LUNG CANCER PATIENT SUPPORT ECHO SESSION 4
TOBACCO CESSATION:
SUPPORTING PATIENTS ACROSS THE CANCER CONTINUUM

AUGUST, 2018
9:00 AM ET
**TODAY’S AGENDA**

<table>
<thead>
<tr>
<th>Time</th>
<th>Presentation</th>
<th>Presenter(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>9:00-9:10</td>
<td>Welcome, roll call, housekeeping</td>
<td>Thomas Asfeldt, RN</td>
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<tr>
<td>9:10-9:45</td>
<td>Didactic Presentation: ECHO Session 4</td>
<td>Tom Houston, MD</td>
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<td>Angela Criswell, MA</td>
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<td>Jamie Ostroff, Ph.D.</td>
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<td>9:45-10:00</td>
<td>Q &amp; A/Discussion</td>
<td>Facilitated by Thomas Asfeldt</td>
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<tr>
<td>10:00-10:15</td>
<td>Program/Case Presentation</td>
<td>Hope Gibson, BSN, RN</td>
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<td>Scotland Cancer Center</td>
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<tr>
<td>10:15-10:25</td>
<td>Q &amp; A/Discussion</td>
<td>Facilitated by Thomas Asfeldt</td>
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<td>10:25-10:30</td>
<td>Conclusion/Next session</td>
<td>Thomas Asfeldt/Octavia Vogel</td>
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*Sessions will be recorded.*  
*Please mute phones when not speaking. Mute cell phones and try to reduce extraneous noise.*  
*Remember to e-mail Octavia Vogel by if you are requesting CME/CEU credit.*
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- The following planners and faculty disclose that they have no financial relationships with any commercial interest.
FACILITATOR & PRESENTERS

Lead Facilitator: Thomas Asfeldt, RN
Sanford Health Systems

Presenters: Tom Houston, MD (Primary Care Physician)
AAFP Rep to Nat’l Lung Cancer Roundtable

Angela Criswell, MA
Lung Cancer Alliance

Jamie Ostroff, Ph.D. (Psychologist)
Memorial Sloan Kettering Cancer Center

Case Presentation: Hope Gibson, RN, BSN (Oncology Navigator)
Scotland Cancer Center
TOBACCO CESSATION: CHALLENGES IN LUNG CANCER SCREENING

Tom Houston, MD
Clinical Professor, Family Medicine
The Ohio State University
LEARNING OBJECTIVES

Following the presentation, participants should be able to:

- Discuss tobacco dependence as a chronic relapsing condition
- Identify key psychological and physiological features of nicotine addiction
- Summarize the major recommendations of the US Public Health Service Clinical Practice Guidelines for treating tobacco use and dependence
- Describe the value of multiple sources of intervention in implementing cessation support for patients across the cancer continuum
SMOKING IN PERSPECTIVE

- Kills more than 488,000 Americans each year
- Causes cancer, heart disease, stroke, pulmonary disease, and adverse pregnancy outcomes
- Adds >$170 billion in direct health costs each year
- Indirect costs, productivity losses $150 billion/year
- Half of all smokers will die from a tobacco related disease unless they quit by middle age

- Lung Cancer: 137,989 (29%)
- Ischemic Heart Disease: 133,300 (28%)
- Chronic Obstructive Pulmonary Disease: 100,600 (21%)
- Other Diagnoses: 56,800 (10%)
- Stroke: 15,300 (4%)
- Other Cancers: 36,000 (8%)

More Than 480,000 U.S. Deaths Attributable Each Year to Cigarette Smoking*

* Average annual number of deaths 2005–2009

- 70% of smokers see a physician/other clinician each year.
- 70% of smokers want to quit.
- Physician’s advice to quit is an important motivator.
- Patients are more satisfied with their health care if their provider offers smoking cessation interventions - even if they’re not yet ready to quit.
Treating Tobacco Use and Dependence

2008 UPDATE

U.S. Public Health Service Clinical Practice Guideline

August 2009
Tobacco dependence is a chronic condition

All tobacco users should be offered evidence based treatment

- Behavioral interventions—even if brief—are effective
- Strong dose response:
  - Length of visits
  - Number of visits
  - Number of providers intervening
- Pharmacologic treatment is effective and at least one medication should be prescribed as part of the treatment plan.
- The combination of behavioral intervention and pharmacotherapy is optimal.

