



Southeastern Multidisciplinary Approaches to Cancer Symposium

Impact of Tobacco Cessation on the Treatment of Cancer Patients

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Disclosures

- Consultant for Varian

This presentation and/or comments will be free of any bias toward or promotion of the above referenced companies or their product(s) and/or other business interests.

This presentation and/or comments will provide a balanced, non-promotional, and evidence-based approach to all diagnostic, therapeutic and/or research related content.

This presentation has been peer-reviewed and no conflicts were noted.



Cultural Linguistic Competency (CLC) & Implicit Bias (IB)

STATE LAW:

The California legislature has passed Assembly Bill (AB) 1195, which states that as of July 1, 2006, all Category 1 CME activities that relate to patient care must include a cultural diversity/linguistics component. It has also passed AB 241, which states that as of January 1, 2022, all continuing education courses for a physician and surgeon **must** contain curriculum that includes specified instruction in the understanding of implicit bias in medical treatment.

The cultural and linguistic competency (CLC) and implicit bias (IB) definitions reiterate how patients' diverse backgrounds may impact their access to care.

EXEMPTION:

Business and Professions Code 2190.1 exempts activities which are dedicated solely to research or other issues that do not contain a direct patient care component.

This presentation is dedicated solely to research or other issues that do not contain a direct patient care component.



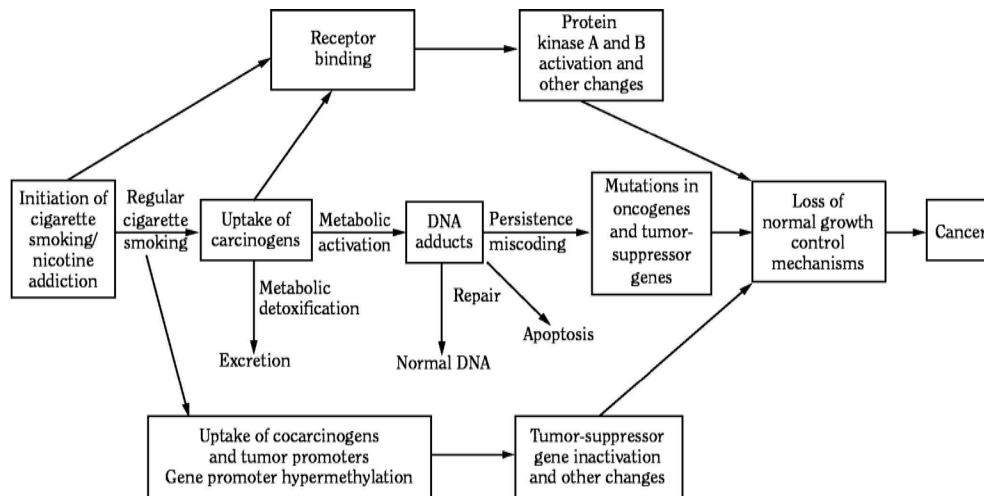
Objective

Learn about updated evidence to support smoking cessation in cancer care and about initiatives to sustain smoking cessation in cancer care programs

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

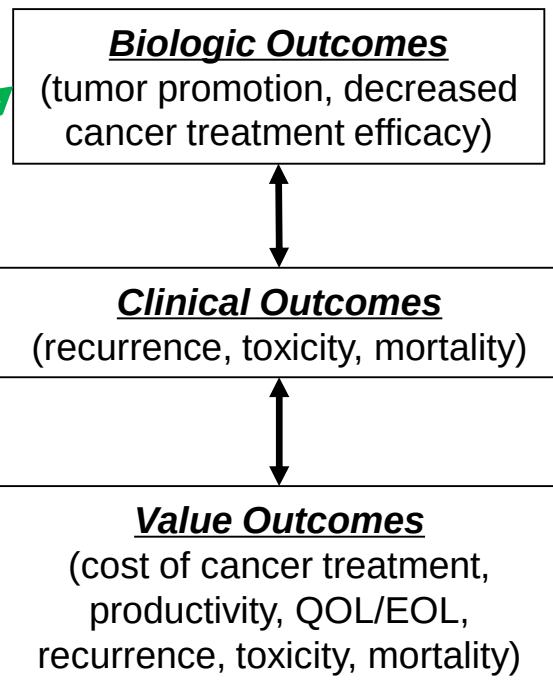
~~The
Historical
Disconnect~~

The Established Carcinogenesis Model



2010 Surgeon General's Report, Fig 5.1

The Reality of Cancer



Addressing
Tobacco Use by
Cancer Patients

The 2014 SGR: Magnitude Estimates

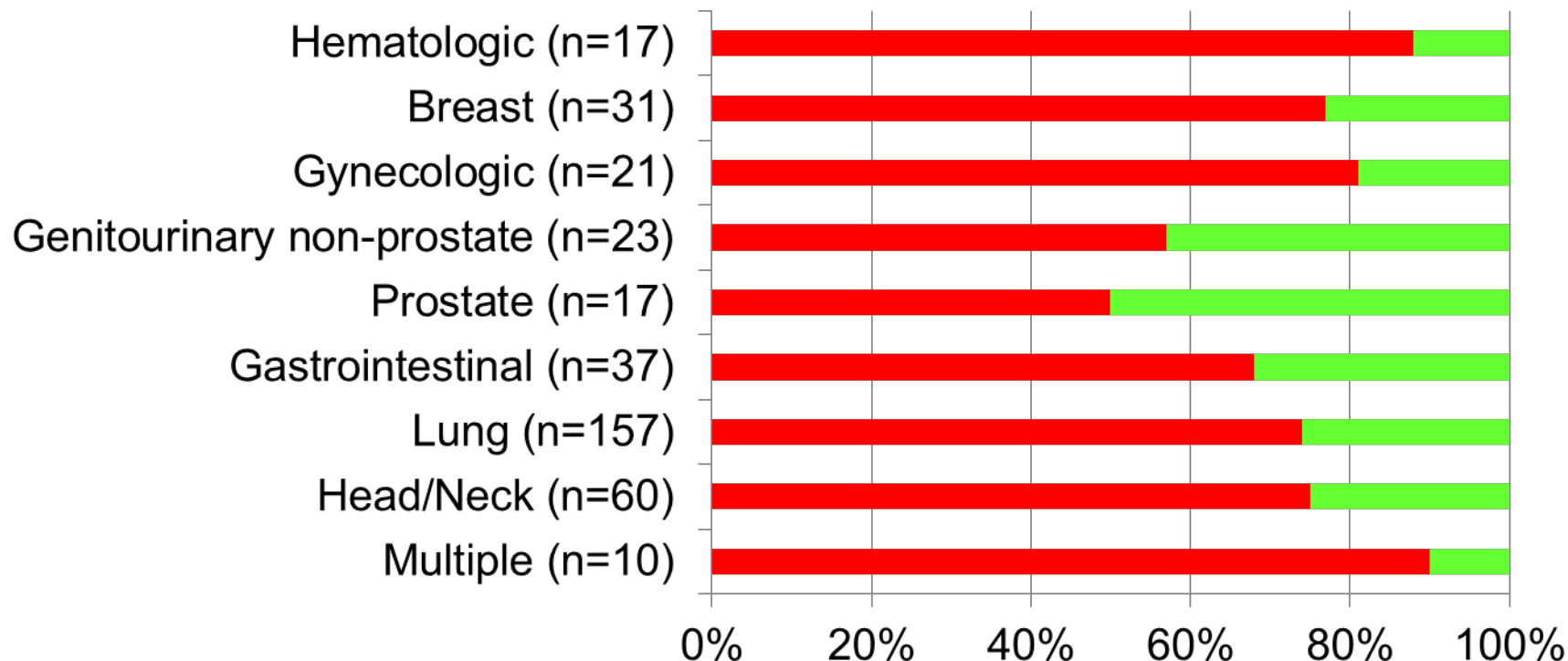
Effect	Studies	Associations (Significant)	RR Magnitude (median)
Overall Mortality	159	87% (62%)	Current: 1.51 Former: 1.22
Overall Survival	62	77% (42%)	
Cancer Related Mortality	58	79% (59%)	Current: 1.61 Former: 1.03
Second Primary	26	100% (100%)	
Recurrence	51	82% (53%)	Current: 1.42 Former: 1.15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

Breadth of Association across Cancer

(one or more negative association)

■ Significant ■ Non-significant



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.

Effect of Smoking on Lung Cancer Staging

ORIGINAL ARTICLE

The International Association for the Study of Lung Cancer Staging Project: The Impact of Smoking Status on Lung Cancer Staging in the Ninth Edition of the TNM Classification

Lawson Eng, MD, SM, FRCPC,^{a,*} William K. Evans, MD, FRCPC,^b Megan Eisele, MS,^c Katherine K. Nishimura, PhD, MPH,^c Stephanie R. Land, PhD,^d Ramon Rami-Porta, MD,^e Carolyn M. Dresler, MD, MPA,^f Hisao Asamura, MD,^g Joelle T. Fathi, DNP,^{h,i} Kendra Lechtenberg, PhD,^j Valerie Rusch, MD, FACS,^k Mahdi Sheikh, MD, PhD,^l Murry W. Wynes, PhD,^j Keelan Zius, PhD,^j Raymond U. Osarogiagbon, M.B.B.S., FACP,^m Graham W. Warren, MD, PhD,ⁿ and the Members of the IASLC Staging and Prognostic Factors Group and of the Advisory Boards, and Participating Institutions and the IASLC Tobacco Control and Smoking Cessation Committee**

