

Smoking--How Can I Quit:

- ✓ *Nicotine replacement therapy?*
- ✓ *Prescription medication?*
- ✓ *Telephone counseling?*
- ✓ *Behavioral therapy?*
- ✓ *Antidepressants?*
- ✓ *Acupuncture?*
- ✓ *Hypnosis?*
- ✓ *Do any of these techniques help older adults quit smoking?*
- ✓ *Which do not work?*
- ✓ *Are any of them dangerous?*
- ✓ *Why bother quitting at that age?*

The second Critical Issue Backgrounder, *CDC Urges Older Adults to Improve Health, Increase Longevity, through Smoking Cessation*, addresses the impact of smoking on older adults and the importance of quitting regardless of age. Quitting tobacco use is important to improve a person's health at any age, but it is especially important for older adults. Almost 70% of smoking-related deaths occur among people who are age 65 and older. For every person who dies of a smoking-attributable disease, CDC estimates there are 20 more people suffering with a least one serious illness from smoking, primarily emphysema, chronic bronchitis, and heart disease. The U.S. Surgeon General has long said that smoking is especially harmful for older adults. Smoking cessation has immediate and long-term benefits, even for people who have smoked most of their lives. In addition, older adults who quit smoking can reduce secondhand smoke dangers for their spouses, grandchildren, friends, and neighbors. The typical excuses older adults give for continuing to use tobacco can be countered by new research, statistics, and evidence-based cessation techniques. There also are new medications and counseling programs (such as telephone quitlines operated in all states) to help adults quit. Older smokers who try to quit are almost twice as likely to succeed as younger adults.

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For additional information, the complete article, "CDC Urges Older Adults to Improve Health, Increase Longevity, through Smoking Cessation" begins at **Page 2*

CDC Urges Older Adults to Improve Health, Increase Longevity, through Smoking Cessation

“The point for older adults is that if you quit smoking, you can not only immediately improve your health, but also add years to your life. That’s a good message for any smoker, but a particularly important one for older smokers.” — Raymond Niaura, Brown Medical School

Giving up tobacco use has benefits at any age, reducing the risk of the “big three” tobacco-related illnesses — heart disease, lung cancer and stroke. Even among older adults who already have tobacco-related diseases, health improvements from cessation include: decreased mortality, reversed respiratory symptoms and improved quality of life.

“The single best step that a smoker can take to protect his or her health — and that of nonsmoking family members — is to quit smoking,” said Matthew McKenna, MD, MPH, Director of the Centers for Disease Control and Prevention’s Office on Smoking and Health. “Quitting smoking has immediate as well as long-term benefits, including reducing risks for diseases caused by smoking such as cancer, heart disease, stroke and respiratory illnesses. Fortunately, there are now more options than ever to help someone quit using tobacco, and it’s important to remember that it’s never too late to take this important step.”

Almost 57% of smokers age 65 or over indicate that they want to quit, according to an article published in CDC’s *Morbidity and Mortality Weekly Report* (MMWR, 2002).

And it is not just the smoker who benefits from cessation. Secondhand smoke is an important issue for older adults, especially for those with respiratory or heart diseases. While many jurisdictions have banned smoking in restaurants and other public places, advocates for older adults are now pushing for smoking bans in apartments, nursing homes and other places where older adults dwell.

“There are also safety issues, such as the fact that older adults who smoke are at a much higher risk for household fires and the injuries that result,” said Kim Hamlett-Berry, PhD, Director of the Office of Public Health Policy and Prevention at the Department of Veterans Affairs (VA).

COUNTERING EXCUSES FOR NOT QUITTING

“I think there really are too many older smokers who think that quitting just won’t make a difference at this point in their lives.” — Kim Hamlett-Berry, VA

The typical excuses that older adults give for continuing to use tobacco can be countered by research, statistics and evidence-based cessation techniques. In fact, research has shown that quitting smoking at any age is beneficial. Below are some of the common reasons that older adults give for not ending their tobacco use, along with good arguments against them:

- ✓ *“Smoking hasn’t killed me yet.”* Smoking harms nearly every organ of the body, causing many diseases and reducing the health of smokers in general, according to the 2004 U.S. Surgeon General’s Report (SGR, 2004). Smoking is especially harmful for older adults, the report concluded. Quitting tobacco use can add two to three years to a person’s life expectancy.

