Beyond ASK: Removing Roadblocks for Cessation Counseling and Medications

December 15, 2023
All participants are muted during the webinar

Questions – including technical issues you may be experiencing – should be submitted through the question pane

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

Please complete the post-webinar evaluation you will receive via email
Introducing our Moderator

Timothy Mullett, MD, MBA, FACS
Thoracic Surgery, University of Kentucky
Markey Cancer Center, Kentucky
Chair, Commission on Cancer
Introducing our Panelists

Richard Matulewicz, MD, MSCI, MS
Urologic Surgeon, Memorial Sloan Kettering Cancer Center (MSK)

Elisa Tong, M.D, M.A
Director, Tobacco Cessation Policy Research Center
Medical Director, Stop Tobacco Program and Assistant Director, Population Sciences, UC Davis Comprehensive Cancer Center
Professor, Division of General Internal Medicine

Danielle, McCarthy, Ph.D
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Division of General Internal Medicine
Department of Medicine
University of Wisconsin School of Medicine and Public Health

Jonathan Kempfert, PharmD
Clinical Pharmacist
University of Wisconsin School of Medicine and Public Health
Agenda

- Welcome
- Data Review
- Clinician Delivery - Dr Matulewicz
- Strategies for No Cost Medication - Dr Tong
- Pharmacists Role in Tobacco Treatment - Dr Kempfert and Dr McCarthy
- Wrap up
- Q & A
Current Practices, Perceived Barriers, and Promising Implementation Strategies for Improving Quality of Smoking Cessation Support in Accredited Cancer Programs of the American College of Surgeons

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Ask and Assist Trends (All)

• *April to October

Ask Rate

Assist Rate

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# Top 3 Strategies For Assisting—
(nearly all or most)

<table>
<thead>
<tr>
<th>April</th>
<th>June</th>
<th>August</th>
<th>October</th>
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<tbody>
<tr>
<td>Referral to Quitline (31%)</td>
<td>Referral to Quitline (35%)</td>
<td>Referral to Quitline (43%)</td>
<td>Referral to Quitline (42%)</td>
</tr>
<tr>
<td>Brief in office counseling (20%)</td>
<td>Brief in office counseling (45%)</td>
<td>Brief in office counseling (59%)</td>
<td>Brief In office Counseling (61%)</td>
</tr>
<tr>
<td>“In house” referral (15%)</td>
<td>“In house” referral (21%)</td>
<td>“In house” referral (26%)</td>
<td>“In house” referral (30%)</td>
</tr>
</tbody>
</table>

N of respondents change over time
% represents frequency chosen. Programs choose more than one strategy
Clinician delivery of tobacco treatment

Richard Matulewicz, MD MSCI MS
Department of Surgery, Urology Service
MSKCC
Disclosures / Support

• NCI K08 #CA259452
• MSK PSRP “COMPOSIT Trial”
• Member: NCCN Guidelines Panel
Evolution in my practice

Unfamiliar
Aware
Learning
Competent
Confidence

I am here.
Brief Smoking Cessation Model

• Using frameworks

• ASK, ADVISE, ASSIST/REFER

• Can be used at individual patient level and to assist with broader efforts

• Basic tenets / principles
Ask / Assessment

• Tobacco use: a critical part of patient medical history

• Accurate documentation

• Involve APPs, applied health professionals, leverage health IT / EMR

• Integrate into workflows
Education / Advise

• Make the connection
  • Causal relationship w/ kidney and bladder cancer, worse outcomes in prostate and testicular

• Integrate motivational counseling and education within your “shpiel”

• Use as preparation for surgery / systemic treatment / radiation
  • The “Fourth Pillar” of cancer care
  • More effective treatment, fewer complications

• Make clear recommendation: “I recommend that you quit smoking because it will help your cancer treatment, I am here to help”

• Keep at it → follow up each visit, reinforce importance
Refer

• Become aware of your local system-level resources and processes
  • Not universally available
  • At MSK → automatic referral to embedded tobacco treatment specialists
  • 1-800-QUIT-NOW, smokefree.gov

• Help with referral process by endorsing the cessation support services provided and making the patient aware of upcoming outreach

• Circle back at next visit to see if contact was made and level of engagement → keep trying
Prescribing

