The Lewin Group
Consumer Advisory Committees:
Recruiting and Retaining Members for Engagement
July 9, 2015 - 2:00pm to 3:00pm

Amy Herr: Thank you and welcome everyone. My name is Amy Herr, and I work with the Lewin Group, and we're so glad you could be with us this afternoon for the Meaningful Consumer Engagement Webinar Series and today's webinar on Consumer Advisory Committees: Recruiting and Retaining Members for Engagement. This webinar is the first in a series presented in conjunction with Community Catalyst and the Lewin Group and supported through the Medicare-Medicaid Coordination Office at the Centers for Medicare and Medicaid Services. MMCO is developing technical assistance and actionable item tools based on successful innovations and care models such as this webinar series. To learn more about our current efforts and resources, please visit http://www.resourcesforintegratedcare.com for more details.

Before we get started, I'd like to remind you that the microphones will be muted throughout this presentation. However, there will be a Q&A opportunity at the end of the presentation. If you have a question, please use the question field on the WebEx to submit it to our team. All of the Q&As and the presentation will be available on the RIC website within a few days. Also at the conclusion of our webinar, we'll have a quick survey about the webinar. Please take a few moments to complete the survey.

At this time, I'd like to introduce our moderator, William Dean. William builds collaborative relationships with Medicare-Medicaid health plans, providing these and other safety net delivery systems with technical assistance and consultative services about consumer engagement and patient activation tools that lead to improved care delivery, better health outcomes, and lower cost of care. Prior to joining Community Catalyst, William was a consultant to the California state senate's subcommittee on Aging and Long Term Care where he staffed bills, analyzed legislation before the committees on human services, health, budget, and fiscal review, and conducted oversight and informational hearings on a variety of issues affecting seniors and people with disabilities. A former geriatric social worker, William is a graduate of Boston College, Salem State University School of Social Work, and the University of the Pacific McGeorge School of Law. William?

William Dean: Thanks, Amy, and thanks everyone for joining this afternoon and for those of you on the West coast for joining in this morning. As Amy said, I'm with Community Catalyst. We're a national non-profit health advocacy health organization that works with consumer advocates in over 40 states to bring the consumer voice to decisions affecting their health care. Those decisions would be both all at the policy level, at the delivery system level, as well as the individual patient provider level.

I'll go ahead right now and introduce today's presenters. John Ruiz, Consumer Liaison with Commonwealth Care Alliance--CCA. John is responsible for creating opportunities to involve members of CCA's One Care program in program development activities and quality initiatives,

including the establishment of five regional consumer advisory committees. Prior to joining CCA, he spent 18 years in the HIV field in various leadership roles. One initiative included overseeing the work of the statewide consumer advisory board for the Massachusetts Department of Public Health HIV AIDS bureau from 2000 to 2005.

Jacqueline Dowdy is a member advocate ombudsman for the Neighborhood Health Plan of Rhode Island--NHPRI. Working there for the past six years, Jackie acts as a bridge between its members and the health plan. Prior to her employment at NHPRI, she worked at Thundermist Health Center in Woonsocket, Rhode Island as the coordinator of school-based health and opened the first elementary school-based health center in the state. Jacqueline received her Master's degree in social work from Yeshiva University in New York in 1996.

Then finally, we're joined by Bessie Deloach, a member of Neighborhood Health Plan of Rhode Island's Member Advisory Committee for Rhody Health Options, a plan for people who have both Medicare and Medicaid. For the last three years, she served as a senior companion in a program administered by the Rhode Island Division of Elderly Affairs and the Federal Administration on Aging. In that role, she assists individuals 55 or older with doctor visits, shopping, managing personal finances, and companionship. Bessie says she enjoys her role as a senior companion and became involved because she knows that navigating the healthcare system can both confusing and frightening, and no one should have to experience that alone. Previously, Bessie held a seat on the state of Rhode Island's Long Term Care Coordinating Council. She has not let her age or her disabilities stop her from doing the things she enjoys most which is helping people. Next slide.

Today's agenda for our webinar is right there before you. We're going to start off with myself just giving a brief overview of meaningful consumer engagement--what is it and why it matters. I'll talk with you a little bit about the toolkit that we've developed for plans and other delivery systems to implement meaningful consumer engagement strategies and the technical assistance that we provide both from Community Catalyst, as well as through our consumer advocates out across the country. Then we'll have our speakers present from their health plan's perspective on successful recruiting and retention strategies for consumer advisory committees. Of course, we'll have the consumer perspective on those approaches from Ms. Bessie Deloach.

