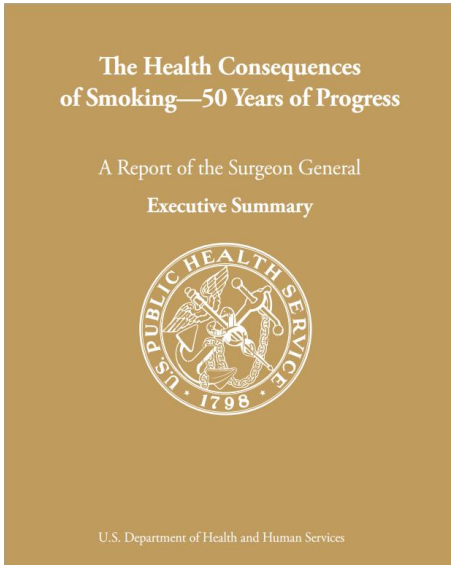
Presentation Overview: Learning Objectives

1. Brief review of clinical rationale for treating tobacco dependence in cancer care
2. Best practices in promoting tobacco cessation among cancer patients and survivors
3. Current gaps in promoting tobacco cessation among cancer patients and survivors
4. Integration of tobacco cessation services across models of oncology care
5. Resources available for achieving tobacco cessation among cancer patients and survivors.
6. Opportunities to address barriers and promote strategies to increase implementation of tobacco treatment

Smoking and Adverse Outcomes for Cancer Patients/Survivors

- Increased overall and cancer specific mortality
- Increased risk of disease recurrence
- Increased risk of second primary cancers
- Increased risk of treatment complications
- Increased risk of other tobacco-related comorbid conditions (CVD, COPD)
- Poor quality of life

SGR, 2014; Warren, Sobus & Gritz, 2014

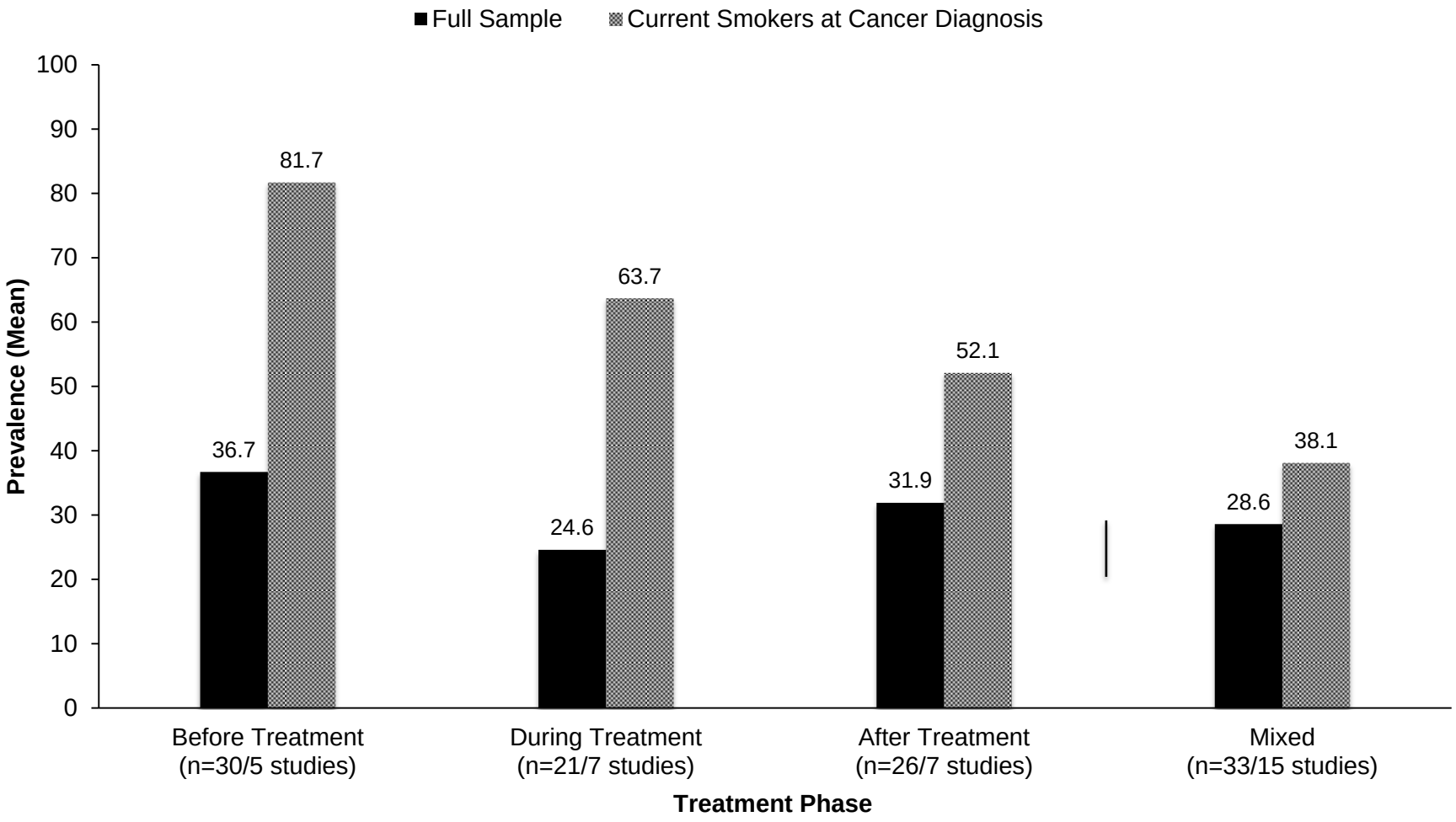


Prevalence of smoking among adult survivors with tobacco-related cancers (TRCS), non-tobacco-related cancers and no cancer: BRFSS (2009)*

Tobacco Use	TRCS	SE	Non-TRCS	SE	No Cancer	SE	p value
Current Smoker	27%	0.009	16%	0.004	18%	0.001	<0.001
Current Smokeless	3%	0.004	3%	0.002	4%	0.001	<0.001
Former Smoker	33%	0.095	26%	0.004	24%	0.001	<0.001

*Underwood et al, 2012, *Adjusted for race, ethnicity, sex, age, employment and insurance*
TRCS= bladder, cervical, esophageal, kidney, leukemia, lung, oral, pharyngeal, pancreatic, stomach

Prevalence of Smoking Following Diagnosis of Lung, Head/Neck Cancers



Burris, Studts, DeRosa & Ostroff, SBM 2015; accepted for publication, CEBP

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National Calls for Action: Tobacco Use Assessment and Treatment in Cancer Care

- National Cancer Institute
- American Society for Clinical Oncology
  - Quality (QOPI) measures
- AACR Policy Statement
- Oncology Nursing Society
- Comprehensive Cancer Control National Partnership
- "Meaningful Use" criteria for EHRs
- Joint Commission/Medicare adopted National Hospital Quality Measures

Tobacco Cessation and Quality Cancer Care

- It is "incumbent on the cancer care community to incorporate effective tobacco cessation as an integral component of quality cancer care"
- Smoking status recommended as core clinical and research data element
- Tobacco cessation treatment recommended as standard of quality care

ASCO, 2009

Original Contribution

National Cancer Institute Conference on Treating Tobacco Dependence at Cancer Centers

By Glen Morgan, PhD, Robert A. Schnoll, PhD, Catherine M. Alfano, PhD, Sarah E. Evans, PhD, Adam Goldstein, MD, MPH, Jamie Ostroff, PhD, Elyse Richelle Park, PhD, Linda Sarna, DNSc, RN, and Lisa Sanderson Cox, PhD

- Recommend that Cancer Centers integrate assessment and treatment of tobacco use into routine clinical care
- Call for more research on developing and evaluating cost-effective cessation treatment delivery models in cancer care

Morgan, et al 2011

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Surveys of Oncologists' Perceptions and Practice Patterns about Tobacco Treatment

Perceptions	IASLC N=1507	ASCO N=1197
Tobacco affects clinical outcomes	91.7%	87.0%
Advising cessation should be standard of cancer care	90.2%	85.8%

% Agree/Strongly Agree

Warren et al, 2013, J of Thoracic Oncology; Warren et al 2013, J Oncol Practice

Tobacco Practice Patterns at Initial Oncology Visit*

Practice Pattern	IASLC	ASCO
Ask about tobacco use	90.2%	89.5%
Assess readiness to quit	78.9%	80.2%
Advise to quit	80.6%	82.4%
Discuss medications	40.2%	44.3%
Actively treat or refer	38.8%	38.6%

% Always/Most of the Time

*Lower rates reported during follow-up visits

Warren et al. J Thorac Oncol, 2013, Warren et al. J Oncol Pract, 2013

Tobacco Use Treatment at the U.S. National Cancer Institute's Designated Cancer Centers

Adam O. Goldstein, M.D., M.P.H.,[1] Carol E. Ripley-Moffitt, M.Div., C.T.T.S.,[1] Donald E. Pathman, M.D., M.P.H.,[1,2] & Katharine M. Patsakham, M.P.H., C.T.T.S.[1]

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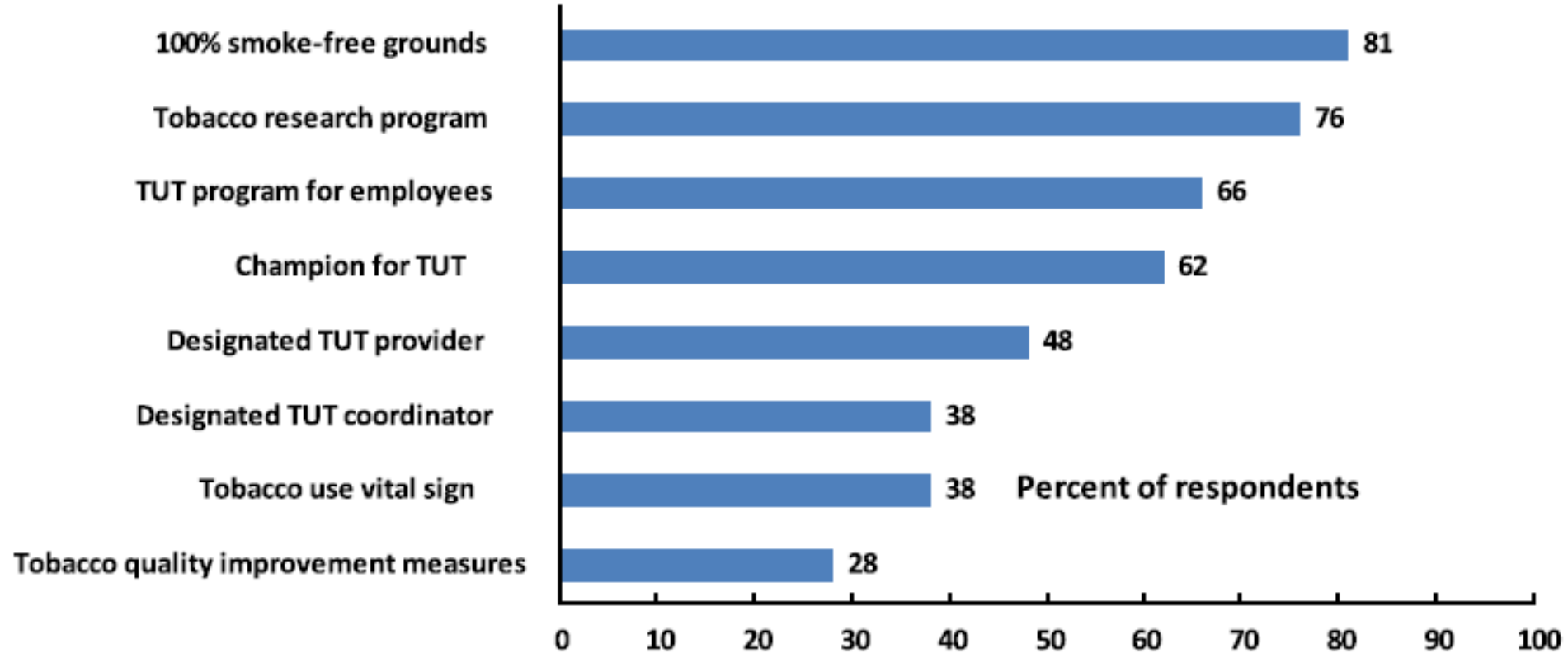
[2] *Cecil G. Sheps Center for Health Services Research, University of North Carolina, Chapel Hill, NC*

