

National Cancer Institute Conference on Treating Tobacco Dependence at Cancer Centers

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Introduction

Despite prevention efforts, changes in social policy, and the advent of effective medications for tobacco dependence, 21% of the US population currently smokes. Further, upward of 50% of patients with cancer who were smokers before their diagnosis continue to smoke, and, even for patients who are able to quit after their diagnosis, relapse rates are substantial. Tobacco use is the leading cause of preventable death in the United States, and continued smoking by patients with cancer can reduce medical treatment effectiveness and diminish quality of life.

The National Cancer Institute (NCI) cancer centers represent nodal points to treat tobacco dependence. NCI cancer centers possess the credibility to help smokers quit, and with the greater life expectancies forecast for patients with cancer, addressing smoking at cancer centers has taken on greater importance. Consequently, in December 2009, the NCI Tobacco Control Research Branch and the Office of Cancer Survivorship sponsored a 1-day meeting at the National Institutes of Health on treating tobacco dependence at NCI cancer centers. This meeting (1) highlighted the importance of treating tobacco dependence in the context of cancer care and survivorship, (2) reviewed guidelines for treating tobacco dependence in the context of cancer care and survivorship, (3) discussed models for tobacco dependence treatment in the oncologic context, (4) discussed barriers to the implementation of tobacco dependence treatment in cancer centers, (5) reviewed strategies to overcome barriers to cessation treatment in cancer settings, and (6) explored scientific questions related to tobacco dependence treatment that require further study. Representatives from each NCI cancer center were invited. The meeting included talks from the NCI and experts in the field, panel discussions, and question-and-answer sessions; 65 members from 40 cancer centers participated. This meeting and overview may help build capacity for the delivery of tobacco dependence treatment at NCI cancer centers.

The Problem

Smoking causes 30% of all cancers and 80% of mortality from head and neck and lung cancer.¹⁻³ Despite policy and scientific

advances, 21% of Americans currently smoke tobacco, upward of 50% of patients with cancer who smoked before diagnosis continue to smoke,⁴ and relapse rates after completion of medical treatment are high.⁵ There are more than 11.7 million cancer survivors in the United States, including more than 325,000 adult survivors of childhood/adolescent cancer.⁶ Upward of 25% of survivors are smokers, including 14% of adolescent cancer survivors.⁷ Continued smoking by patients and survivors decreases survival time,⁸ increases risk for a second primary cancer,⁹ reduces medical treatment effectiveness,^{10,11} and diminishes quality of life after treatment.^{12,13}

Patients with cancer who try to quit smoking typically do so without formal assistance,¹⁴ which yields low success rates.¹⁵ Further, the provision of tobacco use treatment is not considered a “core service” at most NCI cancer centers. The results of a survey of tobacco use treatment at 58 NCI cancer centers presented at this meeting for the first time¹⁶ showed that, although 60% of cancer centers offered some form of tobacco use treatment, such services were often confined to one disease subpopulation (eg, lung cancer). Fewer than half of the cancer centers have designated personnel to offer tobacco use treatment. The availability of tobacco use treatment programs at cancer centers lags behind that of other models of care (eg, nutrition).

What’s Needed

An important first step in encouraging cancer centers to address tobacco dependence is to improve systems for identifying smokers and referring them to suitable treatment programs. A uniform measure of smoking status for patients at each visit can triage patients into effective treatments and assess clinical effects of continued smoking.¹⁷ Including tobacco use as a “vital sign” on patient medical charts increases the rate of identification of smokers, rates of treatment, and cessation rates.^{18,19} Currently, fewer than half of the 58 cancer centers assess smoking status as a vital sign,¹⁶ yet this procedure is cheap, simple, and effective.

