The Lewin Group
Successfully Engaging Members in Plan Governance
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Alana Nur: Thank you. My name is Alana Nur. I am with The Lewin Group. Welcome to the webinar, Successfully Engaging Members in Plan Governance. This is the first session of our 2019 Member Engagement and Plan Governance webinar series. Today's session will include a 60-minute, presenter-led discussion followed up with 30 minutes with a discussion among the participants. This session will be recorded. A video replay and a copy of today's slides will be available at www.resourcesforintegratedcare.com.

The audio portions of the presentation will automatically stream through your computer. Phone lines for this presentation are also available. To access the number click the black phone widget at the bottom of your screen.

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You can see on this slide we have laid out the various continuing education options. If you are a social worker you can obtain continuing education credits through NASW if you complete the pre-test at the beginning of the webinar and complete the post-test. CMS is also offering CEUs for other individuals looking to attend credit for attending this webinar. In order to obtain these credits you must complete the post-test through CMS' learning management system.

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This webinar is supported through the Medicare-Medicaid Coordination Office at the Centers for Medicare-Medicaid Services. MMCO is helping beneficiaries dually eligible for Medicare and Medicaid have access to seamless, high-quality healthcare that includes the full range of covered services in both programs. To learn more about current efforts and resources please visit our website or follow us on Twitter for more details. Our Twitter handle is @Integrate_Care.

At this time I would like to introduce our moderator. Renée Markus Hodin is the Deputy Director of Community Catalyst's Center for Consumer Engagement in Health Innovation. For the past 20 years Renée has worked to bring the consumer perspective to the forefront in health and health innovation. Renée?

Renée Markus Hodin: Thanks so much, Alana. Welcome everyone. I wanted to wish a good morning or good afternoon depending on where you are to everyone participating today; particularly those that are joining us from the Midwest. I hope you are staying safe and warm.

I am so pleased to be with all of you today and to moderate the webinar. As Alana mentioned I am the Deputy Director of the Center for Consumer Engagement and Health Innovation at Community Catalyst. As you might gather from our name the topic of this webinar is truly central to our mission in assuring that the people served by our health system are engaged in all efforts to improve that system. Next slide, please.

I am pleased to introduce our speakers today and also to offer a roadmap for our time together. We will start by hearing from my own colleagues at the Center; Leena Sharma and Marc Cohen. Leena is a Senior Policy Analyst who also heads up the center's work on Medicare-Medicaid enrollees. Leena has been doing this work here Community Catalyst in the Center since 2011. Before joining us here she served as the Public Policy, Advocacy and Volunteer Coordinator at the Greater New Jersey Chapter of the Alzheimer's Association.

Marc is the Center's Research Director and also serves as the Co-Director of the Leading Age LPSS Center at EMS Boston. Over his 25 year career he has conducted extensive research and analysis on a variety of public policy issues affecting the financing and delivery of long-term care services.

Together Leena and Marc will share the findings of their recently-completed research on the Consumer Advisory Council's Established Medicare-Medicaid Plans, or as we may refer to them as MMPs, who are participating in the financial alignment initiative. These bodies are just one way the plans can engage their members in governance. Next slide, please.

We will then hear from two different MMPs; both of whom, I might note, are from the frigid Midwest so they get extra credit for showing up to present to us today and to their offices. We are going to hear from them about how they engage their own members in the governance of their plan serving Medicare-Medicaid enrollees.

We will first hear from the team from Aetna Better Health of Michigan; Angela Addo and Kathryn Hanfland. Angela is the Community Development Manager at Aetna Better Health. In this role she heads up the Community Outreach Team to increase brand awareness and grow plan membership among Medicare-Medicaid enrollees.

Kathryn is part of this team, serving as the plan's Community Development Coordinator. As part of her role she plans and facilitates the plan's Member Advisory Council meetings. Angela and Kathryn will share with us information about the structure of their council, how they recruited and supported members to serve on it and, very importantly, the kind of impact it has had on plan operations. Next slide, please.

We will then change to Ohio and then hear from the team at CareSource; Kristina Rossi and Robyn Rohr. Kris is the Director of Consumer Experience at the plan. In this role Kris leads efforts to help the plan see itself through the eyes of its members. She is responsible for connecting plan leaders with member insights that inform their decision-making and development opportunities.

Robyn is the Senior Insight Manager responsible for developing a common understanding and focus on consumer experience by ongoing research, collaboration and maintaining a shared consumer understanding. In this role Robyn designed, developed and maintains the plan's Member Advisory Committees.

Like the team from Aetna, Kristina and Robyn will share with us information about the structure of CareSource's councils, how they have recruited and supported members to serve on them, and examples of the influence and value they have had on plan operations. Next slide, please.

Here are our learning objectives for the session today. By the end of today's webinar participants should be able to demonstrate knowledge of the member engagement approaches used by MMPs serving dual-eligible beneficiaries. They should be able to recognize strategies that health plans use for recruiting a diverse group of members for roles in plan governance.

They should identify issues in which members who are engaged in health plan governance can have the greatest impact. And they should also be able to recognize strategies for building a culture of engagement within health plans and other systems that are serving populations with complex health and social needs. Next slide, please.

Today we are going to go through this agenda. This is a sense of how it is going to go. We are going to start with a couple polls to get a sense of who is in the audience. We will then shift into a brief overview that I will offer to make sure we are all on the same page about what we mean by governance and why it is important to engage members in plan governance.

We will then hear from our speakers but we will also leave plenty of time for questions and answers. Then finally we ask that you all stay on afterward just to complete a brief evaluation of the webinar. It really helps us what you gained from it and what we could improve on and offer the next time. So, next slide.

Let's start with our first poll to understand who is with us today. First poll is, in what setting do you work? Health plan, ambulatory care setting, long-term care facility, home care agency, community-based organization, consumer organization, if you are in academia or there might be other. Please just select one. We will give everyone a chance to choose one.

Ok, I think we are almost getting all of the results. Maybe we can start showing the poll results. Okay the web, I suspect we may not have absolutely everybody who responded yet showing here but by far our primary audience here is health plans, which make a lot of sense.

Let's go to the next poll. We are going to dig just a little bit deeper to find out who you all are. If you could select the button that best describes your professional area whether you are a health plan, case management, care coordinator, whether you are in customer service at a health plan, administration or management, whether you are in another type of healthcare administration, some sort of provider in pharmacy, social work, advocacy, policy or research or something entirely different. Again, you can only select one so just select the one that best describes your professional area.

Okay, why don't we take a look at who we have in our audience? Let's take a look at the results. It looks like we are largely, again, reflecting our last poll we have lots of folks from health plans. We have a good segment, about one quarter of our audience, who are case managers or care coordinators as well as about a third that are in administration and management in health plans. Great, thank you so much. It is great to know that we have a lot of concentration in health plan participants.