Treatment of tobacco dependence is cost-effective

Healthcare systems must systematize treatment of tobacco dependence
CANCERS CAUSED BY SMOKING

- Lung
- Larynx
- Esophagus
- Stomach
- Pancreas
- Kidney/Bladder
- Cervix
- Oral/pharyngeal
- Acute myeloid leukemia
- Colon/rectal
4000-7000 chemicals and between 60 and 300 carcinogens

Induces carcinogenesis through
- DNA adduct formation
- Free radical formation
- Oxidative stress
- Inhibition of apoptosis
- Radiation effects (Polonium 210)

RELATIVE RISK OF LUNG CANCER BY NUMBER OF CIGARETTES SMOKED PER DAY

CPS1 Data
Current smoker lung cancer mortality risk
11.82 (95% CI, 10.73-13.03)

Former smoker lung cancer mortality risk
4.15 (95% CI, 3.75-4.49)

National Longitudinal Mortality Study
JAMA Int Med 2018; 178(4):469-476
LUNG CANCER MORTALITY RATES FOR SMOKERS, NEVER SMOKERS AND SMOKERS WHO QUIT AT AGE 50

Death Rate per 100,000

Risk of a continuing smoker

Cessation at age 50

Risk avoided by cessation

Residual risk

Age Group

CPS I Data
**UNIQUE QUALITIES OF NICOTINE ADDICTION THROUGH SMOKING**

- Cigarette is a highly engineered drug-delivery system
- Inhaling produces a rapid distribution of nicotine to the brain
- Drug levels peak within 10 seconds in the brain
- Acute effects dissipate within minutes, causing the smoker to continue frequent dosing throughout the day
- Average smoker takes 200-300 boluses to the brain per day

Nature 1989;393:76
Addictive drugs stimulate release of dopamine (brain neurotransmitter)
- Dopamine produces feelings of pleasure
- Pleasure reinforces repeat administration
- Tolerance develops
- Abrupt discontinuation leads to symptoms of withdrawal
NICOTINE WITHDRAWAL SYMPTOMS

- Constant craving of cigarettes
- Insomnia
- Irritability
- Anxiety
- Frustration
- Anger
- Depression
- Difficulty concentrating
- Restlessness
- Decreased heart rate
- Increased appetite

Withdrawal peaks within 24-48 hours and diminishes over 1 month.
Relapse Rates Over Time for Users of Heroine, Cigarettes, and Alcohol

The 5 As: Treating Tobacco as a Chronic Disease

ASK
Do you currently use tobacco?

YES

ADVISE to quit

ASSESS
Are you willing to quit now?

YES
ASSIST
Provide appropriate tobacco dependence treatment

NO
ASSIST
Intervene to increase motivation to quit

NO

ASK
Have you recently quit?

YES
ASSIST
Provide relapse prevention

NO
ASSIST
Encourage continued abstinence

ASK
Have you ever used tobacco?

YES
NO

ARRANGE FOLLOW-UP
## THE 5 A’S

<table>
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<tr>
<th>Ask about tobacco use</th>
<th>Identify and document tobacco use status for every patient at every visit.</th>
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<tr>
<td>Advise to quit.</td>
<td>In a clear, strong and personalized manner urge every tobacco user to quit.</td>
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<tr>
<td>Assess willingness to make quit attempt.</td>
<td>Is the tobacco user willing to make a quit attempt at this time?</td>
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<tr>
<td>Assist in quit attempt.</td>
<td>For the patient willing to make a quit attempt, refer to tobacco cessation counseling and physician</td>
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<tr>
<td>Arrange</td>
<td>At the next follow up contact, inquire about their smoking use status, encourage if in the quit process, assess and refer if still smoking.</td>
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ASK/ACT
ASK/ADVISE/REFER

- Ask every patient about tobacco use
- Act to help them quit
  - On-site counseling/Advice
  - Pharmacotherapy
  - Follow-up
- Refer to local cessation resources
  - Quitlines
  - Patient education materials
  - Self-help guides or Websites
OPPORTUNITIES ABOUND FOR INTERVENTION

- Primary care office
  - Routine care visits
    - Lung cancer screening discussion
- At the referral site
- After the scan
- At follow up with PCP/referral source
- At the next screening cycle
THANK YOU!

You may email questions to:
Octavia.vogel@cancer.org
SMOKING CESSATION AND LUNG CANCER SCREENING: A LOVE STORY

GROWING FROM A MARRIAGE OF CONVENIENCE INTO LIFE PARTNERS
WE CAN’T GO ON TOGETHER WITH SUSPICIOUS MINDS

• Will screening replace cessation as public health priority?
• Will smokers substitute screening for cessation?
Screening Program Staff:

- Screening is already complex. How do we add cessation to all of the other things we’re responsible for?
- How can we “make” people quit?
- If we don’t get people to quit, have we failed?

