

Using a Quitline to Deliver Opt-Out Smoking Cessation for Cancer Patients

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QUESTION ASKED: Can existing statewide resources be used to increase access to evidence-based smoking cessation resources and deliver them to patients with cancer?

SUMMARY ANSWER: By using statewide resources, increasing access to evidence-based smoking cessation programs and delivering them to patients with cancer is achievable. In an increasingly cost-conscious health care environment, collaborative initiatives that use or enhance existing resources should be considered and refined to deliver effective evidence-based care.

WHAT WE DID: Statewide agencies, including the Cancer and Tobacco Control Programs at the Michigan Department of Health and Human Services, the Michigan Oncology Quality Consortium (MOQC), the Michigan Cancer Consortium, and the Quitline vendor National Jewish Health formed the MOQC Initiative, a collaboration to develop and implement a clinical quality improvement initiative with the goal of addressing tobacco use by patients with cancer across Michigan oncology practices. The collaborative designed an opt-out approach for identifying tobacco users and referring them to the Michigan Tobacco Quitline (hereafter referred to as Quitline) within participating practices. As the initiative progressed, patients with cancer who were not referred through the initiative also became eligible for enrollment in the Quitline program.

WHAT WE FOUND: A total of 4,347 patients with cancer enrolled in the Quitline between 2012 and 2017, and annual referrals from oncology practices increased

from 364 (5% of Quitline participants) to 876 (17% of Quitline participants). The 2013-2016 Michigan Behavioral Risk Factor Surveillance System also demonstrated an increase from 60% to 80% in cancer survivors receiving smoking cessation resources. Of 3,892 patients with cancer who had Quitline follow-up data through 2017, 79% completed one or more counseling calls. The 6-month self-reported quit rate for patients with cancer assessed between 2013 and 2016 was 26%.

BIAS, CONFOUNDING FACTORS: The data collected during this project are not designed to argue that an opt-out Quitline approach is the most efficacious mechanism or that centralized statewide resources should supplant or replace existing dedicated tobacco treatment programs at hospitals, cancer centers, or oncology practices. The results do not support or refute whether more intensive interventions are superior or which patients would benefit most from more intensive interventions.

REAL-LIFE IMPLICATIONS: Tobacco cessation as part of cancer treatment improves health outcomes. The MOQC Initiative improved the use of existing tobacco treatment resources by patients with cancer by ensuring that oncology providers had a simple system for delivering tobacco use treatment. This initiative can serve as a model for future collaborative projects and could be cultivated at the physician, state, and national levels. Because smoking can affect other chronic disease states, the MOQC Initiative model may be useful to deliver support to patients with other chronic disease states.

Author affiliations and disclosures are available with the complete article at ascopubs.org/journal/op.

Accepted on December 19, 2019 and published at ascopubs.org/journal/op on January 29, 2020: DOI <https://doi.org/10.1200/JOP.19.00296>

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abstract

PURPOSE Although smoking by patients with cancer and survivors causes adverse outcomes, many patients with cancer do not receive access to evidence-based tobacco use treatment. The purpose of this article is to report on delivery of tobacco use treatment to patients with cancer using a state-supported Quitline.

METHODS Statewide agencies in Michigan partnered with the Michigan Oncology Quality Consortium to develop and implement a clinical quality improvement initiative with the goal of addressing tobacco use by patients with cancer across Michigan oncology practices. The collaborative designed an opt-out approach for identifying tobacco users and referring them to the Michigan Tobacco Quitline (hereafter known as Quitline) within participating practices. As the initiative progressed, patients with cancer who were not referred through the initiative also became eligible for enrollment in the Quitline program.

RESULTS A total of 4,347 patients with cancer enrolled in the Quitline between 2012 and 2017, and annual referrals from oncology practices increased from 364 (5% of Quitline participants) to 876 (17% of Quitline participants). The 2013-2016 Michigan Behavioral Risk Factor Surveillance System also demonstrated an increase from 60% to 80% of cancer survivors receiving smoking cessation resources. Of 3,892 patients with cancer who had Quitline follow-up data through 2017, 79% completed one or more counseling calls. The 6-month self-reported quit rate for patients with cancer assessed between 2013 and 2016 was 26%.

