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Cancer Programs Webinar: Just Ask study

February 16, 2022

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Webinar Logistics

Cancer PROGRAMS

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- Questions will be answered as time permits; additional questions and answers will be posted on the website
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Agenda

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- Welcome
- Addressing Tobacco Use in Cancer Patients
- Why are We Doing this Project?
- Plan-Do-Study-Act| Educational Resources
- Quality Improvement Project – Evaluation Tools
- Review Surveys, Redcap, Application to Accreditation Standards
- Question and Answer
- Wrap up

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Introducing Our Moderator

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Laurie Kirstein MD, FACS
Attending Breast Surgeon
Memorial Sloan Kettering Cancer Center
Associate Professor
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Panelist

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Markey Cancer Center, Kentucky
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Introducing our Panelist

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Graham Warren M.D., Ph.D., F.A.S.C.O.
Professor and Mary M. Gilbreth Endowed Chair of Clinical Oncology
Vice Chairman for Research in Radiation Oncology
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Introducing our Panelist

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Achieving Quality Improvement In Cancer Programs

Addressing Tobacco Use in Cancer Patients

Timothy Mullett, MD, MBA, FACS

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The Challenge of Quality Improvement

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- Demonstration of effective quality improvement has been challenging or elusive in cancer programs
    - Quality Improvement Initiative Standard
    - Several different forms since 2012
    - Evidence-based strategies (DMAIC, PDSA, others)
        - Often not defined well in reports or in action
- Return to Screening PDSA
    - First effort to ‘package the process’
    - Driven by universal challenge of COVID on screening
    - Offer program to all programs
        - Uniformly successful

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Key Objectives

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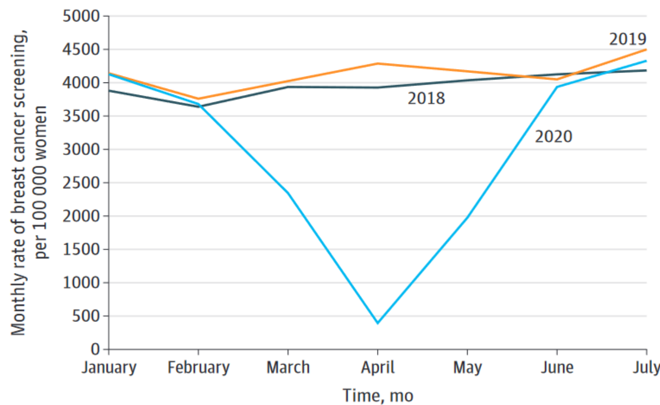
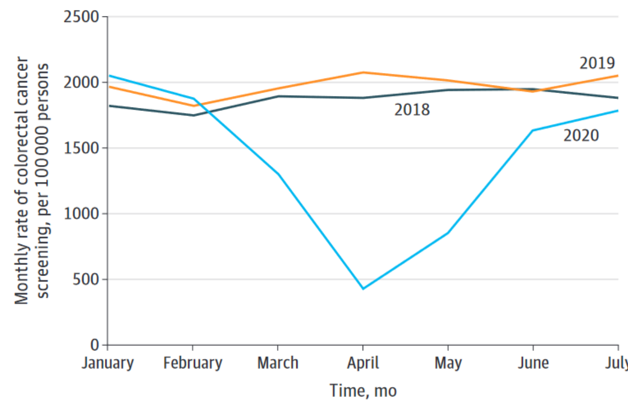
JAMA Oncology | Original Investigation

Association of Cancer Screening Deficit in the United States With the COVID-19 Pandemic

Ronald C. Chen, MD, MPH; Kevin Haynes, PharmD, MSCE; Simo Du, MBBS, MHS; John Barron, PharmD; Aaron J. Katz, PharmD, PhD





COVID-19 & CANCER | NCI DIRECTOR'S REPORT

Sharpless: COVID-19 expected to increase mortality by at least 10,000 deaths from breast and colorectal cancers over 10 years

3 KEY OBJECTIVES:

- Restore Screening
- Close 2020 Screening Deficit (9 million)
- Prevent Unnecessary Cancer Deaths

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Return To Screening Collaboration

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Collaboration

- **American Cancer Society**
- **Commission on Cancer (CoC)**
- **National Accreditation Program for Breast Centers (NAPBC)**

Goal: Accelerate Return To Screening

CoC and NAPBC enthusiastically embraced the concept of a prepared Quality Improvement Initiative

Over 900 projects were completed

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Building on RTS PDSA

- Several models for QI – confusing
- Follow PDSA
    - Familiar for programs
    - Reinforce process
- Narrow lane to achieve results
- Targeted interventions
    - Standardized with national partner
- Rapid development
    - 2022 timeline
- Consideration of future role of tobacco treatment in CoC Cancer Programs

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Tobacco Use Assessment Collaboration

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Collaboration

NCI – Cancer Center Cessation Initiative (C3I)
Commission on Cancer (CoC)
National Accreditation Program for Breast Centers (NAPBC)

Goal: Improve Fidelity of Tobacco Use Assessment in Cancer

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Tobacco and Cancer Task Force Members

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Name	Affiliation
Graham Warren, MD, PhD	Medical University of South Carolina
James Harris, MD	Western Surgical Group CoC Accreditation Committee Chair
Daniel Boffa, MD	Yale School of Medicine CoC Quality Integration Committee Chair
Ellen Hahn, PhD	University of Kentucky College of Nursing
Audrey Darville, APRN, PhD	University of Kentucky College of Nursing
Laurie Kirstein, MD	Memorial Sloan Kettering CoC Education Committee Chair
Jamie Ostroff, PhD	Memorial Sloan Kettering
Jessica Burris, PhD	University of Kentucky College of Public Health
Sarah Shafir, MPH	American Cancer Society
Tim Mullett, MD	University of Kentucky Thoracic Surgery CoC Chair
Elisa Tong, MD, MA	UC Davis Health
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Why are We Doing this Project?

