CANADIAN PARTNERSHIP AGAINST CANCER
PARTENARIAT CANADIEN CONTRE LE CANCER

Implementing Smoking Cessation in Cancer Care Across Canada

A FRAMEWORK FOR ACTION

A product of the Pan-Canadian Tobacco Cessation + Cancer Care Network

OCTOBER 2019

CANADIAN PARTNERSHIP AGAINST CANCER
PARTENARIAT CANADIEN CONTRE LE CANCER

Canadian Partnership Against Cancer
145 King Street West, Suite 900
Toronto, Ontario, Canada M5H 1J8

Telephone: 416-915-9222
Toll free: 1-877-360-1665
Email: info@partnershipagainstcancer.ca
www.partnershipagainstcancer.ca

Implementing Smoking Cessation in Cancer Care Across Canada

A FRAMEWORK FOR ACTION

CONTENTS

1 ACKNOWLEDGEMENTS

The Canadian Partnership Against Cancer (the Partnership) was created in 2006 by the federal government and began its operations in 2007. Since then, our primary mandate has been to move the Canadian Strategy for Cancer Control into action and to help it succeed through coordinated system-level change across the full cancer care continuum. To do this, the Partnership works closely with national, provincial and territorial partners.

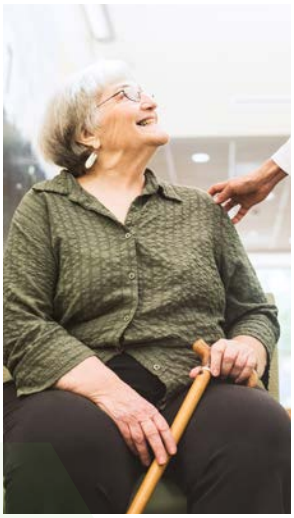
Developing the Pan-Canadian Action Framework for Implementing Smoking Cessation in Cancer Care (the Action Framework) would not have been possible without the participation and dedicated efforts of the members of the Pan-Canadian Tobacco Cessation and Cancer Care Network (PTCCCN). The Partnership would like to acknowledge the significant contributions of the PTCCCN and the numerous expert advisors and leaders, educators, clinicians, patients and family members, policy makers, researchers, health service planners, and cancer control organizations that have helped shape the Action Framework.

This document has been made possible through a financial contribution from Health Canada, through the Partnership. The views expressed herein represent the views of the Canadian Partnership Against Cancer.

Suggested citation when referencing this Framework:
Canadian Partnership Against Cancer. *Implementing Smoking Cessation in Cancer Care Across Canada: A Framework for Action. Toronto (ON): Canadian Partnership Against Cancer; October 2019.*

2 EXECUTIVE SUMMARY

The Action Framework should be used in the design and implementation of an evidence-based smoking cessation support program to ensure all cancer patients in Canada and their families receive optimal support for improved treatment outcomes and quality of life.



The Pan-Canadian Action Framework for Implementing Smoking Cessation in Cancer Care is the first of its kind for Canada. It provides program-level guidance for stakeholders to implement a comprehensive, evidence-based smoking cessation program in cancer care settings to help patients quit tobacco use and ultimately improve health outcomes for patients and yield economic benefits for health systems. The Framework comes at an opportune time, contributing to advancement of both the recently refreshed 2019-2029 Canadian Strategy for Cancer Control, which calls for increased efforts to promote smoking cessation, and Health Canada's Tobacco Strategy, which aims to reduce the use of tobacco to 5% of the population by 2035.

With this Action Framework, it is our goal that all ambulatory cancer care centres in Canada—and those stakeholders responsible for implementing smoking cessation, including provincial/territorial governments, cancer agencies, healthcare administrators, and healthcare providers—will use this Framework to achieve our vision that **every patient with cancer across Canada receives support to quit smoking for the best treatment and quality of life**.

The specific goals of the Action Framework are to:

1. Establish processes for routine identification of tobacco smokers in cancer care settings;
2. Implement processes to systematically support cancer patients/families in quitting smoking, in collaboration with community partners where and when needed;
3. Develop person-centered approaches to smoking cessation along with culturally competent approaches for First Nations, Inuit and/or Métis cancer patients; and
4. Evaluate and sustain smoking cessation approaches for cancer patient

To achieve these goals, the Action Framework consists of several key components that together make up a comprehensive smoking cessation support program. The key components are:

- **Evidence-based Cessation Support** (see Section 5) that comprises **Behavioural Counselling** (i.e., patient engagement, advice and Counselling for cancer patients to quit smoking) and **Pharmacotherapy** (i.e., medications to ease nicotine withdrawal symptoms);
- Cross-cutting **Key Enablers** (see Section 6) to amplify the efficacy and impact of cessation support, including **Person-Centered Approaches, Culturally Competent Engagement** and **Partnerships**;
- **Quality indicators** to measure performance of cessation support programs (see Section 7.1);
- An **Implementation Checklist** (see Section 7.2) that helps to both prepare cancer centres to offer comprehensive cessation support (i.e., pre-implementation) as well as describes a step-wise implementation approach across each component of tobacco cessation support, guiding graduation of programs from bronze, silver to ultimately gold-standard levels.

3 INTRODUCTION

Implementing comprehensive smoking cessation programs in cancer care settings across Canada offers important health impact for patients and meaningful economic benefits for health systems. To realize these benefits, this Action Framework provides program-level guidance to implement an evidence-based smoking cessation program at the frontlines of cancer care and ultimately help patients quit tobacco use. The Action Framework's implementation aligns with priorities in the 2019-2029 Canadian Strategy for Cancer Control and helps move us closer to Health Canada's goal of reducing tobacco use to less than 5% by 2035.[1, 2]

In this document, tobacco refers to the use or cessation of commercial tobacco products, and does not refer to the use or cessation of traditional or sacred tobacco by First Nations or Métis communities. Traditional or sacred tobacco differs from commercial tobacco in that it is used in ceremonial or sacred rituals for healing and purifying.

3.1. Why is Smoking Cessation Important in Cancer Care?

Commercial tobacco use remains the leading preventable cause of cancer in Canada. In addition to causing cancer, patients who continue to smoke while receiving cancer treatment often require higher doses of cancer drugs, receive treatment for longer periods, incur complications from surgeries and are readmitted to hospitals more frequently compared to non-smoking cancer patients.[3] Despite these health consequences, up to 20% of cancer patients continue to smoke after receiving a cancer diagnosis and while receiving first-line cancer treatment.[4] Beyond the health implications, significant economic implications to the healthcare system also exist when patients continue to smoke, translating to $10,678 in additional costs per smoking patient.[5] Efforts that promote smoking cessation in cancer patients therefore play a critical role in improving both patient health outcomes and economic outcomes of the cancer system by increasing the effectiveness of cancer treatment, reducing cancer mortality rates (by up to 30-40%)[6] and resulting in $50-$74 million in cost savings for every 5% of cancer patients that quit smoking.[7]

While evidence-based programs for smoking cessation exist in Canada, services are not consistently offered in cancer care settings where patients receive treatment. The implementation and sustainability of smoking cessation programs that are rooted in best practices is therefore required. As such, the Action Framework was developed to align efforts, accelerate the adoption and implementation of smoking cessation support across Canada and achieve our pan-Canadian targets.

3.2. An Action Framework for Smoking Cessation

In 2017, the Canadian Partnership Against Cancer (the Partnership) established the Pan-Canadian Tobacco Cessation and Cancer Care Network (PTCCCN; the Network) with representation from both tobacco control and cancer control from Canada's 13 provinces and territories, federal government agencies (Health Canada, Public Health Agency of Canada, Indigenous Services Canada) as well as patient and family representatives. The Network was mandated to accelerate action on the integration of evidence-based smoking cessation support within ambulatory cancer care settings.

