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Smoking Cessation  
Leadership Center



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University of California  
San Francisco

# Tobacco Cessation From Evidence to Practice: Contingency Management for People Experiencing Homelessness

Maya Vijayaraghavan, MD, MAS, Director, Smoking Cessation Leadership Center, University of California, San Francisco, Steven A. Schroeder Distinguished Professor of Health and Health Care, Associate Professor of Medicine

February 7, 2024

# Moderator

**Catherine Bonniot**

Executive Director

Smoking Cessation Leadership Center  
University of California, San Francisco

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**Catherine Bonniot, Anita Browning, Christine Cheng, Brian Clark, Jennifer Matekuare, Ma Krisanta Pamatmat, MPH, CHES, Jessica Safier, MA, and Maya Vijayaraghavan, MD, MAS.**

# Thank you to our funders



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- For our California residents, SCLC offers regional trainings, online education opportunities, and technical assistance for behavioral health agencies, providers, and the clients they serve throughout the state of California.
- For technical assistance please contact (877) 509-3786 or [Jessica.Safier@ucsf.edu](mailto:Jessica.Safier@ucsf.edu).





- New CDC Tips Campaign 2024
- Tips From Former Smokers Motivational Cards:  
<https://www.cdc.gov/tobacco/campaign/tips/resources/motivational-cards/index.html>
- Find resources at: <https://www.cdc.gov/tobacco/campaign/tips/index.html>



# Today's Presenter

## **Maya Vijayaraghavan, MD, MAS**

Director, Smoking Cessation Leadership  
Center, University of California, San  
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Professor of Health and Health Care,  
Associate Professor of Medicine



UCSF

University of California  
San Francisco



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# Tobacco Cessation From Evidence to Practice: Contingency Management for People Experiencing Homelessness

Maya Vijayaraghavan, MD MAS

Director, Smoking Cessation Leadership Center

University of California, San Francisco



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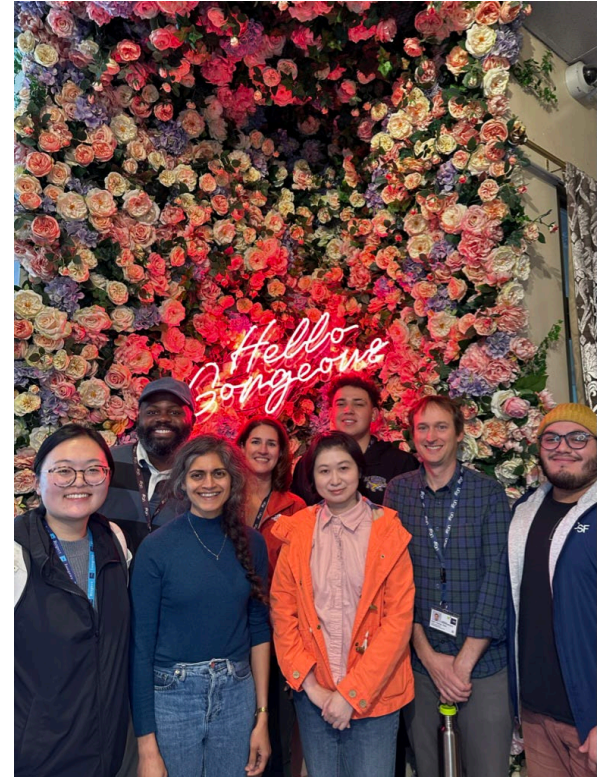
# Acknowledgments

- Funding: Tobacco Related Disease Research Program
- 3 San Francisco Health Network Primary Care Clinics
- San Francisco Department of Public Health
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- Trainees
  - Donna Appiah, MPH; Joshua Miller, PhD; Mel Molina, MD, Dian Gu, PhD; Mark Hawes, PhD



# My research team

- Jordan Cuby, MPH
- Omar Gomez, MA
- Phoebe Lee, BA
- Jessica Alway, MPH
- Deepalika Chakravarty, MS, MSc

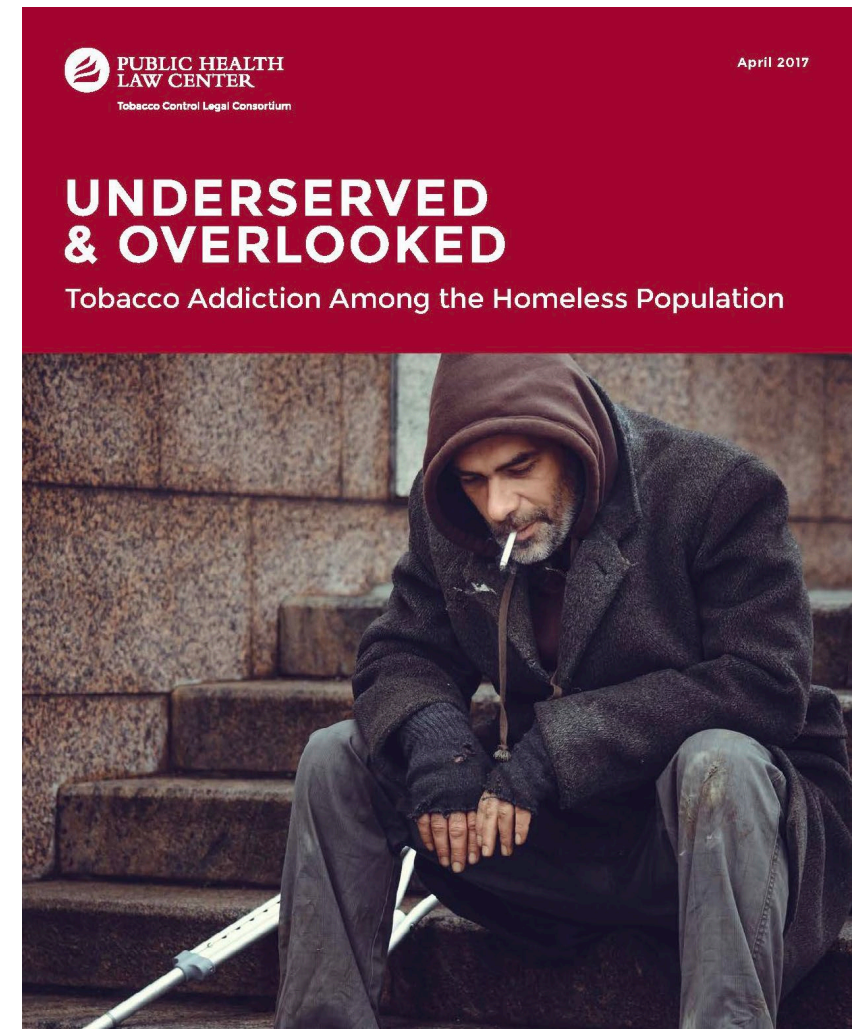


# Objectives

- Describe the epidemiology of tobacco use behaviors
- Describe tobacco-related inequities
- Discuss results from a randomized controlled trial of a contingency management (CM) intervention for smoking cessation
- Discuss policy and practice implications for CM for tobacco use

# Staggering rates of tobacco use

- Prevalence 70% compared to 11% nationally
- Homelessness is an independent risk factor for tobacco use
- Smoking rates are higher among
  - People with mental illness and substance use disorders
  - Justice-involved populations
  - People who identify as sexual and gender minority



