Veteran Health Incentives Pilot (V-HIP): Financial Incentives for Tobacco Cessation (FITC)

Dole 107; January 1, 2026-December 31, 2030 (5Y)

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Summary

Background & Rationale

Tobacco use remains the leading cause of preventable death and disproportionately affects Veterans compared to the general population. VA spends billions on smoking-related care and was estimated to cost VHA $2.7 billion in 2010, representing 7.6% of all healthcare expenditures.[1] Approximately half of all Veterans who smoke attempt to stop each year, yet despite the interest in cessation, treatment utilization remains low. Financial incentives (FI) or contingency management (CM) in combination with behavioral counseling and pharmacotherapy are recommended by the 2026 VA/DoD Tobacco Use Treatment Guidelines to treat tobacco and nicotine use.[2] These use external rewards to encourage desired behaviors (e.g., abstinence) by providing incremental and direct reinforcement, while incentive-based reward programs attempt to induce abstinence by the provision of much larger rewards that are offered less often (e.g., a single occasion or at defined endpoints). CM and FI have high-certainty evidence.[3]

Policy: 38 U.S.C. §1703E pilot authority; waiver for §1720A(d) expansion to include tobacco cessation.

Program Goals

Overarching Program Goals:

1. Primary:
    a. To reduce combustible tobacco use among Veterans by enhancing existing VA cessation treatments with financial incentives (FI).
    b. To improve long-term Veteran health outcomes, including cardiovascular and respiratory health, and reduce suicide risk associated with tobacco use.
2. Secondary:
    a. To assess the return on investment (ROI) of FI for tobacco cessation.

Evaluation Objectives:

1. To assess abstinence from combustible tobacco across intervention groups (enhanced usual care vs enhanced usual care + FI).
2. To determine the impact of enhanced care + FI on secondary cessation outcomes and quality of life.

[1] Barnett PG, Hamlett-Berry K, Sung HY, Max W. Health care expenditures attributable to smoking in military veterans. Nicotine Tob Res. 2015 May;17(5):586-91. doi: 10.1093/ntr/ntu187. Epub 2014 Sep 19. PMID: 25239960; PMCID: PMC5009451.
[2] VA/DoD (2026) Clinical Practice Guidelines for Tobacco Use Treatment. https://www.healthquality.va.gov/HEALTHQUALITY/guidelines/CD/tobacco/Tobacco-Cessation-CPG_2026-Guideline_final_20260109.pdf
[3] Notley, C., Gentry, S., Livingstone-Banks, J., Bauld, L., Perera, R., & Hartmann-Boyce, J. (2019). Incentives for smoking cessation. *The Cochrane database of systematic reviews*, *7*(7), CD004307. https://doi.org/10.1002/14651858.CD004307.pub6

3. To model the intermediate and long-term effects of smoking cessation on clinical outcomes (e.g., cardiovascular health, respiratory health, and suicide risk).
4. To assess the cost effectiveness of FI on tobacco abstinence and quality of life.

Implementation Objectives:

1. To assess the maintenance and feasibility of adding FI to VA care.
2. To assess patient experiences with the financial incentive tobacco cessation program.
3. To assess provider and staff (including program/clinical managers) experiences and attitudes with the financial incentive tobacco cessation program.

Methodology

Using a pragmatic, patient-level, randomized design, 1,400 Veterans who smoke cigarettes will be randomized in a 1:1 ratio to one of two intervention groups: Enhanced Usual Care or Enhanced Usual Care + Financial Incentives (FI). Both intervention groups will receive pharmacotherapy and behavioral counseling delivered by VISN Clinical Research Hub (CRH) Pharmacists through VVC visits. This will include an initial consultation to set a quit date and visits occurring on their quit date as well as at 1-, 2-, 4-, 8-weeks, & 6-months post quit date. Veterans randomized to the FI group can receive up to $800 for sustained cessation throughout the 6-month program. FI is based on biologic confirmation of cessation at weeks 2 ($200), 8 ($200)and 6 ($200+$200 bonus) months. Carbon monoxide (CO) breath tests will be used at specific visits to confirm smoking cessation status for both intervention groups and to justify incentive release for those in the FI group. Participants will be asked to complete a baseline survey to capture demographic information, smoking history, and current health status. They will also be asked to complete follow-up surveys 6-months and 12-months post quit date to assess outcomes. Semi-structured interviews will be used to evaluate patient, provider, and staff experiences with the program after the 12-month period. This work has been deemed non-research and will not have IRB/RDC oversight.

Contents

1.0 Introduction

In alignment with E Dole Act Section 107 statute requirements, VA seeks to develop and implement a pilot project designed to enhance preventative health and lead to improving Veteran health outcomes and reduce health care costs through application of financial incentives (FI). FI is an evidence-based behavioral therapy approach in which individuals are 'reinforced' or rewarded for engaging in positive behavioral change, including through use of financial incentives. The initial demonstration model VA proposes under this pilot program incorporates use of financial incentives into tobacco cessation services to improve rates of long-term abstinence from smoking. Smoking remains the leading cause of preventable disease and disability, and reducing smoking rates will subsequently reduce healthcare expenditures for smoking-related illnesses.

Use of financial incentives to promote long-term abstinence from smoking is strongly supported in the literature. A recent Cochrane Review of 33 mixed-population studies with over 21,600 participants concluded there is "high-certainty evidence" that financial incentives are efficacious in promoting long-term smoking cessation. Analysis of the studies showed absolute rates of abstinence at follow-up ranging from six to 24 months were 7.1% in the control group and 10.6% in the intervention group, meaning individuals who received financial incentives were 49% more likely to achieve long-term cessation than those who did not.[4]

Tobacco use is considered a SUD for purposes of 38 U.S.C. § 1720A or VHA Directive 1160.04(1). VA already provides limited incentives for certain Veterans to participate in tobacco screening and smoking cessation counseling by waiving copayments for outpatient medical care. See 38 CFR § 17.108(e)(11), (13). The expected impact is that pilot program implementation, reporting, and analysis will be less than the appreciated cost savings.