Let's go to the next slide. Oh, I'm sorry this poll came next. Let's also get a sense of how you all currently engage your members, or if you are a provider not in a plan your patients, as the case may be. Do you use advisory councils or committees? Do you have members that are part of Boards of Directors or Committees involved in quality initiatives, focus groups, surveys, or something altogether different. In this case you can choose all that apply.

Okay, why don't we go to the results? Okay, about half of participants note they use committees and councils. A good number of people involve members or patients in quality improvement initiatives and lots, almost half, also use surveys and a good number use focus groups. That's terrific. It sounds like there is a good smattering of approaches.

Okay now we will go to the next slide to the overview about what we really mean by governance; just to make sure we are all on the same page, as I said earlier, and also why it is important to engage members in these approaches. First, what do we mean when we say engagement in plan governance? We are really talking about engagement at the organizational level for the purpose of improving the design and operations of the plan or practice.

This is quite different from the kind of member engagement we hear an awful lot about these days which is engagement of the member in their own care. That is not our topic today but I will note there are many resources on this topic on the Resources for Integrated Care website from previous webinars and other publications.

So, again, what we are referring to today are those types of approaches that include soliciting member feedback through the mechanisms we just polled you on; advisory committees which will be most of our focus today. But as I said it can also refer to members serving on boards of directors or board committees, quality improvement workgroups as well as participation in other approaches to gather member feedback through town hall meetings, member meetings, focus groups or surveys.

So why solicit member feedback in the first place? What is the value proposition? For this I wanted to point you to the National Academy of Medicine who in 2017 developed a guiding framework for what they call patient and family engaged care. I always find this helpful in understanding why these types of approaches are helpful to improving care overall.

Basically these types of structures we just talked about are the kinds of strategic efforts necessary to produce several types of positive results. This is in that National Academy of Medicine framework. Those results include better engagement which can be seen, for example, through increased member or family activation; better decisions, which may be reflected for instance in increased health confidence in making decisions about care; better processes such as improved

care coordination and better experience with the plan providers and most importantly the member, which can be indicated by improved communication or a decrease in grievances.

I encourage you to take a look at that framework at the NAM website. I also should note it also includes a wonderful bibliography of the emerging evidence base for member engagement. Finally, when we ask why engaging members in governance is important we believe that decisions related to member care should always involve members. This reflects strongly the principle of co-design which I am sure many of you are familiar with as well as the oft-heard of mantra of communities like the disability community who say, nothing about us without us.

So with that as an overview I will turn things over to my colleagues at the Center; Leena Sharma and Marc Cohen. Leena, Marc?

Leena Sharma: Great, thank you, Renée and good afternoon everyone. In our brief presentation today my colleague, Marc Cohen and I will be sharing with you some of the findings from our recently published paper on Consumer Advisory Councils in the capitated model of the financial alignment initiative.

As most folks know Consumer Advisory Councils are a requirement written into the three-way contracts between CMS, the state and health plans, Medicare-Medicaid plans. These requirements range from very simple to detailed requirements. So, for example, as you will see on this slide here Michigan has very detailed requirements mandating that advisory councils be composed of at least one-third enrollees. Participants should reflect the diversity of the enrollee population. At least one-half enrollees, caregivers and local representation from key community stakeholders such as advocacy organizations, safe space organizations and other community-based organizations. Next slide, please.

We were really interested in understanding the composition, function and impact of Consumer Advisory Councils now that the demonstrations had been operating for a few years. In order to really understand those different aspects of Consumer Advisory Councils we collected and analyzed data through a mixed-method approach. We first conducted an online survey which we distributed to 35 Medicare-Medicaid plans with 5,000 or more consumers enrolled, 21 of whom responded to the survey. You will note here on the slide that eight plans from these states responded to the survey.

We also conducted telephone interviews with consumers, consumer advocates, health plan representatives and officials from the CMS Medicare-Medicaid Coordination Office. Next slide, please.

One of our first finding was around consumer advisory council recruitment and training. Based on our survey responses it shows that many of the plans don't have typical formal processes to recruit enrollees to participate on the advisory councils but they have various outreach strategies to recruit members.

For example, they will use their Care Management or Member Service departments to identify potential participants. They will invite enrollees with whom they or other members of the

advisory council have prior relationships or they will conduct outreach to enrollees at community events, or through community-based groups or perform direct outreach to enrollees through either cold calls or flyers.

Also asked a question about trainings and the response was 65% of the plans reported they train consumers on how to work effectively on advisory councils. These trainings range from formal orientations that feature mock advisory council meetings to casual overviews of the purpose of the advisory council and the consumer's role. Next slide, please.

As you will see on this slide one of the questions we asked and what we found was around how participants are supported and what incentives are provided to consumers. You will note that transportation, food, ability to accommodate by a care attendant were the most popular forms of supports provided to participants. The other ones are meetings are held in ADA-compliant locations, there are translation services provided, some provide gift cards and stipends and 5% provide child care. Next slide, please.

Our next finding was on common topics on consumer advisory councils and how agendas are set. This was a select all that apply question on the survey so they do not have to be included one very agenda and many plans vary on how they determine which items get included on the Consumer Advisory Council meeting agendas and then the type of items they commonly discussed.

Nearly all of the plans reported that their staff and consumers work together on setting the agenda. As you can see on this chart the most common topics was member benefits and care coordination being the most popular; member benefits at 57% and care coordination at 52%. Next slide, please.

On this slide you will note some of the responses we received on racial and ethnic representation on Consumer Advisory Councils compared to plan membership. As you noted on the earlier slide in Michigan having diversity of enrollee population has been written into the requirements of a lot of the Consumer Advisory Council on three-way contracts and having diverse consumer representation is necessary to ensure that the needs and voices of different communities served by the MMP are considered.

Our survey asked respondents to report on the race and ethnicity of consumers participating on the Advisory Council and within MMP membership. So the dark blue is the percentage of MMPs with consumers of race and ethnicity enrolled and the lighter blue shade is percentage of Consumer Advisory Councils with consumers of race and ethnicity that are participating.

Twenty-one survey respondents were aware of the race ethnicity of the consumers within their membership and of those who participate on the Advisory Council. An important point I want to make is we obtained this information on whether or not certain race ethnicities are represented but not on the proportion of races or ethnicities participating on the Advisory Council or within the member body.

The information collected here suggests that there are disparities between the reported race ethnicity profiles of MMP membership and that associated with consumer representation on the Advisory Council. For example, the Asian Native American population are the most under-represented of the 12 MMPs that enroll Native Americans, Alaskan Natives and Pacific Islanders. Only three have consumers from this community who participate on their Consumer Advisory Councils. Next slide, please.

At this point I will turn it over to my colleague, Marc Cohen.

Marc Cohen: Thank you very much, Leena, and thanks everyone for joining us today. One of the important learnings from our research is that Consumer Advisory Councils don't just automatically set themselves up but they really require investment to work well and be effective. Creating and maintaining them is a serious undertaking that requires staff, time and resources and a dedication to listening to consumers.