We'll conclude the webinar presentations with a couple of polls to learn a little bit more about you all and a question and answer period that you can get some answers to your questions from our presenters. Next slide.

Let me just talk a little bit about meaningful consumer engagement--the basics of why it's important and what we mean by meaningful, consumer, and engagement. When we talk about “meaningful” engagement, we're talking about making sure that your advisory committees have a meeting agenda that's developed with collaboration from your members and is communicated to them in advance of the meeting, so that they have a structure for what's going to be discussed at the next meeting.

It also means that you're getting personal as well as representative stories from your members on an ongoing basis. That feedback should really be about how they're experiencing their care and

how they are hearing in their communities that other people who are similarly situated to them or living in their housing or in their neighborhoods are also experiencing care, because that feedback for the health plan is really helpful and again it is very meaningful.

It also means that the advisory committee is diverse and has diverse representation across the enrollment population, so that goes across the board when it comes to age, gender, race, sexual orientation, languages spoken, disability type, diagnoses--the whole gamut--as well as the folks who are invited to and participating on the advisory committee are not tokenized in any way--that the plan is not checking a box, that they have an advisory committee and that that advisory committee has met four times a year, for instance. The folks there should be valued. Their time and their input should be truly valued and listened to, again, because they're offering these meaningful personal stories.

By “consumer”, what we say there is really that the focus is on the member and the caregiver that you have assembled on your advisory committee and that the focus of the meetings are not solely member education and staff presentations. We have seen that there are some plans that are doing advisory committees where the consumers have a very small role on the advisory committee and their input is not as strong and their voice is not as strong on those committees, so that we would really recommend that the focus of these meetings be on the member and the caregiver and not as much on staff giving presentations to each other or to the members--the consumers that are on there.

Finally, that the advisory committees are really truly “engaging”--that there is active listening going on, that there is reflecting back by the facilitator of what they're hearing from the members, and that there's really a true dialogue about what the members are trying to relay to the plan in terms of how things could be improved. It also means that the plan should develop a feedback loop in which the input of the consumer is communicated up the chain of command through senior management and executive and board of directors--so that there can be some results, some outcomes to their feedback, some answers to what they have either asked or recommendations that they've made, and that there can be improvements that have to do with their feedback.

Of course, we know plans cannot do everything, so then of course, when a plan cannot do what a consumer is asking or what the advisory committee is asking them to do--some kind of explanation as to what the reasons are for that would be really helpful. It just helps people to realize and understand that their feedback is being listened to. Next slide, please.

Again, like I said, we provide toolkits and technical assistance to plans around meaningful consumer engagement. The speakers today have been instrumental in helping Community Catalyst to develop those tools and that technical assistance for plans. We believe that these two organizations especially--Commonwealth Care Alliance and Neighborhood Health Plan of Rhode Island, which are both very successful and highly rated on the CMS star rating plan--that they do consumer engagement at the top 1% of how it should be done in the country. We have those tools available on our website that you'll see in front of you, as well as we do offer one-to-one technical assistance with plans around strategic planning for recruitment and retention.

Consumer training--we've developed a curriculum that we can do a training with your advisory committee members to get them to be the most effective advisory members that they can be. We offer user-friendly tools like invitation letters that basically show how impactful a consumer's relationship can be when they are in an advisory committee. Then we do onsite assessments of how plans are doing their consumer engagement and whether there are some gaps or some improvements that could be made that we would recommend and help them to achieve them. Next slide.

I'm going to ahead and turn it over to John Ruiz to talk about consumer engagement and advisory committees from the perspective of him at CCA. John, are you on mute?

John Ruiz: Thank you, Bill. I'm really excited to be with you today to talk about our success with consumer advisory committees. I'm just going to start with some background information. Massachusetts was the first state approved for the duals demonstration. We specialize in working with adults with complex disabilities between the ages of 21 and 64. Enrollment began October 1st of 2013, and so far, as of May 1st, we have 10,305 enrollees. CCA--Commonwealth Care Alliance--has always had a commitment to consumer engagement. It didn't start with this duals demonstration. It actually started with the duals demonstration for people over 65 about ten years ago. CCA has been holding member meetings and eliciting advice from members from that program on policy and program development activities.