Graham Warren M.D., Ph.D., F.A.S.C.O

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Smoking and the Continuum of Cancer Care

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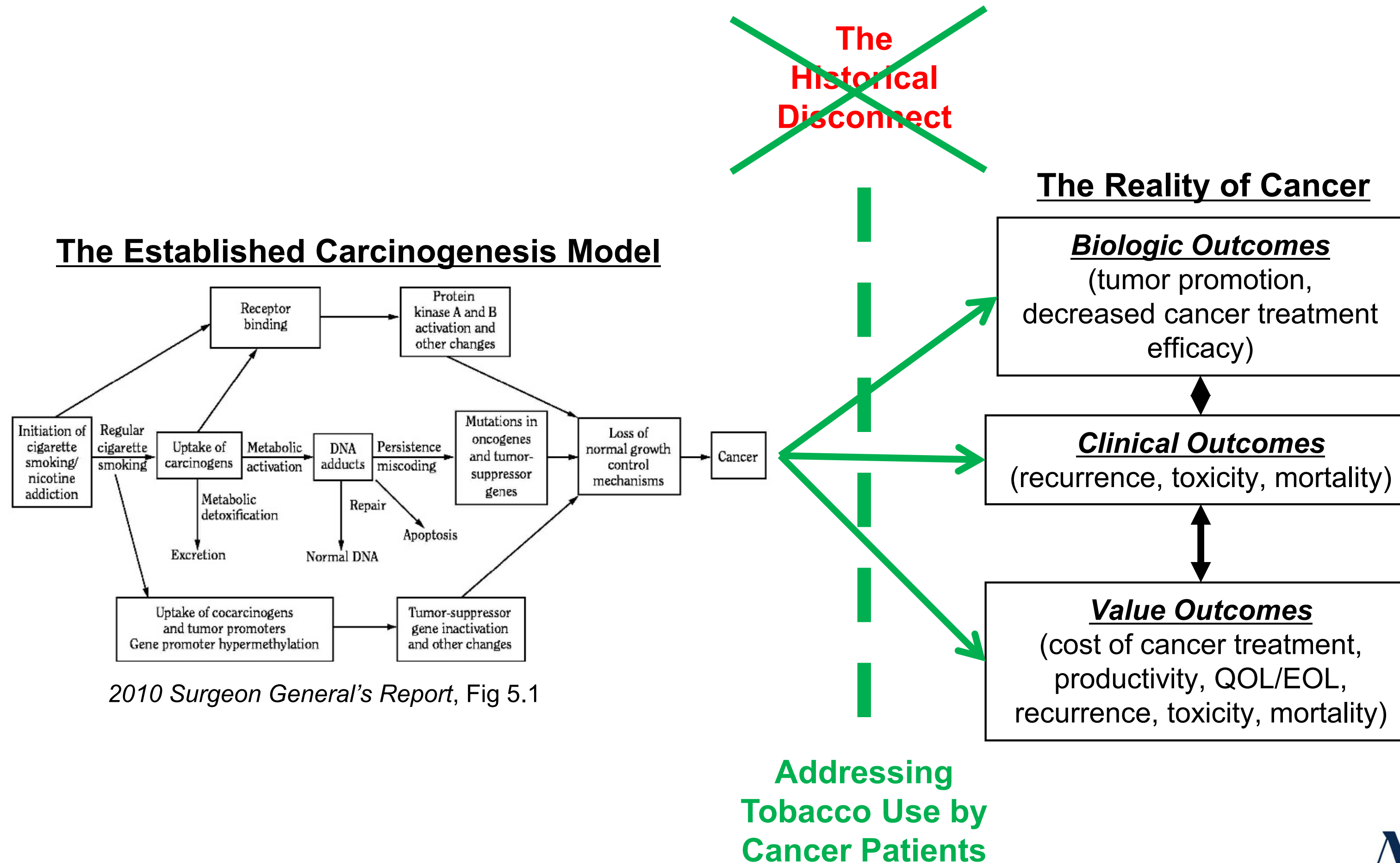

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Why is Addressing Smoking Important for Cancer Treatment?

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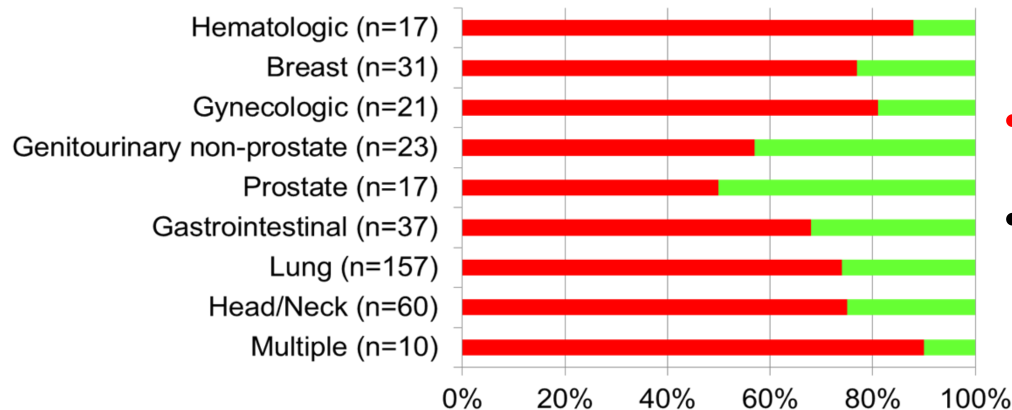
2014 SGR: >400 studies, 500K patients 1990-2012

