

Smoking Prevalence among Older Adults

- In the US, people aged 65 years and older have the lowest prevalence of current smoking (8.3%) among all adults.¹ This is largely due to the premature death of older smokers from tobacco-related disease and cessation among those already experiencing the health effects of tobacco.
 - Men aged 65 and older (9.3%) and women aged 65 and older (7.6%) have met the Healthy People 2010 smoking prevalence objective of less than 12%.¹
 - In comparison, the prevalence among 18-24 year olds is 22.2%, among 25-44 year olds is 22.8%, and among 45-64 year olds is 21.0%.¹
- The prevalence of smoking among adults aged 65 and older in 2007 (8.3% or 3.1 million) decreased significantly from 2006 (10.2% or 3.8 million).¹

Health Risks and Older Smokers

- Approximately 80% of people aged 65 and older have at least one chronic disease condition requiring medical attention.³ Many of these chronic disease conditions are caused or exacerbated by smoking, including lung cancer, cardiovascular disease, chronic obstructive pulmonary disease, hypertension, and diabetic complications.⁴
- Smoking reduces bone density among postmenopausal women, and increases risk for hip fractures in men and women.⁴
- Smokers have two to three times the risk of developing cataracts as nonsmokers.⁴
- Results from a meta-analysis of prospective studies in 2007 found that current smoking is a risk factor for cognitive decline and dementia among older adults when compared with never smoking.⁵

Medicare and Smoking

- Approximately 97% of Americans aged 65 or older were enrolled in Medicare in 2007.⁶
- It is estimated that between 1995 and 2015, tobacco-related diseases will cost Medicare about \$800 billion.⁷
- In 2005, Medicare Part B was expanded to cover intermediate and intensive tobacco cessation counseling, but only for people who have an illness caused or complicated by tobacco use (e.g., heart disease, blood clots, etc.), or who take medications whose effectiveness is complicated by tobacco use. of the South, and persons in more rural areas. ⁴
 - o For covered persons, Medicare will pay for two quit attempts per year, both of which can include up to four intermediate or intensive sessions.
 - o As of 2006, Medicare Part D covers physician-prescribed smoking cessation treatments. It does not cover over-the-counter smoking cessation medications.⁸

Medicaid and Smoking

- Many older Americans also receive coverage through Medicaid in addition to Medicare. In 2005, Medicaid provided coverage to 6.1 million seniors, over 16% of the U.S. population over 65.⁹
- Seniors make up just 10% of Medicaid enrollees, but account for 28% of Medicaid spending. Per capita spending on the elderly enrolled was \$11,800 per enrollee compared to \$2,100 per non-disabled adult.⁹
- Like Medicare, Medicaid coverage of smoking cessation treatments and medications remains limited. As of 2006, 39 states offered coverage for at least one form of tobacco-dependence treatment, however nearly all imposed significant restrictions on these benefits. For example, numerous states require co-payments for medication and others provide no or limited coverage for counseling. Some require prior authorizations and “stepped care.” Four more states offer coverage for pregnant women only. Only one state, Oregon, covered all medications and counseling recommended by the 2000 Clinical guidelines.¹⁰

The Importance and Challenges of Cessation Later in Life

- The benefits of quitting smoking at any stage in life cannot be overstated, and even those smokers who are advanced in age should receive cessation counseling.¹¹ Quitting smoking, even after decades of exposure, can have a substantial effect on longevity.¹²
- Smoking cessation at 65 years of age leads to an increase in life expectancy of 1.4 to 2.0 years for men and 2.7 to 3.7 years for women.¹²
- While older smokers are less likely to attempt quitting than younger smokers, those who do try are more likely than younger smokers to seek assistance and to be successful in their efforts.¹³
- Research has shown that the self-reported physical and mental health of Medicare beneficiaries who have recently quit smoking is similar to those who are current smokers.¹⁴
 - These phenomena could be due to the “ill quitter” effect: that older smokers may decide to stop smoking once they have been diagnosed with a smoking-related illness.¹⁵
- People with clinically significant degrees of cognitive impairment, which become more prevalent with increasing age, find it harder to learn new behaviors and carry out actions, which may undermine patients’ attempts to take part in the treatments and behaviors necessary for successful smoking cessation.¹⁶

Effective Strategies for Cessation in Late-Life Smokers

- The 2008 Update to the Clinical Practice Guideline for Treating Tobacco Use and Dependence cites the following tobacco dependence interventions as effective in older smokers (adults 50 and older): the “4A’s” (ask, advise, assist, and arrange follow-up), counseling interventions, physician advice, buddy support programs, age-tailored self-help materials, telephone counseling, and the nicotine patch.¹⁷
- In a study on the effectiveness of different cessation strategies among the Medicare (65+) population, a telephone Quitline in conjunction with low-cost Pharmacotherapy was the most effective means of reducing smoking in the elderly.¹⁸
- Hospital-based smoking cessation programs, as well as referral to cardiac rehabilitation, are strongly associated with increased smoking cessation rates after a myocardial infarction (MI). Researchers suggest cessation programs for patients post-MI should include screening for depressive disorders because depression is highly prevalent in this population and is strongly associated with persistent smoking.¹⁹
- Medicare Summary Inserts, envelope-sized advertisements for services, have been highly recommended to communicate important information about cessation programs and services to the senior population.²⁰

Caregivers of Lung Cancer Patients

- Research has demonstrated that lung cancer patients are confronted with negative sentiments from friends, family, and doctors, and feel unjustly blamed for their disease.²¹
- Feelings of blame, fault, anger, and pride in caregivers can affect their empathic helping behavior towards patients with lung cancer. Research has found that caregivers who blame or fault patients for having smoked or continuing to smoke and are angry with patients are at risk for providing suboptimal help to and communication with patients coping with lung cancer in the home setting.²²
- Caregivers should keep in mind the addictive nature of cigarette use and avoid making attributions of fault or blame as this might lead to dysfunctional helping behavior.²²

SOURCES

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