Cancer Programs Webinar: Just Ask study
February 16, 2022
Webinar Logistics

- 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
Agenda

• 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
Introducing Our Moderator

Laurie Kirstein MD, FACS
Attending Breast Surgeon
Memorial Sloan Kettering Cancer Center
Associate Professor
Cornell University Medical College
New Jersey
Panelist

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

Jamie S. Ostroff PhD
Chief, Behavioral Science Service
Director, Tobacco Treatment Program
Department of Psychiatry & Behavioral Sciences
Memorial Sloan Kettering Cancer Center
New York
Introducing our Panelist

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
Department of Radiation Oncology
Department of Cell and Molecular Pharmacology and Experimental Therapeutics
Hollings Cancer Center
Medical University of South Carolina

Elisa Tong, M.D. M.A.
Professor of Medicine
Division of General Internal Medicine
UC Davis Health, California
Introducing our Panelist

Erin DeKoster Reuter
Accreditation Senior Manager, Cancer Programs
American College of Surgeons, Illinois
Achieving Quality Improvement In Cancer Programs

Addressing Tobacco Use in Cancer Patients

Timothy Mullett, MD, MBA, FACS
The Challenge of Quality Improvement

- 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
3 KEY OBJECTIVES:

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

**Key Objectives**

**Objectives**

- Prevent Unnecessary Cancer Deaths

**3 KEY OBJECTIVES**

**Restore Screening**

**Close 2020 Screening Deficit (9 million)**

**Prevent Unnecessary Cancer Deaths**

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

© American College of Surgeons 2022—Content cannot be reproduced or repurposed without written permission of the American College of Surgeons.
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
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
Tobacco Use Assessment Collaboration

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
## Tobacco and Cancer Task Force Members

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

Graham Warren M.D., Ph.D., F.A.S.C.O
Smoking and the Continuum of Cancer Care

The Established Carcinogenesis Model

- Receptor binding
- Protein kinase A and R activation and other changes
- Mutations in oncogenes and tumor suppressor genes
- Loss of normal growth control mechanisms
- Cancer

2010 Surgeon General’s Report, Fig 5.1

Addressing Tobacco Use by Cancer Patients

The Historical Disconnect

The Reality of Cancer

Biologic Outcomes
(tumor promotion, decreased cancer treatment efficacy)

Clinical Outcomes
(recurrence, toxicity, mortality)

Value Outcomes
(cost of cancer treatment, productivity, QOL/EOL, recurrence, toxicity, mortality)

© American College of Surgeons 2022—Content cannot be reproduced or repurposed without written permission of the American College of Surgeons.
## Why is Addressing Smoking Important for Cancer Treatment?

### 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
- >400 studies, 500K patients 1990-2012
- 1990 – 2012

### Overall Mortality (159 studies) & Cancer Mortality (58 studies)

<table>
<thead>
<tr>
<th>Effect</th>
<th>Associations</th>
<th>Median RR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall Mortality</td>
<td>87%</td>
<td>Current: 1.51, Former: 1.22</td>
</tr>
<tr>
<td>(159 studies)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cancer Mortality</td>
<td>79%</td>
<td>Current: 1.61, Former: 1.03</td>
</tr>
<tr>
<td>(58 studies)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Effect Types:**
- Hematologic (n=17)
- Breast (n=31)
- Gynecologic (n=21)
- Genitourinary non-prostate (n=23)
- Prostate (n=17)
- Gastrointestinal (n=37)
- Lung (n=157)
- Head/Neck (n=60)
- Multiple (n=10)
How Does this Compare with Other Practice Change?

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)
How Can We Begin to Address Smoking?

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
Purpose: JUST ASK All New Patients About Smoking

**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)
Purpose: JUST ASK All New Patients About Smoking

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)

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

Advising or Assisting is encouraged, but WILL NOT be measured
Plan-Do-Study-Act | Educational Resources

Elisa Tong, M.D. M.A.
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.
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.
• Attend educational webinars with team members and providers.
• Implement selected intervention strategies

• Complete baseline survey assessment & follow-up assessments
  o Baseline data can be obtained retrospectively from the prior month, quarter, or year as available at your site.
  o 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.
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.
PLAN – DO – STUDY - ACT

- 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.
Implementation Strategies

PATIENTS

PROVIDERS

SYSTEM
Smoking Status in the Electronic Health Record

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
For Providers

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 result in poorer treatment response and increased treatment-related toxicity.

