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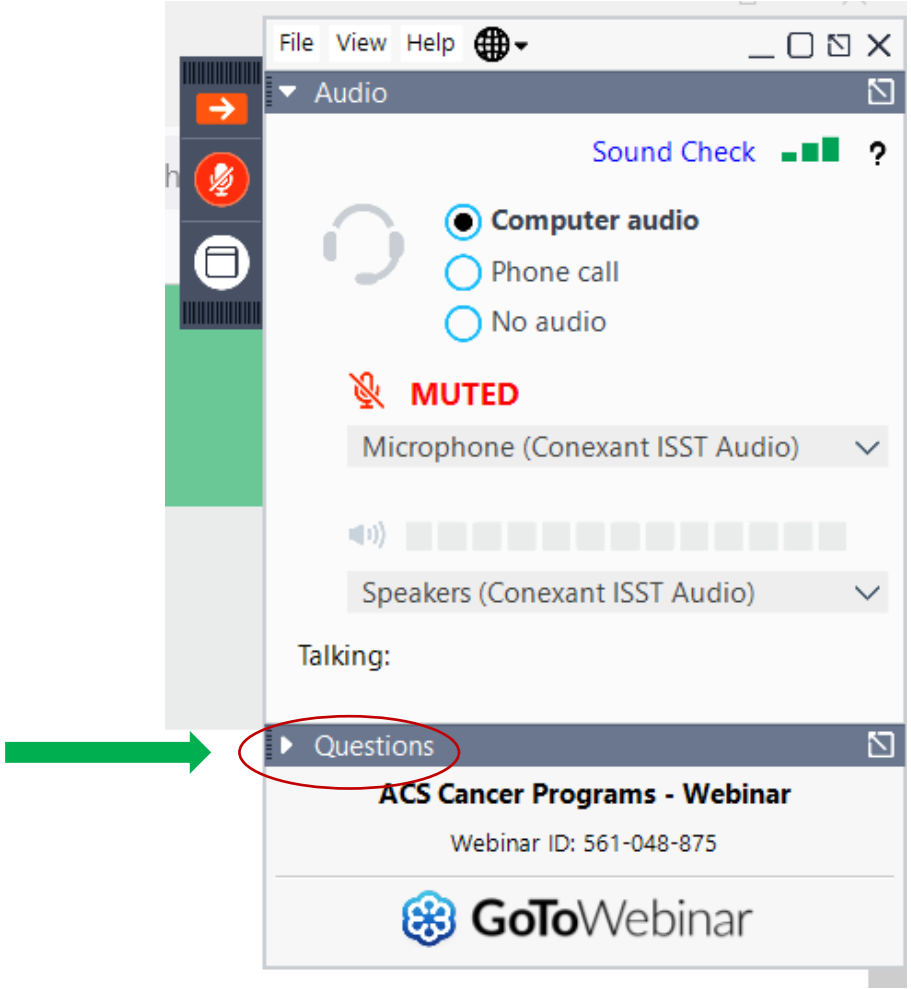
Just ASK: Crucial Conversations

October 7, 2022

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



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Introducing Our Moderator

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

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Introducing our Panelists

- Jamie Ostroff, PhD
- Graham Warren MD, PhD, FASCO
- Audrey Darville, PhD, APRN, NCTTP
- Charles Shelton, MD