Smoking Affects Survival Comparable to Nodal Staging

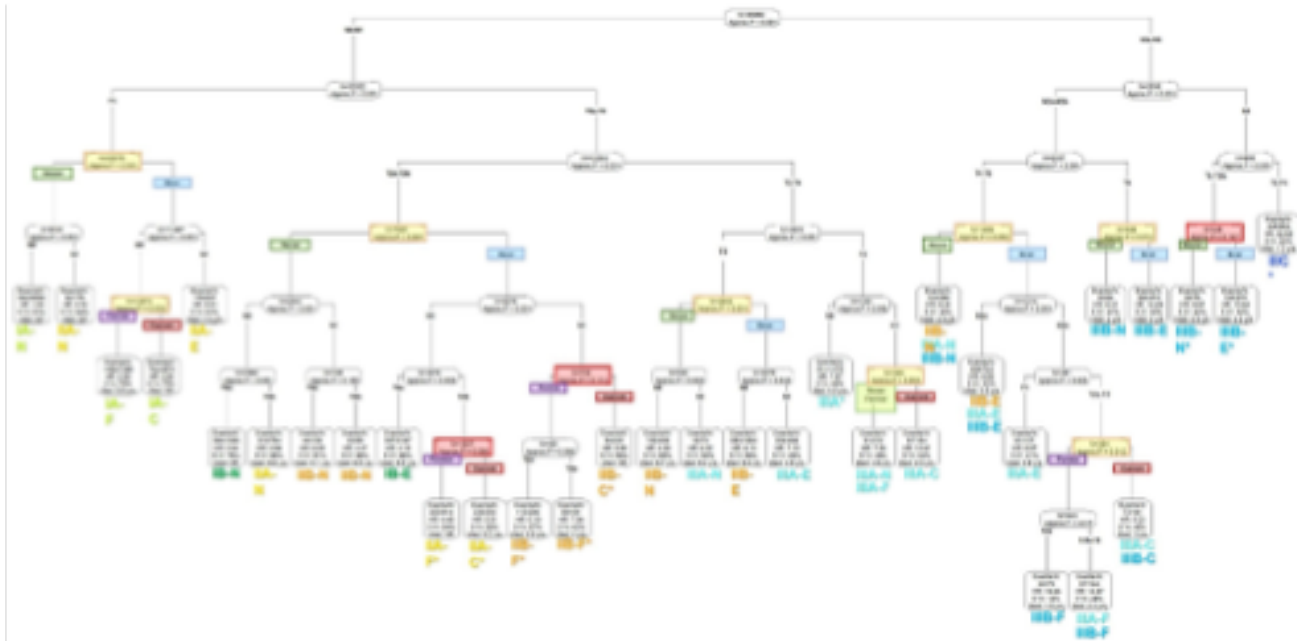


Figure 3. Recursive partitioning analysis survival tree. This figure summarizes the results from our recursive partitioning analysis evaluating the importance of smoking status on survival in comparison to other anatomical descriptors of disease for patients with non-metastatic disease. p values at branch points represent significance testing for the factor used for splitting where yellow boxes represent statistically significant splitting at that node ($p < 0.05$), while red boxes represent non-significant splitting. Smoking status variables are highlighted in green and blue boxes for never and ever smoking, respectively and red and purple for current and former smoking, respectively throughout the tree. The aggregate stage group based on T and N status for each branch is listed at each node alongside smoking status with each aggregate stage group highlighted as a different color.

Cost of Failure due to Smoking

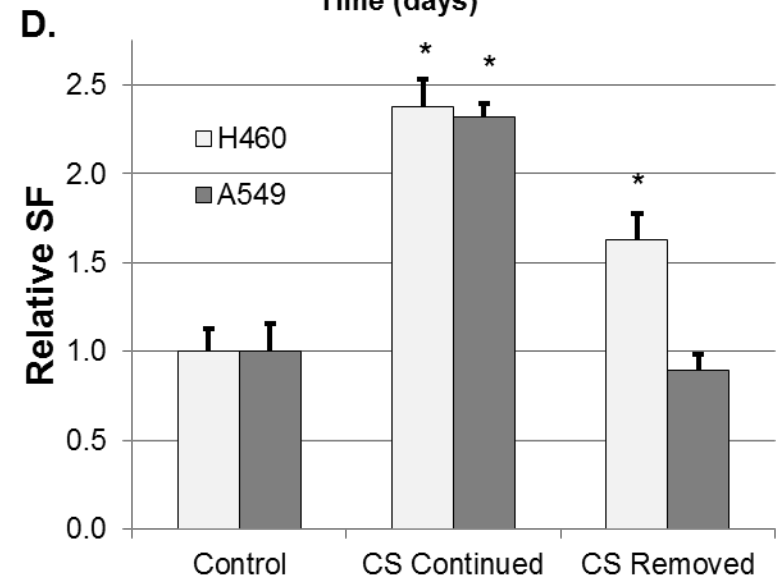
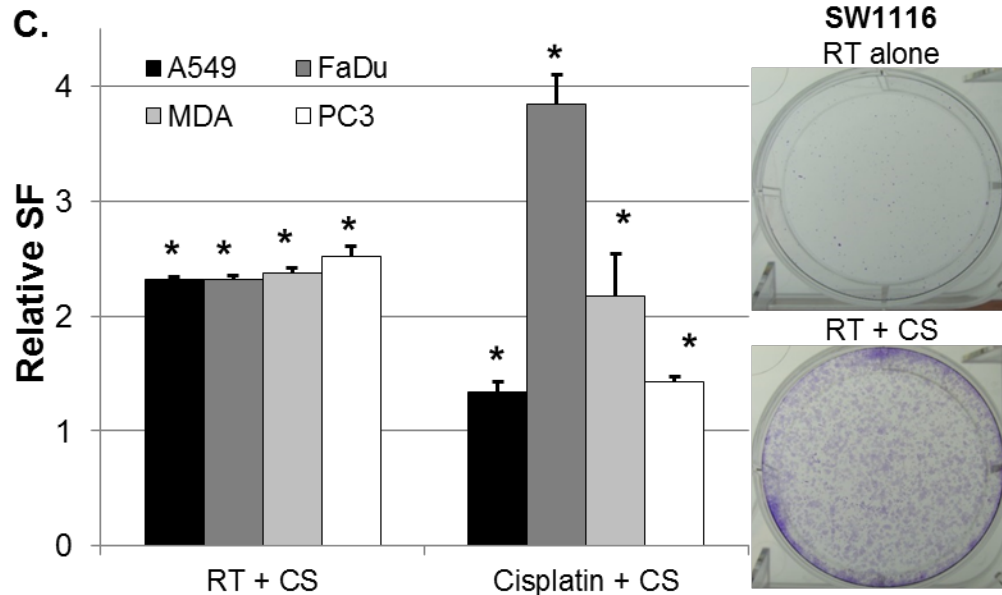
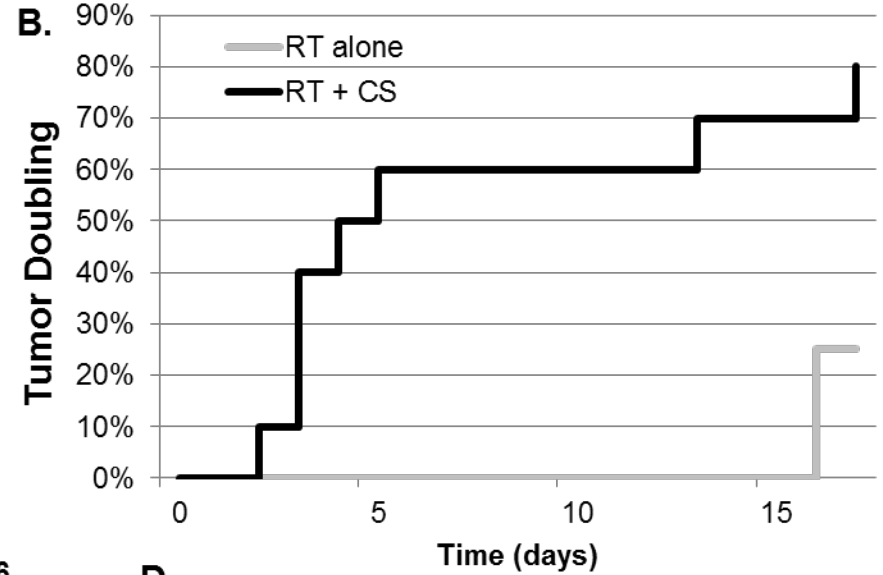
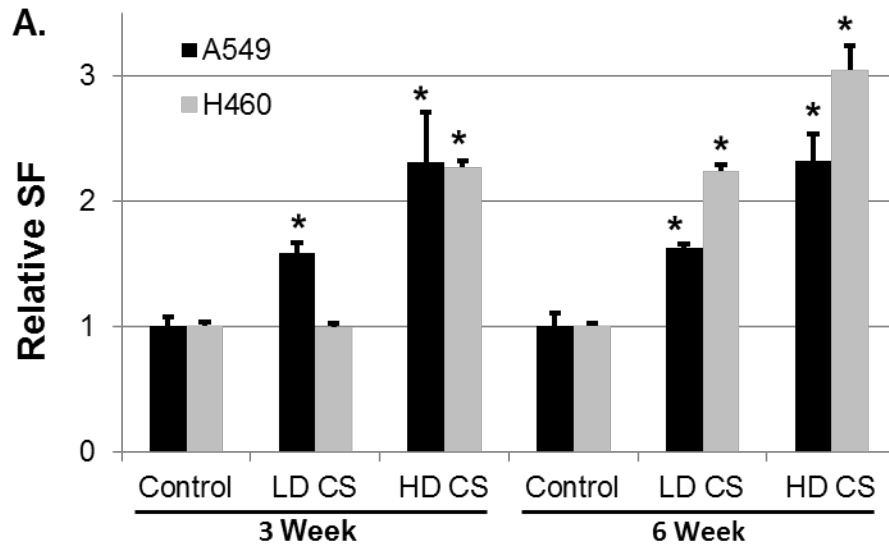
Table 3. Mean Cost Associated With First-line Cancer Treatment Failure Attributed to Smoking per 1000 Total Patients With a 30% Failure Rate of First-line Cancer Treatment Among Nonsmoking Patients and 20% Smoking Prevalence

Odds Ratio ^a	Mean Individual Cost per Treatment Failure, \$			
	10 000	50 000	100 000	250 000
1.1	40 777	203 883	407 767	1 019 417
1.2	79 245	396 226	792 453	1 981 132
1.4	150 000	750 000	1 500 000	3 750 000
1.6	213 559	1 067 797	2 135 593	5 338 983
1.8	270 968	1 354 839	2 709 677	6 774 194
2.0	323 077	1 615 385	3 230 769	8 076 923
2.5	434 483	2 172 414	4 344 828	10 862 069
3.0	525 000	2 625 000	5 250 000	13 125 000

US Estimates (2019): \$3.4 Billion Annually

Pan-Canadian Estimates (2019): \$239 Million Annually

Smoking and Therapeutic Response



Cessation after Diagnosis: A New Gold Standard

JAMA Oncology | Original Investigation

Survival Outcomes of an Early Smoking Cessation Treatment After a Cancer Diagnosis

