ACS CoC Commission on Cancer
American College of Surgeons

Smoking and Cessation Across the Continuum of Lung Cancer Risk, Treatment, and Survival

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Disclosure

- Nothing to disclose

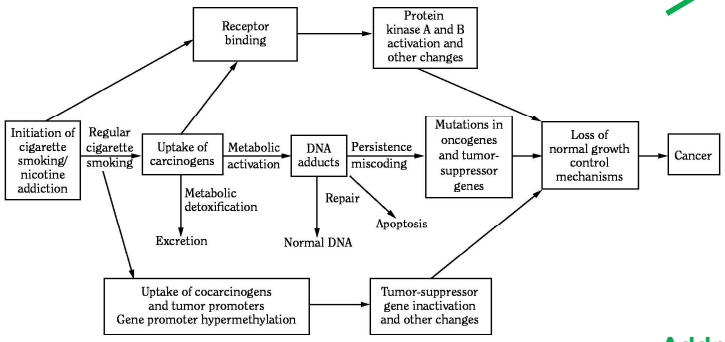
Learning Objectives

1. Understand the impact of tobacco use in cancer care
2. Recognize the importance of tobacco treatment in cancer care
3. Learn effective mechanisms of tobacco treatment

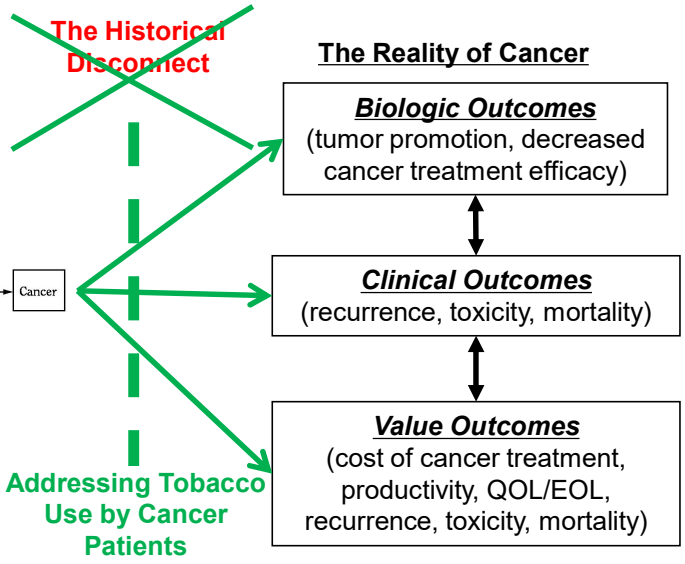
Smoking Across the Continuum of Cancer

- The biologic basis of smoking is well established (mutations, tumor promotion, tx resistance)

The Established Carcinogenesis Model

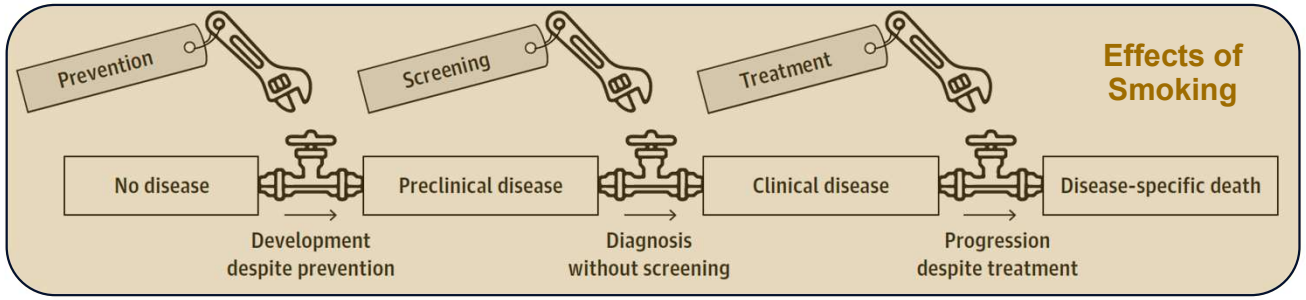


2010 Surgeon General's Report, Fig 5.1



- I like the new concept from Goddard et al. (JAMA Oncol, Dec 2024)
- With my highlight of smoking effects across prevention, screening, and treatment

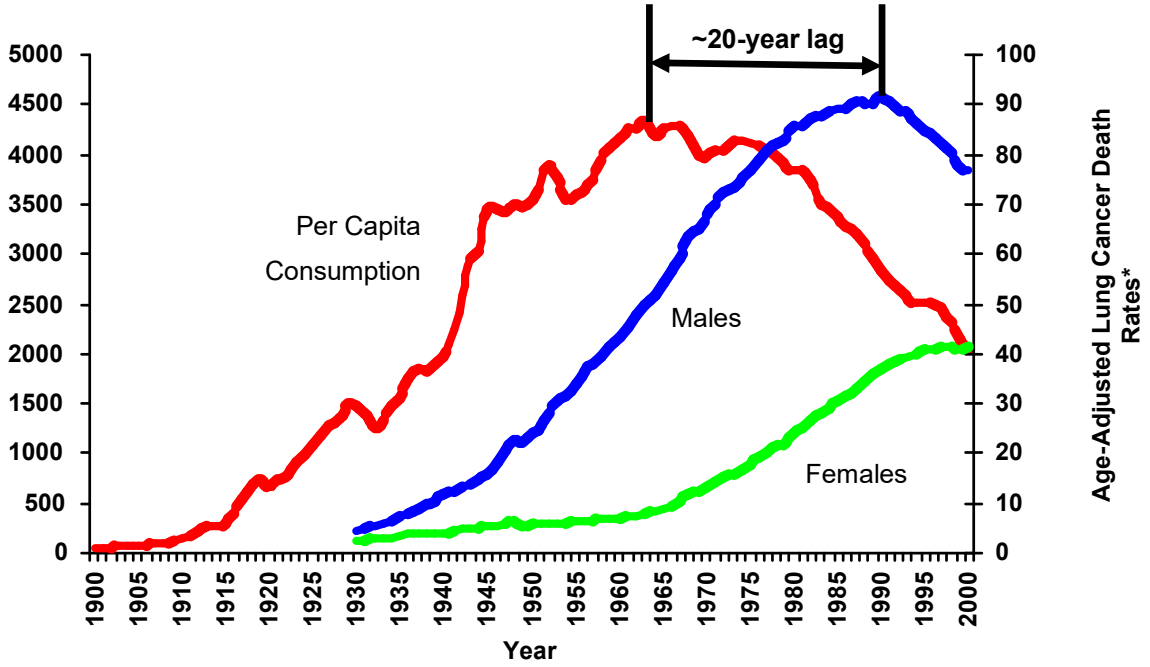
Figure. Opportunities for Averted Cancer Deaths With Prevention, Screening, and Treatment Interventions



This schematic of cancer progression shows opportunities for prevention, screening (for interception and early detection), and treatment advances to partially or completely interrupt the development and/or progression of disease that would cause death.