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Agenda

Welcome and Introduction- Dr. Timothy Mullett

ASKing Without Stigma- Dr. Jamie Ostroff

Advising- Dr. Graham Warren

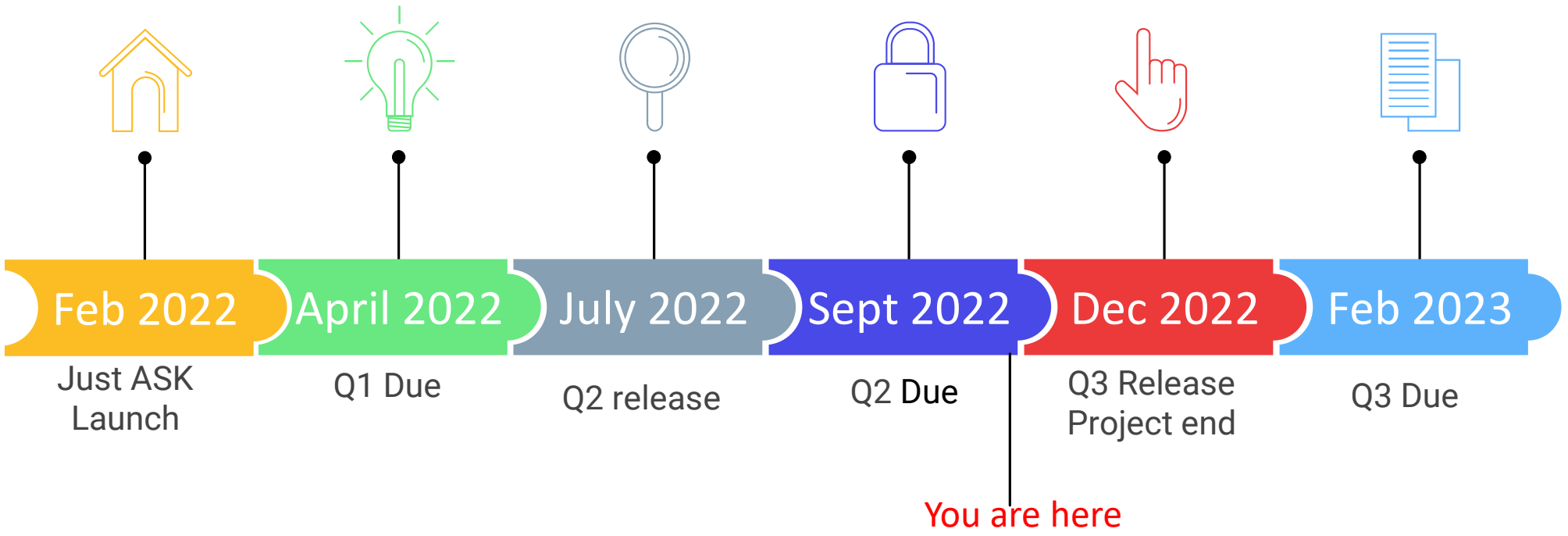
Assisting via a Spectrum of Resources- Dr. Audrey Darville

From the Field- Dr. Charles Shelton

Q & A

Adjourn- Save the date: December 9th at 12pm CT

Just ASK Timeline



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Mid-Year Survey Report Out

Timothy Mullett, MD, MBA, FACS

Program Participants

	Baseline	Mid year
Number of participants	776	730

What is your role?

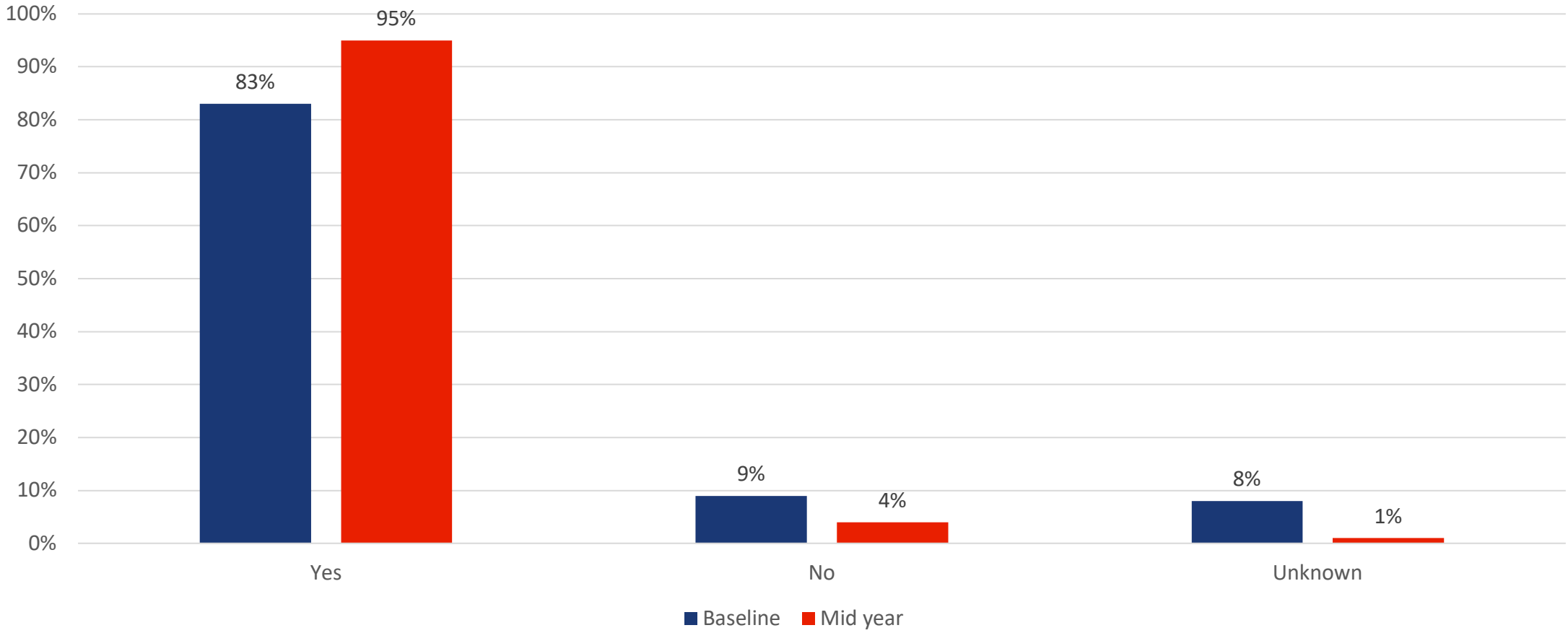
Program Manager or Director	274
Other (accreditation manager, QI coord, Service coord, RN)	179
Registry Staff	175
Oncology Navigator	39
Oncology Nurse	35
Medical or Program Director	16
Data/Business Analyst	11

What smoking cessation resources are currently available?