Kerry Cork, Tobacco Control Legal Consortium; Kushel at al., 2023, CASPEH study



# Epidemiology of tobacco use

- Initiate smoking before age 16
- Average daily cigarette consumption 10 to 13 cpd
- 1/3rd smoke within 30 minutes of waking
- > 50% use other forms of tobacco
  - Cigars/little cigars
  - E-cigarettes



Vijayaraghavan et al., 2013; De Los Reyes et al., 2022; Neisler et al., 2018; Alizaga et al., 2020

# Tobacco-related inequities: Health impact

- Smoking-caused illnesses are the leading preventable causes of morbidity and mortality for those > 50 years
  - Cancers: Bronchus, Lung and Trachea are the most common cancers
  - Cardiovascular disease
  - Tobacco use comprises at least half of the substance use related deaths
- Among those < 45 years, incidence of tobacco-related conditions is 3 times higher



# Tobacco-related inequities: Behavioral factors

“The one element let's say, the cigarette would be the land and then the alcohol would be like the ocean...like the other element, and they go great together...like one after the other. **So when the opiates are wearing off a cigarette will bring the opiates back a little bit.** Yeah, the alcohol was a little different, **with alcohol it just seemed right, it just seems to go hand-in-hand.** With opiates it was more like a tool.”

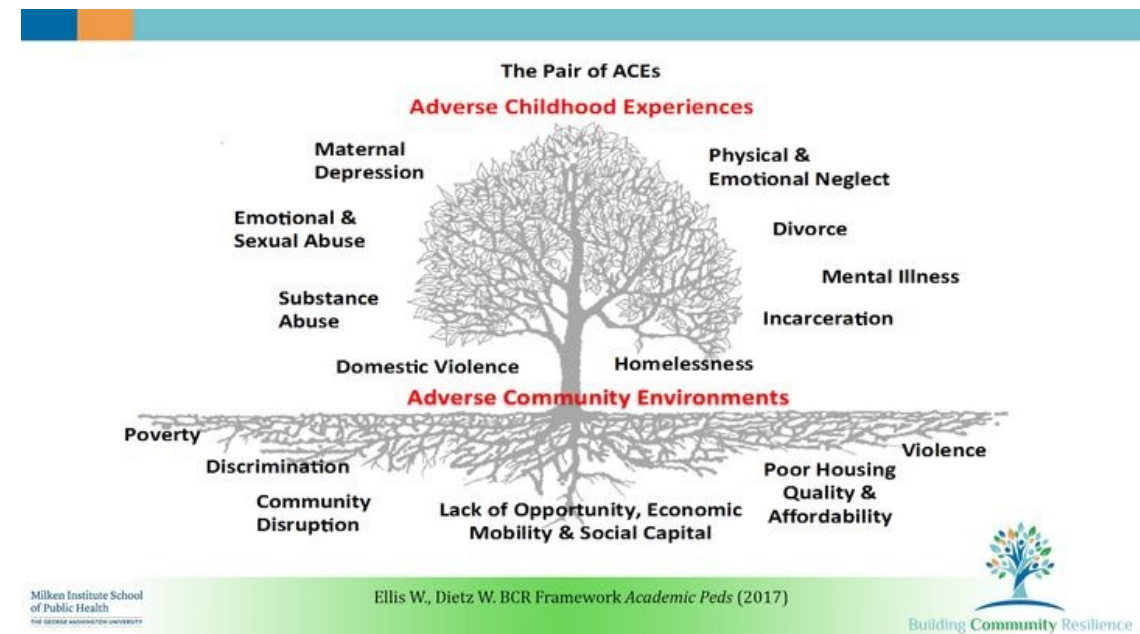
*41-year-old transgender multiracial participant*

Miller et al., 2023

# Tobacco-related inequities: Structural factors

High rates of trauma

- >80% have had lifetime experiences of trauma
- Adverse childhood experiences doubles risk of nicotine dependence
- Trauma linked with PTSD, high-risk behaviors
- Lack of opportunities limit structures for coping and recovery



Estey D et al., 2021; Roberts et al., 2008; Ellis et al., 2017

# Tobacco-related inequities: Structural factors

## Structural and systemic racism and discrimination

- Racism and discrimination associated with stress and tobacco use
- Systemic targeting of racial/ethnic minority groups by the industry
  - High tobacco retail density
  - Marketing of flavored tobacco and menthol



Miller et al., 2023; Apollonio et al., 2005; Yerger et al., 2007; Pearson et al., 2021



# Tobacco-related inequities: Organizational and systems-level factors

Limited opportunities for services

- Myths around tobacco use in this community
  - Not interested in quitting
  - Quitting smoking is a barrier to substance use recovery
- Limited access to integrated tobacco and substance use services

Published in final edited form as:

*Health Promot Pract.* 2019 May ; 20(3): 325–327. doi:10.1177/1524839919835280.

**Engaging Adults Experiencing Homelessness in Smoking Cessation Through Large-Scale Community Service Events**

Maya Vijayaraghavan, MD, MAS<sup>1</sup>, Dorie E. Apollonio, PhD, MPP<sup>1</sup>

<sup>1</sup>University Of California, San Francisco, CA, USA

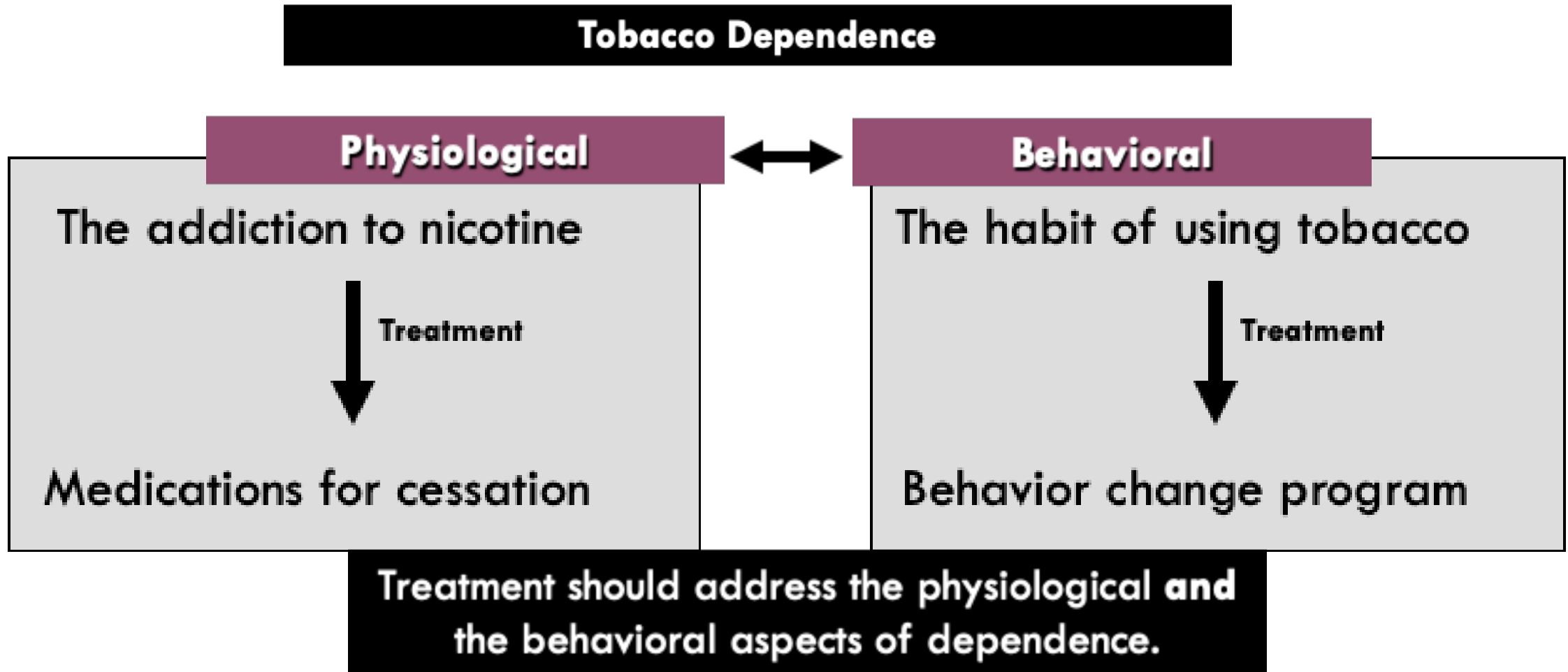
Porter et al., 2011; Prochaska et al., 2017; Vijayaraghavan et al., 2019