According to CDC, within a year of quitting, former smokers reduce their risk of coronary heart disease by half and the risk continues to gradually decline thereafter.

- ✓ *“It’s too late; the damage has been done.”* Smoking cessation at any age has immediate and long-term benefits, thereby reducing risks for diseases caused by smoking. Researchers found that smokers who quit after age 60 had better lung function than their peers who continued to smoke (Higgins, 1993). CDC notes that smoking cessation markedly reduces the risk of recurrent heart attack and cardiovascular death in those diagnosed with coronary heart disease. Quitting smoking also improves exercise tolerance, reduces the risk of amputation and increases overall survival. The most important intervention in managing peripheral artery occlusive disease is smoking cessation. For people with cancer, continuing to smoke can decrease the effectiveness of treatment and the prognosis for survival.
- ✓ *“Smoking relaxes me.”* Actually, smoking stresses the body as the heart beats faster and blood pressure rises. According to the American Society of Health-System Pharmacists, the “relaxation” feeling that smokers cite may be due to deep breathing from inhaling, and the fact that people are often “taking a break” while they smoke, thus distracting themselves from stress. The Society recommends taking a break and doing deep breathing to relax without a cigarette.
- ✓ *“If I quit, I’ll gain weight.”* The Public Health Service (PHS) Clinical Practice Guideline, *Treating Tobacco Use and Dependence*, states that a clinician should acknowledge that quitting smoking is often followed by weight gain (PHS, 2000). However, he or she should also point out that the health risks of weight gain are lower than the risks of continued smoking. As the Surgeon General’s 1990 report concluded, the health benefits of quitting smoking exceed any risks from the average five-pound weight gain or any adverse psychological effects that may follow quitting (SGR, 1990). In addition, physical activity and a healthy diet can help control weight gain.
- ✓ *“I’m about to go in the hospital for surgery, so I can’t deal with quitting now.”* Actually, a stay in the hospital is a good place to start quitting, since patients must abstain from smoking while in the hospital. Older adults should plan to continue cessation when they are discharged. Tracy Orleans, PhD, a Senior Scientist with the Robert Wood Johnson Foundation, calls hospitalization a “teachable moment” for getting smokers to quit. Quitting also will help patients recover from surgery. According to CDC, smokers have a lower survival rate after surgery compared to that of nonsmokers because smoking alters the body’s host defenses and immune response. Smoking may slow bone and wound healing, as well as recovery from surgery and illness, the Agency for Healthcare Research and Quality states in its *Quitting Helps You Heal Faster, Hospital Card* (AHRQ, 2003).
- ✓ *“Been there, done that.”* It is true that many smokers have to try five or six times before they succeed in quitting. However, they can succeed, especially if they take advantage of the cessation counseling and medications now available. “Older adults may be less likely to try to quit smoking than younger people, but if they do try, they are more likely to be successful,” according to Corrine Husten, MD, MPH, Vice President for Policy Development at the Partnership for Prevention.

WHO SMOKES?

“The fact that only 10% of older adults smoke is not a public health victory.”— Jim Bergman, The Center for Social Gerontology

An estimated 20.8% (or 45.3 million) of all adults in the United States smoke cigarettes, including 36.3 million who smoke every day, according to National Health Interview Survey (NHIS) data from 2006 (MMWR, 2007).

That number is much lower among older adults. The NHIS found that about 10.2% of adults age 65 or older smoke, including 12.6% of men and 8.3% of women. An estimated 13 million Americans age 50 or older smoke cigarettes, including 4.5 million who are 65 or over, according to PHS data (PHS, 2000).

So is it good news that fewer older adults smoke? Not entirely. Jim Bergman, JD, co-director of The Center for Social Gerontology (TCSG) in Ann Arbor, Mich., explained that the major reason why the percentage of older smokers is lower than the general population is because so many people who had been smoking their entire lives have already died by that age. “Many smokers die between age 50 and 65 — that is ‘death valley for smokers’,” he said.

For people of all ages, the 2006 NHIS data also show that the prevalence of current smoking is higher among men than women, and higher among blacks than whites and Hispanics (MMWR, 2007). The prevalence of current smoking is highest among people with lower education levels, and among those with low incomes.

