Workshop #2: Improving Quitline Reach and Treatment for Priority Populations
Monday, August 26, 2019
Minneapolis, Minnesota
Panel 1 – Challenges and Opportunities for Reaching Priority Populations

Moderator:
- Corrine Graffunder, PhD, MPH, Director, *Office on Smoking and Health (CDC)*

Panelists:
- Asian Population – Rod Lew, MPH, Principal Investigator, *APPEAL Network*
- LGBT Population – Scout, PhD, Principal Investigator, *National LGBT Network*
- Low SES/Medicaid Population – Sana Hashim, MPH, CPH, CHES, Program Officer, *Center for Health Care Strategies*
Treatment Reach (i.e., proportion of smokers in each population who receives counseling and/or medications from state quitline) by Population, FY16-FY18

<table>
<thead>
<tr>
<th>Population</th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Population</td>
<td>1.01%</td>
<td>0.87%</td>
<td>0.88%</td>
</tr>
<tr>
<td>African American</td>
<td>0.94%</td>
<td>0.93%</td>
<td>0.83%</td>
</tr>
<tr>
<td>American Indian/Alaska Native</td>
<td>0.95%</td>
<td>1.02%</td>
<td>0.93%</td>
</tr>
<tr>
<td>Asian</td>
<td>0.21%</td>
<td>0.21%</td>
<td>0.22%</td>
</tr>
<tr>
<td>Hispanic/Latino</td>
<td>0.55%</td>
<td>0.52%</td>
<td>0.60%</td>
</tr>
<tr>
<td>&lt; HS education (low SES)</td>
<td>0.60%</td>
<td>0.66%</td>
<td>0.62%</td>
</tr>
</tbody>
</table>
Expanding State Quitline Outreach to Asian Americans, Native Hawaiians and Pacific Islanders

Rod Lew, MPH
Asian Pacific Partners for Empowerment, Advocacy and Leadership

Minneapolis, MN
August 26, 2019
Objectives

1. Provide brief background history on AAs and NHPIs
2. Discuss challenges in engaging AAs and NHPIs on cessation through State Quitlines
3. Describe pathway to advancing equity in tobacco control (including cessation)
Who are Asian Americans?

- Represent 5% of U.S. population but fastest growing group
- More than 30 distinct ethnic/language groups
- From history of exclusion to refugee status
- Dispelling myth of model minority
- 60% of Asian Americans are born outside of the United States.
- 1 out of every 3 Asian Americans is limited-English proficient
Top 10 States Ranked by Asian American Population

Who are Native Hawaiians and Pacific Islanders?

- NHOPIs are a distinct racial/ethnic group under OMB
- Native Hawaiians are a sovereign people
- 6 Pacific Island jurisdictions are in the most isolated part of the world with the least amount of infrastructure
- NHPIs have also immigrated to the 48 contiguous states
- The poverty rate for non-Hispanic Whites was 9.8%, lower than the poverty rates of Asians (12.3%) and Native Hawaiians and Pacific Islanders (21.5%).
Smoking Prevalence Ranges for Asian American Men

Prevalence
Tobacco Use among Native Hawaiians and Other Pacific Islanders (NHOPIs)

- Smoking is high for both Native Hawaiian males (up to 42%) and females (up to 35%)

- NHOPI girls had the highest smoking prevalence among middle school girls (25.4%)

- Guam - 2nd highest smoking prevalence among U.S. states and territories

- For Pacific Islanders, tobacco use includes chewing tobacco mixed with betelnut
New Disaggregated Data
**Results from Tobacco Industry Documents 1988-1995**

- AAPI market important due to population growth and geographic clustering
- AAPIs had “predisposition to smoking” and increased consumer purchasing power
- High percentage of AAPI retail business owners
- Philip Morris’ PUSH, PULL and CORPORATE GOODWILL strategies
Quitline History with AANHPIs
The mission of the Asian Smokers’ Quitline (ASQ) is to provide accessible, evidence-based, smoking cessation services in Cantonese, Mandarin, Korean and Vietnamese to Asian communities in the U.S.

