UCSF Smoking Cessation Leadership Center | National Center of Excellence for Tobacco-Free Recovery

SCLC presents:
"Integrating Tobacco Treatment within the Stanford Cancer Center: An NCI Moonshot Initiative"
on Wednesday, October 7, 2020, at 2:00 pm EDT (60 minutes)

Speaker's Responses:

- **Jodi Prochaska, PhD, MPH,** Professor of Medicine, Stanford Cancer Institute
- **Brittany Pike, MS, RN, BSN,** Manager for Health Education, Engagement and Promotion at Stanford Health Care
- **Maura Lau**, Tobacco Treatment Specialist with for Health Education, Engagement and Promotion at Stanford Health Care
- **Kayla Jimenez, M.S.**, Doctoral Student at PGSP-Stanford Psy.D. Consortium
- **Kathleen Gali, PhD,** Postdoctoral Fellow, Stanford Prevention Research Center

I. Funding

Q: Since one of the barriers is lack of insurance coverage for treatment, what do you do to work with the patient if they want to quit and funding is none?

A: We offer free counseling for patients (through practicum program) and free pharmacotherapy visits (funded through grant and Stanford Cancer Institute). Our partner pharmacy also offers reduced cost medications for patients that do not have insurance to cover.

Q: Any opportunities to bill patients' insurance?

A: We don't bill patients for treatment because quitting is already a challenge. We have worked out a model with partnerships (with Alto, Pre-doctoral clinical psychology students, and the cancer center leadership) that allows us to offer our services to patients and their families at zero to very minimal cost.

Q: To scale your model to large numbers of patients, how costly do you estimate it would be, and where could the money come from?

A: To scale our current model, we plan to grow our practicum program and offer group-based, virtual therapy so we can offer counseling to a larger number of patients without additional cost.

Q: Are you able to share the cost to implement this program? Is this programming sustainable?

A: We are fully funded through the National Cancer Institute's (NCI) Cancer Center Cessation (C3I) Grant, part of the Moonshot Initiative (2018-2020). We also have commitment from Stanford Cancer Institute to continue supporting the project for three years beyond the NCI funding period. We continue to look for operational funding opportunities to make the program sustainable. By developing a practicum program, we are able to offer patients free counseling in exchange for doctoral psychology student practicum hours.

II. Data and Analysis

Q: How do your rates of engagement, treatment, and cessation compare to national studies of these measures for cancer centers generally?

A: Our patient engagement is higher (close to 30%) compared to other comprehensive tobacco treatment services within oncology settings, which tend to be about 20%. With regard to abstinence outcomes, the University of Texas MD Anderson Cancer Center, which provides a comprehensive approach to tobacco treatment, has reported a 9-month abstinence rate of 38% among 2779 individuals treated from 2006–2013. This is higher than our 6-month abstinent rate, which is currently at 19%.

Q: Do you have a demographic analysis of cancer patients who choose to be in the program?

A: Yes. Our most recent analysis within a 6 month period between January 2020 through June 2020: 58% male, 42% female; 12% Hispanic, 80% Non-Hispanic, 8% Other; 63% under the age of 65, 37% ages 65 and older.

Q: Would reinforcing at 3 months as well as 6 months increase success at 6 months?

A: Another time point for outreach provides the opportunity for checking in and reengagement. We've received feedback at the 6-mo time point that some patients would have liked more frequent outreach. At this time, we do not have the bandwidth to add a 3-mo follow up.

Q: How long do participants tend to work with the program? And does the 6 month follow start after the participant is no longer in the program or could this occur while a participant is still in the program?

A: The average counseling cadence is three sessions (typically once/week). However, our tobacco treatment specialist and counselors will follow-up with patients longer if needed. The follow-up occurs 6 months post initiation of treatment, whether the patient is still engaged in treatment or not.

Q: What is attrition rate? What was mortality rate in your study sample population?

A: We currently are at 76.5% retention rate at our 6-month follow-up.
0.8% mortality rate. There have been 3 deaths.

III. Process

Q: Is there a mindfulness resource for cessation that you used or can recommend?

A: Yes, https://healthlibrary.stanford.edu/books-resources/mindfulness-meditation.html

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Q: Are patients offered Nicotrol Inhaler or Nicotrol Nasal Spray as options for NRT?

A: Yes. Our partner pharmacy, Alto connects with patients to discuss which NRT option is best for them.

