



Leading Practices in Smoking Cessation for Cancer Patients and Families

October 18, 2018

1:00 - 2:00pm Eastern Time



Today's learning objectives



Increase knowledge on the treatment benefits and health outcomes related to smoking cessation for cancer patients.



Learn about current practices in smoking cessation for cancer patients and families in Canada and abroad.



Promote exchange of these practices among practice and policy specialists to support implementation and adaptation across Canada.

Introducing our guest presenters



Dr. Graham Warren, M.D., PhD
Vice Chairman for Research
Department of Radiation Oncology
Department of Cell & Molecular Pharmacology
Cancer Prevention & Control Program
Hollings Cancer Center
Medical University of South Carolina



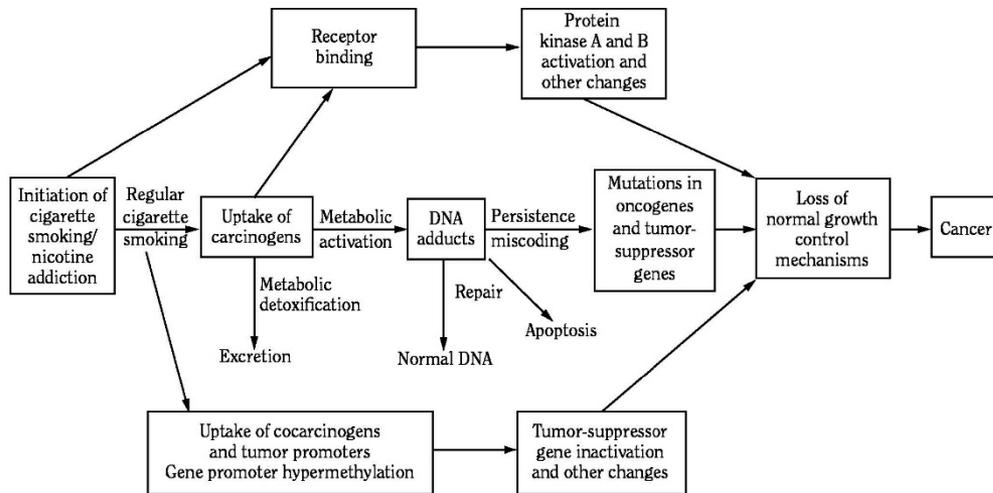
Scott Antle, Project Lead, Smoking
Cessation & Program Manager, Colon
and Cervical Screening,
Cancer Care Program, Eastern Health,
Newfoundland & Labrador

Respecting Traditions



Problem: We don't view Smoking in the Continuum of Cancer

The Established Carcinogenesis Model

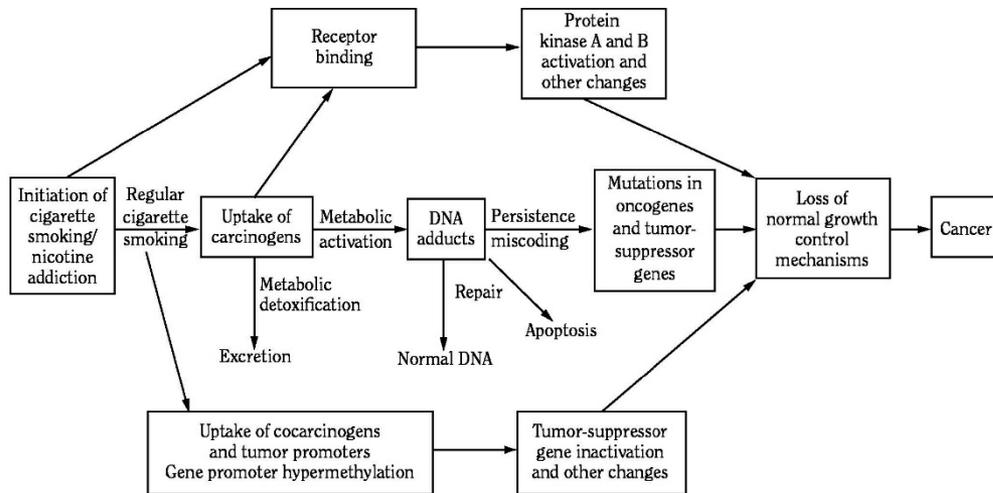


2010 Surgeon General's Report, Fig 5.1

Problem: We don't view Smoking in the Continuum of Cancer

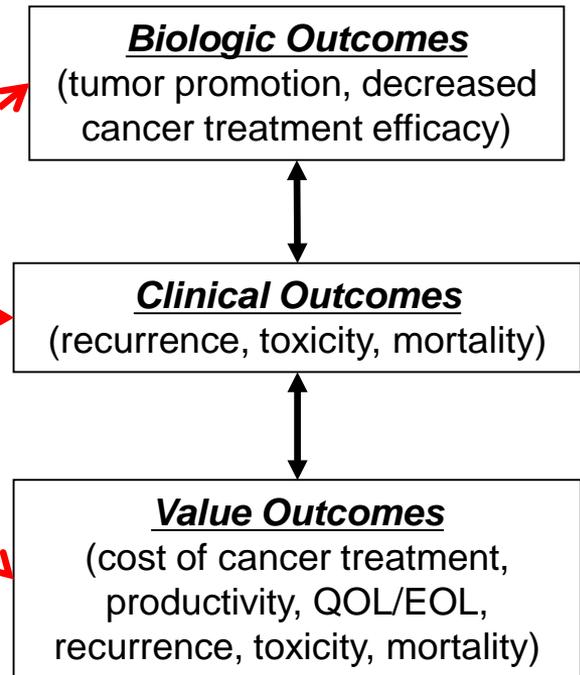
The
Historical
Disconnect

The Established Carcinogenesis Model



2010 Surgeon General's Report, Fig 5.1

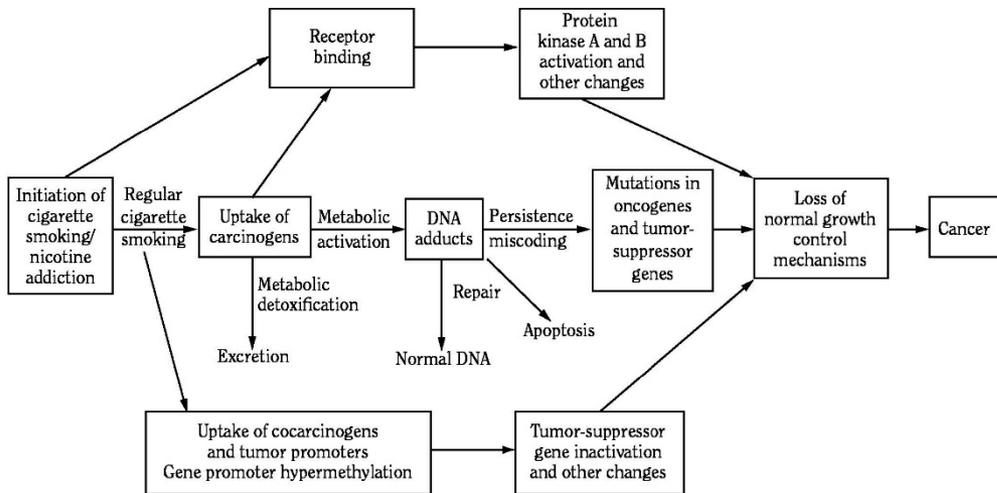
The Reality of Cancer



Problem: We don't view Smoking in the Continuum of Cancer

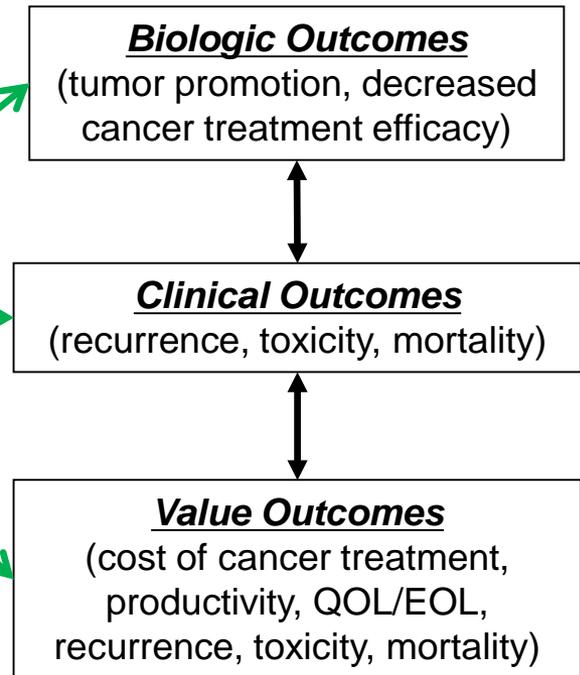
~~The Historical Disconnect~~

The Established Carcinogenesis Model



2010 Surgeon General's Report, Fig 5.1

The Reality of Cancer



Addressing Tobacco Use by Cancer Patients

The 2014 Surgeon General's Report

- Landmark SGR reviewing ~400 studies reporting on over 500,000 patients
- In cancer patients and survivors, the evidence is sufficient to infer a causal relationship between cigarette smoking
 - Adverse health outcomes
 - Increased all-cause mortality
 - Increased cancer-specific mortality
 - Increased risk for second primary cancers
 - Associated with increased risk of recurrence, poorer response to treatment, and increased treatment-related toxicity

U.S. Department of Health and Human Services. The Health Consequences of Smoking—50 Years of Progress: A Report of the Surgeon General. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2014.