# People experiencing homelessness are interested in quitting

- 40%-60% make a quit attempt in the past year
- Most quit attempts are unassisted
- Quit ratio 9% compared to >60% in the general population
- Spontaneous yearly quit rate without treatment is 4%-6%
- Urgent need for cessation treatment in service settings



# Tobacco dependence



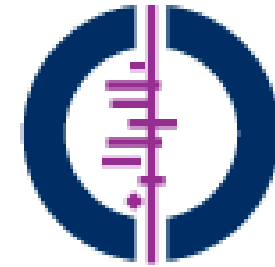
Rxforchange.edu

# Guideline recommended smoking cessation treatment

- Counseling using cognitive behavioral therapy or motivational interviewing
- Pharmacotherapy to address physiologic dependence
  - Nicotine replacement therapy
  - Bupropion
  - Varenicline
- Combination treatment is preferred over monotherapy
- Extended duration preferred
- Medications to prime cessation attempts

USPSTF 2021 guidelines

# Culturally-relevant tobacco use interventions



**Cochrane**  
Library

- Higher intensity or longer interventions
- Interventions that focus on tobacco and substance use
- Contingency management (CM) interventions had the highest abstinence rates
  - Short-term CM, 4-8 weeks duration
  - Small \$\$ amount for vouchers or fishbowl method
  - Limited by small sample sizes

Vijayaraghavan et al., 2020

# Contingency management for tobacco and substance use

- Evidence-based psychosocial therapy supported by three decades of research
- Used primarily for stimulant use disorder but also for opioid and tobacco use disorders
- Provision of incentives to reinforce desired behaviors
  - Abstinence from substances
  - Engagement in treatment
  - Adherence to medications

US Department of Health and Human Services, 2023; Becker SJ et al., 2023

# Types of CM

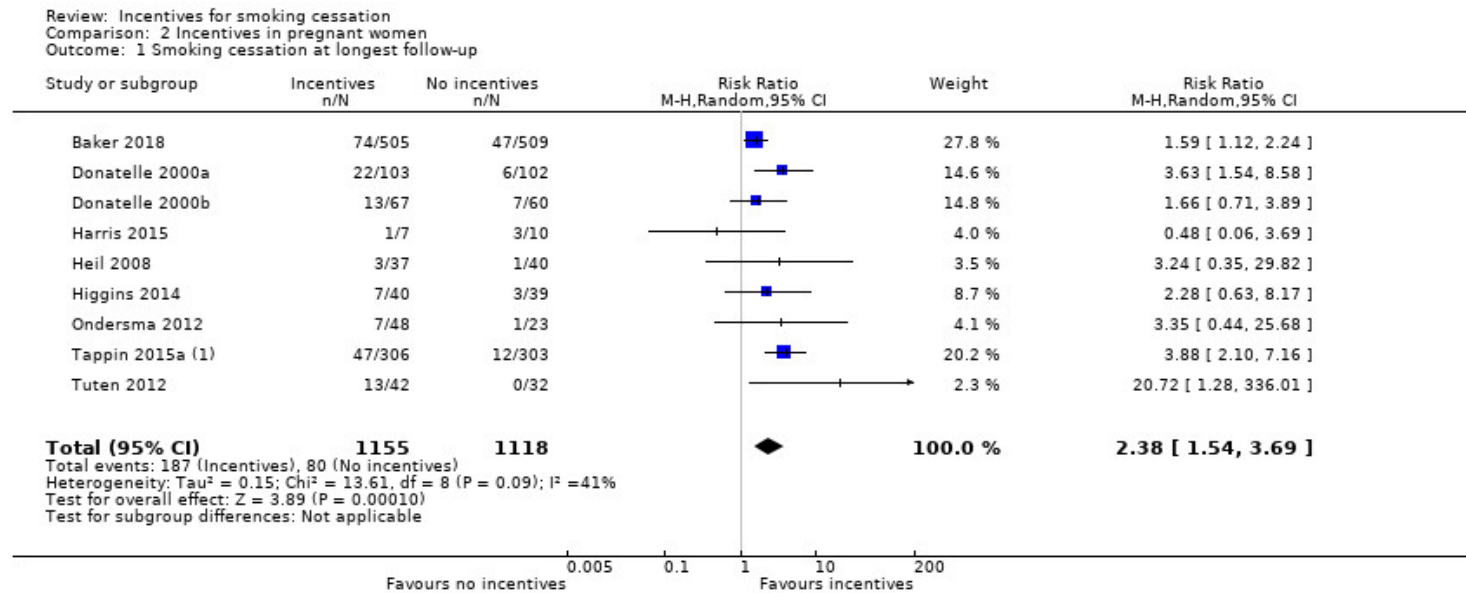
- Prize-based, Fish-bowl method
  - 500 price tickets
  - Half have a monetary value and half don't
  - Prize amounts range for \$1-\$100
- Voucher based
  - Set reinforcement for incentivized behaviors
  - Escalating schedule
  - Reset to 0 when a behavior is not achieved



US Department of Health and Human Services, 2023; Becker SJ et al., 2023

# For tobacco use disorder, CM is effective

- Meta-analysis of 30 clinical trials, 21,600 participants
- 50% more likely to demonstrate 6-month abstinence
- Highest impact among people who used other substances and pregnant women



(1) 12 months post-TQD

Notley et al., 2019

# Coming back to our project...

- Designed a contingency management program for smoking cessation for people experiencing homelessness
- Aims were to:
  - Develop a protocol for a pilot RCT
  - Evaluate the feasibility and acceptability of the protocol





# Engagement in tobacco cessation clinical trials among people experiencing homelessness

- Recruited 26 people with current or recent past experiences of homelessness
- Engaged in primary care at a clinic serving a predominantly homeless population
- People who smoke cigarettes
- In-depth interviews on factors influencing engagement in our proposed clinical trial

Miller et al., 2023

# Study sample

- Median age, 48.5 year (IQR 20.0)
- Gender: 10 male, 12 female, 4 transgender
- Race/ethnicity: 9 Black/African American, 6 Hispanic/Latinx, 8 White
- 88.5% smoked daily, median cigarettes smoked per day 7
- 39% attempted to quit in the past year

Miller et al., 2023



# Tobacco and homelessness

“Yeah, I mean, the housing, the housing is the biggest thing, I'm not going to sit here and run around, and **I don't think I'll be able to stop smoking until I get this housing** thing under control you know, [laughter] it's stressful.”