Our pan-Canadian target is for 100% of ambulatory cancer care centres to offer evidence-based smoking cessation support to cancer patients and families across Canada.

Through efforts defined in the Action Framework and with the dedication of cancer centres across Canada, we can achieve our vision that every patient with cancer across Canada receives support to quit smoking for the best treatment and quality of life.

The Pan-Canadian Action Framework for Implementing Smoking Cessation in Cancer Care was created to provide pan-Canadian level guidance and actionable recommendations on the implementation, refinement and sustainability of evidence-based smoking cessation support for cancer patients in cancer care centres across Canada. More specifically, the specific goals of the Action Framework are to:

1. Establish processes for routine identification of tobacco smokers in cancer care settings;
2. Implement processes to systematically support cancer patients/families in quitting smoking, in collaboration with community partners where and when needed;
3. Develop person-centered approaches to smoking cessation along with culturally competent approaches for First Nations, Inuit and/or Métis cancer patients; and
4. Evaluate and sustain smoking cessation approaches for cancer patients.

3.3. Why is an Action Framework Valuable for Cancer Care Stakeholders and Patients?

The evidence produced to date clearly indicates that substantial benefit can be realized through the implementation of smoking cessation efforts. For health system administrators and regulators (government agencies), patients within their catchment area will receive more optimal care and support and the system will save costs typically associated with cancer patients who smoke. At the frontlines, healthcare providers will practice more efficient medicine, decreasing the time spent, for example, re-administering medicines or performing more lengthy surgeries, and achieving the outcomes that all professionals hope to obtain for their patients. Finally, for cancer patients, the benefits of smoking cessation will provide the best odds that they can fight and overcome cancer.

4 THE PAN-CANADIAN ACTION FRAMEWORK FOR IMPLEMENTING SMOKING CESSATION IN CANCER CARE

4.1. Overview of the Action Framework

To achieve our Vision for the integration of smoking cessation support in cancer care settings, the Partnership and its Network have established a comprehensive cessation Framework that is rooted in evidence and tailored to the Canadian context (see Figure 1 for the smoking cessation as first-line treatment model). Core to the Framework is **Evidence-based Cessation Support** (see Section 5) that comprises two major components: I) **Behavioural Counselling**, which involves patient engagement, advice and Counselling for cancer patients to quit smoking (see Section 5.1), and II) **Pharmacotherapy**, which helps to ease nicotine withdrawal symptoms and complements counselling to increase the probability of success of reducing or quitting smoking (see Section 5.2). Together, these components have been tested through rigorous clinical studies and the combined approach has been proven to increase the probability of successfully quitting smoking after six months.[8]

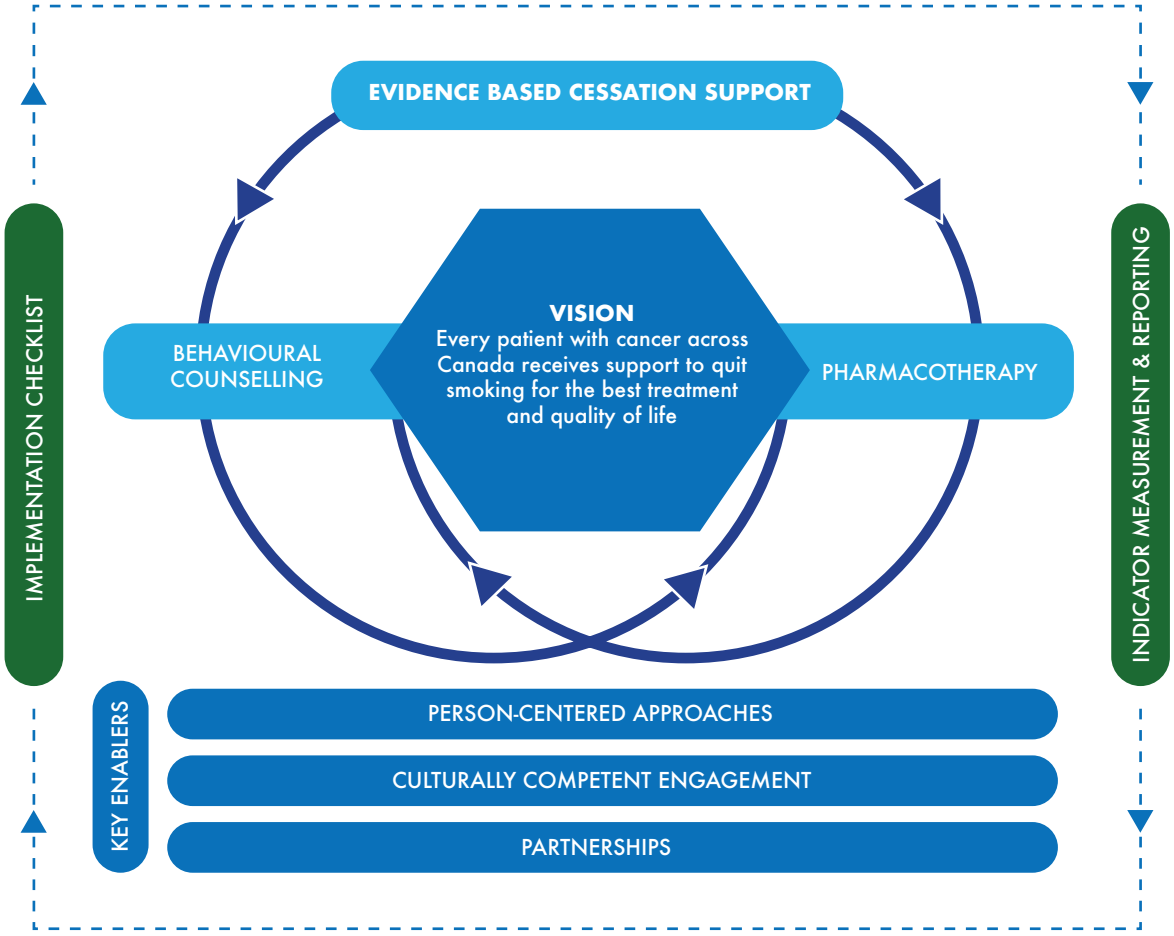
The Framework also includes cross-cutting Key Enablers (see Section 6) designed to amplify the efficacy and impact of cessation support and drive success of the overall Framework. These enablers are:

- **Person-Centered Approaches**—Tailoring and adapting cessation support to account for an individual's unique circumstances;
- **Culturally Competent Engagement**—Accounting for the historical, social and psychological context that may exist among populations, especially among First Nations, Inuit and Métis, to deliver services in an equitable, safe and respectful manner; and
- **Partnerships**—Engaging community partners and stakeholders to strengthen cessation support services within a jurisdiction, avoid duplication of efforts and leverage resources.

4.2. Supporting Implementation and Continuous Improvement

Ultimately, successful integration of cessation support in ambulatory cancer care settings and operationalization of the Key Enablers will require effective implementation. A value-add of the Action Framework is the inclusion of an **Implementation Checklist** (see Section 7.2 and the Appendix) designed to i) prepare cancer centres that are beginning to offer comprehensive cessation support through a pre-implementation assessment and ii) describe a step-wise approach across each component of smoking cessation support that guides graduation of programs from bronze, silver and ultimately gold-standard levels. The inclusion of bronze, silver and gold levels is intended to acknowledge that cancer care centres may be at different points in their journeys with regard to smoking cessation program implementation, while also driving action toward gold-level offerings of smoking cessation support in cancer care. Finally, program evolution is enabled through the measurement and reporting on standardized smoking cessation quality indicators that are described in the final component of the Framework, **Indicator Measurement & Reporting** (see Section 7.1).

