CAMPAIGN for TOBACCO-FREE Kids®

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

The June 2000 guidelines for treating tobacco dependence 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. Of the 12.3 percent of U.S. women who smoke during pregnancy, Medicaid provides insurance coverage for more than half, or for more than 300,000 pregnant women smokers each year.[2] However, only 34 state Medicaid programs offer tobacco cessation services through their approved state plan, with wide variations in the amount, duration, and scope of the coverage.[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.

- 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 to 23% over control groups.

- Pregnant smokers should be encouraged to quit first without using nicotine replacement therapy (NRT) - including gum, patches, inhalers, nasal sprays, and non-NRT bupropion. NRTs (and bupropion) 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).[4]

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.

1400 I Street NW - Suite 1200 - Washington, DC 20005
Phone (202) 296-5469 · Fax (202) 296-5427 · www.tobaccofreekids.org

- Pharmacotherapy should be considered when a pregnant woman is otherwise unable to quit, and when the likelihood of quitting, with its potential benefits, outweighs the risks of the pharmacotherapy and potential continued smoking.

- 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.

The Elderly. Approximately 13 percent of people age 65 and older smoke, which amounts to about five 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] Currently, Medicare – the primary health insurer for the vast majority of all elderly persons in the United States – does not provide any coverage for cessation assistance.

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.

- Smoking cessation interventions that have been shown to be effective in the general population also have been shown to be effective with older smokers. Due to particular concerns of this population (e.g., mobility issues), the use of proactive telephone counseling appears particularly promising for older smokers.

Recommendations from the PHS & Preventive Task Force Guidelines:

- Smoking cessation treatments are effective for older adults. Therefore, older smokers should be provided smoking cessation treatments shown to be effective in this guideline.

- Tobacco cessation counseling is recommended on a regular basis for all patients [including the elderly] who use tobacco products.

Children and Adolescents. Smoking prevalence data for Medicaid-eligible children and adolescents is not available. However, in 2000 smoking rates among all U.S. children in the 8th, 10th and 12th grade was 15 24, and 31 percent, respectively.[8] In light of the unique demographic characteristics of Medicaid beneficiaries (e.g., lower socio-economic status) and the fact that smoking prevalence rates for Medicaid beneficiaries are significantly higher than the U.S. population in general (35% vs. 24%), the smoking rates of Medicaid-eligible children and adolescents are likely higher than these nationwide rates.[9] Currently, states provide limited cessation coverage for children and adolescents through the Early and Periodic, Screening Diagnostic, and Treatment program.[10]

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.

- There is no evidence that NRT or bupropion is harmful for children and adolescents. Clinicians may consider their use when tobacco dependence is obvious. Clinicians should,

however, be confident of the patient's tobacco dependence and intention to quit before instituting drug treatment. Factors such as degree of dependence, number of cigarettes per day, and body weight should be considered.

Recommendations from the PHS & Preventive Task Force Guidelines:

- Clinicians should screen pediatric and adolescent patients, and their parents, for tobacco use and provide strong messages regarding the importance of total tobacco abstinence.

- Counseling and behavioral interventions shown to be effective with adults should be considered for use with children and adolescents. The content of these interventions should be modified to be developmentally appropriate.

- When treating adolescents, clinicians may consider prescriptions for bupropion or NRT when there is evidence of nicotine dependence and desire to quit tobacco use.

- Clinicians in a pediatric setting should offer smoking cessation advice and interventions to parents to limit children's exposure to second-hand smoke.

- Anti-tobacco messages should be included in all health promotion counseling of children, adolescents, and young adults.

National Center for Tobacco Free Kids, November 7, 2001 / Matt Barry

Related Campaign Fact Sheets (available at www.tobaccofreekids.org)

- *Treating Tobacco Addiction And Otherwise Helping People Quit Reduces Tobacco Use*
- *Table: State Cessation-Related Statistics & Potential Savings*
- *Medicare and Medicaid Costs & Savings From Covering Tobacco Cessation (Based on S. 854 & H.R. 3676)*
- *What Kind of Tobacco Cessation Might Medicare, Medicaid, and Private Health Insurers Cover?*
- *Summary of the Durbin-Brownback Tobacco Cessation Bill (S. 854)*

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[1] Fiore MC, et al., *Treating Tobacco Use and Dependence*, U.S. Public Health Service Clinical Practice Guideline, June 2000, http://www.surgeongeneral.gov/tobacco/treating_tobacco_use.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] Matthews, T.J., "Smoking During Pregnancy in the 1990s," *National Vital Statistics Report*, August 28, 2001, 49(7), http://www.cdc.gov/nchs/data/nvsr/nvsr49/nvsr49_07.pdf ; Orleans, CT, et al., "Helping Pregnant Smokers Quit: Meeting The Challenge in the Next Decade," *Tobacco Control*, 2000; 9 (Supplemental III): 6-11; "Births, Marriages, Divorces and Deaths: Provisional Data for January - December 2000," *National Vital Statistics Report*, August 22, 2001, 49(6).

[3] U.S. Centers for Disease Control and Prevention (CDC), "Update on State Medicaid Coverage for Tobacco Dependence Treatments: United States, 1998 and 2000," *Morbidity and Mortality Weekly Report (MMWR)*, in press.

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

[5] CDC, "Cigarette Smoking Among Adults – United States, 1995," *MMWR,* 1997, 46:1217-1220; RAND, *Evidence Report and Evidence-Based Recommendations: Interventions to Promote Smoking Cessation in the Medicare Population*, 2000.

[6] Lacroix, AZ, "Thiazide diuretic agents and prevention of hip fracture," *Comprehensive Therapy* 1991, 17(8)30-9 [published erratum in *Comprehensive Therapy* 1992 February, 18(2):42]; RAND, 2000.

[7] Sachs, DPL, "Cigarette Smoking: Health Effects and Cessation Strategies," *Clinical Geriatric Medicine* 1986; 2:337-362; RAND 2000.

[8] Institute for Social Research, University of Michigan, 26th national survey in the Monitoring the Future series, December 14, 2000.

[9] Orleans, 2000; CDC fact sheet, *Cigarette Smoking Among Adults – United States, 1998*, http://www.cdc.gov/tobacco/research_data/adults_prev/ccmm4939_fact_sheet.htm.

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