*58-year-old Black/African American male participant*



# Attitudes toward engaging in a clinical trial

A method to quit

**“I got excited when you just said all that [information on the clinical trial] so when it comes about, if you could call me and let me know, or a flyer out there or something. I probably would participate just because maybe I'll get the desire [to quit] by doing it.”**

*63-year-old white female participant*



# Barriers to participating

Safety and need to self-isolate

“ I thought that [the study] was just going to be for a week and I said that was why I was going to do this interview, but thinking about the future and coming in frequently, it kind of concerns me a lot because I, you know, **I'm a transgender, and so I have challenges a lot with different people that I encounter throughout the day, and so I'm more content being at home now than I ever have been.**”

*63-year-old Black/African American transgender participant*



# Patient-centric features

Financial incentives for cessation

**“It would be something that I would be interested in because I do want to quit smoking and why not start, you know, and at the same time it's like I can make money to do other things like to pay, pay bills and help my grandkids.”**

*45-year-old American Indian female participant*

# Launching the pilot RCT

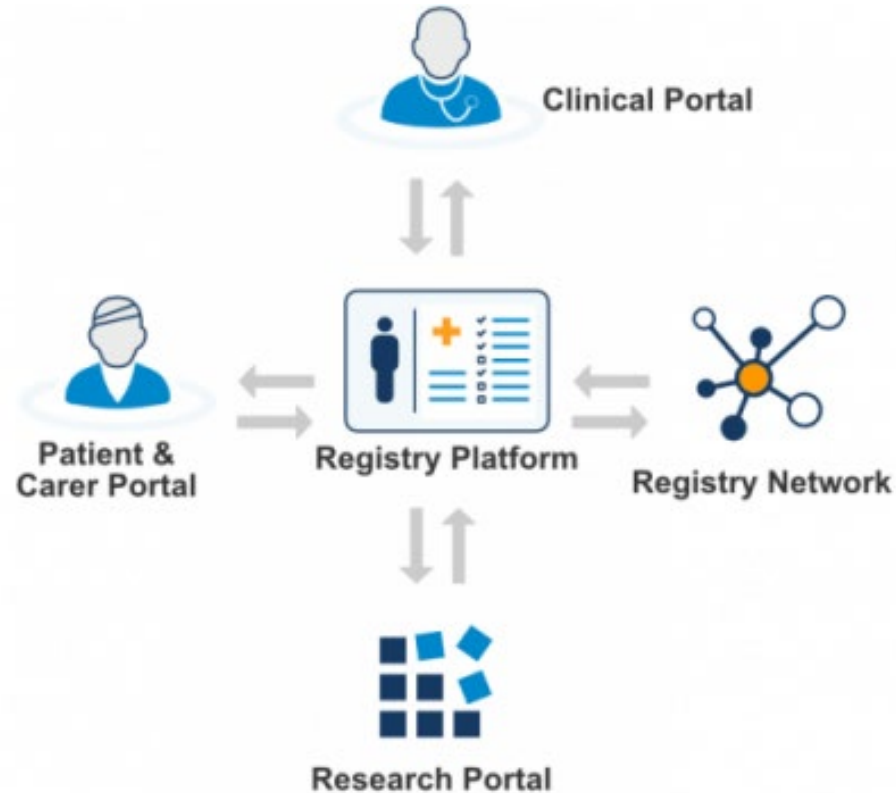
- Increase long-term tobacco abstinence by providing voucher-based incentives for cessation
- Recruitment
  - EHR, in-person recruitment, flyers, Facebook video, incentivizing to refer
- Eligibility criteria
  - Current homelessness
  - Current cigarette smoking
- Randomization stratified on nicotine dependence



Molina et al., 2023



# Creating a tobacco registry of patients in the clinical trial



- Patient registry within EHR for patients enrolled
- Registry inputs included:
  - Current smoking status
  - Counseling – type of provider counseling and date
  - Pharmacotherapy – type and date prescribed
- Monthly data extraction from the EHR

# Intervention vs. Control

	Visit frequency	# of visits	Intervention group potential earnings	
			Total for time period	Average per visit
<b>Week 1</b>	Daily	7 (\$13.00-16.00)	\$101.50	\$14.50
<b>Weeks 2 – 4</b>	Twice weekly	6 (\$16.50-19.00)	\$106.50	\$17.75
<b>Weeks 5 – 13</b>	Weekly	9 (\$19.50-23.50)	\$193.50	\$21.50
<b>Weeks 14– 24</b>	Monthly	3 (\$24.00-25.00)	\$73.50	\$24.50
<b>Total (6 months)</b>		25	\$475	

Control participants get a fixed \$5.00 incentive for attending each visit

# Example 1 -- Escalating incentives CM group

Visit	Abstinence	Streak	Payment	Visit	Earned
Week 1, Day 1	No	0	0	Completed	0
Week 1, Day 2	Yes	1	13	Completed	\$13
Week 1, Day 3	Yes	2	13.5	Completed	\$26.5
Week 1, Day 4	Yes	3	14	Completed	\$40.5

# Example 2 – Reset for missed visit

Visit	Abstinence	Streak	Payment	Visit	Earned
<b>Week 6</b>	<b>Yes</b>	<b>15</b>	<b>20</b>	<b>Completed</b>	<b>\$247.5</b>
<b>Week 7</b>	<b>Yes</b>	<b>16</b>	<b>20.5</b>	<b>Completed</b>	<b>\$268</b>
<b>Week 8</b>	<b>....</b>	<b>0</b>	<b>0</b>	<b>Not completed</b>	<b>\$268</b>
<b>Week 9</b>	<b>Yes</b>	<b>1</b>	<b>13</b>	<b>Completed</b>	<b>\$281</b>
<b>Week 10</b>	<b>Yes</b>	<b>2</b>	<b>13.5</b>	<b>Completed</b>	<b>\$294.50</b>
<b>Week 11</b>	<b>Yes</b>	<b>3</b>	<b>20.50</b>	<b>Completed</b>	<b>\$315</b>

# Example 2 – Schedule for control group

<b>Visit</b>	<b>Abstinence</b>	<b>Streak</b>	<b>Payment</b>	<b>Visit</b>	<b>Earned</b>
<b>Week 3, Visit 2</b>	...	0	0	Not completed	\$35
<b>Week 4, Visit 1</b>	No	0	5	Completed	\$40
<b>Week 4, Visit 2</b>	No	0	5	Completed	\$45
<b>Week 5</b>	No	0	5	Completed	\$50

# Outcomes

- Cumulative CO-verified abstinence at 6-months follow-up:  
number of CO-verified negative samples/total number of study visits
  - Self-report of not smoking
  - CO < 5ppm
- CO-verified point prevalence abstinence at 6-months follow-up

# Sample characteristics – 83 participants

- Gender: 64% male, 25% female, 7% transgender, 4% nonbinary
- Median age 46
- Race/ethnicity: 36% Black/African American, 25% White, 19% Hispanic/Latinx
- Median number of cigarettes smoked per day 9
- 70% smoked within 30 minutes of waking
- 49% attempted to quit in the past year



# Preliminary results – mental health and substance use

<b>Mental health, %</b>	
Depressive symptoms ( CESD-10)	54%
Moderate to severe anxiety (GAD-7)	41%
Ever experienced traumatic event	92%
PTSD	63%
<b>Past 30-days substance use, (%)</b>	
Cannabis	62%
Cocaine	24%
Amphetamines	39%
Problem drinking (AUDIT-C)	34%