• The final frontier
• Start with nicotine replacement therapies (patches, gums, lozenges, sprays)
  • OTC but helpful if given Rx
• Consider additional training for Rx medications
  • MSK TTT-O (Dr Ostroff, PI), online 2 day training
  • Order set utilization (customized provider favorites)
<table>
<thead>
<tr>
<th>Combination NRT (preferred)</th>
<th>Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Standard Dose/Administration</strong>&lt;sup&gt;f,g,h&lt;/sup&gt;</td>
<td>Minimum of 12 weeks of pharmacotherapy is recommended. However, therapy may be substantially extended to promote continued abstinence</td>
</tr>
<tr>
<td>• Begin with 21-mg patch + short-acting NRT&lt;sup&gt;i&lt;/sup&gt;</td>
<td></td>
</tr>
<tr>
<td>▶ If 21-mg patch is not effective, consider using more than one patch to increase the dose to 35 or 42 mg</td>
<td></td>
</tr>
<tr>
<td>• Short-acting NRT: 2 or 4 mg</td>
<td></td>
</tr>
<tr>
<td>▶ 2 mg preferred if time to first cigarette is &gt;30 minutes after waking; or</td>
<td></td>
</tr>
<tr>
<td>▶ 4 mg preferred if time to first cigarette is ≤30 minutes after waking</td>
<td></td>
</tr>
<tr>
<td>▶ Every 1 h (while awake), or more often as needed</td>
<td></td>
</tr>
</tbody>
</table>

| Varenicline<sup>i</sup> (preferred) | |
| • Initiate dosing 1–5 wks prior to quitting | |
| • Days 1–3: 0.5 mg orally, once daily | |
| • Days 4–7: 0.5 mg orally, twice daily | |
| • Day 8 to end of treatment: 1 mg orally, twice daily (if tolerated) | |
|   ▶ Consider increase to 3 mg per day (if tolerated) for those who cut back by ≥50% but have not quit at 6 wks | |
|   ▶ If severe renal impairment (estimated creatinine clearance <30 mL/min): Begin with 0.5 mg once daily and titrate to 0.5 mg twice daily | |
|   ▶ For patients with end-stage renal disease undergoing hemodialysis, 0.5 mg maximum daily, if tolerated | |

| Buproprion<sup>i</sup> | |
| • Initiate dosing 1–2 wks prior to quitting | |
| • Days 1–3: 150 mg orally, once daily | |
| • Day 4 – end of treatment: | |
|   ▶ Sustained release: 150 mg orally, twice daily, if tolerated; or | |
|   ▶ Extended release: 300 mg, once daily, if tolerated | |
| • Maximum 300 mg per day | |
| • Adjust dose or frequency for: | |
|   ▶ Renal impairment<sup>g</sup> | |
|   ▶ Hepatic impairment: Maximum dose 150 mg every other day for moderate/severe hepatic impairment (Child-Pugh score 7–15); For mild hepatic impairment (Child-Pugh score 5–6), consider reducing the dose and/or frequency adjustment. | |
Brief Anecdote

• 65yoM w/ new diagnosis of high risk NMIBC, 40 pack-years, current smoker
Summary

• Tobacco treatment is doable at the point of care, even for busy clinicians

• Assessment and counseling/education can be finessed into your treatment management discussion, probably best if it is

• Comfort comes with time and training, use team approach when you can

• Make it a priority and you’ll see results / clinical impact
Thank you

Questions, others’ experiences
Site Strategies for No-Cost Medications in the NCI Cancer Center Cessation Initiative

Diversity Equity Inclusion Workgroup, NCI Cancer Center Cessation Initiative
Co-Chairs: Jessica Burris, Rashelle Hayes, Elisa Tong

Elisa Tong, MD, MA
Medical Director, Stop Tobacco Program
Assistant Director, Population Sciences
UC Davis Comprehensive Cancer Center
Professor of Internal Medicine, UC Davis Health

Acknowledgments: OISE-20-66590-1 (Prime Award) CRDF Award #66590
Mr. X is a patient with colorectal cancer who smokes a half pack per day and wants to quit.

He tells you his insurance doesn’t cover tobacco cessation medications. While nicotine patches are available over-the-counter, he does not feel he can afford yet another expense with his cancer care, transportation, and other needs.

What can be done to provide equitable tobacco treatment that is sustainable?
Multi-Level Considerations for No-Cost Medications

Patients
- Knowledge, attitudes, behavior
- Financial burden

Providers
- Roles or responsibilities
- Competing priorities and resources

Systems
- Varying levels of state insurance coverage
- Varying levels of sponsorship for state quitlines
1) Compare cancer center sites in offering medications to patients

2) Describe cancer center site strategies for no-cost medications
Patients seen in clinic (n=881,254)
  – Median (range): 23,500 (4,783-169,605)
Patients who report current smoking (n=61,742)
  – Median (range): 1,277 (65-6,632)

