NYS TATE SMOKERS' QUITLINE

The Role of Healthcare Professionals in Lung Cancer Screening
Tuesday, November 28, 2023

ROSWELL PARK COMPREHENSIVE CANCER CENTER

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Moderator

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NYS TATE MOKERS' QUITLINE
1-866-NY-QUITS
(1-866-697-8487) nysmokefree.com

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CME Disclosures

- Speakers
  - Dr. Mary Reid reported that she has financial relationships with BMS, Genentech, and Janssen.
- CME Advisory Committee Members
  - Dr. Grace Dy is a consultant with AstraZeneca, Mirati, and Takeda.
  - Dr. Griffiths reported financial relationships with AAMDS Foundation, AbbVie, Alexion Pharmaceuticals/AstraZeneca Rare Disease, American Society of Hematology, Apellis, Astex Pharmaceuticals, Blueprint Medicines, Celgene/BMS, CTI Biopharma, Dresner Foundation, Genentech, MDS International Foundation, MediCom Worldwide, Nextcure, Novartis, Picnic Health, Physicians Educational ResourceTaiho Oncology, and Takeda.

CME Disclosures

None of the speakers, planners, and committee members, who were not already listed, have any relevant financial relationships with ineligible companies within the last 24 months.

All relevant financial relationships with ineligible companies have been mitigated.

Webinar Goals

The goal of this webinar is to provide education on lung cancer screening to healthcare professionals and all those interested in the topic.

Webinar participants will gain tools and resources for talking with eligible clients/patients about decision-making and addressing barriers for lung cancer screening.

Webinar Objectives

At the conclusion of this webinar, attendees will be able to:

- State three U.S. Preventive Services Task Force eligibility criteria for lung cancer screening.
- Discuss two intervention skills for supporting and educating those eligible for lung cancer screening.
- List three ways the New York State Smokers' Quitline can facilitate education and awareness of lung cancer screening resources for participants and healthcare professionals.

Presenters

Mary Reid, BSN, MSPH, Ph.D.
Professor of Oncology and Chief of Cancer Screening, Survivorship and Mentorship
Roswell Park Comprehensive Cancer Center

Paula Celestino, MPH
Director of Client Relations & Outreach
Roswell Park Cessation Services

Disclosures and Advisements

- Today's presenters have no conflicts of interest to declare.
- There is no funding associated with this webinar and no financial benefit for our presenters.
- The term tobacco throughout this webinar refers to the use of manufactured, combustible commercial products and vape products – *not* the sacred, medicinal and traditional use of tobacco by Native American nations and other indigenous groups.

Lung Cancer Screening

November 2023

Mary Reid, PhD, MSPH
Professor of Oncology
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Buffalo, NY

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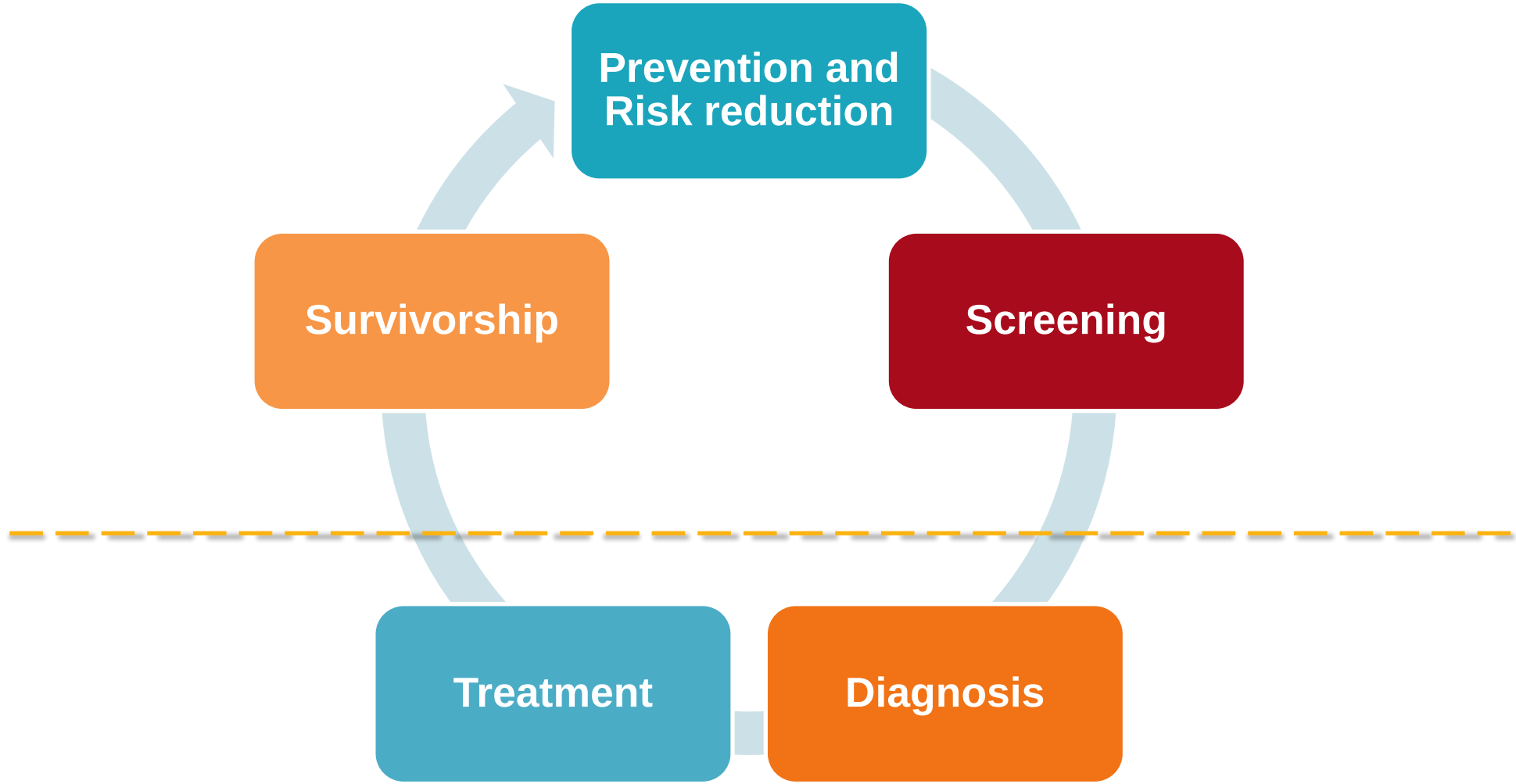
Objectives

1. Implications of Lung Cancer Screening
2. Review of NLST Results Driving Guidelines
3. Current Guidelines
4. Implementations of lung cancer screening and managing nodules

Improve Care Across the Full Continuum



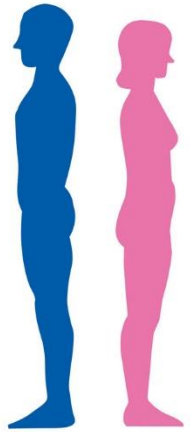
Roswell Outreach and Cancer Screening

- Outreach to community touched 112,999 since 2018
  - Talks, fairs, churches, community events, community stakeholders
- Since 2018:
  - **41,000 breast screenings (10,000 per year in 2022)**
  - **3,700 lung LDCT (3,000 per year in 2023)**
  - **2,360 colorectal screens from 6,000 people reached**
  - **1,577 prostate screenings (DRE with PSA)**

2021 Cancer Estimates

Estimated New Cases

Males			Females		
Prostate	248,530	26%	Breast	281,550	30%
Lung & bronchus	119,100	12%	Lung & bronchus	116,660	13%
Colon & rectum	79,520	8%	Colon & rectum	69,980	8%
Urinary bladder	64,280	7%	Uterine corpus	66,570	7%
Melanoma of the skin	62,260	6%	Melanoma of the skin	43,850	5%
Kidney & renal pelvis	48,780	5%	Non-Hodgkin lymphoma	35,930	4%
Non-Hodgkin lymphoma	45,630	5%	Thyroid	32,130	3%
Oral cavity & pharynx	38,800	4%	Pancreas	28,480	3%
Leukemia	35,530	4%	Kidney & renal pelvis	27,300	3%
Pancreas	31,950	3%	Leukemia	25,560	3%
All Sites	**970,250**	**100%**	**All Sites**	**927,910**	**100%**

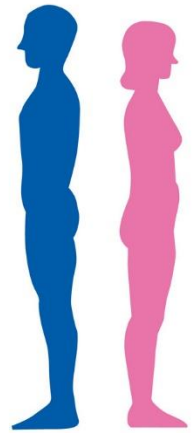


1 in 15 men will develop lung cancer

1 in 17 women will develop lung cancer

Estimated Deaths

Males			Females		
Lung & bronchus	69,410	22%	Lung & bronchus	62,470	22%
Prostate	34,130	11%	Breast	43,600	15%
Colon & rectum	28,520	9%	Colon & rectum	24,460	8%
Pancreas	25,270	8%	Pancreas	22,950	8%
Liver & intrahepatic bile duct	20,300	6%	Ovary	22,950	5%
Leukemia	13,900	4%	Uterine corpus	12,940	4%
Esophagus	12,410	4%	Liver & intrahepatic bile duct	9,930	3%
Urinary bladder	12,260	4%	Leukemia	9,760	3%
Non-Hodgkin lymphoma	12,170	4%	Non-Hodgkin lymphoma	8,550	3%
Brain & other nervous system	10,500	3%	Brain & other nervous system	8,100	3%
All Sites	**319,420**	**100%**	**All Sites**	**289,150**	**100%**



22% of all cancer-related deaths are due to lung & bronchus cancer

Accounting for more deaths than breast, colon, and prostate cancers combined.

Presented by Dr. Jhanelle E. Gray (Moffitt Cancer Center) & Dr. Mary Reid (Roswell Park)

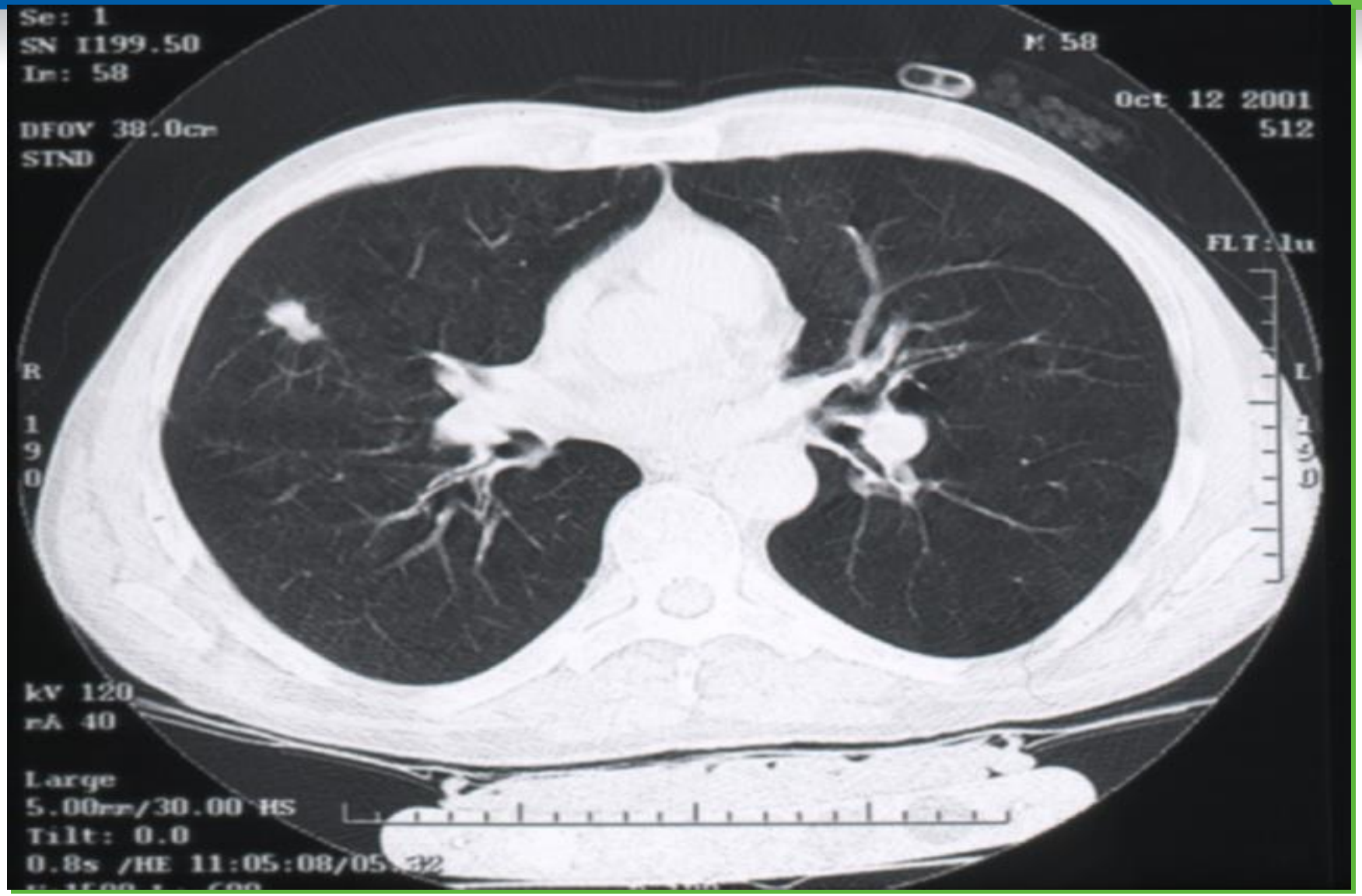
The Results from the National Lung Cancer Screening Trial (NLST)