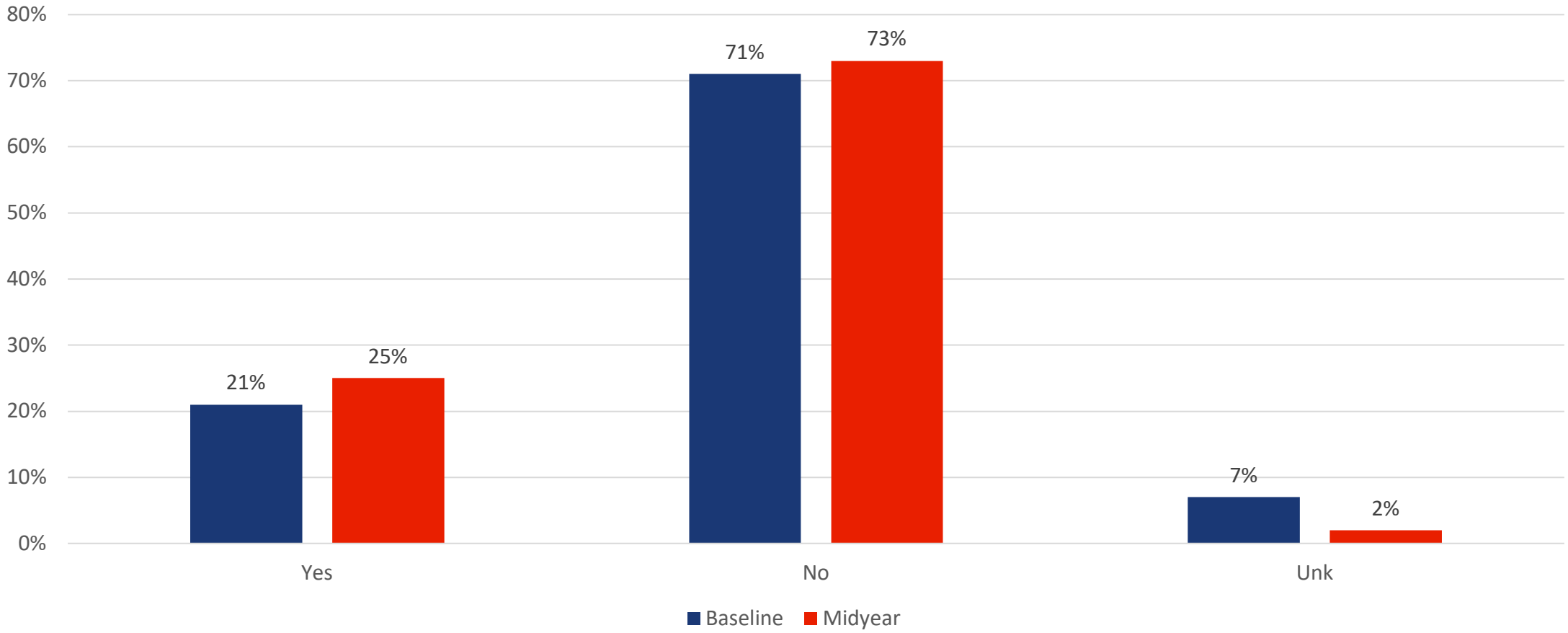
	Referral to other community-based smoking cessation program (%)	Smoking cessation through local hospital (%)	Treatment in clinic by a physician or staff (%)	Referral to other local facility-based smoking cessation program (%)	Smoking cessation embedded in program (%)	Unknown or not available (%)
Baseline (n=776)	52%	38%	32%	28%	19%	14%
Mid year (n=730)	64%	38%	37%	30%	22%	6%

Do you have a system in place for ASKing?

Baseline= 776; midyear=730



Do you have a smoking cessation specialist or counselor embedded in your cancer setting?



Interventions

Gained support of center/program leadership	481
Provided additional staff/clinician training	419
Improved smoking hx and current use documentation tracking/monitoring in EHR	407
Identified additional organizational resources to support smoking cessation	361
Develop patient education materials	314
Identified tobacco tx champions	195
Add a reminder/prompt within clinical workflow	138
Other	70

Implementation Strategies

Shared project participation with Cancer Committee or BPLC	646
Met with key participants as a group at least once	577
Reported selected intervention strategies to Cancer Committee or BPLC	524
Developed a task force or work group with key stakeholders	457
Develop tracking tools or reports within EHR	440
Met with key program leadership, including organizational leaders if applicable	392
Provided feedback to providers and/or patient care staff	367
Evaluated best practices from like organizations	188
Utilized intervention change package resources	148
Other	36

What's next?