It also requires a level of activity at the meetings that ensures that the consumer voice is drawn out and heard. The results of the survey suggest that the most common challenges faced by plans are that enrollees wanted to discuss personal issues rather than agenda items and that plans themselves faced difficulty recruiting consumers to participate in the councils.

Even for those who come to regular meetings almost two in five plans reported that members do not actively participate. There are some difficulties associated with retaining members. Some of the plans presenting a little bit later on will share how they address these particular issues.

During our qualitative interviews one of the members of the Advisory Council said that what was most important is making the experience on the Advisory Council member-focused which makes it easier for them to know what their role is. The meeting has to be "kept in a place where consumers are able to give input and advice on issues that seem most relevant to them." Next slide, please.

Overwhelmingly the information from the Advisory Councils is shared with plan management. In fact, more than half of plans indicate that their management participates in these meetings. The other half of plans has staff report back to them. Clearly the presence of staff at the meeting signals they are valued by the MMP.

Most plans did not have the staff that participates in the Advisory Council report directly into the plan's quality improvement area. This is something the plans want to think about in terms of assuring that there is good coordination about the information that flows from the Advisory Committee back to the plan so they can obtain results.

Bidirectional flows of information between Advisory Councils and plans are necessary to ensure that the Councils can create meaningful change. These channels allow consumers to communicate feedback to health plan leadership and health plan leadership can then make decisions based on this feedback and communicate progress back to Advisory Council participants. Next slide, please.

Almost all plans share information from plan leadership back to the Advisory Council. When this is done information is typically provided by other health plan representatives who attend meetings in person or sometimes remotely. Of course when plan leadership attends they themselves provide information and most of it is done verbally and not necessarily in writing.

We expected that plans utilizing multiple methods to communicate with the Advisory Council would also support multiple modes of communication in the other direction; that is from the Advisory Council back to plan leadership. In fact, we did find a strong correlation between the number of methods used to communicate to plan leadership and the methods used to communicate from leadership back to the Advisory Council. The implication is there appears to be a reciprocal commitment to making sure that the information generated at the meetings and their impacts on policy and/or practice are communicated in multiple ways. Next slide, please.

A key question that underlies all of this research is whether and how the Consumer Advisory Councils influence policy and/or practice that makes a real difference for consumers. As shown in this slide survey respondents report that Advisory Council deliberations have indeed changed how plans perform member outreach and how they structure or deliver benefits. Moreover, results of discussions have also altered how non-medical challenges, that is certain determinants of health, are also addressed.

Clearly most plans believe the deliberations at these meetings have led to both practical and very granular changes in practice. For example, changing non-emergency transportation vendors, as well as to changes to plan policy as it relates to enrollment including the way plans communicate and do outreach to members. To be more concrete an Advisory Council member recounted how a members' 90-day of prescription medication by mail had been changed in a way that led to medications being dispensed in 30-day quantities. Members were not aware of this.

The staff participating in the Advisory Council brought this concern to the Quality Improvement Team who confirmed what consumers were reporting and the challenge this presented to them. And the plan quickly reinstated the 90-day supply of medications. This again makes the point that was made earlier is that these councils provide invaluable institutionalized platform or mechanism for consumers to let plan leadership know what is really important to them. Next slide, please.

I am going to raise just a few concluding thoughts that supplement what is on the screen in front of you. First, the vast majority of plans operate Advisory Councils for the value they provide for both the plan and their membership. We discern a sincere desire among many plans to elevate the consumer voice into their operations which was at the core of why and how they operated their Advisory Councils.

Second, it requires ongoing engagement with Advisory Council members to develop meaningful meeting agendas, to overcome physical, financial and language barriers and to be very intentional about creating efficient and reliable feedback loops.

Third, the issues addressed in the Advisory Council meetings did have an impact on a host of issues which demonstrates the real potential these councils have to better help plans meet the needs of their membership.

Finally, these bodies require investment in training and educating members on the purpose of Advisory Councils, how to communicate ideas and thoughts effectively, how to develop and stick with an agenda and the need to focus on systemic, and not necessarily personal issues. This also means investing in assuring diverse representation on the council by targeting specific communities for recruitment. In particular those who have historically experienced disparities in accessing healthcare.

At this point I am going to turn it over to Angela and Kathryn to continue with our presentation.

Angela Addo: Thank you very much. My name is Angela Addo. I am the Manager of Community Development for Aetna Better Health Premier Plan here in Michigan.

Kathryn Hanfland: Good afternoon. My name is Kathryn Hanfland and I am a Community Development Coordinator for the Aetna Better Health Premier Plan here in Michigan.

Angela Addo: Today we are going to be talking about the fundamentals of engaging members in plan governance. Next slide, please.

I will start with a brief overview of Aetna Better Health Premier Plan in Michigan. We are an MMP, or Medicare-Medicaid plan serving individuals 21 and over who are fully eligible for both Medicare and Medicaid. We are the second largest MMP in Michigan with about 6,500 members. We were launched in 2015 as part of the Medicare-Medicaid Financial Alignment Demonstration which is called MI Health Link here in Michigan.

The demonstration here in Michigan has four service regions. We operate in three of them. Two are on the southeast side of the state and one is on the southwest side of the state. We will talk about that a little bit more in the presentation. I just want to draw your attention to our Aetna value wheel here on the right side of your screen. It talks about our four core values; integrity, excellence, inspiration and caring and it just says that everything we do here at Aetna centers around the people that we serve. Next slide, please.

I want to give you a brief overview of our Premier Plan membership. So this is the total membership for the plan. This shows our membership by race. About 49% of our membership is non-Hispanic white and 41% is non-Hispanic black. About 2% of our membership is Hispanic and about 2% classify themselves as other which could be Arabic, Native American, or Asian. We do not know the ethnicity of about 6% of our population as it was not provided during the time of enrollment. Next slide, please.

This slide shows our membership by sex and age. One thing that I did want to point out is that 55% of our members are under the age of 65. So when you think about individuals who are eligible for Medicare in any way you tend to think of individuals who are 65 and up but we do service individuals who are 21 and up. We have a large portion of our population who are from

the ages of 21 to 64 but we always just try to keep that in mind when we think about the way that we do outreach and the way we recruit members to our advisory council. I just wanted to add that 57% of our membership is female. Next slide, please.

Our advisory council here in Michigan is composed of members, stakeholders and guardians of enrollees. The purpose of the council is to gather feedback about plan programs, services, materials and cultural competence. Our advisory council also reviews and recommends strategies for creation and improvement of all program services and materials. Next slide, please.

I wanted to give you guys a brief overview of how we recruit members to our advisory council. We use two methods primarily; community outreach events which includes senior health fairs, food distribution and events at senior housing facilities. A lot of times we will have a member come up to us and say they are a member of Aetna Better Health Premier Plan and sometimes they will even show us their card and they will give us some feedback about the plan.