The 2023 US National Health Interview Survey data reported that the smoking prevalence among Veterans (not limited to VHA enrollees) was 13.2% compared to 10.6% among non-Veterans.[5] In 2024, of 18 million Veterans, 9 million were enrolled in VHA healthcare.[6] Among enrollees of the VHA, in 2024, 54% reported ever smoking cigarettes, with 11% reporting current smoking (8% daily smoking, 3% nondaily smoking). Smoking cigarettes continues to be the leading cause of preventable disease, disability, and death in the United States. According to the Centers for Disease Control and Prevention (CDC), an estimated 11.5% (28.3 million) of U.S. adults smoke cigarettes, putting them at greater risk for diseases including heart disease, stroke, chronic

[4] Notley, C., Gentry, S., Livingstone-Banks, J., Bauld, L., Perera, R., & Hartmann-Boyce, J. (2019). Incentives for smoking cessation. *The Cochrane database of systematic reviews*, *7*(7), CD004307. https://doi.org/10.1002/14651858.CD004307.pub6

[5] Percentage of current cigarette smoking for adults aged 18 and over, United States, 2023. National Health Interview Survey.," National Center for Health Statistics, 2023. [Online]. Available: Generated interactively: Apr 08 2025 from https://www.cdc.gov/NHISDataQueryTool/SHS_adult/index.html

[6] Trilogy Federal, LLC and Westat, Inc., "2024 Survey of Veteran Enrollees' Health and Use of Health Care." Jan. 2024. Accessed: Dec. 20, 2025. [Online]. Available: https://www.va.gov/VHASTRATEGY/SOE2024/SOE24.pdf

obstructive pulmonary disease (COPD), and lung cancer. Approximately 16 million Americans have a smoking-related disease, and about one in 5 deaths each year (480,000) are smoking-related.[7]

The cost of caring for preventable smoking-related diseases places a significant economic burden on the U.S. health care system. In 2014, the United States spent more than $225 billion on health care for conditions attributable to smoking.[8] The Veterans Health Administration (VHA) spent an estimated $2.7 billion on smoking-related care in 2010. This equates to approximately $3.8 billion when adjusted to 2024 dollars.[9] Enrolled Veterans, unless they choose to disenroll, remain eligible for VA health coverage throughout their lives, meaning VA risks incurring longitudinal costs unlike private payers whose members routinely switch coverage.

There are proven treatments to help people quit smoking. Per VHA Directive 1056, National Smoking and Tobacco Use Cessation Program (dated September 5, 2019) tobacco use treatment must be made available as part of routine care to all Veterans who are attempting to quit. VA delivers evidence-based tobacco use screening and cessation services in accordance with The United States Preventive Services Task Force (USPSTF) Recommendation for Tobacco Smoking Cessation in Adults, Including Pregnant Persons and U.S. Public Health Service (USPHS) Clinical Practice Guidelines for Treating Tobacco Use and Dependence.[10,11] This includes asking all Veterans about their tobacco use at least annually, advising them to stop using tobacco, and providing behavioral interventions and Food and Drug Administration (FDA) approved pharmacotherapy for cessation. Current FDA-approved pharmacotherapies for the treatment of tobacco smoking include nicotine replacement therapies (NRT), bupropion hydrochloride sustained release (SR), and varenicline[12]. In most situations, it is clinically appropriate to encourage Veterans to combine behavioral and pharmacotherapy interventions as evidence suggests using these treatments together can more than double rates of quitting.[13] Veterans may access tobacco cessation services

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[7] Centers for Disease Control and Prevention. (2023). *CDC - Fact Sheet - Current Cigarette Smoking Among Adults in The United States - Smoking & Tobacco Use*. Smoking and Tobacco Use; CDC. https://www.cdc.gov/tobacco/php/data-statistics/adult-data-cigarettes.

[8] Xu, X., Shrestha, S. S., Trivers, K. F., Neff, L. J., Armour, B. S., & King, B. A. (2021). U.S. healthcare spending attributable to cigarette smoking in 2014. Preventive Medicine, 150, 106529. https://doi.org/10.1016/j.ypmed.2021.106529

[9] Barnett PG, Hamlett-Berry K, Sung H y., Max W. Health care expenditures attributable to smoking in military veterans. Nicotine & Tobacco Research. 2014;17(5):586-591. doi:10.1093/ntr/ntu187.

[10] *Treating Tobacco Use and Dependence | Agency for Healthcare Research & Quality*. (2013). Ahrq.gov. https://www.ahrq.gov/prevention/guidelines/tobacco/clinicians/update/index.html

[11] *Recommendation: Tobacco Smoking Cessation in Adults, Including Pregnant Women: Behavioral and Pharmacotherapy Interventions | United States Preventive Services Taskforce*. (2021) www.uspreventiveservicestaskforce.org. https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/tobacco-use-in-adults-and-pregnant-women-counseling-and-interventions#fullrecommendationstart

[12] Office of the Commissioner. (2022, July 21). *Want to quit smoking? FDA-Approved and FDA-Cleared cessation products can help. U*.S. Food And Drug Administration. https://www.fda.gov/consumers/consumer-updates/want-quit-smoking-fda-approved-and-fda-cleared-cessation-products-can-help

[13] *Clinical interventions to treat tobacco use and dependence among adult*. (2022, July 28). Centers for Disease Control and Prevention. https://www.cdc.gov/tobacco/hcp/patient-care-settings/clinical.html.

through their primary care provider, mental health provider, or through tobacco cessation specialty programs.

Despite the availability of effective evidence-based tobacco cessation services, quitting remains a significant challenge for many Veterans. In the 2023 Survey of Veteran Enrollees' Health and Use of Health Care, 48% of Veterans who indicated current smoking reported a recent unsuccessful quit attempt. Of those who attempted to quit, only 35% used non-nicotine prescription medications or NRTs.

Coupling financial incentives with evidence-based tobacco cessation services is likely to increase initial and ongoing engagement with treatment, ultimately leading to greater rates of abstinence. A 2009 update of VA/Department of Defense Clinical Practice Guideline for the Management of SUDs concluded that CM was an effective treatment for stimulant use disorder; however, less than 1% of Veterans with SUDs had received it at the time. [14,15,16] As a result, VA initiated multiple pilot programs using FI to incentivize abstinence from stimulants and cannabis, as well as adherence to inject, table medications for opioid and alcohol use disorders. Since inception of these programs in June 2011, 6,146 Veterans across 119 VA facilities have received FI in a 12-week program to reinforce abstinence from stimulants or cannabis. Results showed 92.6% of 79,954 urine samples obtained have tested negative for the target substance.[17]

Successfully engaging Veterans in relatively short-term tobacco cessation services can lead to significant improvements in health. Individuals who quit smoking for six months are significantly more likely to remain abstinent compared to those who quit for less than six months. One study found that those who reported smoking abstinence for more than 6 months had 87% lower odds of relapse.[18] The American Cancer Society states individuals who quit smoking have improved circulation and lung function within two to three weeks and decreased coughing and shortness of breath within one to 12 months. One to two years after quitting, the risk of heart attack drops dramatically and risk of cancers of the mouth, throat, and larynx decrease by 50% after five to ten years. Ten years after quitting, the risks for other cancers, including lung, bladder, esophagus, and kidney, decrease, and by 15 years, risk for coronary artery disease is comparable to that of an

[14] VA/DoD (2026) Clinical Practice Guidelines for Tobacco Use Treatment. https://www.healthquality.va.gov/HEALTHQUALITY/guidelines/CD/tobacco/Tobacco-Cessation-CPG_2026-Guideline_final_20260109.pdf

[15] VA/DoD (2009) Clinical Practice Guidelines for the Management of Substance Use Disorders.