Demographics of patients who report smoking
- Age: 45% 45-64 yrs, 35% 65+ yrs
- Sex: 49% female
- Race: 68% white, 13% black, 1.4% Asian, 0.3% AI/AN, 6% unknown
- Ethnicity: 3% Hispanic, 5% unknown
- Insurance: 28% private, 38% Medicare, 13% Medicaid, 0.3% no insurance, 2% unknown
Patients who smoke engaged in tobacco treatment (n=8914)
- Median (range): 14.6% (0.3-81.5%)

Patients in tobacco treatment and prescribed nicotine meds (n=3350)
- Median (range): 32.1% (0-100%)

Comparing sites above and below median meds of 32%
- Earlier cohorts were below median
  - 1: 73% (8 of 11)
  - 2: 43% (6 of 14)
  - 3: 9% (2 of 7)
- Patient Characteristics
  - No significant differences by age, sex, race, ethnicity, insurance
Patients who smoke engaged in tobacco treatment (n=3864)*
  – Mean (range): 37% (5-61%)

Patients in tobacco treatment and prescribed nicotine meds (n=1992)*
  – Mean (range): 48% (13-78%)

*Only 8 of 9 sites had available data

Reported funding sources for no-cost medications
  ▪ Charity or philanthropic funds by the institution
  ▪ Health system pharmacy budget
  ▪ Research grants
  ▪ State quitline when free medications available
  ▪ Tribal or state grant
9 Cancer Centers: Assets or Barriers

Common assets
- Tobacco treatment integrated into electronic health record
- All sites able to provide combination nicotine meds
- 5 of 9 sites able to provide full 12 weeks

Common barriers
- Unable to advertise free medication
- Financial status approval required at some sites
- Nicotine medications only dispensed from hospital/clinic pharmacy
- Nicotine medication prescription necessary
“It's difficult. So, this is a major problem of NRT [nicotine replacement therapy] and cancer care. Medicare does not cover over-the-counter medications. So, this is something that somebody needs to take on. I am sure there's a way to get Medicare, Part D programs or other part of Medicare to cover over the counter tobacco treatment... So, somebody needs to find their buddy in Center for Medicaid and Medicare or higher up and get that fixed. Because this is ridiculous... the fact that Medicare, which is our universal health coverage program for older adults, does not cover over the counter medications. It's a major league problem. And combination nicotine replacement therapy is the most effective drug regimen. And it's the most popular and people can get it.”
Summary

- Multi-level barriers for no-cost medications in tobacco treatment

- Integrating medications into tobacco treatment is low, even in cancer care

- Cancer center sites are using internal and external strategies for no-cost medications
  - Philanthropic or institutional policy
  - Quitlines or external grants
Disclosures

• Funding was provided by grant (R35CA197573, M. Fiore, PI) from the National Cancer Institute.

• The funder had no role in study design, data collection and analysis, or the decision to present.

• The authors have no potential conflicts of interest to report.
Designing an Intervention Approach

- Hospital QI initiative
- Multi-disciplinary team designed opt-out intervention approach
- Clinical pharmacists identified as optimal interventionists
  - See all patients at admission and discharge
  - Have training and skills to recommend NRT and refer for quitline counseling
Designing Implementation Strategies

- Adopted delegation protocol to grant authority to order OTC NRT for patients to *pharmacists*
- Pharmacy champions designed workflows and implementation strategies
  - Pilot testing
  - Iterative refinement
  - Training and two-way feedback
  - Program monitoring
Workflow

Admission to inpatient unit

Nurse documents in EHR that patient smoked cigarettes in past 30 days

At medication reconciliation, Pharmacists:
• Advise patients who smoke to quit
• Tell patients they will receive NRT during inpatient stay and WTQL eReferral and NRT at discharge
• Discuss patient goals (reduce, quit, opt out)

Pharmacists place orders for NRT under standing authorization (bupropion, varenicline require prescriber approval)

Pharmacists place eReferral to WTQL and additional NRT orders at discharge

eReferral result is returned to EHR
EHR Tools

- Columns added to pharmacists’ list of patients needing visit/reconciliation

- No need to navigate to patient chart or social history to review smoking status

<table>
<thead>
<tr>
<th>Patient ID</th>
<th>Smoking Status</th>
<th>RPh Intervention Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>0001</td>
<td>X</td>
<td>NA</td>
</tr>
<tr>
<td>0002</td>
<td>✓</td>
<td>X</td>
</tr>
<tr>
<td>0003</td>
<td>✓</td>
<td>X</td>
</tr>
<tr>
<td>0004</td>
<td>✓</td>
<td>✓</td>
</tr>
</tbody>
</table>
### EHR Tools