NLST Endpoints

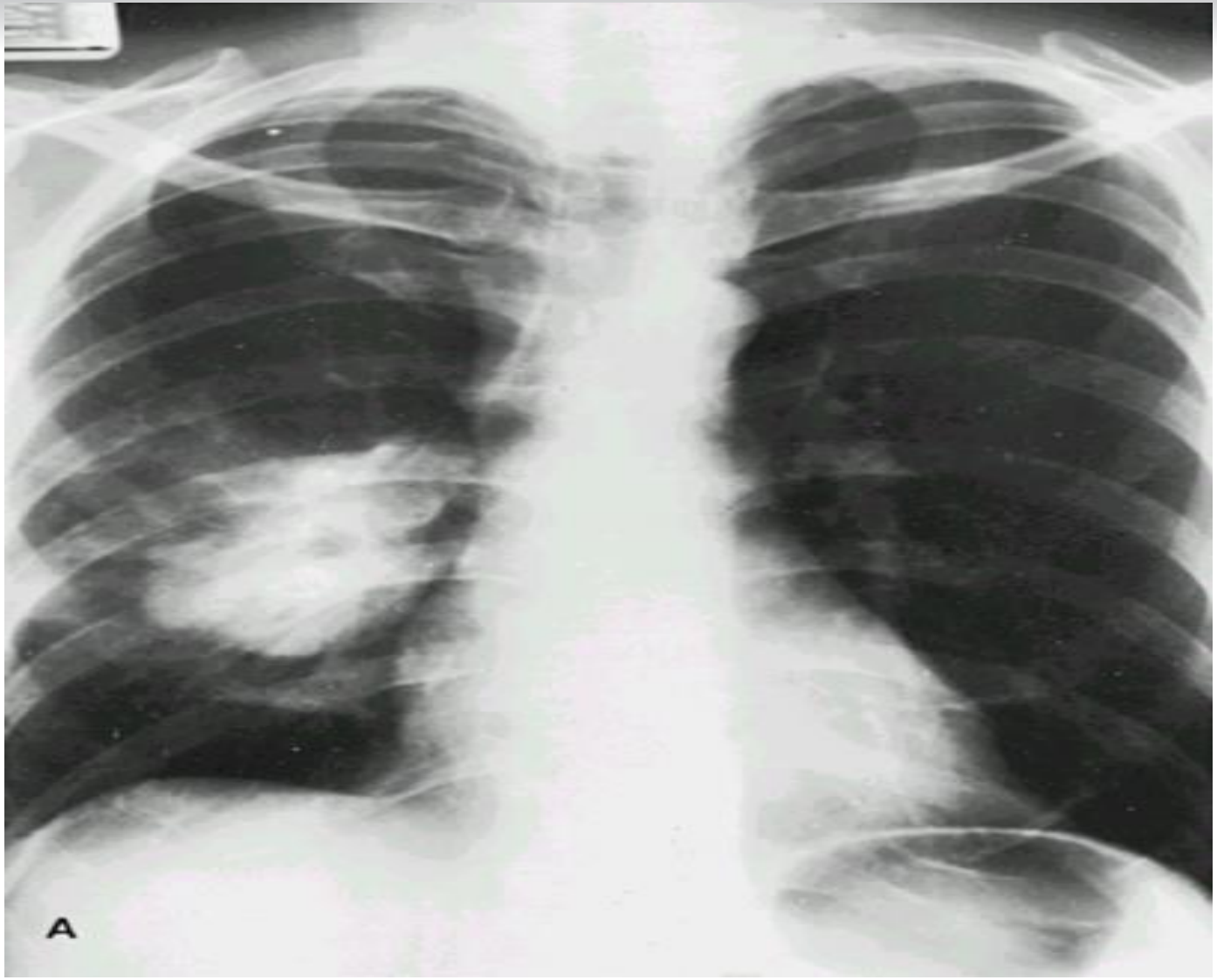
- **Primary Endpoint:** To determine whether 3 annual LDCT reduced mortality from lung cancer relative to screening with CXR.
  - 90% statistical power to detect a 20% reduction

- **Study Design:**
  - A total of 53,454 men and women were recruited.
  - Ages 55 – 74
  - A cigarette history of at least 30 packyears
  - Quit within 15 years
  - Randomized to either the Low Dose CT or Chest X-ray groups

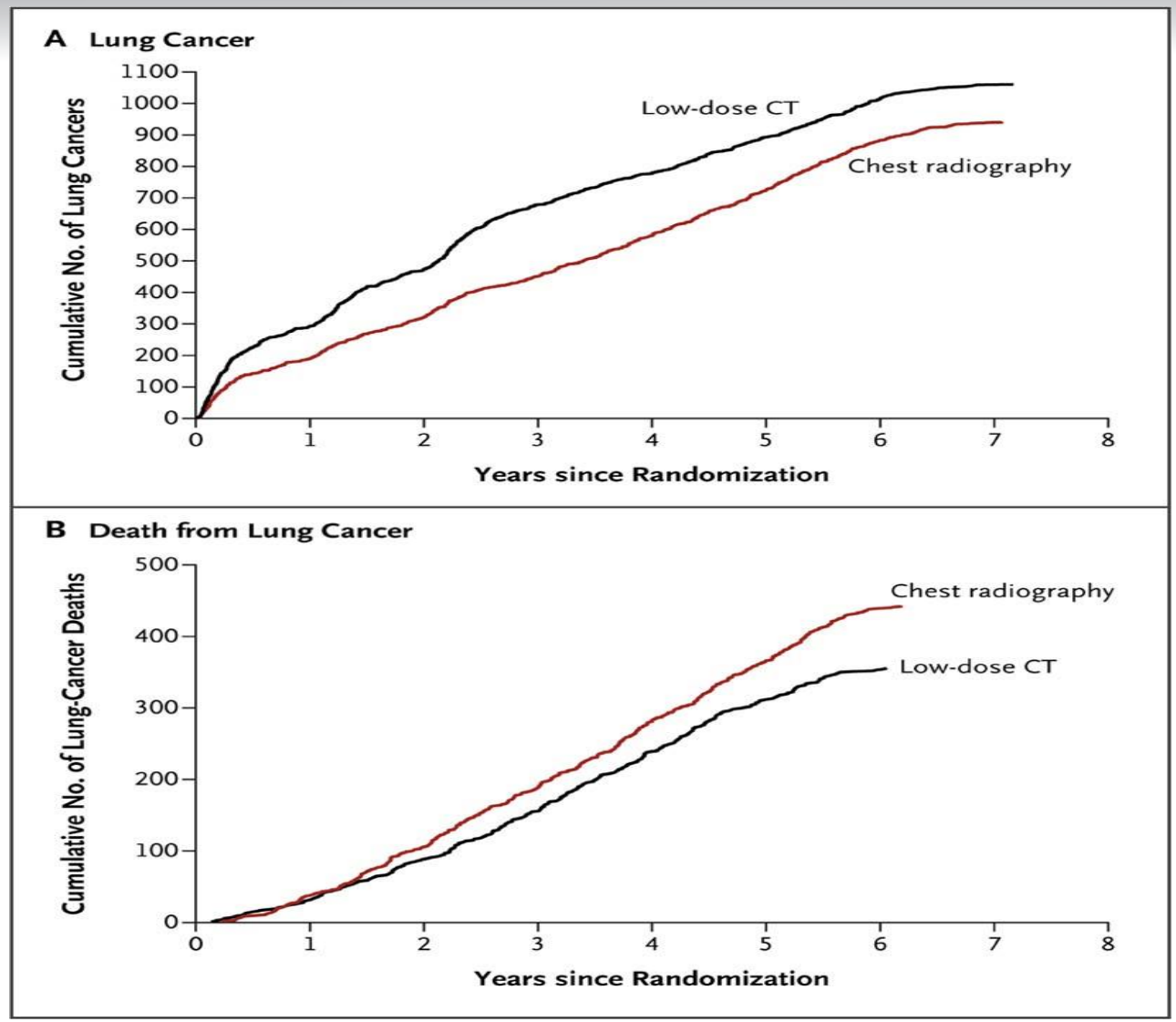
Low Dose CT


Se: 1
SN I199.50
In: 58
M 58
Oct 12 2001
512
DFOV 38.0cm
STND
FLT:lu
R
L
kV 120
mA 40
Large
5.00mm/30.00 HS
Tilt: 0.0

Chest X-ray



Cumulative Lung Cancers Detected & Deaths from Lung Cancer



LDCT resulted in 649 cancers
(3.6% of the positive screens)

CXR resulted in 279 cancers
(5.5% of the positive screens)

Showed 20% reduction in mortality with LDCT compared to CXR

Showed that shifting to early stage diagnosis of lung cancer can improve survival

The NEW ENGLAND JOURNAL of MEDICINE

Same Advantages of LDCT Screening

- Low Dose CT is effective at finding early disease (70% of cancers found early)
- An early lung cure is less expensive than treating advanced cancers (5-10 times)
- Detects cardiac plaques, abdominal aneurysms, asbestosis, lung disease,
  other cancers (breast, kidney, lymphoma)

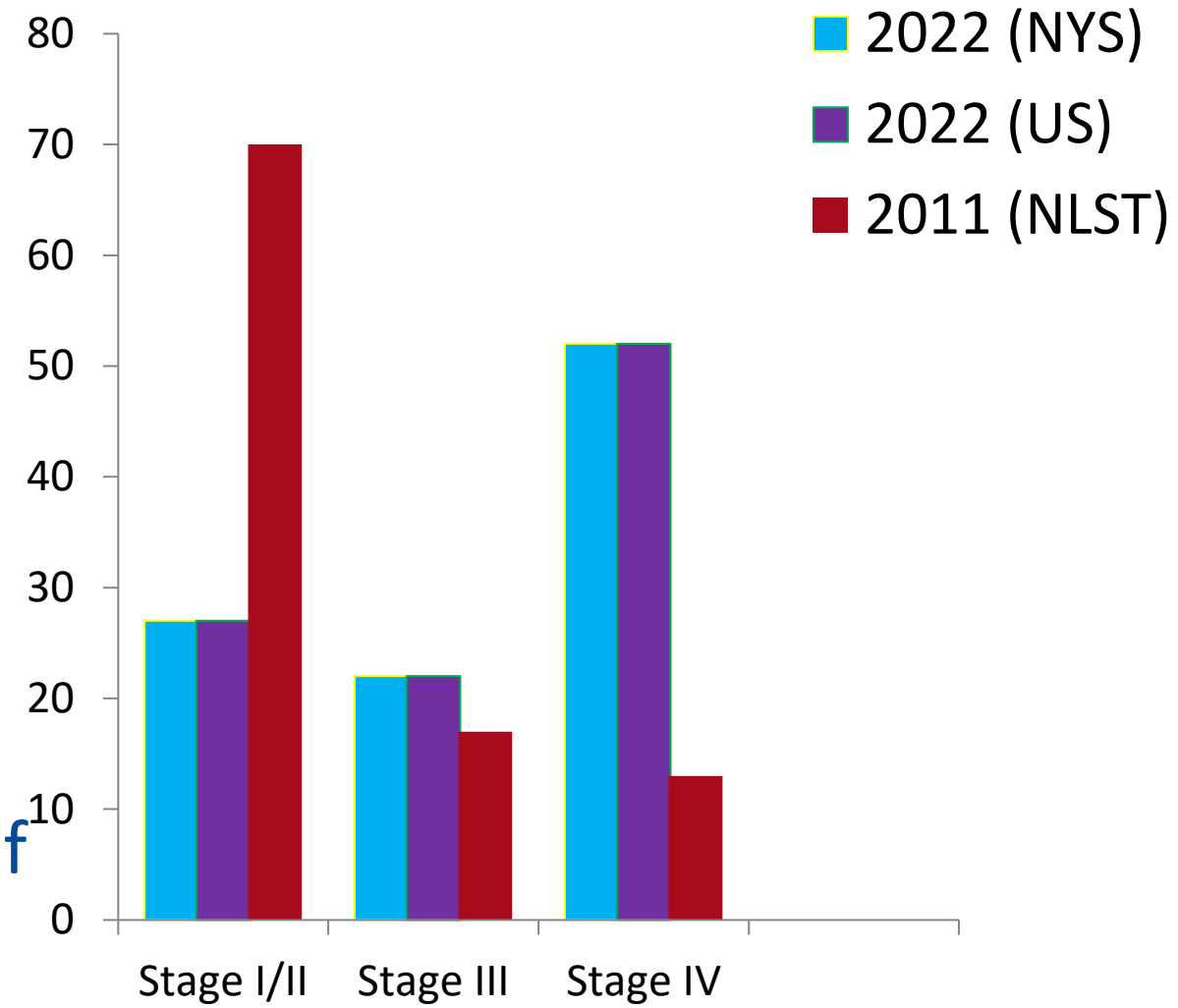
How Many People Are Eligible for LDCT?