# Incentives and follow-up

## Average attendance

- Mean number of visits 14 (SD 9), FU rate at 6-months 57%
- Intervention group 52%, average visits 13/25
- Control group 62%, average visits 16/25

## Average incentive amount

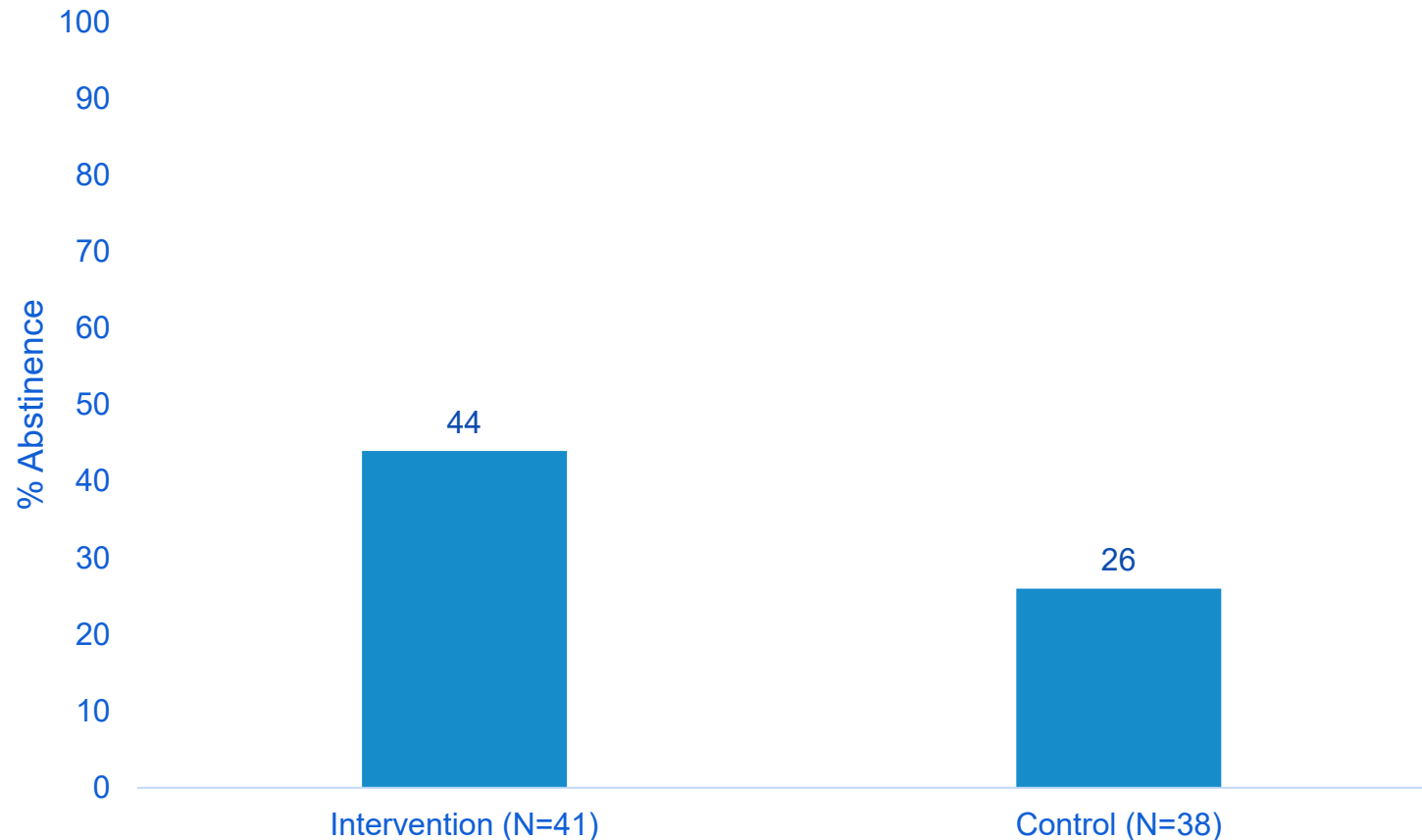
- Intervention group \$225
- Control group \$83

## 7 missed all follow-up visits

- 5 missed all follow-up visits in intervention group (2 incarcerated)
- 2 in control group

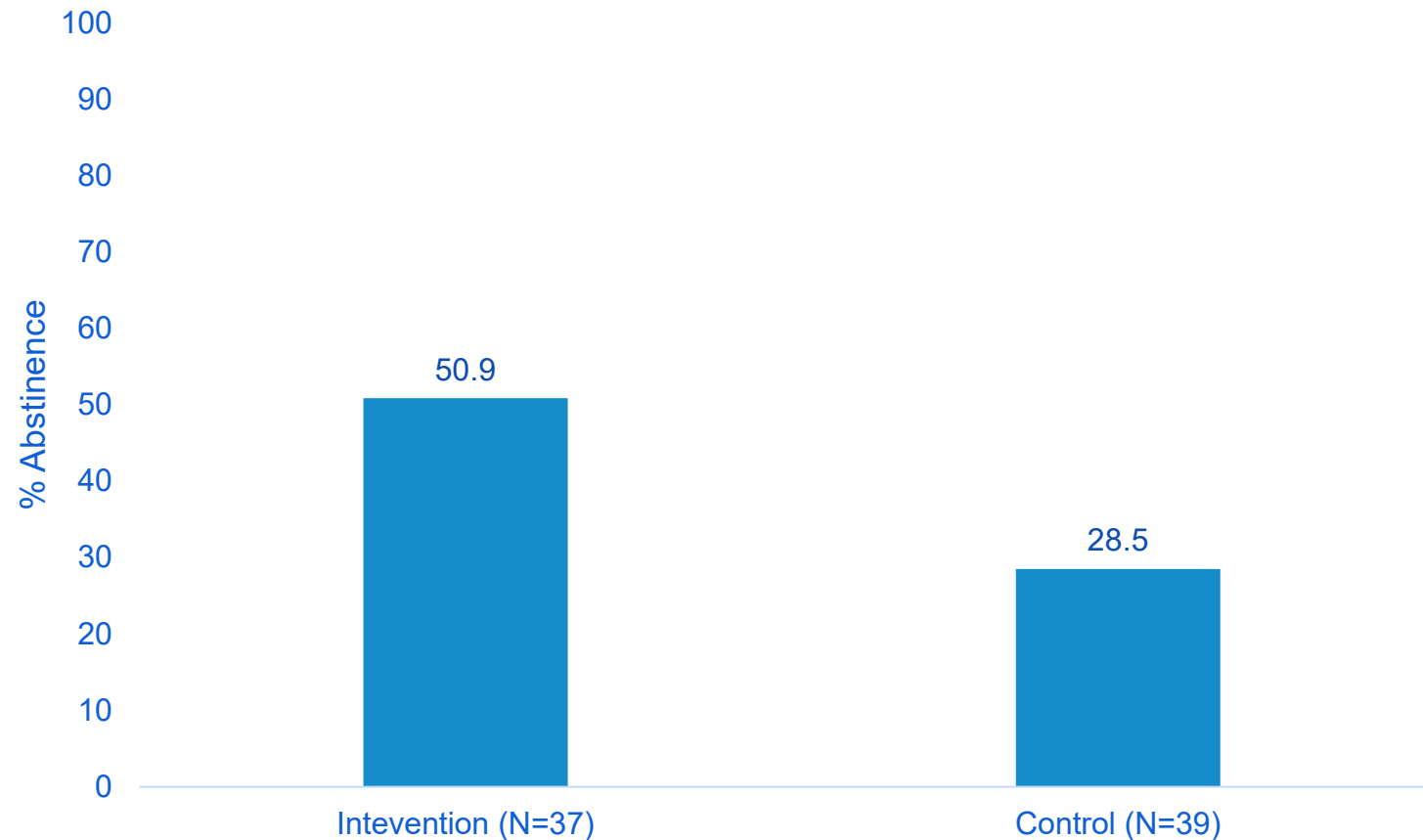
# Preliminary results – Cumulative abstinence at 6-months