Cessation has a ~20-Year Survival Lag… But is the Largest Preventable Risk Factor

- ~80-85% of lung cancers caused by smoking
- Smoking may mediate risk for other risk factors
- CISNET 1975-2020 prevention, screening, and treatment avert 5.94m cancer deaths*
  - 80% (4.75m) from prevention and screening of which
  - 3.75m from lung cancer
    - 98% from tobacco control
    - 2% from screening (not widely used in this timeframe)



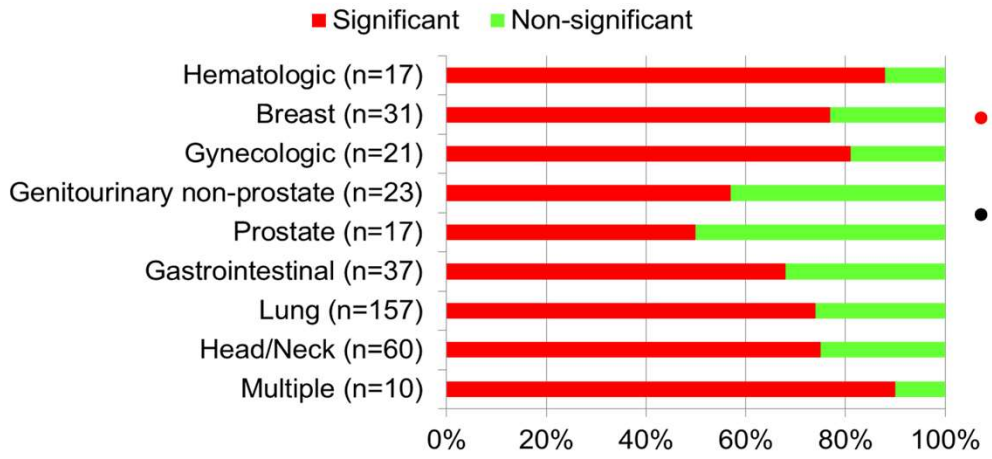
*Age-adjusted to 2000 US standard population.
Source: Death rates: US Mortality Public Use Tapes, 1960-2000, US Mortality Volumes, 1930-1959, National Center for Health Statistics, Centers for Disease Control and Prevention, 2002.
Cigarette consumption: US Department of Agriculture, 1900-2000.

*Goddard et al. JAMA Oncol Dec 2024

Effects of Smoking After a Cancer Diagnosis

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

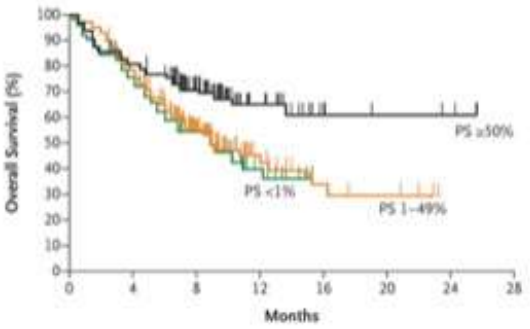
- Smoking after diagnosis adds ~$3.4 billion (US) and $239 million (Canada) in cancer treatment costs annually (2019 estimates)

Benefits of Smoking Cessation

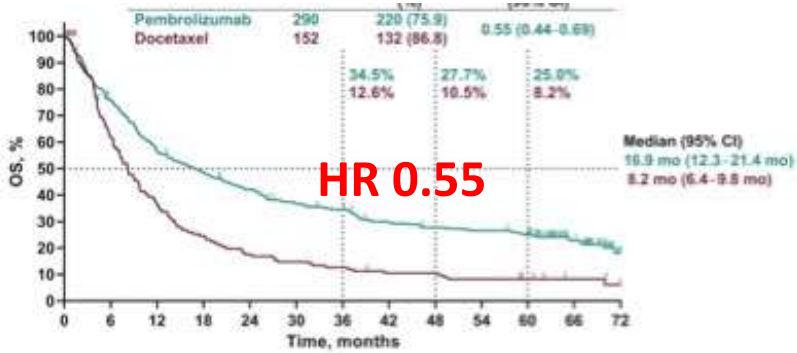
- **Smoking cessation AFTER diagnosis associated with 45% median reduction in mortality**
- Smoking cessation AT ANY TIME reduces non-cancer mortality (heart disease, pulmonary disease, etc.)

2014 SGR, 2020 SGR, Warren C3I 2021,
Warren JAMA Netw Open 2019, Irragori Curr Oncol 2020

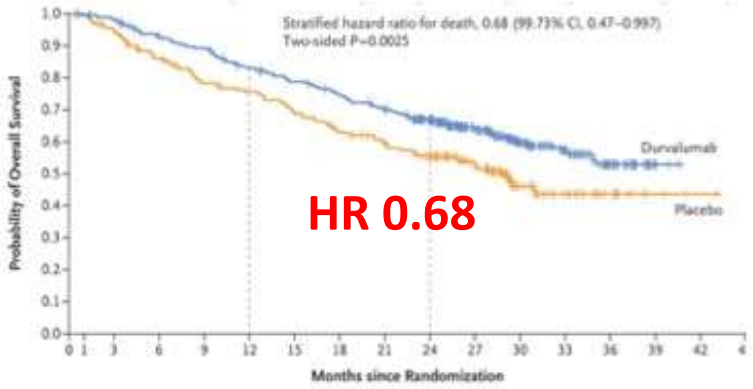
Smoking Cessation in the Context of Lung Cancer Treatment



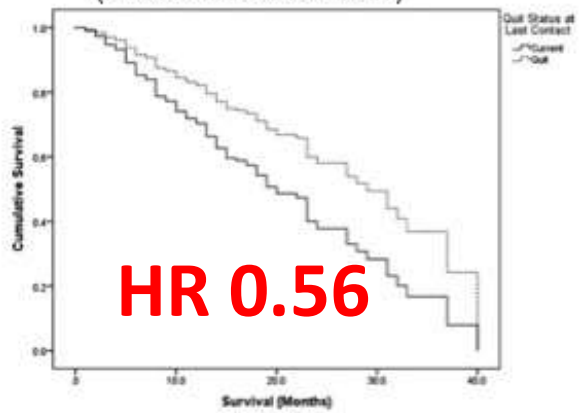
Overall Survival with Pembro by PD-L1 status, Keynote-001
(Garon et al. NEJM 2015)