[16] Watkins, K.E., Pincus, H.A., Smith, B., Paddock, S.M., Mannle Jr., T.E., Woodroffe, A., Solomon, J., Sorbero, M.E., Farmer, C.M., Hepner, K.A., Adamson, D.M., Forrest, L., Call, C., 2011. Veterans Health Administration Mental Health Program Evaluation: Capstone Report. R Corporation, Santa Monica, Calif. TR-956-VHA. Retrieved April 19, 2023, from https://www.mentalhealth.va.gov/docs/capstone_revised_TR956_compiled.pdf

[17] DePhilippis, D., Khazanov, G., Christofferson, D. E., Wesley, C. W., Burden, J. L., Liberto, J., & McKay, J. R. (2023). History and current status of contingency management programs in the Department of Veterans Affairs. *Preventive medicine*, *176*, 107704. https://doi.org/10.1016/j.ypmed.2023.107704

[18] Alboksmaty, A., Agaku, I. T., Odani, S., & Filippidis, F. T. (2019). Prevalence and determinants of cigarette smoking relapse among US adult smokers: a longitudinal study. *BMJ open*, *9*(11), e031676. https://doi.org/10.1136/bmjopen-2019-031676

individual who has never smoked.[19] As risk for developing these smoking-related conditions decreases, so too does health-care spending associated with treatment.

FITC would be the initial demonstration model developed and tested under the V-HIP pilot program. In the future, additional demonstration models using FI to support behavior change other than tobacco cessation may be tested depending in-part on the success of FITC and emerging evidence for use of FI in other areas (e.g., preventative care and distinct, short-term behavioral goals). The subsequent sections provide details on planned design and implementation of FITC.

2.0 Objectives

Program Goals/Objectives:

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    b. To improve long-term Veteran health outcomes, including cardiovascular and respiratory health, and reduce suicide risk associated with tobacco use.
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Evaluation Objectives:

1. To assess abstinence from combustible tobacco across intervention groups (enhanced usual care vs enhanced usual care + FI).
2. To determine the impact of enhanced care + FI on secondary cessation outcomes and quality of life.
3. To model the intermediate and long-term effects of smoking cessation on clinical outcomes (e.g., cardiovascular health, respiratory health, and suicide risk).
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1. To assess the maintenance and feasibility of adding FI to VA care.
2. To assess patient experiences with the financial incentive tobacco cessation program.
3. To assess provider and staff (including program/clinical managers) experiences and attitudes with the financial incentive tobacco cessation program.

[19] *Health Benefits of Quitting Smoking Over Time*. (2020). www.cancer.org. https://www.cancer.org/cancer/risk-prevention/tobacco/benefits-of-quitting-smoking-over-time.html

Program Outcome Measures:

Evaluation Outcomes:

1. *Primary*:
    a. 7-day, CO-verified abstinence at 6-month follow-up.
2. *Secondary*:
    a. 7-day, CO-verified abstinence at 12-month follow-up.
    b. 6-month prolonged abstinence at 6- and 12-month follow-up (self-report).
    c. Quality of life (EQ-5D).
    d. Cost-effectiveness (ICER).
3. *Exploratory*:
    a. Pre-specified subgroup analyses (sex, rurality, age, comorbid mental health, income, use of non-VA care, priority group, etc.).
    b. Intervention fidelity and maintenance.

Implementation Outcomes:

1. Reach, adoption, fidelity of the interventions.
2. Barriers and facilitators to implementation of FI into VA care delivery for smoking cessation (qualitative interviews).

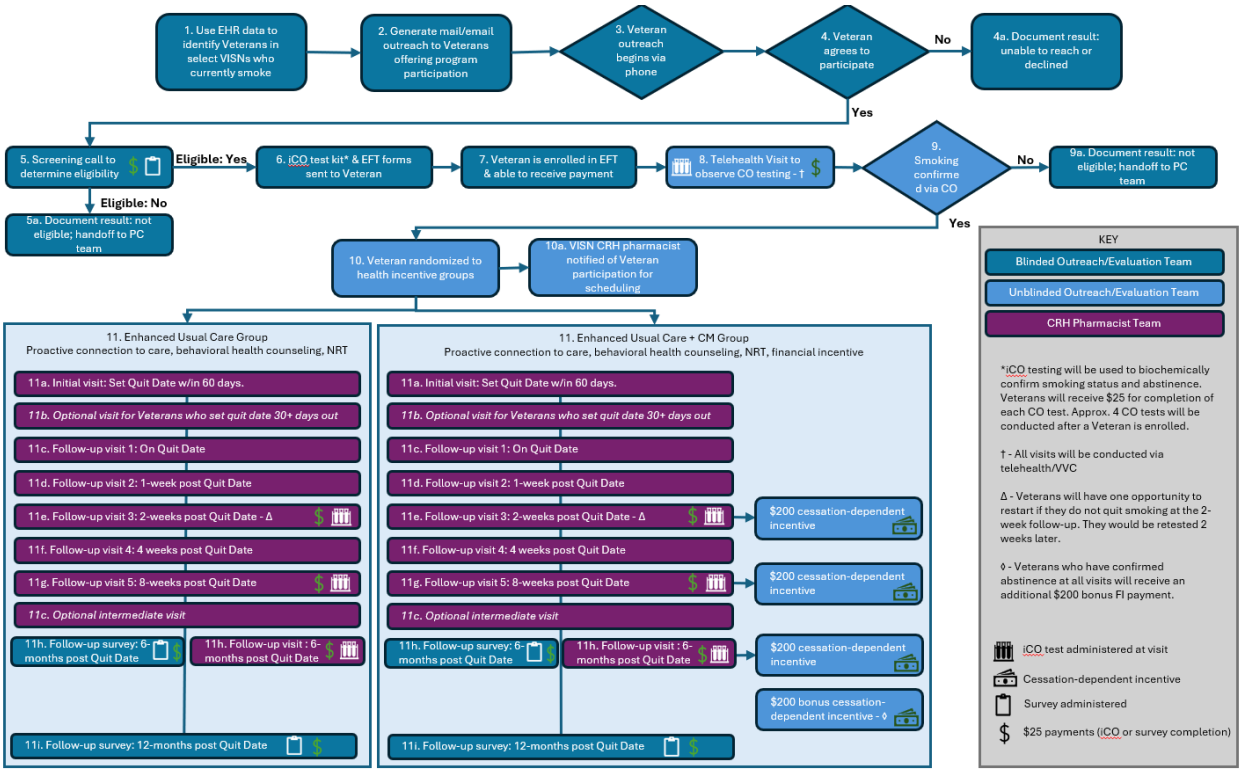
Hypothesis:

Tobacco cessation rates will be higher in the enhanced usual care + FI group than the enhanced usual care group.

3.0 Project Procedures

3.1 Project Design

This project will use a pragmatic, patient-level randomized design with treatment delivered by VISN Clinical Resource Hubs (CRHs). Below is a logic model outlining study procedures, which are described in greater detail herein. Enrollment is expected to take 42 months to complete, with 12 months of follow-up to continue after enrollment target has been reached.