Figure 1: Smoking Cessation as First-Line Cancer Treatment Model



5 EVIDENCE-BASED CESSATION SUPPORT

Evidence-based smoking cessation support consists of a combination of behavioural counselling and pharmacotherapy, which work together to increase the likelihood of cancer patients making a successful quit attempt.[8]

5.1. BEHAVIOURAL COUNSELLING

Behavioural counselling represents the initial entryway for a cancer patient undertaking a journey to quit smoking. While terminology can differ, this critical component of cessation support generally comprises: i) evidence-based smoking cessation models and associated brief or intensive counselling, ii) referral mechanisms, iii) follow-up and relapse prevention efforts, and iv) extended services offered to family and friends. Each of these dimensions is described in more detail below.

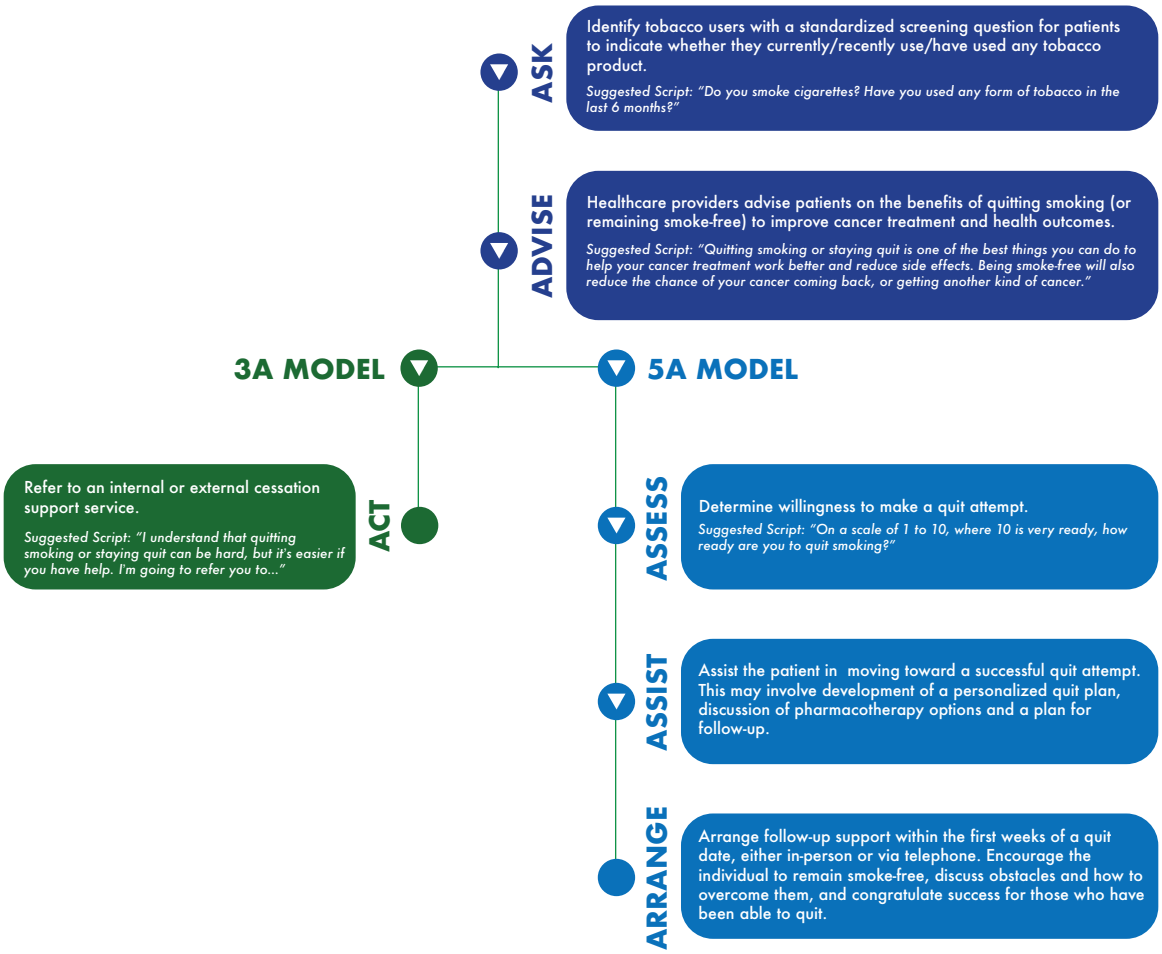
Evidence-Based Smoking Cessation Models

Optimal approaches for successful behavioural interventions offered to cancer patients who smoke have been organized into the **5A and 3A models**. The **5A model** (Ask, Advise, Assess, Assist, Arrange) is an internationally recognized, evidence-based intervention designed for healthcare providers to support smoking cessation by encouraging practitioners to: ask whether a patient smokes, advise on the benefits of quitting, assess their willingness to quit, and assist with cessation and arrange for follow-up contact (see Figure 2). Given the demanding schedules of healthcare providers in a cancer clinic setting, there may be limited time to undertake each stage of the 5A model. For this reason, a more streamlined and condensed version of the model has also been accepted and represents the minimum requirements of the intervention to deliver evidence-based cessation support. This version, termed the **3A model** (Ask, Advise, Act), encourages practitioners to ask whether a patient smokes, advise on the benefits of quitting and act to support the patient in successfully quitting. To date, evidence, albeit limited, exists to demonstrate that either the 5A or 3A model can be effective; depending on resource availability, cancer centres may choose to implement either model.[9]

Regardless of the chosen cessation model, the intensity of the counselling provided may also vary ranging from either brief or intensive. **Brief counselling** lasts approximately one to three minutes and is provided during the natural flow of activities in a clinical or community setting. Evidence demonstrates that brief advice from healthcare providers has a significant effect on smoking cessation rates.[10] More **intensive counselling** lasts for more than 10 minutes and can be carried out as part of a routine clinical or community activity (e.g., as part of the interaction between a nurse and patient in the hospital).

While the healthcare provider will have an opportunity to counsel in the context of a patient's care, options exist for identified smokers to be referred to a trained tobacco treatment specialist, an external service (e.g., quitline), an interactive voice recorder service (IVR), a community service or an internal smoking cessation clinic within the cancer centre for specific sessions on smoking cessation.[10] This support may be provided in-person or by phone, each with its own advantages and disadvantages (see Table 1).

Figure 2: The 3A versus 5A model for smoking cessation support with proposed scripts



Note: Source of suggested scripts are from CCO's Framework for Smoking Cessation in the Regional Cancer Programs. V2.0 (2017).[11]

