



American Society of Clinical Oncology

*Making a world of difference in cancer care*

# Tobacco Cessation Guide

For Oncology Providers



## **ABOUT ASCO**

The American Society of Clinical Oncology (ASCO) is the world's leading professional organization representing physicians of all oncology subspecialties who care for people with cancer. ASCO's more than 30,000 members from the United States and abroad set the standard for patient care worldwide and lead the fight for more effective cancer treatments, increased funding for clinical and translational research, and, ultimately, cures for the many different types of cancer that strike an estimated 12 million people worldwide each year.

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# Tobacco Cessation Guide

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# 1. Talking to Patients About Tobacco Use



## Key Points

- Patients with cancer who continue to use tobacco have poorer treatment outcomes compared to their counterparts who do not use tobacco, regardless of whether the cancer was tobacco related.
- Tobacco use is a serious concern for all patients at all stages of disease, including survivors and those with late-stage disease.
- Blame should not be placed on patients for their tobacco use and/or cancer.
- Relapse is common and should be viewed as a reflection of the individual's addiction to nicotine.
- Tobacco use should be assessed for every patient at every clinic visit.

## Why Do I Need to Talk to My Patients About Their Tobacco Use?

**“Continued smoking negatively affects survival in my cancer patients.”**

—Graham Warren, MD, PhD, *radiation oncologist at Roswell Park Cancer Institute*

Although there is no disputing that tobacco use is the cause of several kinds of cancers, many patients wonder whether it is too late to worry about tobacco use once they have been diagnosed with cancer, a common misconception held by oncologists and patients alike. In fact, evidence shows that patients with cancer who continue to use tobacco have poorer treatment outcomes compared to their counterparts who stop using tobacco, a finding that seems to hold in patients with many different types of cancer,

**Table 1.1. Benefits of tobacco cessation and risks of continued use in patients with cancer**

Tobacco cessation leads to:	Continued tobacco use after diagnosis leads to:
<ul style="list-style-type: none"> <li>• Improved treatment outcomes</li> <li>• Reduced side effects</li> <li>• Improved survival</li> <li>• Decreased risk of infection</li> <li>• Improved breathing and increased energy</li> <li>• Improved quality of life</li> </ul>	<ul style="list-style-type: none"> <li>• Higher complication rates from surgery and slower recovery</li> <li>• Higher treatment-related toxicity from chemotherapy and radiotherapy</li> <li>• Increased risk of cancer recurrence</li> <li>• Increased risk of other serious ailments such as cardiovascular and respiratory disease</li> <li>• Reduced treatment effectiveness</li> <li>• Safety risks for patients with reduced consciousness or on oxygen</li> <li>• Increased risk of second primary cancer</li> <li>• Shorter survival</li> </ul>

regardless of whether the cancer was tobacco related. The good news is that quitting can have health benefits and evidence-based interventions to support quit efforts are available.<sup>1</sup> For this reason, the American Society of Clinical Oncology® encourages oncology healthcare providers to provide tobacco cessation support to their patients.<sup>2</sup> Tobacco use is a serious concern for patients at all stages of disease and points of treatment, including for survivors of cancer and those with advanced stage disease.<sup>3,4</sup> Table 1.1 summarizes the benefits of not using tobacco and the risks of continued tobacco use after diagnosis.

### **What Do I Need to Ask My Patients About Their Tobacco Use?**

Because tobacco use can affect how your patient will respond to their cancer therapy and recovery it is important to get an accurate picture of their past and current tobacco use behaviors.

Tobacco use history and current tobacco use is best measured by asking about duration and amount of tobacco used prior to diagnosis, as well as currently. Included in Chapter 4 are several patient assessment and management tools that illustrate how to obtain this information, such as our Assessment of Tobacco Use History tool (Table 4.1) and Assessment of Tobacco Use During Routine Patient Encounters tool (Table 4.2). Finding out when smokers have their first cigarette after waking up provides an indication of addiction. Past tobacco use is important as even those who may have quit smoking can be vulnerable to relapse. Smokers living with other smokers may face more challenges quitting and remaining tobacco-free. Exposure to second-hand smoke is also a risk for the patient's health. It is important to frame these questions as integral to a patient's program of care and to not place "blame" for their disease.

Even though many cancer patients will report discontinuing their tobacco use immediately prior to their diagnosis, relapse is common, so it is important to assess tobacco use at each patient encounter, as illustrated by the standard questions shown in Table 4.2.

Some patients may be reluctant to share information about their tobacco use because of perceived stigmata. Previous studies have found that patients with cancer who report themselves to be recent former smokers (i.e., have quit in the past year) will sometimes test positive for cotinine, a biomarker of nicotine exposure.<sup>6,7</sup> Thus, routine biochemical testing for tobacco use might be worthwhile for those patients who report recently quitting. For all other patients, self-reported tobacco use status appears to be accurate. If you suspect that a patient is not accurately reporting their tobacco use, one option is to perform a biochemical test to validate their self-report, as illustrated in Table 1.2.

**Table 1.2. Biochemical Tests to Validate Self-reported Exposure**

Method	How it works
Carbon Monoxide (CO)	Can be measured in blood or in an exhaled breath sample. The breath test provides real time feedback on exposure to CO and is typically an accurate measure, within 8-12 hours, of someone smoking tobacco. CO testing is not useful for measuring exposure to non-combustible forms of tobacco and is less effective for non-daily smoking.
Cotinine	Cotinine is a metabolite of nicotine that indicates exposure to nicotine. The half-life is about 48 hours, so the test is good for validating exposure within a few days to a week. Cotinine can be measured in urine, blood, and/or saliva. There are dipsticks/kits that can be purchased for clinic use that allow real-time assessment in saliva and/or urine. Other sources of nicotine, such as use of nicotine medications, e-cigarettes, and even exposure to second-hand smoke, can elevate cotinine levels.

## How Can I Help My Patients to Stop Using Tobacco?

A person newly diagnosed with cancer is often motivated to stop using tobacco and therefore receptive to discussions on how to do so. However, motivation to stop is often not enough to ensure that an addicted tobacco user can refrain from using tobacco in the long term. While many patients will quit at the time of diagnosis or even during therapy, many will begin smoking again because of their addiction to nicotine. Thus, for many patients relapse is not so much caused by a lack of motivation, but is instead a reflection of a person's addiction to nicotine.

Most tobacco users have made prior attempts to quit. Willingness to make an attempt to quit can be assessed by asking your patients if they are ready to stop using tobacco

now. You may find that a patient who is resistant to ceasing tobacco use during one visit will have a completely different attitude about stopping the next time you see him or her. Recommendations to the patient can influence their motivation to stop using tobacco; however, not everyone is ready to stop at a given time, so motivation level needs to be assessed repeatedly. A patient who stops smoking and then relapses may be discouraged the next time you speak with him or her about their tobacco use, so it helps to support the decision to try again.

Nicotine addiction is different from motivation.<sup>9</sup> It doesn't change so readily. Drug addiction is broadly defined as the "persistent, compulsive use of a substance known by the user to be harmful." You can't change someone's biology, but you can assess the level of someone's nicotine addiction and better tailor your treatments accordingly. Anyone who has been a persistent daily smoker over their lifetime is more than likely addicted to nicotine even though many patients will have stopped smoking or cut back substantially on their smoking by the time they come to visit the oncologist. It is important to get an accurate picture of your patient's past smoking behavior to fully appreciate the strength of their nicotine addiction. Those who report a past history of frequent (one pack-plus per day) smoking and who tell you that they usually smoked their first cigarette of the day when they wake up are likely to have a stronger addiction to nicotine, even though they might not be smoking a lot when you see them. Table 4.3 shows the Heaviness of Smoking Index (HSI) which is a simple two-question assessment tool for measuring someone's degree of nicotine dependence.<sup>10,11</sup> Please note that the HSI measure was developed based on the general population. Some patients cut down on or quit using tobacco after a cancer diagnosis. Understanding how a patient has changed their tobacco usage after a tobacco diagnosis is important when determining a cessation plan.