- Continue to refine interventions
  - If you adopted, how do you ensure sustainability?
  - If you adapted, what changes did you need to make? Is what you adapted working now?
  - If you abandoned, then what's next?

- How do you proactively reach those who smoke?

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The Why, When and How of Just ASK

Jamie Ostroff, PhD

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To provide effective tobacco cessation treatment, you must **ASK** about smoking status. **It's the first step.**

1. **A**sk about smoking status ⟵
2. **A**dvise patients who smoke to quit
3. **R**efer patients who smoke to a treatment program, or
   Connect patients who smoke with a treatment program

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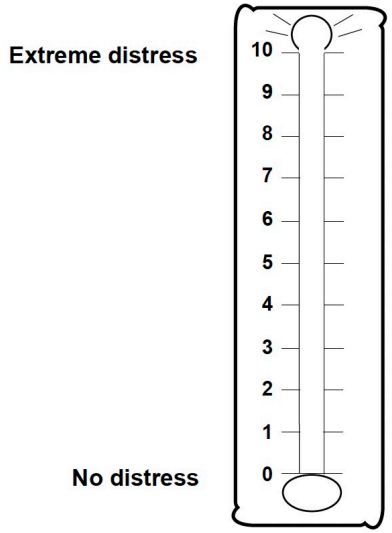
NCCN Guidelines Version 1.2022
Distress Management

At transitions of care

Once a month

Pair with distress screening

At *1st* encounter
(not sensitive to behavior change)



Physical Concerns
- ❑ Pain
- ❑ Sleep
- ❑ Fatigue
- ❑ Tobacco use
- ❑ Substance use
- ❑ Memory or concentration
- ❑ Sexual health
- ❑ Changes in eating
- ❑ Loss or change of physical abilities

At *every* encounter
(not sensitive to practical demands)

You decide. Serial assessment is expected.

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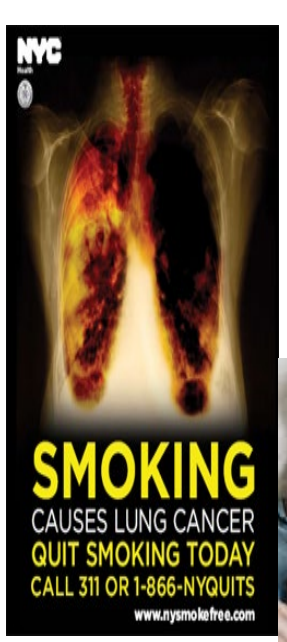
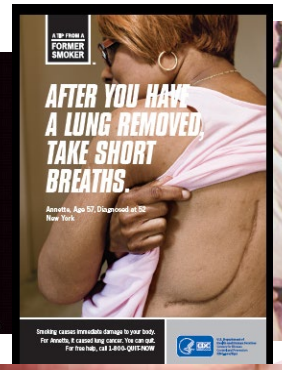
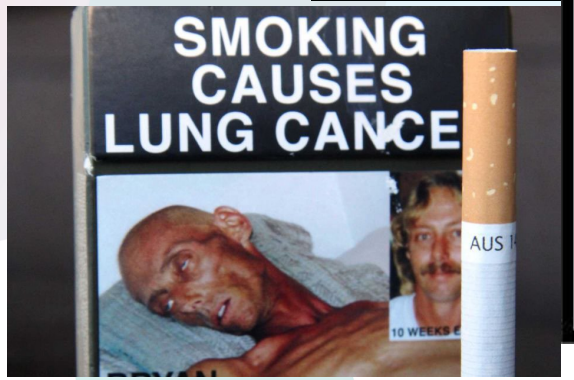
Cancer, Smoking Fear and Stigma





WARNING:
Cigarettes
cause
cancer.



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Decreasing Smoking but Increasing Stigma? Anti-tobacco Campaigns, Public Health, and Cancer Care

Kristen E. Riley, PhD, Michael R. Ulrich, JD, MPH, Heidi A. Hamann, PhD, and Jamie S. Ostroff, PhD

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How do you ASK?

You're not still smoking, are you?

Do you smoke?

Are you a smoker?

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How does stigma interfere with ASK?