What does ASQ offer?
• Live agents who speak Chinese, Korean or Vietnamese answer calls
• One-on-one cessation counseling in Chinese, Korean and Vietnamese
• Free nicotine patches sent directly to eligible smokers
• In-language self-help materials
• Take back and Transfer (TNT) Codes:
  Chinese: 80, Korean: 81, Vietnamese 82 (PDF)

Service Hours:
• Mon – Fri, 7am – 9pm PT (10am – midnight ET)
  Chinese 1-800-838-8917
  Korean 1-800-556-5564
  Vietnamese 1-800-778-8440

www.asiansmokersquitline.org
ASQ’s Partners highlights……

- New York City Department of Health and Mental Hygiene ran a campaign "Fades like Smokes" in summer 2018 to promote ASQ Chinese Quitline:

  Enrollment from New York to ASQ had more than doubled when compared to prior month.
ASQ’s Partners highlights......

- CBOs utilize ASQ web enrollment to help smokers to quit:
  - For ex. AAFE helps smokers sign up ASQ service online. AAFE members enrollment has almost tripled since 2018.
- Increase the use of Electronic Health Records (EMR) referrals
  - Provider referrals that via e-referral system has increased 60%
- Co-written press release (ex. NCAPIP and APPEAL)
- Co-branded materials (ex. CAPS, LADPH)
- Promoted ASQ at local events (ex. North American Chinatown Smoke Free Day, Lunar New Year)
### 2018 AANHPIs Reached by State Quitlines

#### FY2018 Annual Survey Data

<table>
<thead>
<tr>
<th></th>
<th>Column A: ASQ only</th>
<th>Column B: State Quitlines (n=48) + ASQ</th>
<th>% Reached by ASQ (Column A/Column B)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total # of unique tobacco users who received evidence based services</td>
<td>1,479</td>
<td>323,478</td>
<td>0.46%</td>
</tr>
<tr>
<td>Among the total # of unique tobacco users who received evidence based services, those who identified as Asian</td>
<td>1,479</td>
<td>5,011</td>
<td>29.5%</td>
</tr>
</tbody>
</table>

.21% reached by State Quitlines overall

2018 Data provided by NAQC
Why Quitlines are a Challenge for Reaching AAs and NHPIs
Potential Factors for Low State Quitline Outreach to AAs and NHPIs?

- Diversity and perception of AAs and NHPIs
- While ASQ is in Cantonese, Mandarin, Vietnamese and Korean, there are many other languages needed
- The ASQ Effect
- ATT language service doesn't work
- Even those AANHPI groups that speak English still require culturally tailored outreach and programs
Potential Factors for Low State Quitline Outreach to AAs and NHPIs?

- Some AANHPIs don't go outside their family to seek support
- Readiness levels to quit for some AANHPI communities may still be low
- Quit lines require extensive and targeted media outreach (e.g. CA's media campaign)
- Impact of policy change paradigm
- Complexity of Tobacco products
An Equity Framework is Needed
Health Equity is about...

- implement policies to create systems change, and
- building community power to engage all communities in policy change
Cessation is a Community Norm Change not an Individual Norm Change

May Require a focus on Community Readiness and a Different Pathway
The Journey To
Tobacco Control
Policy Change

Assessment
- Community Readiness Assessment
- Coalition Assessment
- Key Informant Interviews
- Political Landscaping
- Leadership Summit and Trainings

Capacity Building
- Coalition Development
- Technical Assistance and Coaching
- Policy Project Development
- Organization Bridge

Policy Change
- Community Impact Assessment
- Community Dissemination
- Coalition Refinement

Corporate Policy
- Legislative Policy
- Mainstream Policy
- Community Policy

* In times of drought (lack of resources), the river may dry up.
** The river is highly fluctuating; to go forward, you may need to go backwards on the river.
*** The wider the policy stream is, the more people and diversity is needed to be successful.

Vision of a community without tobacco disparities.
“APPEAL trainings are intense, in-depth, refreshing, and understands and embraces the diversity and cultural perspectives of the participants. And most of all you feel good… because for the first time my history, cultural, and experiences -- were allowed at the table.”

- Brandie Flood, Center for Multicultural Health
LAAMPP Fellows Help Influence Passage of Minnesota Tobacco Tax
Helps Pass Smoke-free Foster Care Policy in Ramsey County
How do we Measure Health Equity?