Another indication of our commitments to consumer involvement is that our founders are people from advocacy organizations like Community Catalyst, Healthcare for All in Massachusetts, and the Boston Center for Independent Living. We do this, and we really believe in consumer engagement--not because it's a contractual mandate, but because we believe at our core that consumers bring unique perspectives as experts in their own lives--expertise that we as an organization don't have. We're really serious about--we really feel that our expertise is not complete without the expertise of our members.

We have dedicated staff. I was hired specifically to engage consumers in our demonstrations. The good thing for me--what turned out really well--is that we already had buy-in from the organization to have advisory committees by the time I came onboard, so I didn't have to get the buy-in from the organization that others have to get, but I certainly had to get buy-in for the model that I proposed to the organization. Next slide.

We set out to establish five regional advisory committees, spanning the nine counties where we operate. We have northeastern and southeastern Massachusetts advisory committees, central Massachusetts, western Mass, and Boston. We wanted to do it regionally because we're all about community living, independent living within the community, and so we felt strongly that our groups should be community-based. It also gives them visibility in the community, so that others in the community know that there is a group of people looking out for them.

We are currently meeting on a quarterly basis. Initially, we started every other month to maintain the momentum of the group. Six months into the group, we switched to quarterly meetings. The meetings are three hours long. We have the organization's agenda for one hour. We also have one

hour for the member agenda. This is sort of an open forum where members can actually talk about anything they want to.

We do educational activities as well. We really have to do some education and teach things like our program model, our values as an organization, our principles. We needed to train people on what care coordination means, care integration, individualized care planning. Those are all topics that we wanted feedback on. Unless we do training with members, they're not going to have enough context to give us advice. We made sure that the first meeting was an all-day training. We provide a stipend for people who attend--for attending the meetings--$25 per meeting. It's a total of $100 per year.

We also provide lunch and transportation. We either provide the transportation ourselves or we reimburse people for their own transportation. The meetings are private, although personal care attendants, caregivers, and others are allowed in the meetings to support the member in fully participating in the meeting. For example, we have two people that are quadriplegic and they need their personal care attendants present at the meeting to help them eat their lunch and to help them go to the bathroom and so forth and so on. We also provide ASL interpretation and basically anything else that facilitates the members' attendance and full participation in the meetings. Next slide.

One of the things we wanted to make sure of is that we have a structure for our consumer advisory meetings. There is a facilitator. I currently facilitate all of the meetings. We have a structure loosely based on Robert's Rules, because we feel that there needs to be an agenda in the meeting. People need to speak in turn so that we can actually get through the agenda and make decisions about the type of feedback that we want to give to Commonwealth Care Alliance.

We also allow proxies, so if a member wants to join the group and they cannot be physically present at the group, they can designate someone that they trust to come to the meetings and to represent their interests.

In terms of recruitment, we have used multiple recruitment methods as listed on the slide. The first method we used was a mailing to about 1,000 of our members, hoping to get a 10% return rate. The mailing contained an application for membership and a cover letter inviting people to apply. This was pretty successful, as we ended up with about 80 applications from this mailing. Some of the applicants said that they were motivated or inspired to join by the cover letter that they received with the application, which is a letter that I wrote inviting them to join.

I'm going to just read really quickly an excerpt from that letter so that you know what I'm talking about when it comes to inspiration. Here it goes. “This is a very exciting time in the history of healthcare rights for people with disabilities. The long-held vision for the kind of care that gives people with disabilities control over their own lives, the dignity to make their own decisions and choices, and the freedom to live independently in the community is embodied in the One Care program. We are making history. Will you join us?”

As a result, from the 80 applications, we seated about 48 members, and that left us with about 12 slots to fill with other members who were not yet represented in the groups. Other recruitment

methods that we used included advertising materials, referrals from our clinicians, and care managers, because they had the most contact with our members. We also set out to establish relationships in the community with service providers and disability advocates, and that was another way to solicit referrals. All of the candidates committed to being in the groups for at least two years. As I said earlier, we provided training before asking for input. Next slide.