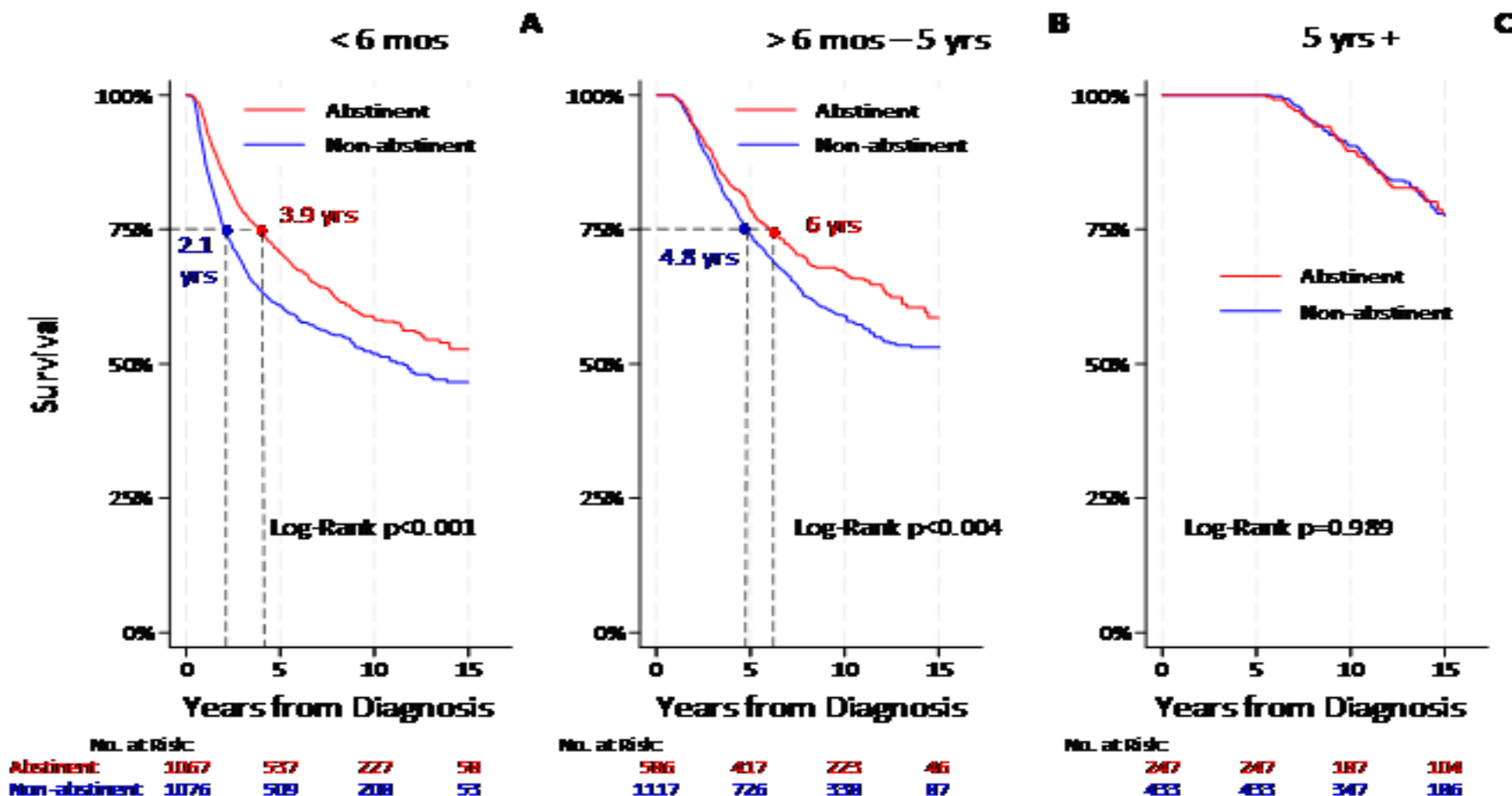
October 31, 2024

Paul M. Cinciripini, George Kypriotakis, Janice A. Blalock, Maher Karam-Hage, Diane M. Beneventi, Jason D. Robinson, Jennifer A. Minnix, Graham W. Warren

Question: Does the timing of entry into a smoking cessation program after a cancer diagnosis influence overall survival?

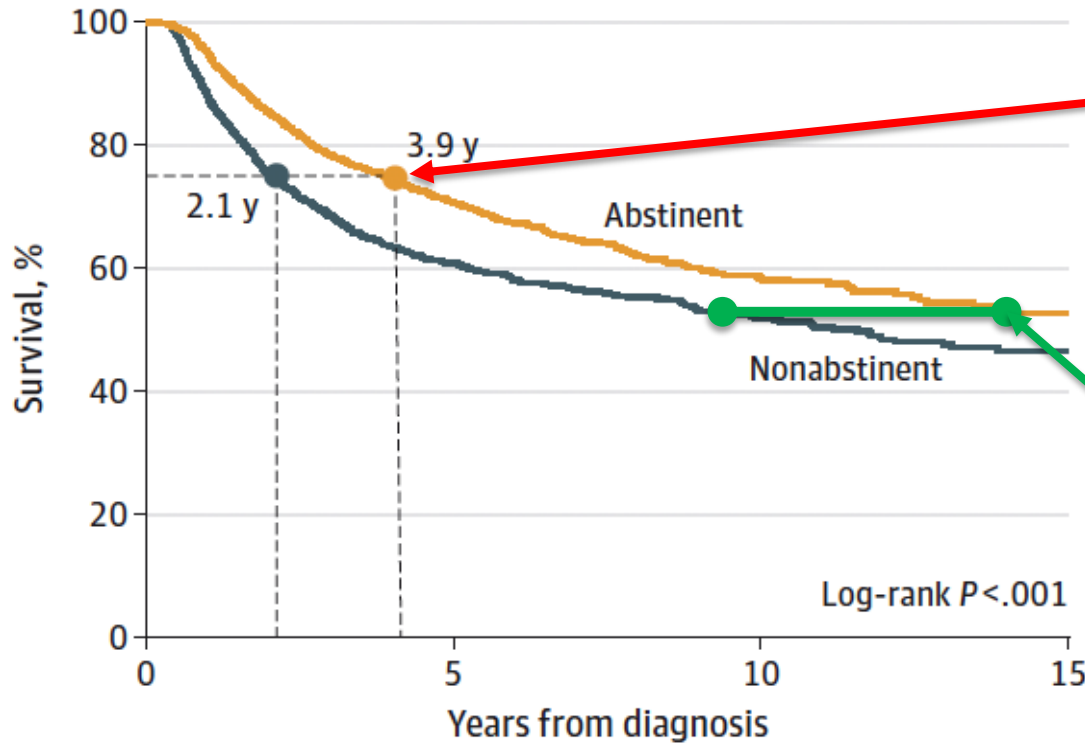
Get Patients into Tobacco Treatment ASAP after a Cancer Diagnosis (or during workup!)

TRTP within 6 months of dx adds 1.8+ years of life!!!



1.8 Years May Be Conservative...

A <6 mo

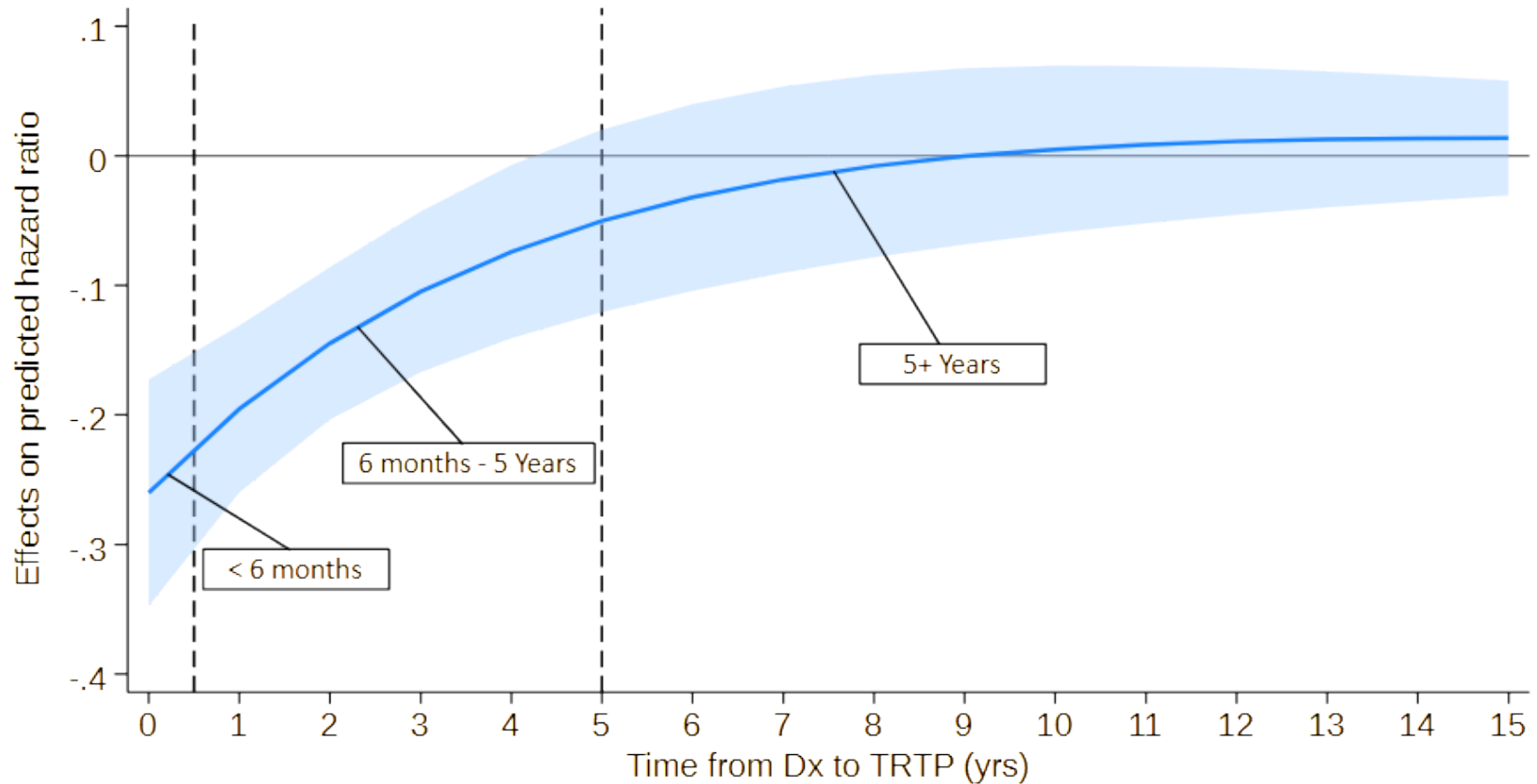


1.8 years at 75th percentile

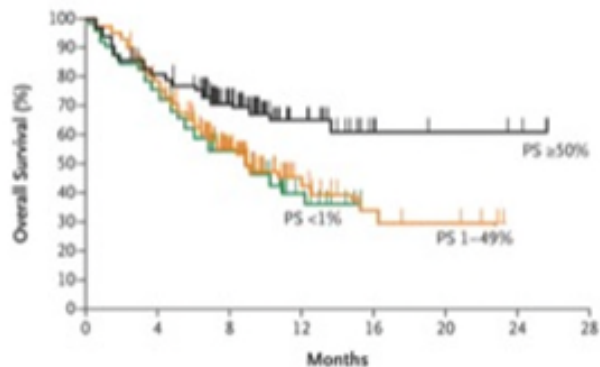
Approximately 4 years at 50th percentile