Treatment Guidelines

The US Public Health Service’s *Treating Tobacco Use and Dependence Clinical Practice Guideline* identifies effective treat-

Table 1. Treatment Models at Cancer Centers

Program Characteristics	Programs			
	Massachusetts General Hospital	Memorial Sloan-Kettering Cancer Center	MD Anderson	Moffitt
Identification of tobacco users	Electronic assessment at admission, computerized order entry, electronic referral	Inpatient and ambulatory nursing assessment	Referral by health care provider, self referral, electronic referral at follow-up appointments	Comprehensive admission assessment interview (EMR)
Eligibility	Current smokers, recent quitters (past 12 mo)	Current smokers, recent quitters (past 30 d)	Current smokers, recent quitters (past 12 mo)	Current smokers, recent quitters (past 90 d)
Treatment intensity	Level 4	Level 4	Level 4	Level 3
Treatment modality	Individual counseling at bedside, referral to quit line or internal automated phone reminder system with call-back option, self-help guide	Individual face-to-face, telephone counseling	Individual face-to-face counseling, telephone and Webcam counseling	Cessation classes
Funding source(s)	Hospital operating budget/clinical revenue	Hospital operating budget/clinical revenue	State tobacco settlement funds	Hospital operating budget

NOTE. Level 1: hospital contact for < 15 minutes and no discharge support; level 2: hospital contact for > 15 minutes and no discharge support; level 3: any hospital contact and postdischarge support lasting 1 month or less; level 4: any hospital contact and postdischarge support lasting more than 1 month.

ments and clinical practices.¹⁸ The *Guideline* underscores that tobacco dependence is a chronic disease with the need for repeated intervention. Interventions as brief as 3 minutes can help smokers who are ready to quit to utilize effective treatments, motivate smokers who are not ready to quit to consider treatment, and reduce the risk of relapse among patients who have recently quit smoking.¹⁸ Health care providers are advised to offer, or facilitate access to, counseling and guideline-recommended medications, which are most effective when combined. Approved medications include nicotine replacement therapy (gum, patch, nasal spray, inhaler, lozenge), bupropion, and varenicline. The extended use or combination of these medications does not present a known health risk and may increase abstinence.¹⁸ Because quit-line counseling is available in all states, has broad reach, and is effective in diverse populations, clinicians could use this resource as an option.

What’s Needed

Few studies have examined tobacco dependence interventions for patients with cancer and survivors, especially among adolescents. Many existing trials have used small samples and lacked biochemical verification.²⁰⁻²² Only one placebo-controlled trial of an FDA-approved pharmacotherapy agent has been conducted in patients with cancer,²³ and only one large smoking cessation clinical trial has been conducted with adolescent survivors²⁴; a second trial with childhood cancer survivors is underway.²⁵ Cancer centers can play a pivotal role in designing and implementing studies and evaluating methods for dissemination of treatments. Studies could evaluate the use of the full cancer treatment team (*v* a single interventionist) or could examine the optimal timing or duration of tobacco use treatment. Developing and testing novel behavioral interventions is an important direction for future research, as are models that include family members in, or as targets of, the intervention. Research is needed on how to integrate cessation treatment into care delivery and how to sustain cessation. The integration of tobacco use treatments into cancer centers should be guided by existing guidelines and innovative research.

Treatment Models

The meeting highlighted tobacco dependence treatment programs at four cancer centers. These programs are summarized in Table 1 but include the following components:

- Multidisciplinary team for establishing policies and practices.
- Standardized screening method to identify all smokers at intake and throughout clinical care.
- Tobacco treatment specialists.
- Intake to guide treatment planning and initiate referrals for more intensive treatments.
- Counseling to build motivation and coping skills and to prevent relapse.
- Liaison with oncology care team and education on cessation medications.
- Staff and patient education about the benefits of cessation and risks of continued smoking.
- Tobacco cessation research programs that complement and benefit from clinical service.
- Collection and monitoring of cessation outcomes and quality of care performance data.

Barriers to Implementation

Despite supportive policies from oncologic organizations,²⁶⁻²⁸ treatment for tobacco dependence is still not part of standard cancer care, and only 7% of cancer clinical trials assess smoking status.²⁹ Barriers to the provision of tobacco dependence treatment in the oncologic context are common across health care settings (eg, lack of physician time²⁸). Unique barriers and strategies to overcome these barriers³⁰ are reviewed below and in Table 2.