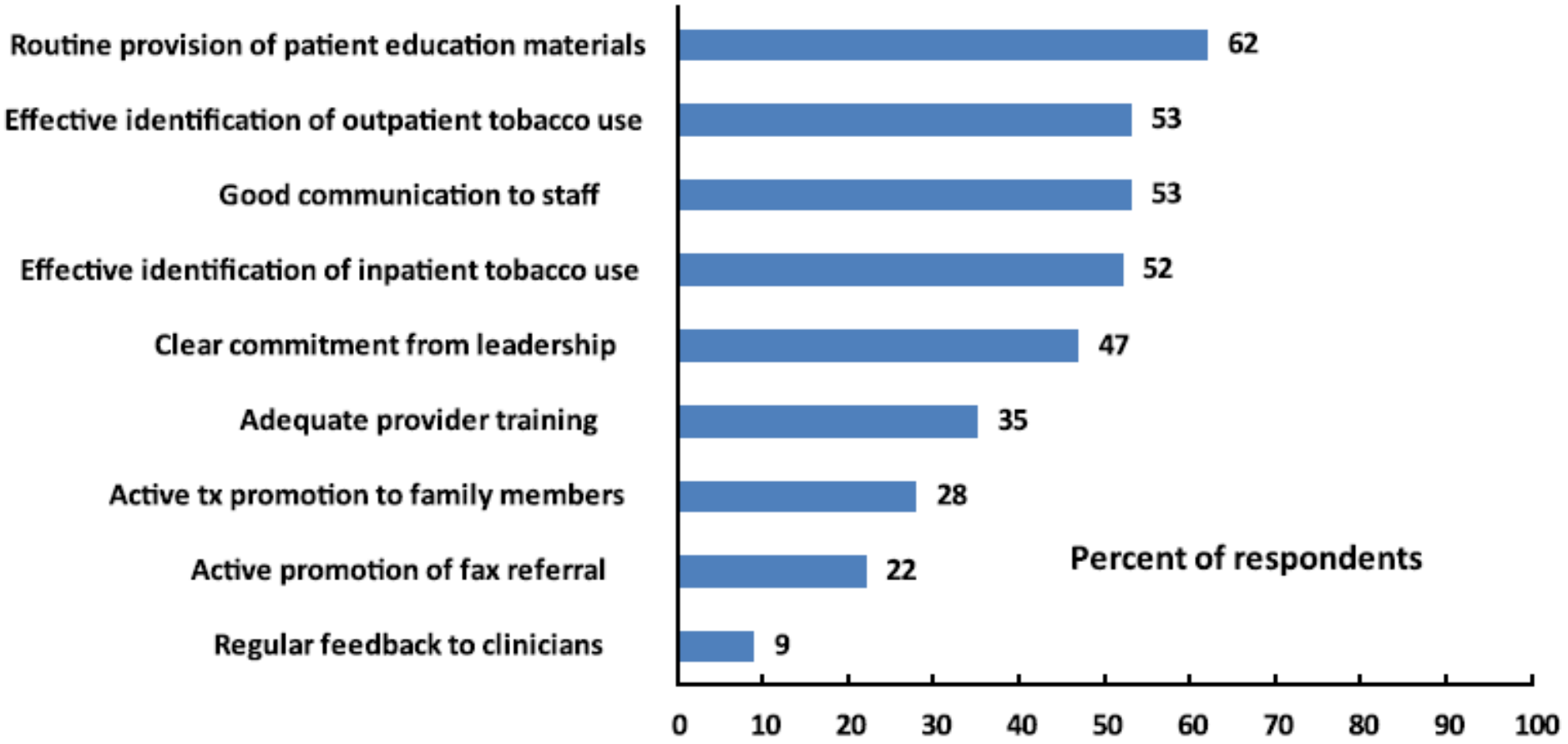
Corresponding Author: Adam O. Goldstein, M.D., M.P.H., *Department of Family Medicine, UNC School of Medicine, University of North Carolina, CB 7595, Chapel Hill, NC 27595, USA. Telephone: 919-966-4090; Fax: 919-966-6125; E-mail: aog@med.unc.edu*

Current Tobacco Treatment Practices at Comprehensive Cancer Centers (n = 58)



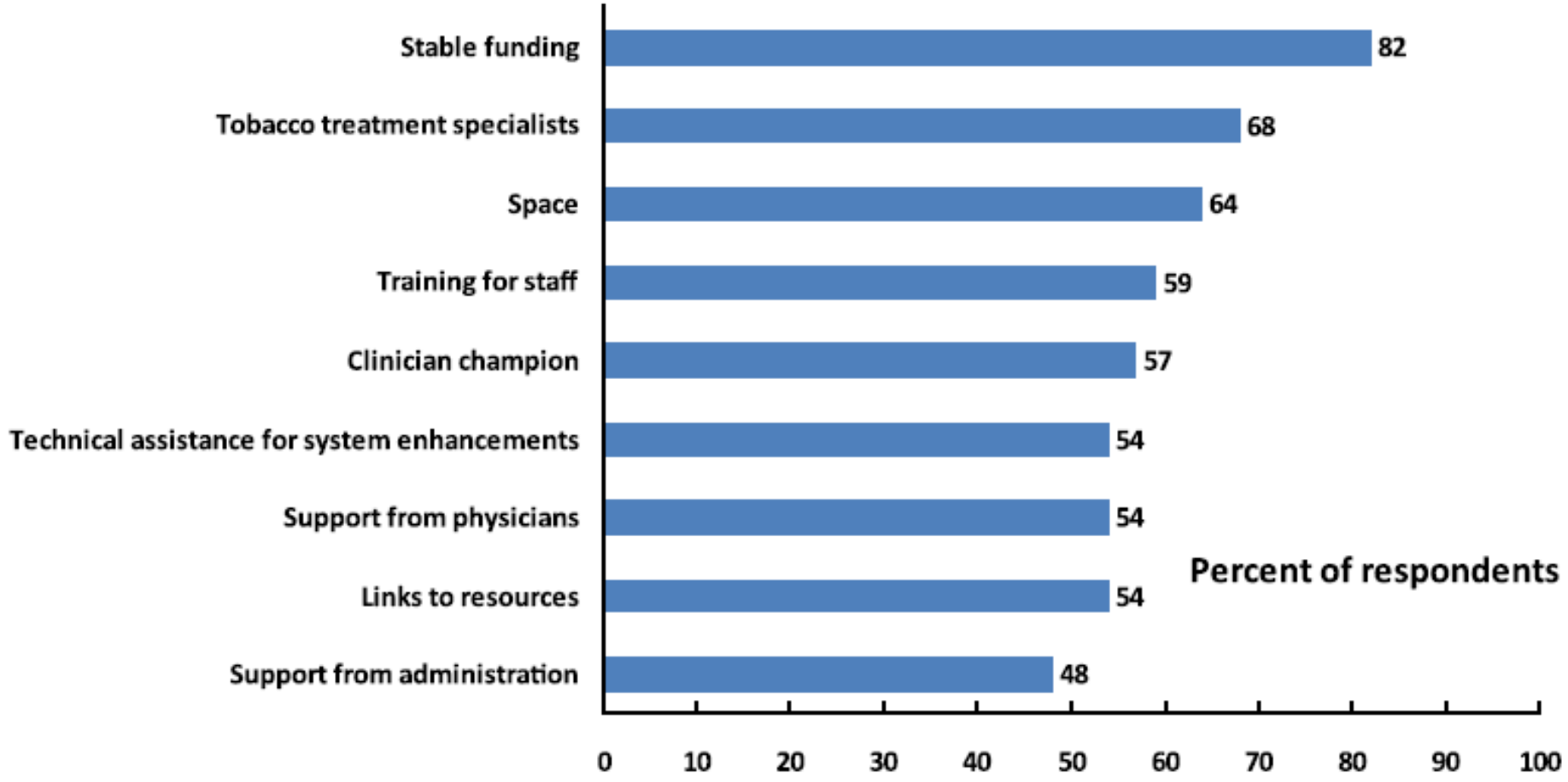
Goldstein, et al., 2012

Implementation strategies at Comprehensive Cancer Centers (n = 58)



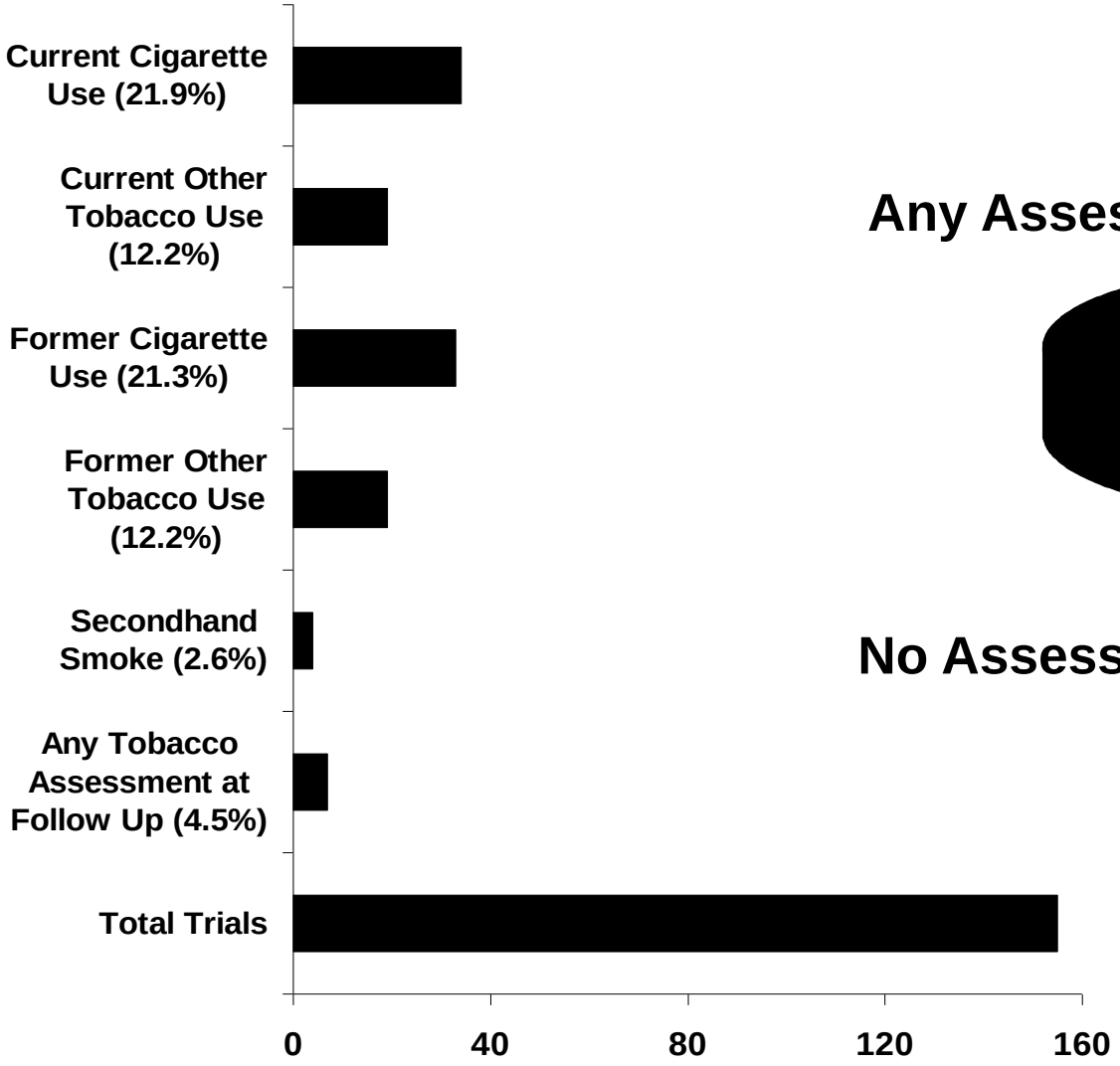
Goldstein, et al., 2012

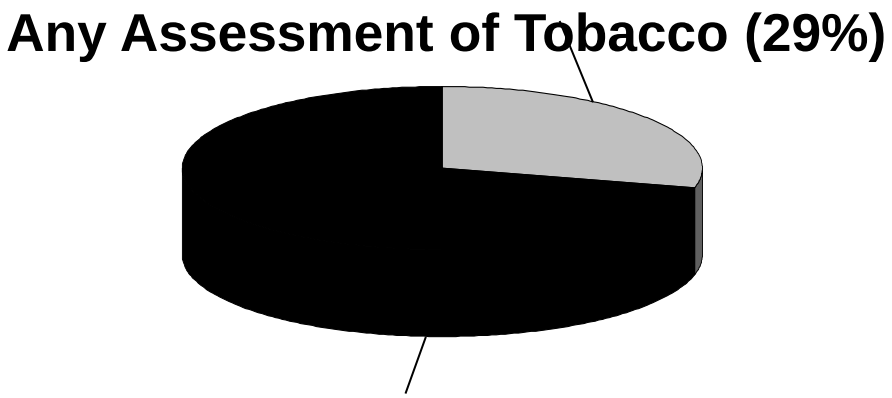
Factors perceived "likely" or "very likely" to improve TUT at Cancer Centers (n = 58)