The 2014 SGR: Magnitude Estimates

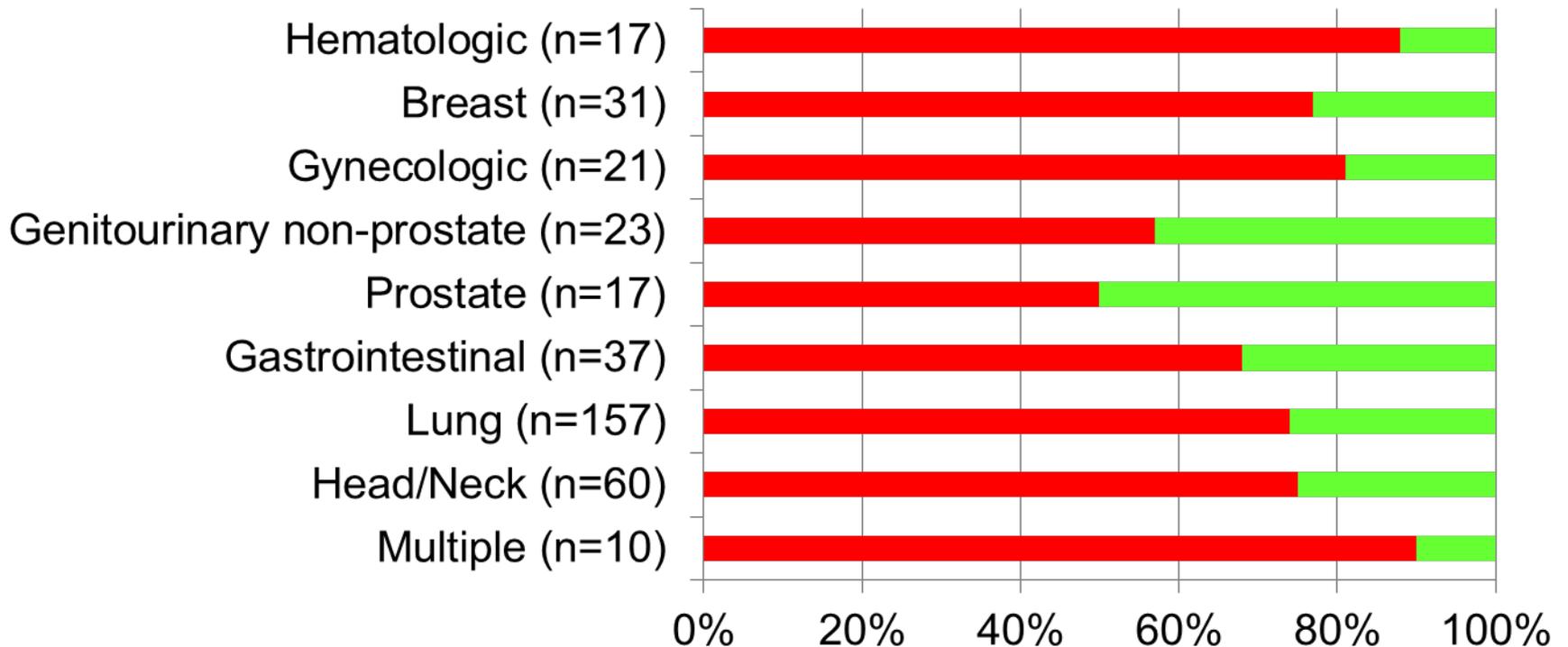
Effect	Studies	Associations (Significant)	RR Magnitude (median)
Overall Mortality	159	87% (62%)	Current: 1.51 Former: 1.22
Overall Survival	62	77% (42%)	
Cancer Related Mortality	58	79% (59%)	Current: 1.61 Former: 1.03
Second Primary	26	100% (100%)	
Recurrence	51	82% (53%)	Current: 1.42 Former: 1.15
Response	16	72%	
Toxicity	82	94% (80%)	

U.S. Department of Health and Human Services. The Health Consequences of Smoking—50 Years of Progress: A Report of the Surgeon General. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2014.

Negative Associations of Smoking

(one or more negative association)

■ Significant ■ Non-significant



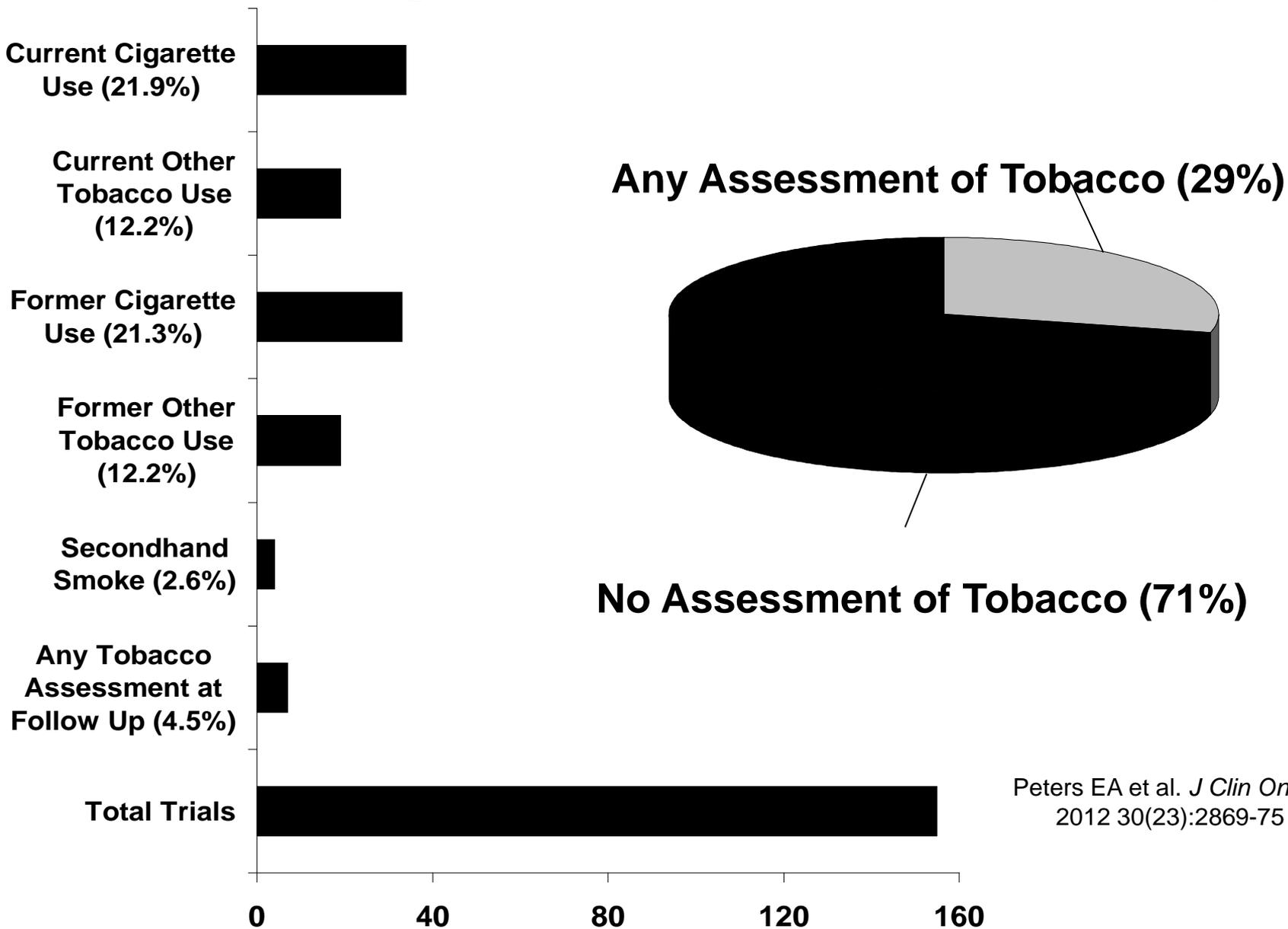
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Cessation and Overall Mortality

<i>Persistent versus Quit</i>	
Al-Mamgani et al., 2014	5.25 (3.47-7.95) (calculated) (n=267, H/N, larynx)
Roach et al., 2016	2.07 (1.02-4.20) (n=119, lung)
Dobson Amato et al., 2015	1.79 (1.14-2.82) (n=224, lung)
Tao et al., 2013	1.76 (1.37-2.27) (n=411, male mult sites)
Passarelli et al., 2016	1.50 (RR 2.57 p vs. 2.34 q) (calc) (n=786, breast)
Browman et al., 2002	1.22 (0.79-1.87) (calculated) Comparison of smokers of >1 cig/day vs. <1 cig/day including nonsmokers
<i>Quit versus Persistent</i>	
Nia et al., 2005	0.34 (0.16-0.71) (n=204, lung)
Chen et al., 2010	0.54 (0.37-0.77) (n=163, lung, SCLC)
Sandoval et al., 2009	0.77 (0.34-1.73) (n=85, H/N, oral cavity)
Choi et al., 2016	0.88 (RR 2.38 q vs. 2.71 p) (calc) (n=245, H/N)

Continued smoking increases risk ~1.6-1.7
as compared with quitting smoking
(smoking cessation can improve outcome?!?)

Assessing Tobacco in Cooperative Groups



Peters EA et al. *J Clin Oncol*,
2012 30(23):2869-75

Tobacco Assessment by Oncologists

(Always/Most of the time)

Parameter	IASLC (n=1507)	ASCO (n=1197)	NDCC (n=887)
Ask if use tobacco	90.2%	89.5%	90.2%
Ask if will quit	78.9%	80.2%	78.5%
Advise to quit	80.6%	82.4%	83.3%
Discuss medications	40.2%	44.3%	36.7%
Actively treat	38.8%	38.6%	35.1%

Effects of Perceptions on Practice

TABLE 5. Multivariate Associations of Perceptions and Barriers on Practice Patterns in Respondents

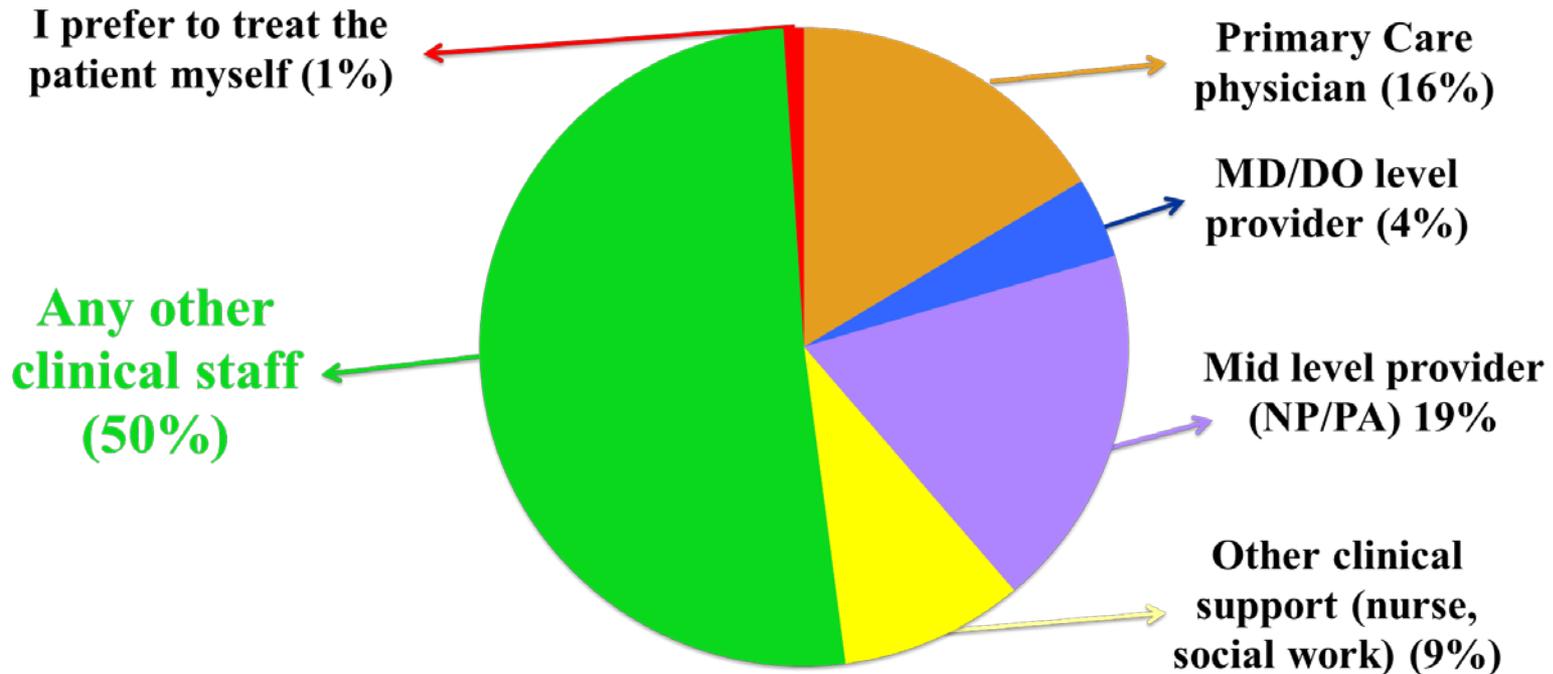
Perceptions and Barriers	Ask Your Patients if They Smoke, OR (95% CI)	Ask Patients Who Smoke if They Will Quit, OR (95% CI)	Advise Patients Who Smoke to Stop, OR (95% CI)	Discuss Medication Options, OR (95% CI)	Actively Treat or Refer Patients, OR (95% CI)
Current smoking or tobacco use impacts treatment outcomes in cancer patients	1.79 (0.91–3.52)	1.07 (0.79–1.46)	1.21 (0.89–1.66)	1.19 (0.93–1.53)	1.16 (0.90–1.50)
Tobacco cessation should be a standard part of cancer treatment interventions	1.06 (0.55–2.04)	2.07 (1.56–2.75)	1.74 (1.31–2.32)	1.17 (0.92–1.49)	1.52 (1.18–1.96)
Waste of time- cessation does not affect outcomes in cancer patients	1.37 (0.90–2.07)	1.09 (0.89–1.33)	1.24 (1.02–1.51)	0.84 (0.73–0.96)	0.76 (0.66–0.88)
Inability to get patients to quit tobacco use	1.12 (0.71–1.77)	1.32 (1.07–1.61)	1.19 (0.97–1.47)	1.01 (0.87–1.16)	1.03 (0.89–1.19)
Patient resistance to cessation treatment	1.16 (0.75–1.82)	0.90 (0.72–1.11)	1.02 (0.82–1.27)	0.90 (0.77–1.05)	0.94 (0.81–1.11)
I have had adequate training in tobacco assessment and cessation interventions	1.03 (0.65–1.64)	1.40 (1.14–1.71)	1.19 (0.97–1.45)	1.39 (1.22–1.58)	1.64 (1.43–1.88)
Lack of training or experience in tobacco cessation interventions	1.23 (0.72–2.09)	1.01 (0.79–1.30)	1.06 (0.82–1.37)	0.70 (0.59–0.84)	0.92 (0.77–1.09)
Clinicians need more training in tobacco assessment and cessation interventions	0.95 (0.55–1.64)	1.35 (1.05–1.73)	1.23 (0.95–1.59)	1.33 (1.11–1.60)	1.06 (0.88–1.27)
Lack of time for counseling or to set up a referral	1.09 (0.68–1.76)	0.94 (0.76–1.15)	0.93 (0.75–1.15)	0.79 (0.69–0.91)	0.80 (0.69–0.93)
None or limited provider reimbursement	0.97 (0.61–1.55)	0.90 (0.73–1.11)	0.87 (0.70–1.08)	1.12 (0.97–1.30)	1.00 (0.86–1.16)
Lack of available resources or referrals for cessation interventions	0.93 (0.55–1.58)	0.87 (0.69–1.09)	1.10 (0.87–1.40)	0.92 (0.78–1.08)	0.70 (0.60–0.83)