Total no. of negative CO samples/total no. of possible visits (missing=not abstinent)



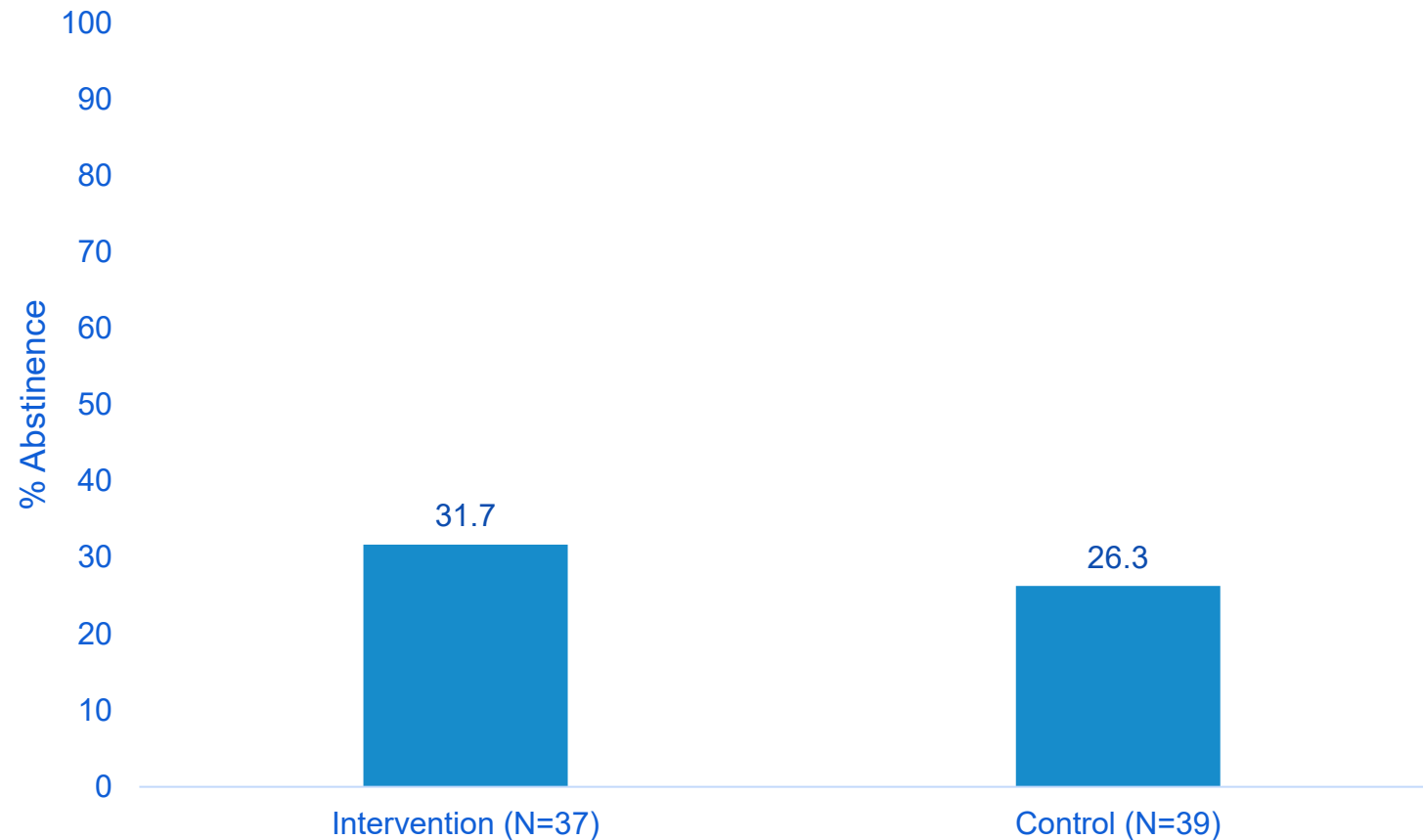
# Cumulative abstinence at 6-months

Total no. of negative CO samples/total no. of possible visits (excluding those who are missing)



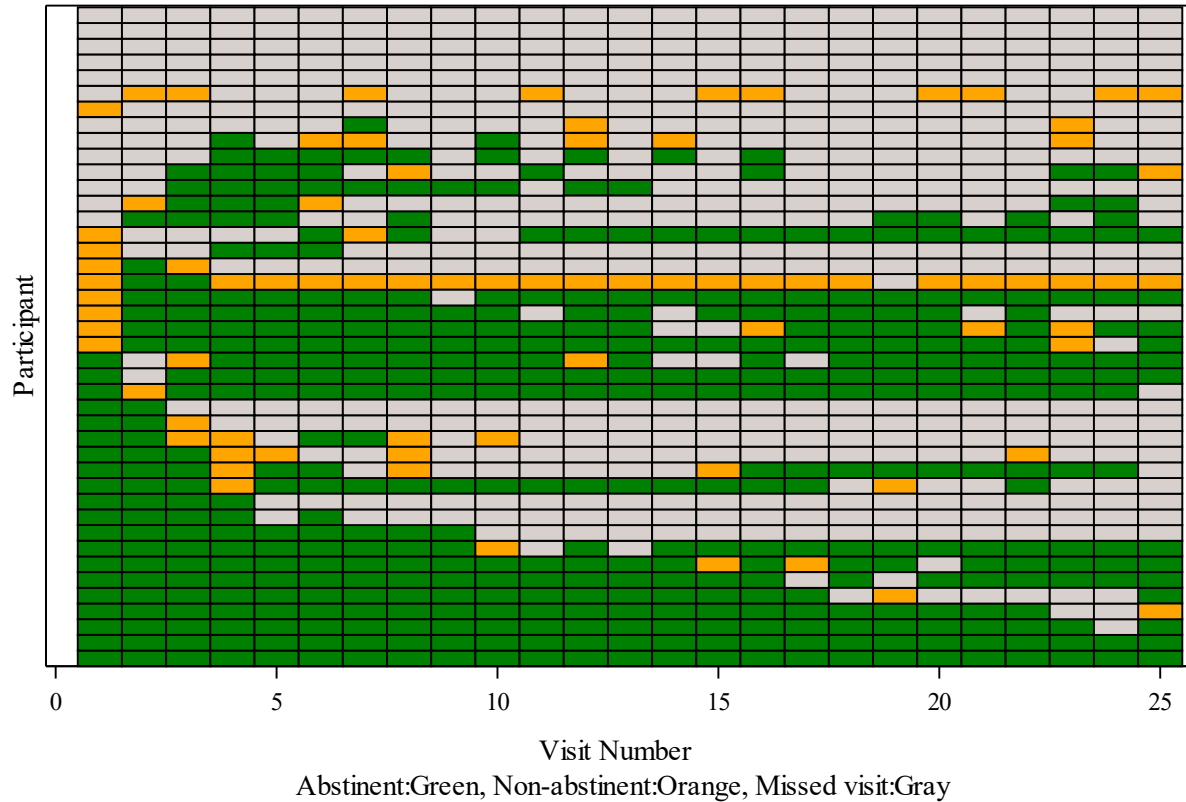
# Point prevalence abstinence at 6-months