CONCLUSION Using statewide resources to increase access to evidence-based smoking cessation assistance to patients with cancer is achievable. In an increasingly cost-conscious health care environment, collaborative initiatives that use or enhance existing resources should be considered and refined to deliver effective evidence-based care.

JCO Oncol Pract 16. © 2020 by American Society of Clinical Oncology

INTRODUCTION

Smoking by patients with cancer and cancer survivors causes adverse outcomes, including increased overall and cancer-specific mortality,¹ and it can lead to substantial incremental costs for cancer treatment.² Asking patients about their tobacco use status and providing evidence-based treatment, including counseling and tobacco pharmacotherapy, is supported as a clinical standard of care for all patients with cancer.³ However, surveys of cancer centers and providers have repeatedly demonstrated limitations in identifying tobacco use, providing advice to quit, and providing treatment to help patients with cancer quit smoking.⁴⁻⁷ Consequently, many patients with cancer who use tobacco at the time of diagnosis continue to engage in tobacco use.^{8,9}

Barriers to providing smoking cessation treatment include a lack of provider time, training, and resources.¹⁰ Opt-out approaches to treat smoking can address some of these concerns by using standardized methods to assess tobacco use and automate referrals to dedicated smoking cessation resources.¹¹ An opt-out approach gives patients access to trained personnel who discuss the benefits of smoking cessation and deliver counseling and pharmacotherapy, which increases the success of tobacco cessation programs.³ Previous institutional opt-out approaches using phone-based tobacco treatment have shown promise,¹² but data that evaluate the use of existing statewide resources to deliver an opt-out tobacco treatment program across multiple cancer clinics are limited. This article reports on a clinical quality

Author affiliations and support information (if applicable) appear at the end of this article.

Accepted on December 19, 2019 and published at ascopubs.org/journal/op on January 29, 2020; DOI <https://doi.org/10.1200/JOP.19.00296>

The contents of this article are solely the responsibility of the authors and do not necessarily represent the official views of the Centers for Disease Control and Prevention.

improvement initiative to increase access to tobacco treatment for patients with cancer by using the Michigan Tobacco Quitline (hereafter called Quitline) in cancer clinics across the state.

METHODS

Purpose and Partnership

To address tobacco use in patients with cancer, a clinical quality improvement project was conceptualized in 2011 to develop and implement a statewide program to increase access to evidence-based tobacco treatment at oncology practices throughout the state of Michigan. An initial analysis of tobacco assessment and treatment documented by Michigan oncology practices demonstrated that less than 15% of patients reporting tobacco use were referred for treatment, less than the nationally reported Quality Oncology Practice Initiative (QOPI) average of 47%.¹³ To address this gap, a collaborative was formed between the Cancer and Tobacco Control Programs at the Michigan Department of Health and Human Services (MDHHS), the Michigan Oncology Quality Consortium (MOQC), the Michigan Cancer Consortium (MCC), and National Jewish Health (NJH). The MCC is a statewide consortium of more than 100 organizations dedicated to reducing the cancer burden in Michigan that is supported by the MDHHS Cancer Prevention and Control Program. The MDHHS Tobacco Control Program supports and evaluates the Quitline. NJH is the Quitline vendor that provides tobacco treatment counseling by telephone and pharmacotherapy to patients, as well as technical assistance and data to referring providers. MOQC is a Collaborative Quality Initiative aligned with the University of Michigan Rogel Cancer Center and funded by Blue Cross Blue Shield of Michigan. MOQC uses data gathered from oncology practices as part of the national QOPI program to identify areas for improving the care of patients with cancer in Michigan.