Analyses are adjusted for country, work setting, years passed since terminal degree, percent of time devoted to patient care, and history of tobacco use.

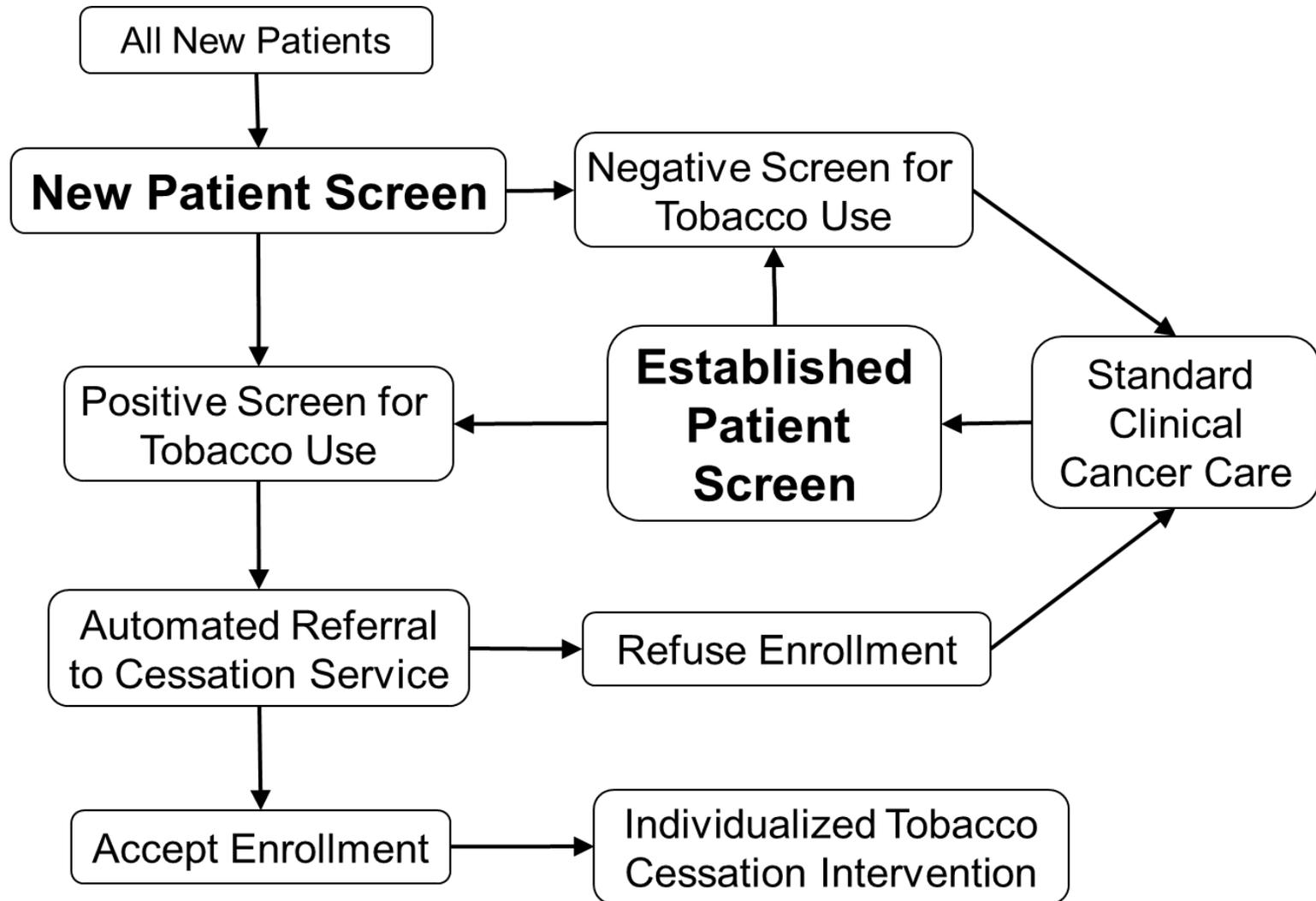
Who Should Provide Support?

(NCI survey)

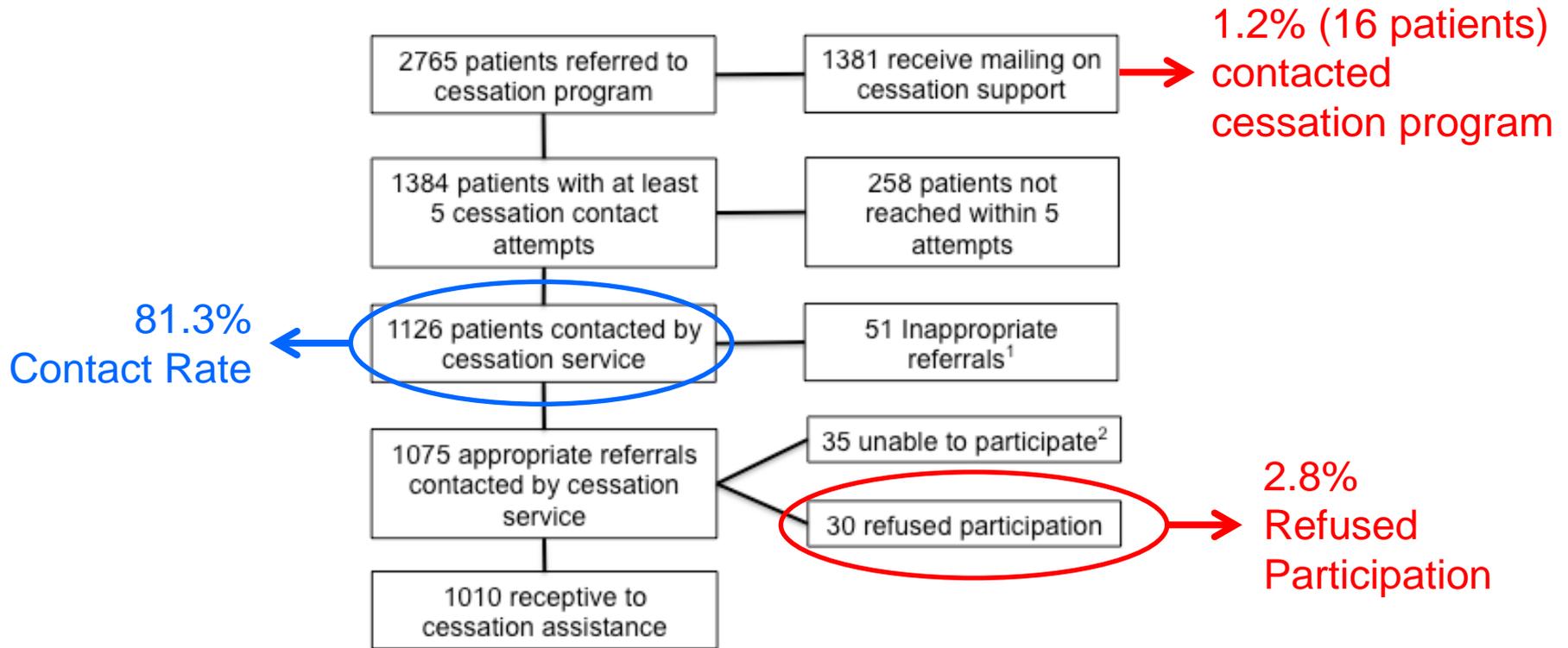
What provider do you prefer to provide cessation assistance?