No. at risk				
Abstinent	1067	537	227	58
Nonabstinent	1076	509	208	53

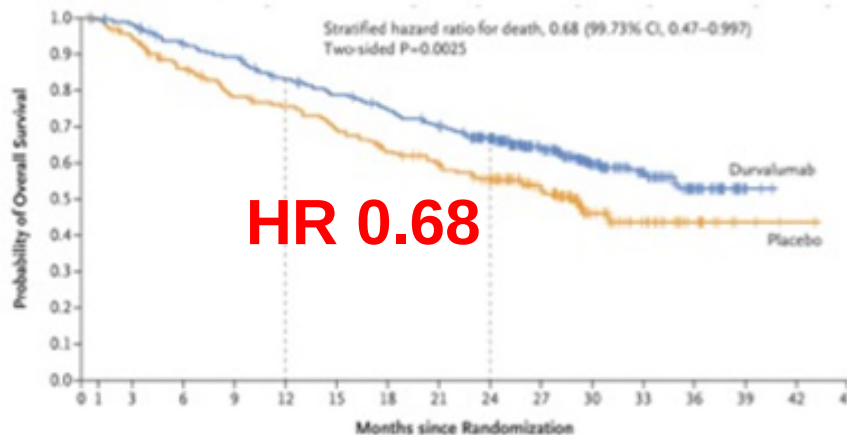
Survival Benefit vs. Time to Cessation Entry



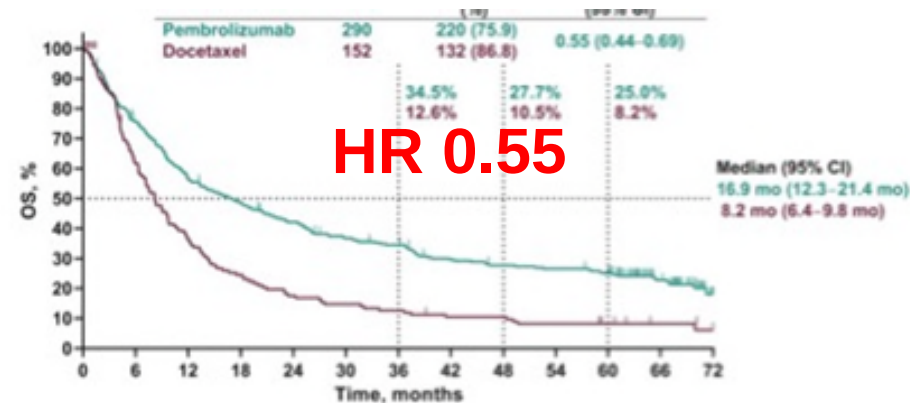
How Does Cessation Compare with Revolutions in Lung Cancer Care?



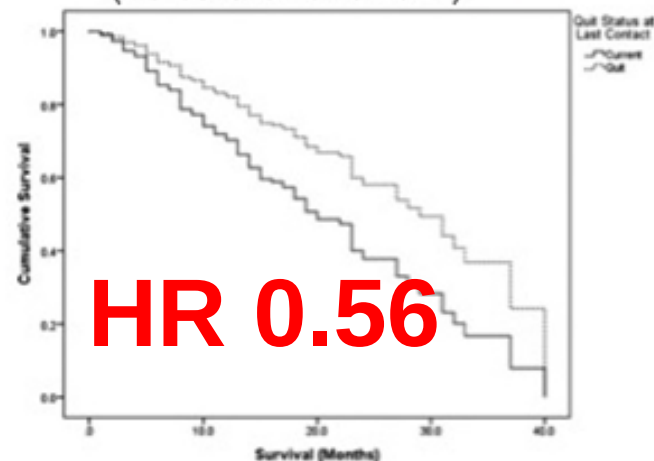
Overall Survival with Pembro by PD-L1 status, Keynote-001 (Garon et al. NEJM 2015)



Overall Survival with Duvalumab, Pacific Trial (Antonia et al. NEJM 2018)



Overall Survival with Pembro, PD-L1 >50 Keynote-010 (Herbst et al. JTO 2021)



Smoking Cessation added to first line NSCLC treatment (Dobson-Amato et al. JTO 2015)

Tobacco Assessment by Oncologists

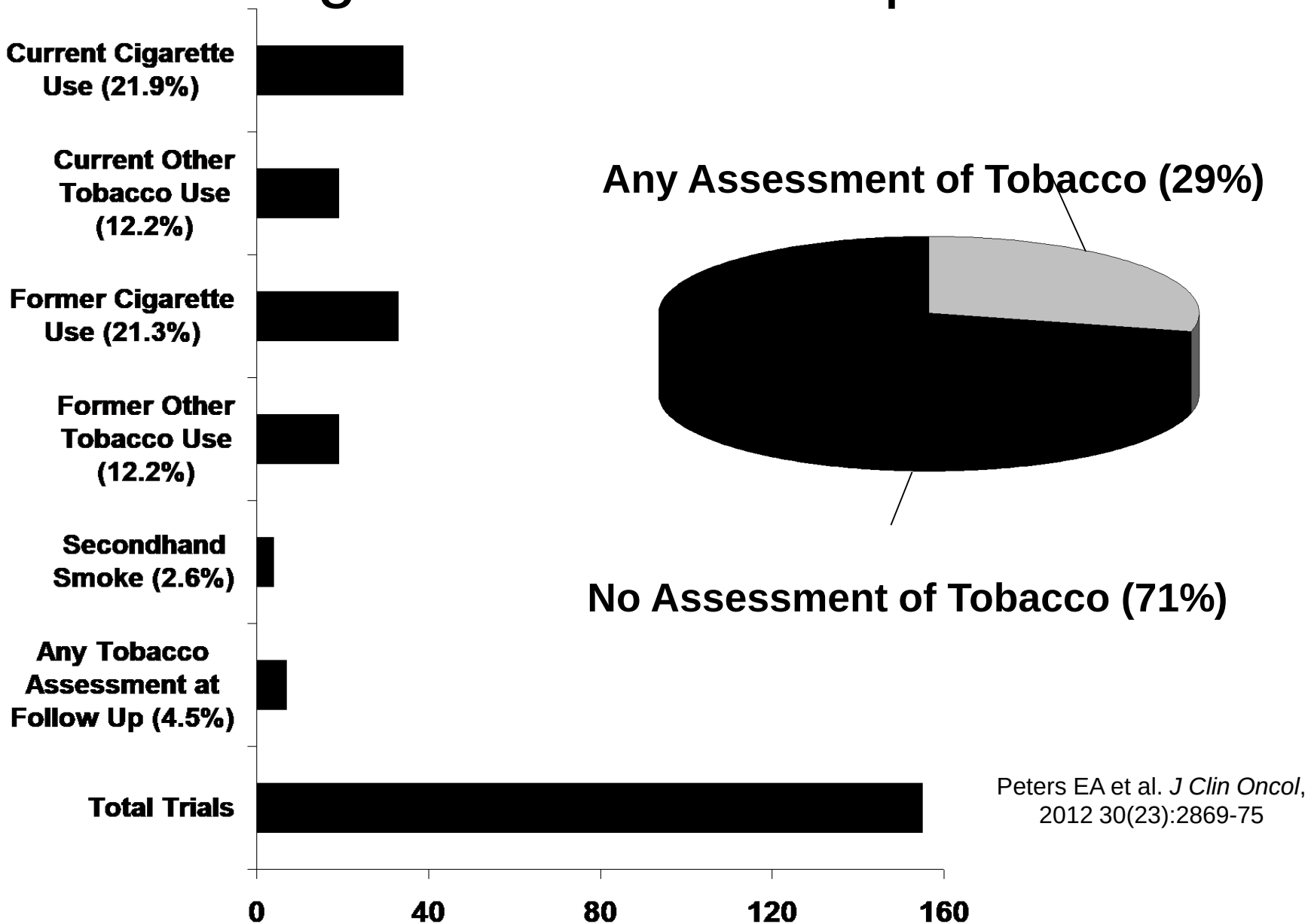
(Always/Most of the time)

Parameter	IASLC (n=1507)	ASCO (n=1197)	NDCC (n=887)
Ask if use tobacco	90.2%	89.5%	90.2%
Advise to quit	80.6%	82.4%	83.3%
Actively treat	38.8%	38.6%	35.1%

- Predictive barriers by oncologists
 - Lack of education and experience in cessation
 - Lack of time
 - Lack of resources

Warren GW et al. *J Thorac Oncol* 2013
Warren GW et al. *J Oncol Pract* 2013
Pommerenke et al. *AACR 2014 Annual Meeting*
Warren et al. *J Thorac Oncol* 2015