The value of assessing nicotine addiction is that it will help tailor a treatment plan for tobacco cessation. Patients with cancer who are more addicted will probably need more support to help them with their tobacco dependence. The next chapter of this guide describes materials and techniques you can use to motivate your patients to stop using tobacco. Chapter 3 summarizes the current evidence on behavioral and pharmacologic treatments for nicotine addiction and provides a simple guide for tailoring treatments to patients based upon their motivation to stop using tobacco and their level of nicotine addiction.

Chapter 4 provides some practical tips on how to incorporate tobacco assessment and treatment into the routine practice of oncology and get reimbursed for doing so.



## 2. Motivating Patients to Stop Using Tobacco

### Key Points

- Be direct with your patients about how tobacco use will diminish the effectiveness of their treatment, including surgery, radiation therapy, and chemotherapy.
- Talk to your patients at every visit to monitor their attempts to quit, any successes in quitting, and any relapses.
- Anticipate any misconceptions your patients may have about the risks of tobacco use and quitting; keep the conversation focused on the importance of changing their tobacco use habits and the benefits of quitting.

### What Should I Tell My Patients About Tobacco Use and Their Cancer Treatment?

**“Tell your patients that the most important thing they can do to help their treatment is to stop tobacco use.”**

—Graham Warren, MD, PhD, *radiation oncologist at Roswell Park Cancer Institute*

In planning your patient’s care it is essential to also talk to them about their tobacco use. When conveying the impact of tobacco use on their treatment, the best approach is the most direct one—tell your patients that tobacco use will diminish the effectiveness of their treatment. In other words, for patients to have the best possible odds of success for their treatment and long-term survivorship they need to stop using tobacco. There is now accumulated evidence documenting the adverse effects of tobacco use on treatment outcomes for many types of cancer and treatment modalities, including cancers not directly caused by tobacco use (e.g., breast and prostate cancer).<sup>3</sup>

Treating tobacco dependence can be viewed as part of symptom management. Hospitalization is an excellent opportunity to support patients by reducing nicotine withdrawal and discomfort through the use of medications (as described in Chapter 3) and placing them in a smoke-free environment.

Table 2.1 provides information you can share with your patients to educate them about how their continued use of tobacco during cancer treatment can adversely influence outcomes related to surgery, radiation therapy, and chemotherapy. You can point out to your patients that cigarette smoking is considered one of the top risk factors for developing complications after surgery. The vasoconstrictive actions of nicotine can impede blood flow. At the same time, smoking increases the amount of carbon monoxide circulating in the blood at the expense of oxygen. This deadly combination raises risks that can compromise wound healing after surgery and increase the likelihood of surgical



**Table 2.1. Impact of Smoking on Cancer Treatments**

Surgery	Radiation	Chemotherapy
<ul style="list-style-type: none"> <li>• Increased complications from general anesthesia</li> <li>• Increased risk of severe pulmonary complications</li> <li>• Detrimental effects on wound healing, including:                             <ul style="list-style-type: none"> <li>◦ Compromised capillary blood flow</li> <li>◦ Increased vasoconstriction</li> <li>◦ Increased risk of infection</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• Reduced treatment efficacy</li> <li>• Increased toxicity and side effects, including:                             <ul style="list-style-type: none"> <li>◦ Xerostomia (dry mouth)</li> <li>◦ Oral mucositis</li> <li>◦ Loss of taste</li> <li>◦ Pneumonitis</li> <li>◦ Soft-tissue and bone necrosis</li> <li>◦ Poor voice quality</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• Potential exacerbation of side effects including:                             <ul style="list-style-type: none"> <li>◦ Immune suppression</li> <li>◦ Weight loss</li> <li>◦ Fatigue</li> <li>◦ Pulmonary and cardiac toxicity</li> </ul> </li> <li>• Increased incidence of infection</li> </ul>

site infections. Smoking also raises the risk of severe pulmonary complications, including bronchospasms, during and after surgery, and increases complications from general anesthesia due to the fact that smokers may have more mucus in their lungs and be less able to clear that mucus. Because of these issues and others, many surgeons insist that their patients stop smoking for at least two weeks before an operation and, if time permits, encourage much lengthier abstinence prior to surgery.

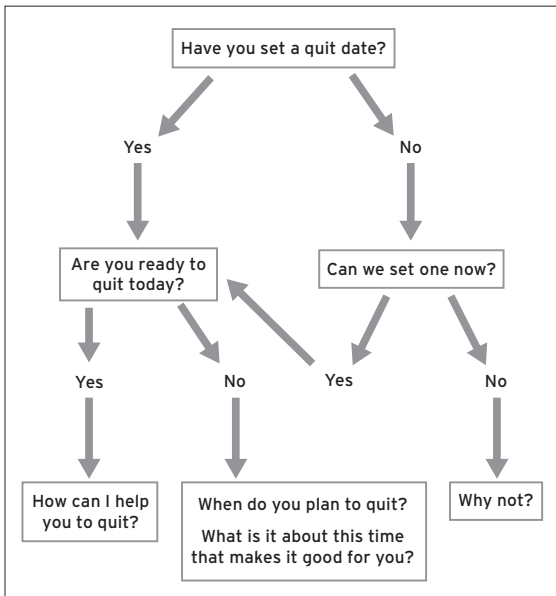
For patients undergoing radiation therapy, you can point out that patients who continue to smoke have lower rates of complete response to radiation when compared with nonsmokers and smokers who quit prior to treatment. They may also experience increased toxicity and side effects. Side effects associated with continuing to smoke during radiation include oral mucositis, loss of taste, xerostomia (dry mouth), weight loss, fatigue, pneumonitis, soft tissue and bone necrosis, and poor voice quality.<sup>3</sup>

For patients receiving chemotherapy you can point out that studies show that smoking has the potential to exacerbate drug toxicity and side effects, thereby making patients even sicker during the treatment than they would be otherwise.<sup>12,13</sup> Smoking may also impair the patient’s immune function, increase the incidence of infection, and exacerbate common side effects like weight loss, cachexia, fatigue, and pulmonary and cardiac toxicity.<sup>4</sup> Smoking may also alter the metabolism and/or mechanism of action of their chemotherapy—making it less effective. As part of the effect of a changing metabolism, the patient should gain an increased appetite after quitting smoking. Adequate nutrition is important no matter what type of cancer treatment is undertaken to prevent weight loss as much as possible—and quitting smoking can help prevent weight loss.

**When is the Best Time to Talk to My Patients About Their Tobacco Use?**

It is important to talk about your patient’s tobacco use during every visit to monitor ongoing attempts to quit, relapses, and success in quitting. A person newly diagnosed

**Figure 2.1. Assessing Motivation to Stop Smoking**



with cancer is often motivated to stop using tobacco and therefore receptive to discussions on how to do so. However, not everyone is ready to stop at a given time, so motivation needs to be assessed repeatedly. Motivation or readiness to stop using tobacco can change frequently during the course of treatment. For example, you may find that a patient who is resistant to stopping on a previous visit will have a completely different attitude about stopping the next time you see him or her. Also, those who might have stopped using tobacco previously may have relapsed. Those who have relapsed are likely to be discouraged. It is important that you assess tobacco use and motivation each time you speak with your patients and support cessation intentions and actions. Even those patients who say that they are not ready to quit need intervention, including information about resources.<sup>14-16</sup>

The best way to assess a patient’s

readiness to stop using tobacco is to ask those who report using tobacco if they have set a quit date. As shown in Figure 2.1, if the patient says yes, then follow up by asking if he or she is ready to quit today. If the patient says yes again, ask how you can help them quit. If the patient is not ready to quit ask him or her when they plan to and what works about the date they have chosen. These questions will allow you to rapidly identify a patient’s readiness to stop using tobacco as well as potential blockers that may need to be addressed in order to move the patient from simply talking about stopping tobacco use to actually doing so. If the patient has not set a quit date, ask them if you can set one together immediately. If they say yes, then start with the sequence above. If they answer no, then ask them to explain why. This will provide insight into the patient’s reasoning and may reveal what factors and information are influencing their decisions about tobacco use. It is appropriate and even necessary that smokers unwilling to quit be counseled to reduce their tobacco use, as evidence shows this to be a catalyst for eventual cessation of tobacco use. Evidence also supports offering free samples of nicotine medications to smokers unwilling to quit as a way to prompt a quit attempt.