Effect	Associations	Median RR
Overall Mortality (159 studies)	87%	**Current: 1.51** Former: 1.22
Cancer Mortality (58 studies	79%	**Current: 1.61** Former: 1.03



Overall Mortality Among 129 studies, 2013-17

- Smoking at diagnosis with 61% increased risk
- Smoking at follow-up with 113% increased risk

Financial Effects of Smoking at Diagnosis

- Smoking after diagnosis adds ~$3.4 billion in cancer treatment costs annually (2019 estimates)

Benefits of Smoking Cessation

- **Smoking cessation AFTER diagnosis associated with 45% median reduction in mortality**
- Smoking cessation AT ANY TIME reduces non-cancer mortality (heart disease, pulmonary disease, etc.)

2014 Surgeon General's Report
2020 Surgeon General's Report
GW Warren, C3I Spring Meeting 2021

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How Does this Compare with Other Practice Change?

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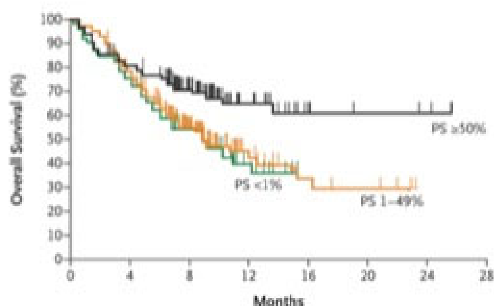
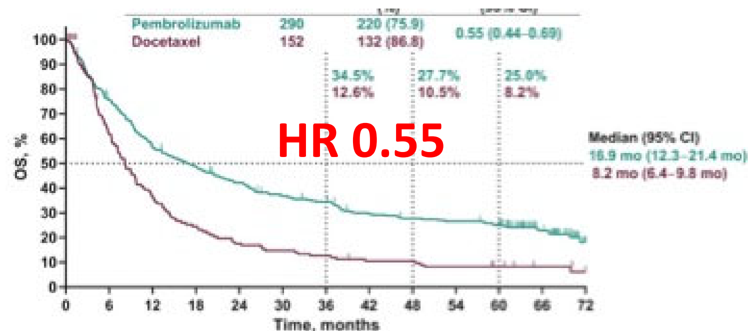
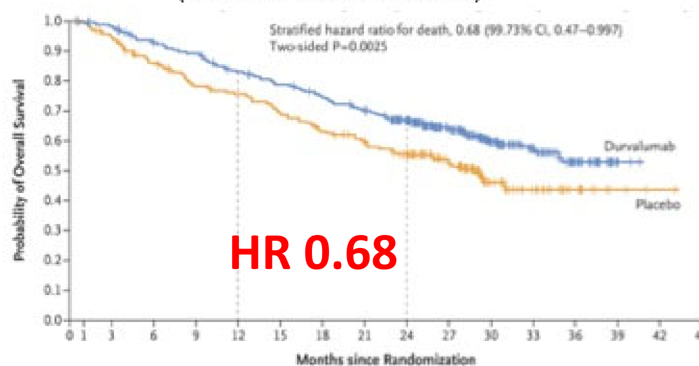


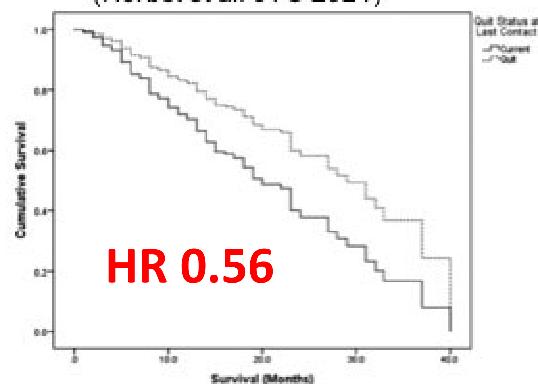
Overall Survival with Pembro by PD-L1 status, Keynote-001 (Garon et al. NEJM 2015)



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



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



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

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How Can We Begin to Address Smoking?

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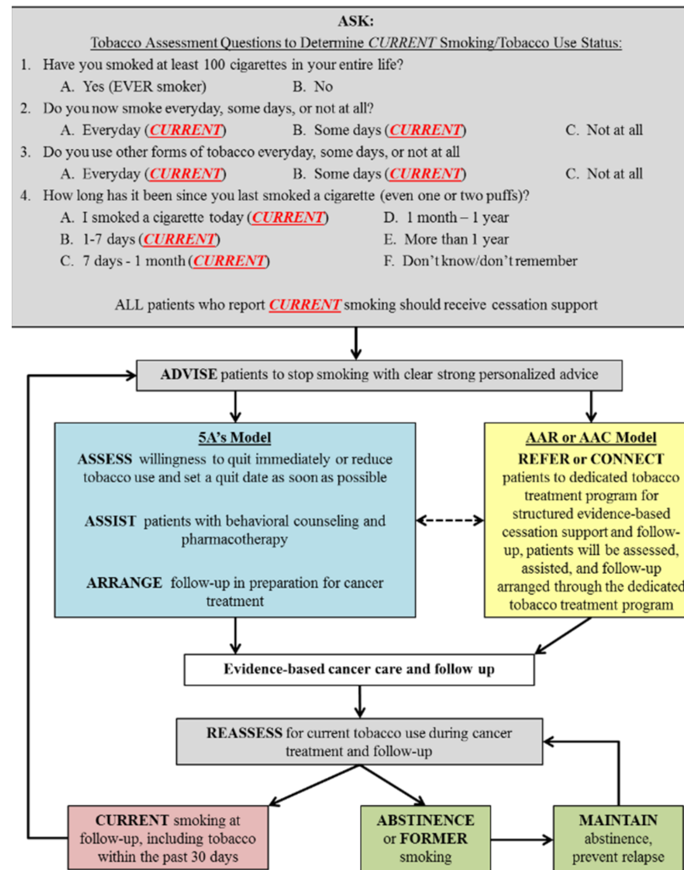
Deficiencies in Care