Goldstein, et al., 2012

Assessment of Tobacco Use in NCI Cancer Cooperative Group Trials





Peters et al, 2012; Gritz, Dresler & Sarna, 2005

Barriers to Addressing Tobacco Use Among Cancer Patients

- **Patient Barriers**
  - Stigma deters help-seeking
  - Distress
  - Low quitting self efficacy
  - Nicotine addiction/withdrawal symptoms
- **Systems barriers**
  - Absence of standardized tobacco use assessment
  - Lack of available resources
  - Lack of referral options
  - Lack of clinical workflow
  - Reimbursement
- **Provider barriers**
  - Competing priorities
  - Lack of time
  - Perceived patient resistance
  - Discomfort/Avoidance: Don't want to worsen distress/upset the patient
  - Lack of knowledge, training and confidence in how to help patients quit

Warren et al, 2013; Warren et al, 2013; Sarna et al, 2000

Bottom Line… Missed Opportunities

- Tobacco use assessment and treatment is not yet standard of care:
  - <30% of NCI-funded clinical trials assess smoking status
  - Only 60% of Comprehensive Cancer Centers offer some form of tobacco treatment
  - <50% of oncology providers routinely provide tobacco treatment assistance
- Patient, Provider and Systems-level barriers exist

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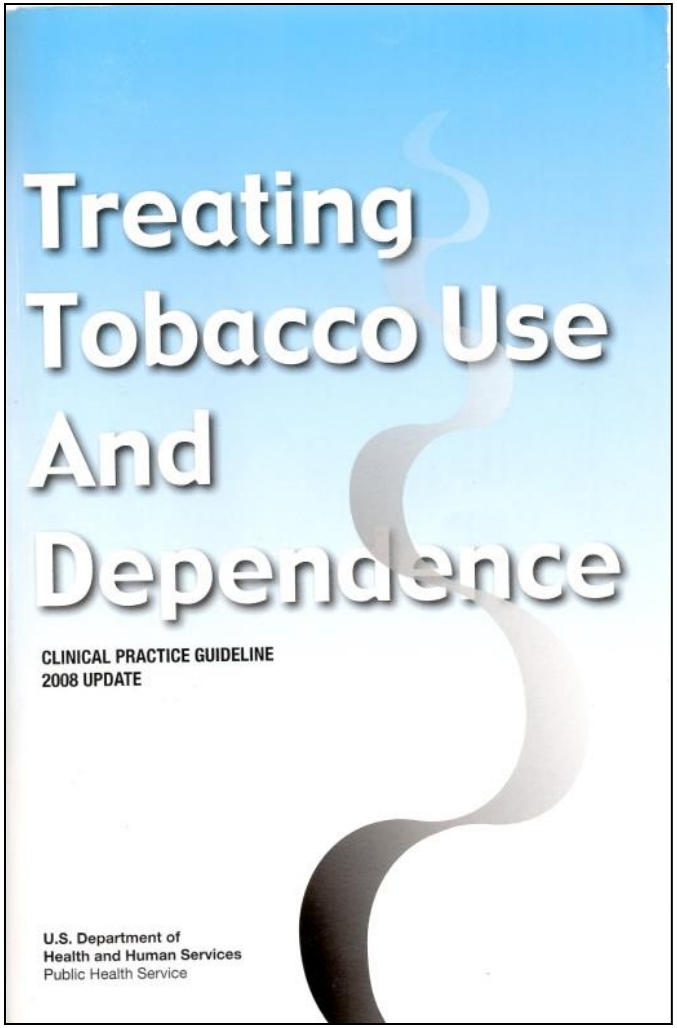
United States PHS Guidelines: Treating Tobacco Use and Dependence

- Ask
- Advise
- Assess
- Assist
- Arrange



Smoking Cessation Pharmacotherapy Guidelines

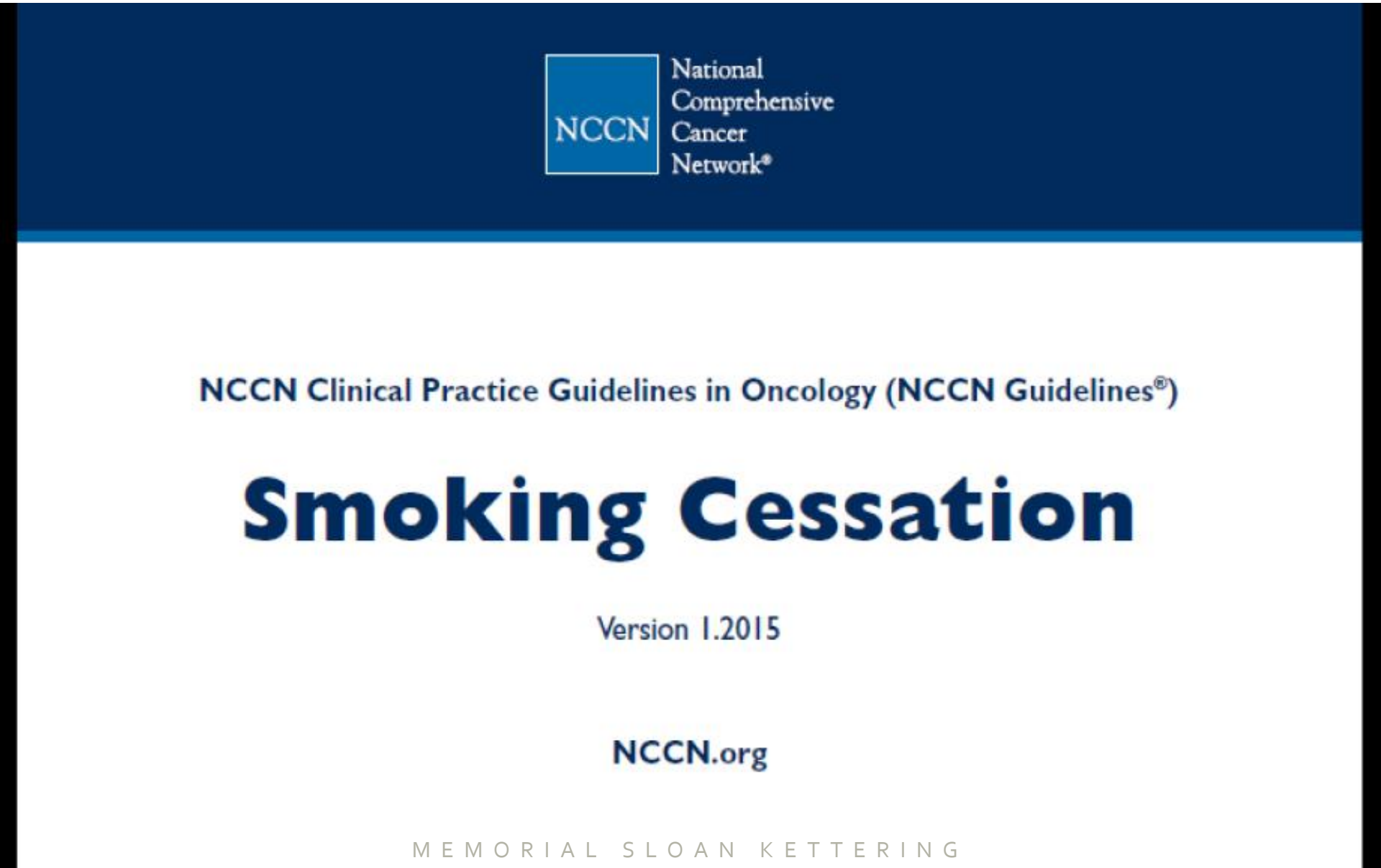
Pharmacotherapy	Dosage	Duration	Availability	Precautions/Contraindications	Adverse Effects	Patient Education
◆ Nicotine Patch **NicoDerm CQ®** **Habitrol®**	**If smoking 11cig/d or >:** ◆ 21mg/24 hr ◆ 14 mg/24 hr ◆ 7 mg/24 hr **If smoking 10 cig/d or <:** ◆ 14 mg/24 hr ◆ 7 mg/24 hr	◆ 6 weeks ◆ 2 weeks ◆ 2 weeks ◆ 6 weeks ◆ 2 weeks	◆ Over the Counter **(OTC)** ◆ Medicaid reimbursement by prescription only	◆ Uncontrolled Hypertension	◆ Skin irritation Redness Swelling Itching ◆ Disruption in Sleep Nightmares Vivid dreams	◆ Instruct patient to rotate patch site daily ◆ Instruct patient to remove patch prior to bedtime if sleep is disrupted and bothersome.
◆ Nicotine Polacrilex Gum **Nicorette Gum®**	◆ **2mg** if smoking **24 or < cig/d** ◆ **4 mg if smoking 25 or > cig/d** ◆ Do not exceed 24 pieces of gum/24 hr	◆ Up to 12 weeks	◆ Over the Counter **(OTC)** ◆ Medicaid reimbursement by prescription only	◆ Poor dentition ◆ Xerostomia	◆ Hiccups ◆ Upset stomach ◆ Jaw ache	◆ Chew gum on a fixed schedule ◆ "Chew & Park" each piece of gum for 30 minutes ◆ Avoid eating/drinking anything except water 15 minutes before & during chewing
◆ Nicotine Lozenge **Commit®**	◆ **2mg** if smoking the first cigarette ***more than*** 30 minutes after waking up ◆ **4 mg** if smoking the first cigarette ***within*** 30 minutes after waking up ◆ Do not use more than 20 lozenges/day	◆ Up to 12 weeks	◆ Over the Counter **(OTC)** ◆ Medicaid reimbursement by prescription only	◆ Xerostomia	◆ Local irritation to mouth & throat ◆ Upset stomach	◆ Avoid eating/drinking anything except water 15 minutes before & during when using a lozenge ◆ Each lozenge will take 20 – 30 minutes to dissolve
◆ Nicotine Inhalation System **Nicotrol Inhaler®**	◆ 6 – 16 cartridges/day	◆ Up to 6 months	◆ Prescription Only		◆ Local irritation to mouth & throat ◆ Upset stomach	◆ Each cartridge will take 80 – 100 inhalations over 20 minutes ◆ Instruct patient to puff on inhalers like a cigar. Absorption is in the buccal mucosa.
◆ Nicotine Nasal Spray **Nicotrol NS®**	◆ **0.5mg**/inhalation/nostril 1-2 times/hr or PRN dosing	◆ Up to 12 weeks	◆ Prescription Only	◆ Sinus infections	◆ Nose/eye/upper respiratory irritation	
◆ Bupropion **Zyban®** **Wellbutrin SR®**	◆ 150 mg daily x 3 days **THEN** ◆ 150 mg BID	◆ 12 weeks	◆ Prescription Only	◆ History of seizures ◆ History of eating disorders Bulimia Anorexia	◆ Insomnia ◆ Dry mouth ◆ Restlessness ◆ Dizziness	◆ Overlap with smoking for 1-2 weeks ◆ Does not need to be tapered off
◆ Varenicline **Chantix®**	◆ Days 1-3: 0.5mg po daily THEN ◆ Days 4-7: 0.5mg po BID THEN ◆ Days 8-End of treatment: 1mg po BID	◆ 12 weeks ◆ If the patient has quit smoking, may be given another 12 weeks of treatment	◆ Prescription Only	◆ Kidney problems or undergoing dialysis ◆ Pregnant or planning of getting pregnant ◆ Breast feeding	◆ Mild nausea ◆ Sleep problems ◆ Headaches	◆ Take medication with a full glass of water after you eat a meal. ◆ Allow 8 hours between each dose ◆ Take this medication a few hours before bedtime to avoid restlessness ◆ Overlap with smoking for 1-2 weeks Does not need to be tapered off