- Guilt, shame, blame, distress
- Avoidance
- Misreporting

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PEC Innovation 1 (2022) 100025

Contents lists available at ScienceDirect

PEC Innovation

journal homepage: www.elsevier.com/locate/pecinn

Reducing stigma triggered by assessing smoking status among patients diagnosed with lung cancer: De-stigmatizing do and don't lessons learned from qualitative interviews

Jamie S. Ostroff [a,*], Smita C. Banerjee [a], Kathleen Lynch [a], Megan J. Shen [b,c], Timothy J. Williamson [a], Noshin Haque [a], Kristen Riley [d], Heidi A. Hamann [e], Maureen Rigney [f], Bernard Park [g]

Do’s and Don'ts of Empathic Communication (based on real patient expe

- **Empathic Opportunity (Emotion)**
- **DON’T**

- **Empathic Opportunity (Emotion)**
- **DO**

- **Empathic Opportunity (Introduction)**
- **DON’T**

- **Empathic Opportunity (Introduction)**
- **DO**

Don’ts for De-Stigmatizing Interactions about Smoking

1. Don’t **blame**.	4. Don’t be **nihilistic** and offer poor prognosis.
2. Don’t **presume**	5. Don’t avoid the patient.
3. Don’t make threats about **sub-optimal care** delivery for patients who smoke.	

Do's for De-Stigmatizing Interactions about Smoking

Do **normalize** taking smoking history.	Do **offer tobacco cessation and other resources (like support groups).**
Do **acknowledge** the causal relationship between smoking and lung cancer, as well as other known and unknown risk factors for lung cancer.	Do **avoid judgment-laden questions.**
Do **acknowledge** nicotine addiction and quitting challenges (for patients who smoke).	Do **create a "personal connection"** with the patient.
Do **respond empathically** to patients receiving distressing information.	Do **maintain eye contact** and sit at eye-level with the patient.
Do ask more **open-ended questions** about patient experiences.	Do **maintain a body position** that is oriented toward the patient.
Do allow patients time to **ask questions**.	Do **maintain consistent tone throughout the consultation**.
Do **provide a rationale** for asking smoking-related questions.	Do get more **communication training**.
Do **offer hope**.	Do get **educated about smoking status and lung cancer**.

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How do you ASK? Suggested Blueprint for Getting Started

Strategies	Skills	Process Tasks
1. Agenda setting	- Declare agenda - Normalize - Provide clinical rationale (for asking about smoking history) - Invite agenda - Negotiate agenda, if appropriate	- Greet patient appropriately - Make introductions - Ensure patient is clothed - Sit at eye-level
2. Questioning and history taking	- Ask open questions - Clarify - Restate	- Follow the list of questions for taking smoking history
3. Recognize or elicit a patient's empathic opportunity	- Ask open questions (about smoking) - Acknowledge - Encourage expression of feelings	- Notice patient's nonverbal communication
4. Work towards a shared understanding of the patient's emotion/experience	- Ask open questions - Check patient understanding - Clarify - Restate	- Avoid leading questions/blaming statements - Avoid giving premature reassurance
5. Empathically respond to the emotion or experience	- Acknowledge - Validate - Normalize - Praise patient efforts	- Identify patient's strengths and sources of support - Provide clear physician recommendation for quitting - Emphasize benefits of quitting
6. Facilitate coping and connect to social support	- Prepare patient for recurring smoking assessment - Suggest counterarguments (will vary by smoking status) - Invite questions	- Make referrals - Express a willingness to help - Make partnership statements
7. Close the conversation	- Praise patient efforts - Endorse question asking - Review next steps	- Reinforce joint decision making

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Suggested Phrases

OPENER: Smoking cigarettes can greatly impact your cancer care and recovery. I do appreciate that discussing smoking can be a sensitive topic but I want you to understand that we ask all of our patients about cigarette smoking so that we can provide the best possible cancer care, including providing smoking cessation support to help you quit smoking/be smoke-free.

ASK: In the past 30 days, have you smoked cigarettes, even a puff?

Given that reducing smoking or quitting completely can improve your cancer treatment and your recovery, a referral to our Treatment Tobacco Program (TTP) will be placed. You should expect a phone call from the TTP staff who will tell you more about our cessation support services.

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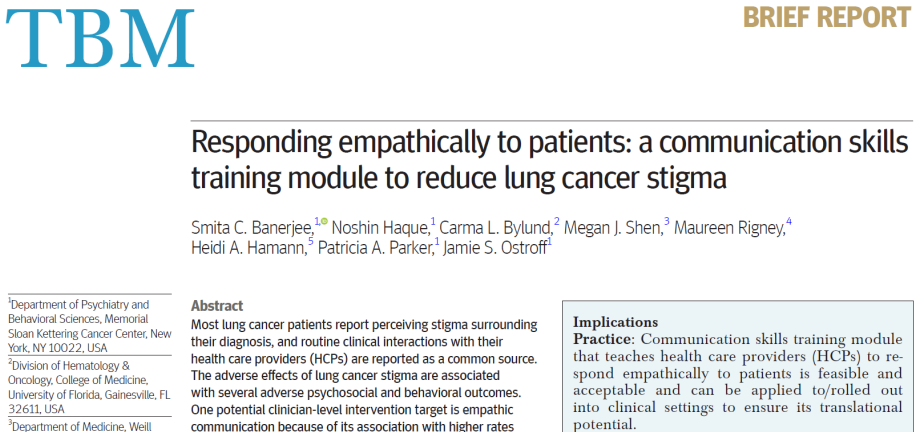
Empathic Communication Skills Training to Reduce Stigma