- **14.3 million people (32% of all smokers**) are eligible under the USPTF 2021 guidelines

- The ACS 2023 guidelines that remove the quit-within-15-years requirement, increases the number to **19.2 million (43% of Smokers)**

The Shift in LC Stage with Screening

- Eligibility for LDCT:
  - 50 years of age
  - 20 years of smoking
- In **NYS** only 4.9% of eligible people are screened
- **Nationally**, 4.5% of eligible people are screened
- $131 Million can be saved each year in NYS from the treatment of advanced lung cancer



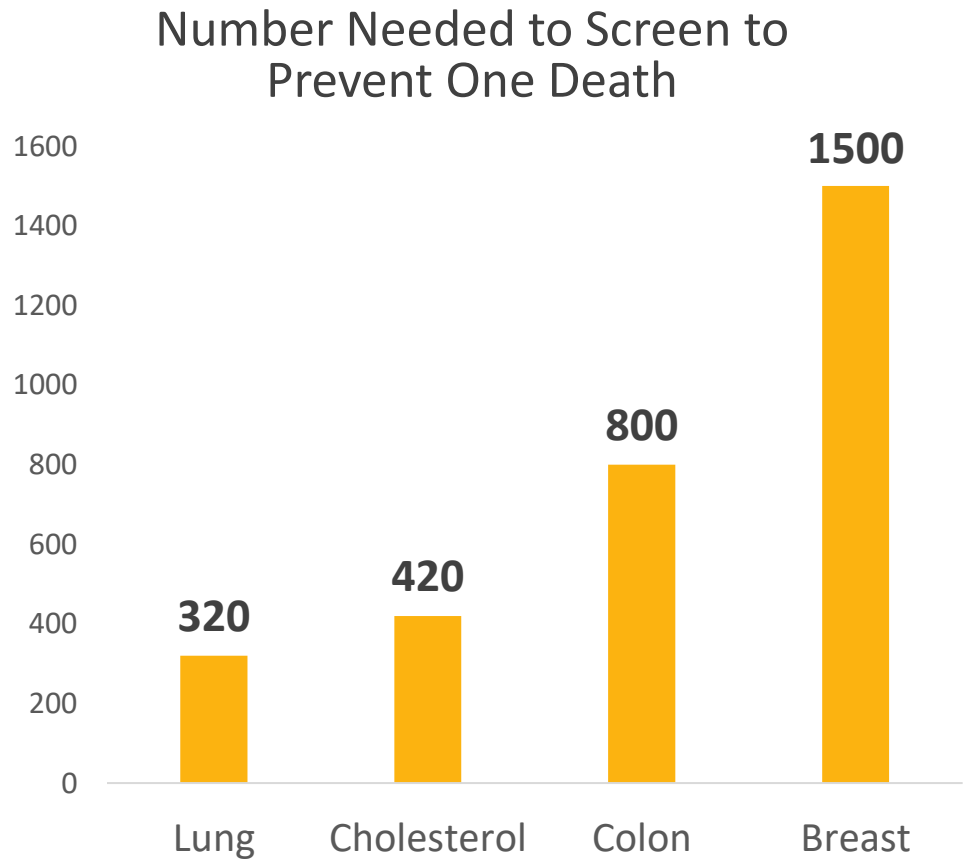
Effectiveness of Lung Cancer Screening

320 people need to be screened prevent one lung cancer death

70% of lung cancers found were early stage

26% lung cancer mortality reduction in men

up to 61% lung cancer mortality reduction in women



Presented to Congress by Dr. Jhanelle E. Gray (Moffitt Cancer Center) & Dr. Mary Reid (Roswell Park)

Challenges with Treating Advanced Stage Lung Cancer

Mortality

46% of patients are diagnosed at an advanced stage when survival rates are low and treatment options are limited.

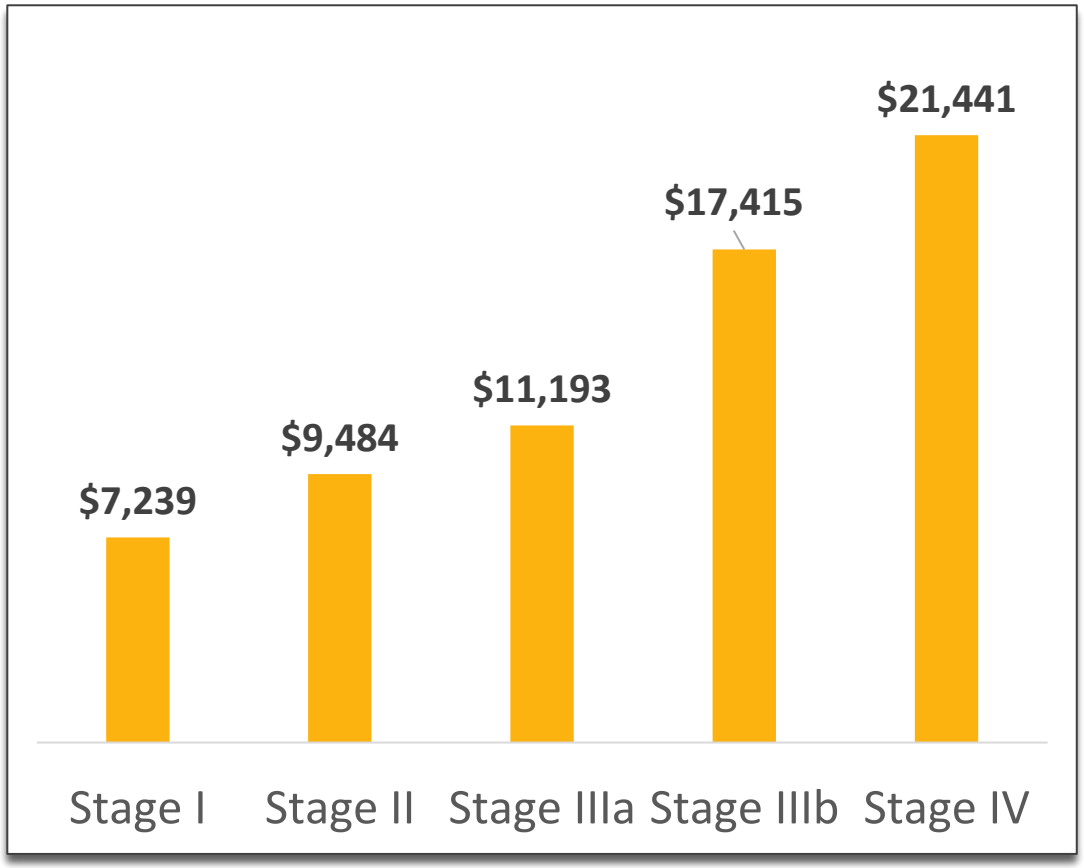
Health Disparities

Blacks have **lower survival rates** and are more likely to be diagnosed at an advanced stage compared to Whites.

Financial Toxicity

Treatment costs are significantly higher for patients with **Stage IV lung cancer ($21,000/month)** compared with Stage I lung cancer ($7,000/month).

Treatment Costs by Stage for NSCLC



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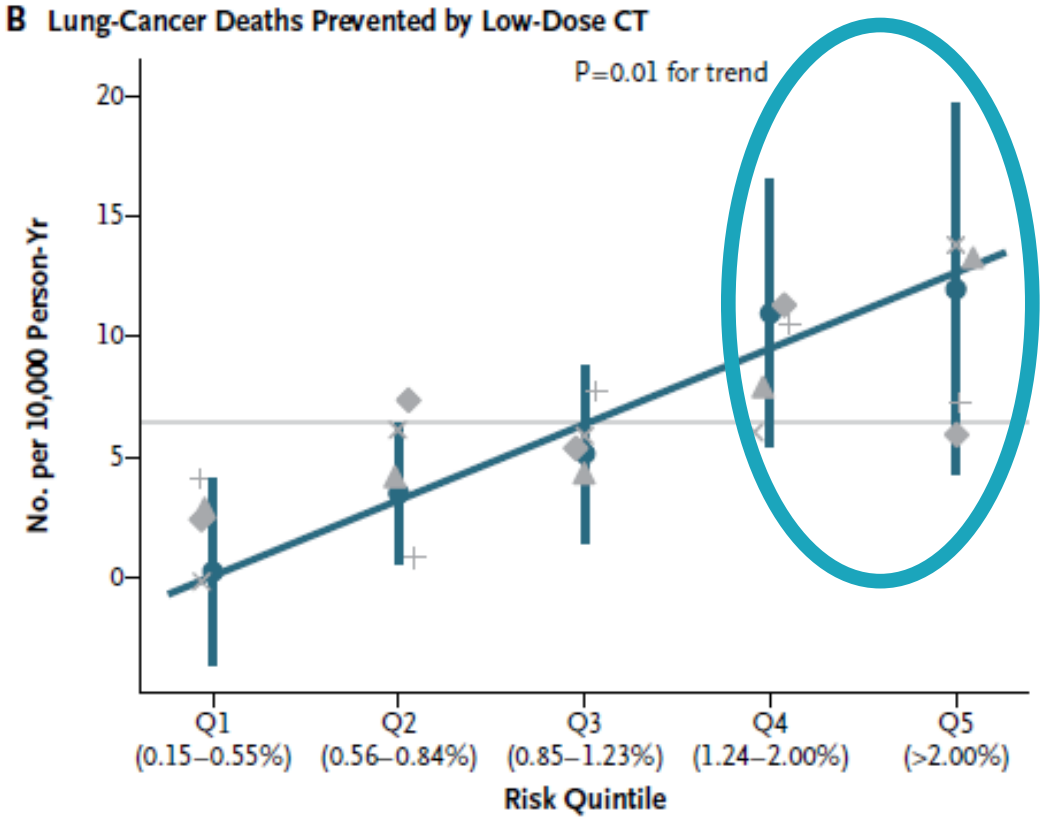
Efficacy of LDCT Screening by Risk Quintile

LDCT Efficacy by Risk



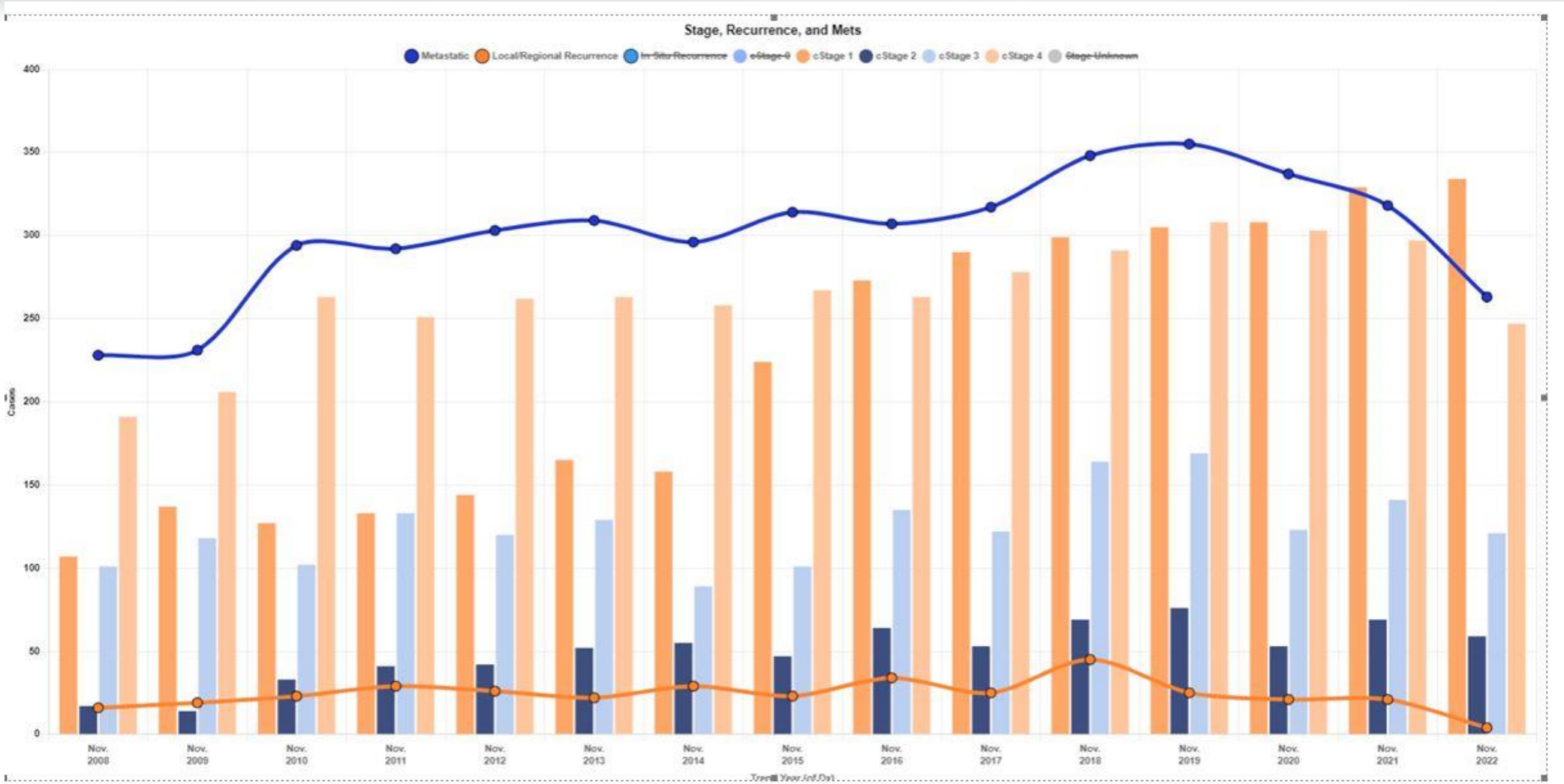
Important Risk Factors

- Age
- Pack-years
- Lower years since quitting
- COPD
- Family with lung cancer
- Body mass index