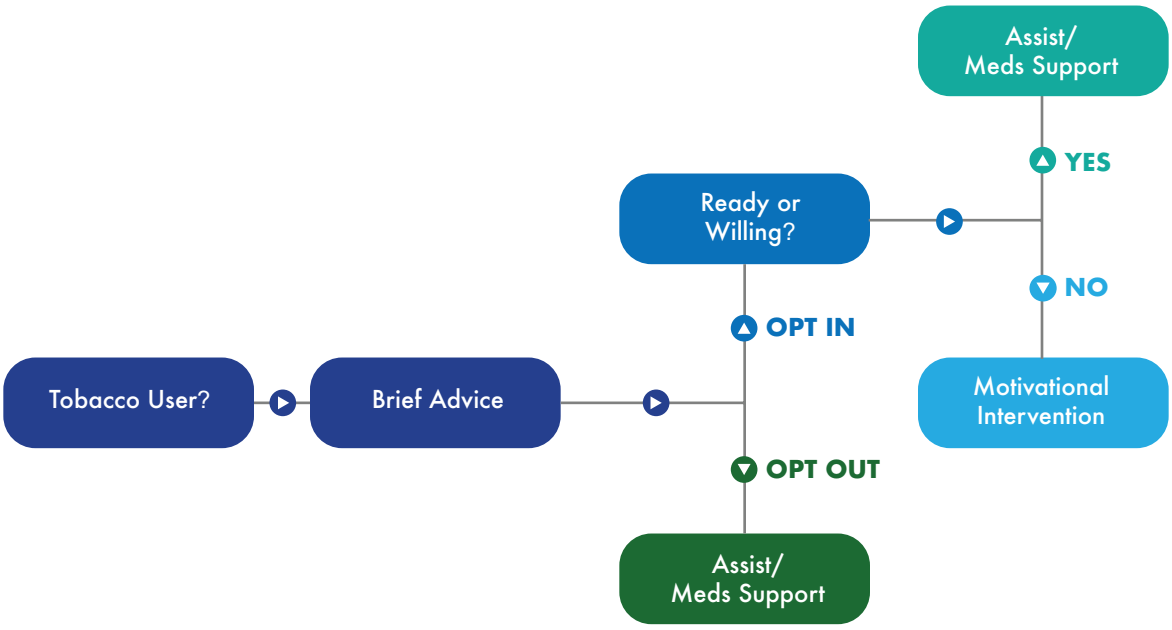
The Opt-Out Referral Mechanism

Traditionally, smoking cessation support has defaulted to referrals when a patient "opts-in" to receiving cessation support, which limits or delays access to effective tools to quit smoking—particularly since only a minority of smokers will identify as "ready to quit".[12]
However, current evidence suggests that patients who report they are "not ready to quit," actually quit at the same rate as those who identify as "ready". For this reason, recent theories suggest an "opt-out" approach, where cessation support is proactively provided to patients who smoke regardless of their willingness/readiness to quit, should be the default. As with other medical care services, a patient can opt-out of the referral if they so choose (see Figure 3).

Research has shown that an opt-out referral mechanism has several benefits[12]—it:

- Transitions smoking cessation support to a standard component of quality cancer care;
- Reduces the time spent by healthcare practitioners in assessing patients;
- Decreases the refusal rate to adopt smoking cessation support;
- Increases patient participation in cessation support services via automated enrolling (vs. self-enrollment); and
- Begins treatment earlier to enhance the potentially benefits of quitting in relation to cancer treatment effectiveness.

Figure 3: Opt-in and opt-out approaches to referrals for smoking cessation support



Toward Implementing Gold-Standard Smoking Cessation Support

Implementation of either the 3A or 5A smoking cessation support model represents the minimum requirement and a critical first step towards supporting patients to quit smoking (Bronze Level). Incorporation of an opt-out approach would ideally follow to ensure more patients are being referred to cessation support (Silver Level). Furthermore, mechanisms for relapse prevention and follow-up, and extension of referral services to family/friends to ensure that cancer patients remain smoke-free should be implemented (Gold Level).

Furthermore, simply offering smoking cessation treatment, without assessing and discussing the patients' current motivation to quit, is the preferred approach for healthcare providers as it is easier and less time-consuming to implement.[13]

Relapse Prevention and Follow-Up

Evidence-based smoking cessation support is not foolproof—smoking relapse is common, particularly when coupled with a stressful life event such as a cancer diagnosis.[14] In many cases, a cancer diagnosis leads to an immediate short-term quit attempt with relapse typically occurring within one to six months.[15] Indeed, this cycle can repeat itself as it can take a patient multiple quit attempts in order to achieve long-term smoking cessation.[16] Therefore, helping cancer patients maintain smoking abstinence is an important component of a cancer centre's smoking cessation program.

Where resources are available, a comprehensive smoking cessation support should include mechanisms of follow-up and relapse prevention to ensure that recent quitters—patients who may have quit smoking within the past six months—are provided with advice and referrals for re-treatment that can help them remain smoke-free. It is also important that healthcare providers remain empathetic and continue to promote smoking cessation throughout cancer care as patients recover.

Extending Offer of Cessation Support to Family and Friends

Support from family and friends can have a positive influence on a patient's ability to quit smoking. In contrast, living with individual(s) who smoke can serve as a significant barrier to smoking cessation.[17] When possible, family members, friends and/or significant others should be informed of the benefits of quitting smoking on the effectiveness of cancer treatment and overall health outcomes for the patient and the impact that their positive/negative reinforcement could have on the patient's ability to quit smoking. While the pathway of support for family members/friends may look different than that of the cancer patient, a cancer centre should consider sharing information or referring family members/friends to a quitline or a community cessation support partner to deliver the support.

Over time, cancer centres should strive to incorporate a comprehensive behavioural counselling support program consisting of proven cessation models (5A or 3A models), opt-out referral mechanisms, relapse and prevention support and engagement with family and friends to achieve the best results.

5.2. Pharmacotherapy

Pharmacotherapy forms an important component of evidence-based and comprehensive smoking cessation support and should complement behavioural counselling efforts. The therapy can take several forms, specifically:

- Nicotine replacement therapy (NRT), which delivers nicotine that does not involve smoking tobacco (e.g., a patch, gum, lozenge, inhaler, or spray) and is generally available over the counter.
- Medications such as Bupropion or Varenicline that chemically interfere with nicotine receptors in the brain to reduce withdrawal symptoms and require a prescription from a medical professional.
- Natural health products such as Cytisine, which also reduce tobacco cravings by blocking nicotine receptors.

While these pharmacotherapies can be purchased across Canada, the degree of government coverage for these aids varies and depends on eligibility requirements such as age, health insurance plan, duration of coverage and the upper limit of reimbursement. Furthermore, the authority of certain healthcare professionals (e.g., pharmacists, nurse practitioners, other allied health professionals) to prescribe pharmacotherapies also varies by province and territory. To learn more about current cessation aid availability in your province or territory, please see Cessation Aids Coverage Infographic.

While the combination of behavioural counselling and pharmacotherapy can yield statistically significant improvement in smoking cessation rates, cancer patients may require a range of different approaches based on, for example, the source of the cessation support services, the delivery of the intervention, and whether pharmacotherapy is included.[18] Table 1 summarizes the different approaches and provides the advantages and disadvantages of each.

Toward Implementing Gold-Standard Smoking Cessation Support

Supporting healthcare providers in cancer care settings to prescribe medication/NRT for cancer patients who smoke represents initial steps in a comprehensive smoking cessation support (Bronze Level). Cancer centre administrators and clinical leaders should work together with provincial/territorial governments to offer subsidized medication/NRT for cancer patients (Silver Level) along the path toward providing these products at no cost to the patient (Gold Level).

Table 1: Smoking cessation support parameters, including consideration of advantages and disadvantages

Cessation Service Source	Delivery Mechanism	Pharmaco-therapy Provided	Level of Intervention	Example	Advantages	Disadvantages
Onsite at cancer centre	In-person	Y	3A or 5A Brief or intensive	Clinician or tobacco treatment specialist meets with patient at clinic site, discusses cessation, provides medications	- Easier to track follow-up - Ability to track biochemical confirmation - Coordination with patient's cancer care - One-stop shop for patients	- More resources (clinic space and clinician time) required - Lesser reach for patients who cannot attend in person - Only serve during clinic hours
	Phone	Y	3A Usually brief	Tobacco treatment specialist receives referral from clinician, calls patient, discusses cessation, makes medication recommendation	- Patients can participate in cessation counselling from home (may increase reach) - Easier to track follow-up	- Unable to provide immediate medications (i.e., at point of care) - Less personal contact
Offsite Partner	In-person	Y	3A Brief or intensive	Tobacco treatment specialist receives referral, makes appointment to see patient, discusses medications, provides medication	- Less resource-intensive for cancer centre - Patient may receive more in-depth (intensive) counselling support	- Cessation support provided at a separate clinic (patient travel required) - Less coordinated with patient's overall cancer care
	Phone	Y	3A Usually brief	Phone-based program such as quitline receives patient information via a referral from cancer centre, calls patient to discuss cessation and medications	- Patients can participate in cessation counselling from home (may increase reach) - Less resource-intensive for cancer centre	- Difficulty obtaining patient information (e.g., follow-up, quit rates) from external resource - Unable to provide immediate medications (i.e., at point of care)
Interactive Voice Recorder (IVR)	Phone	N	3A Brief	Patient is contacted by an IVR and cessation support delivered through automated system	- Patients can participate in cessation counselling from home (may increase reach) - No human resources required	- No personal connection - No pharmacotherapy provided

6 KEY ENABLERS

The Key Enablers—person-centered, culturally competent and partnerships—are cross-cutting to all components of a comprehensive smoking cessation program in cancer care settings and will contribute to the overall efficacy, impact and success of the Action Framework. Each Key Enabler is described below.