In terms of retention strategies, retention is actually--I'm not going to sugarcoat it--it's actually more challenging than recruitment: so how do we hold people's interest over the long term? Our best practice approaches include number one--structure and process, which I've already talked about, number two--communication with our members, for example, reminder phone calls, checking in with people who may have missed the meeting and asking them for their feedback over the phone or via emails so that they can be counted in the feedback that was given to CCA. We also hold interactive activities that promote group building. These can be like energizers, ice breakers, small group work, and so forth, much like a trainer would use in a training.

We also make sure that we provide ADA-related accommodations like ample meeting space for wheelchair users and ramps, transportation. We have a code of conduct to make sure that everybody is respectful to one another. We provide transportation as I mentioned earlier. There is an open forum as I mentioned earlier as well, so that people feel, if they didn't feel heard during the one hour that we have CCA's agenda, they have an opportunity to speak out in the open forum or if they want to bring new issues to the group.

There is a feedback loop, and I can't stress the importance of having a feedback loop. We have an internal committee made up of senior VPs and CCA people who have the authority to effect change in the organization. We meet with them quarterly to set the agenda for the next meeting, but also to debrief what happened at the last meeting and figure out and decide what we're going to do with member feedback.

Then at the next meeting we go back to the members and communicate CCA's response to their feedback. That's really important, and at every meeting we make sure that they know that CCA has heard them, has valued their input, and that they will act upon it. If we can't act upon it, we'll certainly let people know why we can't act upon it. It could be a budgetary issue or it could be a regulatory issue.

In terms of what these groups have accomplished so far, I'll just share with you one of the group's successes. Early on in the implementation of the program our communication with members was not great. There was so much happening, so many wheels turning to implement the program, that some of our communication fell through the cracks. Consumers let us know about that at every meeting. For example, "I don't know who my care manager is," "I had an assessment but I don't know what happens next," and so forth.

We developed some letters to make sure that we communicate with our members and not leave them in the dark. One letter says your assessment is coming up, we may need to make an appointment with you, or your new care manager is so-and-so or another letter for people who refuse assessments. We have some people who have refused assessments, and so there is a letter to communicate with them the importance of that assessment. We want to make sure that people

know that they have a care plan, so we actually scripted some of our nurses to make sure that they know that after they do the assessment that the member knows what happens next, because that's one of the areas that we weren't communicating well in. Thanks to their advice, we were able to improve our communication with our members.

That's just one of many changes that we've been able to make as a result of consumer engagement. I'm just going to pass it on to Jackie from Neighborhood Health Plan.

Jacqueline Dowdy: Thank you, John. Again, my name is Jackie Dowdy, and I'm here with Bessie Deloach, one of our members on our Rhody Health Options member advisory committee. Currently, Neighborhood has an MOU pending for our duals demonstration. We have over 28,000 duals in the state of Rhode Island. Rhody Health Options is the health plan option for this particular population. We are currently in stage one of the program, which means that we are currently covering the Medicaid-managed care: long term care folks.

Enrollment began back in October of 2013, and at that point we had about 16,000 enrollees. Currently there are approximately 17,000 duals and approximately 450 Medicaid only members. We at Neighborhood feel as if we have a commitment to consumer engagement. I just wanted to correct Bill: I've been working with Neighborhood for 14 years, and myself and the manager of our external affairs, Ken Pariseau, we've been running our member advisory committees for about 12 or 13 years. Rhody Health Options is our newest advisory committee, because it's our newest line of business.

We truly believe that if an organization does not have staff that's dedicated to making sure that these member advisory committees will work, that they will not be successful. It is my job to facilitate the member advisory committees, and that's a part of my job description. It doesn't fall under that sentence that says "…and whatever else your boss would like to give you." It is actually a role. It is my job to make sure that these advisory committees are being facilitated correctly. Next slide, please.

Rhody Health Options member advisory committees--I'm just going to provide you with an overview. Currently our meetings are being held at Neighborhood Health Plan on a bi-monthly basis. When we first began running them, we were running them on a monthly basis. We provide our participants with a stipend of about $60. We feel comfortable providing that $60 stipend, because we know that we are under the threshold of the $600 that would be considered reported taxable income, and so we're comfortable in doing that. If any of our members are in need of child care, we'll also provide them with a $25 stipend so that they may be able to obtain childcare, so that they can attend the meeting without their children.

Our Rhody Health Options advisory committee is held during the daytime, so we're always very careful to provide our committee with not just a good meal, but we want to make sure that it is a meal that is appropriate because we have folks that have dietary restrictions. We make sure that it works for everyone.