IMPACT OF SMOKING

“Smoking causes disease in nearly every organ of the body... The toxins from cigarette smoke go everywhere the blood flows.” — U.S. Surgeon General

Tobacco-related illness adds to poorer quality of life and disability among older adults. As previously noted, smoking is especially harmful for older adults. Smoking increases a person’s risk for lung disease (such as bronchitis or emphysema); cancers of the lung, mouth, esophagus, stomach, pancreas, cervix, kidney and bladder; heart disease and stroke; and a shorter life (on average, smokers die 14 years earlier than nonsmokers). The American Lung Association’s fact sheet on older smokers states that people this age are at a greater risk from smoking because they generally have smoked for an average of 40 years, are more likely to be heavy smokers and often already have smoking-related illnesses (ALA, 2007).

Cigarette smoking is the leading preventable cause of disease and death in the United States, resulting in approximately 438,000 deaths each year, according to CDC. Of these, a much higher proportion — about 68% or 300,000 deaths — occur among people who are age 65+.

For every person who dies of a smoking-attributable disease, CDC estimates there are 20 more people suffering with a least one serious illness from smoking, primarily emphysema, chronic bronchitis and heart disease (MMWR, 2003).

Smoking causes and increases the severity of many diseases and conditions that are likely to occur in an older population, such as circulatory and vascular conditions, diabetes and osteoporosis, Hamlett-Berry

said. Older smokers may also have other risk factors for poor health, such as having an overall lower activity level. “Smoking along with these medical comorbidities really contributes to higher use of health care services and poorer quality of life,” she said. “Smoking may also alter the efficacy of some medications used by the elderly smokers, affecting the therapeutic drug levels for conditions such as arthritis, hypertension and diabetes. That is an important consideration.” Smoking also can accelerate cognitive decline in older adults as well, Hamlett-Berry said.

The Surgeon General has reported that smokers are more likely to develop chronic obstructive pulmonary disease (COPD) and there is an increased risk of respiratory infections and deaths from pneumonia and influenza among elderly smokers. The prevalence of COPD — which includes chronic bronchitis, emphysema and asthma — is highest among men and women age 65 years or older (16.7% among men and 12.6% among women). Other conditions associated with smoking include increased depression and anxiety; an increased risk for hip fractures; nuclear cataracts of the eye; hypertension; skin wrinkling and discoloration; and increased use of other drugs and alcohol (SGR, 2004).

“The hard part for older smokers is that period before you die, when you are suffering from emphysema, cancer, stroke or heart disease that is caused by smoking,” Bergman said. “That is the terrible part, when you walk three steps and have to stop to catch your breath.”

SECONDHAND SMOKE ISSUES

“For older adults, secondhand smoke is a very important issue, whether it be in public, workplace, multi-unit living arrangements such as apartments or condominiums, or nursing homes.” — Jim Bergman, The Center for Social Gerontology

The Surgeon General concluded in 2006 that there was no risk-free level of secondhand smoke exposure, and that exposure of adults to secondhand smoke has immediate adverse effects on the cardiovascular system and causes coronary heart disease and lung cancer. Secondhand smoke is especially problematic for people who already have respiratory conditions or heart disease.

While 90% of older adults do not smoke, “secondhand smoke has a direct effect on any older person,” Bergman stated.

A recent Indiana University study found that, following a countywide smoking ban, the number of hospital admissions for heart attacks among non-smokers with no history of heart disease declined by 70%. The researchers associated the decline with the reduced exposure to secondhand smoke among non-smokers (Seo, 2007).

The dangers of secondhand smoke for grandchildren or a frail spouse may also motivate an older adult to quit smoking.

The TCSG has been focusing on smoke-free multi-unit housing, including public housing, nursing homes and other places where seniors live. At the beginning of 2004, there were less than 10 public

housing authorities that had smoke-free policies for any of their buildings, Bergman said. “Now there are over 60 that are smoke-free, 23 of which are in Michigan.” Smoke-free, multi-unit housing “is one of the most exciting issues in the tobacco-control arena,” Bergman added.

The good news is that CDC has reported that secondhand smoke exposure has decreased dramatically over the past 20 years. A Behavioral Risk Factor Surveillance System survey of 14 states and one territory found that Arizona (82.9%), the Virgin Islands (82.4%) and Nevada (79.0%) had the highest percentages of respondents who said smoking is not permitted in their homes (MMWR, 2006). The lowest percentages of people with smoke-free homes were in Kentucky (63.6%) and West Virginia (65.4%).

