KEY TOBACCO-CESSATION FINDINGS AND RECOMMENDATIONS FROM THE U.S. PUBLIC HEALTH SERVICE AND U.S. PREVENTIVE SERVICES TASK FORCE FOR SPECIFIC POPULATIONS

The updated *Treating Tobacco Use and Dependence: 2008 Update—A Clinical Practice Guideline* of the U.S. Public Health Service (PHS) and the 1996 guidelines for preventive clinical services of the U.S. Preventive Services Task Force (Preventive Task Force) are two of the most important U.S. studies of tobacco cessation.[1] These two documents, along with other supporting research, make a compelling case for providing coverage for tobacco-cessation treatment and assistance to several key populations covered by the Medicare and Medicaid programs that do not yet have adequate access to cessation assistance: the elderly, pregnant women, and children and adolescents.

Pregnant Women. More than 10 percent of U.S. women smoke during pregnancy, and 20 percent of pregnant women enrolled in Medicaid use tobacco products.[2] As of October 1, 2010, the federal Affordable Care Act requires all state Medicaid programs to cover a comprehensive tobacco cessation benefit for pregnant women, which includes both counseling and medications.[3]

Findings from the PHS & Preventive Task Force Guidelines:

- Smoking during pregnancy causes low birth weight births, pre-term deliveries, increased risk of miscarriage, fetal growth retardation, sudden infant death syndrome, spontaneous abortions, placental abruption, cleft palates and cleft lips and childhood cancers.[4]
- An estimated 20 percent of low-weight births could be avoided by quitting smoking before or during pregnancy.
- Two-thirds of female smokers continue to smoke during pregnancy.
- Pregnant women who stop smoking by the 30th week of gestation have infants with higher birth weights than infants born to women who smoke throughout pregnancy.
- In pregnant women, clinical trials of cessation counseling have reported improvements in abstinence rates of 5 percent to 23 percent over control groups.
- Pregnant smokers should be encouraged to quit first without using nicotine replacement therapy (NRT) – including gum, patches, inhalers, nasal sprays, non-NRT bupropion, and varenicline. NRTs (and bupropion, varenicline) should only be used during pregnancy if the increased likelihood of smoking abstinence, with its potential benefits, outweighs the risk of drug treatment (e.g., fetal nicotine toxicity) and smoking (this finding also applies to lactating women).
- There is a high rate of relapse in post-partum women, even if they stopped smoking for six or more months during their pregnancy.

Recommendations from the PHS & Preventive Task Force Guidelines:

- Because of the serious risks of smoking to the pregnant smoker and the fetus, whenever possible pregnant smokers should be offered extended or augmented psychological interventions that exceed minimal advice to quit.
- Although abstinence early in pregnancy will produce the greatest benefits to the fetus and expectant mother, quitting at any point in pregnancy can yield benefits. Therefore, clinicians should offer effective smoking cessation interventions to pregnant smokers at the first prenatal visit as well as throughout the course of pregnancy.
- Pregnant women and parents with children living at home also should be counseled on the potentially harmful effects of smoking on fetal and child health.
- Continual reinforcement of the harms of maternal smoking to children may help prevent relapse among post-partum women.

The Elderly. Approximately 7.9 percent of people age 65 and older smoke, which amounts to more than 3.4 million people.[5] But even in this age group, smokers who quit can achieve cardiovascular mortality

rates similar to those of nonsmokers.[6] In addition, a person who smokes for more than 20 cigarettes per day but quits at age 65 will still, on average, increase his or her life expectancy by two to three years.[7]

Since January 2006, Medicare—the primary health insurer for the vast majority of all elderly persons in the United States—has provided full tobacco cessation and treatment coverage for beneficiaries, including intermediate and intensive cessation counseling and prescription medications (though prescription medications were covered under Part D, over-the-counter medications were not). The passage of the Affordable Care Act in 2010 closed the Medicare Part D "donut hole," making medications more affordable, and also adds the benefit of a prevention and wellness visit with the member's doctor. Medicare covers tobacco cessation counseling services for all Medicare beneficiaries.[8]

Findings from the PHS & Preventive Task Force Guidelines:

- Smoking cessation in older smokers can reduce the risk of myocardial infarction, death from coronary heart disease, and lung cancer. Abstinence can also promote more rapid recovery from illnesses that are exacerbated by smoking and can improve cerebral circulation.
- Older smokers who quit can reduce their risk of death from coronary heart disease, COPD, and lung cancer and decrease their risk of osteoporosis. Moreover, abstinence can promote more rapid recovery from illnesses that are exacerbated by smoking and can improve cerebral circulation. In fact, age does not appear to diminish the desire to quit or the benefits of quitting smoking, and treatments shown to be effective in this Guideline have been shown to be effective in older smokers.

Recommendations from the PHS & Preventive Task Force Guidelines:

- Research has demonstrated the effectiveness of the "4 A's" (ask, advise, assist, and arrange follow up) in patients ages 50 and older. Counseling interventions, physician advice, buddy support programs, age-tailored self-help materials, telephone counseling, and the nicotine patch all have been shown to be effective in treating tobacco use in adults 50 and older.
- Tobacco cessation counseling is recommended on a regular basis for all patients (including the elderly) who use tobacco products.