Transportation can also be arranged if necessary, but with transportation and having run these committees--like I said--for about 12 or 13 years, it really wasn't until we began to do it for this

particular population that we ran into some issues that we were not aware of. For those health plans that may be looking to start advisory committees, you just want to make sure that you're aware that, especially with this particular population, that there are a lot of adults with disabilities and folks that were in wheelchairs. It meant trying to identify different modes of transportation than we were used to. We have several cab companies that we're used to working with, and they never required us to ask if you have a wheelchair van or if it's possible if you could transport someone with an extra large walker. These things are really important when you work with this population, so we want to make sure that you're aware of that.

Our structure and composition--as I said, these groups are currently being facilitated by myself, the member advocate, and Ken Pariseau, the manager of external affairs. Our current committee is a mirror of our member population. When I say that, what I mean is that the majority of the committee are duals. Then we have about a good 3-4% which are Medicaid only, but they still fall under this population. Next slide, please.

Recruitment--there are very many different ways that you can recruit. We, again, have recruited differently for this population as well. As a member advocate, it's my job to make sure that these meetings are running smoothly. When we talk about making sure that we have the right member who is going to sit on the advisory committee, I will believe that the most appropriate folks come through my telephone conversations that I have with folks. As a member advocate, I receive calls from members on a daily basis. It's in those calls that I can hear who is the individual that is capable of advocating for themselves or their family members. Does it make sense to invite them to an advisory committee meeting? For me, I think that we get good members in general, but the best members come through my conversations on the telephone.

We also recruit through community events. We get referrals from many of the advocates in the community as well. Very often and yesterday, as a matter of fact, myself and Ken Pariseau, we met with a manager and a supervisor from medical management department to let them know that we will be getting ready to start two additional groups. We were looking for their help to help recruit for particular members for these groups. We've asked them to please provide my phone number to folks, let me know that so-and-so will be calling, and I'll be prepared to do a telephone interview with that individual.

We also put ads in the neighborly quarterly newsletter, and that's to both providers and members. Providers are also able to make recommendations to us or to refer an individual so that they too can be a part of our advisory committee. Then there's always word of mouth. We've found that our members are excited to be here. It's not uncommon for me to receive a phone call from a member who will say something like, "Jackie, I have a friend who I told what I was doing, as far as being on the advisory committee meeting, and he or she would like to join. Can you just talk to them and maybe they can't join now, but maybe at another time?" Word of mouth is also very helpful through recruitment. Next slide, please.

We've never at Neighborhood Health Plan had a problem with retention. As a matter of fact, it was just this past year that we had to draw up some guidelines so that folks knew that they couldn't be on our advisory committees for years and years and years. There are a couple of women that we worked with that had been on the committee since its inception. Now, not

necessarily did they really have options, because, like I said, they just started in October of 2013, but some of the other groups that we started, folks are on from the beginning. We had to let them know that you have to cycle off. We had to draw up contracts with folks to let them know that they are limited to two-year terms, but that they may come back on at a later date.

We feel as though our members enjoy being a part of this because they feel as though they're making a good contribution to the health plan--to a good health plan. They feel as though they're being heard. They know that if they ask myself or Ken a question or if there's an issue that they bring up, that Ken and I are going to bring it to the next level and we're going to come back with answers for them. We don't leave people hanging. We found that important early on. If someone had an issue, we realize that if it was affecting one individual, then there are probably thousands of others that it was affecting as well. We wanted to make sure that not only did we get answers to it, but did it make sense to also make changes so that no one else would have to experience it.

We also believe that they enjoy the connections that they build with one another. I can think of two women that are in our group who have become so close that one of them now does respite for the other one's child who has some behavioral health issues. They begin to trust each other. They become family. They become friends. It's a very close knit community. I'll also tell you that the meals and the stipends don't hurt. Again, we provide our members with meals for this particular group. It's lunchtime meals, and so we always careful to make sure that the meals that we are providing are appropriate for everyone. If not, we are able to order different things for different people, and the $60 per meeting stipend--that does not hurt at all either.