Patients who smoke might not request help because of their guilt over smoking,³¹ fear of being stigmatized,³² or fatalism about their disease.³³ Variability in patient smoking over time (eg, high quit rates at diagnosis but high relapse rates), hinders identification. Patients with cancer show high levels of nicotine dependence,³⁴ possibly requiring combination³⁵ or extended³⁶ treatments. Enforced abstinence as a result of no-smoking pol-

Table 2. Strategies to Address Barriers to Implementation of Tobacco Dependence Treatment in Comprehensive Cancer Centers

Barriers/Challenges	Strategies
Health care providers	
Lack of awareness of tobacco use as a major factor in cancer control	Provide continuing education programs for oncology professionals within cancer centers.
Limited knowledge about tobacco dependence treatment as a result of lack of content in professional education, licensure, and oncology specialty examinations	Ensure that tobacco control is included as part of fellowship/graduate programs/certification examinations in oncology.
Lack of awareness of Clinical Practice Guideline	Conduct and evaluate media campaigns on the importance of tobacco dependence treatment targeting oncology healthcare professionals.
Lack of awareness of available resources	Access existing resources (Table 2).
Limited leadership	Identify oncology champions/coordinators to spearhead implementation and evaluation of tobacco interventions and to lead advocacy efforts. Recruit leaders across professional groups and consider strategic alliances with tobacco control groups.
Negative attitudes, including the perception that patients are not motivated to quit and frustration when smokers relapse; patient guilt or fatalism	Include information about Motivational Interviewing strategies in educational programs. Dispel myths and misconceptions about tobacco dependence treatment and provide a foundation for understanding the power of the addiction.
Lack of time or not a priority	Brief interventions are effective and all tobacco users deserve an intervention. A team approach, using a variety of healthcare professionals, may reduce the time needed by a single individual. A designated tobacco counselor may be useful for those who need more intensive treatment. Support and follow-up by telephone quit-line.
Smoking among health care professionals	Develop/expand tobacco dependence treatment for all employees.
Institutional/System	
Tobacco dependence treatment not a vital aspect of cancer care in many institutions. Not included as a metric of quality, care and provider interventions not recognized	Encourage cancer centers to develop a system for identifying smokers and referring to tobacco dependence treatment. Encourage cancer centers to make treatment of tobacco dependence part of their core mission and strategic plan. Encourage centers to develop outstanding models of care and publication in professional journals and in communications to the public.
Lack of comprehensive tobacco assessment and dependence treatment	Include ongoing assessment of tobacco use of all patients on all medical records. Indicate delivery of advice to quit, the provision of counseling, pharmacotherapy, and methods for monitoring and addressing relapse. Assess exposure to secondhand smoke. As appropriate, include assessment and support for family members.
Limited incentive for intervention	Hold a leadership summit to develop strategies to integrate tobacco dependence treatment as part of quality cancer care and public policy. Develop a quality improvement mechanism for ongoing assessment and feedback on implementation of tobacco dependence within the cancer center.
Limited patient and family awareness of the importance of quitting tobacco use and decreasing exposure to second-hand smoke	Provide patient-friendly materials about quitting, including information about the Quit-line, the role of medications and the importance of family support. Create materials specific to the cancer center. Increase patient demand through a media campaign focusing on special resources at the cancer center.
Limited insurance coverage for intervention	Develop a system to clearly identify the types of coverage by various insurers.
Lack of awareness of existing coverage in different public and private plans	Engage oncology leadership in collaborative efforts to promote coverage by insurers.
Limited space and resources	Provide data about the effectiveness of tobacco dependence treatment to cancer center leadership to support need for space allocation and resources. Support for in-house tobacco treatment specialists/coordinators may improve quality care.
Policy	
Lack of comprehensive smoke-free campus policies	Develop policies and strategies to ensure that Cancer Centers are smoke-free.
Limited implementation of existing tobacco control policies in guiding oncology practice	Encourage professional organizations to develop and evaluate the implementation of policies.
Lack of recognition of quality programs	Changes in the Joint Commission Quality Indicator for tobacco dependence treatment to increase awareness of outstanding organizational efforts. Highlight model programs on NCI website.
Research	
Limited research in tobacco dependence treatment and patients with cancer	Provide opportunities within and between cancer centers for discussions and collaborations between oncology and tobacco control researchers.
Few oncology researchers are experts in tobacco control and vice versa	
Lack of inclusion of tobacco use in cancer clinical trials	Encourage cancer centers to make data collection about tobacco use essential to any human cancer trial.