### **What Do I Say to Patients Who Tell Me They are Not Ready to Stop Using Tobacco?**

Every patient will have an explanation about why they are or are not ready to stop using tobacco. In some cases patients may have misconceptions about the health risks of tobacco use and of

**Table 2.2. Tobacco Cessation Excuses and Physician Responses**

Excuse	Physician Responses	Rationale for Response
<p>"I've tried everything and just can't stop smoking."</p>	<p>"What exactly have you tried? I'd like to write these down so we can figure out what to do next."</p> <p>"Every attempt to change behavior teaches us something even if it doesn't work. What have you tried and what problems did you encounter?"</p> <p>"Most of my patients go through several attempts to quit before they find a way to make it stick. Can we develop a plan together to try to make this next attempt last longer?"</p>	<p>This response sends a signal to the patient that you are serious about helping them cease tobacco use and normalizes the repeated and cyclical nature of the process of quitting.</p>
<p>"I really don't want to stop smoking."</p>	<p>"We have talked about how detrimental ongoing smoking is to your cancer care. Can you help me understand how you've arrived at that decision?"</p> <p>"Can we discuss any reasons you might have for quitting smoking that are important to you?"</p>	<p>This response forces the patient to confront the irrational basis for their smoking behavior. Smoking is an addiction not a lifestyle choice. Once the patient understands this, you can work together to find ways to overcome the addiction process.</p>
<p>"I'm already stressed out dealing with my cancer. I need smoking to calm my nerves."</p>	<p>"How does smoking calm your nerves? People who smoke actually have higher levels of stress than people who do not."</p> <p>"What would make you feel less stressed? We have other ways to relieve your anxiety."</p> <p>"What if we could use a treatment that helps you quit smoking and alleviates some stress at the same time?"</p>	<p>This response allows you to educate patients about how nicotine affects how they feel. In many people, the so-called calming effect of smoking is a response to nicotine withdrawal, which can start 20 minutes or fewer after their last cigarette. When the body starts to crave nicotine, a cigarette can help relieve the tension. Physiologically, though, nicotine stimulates the body, speeding up the heart. It is a tough cycle to escape, which is why nicotine medications can help a patient cope with withdrawal.</p> <p>Regarding stress from cancer and treatment, that is understandable. However, continued tobacco use only adds to that stress since it markedly reduces the benefits of treatment.</p> <p>Bupropion (Wellbutrin/Zyban) and behavioral treatments can address depression and anxiety too.</p> <p>Some of the medications recommended for smoking cessation will reduce withdrawal symptoms and help with stress.</p>

quitting. It is important to anticipate these barriers and provide responses that can keep the conversation focused on the importance of changing tobacco use habits. Table 2.2 provides examples of different excuses patients use to delay quitting and potential responses for physicians.<sup>16</sup>

**Table 2.2 Tobacco Cessation Excuses and Physician Responses** (*continued*)

Excuse	Physician Responses	Rationale for Response
“The harm from smoking has already been done.”	“No doubt some harm has been done, but that is not an excuse to keep smoking. Every cigarette you smoke continues to do damage to your body and diminishes the effectiveness of your treatment. You need to stop smoking now more than ever.”	This response tells the patient it is not too late to get a benefit from giving up tobacco.
“I enjoy smoking.”	“Can you tell me exactly what you enjoy about smoking?” “Can we think of alternative ways to experience that enjoyment that would not involve smoking?”	This response tells the patient that it’s not smoking that they enjoy, but rather that they do not enjoy the way they feel when they are not doing so—such as the withdrawal symptoms of irritability, crankiness, nervousness, and anxiousness. There is also evidence that smoking can lead to anhedonia. <sup>12</sup>
“I’ve cut down on my smoking.”	“When are you going to stop?” “Where are you getting the cigarettes that you are smoking?” “How can I help you get rid of the cigarettes you’re smoking now?” “That’s great progress, but we need to remain focused on quitting for good. What do you think is keeping you from quitting entirely?”	This response tells the patient that even a few cigarettes is too many—taking in less poison than before still means they are consuming poison! Although the focus here is on cancer treatment, a single cigarette a day increases cardiovascular risk. It will also be easy for patients to return to their normal pattern of smoking if they don’t remain focused on complete cessation.
“Now is not a good time to talk about my smoking.”	“You need to quit now to optimize your treatment.” “What needs to happen to make you feel ready to make a serious attempt to quit smoking?”	This response tells patients that they need to recognize that delaying a discussion about smoking cessation is not an option. The benefits to be gained by not smoking are best claimed before they start therapy not after it is complete.

**Table 2.3. Using the 5-Rs to motivate patients to quit**

Step	Physician's Role
Relevance	Encourage the patient to identify the personal relevance in quitting tobacco use.
Risks	Ask the patient to identify the negative consequences of quitting tobacco.
Rewards	Ask the patient to identify the positive consequences of quitting tobacco.
Roadblocks	Ask the patient to identify their personal barriers to quitting tobacco.
Repetition	Providers should continue to use the 5 R's for unmotivated patients at every clinical interaction. Additionally, the 5 R's can be used to help patients after a failed quit attempt to encourage future attempts until they reach success.

Source: [www.ahrq.gov/clinic/tobacco/tobaqrg2.htm#Unwilling](http://www.ahrq.gov/clinic/tobacco/tobaqrg2.htm#Unwilling)

Some patients may respond more effectively to motivational interventions. The 5-Rs approach (Relevance, Risks, Rewards, Roadblocks, Repetition) is an example of a motivational intervention, which relies on patients to identify and discuss their own reasons for quitting (as illustrated in Table 2.3).

Motivation to stop is often not enough to ensure that the patient can refrain from using tobacco. The next chapter briefly summarizes the current evidence on behavioral and pharmacologic treatments for nicotine addiction.

### 3. Treating Nicotine Dependence in Patients with Cancer



#### Key Points

- Tobacco addiction should be considered an addiction to nicotine, due to the role played by nicotine receptors in the brain.
- Work with your patients to develop incremental and realistic goals for their tobacco cessation.
- Physician-recommended, evidence-based cessation strategies increase the likelihood patients will try to quit and enhances the potential for the quit attempt to be successful. Electronic cigarettes and smokeless tobacco should not be used for the purposes of cessation because they are not evidence-based methods for halting tobacco use.
- To best meet your patient's cessation needs, consider his or her use history, cancer treatment plan, and any medical contraindications to pharmacologic treatments when designing a quit strategy.