- Most institutions don’t incorporate smoking into cancer care
- Most oncologists don’t assist patients
- Most patients don’t receive help
- Most patients continue to smoke after diagnosis



Evidence-Based Care

- The 5A’s Model
  - **Ask**
  - Advise
  - Assess
  - Assist
  - Arrange
- The 3A’s/AAR/AAC Model
  - **Ask**
  - Advise
  - Assist, Refer, or Connect
- **Start by JUST ASKing all new patients about smoking**

Warren and Simmons. Ch. 33 DeVita *Principles and Practice of Oncology* 11th ed. 2018

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Purpose: JUST ASK All New Patients About Smoking

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ASK

- Ask all new patients about smoking
- Identify current smoking

ADVISE

- Continued smoking negatively affects cancer treatment
- Smoking cessation can improve survival

ASSIST, REFER, or CONNECT

- Clinicians can assist patients with quitting: counseling and medication
- Refer/Connect: institutional, community, or quitlines (1-800-QUIT-NOW)

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Purpose: JUST ASK All New Patients About Smoking

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The purpose of this PDSA is to improve ASKing for all new cancer patients

Advising or Assisting is encouraged, but WILL NOT be measured

ASK

- *Ask all new patients about smoking*
- *Identify current smoking*

ADVISE

- Continued smoking negatively affects cancer treatment
- Smoking cessation can improve survival

ASSIST, REFER, or CONNECT

- Clinicians can assist patients with quitting: counseling and medication
- Refer/Connect: institutional, community, or quitlines (1-800-QUIT-NOW)

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Plan-Do-Study-Act | Educational Resources

Elisa Tong, M.D. M.A.

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Quality Improvement Project Schema

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Part 1: Education

Participate in educational webinars as scheduled – encouraged but not required.

Part 2: Intervention

ASK all newly diagnosed cancer patients about smoking and report results:

1. Total number of newly diagnosed cancer patients seen.
2. Number of patients asked about smoking status.
3. Number of patients identified as currently smoking.

Part 3: Assessment

REDCap surveys due April 1, 2022, September 1, 2022 and February 1, 2023.

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PLAN – DO – STUDY - ACT

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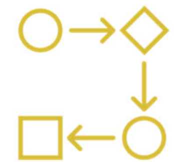
Step 1a: Assemble a team to discuss how assessment of smoking will be conducted

- Identify and convene stakeholders to engage involved in ASKing about smoking



Step 1b: Discuss specific and achievable goals for your cancer program.

- Share resources about the importance of addressing smoking in cancer care
- Assess current workflow. Define how your cancer program will complete ASK reporting requirements.

Step 1c: Create a plan to improve ASKing for all new cancer patients.

- Select intervention strategies to improve ASKing about smoking.
- Schedule calendar holds to attend educational webinars and complete assessments.

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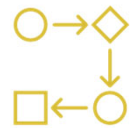

- Attend educational webinars with team members and providers.
- Implement selected intervention strategies

- Complete baseline survey assessment & follow-up assessments
  - Baseline data can be obtained retrospectively from the prior month, quarter, or year as available at your site.
  - Report core QI metrics.
    - How many new patients were seen? (denominator)
      - Definition of "new patient" may include those presenting for cancer workup, diagnosis, or start of treatment.

    - How many new patients have smoking status assessed? (numerator)
      - Definition of smoking status is in **Appendix 1**.

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PLAN – DO – STUDY - ACT

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- Monitor progress in ASKing about smoking status. Extract assessment data on a regular basis, preferably monthly from the electronic health record (EHR), to see if more patients are being ASKed about smoking.

- Meet with team members on a regular basis to discuss assessment data. Work to identify gaps, barriers, and systemic deficits related to ASKing (e.g., by patient characteristics, provider department, workflow, etc.).

- *The ideal program target goal should be to increase ASKing by 20% over baseline or achieve a >90% overall ASKing rate among new cancer patients. The proposed program target goal is not a required compliance criteria to meet standards for this project, but members should endeavor to improve ASKing as much as reasonably possible within their center.*

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PLAN – DO – STUDY - ACT

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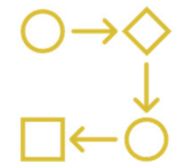
- Reflect on the success and challenges of the project.



- Refine intervention strategies with stakeholders and sustain the quality improvement.

- Present final results to the cancer committee.

- Consider future interventions to ASSIST patients with smoking cessation. Any site that wants to provide assistance to patients can refer patients to free state quit lines (1-800-QUIT-NOW), identify existing local smoking cessation programs, or assist patients directly with counseling and medications in clinic.