We try to keep our advisory council applications on-hand at community outreach events so that we can hand it to someone fi they express interest in the advisory council once we talk to them about it and they can fill it out then or they can take it and mail it. Our application is also available on our website online so members can download it and send it in if they are interested in participating.

We also use our Care Coordination Team to make recommendations about advisory council members. Our Care Coordinators will often recommend members who are very actively engaged in their care plans or who provide really good feedback about plan services and how they are working so they feel like if a person is able to really be active in their own care planning or provide good feedback they would be a good candidate to participate on our advisory council. Then we will have the person fill out an application. Next slide, please.

As I mentioned earlier Aetna Better Health Premier Plan operates in three of the four service areas in the state of Michigan for the MMP demonstration plans. We operate in region four which is in Southwest Michigan and contains eight counties. This region tends to be more rural. We operate in region seven which is Wayne County where the city of Detroit is located. We also operate in region nine which is McComb County. Region seven and nine are more urban areas.

You can see a brief overview of the demographics of our members. In region four we have 16 members and three caregivers on our advisory council. Our advisory council is 58% female and 53% Caucasian. We also have Native American representation on the advisory council and the age range is 33 to 74.

In region seven to nine we have seven members; 57% of our members are female, 100% of our participants are African American and their age ranges are 39 to 74. We did want to point out if you look at our two advisory councils on each side of the state in total it is a closer representation of our plan membership as far as demographics are concerned -- 50% of our total advisory council is African American, 46% is Caucasian and of course 4% is Native American.

One thing we are looking at next year is we want to assess where we have any diversity gaps on each side of the state and tweak our recruitment efforts to ensure that the council is representative of the plan in each region.

Our council meets four times a year on each side of the state; so we have eight meetings in total. We provide transportation along with a $25 stipend and lunch to support participation. I really want to emphasize that our council is fully engaged with the plan. We do not have issues with attendance. Our council members are super excited to attend the meetings and when they do miss a meeting for whatever reason they are really upset about it. So we have great participation from our council. Next slide, please.

With that I will pass it to Kathryn so she can talk to you about building a culture of engagement.

Kathryn Hanfland: Thank you, Angela. I want to discuss about how we build a culture of engagement in our advisory council. First off we do encourage an open environment free of judgment. Our MAC charter actually indicates that each member (inaudible) be confidential and anything that is shared with any advisory council meetings that we listen to each other with respect of each other's views and opinions.

In addition to that every meeting we have we do have a little verbiage at the bottom of our sign-in sheet that just reiterates the policies for the MAC charter, that we do respect each other's opinions and that we keep everything confidential. This includes any guests that come to the meeting that are not regular attended advisory council members who do also sign a nondisclosure agreement.

In our advisory council all of the topics are centered around the members, not the health plan. So our members have the floor for the majority of the meeting and our members, caregivers and partner agencies sit at the board room table and staff tend to sit along the wall depending on the size of our meetings that day we could have additional guest speakers that make our meeting larger so our staff tends to sit away from the table so the focus is still on the members and the caregivers.

Our advisory council members can suggest meeting topics. For instance, we could have a member suggest transportation and our transportation vendor has been coming to the meetings for the past few years and our members provide them feedback on other policies and what they could do to help improve the transportation process. For instance, they did suggest perhaps having ID cards for their drivers so they can verify they are working for the transportation company as well as improvement to the transportation vendor customer service team.

Our members are also able to invite guest speakers so if they have topics or people they would like to hear information about that could help our health plan they are encouraged to invite people to attend and we can get that put on the agenda. Our members do lead the conversations. When we have our vendor with transportation there our members are fully engaged and they are the ones doing all of the leg work. We are just the ones there to help facilitate the flow of conversation.

Members can also provide feedback on proposed agenda items. We typically will send out the invitation to the meetings about one month prior to the meeting that is scheduled. Inside that invitation we do include a proposed agenda. If a member decides there is something they want to talk about they can call us with a proposed agenda item. Or at the end of all of our meetings we do ask them to provide any new topics that they want to discuss for the next council meeting.

We did have one of our members ask for information about the opioid crisis and how it affects access to pain medications. One of our meetings we invited our Director of Pharmacy who discussed the limitations of prescribing opioids and the hoops we have to jump through to get those medications administered. Because of that our members have an interest in the Narcan training learning about the opioid crisis so we are looking at implementing those kinds of trainings as well as the CPR classes they have expressed an interest in as well. Next slide, please.

If you look at the graphic on your right you will see how our advisory council, the health plan and the Quality Management Improvement Oversight Committee all work together. The flow of communication is open and they all report back to our plan's governing board. To keep that fluid one of our advisory council members also serves on our plan's governing board to act as a liaison between the two entities.

Our CEO also attends all of our advisory council meetings as well as all of the plan's governing board meetings. In her absence, if she is unable to attend, she does send the COO for consistency of executive leadership in both of those meetings. All of our advisory council meetings are reported to the Quality Oversight Committee as well as the plan's governing board and here you will find the importance of having the advisory council members serve on the governing board so that they can ensure the information we did report on the minutes is properly reported to the governing board.

Members can provide feedback from any of the council meetings to the health plan that need to be implemented. It gets reported to the respective department of the health plan. If any changes or updates need to be made they are shared with the committee and reported back to the advisory council. Next slide, please.

The impact the advisory council has here at the Aetna Better Health Premier Plan most recently is member communication materials and marketing pieces. Our members wanted to have more information about communication in what is happening with benefits and typical health information so that has led to the creation of a member magazine we are actually working on. This magazine will contain any updates about benefits for the health plan that will also be included in their new member handbook at the beginning of the year. However, it is in a more attractive format as far as a glossy, magazine-type style publication.

We would have updates about benefits as well as different health issues like in the flu season an article about getting your flu shot and any kind of vaccinations that are pertinent to our membership body. This past year we did a complete overhaul of our member outreach brochures and materials. Our members provided feedback on the appearance and content of the brochures.

They wanted us to include more inclusive photos that reflect the proper age, sex and race of our membership population. So we did add some more diverse photographs in our marketing materials and made the materials easier for communication to our audience. Council members do bring us information about competitor benefits and ask us to compare our offerings to make our health plan more competitive. Based on this information we do review that and sometimes we can add to or change our benefits. As any new or revised benefits are implemented and the marketing materials for the benefits are designed the council is consulted to ensure that one, the benefit is administered in any way that makes it easily accessible to members and two, that the marketing materials clearly communicate what the new benefit is.

This past year we did a revision of our value-added benefit package for members. The past few years we had an over-the-counter benefit of $20 per month from a specific catalog. Based on recommendations from our council we changed that this year to a $90 quarterly amount they can use by either a debit card taken to participating retailers or on our website. We do have an online link so they can order those items as well. If they have any issues accessing the internet their care coordinator can help them with that too.

Also additionally for 2019 our members highly advocated for a fitness benefit to be more competitive with the other health plans so we did add that to the new benefits. With the revision of these new benefits came to the next slide we will get into and I will show you the breakdown of what happened. Next slide please.