3.2 Population of Interest

This project will enroll 1,400 Veterans enrolled in VA health care who smoke cigarettes and are willing to set a quit date within 2-60 days of enrollment. Veterans will be recruited through VISN CRHs using population-based sampling. VHA EHR Health Factor data (via PERC dashboard infrastructure) will be used to identify individuals who currently smoke within the selected VISNs. Health Factors data are collected nationally using a clinical reminder process, and the tobacco use clinical reminder is primarily implemented in VHA outpatient settings (primary care, mental health, and other specialty clinics). These data are transmitted nightly to a national VHA Corporate Data Warehouse (CDW). We will utilize Health Factor data from the CDW to classify Veteran patients as current tobacco users and the associated outpatient visit data records will inform us as to which VHA facility the patient was assessed for tobacco use. Finally, data from the CDW patient data domain will provide us the patient's sex and contact information. The Health Factors tables will be used to generate a random list of Veteran men and women identified as current tobacco users, during a VHA clinical care visit, in the past month. We will oversample women to achieve a minimum 30% women in the final sample. The team will be mindful of urban vs. rural recruitment, but will not initially oversample based on rurality.

3.3 Inclusion/Exclusion Criteria

Inclusion:

- Age ≥18.
- Enrolled in VA health care.
- Assigned to a primary care provider in a participating VISN (currently 4, 12, 17, 20).
- Has a valid mailing and/or email address on file.
- Currently smokes cigarettes:
    - Reported as a current tobacco user per clinical data in the EHR.
    - Self-reported having smoked ≥5 cigarettes per day at the time of recruitment call.
    - CO pre-enrollment verification of smoking status (≥8 PPM).
- Willing to set a quit date within 2–60 days of first pharmacist visit.
- Device/internet capable (assessed via digital divide consult if needed).
- Able to receive payment via direct deposit and enrolled in EFT prior to randomization.

Exclusion:

- Enrolled in hospice care or diagnosed with a condition where there is less than 12-months of expected survival.
- Diagnosis of cognitive impairment.
- No phone contact on file.
- Unwilling or unable to participate in telemedicine visits.

3.4 Intervention Groups

Enhanced Usual Care Group (700 Veterans):

- Participants will receive CRH counseling, pharmacotherapy as recommended by pharmacist, and periodic iCO testing to determine smoking cessation status.
- Participants will be asked to complete baseline, 6-month, and 12-month surveys to collect data not otherwise specified in the EHR.
- Participants will receive $25 for each iCO test and $25 for each survey completed.

Enhanced Usual Care + FI Group (700 Veterans):

- Participants will receive CRH counseling, pharmacotherapy as recommended by pharmacist, and periodic iCO testing to determine smoking cessation status.
- Participants will be asked to complete baseline, 6-month, and 12-month surveys to collect data not otherwise specified in the EHR.

- Participants will receive $25 for each iCO test and $25 for each survey completed.
- Participants will receive up to $800 for quitting and remaining quit. Assessment time points will be 2-weeks, 8-weeks, and 6-months post quit date. Each iCO test result that indicates sustained smoking cessation (<6 PPM) will result in a $200 FI payment (up to $600 total). If participants quit at 2-weeks and remain quit at 8-weeks and 6-months post quit date, they will receive an additional $200 bonus FI payment.

Administrative Usual Care Group (Observational) Group:

- An observation-only group will be used during the evaluation stage of the project. Data will be obtained from the CDW; no contact with patients will be required.

3.5 Schedule of Activities

Recruitment/Screening:

Documentation of this step will take place within a CCDOR Tracking Application.

Identification: [INSERT INFO ON DASHBOARD AND IDENTIFICATION PROCEDURES].

Mailed outreach: Participants who meet initial inclusion criteria will be sent a letter detailing the project along with an opt-out postcard to return if they are not interested in being contacted. Interested participants will be able to call the project-specific line to be screened for eligibility.

Emailed outreach: Participants who meet initial inclusion criteria will be sent an email via Qualtrics detailing the project. Interested participants will be able to complete an online screener via Qualtrics or call the project-specific line to be screened for eligibility.

Phone outreach: Participants who have not returned an opt-out postcard or completed the online screener will be contacted via phone by project staff members. Staff will follow a 3-call protocol (voicemail, no voicemail, voicemail) before considering a participant as not interested and removing them from the list as unable to be contacted. Potential participants who are able to be reached via phone will be screened to determine eligibility (see Inclusion/Exclusion Criteria above).

Program Enrollment:

Documentation of this step will take place within a CCDOR Tracking Application.

Potential participants who meet eligibility criteria will be sent an iCO breath test kit, a form to enroll in VA's Electronic Funds Transfer (EFT) program, and a baseline survey.

Participants will also be scheduled for a VVC telehealth visit 2-weeks post-enrollment. This initial visit will be conducted by project staff on the implementation team and will be used to: 1) assist Veterans in setting up their iCO breath tests for the remainder of their participation in the program, 2) confirm smoking status via iCO breath test, 3) confirm EFT enrollment to ensure swift payment processing times, and 4) be randomized into one of the two intervention groups (see Study Groups above). If randomized to the FI group, it will be discussed at the time of randomization.

Randomization:

Documentation of this step will take place within a CCDOR Tracking Application.

Veterans will be randomized in a 1:1 ratio into one of two intervention groups: Enhanced Usual Care or Enhanced Usual Care + FI. To ensure unbiased data collection, allocation to intervention group will occur following completion of the baseline surveys. We will use a blocked randomization scheme, stratified by CRH pharmacist and participant sex, using randomly permuted blocks of size 2, 4, and 8 generated by the project statistician, in a sequential manner unknown to project staff or the participants prior to randomization. Outcomes assessment and processing will be conducted by project staff blinded to intervention assignment. If participants are randomized to Enhanced Usual Care + FI, this will be discussed at the time of randomization. Participants will also receive information on their specific program via mail. Participants who are randomized to the Enhanced Usual Care + FI group will additionally be sent an agreement/understanding form about the incentive provision, which will also be discussed at the time of randomization.

CRH Pharmacist Visits:

Documentation of this step will take place within a project-specific PERC Dashboard.

After randomization, the project staff team will then notify the proper CRH Pharmacist Lead of participant enrollment. Leads will then schedule (or facilitate scheduling) their initial visit with participants. Participants in both intervention groups will receive congruent VVC visits with a CRH pharmacist based on VISN.

Pharmacists will have insight into which intervention each participant is receiving (enhanced usual care vs. enhanced usual care + FI) and will be trained on how to discuss the FI aspects of the project, including failures. Participants who are not in the FI group will not be made aware that there is a FI group.

Visits will follow this schedule:

Initial visit: This visit will be used to establish care with the pharmacist team. Pharmacists will reiterate the project overview, discuss treatment options, order medications, and address any patient concerns that

currently exist. It will also be used to set the patient's quit date within 60 days. No iCO test will be administered.