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Implementation Strategies

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PATIENTS

PROVIDERS

SYSTEM

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Smoking Status in the Electronic Health Record

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Social History: Tobacco Use

- Current every day smoker
- Current some day smoker
- Former smoker
- Never smoker
- Smoker, current status unknown
- Unknown if ever smoked
- Heavy tobacco smoker
- Light tobacco smoker

Suggested script & definitions:

"Have you ever smoked in your life?"
NO = Never smoker

"When did you last smoke?"
≥ 30 days = Former smoker

"How much do you smoke?"
Daily = Current every day smoker
>10 cigarettes/day = Heavy smoker

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For Providers

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Smoking and Cancer
What Healthcare Professionals Need to Know

Smoking Causes Cancer

One out of every three cancer deaths in the U.S. is related to cigarette smoking. Smoking causes 12 types of cancer, including cancers of the lung, larynx, oral cavity and pharynx, esophagus, pancreas, bladder, stomach, liver, colon and rectum, kidney and renal pelvis, cervix, and acute myeloid leukemia (AML). Additionally, secondhand smoke exposure causes lung cancer.

Research shows that, in both patients with cancer and cancer survivors, smoking:

- Increases the risk of death, including death from cancer.
- Increases the risk for development of additional primary cancers which are smoking-related.
- May increase risk of cancer recurrence.
- May result in poorer treatment response and increased treatment-related toxicity.

Smoking cessation protects against cancer and benefits both patients with cancer and cancer survivors. Healthcare professionals, particularly those in oncology care, should treat patients' tobacco use and dependence.

Smoking Cessation Protects Against Cancer

Smoking cessation is one of the most important actions people who smoke can take to improve their health and reduce their risk for cancer. This is true for all people who smoke, regardless of age or smoking duration and intensity. For patients with cancer, studies suggest that quitting smoking can significantly reduce mortality and improve their prognosis.

Benefits of Smoking Cessation

- Reduces the risk of 12 different types of cancer, including lung, larynx, oral cavity and pharynx, esophagus, pancreas, bladder, stomach, colon and rectum, liver, cervix, kidney, and acute myeloid leukemia (AML).
- After cessation, the risk of developing cancer (compared to continued smoking) drops over time:
  - 5 to 10 years after quitting: added risk* of cancers of the larynx, oral cavity, and pharynx drops by half.
  - 10 years after quitting: risk of cancers of the bladder, esophagus, and kidney decreases.
  - 10 to 15 years after quitting: added risk* of lung cancer drops by half.
  - 20 years after quitting: risk of cancers of the larynx, oral cavity, pharynx, and pancreas drops to close to that of someone who does not smoke.
  - 20 years after quitting: added risk* of cervical cancer drops by about half.

*The added risk of cancer above that of the general population which is linked to smoking.

Benefits of Smoking Cessation for Patients With Cancer

- Improves the prognosis of patients with cancer.
- May improve all-cause mortality in patients with cancer.

Clinical Interventions Work

Tobacco use and dependence is a chronic, relapsing condition that often requires repeated intervention and long-term support. Quitting can be hard, but evidence-based treatments (listed below) improve success.

- **Behavioral Counseling:** Counseling can be in person (one-on-one or in a group) or over a telephone quitline. Text messaging and web-based interventions also help people quit smoking.
- **Medication:** Seven medications are approved by the U.S. Food and Drug Administration (FDA) for smoking cessation (see text box).
- **Combining Treatments:** Counseling and medication are effective on their own, but using them together can more than double the chances of quitting. Combining long-acting NRT (patch) with short-acting NRT (e.g., gum, lozenge) also increases the chances of quitting.

FDA-Approved Medications

- **Nicotine Replacement Therapy (NRT)** reduces nicotine withdrawal symptoms and is available over the counter (patch, gum, and lozenge) and by prescription (inhaler and nasal spray).
- **Varenicline** is a nicotine receptor partial agonist available only by prescription. It reduces nicotine withdrawal symptoms (including craving) and reduces the rewarding effects of cigarettes by blocking nicotinic receptors.
- **Bupropion** is a dopamine and norepinephrine reuptake inhibitor with nicotine receptor antagonist properties. It reduces craving and other withdrawal symptoms and is available by prescription only.

The Entire Clinical Care Team Can Help

A team approach is the best way to treat tobacco use and dependence. Integrating treatment into the routine clinical workflow and engaging the entire healthcare team in treatment delivery can make a difference.

Advise Patients to Quit

- Talk to patients at every visit about their tobacco use. Even brief advice can influence a patient's decision to quit smoking.
- Advise patients that quitting is one of the most important things they can do to improve their health and prognosis.
- Remind patients that it is never too late to quit smoking. Quitting is beneficial at any age.
- Provide patients support, regardless of their readiness to quit.

Offer Patients Treatment

- Offer patients a combination of counseling and medications.

Refer Patients to Additional Support

- Refer patients to cessation resources and programs in your health system and community. You can also refer them to telephone quitlines (1-800-QUIT-NOW) and web- and text-based programs.

Follow Up With Patients

- Assess your patients' progress over time and provide additional support. It may take several attempts for them to quit smoking.
- Try new strategies, like new medications the patient hasn't tried, medication combinations, or new approaches to handling triggers.
- Provide ongoing support and encourage patients to keep trying and not give up.