#### Understanding Tobacco Dependence

Most people who smoke want to stop. Unfortunately, it is hard to do so, despite the many good reasons for stopping. While what you say to your patients can influence their motivation to stop using tobacco, dealing with nicotine addiction is a different challenge. Tobacco addiction can be considered a “brain disease” because of the role played by nicotine receptors located in the brain. Many patients with cancer who quit

at the time of diagnosis will start smoking again once they complete treatment and begin to feel their health improve. They may also encounter social cues that reinforce smoking as they begin to recover from cancer treatment. Thus, for many patients with cancer, relapse is not so much a failure of motivation but is more tied to the reality of their nicotine addiction and their sometimes poor preparation for attempting to quit.<sup>3</sup>

Anyone who has a history of persistent, daily use of tobacco is addicted. Those who have a past history of using tobacco more frequently every day and report that their typical pattern of smoking had them lighting up as soon as they wake up are likely to have a stronger addiction to nicotine and thus are more prone to relapse after stopping smoking. The Heaviness of Smoking Index (HSI), located in Chapter 4, is a simple two-question assessment tool for assessing someone's degree of nicotine dependence.<sup>10,11</sup>

Work with your patients to help them develop realistic expectations and goals for changing their behavior. Patients need to understand that merely reducing the number of cigarettes smoked per day or the type of tobacco product used will not provide them with the full health benefits that total cessation would, although for those not ready to quit, reducing their tobacco use should be encouraged as a step toward eventual tobacco cessation. Recognize that the thought of going without cigarettes can be overwhelming to many addicted smokers, since most have tried and failed to sustain an attempt to quit in the past.

Not everyone will be ready to quit immediately. Your job is to offer patients opportunities to stop and assistance with doing so when they are ready to accept it. You may want to involve the patient's family in these discussions as some family members may also be struggling with tobacco dependence.

A brief tobacco use assessment can help identify those individuals who are highly nicotine-dependent and/or lack the motivation and confidence to quit so that treatment options can be customized to the individual. Set realistic goals for your patients so that they can gain confidence and a sense of control over their tobacco use. For patients who are not ready to throw their cigarettes away, work with them to set incremental goals that lead eventually toward cessation such as delaying the first cigarette of the morning, limiting places and times where smoking is allowed, and gradually replacing cigarettes with substitutes such as nicotine gum, hard candy, and water. This can help patients build confidence in controlling their smoking.

## **Use Evidence-Based Treatments**

Because most quitting attempts are unplanned, most who have quit successfully report doing so without any type of cessation assistance. However, it is a myth that quitting without assistance is the most effective way to overcome nicotine addiction. Physician-relayed advice on smoking cessation increases the likelihood that patients



will try to quit and enhances the odds that those who do so will remain tobacco-free. Even brief tobacco-dependence treatment interventions are effective and should be offered to all tobacco users. Long-term cessation rates approach 20% with counseling and increase to 30% when counseling is combined with pharmacotherapy.<sup>2</sup> Based on a comprehensive review of the efficacy of different smoking cessation treatments, the United States Public Health Service (USPHS) has recommended that everyone who smokes receive counseling and support to quit, preferably in combination with pharmacotherapy.<sup>1</sup> Support can be delivered through individual or group counseling or through the telephone via a quitline. Three classes of medication have been shown to be efficacious in treating nicotine dependence. Table 3.1 provides a brief summary of each of these FDA-approved medications.

**Table 3.1. Comparison of FDA-approved Drug Therapies for Smoking Cessation**

Therapy	Mechanism of action	Dosage and duration	Efficacy compared to placebo or other therapies	Side-effects and special cautions	Precautions
Nicotine Replacement Therapies					
Patch Gum Lozenge Inhaler Nasal Spray	Reduces nicotine withdrawal symptoms	<p>PATCH</p> <ul style="list-style-type: none"> <li>• Dose: 21, 14, 7 mg/24 hours</li> <li>• Duration: Up to 12 weeks</li> </ul> <p>GUM</p> <ul style="list-style-type: none"> <li>• Dose: 2 &amp; 4 mg/ up to 24 pieces/ day</li> <li>• Duration: Up to 12 weeks</li> </ul> <p>LOZENGE</p> <ul style="list-style-type: none"> <li>• Dose: 2 &amp; 4 mgs; up to 20/day</li> <li>• Duration: Up to 12 weeks</li> </ul> <p>INHALER</p> <ul style="list-style-type: none"> <li>• Dose: 6-16 cartridges/day</li> <li>• Duration: Up to 6 months</li> </ul> <p>NASAL SPRAY</p> <ul style="list-style-type: none"> <li>• Dose: 8-40 doses/day</li> <li>• Duration: 3-6 months</li> </ul>	Effective in reducing withdrawal symptoms during tobacco abstinence and increases the odds of quitting for 6- 12months by 1.5-to-2 times	Local irritation (i.e., mouth sores, skin rash, nasal and throat irritation) associated with the route of administration of the medication (i.e., mouth—gum, lozenge, inhaler; skin—patch; nasal irritation—nasal spray). Sleep disturbance is common for those using the 24-hour nicotine patch. Nausea, dizziness, and rapid heartbeat can occur in some patients who concurrently smoke and use medication.	NRT should be used cautiously among patients who are within 2 weeks of an acute myocardial infarction, those who have significant arrhythmias, and by those who report worsening symptoms of angina. Pregnancy category C (nicotine gum) and category D (transdermal patches, inhalers, and spray nicotine products).

Therapy	Mechanism of action	Dosage and duration	Efficacy compared to placebo or other therapies	Side-effects and special cautions	Precautions
<b>Non-Nicotine Replacement Medications</b>					
Bupropion SR	Bupropion is a selective dopamine/norepinephrine reuptake inhibitor which seems to help modulate negative mood states and lowers the intensity of cravings to smoke.	Dose: Start 1-2 weeks before quit date with 150 mg every morning for first 3 days, then take 150mg twice daily  Duration: Up to 12 weeks with maintenance lasting up to 6 months	Bupropion increases the odds of smoking cessation twofold compared to placebo.	Dry mouth and sedation, insomnia	Not recommended for patients with a history of seizure disorders, current substance abuse, or other conditions that may lower the seizure threshold. Serious neuropsychiatric events, including but not limited to depression, suicidal ideation/ attempts, and completed suicide have been reported in patients taking bupropion for smoking cessation. Pregnancy category C.
Varenicline	Partial nicotine receptor agonist that reduces nicotine withdrawal symptoms by stimulating dopamine release and blocking the uptake of nicotine in the brain.	Dose: Start 1 week before quit date with a 0.5mg tablet every morning for first 3 days; on days 4-7 take 0.5 mg tablet twice daily; Day 8 to the end of treatment take a 1 mg tablet twice daily  Duration: Up to 12 weeks with maintenance up to 6 months	Varenicline increases the odds of smoking cessation threefold compared to placebo.	Nausea, sleep disturbances, and headache. Constipation, flatulence, and vomiting	Recent reports to the FDA have linked the use of varenicline to increased risk of cardiovascular events and suicidal thoughts, depression, and aggressive and erratic behavior. A recent report has noted a possible association between varenicline and cardiovascular events.  Pregnancy category C.

Sources: Adapted from Cummings KM, Mahoney MC. Strategies for smoking cessation: what is new and what works? Expert Review of Respiratory Medicine 2008; 2:201-213; Mahoney MC, Hyland A. Tobacco Cessation. In: South-Paul J, Matheny SC, Lewis EL, eds. *Current Diagnosis & Treatment in Family Medicine*, 2nd ed. New York, NY: McGraw-Hill., 2007, 626-633.