Conceptualization, Intervention Design, and Delivery

A timeline for this initiative is provided in [Figure 1](#). Representatives from the MDHHS attended an Institutes of Medicine conference at which issues surrounding tobacco use and cancer treatment outcomes were discussed.¹⁴ A physician champion (G.W.W.) was identified to serve as a content expert in addressing tobacco use by patients with cancer on the basis of prior experience in developing opt-out approaches for tobacco treatment in cancer care.¹² Calls were held every 2 weeks between project leaders to develop and execute the project. The MCC and MOQC promoted the Ask, Advise, Refer model to oncology practices for identifying tobacco users and proactively referring them to receive tobacco treatment via a fax referral to the Quitline. The collaborative used lean management experts and principles to develop a practice change packet; provide patient and provider resources; and plan three in-person learning sessions, periodic conference calls, and

site visits for participating practices.¹⁵ Throughout this article, the overall program will be referred to as the MOQC Initiative.

Before the MOQC Initiative, free counseling and pharmacotherapy from the Quitline was limited primarily to Michigan residents who were currently pregnant, had state-funded insurance, or had no insurance. The MDHHS Tobacco Control Program provided funding to increase eligibility to include all Michigan residents with a cancer diagnosis (new or previous), regardless of their insurance status. Beyond communicating this protocol change to NJH, no additional changes were necessary for the Quitline to begin delivering tobacco treatment to referred patients. Each clinic assessed tobacco use by using their existing resources and tailored workflow. Clinical teams informed patients currently using tobacco that referrals to the Quitline for tobacco treatment are sent as part of standard clinical practice. Each clinic then completed a standardized paper referral form and faxed it directly to the Quitline. Quitline Quit Coaches then initiated one of three call attempts within 48 hours of receiving the referral to enroll the patient into the Quitline.¹⁶ Quit Coaches asked patients if they would like to participate and, if so, they completed a 10-minute intake call to collect demographic and baseline tobacco use information. Quit Coaches then completed the initial coaching session immediately after intake or scheduled it for a follow-up call. During this project, Quitline treatment included four proactive outbound counseling calls to patients, unlimited inbound calls, and up to 8 weeks of free nicotine replacement therapy (NRT) as patches, gum, or lozenges, which was mailed directly to eligible patients.

Practice Engagement

In April 2013, a day-long collaborative orientation was held with 18 oncology practices interested in participating in the MOQC Initiative. Expectations for participating included identifying a champion, collecting baseline data, participating in three learning collaborative meetings and interim conference calls, tracking progress, and documenting lessons learned. During the collaborative meetings, experts in tobacco treatment and process improvement provided information to participating practices on the importance of smoking cessation for patients at the time of cancer diagnosis and treatment, provided lean management tools and processes, and helped practices create a plan for implementation. Tools provided to facilitate the workflow changes within the practice setting included a change packet, a prepopulated fax referral form, and visual decision-making aides.¹⁵ Patient education tools provided to practices included table tents, staff buttons, handouts, and posters. Provider education tools included professional statements, literature summaries, and motivational interviewing scripts. Practices obtained a confirmatory fax for each referral to the Quitline and could consult the Quitline for specific patient follow-up. Twice a year, practices