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



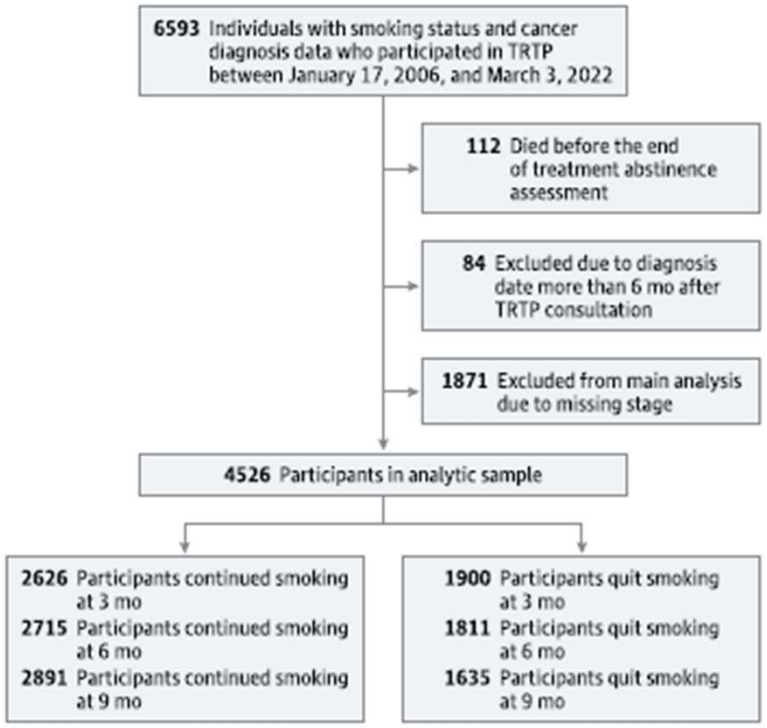
Overall Survival with Duvalumab, Pacific Trial
(Antonia et al. NEJM 2018)



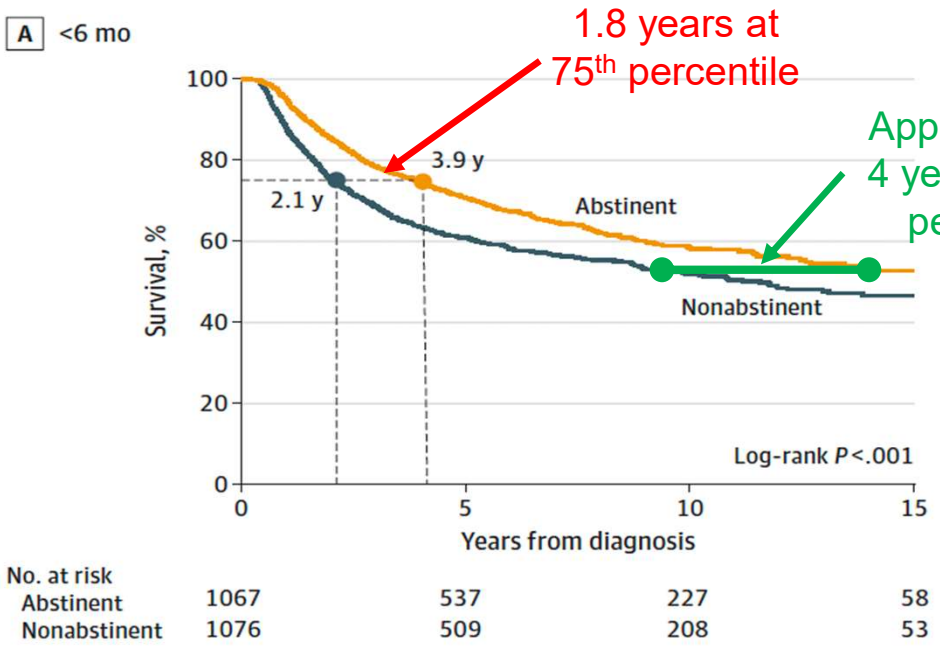
Smoking Cessation added to first line NSCLC treatment
(Dobson-Amato et al. JTO 2015)

Cessation After Diaanosis and Survival

Figure 1. Study Flow Diagram



Currently smoking patients with cancer in the Tobacco Research and Treatment Program (TRTP) at the University of Texas MD Anderson Cancer Center were enrolled in the study. After the exclusions noted in the flow diagram, 4526 individuals remained in the analytic sample.



Quitting smoking as soon as possible after diagnosis results in the highest improved survival

Cinciripini et al. JAMA Oncol Nov 2024

National Implementation Efforts

- **NCI Smoking Cessation at Lung Examination (SCALE) Initiative**
  - 8 centers funded to implement cessation into LDCT
- **NCI Cancer Centers Cessation Initiative (C3I)**
  - 52 NCI Designated Cancer Centers funded over 2 years to develop clinical cessation programs
- **National Canadian Partnership Against Cancer (CPAC) Initiative**
  - Increased access to cessation support from 26% of centers in 2016 to 95% in 2022
- **American College of Surgeons Commission on Cancer (CoC)**
  - Just ASK: 700+ sites participated in increased identification of tobacco use (yr 1)
  - Beyond ASK: 300+ sites develop cessation approaches (yr 2)

Cancer PROGRAMS
AMERICAN COLLEGE OF SURGEONS

CANCER PROGRAMS

Study Completed over 2022

Just ASK Quality Improvement Project & Clinical Study

Improving Assessing and Documenting Tobacco Use during Cancer Treatment

CANCER PROGRAMS

Study Completed over 2023

Beyond ASK Quality Improvement Project

Improving Referral to Effective Tobacco Treatment

Improved Care for Nearly 1 Million Patients

JustASK (2022)

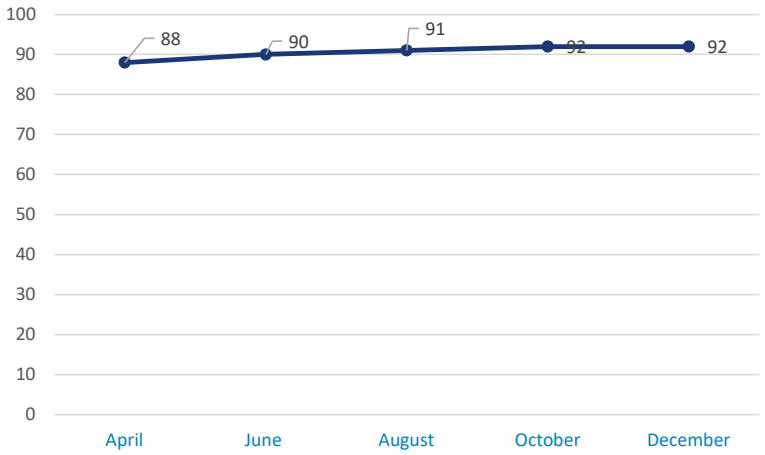
- Roughly 700 cancer programs
- About 650,000 cancer patients