There is evidence supporting the idea that heavily addicted smokers may not get enough nicotine from the standard dosages of nicotine replacement medications and would benefit from higher dosages. In addition, it is well known that there is wide individual variation in how smokers metabolize and respond to nicotine, which may help explain varying treatment effects. Recent studies have found that combination nicotine replacement therapy (NRT)—such as using the nicotine patch with an oral dose form (i.e., gum or lozenge)—can increase quit rates compared to the patch alone.<sup>1</sup> Several studies

have also found a benefit from starting pharmacotherapy a few weeks before quitting completely as a way to help smokers wean themselves off of cigarettes and desensitize them to the reinforcing effects of nicotine addiction. Electronic cigarettes, known as e-cigarettes, have become an increasingly popular option for smokers who are trying to wean themselves off of traditional cigarettes. As an unregulated product, e-cigarettes should not be used for tobacco cessation; there is no evidence that they are effective.<sup>1</sup> Some patients may consider switching to smokeless tobacco as a means to stop smoking. While smokeless tobacco is certainly less dangerous than smoking, such products also contain nicotine and other toxins that may increase the risk of illness. Using smokeless tobacco for tobacco cessation is not a recommended approach. For now, it is recommended that smokers serious about stopping use only evidence-based treatment methods for addressing nicotine dependence.

## **Tailor Your Treatment Plan to Meet Your Patient's Needs**

Evidence-based tobacco cessation interventions include the combination of support and use of pharmacotherapy.<sup>17</sup> Understanding a patient's tobacco use history in combination with his or her specific cancer treatment plans will allow you to design a strategy for monitoring efforts to quit. Because efficacy of treatment for tobacco cessation relies on successful delivery, it is important to consider medical contraindications to pharmacologic treatments. For example, a patient with oral cancers should not be prescribed oral nicotine replacement options like gums or inhalers. A nicotine patch would be a preferable option.

Relapse is likely, so you need to ask patients about their smoking habits every time you see them. This is part of the process and not a failure of your intervention. When basic advice or treatment is unsuccessful, a stepped-care model of treatment, where more intense counseling and drug therapies are combined, will allow you to keep moving patients toward sustaining longer periods of smoking cessation. Table 3.2 provides a

simple guide for tailoring treatments to patients based upon their motivation to stop using tobacco and their level of nicotine addiction.

**Table 3.2. Tailoring Tobacco Cessation Treatment Plan Based on Motivation and Level of Nicotine Addiction**

Motivation	Level of nicotine addiction		
Are you ready to stop using tobacco now?	Recommendation for low nicotine addiction (0-2)	Recommendation for medium nicotine addiction (3-4)	Recommendation for high nicotine addiction (5-6)
YES	Behavioral counseling and self-help guide to support quitting attempt and reinforce the benefits of tobacco cessation. Telephonic quitlines can provide excellent behavioral counseling support (1-800-QUITNOW in the US; online: <a href="http://www.smokefree.gov">www.smokefree.gov</a> )	Behavioral counseling individually or in a group setting combined with approved pharmacotherapy such as nicotine replacement therapy, bupropion or varenicline. Telephonic quitlines can provide excellent behavioral counseling support (1-800-QUITNOW in the US; online: <a href="http://www.smokefree.gov">www.smokefree.gov</a> )	Behavioral counseling individually or in a group setting combined with higher dose formulations of approved pharmacotherapy and combination therapies (for example bupropion and nicotine patch, or the nicotine patch and an oral dose forms of nicotine medications such as gum and lozenge) if individual treatments fail to provide sufficient relief from cravings. Telephonic quitlines can provide excellent behavioral counseling support (1-800-QUITNOW in the US; online: <a href="http://www.smokefree.gov">www.smokefree.gov</a> ). Consider referral to a tobacco dependence treatment specialist or mental health professional, especially if the patient has mental health or substance abuse problems.
NO	Behavioral counseling combined with information on the benefits of discontinued tobacco use.	Behavioral counseling combined with information on the benefits of discontinued tobacco use. Consider using pharmacotherapy as a way to get patients to reduce their tobacco consumption.	Behavioral counseling combined with information on the benefits of discontinued tobacco use. Consider using pharmacotherapy as a way to get patients to reduce their tobacco consumption. Consider referral to a tobacco dependence treatment specialist or mental health professional, especially if the patient has mental health or substance abuse problems.

As illustrated in the table above, pharmacotherapy is useful for those who score moderate or high on the HSI. In fact, recent research suggests combining faster delivery nicotine medications such as the gum or lozenge with slower delivery nicotine patches for those who are most addicted to nicotine can improve withdrawal relief and increase the likelihood of long-term cessation.<sup>18</sup> For those who are not ready to stop using tobacco, counseling emphasizing the 5-Rs (Relevance, Risks, Rewards, Roadblocks, and Repetition) can help patients progress to a point where they are ready to make a quit attempt. The majority of tobacco users do want to quit and the perception of a patient's lack of motivation should not be used as a barrier to intervention. Although evidence on the use of bio-feedback is mixed, it might be worth considering the use of medical tests to demonstrate to patients how tobacco is harmful to them. For example, a simple carbon monoxide breath test can illustrate the adverse impact of smoking, which may be important to those undergoing surgery. A blood, urine, or saliva test for cotinine (a metabolite of nicotine) can allow you to talk with your patients about the adverse impact of nicotine on cancer cell growth, which can affect their response to therapy. A pulmonary function test can also be an informative way to show patients how smoking is affecting their lung capacity.

All of these efforts can include system-wide interventions, such as telephone calls from a team member to reinforce the patient's decision to quit, review of the benefits of quitting, and assistance to a patient to resolve any residual problems arising from quitting. The next chapter talks about how to incorporate tobacco assessment and treatment into your routine practice of oncology and get reimbursed for doing so.

## 4. Incorporating Tobacco Dependence Treatment into Your Practice

### Key Points

- Incorporate tobacco use screening and cessation service delivery into routine practice by educating every staff member about the dangers of tobacco use, disallowing tobacco use on clinic grounds, and helping staff members cease tobacco use.
- Quitting tobacco should always feel possible for any individual trying to stop.
- Successful cessation attempts occur across multiple interactions - clinic visits, phone calls, quitlines, counseling, etc.
- Electronic medical records have made it easier to integrate cessation into everyday clinical practice; at a minimum smoking status should be included in EMRs and should be updated at every visit.
- Reimbursement for tobacco cessation is covered by insurers (Medicare, Medicaid, private insurance, no insurance) and state; quitlines are a free resource accessible by every tobacco user in the United States.
- Multiple free resources exist to help your patients and staff quit smoking.

### Make it a System Change

In order to fully support a patient's efforts to stop smoking you need to incorporate tobacco screening and cessation service delivery into your routine practice.<sup>19</sup> It is important for you to work not only with your patients to assist them in overcoming their addiction to tobacco, but also to engage and encourage members of your healthcare team to do the same.

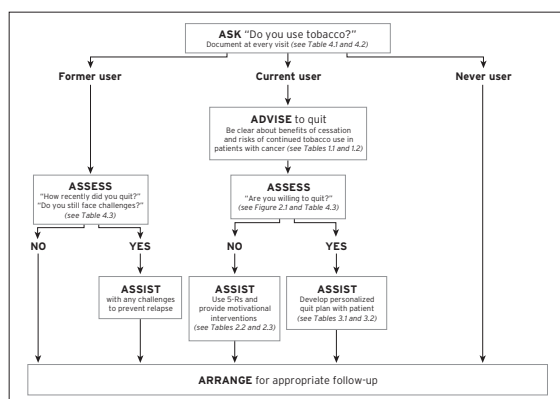
Ensure that tobacco use questions are asked of patients at each visit and that their responses are documented. Nurses should be involved with the assessment of tobacco use and can deliver highly effective cessation interventions that could include a formal, effective program of inpatient visits promoting cessation, supplementary education materials, and post-discharge follow-up contact.