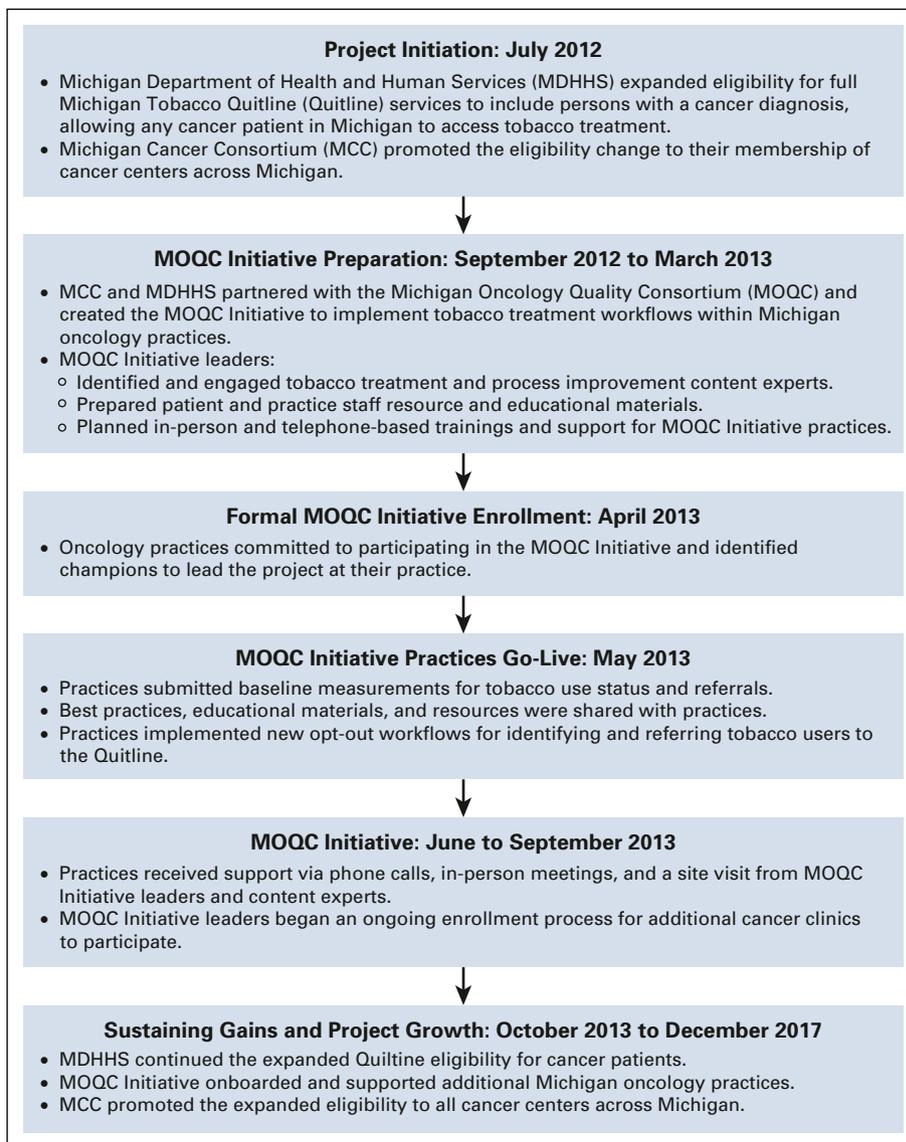


FIG 1. Timeline of Michigan Oncology Quality Consortium (MOQC) Initiative tobacco cessation activities between July 2012 and December 2017.

received performance feedback on the number of tobacco users receiving initial chemotherapy who had also received tobacco cessation counseling or had been referred for services in the past year. To reach as many patients with cancer as possible, additional oncology practices were invited to participate in the MOQC Initiative on an ongoing basis. The MOQC Initiative was promoted through both the MOQC and MCC networks.

Analyses

Descriptive data were collected by NJH and were shared with MOQC and MDHHS to track the progress and outcomes of the project. Data included the number of practices participating, referrals made, contacts made (patients answering the call from the Quitline), patients enrolled into the Quitline, NRT products sent to patients, and aggregate self-reported 3-, 6-, and 12-month quit rates collected on a rolling basis by an independent vendor as part of standard Quitline operations. Analyses used existing de-identified

data and the project was deemed exempt by the Institutional Review Board at the University of Michigan.

RESULTS

In the first MOQC Initiative year, 2013, tracking information on tobacco assessment and referral to the Quitline was deemed most important. In the first year, 95% of patients with cancer had a documented tobacco use assessment, and 61% of eligible patients with cancer were referred to the Quitline. MOQC Initiative practices referred 694 patients with cancer, and 308 (45%) were successfully contacted by the Quitline. Of patients contacted, 26% declined participation. The proportion of patients enrolled in the Quitline identifying as patients with cancer increased between May and December 2013 from 62 to between 80 and 123 per month.