icies can be aversive, reducing future quit attempts. Treatment options may be limited by medical contraindications, including trouble swallowing, or by depression; these conditions may require specialized treatments.^{37,38}

Health care providers may lack awareness of the prognostic importance of smoking, lack the skill to treat smoking, or worry about exacerbating patient guilt. Many cancer centers have inadequate procedures to identify patients who smoke and triage

Table 3. Selected Resources for Patients, Health Care Professionals, and Institutions to Support Education and Treatment of Tobacco Dependence in Cancer Centers

Resource Type	Location
Agency for Healthcare Research and Quality's Clinical Practice Guideline	http://www.ahrq.gov/path/tobacco.htm
Telephone quit line: online smoking cessation counseling	1-800 Quit-Now; http://www.naquitline.org/?page=AboutNAQC
National Cancer Institute's Smokefree.gov: online quitting assistance	http://www.smokefree.gov/
Center for Tobacco Research and Intervention at the University of Wisconsin: materials for health care providers, researchers, smokers, insurers, employers, and advocates	http://www.ctri.wisc.edu/
Association for the Treatment of Tobacco Use and Dependence: lists of tobacco dependence treatment training programs	http://www.attud.org/findprog.php
National Alliance for Tobacco Cessation: online smoking cessation program	http://www.becomeanex.org/
Smoking Cessation Leadership Center at University of California, San Francisco	http://smokingcessationleadership.ucsf.edu/
Destination Tobacco Free: A practical tool for hospitals and health systems provides detailed support for implementing a tobacco-free policy	http://smokingcessationleadership.ucsf.edu/HospitalSF.htm
Tobacco-Free Nurses: resources for nurses including a library of publications	www.tobaccofreenurses.org
American Cancer Society: materials on tobacco for health care professionals and patients, including the Quit for Life telephone-based counseling program offered through Free and Clear	http://www.cancer.org/docroot/PED/ped_10.asp
Resources for patients with mental health and substance abuse disorders	http://smokingcessationleadership.ucsf.edu/BehavioralHealth.htm http://smokingcessationleadership.ucsf.edu/Downloads/MH/Toolkit/NASMHPToolkit.pdf
Society for Nicotine and Tobacco Research: provides links and information to latest research about tobacco	http://www.srnt.org

them to treatments. The Joint Commission may include documentation of tobacco use status, delivery of treatments, and provision of follow-up care as a quality indicator.³⁹ The transition to electronic medical records may incorporate tobacco use as a vital sign¹⁹ and use electronic reminders to ensure compliance with repeated assessments and treatment referral.²⁰

Given practical constraints, it is unreasonable to expect that health care providers can provide comprehensive tobacco dependence treatment. Nevertheless, tobacco dependence treatment must become a greater priority at cancer centers. The burden of treatment can extend beyond the oncologist to include nurses, pharmacists, psychologists, and social workers. Referral to in-house or community-based treatments or quit lines is essential. Resources are available to assist with the integration of tobacco use assessment and treatment into cancer centers (Table 3).

Summary

The convergence of motivated and talented clinicians, enhanced technology, treatment guidelines, models of care, and evolving hospital accreditation standards may accelerate progress in treating tobacco dependence at NCI cancer centers. With a constituency of close to 12 million Americans living with cancer,⁶ cancer centers have the opportunity to be the exemplars in tobacco dependence research and treatment. Cancer centers, with their talented and committed faculty, are optimally positioned to perform cutting-edge research, inform the field of tobacco dependence treatment, and meet the call to action from the NCI⁴⁰ and ASCO.²⁷ The Treating Tobacco Dependence at Cancer Centers meeting served as a springboard to develop or refine center approaches to treating tobacco dependence and expanded and energized the community of scientists devoted to this endeavor. Priorities to enhance the

quality of care for tobacco dependence at cancer centers include (1) developing consensus regarding the assessment of smoking status, (2) refining electronic medical records and clinical trials to ensure the identification and referral of smokers, (3) evaluating novel treatments for cancer patients, and (4) evaluating methods to overcome barriers to providing smoking cessation treatment. The academic resources at cancer centers and the motivation and commitment of cancer center representatives suggest that the future will see cancer centers leading the way in treating tobacco dependence and contributing substantially to further reductions in tobacco-related morbidity and mortality.

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