US Clinical Guideline Recommendations

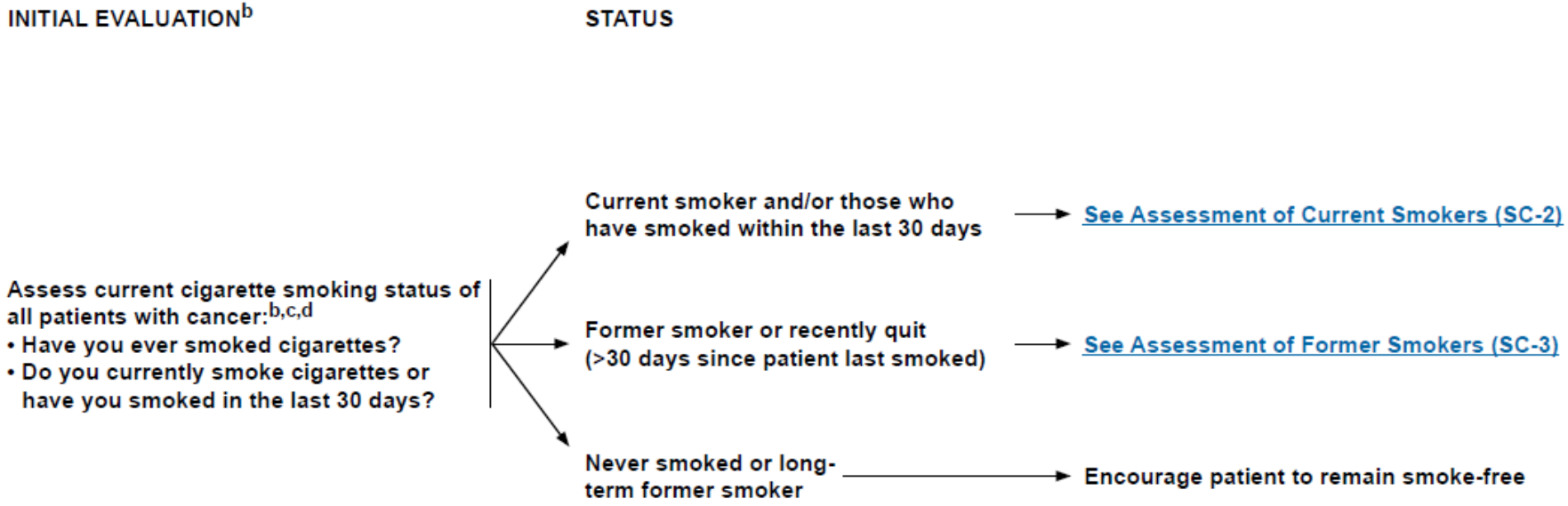
Product	Odds Ratio
Nicotine Gum	1.5-2.2
Nicotine Patch	1.9-2.3
Nicotine Inhaler	2.1
Nicotine Nasal Spray	2.3
Nicotine Lozenges	1.95
Varenicline (Chantix)	3.1
Bupropion (Zyban)	2.0

Fiore et al. Clinical Practice Guidelines, 2008
Several cessation medication combinations have superior outcomes

NCCN Guidelines



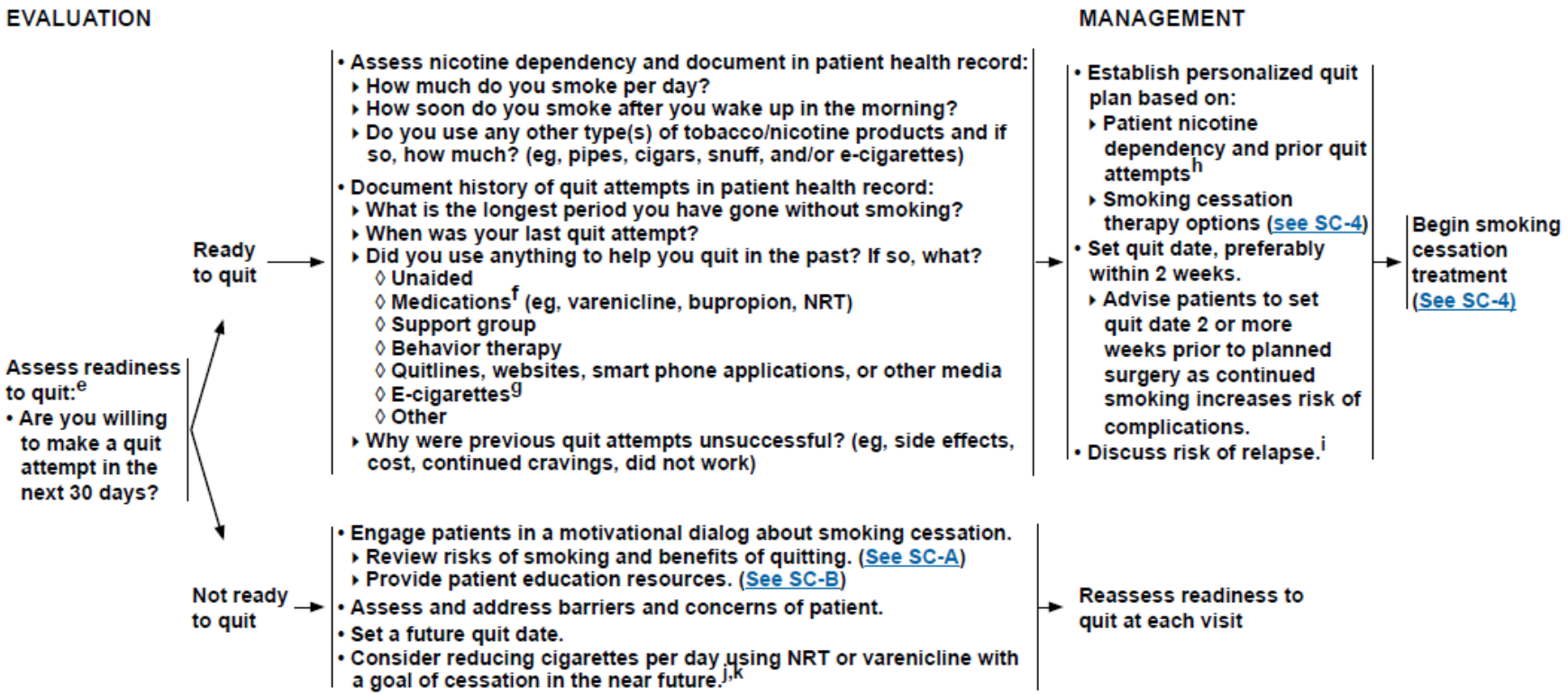
EVALUATION AND ASSESSMENT OF PATIENT SMOKING[a]



[a]For the purposes of this guideline, "smoking" refers to cigarette use.
[b]Initial evaluation and assessment of patient smoking may be completed by any member of the health care team, including physicians, nurses, medical assistants, health educators, or other dedicated staff.
[c]Smoking status should be documented in the patient health record and assessment should be repeated at every visit (less often for patients with remote smoking histories).
[d]Smoking cessation should be offered to all smokers with cancer regardless of cancer prognosis. See Smoking-Associated Risks for Patients With Cancer (SC-A).

Note: All recommendations are category 2A unless otherwise indicated.
Clinical Trials: NCCN believes that the best management of any cancer patient is in a clinical trial. Participation in clinical trials is especially encouraged.

CURRENT SMOKERS (Smoked Within Last 30 Days)
EVALUATION AND ASSESSMENT



[e]Physicians and members of the health care team should discuss potential risks and benefits of quitting with each patient. Readiness to quit is to be determined by both physician and patient.
[f]Document type and dose of medications used during previous quit attempts.
[g]There is currently insufficient evidence to support the use of electronic nicotine delivery systems (e-cigarettes) in smoking cessation for patients with cancer.
[h]Adjustments to therapy length, intensity, and surveillance may be considered, as clinically indicated, for patients with high nicotine dependency and/or prior unsuccessful quit attempts.
[i]Providers should discuss risk of relapse and smoking slips and provide guidance and support to encourage continued smoking cessation attempts.
[j]Making an immediate quit attempt is preferred but smoking reduction may be considered with a goal of cessation. Setting a future quit date is preferred (ie. 1-3 mo).
[k]See Principles of Smoking Cessation Pharmacotherapy (SC-C)

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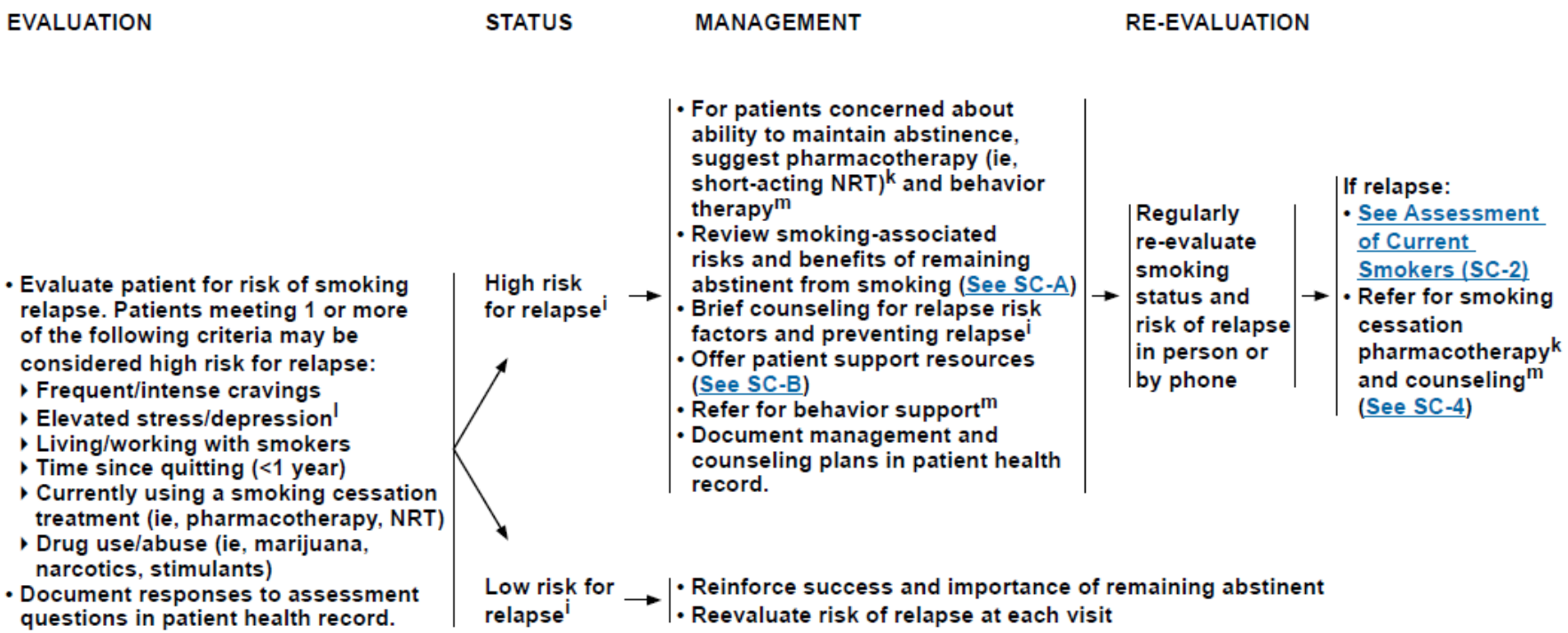
FORMER SMOKERS AND RECENT QUITTERS (>30 Days Since Last Smoked)
EVALUATION AND ASSESSMENT



[i]Providers should discuss risk of relapse and smoking slips and provide guidance and support to encourage continued smoking cessation attempts.
[k]See Principles of Smoking Cessation Pharmacotherapy (SC-C).
[l]Evaluate patient for psychiatric comorbities and refer to specialist if indicated.
[m]See Principles of Behavior Therapy (SC-D).