An interim analysis was completed for MOQC Initiative referrals between January and December of 2015 to assess

referrals as well as quit rates. A total of 1,048 referrals were made from 39 oncology practice sites, and 394 (38%) were successfully contacted by the Quitline. Of patients contacted, 28% declined participation. Self-reported quit rates for Quitline participants with cancer who completed follow-up in 2015 at 3, 6, and 12 months were 30% (n = 198), 28% (n = 138), and 30% (n = 199), respectively.

Through 2017, 4,347 patients with cancer enrolled in the Quitline from practice sites that participated in the MOQC Initiative and from those that did not (Table 1). A substantial increase in enrollment from 364 in 2012 to 648 in 2013 coincided with the MOQC Initiative launch and continued an upward trend to 876 in 2017. The proportion of Quitline participants who were patients with cancer also increased accordingly during this time from 5% to 17%, which supports a positive effect of the MOQC Initiative on patients with cancer receiving treatment through the Quitline.

To evaluate whether the MOQC Initiative influenced other statewide measures for patients with cancer, specific data for cancer survivors collected by the Michigan Behavioral Risk Factor Surveillance System (MiBRFSS) were analyzed. The MiBRFSS is an annual, state-wide telephone survey that collects self-reported cancer diagnoses and smoking habits.¹⁷ The 2013-2016 MiBRFSS data are provided in Table 2. MiBRFSS data show an increase in the percentage of responders stating that they have a previous cancer diagnosis, have used tobacco, and have received a referral to cessation resources from 60% in 2013 to 80% in 2016.

Follow-up data were available for 3,892 patients with cancer enrolled in the Quitline program between 2013 and 2017. Engagement in Quitline coaching is detailed in Table 3 and includes the number of completed intake or coaching calls for enrolled patients. Most patients (58%) completed only the intake call or one coaching call; 16% completed four or more calls. A total of 2,064 unique (nonduplicate) patients with cancer made one or more attempts to quit using tobacco between 2013 and 2017, and 2,291 NRT supplies were provided to patients. Quality control measures to assess Quitline effectiveness in 638 patients with cancer participating in the Quitline between

2013 and 2016 demonstrated an aggregate 6-month self-reported quit rate of 26%.

DISCUSSION

Results of this clinical implementation initiative demonstrate that statewide resources can be used to facilitate delivery of tobacco treatment to patients with cancer across multiple oncology treatment centers. Data support that high rates of patient identification and referral are possible, but an approximately 40% patient contact rate (45% in the first year and 37% for the interim analysis in 2015) by the Quitline suggests that methods of contacting patients need improvement. Reasons for unsuccessful contact were not available for analysis. Approximately one third of patients who were successfully contacted refused participation. Cumulatively, data suggest that for a given cohort of 100 patients with cancer who use tobacco with a 90% referral rate, 40% contact rate, and 28% refusal rate, approximately 26 patients will participate in the cessation program. Achieving participation in approximately 26% of patients exceeds recent published data for opt-in approaches of approximately 3% in patients with cancer using interactive voice response technology,¹⁸ but that rate is less than the enrollment rate using institutional phone-based opt-out approaches.¹² Importantly, results from the MiBRFSS suggest that many patients may receive support from other resources beyond the MOQC Initiative, although information on those resources is not available.

These data represent the largest assessment of the clinical implementation of statewide resources to address the deficits in treating patients with cancer for tobacco use. A survey of 58 National Cancer Institute (NCI) Designated Cancer Centers suggests that 79% provide access to an internal or external tobacco dependence treatment program and 62% provide patient education materials, but only 52% are effectively assessing tobacco use status in patients with cancer.⁶ A more recent analysis of 28 Commission on Cancer programs demonstrated that while most centers captured tobacco status, delivery of tobacco treatment was poor.⁷ Although surveys demonstrate that approximately 90% of oncologists ask about tobacco use

TABLE 1. Number of Michigan Tobacco Quitline Patients With a Cancer Diagnosis Enrolled by Calendar Year (January to December)

Year	Patients Enrolled in Quitline		
	No. Who Had a Cancer Diagnosis	Total No. Enrolled	Patients Who Had a Cancer Diagnosis, %
2012	364	7,449	4.9
2013	648	5,997	10.8
2014	689	4,865	14.2
2015	828	4,424	18.7
2016	942	6,036	15.6
2017	876	5,184	16.9

NOTE. Enrollments included sites that did or did not participate in the Michigan Oncology Quality Consortium Initiative.