Q: How receptive were patients to using NRT? Chantix? Varenicline?

A: The majority of patients who enroll into treatment initially are receptive to medication as the first line of treatment. With additional follow-up from our Tobacco Treatment Specialist, they explore other treatment modalities.

Q: For the students who are providing the behavioral counseling, how many sessions do they provide? Now that it is telehealth?

A: The students gain clinical practicum hours for in-person and telehealth visits. Pre-COVID, our model was mostly virtual. The shift from mostly virtual to completely virtual did not impact the student workflow and hours much.

Temporarily, students are also able to gain clinical practicum hours for telephone counseling, which some patients prefer.

Q: Have you seen issues with cannabis users having a harder time quitting tobacco smoking?

A: The patients that are using cannabis, for the most part, do not mix it with tobacco. There have been a couple of patients that disclosed using tobacco wrappers to make it easier to use cannabis. When we would touch base on the topic, and they would ask for alternatives, we would discuss utilizing cannabis oils or edibles, so there would be no tobacco products, and the inhalation of cannabis into the lungs would be eliminated.

Q: Are you screening for pack years history and also referring to lung cancer screening? If yes, how is that going?

A: Our clinics are screening and documenting for pack years in each patient. In current state, every patient with 30+ pack years between the ages of 55 years to 80 years triggers our Tobacco Treatment Specialist to refer. The volume is low so we haven't encountered many cases.

Q: Is there a good or alternative way to test biochemical validation in the time of COVID?

A: Unfortunately, there is not as it still requires the handling of human samples. We have put a hold on this verification process during COVID.

Q: Were you able to change EPIC documentation to document follow up? Or was the documentation manual tracking?

A: During our pilot, we used a manual tracker (Excel Spreadsheet) to track follow-up. However, that became inefficient with our expansion. As part of our expansion, we integrated our documentation and tracking into Epic using a flowsheet that automatically feeds updates into each patient's snapshot chart.
This snapshot is viewable across all clinical providers and quickly communicates patients' tobacco use and treatment status to all care team members.

Q: Can you elaborate on the details of the treatment model between the TTS and Treatment Options staff? Does TTS provide education or counseling or mainly check if patients are interested in treatment and then link/message to treatment staff for setting up a 1:1 counseling session to discuss medication options?

A: Our TTS (Maura) is the first point of contact for patients. Maura assesses patient's current tobacco use and discusses treatment options with patients. Next steps, includes enrolling patients into specific treatment types (pharmacotherapy/medications as well as behavioral therapy such as 1:1 counseling). One of these specific treatment types is 1:1 counseling, which is provided by pre-doctoral clinical psychology students like Kayla.

Q: Having a TTS on staff seems like a critical resource for your program. What advice would you have for organizations that don't have TTS staff and would only be able to refer/connect patients to the California Smokers Helpline?

A: We partner with pre-doctoral clinical psychology students who provide counseling to patients as part of their training. Perhaps, collaborating with students from graduate programs for psychology, counseling and/or therapy to explore opportunities for the students and for your site. Perhaps, cross training staff and offer professional development opportunities for staff interested but also being mindful of their bandwidth. The Mayo Clinic offers an excellent TTS training.

Q: Are there any opt-out interventions related to digital health/therapies, and integrated with the tele-health sessions?

A: We continue to offer counseling and pharmacotherapy visits through telehealth. Telehealth interventions were also offered pre-COVID based on patients' needs and preferences.

Q: What was the % favorable response of oncologist physicians to this program? Any problems reported?

A: In the beginning, it was an adjustment for some clinicians going with an opt-out approach. Within a few months, however, we built trust with the teams and were able to show some effectiveness with our program. From there, it was less convincing and more clinicians approaching us with interest in offering the program to their patients.

Q: Does the patient talk to the doctor about quitting or would the doctor make the referral for the patient is that something that they have to do on their own?

A: We apply an opt-out model whereby all patients identified as tobacco users by the Medical Assistants are directly pulled into a weekly report by our Tobacco Treatment Specialist (Maura Chandler). The doctor is made aware of the patients' tobacco use by the MA and briefly shares about tobacco cessation, but our Tobacco Treatment Specialist is the one who speaks directly with patients about quitting and treatment options available to them.

Q: Do you ever get any backlash using the opt-out approach from patients who don't want to quit?

A: To date, we haven't had any backlash from patients using the opt-out approach.