Children and Adolescents. In 2011, 18.1 percent of high school students were cigarette smokers and half (49.9%) of them tried to quit.[9] Smoking prevalence data for Medicaid-eligible children and adolescents are not available. In light of the unique demographic characteristics of Medicaid beneficiaries (e.g., lower socio-economic status) and the fact that adult smoking prevalence rates for Medicaid beneficiaries are higher than the U.S. population in general (33.5% vs. 19%), the smoking rates of Medicaid-eligible children and adolescents are likely higher than these nationwide rates.[10] Currently, states provide limited cessation coverage for children and adolescents through Early and Periodic Screening, Diagnostic, and Treatment services.[11]

Findings from the PHS & Preventive Task Force Guidelines:

- Children and adolescents who are active smokers have an increased prevalence and severity of respiratory symptoms and illnesses, decreased physical fitness, and potential retardation of lung growth.
- Adolescents are interested in quitting, but may have to make more quit attempts before being successful compared to adults. About four percent of adolescents aged 12 to 19 successfully quit smoking each year.
- Despite being two times more likely to successfully quit using a cessation program, adolescents usually try to quit unassisted.
- While there is no evidence that NRT or bupropion is harmful for children and adolescents, there is also little evidence of their effectiveness in helping youth quit in the long term.

Recommendations from the PHS & Preventive Task Force Guidelines:

- Clinicians should ask pediatric and adolescent patients about tobacco use and provide a strong message regarding the importance of totally abstaining from tobacco use.
- Counseling has been shown to be effective in treatment of adolescent smokers. Therefore, adolescent smokers should be provided with counseling interventions to aid them in quitting smoking.
- Cessation counseling delivered in pediatric settings has been shown to be effective in increasing abstinence among parents who smoke. Therefore, to protect children from secondhand smoke, clinicians should ask parents about tobacco use and offer them cessation advice and assistance.
- Anti-tobacco messages should be included in all health promotion counseling of children, adolescents, and young adults.

Campaign for Tobacco Free Kids, July 2, 2013 / Lorna Schmidt

For more information on tobacco cessation, see Campaign factsheets at http://www.tobaccofreekids.org/facts_issues/fact_sheets/policies/cessation/.

---

[1] Fiore, MC, et al., *Treating Tobacco Use and Dependence: 2008 Update*, U.S. Public Health Service Clinical Practice Guideline, May 2008, http://www.surgeongeneral.gov/tobacco/treating_tobacco_use08.pdf; Report of the U.S. Preventive Services Task Force, "Guide to Clinical Preventive Services: Second Edition," U.S. Public Health Service, 1996, http://odphp.osophs.dhhs.gov/pubs/guidecps/tcpstoc.htm.

[2] Martin, JA, et al., "Births: Final Data for 2005," *National Vital Statistics Reports* 56(6), December 5, 2007, http://www.cdc.gov/nchs/data/nvsr/nvsr56/nvsr56_06.pdf. McMenamin, SB, et al., "Medicaid coverage of tobacco-dependence treatment for pregnant women: impact of the Affordable Care Act," *American Journal of Preventive Medicine,* 43(4):e27-29, October 2012.

[3] See Sec. 4107 of the Affordable Care Act, http://www.gpo.gov/fdsys/pkg/BILLS-111hr3590enr/pdf/BILLS-111hr3590enr.pdf.

[4] For more on smoking and pregnancy, see Campaign for Tobacco-Free Kids Factsheet, *Harm Caused by Pregnant Women Smoking or Being Exposed to Secondhand Smoke*, http://www.tobaccofreekids.org/research/factsheets/pdf/0007.pdf.

[5] CDC, "Current Cigarette Smoking Among Adults—United States, 2011," *MMWR,* 61(44), November 9, 2012, http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6144a2.htm. U.S. Census Bureau, *Annual Estimates of the Resident Population for Selected Age Groups by Sex: April 1, 2010 to July 1, 2012.*

[6] Lacroix, AZ, "Thiazide diuretic agents and prevention of hip fracture," *Comprehensive Therapy* 17(8)30-9, 1991 [published erratum in *Comprehensive Therapy* 18(2):42, February 1992; RAND, *Evidence Report and Evidence-Based Recommendations: Interventions to Promote Smoking Cessation in the Medicare Population*, 2000.

[7] Sachs, DPL, "Cigarette Smoking: Health Effects and Cessation Strategies," *Clinical Geriatric Medicine* 2:337-362, 1986; RAND, *Evidence Report and Evidence-Based Recommendations: Interventions to Promote Smoking Cessation in the Medicare Population*, 2000.

[8] Centers for Medicare and Medicaid Services (CMS), "Tobacco-Use Cessation Counseling Services," February 2012, http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/smoking.pdf. American Lung Association, "Helping Smokers Quit: Tobacco Cessation Coverage 2012," November 2012, http://www.lung.org/assets/documents/publications/smoking-cessation/helping-smokers-quit-2012.pdf.

[9] CDC, "Youth Risk Behavior Surveillance—United States, 2011," *MMWR Surveillance Summaries* 61(4), June 8, 2012, http://www.cdc.gov/mmwr/pdf/ss/ss6104.pdf.

[10] CDC, "Summary Health Statistics for U.S. Adults: National Health Interview Survey, 2011," *Vital and Health Statistics,* 10(256), December 2012.

[11] Westmoreland, T, Director, Center for Medicaid and State Operations, HCFA, memo to State Medicaid Directors, January 5, 2001.