1. Funding through Truth Initiative
2. 16 of 50 states completed Equity Needs Survey
3. Key Arenas of Measuring Equity
   - Funding and Resource Allocation
   - Staffing
   - Leadership Advocacy
   - Community Engagement
   - Accountability Systems
4. Principles of Health Equity
Health Equity Principles

- Health equity as defined by systems change or building community power
- Address tobacco industry targeting
- Address institutional racism and homophobia (including implicit bias, institutional and explicit)
- Engage and empower communities all along the spectrum of tobacco control
- Strengthen local community efforts
- Nurture development of the next generation of community leaders
- Movement toward “Health Equity as a Policy Goal”
What APPEAL can provide?

- Opportunity to connect through the CDC-funded ASPIRE Network
- Access to Promising Practices Repository
- Technical Assistance on connecting with AA and NHPI communities in your state
- FREE one-day training for completing Assets and Needs Assessment Survey
Summary

- Ask why not more AAs and NHPIs. Ask instead what are we doing to build capacity and equity in working with AAs and NHPIs
- Focus not on cessation alone (or policy alone) but instead focus on cessation and tobacco within a larger context of the AA and NHPI community
- Embrace a new paradigm shift to one on Health Equity as a Policy Goal
A New View of Tobacco Control

www.appealforhealth.org
rodlew@appealforhealth.org
Successfully Engaging LGBTQ+ Communities
Dr. Scout

I run one of eight CDC-funded tobacco and cancer disparity networks. In this capacity I spend a lot of my time helping invoke system changes that build capacity of CDC grantees and health care groups to reach and serve sexual and gender minorities.
Quitline Partnerships
Partnerships

What have we done before and are interested in again?

- State staff trainings & technical assistance for LGBTQ engagement
- Quitline staff trainings
- Development of tailored outreach materials
  - We have a series of ads already available for you to brand
  - New quitline poster coming next!
Population Overview & Nuances
Words are changing
Sexual Orientation Yes & No

Yes
• Lesbian
• gay
• Bisexual
• bi
• Pansexual
• asexual (ace)
• ace spectrum
• two spirit
• queer

No(tes)
• homosexuals
• please do not forget bi erasure
• please do not forget pan is a subset of bi
Gender Identity Yes & No

Yes
- transgender
- trans
- trans man
- trans woman
- transgender person
- cis
- enby
- nonbinary
- genderqueer & queer

No(tes)
- transgenders
- transgendered
- transman
- transwoman
- transgenderism
- tranny (quite inflammatory)
- please do not say straight is the opposite of LGBT
- two spirit
Groupings?

Yes
- LGBT
- LGBTQ
- LGBTQ+
- LGBTQI
- queer
- SOGI
- SGM (often federal)
Bi moment
Pronouns

Notes

● increasing use of gender neutral pronouns
● Need to get more comfortable with them? Practice.
● Unsure which to use? Ask.
● Flub it? Apologize quickly and move on.
● The power of an email tagline.
Shifting demographics

Gen Z more familiar with gender-neutral pronouns

% saying they personally know someone who prefers that others refer to them using gender-neutral pronouns

- Gen Z: 35
- Millennial: 25
- Gen X: 16
- Boomer: 12
- Silent: 7


"Generation Z Looks a Lot Like Millennials on Key Social and Political Issues"

PEW RESEARCH CENTER
2017 BRFSS

- Heterosexual
- Refused
- Gay/Les
- Bisexual
- Don’t Know
Shifting demographics - 14.7M
Our number one health risk

LGBT people use tobacco at rates higher than the general population. 40%
Successful Engagement
1
Promote LGBT professional leadership and safety in your organization and the arena.
1
Promote LGBT professional leadership and safety in your organization and the arena.

Include LGBTQ+ community members in advisory groups.

http://us.cochrane.org/serving-advisory-panel
Collect LGBTQ+ data.

Enhanced LGBT Measure As Tested

Across your lifetime, do you consider yourself to be gay, lesbian, bisexual, and/or transgender?