Automated Screening and Treatment



Participation at First Cessation Contact



1. Includes 12 never smokers and 39 former smokers with no tobacco use in the past 30 days
2. Includes 12 patients in end-of-life situation and 23 patients in assisted living arrangement with contact by proxy

New Patient Screen Yield

98.8% of patients captured with 3 questions

Referral Question	% of Total Referrals for Current Users	% of Total Referrals for Former Users	% of Total Referrals
Do you now smoke cigarettes everyday, some days, or not at all?	93.7%		83.1%
Do you currently use any other tobacco products such as cigars, pipes, chewing tobacco, snuff, dip, SNUS, clove cigarettes, kreteks, or bidis?	6.3%		5.6%
About how long has it been since you last smoked a cigarette, even a puff?		89.0%	10.1%
About how long has it been since you last smoked/used other tobacco products such as cigars, cigarillos, little cigars, pipe tobacco, or used chewing tobacco, snuff, dip, or SNUS even once?		1.4%	0.2%
Are you currently using any of the following methods or strategies to try to quit?		2.7%	0.3%
Are you interested in stopping tobacco use or speaking with our tobacco cessation specialist?		6.8%	0.8%

Extending assessment to every month delayed referral in only 3 of 428 cessation referrals (0.7%)

Automated Cessation and Mortality

Continuous Variables	<i>N</i>	Mean	Hazard Ratio	95% CI	<i>p</i>
Age at diagnosis (years)	224	61.9	1.04	1.02–1.06	0.001
Pack-years	224	59.7	1.00	0.99–1.01	0.495
Days between diagnosis and last contact	224	100.9	0.999	0.998–1.001	0.227
Categorical Variables	<i>N</i>	%	Hazard Ratio	95% CI	<i>p</i>
Sex					
Female	134	59.8	1.00	Ref.	0.051
Male	90	40.2	1.45	1.01–2.14	
Clinical stage					
Stage I/II	81	36.2	1.00	Ref.	<0.001†
Stage III	65	29.0	2.53	1.39–4.61	
Stage IV	78	34.8	8.72	4.93–15.40	
ECOG status					
0	127	56.7	1.00	Ref.	0.265
≥1	97	43.3	1.26	0.84–1.89	
Tumor histology					
NSCLC	197	87.9	1.00	Ref.	0.626
Other lung cancer	27	12.1	0.87	0.50–1.52	
Quit status at referral					
Quit	48	21.4	1.00	Ref.	0.393
Current	176	78.6	0.80	0.48–1.34	
Quit status at last contact					
Quit	95	42.4	1.00	Ref.	0.012†
Current	129	57.6	1.79	1.14–2.82	

115 of 224 patients (51.3%) were deceased by the end of the follow-up period. The model is adjusted for all variables shown in this table based upon a Cox proportional hazards model.

**N* = 224 of 250 due to 22 records missing clinical stage, two missing pack-years, and two missing both clinical stage and pack-years.

Bold indicates statistically significant at *p* < 0.05.

CI, confidence interval; ECOG, Eastern Cooperative Oncology Group; NSCLC, non-small-cell lung cancer.

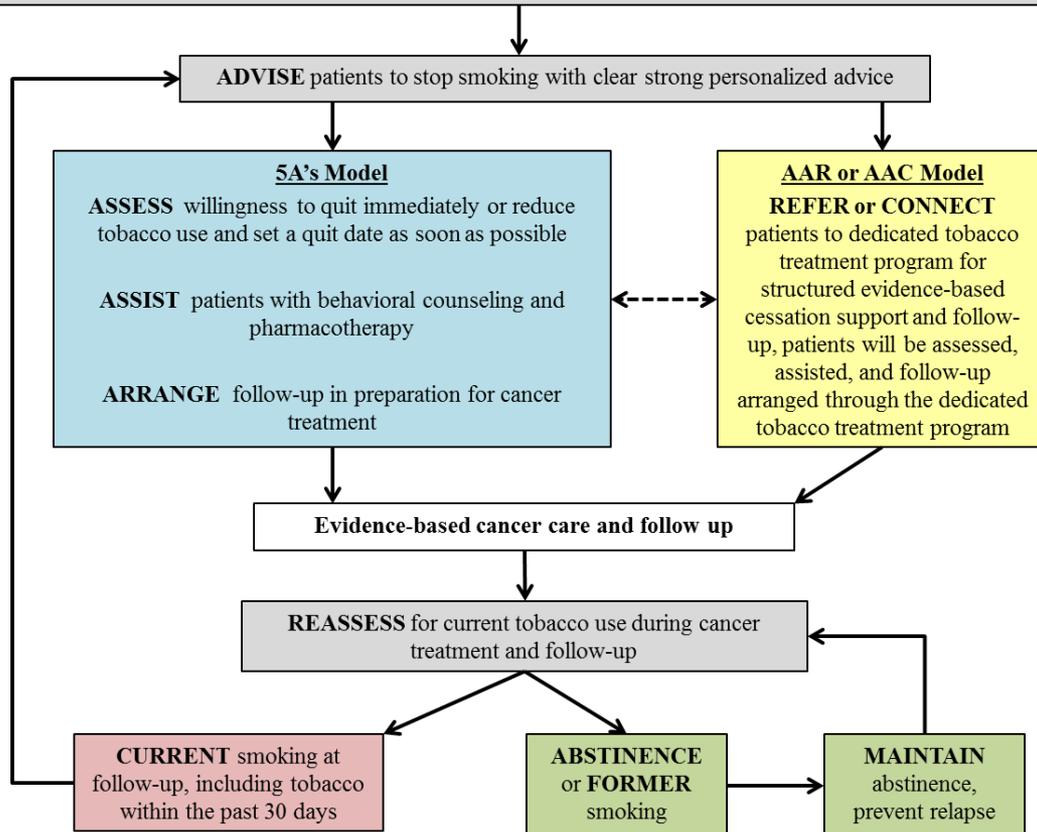
A "5 A's," "AAR", and "AAC" Models for Screening and Smoking Cessation Treatment

ASK:

Tobacco Assessment Questions to Determine *CURRENT* Smoking/Tobacco Use Status:

- Have you smoked at least 100 cigarettes in your entire life?
 - Yes (EVER smoker)
 - No
- Do you now smoke everyday, some days, or not at all?
 - Everyday (*CURRENT*)
 - Some days (*CURRENT*)
 - Not at all
- Do you use other forms of tobacco everyday, some days, or not at all?
 - Everyday (*CURRENT*)
 - Some days (*CURRENT*)
 - Not at all
- How long has it been since you last smoked a cigarette (even one or two puffs)?
 - I smoked a cigarette today (*CURRENT*)
 - 1 month – 1 year
 - 1-7 days (*CURRENT*)
 - More than 1 year
 - 7 days - 1 month (*CURRENT*)
 - Don't know/don't remember

ALL patients who report *CURRENT* smoking should receive cessation support



Implementing Cessation into Practice

- The 5 A's Model
 - Ask
 - Advise
 - Assess
 - Assist
 - Arrange
- Implementing cessation into clinical care should consider new and follow-up approaches

NCCN Guidelines



NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines®)

Smoking Cessation

Version 1.2015

NCCN.org

Continue

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NCI/AACR Structured Questions

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Special Report

Clinical
Cancer
Research

Research Priorities, Measures, and Recommendations for Assessment of Tobacco Use in Clinical Cancer Research

Stephanie R. Land¹, Benjamin A. Toll², Carol M. Moinpour³, Sandra A. Mitchell¹,
Jamie S. Ostroff⁴, Dorothy K. Hatsukami⁵, Sonia A. Duffy⁶, Ellen R. Gritz⁷, Nancy A. Rigotti⁸,
Thomas H. Brandon⁹, Sheila A. Prindiville¹⁰, Linda P. Sarna¹¹, Robert A. Schnoll¹²,
Roy S. Herbst¹³, Paul M. Cinciripini⁷, Scott J. Leischow¹⁴, Carolyn M. Dresler¹⁵,
Michael C. Fiore¹⁶, and Graham W. Warren^{2,17,18}

Cognitive Testing of Tobacco Use Items for Administration to Patients with Cancer and Cancer Survivors in Clinical Research

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Jasmine N. M. Folz, MA⁵; James L. Gulley, MD, PhD⁸; Eva Szabo, MD⁹; Thomas H. Brandon, PhD¹⁰;
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Core Items

1. **Have you smoked at least 100 cigarettes (5 packs=100 cigarettes) in your entire life?**

- Yes
- No
- Don't know/Not sure

4. **How many total years have you smoked (or did you smoke) cigarettes? Do not count any time you may have stayed off cigarettes.**

_____ Years *If you smoked less than one year, write "1."*

5. **On average when you have smoked, about how many cigarettes do you (or did you) smoke a day?**

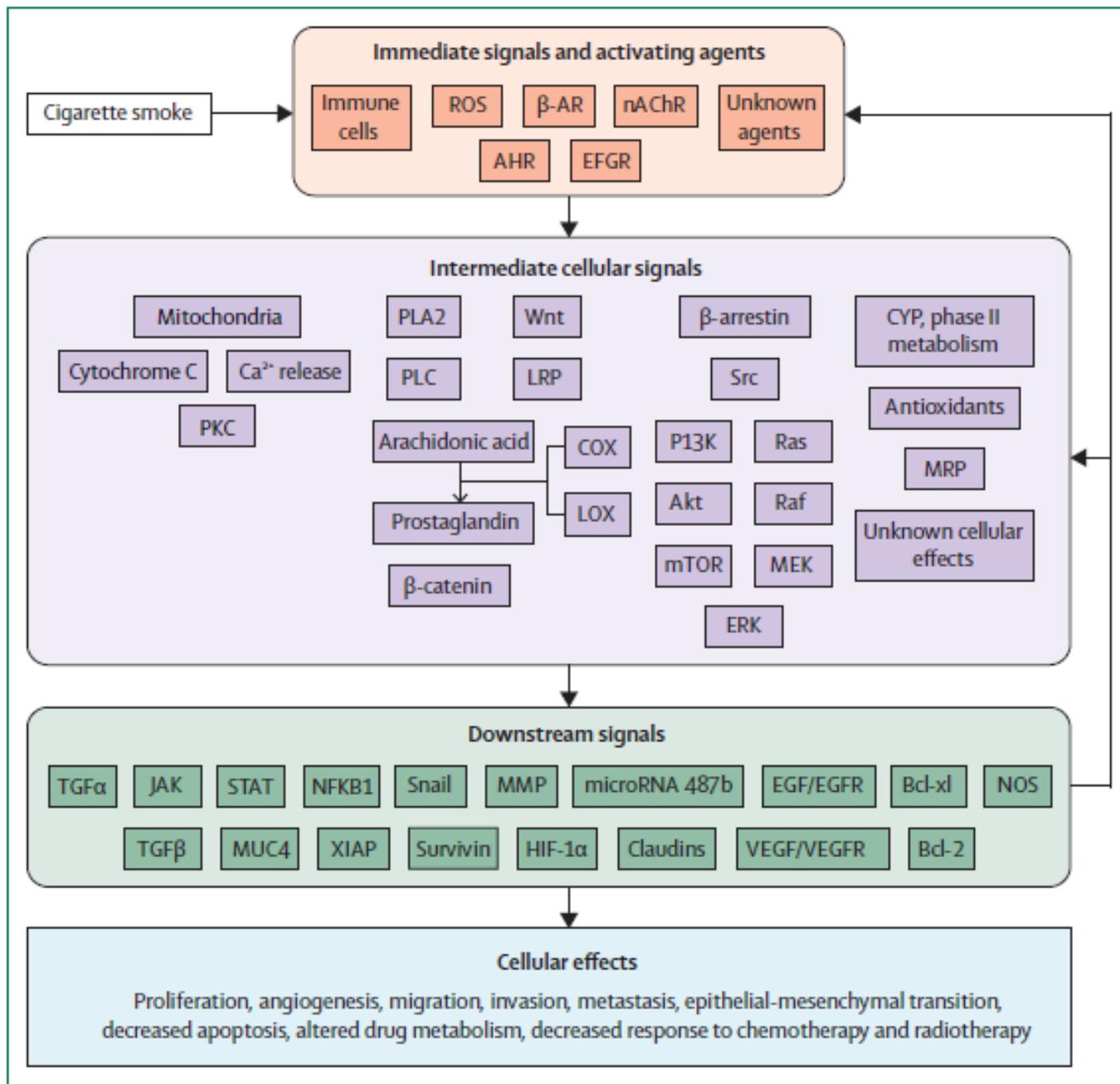
A pack usually has 20 cigarettes in it.