Optional intermediate visit: For participants who set a quit date >30 days from their initial visit, they will have the option to request an intermediate visit to reconvene prior to quit date. No iCO test will be administered.

Quit date visit: Pharmacists will meet with participants on their designated quit date to see how treatment is working, make adjustments as needed, and reinforce quit date. They will also provide behavioral counseling to assist patients in staying quit. No iCO test will be administered.

1-week post quit date: Pharmacists will meet with participants to see how treatment is working, make adjustments as needed, and reinforce quit date. They will also provide behavioral counseling to assist patients in staying quit. No iCO test will be administered.

2-weeks post quit date: Participants will be asked to complete an iCO breath test at the start of this visit to determine smoking cessation status and will later be given $25 for completing the blow. Pharmacists will check-in on how treatments are working and make adjustments as needed. They will also provide behavioral counseling to assist patients in staying quit (or to encourage quitting if a participant's iCO test is not indicative of cessation).

For participants in the FI group: If a participant's iCO test indicates they have quit smoking (<6 PPM), they will receive a $200 FI in addition to the $25 blow payment. Pharmacists will discuss iCO results, consequences (receiving FI vs. not receiving FI), and next steps (option to still receive FI if quit at future visits).

4-weeks post quit date: Pharmacists will check-in on how treatments are working and make adjustments as needed. They will also provide behavioral counseling to assist patients in staying quit. No iCO test will be administered.

8-weeks post quit date: Participants will be asked to complete an iCO breath test at the start of this visit to determine smoking cessation status and will later be given $25 for completing the blow. Pharmacists will check-in on how treatments are working and make adjustments as needed. They will also provide behavioral counseling to assist patients in staying quit (or to encourage quitting if a participant's iCO test is not indicative of cessation).

For participants in the FI group: If a participant's iCO test indicates they have quit smoking (<6 PPM), they will receive a $200 FI in addition to the $25 iCO blow payment. Pharmacists will discuss iCO results, consequences (receiving FI vs. not receiving FI), and next steps (option to still receive FI if quit at future visits).

Optional intermediate visit: Participants may request an intermediate visit between their 8-week and 6-month visits to check-in with their pharmacist(s). This visit is optional and will not impact eligibility for bonus FI.

6-months post quit date: Participants will be asked to complete an iCO breath test at the start of this visit to determine smoking cessation status and will later be given $25 for completing the blow. Pharmacists will check-in on how treatments are working and make adjustments as needed. They will also provide behavioral counseling to assist patients in staying quit (or to encourage quitting if a participant's iCO test is not indicative of cessation).

For participants in the FI group: If a participant's iCO test indicates they have quit smoking (<6 PPM), they will receive a $200 FI in addition to the $25 iCO blow payment. Pharmacists will discuss iCO results, consequences (receiving FI vs. not receiving FI), and potential bonus FI if participant has remained quit from 2-week visit onward and has not missed any of their pharmacist visits.

Follow-up Evaluation Contacts:

Documentation of this step will take place within a CCDOR Tracking Application.

6-months post quit date: At 6-months post initial quit date, all participants (regardless of program completion; unless participant states they do not want to be contacted further) will be sent a follow-up survey via mail or Qualtrics depending on each participant's preference. iCO breath test results will be obtained from the 6-month pharmacist visit if available. If a participant did not attend their 6-month post quit date pharmacist visit and they indicate they have remained smoke-free in their survey (based on 7-day point prevalence), they will be asked to schedule a VVC visit with a member of the evaluation team to conduct an iCO breath test to validate smoking cessation status. If a participant completes this iCO test, they will receive $25 for the blow, but they will not receive any FI (if in the enhanced usual care + FI group) because of the missed appointment.

12-months post quit date: At 12-months post quit date, all participants (regardless of program completion) will be sent a follow-up survey. If they indicate they have remained smoke-free (based on 7-day prevalence), participants will be asked to schedule a VVC visit with a member of the evaluation team to conduct an iCO breath test to validate smoking cessation status. If a participant completes this iCO test, they will receive $25 for the blow.

Failure handling:

Failed first iCO test (initial 2-week visit)

For purposes of this project, successful smoking cessation is any iCO reading below 6 PPM. Veterans will have one opportunity to restart the program if they do not quit smoking at the 2-week follow-up visit. Failure date would become their new quit date for future appointment and follow-up purposes. They would be retested 2-weeks later (this would become their new 2-week visit post quit date).

Failed iCO tests (adjusted 2-week, 8-week, 6-month visits)

If a participant fails future iCO tests (≥6 PPM), they will be given the opportunity to continue participating in the program and receive future FI payments (if in the FI group). If participants choose not to continue their quit attempt, the pharmacist team will initiate a handoff to the patient's PCP/PACT Pharmacist/BHIP team to ensure their primary care team is aware of their quit attempt and can continue to provide support if necessary.

For participants in the FI group: If a participant's iCO test indicates they have not quit smoking (≥6 PPM), they will not receive a $200 FI for that visit. However, they will still be eligible for future FI payments. One failed iCO test would disqualify a participant from receiving the $200 bonus FI at the end of the program.

Missed appointments

Participants will be allowed 1 missed appointment throughout their participation in the program without impact to FI payments. If a participant misses ≥2 appointments, they will be offered the opportunity to continue in the program, but will not be eligible for the FI bonus payment at the end of the program. They would still receive any of the standard $200 FI payments and $25 for any iCO tests administered. If participants choose not to continue their quit attempt (or are unable to be contacted after ≥2 missed appointments), the pharmacist team will initiate a handoff to the patient's PCP/PACT Pharmacist/BHIP team to ensure their primary care team is aware of their quit attempt and can continue to provide support if necessary.

Initial ineligibility

Participants who are not eligible for the study will receive information on VA's QuitVET resource to assist them in quitting smoking. The team will also initiate a handoff to the patient's PCP/PACT Pharmacist/BHIP team to ensure their primary care team is aware of their interest in starting a quit attempt and can continue to provide support if necessary.

3.6 Payment Information

Participants will receive payments at the following intervals:

	$25 survey payment	$25 iCO test payment	$200 FI payment (FI Group only)	$200 bonus FI payment (FI group only)
Enrollment	**X**	**X**		
2-weeks post quit date		**X**	**X**	

8-weeks post quit date		**X**	**X**	
6-months post quit date	**X**	**X**	**X**	**X**
12-months post quit date	**X**	**X**		

Participants will be paid primarily using the VA's electronic funds transfer (EFT) process. It will be an enrollment requirement for participants to return an EFT enrollment form and be successfully paid for their initial iCO breath test to confirm smoking status. Gift cards will be used as a secondary method of payment for Veterans who are unable to maintain EFT set up.