6.1. Person-Centered

A cancer diagnosis is an unexpected and life-changing event that may be exacerbated by a cancer patient's personal circumstances.[19] Such an event may lead some patients to continue or re-initiate smoking as a coping mechanism. Delivery of smoking cessation support services should therefore be sensitive to a patient's personal circumstances and align with the patient's unique background, preferences, values and culture.

A person-centered smoking cessation program should: i) include patients as advisors on committees to share personal perspectives and serve as co-creators in the development (and refinement) of a cessation support program, ii) gather feedback from patients on their experience with the cessation support program through questionnaires or interviews, and iii) use screening tools that systematically guide a healthcare practitioner through a series of questions to understand a patient's personal circumstances and lead to tailored delivery of cessation support services.

Toward Implementing Gold-Standard Smoking Cessation Support

Initially, the centre's advisory or planning committee for smoking cessation support should have a patient representative as an active, contributing member to co-create the program offered by the centre (Bronze Level). Gathering feedback from patients on their individual experiences (Silver Level) will then allow administrators to shape future versions of the programs based on these insights. Finally, the incorporation of and use of tools to evaluate patient experiences and adapt smoking cessation support based on circumstance (Gold Level) will deliver a truly person-centered program.

6.2. Culturally Competent Engagement

Ambulatory cancer care centres should recognize and deliver cessation support in a culturally safe manner that recognizes the diverse cultural backgrounds of its patients, including First Nations, Inuit and Métis.[20] Cultural safety involves using a systematic approach to understanding the power differentials that are inherent in health service delivery and may include the integration of trauma-informed care into cessation support services to create a culturally safe environment and help identify triggers that may affect a patient's ability to quit. Cancer centre staff should be encouraged to engage in culturally competent practices—knowledge, behaviour, attitudes and policies that enable individuals to work effectively with various ethnic and cultural groups. Staff trained in cultural competency will further increase awareness and understanding of the history of First Nations, Inuit and Métis and provide cessation support in an equitable manner, without discrimination.[21] Existing training models and opportunities may be available through the community, First Nations, Inuit and/or Métis local and regional governments and organizations, the local health authority or online through provincial health authorities (e.g., Cancer Care Ontario, BC Provincial Health Services Authority).

Toward Implementing Gold-Standard Smoking Cessation Support

All staff that contribute to a smoking cessation support program will have cultural competency training available to them (Bronze Level) and have resources at their disposal to provide Indigenous peoples with additional, contextualized information on the benefits of smoking cessation (Silver Level). All staff are required to receive cultural competency training and deliver culturally safe approaches to support smoking cessation (Gold Level).

Toward Implementing Gold-Standard Smoking Cessation Support

Ambulatory cancer care centres will form a multidisciplinary team that contributes to a smoking cessation support program (Bronze Level) and then expand its network into the community to broaden the referral network, increase capacity, and enhance efficiency of the centre's cessation support program (Silver Level) and establish feedback mechanisms to enable information sharing between cancer centres and community partners (Gold Level).

6.3. Partnership

The efficient and effective delivery of smoking cessation interventions for cancer patients (with or without their families), is optimized through the engagement of multidisciplinary teams and partners. Within the cancer centre, the smoking screening question may be asked by an oncologist or an intake coordinator supporting the patient in their initial administrative paperwork.

This multidisciplinary team model can help to address barriers around time and workload challenges by sharing the responsibility across disciplines. External to the cancer centre, the program should also consider partnerships with a range of organizations/groups to leverage existing efforts, share resources and prevent overburdening any one healthcare professional or discipline (see Table 2). Importantly, the roles and responsibilities for all team members/partners involved should be clearly defined in an operational plan or clinical pathway to ensure everyone is aware of expectations and roles and responsibilities.

Table 2. Cessation Support Partners (Non-exhaustive list of local or pan-Canadian partners)

Organization/Group	Reason for Partnership
Ministries of Health and Social Services	• Responsible for tobacco control efforts in a given province or territory • Funds provincial/territorial coverage for NRT and cessation medications • Funds publicly available cessation programs
Smokers' Helpline or jurisdictional quitline	• Provides cessation services for the general population free of charge • Develops ongoing and tailored cessation support activities (e.g., development of a quit plan) • Provides services in multiple languages
Mental health and addictions	• Considers smoking as an addiction • Provides trauma-informed counselling for cessation
Indigenous organizations	• Co-design culturally competent cessation approaches
Community tobacco cessation programs	• Creates linkages to cessation supports available in a patient's community
Tobacco coalitions or advocacy groups	• Leads or supports efforts to improve tobacco control policies and programs, including access to pharmacotherapy
Research/academic institutions	• Supports evaluation efforts to inform impact and sustainability

7 INDICATORS AND IMPLEMENTATION

The Framework also include tools to support the user in implementing and sustaining smoking cessation support in cancer care settings. The implementation tools include: i) standardized smoking cessation Quality Indicators to enable performance measurement and reporting, and ii) an Implementation Checklist to guide the implementation and refinement of a smoking cessation program at a cancer care centre through incremental levels of adoption (i.e., Pre-Implementation, Bronze, Silver and Gold).

7.1. Indicator Measurement and Reporting

Quality indicators have been developed to enable standardized data collection and reporting and offer an opportunity to consistently monitor and evaluate the uptake and effectiveness of smoking cessation support across the Canadian cancer system.

This Framework includes six standard quality indicators to measure the level of adoption, reach, uptake and effectiveness (or outcomes) of support programs at ambulatory cancer care centres offering smoking cessation support to patients with or without their families (see Table 3 and the **Appendix** for data specifications tables).

Toward Implementing Gold-Standard Smoking Cessation Support

Initially, provinces/territories will measure and report on the number of cancer care centres within their jurisdiction that offer smoking cessation support (indicator 1) and the percentage of cancer patients that are screened for tobacco use (indicator 2) and accepted a referral to a smoking cessation service (indicator 3) (Bronze Level). The number of patients that receive support through centres (indicator 4) will represent the next stage of evolution of the indicator set (Silver Level). Measurement and reporting of outcome indicators [e.g., patients reporting that they have quit smoking (indicator 5) for one week (indicator 6a) or 6 months (indicator 6b) after a referral to a smoking cessation service] will form the most comprehensive performance indicators measurement and reporting system (Gold Level).

