Building Collaborative Relationships
August 23, 2012
Learning Objectives

• Objective 1: Explain the role of the FQHC provider and Program Partners in the Rewards to Quit program

• Objective 2: Review the goals and target populations served in this 5-year smoking cessation grant program

• Objective 3: Describe the essential operational components and processes of the Rewards to Quit program
Program Partners

- Department of Social Services – Lead Agency (Medicaid)
- Community Health Network of CT – ASO
- Yale University – Study Design and Evaluation
- Department of Public Health – CT QuitLine
- Department of Mental Health & Addiction Services – LMHAs
- Hispanic Health Council – Peer Coaching & Focus Groups
Overview

- Highly specialized tobacco cessation program offered by CT Department of Social Services for Husky A, C and D members age 18 and over

- The goal of the Rewards to Quit program is to:
  - Study the impact of financial incentives on quitting, with a special focus on:
    - Pregnant and Post-Partum Women
    - Members with SMI
  - Reduce rates of CT Medicaid members who smoke by 25-30%
Covered Services

- Medicaid-covered services – available to all
  - Smoking Cessation Counseling
  - Nicotine Replacement Therapy
  - Rx Medications (Chantix and certain antidepressants)

- CT QuitLine Access – available to all 1–800–784–8669

- Financial incentives for eligible HUSKY A, C and D members age 18 and over

- Rewards to Quit Incentives paid to Treatment Group participants only
# Treatment and Incentives Table

<table>
<thead>
<tr>
<th>SMOKER (S)</th>
<th>RANDOMIZED IN (Treatment)</th>
<th>RANDOMIZED OUT (Control)</th>
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<tbody>
<tr>
<td></td>
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<tr>
<td>SMOKER/TREATMENT GROUP (ST)</td>
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<tr>
<td>SMOKER/TREATMENT GROUP/INCENTIVE (STI)</td>
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Provider participation is key to program success

<table>
<thead>
<tr>
<th>Responsibility</th>
<th>Randomized In (Treatment)</th>
<th>Randomized Out (Control)</th>
<th>Connecticut Quitline</th>
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</thead>
<tbody>
<tr>
<td>Screen for tobacco use</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Enroll smoker in incentive program</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Provide smoking cessation services/products</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Tobacco cessation counseling</td>
<td>X</td>
<td>X</td>
<td>X*</td>
</tr>
<tr>
<td>NRT</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prescribe medications</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Provide referrals if necessary</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Administer CO test, if requested by member</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Track and report activities for purposes of incentives</td>
<td>X</td>
<td></td>
<td>X</td>
</tr>
</tbody>
</table>

* Existing Quitline protocols
Rewards to Quit implemented through select providers

• Types of Providers
  – Local Mental Health Agencies (voluntary)
  – Obstetrics Providers (voluntary)
  – Pediatricians (voluntary)
  – Person-Centered Medical Homes (required)

• Randomization to occur by provider, not by individual
  – Randomization within each provider type
  – Randomization by site for large practices
Tobacco Cessation Incentives
How do they work?

• Incentive activities awarded to members on a reloadable Rewards to Quit debit card

• The **maximum** potential Rewards to Quit incentives per member is **$350.00**

• The maximum payment per member for each incentive activity is as follows:
  • **QuitLine Counseling Calls:** $5/each call with maximum of **10** calls - Incentive Payment of **$50.00**;
  • **Counseling Sessions:** $5/each session with maximum of **10** sessions - Incentive payment of **$50**;
  • **Tobacco-free CO breathalyzer tests:** $15 per negative test with a maximum of **12** tests per member. An additional $40 bonus can be earned (4) $10 negative CO tests per member after (3) successes.

• No financial incentive for NRT or prescription medications
Rewards to Quit participants are randomized into two groups (Treatment and Control) at LMHAs, FQHCs, and PCMH provider sites to study the impact of low and high level incentives on smoking cessation throughout the research grant period.

- **Treatment Group Forms**
- **Control Group Forms**
Congratulations on enrolling in the Rewards to Quit program!

Your new HUSKY Health Rewards to Quit MasterCard® card will be sent to you soon.

You can earn up to $350 on your Rewards to Quit card by participating in any of these smoking cessation activities:
• Quitline Counseling Calls: $5 for each call, up to 10 calls, to the Department of Public Health Quitline at 1.800.784.8669.
• Counseling Sessions for Quitting Smoking: $5 for each smoking cessation counseling session, up to 10 sessions.
• Tobacco-Free CO Breathalyzer Tests: $15 for each negative CO Breathalyzer test, up to 12 negative tests.