Finally, I have to say that our members really do develop close relationships with myself and with Ken. Sometimes I get calls from them two or three times a week just to say, "Hi. How are you doing, Jackie?" or to say, "This is what's going on. Can you help me find out an answer?" or "I ran into someone and this is what they're experiencing. Maybe you can bring that back to the health plan." We really enjoy our groups and we believe that our membership enjoy coming. Next slide, please.

I'd like next to turn it over to Bessie Deloach. She's a RHO member, and she's been at our committee since right before it started in 2014. Bessie?

Bessie Deloach: Hi, everyone. I think I'll probably start just speaking about what retention has been for me. First and most important to me is that our committee advocate leader to have an effective attitude towards all of our members. As a retiree, I need the networking opportunities that I don't get anymore now that I'm at home. Also, we need our advocate leader to address all issues and questions at the meeting and/or retain the committee member for one-on-one assistance by phone or letter, which is always done in our meetings. We also need our advocate member to prompt us and encourage us throughout our questions and issues for very in-depth explanations. Then it seems like whatever is being presented addresses all of us. It's important to us members for review of all of the past meetings also, nothing is forwarded to the next meeting. All issues and questions are addressed during our meeting unless feedback is for all attendees.

Recruitment--I have very little participation, but I have been able to bring flyers and brochures to two Rhode Island organizations, Stand Down of Rhode Island for homeless war veterans. We're

very appreciative of literature from Neighborhood Health Plan. And the Urban League of Rhode Island upcoming health fair--I will also be there to hand out literature. This literature contains both contact numbers and names, which I feel is vital if you're going to hand out literature at all. I think that's about it. Thank you very much.

Jacqueline Dowdy: Thank you, Bessie is all set.

William Dean: Thank you, John, Jackie, and Bessie, so much for sharing your knowledge and experiences of recruitment and retention strategies for your advisory committee that you've planned. Now, we've like to learn a little bit more about our participants and their recruitment and retention strategies at their respective health plans or delivery systems. We'll have you all participate in two polls.

The first poll, I'll read out the question and the options and you can select all that apply. The first question is which is these CAC--Consumer Advisory Committee--recruitment strategies do you use? Please select all that apply. Letter campaign that inspires, as John talked about, telephone call outreach, referral from member services and/or providers, referrals from consumer advocates and/or community leaders like civic or religious groups, advertisements as on your website, in your member newsletter, flyers that you can bring to community fairs, et cetera, and health fairs or community forums. Again, select all that apply. We'll give you a couple of moments to think about this and look at the results.

We've got some results here. It looks like the highest strategy used is referrals from member services or providers which makes a lot of sense. As John and Jackie both said, they often know the members the best. They know those who are advocates for themselves and maybe represent others the best. That makes a lot of sense. It looks like the lowest was the letter campaign that inspires, so this might be hopefully a good tip that we were able to share with you all. It might be something that maybe inspires you all to do, as you recruit, more folks to your advisory committees in the future.

I think we'll move on to our second question, if you don't mind, which is which is these CAC--Consumer Advisory Committee--retention strategies do you use? Again, please select all that apply. Consumer input gets elicited, including a discussion of recommendations for improvement, structure and process for meetings, including an agenda and/or code of conduct--what I think John referred to as ground rules, consumer training, support, or team building activities, feedback loop and/or C-level or executive level attendance at the meeting--what I think John might have talked to you about as referred to as a debriefing committee--accommodations including transportation and others of course, and compensation for time as in a stipend that they both discussed that use. Again, please select all that apply and we'll give you a couple of minutes for that.

Great. It looks like our top contender here was that consumer input gets solicited and discussion of recommendations for improvement, so that's great. Obviously, that is what we hope is the goal of every advisory committee--that that is the point of having them assembled there and talking with them and finding out how you all can improve your care--and the lowest being the compensation for time or stipend used. That might be something that we might want to take

some questions on. I think there might be some in the queue about that already. Also, fairly low are the training and the feedback loop, so also a couple of other possibilities for improvement in your process and retention strategies for the future.

I think with that we'll move on to the question and answer period. Thank you all for participating in the poll. Please go ahead and submit your questions to any of the presenters, if you haven't done so already. I'll conclude this part of the webinar just by saying thank you to the participants and to the presenters today for this dialogue and for this webinar. Hopefully we can continue this for the next 15 minutes and have a robust question and answer period and answer anything that you would like to learn from us that we did not cover in the presentation. Thank you.