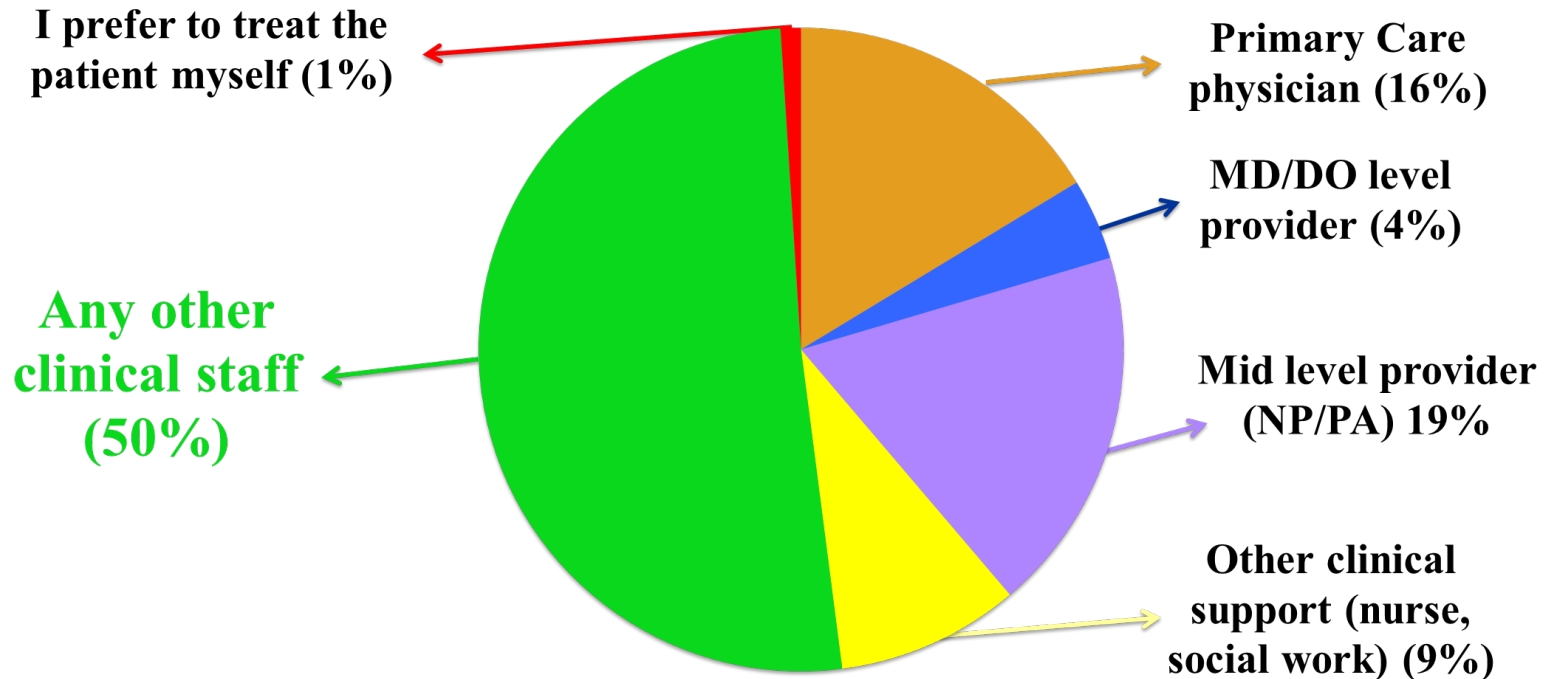
Assessing Tobacco in Cooperative Groups



Who Should Provide Support?

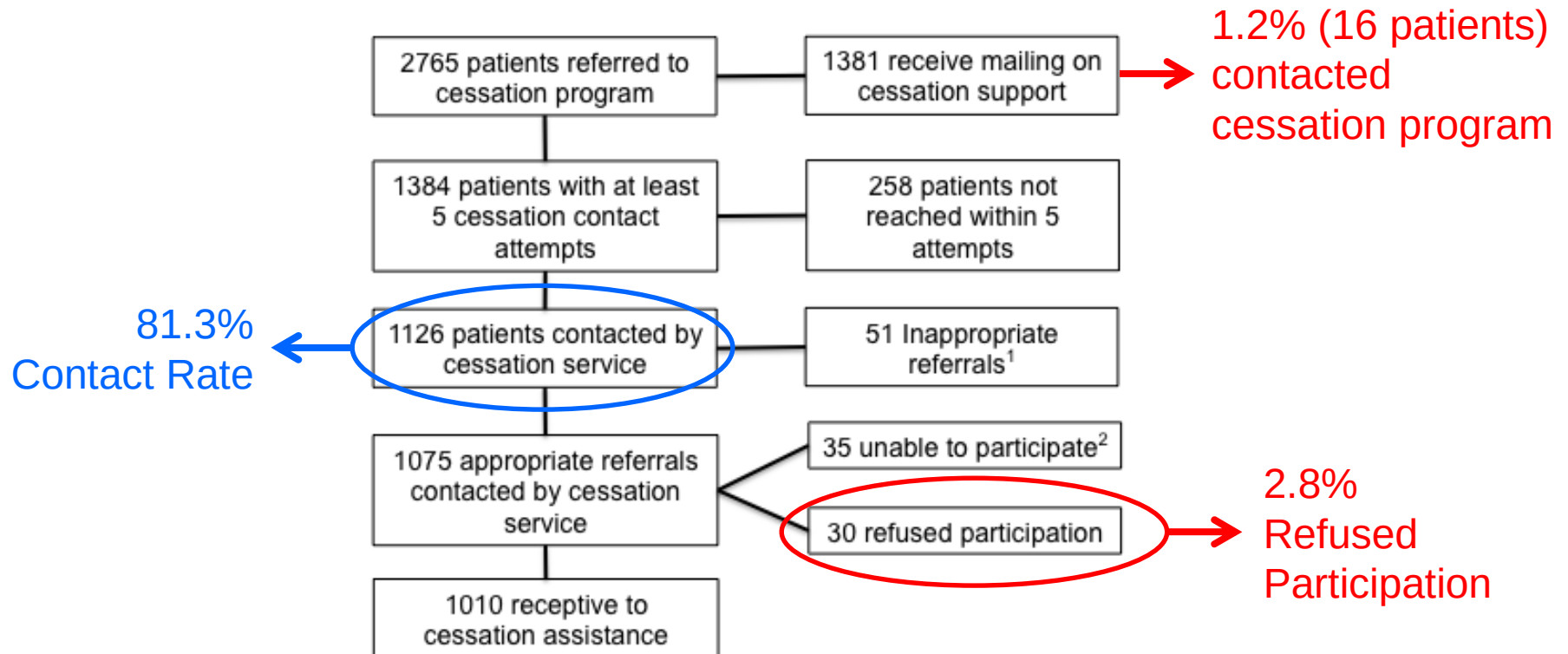
(NCI survey)

What provider do you prefer to provide cessation assistance?



10% of respondents felt adequately trained
55% of respondents said train someone else in my clinic

Opt-Out 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%)

Opt-Out Cessation and Mortality

Continuous Variables	N	Mean	Hazard Ratio	95% CI	p
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	N	%	Hazard Ratio	95% CI	p
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.

**44% reduction
in mortality**

Resources: NCCN Guidelines



NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines®)

Smoking Cessation

Version 1.2015

NCCN.org

Continue

Version 1.2015, 03/08/15 © National Comprehensive Cancer Network, Inc. 2015. All rights reserved. The NCCN Guidelines® and this illustration may not be reproduced in any form without the express written permission of NCCN®.

NCI/AACR Structured Questions

Published OnlineFirst February 17, 2016; DOI: 10.1158/1078-0432.CCR-16-0104

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

Stephanie R. Land, PhD^{1,2}; Graham W. Warren, MD, PhD^{3,4}; Jennifer L. Crafts, PhD⁵; Dorothy K. Hatsukami, PhD⁶;
Jamie S. Ostroff, PhD⁷; Gordon B. Willis, PhD²; Veronica Y. Chollette, RN, MS²; Sandra A. Mitchell, PhD, CRNP, AOCN²;
Jasmine N. M. Folz, MA⁵; James L. Gulley, MD, PhD⁸; Eva Szabo, MD⁹; Thomas H. Brandon, PhD¹⁰;
Sonia A. Duffy, PhD, RN¹¹; and Benjamin A. Toll, PhD¹²

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

Standardized Metrics



Figure 1. Process flow of tobacco use treatment program (TTP) and recommended metrics. Patients from a chosen target population. Depending on the institution or setting, this may include all patients at a particular institution, all cancer patients with a targeted disease to be evaluated, etc. Tobacco use treatment may include an institutional tobacco treatment program, an external program to which a patient is referred, or a Quitline. In the case of Quitline with a non-closed referral system, reporting on reach, enrollment, and engagement is not possible.

Pan-Canadian Tobacco Cessation + Cancer Care Network



CPAC: Implementation Checklist

- Understand the Importance of Smoking Cessation as a Core Component of Cancer Care
- Identify Patients Who Need Assistance
- Determine What Resources Are Available to Assist Patients to Quit Smoking
- Choose an Assist Pathway that will work for your Program