Table 3. Standard Quality Indicators

Organization/Group	Reason for Partnership
Adoption	1. Percentage of ambulatory cancer centres that offer smoking cessation support to cancer patients (+/- their families).
Reach	2. Percentage of new cancer patients at ambulatory cancer centres screened for current or recent (past 6 months) tobacco use within 28 days of their first centre visit. 3. Percentage of cancer patients who are current or recent tobacco users that were offered a referral to a tobacco cessation service.
Uptake	4. Percentage of current or recent tobacco users who participated in a tobacco cessation service, after receiving a referral to a tobacco cessation service.
Outcomes	5. Percentage of ambulatory cancer patients who report reduced smoking or tobacco use, after accepting a referral to a tobacco cessation service. 6. Percentage of ambulatory cancer patients who report abstinence from tobacco in the past 7 days, after accepting a referral to a tobacco cessation service. 7. Percentage of ambulatory cancer patients who report abstinence from tobacco in the past 6 months, after accepting a referral to a tobacco cessation service.

A special note for the territories: some Checklist items may need to be completed in collaboration with provincial partners where patients from the territories receive their cancer treatment as key partners in cessation support for cancer patients.

7.2. Implementation Checklist

The Action Framework also includes an Implementation Checklist to serve as a user-friendly and practical guide for cancer care centres to i) assess the current level of its smoking cessation support program (i.e., Pre-Implementation, Bronze, Silver, Gold levels) according to standardized criteria and ii) identify steps for the program to 'graduate' to the next level of adoption (see Implementation Checklist on page 19). The Checklist can be used by all centres, regardless of where a centre/jurisdiction is along the journey of implementing smoking cessation as the levels are not mutually exclusive and can be assessed independently (e.g., some components of a cancer centre's smoking cessation program may meet the Gold standard criteria whereas other areas may be Bronze/Silver) to determine an overall implementation standing.

As an initial step and particularly for those centres just beginning to adopt smoking cessation support, a Pre-Implementation category is included within the Implementation Checklist (Page 19). This category is designed to assist jurisdictions/centres in assessing their resource capacity and readiness for implementation. A key component in preparing for implementation is securing buy-in from senior management/leadership to demonstrate the cancer centre's commitment to smoking cessation for cancer patients. The identification of Executive Champions, announcements at town hall meetings and inclusion in strategic planning efforts can help to build buy-in from a multidisciplinary team of staff (e.g., oncologists, nurse practitioners, administrative staff, IT support) and lead to a comprehensive effort.

How to Apply the Implementation Checklist in Practice

Using the Implementation Checklist, read the criteria for each of the four levels and check the box that best applies to the current state of the cancer centre/jurisdiction to 'score' each component of a comprehensive smoking cessation program, as outlined in this Framework (Pre-Implementation=score of 0, Bronze=score of 1, Silver=score of 2, Gold=score of 3) to provide an indication of the overall level of implementation or 'standing' (i.e., Pre-Implementation, Bronze, Silver, Gold) of the program, as follows:

- Pre-Implementation: Total score of 0
- Bronze: Total score of 1-6
- Silver: Total score of 7-12
- Gold: Total score of 13-18

This Checklist provides an assessment of a cancer centre's/jurisdiction's current implementation standing in relation to their smoking cessation program/efforts while also providing guidance on how to expand or refine a smoking cessation program in cancer settings to "get to gold".

IMPLEMENTING SMOKING CESSATION IN CANCER CARE ACROSS CANADA
A FRAMEWORK FOR ACTION

Implementation Checklist: A user-friendly and practical guide for cancer care centres to assess the current level of its smoking cessation support program according to standardized criteria for each of the Framework categories and identify steps for the program to 'graduate' to the next level of adoption (i.e., Bronze, Silver, Gold) working toward gold-standard cessation support.

Category	Pre-Implementation (Score of 0)	Bronze (Score of 1)	Silver (Score of 2)	Gold (Score of 3)	Score
Behavioural Counselling	☐ Understand the financial implications of implementing behavioural counselling; establish/-maintain infrastructure to support referrals for cessation services and patient tracking; develop communication materials	☐ 3A or 5A model is implemented	☐ 3A or 5A model with an opt-out approach is implemented	☐ 3A or 5A model with an opt-out approach is implemented and mechanisms for relapse prevention and follow-up, and extending cessation support to family and friends are established	___ /3
Pharmaco-therapy	☐ Determine the level of access and the pathways in which cancer patients can receive pharmacotherapy	☐ Prescription for medication/ NRT is provided	☐ Subsidized medication/ NRT is provided	☐ Free medication/NRT is provided	___ /3
Person-Centered	☐ Assess availability of a patient representative to participate in smoking cessation program and meet with Patient and Family Advisory Committee representative for engaging patients	☐ Patient(s) is represented on the program planning/ advisory committee	☐ Patient(s) is represented on the program planning/advisory committee and patient feedback on the cessation program is gathered	☐ Patient(s) is represented on the program planning/ advisory committee, patient feedback is gathered, and tools are used to evaluate patient outcomes and adapt the program accordingly	___ /3
Culturally Competent	☐ Understand the current status of cultural competency training of staff and develop training materials for untrained staff	☐ Cultural competency training is available for all staff	☐ Cultural competency training is available for all staff and culturally specific resources are available for patients	☐ Cultural competency training is required for all staff, culturally specific resources are available for patients and smoking cessation interventions incorporate culturally safe approaches	___ /3
Partnership	☐ Determine availability of smoking treatment expertise, either via an internal smoking cessation clinic, external service, an interactive voice recorder service (IVR), and/or community service	☐ A dedicated, multidisci-plinary team for the cessation program is assembled	☐ A dedicated, multidisciplinary team for the cessation program is assembled and community partners are engaged as part of the referral network	☐ A dedicated, multidisciplinary team for the cessation program is assembled, community partners are engaged as part of the referral network and feedback mechanisms for information sharing between the centre(s) and community partners is established to track patient progress/ outcomes	___ /3
Indicator Measurement and Reporting	☐ Develop tools to track program performance and assess IT infrastructure to support data collection and reporting against quality indicators	☐ Collect and report on the adoption and reach indicators (indicators 1-3)	☐ Collect and report on adoption, reach and uptake indicators (indicators 1-4)	☐ Collect and report on adoption, reach, uptake and outcomes indicators (indicators 1-6)	___ /3
TOTAL SCORE AND LEVEL (Pre-Implementation: 0; Bronze: 1-6; Silver: 7-12; Gold: 13-18)					___ /18

8 CALL TO ACTION

The Action Framework should be used in the design and implementation of an evidence-based smoking cessation support program to ensure all cancer patients in Canada and their families and friends receive optimal support for improved treatment outcomes and quality of life.

Smoking cessation is first-line cancer treatment and an essential part of quality cancer care. Quitting smoking at the time of a cancer diagnosis is one of the best things a patient can do to improve their cancer treatment and health outcomes.[22] While evidence-based approaches to smoking cessation exist in Canada, services are not routinely offered in ambulatory cancer care centres and an Action Framework to accelerate adoption across the cancer system did not exist prior to this one.

This Framework articulates the vision of integrating smoking cessation support in ambulatory cancer care settings to ensure that every cancer patient across Canada receives the appropriate support they require in order to improve treatment outcomes and quality of life. By 2022, 100% of ambulatory cancer care centres should be offering smoking cessation support to cancer patients that are rooted in best practices and evidence to improve outcomes for the cancer system and its patients. This Framework puts forward actionable, practice-based recommendations to inspire cancer care centres to enhance the overall efficacy, impact and success of smoking cessation programs across Canada.

It is hoped that everyone involved in providing smoking cessation support in ambulatory cancer care settings—oncologists, nurses, social workers, community partners and government policymakers—will use the Action Framework to guide the design, implementation, monitoring and evaluation of their evidence-based smoking cessation programs. This will require all stakeholders to be champions of smoking cessation as first-line cancer treatment and offer and sustain the supports necessary for cancer patients to quit smoking and remain smoke-free throughout their cancer journey.