Amy Herr: Thank you, William, and thank you to John, Jackie, and Bessie for sharing your knowledge and experiences. As Bill mentioned, in the remaining amount of time we have left we want to turn our attention to your questions. There are a few ways you can submit them. You can use the chat feature on the WebEx or you can use our AT&T operator. Cynthia, at this time, can you remind our participants how to submit a question over the phone?

Cynthia: Certainly. On the phone lines, if you do have a question, please press star followed by zero. An operator will take your name and give you further instructions. Once again, on the phone lines, if you do wish to ask a question or make a comment, press star and then zero. An operator will take your name and give you further instructions. One moment, please.

Amy Herr: While we're waiting for the first question on the phone, let me just put out one question here that's been asked on the web platform. For John and Jacqueline, how do you determine the topics for the consumer advisory committee meetings?

John Ruiz: This is John. The topics are in two ways. We ask consumers what they want to hear about, but we have an internal committee of senior managers in the organization, and they also give us suggested topics--things they want to learn about from the consumer community.

Jacqueline Dowdy: Hi. This is Jackie. The way that we do it has been in two ways. One way is we expect all of our vice presidents to provide us with a question which we then send out to the members of the group. Then that sparks conversations and that's where we get a lot of our issues from. The other thing is each meeting is always a follow-up from the last meeting, so there are always issues brought to the previous meeting that we are able to discuss with them and provide answers to them when we get to the next meeting.

Amy Herr: Thank you. Do we have any questions coming through the telephone line?

Cynthia: On the phone line, Carol Moore, if you still have a question, go ahead and hit star and then one to queue up. Your line is open.

Carol Moore: Yes. Thank you. I really enjoyed this robust discussion. My question is for Jackie out of the Rhode Island plan. You mentioned that you have no problem with retention which I think is fantastic. You have a two-year term limitation, but the member can rejoin later. Can you

give an example of when that person can rejoin? Do you have to sit out for two years and then come back? How does that work?

Jacqueline Dowdy: That's a very good question. The way that we do it is that they're on two years. They're off for two years, and then they can come back on for two years.

Carol Moore: Got it. Thank you. Thank you very much.

Cynthia: Thank you. Once again, you may press star and then zero to queue up for your questions. It looks like we have one more coming in. It will be just a moment. If you have given your name to the operator, go ahead and press star and then one to queue up for your question. Once again, if you have given your name to the operator, you may press star one to queue up for your question. If you have not given your name to the operator, press star and then zero. We'll go to the line of Susan Shane. Your line is open.

Susan Shane: Hello. This is Susan Shane calling from Vermont. I am facilitating a consumer advisory group for our accountable care organization which is made up of 14 different hospitals in the state. The challenge that I find is that issues that are discussed by our group and the recommendations made are not quickly answered or we can make those recommendations out to the various entities, but as an organization we can't change things--change a plan or change coverage or necessarily make anything happen in a short period of time, which I am concerned will be frustrating for the members over time.

Jacqueline Dowdy: Hi. This is Jackie again. I agree with you. That can be frustrating. The information that is brought to our meetings is then brought to what we call a member satisfaction workgroup. This member satisfaction workgroup is made up of every department in our organization that touches a member. This is where we work on the issues. What we do is we find that when we come back to that next meeting sometimes we can't come back and say, "You know what? They thought all of your recommendations were great, and they're going do them," but there are bits and pieces that the group may or may not agree with and we share that with the group. Then we go on to continue to discuss what can we do to make it better. You're right. It can be both frustrating, not only for the group, but for the facilitator as well.

Susan Shane: Thank you for that, because we always have that feedback loop of we've discussed this with our clinical advisory board and with our board of managers. They're very interested in the outcome and I often don't have a real result at this time for them. Any ideas--

John Ruiz: This is John. One of the things I do is I'm really honest with the groups. One of the things I say is if we don't have a quick response, we'll say in our organization there are various departments that are impacted with a decision or a change in policy or procedure, and so these things take time to process, and the impact across all departments takes time to process. As soon as a decision is made we will get back to you. That has worked really well for us. They know that some things just require time.

Susan Shane: That's wonderful. Thank you.

John Ruiz: You're welcome.

Cynthia: I'm seeing no further questions in queue at this time. Please continue.