TBM

BRIEF REPORT

Responding empathically to patients: a communication skills training module to reduce lung cancer stigma

Smita C. Banerjee,[1] Noshin Haque,[1] Carma L. Bylund,[2] Megan J. Shen,[3] Maureen Rigney,[4] Heidi A. Hamann,[5] Patricia A. Parker,[1] Jamie S. Ostroff[1]

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[2]Division of Hematology & Oncology, College of Medicine, University of Florida, Gainesville, FL 32611, USA
[3]Department of Medicine, Weill

Abstract

Most lung cancer patients report perceiving stigma surrounding their diagnosis, and routine clinical interactions with their health care providers (HCPs) are reported as a common source. The adverse effects of lung cancer stigma are associated with several adverse psychosocial and behavioral outcomes. One potential clinician-level intervention target is empathic communication because of its association with higher rates

Implications

Practice: Communication skills training module that teaches health care providers (HCPs) to respond empathically to patients is feasible and acceptable and can be applied to/rolled out into clinical settings to ensure its translational potential.

[Thoracic Oncology Original Research]

CHEST

Oncology Care Provider Training in Empathic Communication Skills to Reduce Lung Cancer Stigma

Check for updates

Smita C. Banerjee, PhD; Noshin Haque, BA; Elizabeth A. Schofield, MPH; Timothy J. Williamson, PhD, MPH; Chloe M. Martin, PhD; Carma L. Bylund, PhD; Megan J. Shen, PhD; Maureen Rigney, LCSW; Heidi A. Hamann, PhD; Patricia A. Parker, PhD; Daniel C. McFarland, DO; Bernard J. Park, MD; Daniela Molena, MD; Aimee Moreno, BA; and Jamie S. Ostroff, PhD

- Well-intended and clinically indicated assessments of smoking history may activate feelings of guilt, regret and stigma.
- Empathic communication skills training designed to prevent and mitigate stigma during medical encounters.
- Feasible, acceptable and promising provider-level intervention
- National multi-site trial of ECS training with OCPs treating patients with lung cancer is underway (R01CA255522; MPI: Banerjee/Ostroff)

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Empathic communication skills training is a feasible, acceptable and promising provider-level intervention for reducing stigma

Taking a smoking history does NOT need to be a painful medical procedure!

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ADVISING Patients About Smoking and Smoking Cessation

Graham Warren MD, PhD, FASCO

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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)

Patients must understand WHY this is important and WHAT to do

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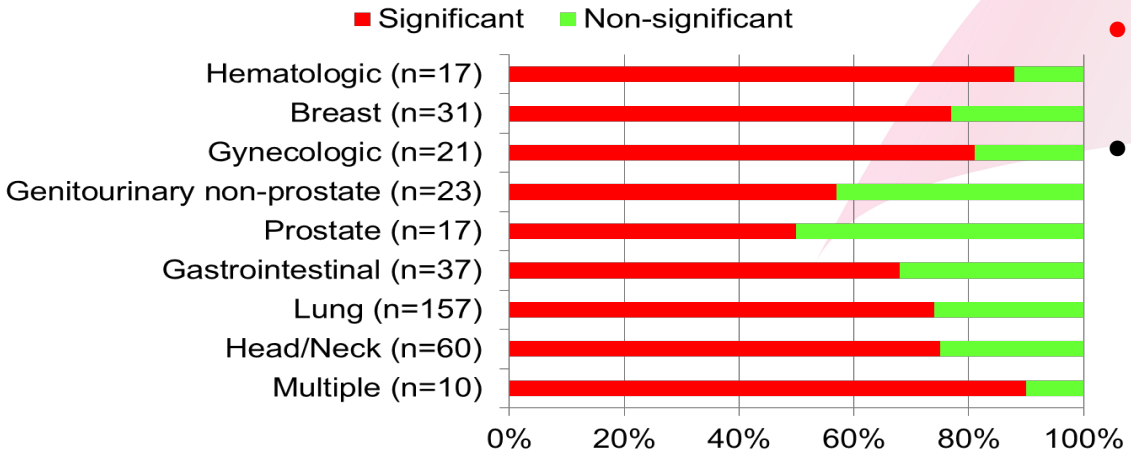
2014 SGR: >400 studies, 500K patients 1990-2012

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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Simple, Clear, Concise, and Effective Advice

- **Three key components**
  1. Smoking is BAD
  2. Smoking cessation is GOOD
  3. WE CAN HELP

- Cancer is complicated, *smoking is simple*
- Deliver a clear and concise *message that patients will remember*
- Provide an effective solution
  - Help them quit
  - Refer to an institutional or community program
  - Refer to the state Quitline (1-800-QUIT-NOW)
  - Find an evidence-based program to help