_____ Number of cigarettes per day

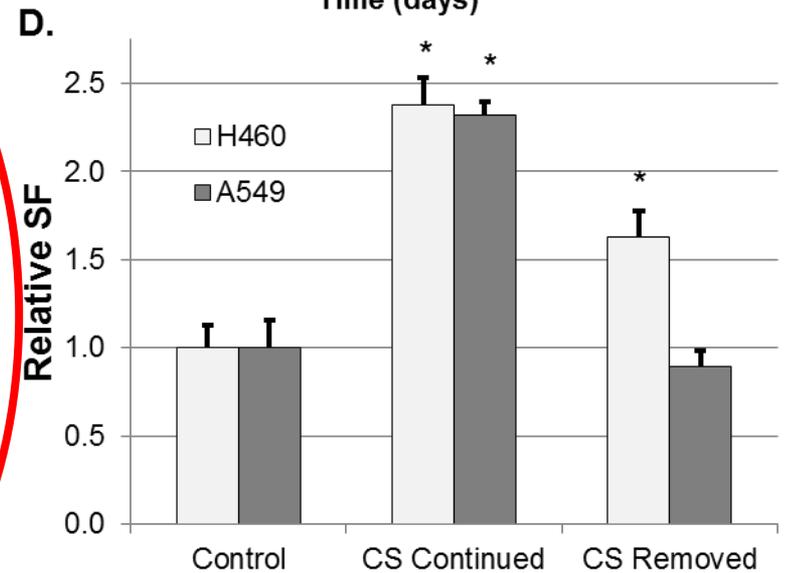
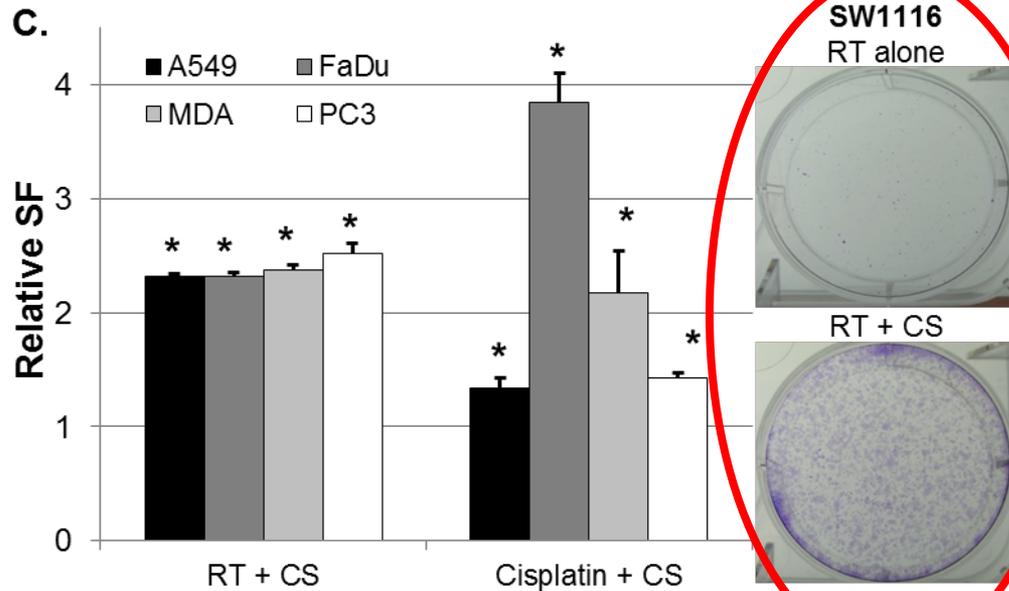
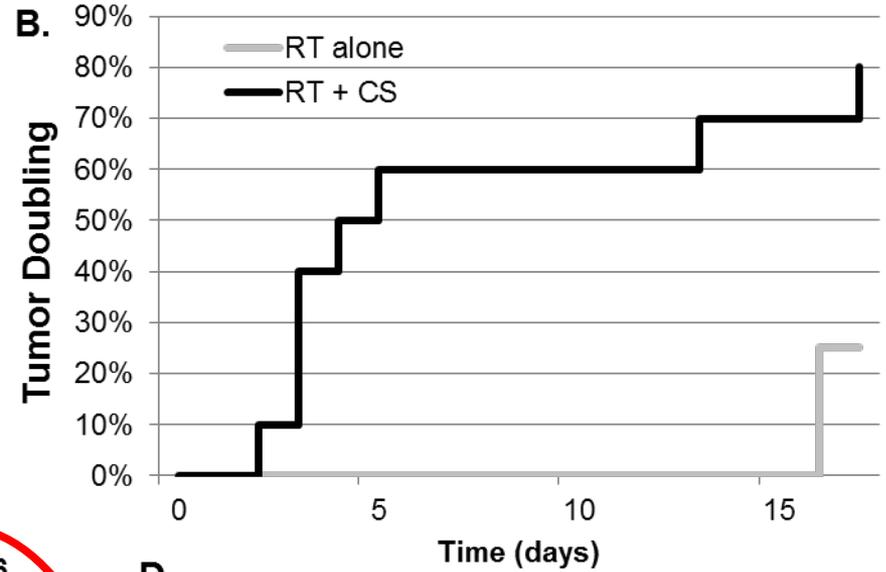
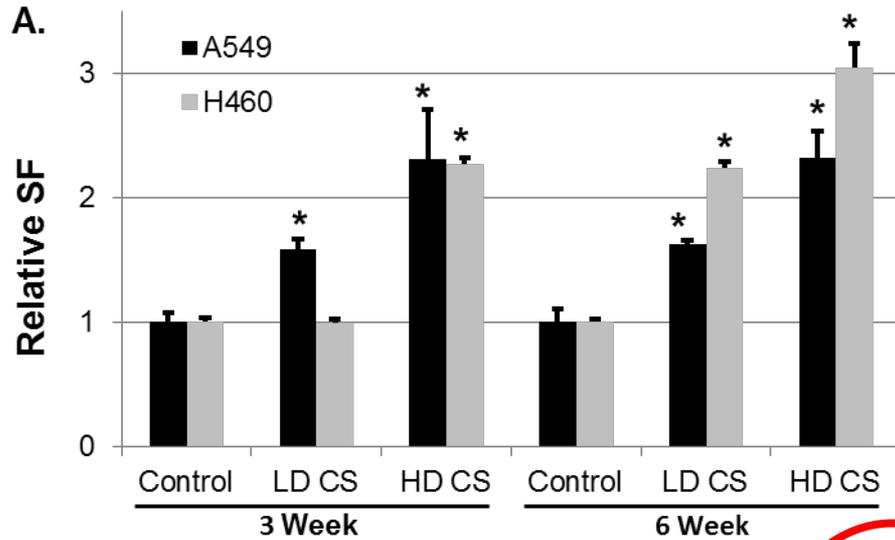
6. **How long has it been since you last smoked a cigarette (even one or two puffs)?**

First check which one of the following choices applies to you. Then, if applicable, write a number on the line for how many days, weeks, months, or years it has been since your last cigarette.

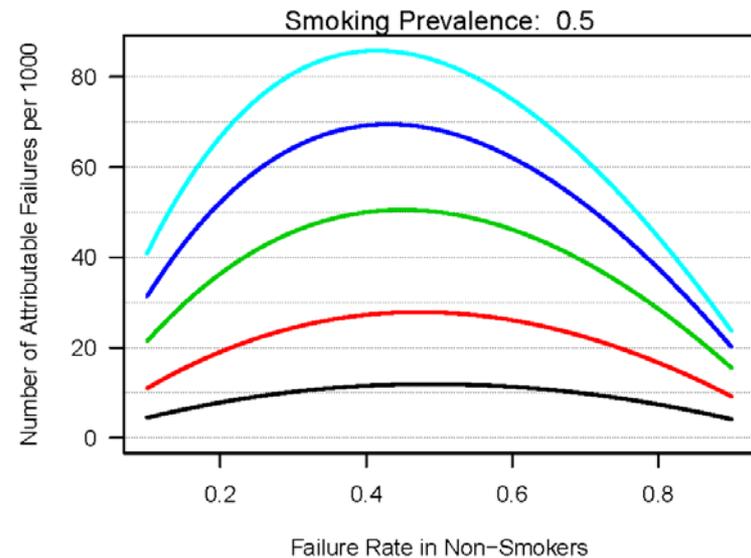
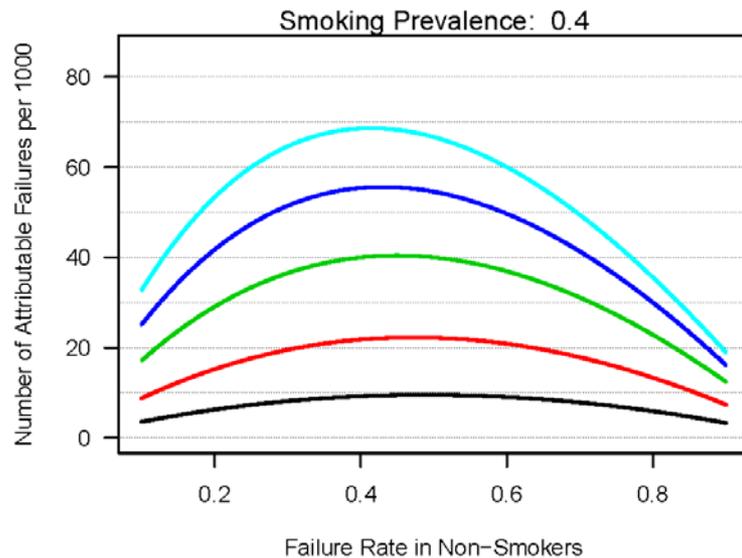
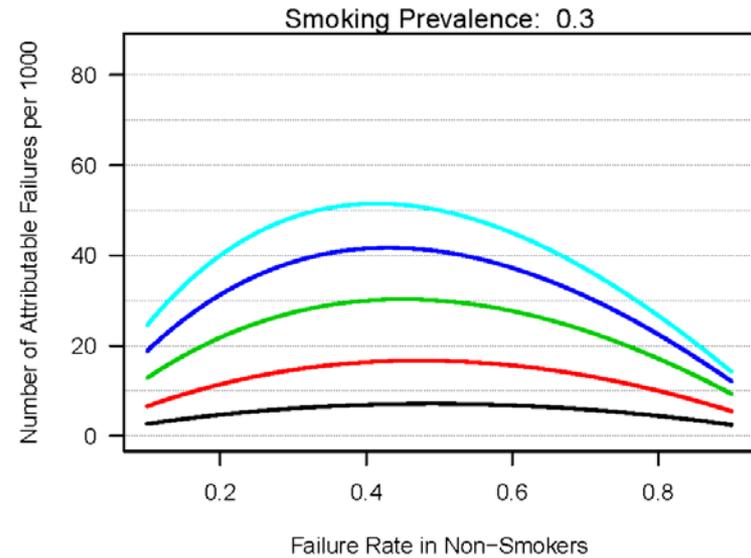
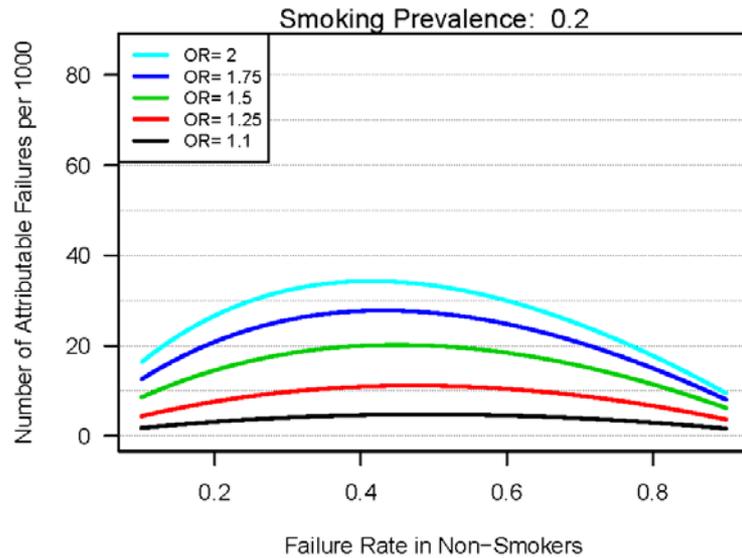
- I smoked a cigarette today (at least one puff).
- 1-7 days. ➔ Number of days since last cigarette: _____
- Less than 1 month. ➔ Number of weeks since last cigarette: _____
- Less than 1 year. ➔ Number of months since last cigarette: _____
- More than 1 year. ➔ Number of years since last cigarette: _____
- Don't know/Don't remember