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, 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 cancer of the lungs, oral cavity, and pharynx drops by half.
  - 10 years after quitting: risk of cancer 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.
- 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 overall survival in patients with cancer.

For Patients

Quit Smoking Before Your Operation

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

Smoking increases the risk in the arteries and decreases your ability to fight infection. It also increases the risk of pneumonia and other breathing problems. Artery function improves if you quit 3 weeks before your procedure.

The nicotine in cigarettes can increase your blood pressure, heart rate, and risk of arteriosclerosis (irregular heart beats). The carbon monoxide in cigarettes decreases the amount of oxygen in your blood. Quitting 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.

A smoker has 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.

Smoking Increases Your Risk of Wound Complications

Smoking cessation counseling before a surgical procedure increases the quit rate.

- Multiple approaches: counseling, plus medication and quit lines work best to help you stop for life.
- You will need to be receiving pain medication after surgery, which will decrease your withdrawal effects.

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 stop for life.

Smoking Increases Your Risk of Cancer Recurrence

Smoking interferes with all phases of wound healing. It also decreases the ability of the skin to fight harmful and fight infections. Having a wound infection increases the average length of stay by 2 to 3 days. Getting 4 weeks before a surgical procedure reduces postoperative complications by 30 to 30 percent.

Studies identify that patients who smoke have:
- Increased wound infection and splitting open of the wound in patients having general surgery on hip and knee replacements.
- Increased incisional and recurrent inguinal hernias.
- Lack of bone healing after orthopedic surgery.
- Significantly higher rates of deep surgical site infections and re-operation following plastic surgery.
- Greater pain intensity and higher amounts of narcotics needed for pain control.

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

Secondhand smoke causes lung cancer in both children and adults who don’t smoke.
For Peers: NCI Cancer Center Cessation Initiative – 52 Centers

Quality Improvement Project

Evaluation Tools

Jamie Ostroff, PhD
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
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.

<table>
<thead>
<tr>
<th>Date of completion of form</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of individual completing form</td>
</tr>
<tr>
<td>Email of individual completing form</td>
</tr>
<tr>
<td>Name of CoC Facility</td>
</tr>
<tr>
<td>Facility CoC ID Number (FIN #)</td>
</tr>
</tbody>
</table>

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
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:

<table>
<thead>
<tr>
<th>Asking patients whether they currently smoke cigarettes or use other types of tobacco products.</th>
<th>Always</th>
<th>Most of the time</th>
<th>Sometimes</th>
<th>Rarely</th>
<th>Never</th>
</tr>
</thead>
<tbody>
<tr>
<td>Advising patients who smoke to quit.</td>
<td>Always</td>
<td>Most of the time</td>
<td>Sometimes</td>
<td>Rarely</td>
<td>Never</td>
</tr>
<tr>
<td>Assisting patients who smoke to quit.</td>
<td>Always</td>
<td>Most of the time</td>
<td>Sometimes</td>
<td>Rarely</td>
<td>Never</td>
</tr>
</tbody>
</table>

Document smoking status/tobacco use in...
Section III. Implementation Barriers

Rationale

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

Screen Shot/Sample Items

<table>
<thead>
<tr>
<th>Section III. Implementation Barriers</th>
</tr>
</thead>
<tbody>
<tr>
<td>To what extent do you perceive these barriers for promoting smoking cessation among cancer patients who are current smokers at your cancer care setting?</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Lack of staff time for counseling.</td>
</tr>
<tr>
<td>Lack of staff training in smoking cessation interventions.</td>
</tr>
</tbody>
</table>
Section IV. Implementation Strategies

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

<table>
<thead>
<tr>
<th>Section IV. Implementation Strategies</th>
</tr>
</thead>
<tbody>
<tr>
<td>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):</td>
</tr>
<tr>
<td>Staff/Clinician Training</td>
</tr>
<tr>
<td>Gain support of site leadership</td>
</tr>
</tbody>
</table>
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.

<table>
<thead>
<tr>
<th>Agree</th>
<th>Somewhat Agree</th>
<th>Neither Agree or Disagree</th>
<th>Somewhat Disagree</th>
<th>Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>People who work here are committed to implementing tobacco use assessment and treatment.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>People who work here are motivated to implement tobacco use assessment and treatment.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

© American College of Surgeons 2022—Content cannot be reproduced or repurposed without written permission of the American College of Surgeons.
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)
Review Surveys, Redcap, Application to Accreditation Standards

Erin DeKoster Reuter
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.
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
Conclusion

• 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
Question and Answer
Cancer Programs has Continuing Education Credits

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