You can earn even more money if you stick with your quit smoking activities. You can earn an extra $15 if you complete 5 counseling sessions (Quitline or in-person), or $30 if you complete 10 sessions. You can also earn an extra $10 every time you have 3 tobacco-free Breathalyzer tests in a row, up to $40.

For each of these activities, your Rewards to Quit card will be reloaded with money that you can use as a credit card to make purchases.

Your HUSKY Health Rewards to Quit card does not have a PIN and can’t be used at an ATM. Just select “Credit” and sign for your purchase.


Rewards to Quit is a HUSKY Health Program initiative.
Reloadable MasterCard (Phase 1)
Reloadable Card
Coming in November 2012 (Phase 2)
Welcome, Sheri

You guys are great!!! Congrats on your first day of your journey. 

Welcome to your single source for all you need to know about your pre-tax benefits. Request payment, check payment status, view account balance and summary information, access important notifications about your account, and more!

You are all great to work with!

www.webmd.com
OB-GYNs and Pediatricians

- Active involvement of DSS Medical Director in forging relationships
- Presentations/meetings with provider associations
- Early identification of issues/concerns; proactively address potential problems
- Solicitation of provider input throughout process
Person-Centered Medical Homes

• Smoking cessation programming and Rewards to Quit is embedded in CT PCMH initiative

• A Person-Centered Medical Home is an effective method of providing comprehensive primary care that facilitates partnerships between patients, their families and primary care providers

• It is not a building, house or hospital, but rather an approach to providing health care services in a high-quality and cost effective manner
Practice Transformation/PCMH

• Interdisciplinary Provider-led Primary Care Teams
  
  o Promoting leadership development
  
  o Promoting team-based care
  
  o Creating a culture of CQI
  
  o Promoting workflow redesign
  
  o Supported by data analytics / quality reporting
Glide Path Supports Tobacco Cessation

- Monitors & Tracks timelines/progress towards Rewards to Quit deliverables
- Practices embrace tobacco cessation for members
- Select tobacco cessation as chronic disease management measures
PCMH / Rewards to Quit
Support Mechanisms

• Introduce tools and educational resources

• Evidenced-based clinical guidelines

• Educational forums and learning collaboratives

• Improving quality through data analytics

• Introduce role of Health Educators & Care Managers

• Provide an inventory of local and state community-based resources
Our Transformation Team
How We Assist with Rewards to Quit

“Highly Skilled Transformation Specialists”

• Working on-sight with individual practices
• Providing email, telephonic and web-based support
• Answering the critical questions
• Education and training for providers
• Promoting workflow and assessment redesign
Intensive Care Management Program

Care Management is a process which identifies members with high risk clinical conditions that severely impact activities of daily living.

Role of ICM Care Manager:

- Assess, develops and coordinates a member centric integrated care plan
- Collaborates with the interdisciplinary team, member and provider
- Integrates a hybrid model of “face to face” and telephonic communication
- Works collaboratively with external regulatory agencies and waiver programs
Intensive Care Management
Intensive Care Management Program Goals

Program Goals

• Engage members in self care through education, self-help coaching and patient centered care planning

• Minimize fragmentation of care via identification of gaps in services, and barriers to care

• Reduce avoidable hospitalization admissions and inappropriate utilization of the Emergency Department

• Coordinate care by linking the member to providers, medical and behavioral health services, waiver programs, social and other support services and, to Patient Centered Medical Homes (PCMH) as needed

• Mitigate poor outcomes and high costs at the individual and system levels
Intensive Care Management Program

• Referral Criteria

• Members at high risk may include any one or more of the following:
  Acute or chronic conditions with or without BH conditions

• Clinical gaps in care

• Repeated hospitalizations or high ED utilization

• Uncontrolled pain issues

• Low adherence to treatment plans or medication regimes

• Poor support network
Intensive Care Management

Referral Process

• Contact Provider Line - **1-800-440-5071** and when prompted dial **EXT 2011** to request ICM services

• ICM Care Managers works collaboratively with designated providers for member identification and care plan development
Community Support Services Program
Learning Objectives

• What is the Mission of the Community Support Services Program?
• Who is the Human Services Specialist and What is their Role?
• How is the Community Support Services Program Structured?
• What types of Community Resources can the Human Services Specialist assist with?
• How does the Community Support Services Program Support Person-Centered Medical Home Models of Care?
• Question and Answer
Community Support Services

Goals

• Assists families in meeting their basic needs.
• Helps identify and access resources within the community.
• Reduces barriers to maintaining a healthy lifestyle.
Community Support Services Team

- Director of Community Support Services
- One Manager of Community Support Services
- 11 Human Services Specialists
  - Regionalized (5 Regions)
  - Bilingual Staff
  - Language Line
What does the Human Services Specialist do?