Smoking Cessation Resources *for Clinicians*

- CDC resources: www.cdc.gov/TobaccoHCP; Caring for Cancer Survivors Who Use Tobacco available at www.cdc.gov/cancer/survivors/health-care-providers/tobacco-use.htm
- Million Hearts resources: Tobacco Treatment Protocol, Action Guide, and Change Package available at millionhearts.hhs.gov
- Treating Tobacco Use and Dependence, Clinical Practice Guideline: 2008 Update available at www.ahrq.gov
- U.S. Preventive Services Task Force: Tobacco Smoking Cessation in Adults, Including Pregnant Women: Behavioral and Pharmacotherapy Interventions available at www.uspreventiveservicestaskforce.org
- National Comprehensive Cancer Network Guidelines for Smoking Cessation available at www.nccn.org

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https://www.cdc.gov/tobacco/patient-care/care-settings/pdfs/cdc-osh-hcp-oncology-factsheet-508.pdf

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For Patients

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Quit Smoking
Before Your Operation

SURGICAL PATIENT EDUCATION PROGRAM
Prepare for the Best Recovery

Did you know that before surgery is the best time to quit smoking?

- ✓ You will decrease your risk of complications.
- ✓ Hospitals are a smoke-free environment, so you won't be tempted.
- ✓ The quit rate is much higher when you quit before your operation.

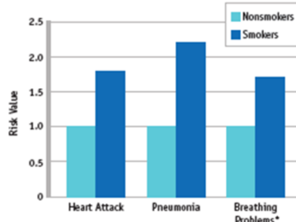
Do your part and quit now! *Your surgical team is here to help.*

Smoking Increases Your Risk of Heart and Breathing Problems[1]

Smoking increases the mucus in the airways and decreases your ability to fight infection. It also increases the risk of pneumonia and other breathing problems. Airway function improves if you quit 8 weeks before your procedure.

The nicotine from cigarettes can increase your blood pressure, heart rate, and risk of arrhythmias (irregular heart beat). The carbon monoxide in cigarettes decreases the amount of oxygen in your blood. Quitting at least 1 day before your operation can reduce your blood pressure and irregular heart beats.

Smokers have an increased risk of blood clots and almost twice the risk of a heart attack as nonsmokers.

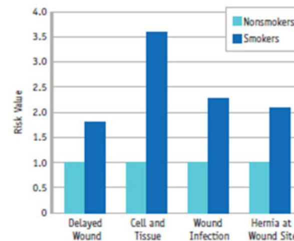


*Breathing problems such as coughing, wheezing, and low oxygen levels are increased in smokers.

A smoker is **2.2 times more likely to get pneumonia** than a nonsmoker. So if a nonsmoker has a 10 percent risk, a smoker has a 22 percent risk.[2]

Quit Smoking
Before Your Operation

Smoking Increases Your Risk of Wound Complications[3]



Oxygen is needed for your tissues to heal. Smoking can decrease the amount of blood, oxygen, and nutrients that go to your surgical site. **A smoker has almost 4 times the risk of tissue damage** at the surgical site.[4]

Smoking interferes with all phases of wound healing. It also decreases the ability of the cells to kill bacteria and fight infection. Having a wound infection increases the average length of stay by 2 to 4 days. Quitting 4 weeks before a surgical procedure reduces postoperative complications by 20 to 30 percent.

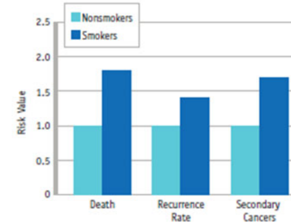
Studies identify that patients who smoke have:

- Increased wound infection and splitting open of the wound in patients having general surgery or hip and knee replacements.
- Increased sternal (chest bone) wound infection after coronary bypass surgery.
- Increased wound necrosis (tissue death) after mastectomy and breast reconstruction.
- Increased incisional and recurrent inguinal hernias.
- Lack of bone healing after orthopaedic surgery.
- Significantly higher rates of deep surgical site infections and re-operation following plastic surgery.[5]
- Greater pain intensity and higher amounts of narcotics needed for pain control.

Smoking Cessation at the Time of Surgery May Be the Best Time to Quit

- Smoking cessation counseling before a surgical procedure increases the quit rate.
- Multiple approaches (counseling plus medication and quit lines) work best to help you stay quit for life.
- You will most likely be receiving pain medication after surgery, which will decrease your withdrawal effects.

Smoking Increases Your Risk of Cancer Recurrence[6]



Smoking is known to cause 12 different types of cancer. **Cigarette smoking is the number one cause of lung cancer.**[6]

Secondhand smoke causes lung cancer in both children and adults who don't smoke.[7]

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Treatment

The following treatments are proven to be effective for smokers who want help to quit. Be sure to discuss with your doctor what is right for you.

- **Cold turkey:** Quitting on your own because you are motivated to have a successful surgery.
- **Smoking cessation counseling with your doctor/professional.**
- **Telephone counseling: Call the Quit Line at 1-800-QUIT-NOW (1-800-784-8669).** Help is free and all information is confidential.
- **Behavior therapy:** Training to help you cope when you want a smoke.
- **Medications, including:**
  - **Varenicline (Chantix)** and **bupropion SR (Zyban)** both require a prescription and are started 1 to 2 weeks before quitting.
  - **Nicotine replacement therapy (NRT)** delivers a safer source of nicotine than cigarettes, may decrease the withdrawal effect, and may help prevent overeating.
- **E-cigarettes are batte… nicotine and other ad… of an aerosol.** The FD… products for smoking c… harms in adults, teens, …