BeyondASK (2023)

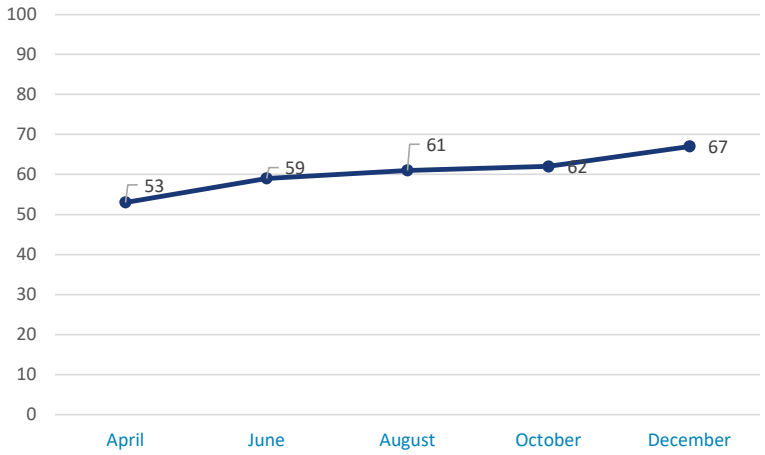
- Roughly 300 cancer programs
- About 250,000 cancer patients

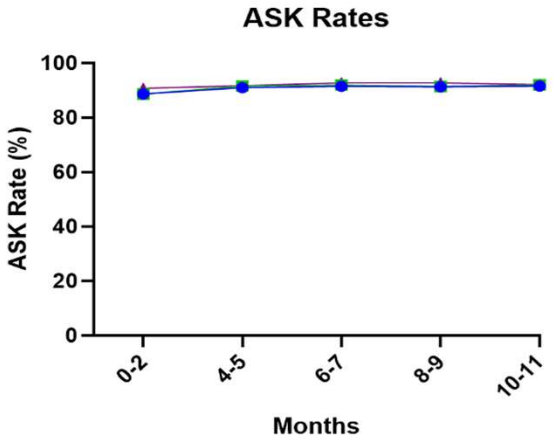
JustASK
Ask and Assist Trends (All)

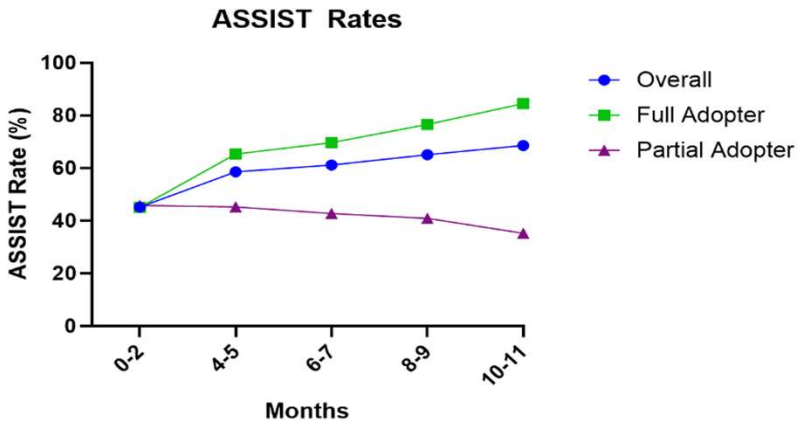
- Ask Rate
  - Most programs had participated in JustASK project