3.7 Estimated Project Timelines

Fiscal Years	**FY 2026**				**FY 2027**				**FY 2028**				**FY 2029**				**FY 2030**				**FY 31**	
Project Years	**Y1**				**Y2**				**Y3**				**Y4**				**Y5**					
Project Quarters	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**		
Calendar Months	**Jan – Mar 2026**	**Apr – May 2026**	**Jun – Sept 2026**	**Oct – Dec 2026**	**Jan – Mar 2027**	**Apr – May 2027**	**Jun – Sept 2027**	**Oct – Dec 2027**	**Jan – Mar 2028**	**Apr – May 2028**	**Jun – Sept 2028**	**Oct – Dec 2028**	**Jan – Mar 2029**	**Apr – May 2029**	**Jun – Sept 2029**	**Oct – Dec 2029**	**Jan – Mar 2030**	**Apr – May 2030**	**Jun – Sept 2030**	**Oct – Dec 2030**		
Planning Activities																						
Develop Evaluation Framework & Metrics	X																					
Create Data Collection Instruments	X	X																				
IRB Non-Research Determination	X	X																				
Recruit & Train Team	X	X	X																			
Set-up Data Management Systems/Dashboards		X	X																			
Supply Procurement		X	X			X				X				X								
Data Collection																						
Pilot to test procedures (~30 participants)			X	X	X	X																
Participant Recruitment, Baseline Data Collection, & Randomization				X	X	X	X	X	X	X	X	X	X	X	X							
Intervention Delivery				X	X	X	X	X	X	X	X	X	X	X	X	X	X					
CO Testing & Incentive Tracking				X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X			
Follow-Up Surveys						X	X	X	X	X	X	X	X	X	X	X	X	X	X			
Qualitative Interviews								X	X	X	X	X	X	X	X	X	X	X	X			
Implementation Process Monitoring				X	X	X	X	X	X	X	X	X	X	X	X	X	X					
Data Quality Checks & Cleaning				X		X		X		X		X		X		X		X				
Reporting																						
Congressionally Mandated Reports (1								X				X				X				X		

year after program start)																					
Congressionally Mandated Final Report (90 days after program completion)																					X
Implementation Evaluation							X	X	X	X	X	X	X	X	X	X	X	X	X	X	
Data Analysis												X	X	X	X	X	X	X	X	X	
Prepare Final Evaluation Report																	X	X	X	X	
Dissemination Activities													X	X	X	X	X	X	X	X	

4.0 Study Evaluations

4.1 Evaluation Goals

1. To assess abstinence from combustible tobacco across intervention groups (enhanced usual care vs enhanced usual care + FI).
2. To determine the impact of enhanced care + FI on secondary cessation outcomes and quality of life.
3. To model the intermediate and long-term effects of smoking cessation on clinical outcomes (e.g., cardiovascular health, respiratory health, and suicide risk).
4. To assess the cost effectiveness of FI on tobacco abstinence and quality of life.

4.2 Evaluation and Implementation Metrics

The team will use a sequential explanatory mixed-methods approach to understand the process of implementing the interventions and to gather multi-shareholder (patients, providers, project managers, etc.) perspectives on implementation barriers.[20,21] Results will be used to identify and explain variation in intervention implementation and effectiveness and to develop a data-driven plan for future implementation and dissemination of FI use for tobacco cessation within VA.

The primary quantitative process outcomes will be intervention reach, adoption, and fidelity. Reach is defined as the extent to which an intervention reaches the target population (e.g., percent of smokers who are reached and eligible for enrollment in the intervention). Adoption is defined as the proportion and representativeness of settings and intervention agents that initiate the program.

[20] Curran GM, Bauer M, Mittman B, Pyne JM, Stetler C. Effectiveness-implementation hybrid designs: combining elements of clinical effectiveness and implementation research to enhance public health impact. *Med Care.* 2012;50(3):217-226.
[21] Hagedorn HJ, Stetler CB, Bangerter A, Noorbaloochi S, Stitzer ML, Kivlahan D. An implementation-focused process evaluation of an incentive intervention effectiveness trial in substance use disorders clinics at two Veterans Health Administration medical centers. *Addiction science & clinical practice.* 2014;9(1):12-12.

Fidelity is defined as the extent to which the intervention is delivered as intended. We will also evaluate the intervention's potential maintenance and sustainability.

Conceptual framework. Methods will be guided by the Practical Robust Implementation and Sustainability Model (PRISM).[22] PRISM expands the Reach, Effectiveness, Adoption, Implementation, Maintenance (RE-AIM)[23] outcomes framework to incorporate multi-level contextual outcome determinants, including stakeholder perspectives on the intervention, stakeholder characteristics, and the external environment and infrastructure for implementation and sustainability.

DOMAIN	DESCRIPTION	METRIC/MEASURE
Reach	Proportion of Veterans offered participation and proportion engaged	-Refusal/ineligibility rate -Representativeness of the population (sex, age, rurality, comorbid MH, income, use of non-VA care, priority group, etc) -Treatment initiation -QuitLine referrals
Effectiveness	Impact on smoking cessation and health outcomes Treatment utilization	-Cessation/quit rates -Cost effectiveness (QALY/ cost per quit) -Health factor data -Patient experience outcomes -Combined tobacco treatment (meds + visits) -Adequate treatment dose (≥4 visits)
Adoption	Organizational uptake and willingness to adopt the intervention	-Sites/providers implementing the program -Barriers/facilitators
Implementation	Consistency, quality, and feasibility of delivery. Acceptability of program treatments	-Fidelity to protocol (appropriate medications delivered, number and timing of visits, reliable iCO collection/documentation, payments delivered) -Reasons for exclusion (lack of device, low iCO, etc.) -Reasons for drop-out -Patient/provider experience
Maintenance	Long-term sustainability at VISN and site level	-Continued program delivery -Funding availability -Cost per user

[22] Feldstein AC, Glasgow RE. A practical, robust implementation and sustainability model (PRISM) for integrating research findings into practice. *Jt Comm J Qual Patient Saf.* 2008;34(4):228-243.

[23] Glasgow RE, Vogt TM, Boles SM. Evaluating the public health impact of health promotion interventions: the RE-AIM framework. *Am J Public Health.* 1999;89(9):1322-1327.

		-Implementation at smaller VAs w/o existing infrastructure

Recruitment records and intervention process data. We will keep detailed recruitment records through the electronic recruitment tracking database. This data will be used to characterize the reach of the intervention, including the percent of smokers in our recruitment pool who are reached for an enrollment offer, the percent of reached smokers who are eligible for the intervention based on screening, and reasons for ineligibility. We will use recruitment records to calculate intervention adoption, defined as the percent of Veterans who enroll. We will track reasons for enrollment refusal. We will use intervention process data from the clinical-facing dashboard as a way to measure intervention fidelity.

Veteran surveys. The surveys completed by Veterans will be used to capture patient characteristics that we will analyze as potential moderators of our quantitative implementation outcomes.

4.5 Qualitative Interviews (Patient/Provider Experience)

At the end of the project, we will conduct semi-structured interviews to gain a richer understanding of the mechanisms underlying the quantitative results. We will conduct interviews with 4 groups of shareholders.