Medication	
Varenicline*	Or…
Bupropion*	Or…
Nicotine patch	Ap…
Nicotine gum	Ch…
Nicotine lozenge	Di…
Nicotine inhaler*	Sp…
Nicotine nasal spray*	Sp…

Helpful Resources

Call a Quit Line at 1-800-QUIT-NOW or 1-800-784-8669
SPANISH: 1-855-DÉJELO-YA (1-855-335-3569)
MANDARIN AND CANTONESE: 1-800-838-8917
KOREAN: 1-800-556-5564 VIETNAMESE: 1-800-778-8440

National Cancer Institute Tobacco Line
1-877-448-7848 (also available in Spanish)

American Lung Association
https://www.lung.org/quit-smoking

Government Quit Smoking Resources
http://teen.smokefree.gov
http://espanol.smokefree.gov
http://women.smokefree.gov

Center of Disease Control
Quit lines and access to all online state tobacco information:
https://www.cdc.gov/tobacco/basic_information/for-health-care-providers/quitlines-other/index.html

American Society of Anesthesiologists
https://www.asahq.org/about-asa/newsroom/news-releases/2019/03/psaw

References

1. Turan A, Mascha EJ, Roberman D, Turner PL, et al. Smoking and perioperative outcomes. Anesthesiology. 2011;114(4):837-846.

Quit Smoking
Before Your Operation

Your Action Plan. *Doing Your Part for the Best Surgical Recovery.*

My quit day is: ____________ *Pick the day and mark your calendar.*

Getting Help	My Action (Write in boxes below)
Call the quit line.	1-800-QUIT-NOW or 1-800-784-8669
Decide on a plan, like using nicotine replacement or going to a smoking cessation class.	My plan instead of smoking:
If you use varenicline or bupropion, take your dose each day leading up to your quit day as instructed.	Start date for medication:
Ask your friends and family to support you.	Who will help:
Remove all tobacco products from your home, car, and work.	I got rid of tobacco on: Sign:
Stock up on oral substitutes like gum or hard candy, carrot sticks, or straws.	What I like to chew on:
Think about any previous quit attempts and what worked and what did not.	What worked: What did not work:
On Your Quit Day	**My Action** (Write in boxes below)
Keep busy and active. Drink lots of water or fruit juice.	What I am doing instead:
Rely on your friends and family for encouragement.	Who is helping?
Avoid being around other smokers at first as much as possible.	I feel comfortable around:
Avoid alcohol or coffee if you associated them with smoking.	I need to avoid:
Change your routine and avoid situations where there is an urge to smoke.	What do I like to do when there is no smoking?

"I Can Quit" Plans ____________

This information is provided by the American College of Surgeons (ACS) to educate you about preparing for your surgical procedure. It is not intended to take the place of a discussion with a qualified surgeon who is familiar with your situation. The ACS has endeavored to present information for prospective surgical patients based on current scientific information; there is no warranty on the timeliness, accuracy, or usefulness of this content.

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https://www.facs.org/-/media/files/education/patient-ed/quit_smoking.ashx

For Peers: NCI Cancer Center Cessation Initiative – 52 Centers

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https://cancercontrol.cancer.gov/brp/tcrb/cancer-center-cessation-initiative

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Quality Improvement Project

Evaluation Tools

Jamie Ostroff, PhD

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Appendix 3: Assessment Form

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Overall goal is to describe current practices, barriers, strategies and readiness to adopt smoking cessation assessment and treatment at your cancer care setting.

Section I.	Background Information	15 items
Section II.	Current Smoking Assessment and Treatment Practices	12 items
Section III.	Implementation Barriers	11 items
Section IV.	Implementation Strategies	7 items
Section V.	Organizational Prioritization	4 items
Section VI.	Clinical Data Reporting and Metrics (ASK)	4 items

Estimated Time for Completion of Sections I. to V. 60 mins

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Section I. Background Information

Rationale

- To describe your cancer care setting
- These questions focus on describing relevant setting characteristics and contextual background

Screen Shot/Sample Items

Appendix 3: REDCap Evaluation Tool

These data are collected at baseline (by April 1, 2022) and will be evaluated again by September 1 2022 and February 1, 2023 after initiation of the QI project at your site.

Section I. Background Information. The section provides background information about your site.

Date of completion of form	
Name of individual completing form	
Email of individual completing form	
Name of CoC Facility	
Facility CoC ID Number (FIN #)	
CoC Cancer Program Category	○ Academic Comprehensive Cancer Program ○ Community Cancer Program ○ Comprehensive Community Cancer Program ○ Freestanding Cancer Center Program ○ Hospital Associate Cancer Program ○ Integrated Network Cancer Program ○ NCI-Designated Comprehensive Cancer Program ○ NCI-Designated Network Cancer Program ○ Pediatric Cancer Program ○ Veterans Affairs Cancer Program

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Section II. Current Smoking Assessment and Treatment Practices

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Rationale

- To describe your current clinical practices for assessing smoking status and providing smoking cessation treatment to patients who currently smoke

Screen Shot/Sample Items

Section II. Smoking Assessment and Smoking Cessation Practices

The following questions ask about tobacco assessment and treatment services that are currently available for **newly** diagnosed cancer patients treated at your setting. Please indicate how frequently your oncology care providers do the following during new visits:

	Always	Most of the time	Sometimes	Rarely	Never
ASK patients whether they currently smoke cigarettes or use other types of tobacco products.					
ADVISE patients who smoke to quit.					
ASSIST patients who smoke to quit.					
Document smoking status/tobacco use in					

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Section III. Implementation Barriers

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Rationale

- To describe your perceived challenges in assessing smoking status and providing smoking cessation treatment to patients who currently smoke

Screen Shot/Sample Items

Section III. Implementation Barriers

To what extent do you perceive these barriers for promoting smoking cessation among cancer patients who are current smokers at your cancer care setting?