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Smoking is bad

- **Don’t make advice complicated**
  - Patients already have information overload from cancer treatment
  - Virtually everyone already knows smoking is generally bad
  - *Convincing people is not difficult*

- **Example statements**

“Smoking is still bad, even after a cancer diagnosis”

“Smoking is bad for your cancer treatment”

”Cancer doesn’t make the effects of smoking go away”

“Cancer doesn’t make smoking OK”

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Simply Stated: Smoking Cessation is GOOD

- Cessation after diagnosis is associated with:
  - Improved survival
    - REMEMBER: cessation also improves non-cancer survival
  - Improved cancer control
  - Improved cancer treatment toxicity
  - Reduced risk of getting a second cancer

- **Example statements**

”The best thing YOU can do to make treatment better is to quit smoking”

“It’s never too late to quit smoking, especially after a cancer diagnosis”

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WE CAN HELP

- **If smoking is bad and cessation can improve outcomes, we must give patients direction**
  - Advice should clearly define the problem and provide a solution

- **<u>Example statements</u>**

”We have a program to help you quit smoking”

“I HAVE NO IDEA HOW TO QUIT SMOKING, but we have a program to help”

“I will help you quit smoking” (caution, prefer ”we will…”)

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Advice for Screening/Workup (kind of long)

I'm concerned that you might have cancer.

We're going to start working on this, but we also need to talk about quitting smoking. If this is cancer, quitting smoking can help you live longer and feel better.

ONE OF THE BEST THINGS YOU CAN DO RIGHT NOW IS DECIDE TO QUIT SMOKING, AND WE CAN HELP YOU

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Commitment to Smoking Cessation

- Smoking cessation is a partnership
  - Patients should commit to quit smoking
  - Health systems should commit to providing clear evidence-based support
- Provide consistent advice throughout the continuum of cancer care
  - EVERYONE can provide this advice
  - Everyone can know smoking is bad and cessation is good
  - Everyone can also know there is a program to help patients quit
- Many will reduce smoking, and this is good
  - Don’t give up on encouraging patients to reduce further and ultimately quit
  - Don’t criticize or stigmatize
- Statements can make great posters, brochures, recordings, and videos

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Assisting: Providing a Spectrum of Resources

Audrey Darville, PhD, APRN, NCTTP

University of Kentucky College of Nursing

Director, BREATHE Online Tobacco Treatment Specialist Training Program

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Assisting: Quitting is a *Process*

- Meet the patient where they are
- Provide/enlist services to develop and promote practical treatment plans tailored to the individual, recognizing potential barriers
- Anticipate relapse and develop a plan to prevent it (Just Ask every visit!)

Teachable Moment

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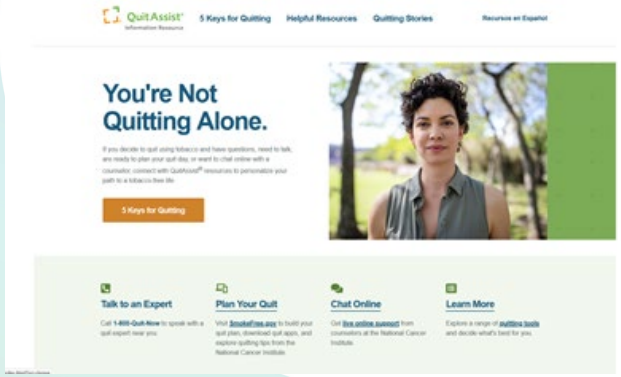
Cessation Counseling More Than Doubles the Probability of Success

- **Individual counseling:** in-person, telehealth, phone, text
- **Quitlines:** proactive referrals to the quitline most effective
- **Online:** (becomeanex.org, smokefree.gov)
- **Group:** Local health departments or some healthcare systems; schedules and provision of medication varies
- **I-Phone apps/Text to Quit:** Be wary of ‘wolves in sheep’s clothing’



Sponsor: Altria/Phillip Morris

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Individual treatment

- 8 cessation counseling sessions/year (99406, 99407) covered by Medicare; billed by qualified providers
- Medicaid coverage varies by state; many cover same as Medicare (or more!) and may allow for billing by additional providers
- Tobacco Treatment Specialists can provide intensive, tailored treatment for all types of tobacco and dual-product use.

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What is a Tobacco Treatment Specialist (TTS)?