Category	Pre-Implementation (Score of 0)	Bronze (Score of 1)	Silver (Score of 2)	Gold (Score of 3)	Score
Behavioural Counseling	☐ Understand the financial implications of implementing behavioural counselling; establish/-maintain infrastructure to support referrals for cessation services and patient tracking; develop communication materials	☐ 3A or 5A model is implemented	☐ 3A or 5A model with an opt-out approach is implemented	☐ 3A or 5A model with an opt-out approach is implemented and mechanisms for relapse prevention and follow-up, and extending cessation support to family and friends are established	___/3
Pharmacotherapy	☐ Determine the level of access and the pathways in which cancer patients can receive pharmacotherapy	☐ Prescription for medication/ NRT is provided	☐ Subsidized medication/ NRT is provided	☐ Free medication/NRT is provided	___/3
Person-Centered	☐ Assess availability of a patient representative to participate in smoking cessation program and meet with Patient and Family Advisory Committee representative for engaging patients	☐ Patient(s) is represented on the program planning/ advisory committee	☐ Patient(s) is represented on the program planning/ advisory committee and patient feedback on the cessation program is gathered	☐ Patient(s) is represented on the program planning/ advisory committee, patient feedback is gathered, and tools are used to evaluate patient outcomes and adapt the program accordingly	___/3
Culturally Competent	☐ Understand the current status of cultural competency training of staff and develop training materials for untrained staff	☐ Cultural competency training is available for all staff	☐ Cultural competency training is available for all staff and culturally specific resources are available for patients	☐ Cultural competency training is required for all staff, culturally specific resources are available for patients and smoking cessation interventions incorporate culturally safe approaches	___/3
Partnership	☐ Determine availability of smoking treatment expertise, either via an internal smoking cessation clinic, external service, an interactive voice recorder service (IVR), and/or community service	☐ A dedicated, multidisciplinary team for the cessation program is assembled	☐ A dedicated, multidisciplinary team for the cessation program is assembled and community partners are engaged as part of the referral network	☐ A dedicated, multidisciplinary team for the cessation program is assembled, community partners are engaged as part of the referral network and feedback mechanisms for information sharing between the centre(s) and community partners is established to track patient progress/ outcomes	___/3
Indicator Measurement and Reporting	☐ Develop tools to track program performance and assess IT infrastructure to support data collection and reporting against quality indicators	☐ Collect and report on the adoption and reach indicators (indicators 1-3)	☐ Collect and report on adoption, reach and uptake indicators (indicators 1-4)	☐ Collect and report on adoption, reach, uptake and outcomes indicators (indicators 1-6)	___/3
TOTAL SCORE AND LEVEL (Pre-Implementation: 0; Bronze: 1-6; Silver: 7-12; Gold: 13-18)					___/18

CPAC: Knowledge Products

Date	Title
2015	Economic evaluation of smoking cessation programs in the oncology setting: rapid literature review
2017	Cessation aids and coverage in Canada (refreshed periodically through 2021)
2017	Integrating smoking cessation and relapse prevention to improve quality of cancer care
2017	Key cost estimates on cancer treatment and smoking cessation in Canada
2017	Key evidence from peer-reviewed and grey literature on smoking cessation for cancer patients
2017	Quotes from cancer patients who quit smoking
2017	Leading practices in smoking cessation for persons living with mental illnesses and/or addictions
2018	Leading practices in smoking cessation for cancer patients
2019	Quitting smoking can improve cancer treatment
2019	Leading practices in First Nations, Inuit, and/or Metis smoking cessation
2019	Leading practices in smoking cessation for persons living with mental illness and/or addictions
2019	Commercial tobacco policy pack: local and provincial/territorial governments
2019	Smoking cessation and cancer care action framework
2020	Leading practices in clinical smoking cessation
2021	Smoking cessation in cancer care across Canada, 2020
2021	Business case to improve access to smoking cessation medications in Canada
2021	Financial coverage of smoking cessation medications in Canada, 2021

CPAC: Infrastructure Outcomes

Access increased from 26% in 2016/17 to 95% in 2022

JURISDICTION	BEHAVIOURAL COUNSELLING	PHARMACO- THERAPY	PERSON- CENTERED	CULTURALLY COMPETENT	PARTNERSHIP	INDICATOR MEASUREMENT AND REPORTING	PROVINCIAL/ TERRITORIAL LEVEL
Yukon	G	G	P	S	G	S	GOLD
Northwest Territories	B	G	P	G	P	P	SILVER
Nunavut	B	G	B	S	B	P	SILVER
British Columbia	G	G	G	S	G	G	GOLD
Alberta	B	S	S	B	S	B	SILVER
Saskatchewan	S	G	B	B	S	P	SILVER
Manitoba	S	G	G	B	G	S	GOLD
Ontario	S	S	G	S	S	G	GOLD
New Brunswick ^b	G	G	G	B	G	G	GOLD
Nova Scotia	S	S	B	P	S	P	SILVER
Prince Edward Island	G	G	S	B	G	S	GOLD
Newfoundland and Labrador	S	G	G	S	S	G	GOLD
Average level for each category	SILVER	GOLD	SILVER	BRONZE	SILVER	SILVER	CANADA: SILVER

CPAC: Reach Outcomes

Jurisdiction	Patients screened	Current Smoking	Referrals Provided	Referrals Accepted
A	5,212/5,485 (95%)	924/5,485 (17%)	281/924 (30%)	209/281 (74%)
B	194/1,936 (10%)	36/194 (21%)	16/36 (44%)	n/a
C	721/721 (100%)	178/721 (25%)	138/178 (78%)	66/138 (48%)
D	74,964/127,804 (59%)	11,658/127,804 (9%)	7,503/11,658 (64%)	3,605/7,503 (48%)
E	40,712/45,085 (90%)	3,155/41,583 (8%)	93/1,255 (7%)	n/a
F	35,696/59,701 (60%)	9,631/59,701 (16%)	n/a	69/186 (37%)
G	61/80 (76%)	18/80 (23%)	16/18 (89%)	12/16 (75%)
H	4,486/4,633 (97%)	930/4,633 (20%)	724/930 (78%)	310/724 (43%)
I	11,827/45,348 (26%)	6,987/45,348 (15%)	1,974/6,987 (28%)	580/1,974 (29%)
J	4,364/5,742 (76%)	566/5,742 (10%)	384/566 (68%)	n/a
Median	76%	16%	64%	48%

ACOS Commission on Cancer

Access to ~1,500 cancer centers, ~70% of cancer patients
Just ASK (776 programs) and **Beyond ASK** (>300 programs)

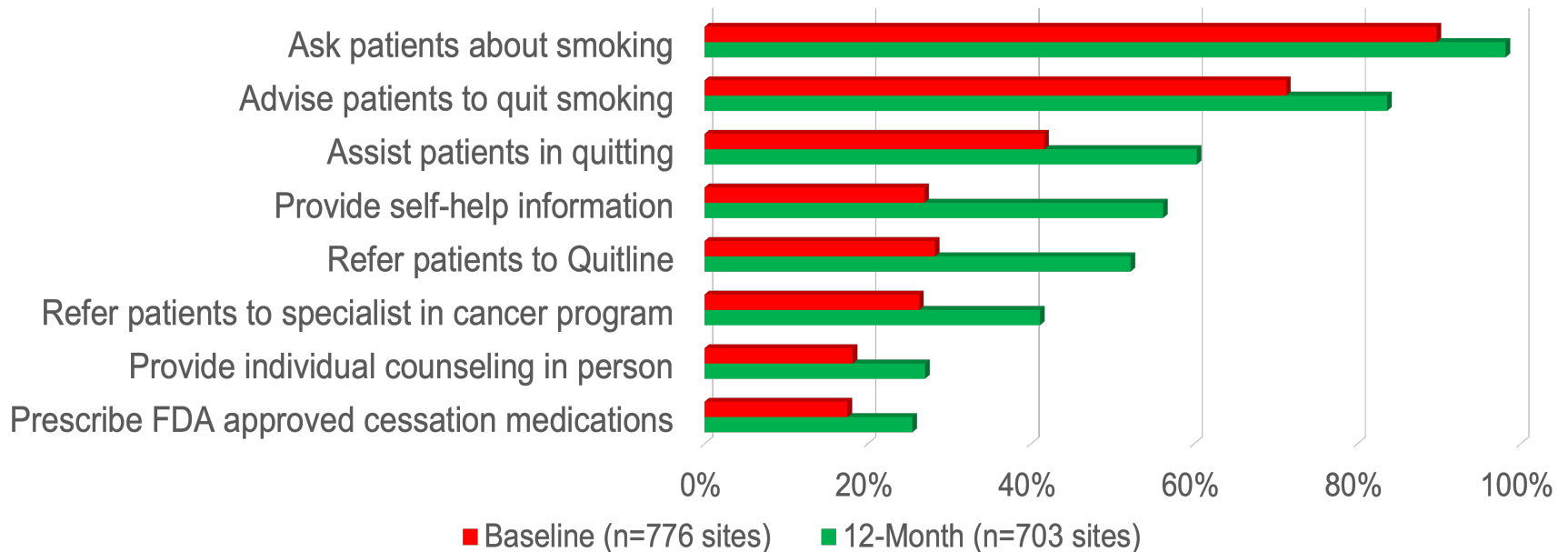
The screenshot displays the ACS website's navigation and content for the Just ASK project. The top navigation bar includes links for JACS, Jobs, Events, Find a Surgeon, Patients and Family, Contact, My Profile, Shop, and a prominent Donate button. Below this is the ACS logo with the tagline "Inspiring Quality: Highest Standards, Better Outcomes" and a search bar. A secondary navigation bar lists COVID-19, Member Services, Quality Programs, Education, Advocacy, Publications, and About ACS. The breadcrumb trail indicates the path: American College of Surgeons > Quality Programs > Commission on Cancer > Just ASK Quality Improvement Project & Clinical Study. The left sidebar contains a "Commission on Cancer" logo and a list of links: Commission on Cancer, About the Commission on Cancer, CoC Standards and Resources, Apply for Accreditation, Accreditation Information, Find a CoC-Accredited Center, Site Visit Reviewer Profiles, and Become a Site Visit Reviewer. The main content area features the title "Just ASK Quality Improvement Project & Clinical Study" followed by a paragraph describing the 2022 CoC and NAPBC Assessment of Smoking in New Cancer Patients PDSA project. It states that Just ASK is an elective quality improvement project focused on strengthening evidence-based care across participating programs by leveraging existing resources to address smoking by ASKing all newly diagnosed cancer patients about their smoking status. The goal is to increase and improve the integration of smoking assessment as a standard of care. Participation requires completion of three questionnaires to track progress. The opportunity is provided to all currently accredited Commission on Cancer (CoC) and National Accreditation Program for Breast Centers (NAPBC) programs, as well as those that have applied for CoC or NAPBC accreditation. A link to submit questions to accancerprograms@facs.org is provided. Below this are links for the Just ASK Project and Clinical Study, Just ASK Frequently Asked Questions, Compliance Checklist, and Access REDCap Questionnaire. The section "Project Overview and Deadlines" is partially visible at the bottom.