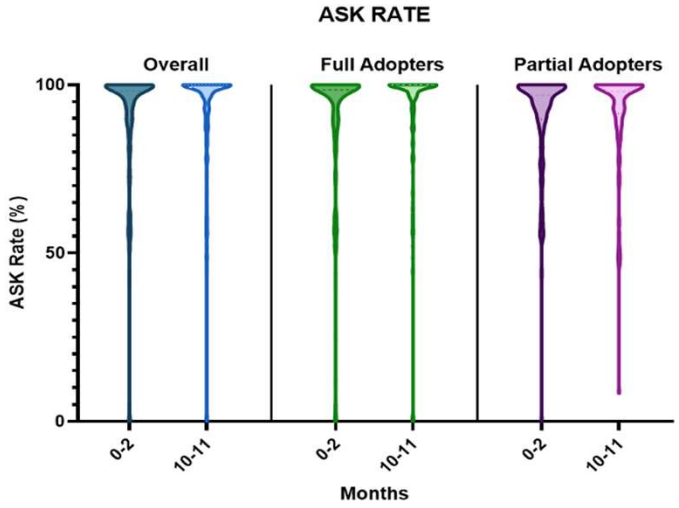


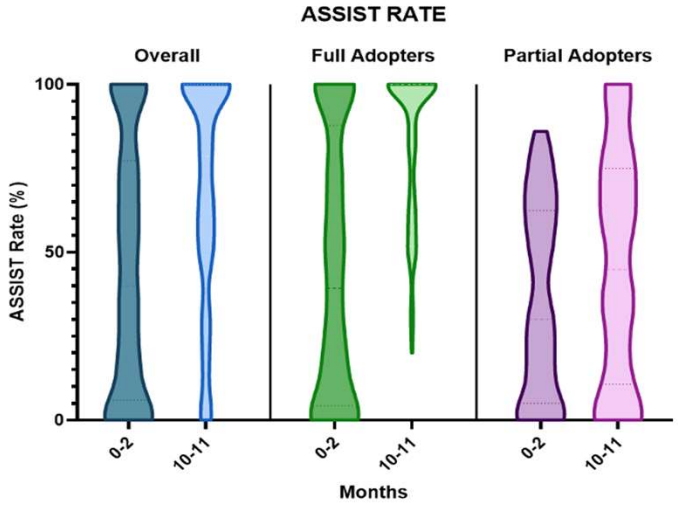
- Assist Rate

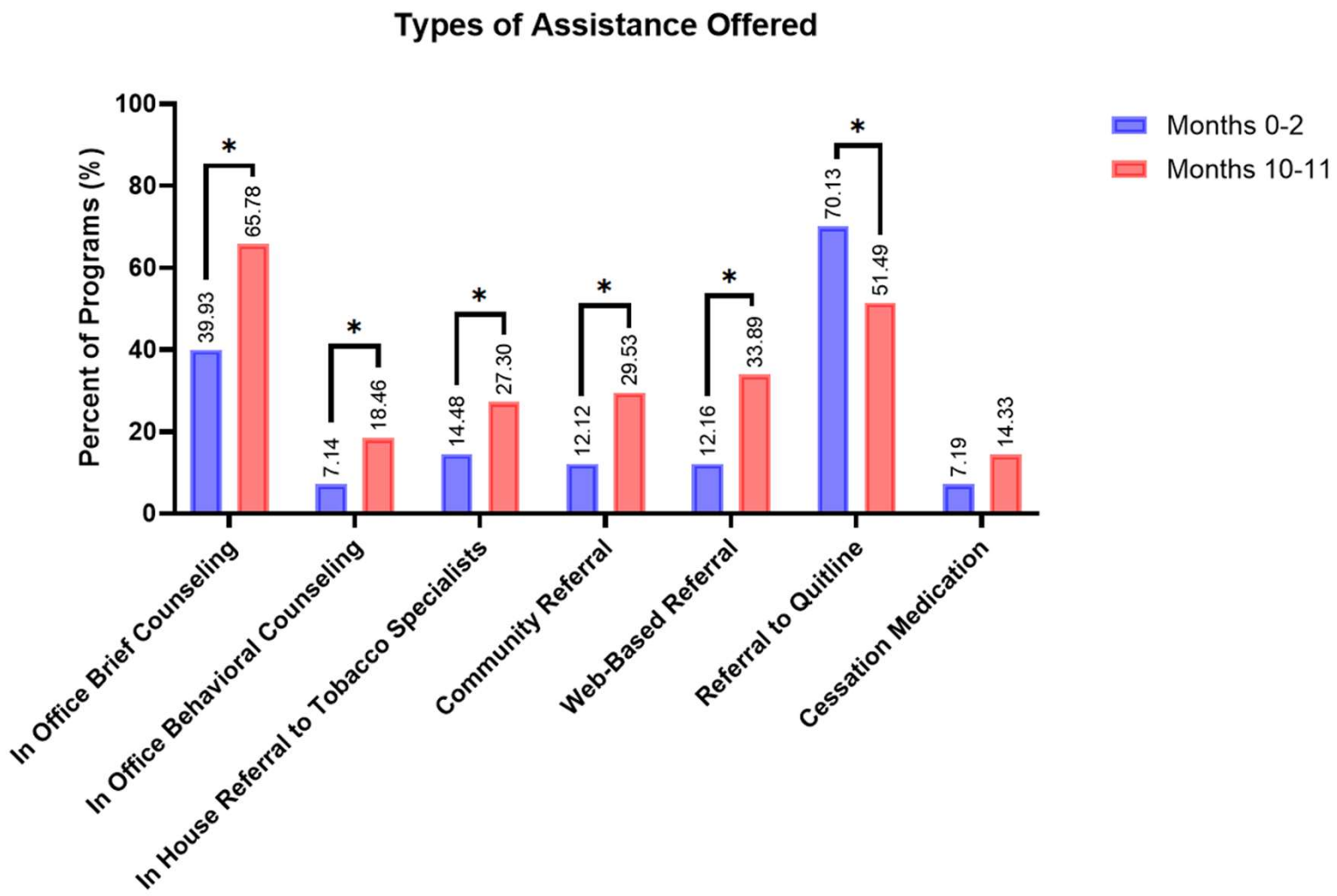












NEW CoC STANDARD 5.9

Programs will have to show plans for implementation & perform internal audit in 2026

Measured for compliance in 2027 Site Reviews

All cancer patients in CoC Accredited facility

Assess for tobacco use in the last 30 days

Determine the ASK Rate	Threshold for compliance = 90%

Assist patients found to be POSITIVE in Tobacco Use to EFFECTIVE tobacco treatment

Determine the ASSSIST Rate	Threshold for compliance = 80%

Commission on Cancer
American College of Surgeons

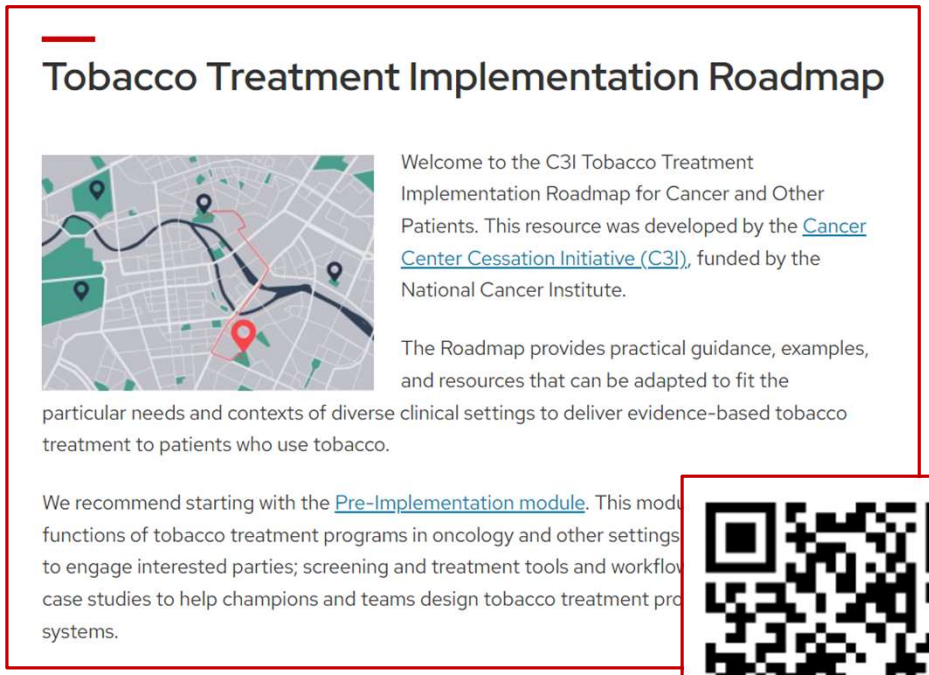
Resources for Tobacco Treatment in Cancer

Cancer Center Cessation Initiative (C3I)

- In 2017, NCI announced the Cancer Center Cessation Initiative as part of the Cancer Moonshot$_{SM}$.
- 52 NCI-designated cancer centers (CCs) funded from 2017 to 2021
  - UW served as the Coordinating Center and was therefore ineligible to be a participating center.
- Goal: Enhance capacity of CCs to treat tobacco use of all oncology patients who smoke. Funded centers were charged with:
  - Taking a population-based approach
  - Increasing the proportion of patients who received cessation treatment and their cessation outcomes
- Impact: More than **100,000** patients **reached** since 2018

www.TobaccoTreatmentRoadmap.org

A practical guide to implementing tobacco treatment programs in your cancer clinics



- *Modules*:
  - Pre-Implementation
  - Implementation
  - Sustainability
  - Treatment for All
- *Resources*:
  - Planning tools
  - Case studies
  - EHR screenshots and samples
  - External toolkits
  - Billing guidance
  - Team building and engagement tools

ACS CoC Commission on Cancer

American Heart Association®
Certified Professional
Tobacco Treatment

Certified Professional by the American Heart Association – Tobacco Treatment

The American Heart Association (AHA) is collaborating with
The Association for the Treatment of Tobacco Use and Dependence (ATTUD)
to improve tobacco treatment efforts

American Heart Association.