On your screen you are going to see an example of one of our newest brochures we came up with this year. On the left-side of the screen we did include a more diverse photograph that represents our member body as well as right next to it is a list of all of the covered benefits that are required of all MMP plans.

On the other side of that flyer is a breakdown of all the additional benefits that Aetna Better Health Premier Plan offers our members. So we highlight the difference of what is basic coverage and what we cover in addition so this also highlights the increased over-the-counter benefit as well as the new fitness benefit that we offer. Next slide, please.

I am going to hand it over to Angela and she is going to talk about our CAHPS scores.

Angela Addo: Thank you, Kathryn. One of the things our advisory council has been really helpful with is getting a little bit more insight into our CAHPS scores. As many of you know CAHPS is the Consumer Assessment of Healthcare Provider and System Survey. We just wanted to get a little bit more insight into some of the scores we would like to improve.

The first thing we wanted to ask our advisory council members about was how we could improve our response rate for the survey. We explained to them that it is a survey that health plans send out to assess member satisfaction with the plans and providers and we just wanted to kind of get their feedback about that. We also explained to them that the survey is used to compare us against other plans that are similar to ours.

One of the things that they asked us is who actually receives the survey? We explained that we don't know who receives it but it is only a subset of the membership. So the advisory council suggested we send out a communication to all of our members prior to the implementation of the CAHPS survey to let them know that the survey is coming out and we would appreciate their honest feedback. They also said that we should let members know if there is any outstanding concerns or anything they wouldn't rate us well on they should contact Member Services and see if they can't get those issues addressed.

One of the other items we wanted to ask advisory council members about as far as our CAHPS scores were concerned was the availability of specialists in our provider network because our scores are not where we would like for them to be. So the advisory council gave us feedback that perhaps one of the reasons people didn't rate us as we would have liked to have been rated was because there is some confusion about prior authorizations and what services require prior authorizations and the difference between prior authorizations and referrals. So as part of the member magazine that Kathryn mentioned earlier we are putting that article together to explain the difference between referrals and prior authorizations and to list some services that might need prior authorizations.

We also learned during this discussion that especially on the west side of the state where we have a more rural area that specialists are not as easily accessible as members would like them to be. We are sharing that information with our Provider Services team to ensure that certain specialists are more easily accessible for our members.

There were also two other kind of topics that came from discussion with our advisory council about ways we can better communicate with our members and educate our members. Our members expressed they were having issues accessing their dental benefits. What we found out was our members would call the dental office and say, "Hey, I have Aetna, do you accept that?" The dental office would say yes we do but in fact Aetna Better Health Premier Plans are covered by Dentaquest. So we identified that as an opportunity for member education about how members actually access their dental benefits so we are creating a marketing piece to notify members about all of the dental services that are covered and to let them know if they need help finding an in-network dental provider they should contact Member Services.

We recently learned that members are not aware of the grievance and appeals process and that they do have the right to file a grievance or to appeal a decision the health plan made that they are not satisfied with so we are in the process of creating educational materials around that particular topic as well. Next slide, please.

With that I will pass it to Kathryn to wrap up.

Kathryn Hanfland: Thanks, Angela. We talked about the impact of the advisory council on the health plan itself but we want to wrap up the discussion about the impact the Advisory council has on our advisory council members. With that our advisory council members have a shared sense of purpose among our members. They are making a difference to the health plan, our members and potential members that will enroll into our health plan. They meet other people and other members who share similar experiences and members experience gratefulness at the

knowledge they are not alone in their health journey; that some people have similar experiences, whether it be housing issues, whether it be certain ailments but it is nice that they meet people that have these same experiences in life.

They meet new friends among these. So a couple of our members have exchanged phone numbers and interacted with each other between our meetings. That is something we encourage at the health plan; socialization. Watching these relationships flourish over the past few years has been very warm to know that this comes from the advisory council.

They have a feeling of family so our advisory council is very welcoming. Everybody knows everybody and one of our members shared that her council was like her family and that the health plan and the membership of the council shows better concern for her in certain instances than her actual family. So that is something that is openly expressed and we find very beneficial to our particular council.

Our advisory council is member-centered as I reiterate but it is also very self-sustainable. We have 100% confidence if we were ever to leave the health plan, Angela or myself that our members will continue leading the discussions and the council will continue. Aetna Better Health Premier Plan staff helps plan and facilitate the meeting but the members do lead it.

One last example I kind of want to leave you with is we hosted an Aetna Senior Leadership Meeting here at our office in Detroit and as part of their visit we had our member advisory council members make a presentation to our executive leaders from all of the Aetna Medicaid plans in our region including two other MMP plans so that they can provide insight to successes and barriers in our programs. It was powerful and they provided invaluable insights and I think it further demonstrates the value that we place on the inputs of our advisory council.

Our members feel empowered to make these decisions and to speak on behalf of all of our members here at the health plan. Aetna as a whole has a tag line, you don't join us, we join you. With our advisory council it is just that; they don't join us, we join them.

Thank you for listening to our part of the presentation. We are going to pass it over to Kristina Rossi and Robyn Rohr.

Kristina Rossi: Hi, thank you. This is Kris and I lead the Consumer Experience Department at CareSource. Robyn and I are pleased to share our approach for creating successful advisory councils today. Next slide, please.

CareSource -- I wanted to offer a bit of context about CareSource. We are a non-profit, mission-based, managed-care organization founded in Dayton, Ohio in 1999. We serve approximately two million members across four different product lines and we are in five different states or markets as we refer to them.

As a company we focus on the most vulnerable populations with our largest volume of membership being in Medicaid. Our MyCare demonstration which is relevant to our topic today

is based in three regions in northeast Ohio which is the Cleveland area and has approximately 30,000 MyCare members. Next slide, please.

Our consumer advisory councils are part of a larger strategy within CareSource on member and provider feedback. The consumer experience, or CX Department, manages our advisory councils in most of our markets of business and that includes MyCare. Within our department we have staff who are responsible for ensuring success. As Marc mentioned earlier advisory councils are a very large effort and we want to make sure they are meaningful for our members as well as for our business owners.

What you will see here is kind of a large-scale process flow that shows you how we use feedback that we collect. The first part of our process is the CX department collects qualitative and quantitative feedback across all product lines and markets. We collect this information via surveys and other methods including the advisory councils.

The second part of our overall process involves sharing that information back with our market leaders and business owners. So we share detailed summaries with those leaders and we also regularly share overview summaries with the entire organization via our internal website. We try to be as transparent as possible with our staff about the information we gather about our members.

Finally the goal of sharing this feedback is really to drive improvements. Accountable parties form action plans to address areas of opportunity that are identified through these various methods. Now I am going to hand off to Robyn Rohr, a Senior Insight Manager within the Consumer Experience Department. Robyn has played a lead role in developing and refining our Member Advisory Council approach.