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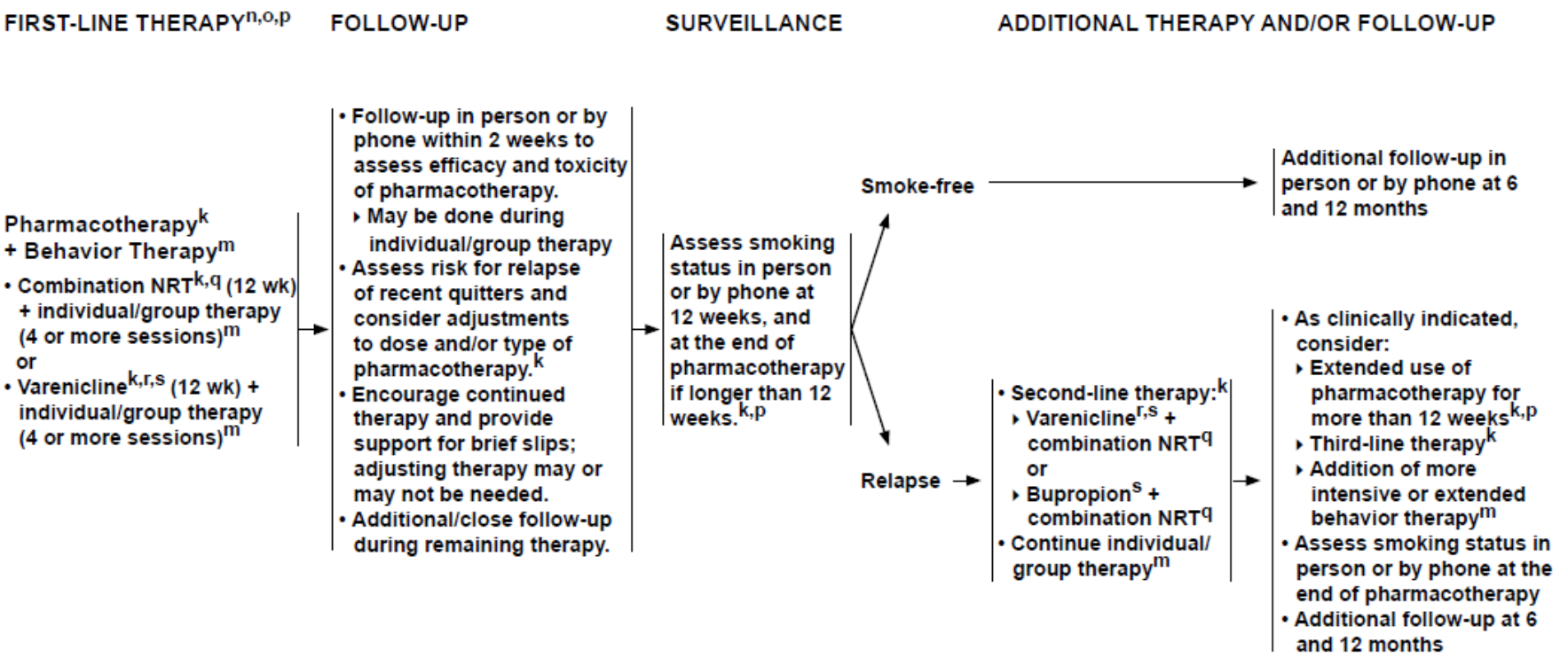
GENERAL APPROACH TO SMOKING CESSATION DURING CANCER TREATMENT



[k] See Principles of Smoking Cessation Pharmacotherapy (SC-C).
[m] See Principles of Behavior Therapy (SC-D).
[n] Efficacy data are lacking for the use of e-cigarettes and alternative therapies (eg, hypnosis, acupuncture, nutritional supplements). Patients should be encouraged to use evidence-based cessation methods to avoid delay in achieving smoking abstinence. See SC-C (2 of 2).
[o] The use of marijuana, or other substances associated with smoking relapse, is discouraged for those attempting to quit smoking.
[p] Therapy may be extended to promote continued cessation (ie, 6 mo–1 yr) while attempting to avoid extended therapy if possible.
[q] Combination NRT is defined as the use of nicotine patch + short-acting NRT (gum/lozenge/inhaler/nasal spray).
[r] Nausea is a common side effect of varenicline and may need to be managed for patients with cancer, especially during chemotherapy.
[s] If prescribing varenicline or bupropion, document patient's history of mental illness or suicidal ideation.

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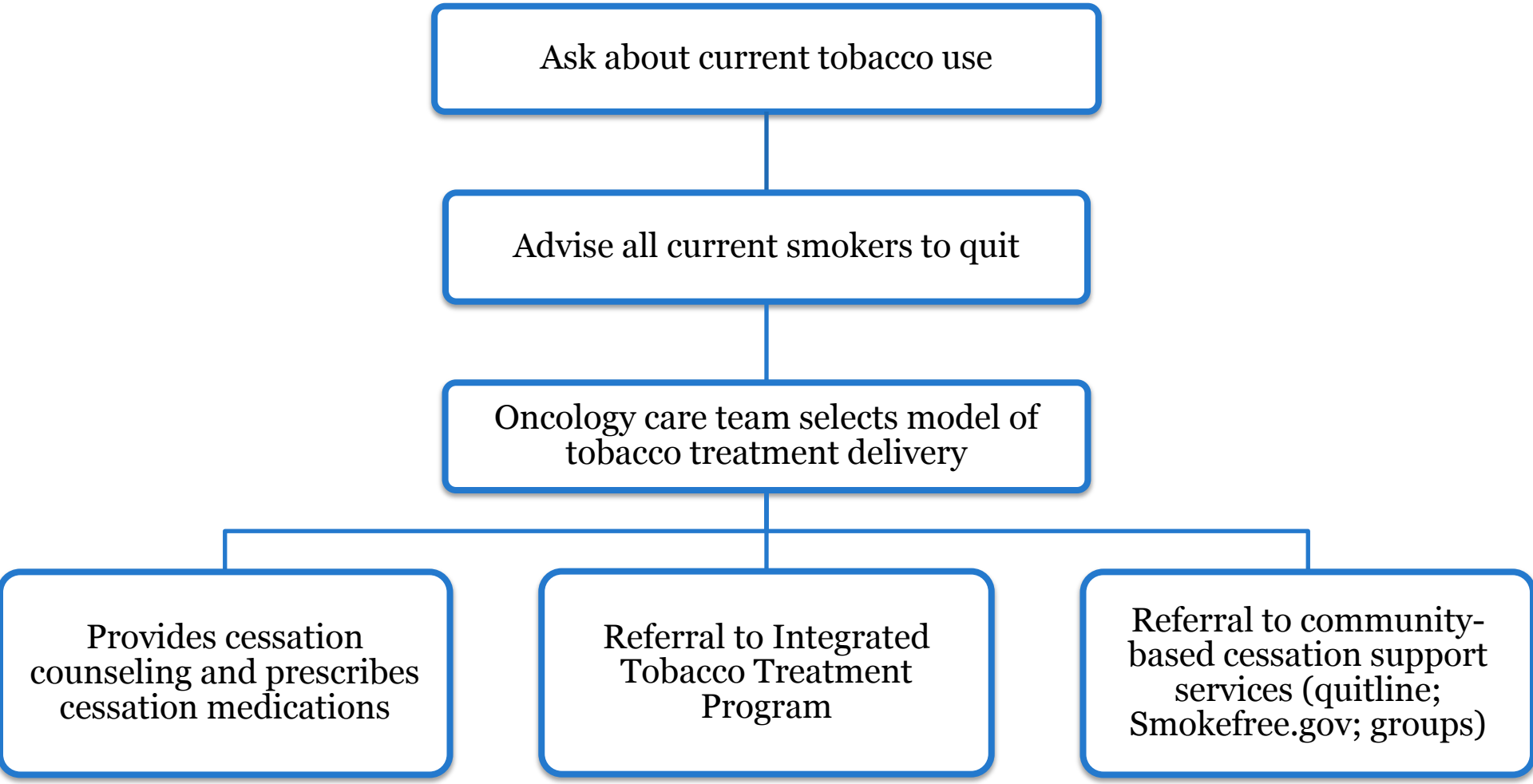
Models of Tobacco Treatment