TABLE 2. Data from the Michigan Behavioral Risk Factor Surveillance System Between 2013 and 2016 for Patients With a Previous Cancer Diagnosis Who Used Tobacco and Were Referred to Tobacco Cessation Resources

Year	Tobacco Users With a Cancer Diagnosis Who Report Being Referred to a Cessation Resource	
	No.	%
2013	92	60
2014	95	64
2015	104	71
2016	197	80

and 80% to 90% advise patients to quit smoking, less than half of the oncologists regularly provide support for quitting.^{4,5} A survey of 1,691 new patients with cancer who reported smoking found that 73% were willing to consider quitting smoking and 56% were ready to quit within the next month.¹⁹ However, analysis of the Cancer Prevention Study II Nutritional Cohort found that only 31% of patients with cancer who smoked reported quitting at 2 years after a cancer diagnosis.⁹ A recent review of 131 published studies evaluating the patterns of tobacco use in patients with lung or head and neck cancer revealed that only 32 reported any information on tobacco use at one or more follow-up intervals, with a median of 43% of patients reporting current smoking at diagnosis and at follow-up.⁸ These authors further highlight that data about amount of smoking, quit attempts, abstinence, receipt of cessation treatment, or follow-up after cancer diagnosis was missing from more than 90% of studies. Because smoking by patients with cancer and cancer survivors increases mortality,¹ and because many studies that evaluate smoking at follow-up do not adequately account for smoking at the time of death, it is likely that smoking cessation rates at any time after a cancer diagnosis are lower than estimated.

The MOQC Initiative addresses identified barriers to providing tobacco use treatment: lack of provider time, training, and resources.¹⁰ The collaborative successfully demonstrates that existing resources and collaboration can

TABLE 3. Number of Calls Completed by Patients With Cancer Who Enrolled in the Michigan Tobacco Quitline Between 2013 and 2017

No. of Coaching Calls Completed	Enrolled Patients	
	No.	%
Intake only	799	21
1	1,448	37
2	625	16
3	385	10
4	289	7
> 5	346	9
Total	3,892	100

be used for an opt-out approach for patients with cancer in which tobacco users are routinely identified and referred for tobacco treatment, proactively contacted by the program, presented with the benefits of quitting, and asked to participate. Patients had to actively refuse intervention once contacted by Quitline staff. This infrastructure is promising, but has lower contact and participation rates than previously reported for institutional opt-out approaches. An opt-out treatment approach identified and referred 1,384 patients with cancer who currently smoke to a dedicated tobacco cessation program conducted by telephone.¹² Of patients referred, 81% were successfully contacted and only 3% declined participation. In contrast, a separate cohort of 1,499 patients with cancer who screened positive for tobacco use were counseled about the benefits of cessation as it related to their cancer treatment and were asked whether they would like to participate in an established interactive voice response–initiated smoking cessation program.¹⁸ Only 11% accepted the referral and 3% enrolled. These are significant differences in reported participation rates. Results from the MOQC Initiative fall between these two examples and support using statewide Quitline resources to increase delivery of tobacco treatment to a large cohort of patients with cancer.

The 26% quit rate collected from patients with cancer who participated in the Quitline seems comparable to or better than recently published self-reported quit rates of 17% to 29% for Quitline callers participating in counseling across several states,²⁰ but less than the 31% 6-month quit rates for all Michigan resident Quitline participants in 2016.²¹ The higher quit rate for the overall Michigan resident Quitline participants could reflect higher quit rates for opt-in participants, which represented more than 80% of total Michigan Quitline participants in 2016. Previous studies suggest that patients with a smoking-related cancer were more likely to decline smoking cessation treatment²²; however, recent data show that cancers more related to smoking were associated with patient confidence of remaining smoke free.²³ There were no data available to evaluate demographic patterns, biochemical confirmation, or estimates of quit rates for patients not participating in the Quitline for comparison.