- No
- Yes

[If No continue. If Yes, probe with the following question.]
[If callers show concern about this question, feel free to add the following sentence:] “LGBT people smoke at higher rates than others; we ask this to ensure we’re serving all people equally.”

Thanks, indicate all of the following which apply to you:

- Bisexual,
- Gay or
- [for a woman] Lesbian,
- Queer,
- Transgender or gender variant and assigned male at birth,
- Transgender or gender variant and assigned female at birth.

*All square brackets indicate instructions to survey administrators, this is not information that is to be read aloud.
4

Establish cultural competency standards for programs.

Number of publicly listed LGBT-welcoming health providers in North Dakota before LGBT training? 6

Number after? 76

#LGBTTrainingWorks
5
Fund community based programs to promote health equity.

Click to Read the Iowa LGBT Health & Wellness Study 2013-14
6
Routinely integrate LGBTQ+ tailored materials into existing wellness campaigns.
Disseminate findings and lessons learned.
Thank you.

For more information contact us at info@cancer-network.org.
Expanding Tobacco Quitline Reach to People of Low Socioeconomic Status

North American Quitline Consortium: Workshop II | August 26, 2019
Sana Hashim, MPH, CPH, CHES, Program Officer

Made possible by the Robert Wood Johnson Foundation
About the Center for Health Care Strategies

A nonprofit policy center dedicated to improving the health of low-income Americans
Promoting the adoption of evidence-based interventions in collaboration with health care purchasers, payers, and providers

High-burden health conditions 6

Evidence-based interventions that improve health and control costs 18

Six High-Burden Health Conditions

- Control Asthma
- Reduce Tobacco Use
- Prevent Type 2 Diabetes
- Prevent Unintended Pregnancy
- Improve Antibiotic Use
- Control High Blood Pressure
Smoking Prevalence & Medicaid Coverage of Cessation

- Smoking rate among Medicaid: 25.3% versus privately insured: 11.8%
- Medicaid spends approximately $39 billion annually on treating smoking-related diseases
- As of June 2019, only 15 states have Comprehensive Medicaid Coverage of Cessation Treatments.
  - Individual, group, and telephone counseling and seven Food and Drug Administration (FDA)–approved medications
Increase access to evidence-based tobacco cessation treatments, including individual, group, and telephone counseling and Food and Drug Administration (FDA)-approved cessation medications (in accordance with the 2008 Public Health Service Clinical Practice Guideline\(^1\) and the 2015 U.S. Preventive Services Task Force (USPSTF) tobacco cessation recommendation statement).\(^2\)

Remove barriers that impede access to covered cessation treatments, such as cost-sharing and prior authorization.

Promote increased use of covered treatment benefits by tobacco users.
CDC’s 6|18 Initiative Participants
Three Phases of Implementing Medicaid-Public Health Prevention Activities in CDC’s 6|18 Initiative

As part of the Centers for Disease Control and Prevention's (CDC) 6|18 Initiative, state Medicaid and public health agencies are collaborating to implement proven prevention interventions that aim to improve health outcomes and control costs. This infographic shares three key phases of implementation.

<table>
<thead>
<tr>
<th>Phase</th>
<th>Approaches</th>
<th>Mechanisms</th>
</tr>
</thead>
</table>
| Medicaid Coverage | ⭩ Reimburse for physician and non-physician provider services to improve access to care  
  ⭩ Eliminate cost-sharing or prior authorization requirements to remove barriers to care  
  ⭩ Separate (unbundle) payments for related services to promote appropriate remuneration | ⭩ Conduct assessment of services already provided by Medicaid MCOs  
  ⭩ Implement managed care plan coverage changes in pilot settings  
  ⭩ Revise MCO contract language  
  ⭩ Amend Medicaid State Plan or secure new Medicaid waiver  
  ⭩ Pass new legislation |
| Provider Adoption | ⭩ Promote covered benefits to providers to increase provision of or referral to these services, with guidance on billing procedures to facilitate payment | ⭩ Recommend opportunities to align 6|18 Initiative quality measures with existing quality improvement/payment incentive programs  
  ⭩ Create fact sheets on billing codes, benefits, and quality measures  
  ⭩ Conduct online and in-person trainings that offer CMEs  
  ⭩ Share benefit changes via promotional materials and provider bulletins |
| Consumer Utilization | ⭩ Target promotion of covered benefits to members to build awareness of available benefits and services | ⭩ Promote benefits and services at community events or through community organizations  
  ⭩ Promote in point-of-care settings (e.g., office posters, pharmacy bags) and public spaces (e.g., transit ads, billboards)  
  ⭩ Air local radio and TV ads  
  ⭩ Create population-specific online ads using Facebook or Google |