As of January 2008, 488 cities in 35 states and the District of Columbia had banned smoking in restaurants, according to the American Nonsmokers’ Rights Foundation, which tracks tobacco control ordinances, bylaws and regulations. In addition, 26 states had smoke-free laws on their books and four more states had laws that will go into effect in the future.

COST OF SMOKING

In addition to the cost to the smoker for purchasing tobacco products, the burden to the nation in terms of health care costs for those who smoke is extremely high. In 2004, smoking-related health care costs were over \$96 billion per year in direct medical expenses as well as more than \$97 billion annually in lost productivity, as stated in CDC’s *Best Practices for Comprehensive Tobacco Control Programs—2007* (CDC, 2007).

Medicare spent an estimated \$14.2 billion — almost 10% of its entire budget — on smoking-related illnesses in 1993, researchers estimate (Zhang, 1999).

In 2005, the Society of Actuaries estimated that the effects of exposure to secondhand smoke cost the United States \$10 billion per year.

BENEFITS OF QUITTING

“The message to older adults who smoke — and their health care providers — should be that it is never too late to quit, that there will be benefits.” — Kim Hamlett-Berry, VA

There is strong evidence that quitting tobacco use, even after 30 or more years of regular smoking, can benefit an older adult (Morgan, 1996). According to the 2004 Surgeon General’s Report, *The Health Consequences of Smoking*, a smoker’s body begins a series of changes with a drop in heart rate within just 20 minutes after smoking that last cigarette. Then, 12 hours after quitting, carbon monoxide levels in the blood drop to normal. Within 2 weeks to 3 months after quitting, a former smoker’s heart attack risk begins to drop and lung function begins to improve. In 1 to 9 months after quitting, coughing and shortness of breath decrease. One year after quitting, the added risk of coronary heart disease is half that of a smoker’s. Five to 15 years after quitting, a former smoker’s stroke risk is reduced to that of a

nonsmoker's. Ten years after quitting, a former smoker's lung cancer death rate is about half that of a smoker's and the risk of cancers of the mouth, throat, esophagus, bladder, kidney and pancreas decrease. Finally, 15 years after quitting, the risk of coronary heart disease is back to that of a nonsmoker's risk.

"We know that older adults can greatly benefit from stopping smoking, and they can really be successfully engaged in evidence-based smoking cessation programs, including counseling and pharmacotherapy," Hamlett-Berry said. Even for the frail elderly, smoking cessation produces clear benefits in terms of decreased mortality, reversed respiratory symptoms, decreased psychological distress and overall improvements in the quality of life, she added.

Various research studies show an improvement in physical and mental functioning among smokers who quit, compared to those who continue to smoke. For example:

- People who quit at age 65 after smoking more than 20 cigarettes a day increased their life expectancy by two or three years (Sachs, 1986). Quitting smoking at age 65 or older reduces by nearly 50% a person's risk of dying of a smoking-related disease (SGR, 2004).
- People who stop smoking after age 60 also have better pulmonary function than those who continue to smoke (Higgins, 1993).

"In fact, age does not appear to diminish the benefits of quitting smoking," the PHS concluded in its Clinical Practice Guideline (PHS, 2000).

HELPING OLDER ADULTS TO QUIT

"The methods that are out there that are known to be effective work equally well with older adults." — Raymond Niaura, Brown Medical School

Quitting tobacco use is a complex issue, involving not only physical addiction, but also an emotional and psychological component — and a complete change in daily routine.

Tobacco products and nicotine are addictive, and those who quit are prone to relapses. The 1988 *Surgeon General's Report on the Health Consequences of Smoking* declared nicotine as an addictive drug similar to heroin or cocaine. Withdrawal symptoms may include irritability, sleep disruptions, headache, depression, anxiety, difficulty concentrating, decreased heart rate, increased appetite or weight gain, and tobacco cravings, according to the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders: DSM-IV* and other sources (Hughes, 1991).

Many smoking cessation experts said there is generally no need to create individualized approaches to smoking cessation, even with older adults. The tried-and-true approaches — physician advice, cessation counseling, buddy support systems and the nicotine patch — can be used with almost all populations and have been shown to be effective with older adults.