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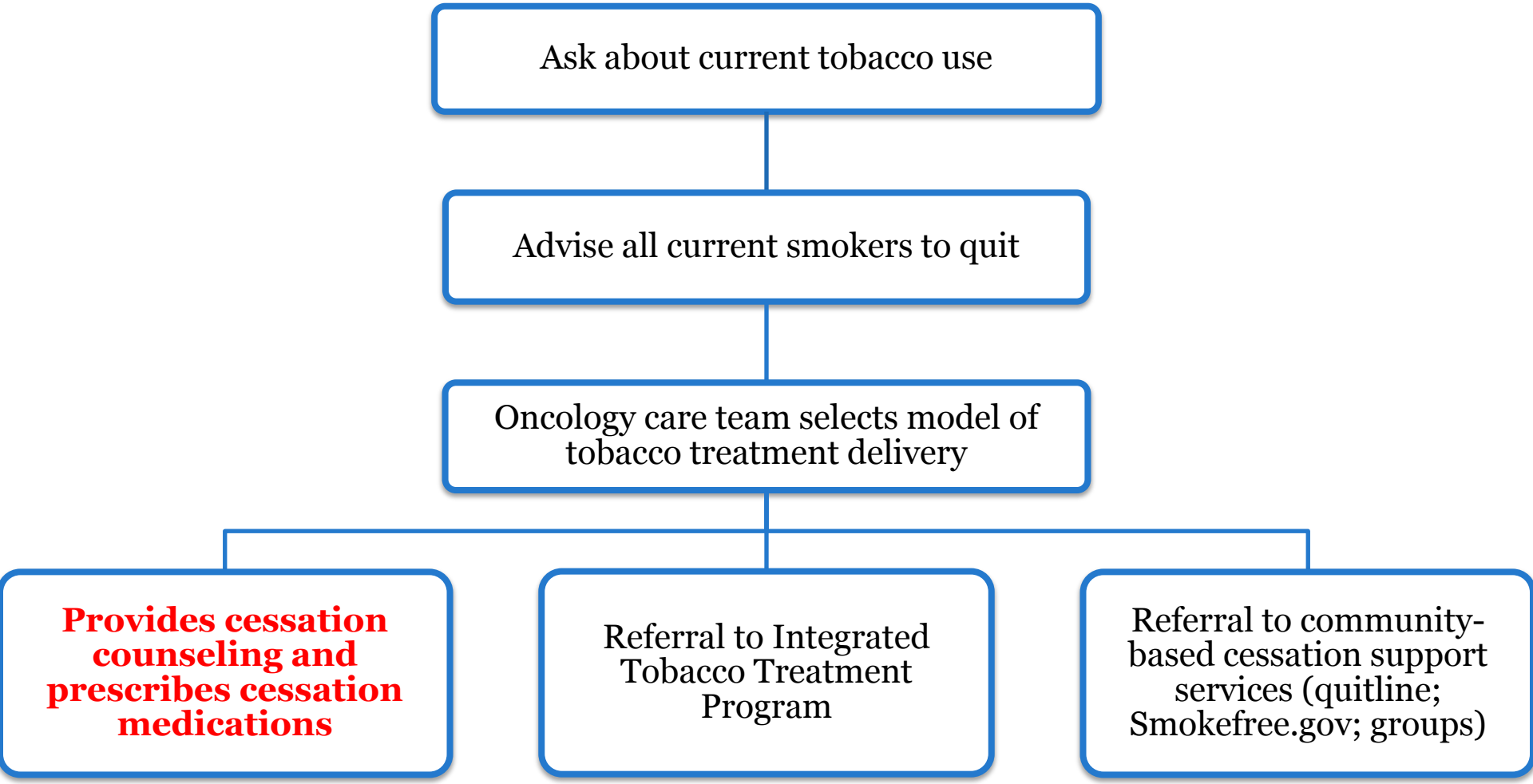
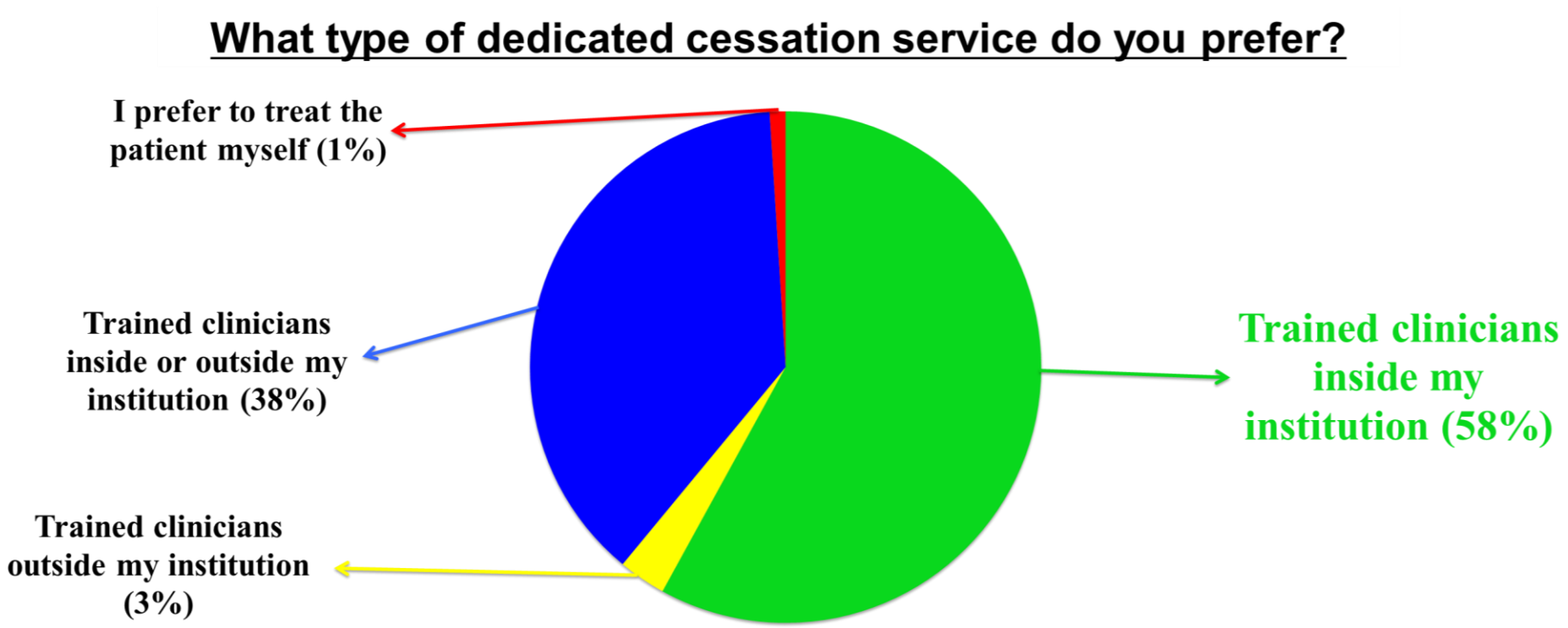
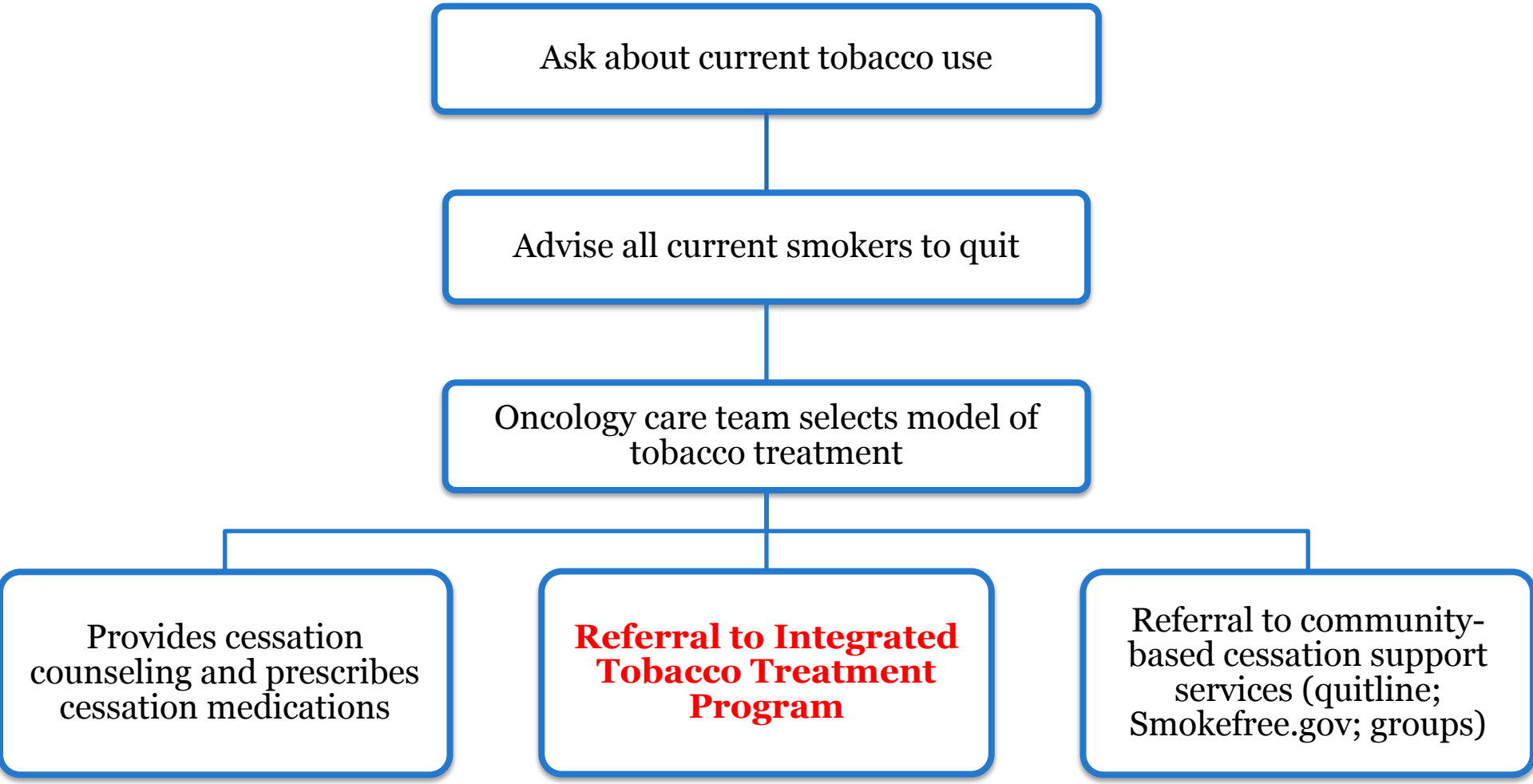


Oncologists' Preferences for Tobacco Treatment Delivery



Pommerenke et al. AACR 2014 Annual Meeting

Models of Tobacco Treatment



ASK: Tobacco Use Screener

- In the past 30 days, have you smoked cigarettes or used any other forms of tobacco (cigars, pipe, smokeless tobacco)?
  - **Every day***
  - **Some days***
  - Not at all

**Tobacco use screening is routinely assessed on Ambulatory and Inpatient Adult Health Screening Forms*

Source: Modified BRFSS, MU "compliant" screener for current tobacco use

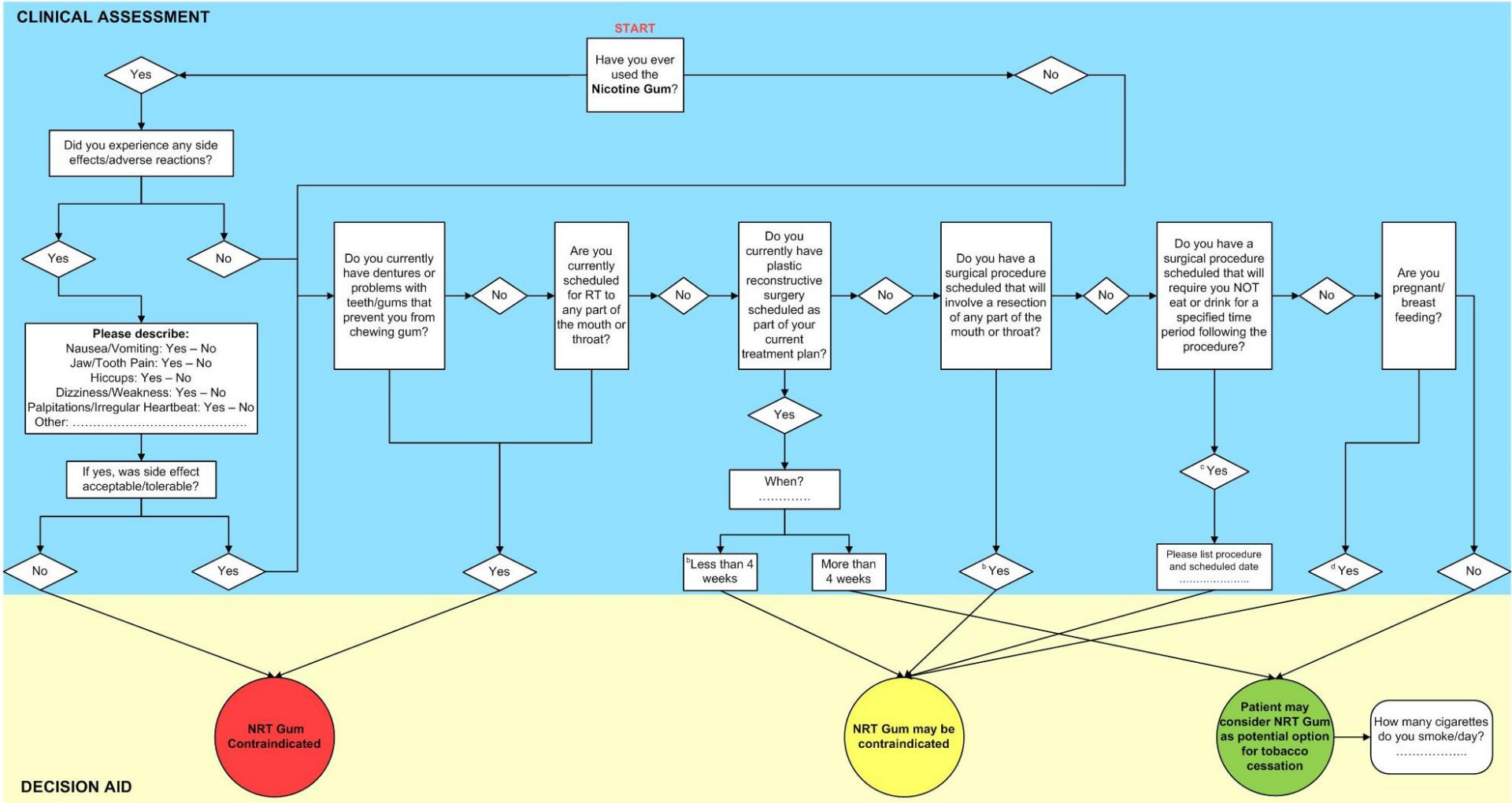
Advise

- Provide patient with specific education about risks of persistent smoking and **the benefits** of quitting
  - Offer advice on the safety and efficacy of cessation medications as well the benefits of seeking behavioral counseling

Refer/Prescribe

- Refer smokers to Tobacco Treatment Specialist (TTS) for cessation counseling
- Use of cessation medication reduces acute nicotine withdrawal *(e.g., restlessness, irritability, cravings, difficulty concentrating)*.
- Use of cessation medication also increases the likelihood of cessation.