Educate all your staff (including schedulers, receptionists, nurses, etc.) about the harms of tobacco use and why cessation is important. Stress the important role your staff plays in helping your patients successfully quit and how those efforts will improve patient care.<sup>19</sup> If tobacco use is not allowed on your clinic grounds and/or your staff is not allowed to use tobacco during business hours, reinforce why those decisions have been made. Help your staff feel like they are part of your practice's tobacco cessation efforts by giving each member a specific role and asking them for feedback on how

the system can be implemented and improved. For example, administrators can help create tobacco-free policies and ensure tobacco cessation coverage for staff members. Receptionists and schedulers can distribute tobacco use surveys and conduct follow-up phone calls. Nurses and paraprofessionals can assess patients' readiness to quit and provide counseling and follow-up.

Finally, quitting tobacco use should always feel possible for any individual who is trying to stop, whether they are a patient or staff member.<sup>19</sup> Most people make multiple attempts to quit before they are ultimately successful. Be supportive of each individual's attempts. Try to decrease the stigma attached with tobacco use; it can demotivate and shame the individual trying to quit. Recognize the chronic nature of nicotine addiction and the propensity for relapse, and provide the person with a supportive environment.

**Figure 4.1. Incorporating the 5-As of tobacco cessation into practice**



## Patient Assessment and Management

### The 5-As of Tobacco Cessation

Tobacco cessation treatment can and should be a team effort. Also, successful cessation attempts occur across multiple interactions—clinic visits, quitline phone calls, follow-up appointments, etc. The 2008 Public Health Service Tobacco Cessation Guidelines recommend organizing a patient's quit attempt around the "5 As"—Ask, Advise, Assess, Assist, and Arrange.<sup>20</sup> Figure 4.1 provides a schematic for incorporating the "5 As" into your practice, from the initial visit to long-term follow-up of former tobacco users.

#### Ask

Every patient should be asked about their tobacco use at every clinic visit.<sup>20</sup> Responses should be documented. Current use and historic use is best measured by asking about duration and amount of tobacco use prior to the cancer diagnosis. Table 4.1 (Assessment of Tobacco Use History) serves as an example of how to obtain this information.

Even though many cancer patients will report discontinuing their tobacco use immediately prior to their diagnosis, relapse is common, so it is important to assess tobacco use at each patient encounter, as illustrated by the standard questions shown in Table 4.2.

#### Advise

All current tobacco users should be advised to quit immediately. Be clear about the risks of continued tobacco use and the benefits of cessation for patients with cancer (see Table 1.1). Try to personalize the information as much



## Table 4.1. Assessment of Tobacco Use History

### Current Tobacco Use Assessment

1. Have you smoked at least 100 cigarettes in your entire life?  
A. Yes      B. No
2. How often do you currently smoke cigarettes?  
A. Every day    B. Some days    C. Never
3. Do people in your household other than you smoke in the home?  
A. Yes (if yes, how many? \_\_\_\_ )    B. No
4. Is smoking allowed in your workplace?  
A. Yes      B. No

If [1=A & 2=A or B or 3=A]—Current Tobacco Users

If [1=A & 2=C & 3=A or B]—Former Tobacco User

If [1=B & 2=C & 3=B]—Never Tobacco User

### If the patient is a **CURRENT** tobacco user, ask...

1. At what age did you start smoking/using tobacco?  
\_\_\_\_ (years) *[To calculate duration for current smokers, subtract age at initiation from current age.]*
2. On average, how many cigarettes have you smoked per day over this time?  
\_\_\_ cigarettes per day
3. How soon after you wake up in the morning do you smoke your first cigarette?  
A. Within 30 minutes    B. After 30 minutes
4. Have you ever tried to stop smoking?  
A. Yes      B. No
5. Do you currently use any other tobacco products such as cigars, pipes, chewing tobacco, snuff, dip, clove cigarettes, kreteks, bidis, waterpipe, or e-cigarette?  
A. Yes      B. No

### If the patient is a **FORMER** tobacco user, ask...

1. How long has it been since you last smoked regularly (i.e., every day or some days)?  
A. Within the past month (0-1 month ago)  
B. Within the past three months (1-3 months ago)  
C. Within the past six months (3-6 months ago)  
D. Within the past year (6-12 months ago)  
*[Code as: Recent Former Smoker]*  
E. With the past five years (1-5 years ago)  
F. Within the past 15 years (5-15 years ago)  
G. 15 or more years ago  
*[Code as: Long-term Former Smokers]*  
H. Don't know/Not sure  
I. Never smoked regularly
2. At what age did you start smoking/using tobacco?  
\_\_\_\_ (years) *[To calculate duration for current smokers, subtract age at initiation from current age.]*
3. When you were smoking regularly, how many cigarettes did you smoke per day, on average?  
\_\_\_ cigarettes per day
4. Do you currently use any other tobacco products such as cigars, pipes, chewing tobacco, snuff, dip, clove cigarettes, kreteks, bidis, waterpipe, or e-cigarette?  
A. Yes      B. No

as possible, and include information on how continued tobacco usage can affect treatments like chemotherapy, radiation, or surgery (see Table 2.1). Also discuss any familial, social, or economic costs.

### Assess

For current tobacco users, assess their willingness to quit. Figure 2.1 provides a schematic for how to approach patients about this and how to encourage them to set a quit date, even if they are not ready to quit immediately. Patients may have many excuses for why they cannot quit or are not ready to quit. Be prepared to offer thoughtful responses to each answer or “excuse,” reinforcing that quitting is important. Table 2.1 includes common patient excuses and options for how providers can reasonably respond to those excuses. Patients who are not willing to quit immediately may respond more effectively to motivational interviewing, which relies on patients to identify their own reasons for quitting. The 5-Rs can be a good way to start this type of conversation (Table 2.3).

It is also important to get an accurate picture of your patient’s level of nicotine addiction. Table 4.3, the Heaviness of Smoking Index (HSI), is a simple two-question measure to determine an individual’s degree of nicotine dependence.<sup>10,11</sup> Please note that the HSI measure was developed based on the general population. Some patients cut down on or quit using tobacco after a cancer diagnosis. Talking to your patient

**Table 4.2. Assessment of Tobacco Use During Routine Patient Encounters**

1. Since your last visit, have you used any tobacco products?  
A. Yes      B. No
  
2. Have you made any attempts to stop smoking since your last visit?  
A. Yes      B. No
  
3. Are you currently using any of the following methods to try to quit using tobacco?  

A. Nicotine patch	G. Varenicline (Chantix)	N. Anything else?
B. Nicotine gum	H. Quitline	_____
C. Nicotine lozenge	I. Support groups	_____
D. Nicotine inhaler	J. Psychotherapy	_____
E. Nicotine nasal spray	K. Online program	
F. Bupropion (Wellbutrin, Zyban)	L. E-cigarettes	
	M. Hypnosis	
  
4. If you haven’t stopped smoking yet, are you ready to try now?  
A. Yes      B. No
  
5. Would you like help to stop smoking?  
A. Yes      B. No

about whether they have changed their tobacco usage since their diagnosis is important in cessation planning. In a busy practice, it can be difficult to have this discussion. However, simply discovering how soon after waking a tobacco user has their first cigarette can help to assess addiction in this setting. Anyone having a cigarette within 30 minutes of waking up is highly addicted.

For former tobacco users, be sure to ask how recently they quit using tobacco and if they are facing any difficulties in their ongoing quit attempt. The HSI can also help assess level of addiction for former smokers and identify individuals at high risk for relapse. Identifying any patients at risk for relapse and preventing that relapse from occurring is vitally important.

### **Assist**

Work with patients ready to quit to put together a personalized quit plan, including target quit date, counseling, quitline or community referrals, prescription for FDA-approved tobacco cessation treatment agents (if needed), and expected quit attempt challenges (including nicotine withdrawal symptoms).<sup>20</sup> For a comparison of all currently FDA-approved tobacco cessation treatment drugs see Table 3.1. Guidance for possible treatment options depending on level of nicotine addiction can be found on Table 3.2.