Infographic available on 6|18 Initiative Resource Center
Framing the Issue
The definition of “low-income" is a function of the Federal Poverty Level (FPL), typically 150 – 200% of the household income defined as the poverty threshold.

However, there are significant variances in employment, health insurance, education, marital status, English proficiency, race/ethnicity, nativity, sexual orientation, etc.

Bottom Line: “Low-income” is not a monolith and tobacco use is just one aspect of a complex lived experience
Prevalence of Tobacco Use by Income and Education
Industry Role in Increasing Demand for Tobacco

- Marketing, advertising, and promotional strategies often directed at low-income populations.
- Industry relationships with organizations that work with homeless populations.
- $7.3 billion spent in 2014 on discounts and coupons alone to lower prices.
Adverse Childhood Experiences (ACEs) are stressful or traumatic events, including abuse, neglect, and household dysfunction, that occur during childhood.

- Poverty is considered an ACE, due to the toxic stress of the lived experience of poverty.
- Smoking is strongly associated with ACEs.

Relationship between the number of ACEs and negative health and well-being:

<table>
<thead>
<tr>
<th># of ACEs</th>
<th>Risk for Negative Health and Well-Being</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>≥5</td>
<td>≥5</td>
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</table>
Solutions
National Academy of Medicine (NAM): Six Domains of Healthcare Quality

- **Safe**: Avoiding injuries to patients from the care that is intended to help them
- **Timely**: Reducing waits and sometimes harmful delays for patients and providers
- **Effective**: Providing the appropriate level of services based on scientific knowledge
- **Efficient**: Avoiding waste, including waste of equipment, supplies, ideas, and energy
- **Equitable**: Providing care that does not vary in quality because of personal characteristics
- **Patient-Centered**: Providing care that is respectful of and responsive to individual patients
Health equity is the opportunity for everyone to reach their “full health potential.”

No one is prevented “from achieving this potential because of their social position or other socially determined circumstance.”

Health equity in tobacco prevention and control is the opportunity for all people to live a healthy, tobacco-free life.
Cultural competence is the ability to understand, communicate with and effectively interact with people across cultures.

Cultural humility is the ability to maintain an interpersonal stance that is other-oriented (or open to the other) in relation to aspects of cultural identity that are most important to the [person].

Cultural humility is defined by:

- A lifelong commitment to self-evaluation and self-critique
- A view for addressing power imbalances
- Enabling successful partnerships with people and groups who advocate for others

Consider Intent versus Impact
An approach to problem solving, that develops solutions to problems by involving the human perspective in all steps of the problem-solving process.

Human involvement typically takes place in observing the problem within context, brainstorming, conceptualizing, developing, and implementing the solution.

“Nothing about me, without me.”
Learning what smokers experience in their daily lives offers a path for reducing stress and supporting smokers more compassionately when they are ready to quit.

Interviews revealed that, although most of the participants who used tobacco knew about the programs and resources available for quitting, they said their immediate need was for help with the causes of stress that lead them to continue tobacco use.

Freeing up stress would allow them to concentrate on being a better person who could serve their family and community.

Lack of support among family and friends when they did attempt to quit, and wished they had someone who would be an ally to encourage them through the process.
**Goals**

» Assess and address variation in Medicaid MCO tobacco cessation benefits and services.

» Increase provider, enrollee and community-based organizations’ awareness and use of free Medicaid tobacco cessation benefits and services.

**Activities and Accomplishments**

» Surveyed Medicaid MCOs to identify variation in benefits and used results to engage with MCOs not following state cessation policies – resulting in improved and more uniform cessation treatment coverage.

» Increased awareness of free Medicaid benefits by engaging community groups and populations most disparately impacted by the health harms of tobacco.