- ***Q5: 161 LDCT to save a life versus***
- ***Q1: 5200 LDCT to save a life***

Kovalchik et al, NEJM, 2013

Lung Cancer Diagnoses at Roswell



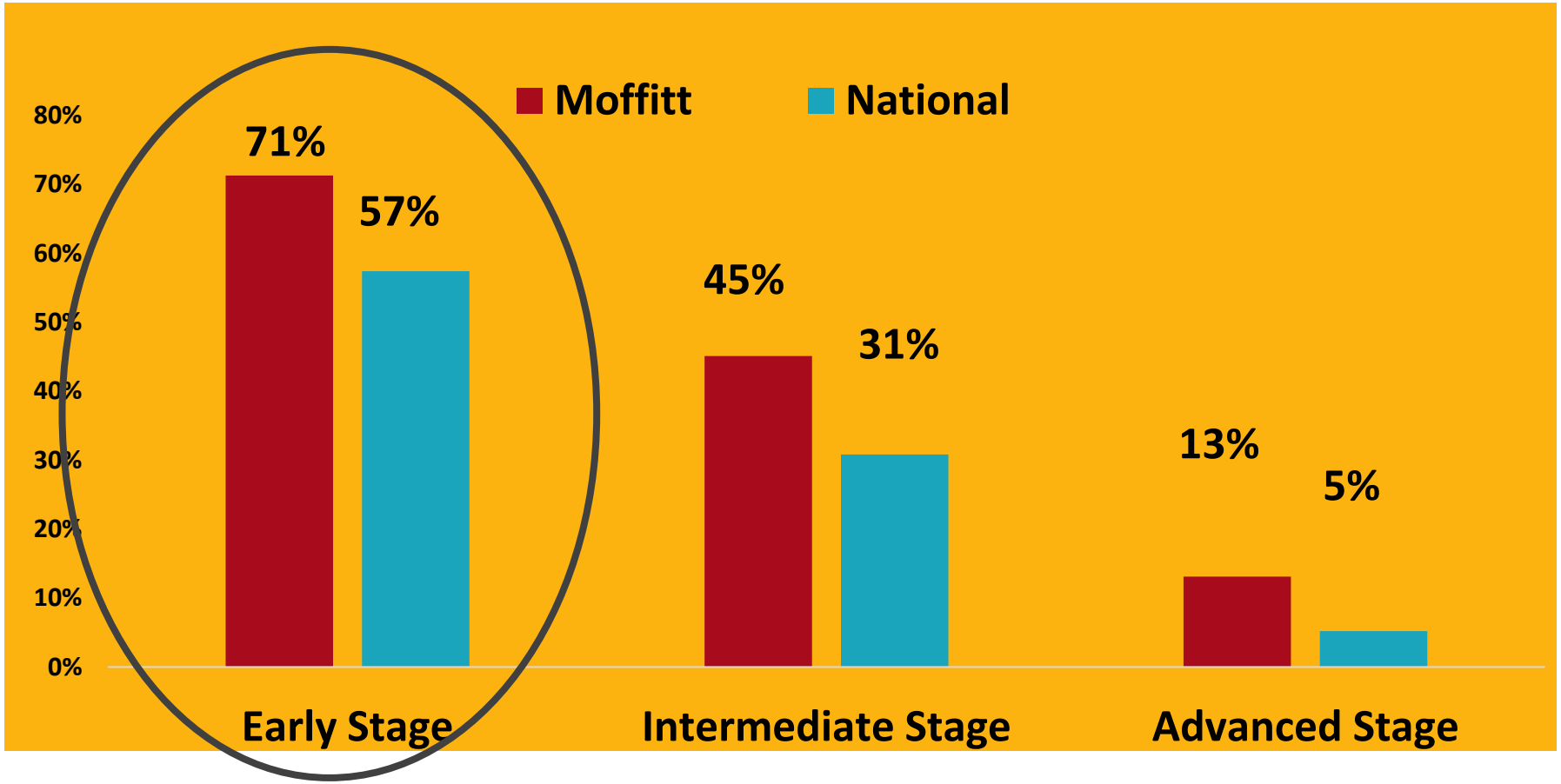
Stage 1 Dx:
2008 = 21%
2022 = 38%

Stage 1+2 Dx:
2022 = 45%

Local Regional Recurrence Is Decreasing

Why is Early Lung Cancer Detection Important?

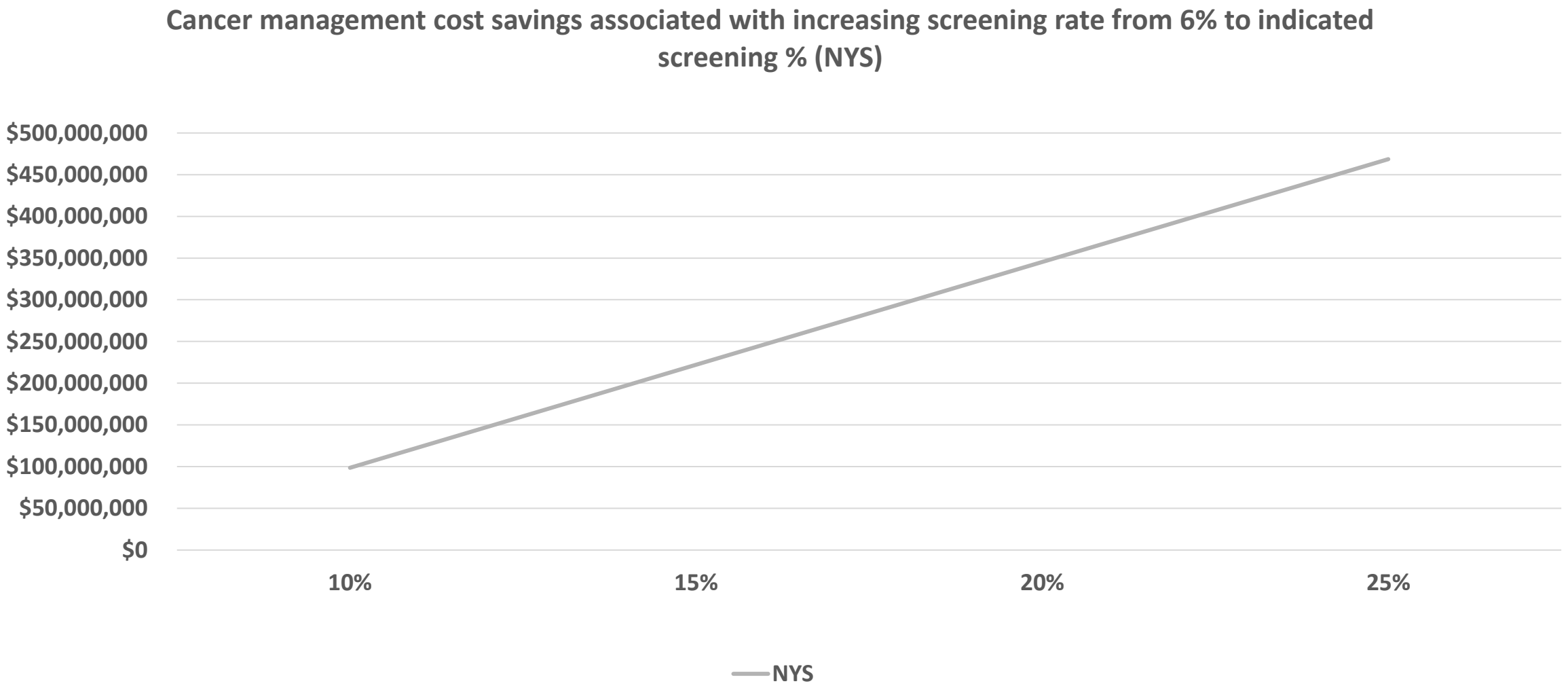
5-Year Survival Rate



US Lung Cancer 5-Year Survival: 25%

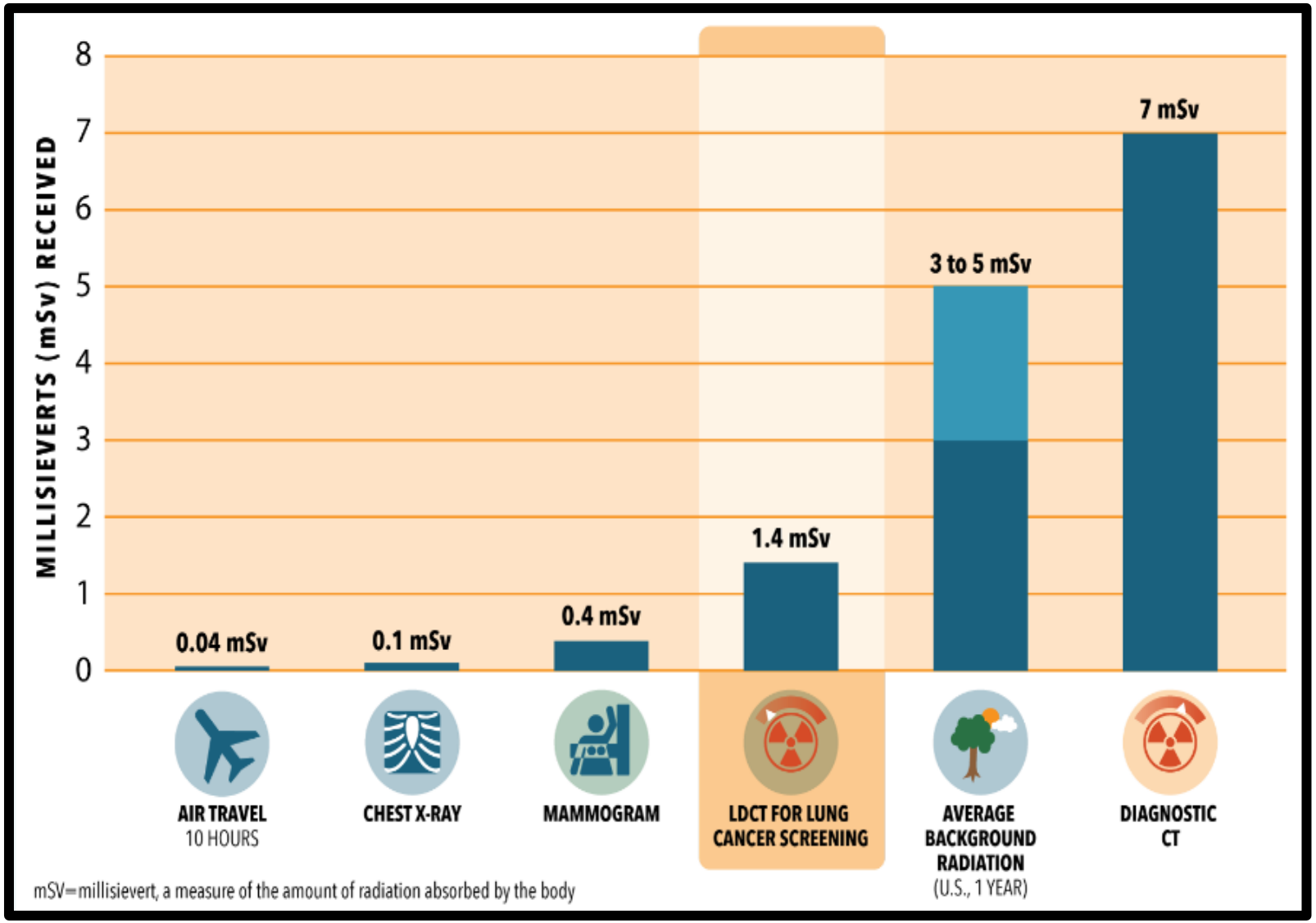
Presented to Congress by Dr. Jhanelle E. Gray (Moffitt Cancer Center) & Dr. Mary Reid (Roswell Park)