Patient frame of reference: anticipated stigma and judgement

“You feel stigmatized for having a lung scan, because you’re stigmatized for smoking....”

“...They look at you like you’re a low life, uneducated, and just an ignorant person. You smokers....”

Online comment to news story on tobacco control efforts in KY.

Stephen
Great !!
And if you continue to smoke after knowing the health risk there should not be any Medicare benefits.

8 hours ago · Like · 4 · Reply
“All persons enrolled in a screening program should receive smoking cessation interventions….The USPSTF encourages incorporating such interventions into the screening program.

- SDM must include counseling on maintaining abstinence if former smoker, importance of cessation if current smoker, information on cessation interventions if appropriate.
- Radiology imaging facility criteria: must “make available smoking cessation interventions for current smokers.”
I WANT TO KNOW WHAT LOVE IS.
I WANT YOU TO SHOW ME.
THIS IS HOW WE DO IT…

Smoking Cessation Resources Used

- Quitline: 157
- Counseling within Facility: 153
- Printed Resources: 142
- Counseling outside Facility: 81
- Online Resources: 72
- Other: 29

# of Facilities Using Resource
Does your program conduct follow-up with smokers referred to cessation services?

- Follow-up by treatment counselor
- Phone calls from screening program at 3 & 6 months
- In person follow-up at next visit
- Fax or EHR update from Quitline
A patient’s smoking history, as viewed by a “basic, out-of-the-box” EHR:

- Smoking status
- Type of tobacco used
- # of cigs/packs per day/week
- If quit, number of years
- Might also capture # of previous quit attempts

Source: Schindler-Ruwish et al., TBM 2017;7:148-156
EHRs can more fully document and support cessation interventions, but modification requires energy and resources.

**Ask:** tobacco use status & history  
**Advise:** language advising quit, documentation of advice given  
**Assess:** prompt to ask about & document willingness to quit  
**Assist:** brief counseling language; referral to TTS, Quitline; medication prescribing, dosage decision support; patient education materials; treatment order set  
**Arrange:** support for patient follow-up; electronic “pass back” of patient notes from TTS or Quitline.

Source: Schindler-Ruwish et al., *TBM 2017;7:148-156*
HELP ME GET MY FEET BACK ON THE GROUND
WON’T YOU PLEASE, PLEASE HELP ME?

https://lungcanceralliance.org/for-professionals/

THANK YOU!

You may email questions to:
acriswell@lungcanceralliance.org
TOBACCO CESSATION: CHALLENGES IN LUNG CANCER CARE

Jamie Ostroff, PhD
Memorial Sloan Kettering Cancer Center
HEALTH CONSEQUENCES OF SMOKING

Cancers
- Oropharynx
- Larynx
- Esophagus
- Trachea, bronchus, and lung
- Acute myeloid leukemia
- Stomach
- Liver
- Pancreas
- Kidney and ureter
- Cervix
- Bladder
- Colorectal

Chronic Diseases
- Stroke
- Blindness, cataracts, age-related macular degeneration
- Congenital defects—maternal smoking; orofacial clefts
- Periodontitis
- Aortic aneurysm, early abdominal aortic atherosclerosis in young adults
- Coronary heart disease
- Pneumonia
- Atherosclerotic peripheral vascular disease
- Chronic obstructive pulmonary disease, tuberculosis, asthma, and other respiratory effects
- Diabetes
- Reproductive effects in women (including reduced fertility)
- Hip fractures
- Ectopic pregnancy
- Male sexual function—erectile dysfunction
- Rheumatoid arthritis
- Immune function
- Overall diminished health

Source: Surgeon General’s Report, 2014
HEALTH CONSEQUENCES OF SMOKING FOR CANCER PATIENTS/SURVIVORS

- Adverse health outcomes of cigarette smoking in cancer patients and survivors
  - Cigarette smoking increases all-cause mortality
  - Cigarette smoking increases cancer-specific mortality
  - Cigarette smoking increases risk for second primary cancers.
  - Cigarette smoking increases risk for disease recurrence.

- Adverse health outcomes provide strong justification for the integration of evidence-based tobacco treatment in cancer care settings

Surgeon General’s Report, 2014
WHY BOTHER?