% abstinent at 6 months/total no. who made the 6-months visit (missing=not abstinent)

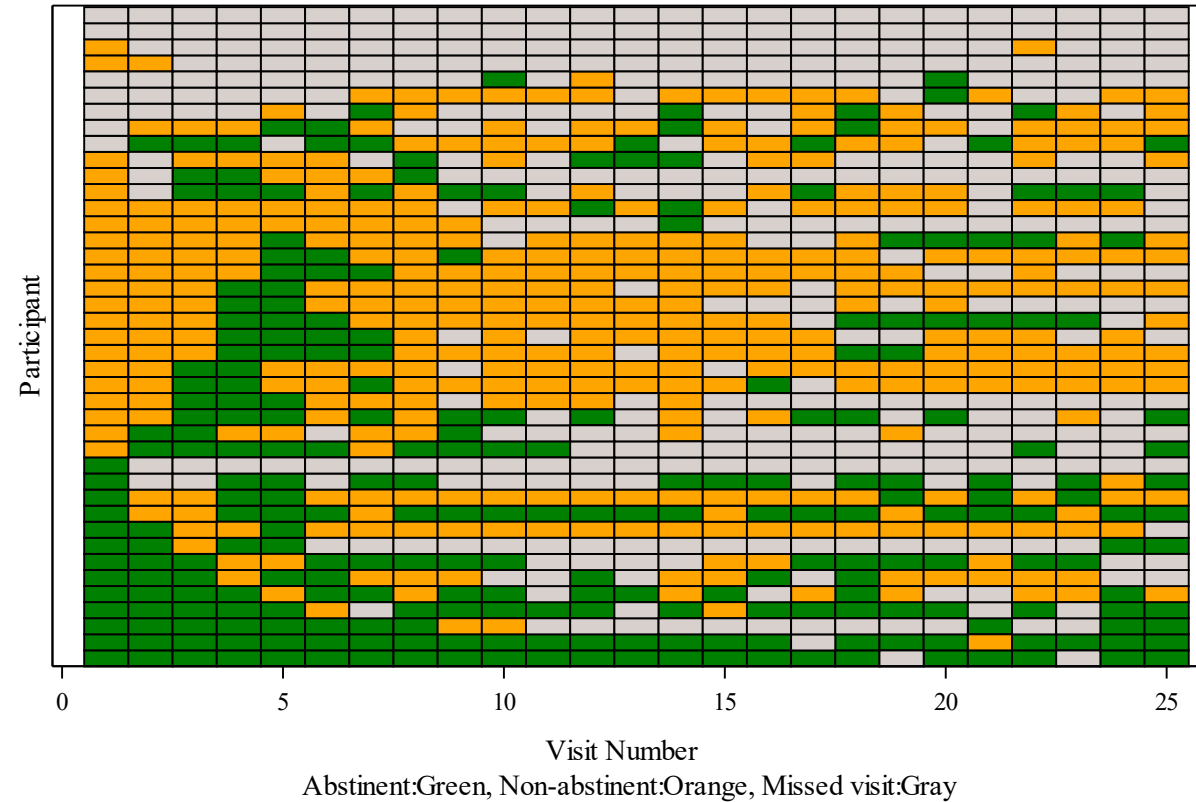


# Visual representation of quitting during the study duration

Abstinence at follow-up visits by Treatment group  
Treatment Group=Group A



Abstinence at follow-up visits by Treatment group  
Treatment Group=Group B



# Streak length for those with 2 or more consecutive visits with abstinence

- Average streak length in days
  - Intervention: 73 days
  - Control: 23 days
  - Caveat: Length of time between visits vary; Does not assume continuous abstinence
- 97% of the intervention participants started their first sustained streak in the first 4 weeks
- 70% started their longest streak in the first 4 weeks



# How did people use their money?

In-depth interviews at 12-month follow-up

- Toiletries
- Food
- Extra cash for supplies
- Supplies for pets



# Summary of findings and lessons learned

- More quitting in the CM group
  - Half had sustained quitting that lasted duration of the study
  - Three-fourths had sustained abstinence over > 2 visits
  - More missed visits
- Quitting also took place in the control group at rates higher than expected
  - Incentives to engage might have helped

# Next steps

- Complete data collection
- Analysis
  - Efficacy and cost-effectiveness analysis
  - Patterns in quitting – who are likely to sustain quit attempts
- In-depth interviews on participating in the RCT
- Curriculum on field work
  - Trauma-informed and resilience-building training for research staff
- Next iteration -- integrate incentives for engagement, fewer visits

Despite its effectiveness, CM is under-  
utilized

**The New York Times**

## ***This Addiction Treatment Works. Why Is It So Underused?***

An approach called contingency management rewards drug users with money and prizes for staying abstinent. But few programs offer it, in part because of moral objections to the concept.



Abby Goodnough New York Times, October 27, 2020

# Applications of CM in health systems and in federal and state-wide initiatives

- In 2011, the VA implemented a nation-wide initiative for stimulant and other substance use disorders
- Some forms of CM is allowed under some
  - Substance Abuse Mental Health Services Administration
  - State and tribal opioid response grants
  - Health Resources and Services Administrations' rural communities grants
  - Limitation of \$15/incentive, max of \$75/year

US Department of Health and Human Services, 2023; Becker SJ, 2023; VA Contingency Management Program

# System and policy level barriers – Paying for contingency management services

**Contingency management may be considered a violation of anti-fraud or anti-kickback laws**

**“The AKS is a criminal law that prohibits the knowing and willful payment of “remuneration” to induce or reward patient referrals...for any services that can be billable to federal health programs.”**

-- Anti-Kickback Statute [42 U.S.C § 1320a-7b(b)]



# Section 1115 demonstrations

Section 1115 of the Social Security Act gives the Secretary of the Health and Human Services authority to **approve pilot or demonstration projects that would improve or promote the objectives of Medicaid programs**. CMS reviews and approves the objectives of each proposal.