	Completely Agree	Somewhat Agree	Neither Agree or Disagree	Somewhat Disagree	Completely Disagree
Lack of staff time for counseling.					
Lack of staff training in smoking cessation interventions.					

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Section IV. Implementation Strategies

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Rationale

- To consider the feasibility and effectiveness of several potential implementation strategies for improving delivery of smoking assessment and treatment at your setting

Screen Shot/Sample Items

Section IV. Implementation Strategies

The next set of questions focus on the potential implementation strategies for actively improving the delivery of smoking cessation treatment at your cancer care setting. Please read each statement and indicate which ones seem feasible and/or effective for your site. **Which strategies do you think would be feasible and effective in improving delivery of smoking assessment and treatment at your site (check all that apply):**

	Feasible	Effective
Staff/Clinician Training.		
Gain support of site leadership.		

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Section V. Organizational Priority and Readiness

Rationale

- To consider the organizational readiness for improving delivery of smoking assessment and treatment at your setting

Screen Shot/Sample Items

Section V. Organizational Readiness and Priority

The next set of questions focus on the organizational readiness for delivering smoking cessation treatment at your cancer care setting. Please read each statement and indicate which response best reflects your setting's readiness to implement tobacco use assessment and treatment.

	Agree	Somewhat Agree	Neither Agree or Disagree	Somewhat Disagree	Disagree
People who work here are committed to implementing tobacco use assessment and treatment.					
People who work here are motivated to implement tobacco use assessment and treatment.					

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Section VI. Clinical Data Reporting and Metrics (ASK)

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Rationale

- To provide clinical data on the quality of assessing smoking status at your cancer care setting during pre-specified timeframes

Screen Shot/Sample Items

Section VI. Clinical Data Reporting and Metrics (ASK):
These data are collected at baseline (by April, 1, 2022) and again by September 1, 2022 and February 1, 2023 after initiation of the QI project at your site

For this reporting period, please extract data (numerator and denominator) and report ASK metrics from ….	… the following time periods: **January 1 to December 31, 2021 by April 1, 2022 in the baseline REDCap survey; **January 1 – June 30, 2022 in the second REDCap due September 1, 2022; and **July 1 – December 31, 2022 in the third REDCap due February 1, 2023.
What clinical setting are you analyzing?	Choose one reply o A single clinical setting (describe) o Multiple clinical settings (describe) o All cancer patients seen at this facility
How many new patients were seen during this baseline period? (DENOMINATOR)	
How many new patients were ASKed about smoking during a cancer workup, diagnosis, or initial consultation for cancer treatment? (NUMERATOR)	

How many patients reported current smoking? (NUMERATOR)	

DRAFT

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Review Surveys, Redcap, Application to Accreditation Standards

Erin DeKoster Reuter

ACS AMERICAN COLLEGE OF SURGEONS

Credit for CoC and NAPBC Standards

Completing the PDSA QI project will fulfill the following CoC Standards:

- Quality Improvement Initiative 7.3
- Cancer Prevention Event 8.2
- Clinical Research Accrual 9.1

Completing the PDSA QI project will fulfill the following NAPBC Standards:

- Cancer Prevention, Education, and Early Detection Programs 4.1
- Quality and Outcomes 6.1 (counts toward one of two studies)

Programs can claim either CoC credit or NAPBC credit, but not both.

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Next Steps

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Full study protocol will be posted to the ACS Cancer Programs website by early March

- The recording of today's webinar & a FAQ will be posted to the web page

The baseline REDCap assessment/survey will be released in early March to be completed by participating programs by **April 1, 2022**

- Additional assessments/surveys will need to be completed by **September 1, 2022** and **February 1, 2023** to count towards compliance

Three webinars are planned throughout the year to support the study (attendance is encouraged but not required)

The above will be communicated via emails and in the Cancer Programs Newsletter

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Conclusion

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- Tobacco use in cancer patients has a negative impact on:
  - Compliance
  - Recurrence Rates
  - Overall Mortality
- Tobacco treatment during cancer treatment improves outcomes
- Assessment and documentation of tobacco use in the cancer care setting is variable
- The PDSA Quality Improvement Initiative is designed to help us take the FIRST step in getting cancer patients at risk for tobacco-related complications the treatment they need

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Question and Answer

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Cancer Programs has Continuing Education Credits

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Physician's, Nurse's, or Certified Tumor Registrar's Cancer Programs offers free education credit courses on our learning management system (LMS). Below is a short list of some of our courses at *Learning.facs.org*:

- AJCC yc Stage Classification—When and How to Use
- Registrar's Guide to Updating Radiation Data Items
- AJCC Cervix Uteri – Version 9 Cancer Staging System
- *Survivorship Program: Standard 4.8
- *Operative Standards for Cancer Surgery: Standards 5.3-5.8
- *Taking the Mystery Out of QI Projects Per Standard 7.3: A How-to Guide
- *Oncology Nursing Credentials: Standard 4.2
- NAPRC: Practical Tips, Pearls, and Advice from the Trenches PART 1 and 2
- *Surgical Emergencies in Advanced Cancer Patients
- *Surgical Oncology for the General Surgeon
- *Pelvic MRI for Rectal Cancer: Tips on Interpretation
- CAnswer Forum LIVE – 2019-2021

**CME offered*

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