Smoking and Therapeutic Response



MONEY: Attributable Failure



Annual Cost of Failures Due to Smoking (in the U.S.)

Estimated National Cost for 1.6 Million Cancer Patients

Baseline Failure

(in non-smoking) 0.3

Smoking Risk 1.6

	Cost of Next Line Cancer Treatment			
Smoking Prevalence	\$10,000	\$50,000	\$100,000	\$250,000
0.05	85424K	427119K	854237K	2135593K
0.10	170847K	854237K	1708475K	4271186K
0.20	341695K	\$1.7 billion	\$3.4 billion	8542373K
0.30	512542K	2562712K	5125424K	12813559K
0.40	683390K	3416949K	6833898K	17084746K
0.50	854237K	4271186K	8542373K	21355932K

Attributable Cost in Canada

- Canadian population: 36,585,000
 - Canadian cancer incidence: 206,200
 - 5-year cancer mortality rate: 40%
 - Smoking prevalence in Canada: 16.9%
 - NOTE: ~30% of cancer patients who smoke misrepresent
 - Adjust to ~20% prevalence
 - Canadian smoking cancer patient prevalence: ~41,240
- **4,789 attributable first line failures** due to smoking
- Annual cost of first line treatment
 - For \$10K per failure: ~\$48 million
 - **For \$50K per failure: ~\$239 million**

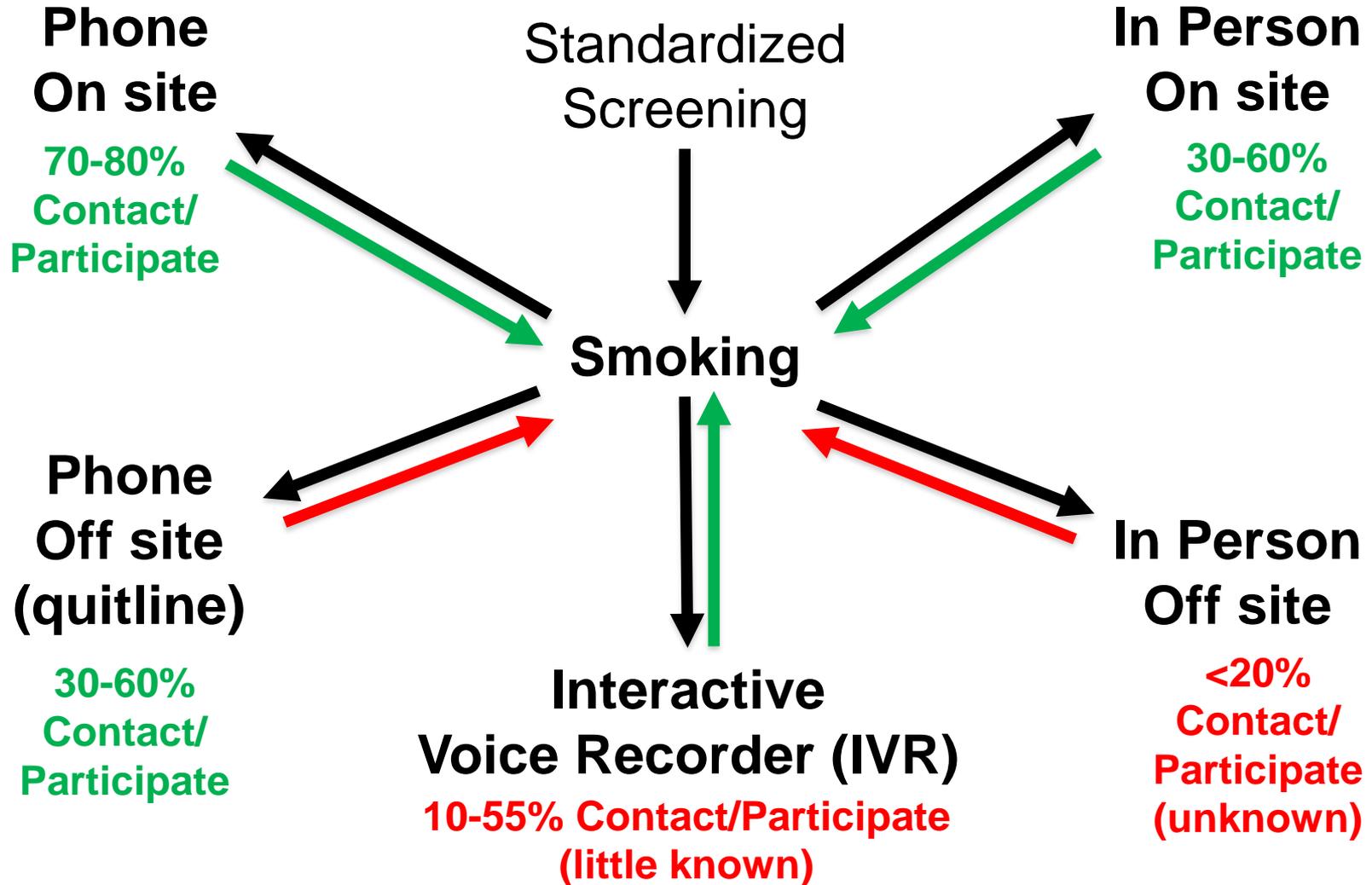
Magnitude Comparison

	Genome Driven Oncology¹	“Tobacco Cessation Adjuncted Oncology”
% of cancer patients who may benefit	5%	16.9%
Cost of sequencing	\$500 - \$3,000 (est. average \$1,500)	\$0
Cost of treatment	\$15,000 - \$250,000 (est. average \$80,000)	\$200 - \$1,500 (\$974: intensive + V + NRT) ²
Clinical benefit	54% response for 29.5 median months	~40% reduction in mortality
Cost per 1000 total patients	\$4.075 million	\$0.164 million
Cost ratio per 1000 total patients	~25:1	

1. Marquart J et al., *JAMA Oncol* 2018
2. CPAC Cost Estimates for Smoking Cessation 2017

Institutional Approaches: Expectations

(assuming 'Opt-Out' approach)



AAR and AAC

- **ASK**
 - Identify use with structured assessments
- **ADVISE**
 - ALL CLINICAL STAFF should advise
 - “Tobacco is BAD for your cancer treatment and quitting is the best thing you can do to help us succeed with your cancer treatment
 - “I don’t know how to get you to quit, but our cessation service will contact you to help”
 - “How are you doing this week?”
 - “You quit (or reduced)? Awesome! Great job!”
- **REFER or CONNECT (or TREAT DIRECTLY)**

Primary Care Message

I'm concerned about these findings.

We're going to start working on this, but we also need to talk about quitting smoking. If this is cancer, quitting smoking can help you live longer and feel better.

**ONE OF THE BEST THINGS YOU CAN DO
RIGHT NOW IS DECIDE TO QUIT SMOKING,
AND I CAN HELP YOU**

Summary

- Mortality Risks of Continued Smoking
 - vs. not smoking (2014 SGR): ~1.5-1.6
 - vs. quitting after diagnosis: ~1.6-1.7
 - VERY LOW NUMBER NEEDED TO TREAT
- \$3.4 billion annual cost of smoking on cancer treatment in the U.S. after first line cancer treatment failure
- 70-80% contact rate for cessation support (by phone)
- Plain term yields
 - 1/3 will quit
 - 1/3 will reduce
 - 1/3 will not change

What Do You Think We Should Do?

- Get every cancer patient who smokes into a tobacco treatment program
 - **Get everyone in as a priority for starting cancer treatment**
- Does everyone really need high intensity intervention?
 - Who needs more vs. less support?
 - What is the true best intervention in the context of cancer care?
- What are the biologic effects of smoking?
 - Will this affect targeted therapeutics?
 - Are there existing treatments that are more effective?
- What are the most cost effective approaches to improving cancer treatment outcomes?
 - Cessation vs. paying for 2nd-3rd-4th-... line care?

An Example from Practice: Developing and Implementing Smoking Cessation Supports for Cancer Patients



Eastern
Health

*Scott Antle
Project Lead, Smoking Cessation
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NL Colon Screening / Cervical Screening
Cancer Care Program, Eastern Health*



www.easternhealth.ca

Acknowledgments

- **Smoking Cessation Project Working Group**
- **Dr. Suzanne Drodge**
- **Smoking Cessation Pilot Planning Group**
- **Out Patient Pharmacy Health Sciences Centre, Eastern Health**
- **Department of Children, Seniors and Social Development**
- **Smoking Cessation Pilot Program Clinicians**
- **CPAC Prevention Team**



Objectives

- **Demonstrate the need for smoking cessation in Ambulatory Oncology in NL**
- **Describe the process of planning a smoking cessation pilot program to include provision of Pharmacotherapy**
- **Achieving Success (Current State)**
- **Challenges/Lessons Learned**
- **The Future**

The Case for Smoking Cessation



"THERE ARE TWO TREATMENT OPTIONS: NICOTINE GUM TO GET OFF THE PATCH, OR THE PATCH TO GET OFF NICOTINE GUM."

The Case for Smoking Cessation

- NL has among the highest rates of daily smoking in the country (Approximately 1 in 5 people)
- NL has the highest ASI for all cancers at 586.8/100,000 (Canadian Cancer Stats 2017)
- Among the highest ASM at 233.3/100,000
- 22% of new patients to the cancer care program in NL self-identify as current smokers

The Case for Smoking Cessation (2015)

- Cancer patients were told of the benefits of being smoke free
- The Cancer program could refer to Smokers Helpline for support or possible pharmacotherapy assistance through provincial drug plan
- In 2015 CPAC issued a call for proposals in tobacco cessation and cancer care
- The Cancer Care Program was successful in receiving funding to plan a smoking cessation program

Setting the Plan



“Since we’re not allowed to smoke in the office, I put tobacco in the brownies.”