- Improves survival
- Decreases risk of disease recurrence
- Decreases risk of second primary cancers
- Decreases risk of treatment (surgery, radiation, chemotherapy) side effects and complications
- Improves treatment response and effectiveness
- Decreases risk of other tobacco-related comorbid conditions (CVD, COPD)
- Improves quality of life (better pain control, reduced distress/stigma)
Smoking Rates by Cancer Type

*statistically significant difference between lung and colorectal cancer (p<.05)

Park et al, Cancer, 2012
PATTERNS AND PREVALENCE OF SMOKING FOLLOWING DIAGNOSIS OF LUNG, HEAD/NECK CANCERS

Source: Burris, Studts, DeRosa & Ostroff, 2015, CEBP
• Combining pharmacologic therapy and behavior therapy is the most effective approach and leads to the best results for smoking cessation.
  The two most effective pharmacotherapy agents are combination nicotine replacement therapy (NRT) and varenicline.
  High-intensity behavior therapy with multiple counseling sessions is most effective, but at least a minimum of brief counseling is highly recommended. Quitlines may be used as an adjunct, especially in lower-resource settings.

• Smoking status should be documented in the patient health record. Patient health records should be updated at regular intervals to indicate changes in smoking status, quit attempts made, and interventions utilized.

• Smoking relapse and brief slips are common and can be managed. Providers should discuss this and provide guidance and support to encourage continued smoking cessation attempts. Smoking slips are not necessarily an indication to try an alternative method. It may take more than one quit attempt with the same therapy to achieve long-term cessation.

• Smoking cessation should be offered as an integral part of oncology treatment and continued throughout the entire oncology care continuum, including surgery and end-of-life care. An emphasis should be put on patient preferences and values when considering the best approach to fostering smoking cessation during end-of-life care.
Integrating Tobacco Treatment Into Cancer Care: A Randomized Controlled Comparative Effectiveness Trial (1R01CA166147) the Smokefree Support Study 1.0

Park, Ostroff, Perez et al., Contemporary Clinical Trials, 2016
Cancer Treatment

- Patient scheduled for appointment
- Patient enters cancer center
- Cancer treatment plan determined

Tobacco Treatment

- Patient identified as smoker
- Patient’s current smoking confirmed
- Smokers recruited
- Randomized

- Standard Treatment
  - 4 weekly counseling sessions + medication advice
  - 3-month survey

- Intensive Treatment
  - 4 weekly counseling sessions + medication
  - 4 biweekly proactive counseling sessions + medication
  - 3 monthly proactive booster counseling sessions
  - 6-month survey

Not current smoker
Refusal/Ineligible
Primary Outcome: Biochemically-Confirmed Quit Rates at 6 months

Among those abstinent at 3-months:
- 30% relapsed between 3 and 6 months

Among those abstinent at 6-months:
- 65% quit at 3 months (early quitters)
- 35% quit at 6 months (late quitters)

Park, Ostroff et al 2018, Annual ASCO Meeting, Chicago
MODELS OF TOBACCO TREATMENT IN CANCER CARE

Ask about current tobacco use

Advise all current smokers to quit

Oncology care team selects model of tobacco treatment delivery

Provide cessation counseling and prescribe cessation medications

Referral to Integrated Tobacco Treatment Program

Referral to community-based cessation support services (quitline; Smokefree.gov; groups)
STIGMA

Intensity of Stigma

Healthcare providers are often under pressure to include screening for mental health and substance use.

Certification of the patient as a smoker

Conclusion: Although the "smoker's attitude" is widely known, there is evidence that patients may harbor stigmatizing beliefs about smoking that can influence their healthcare provider's approach to smoking cessation counseling. This pairing of ethical and legal issues highlights the need for healthcare providers to be well-prepared to effectively address these issues in the context of patient care.
Your patients are more likely to become smoke-free if you advise them to quit smoking and encourage them to work with our tobacco treatment counselors.

Empathic discussion may improve patient engagement and influence adherence to the treatment plan with greater appreciation of how important quitting is for their treatment and overall health outcomes.

Refer patients to the Tobacco Treatment Program
PROVIDE RATIONALE FOR ASKING, ADVISING AND REFERRING: TALKING POINTS

- Quitting smoking can help **reduce surgical complications** and shorten recovery time.
- Quitting smoking **lowers the risk of your cancer coming back** or getting a **different tobacco-related cancer**.
- People with cancer who stop smoking **respond better to chemotherapy and radiation**, live longer, and have fewer side effects from their treatments.
- **Safe and effective tobacco treatment exists**.
- **We have staff with specific expertise in helping cancer patients quit and stay quit**.
ASCO TOBACCO TREATMENT TOOLKITS

Tobacco Cessation Guide
For Oncology Providers
Now Available!