MSK Cessation Pharmacotherapy Decision Trees: NRT Gum



[a] *Nicotine gum is contraindicated for 1 week prior to plastic surgery and 4 weeks following plastic surgery*

[b] *Patient may find it uncomfortable to use nicotine gum until oral surgical wounds are completely healed*

[c] *Patient will not be able to use nicotine gum while on "no food or drink" precautions*

[d] *Patient will not be able to use nicotine gum while on "no food or drink" precautions*

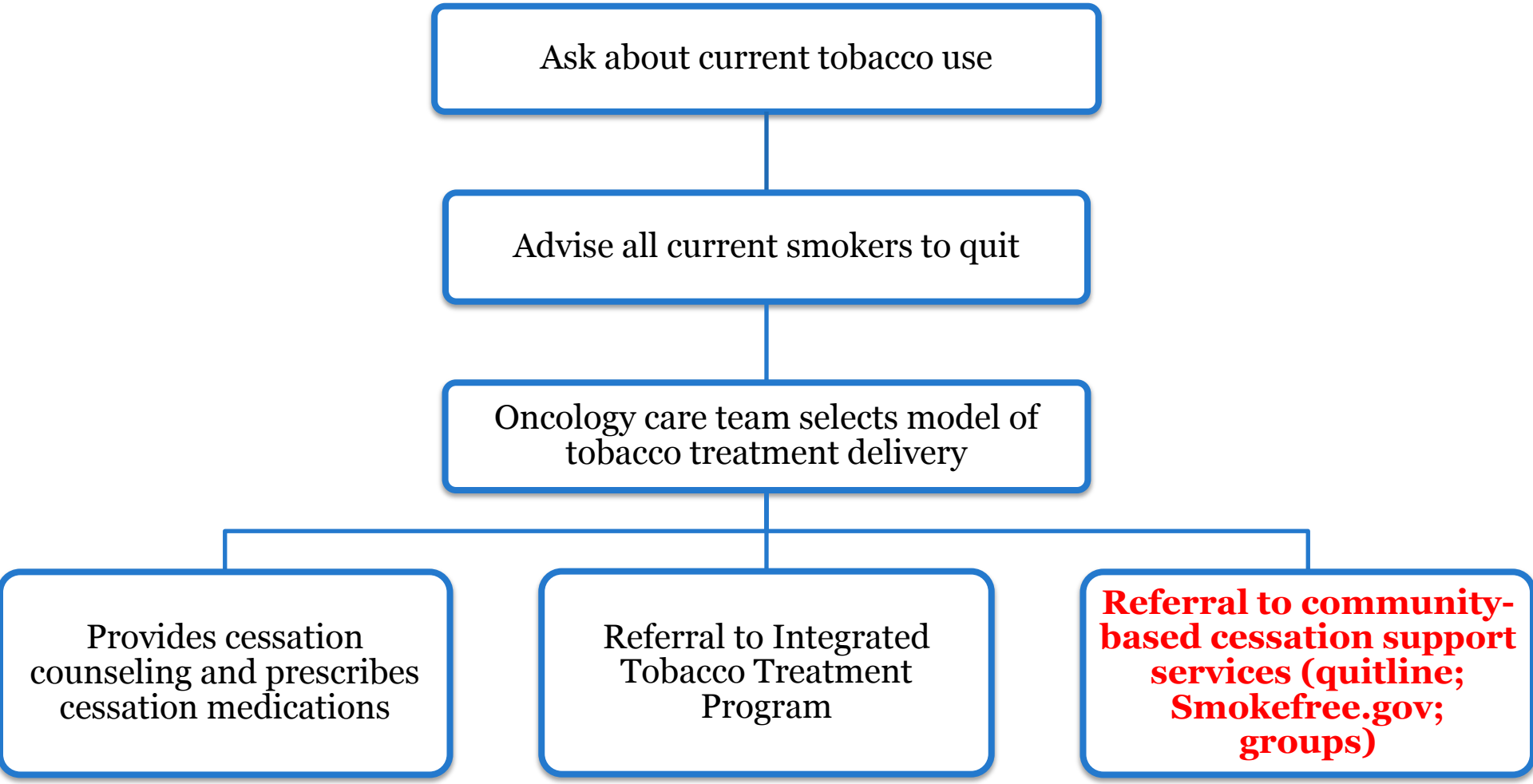
Dosing Notes

- **2mg** if smoking **24 or < cig/d**
- **4mg** if smoking **25 or > cig/d**

(Up to 12 weeks)

Do not exceed 24 pieces of gum/24hr

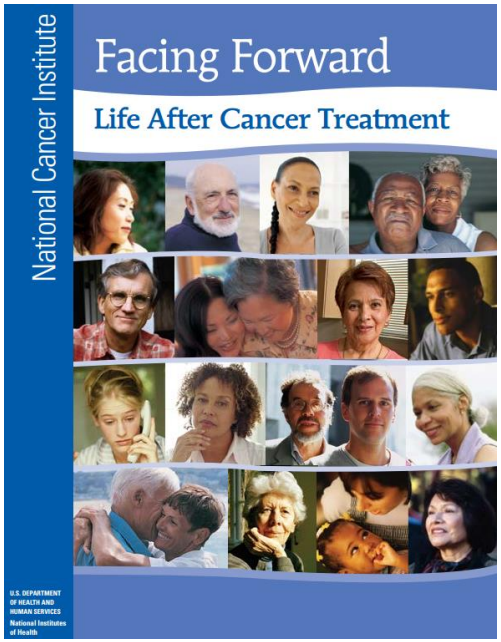
Models of Tobacco Treatment

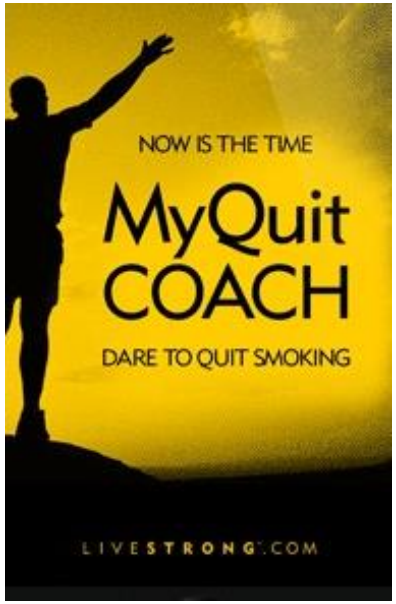


Community-based Cessation Resources and Referrals

ex a new way to think about quitting smoking

NORTH AMERICAN QUITLINE CONSORTIUM





smokefree.gov

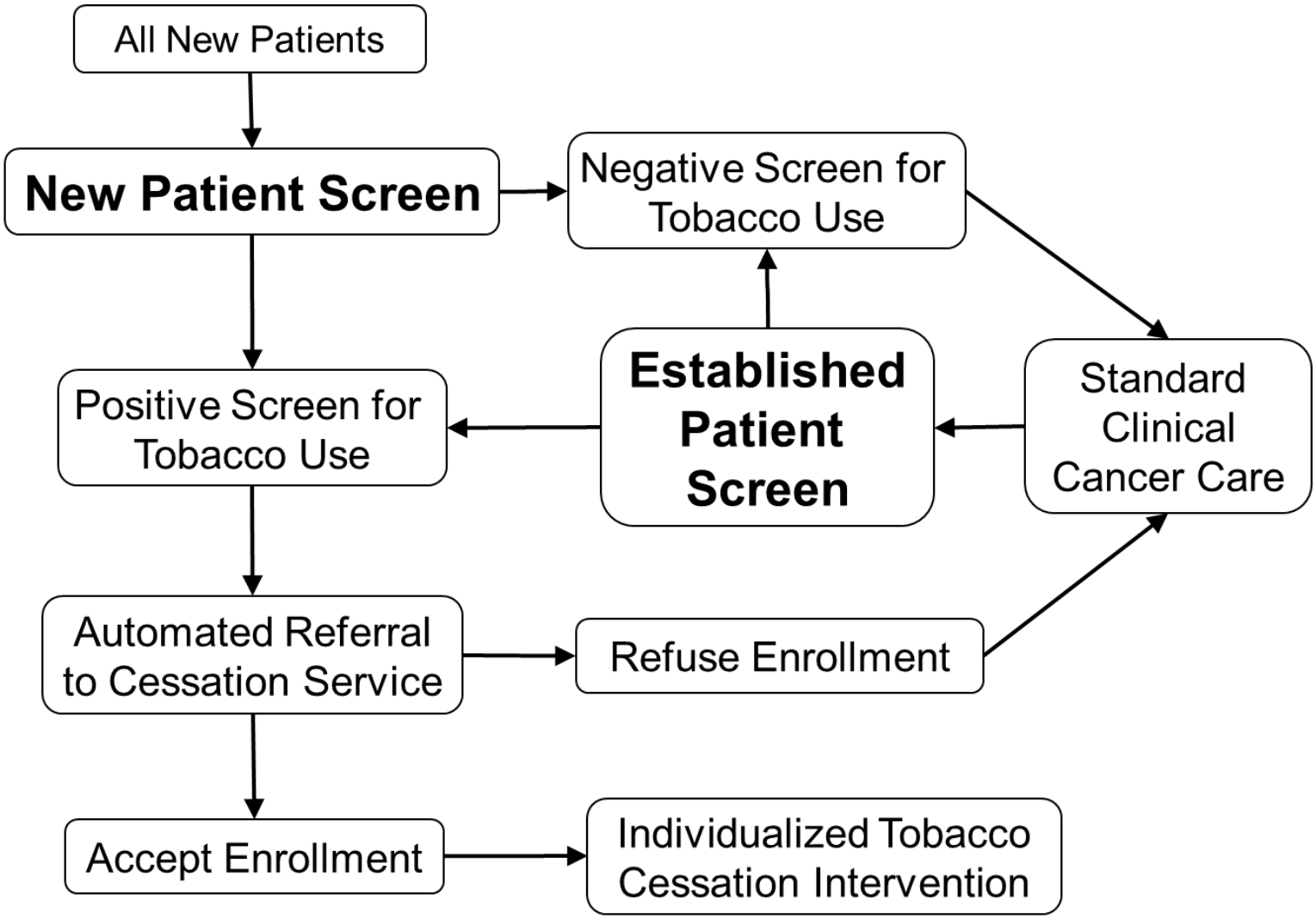
American Cancer Society®

Examples of Tobacco Treatment Models at Cancer Centers

Program Characteristics	Massachusetts General Hospital	Memorial Sloan Kettering Cancer Center	MD Anderson	Moffitt
Identification of tobacco users	Electronic assessment at admission, computerized order entry, electronic referral	Inpatient and ambulatory nursing assessment, automated referral	Referral by health care provider, self referral, electronic referral at follow-up appointments	Comprehensive admission assessment interview (EMR)
Eligibility	Current smokers, recent quitters (past 12 mo)	Current smokers, recent quitters (past 30 d)	Current smokers, recent quitters (past 12 mo)	Current smokers, recent quitters (past 90 d)
Treatment Intensity	Level 4	Level 4	Level 4	Level 3
Treatment Modality	Individual counseling at bedside, referral to quit line or internal automated phone reminder system with call-back option, self-help guide	Individual face-to-face counseling, telephone counseling with in house Tobacco Treatment Specialists	Individual face-to-face counseling, telephone and Webcam counseling	Cessation classes
Funding source(s)	Hospital operating budget/clinical revenue	Hospital operating budget/clinical revenue	State tobacco settlement funds	Hospital operating budget
NOTE: Level 1: hospital contact for < 15 minutes and no discharge support; level 2: hospital contact for > 15 minutes and no discharge support; level 3: any hospital contact and post-discharge lasting 1 month or less; level 4: any hospital contact and post-discharge support lasting more than 1 month				

Morgan, et al., 2011

Automated Screening and Treatment: Roswell Park Cancer Center



Warren GW et al., Cancer 2014

Memorial Sloan-Kettering is a Tobacco-Free Institution.

This applies to any campus including sidewalks of every site owned or operated by MSKCC, including all research facilities and regional network sites.

Memorial Sloan-Kettering Cancer Center

Help us protect everyone's health.