NYS Cost Savings by Decreasing Immunotherapy



Radiation Doses from Lung Cancer Screening

- A Diagnostic CT has 5 times the amount of radiation than that of Low-Dose CT



Eligibility

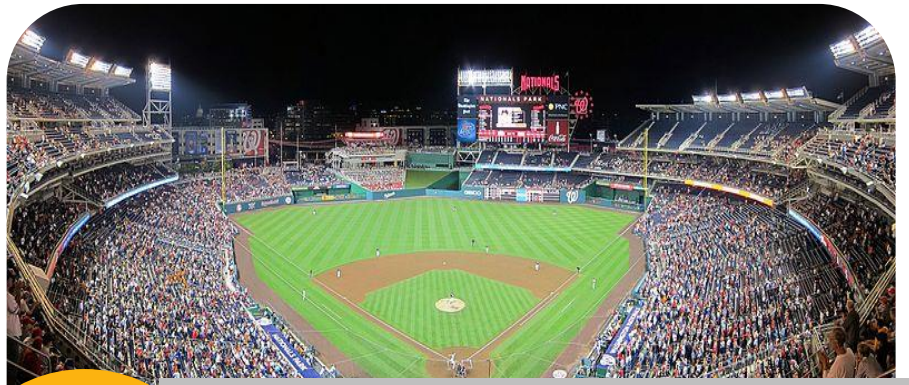
Eligibility Criteria

2021 United States Preventive Service Task Force (USPSTF) Recommendations:

- ❑ **50 – 80** years of age
- ❑ Currently smoking or quit within **15 years**
- ❑ **20+** pack year smoking history

Pack year
=
# of years smoked
x
# of cigarette packs smoked per day

14.5 million **people are eligible for screening** *– more people than reside in the state of Pennsylvania*



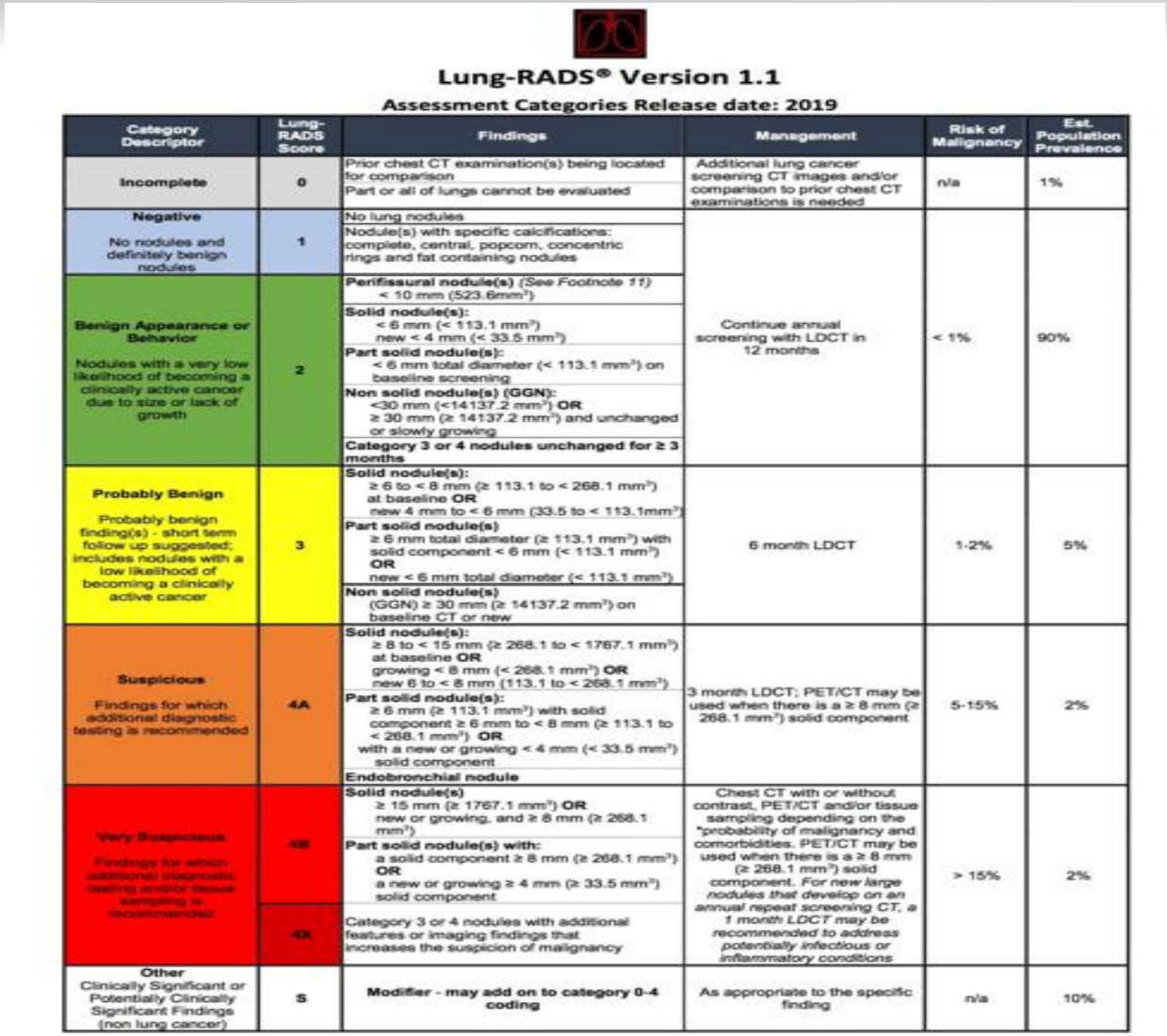
60 thousand **lives could be saved <u>per year</u> if every eligible person were screened** *– more people than can be held in Washington Nationals Baseball Park*

Presented by Dr. Jhanelle E. Gray (Moffitt Cancer Center) & Dr. Mary Reid (Roswell Park)

Focused LC Screening by Risk Level

- 50+ Pack Years exposure to cigarettes
- Current Smokers
- Smoked 1½ packs of cigarettes per day
- Former smokers quit ≤10 years
- Moderate-severe COPD (FEV1 ≤ 70%)
- Positive family history in first degree relatives
- History of pneumonia

LungRADS



Lung-RADS® Version 1.1

Assessment Categories Release date: 2019

Category Descriptor	Lung-RADS Score	Findings	Management	Risk of Malignancy	Est. Population Prevalence
Incomplete	0	Prior chest CT examination(s) being located for comparison Part or all of lungs cannot be evaluated	Additional lung cancer screening CT images and/or comparison to prior chest CT examinations is needed	n/a	1%
Negative No nodules and definitely benign nodules	1	No lung nodules Nodule(s) with specific calcifications: complete, central, popcorn, concentric rings and fat containing nodules	Continue annual screening with LDCT in 12 months	< 1%	90%
Benign Appearance or Behavior Nodules with a very low likelihood of becoming a clinically active cancer due to size or lack of growth	2	**Perifissural nodule(s)** *(See Footnote 11)* < 10 mm (523.6mm³) **Solid nodule(s):** < 6 mm (< 113.1 mm³) new < 4 mm (< 33.5 mm³) **Part solid nodule(s):** < 6 mm total diameter (< 113.1 mm³) on baseline screening **Non solid nodule(s) (GGN):** <30 mm (<14137.2 mm³) **OR** ≥ 30 mm (≥ 14137.2 mm³) and unchanged or slowly growing **Category 3 or 4 nodules unchanged for ≥ 3 months**			
Probably Benign Probably benign finding(s) - short term follow up suggested; includes nodules with a low likelihood of becoming a clinically active cancer	3	**Solid nodule(s):** ≥ 6 to < 8 mm (≥ 113.1 to < 268.1 mm³) at baseline **OR** new 4 mm to < 6 mm (33.5 to < 113.1mm³) **Part solid nodule(s)** ≥ 6 mm total diameter (≥ 113.1 mm³) with solid component < 6 mm (< 113.1 mm³) **OR** new < 6 mm total diameter (< 113.1 mm³) **Non solid nodule(s)** (GGN) ≥ 30 mm (≥ 14137.2 mm³) on baseline CT or new	6 month LDCT	1-2%	5%
Suspicious Findings for which additional diagnostic testing is recommended	4A	**Solid nodule(s):** ≥ 8 to < 15 mm (≥ 268.1 to < 1767.1 mm³) at baseline **OR** growing < 8 mm (< 268.1 mm³) **OR** new 6 to < 8 mm (113.1 to < 268.1 mm³) **Part solid nodule(s):** ≥ 6 mm (≥ 113.1 mm³) with solid component ≥ 6 mm to < 8 mm (≥ 113.1 to < 268.1 mm³) **OR** with a new or growing < 4 mm (< 33.5 mm³) solid component **Endobronchial nodule**	3 month LDCT; PET/CT may be used when there is a ≥ 8 mm (≥ 268.1 mm³) solid component	5-15%	2%
Very Suspicious Findings for which additional diagnostic testing and/or tissue sampling is recommended	4B	**Solid nodule(s)** ≥ 15 mm (≥ 1767.1 mm³) **OR** new or growing, and ≥ 8 mm (≥ 268.1 mm³) **Part solid nodule(s) with:** a solid component ≥ 8 mm (≥ 268.1 mm³) **OR** a new or growing ≥ 4 mm (≥ 33.5 mm³) solid component	Chest CT with or without contrast, PET/CT and/or tissue sampling depending on the *probability of malignancy and comorbidities. PET/CT may be used when there is a ≥ 8 mm (≥ 268.1 mm³) solid component. *For new large nodules that develop on an annual repeat screening CT, a 1 month LDCT may be recommended to address potentially infectious or inflammatory conditions*	> 15%	2%
	4X	Category 3 or 4 nodules with additional features or imaging findings that increases the suspicion of malignancy			
Other Clinically Significant or Potentially Clinically Significant Findings (non lung cancer)	S	**Modifier - may add on to category 0-4 coding**	As appropriate to the specific finding	n/a	10%

LDCT Radiology Reports should include:

- LungRADS Score
- Description of Primary Nodules
  - Size
  - Location
  - Solid Component Size
  - Stable, New, Growing
  - Reference CT Date
- LungRADS **DOES NOT** account for clinical risk factors

Management

LungRADS Definitions

Score	Category (%)	Findings	Management
0	Incomplete (1%)	Incomplete, suspected infection	0-3 months LDCT
1	Negative (39%)	No lung nodule, Benign nodule	12 months LDCT
2	Benign (45%)	< 6mm solid/part solid or <30 mm non-solid nodule Resolved 3 or 4A nodule(s)	12 months LDCT
3	Probably Benign (9%)	6-8mm solid/part solid or >30mm non-solid or new >4-6mm nodule	6-months LDCT
4A	Suspicious (4%)	≥8 and ≤15mm solid or new ≥6-8mm nodule; part-solid with new/growing >4mm solid component, atypical cystic nodule	3-month LDCT Consider PET/CT if ≥8mm solid component
4B	Very Suspicious (2%)	≥15 mm solid or new/growing solid >8mm or atypical cystic nodule or slowly growing nodule	Diagnostic CT w/ or w/o contrast, PET/CT if >8mm solid nodule; tissue sampling (biopsy) And/or referral for further clinical evaluation
4X	Added Features (1%)	Category 3 or 4 with additional features suspicious for cancer	
S	Modifier- Potentially Significant (10%)	Significant finding not related to lung cancer	As appropriate

NCCN Guidelines Version 2.2019
Lung Cancer Screening

NCCN Guidelines Index
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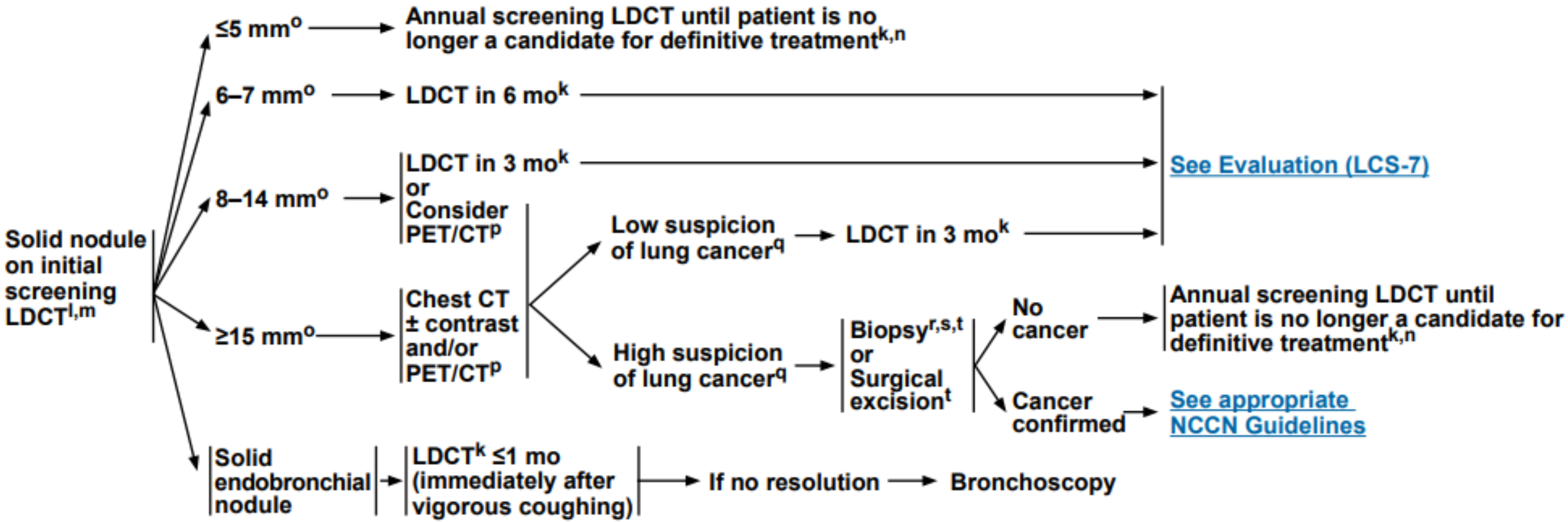
Discussion

EVALUATION OF SCREENING FINDINGS

FOLLOW-UP OF SCREENING FINDINGS



[k]All screening and follow-up chest CT scans should be performed at low dose (100–120 kVp and 40–60 mAs or less), unless evaluating mediastinal abnormalities or lymph nodes, where standard-dose CT with IV contrast might be appropriate (see LCS-A). There should be a systematic process for appropriate follow-up.