However, there are some unique aspects and special considerations for working with older smokers. Professionals must be aware that older smokers are likely to be long-time tobacco users, may be facing a

health crisis that precipitated the desire to quit, or may be facing huge losses in their life — such as loss of their independence or death of a spouse — in addition to giving up tobacco use.

Older adults need to know that there are many cessation services, including those available through Medicare, private health insurance plans, telephone quitlines and some employer-provided retiree health plans.

Research shows that older adults are willing to try to quit. The University of Wisconsin Center for Tobacco Research and Intervention set up a demonstration Wisconsin Tobacco Quit Line study in 2002. More than 1,800 Wisconsin seniors called the quitline and 1,300 enrolled for telephone counseling and free nicotine patches. Quitlines provide individualized coaching for smokers who want to quit. The study found that 90% of the callers set a quit date and more than 43% succeeded in quitting. The program provided free nicotine patches and telephone counseling.

Role of the Professional. According to the National Cancer Institute (NCI), doctors, dentists and even pharmacists can be good sources of information about the health risks of smoking and the benefits of quitting. They can describe the proper use and potential side effects of nicotine replacement therapy and other medicines, and they can help people find local quit-smoking resources.

Based on focus groups conducted with older adults, TCSG found that physicians and other medical professionals are probably the best catalyst to get older adults to quit smoking. Among older adults who had recently quit smoking, advice to quit given by these professionals had more influence than that from family or friends, Bergman said. “We really need health professionals to talk to older smokers when they come in for medical appointments,” Bergman said.

For patients willing to quit, health care professionals should provide assistance with setting a quit date; outlining the quit plan; providing self-help materials that are culturally, educationally and age-appropriate for the patient; and discussing the use of medications to reduce withdrawal symptoms, unless contraindicated (Boyd, 1996).

CDC’s *A Practical Guide to Working with Health-Care Systems on Tobacco-Use Treatment* outlines several ways in which health care professionals can promote access to effective tobacco-dependence treatment (CDC, 2006). Physicians can provide brief counseling to patients who use tobacco or have recently quit and refer patients to quitlines and other available cessation resources (Revell, 2005). They can offer first-line tobacco-dependence pharmacotherapies approved by the Food and Drug Administration (FDA) to all tobacco users who are trying to quit (PHS, 2000). In a hospital setting, health care professionals can provide inpatient tobacco-dependence consultation services and medication and ensure that discharged patients are referred to a quitline or other services for ongoing counseling and follow-up (Solberg, 2004).

Medications. The PHS Clinical Practice Guideline identifies medications approved by FDA to help smokers quit (PHS, 2000). These medications include nicotine replacement therapy and a number of other prescription non-nicotine medications. Nicotine-replacement therapies, which help relieve nicotine withdrawal symptoms, can be in the form of a gum, an inhaler, a nasal spray or a patch. A prescription is required for the inhaler, nasal spray, and some patch products. Non-nicotine medications include Bupropion SR (Zyban®) and Varenicline Tartrate (Chantix™). Side effects of nicotine-replacement therapies vary by product, but may include mouth, nasal or skin irritation; nausea; or insomnia. Side effects of Bupropion SR include insomnia and dry mouth. Nausea was the most common adverse event associated with Chantix in clinical trials. However, FDA reported in February 2008 that serious neuropsychiatric symptoms have occurred in some patients taking Chantix. These symptoms include changes in behavior, agitation, depressed mood, and thinking about or attempting suicide. As with any medications, people should consult with their health care providers and carefully read the information on the package.

Raymond Niaura, PhD, a principle investigator on the Medicare Stop Smoking Program (MSSP) demonstration funded by the Centers for Medicare & Medicaid Services, said care must be taken when prescribing smoking cessation medication to frail older adults taking other medications. In addition, when people quit smoking, their metabolism of other medications may change. “So what we recommend is a higher level of medical monitoring that takes place when older patients use these medications,” said Niaura, who also is a professor of psychiatry and human behavior at Brown Medical School and Butler Hospital. “By and large our experience in the MSSP was that there were very few adverse events in the study and most of them were handled by the physician. So generally they are pretty safe drugs, but with any medication in an older adult you want to exercise a little extra caution,” Niaura added.