There are several limitations to this project. The results are particularly useful for demonstrating how statewide resources can be used to provide tobacco use treatment to patients with cancer. However, data are not designed to argue that an opt-out Quitline approach is the most efficacious mechanism or that centralized statewide resources should supplant or replace existing dedicated tobacco treatment programs at hospitals, cancer centers, or oncology practices. The results do not support or refute whether more intensive interventions are superior, or which patients would benefit most from more intensive interventions. Because smoking can affect therapeutic outcomes and cost for cancer treatment^{1,2} and other chronic

disease states, there is a significant need to provide smoking cessation support to patients across multiple disease states.^{24,25} The MOQC Initiative model could be useful to deliver support to patients diagnosed with other chronic diseases, but no data are available to correlate participation with practice enrollment or opt-out approaches in other chronic diseases. The rise in patient-reported access to tobacco cessation resources (Table 2) correlates with increases in the use of the Quitline by patients with cancer (Table 1), but there are no direct measures of whether this increase was attributed entirely to the MOQC Initiative. Data for smoking by cancer survivors in the MiBRFSS before 2013 were not available; thus, it is unclear whether the initial 60% reported MiBRFSS rate in 2013 was influenced by the initial implementation of the MOQC Initiative.

The MOQC Initiative improved use of existing tobacco treatment resources by patients with cancer by ensuring

that oncology providers had a simple system for delivering treatment for tobacco use. This initiative can serve as a model for future collaborative projects and could be cultivated at the physician, state, and national levels. The NCI recently emphasized the critical need to address tobacco use by patients with cancer by providing 42 NCI Designated Cancer Centers with resources to develop dedicated tobacco treatment programs through the Cancer Moonshot program.²⁶ Given the large number of patients with cancer who received service through this approach, it is prudent to further explore expanded Quitline access for patients with cancer as a primary or supplementary resource along with other programs dedicated to treating tobacco use. In programs with few providers, limited resources, or patients distributed across a wide area, this approach could be particularly useful. The MOQC Initiative provides a strong justification for investigating optimal approaches for phone-based opt-out approaches for patients with cancer.

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PRIOR PRESENTATION

Presented in part as an abstract or poster at the 21st Annual Institute for Healthcare Improvement Scientific Symposium, Orlando, FL, December 7, 2015 and at the ASCO Annual Meetings in 2014 and 2018.

SUPPORT

Supported by Cooperative Agreements No. NU58DP006109, DP003040, and NU58DP005349 from the Centers for Disease Control and Prevention.

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AUTHORS' DISCLOSURES OF POTENTIAL CONFLICTS OF INTEREST AND DATA AVAILABILITY STATEMENT

Disclosures provided by the authors and data availability statement (if applicable) are available with this article at DOI <https://doi.org/10.1200/JOP.19.00296>.

AUTHOR CONTRIBUTIONS

Conception and design: All authors

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Final approval of manuscript: All authors

Accountable for all aspects of the work: All authors

ACKNOWLEDGMENT

We thank Jane Severson for leading the design and implementation of this collaborative and the leaders and staff of the Michigan Department of Health and Human Services and Michigan Oncology Quality Consortium for developing, implementing and maintaining the initiative. We also thank the National Jewish Health Quitline coaches, management, and evaluation team for delivering tobacco treatment to Michigan residents, Blue Cross Blue Shield of Michigan, whose support is valued and appreciated, and the participating hematology/oncology clinics that work daily to improve outcomes for people living with cancer.

This initiative was supported by Cooperative Agreements No. NU58DP006109, DP003040, and NU58DP005349 from the Centers for Disease Control and Prevention. Michigan Oncology Quality Consortium is funded by Blue Cross Blue Shield of Michigan.

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AUTHORS' DISCLOSURES OF POTENTIAL CONFLICTS OF INTEREST

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No other potential conflicts of interest were reported.