» Analyzed the All Payer Claims Database to establish a baseline for utilization of cessation medications across payers.
Accomplishments: South Carolina Reducing Tobacco Use

Goals

» Expand access to evidence-based tobacco cessation treatments, including individual, group, and telephone counseling and FDA-approved cessation medications.

» Remove barriers that impede access to covered cessation treatments.

» Promote increased utilization of covered treatment benefits by tobacco users.

Activities and Accomplishments

» Obtained federal funding match for Quitline services provided to Medicaid beneficiaries to support program sustainability.

» Surveyed MCOs on cessation treatment coverage; used survey results to standardize cessation treatment coverage across MCOs.

» Removed co-payment and prior authorization for tobacco cessation medications and counseling for all full benefit FFS and MCO beneficiaries.
ACCOMPLISHMENTS: Colorado Reducing Tobacco Use

Goals

» Remove barriers that impede access to covered cessation treatments, such as cost sharing and prior authorization.

» Promote increased utilization of covered treatment benefits by tobacco users.

Activities and Accomplishments

» Colorado Medicaid removed copays from all seven FDA-approved cessation medications effective November 1, 2017.

» Ran targeted consumer-facing digital media campaign to promote Medicaid tobacco cessation benefit, which delivered 9.9 million impressions.

» Enacted a new regulation allowing pharmacists to prescribe cessation medications.
QuitlineNC: One Quitline Approach in North Carolina

- After conversations with the Health Secretary, North Carolina agreed to support one quitline under Medicaid managed care: QuitlineNC.

- If North Carolina had not participated in 6|18, there likely would have been a number of separate quitlines serving the Medicaid population, leading to:
  - variable services,
  - little opportunity for a coordinated approach to promote services,
  - and ultimately reduced referrals and access to cessation services.

- Link to Blog: 6|18 Initiative a Win-Win for Medicaid and Public Health: A Conversation with North Carolina on Tobacco Cessation
What else can Quitlines do?

- **Compare/Triangulate** 1) how callers hear about the quitline, 2) your media portfolio, and 3) the most popular forms of media among the sub-population
- **Listen** to your residents, including those who have used the quitline
- **Co-create** and **invite insights** on advertising before launch
- **Connect** with providers who primarily serve low income individuals
- **Integrate** quitlines into health systems, like Federally Qualified Health Centers
- **Build** partnerships with community organizations that serve this group
- **Collaborate** with your Medicaid department, in addition to other agencies who serve this population (e.g. HUD, WIC, SNAP, etc.)
- **Explore** how your service provider can tailor their approach
The 6|18 Initiative Approach
Benefits of Medicaid-Public Health Collaboration

- Build/enhance cross-agency partnerships
- Implement concrete interventions that align with state payment reform activities and goals
- Improve health and control costs using evidence-based interventions
- Receive targeted technical assistance
- Learn from and share experiences with other states
Typical 6|18 Initiative Activities

- Work plan development
- Targeted technical assistance
- Peer-to-peer information exchange
- Capacity building
- Access to a range of how-to tools and resources
- In-person meetings
Visit CHCS’ Resource Center for Implementing CDC’s 6|18 Initiative

- **Online resource center**, made possible by the Robert Wood Johnson Foundation, to help Medicaid agencies and MCOs collaborate with public health departments to launch 6|18 interventions
- Offers **practical how-to resources**, including:
  - **6|18 in Action** - Interactive map of 6|18 activities from across the country and profiles of select state activities
  - **General resources** to help stakeholders get started with 6|18 interventions
  - **Health condition-specific resources** to guide the implementation of CDC’s 6|18 Initiative strategies

[www.618resources.chcs.org](http://www.618resources.chcs.org)
Build the Capacity of the Public Health & Medicaid Partnership

- Blog post:
  A Marriage between Medicaid and Public Health: A Q&A on Partnering for Prevention

- For Public Health:
  Understanding Medicaid’s Role in CDC’s 6|18 Initiative: Primer and FAQ

- For Medicaid:
  Understanding Public Health’s Role in CDC’s 6|18 Initiative: A Primer for Medicaid Partners
For more information, contact:

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shashim@chcs.org
(609) 528-8400
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