For former users who are at risk of relapse, determine what challenges they are facing and make any necessary revisions to their current quit plan.<sup>20</sup>

The combination of pharmacotherapy with brief advice from clinicians and/

### **Table 4.3. Heaviness of Smoking Index (HSI)**

1. On the days that you smoke, how soon after you wake up do you have your first cigarette?
  - A. Within 5 minutes (3 points)
  - B. 6- 30 minutes (2 points)
  - C. 31-60 minutes (1 point)
  - D. After 60 minutes (0 points)
2. How many cigarettes do you typically smoke per day?
  - A. 10 or fewer (0 points)
  - B. 11-20 (1 point)
  - C. 21-30 (2 points)
  - D. 31 or more (3 points)

#### **SCORING:**

0-2: low addiction

3-4: moderate addiction

5-6: high addiction

or counseling helps to optimize rates of cessation and is considered a standard of care for treating nicotine dependence. The Joint Commission has made tobacco use screening, treatment, and follow-up assessment a recommended part of quality assurance for hospitalized patients (see: [www.ctri.wisc.edu/joint.pdf](http://www.ctri.wisc.edu/joint.pdf)).

### **Arrange**

All patients with cancer advised to stop using tobacco, whether referred outside your practice or not, should receive follow-up contact either in person or via telephone within a week or two to assess their progress in altering tobacco-use behaviors. Additional follow-up contact is recommended so that the importance of discontinuing tobacco use is conveyed to the patient. Many state quitlines have systems in place to provide information

back to the referring medical clinic if the patient was enrolled into a quitline counseling program. Call 1-800-QuitNOW in the USA (many other countries have established quitlines also) and inquire about services that your state can provide to patients. For patients who are struggling to remain tobacco free, including those with mental illness and substance abuse problems, you should consider a referral to a psychologist or a professionally trained smoking cessation counselor. During the follow-up period it is important to reinforce the patient's accomplishments regarding efforts made to change their tobacco use behavior. Contact can be particularly helpful to assess pharmacotherapy use and problems. A supportive environment must exist for patients to feel comfortable if they have resumed smoking. In the event tobacco use has resumed, talk to the person, focus on the positives, and try to figure out how to make their next attempt more successful. Work with the individual to either modify their cessation plan or build a new one, paying close attention to any cultural, emotional, literacy, or behavioral barriers that may exist.<sup>19</sup>

## **Patient Management Tools**

Many patient management tools exist. Picking which ones to implement will depend on your practice and may not be necessary for every patient that is being treated.

With electronic health records becoming more widespread, it has become easier to integrate tobacco cessation into everyday clinical practice. At minimum, tobacco use status should be included in the EHR and should be automatically obtained at every visit. Tobacco use status can serve as a trigger to automate prompts for further questions on historic tobacco use, environmental exposures, and previous quit attempts.<sup>19</sup> Teachable moments/motivational interviewing prompts can be integrated into the EHR for annual visits or during follow-up of tobacco-related conditions.<sup>19</sup>

In addition to EHR integration, your office can also create a tobacco-use registry.<sup>19</sup> The registry can be as simple as an excel spreadsheet listing patients in your practice who are current or former tobacco users, along with their willingness to quit, quit plan details, most recent follow-up contact, and quit status. Registries can serve as an easy way to identify which patients need cessation and follow-up services, who may be at risk for relapse, and how your practice is performing.<sup>19</sup> Registries may be incorporated as part of an EHR, but can be created separately, as well.<sup>19</sup>

Your practice can create and implement other tools, as well, such as:

- Tobacco-cessation visit note template
- Tobacco treatment plan template
- Tobacco-cessation visit checklist template
- Chart identification flags (smoking status is flagged in the patient chart)

## Obtain Appropriate Reimbursement for Tobacco Cessation Treatment

Systematic barriers, such as concerns about insurance reimbursement or not knowing where to refer patients for tobacco cessation support have been identified as being detrimental to smoking cessation in oncology practice. Therefore, it is important to have systems in place to provide all tobacco users with information about quitting, including:

- In-house cessation support
- Referrals to quitlines (e.g., by fax referrals)
- Referrals to community resources to support tobacco cessation (support groups, Internet resources)
- Information on insurance reimbursement

Coverage for these treatments varies by insurer and state. Information on coverage, including coding, can be found below according to insurance type. Table 4.4 provides a quick overview.

### Medicare

In 2010, the Department of Health and Human Services expanded Medicare coverage to include evidence-based tobacco cessation counseling, removing a barrier to treatment for all tobacco users covered by Medicare. Under the new coverage, an individual who

**Table 4.4. Overview of tobacco cessation coverage by insurance type**

Insurance Status	Coverage Information
Medicare	<ul style="list-style-type: none"> <li>• Evidence-based tobacco cessation counseling is covered</li> <li>• Part D covers FDA-approved cessation drug therapies; over-the-counter therapies are typically excluded</li> </ul>
Medicaid	<ul style="list-style-type: none"> <li>• Comprehensive cessation benefits are covered for pregnant women with no cost sharing</li> <li>• As of January 1, 2014, all state Medicaid programs will be required to support all FDA-approved tobacco cessation medications without requiring co-pays</li> </ul>
Private Insurance	<ul style="list-style-type: none"> <li>• Patient Protection and Affordable Care Act (ACA or health reform bill) requires all insurance plans to provide evidence-based tobacco cessation interventions</li> <li>• Providers should check with individual insurance plans for coverage specifics</li> </ul>
No Insurance	<p>Options could include:</p> <ul style="list-style-type: none"> <li>• Quitlines (1-800-QUITNOW)</li> <li>• Online cessation resources (see Tables 4.1 and 4.2)</li> <li>• Flexible spending accounts</li> <li>• Employee assistance programs</li> <li>• Community resources</li> <li>• Out of pocket spending</li> </ul>

uses tobacco and is covered by Medicare will be able to receive tobacco cessation counseling from a qualified physician or other Medicare-recognized practitioner who can work with them on tobacco cessation. Payment is based on two Healthcare Common Procedural Coding System (HCPCS) codes:

- **G0375:** Smoking and tobacco use cessation counseling visit; intermediate, more than three minutes and up to 10 minutes
- **G0376:** Smoking and tobacco use cessation counseling visit; intensive, more than 10 minutes

Additional payment may be received based on the evaluation and management service (99201-99215, including modifier -25) provided on that same day and separately identifiable from smoking cessation counseling. Counseling which lasts fewer than three minutes is included in the standard physician visit and is not separately reported. Medicare beneficiaries are eligible for up to four counseling sessions for each attempt to quit and up to two attempts to quit are covered over a 12-month interval. A useful resource which provides a listing HCPCS, CPT, & ICD-9 codes related to tobacco cessation counseling can be found at: [www.aafp.org/online/etc/medialib/aafp\\_org/documents/clinical/pub\\_health/askact/coding.Par.0001.File.tmp/Coding-list.pdf](http://www.aafp.org/online/etc/medialib/aafp_org/documents/clinical/pub_health/askact/coding.Par.0001.File.tmp/Coding-list.pdf). The ICD-9 code for Nicotine Dependence is 305.1. In addition to the two G-codes, alternative HCPCS codes include S9075 for smoking cessation treatment and S9453 for smoking cessation classes. Quitlines serve as an excellent free tobacco cessation resource that all patients can access, regardless of insurance status. The patient's health record should document all services provided.

Medicare Part D has covered FDA-approved cessation drug therapies for eligible beneficiaries since 2006 as part of the prescription drug benefit; over-the-counter formulations of nicotine replacement therapies are generally excluded.