9 APPENDIX: DATA SPECIFICATION TABLES FOR SHARED QUALITY INDICATORS

Definitions	
Ambulatory cancer centres	Cancer centres that provide services on an outpatient basis, where the health care services are provided to the patient within a calendar day. *(Source: Cancer Care Ontario Ambulatory Cancer EMR Extraction Standard – Implementation Guide)*
Tobacco cessation support	Cessation support is intended to help cancer patients reduce or abstain from tobacco use during and beyond cancer treatment. Evidence-based clinical components of tobacco cessation support include: • the identification of recent or current tobacco use; • advising on the benefits of quitting and referring to evidence-informed cessation interventions; and • providing consistent follow-up. *(Source: Ottawa Model for Smoking Cessation – Best Practices for Clinical Smoking Cessation in Canada)*
Commercial tobacco use	Throughout this document, when we refer to tobacco use we mean commercial tobacco. Commercial tobacco is manufactured for recreational and habitual use in cigarettes, smokeless tobacco, pipe tobacco, cigars, hookahs, and other products. This is distinct and separate from traditional (sacred) tobacco use by Indigenous peoples. *(Source: First Nations Health Authority – Respecting Tobacco)*
Referral to cessation support	A referral connects a patient with an internal or external cessation service and is directly arranged by the cancer centre for the patient. A referral does not include providing written material or information such as a brochure.
Reduced tobacco use	A reduction is defined as any decrease in the daily intake of smoking and tobacco use without quitting.

Indicator 1: Cancer centres offering tobacco cessation support	
Definition	Percentage of ambulatory cancer centres that offer tobacco cessation support to cancer patients (+/- their families)
Rationale for measurement	Evidence demonstrates that quitting smoking at the time of a cancer diagnosis is one of the best things an individual can do to improve their health and treatment outcomes. Therefore, cancer centres should be equipped to support cancer patients in quitting smoking and preventing relapse. Ideally, family members who smoke should also be offered cessation support since smoking abstinence among family members has been shown to support patients who are trying to quit.
Numerator	The number of ambulatory cancer centres that offer tobacco cessation support to cancer patients (and their families, if applicable)
Denominator	The total number of ambulatory cancer centres within a province/territory
Exclusion criteria	• Inpatient care facilities
Optional stratification variable(s)	• Patient demographics (e.g., age, sex, income, cancer type, etc.)
Data source	To be determined at provincial/territorial level
National Target	100% of ambulatory cancer centres in Canada offering tobacco cessation support to cancer patients and/or their families *(Recommended by Pan-Canadian Tobacco Cessation + Cancer Care Framework)*

Indicator 2: Cancer patients screened for tobacco use	
Definition	Percentage of new cancer patients at ambulatory cancer centres screened for current or recent (past 6 months) tobacco use within 28 days of their first centre visit
Rationale for measurement	The identification of newly diagnosed cancer patients who could benefit from assistance with tobacco cessation and supporting them to quit and prevent relapse is an important component of quality cancer care. Screening offers healthcare providers an opportunity to educate patients on the benefits of quitting and offer patients tobacco cessation support.
Numerator	The number of ambulatory cancer patients screened for current or recent tobacco use within 28 days of their first visit
Denominator	The number of new cancer patients who received care at an ambulatory cancer centre
Exclusion criteria	• Screening completed at inpatient care facilities
Optional stratification variable(s)	• Patient demographics (e.g., age, sex, income, cancer type, etc.)
Data source	To be determined at provincial/territorial level
National Target	100% of new ambulatory cancer patients at cancer centres will be screened for current or recent smoking or tobacco use within 28 days after a patient's first clinic visit *(Recommended by Pan-Canadian Tobacco Cessation + Cancer Care Framework)*

Indicator 3: Current or recent tobacco users offered referrals to tobacco cessation services	
Definition	Percentage of cancer patients who are current or recent tobacco users that were offered a referral to a tobacco cessation service
Rationale for measurement	Continued tobacco use during cancer treatment can have a negative impact on treatment related outcomes. Therefore, cancer patients should be made aware of the implications of continued tobacco use, and referred to cessation services as part of their cancer treatment to support a quit attempt and/or prevent relapse.
Numerator	The number of current or recent tobacco users that were offered a referral to a tobacco cessation service
Denominator	The number of cancer patients who are current or recent tobacco users
Exclusion criteria	• Current or recent tobacco users who are deceased

Optional stratification variable(s)	• Provider of cessation service(s)
	  ◦ Internal
	  ◦ External
	  ◦ Both
	• Type of cessation service(s)
	  ◦ Pharmacotherapy
	  ◦ Counselling (telephone, in-person, or live chat)
	  ◦ Both
	• Patient demographics (e.g., age, sex, income, cancer type, etc.)

Data source	To be determined at provincial/territorial level
National Target	100% of cancer patients who are current or recent tobacco users will be offered a referral to a tobacco cessation service for support in making a quit attempt or remaining smoke-free *(Recommended by Pan-Canadian Tobacco Cessation + Cancer Care Framework)*

Indicator 4: Tobacco users participating in tobacco cessation services	
Definition	Percentage of current or recent tobacco users who participated in a tobacco cessation service, after receiving a referral to a tobacco cessation service.
Rationale for measurement	Provision of evidence-based cessation services (counselling and/or pharmacotherapy) is the best way to support a current or recent tobacco user to reduce or quit smoking or tobacco use and should be offered to all cancer patients who identify as current or recent tobacco users.
Numerator	The number of current or recent tobacco users that participated in a tobacco cessation service
Denominator	The number of current or recent tobacco users that offered a referral to a tobacco cessation service
Exclusion criteria	• Current or recent tobacco users who are deceased

Optional stratification variable(s)	• Provider of cessation service(s)
	  ◦ Internal
	  ◦ External
	  ◦ Both
	• Type of cessation service(s)
	  ◦ Pharmacotherapy
	  ◦ Counselling (telephone, in-person, or live chat)
	  ◦ Both
	• Patient demographics (e.g., age, sex, income, cancer type, etc.)

Data source	To be determined at provincial/territorial level
National Target	No national target available; targets for this indicator may be determined at provincial/territorial level

Indicator 5: Current or recent tobacco users who reported reduced tobacco use	
Definition	Percentage of ambulatory cancer patients who report reduced smoking or tobacco use, after accepting a referral to a tobacco cessation service. It is recommended that reduction in tobacco use be assessed monthly.[1]
Rationale for measurement	Although completely quitting smoking or tobacco use is best for improving health and treatment outcomes, reducing tobacco use will offer patients with health benefits. Patients should be encouraged and supported to continue to reduce the amount of tobacco they use, with the goal of cessation.
Numerator	The number of current or recent tobacco users that continue to smoke but report a reduction in tobacco use (e.g., some days from every day)
Denominator	The number of current or recent tobacco users that accepted a referral to a tobacco cessation service
Exclusion criteria	• Current or recent tobacco users who are deceased

Optional stratification variable(s)	• Provider of cessation service(s)
	  ◦ Internal
	  ◦ External
	  ◦ Both
	• Type of cessation service(s)
	  ◦ Pharmacotherapy
	  ◦ Counselling (telephone, in-person, or live chat)
	  ◦ Both
	• Patient demographics (e.g., age, sex, income, cancer type, etc.)

