**SCLC's webinar**

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

**2/7/24**

**Post-webinar Q and A**

How to offer/dispense cessation medication during popup clinic?

Response: Counseling can be offered and medications can be prescribed during pop up clinic to anyone who is interested. For example, one of our clinics in our study was a pop up clinic for HIV for people who are unhoused and providers prescribed ART for pick up in clinic, but they also sent meds for cessation to the pharmacy linked with their clinic. Pharmacists in the pop up clinics went over how to use meds.

Can you speak to consuming nicotine via vaping vs smoking cigarettes and rates for people experiencing homelessness. i am thinking that the rates are higher for this population for smoking cigarettes . There is the comradery of sharing substance  for example. food for thought. Thank you

Response: In our studies, 70% or more are using combustible tobacco. But we have some people (20% or more) who are also using e-cigarettes concurrently with cigarettes. The other common other tobacco product is little cigars. We have not yet looked at e-cigarette data in this study, but in a previous study we published among people experiencing homelessness, we found that 20% were dual cig and e-cig users and there were perceptions that e-cigarettes were less harmful than cigarettes. Here is information on the study: Durazo A, Hartman-Filson M, Elser H, Alizaga NM, Vijayaraghavan M. E-Cigarette Use among Current Smokers Experiencing Homelessness. Int J Environ Res Public Health. 2021 Apr 1;18(7):3691. doi: 10.3390/ijerph18073691. PMID: 33916203; PMCID: PMC8037859.

Do participants receive cash, bank deposit, restricted debit card, or gift card as incentive?

Response: We provide incentives in the form of gift cards to local preferred retailers like CVS, Walgreens, Target, or other local grocery store preferred by our participants.

Hi Everyone.  How much did you budget per participant for the contingency management?

Response: Participants had the chance to earn up to $475 just for contingency management over a period of 6 months. They could earn additional incentives for completing follow-up surveys, but the amount set for contingency management was $475.

Do you have higher dropout rate for the trial group?

Response: Yes the contingency management group did have an average follow-up rate of 13/25 visits and the control group had an average of 15/25 so they were slightly less likely to follow-up, though not by much. It is important to note that even though there were more missed visits in the contingency management group, we did actually see them on average 13 times (and more) over a period of 6 months which is not too bad. In future iterations of this work, we are thinking about incentivizing both engagement and abstinence so people will be encouraged to show up and they will get an additional incentive for abstinence.

Missed the initial part of the presentation. Assume that the two groups had received smoking cessation interventions; can you describe these and how this was controlled for? Could the clients have been using e-cigarettes/vaping during the study. Was this use able to be detected by the CO meter?

Response: The goal of this study was to provide incentives/CM as an adjunct to guideline recommended tobacco treatment – patients were getting guideline recommended tobacco treatment through their primary care providers as part of usual cessation care and we were able to build a registry within Epic, our electronic health record, to extract data on how often they were receiving tobacco treatment as part of routine primary care. The provision of tobacco treatment was not part of our intervention. There were participants who were concurrently using other tobacco products – we are exploring this data. The expired CO reading might capture ongoing cannabis use that is smoked, but I don't think it captures e-cigarette use as to my understanding there is no expired CO with e-cigarette use.

How About easy access to the NRT's needed? Any resources that you know available to this population, that provide onsite access in their shelters or type of Bridge Housing?

Response: In another project we have partnered with community-based pharmacies to provide counseling, furnish NRT, and deliver meds to shelters.

Who can ask for a Section 1115 Waiver?

Response: State health departments can ask for Section 1115 waivers.

Was your study exclusive for combustible cigarette users?

Response: Yes our study was only for combustible cigarette use – they had to have been smoking cigarettes daily and have an expired CO reading > 8 to capture people who smoke regularly.

What are you doing for people who want to quit but fear and anxiety are holding them back from taking this step even though we are providing medication and counseling

Response: I think this is an ongoing conversation and our approach is to continue to offer counseling and treatment in a way that addresses the fear and anxiety using trauma-informed approaches. We acknowledge that this process takes time, but every effort or attempt will bring people closer and increase their self-efficacy in quitting. If fear or anxiety is one of the motivators to not try, you might want to consider addressing anxiety as a barrier to quitting and SSRIs may be helpful while also addressing smoking cessation, particularly if tobacco use is being used as a way to treat anxiety.

How do you address the perception of tobacco use being seen as harm reduction within the Homeless/SUD community rather than addressing it as a serious nicotine addiction or as a part of whole health care? Great presentation, thank you.

Response: This is an important point as the discussion around substance use harm reduction can sometimes underestimate harms of tobacco. I have usually framed this as addressing tobacco use is reducing harm, and when we work together and address tobacco use with other substance use, it is harm reduction. Addressing tobacco use with other substance use has the potential to increase abstinence from all substances and improve mental health outcomes. While some may prefer to stop using substances and tobacco use sequentially, we can still discuss the options of addressing all of them together and provide support.

Anderson CM et al. Incentives and Patches for Medicaid Smokers: An RCT AmJPrevMed showed that incentives work and other research noted they were cost effective but CA did not continue the incentives after the program stopped. why?

Response: This study that you are referring to was called the Medical Incentives to Quit smoking (MIQS) study was funded by a CMS grant to the CA Department of Health Care Services and was created by the Medicaid Prevention of Chronic Disease Program as part of the Affordable Care Act. Once the grant funding ended the incentives ended. The main way that these studies are done and incentives are provided is through grant funding because there are system/policy level barriers to paying for incentives on a large scale – unless a state uses their Section 1115 waiver for providing incentives.

What was the most commonly used NRT and/or NRT combination?

Response: Our study did not provide NRT or meds. We provided the incentives as an adjunct to guideline recommended tobacco treatment that people would receive during routine primary care. We wanted to make our model sustainable and if people received tobacco treatment during primary care, our study is aimed at showing the efficacy of incentives. If found to be efficacious, then we would scale up the study to other clinics using grant funding and generate evidence that such approaches do work and present that evidence to state dept of health to apply for Section 1115 waivers to fund such approaches in a broader way.

For CA's currently approved 1115 demonstration, does it expand CM to tobacco use treatment or is it currently not for CM tobacco use treatment?

Response: No it is not for tobacco use in CA. It is only for stimulant use but I do think there is scope to integrate tobacco use in current Section 1115 waivers.

Have you developed tipsheets how to communicate tobacco cessation with homeless or neighbor?

Response: We use a standard workflow using the 5As and/or 2As and R to discuss tobacco use just as we would discuss with any individual who smokes, whether they are housed or unhoused. We are creating a tipsheet that might address common myths to addressing tobacco use among people who are unhoused or experiencing homelessness that we will post our website. This is a good paper to review on a workflow on how to treat tobacco use for all people who report current smoking: https://jamanetwork.com/journals/jama/article-abstract/2788777