MSKCC Tobacco Cessation Program Stepped-Care Model (est 1999)

STEP 3: MAXIMUM INTENSITY

- Clinic treatment (individual counseling)
- Address psychiatric, substance abuse comorbidity
- Combination pharmacotherapy
- Long-term follow-up and maintenance

STEP 2: MODERATE INTENSITY

- First-line pharmacotherapy
- Brief motivational and cessation counseling
- Arrange referral and/or follow-up

STEP 1: MINIMUM INTENSITY

- Identify all current smokers
- Personalized advice
- Self-help materials

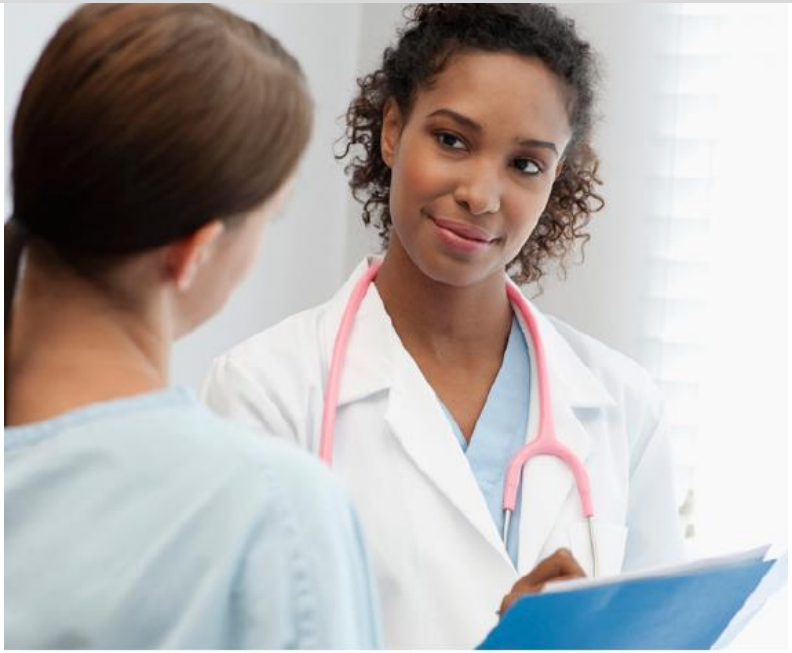
Recommended ingredients of Tobacco Treatment Models

1. Multidisciplinary team for establishing policies and practices
2. Staff and patient education about the benefits of cessation and risks of continued smoking for cancer patients
3. Standardized screening method to identify all smokers at intake and throughout continuum of cancer care
4. Embed clinical staff with expertise in evidence-based tobacco treatment (Tobacco Treatment Specialists)
5. Patient-centered tobacco treatment plan that build and maintains quitting motivation and strengthen skills in coping with smoking urges
6. Liaison with oncology care team re cessation medications
7. Tobacco cessation research programs that complement and benefit from clinical service
8. Collection and monitoring of cessation outcomes, cost and quality of care performance data

Presentation Overview: Learning Objectives

1. Brief review of clinical rationale for treating tobacco dependence in cancer care
2. Best practices in promoting tobacco cessation among cancer patients and survivors
3. Current gaps in promoting tobacco cessation among cancer patients and survivors
4. Integration of tobacco cessation services across models of oncology care
5. Resources available for achieving tobacco cessation among cancer patients and survivors
6. Opportunities and strategies to increase implementation of tobacco cessation best practices and address gaps

ASCO Tobacco Cessation Toolkits



ASCO
American Society of Clinical Oncology
Making a world of difference in cancer care

Tobacco Cessation Guide

For Oncology Providers

ASCO
American Society of Clinical Oncology
Making a world of difference in cancer care

Stopping Tobacco Use After a Cancer Diagnosis

Resources and Guidance for Patients and Families

Cancer.Net

Tobacco Treatment Resources for Cancer Patients and Providers

- ASCO Tobacco Cessation Guide for Oncology Providers http://www.asco.org/sites/default/files/tobacco_cessation_guide.pdf
- Toolkit intended to help oncology providers integrate tobacco cessation strategies into their patient care.
- NCCN Clinical Practice Guidelines in Oncology for Smoking Cessation http://www.jnccn.org/content/13/5S/643.full.pdf+html
- AACR-ASCO Policy on Electronic Nicotine Delivery Systems (ENDs) http://www.asco.org/sites/www.asco.org/files/e-cig_january_2015.pdf
- ASCO University Bookstore http://store2.asco.org/Asco-Cancer-Prevention-Curriculum-CD/dp/B0072H6ZG2
- Cancer prevention curriculum with information on smoking cessation
- Surgeon General's Report http://www.surgeongeneral.gov/library/tobaccosmoke/report/index.html
- Chapter 5 of the report is focused on cancer and tobacco use http://www.surgeongeneral.gov/library/tobaccosmoke/report/chapter5.pdf
- ASCO Tobacco Control Policy http://jco.ascopubs.org/content/early/2013/07/29/JCO.2013.48.8932.full.pdf
- ASCO's tobacco cessation policy statement, 2012 update
- American Association for Cancer Research: Assessing Tobacco Use by Cancer Patients and Facilitating Cessation http://www.aacr.org/AdvocacyPolicy/GovernmentAffairs/Documents/AACRStatement_TobaccoUseCancerPatients_2013_CCR___f3f578.pdf
- Oncology Nursing Society https://www.ons.org/advocacy-policy/positions/policy/tobacco
- Nursing Leadership in Global and Domestic Tobacco Control statement, 2008 update
- SmokeFree.gov Resources for Healthcare Professionals http://smokefree.gov/health-care-professionals

See handout for additional information

Presentation Overview: Learning Objectives

1. Brief review of clinical rationale for treating tobacco dependence in cancer care
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4. Integration of tobacco cessation services across models of oncology care
5. Resources available for achieving tobacco cessation among cancer patients and survivors
6. Opportunities to address barriers and promote strategies to increase implementation of tobacco treatment

Future Directions and Action Steps

- Identify and address patient, provider and systems level barriers
- Create opportunities for tobacco treatment training and practice facilitation
- Establish, monitor and provide performance feedback on quality of tobacco treatment metrics

Addressing Provider Barriers

Barriers/Challenges	Strategies
Lack of awareness of risks of persistent tobacco use	Provide continuing education programs for oncology professionals
Limited knowledge of evidence-based tobacco dependence treatments	Include tobacco control in fellowship/graduate programs/certification examinations in oncology
Lack of awareness of available cessation resources	Media campaign
Limited leadership	Identify and cultivate oncology champions to spearhead advocacy and implementation efforts
	Recruit leaders across professional groups and consider strategic alliances with community-based tobacco control groups
Negative attitudes, including perceived patient resistance to quitting and frustration when smokers relapse	Emphasize motivational interviewing strategies in educational programs
	Dispel myths and misconceptions about tobacco dependence treatment and provide a foundation for understanding nicotine addiction
Lack of time or competing priorities	Brief interventions are effective. Consider embedding a designated tobacco treatment specialist for those who need more intensive treatment. Consider telephone quitline referral for support and follow-up.
Smoking among health care professionals	Develop/expand tobacco dependence treatment for all employees

Morgan, et al., 2011

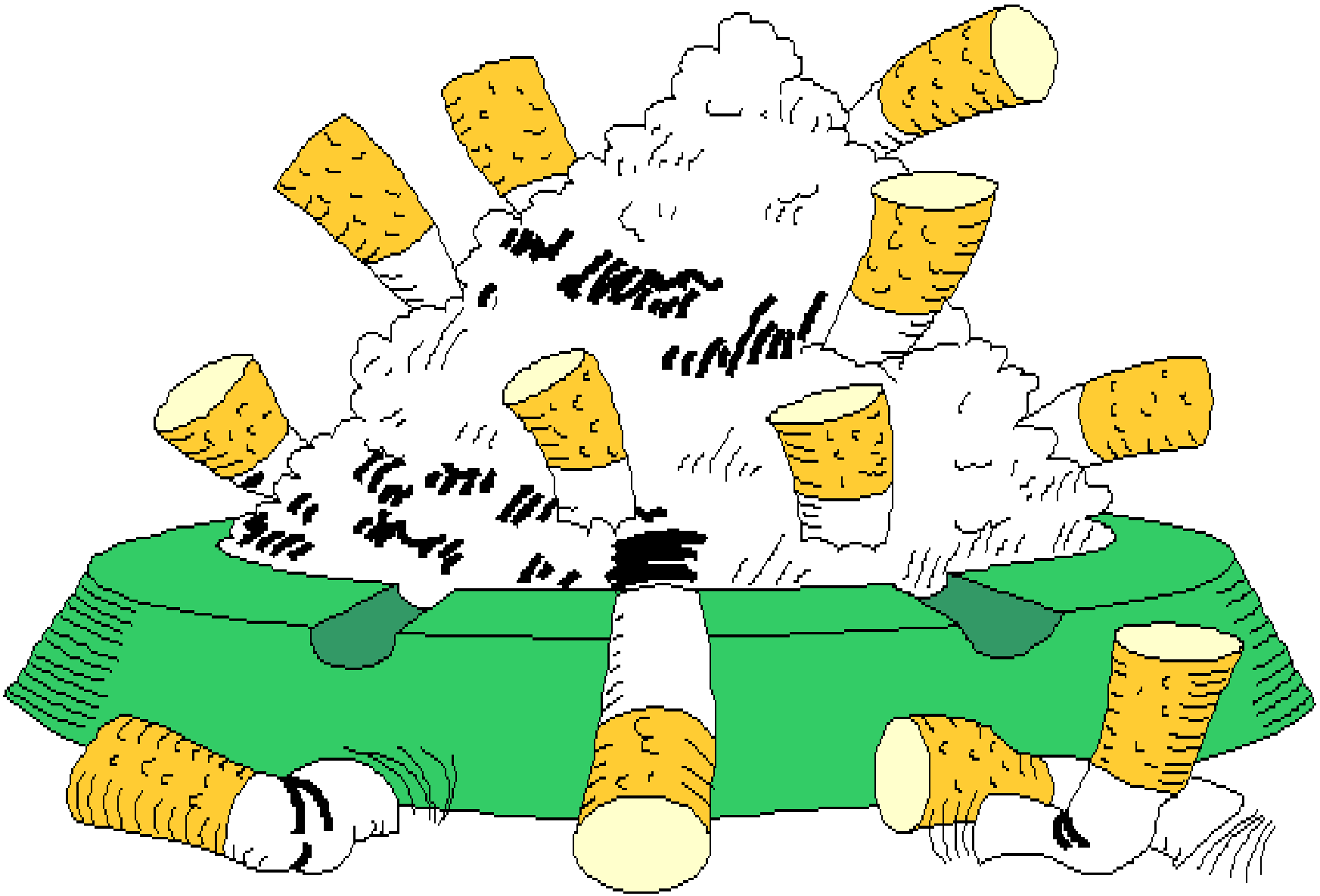
Addressing Institutional/Systems Barriers

Barriers/Challenges	Strategies
Low institutional priority	Identify clinical and administrative champions/stakeholders
	Establish tobacco treatment as an integral part of active and post-treatment quality care
	Tobacco –free hospital policies
	Include tobacco treatment as quality cancer care metric (See ASCO QOPI, Joint Commission)
Lack of standardized method for tobacco use screening comprehensive tobacco assessment	Develop and maintain an automated system for identifying all current smokers See GEM website for AACR-NCI Taskforce Recommendations
	Assess exposure to other tobacco products and secondhand (household) smoke exposure .
Lack of clinical protocol	Embed in-house tobacco treatment specialist Follow Clinical Guidelines (NCCN) for best practices Document tobacco use status in EHR; advice to quit and treatment delivery
Limited patient/family awareness of the importance of quitting tobacco use and decreasing exposure to second-hand smoke	Disseminate cancer-specific education materials about benefits of quitting for cancer patients and survivors
Low patient utilization and program reach	Monitor provider referrals Address stigma and train oncology providers to provide empathic counseling and quitting support
Lack of reimbursement	Develop a billing system to support insurance coverage (ICD, CPT Codes)
Lack of provider adherence to clinical practice guidelines and lack of awareness of cessation outcomes	Develop a quality improvement mechanism for ongoing assessment and feedback on adherence to tobacco treatment guidelines Provide data about the effectiveness of tobacco dependence treatment

Take Home Messages

- Despite risks of persistent smoking, a substantial proportion of cancer patients/survivors are current smokers
- Oncology providers view tobacco cessation as a priority for their patients who smoke
- In most settings, tobacco dependence treatment has not yet been integrated as standard of cancer care
- Systems changes involving staff training, practice facilitation, quality of care metrics, performance feedback can improve quality of care

THE END!



Thank you!

Questions for Dr. Ostroff?

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