<https://www.facs.org/quality-programs/cancer/coc/pdsa-just-ask>

<https://www.facs.org/quality-programs/cancer/coc/pdsa-just-ask>

CoC: Just ASK Results

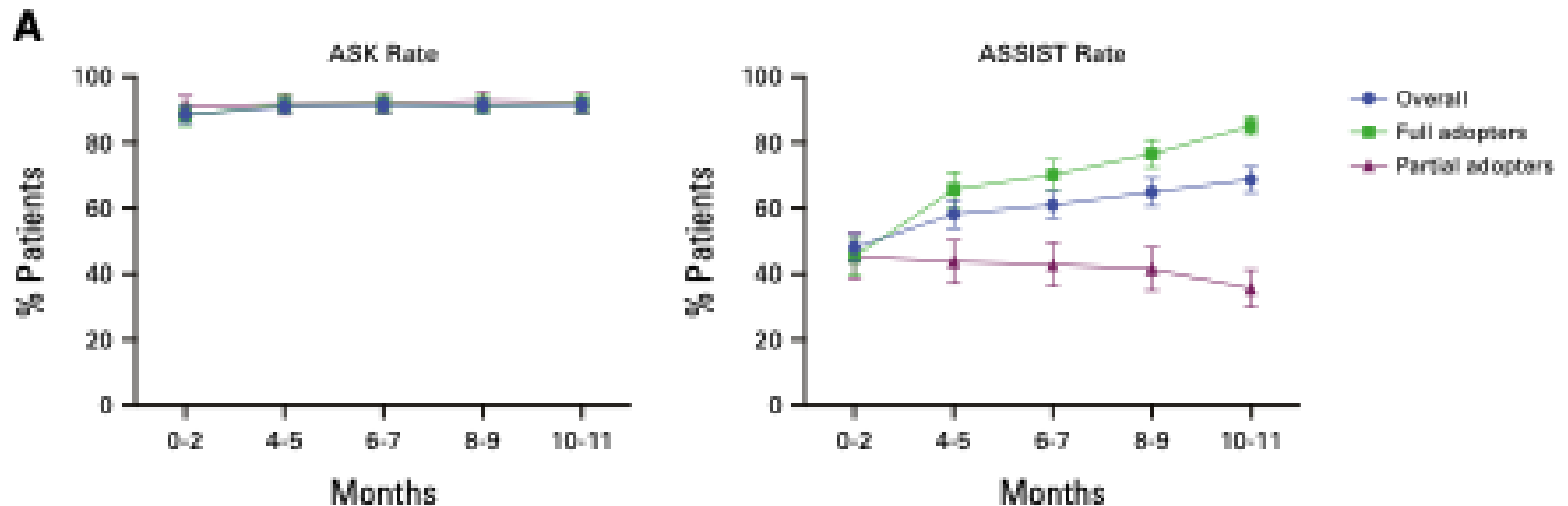
Assessment and Treatment Practices (Always or Usually)



CoC: Beyond ASK Results

National Quality Improvement Initiative to Increase Smoking Cessation Assistance in Commission on Cancer Programs and National Accreditation Program for Breast Centers

Tracey Pu, MD¹; Jessica L. Burris, PhD²; Richard S. Matulewicz, MD, MSCI, MS³; Danielle E. McCarthy, PhD⁴; Jamie S. Ostroff, PhD⁵; Eileen M. Reilly, MSW⁶; Rachel C. Shelton, ScD, MPH⁷; Graham W. Warren, MD, PhD⁸; Ronald J. Weigel, MD, PhD, MBA⁹; Timothy W. Mullett, MD, MBA¹⁰; and the Beyond ASK Quality Improvement Task Force



CoC: Beyond ASK Results

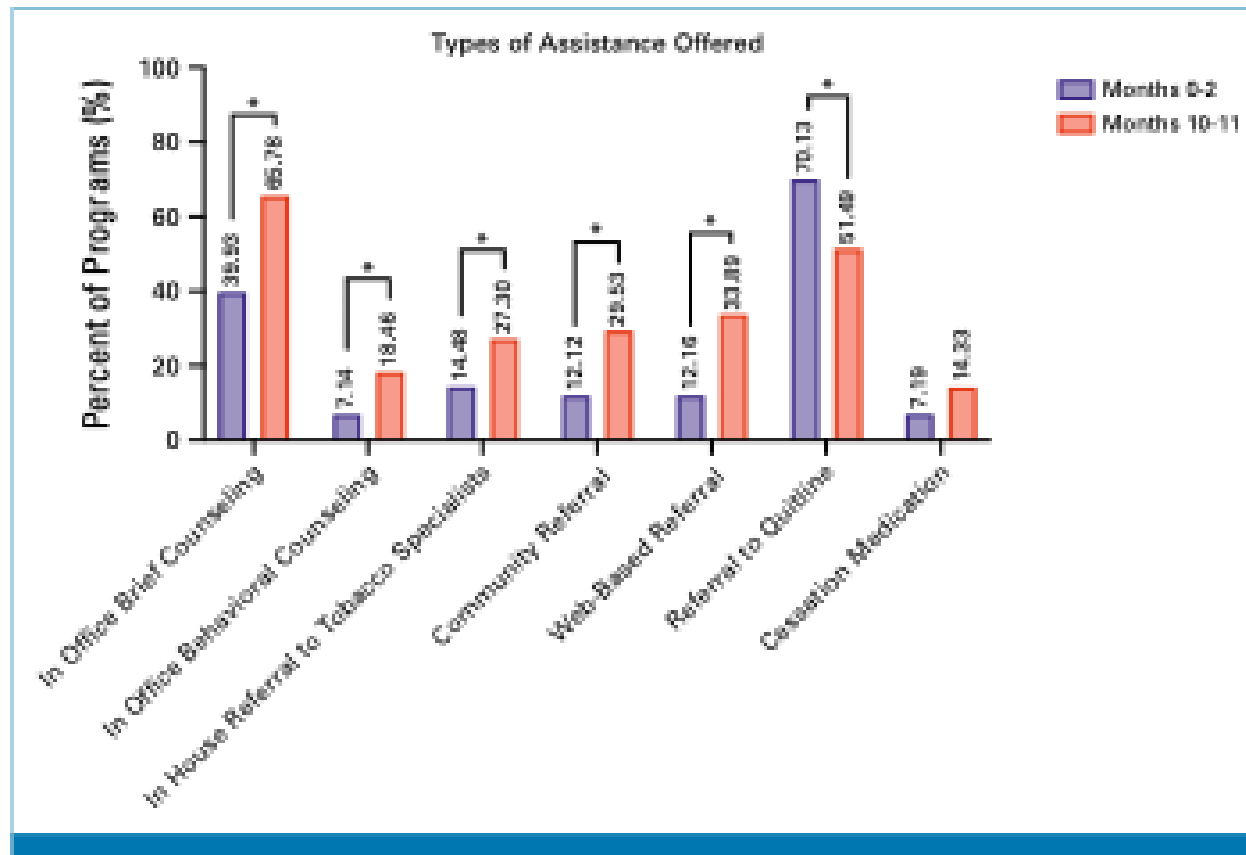
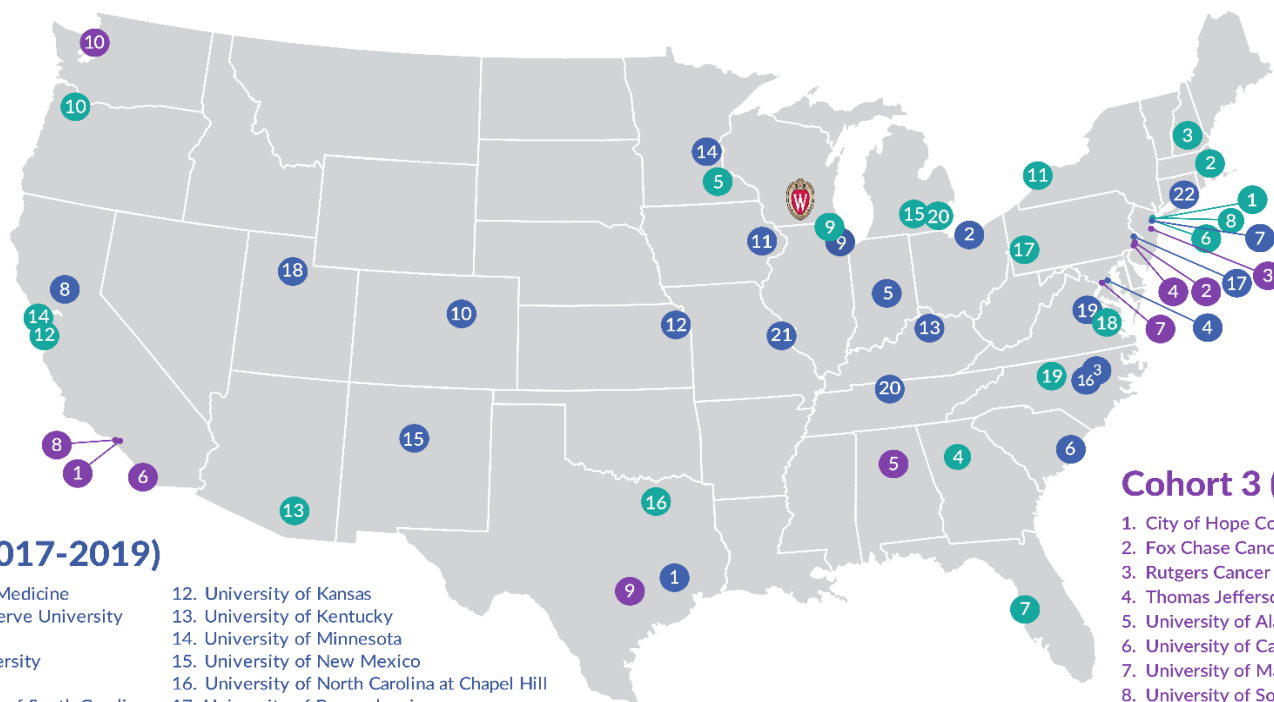


FIG 2. Types of assistance offered most or nearly all of the time at baseline (months 0-2) versus final (months 10-11) survey. *Denotes significance $P < .01$. Values reported as percentage of programs reporting most or nearly all compared with the three less frequent responses, "some," "few," and "none".