Robyn Rohr: Thanks, Kris. As Kris mentioned we conduct quarterly council meetings in each of the three regions we serve our dual eligible members. The meetings are 90 minutes each and we follow an interactive, focus group style format. In addition to the MyCare member and family caregiver attendees we also include community advocates and local ombudsmen. The meetings are well attended by CareSource employees, as Kris had mentioned.

These employees might be care managers, those in positions of leadership at CareSource and others for whom the discussion topics might be hyper-relevant. For example, if we are getting feedback on the effectiveness of a particular member communication piece the marketing team member responsible for this document would come to hear this member feedback directly.

As another example, during last quarter's meetings we conducted user testing of our new website. A few of our digital strategy team members came to the meeting to watch the members interact with the new platform. Through this exercise we also learned a lot about our members' online habits and the challenges that many of our non-computer-literate members face. Next slide, please.

Our member meetings have evolved a lot in the last four to five years to be true advisory meetings. We think of them as ongoing focus groups which really helps to guide our approach

and gain insight to drive improvement strategies. We found the best meeting locations are free or low-cost facilities that are well known and easily accessible. So places like community centers, YMCAs, libraries and senior centers work very well.

Meeting times that are scheduled around the lunch hour also make it convenient for the members to attend. Evening meetings though are sometimes necessary to accommodate member schedules as well.

To maintain diversity we randomly recruit members who are mapped to be within a close radius to the meeting facility. If they live within a 15 or so minute commute they are more likely to come to the meeting. We also like to make sure the meeting location is close to a bus stop when possible.

Our goal is to land on an established group of members as Aetna does who consistently return to the quarterly meetings. By having established members you are able to build upon learnings over time and work very collaboratively on developing new initiatives with this group. Kathryn talked a lot about the ways they do that as well. If different members come to each of the meetings it is much more difficult to do this.

When establishing a new council it might be necessary to cast a wide net the first few meetings. We may mail invitations to 3,000 members in order to get 10 to attend but if they see value in a meeting they are very likely to return to the next one. After a few rounds of this initial recruiting you should be able to land on an established group of around 15 or so who will return to the upcoming meetings. Our goal is to have around ten members at each meeting for an ideal focus group format.

To prepare members to participate effectively orientation and training is provided to the new groups to set expectations and provide motivation. A few expectations we set for council members is that they are active participants and that they share their feedback. We also set the expectation that CareSource will utilize their feedback and drive improvements from that feedback. We collaborated with community catalysts and a state advocacy group to provide the training to our councils. As part of this training the members helped create rules of engagement for meetings such as giving attention to the person speaking and limiting sidebar conversations.

These rules of engagement were really helpful and we printed them onto a poster board and display them as a reminder at each meeting. In addition, conversations around what contributes to the success of an advisory council as well as their hopes and fears about participation in that council were also included in the training.

Advisory council t-shirts were designed and provided to the groups. They are worn to each meeting and they really help bond everyone as a group. The CareSource employees also wear the t-shirts to help provide a level playing field and they make the members feel more comfortable and the members really do love wearing those shirts. Next slide, please.

The Consumer Experience Department has strong relationships across the company that we leverage to ensure we are getting the most valuable insight from members to drive

improvements. Meeting topics often include current and future communication pieces, digital tools such as our website or mobile app and programs and services we provide, much like Aetna.

In order to demonstrate we are listening and taking action on their feedback we begin each meeting with an update on what we have done as a result of the feedback received at the previous quarter's meeting. So we find that this is kind of our secret sauce for ensuring that members return to the meetings. It is a chance to demonstrate we are listening and that their feedback really does make a difference.

We also always reserve time in the agenda to allow members to bring up their own topics for discussion and we have care management staff in attendance to help individual members troubleshoot issues they may be having after the meeting as well. When and if a member brings up a personal health question in a broad group discussion we let them know that we respect their privacy and that someone is there to listen and assist after the meeting. We want the member to feel heard but we are cautious not to derail the meeting or violate anyone's privacy even if they bring up the issue for discussion. This is always a great time to get those care managers in attendance involved. Next slide, please.

To implement a successful advisory council program it is important to include the individuals both externally and internally. From an external perspective community partners such as the ombudsman are able to listen to our member feedback and they can also inform us of issues that may be of relevance to our members. The advisory council also provides the perfect opportunity for internal stakeholders to hear member perspectives first-hand. These stakeholders might be from marketing, digital strategy, transportation or really any other relevant area.

They often attend the meetings in person and for those who can't attend we do offer videotapes and written transcripts of all meetings. Full summary reports are written and shared across the enterprise as well, as Kris had mentioned. Across our company we strive to incorporate the member's perspective in as many of our initiatives as possible and we find these meetings to be one of the best ways to gain this insight.

Care management staff are always on hand to address all number of questions and help them troubleshoot individual issues or barriers if needed to. The Consumer Experience Team has dedicated staff, as Kris had mentioned, for planning and executing the quarterly meetings. As we expanded the use of advisory councils across our products and states we began partnering with a research center specialized in focus group facilitation to help us manage the administration of the councils.

This vendor manages the more labor-intensive tasks such as sending reminder invitations, managing our RSVPs, ordering food and making reminder calls. However, CareSource and the Consumer Experience Team remain very actively engaged and we often co-moderate along with the vendor at the meetings. Next slide.

An example of how we have put our member feedback into action can be seen in our Where to Go For Care magnet. Over several meetings we noticed a pattern that showed many members

didn't fully understand the range of care options available to them. Therefore they were often defaulting to the Emergency Room for many of their care needs.

The Consumer Experience and MyCare teams worked together to gather council feedback about how members decide where to get care, what barriers they face and how we can help to better educate them and influence their behavior. Next slide.

Members suggested including high-level information regarding the various places they can seek care for their needs with examples of the types of services offered at these points of care. They also help us to determine the best names for the points of care. We changed our reference of retail clinic to convenience care clinic, for example, because it was more familiar and intuitive to the members. While this graphic is appropriate to use in a variety of communication channels such as a newsletter or on our website but the members felt that a magnet format would be the most useful and durable way to communicate this information. They also wanted to be able to place it on their refrigerator where they would easily be able to find it when they needed it.

Our care managers currently provide this magnet to our members during the face-to-face visits and it is really well liked by the members. The magnets are now also being piloted with some of our Ohio Medicaid members and the impact is currently being assessed. Each year we strive to partner with the advisory councils to drive at least one key initiative like this. These are really big wins for our members and they provide our councils with an example of the impact they are having on the health plan and the lives of our members.

We have learned a lot over the last several years about the strategies for implementing successful advisory councils and we really appreciate the opportunity to share this with you today. Now I will pass it back to Renée.

Alana Nur: Renée maybe is on mute. However, if everyone could enter now I want to just hear a little bit from everyone. Try to keep it with what occurred today from Aetna and CareSource. Renée was that you?

Renée Markus Hodin: That was me, yes. Sorry my mute button was being very slow. I am happy to take it from here if you'd like.