[l]The NCCN Guidelines for Lung Cancer Screening are harmonized with Lung-RADS (http://www.acr.org/Quality-Safety/Resources/LungRADS). Pinsky PF, Gierada DS, Black W, et al. Performance of Lung-RADS in the National Lung Screening Trial: a retrospective assessment. Ann Intern Med 2015;162:485-491.

Example of LCS in a Healthcare System

REGISTRY SUMMARY – THROUGH SEPTEMBER 2022

Analysis of Positive Scans - St. Elizabeth Healthcare --- 1/1/2015 - 2022 YTD

Year	2015	2016	2017	2018	2019	2020	2021	2022	TOTAL	% Scans	False Positive	False Discovery	
Total LDCT LC Scr. SCANS	252	753	1965	3585	4082	3843	6084	5767	26331	*	**	***	
Tot. # Unique Patients Scanned	237	716	1649	2751	2267	1332	1964	2064	12980				
Annual					1815	2511	4120	3703	12149				
Baseline					2267	1332	1964	2064	7627				
Annual LCS - % of total					44.5%	65.3%	67.7%	64.2%					
Follow-Up/Interval Screens	9	32	100	168	293	286	430	353	1671				
Cat 1	127	457	1164	2194	2312	2284	3630	3248	15416	58.55%			
Cat 2	76	201	506	887	1250	1118	1760	1775	7573	28.76%			
Cat 3 (Indeterminate)	22	47	143	240	250	256	401	411	1770	6.72%			
Cat 4 (Suspicious) - Total	27	48	152	264	270	185	293	320	1559	5.92%	4.38%	73.89%	
Cat 4A	16	33	108	186	188	134	230	262	1157	4.39%			
Cat 4B	11	15	44	78	82	45	58	54	387	1.47%			
Cat 4X						6	5	4	15	0.06%			
Cat 3 + Cat 4 - Combined	49	95	295	504	520	441	694	731	3329	12.64%	11.10%	87.77%	
Lung Cancer	5	16	37	82	81	51	66	69	407	1.55%	#Lung Cancer Screens to find 1 LC =		64.7
										3.14%	#Unique Patients Screened to find 1 LC =		31.9

- Utilizing EHR (Epic) and EON to manage LDCTs
- 49% of eligible people screened
- Monitors individual provider compliance with guidelines

Thanks for Dr. Mike Gieske, Director of Lung Cancer Screening, St. Elizabeth Healthcare, Lexington KY

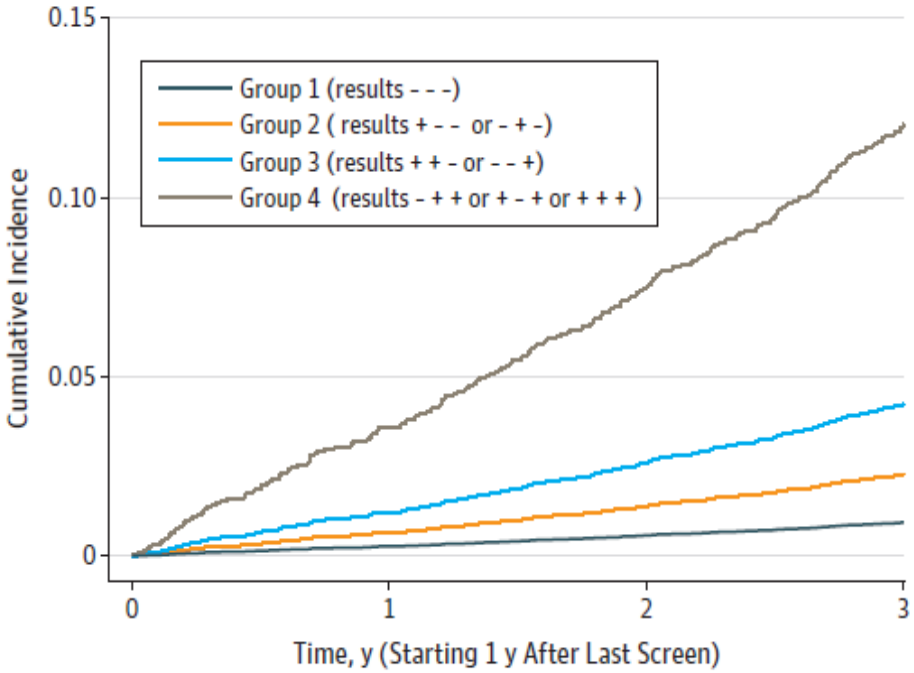
Fleischner Guidelines for Incidental Nodules

	SIZE		
PARTSOLID	<6 mm	6-8 mm	>8 mm
		Single	
Low Risk	No routine follow-up	CT at 6-12 mos; Then 18-24 mos	CT at 3 mos, PET/CT or biopsy
High Risk	Optional CT in 12 mos	Same	CT at 3 mos, PET/CT or biopsy
		Multiple	
Low Risk	No routine follow-up	Same	CT at 3-6 mos; Then 18-24 mos
High Risk	Optional CT in 12 mos	Same	CT at 3-6 mos; Then 18-24 mos

	SIZE		
SOLID	<6 mm	≥6 mm	Same
Ground Glass	No routine follow-up	CT at 6-12 mos; Routine every 2-5 years	
Part Solid	No routine follow-up	CT at 3-6 mos; Routine every 5 years	
		Multiple	
	CT in 3-6 mos.; Stable, every 2-4 years		CT at 3-6 mos; Manage worst nodule

Validation of Risk Model Including LDCT Results

Figure 2. Cumulative Incidence of Lung Cancer in the National Lung Screening Trial Low-Dose Computed Tomography Group Occurring 1 to 4 Years After the Last Low-Dose Computed Tomography Screen Among 23 227 Participants[a]



No. at risk

Group 1	18 770	18 581	18 294	16 417
Group 2	3048	2998	2932	2586
Group 3	974	944	908	774
Group 4	435	405	388	323

Positive LDCTs

- LungRADS 3 or >6 mm nodule
- Increase risk of new lung cancers
- 2-3 positive CTs with the last positive (Group 4) **OR=8.97**
- ***Positive LDCT*** means **Highest Risk** groups identify the patients in greatest need for frequent screening

Tammemagi et al.

Nodule Qualities Requiring Special Management

- LungRADS Score of 3 or more (6 mm)
- Any growing Nodule
- New nodule at follow-up CTs that is not a suspected infection
- Solid Nodules of ≥ 8 mm- 1.4 cm
- Semi-Solid Nodules ≥ 1 cm
  or solid component > 5 mm
- Ground Glass Opacity Lesions ≥ 2 cm

Lung Cancer Surveillance in Cancer Survivors

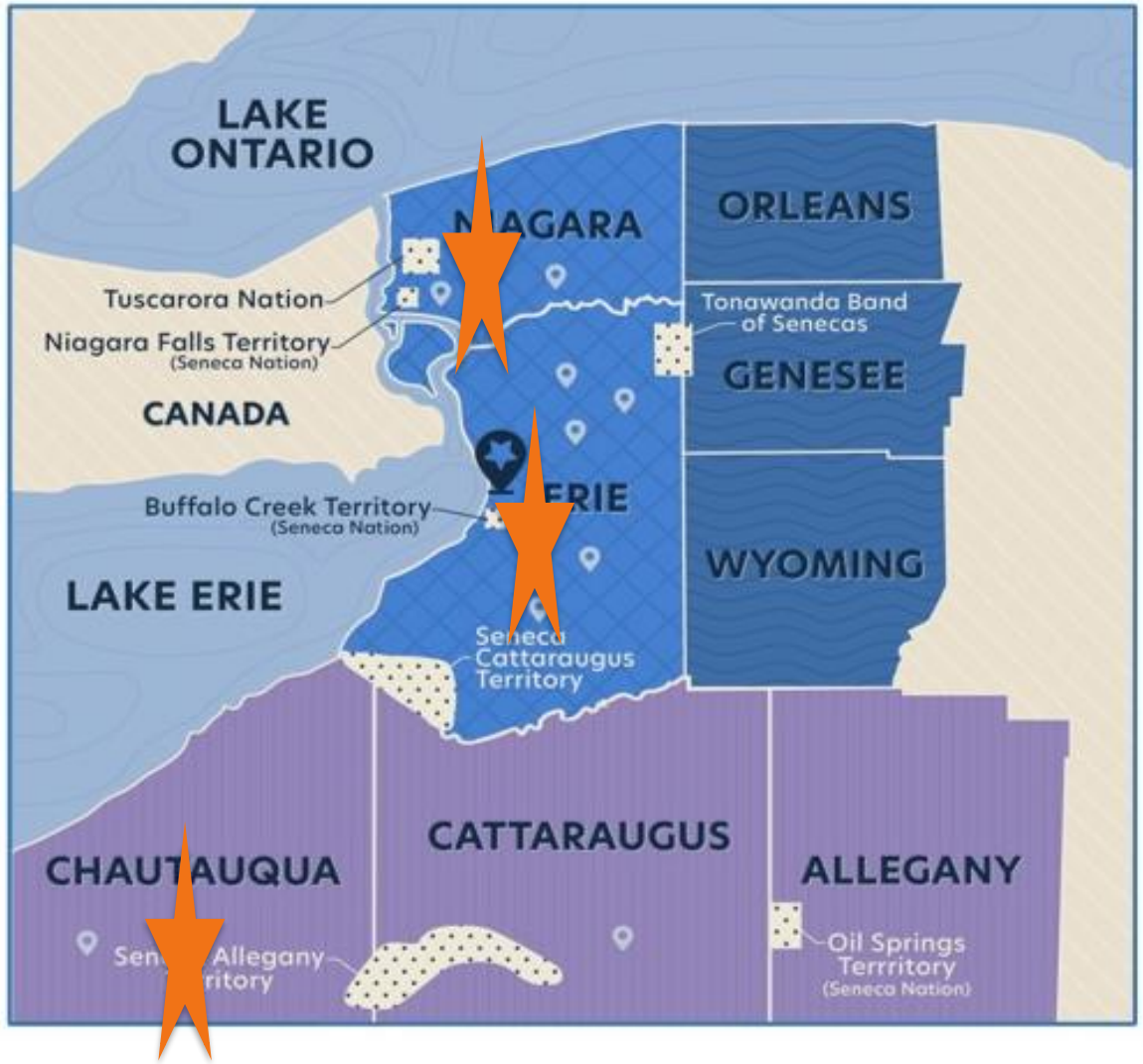
- Second lung cancer primaries are more common among patients who:
  - Continue to smoke
  - Have substantial smoking history (>50 PY)
  - Chest radiation
  - Risk factors: COPD, family history, pneumonia, prior aerodigestive cancers, smoked within 10 years
- All chest CTs should be reviewed for incidental findings
- Refer to Lung Cancer Screening Program
- Medical and Surgical Oncology should not manage nodules

Lung Cancer Screening on EDDY

(Early Detection Driven to You)

ROSWELL PARK®
COMPREHENSIVE CANCER CENTER

Counties of WNY Covered by This Program



WESTERN NEW YORK CATCHMENT AREA

- URBAN/SUBURBAN
- APPALACHIAN
- RURAL
- NATIVE AMERICAN TERRITORY
- ROSWELL PARK COMPREHENSIVE CANCER CENTER
- ROSWELL PARK PRACTICES, SATELLITES, AND AFFILIATES
- **FIRE DEPARTMENTS FOR SCREENING (Niagara Falls, Buffalo, Jamestown, Olean)**