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phone: (216) 371-8600 / e-mail: ft@funnytimes.com

Setting the Plan

- **Where to start:**

- Acquired a staff resource
- Formed working groups/committees
- Reviewed best practice, gather evidence
- Understand current provision of cessation and pharmacotherapy
- Formed partnerships and key champions
- Think in terms of Sustainability

Just jump in!!!

Setting the Plan

- The NL project used the sustainable plan from Washington University www.sustaintool.org to focus the planning path forward
- The sustainability assessment, allowed the project to:
 - Identify gaps
 - Strengthening & form relationships (SHL, Dept. of CSSD)
 - Develop a plan (patient flow/algorithm)
 - Identify key champions and potential resources
 - Initiate a cultural shift in cancer care re: smoking cessation
 - Develop & seek feedback from physicians, staff and patients



Building Momentum

- Challenge was to enhance and build on the awareness of the importance of smoking cessation in Ambulatory Oncology among:
 - Physicians & staff
 - patients
- Think in terms of System Change...
 - Provide patients with the tools to make a difference in their treatment (70% of patients want to do something to take control of their health)
 - Enhance the notion of smoking cessation is a supportive service
 - Smoking cessation becomes a standard of care



Building Momentum

- The project sought to seek feedback and build knowledge to support the beginnings of system change...
 - Engaged Content Experts (Dr. Bill Evans)
 - Staff/Physician/Patient Engagement
 - Education Opportunities (TEACH)
 - Leveraged other CPAC projects (FNIM, Screening for Distress)
- The process was support by CPAC through:
 - Knowledge translation (webinars and F2F meetings)
 - Information sharing



Building Momentum

- All feedback indicated the need for **free access to pharmacotherapy**
- **Tipping Point:**
 - **CPAC's dissemination of cessation costs in comparison to traditional treatments**

Building Momentum

ENGAGEMENT SUCCESS IN THE PLANNING OF A SMOKING CESSATION AND RELAPSE PREVENTION PROGRAM IN AN AMBULATORY ONCOLOGY SETTING

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LEARNING OBJECTIVES

- Plan a smoking cessation and relapse prevention clinical program in Cancer Care in NL
- Achieve high level engagement among leadership and staff to increase awareness and practice of smoking cessation

BACKGROUND AND PROJECT OBJECTIVES

Evidence is conclusive on the adverse relationship of continued tobacco use after a cancer diagnosis on cancer treatment side effects and survivorship. The 2014 US Surgeon General Report on Smoking and Health concluded there was sufficient evidence to infer a causal relationship between cigarette smoking and increased all-cause mortality and cancer-specific mortality. Therefore, smoking cessation may be one of the best things a cancer patient can do after a cancer diagnosis. Additionally, smoking cessation should be a standard of care in ambulatory oncology settings.

In 2015 the Cancer Care Program of Eastern Health received funding from the Canadian Partnership Against Cancer (CPAC) to develop a plan for delivery of a smoking cessation and relapse prevention clinical program. Key project deliverables would result in a plan for the development of a sustainable program that integrates cessation counselling, pharmacotherapy and behavioral therapy, providing a patient the best opportunity to become smoke free.

With approximately 22% of new cancer patients self-identifying as a current smoker upon entry into the cancer care program, a best practice cessation program can have a significant benefit for cancer patients in NL.

METHODS

A variety of methods were used to engage staff and physicians on the planning for a clinical smoking cessation program (key project deliverable). Methods included:

- Presentations at department meetings and endorsement from Clinical and Divisional Chiefs
- Presentations by content experts
- Grand rounds on tobacco cessation specific to cancer care
- Staff focus groups (Table 1)
- Stakeholder surveys (Table 2)
- Patient surveys (Figures 1 and 2)
- Educational opportunities for staff and physicians to include standard clinical guidelines
- Build external partnerships to provide patients with behavioral therapy services
- Feedback on draft clinic pathway for smoking cessation with a multi-disciplinary approach to operations
- Creation and strengthening of new and existing community partnerships in smoking cessation resources

Patient and family survey: 48 participants (3 week period)

Asked About Smoking History

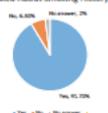


Figure 1: Percentage of cancer patients who were asked about their smoking status upon entry into the cancer care program, 48 total responses.

Offer Smoking Cessation

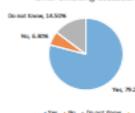


Figure 2: Patient and family survey results demonstrating opinions on if the cancer program should help patients quit smoking, 48 total responses.

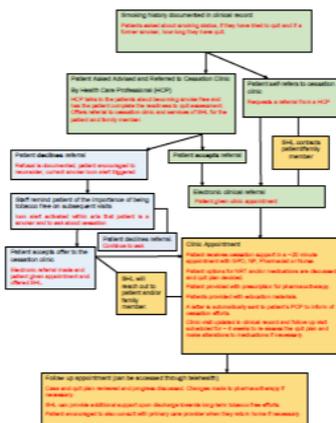


Figure 3: Draft smoking cessation patient pathway in Cancer Care Program.

RESULTS

From the initial introduction of a smoking cessation clinical plan, engagement among staff and physicians was high. A sense of "ownership" in program planning and development was created early as program staff and physicians understood the benefit a cessation program offered their patients. The introduction of a smoking cessation program in departmental meetings was followed up with expert presentations, strengthening of community partnerships and feedback mechanisms which solidified the benefits of smoking cessation to oncology care. In addition, the smoking cessation planning project aligned with other CPAC funded initiatives to build on the strength of those projects along common outcomes or deliverables. From this work various themes and outcomes developed:

- Champions emerged among cancer program staff and physicians across several disciplines to include medical and radiation oncology
- Groups recognized the positive impacts of smoking cessation and the opportunity to influence patients as requests for smoking cessation topics increased
- Planning feedback from staff was regular and beneficial as demonstrated in feedback from staff driven focus groups (Table 1)
- Inquiries on current pharmacotherapy coverage, and increased referral to the Smoker's Helpline were observed as a patient survey indicated that more than 90% of the time they were asked about their smoking history (Figure 1)
- Patients were given a sense of ownership in project planning as through surveys 79.2% believed the cancer program should offer smoking cessation services
- Endorsement and engagement from external partners such as the Canadian Cancer Society and Smoker's Helpline

Staff Focus Groups

Smoking Cessation Program/Clinic Components
Informal
Accessible (Telehealth)
Offered to patients outside of St. John's
Opened to patients and family members
Self-referrals
Peer support and education elements
Patient centered approach
Cessation aids and medications available

Table 1: Summary of staff focus group sessions on smoking cessation program/clinic structure

Stakeholder engagement surveys tables. 24 surveys sent 11 respondents

Components	Somewhat important n, %	Moderately important n, %	Very important n, %
Referral to Smoker's Helpline	1 (9.1%)	2 (18.2%)	8 (72.7%)
Behavioral Therapy	-	4 (36.4%)	7 (63.6%)
Support group for patients	2 (18.2%)	5 (45.5%)	4 (36.4%)
Education sessions for patients and their family members	2 (18.2%)	2 (18.2%)	7 (63.6%)
Education sessions for health professionals	-	3 (27.3%)	8 (72.7%)
Integration and linkage with primary care providers (i.e., letters of participation in the cessation clinic and role for PCP in follow-up care)	1 (9.1%)	3 (27.3%)	7 (63.6%)
Support after discharge from Cancer Care Program	1 (9.1%)	2 (18.2%)	8 (72.7%)
Nicotine Replacement Therapy	-	2 (18.2%)	9 (81.8%)
Prescription medications	-	2 (18.2%)	9 (81.8%)

Table 2: Rating potential components of a tobacco cessation program in terms of importance

CONCLUSION

A high level of engagement among physicians, staff and external partners is crucial for the development of a clinical program for smoking cessation in cancer care which will provide significant benefit to cancer patients in NL. Without such engagement a sustainable program would not be possible.

Achieving Success:

- The timing of the economic data aligned with the goals of the Provincial Government's Way Forward document to reduce NL's smoking rates
- Cessation was identified as a key to achieving a reduction in smoking rates
- An opportunity emerged to present a proposal for a pilot clinical smoking cessation program in the cancer care

Achieving Success: Smoking Cessation Pilot Program November 2017

- A proposal was submitted that built the case for:
 - Free access to pharmacotherapy
 - Benefits to the patient
 - Economic benefits
 - Overall goal of a sustainable smoking cessation program in cancer care
- **Smoking Cessation Pilot Program**
 - ✓ ½ day 1x week
 - ✓ pilot targeting new head/neck, lung, breast and gyne cancer patients
 - ✓ 4 Clinicians (Multi-disciplinary)
 - ✓ Partner with the Out-patient pharmacy to provide Pharmacotherapy
 - ✓ Smokers Help Line referrals



Challenges/lessons learned



“But, can you help me quit smoking?”



Challenges

- Cancer programs are complex environments
- Provide patients with a simple process of receiving pharmacotherapy
- Cultural change is required to make cessation a standard of care:
 - Staff
 - Leadership
 - Physicians
- Sustainability

Lessons Learned

- **Data systems and patient flow**
 - Complex environments and geography
- **Simplify the need**
 - Use the cost-benefit relationship as an advantage
- **Keeping the process moving**
 - Share information among key champions, executive/clinical leadership
- **Expect the unexpected**
 - Think long term!

Pilot thus far... Evaluation

- Patients tell us...
 - Improved quality of life with a reduction in smoking behaviours
 - Many are motivated to quit smoking
 - Value the clinical appointment
 - Prefer to stay in touch with the clinician (understand the diagnosis)
 - Provision of pharmacotherapy is essential

The Future...

- A second CPAC project with the **goal** of advancing smoking cessation in Ambulatory Oncology
- **3 themes:**
 - Change Management
 - Smoking cessation a standard of care
 - Educational Development
 - Staff, physicians and patients
 - Telehealth
 - Smoking cessation services available in regional cancer centres

Thank You

IT'S NEVER TOO LATE TO

Quit Smoking

We are here to help.



Ask your health care professional for information on how quitting smoking can help with your cancer treatment.



Leading Practices in Smoking Cessation Program Scan Resources

Smoking Cessation Program Scan Resources



<http://www.cancerview.ca/preventionandscreening/tobacco/#leadingpractices>





LEADING PRACTICES IN CLINICAL SMOKING CESSATION



CANADIAN PROGRAM SCAN RESULTS

APRIL 2018 (v5.0)



Summary of updates from April 2018

- Most programs sustained + expansion to new settings
 - 4 programs discontinued
- Strong alignment with pan-Canadian evidence-based guidelines
- New information added on health care providers who are authorized to prescribe cessation aids
- Cytisine is now authorized in Canada as smoking cessation medication
 - Currently not publicly funded in any jurisdiction
- Two jurisdictions (NB + NL) expanded cessation aid coverage
- Opportunities remain to increase access to smoking cessation aids across all jurisdictions

Cessation Aids and Coverage in Canada

Cessation aid legend:

-  Bupropion (BUP)
-  Varenicline (VAR)
-  Cytisine (CYT)
-  Nicotine Replacement Therapy (NRT, e.g., patch, gum, lozenge, mist, inhaler)

Eligibility:

-  Yellow glow indicates limited access

Health Professionals Who Can Prescribe Cessation Aids:

-  Pharmacists
-  Physician Billing Code General (e.g., Health Promotion Counselling)
-  Physician Billing Code Smoking Cessation Specific
-  Nurse Practitioners
-  Dentists
-  Other allied health professionals

FEDERAL (Indigenous Services Canada)

First Nations Inuit Health Non-Insured Health Benefits Program

started in 2001
 ELIGIBILITY DETAILS:
 Registered for NIHB and not covered by other benefits eligible to receive up to three courses of treatment in a 12 month period for free. Two 12 wk/yr courses of NRT (e.g., patch), one 12 wk/yr course of gums, lozenges and inhalers. Meds with a prescription are also covered.