According to the PHS, there is no real evidence of effectiveness for acupuncture or hypnotism to help smokers quit, Dr. Husten said.

Telephone Quitlines. Research has shown that tobacco use cessation counseling is both clinically effective and cost-effective. Telephone counseling adds another dimension to that equation by offering services that older adults can receive in their homes and on demand. Developed by the National Network of Tobacco Cessation Quitlines, the 1-800-QUIT-NOW toll-free access number is a collaboration among the states, CDC, NCI and the North American Quitline Consortium (NAQC) to help tobacco users quit by routing callers to their respective state quitlines — telephone-based services offer counseling, information, self-help materials and, in some instances, nicotine replacement therapy.

“The benefit of this national network is that it provides a single point of access for every American smoker so that they can get the tools that they need to quit tobacco,” said Cathy Backinger, PhD, MPH, chief of NCI’s Tobacco Control Research Branch.

Linda Bailey, president and CEO of NAQC, added, “We know that quitlines work for many smokers and other tobacco users. The scientific evidence supporting their effectiveness continues to grow and is one of the reasons all 50 states and all five U.S. territories now have quitlines as part of their tobacco control programs.” By bringing quitline partners together — including state and provincial quitline administrators, quitline service providers, researchers and national organizations in the United States, Canada and Mexico — NAQC helps facilitate shared learning and encourages a better understanding of quitline operations, promotions and effectiveness to improve quitline services.

The effectiveness of these various approaches to cessation was examined by the MSSP study, conducted by RAND under contract to CMS in 2002-2004, involving 7,350 older (age 65+) tobacco users in seven states (Alabama, Florida, Missouri, Ohio, Oklahoma, Nebraska and Wyoming). The success rates of the various interventions tested were:

- 19.3% for telephone quitline service with pharmacotherapy coverage (nicotine patch).
- 15.8% for physician counseling and medication (nicotine patch or Zyban with a \$5 copay).
- 14.1% for brief physician counseling (up to four visits) using the PHS quit guidelines.
- 10.2% for self-help.

The MSSP demonstration found that the quitlines had the overall highest success rate. The study found physician counseling — alone or in conjunction with pharmacotherapy — was the most cost-effective intervention.

PAYING FOR SMOKING CESSATION TREATMENT

Medicare. An estimated 4.4 million Medicare beneficiaries smoke and that number could grow to 5 million by 2012 (Barry, 2002). In response to a request from the Partnership for Prevention, the Medicare program began covering smoking and tobacco-use cessation counseling in March of 2005. The PHS Clinical Practice Guideline supports the effectiveness of counseling (PHS, 2000). Medicare only covers counseling services for beneficiaries who are diagnosed with a smoking-related illness or who are taking medicines that may be affected by tobacco. Thus, Medicare cessation counseling is available for health conditions such as heart disease, cerebrovascular disease, multiple cancers, lung disease, weak bones, blood clots, and cataracts, or for beneficiaries who are taking medications whose metabolism or dosing is complicated by tobacco use (such as antidepressants) (CMS, 2005).

The counseling, available under Medicare Part B, includes a limited number of smoking cessation visits with a Medicare-approved provider, generally a physician, psychologist, social worker or rural health clinic professional. Medicare will cover two cessation attempts per year, with a maximum of four sessions per quit attempt. Medicare-covered counseling services are subject to beneficiary deductibles and copayments, said Marcel Salive, MD, MPH, Director of the Division of Medical and Surgical Services

with the CMS Coverage & Analysis Group. That can mean that a Medicare beneficiary must pay 20% of the Medicare-approved amount after meeting the annual Part B deductible, according to CMS.

Assuming 2% of Medicare beneficiaries utilize the counseling services, and 20% of those quit smoking, the Campaign for Tobacco-Free Kids estimated in 2002 that paying for cessation counseling would cost Medicare \$112 million over 10 years. That would be offset by health-care savings of \$75 million over 10 years for the Medicare program and another \$62 million saved by state, third-party payers and individuals over the same period (Barry, 2002; CMS, 2005). By comparison, CMS paid out a total of \$408 billion in benefits for all health care for Medicare beneficiaries in 2006, according to the latest report from the Medicare Trustees.