Shareholder groups:

1. Veterans in the enhanced usual care only group
2. Veterans in the enhanced usual care + FI group
3. Providers involved in the intervention
4. Operational project leads/managers/staff involved in project oversight.

To understand Veteran perspectives, we will conduct interviews with 12-16 Veterans who were randomized to each of the intervention groups. We will include Veterans who did and did not complete the full treatment program to help identify barriers and facilitators of the intervention. For these Veteran interviews, we will sample an equal number of women and men, so that we can explore the unique experiences and potential differences in intervention outcomes of women Veterans compared to male Veterans. We will include a diverse sample of Veterans based on age, race/ethnicity, and era of military service.

We will conduct interviews with 12-16 providers involved in delivering the intervention to understand their perspectives on potential barriers and facilitators toward implementing and maintaining the intervention in the future.

We will interview operational project managers to ensure program delivery and outcomes have met operational needs and discuss areas for improvement. We will also interview project staff to understand their perspectives with the project's processes (e.g., recruitment and FI delivery).

Interview procedures. Interviews will be conducted by phone or TEAMS audio, be audio recorded, and last 30-60 minutes. A trained interviewer will follow an interview guide with a set of pre-specified questions and follow-up probes.

Veteran interviews will cover:

1. Perspectives about the intervention, such as its perceived effectiveness, appropriateness, and feasibility
2. Challenges and successes in engaging in/delivering the intervention among Veterans
3. Recommendations for future intervention adaptations and/or implementation.

VA staff interviews will cover:

1. Organizational perspectives about the intervention, such as its perceived effectiveness, appropriateness, feasibility, and costs
2. Organizational characteristics that may facilitate or impede intervention implementation, including the implementation climate, culture, norms, VA policies, potential intervention infrastructure (e.g., staff availability, workflow compatibility)
3. Perceived feasibility, fit, and relative advantage (or disadvantage) of implementing the intervention
4. Potential maintenance/sustainability of the intervention.

Interview Compensation: Veterans will each receive a $50 payment for completing an interview. VA clinical staff will not receive payment.

4.4 Sample Size and Power

Sample size calculations are based on the power needed for the primary outcome – CO-verified 7-day smoking abstinence assessed at 6-month follow-up. An initial sample size of 700 participants per condition (N=1400) will provide at least 80% power to detect a 6% increase in abstinence in the Enhanced Usual Care + FI group across a range of plausible abstinence rates in Enhanced Usual Care only group (5-15%) (aim 1). This assumes a .05 significance level and a 75% participant retention/biochemical verification response rate.

4.5 Data Analysis

Primary and secondary analyses

For the dichotomous outcomes, including biochemically verified smoking abstinence at 6-months, simple proportions will be computed for each intervention group including 95% confidence intervals. We will use separate logistic regressions to model the log odds of these outcomes as a function of intervention group. Likelihood ratio tests, using .05 significance levels, will be implemented to test whether Enhanced Usual Care + FI, vs Enhanced Usual Care only, increases rates of abstinence.

Generalized linear models will be used in the analysis of continuous and non-binary outcomes (e.g. EQ-5D subscales). These models will be fit with appropriate distribution and link functions to match the form of the data. Likelihood ratio tests will be used to assess the incremental effect of Enhanced Usual Care + FI with model-based estimates of effect magnitude with corresponding confidence intervals.

In addition to the main outcomes analyses above, we will use longitudinal modelling to examine the effect of the intervention across time points (6- and 12-month assessments). We will fit mixed effects logistic regressions to model the dichotomous intervention outcomes with random effects for the intercept and time (varying across individuals) and fixed effects for intervention and intervention by time (overall effect). A similar mixed model approach will be used in the analysis of the continuous and non-binary secondary outcomes. Likelihood ratio tests and model-based effect estimates, with corresponding confidence intervals, will be used to assess intervention effects.

Analyses will use an intent-to-treat approach. Randomization is expected to balance the distribution of participant characteristics between intervention groups. If balance is not achieved, unbalanced covariates will be included in adjusted regressions analyses. To assess the potential impact of missing outcome data on the analyses discussed above, we will implement a series of analyses employing methods for data missing at random and data not missing at random.

Exploratory subgroup analyses

We will examine variation in the treatment effects within pre-specified subgrouping factors of sex (male vs female) and rurality (rural/highly rural vs urban). Separately within each subgroup, we will use similar regression modelling procedures described above to test the effect of Enhanced Usual Care + FI vs Enhanced Usual Care only on the primary and secondary outcomes.

4.6 Cost Effectiveness Analysis

The team will work with a health economist to assess short- and long-term cost effectiveness of implementing FI for smoking cessation within VA.

Short-term Questions (assessed 12 months after quit date; pilot data):

1. What is the cost-effectiveness of financial incentives on smoking abstinence?

   This analysis will use the difference in 7-day CO-verified abstinence at 6-month follow-up as the primary effectiveness measure. Measures of effectiveness and costs will be aggregated, and incremental cost-effectiveness ratios (ICERs) will be constructed for (1) the enhanced Usual Care (UC) and (2) the enhanced Usual Care + Financial Incentive (UC + FI) groups. The ICER will determine the effectiveness of UC + FI program and take the form: (C(UC + FI) – C(UC)) / (O(UC + FI) – O(UC)) where C(UC + FI) – C(UC) is the expected difference in the costs (C) between UC + FI and UC and O(UC + FI) – O(UC) is the expected difference in the outcome of interest (O), namely the numbers of individuals achieving 7-day CO-verified abstinence at the 6-month follow-up. This ratio represents the cost for which an added unit of the outcome can be "purchased" by replacing UC with UC + FI (i.e. cost-per-quit).

   We will use bootstrap methods to estimate standard errors and confidence intervals for this analysis. This approach provides a nonparametric means of incorporating the correlation of costs and outcomes into standard errors. Sources of uncertainty in the specification of components of the cost measures will be addressed by employing probabilistic sensitivity analyses, where the distributions of the variables representing the analytical assumptions are allowed to vary simultaneously, thus testing the robustness of the findings[24]. Using this approach, ICER point estimates will be derived using a random sample of 10000 sets of parameters from their estimated probability distribution. This analysis will be repeated to consider the effects of different types of response biases. We will similarly use probabilistic modelling to extend the findings from the V-HIP cohort to the larger target population of VHA patients who are currently smoking. In these analyses, the total costs of the programs will not change but the effectiveness measures will change under the different modelled scenarios.