BRITISH COLUMBIA ♦♦♦X

BC Smoking Cessation Program

started in 2011
 ELIGIBILITY DETAILS:
NRT: BC resident, active and valid Medical Services Plan coverage, obtain from community pharmacy, free for up to 12 continuous wk/yr.
BUP/VAR: BC resident, active and valid Medical Services Plan coverage. Beneficiaries in FairPharmaCare plan have coverage for up to 12 continuous wk/yr, or beneficiaries in PharmaCare Plans B, C, or G eligible for free meds for up to 12 continuous wk/yr.

ALBERTA ■♦♦

Alberta Health Supplementary Health Benefit Program/Alberta Drug Benefit List

started in 1998
 ELIGIBILITY DETAILS:
 Recipient of one of these Alberta Health plans (Assured Income for the Severely Handicapped, Income Support, Alberta Adult Health Benefit, Alberta Child Health Benefit) eligible for free NRT to a lifetime maximum of \$500, or free BUP for 12 wk/yr. Special Authorization for 24 wk/yr in conjunction with cessation counselling, *started in 2011*

ELIGIBILITY DETAILS:
 18+ and covered under Non-Group Coverage. Coverage for Seniors and/or Palliative Coverage may receive reduced cost VAR for 12 wk/yr (or 24 wk/yr via Special Authorization).

QuitCore
started in 2016
 ELIGIBILITY DETAILS:
 Individuals enrolled in the QuitCore program are eligible to receive up to \$500.00 CAD of NRT coverage/year. Additional coverage for VAR or BUP is also offered for participants of QuitCore with a prescription.

YUKON ♦♦

QuitPath

started in 2009
 ELIGIBILITY DETAILS:
 18+ and enrolled in QuitPath, free 12 wk/yr.

NORTHWEST TERRITORIES ♦♦

Northwest Territories Health Care Plan

started in 2014
 ELIGIBILITY DETAILS:
 18+ and not covered by NIHB or other benefit program, free for 12 wk/yr.

NUNAVUT ▲X

Extended Health Benefits
started in 2011
 ELIGIBILITY DETAILS:
 18+ and not covered by NIHB or other benefit program, free for 12 wk/yr.

NEW BRUNSWICK ■♦♦

New Brunswick Prescription Drug Program (NBPD)P

started in 2014
 ELIGIBILITY DETAILS:
BUP/VAR: 18+ and covered by the New Brunswick Prescription Drug Program (NBPD) or New Brunswick Drug Plan, eligible for reimbursed meds for 12 wk/yr. Special authorization can cover an additional 12 wk/yr.

New Brunswick Drug Plan (NBDP)

started in 2016
 ELIGIBILITY DETAILS:
 18+ and covered by NBPD or NBDP, eligible reimbursement for 12 weeks of NRT (84 patches/960 lozenges) per year. Special authorization can cover an additional 12 wks.

NEWFOUNDLAND AND LABRADOR ■♦♦

Newfoundland and Labrador Smoking Cessation Program for Individuals with Low Income

started in 2014
 ELIGIBILITY DETAILS:
BUP/VAR: 18+ who are registered under Newfoundland and Labrador Prescription Drug Program Foundation, Access, or 65+ Plan, Co-pay up to \$75 for meds for 12 wk/yr.
PATCH: 18+ who are registered under the Newfoundland and Labrador Prescription Drug Program's Foundation, Access and 65+ Plans are eligible to receive up to 12 weeks (84 days in a row) of the Habitrol Patch within a 365 day period, with a co-pay arrangement up to \$75.00. Special authorization can cover additional doses.

PRINCE EDWARD ISLAND ♦♦X

QuitCare *started in 2001*
 ELIGIBILITY DETAILS:
 18+ and enrolled in QuitCare program eligible for \$75/yr reimbursement on NRT and BUP

Prince Edward Island Financial Assistance, Children in Care, Family Health Benefit, and Catastrophic Drug Programs
started in 2015
 Individuals eligible for Financial Assistance, Children in Care, Family Health Benefit and Catastrophic Drug programs eligible for BUP + VAR for 12 wk/yr.

SASKATCHEWAN ■♦♦X

Saskatchewan Drug Plan

started in 2011
 ELIGIBILITY DETAILS:
 Covered under Supplementary Health Plan (Plan 1 receive for reduced cost, Plan 2 and 3 receive for free), or covered under Saskatchewan Aids to Independent Living receive for free, or covered under Special Support Program, Guaranteed Income Supplement, Saskatchewan Income Plan, Family Health Benefits, Seniors' Plan receive for reduced cost 12 wk/yr.

MANITOBA ■♦♦X

Manitoba Pharmacare

started in 2011
 ELIGIBILITY DETAILS:
VAR: 18+ and covered by Pharmacare eligible for reduced cost meds (\$350) for 12 wk/yr, recipients of the Manitoba Employment and Income Assistance Program do not pay deductible.

ONTARIO ■♦♦X

Ontario Drug Benefit Program

started in 2011
 ELIGIBILITY DETAILS:
 Ontario Drug Benefit Program recipients receive coverage for prescription medications for smoking cessation up to 12 wk/yr provided they are enrolled in a smoking cessation program.

QUEBEC ■♦♦V

Quebec Public Prescription Drug Insurance Program

started in 2000
 ELIGIBILITY DETAILS:
 Seniors, individuals on social assistance, or individuals without health insurance eligible for free meds and NRT for 12 wk/yr.

NOVA SCOTIA ■♦♦

ELIGIBILITY DETAILS:
 Some health zones subsidize the cost of NRT and/or VAR.



LEADING PRACTICES IN FIRST NATIONS, INUIT, AND MÉTIS SMOKING CESSATION



CANADIAN PROGRAM SCAN RESULTS
APRIL 2018 (v4.0)



Summary of updates from April 2018

- Most programs sustained + expansion to additional settings
- Strong alignment with pan-Canadian evidence-based guidelines
- New cultural competency training opportunities and resources for staff introduced in some jurisdictions

CANADIAN PARTNERSHIP
AGAINST CANCER



PARTENARIAT CANADIEN
CONTRE LE CANCER

LEADING PRACTICES IN SMOKING CESSATION FOR PERSONS LIVING WITH MENTAL ILLNESSES AND/OR ADDICTIONS



CANADIAN PROGRAM SCAN RESULTS
APRIL 2018 (v2.0)



Summary of updates from April 2018

- Sustained programs + expansion to new settings
- Strong alignment with pan-Canadian evidence-based guidelines
- NT began offering tailored quitline services for persons living with mental illnesses and/or addictions (new total 11/13 jurisdictions).
- 3 jurisdictions (NT, ON, NS) new or updated smoking cessation policies, protocols or capacity building initiatives to support persons living with mental illnesses and/or addictions (new total 11/13 jurisdictions).

How can I use the program scans in my practice?

- Informing decision-making around adoption/adaptation of programs
- Developing knowledge products (e.g., briefings, presentations, reports)
- Supporting knowledge transfer and exchange



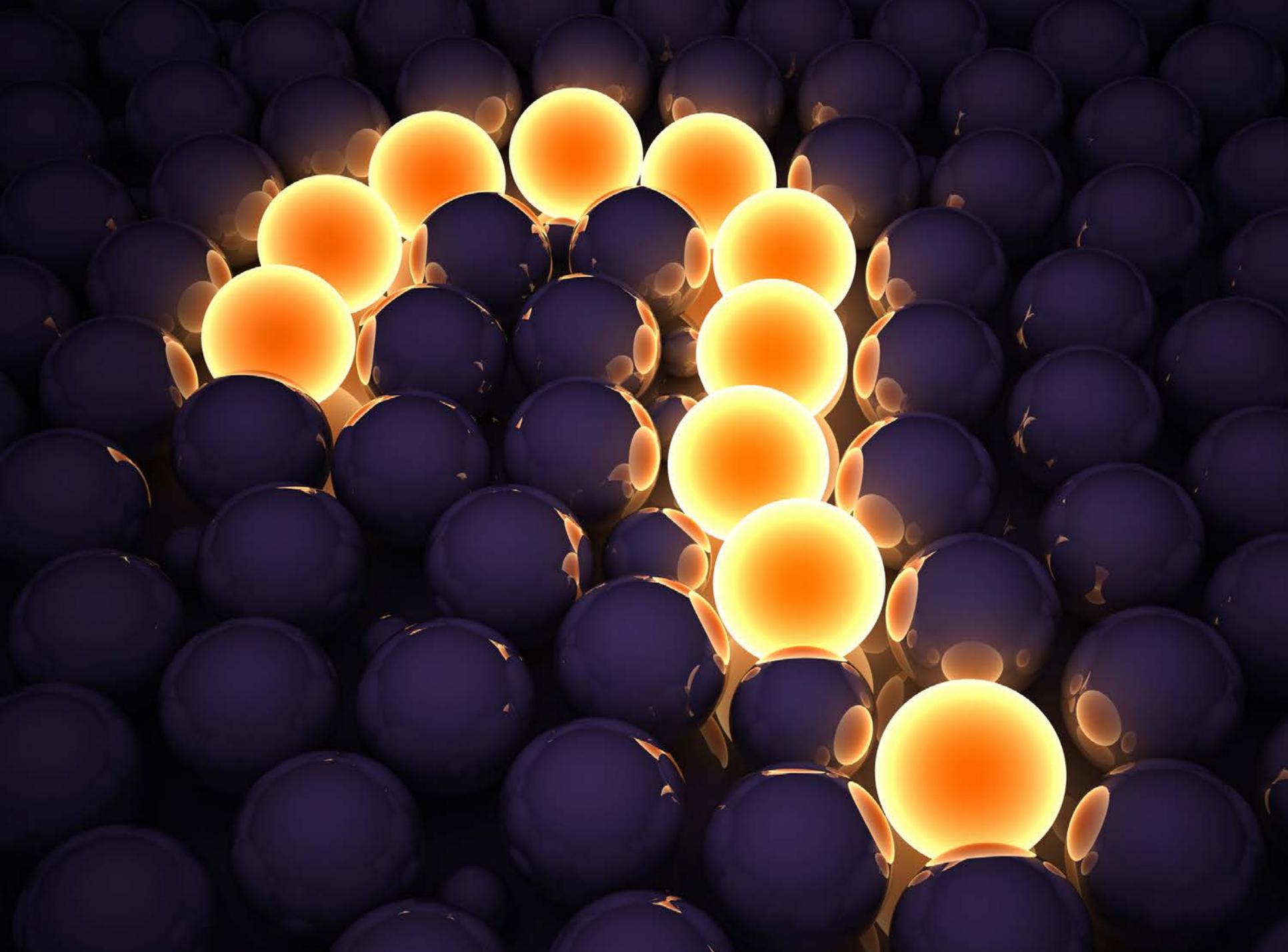
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