A global leader in fighting heart disease and stroke and helping families and communities thrive

www.heart.org

ATTUD
Association for the Treatment of Tobacco Use and Dependence

A non-profit, multi-disciplinary organization of professionals dedicated to supporting the efforts of those providing clinical tobacco dependence services and increasing access to evidence-based treatments

www.attud.org

Certification Process

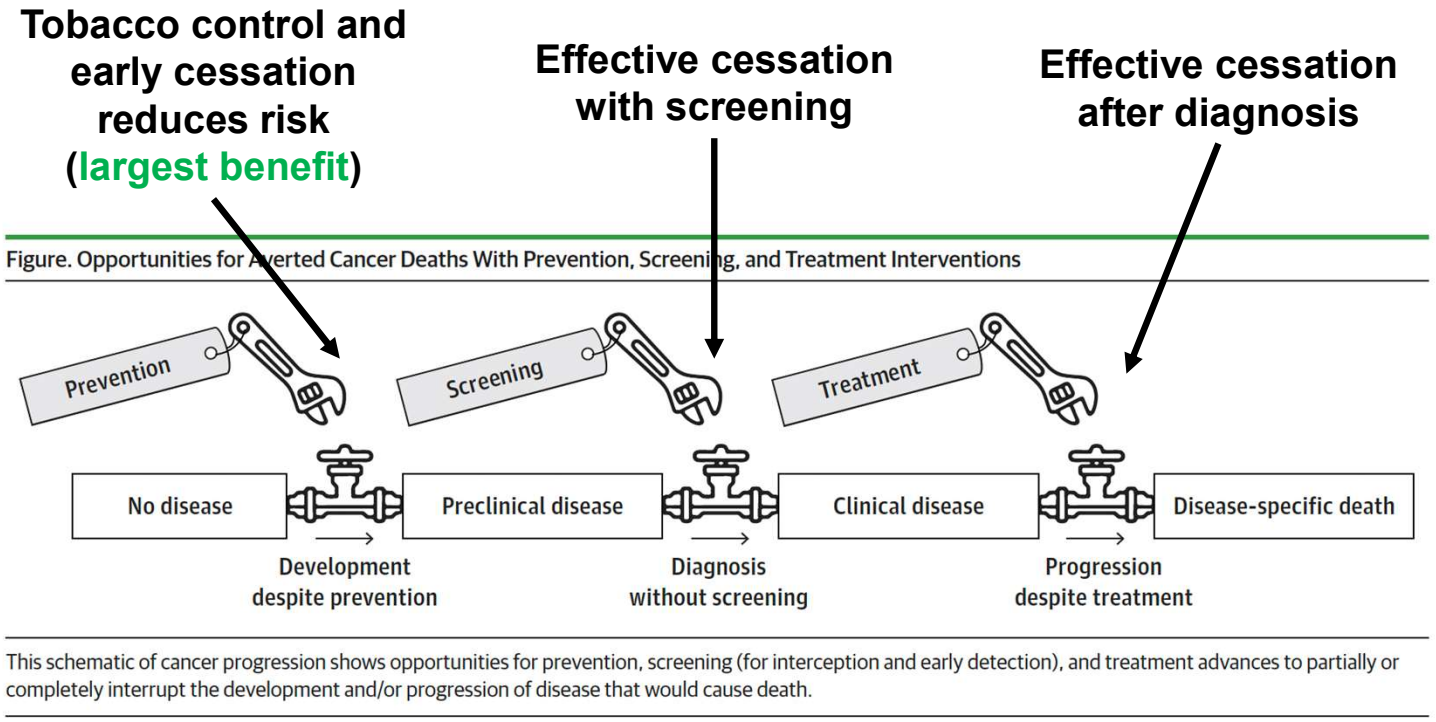
Eligibility Requirements:

- Associates degree level of education
- Completion of an accredited Tobacco Treatment Specialist training program
- Payment of required fee(s)

Certification Maintenance:

- Over 3 years, obtain 20 CE credits in approved tobacco treatment and related subject areas
- Alternatively, individuals may opt to retake the exam at full cost in lieu of continuing education credits

Smoking Must be Addressed with All Steps of the Lung Cancer Continuum



Smoking cessation may be the EASIEST, CHEAPEST, and LOWEST TOXICITY approach to significantly improve patient outcomes

Summary

- Smoking is the largest preventable risk factor for lung cancer
- Tobacco control (primary and smoking cessation) is a proven method to reduce lung cancer incidence and mortality
- Smoking/tobacco may interact with other risk factors
  - Mixed vs. pure risk factors
- Clear evidence supports clear clinical benefits for smoking cessation across the entire spectrum of lung cancer risk, diagnosis, treatment, and survival

Efforts to address lung cancer must consider smoking and cessation

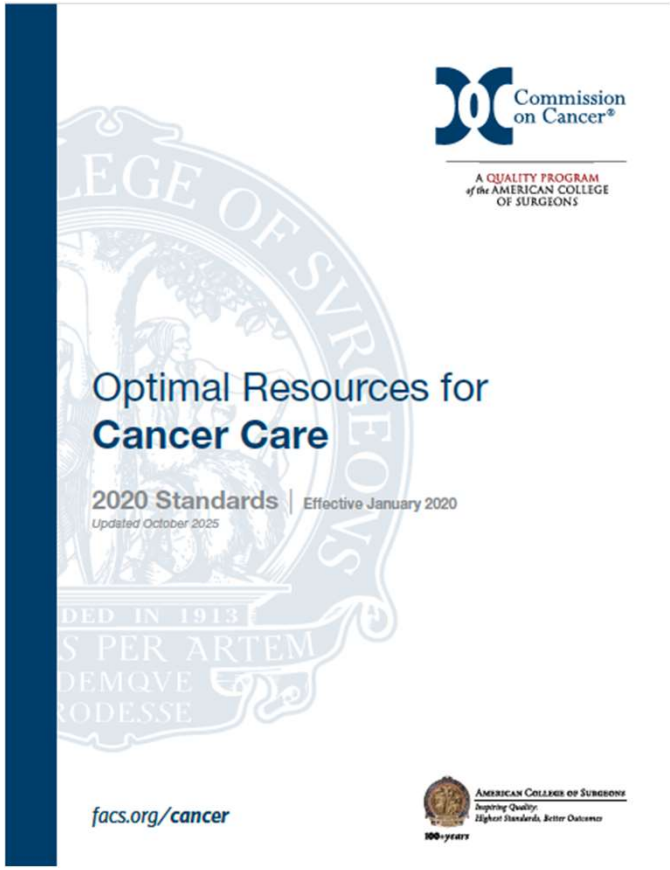
ACS CoC Commission on Cancer
American College of Surgeons

Standard 5.9: How to Achieve Compliance

Aaron Bleznak, MD, MBA, FACS, FSSO
Chair, CoC Accreditation Committee

CoC Accreditation Standards

New Standards Manual



IMPLEMENTATION DATE: JANUARY 1, 2026

5.9 Smoking Cessation for Patients with Cancer

Definition and Requirements

Cigarette smoking by patients with cancer and survivors causes adverse health outcomes. Smoking cessation at or following a cancer diagnosis improves cancer outcomes and enhances quality of life.