- Empowers families to improve their healthcare.
- Refers to community organizations and providers.
- Assists families in identifying natural supports.
- Encourages self-advocacy.
Program Structure

• Visits
  • Home
  • Community
  • Telephonically

• Intakes assess:
  – Social Service Needs
  – Emotional Healthcare Needs
  – Physical Healthcare Needs

• Resources are provided to alleviate barriers.
Community Resource Assistance Available

- Housing
- Food
- Clothing
- Utility Assistance
- Childcare
- Behavioral Health Services
- Dental Services
- State Benefits
- Disability Services
- Employment Services
- Parenting Supports
- Holiday Supports
- Educational Supports
- Youth Programs
- Cancer Supports
- Domestic Violence Supports
- Legal Services
- Vision Services
Quarter 2 Results: Community Resource Assistance Provided

Community Support Services Community Resources Provided
2nd Quarter, 2012

Community Resource Categories

Total Number Provided Per Person

- April
- May
- June

REWARDS TO QUIT

HUSKY HEALTH CONNECTICUT

RQLHE0005-0812 33
Follow-Up

• Continued Availability for Ongoing Support

• Post-Intervention Assessment

• Satisfaction Surveys
CHNCT Philosophy

• Member-Centered Care
  – Dignity and Respect
  – Information Sharing
  – Participation
  – Empowerment
Supporting Person-Centered Medical Home

NCQA Standard 4 Provide Self-Care Support and Community Resources

<table>
<thead>
<tr>
<th>Provider Benefits</th>
<th>PCMH Structure</th>
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<tbody>
<tr>
<td>Enhanced Reimbursements</td>
<td>Conformity with NCQA Standards</td>
</tr>
<tr>
<td>Higher Levels of Intrinsic Motivation</td>
<td>Provide Access/Continuity of Care</td>
</tr>
<tr>
<td>Improved Communication</td>
<td>Identify/Manage Patient Populations</td>
</tr>
<tr>
<td>Increased Knowledge-EHR</td>
<td>Plan and Manage Care</td>
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<tr>
<td>Investment for Increased Profitability</td>
<td>Self-Care Support &amp; Resources</td>
</tr>
<tr>
<td>NCQA Recognition</td>
<td>Track and Coordinate Care</td>
</tr>
<tr>
<td></td>
<td>Measure and Improve Efficiency</td>
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<table>
<thead>
<tr>
<th>Patient Benefits</th>
<th>Outcomes</th>
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<tbody>
<tr>
<td>Improved Quality of Care</td>
<td>Savings in Healthcare Costs</td>
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<tr>
<td>Person-Centered Care Plan Goals</td>
<td>Reduction in Duplicate Services</td>
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<tr>
<td>Improved Communication</td>
<td>Decreased Racial/Ethnic Disparities</td>
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<tr>
<td>Patient Self-Management</td>
<td>Healthier Outcomes</td>
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<tr>
<td>Ownership of Your Healthcare</td>
<td>Improved Standards of Life</td>
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<td>24/7 Access to Care</td>
<td>Quality Improvement Initiatives</td>
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<tr>
<td>Access to Your Medical Information</td>
<td>Catalyst for Payment Reform</td>
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<tr>
<td>Enhanced Trust in Providers</td>
<td>Catalyst for Delivery System Reform</td>
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<td>Intensive Care Management</td>
<td>Cost Containment</td>
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4A: Support Self-Care Process

4B: Referrals to Community Resources
A Support System

• The Human Services Specialist is always available to encourage, empower, and assist.

• Positive outcomes in the member’s healthcare is our top priority.
Making a Referral

Manager of Community Support Services:

- Tiffany Huntoon
  1-800-859-9889 ext. 4102
  thuntoon@chnct.org

For More Information about CHNCT, Inc.

Website

www.chnct.org

Toll-Free: 1.800.859.9889
Fax: 1.203.265.7948
Questions ?