### **Medicaid**

As per the Patient Protection and Affordable Care Act (PPACA or health reform bill), Medicaid tobacco cessation coverage has been expanded. As of 2010, all state Medicaid plans must cover a comprehensive cessation benefit for pregnant women with no cost-sharing.<sup>21</sup> Beginning January 1, 2013, states that cover preventive services like tobacco cessation will receive increased federal reimbursement; as of January 1, 2014, all state Medicaid programs will be required to support all FDA approved smoking cessation medications without requiring co-pays or other financial barriers.<sup>21</sup> Quitlines offer state-specific services Medicaid recipients can access free of cost.

### **Private Insurance**

The PPACA bill also requires private health insurance plans to provide evidence-based tobacco cessation counseling and interventions to all adults and pregnant women.<sup>22,23</sup> This requirement stems from the health reform bill's inclusion of all United States Preventive Services Task Force (USPSTF) Grade A and B Recommendations in private insurance coverage;<sup>23</sup> the provision of tobacco cessation strategies to adults

and pregnant women is a USPSTF Grade A recommendation.<sup>24</sup> Although physicians will need to check with insurance plans to determine what specific interventions are included and to what degree they are covered (e.g., how many counseling sessions are covered), the health reform bill requires screening and cessation interventions be provided with no co-payment or co-insurance.<sup>22</sup> Despite these regulations, whether and to what extent tobacco cessation will be covered is unclear at the time of this publication. Many private insurance plans cover medications for tobacco dependence but they vary in their policies regarding reimbursement. Regardless of coverage specifics, quitlines serve as an excellent free tobacco cessation resource that all patients can access.

### **No Insurance**

For patients who either do not have insurance or who have insurance that does not cover tobacco cessation explicitly, other options include:

- Quitlines (1-800-QUITNOW)
- Online cessation resources (see Tables 4.5 and 4.6)
- Flexible spending accounts (patients should see if tobacco cessation is an allowable expense)
- Employee assistance programs (some employers will cover a quit attempt in their EAP)
- Community resources (support groups, etc.)
- Out-of-pocket spending

### **Resources for Patients and Practitioners**

You do not have to invest a great deal of time or money to equip your office with free resources to help your patients and staff quit smoking. Table 4.4 lists tobacco cessation resources you can share with your patients to help them overcome their nicotine addiction. Table 4.5 provides links to tobacco cessation resources for health professionals.



**Table 4.5. Links to free patient focused tobacco cessation resources**

<b>Non-pharmaceutical Cessation Support</b>
<p><b>Smokefree.gov</b> www.smokefree.gov 1-800-QUIT-NOW (1-800-784-8669); TTY 1-800-332-8615 (in the U.S.) Free online tobacco cessation site with access to a toll free help line, quit coaching, a free quit plan, free educational materials, and referrals to local resources. Information about quitlines in other countries can be found at <a href="http://globalqlnetwork.wordpress.com/">http://globalqlnetwork.wordpress.com/</a>.</p> <p><b>Help for Smokers and Other Tobacco Users</b> <a href="http://www.ahrq.gov/consumer/tobacco/helpsmokers.htm">www.ahrq.gov/consumer/tobacco/helpsmokers.htm</a> Patient materials based on the Public Health Service Guideline</p> <p><b>Become an EX</b> <a href="http://becomeanex.org">http://becomeanex.org</a> Free online quit-smoking program from the American Legacy Foundation</p> <p><b>Quit for Life</b> <a href="http://www.quitnow.net">www.quitnow.net</a> Free online quit-smoking program from the American Cancer Society</p> <p><b>Freedom From Smoking®</b> <a href="http://www.ffsonline.org">www.ffsonline.org</a> Freedom From Smoking Online, or FFS Online, is a quit-smoking program from the American Lung Association. There is a small fee required to register for this program.</p> <p><b>QuitNet</b> <a href="http://www.quitnet.com">www.quitnet.com</a> A comprehensive on-line tobacco cessation support program. QuitNet hosts the world's largest community of smokers and ex-smokers.</p>
<b>Pharmaceutical Aids for Cessation— Online Support</b>
<p><b>Way to Quit</b> <a href="http://www.way2quit.com">www.way2quit.com</a> This online cessation program is sponsored by the makers of nicotine medications.</p> <p><b>My Time to Quit</b> <a href="http://www.mytimetoquit.com">www.mytimetoquit.com</a> This online cessation program is sponsored by the makers of varenicline (Chantix/Champix).</p>

**Table 4.6. Links to information for health professionals**

Information for Health Professionals
<p><b>ASCO</b> <a href="https://store.asco.org/eCommerce/Orders/Product.aspx?categoryId=2&amp;productId=124">https://store.asco.org/eCommerce/Orders/Product.aspx?categoryId=2&amp;productId=124</a> Cancer prevention curriculum with information on smoking cessation</p> <p><b>ASCO Tobacco Control Policy</b> <a href="http://www.asco.org/asco/downloads/TobaccoControl.pdf">www.asco.org/asco/downloads/TobaccoControl.pdf</a> ASCO's tobacco cessation policy statement, 2003 update</p> <p><b>Clinical Practice Guideline: Treating Tobacco Dependence 2008 Update</b> <a href="http://www.surgeongeneral.gov/tobacco">www.surgeongeneral.gov/tobacco</a> Surgeon General Reports on tobacco control topics</p> <p><b>National Quitline Consortium Website for North America</b> <a href="http://www.naquitline.org">www.naquitline.org</a> Consortium aimed at maximizing the use of quitlines nation-wide. For global quitline information, go to <a href="http://globalqlnetwork.wordpress.com/">http://globalqlnetwork.wordpress.com/</a></p> <p><b>National Tobacco Cessation Collaborative (NTCC)</b> <a href="http://csmbc.aed.org/ntcc/index.htm">http://csmbc.aed.org/ntcc/index.htm</a> Database on tobacco cessation research, policy, and resources</p> <p><b>Tobacco Free Nurses</b> <a href="http://www.tobaccofreenurses.org">www.tobaccofreenurses.org</a> National program to help nurses who want to help their patients to quit</p> <p><b>Oncology Nursing Society</b> <a href="http://www.ons.org/Publications/Positions/Tobacco">www.ons.org/Publications/Positions/Tobacco</a> Nursing Leadership in Global and Domestic Tobacco Control statement, 2008 update</p> <p><b>US Surgeon General Report</b> <a href="http://www.surgeongeneral.gov/library/tobaccosmoke/report/index.html">www.surgeongeneral.gov/library/tobaccosmoke/report/index.html</a> Chapter 5 of the report is focused on cancer and tobacco use (<a href="http://www.surgeongeneral.gov/library/tobaccosmoke/report/chapter5.pdf">www.surgeongeneral.gov/library/tobaccosmoke/report/chapter5.pdf</a>)</p> <p><b>RX for Change</b> <a href="http://rxforchange.ucsf.edu/">http://rxforchange.ucsf.edu/</a> Comprehensive curriculum to equip health professionals with evidence-based knowledge for assisting patients with quitting.</p>
Information for Global Health Professionals
<p><b>WHO Framework Convention on Tobacco Control</b> <a href="http://www.who.int/fctc/en">www.who.int/fctc/en</a> International resource detailing global tobacco control recommendations as well as country-specific tobacco control efforts.</p> <p><b>WHO Tobacco Free Initiative</b> <a href="http://www.who.int/tobacco/en/">www.who.int/tobacco/en/</a> International resource detailing global tobacco control recommendations, provider resources, as well as country-specific tobacco control efforts.</p> <p><b>TreatTobacco.net</b> <a href="http://www.treattobacco.net">www.treattobacco.net</a> Database and educational resource from the Society for Research on Nicotine and Tobacco on treatment of tobacco use and dependence.</p>

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