Thanks. Thank you speakers, Kris and Robyn but also to Leena and Marc and to Angela and Kathryn. At the Center we often say when it comes to meaningful consumer engagement the devil is in the details and so I wanted to thank you all for sharing so many of the specific details on how you have created your consumer advisory committees and how you have continued to support members and maintain those councils.

We are getting ready to start our Q&A time. I know that some of you have already submitted questions and answers during the speakers' times but before we turn to those we wanted to turn back to you all in the audience to take a quick pulse and ask you to use that Q&A section on the bottom left of your screen -- there is a little picture of it there -- to ask you of the strategies you have heard today from all of the different speakers what strategies would you like to try at your plan or your practice in order to engage members?

Are you already using some familiar strategies before? Or currently? Have you used them before? Just sort of a brief answer to that question or those questions again using the Q&A box at the bottom left of your screen. I will call out a few of these.

Someone answered that they take the CAHPS survey to the advisory council or maybe they want to. Somebody noted they are already using most of these. Similarly others say they are using similar strategies, member focus groups, providing transportation. Let's see what else.

Oh this is a good one of course. Feed them and they will come. So that could not be more right. Having food is definitely an incentive for showing up no matter who you are. They use somebody wrote that they like the mass email idea. I think that was raised by CareSource. Someone noted they are using gift cards. Boy there is a lot coming in. Thank you all for this.

Oh somebody wrote this and I liked this as well. I like the t-shirt idea and that all the plans shared in regards to personalizing the experience for the members. I think I will just read a couple more because there are so many.

This one we might be able to handle a little bit later. Somebody wrote, we are having a board member attend the Advisory Council and I was concerned her presence would inhibit member participation, that there might be an intimidation factor. That might be something our speakers can speak to in a minute or two.

I will read one more. I really like the idea of conducting outreach to members that are within 10-15 minutes of travel time from the meeting facility to ensure in-person attendance. Yes, that was very smart. Boy there are so many more that I could read. Somebody liked the magnet. Boy sending the agenda ahead of time, those are great practices as well. I could go on and I thank you all for putting this in. We will put this together in order to help inform our following webinars in this series.

So at this time I want to hand it over back to Alana to take us into the Q&A section. We do have many questions. Alana?

Alana Nur: Great, thank you so much Renée and thank you so much Leena, Marc, Angela, Kathryn and Robyn for your presentations. Your insight is very valuable. Yes, we have had a number of questions already come in. We now have a few minutes to answer some of those questions. At this time if you have any questions you can submit them in the Q&A feature you just used for responding to the discussion question as well. So please type them into the Q&A box and press Submit.

I will start asking some of these wonderful questions we are getting. Thank you everyone so much for your questions.

One of the questions we have, and this can go either for the Aetna folks or CareSource do either of you place a term limit on how long advisory council members can serve on the committee? If so, how long?

Kristina Rossi: This is Kris from CareSource. We kind of think about it as being approximately two years. If we feel like the group is maybe getting stale it is possible we would do it more often than that. Likewise we may not always keep it at two years but that is kind of a rule of thumb.

Alana Nur: Angela, do you have any limits for how long members can serve as well?

Renée Markus Hodin: This is Renée. It looks like our Aetna folks got disconnected and they are going to call back in. So let's proceed with some of the other questions for CareSource or for Leena and Marc at the Center.

Alana Nur: Well great. Leena and Marc I have a question for you. You mentioned how important training is and you mentioned a couple of examples. Can you talk a little bit about what you have heard have been the most valuable types of training from participants? Either through the plan or from your interviews or your survey?

Leena Sharma: This is Leena. I can take that question and then Marc if you have anything else to add as well.

Marc Cohen: Sure.

Leena Sharma: I think one of the things I can speak to some of the past experiences we have had working with our advocacy partners on the ground and some health plans. The most helpful types of trainings are ones where consumers are able to get both general education about the program and what the consumer advisory council means and the purpose of it as well as some details around what their role will be. I think they find when they are serving on an advisory council alongside plan staff or someone mentioned earlier a board or executive leadership attending there can be this power dynamic in the room. So training and particularly ongoing training is really useful for members so they can feel like they are sort of on an even playing field and are able to understand the conversation, follow the conversation as well as ask questions that are appropriate to the conversation.

Marc Cohen: One more point on that. One of the things we learned is there is a wide range in the types of formal orientations and trainings. I recall a number of plans talked about having mock advisory council meetings which simulate for people what might actually occur during a meeting and this gets to the point that Leena was making that some people may feel somewhat intimidated and an earlier finding suggested that a lot of people come but they really don't speak up.

Part of that I think is setting the stage, getting people comfortable and so doing a mock meeting might be one part of a training to get people comfortable to speak up.

Alana Nur: Thank you both. To the Aetna and CareSource folks, are there things you have done that have helped your participants speak up and feel like maybe they are more on an even playing field and comfortable participating?

Renée Markus Hodin: I just wanted to confirm you were directing towards CareSource?

Alana Nur: Either CareSource or Aetna, either one of you. I would love to hear from both.

Leena Sharma: What we do to ensure participation is if we notice someone is being kind of quiet we may ask them directly. The group really knows each other. So we try to solicit and draw people out. Just naturally some people are more introverted than others and so we try to ask questions and draw them out if we have noticed that somebody is being quiet. Likewise if someone is seeming to want to talk a whole lot we try to say thank you so much for your feedback let's make sure we are hearing from somebody else. So kind of some basic moderation skills.

Kathryn Hanfland: Hi this is Kathryn with Aetna. To answer that question at our health plan we really have a lot of member participation. They are very open with sharing things that they have but our rapport we have established with them over the years has helped engage them. We also start off all of our meetings with an ice breaker, whether it will be this summer we will go around the room, introduce yourself, where are you from? Are you from a health plan or whatever city you are from and then what you like about summer? Something to break the ice. People find that just relaxes them and gets them ready for engagement in the actual meeting itself.

Angela Addo: This is Angela. I just want to add that I think when people join we always emphasize this is about the member. This is about you. A lot of the change and a lot of the things we do we are not going to be successful unless we have input from our members. So I think when members understand just how important it is for them to kind of share their input and they see how our advisory council meetings are really about the members who are engaging. They become more comfortable with engaging as well.

Alana Nur: Great. Thank you all so much. So going on with facilitation challenges that might come up, Marc and Leena brought up that a challenge is that member may share personal items, rather than things about the broader membership. I know CareSource you spoke a little bit about this. For members that bring up issues that may be more personal or private, what are some of the things that you do and strategies you use and maybe even any specific language that you might use to really bring the focus back to more global issues? That can be for CareSource or Aetna either one.

Angela Addo: Hi, this is Angela from Aetna. I will just say that normally we will say, "Can we table that issue? I will connect you with a care coordinator." Because a lot of times our care coordinators will attend the meetings. We will just say, "You know what? Thank you for sharing that. We want to table that issue but we do want to make sure it is taken care of before or addressed before you leave the meeting."

That is kind of the strategy we use to ensure that personal issues don't overtake the meetings.