A professional who:

- Possesses skills, knowledge and training to provide effective, evidence-based interventions for tobacco dependence across a range of intensities.
- Engages in educating others (health care professionals, administrators, scientists, communities, tobacco users) about tobacco dependence treatment and prevention.
- Received specialized training through an accredited program: http://ctttp.org/

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Quitlines: More than a phone call…

- Free to users; contracted by state tobacco control departments
- Many provide targeted services to special populations with TTS-trained counselors
- Provide services in multiple languages
- Some EHRs can be linked to state quitline services for automated referrals
- Widely promoted
- May provide free NRT
- Data exchange is available

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How we ASK in a Small Community

Charles Shelton MD

Radiation Oncology/Chair CA Committee

The Outer Banks Hospital

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Small Critical Access Hospital- background

- Limited resources, small <21-bed, no ICU, with focus on essential services. Rural eastern NC. Only 2 oncologists at our hospital (1 rad onc and 0.5 med onc)
- We have “high risk” population with regards to substance use, including tobacco (we are in tobacco belt state of NC)
- Tobacco use is actually considered the lesser of many risky lifestyle habits (we have high alcohol use, and illicit drug use including heroin)
- 21% of our cancer patients are current smokers, 66% are ever smokers, and only 34% of cancer patients are never smokers so we realize tobacco is part of our geography and culture more than a lot of communities
- 100% of our Lung cancer patients are ever smokers!

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As part of this study, we realized we do pretty well with Asking part

- N=187/187 analytic cases Jan –Dec 2021 were asked about smoking habits, so we feel we did this well already in part because all patients are part of EMR (EPIC) that has this built in for PCP, etc.
- Where we did/do poorly in the ASK process is in engaging the patient to become empowered themselves to quit. I do not think anybody can quit an addiction unless THEY decide to do it. *It is our job to empower!!*
- Even though we mention smoking cessation is beneficial, *very few of our oncology providers explained the reasons why*
  - Example: wound healing issues in our breast patients, poor tolerance to therapy in chemo-radiation patients, risks of DVT's higher, post-op dehiscence in pelvic cancer patients, etc.
- We find a cancer diagnosis is an opportune time to motivate patients to quit, and by sharing the associated risks and benefits, we hope to improve quit rates.

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Our Ask process

- At intake with new patient, we include risk assessment in all patients, including smart phrases for tobacco use (among other risks) we created within EPIC and that we share as users
- We discuss with patients what we and they think may have contributed to their cancer- including genetics, family history, environmental factors, and lifestyle risk choices
- We ask them if they know of any risks they may have been exposed to and then address them as part of the consultation visit (patients with strong FH get considered for genetics risk assessment, etc.)
- We discuss our model of risk mitigation through a clinic that is part of the cancer journey into survivorship (Lifestyle Clinic)
- We let patients know we have a team of specialists who can help them choose goals to lower their risks of future cancers, and help them get through the journey of cancer care.
- We assess how motivated they are to participate and then ask them if they would like to be given tools to help empower their own desired outcomes.
- If they are motivated to do so, we refer patients to our Wellness Center, which is headed by a physician boarded in Integrative Medicine and Lifestyle Medicine (Dr. Christina Bowen) and wellness team
- Our Nurse Navigator makes the referral and then follows up with the process to help keep patients compliant with these visits
- We discuss ALL active oncology patients regularly by having weekly med onc/rad onc rounds (together we see >95% of patients) which allows forum to address this as well

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Several QI's planned in 2023/24

1. Since we already ASK 100% we decided we wanted to ASSESS the motivational part of patients for quitting by integrating *motivational techniques* at time of initial consult, and in subsequent visits (e.g. using patient success stories and examples of how we helped others like themselves)
2. We plan to *document* the ADVISE component better including the use of data given as part of this QI. We share with patients the improvement in not only QOL outcomes (like infections) but also the survival benefits to quitting, and then track what % of patients are willing to be referred to a smoking cessation team or to their primary provider for help quitting (ASSIST).
3. Our goal is to improve over baseline for all 3 A's (making the ASK process easier and friendlier and more engaging/empathic; making the ADVISE component less authoritarian and better understood in terms the patient can relate to; and improving the formal ASSIST component by letting patients know we do this for ALL patients, and they deserve only the best we have to offer, regardless of whether or not they initially succeed, so, in summary we plan to ASSIST 100% of patients who are current smokers; as a side note, some former smoker relapse in times of stress, so we also address this with them at the time of consult and let them know we are here for them and have already built a program around this if this is the case for them, as well)

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Conferences:

ACS Cancer Accreditation Programs: Continually Advancing Quality Cancer Care – **Virtual**
Available now through December 31, 2022

Webinars:

CAnswer Forum LIVE – October 2022
Wednesday, October 12, 2022, at 12 PM CDT

https://www.facs.org/quality-programs/cancer-programs/education/

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Thank you for joining the webinar today!

- Please help us improve future webinars by completing the evaluation
- Webinar posted online https://www.facs.org/quality-programs/cancer-programs/pdsa-just-ask/

Educational Webinar Series

A series of educational webinars will address many questions about the PDSA. Programs are encouraged to attend these webinars for more detailed information about the project. Attendance is not required but is strongly encouraged. Recordings and slides are available through the links below. Registration is required to listen to recorded webinars.

Previous Webinars

June 8, 2022
Watch recording | Webinar slides

April 29, 2022
Watch recording | Webinar slides

April 1, 2022
Watch recording | Webinar slides

February 16, 2022
Watch recording | Webinar slides