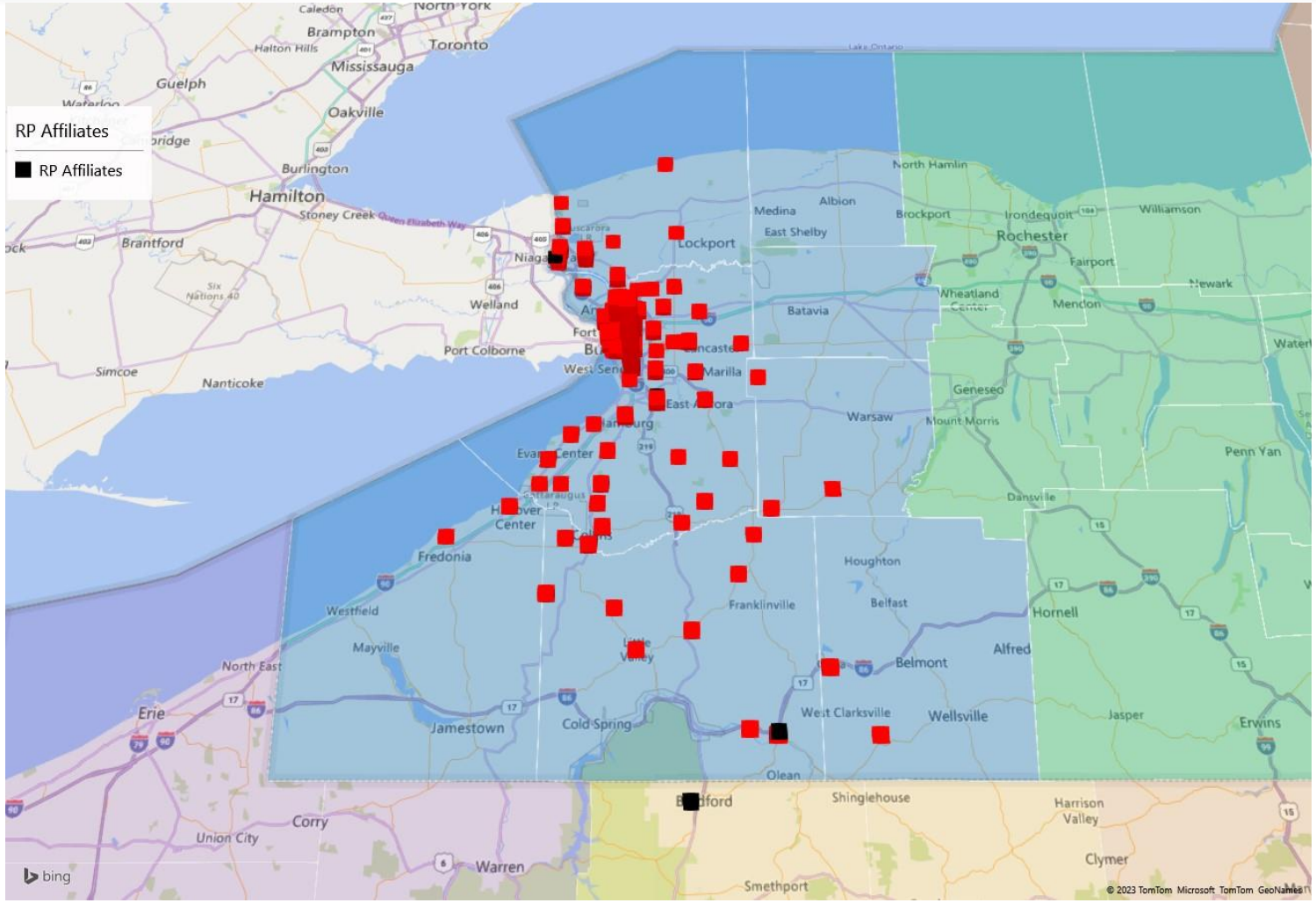
EDDY Mobile Low-Dose CT Unit

- Reaching **underserved populations** (urban and rural) by geography, mental health, poor access, low SDOH
- Reaching high risk populations:
  - **Fire Fighters and First Responders**
  - **HIV+ survivors**
  - **High Risk Industries (Asphalt)**
- Providing navigation for follow-up and management of lung nodules
- Utilizing local facilities to provide follow-up for highest risk at the convenience of the patients

EDDY Operations

- Screening **Tuesday, Wednesday, Thursday** (60 scans per Week)
- All LDCTs read by **Roswell Park Radiologists**
- Results Communicated to **Patients and Primary Care Providers**
- Staff include **Community Navigators, Physicians Assistants, Nurses, Radiology Technicians, Scheduling Liaisons**

Zip Codes for People Screened on EDDY



Limitations of Lung Cancer Screening

- Rates of **false positives**
  - NLST rates
  - Highest in lower risk patients
- **Co-morbidities** from interventional procedures
  - Refer to experienced interventionist
- **Burden** on the primary care providers
  - Close to 85% of patients screened have ≥ 1 nodule
  - 27% expected to be require additional surveillance

Summary

- Lung cancer screening can change the stage at diagnosis and impact long term survival
- Comprehensive lung cancer screening will have the largest impact on cancer mortality
- Early detection of lung cancer saves health systems important resources

Thank you

EDDY Team

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Elizabeth Bouchard

Websites with Information

- https://nlcrt.org/resource-center/
  - Patient Education Materials
- https://nlcrt.org/lungplan-overview/
  - Lung Cancer Screening Program Financials
- https://www.acr.org/Clinical-Resources/Lung-Cancer-Screening-Resources
  - Resources for Providers and Patients

The Role of Healthcare Professionals in Lung Cancer Screening

Paula Celestino, MPH
Roswell Park Cessation Services

Quitlines: Important Role for LCS Education

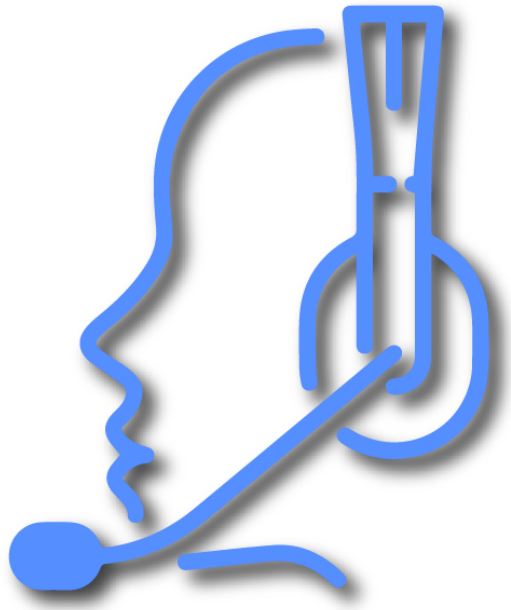
- There is mounting recognition around the role quitlines can play in decreasing deaths from lung cancer by educating participants about LCS.
- More than half of all U.S. quitline participants may be eligible for lung cancer screening.
- NYS Quitline records indicate that between 9/1/2022-8/31/2023, of 22,999 participants, 68% reported being >49 years old.
- Of these participants, 72% estimated to be at >19 pack years.

NYS Quitline to Incorporate LCS Education

NYS DOH recently approved Roswell Park to develop a lung cancer screening education protocol for the NYS Quitline *(in development)*

Telephonic

- Comprehensive LCS training for Treatment Specialists
- Screening tool to identify participant LCS eligibility
- Educational messaging to include:
  - Basic description of LCS as a means of early detection
  - Advising to speak to their healthcare professional
  - Basic insurance information (accessing and inquiring)
  - Offering information by mail or download



The NYS Quitline LCS Educational Protocol

Digital Content

www.nysmokefree.com

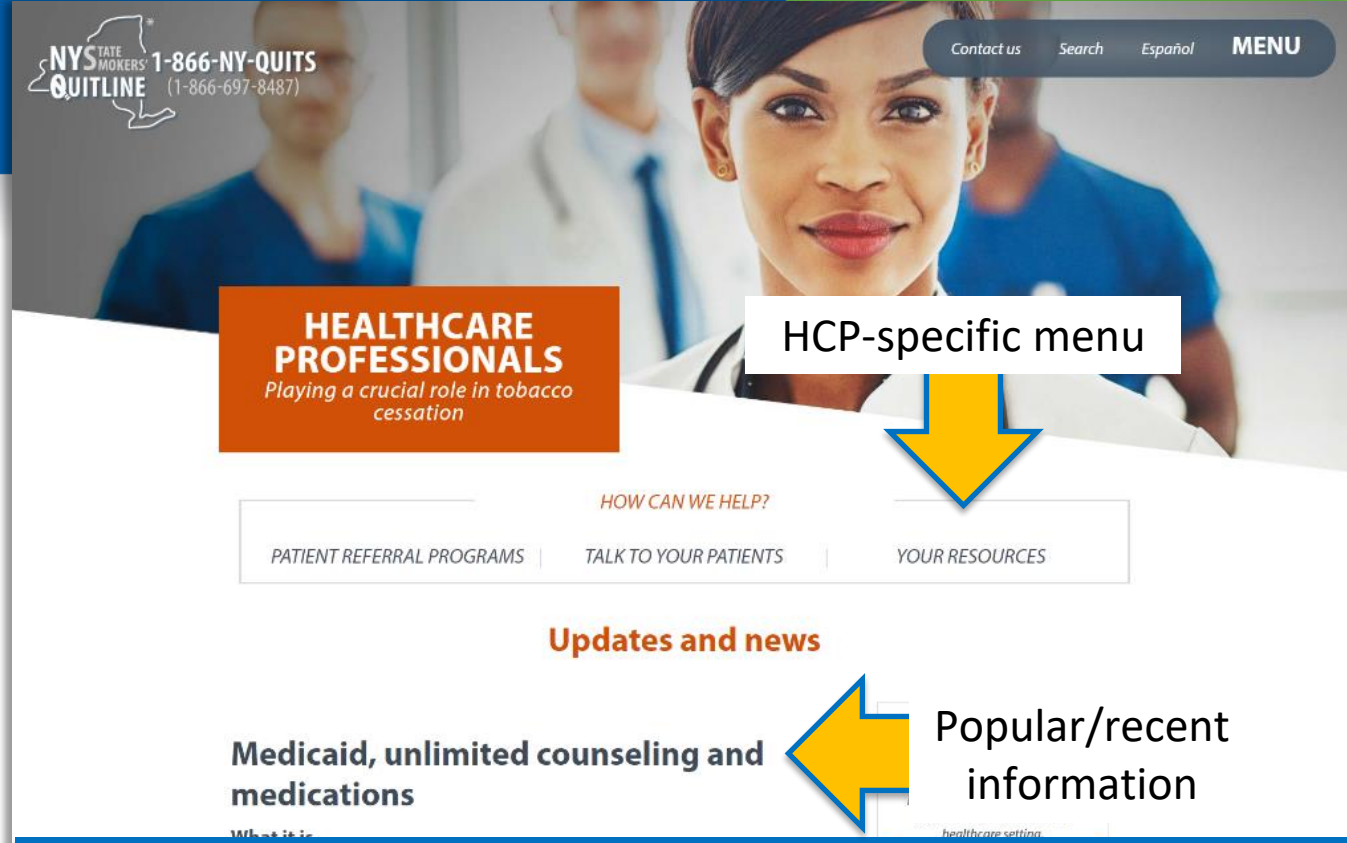
- Eligibility determination
- Resources and emerging information
- Downloadable materials for public and healthcare settings

Outreach & Promotion

- Messaging through email and/or text
- Webinars
- E-newsletter features
- Social media
- Earned media

Healthcare Professionals

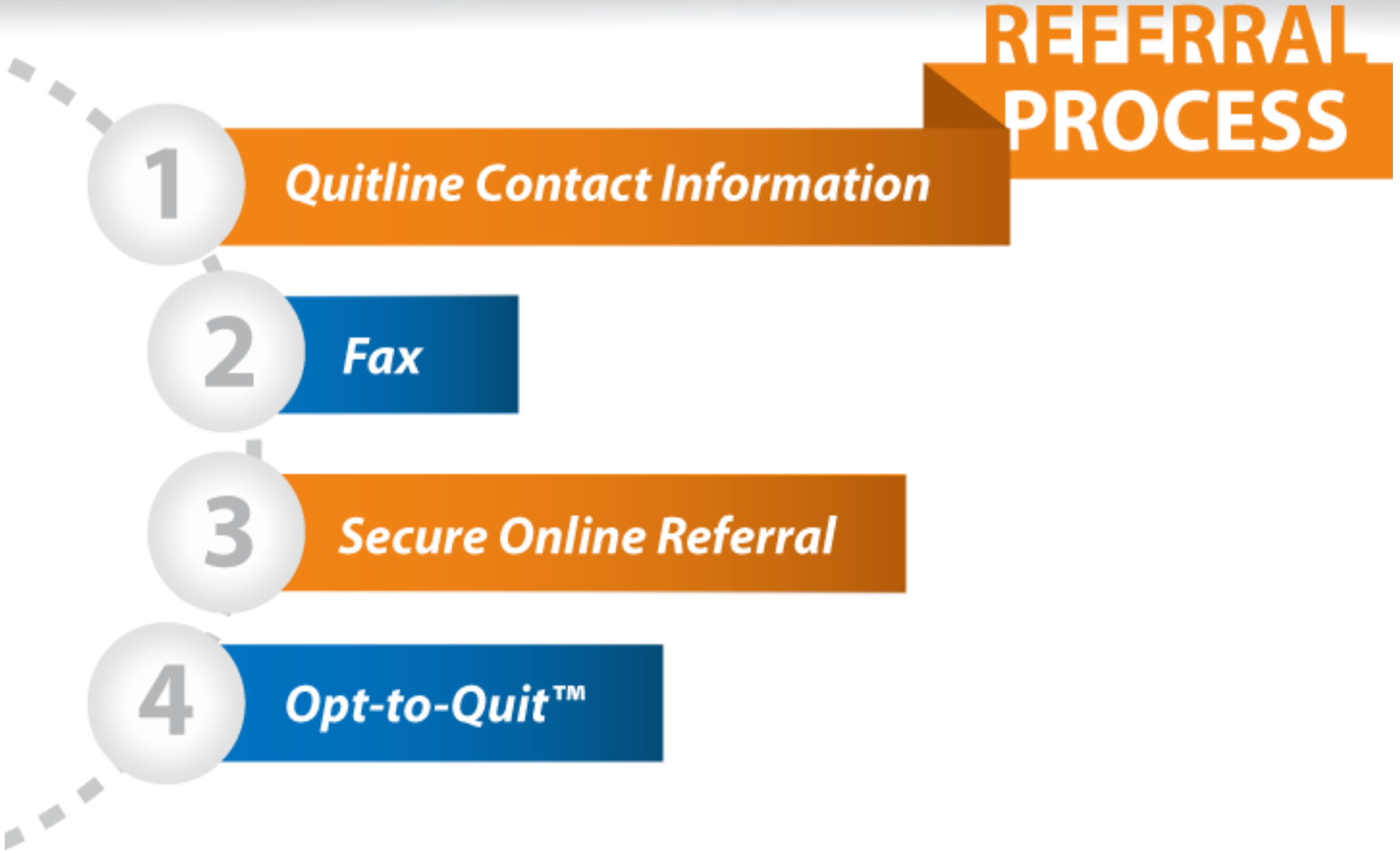
- Patient Referral Program
- Talking to patients about quitting
- Digital and print materials



Where can I find this?