- Simple form to track intervention offer and delivery

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>Opt out</th>
<th>Completed</th>
<th>N/A (if non smoker/quit)</th>
<th>Patient excluded</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does patient smoke</td>
<td></td>
<td></td>
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<tr>
<td>Patient provided nicotine</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>replacement</td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient referred to quit line</td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Smoking cessation Intervention</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Completed</td>
<td></td>
<td></td>
<td>Not completed (see comment)</td>
<td>Patient excluded</td>
<td></td>
</tr>
</tbody>
</table>
EHR Tools

- Information from EHR tools flows directly into notes pharmacists enter when documenting orders placed per protocol

```
Pharmacist Tobacco Cessation [192] Delegation Protocol
Have you ever used tobacco?: Yes
Type: Cigarettes
Tobacco Use Status: Currently using - interested in quitting
Would you like nicotine replacement while in the hospital?: Yes
Is patient excluded ?: No
RPh: does patient smoke?: Yes
Patient provided nicotine replacement: Yes
Patient referred to quit line: Yes
Smoking cessation intervention: Completed

Orders entered: nicotine patches, nicotine mini lozenges, and Wisconsin Quit Line referral.
Protocol Link:
```
Nicotine Replacement Therapy (NRT) Order Sets

• For patients that use ≥10 cigarettes a day:
  ▪ Nicotine patch (21 mg)

• For patients who use <10 cigarettes a day:
  ▪ Nicotine patch (14 mg)

• For patients who start smoking within 30 minutes of waking:
  ▪ Nicotine Mini-lozenge (4 mg) OR
  ▪ Nicotine gum (4 mg)

• For patients who start smoking more than 30 minutes after waking:
  ▪ Nicotine Mini-lozenge (2 mg) OR
  ▪ Nicotine gum (2 mg)

• Patch and/or oral nicotine therapy offered to all patients who smoke
Wisconsin Tobacco Quit Line eReferral

• Closed-loop eReferral via EHR alert & order set (result returned to EHR)

• Services:
  ▪ Free quit coaching via web, phone, text, or virtual groups
  ▪ 24/7 services
  ▪ Free mailed 2-week supply of NRT
  ▪ Self-help materials
  ▪ Intensive treatment if identify American Indian, Native American, or Alaska Native
Iteratively Refined Implementation Strategies

- Group trainings
- Follow-up in huddles by pharmacy leaders and residents on units
- Surveys, interviews to gather input
- Patient handouts
- EHR tools
Reach

% of Patients of Eligible Patients who Received Treatment

<table>
<thead>
<tr>
<th></th>
<th>Baseline (N=1761)</th>
<th>Implementation (N=2214)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ordered NRT</td>
<td>43.6%</td>
<td>50.4%</td>
</tr>
<tr>
<td>WTQL eReferral</td>
<td>0.9%</td>
<td>11.9%</td>
</tr>
<tr>
<td>Any Treatment</td>
<td>43.8%</td>
<td>52.6%</td>
</tr>
</tbody>
</table>

* Chi-square p < .0001
Pharmacists placed 1.4% of NRT orders at baseline and 20.6% of NRT orders during implementation.

Varenicline was ordered 14 times (1.8% of all orders) in baseline and 15 times (1.4% of all orders) during implementation. Bupropion was not ordered in either period.
Implementation

• Disparities in smoking treatment by race and ethnicity decreased post- vs. pre-implementation

• Pharmacists completed smoking treatment form at 1383 (62.5%) first admissions for 2214 patients
  ▪ 730 (52.8%) of patients initially opted out of NRT
    ▪ 185 (25.3%) later opted to receive NRT
  ▪ 1008 (72.9%) initially opted out of WTQL eReferral
    ▪ 22 (2.2%) later opted to receive eReferral
Conclusions

• Increase in reach following implementation
  ▪ Both pharmacotherapy and quitline referrals increased
  ▪ Disparities by race and ethnicity decreased
• Pharmacists documented addressing tobacco with 62.5% of eligible patients
• Pharmacists can help to fill the gaps in tobacco treatment reach
Acknowledgements

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References


ACS Cancer Conference 2024

February 22-24, 2024 | Austin, TX

Save the Date

facs.org/cancerconference
ACS/Clinical Congress 2024

Achieving Our Best Together: #Inclusive Excellence

SAVE THE DATE!

October 19–22
San Francisco, CA

New Saturday–Tuesday Program
Reminders

Data collection ends today December 15
Patients seen between October 1-November 30

Save the Date: March 8th at 12p CT
Optional final presentation of all Just ASK/Beyond ASK findings.

More information will be provided in a future Cancer Program Newsletter
Questions?