Amy Herr: Thank you. A couple of people have asked about the stipend, so we wanted to address the stipends. Specifically, one person asked, "Have you had any problems with the stipends, because we've heard that you won't be able to give stipends due to the Medicare marketing guidelines?"

John Ruiz: This is John. My feeling about that is that a stipend is not necessarily a marketing strategy to get people to stay in the program. I know that that's real in other states, but we really feel strongly that people's time is valuable. One of the ways in which we value their input is by paying them for their time.

We did have questions about how that might affect their eligibility for the public programs that they're receiving assistance from like Medicaid. We looked into that. A hundred dollars a year doesn't really affect anyone's eligibility for services. It's not a lot of income. It's not taxable income, because as Jackie said earlier, it doesn't reach the threshold of $600. I think it's a moral issue. To this date I haven't heard or seen any regulatory mandate that we can't pay stipends. I mean, we don't even have to call it stipends. It's actually payment for their time.

Jacqueline Dowdy: If I could just add also, we had that question out, because we don't want to do anything that is against the rules. Right now we're in phase one of the demonstration project, and we don't feel as though we are doing anything against the rules, because the Medicare portion is not in plan yet, but we also look at these individuals as employees. They are consultants. They come to us with ideas. They help us to make the plan a better plan, not just for themselves, but for the other 170,000 members that we serve. We too look at it as though we're paying them for a job that they do.

John Ruiz: One more thing I wanted to add--we actually have members assigned an attestation saying that--sort of explaining how this might affect their eligibility or not affect their eligibility for programs, that their participation in the advisory committees and the $25 they get is not--they can leave the group at any time. Getting a stipend is not a way of keeping you engaged with the program. People can dis-enroll from the One Care program at any time as well. We have people sign this attestation just to make sure and have verification that we've communicated that to the member.

Amy Herr: We have time for one more question, but in the meantime we wanted to put our survey up on the screen here. Please go ahead and fill that out before you log off. We'd love to get your feedback for the next webinar. Our final question is from a caller who said, "How long does it take to establish a sustainable consumer advisory committee? We've had a committee that's been operating for about a year, but different members come to each meeting and they haven't really coalesced yet."

John Ruiz: I would say you're always going to have people who come and go. I think that's just the reality, but I think that if you employ group-building activities and you can affect how people

bond in the group, I think that will go a long way in keeping people engaged. There are two of our advisory groups where people are looking forward to attending the meeting. They've bonded as a group. In fact, one of those groups wants to meet every month because they want to see each other every month. I think it's important to promote the bonding of the group, that people really look forward to the meetings, that the meetings are orderly, that people aren't personally attacked, and preventing those things helps people stay engaged.

Jacqueline Dowdy: I'd just like also to add that what we've found here at Neighborhood is that these people that sit around this table for us bi-monthly--first of all, they're upset because the meetings have gone from monthly to bi-monthly. They would prefer to meet monthly--they enjoy the company of each other, and they absolutely enjoy the company of myself and Ken. We don't talk down to them. Everyone in this room is an equal. No one is better than the next person. Everybody's questions are answered. If we don't know the answer for you today, we will get it and we will bring it back to you.

We make ourselves available to the individuals in each of our groups and in between groups so that they know if something is going on or if they need someone to speak to, that they can pick up the phone and call myself or Ken, and we're going to help them to get the answers to the questions or the issues that they may have. I think that that also goes a long way. It lets them know and it lets them see that they are not tokenized, that everything that they're saying to us we're listening to. We're seeing what we can do to make things better for them and for the rest of the folks on our plan. I think they appreciate that.

Amy Herr: Great. Thank you. I wanted to thank our speakers again--William, John, Jackie, and Bessie. Thank you very much for your presentations.

John Ruiz: You're welcome.

Amy Herr: We want to let everyone know we'll be posting the slides and a transcript of this call on our website, www.resourcesforintegratedcare.com, this afternoon or tomorrow. We invite you to go to that website. Again, it's www.resourcesforintegratedcare.com--to register for our next call in two weeks from today on Training Consumers for Engagement: Developing a Curriculum that Empowers Members on Wednesday July 23rd from 2:00 to 3:00 p.m. Eastern time. Have a wonderful afternoon. This concludes the webinar.

Cynthia: Thank you, and ladies and gentlemen, that does conclude your conference call for today. Thank you for your participation and for using AT&T Executive Teleconference service. You may now disconnect.