# Section 1115 Demonstrations – California



## THE RECOVERY INCENTIVES PROGRAM: CALIFORNIA'S CONTINGENCY MANAGEMENT BENEFIT

MEDI-CAL TRANSFORMATION

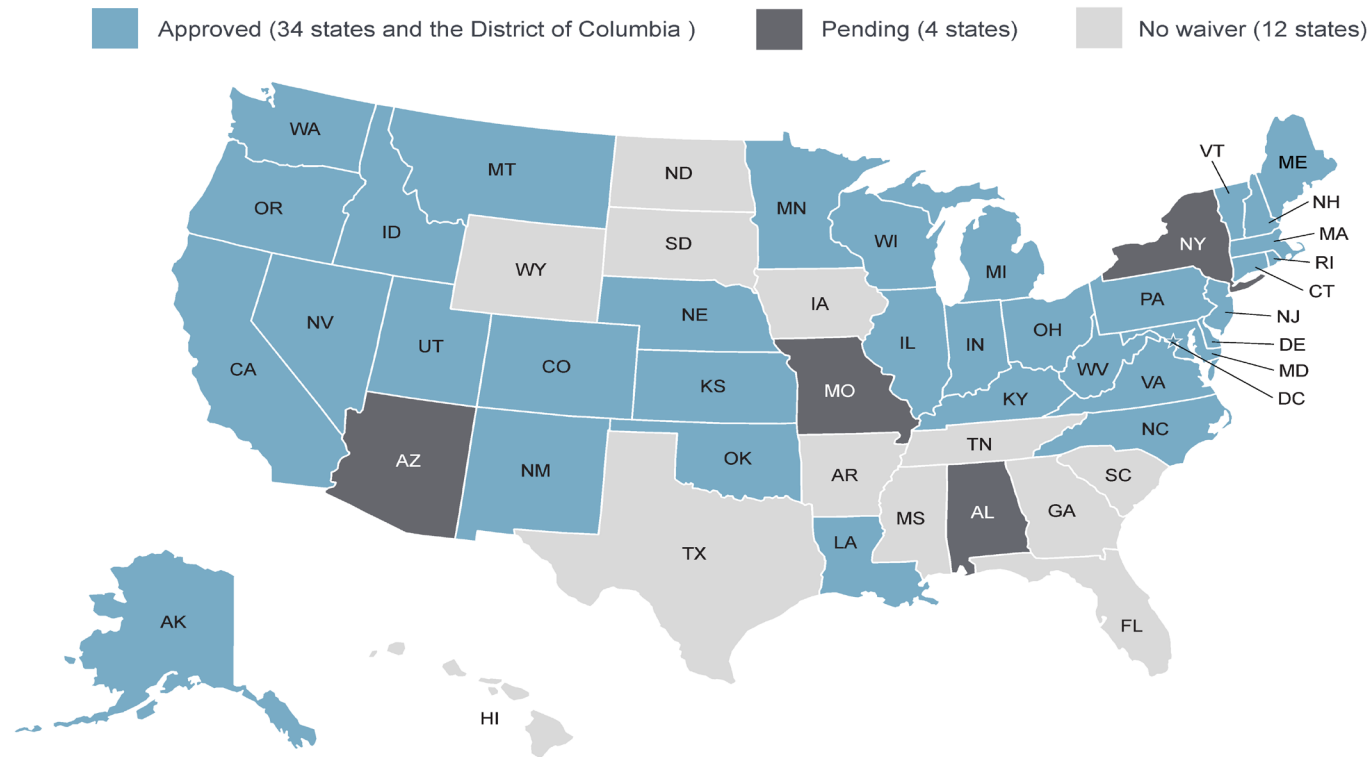
### The Intervention: Contingency Management through the Medi-Cal Recovery Incentives Program

To expand access to evidence-based treatment for stimulant use disorder and address the substance use disorder crisis, California is implementing Medi-Cal coverage of contingency management services in 24 participating pilot counties covering 88% of the Medi-Cal population through the [Recovery Incentives Program](#). Unlike opioids, there are no FDA-approved medications to treat the use of methamphetamines, cocaine, or other stimulants. Contingency management, however, is the most effective evidence-based treatment for stimulant use disorder and has been shown to improve treatment outcomes, including the decrease or cessation of drug use, and longer participation in treatment than other treatment options.

California is the first state in the nation to offer contingency management as a Medicaid benefit through the Recovery Incentives Program. The program uses evidence-based clinical protocols that deliver earned incentives to patients who achieve target treatment outcomes such as not using stimulants. Earning

# Section 1115 demonstration projects

## States with Approved or Pending Section 1115 Substance Use Waivers



In 2023, CMS approved Washington state to offer Medicaid coverage of CM for all SUD

**Note:** This map reflects states with approved or pending Section 1115 substance use disorder demonstrations as of November 2023.

Pending does not include states that have pending requests to renew or amend an approved demonstration.

**Source:** MACPAC, 2023 analysis of Section 1115 substance use disorder Medicaid demonstrations (CMS 2023).

MACPAC , 2023 analysis of Section 1115 Medicaid demonstration for substance use

# Implementation – How do we do this?

- Broaden scope to address tobacco and substance use
- Encourage states to apply for Section 1115 waivers
- Technical assistance for integrating CM into clinical, substance use treatment, street medicine, shelters, re-entry programs
  - CM providers receive training and education
  - Designating champions
  - Readiness attestations prior to implementation
  - Fidelity assessments
  - Addressing misconceptions

# Take home messages

- Offer guideline recommended tobacco treatment
- Opportunity to integrate CM and/or incentive-based protocols into tobacco treatment
- Every encounter in primary care, behavioral health, and social services counts to address tobacco use
- Saves lives
- Improves financial stability
- Reverses structural inequities linked with high rates

Submit questions via the 'Q & A' box





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**California Psychologists:** The California Board of Psychology recognizes and accepts for continuing education credit courses that are provided by entities approved by the Accreditation Council for Continuing Medical Education (ACCME). *AMA PRA Category 1 Credit™* is acceptable to meeting the CE requirements for the California Board of Psychology. Providers in other states should check with their state boards for acceptance of CME credit.

**California Behavioral Science Professionals:** University of California, San Francisco School of Medicine (UCSF) is approved by the California Association of Marriage and Family Therapists to sponsor continuing education for behavioral health providers. UCSF maintains responsibility for this program/course and its content.

Course meets the qualifications for 1.0 hour of continuing education credit for **LMFTs, LCSWs, LPCCs, and/or LEPs** as required by the California Board of Behavioral Sciences. Provider # 64239.

**California Addiction Counselors:** The UCSF Office of Continuing Medical Education is accredited by the **California Consortium of Addiction Professional and Programs (CCAPP)** to provide continuing education credit for California Addiction Counselors. UCSF designates this live, virtual activity, for a maximum of 1.0 CCAPP credit. Addiction counselors should claim only the credit commensurate with the extent of their participation in the activity. Provider number: 7-20-322-0724.



**Free CME/CEUs** will be available for all eligible California providers, who joined this live activity thanks to the support of the California Tobacco Prevention Program (CTPP)

For our California residents, SCLC offers regional trainings, online education opportunities, and technical assistance for behavioral health agencies, providers, and the clients they serve throughout the state of California.

For technical assistance please contact (877) 509-3786 or [Jessica.Safier@ucsf.edu](mailto:Jessica.Safier@ucsf.edu).

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# Post Webinar Information

- You will receive the following in our post webinar email:
  - ✓ Webinar recording
  - ✓ Instructions on how to claim FREE CME/CEUs
  - ✓ Information on certificates of attendance
  - ✓ Other resources as needed
- All of this information will be posted to our website at <https://SmokingCessationLeadership.ucsf.edu>



SCLC next live webinar is on Opioids and Tobacco Use with **Dr. Shadi Nahvi**, Professor, Department of Medicine (General Internal Medicine) and Professor, Department of Psychiatry and Behavioral Sciences at Albert Einstein College of Medicine

- **Tuesday, March 5, 2024**
- **2:00 pm – 3:00 pm EDT**



# Contact us for free technical assistance



- **Visit** us online at [smokingcessationleadership.ucsf.edu](https://smokingcessationleadership.ucsf.edu)
- **Call** us toll-free at **877-509-3786**
- **Provide Feedback** - complete the evaluation, which you will see at the end of this webinar

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