Long-term Questions (assessed >2-5 years after quit date; modeling):

1. What is the effect of financial incentives on patient quality of life over the lifespan?

   The long-term effects of UC + FI vs UC on patient Quality of Life (QoL) will be compared using a state transition model, which will represent the progression of the V-HIP participants over their lifespan. This model will be used to project the effect of 7-day CO-verified abstinence at the 6-month follow-up on future smoking status and the associated changes in QoL. This analysis will then project the quality-adjusted life years (QALYs) that

[24] Gold MR, Siegel JE, Russell LB, Weinstein MC. Cost-effectiveness in Heath and Medical Care. New York: Oxford University Press; 1997.

would be realized within the UC + FI and UC cohorts over a life-time horizon. QALYs are an important, patient-focused outcome that policymakers may consider when making decisions about whether specific intervention is worth the cost.

This analysis will employ a state transition model which was used in previously published cost-effectiveness analyses of currently smoking patients from psychiatric cohort and among smokers enrolled in publicly funded health insurance plans for low-income people[25,26]. The model will be modified to incorporate parameters from our study, including: participant age, gender, costs of smoking cessation services and financial incentives, as well as smoking status and quality of life (EQ-5D) at the 6-month follow-up assessment. Population parameters to be used in this model will reflect the general VHA patient population. These parameters will be used to model subsequent transitions between current smoker, former smoker and death, starting from each participant's status at the 6-month follow-up until the end of life and the associated changes in QoL across these transitions. The QoL estimates for current and former smokers will be queried from previously published age- and gender-specific estimates and applied to the V-HIP cohort[27,28]. This model will use a 3-month transition cycle and all future life years, costs and QALYs will be discounted at 3% per year[29]. What are the implications of financial incentives for smoking cessation on the number of major adverse cardiovascular events (MACE)?

2. What is the effectiveness of financial incentives for smoking cessation on a) ED visits/hospitalizations, b) major adverse cardiovascular events (MACE), and c) overall VA healthcare utilization over a five-year post-intervention period.

   The effects of UC + FI vs UC only on ED visits/hospitalizations, major adverse cardiovascular events, and overall VA healthcare utilization over the five-year post-program period will be compared using a state transition model similar to that described above.

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[25] Thao V, Nyman JA, Nelson DB, Joseph AM, Clothier B, Hammett PJ, Fu SS. Cost-effectiveness of population-level proactive tobacco cessation outreach among socio-economically disadvantaged smokers: evaluation of a randomized control trial. Addiction. 2019 Dec;114(12):2206-2216. doi: 10.1111/add.14752. Epub 2019 Sep 4. PMID: 31483549; PMCID: PMC6899559.

[26] Barnett PG, Wong W, Jeffers A, Hall SM, Prochaska JJ. Cost-effectiveness of smoking cessation treatment initiated during psychiatric hospitalization: analysis from a randomized, controlled trial. J Clin Psychiatry. 2015 Oct;76(10):e1285-91. doi: 10.4088/JCP.14m09016. PMID: 26528651; PMCID: PMC4988964.

[27] Vogl M, Wenig CM, Leidl R, Pokhrel S. Smoking and health-related quality of life in English general population: implications for economic evaluations. BMC Public Health. 2012 Mar 19;12:203. doi: 10.1186/1471-2458-12-203. PMID: 22429454; PMCID: PMC3352300.

[28] Barnett PG, Wong W, Jeffers A, Hall SM, Prochaska JJ. Cost-effectiveness of smoking cessation treatment initiated during psychiatric hospitalization: analysis from a randomized, controlled trial. J Clin Psychiatry. 2015 Oct;76(10):e1285-91. doi: 10.4088/JCP.14m09016. PMID: 26528651; PMCID: PMC4988964.

[29] Neumann P. J., Sanders G. D., Russell L. B., Siegel J. E., Ganiats T. G. *Cost-Effectiveness in Health and Medicine*. Oxford: Oxford University Press; 2016.

Data Sources

The annual costs of VA provided care is estimated through the Managerial Cost Accounting (MCA) datasets. For inpatient care, we will use the MCA treating specialty file. For outpatient care, we will use the MCA Opat file, which includes ambulatory services and outpatient pharmacy. For VA purchased care, we will include costs as reported in the Integrated Veterans Care Consolidated Dataset (IVC-CDS).

5.0 Reporting

[INSERT INFO ON CONGRESSIONAL REPORTING]

6.0 Communication Plan

Meeting Schedules

- Implementation/Evaluation Team meetings (primarily Mpls personnel): Weekly on Thursdays @ 9:30a CT.
- CCPI check-in meetings: bi-weekly on Fridays @ 1:30p CT

Staffing Model

- RA/SC (screening/enrollment, $25 iCO reimbursements, surveys at baseline, 6m, & 12m)
- PM (randomization, financial incentives)
- Pharmacists (counseling, iCO observation, documentation of results)

Training

The implementation team will develop trainings for (See Appendices):

- Outreach procedures
- iCO device set up and troubleshooting
- Discussing financial incentives
- Payment procedures
- Pharmacist counseling

7.0 Resources & Personnel

Implementation/Evaluation Teams (Mpls VA)

Implementation Team Lead: Anne Melzer, MD, MS (Anne.Melzer2@va.gov)

Project Manager Contact: Hope Salameh, MPH (Hope.Salameh@va.gov)

Evaluation Team Leads: Steven Fu, MD, MSCE (Steven.Fu@va.gov) & Pat Hammett (Patrick.Hammett@va.gov)

Project Manager Contact: Ali Woodward-Abel, MPH (Alicia.Woodward-Abel@va.gov)

Project Staff:

- Sarah Becker (Sarah.Becker4@va.gov) – SC
- TBD – RA
- TBD – RA

CCDOR Data/Stats:

- Ann Bangerter (Ann.Bangerter@va.gov)
- TBD - Masters Statistician

CRH Pharmacist Teams

VISN	PHARM LEAD/CONTACT	PHARMACIST	LOCATION
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12	Brendon Hogan (Brendon.Hogan@va.gov)		
17	Rosana Steavenson (Rosana.Steavenson@va.gov)		

20	Shelby White (Shelby.White@va.gov)		

Other Partners

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Claire Hannemann	PM, PERC Dashboard	Claire.Hannemann@va.gov

8.0 Regulatory & Waivers

OMB Waiver


Dole 105 and 107 Pilot Evaluation OMB


HIL-Dole OMB exemption memo_sig

Non-Research Determination


FW_ Non Research Determination - Dol


Non-Research Letter_Dole SUD Tob

CM Guidance


OGC Guidance on CM.msg


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9.0 Appendices

Project Materials

[INSERT LINK TO FOLDER WITH MATERIALS (SURVEYS, SCRIPTS, ETC)]

Payment Procedures

[INSERT HOW-TO LINK FOR EFT PAYMENT PROCESS]

iCO Breath Test Procedures

[INSERT HOW-TO LINK TO iCO PROCEDURES/TROUBLSHOOTING]

Scheduling Procedures

[NEED HOW-TO ON SCHEDULING VVC VISITS FOR ENROLLMENT & 6M]

[NEED HOW-TO ON HAND-OFF TO PHARMACISTS]

Pharmacist Training Procedures

[NEED TO DEVELOP & CREATE “BINDER”]