The cancer committee must implement a process for patients with newly diagnosed cancer to be screened for current smoking. Patients who report current smoking must receive or be referred for smoking cessation treatment consistent with evidence-based guidelines. Services to deliver evidence-based smoking cessation treatment must be available on site or by referral (for example to the state quitline).

For purposes of this standard, current smoking is limited to cigarette smoking.

Screening
Screening for smoking must be performed for patients newly-diagnosed with cancer at an initial patient encounter or consultation within the accredited program for cancer treatment. Continued screening during follow-up visits is encouraged but not required by this standard.

Screening for smoking must identify patients as currently smoking, formerly smoking, or never smoking (options mutually exclusive). For this standard, current smoking is defined as any smoking within the past 30 days.

Timing of Screening
Cancer programs must conduct and document screening for current smoking at the patient's first encounter or an initial consultation at the accredited cancer program for cancer treatment.

Method of Screening
Cancer programs may utilize standardized screening protocols available through most medical record systems. Documentation must be in a structured, accessible format (ideally, a core data element in the electronic medical record). Programs that screen using paper-based methods must be able to evaluate data to provide an annual report to the cancer committee.

Assessment and Referral
All patients who report current smoking must be referred or receive access to evidence-based smoking cessation treatment within 30 days of the screening for smoking status. Evidence-based smoking cessation treatment must be available either on site or by referral with an established protocol.

Cancer programs must provide access to smoking cessation treatment, either on-site or by referral, consisting of core elements of behavioral counseling and pharmacotherapy, which must include one or more of the following:

- Individual counseling by certified Tobacco Treatment Specialists
- Physicians or healthcare providers providing counseling concordant with evidence-based smoking cessation guidelines.
- Referral to on-site smoking cessation group or classes
- Referral to state quitlines or other community resources such as Health Departments or the American Cancer Society free smoking cessation program
- Prescription of FDA-approved smoking cessation medication
- Enrollment in established mobile health program (example: SmokefreeTXT)
- Any combination of the above treatment approaches

Providing brochures with patient education without referral to treatment does not meet the standard. Additionally, verbal suggestions for smoking cessation without evidence-based concordant counseling does not meet the standard.

Tools
The Cancer Committee selects and approves the local method for screening, documentation, and referral using evidence-based approaches. Screening must use standardized assessments, cannot rely simply on reviews of prior assessments (copy forward), and must be documented in the medical record. Smoking status from primary care visits or other non-cancer visits do not meet the requirements of the standard.

Smoking cessation treatment should include core elements of behavioral counseling and pharmacotherapy.

Protocol for Identifying and Referring Patients who Smoke
A protocol must be in place for identifying and referring patients with newly diagnosed cancer who currently smoke to evidence-based smoking cessation treatment. The protocol must outline the methods of treatment available on-site or by referral.

Auditing Smoking Cessation Process
Each calendar year, the cancer committee must conduct an internal audit of a minimum of 20 patients with newly diagnosed cancer to determine:

- The number of patients with newly diagnosed cancer screened
- The number of patients with newly diagnosed cancer who reported current smoking

3. If the internal audit demonstrates the required thresholds were not met, then an action plan must be documented in the cancer committee meeting minutes and implemented by the cancer program.

Resources

Empowered to Quit: Tobacco Cessation Program | American Cancer Society
Evidence-based, free email intervention which demonstrated same (or slightly better) effectiveness as pharmacotherapy + counseling.

Quit Tobacco: How To Quit Smoking or Smokeless Tobacco | American Cancer Society
Resources on quitting use of tobacco products.

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Requiring Annual Review.

Standard 5.9: Smoking Cessation for Patients with Cancer

CoC

Read

CoC Standards
Cancer Program Infrastructure

Implement

Data Collection
Analysis
Reporting Tools

Do the Work

Report

Feedback
Quality Improvement
Planning

Assess & React

Clarification on Reporting Timelines

Standards Requiring Annual Review

Work to obtain compliance in one Commission on Cancer (CoC) standard may not replace, duplicate, or augment the work required to obtain compliance with another standard. The exceptions to this rule are Standard 6.4: Rapid Cancer Reporting System: Data Submission and Standard 7.3: Quality Improvement Initiative.

The following standards must be reported at the first quarter meeting of the following year. The report must include a full calendar year of reporting data. For example, reports on 2025 activity must include data from all of 2025 and be reported at a meeting in the first quarter of 2026. Reports provided to the cancer committee with a partial calendar year of reporting data must also be included in the final report given at the first quarter meeting of the following year. The reports must be documented in the cancer committee meeting minutes and include all elements.

- Standard 2.5: Multidisciplinary Cancer Case Conference
- Standard 4.4: Genetic Counseling and Risk Assessment
- Standard 4.5: Palliative Care Services
- Standard 4.8: Survivorship Program
- Standard 5.2: Psychosocial Distress Screening
- Standard 9.1: Clinical Research Accrual

The following standards require an annual evaluation, but do not necessarily require data review. These standards may be presented and discussed with the cancer committee at any time during the calendar year under evaluation or at a meeting during the first quarter of the following year.