For beneficiaries who purchase Medicare Part D prescription drug coverage, certain smoking cessation medications such as Zyban are covered. Part D participants may have to meet requirements for deductibles or copayments, and coverage may vary depending on what stage of prescription drug coverage (initial coverage period, gap or “donut hole,” catastrophic coverage) that they are in. Some Part D plans may offer more expensive drugs, like Chantix, with a higher copayment.

In *A Practical Guide to Working with Health-Care Systems on Tobacco-Use Treatment*, CDC suggests eliminating or minimizing co-pays or deductibles for counseling and medications (CDC, 2006).

Medicare does not pay for over-the-counter smoking cessation products, such as nicotine patches. Medicare also does not pay for telephone quitline counseling.

Veterans. “With smoking being the leading cause of preventable death and disease in the United States, cessation is a public health priority for the VA,” Hamlett-Berry said. The rate of smoking among the 5 million veterans receiving VA care is higher than the general population — about 22.2% for those enrolled in VA care and as high as 32% among active service personnel. “The culture of tobacco in the military is very different, so we do have a patient population that smokes at a much higher rate,” she said.

Unlike Medicare, the VA does not require a copayment for smoking cessation counseling and its prescription drug formulary includes all the FDA-approved medications for smoking cessation. The VA health care system is one in which veterans with disabilities or illnesses related to their military service and veterans with lower incomes are priority populations for care.

The VA also encourages other practitioners, besides physicians and licensed psychologists, to provide tobacco cessation counseling. “The research evidence is really pretty clear that while brief counseling with the primary care physician is effective, there is no evidence indicating that one health care professional category is more effective than another,” Hamlett-Berry said. “Everyone who smokes or uses tobacco should receive advice to quit and an offer of assistance of evidence-based care from a number of health care providers throughout the system.”

The VA also tries to be flexible in its approach, allowing disabled veterans or those living far away from a VA facility to receive telephone counseling, or counseling and support through telemedicine services. For veterans who are enrolled in VA care who prefer to use their own state's telephone quitline, the VA will provide them with the contact information, and veterans can receive their smoking cessation medications through their VA pharmacy. VA does not offer quitline services directly.

CDC's ROLE

CDC provides national leadership for a comprehensive, broad-based approach to reducing tobacco use which includes many interventions that are applicable to the older adult population. Broadly speaking, CDC's national tobacco control program involves preventing young people from starting to smoke, eliminating exposure to secondhand smoke, promoting quitting among young people and adults, and identifying and eliminating disparities in tobacco use among different population groups. Essential elements of this approach include state-based and community-based interventions, counter-marketing, policy development, surveillance and evaluation. These activities target groups — such as young people, racial and ethnic minorities, and people with low incomes or low levels of education — who are at highest risk for tobacco-related health problems.

Because a substantial body of research demonstrates that comprehensive tobacco control programs reduce smoking-attributable mortality, prevalence, initiation and cigarette consumption, CDC also continues to support basic implementation programs to prevent and control tobacco use in all 50 states, the District of Columbia, 7 U.S. territories, and 7 tribal-serving organizations. In addition, CDC funds national networks to reduce tobacco use among priority populations. CDC provides technical assistance and training to help states plan, establish and evaluate these tobacco control programs. CDC works with a variety of national and international partners to ensure that diverse groups are involved in these tobacco control efforts.

CDC translates research into practice by keeping the public, policy makers, health professionals and other partners informed about current developments and initiatives in tobacco control. In partnership with federal, state and local agencies, CDC provides materials and resources such as *Best Practices for Comprehensive Tobacco Control Programs—2007*, *Key Outcome Indicators for Comprehensive Tobacco Control Programs*, a Smoking & Tobacco Use Web site, *Telephone Quitlines: A Resource for Development, Implementation, and Evaluation*, *Quit Tips* for individuals, and the *Guide to Community Preventive Services: Tobacco Use Prevention and Control*, which rates tobacco-cessation strategies. Strategies showing the strongest evidence of effectiveness include:

- ✓ Health care provider reminder systems (to ask patients about smoking).
- ✓ Lower client out-of-pocket costs for effective cessation therapies.
- ✓ Multi-component interventions that include telephone quitlines.
- ✓ Public education campaigns combined with other interventions.
- ✓ Smoking bans and restrictions.

- ✓ Tobacco product price increases.