The Cancer Patient Tobacco Use Questionnaire (C-TUQ)

C-TUQ asks cancer patients and survivors about their tobacco use. The questionnaire will help yield important research variables and allow harmonization across studies. The questions can be used at study entry and during follow-up. This questionnaire was designed and validated by an expert task force.

- C-TUQ Core: a short form with just 4 smoking status and history items, for broad use in cancer research
- C-TUQ Extension: a set of items from which to select for comprehensive assessment. Includes newly designed and validated items for smoking history and status relative to cancer diagnosis and treatment. Also addresses use of other tobacco products (such as e-cigarettes), secondhand smoke exposure, and cessation.

Access the latest information and updates, and share your experience, by visiting the Tobacco Use by Cancer Patients workspace at [https://www.gem-measures.org](https://www.gem-measures.org).
Next Training Workshop will be held October 19 & 20, 2018
New York City

For more information, visit: www.mskcc.org/TobaccoCare

Supported by NCI Award R25CA217693
THANK YOU!

You may email questions to: Octavia.vogel@cancer.org
CASE STUDY

Hope Gibson RN, BSN, Oncology Navigator
Scotland Cancer Treatment Center
1. POPULATION OF SCOTLAND COUNTY IS 35K AND DESIGNATED AS A RURAL COUNTY
2. RANKED 2\textsuperscript{ND} HIGHEST IN STATE FOR UNEMPLOYMENT AND IS RANKED 99\textsuperscript{TH} OUT OF 100 FOR HEALTH OUTCOMES.
3. IN 2016 THERE WERE 423 DEATHS AND 108 WERE CANCER RELATED DEATHS WITH CARDIO RANKED 2\textsuperscript{ND} AND LUNG CANCER IS THE \#1 CAUSE OF DEATHS

- Our hospital campus went tobacco free in 2006
- We have a Certified Tobacco Treatment Specialist (CTTS)
- Classes are offered as people call to schedule
- RESULTS OVER LAST 12 MONTHS:
  - 19 referrals received
  - 11 registered for class (58%)
  - 10 attended class (91%)
  - 5 completed (50%)

Reasons for not attending/completing tobacco cessation class:
1. Transportation
2. Someone else in home is smoker – difficult for successful quitting
3. "Not ready to Quit"
LDCT SCREENINGS

86 LDCT PERFORMED IN 2016
170 LDCT PERFORMED IN 2017
113 RECEIVED LDCT SO FAR IN 7/2018 (PROJECTED TO EXCEED 2017)

2017: 91% BASELINE SCREENINGS / 9% ANNUAL SCREENINGS
2018: 83% BASELINE SCREENINGS / 17% ANNUAL SCREENINGS

2018 ADDITIONAL STATS
68% WERE CURRENT SMOKERS
AVERAGE PACK YEAR WAS 40
MEDIAN AGE WAS 65

113 Patients with LDCT Results in 2018
In 2017, 3 industries/community events were offered LDCT screening tool.

265 Encounters with 155 people completed the survey tool

11 met criteria and was referred back to PCP

Only 1 out of the 11 had LDCT performed which resulted in a LungRad 3 (short term FU)
1. Head & Neck Cancer that MD said if you don’t quit smoking I can’t treat you because…..
   Patient attended tobacco cessation class and quit. Subsequently received radiation therapy.

2. 34 year old female snuff dipper – surgical patient -accepted and scheduled for class but did not show up

3. 30 year old male smoker with hematology issues and mother present – accepted our handouts and information but very reluctant to engage in conversation about quitting.

Suggestions/recommendations/ideas?
THANK YOU!

You may email questions to:
Octavia.vogel@cancer.org
JOIN US NEXT MONTH FOR LUNG CANCER PATIENT SUPPORT ECHO SESSION 5
TREATMENT PLANNING: OVERCOMING LACK OF CONCORDANCE WITH STAGING AND MANAGEMENT GUIDELINES
THURSDAY, SEPTEMBER 27, 2018
9:00 AM ET

Presenters:
Gerard Silvestri, MD (Pulmonologist)
Professor of Medicine
Medical University of South Carolina
Patricia Rivera, MD (Pulmonologist)
Clinical Research, Thoracic Oncology Program
School of Medicine, UNC-Chapel Hill
Facilitator/Co-Presenter:
John Ruckdeschel, MD (Oncologist)
Director, UMMC Cancer Institute
Case Presentation:
Volunteers needed