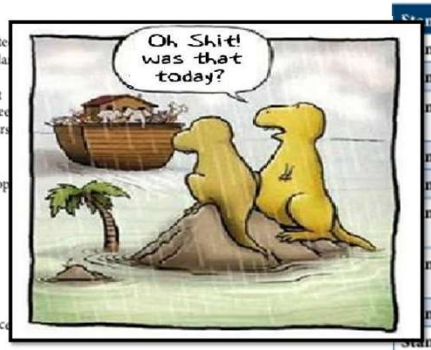
- Standard 4.2: Oncology Nursing Credentials
- Standard 4.6: Rehabilitative Care Services
- Standard 4.7: Oncology Nutrition Services
- Standard 8.1: Addressing Barriers to Care

The following standards require annual activities such as audits, projects, reports, or events. They must be conducte and presented to the cancer committee within the calenda year per the frequency required in the standard. The presentation to the cancer committee may be provided at any time during the calendar year after the activity has be completed. These standards cannot be presented in the firs quarter of the following calendar year.**

- Standard 2.2: Cancer Liaison Physician*
- Standard 5.1: College of American Pathologists Synop Reporting
- Standard 5.9: Smoking Cessation for Patients with Cancer
- Standard 6.1: Cancer Registry Quality Control
- Standard 6.4: Rapid Cancer Reporting System: Data Submission*
- Standard 7.1: Quality Measures
- Standard 7.2: Monitoring Concordance with Evidenc Based Guidelines
- Standard 7.3: Quality Improvement Initiative*
- Standard 7.4: Cancer Program Goal*
- Standard 8.2: Cancer Prevention Event
- Standard 8.3: Cancer Screening Event

*Standard requires multiple status updates per calendar year. Both updates must be provided within the calendar year or per standard requirements.

**Standards 7.3 and 7.4 activities can be extended into a second year. To be compliant, the intent to do so must be stated during the calendar year the quality improvement or goal was initiated and a final report must be given in the subsequent year after the QI or goal is completed.



Standard	Data Required	Review Timeframe
ndard 2.2: Cancer Liaison Physician*	Activity Completed	During the year of activity
ndard 2.5: Multidisciplinary Cancer Case Conference	Full Calendar Year	Q1 of the following year
ndard 4.2: Oncology Nursing Credentials	12 months of Observations	During the year of activity or Q1 following year
ndard 4.4: Genetic Counseling and Risk Assessment	Full Calendar Year	Q1 of the following year
ndard 4.5: Palliative Care Services	Full Calendar Year	Q1 of the following year
ndard 4.6: Rehabilitative Care Services	12 months of Observations	During the year of activity or Q1 following year
ndard 4.7: Oncology Nutrition Services	12 months of Observations	During the year of activity or Q1 following year
ndard 4.8: Survivorship Program	Full Calendar Year	Q1 of the following year
Standard 5.1: CAP Synoptic Reporting	Activity Completed	During the year of activity
Standard 5.2: Psychosocial Distress Screening	Full Calendar Year	Q1 of the following year
Standard 5.9: Smoking Cessation for Patients with Cancer	Activity Completed	During the year of activity
Standard 6.1: Cancer Registry Quality Control	Activity Completed	During the year of activity
Standard 6.4: RCRS: Data Submission*	Activity Completed	During the year of activity
Standard 7.1: Quality Measures	Activity Completed	During the year of activity
Standard 7.2: Monitoring Concordance with Evidence-Based Guidelines	Activity Completed	During the year of activity
Standard 7.3: Quality Improvement Initiative*	Activity Completed	During the year of activity
Standard 7.4: Cancer Program Goal*	Activity Completed	During the year of activity
Standard 8.1: Addressing Barriers to Care	12 months of Observations	During the reporting year or Q1 following year
Standard 8.2: Cancer Prevention Event	Activity Completed	During the year of activity
Standard 8.3: Cancer Screening Event	Activity Completed	During the year of activity
Standard 9.1: Clinical Research Accrual	Full Calendar Year	Q1 of the following year

Standard 5.9: Process

Process Requirements

- Must implement process to screen for smoking status in patients with newly diagnosed cancer at initial consultation at accredited program for cancer treatment
- Referrals must receive or be referred for smoking cessation treatment consistent with evidence-based guidelines.
- Services must be available on-site or by referral

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- Must implement process to screen for smoking status in patients with newly diagnosed cancer at initial consultation at accredited program for cancer treatment
- Referrals must receive or be referred for smoking cessation treatment consistent with evidence-based guidelines.
- Services must be available on-site or by referral

Assessment and Referral

All patients who report current smoking must be referred or receive access to evidence-based smoking cessation treatment within 30 days of the screening for smoking status. Evidence-based smoking cessation treatment must be available either on site or by referral with an established protocol.

Cancer programs must provide access to smoking cessation treatment, either on-site or by referral, consisting of core elements of behavioral counseling and pharmacotherapy, which must include one or more of the following:

- Individual counseling by certified Tobacco Treatment Specialists
- Physicians or healthcare providers providing counseling concordant with evidence-based smoking cessation guidelines.
- Referral to on-site smoking cessation group or classes
- Referral to state quitlines or other community resources such as Health Departments or the American Cancer Society free smoking cessation program
- Prescription of FDA-approved smoking cessation medication
- Enrollment in established mobile health program (example: SmokefreeTXT)
- Any combination of the above treatment approaches

Providing brochures with patient education without referral to treatment does not meet the standard. Additionally, verbal suggestions for smoking cessation without evidence-based concordant counseling does not meet the standard.

Standard 5.9: Smoking Cessation for Patients with Cancer

Audit Requirements

- Each year, cancer committee must conduct an internal audit of a minimum of 20 patients with newly diagnosed cancer to determine:
  - # screened
  - # who reported current smoking
  - # who reported smoking and received/were referred for smoking cessation treatment

- Action plan required if audit shows:
  - Less than 90% of patients were screened for smoking status
  - Less than 80% of current smokers were referred for treatment

Auditing Smoking Cessation Process

Each calendar year, the cancer committee must conduct an internal audit of a minimum of 20 patients with newly diagnosed cancer to determine:

- The number of patients with newly diagnosed cancer screened
- The number of patients with newly diagnosed cancer who reported current smoking
- The number of patients with newly diagnosed cancer who reported current smoking who received or were referred to smoking cessation treatment

The internal audit must include, at a minimum, 10 patients who currently smoke to determine whether they were referred. If the initial 20 medical records reviewed do not include 10 patients who currently smoke, additional medical records must be reviewed until at least 10 patients who currently smoke and their referral status are identified.

A refusal of a referral by the patient counts as a referral for purposes of the internal audit.

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Standard 5.9: Smoking Cessation for Patients with Cancer

For cancer programs that use multiple smoking cessation methods, programs are encouraged, but not required, to document how many patients use each method of treatment.

The results of the completed internal audit, including any action plans, must be presented to the cancer committee and the presentation must occur during the same calendar year. The results of the audit and any required action plans are documented in the cancer committee meeting minutes.

Standard 5.9: Smoking Cessation for Patients with Cancer

- **Double Dipping:** Work to obtain compliance with one CoC standard may not replace/duplicate/augment the work required to obtain compliance with another standard
  - Notable exceptions are NCDB reporting and QI projects

- Improving an existing process for identification of current smokers and referral to smoking cessation could be a S7.3 QI project

Any Questions?

Thank you!

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