Cancer Center Cessation Initiative (C3I) Funded Centers

Cohort 1, Cohort 2, and Cohort 3

Impact: over 95,000 patients between 2018-22



Cohort 1 (2017-2019)

1. Baylor College of Medicine
2. Case Western Reserve University
3. Duke University
4. Georgetown University
5. Indiana University
6. Medical University of South Carolina
7. New York University
8. University of California Davis
9. University of Chicago
10. University of Colorado
11. University of Iowa
12. University of Kansas
13. University of Kentucky
14. University of Minnesota
15. University of New Mexico
16. University of North Carolina at Chapel Hill
17. University of Pennsylvania
18. University of Utah
19. University of Virginia
20. Vanderbilt University
21. Washington University
22. Yale University

Cohort 2 (2018-2020)

1. Columbia University
2. Dana-Farber/Harvard Cancer Center
3. Dartmouth College
4. Emory University
5. Mayo Clinic
6. Memorial Sloan Kettering
7. Moffitt
8. Mount Sinai
9. Northwestern University
10. Oregon Health and Sciences University

Cohort 3 (2020-2021)

1. City of Hope Comprehensive Cancer Center
2. Fox Chase Cancer Center
3. Rutgers Cancer Institute of New Jersey
4. Thomas Jefferson University
5. University of Alabama at Birmingham
6. University of California, San Diego
7. University of Maryland
8. University of Southern California
9. University of Texas
10. University of Washington

11. Roswell Park
12. Stanford University
13. University of Arizona
14. University of California San Francisco
15. University of Michigan
16. University of Texas Southwestern
17. UPMC Hillman
18. Virginia Commonwealth University
19. Wake Forest University
20. Wayne State University

Sustainment of Tobacco Use Treatment Programs Across National Cancer Institute–Designated Cancer Centers

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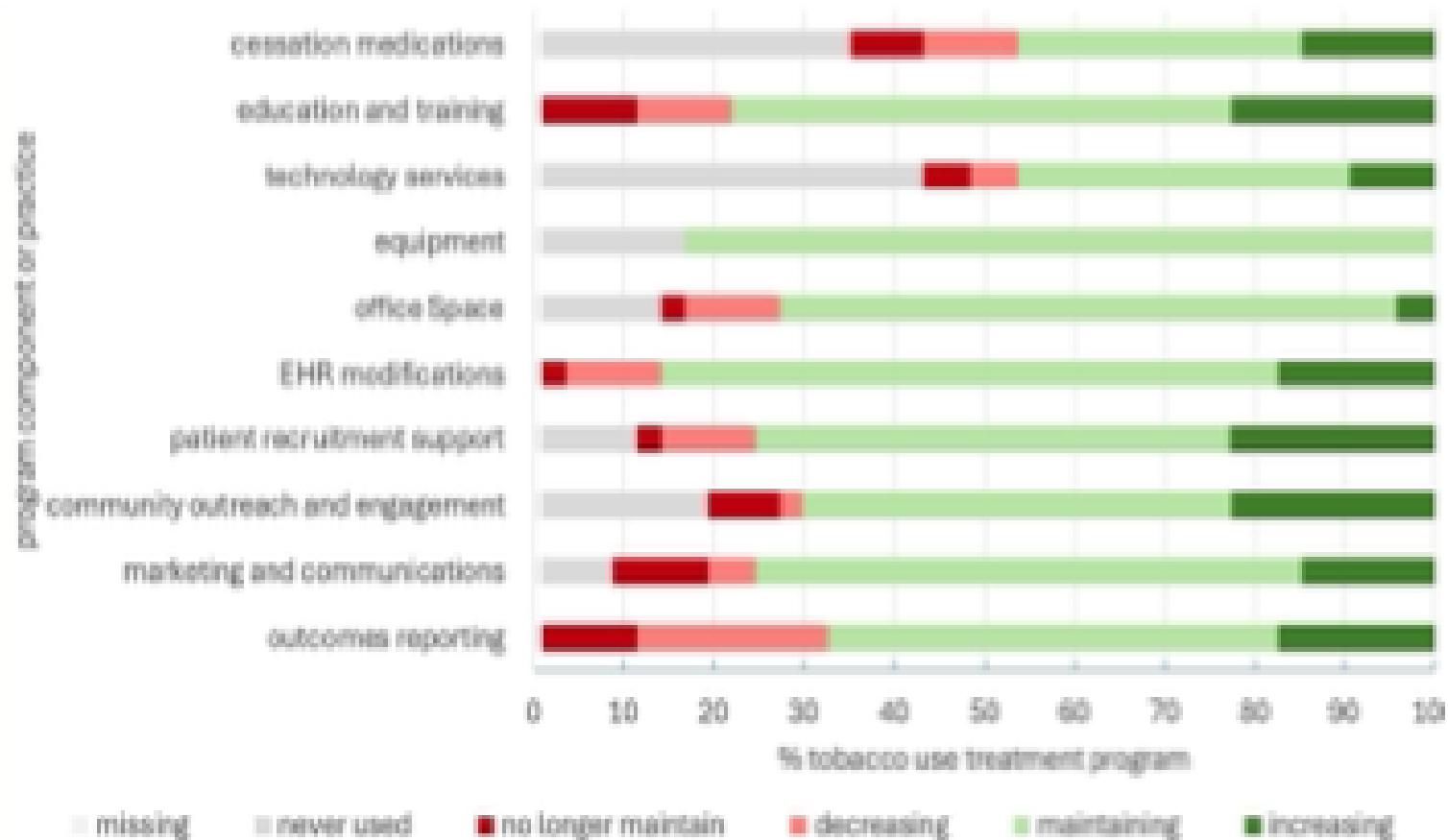


FIGURE 1 | Maintenance of tobacco use treatment program components and practices.

CoC Accreditation Standard 5.9

Smoking Cessation for Cancer Patients



Implementation Date: January 1, 2026

Standard 5.9: Smoking Cessation for Patients with Cancer

Definitions and Requirements

Cigarette smoking by patients with cancer and survivors causes adverse health outcomes. Smoking cessation at or following a cancer diagnosis improves cancer outcomes and enhances quality of life.

The cancer committee must implement a process for patients with newly diagnosed cancer to be screened for current smoking. Patients who report current smoking must receive or be referred for smoking cessation treatment consistent with evidence-based guidelines. Services to deliver evidence-based smoking cessation treatment must be available on site or by referral (for example to the state quitline).

For purposes of this standard, current smoking is limited to cigarette smoking.

<https://accreditation.facs.org/accreditationdocuments/CoC/Resources/SmokingCessation/Standard5.9.pdf>

CoC Accreditation Standard 5.9

Auditing Smoking Cessation Process

Each calendar year, the cancer committee must conduct an internal audit of a minimum of 20 patients with newly diagnosed cancer to determine:

- The number of patients with newly diagnosed cancer screened
- The number of patients with newly diagnosed cancer who reported current smoking
- The number of patients with newly diagnosed cancer who reported current smoking who received or were referred to smoking cessation treatment

The internal audit must include, at a minimum, 10 patients who currently smoke to determine whether they were referred. If the initial 20 medical records reviewed do not include 10 patients who currently smoke, additional medical records must be reviewed until at least 10 patients who currently smoke and their referral status are identified.

A refusal of a referral by the patient counts as a referral for purposes of the internal audit.

An action plan must be documented in the cancer committee meeting minutes if:

- Less than 90% of patients with newly diagnosed cancer received current smoking status screening, **and/or**
- Less than 80% of patients with newly diagnosed cancer were treated or referred to smoking cessation treatment

Sustainability?

How can we sustain clinical practice?

Research initiative? - FAIL

Voluntary compliance? – FAIL

Billing? – FAIL

Let patients deal with it themselves - FAIL

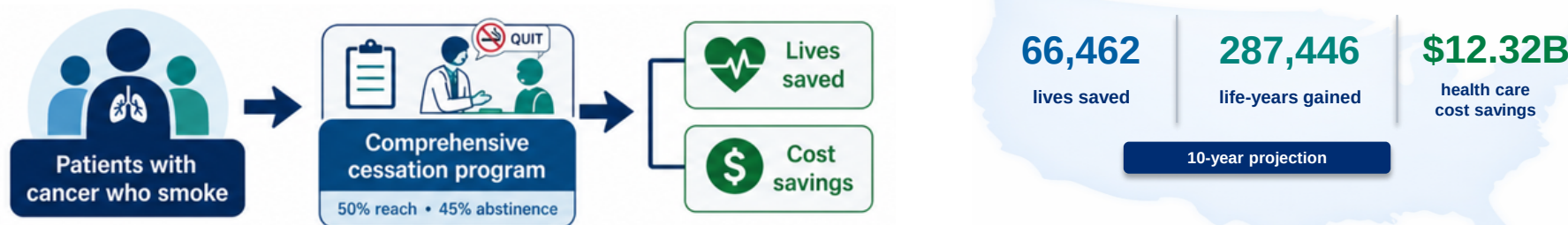
National prioritization? – Success?

Accreditation? – Success?

What if We Made This Happen...

Survival and Economic Benefits of Implementing Evidence-Based Tobacco Treatment Across US Cancer Care

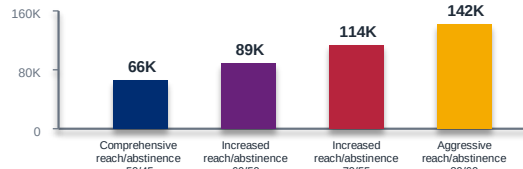
Comprehensive cessation programs can save lives and reduce health care costs nationwide.



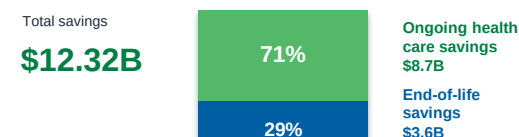
Lives saved over time



10-year lives saved by treatment scenario



Total cost savings over 10 years



Benefits accrue rapidly:
9,011 deaths averted in year 1.



Savings remain positive
even at substantial program costs.



Greater reach and quit success
produce even larger national gains.



Impact depends on:



Reach

Abstinence

Relapse



Embedding comprehensive tobacco treatment in oncology care is a high-value national strategy.

A Final Question, and Suggestion...

(from prior talks)

Is it malpractice to omit smoking from cancer care, and **is it** scientifically ethical to omit smoking from research?

Addressing tobacco in cancer care *may be* the EASIEST, CHEAPEST, and LOWEST TOXICITY approach to significantly improve patient outcomes

Advancing Suggestions?

IT IS malpractice to omit smoking from cancer care, and IT IS NOT scientifically ethical to omit smoking from research?

Addressing tobacco in cancer care *probably* is the EASIEST, CHEAPEST, and LOWEST TOXICITY approach to significantly improve patient outcomes