Data source	To be determined at provincial/territorial level
National Target	No national target available; targets for this indicator may be determined at provincial/territorial level

[1]Source: The Cancer Patient Tobacco Use Questionnaire (C-TUQ) Fact Sheet. Available at: https://cancercontrol.cancer.gov/brp/tcrb/documents/C-TUQ_Flyer_Questionnaire-508.pdf

Indicator 6: Current or recent tobacco users who reported abstinence from tobacco	
Definition	**a.** Percentage of ambulatory cancer patients who report abstinence from tobacco in the past 7 days, after accepting a referral to a tobacco cessation service **b.** Percentage of ambulatory cancer patients who report abstinence from tobacco in the past 6 months, after accepting a referral to a tobacco cessation service It is recommended that abstinence from tobacco be assessed monthly.[2]
Rationale for measurement	Quitting smoking or tobacco use is best for improving health and treatment outcomes and cancer patients should be offered evidence-based supports to do so.
Numerator	**a.** The number of current or recent tobacco users who reported no smoking or tobacco use in past 7 days (7-day point prevalence quit rate) **b.** The number of current or recent tobacco users who reported no smoking or tobacco use in past 6 months (6-month continuous quit rate)
Denominator	The number of current or recent tobacco users that accepted a referral to a tobacco cessation service
Exclusion criteria	• Current or recent tobacco users who are deceased

Optional stratification variable(s)	• Provider of cessation service(s)
	  ◦ Internal
	  ◦ External
	  ◦ Both
	• Type of cessation service(s)
	  ◦ Pharmacotherapy
	  ◦ Counselling (telephone, in-person, or live chat)
	  ◦ Both
	• Patient demographics (e.g., age, sex, income, cancer type, etc.)

Data source	To be determined at provincial/territorial level
National Target	No national target available; targets for this indicator may be determined at provincial/territorial level

[2] Source: The Cancer Patient Tobacco Use Questionnaire (C-TUQ) Fact Sheet. Available at: https://cancercontrol.cancer.gov/brp/tcrb/documents/C-TUQ_Flyer_Questionnaire-508.pdf

10 REFERENCES

1. Canadian Partnership Against Cancer. (2019). *Canadian Strategy for Cancer Control*. Toronto, ON. Retrieved from: https://www.partnershipagainstcancer.ca/cancer-strategy/
2. Government of Canada. (2019). *Canada's Tobacco Strategy*. Ottawa, ON. https://www.canada.ca/en/health-canada/services/publications/healthy-living/canada-tobacco-strategy.html
3. Balmford, J., Leifert, J. A., & Jaehne, A. (2014). "Tobacco dependence treatment makes no sense because"…: rebuttal of commonly-heard arguments against providing tobacco dependence treatment in the hospital setting. *BMC Public Health, 14*, 1182. https://doi.org/10.1186/1471-2458-14-1182
4. Liu, J., Chadder, J., Fung, S., Lockwood, G., Rahal, R., Halligan, M., … Bryant, H. (2016). Smoking behaviours of current cancer patients in Canada. *Current Oncology* (Toronto, Ont.), *23*(3), 201–203. https://doi.org/10.3747/co.23.3180
5. Warren, G. W., Cartmell, K. B., Garrett-Mayer, E., Salloum, R. G., & Cummings, K. M. (2019). Attributable Failure of First-line Cancer Treatment and Incremental Costs Associated With Smoking by Patients With Cancer. *JAMA Network Open, 2*(4), e191703. https://doi.org/10.1001/jamanetworkopen.2019.1703
6. U.S. Department of Health and Human Services. *The Health Consequences of Smoking: 50 Years of Progress. A Report of the Surgeon General*. Atlanta, GA; 2014
7. Iragorri, N., Essue, B., Timmings, C., Keen, D., Bryant, H., & Warren, G. (2019). *The cost of failed first-line cancer treatment due to continued smoking in Canada. In review*.
8. Stead, L. F., Koilpillai, P., Fanshawe, T. R., & Lancaster, T. (2016). Combined pharmacotherapy and behavioural interventions for smoking cessation. *Cochrane Database of Systematic Reviews*. https://doi.org/10.1002/14651858.CD008286.pub3
9. Models of smoking cessation brief interventions in oral health. (2013). *New South Wales Public Health Bulletin, 24*(3). https://doi.org/10.1071/NB12090
10. Canadian Public Health Association. (2017). Stop Smoking: A Smoking Cessation Resource for Those Who Work with Women. Section 3: One-on-One Smoking Cessation Intervention. Retrieved from: https://cpha.ca/sites/default/files/uploads/resources/stopsmoking/sect_3_e.pdf
11. Cancer Care Ontario. (2017). *Framework for Smoking Cessation in the Regional Cancer Programs* (v2.0). Toronto, ON.
12. Richter, K. P., & Ellerbeck, E. F. (2015). It's time to change the default for tobacco treatment: Changing the default. *Addiction, 110*(3), 381–386. https://doi.org/10.1111/add.12734
13. Kotz, D. (2015). Implementation of a new "opt-out" default for tobacco treatment is urgently needed, but requires free access to evidence-based treatments. *Addiction* (Abingdon, England), *110*(3), 387–388. https://doi.org/10.1111/add.12793
14. Díaz, D. B., Brandon, T. H., Sutton, S. K., Meltzer, L. R., Hoehn, H. J., Meade, C. D., … Simmons, V. N. (2016). Smoking relapse-prevention intervention for cancer patients: Study design and baseline data from the surviving SmokeFree randomized controlled trial. *Contemporary Clinical Trials, 50*, 84–89. https://doi.org/10.1016/j.cct.2016.07.015
15. Toll, B. A., Brandon, T. H., Gritz, E. R., Warren, G. W., Herbst, R. S., & AACR Subcommittee on Tobacco and Cancer. (2013). Assessing tobacco use by cancer patients and facilitating cessation: an American Association for Cancer Research policy statement. *Clinical Cancer Research: An Official Journal of the American Association for Cancer Research, 19*(8), 1941–1948. https://doi.org/10.1158/1078-0432.CCR-13-0666

16. Chaiton, M., Diemert, L., Cohen, J. E., Bondy, S. J., Selby, P., Philipneri, A., & Schwartz, R. (2016). Estimating the number of quit attempts it takes to quit smoking successfully in a longitudinal cohort of smokers. *BMJ Open, 6*(6), e011045. https://doi.org/10.1136/bmjopen-2016-011045
17. Gritz, E. R., Fingeret, M. C., Vidrine, D. J., Lazev, A. B., Mehta, N. V., & Reece, G. P. (2006). Successes and failures of the teachable moment: Smoking cessation in cancer patients. *Cancer, 106*(1), 17–27. https://doi.org/10.1002/cncr.21598
18. Nayan, S., Gupta, M. K. & Sommer, D. D. (2011). Evaluating Smoking Cessation Interventions and Cessation Rates in Cancer Patients: A Systematic Review and Meta-Analysis. *ISRN Oncology*. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3195844/
19. Canadian Partnership Against Cancer. Living with Cancer: *A Report on the Patient Experience*. Toronto (ON): Canadian Partnership Against Cancer; 2018 Jan. 50 p.
20. Wardman D, & McKennitt, D. *Addressing Commercial Tobacco Use among Indigenous Peoples. A Clinical Guide to Tobacco Reduction and Cessation*, Edition: 2, Chapter: 27, Publisher: Centre for Mental Health and Addiction, pp.517.
21. Truth and Reconciliation Canada. (2015). *Honouring the truth, reconciling for the future: Summary of the final report of the Truth and Reconciliation Commission of Canada*. Winnipeg: Truth and Reconciliation Commission of Canada.
22. Duffy, S. A., Louzon, S. A., & Gritz, E. R. (2012). Why do cancer patients smoke and what can providers do about it? *Community Oncology, 9*(11): 344–352. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3500959/

CANADIAN PARTNERSHIP AGAINST CANCER
PARTENARIAT CANADIEN CONTRE LE CANCER

CONTACT US

Canadian Partnership Against Cancer
145 King Street West, Suite 900
Toronto, Ontario, Canada M5H 1J8

Telephone: 416-915-9222
Toll free: 1-877-360-1665
Email: info@partnershipagainstcancer.ca
www.partnershipagainstcancer.ca