NYSmokeFree.com/HealthCare or under "MENU" then "Healthcare Professionals"

Patient Referral Program



Secure Patient Online Referral

Fax-to-Quit Referral

Referring Provider

Referral No: NEW

Darlene Drake
Test

Buffalo NY 14215
Phone:(716) 845-1700
Fax:

If any of these information is incorrect, please call NYS Quitline to correct it or change it in your profile page.

Reference Code (OPTIONAL)

Tobacco User Information

First Name:
Last Name:
Address 1:
Address 2:
City:
State: NY (Only New York State residents are eligible for Quitline services)
Zip:
Phone:
eMail:

Enter Phone with Area Code + 7 Digit Number.

When should we call? Week: During the Week Time: Morning 9a-12p

Gender:
Language: English

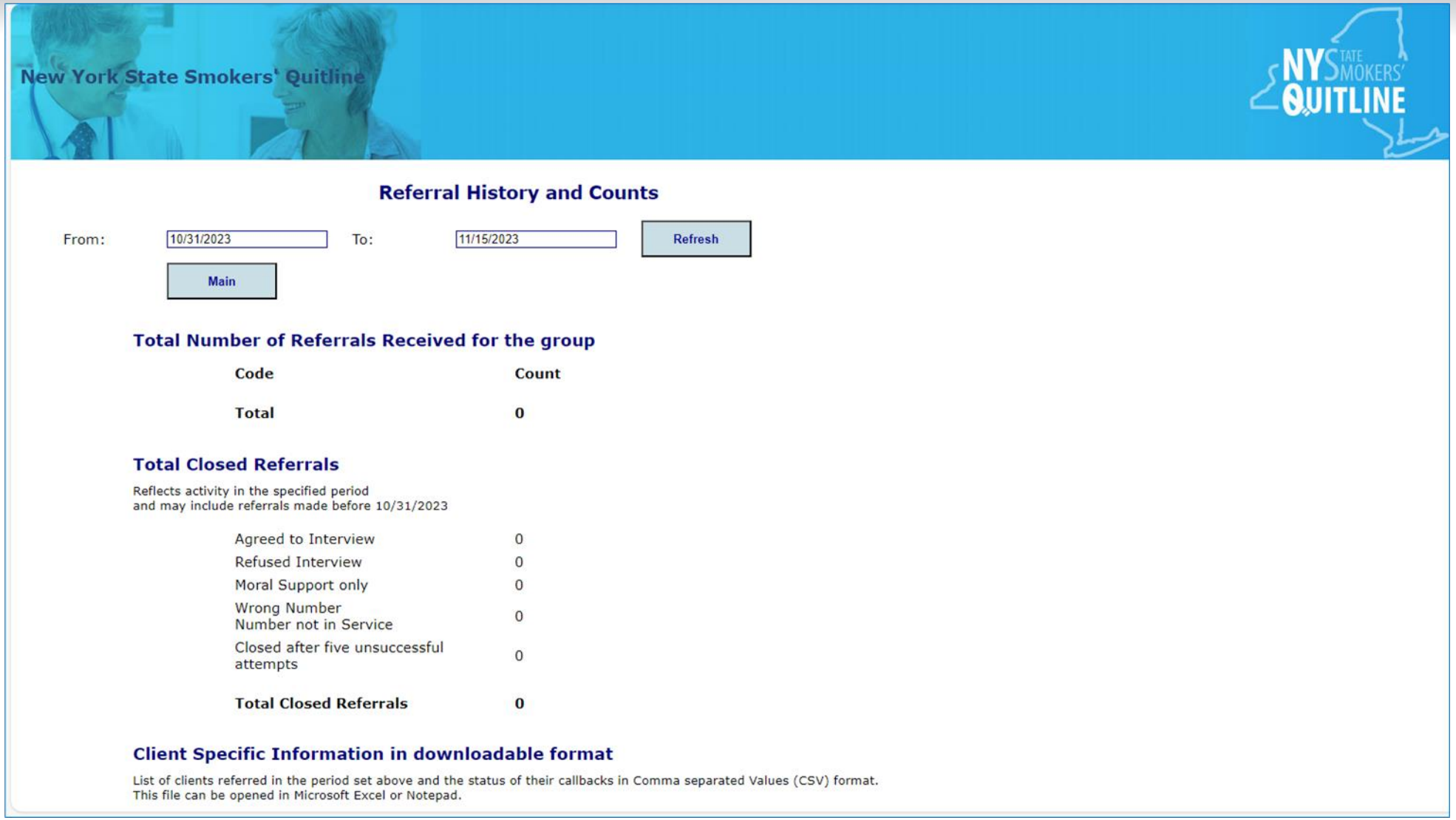
Date of Birth:
Enter in mm/dd/yyyy format or pick from the pop-up calender.

SEND PROGRESS REPORT:

- ○ Secured Site Access (online)
- ○ Fax (provider secured)
- ◉ DO NOT SEND PROGRESS REPORT

If a selection is not indicated, no progress report will be made available.

Secure Patient Online Referral Reporting



NYQuits Community Connect

Some people do not have the means to access the free Quitline services

- not having (cell) phones
- lack of cell phone minutes
- lack of technology access
- lack of technology skills and/or they function best with face-to-face interaction

Program designed to reach those in community settings affected by tobacco related inequities, including access to tobacco dependence treatment. ***Pilot underway.***

Model allows Health Care Community Programs and Community-Based Organizations to offer and assist tobacco and vape patients/clients with accessing Quitline services at the **point-of-service/care**.

Materials

Order, print, and share materials relevant to your patients.

- Thinking About Quitting? (brochure and cards)
- Quitline handout
- Other materials and downloadable fact sheets

Where can I find this?

NYSmokeFree.com/Materials

or under “MENU” then “Tools & Resources”

Online News Room: *nysmokefree.com/newsroom*

LATEST NEWS

Press release | ***Support Available for New York State's Indigenous Peoples to Quit Commercial Tobacco***
View this press release

Newsletter | ***Quitters Always Win!*** | ***Fall 2023***
View this newsletter

Press release | ***Starting This October, a Sign to Quit Smoking***
View this press release

Webinar | ***Supporting Patients with Disabilities in Becoming Tobacco-Free*** *(CE eligible)*

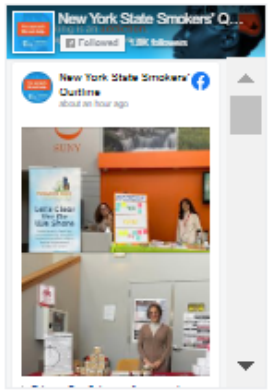
Learn more

Check out past press releases, newsletters, podcasts, and webinars by visiting our *Press Archive*.

GET UPDATES

Be the first to learn about the latest news from the New York State Smokers' Quitline. *Whether you're a member of the media, a healthcare professional, or a partner in the fight against tobacco, you'll find our emails helpful!*

Subscribe now!



Follow us on

NYS TATE MOKERS' QUITLINE 1-866-NY-QUITS (1-866-697-8487)

Smoking is an addiction.
Take the time, *make a difference.*
Learn more.

Having trouble viewing this email? View in browser.

Welcome to *The Check-Up,*

a periodical electronic brief from the **New York State Smokers' Quitline** (Quitline) offering healthcare professionals quick tips and reminders in their quest to assist clients and patients who use commercial tobacco and/or vape products in achieving freedom from nicotine addiction.

Tobacco and Disabilities Webinar On-Demand

Be sure to watch our most recent webinar on-demand, titled, "**Supporting Patients with Disabilities in Becoming Tobacco-Free.**" Continuing education (CE) credit will be available through May 10, 2025 for physicians, nurses, pharmacists, and other healthcare professionals.

View the webinar and earn CE credit

Quitline Initiatives to Expand Focus on Health Equity

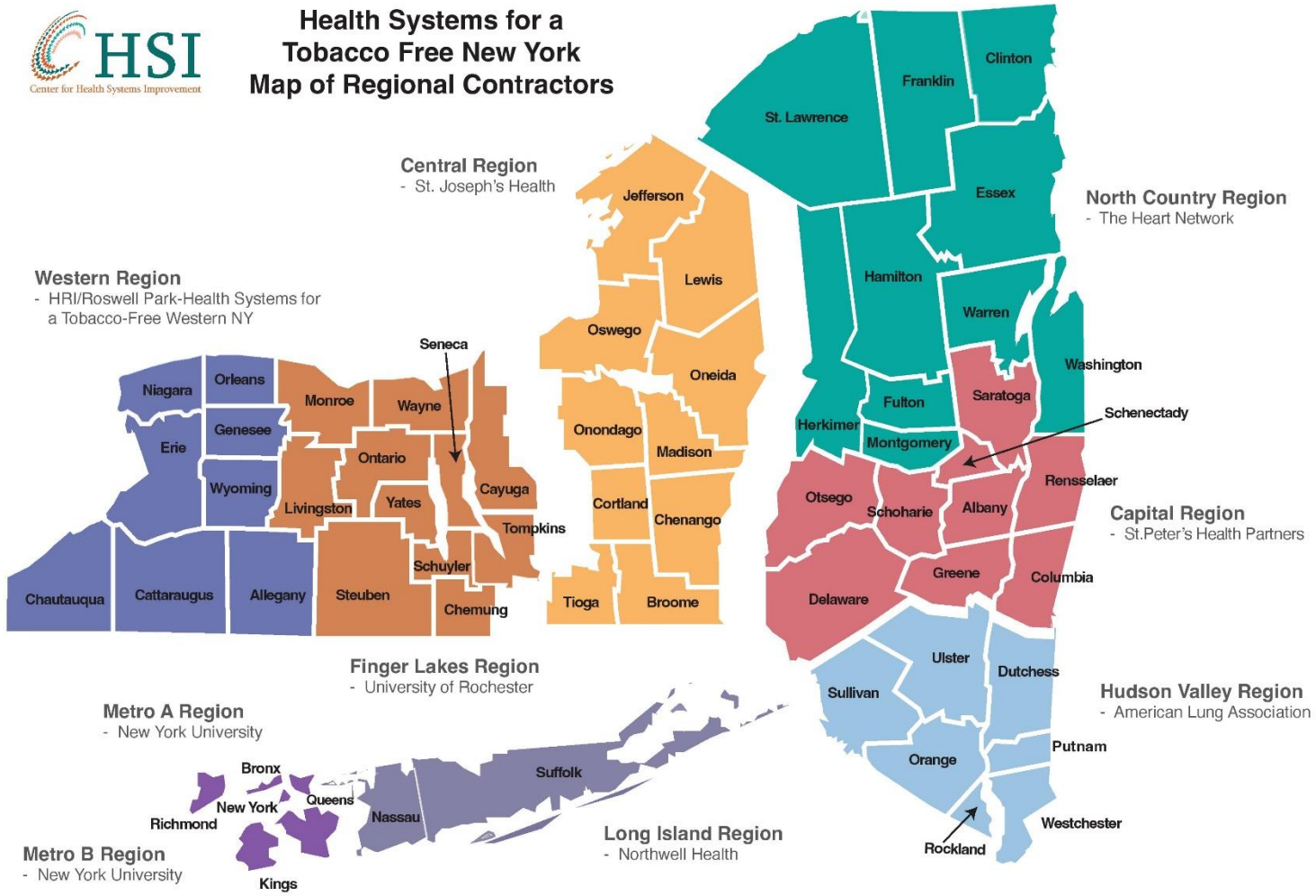
Roswell Park Comprehensive Cancer Center recently applied for and received an extension to operate the Quitline for five more years. As part of the directive from the New York State Department of Health (NYSDOH), upcoming marketing and outreach efforts will include an **expanded focus on health equity and connections with community-based organizations**. Quitline team members and the NYSDOH's Bureau of Tobacco Control leadership team *(pictured)* recently met at Roswell Park for initial planning efforts.

Regional Assistance through HSTFNY

HEALTH SYSTEMS FOR A TOBACCO-FREE NEW YORK

Visit online:

https://www.nyhealthsystems.org



Questions

Post Webinar

Thank you for attending today's webinar.
Please complete the evaluation:
https://www.surveymonkey.com/r/NYSSQLWebinar112823

1-866-NY-QUITS
(1-866-697-8487)
nysmokefree.com

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THANK YOU!