FUTURE PUBLIC POLICY DIRECTIONS

Successful tobacco control requires a multi-faceted approach. For its part, CDC will continue to work with policy makers, health officials, partners and the public to ensure that tobacco control remains a core component of public health domestically and globally. It also will sustain and expand the capacity and reach of quitlines; advance the implementation of smoke-free policies; identify and disseminate the evidence base needed to reduce tobacco-related disparities; help states increase resources for comprehensive tobacco control programs; and investigate the public health implications of smokeless tobacco use.

It also will be important to make sure that older smokers and their health care providers are aware of the benefits of quitting at this age. “Older adults need accurate information about the importance of quitting, the new tools that we have available, that Medicare is a resource for them and that quitlines are available,” Niaura said.

Public health professionals need to consider practical ways to reach older smokers and inform them about what is available and where to get it. “The way that we are going to reach older smokers may not be the way that we are marketing or targeting younger smokers on tobacco use,” Hamlett-Berry said. “It may be more about outreach to community centers that serve older adults, engaging church organizations and other local organizations that older adults look to for information and services and seeing what can be done to engage them.”

The aging network — state and local area agencies on aging and Indian programs that work with older adults — also need to step up to the plate, Bergman said. TCSG has worked with the aging network to get them interested in smoking cessation programs, “but there wasn’t enough money around” to have significantly increased interest in this.

Future research may shed light on why people smoke and how to prevent them from starting. This may open up new avenues for public policy. Niaura noted that he is involved in an ongoing three-generation study of factors that influence smoking from generation to generation and what influences quitting behavior. Meanwhile, as the PHS recommends, researchers should continue to look at interventions aimed specifically at older smokers, the efficacy of prescription drug approaches in this population and how to motivate older smokers to quit (PHS, 2000).

“We know how to deal with the smoking issue; it is not a mystery to anybody,” Bergman said. The bottom line is that, in the words of the Institute of Medicine, “the tobacco use epidemic can be stopped.” If all states fully implemented proven strategies for tobacco use prevention and control, the nation could prevent the staggering toll that tobacco use takes on not only older adults and their families, but their communities as well.

This document is available online at www.chronicdisease.org. It was written by Nancy Aldrich. William F. Benson was senior editor and project manager.

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ADDITIONAL RESOURCES:

Americans for Nonsmokers' Rights, <http://www.no-smoke.org/>
CDC Smoking & Tobacco Use website, <http://www.cdc.gov/tobacco/>
Guide to Community Preventive Services: Tobacco, <http://www.thecommunityguide.org/tobacco/default.htm>
Helping Smokers Quit: A Guide for Clinicians, http://www.publichealth.va.gov/documents/VA_Pocket_Guide.pdf
Key Outcome Indicators for Comprehensive Tobacco Control Programs, http://www.cdc.gov/tobacco/tobacco_control_programs/surveillance_evaluation/key_outcome/
National Cancer Institute, Smoking and Cancer website, <http://www.cancer.gov/cancertopics/tobacco>
North American Quitline Consortium, <http://www.naquitline.org/welcome.asp>
Quit Smoking: Consumer Interactive Tool, <http://pda.ahrq.gov/consumer/qscit/qscit.htm>
Quit Tips, http://www.cdc.gov/tobacco/quit_smoking/how_to_quit/quittip.htm
Secondhand Smoke in Apartments and Condominiums: A Guide for Owners and Managers, <http://no-smoke.org/document.php?id=214>
Smokefree.gov, <http://www.smokefree.gov>
The Smoker Next Door: Handling Unwanted Tobacco Smoke in Apartments and Condominiums, <http://no-smoke.org/document.php?id=213>
Telephone Quitlines: A Resource for Development, Implementation, and Evaluation, http://www.cdc.gov/tobacco/quit_smoking/cessation/quitlines/
A Toolkit for Implementing Smoke-Free Laws, <http://goingsmokefree.org/>
Treating Tobacco Use and Dependence, <http://www.ahrq.gov/path/tobacco.htm>
VA Smoking Cessation website, <http://www.publichealth.va.gov/smoking/>
You Can Control Your Weight as You Quit Smoking, <http://win.niddk.nih.gov/publications/smoking.htm>
You Can Quit Smoking: Consumer Guide, <http://www.ahrq.gov/consumer/tobacco/quits.pdf>

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