Kristina Rossi: This is Kris from CareSource. I would say we have a very similar approach. Same type of wanting to make sure the person feels heard; we maintain their privacy and then try to just let them know we will talk with them at the end of the meeting.

Alana Nur: Great. Thank you both so much. When you started your council either one of you, CareSource or Aetna, were you at all fearful you would get feedback or suggestions that may be hard to address? Or something that is unrealistic or things you couldn't do? Do you come across that as a challenge and is there anything you may have done to address that concern?

Kristina Rossi: This is Kris. We can speak to that. What we try to do when we set expectations is that is really a natural part of that where we let them know we are really looking for their feedback regardless of if it is something we can change immediately. We also try to set expectations in that things such as a benefit design or larger issues is not something likely to be altered within three months. We are not going to be coming back the next time and saying okay we have completely revised our benefits. Here is the new information.

I think it is really about setting expectations but then continuing, as Robyn, said with letting them know how we are implementing the feedback we are receiving. So it is really trying to hold the balance of we hear you, and some things we are going to be able to implement and others might take a while or might not be feasible kind of depending. That is something we don't see as a challenge too often because we set that expectation up front.

Kathryn Hanfland: This is Kathryn with Aetna. We do have a similar approach. Additionally though even if we can't -- when it comes to benefits if we can't tackle that right away obviously it takes some time to update those benefits we do communicate with the members. We recap what was discussed and if there are any new updates about the process or where the suggestions are at within our executive leadership that is communicated to the council members. Just to assure them we did not forget about their question or concern. We are still working on it and we will get them an update as soon as we can.

Alana Nur: Thank you both so much. Turning a little bit towards recruitment Leena and Marc I will start with you. You showed that how plans reported that getting diverse representation on consumer advisory council is a challenge. Do you have any recommendations or things that came out or suggestions for recruiting people from under-represented communities?

Leena Sharma: This is Leena. Marc please feel free to chime in. Just from our experience working with advocacy partners on the ground some of the best practices and best places to recruit consumers are through community-based organizations, senior housing facilities, building relationships with the residence service coordinators has been very successful. Churches and food banks and these are just some examples of places where advocates we have partnered with engaged with consumers.

We have also known that our partners on the ground collaborate with health plans and conduct outreach together so that when people in the community see a trusted organization with a health plan they are more likely to be receptive to what their health plan is asking. We have seen this

happen on the ground in states like Ohio and Rhode Island where partners we have worked with have worked in collaboration with the Medicare-Medicaid plans over there on the ground.

Marc Cohen: One other point to mention is that when we were looking at our analysis and looking at the types of things plans were doing to facilitate people participating we did notice a correlation between the number of what we call accommodations a health plan offers to potential participants and the difficulty they experience with respect to recruiting and retaining.

For example, plans that make the offer of assisting with transportation. They may have food at the meetings. Obviously translation services and so on. The more of those basic sort of infrastructure issues that are addressed the easier it is to attract people and retain them.

Alana Nur: Great thank you Marc and Leena. To both CareSource and Aetna are there strategies, similar ones that Leena mentioned Marc that have worked for you for recruiting people from under-represented communities from your membership?

Kathryn Hanfland: This is Kathryn with Aetna. We have a lot of similar strategies. We provide transportation. Everybody knows that when they come they are going to get a well-balanced lunch that has all the nutrients needed and healthy but also the sense of family. People know who is going to be at the council meetings. They know they are going to see their favorite people. Just even that in itself is something that keeps members coming back.

Kristina Rossi: This is Kris from CareSource. As Robyn just discussed we really take a -- we send invitations to a very broad number of members within the area we are going to be holding our meetings and that has worked effectively to help us to get a diverse group of people, of members. We also offer transportation. That benefit and we have food at the meetings. Those things I think do help provide some incentive.

One thing not particularly as relevant to MyCare but when we think about our other councils is we provide child care. Kind of depending on the audience and the advisory council that can be helpful knowing that can be a barrier for some members.

Alana Nur: Great, thank you. For both Aetna and CareSource how do you go about choosing people that might be a best fit for the consumer advisory council? Can you say a little bit about your application process? What types of information do you gather from potential members?

Kathryn Hanfland: This is Kathryn from Aetna. I'd be happy to answer that question. We have our application on our website and of course we always carry it around but we get just basic demographic information. We have a section on the application that says tell us about yourself and about your background, if you are on any other advisory councils or have any experience in that. Then also why they want to be on the committee, what will they offer to the team? Then are they part of any other part of committees, their race and ethnicity and if they can attend meetings day, night, evenings or weekends and what their availability is.

Do they need transportation? Interpretation? Then what is their membership category? Are they a member, a family member a community organization or just an advocate for the member? We

collect that information and then based on the diversity of the advisory council is who is selected to be on the Advisory Council. So if we have 100% of African-Americans and we had somebody that was more diverse in representing the population and another person with the same qualifications but was from an African-American population we would likely go with the other diverse person and that way we could add more diversity to the advisory council.

So there is a selection process and that does state on our application that we do select based on gender, diversity and the race diversity as well. It is available on our website so anybody can view it as well.

Alana Nur: Kris or Robyn anything to add from your experience at CareSource and your application process?

Kristina Rossi: Yes, this is Kris from CareSource and we really think of it as kind of we I guess would look at it from the other way around. We start with an invitation to a broad group of members. As we said, Robyn had mentioned, it could be about 3,000 invitations that will get us down to perhaps ten regular attendees, ideally 15, who are members of the council but maybe ten at each meeting.

Then from that in terms of the types of things we collect from them we verify eligibility before each meeting making sure the members continue to be our members. That is one check we do. As far as the collecting of information we just confirm we have the accurate contact information because they are our members. This is information we have about them.

Then in terms of the kind of what do you bring to the meeting that is really something we talk about when we are starting up new councils, making sure that the members understand what we are looking for, what will be expected in terms of participation and so we have found this to be a really successful way to find people who self-select as wanting to participate in the program.

We certainly have people who are more active participants than others but that is kind of a natural blending within any group.

Alana Nur: Great. Thank you so much. We are wrapping up on time today so at this time if you have any additional questions or comments please email RIC@lewin.com. Following today's presentation a recording and a transcript will be available on the Resources for Integrated Care website shortly. We also would like to invite everyone to the next webinar in our Member Engagement and Plan Governance series, Recruiting Members and Supporting Participation in Plan Governance, scheduled for March 2019.

As a reminder, additional guidance about obtaining credits and accessing the links to the post-test can be found within the Continuing Education Credit Guide and the Resource Guide on the left-hand side of your screen or at the Resources for Integrated Care website.

Thank you so much for joining us today. Please complete the brief evaluation of our webinar so we can continue to deliver high-quality presentations. If you have any questions for us please email us at RIC@lewin.com.

Thanks again so much to all of our speakers. Thanks to everyone who participated. Have a wonderful afternoon and thank you so much for joining us today.