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Medi-Cal Member Advisory Committee: Design Recommendations for the California Department of Health Care Services

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About the Authors

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The Center for Health Care Strategies (CHCS) is a policy design and implementation partner devoted to improving outcomes for people enrolled in Medicaid. CHCS supports partners across sectors and disciplines to make more effective, efficient, and equitable care possible for millions of people across the nation. For more information, visit www.chcs.org.

About the Foundation

The California Health Care Foundation (CHCF) is an independent, nonprofit philanthropy that works to improve the health care system so that all Californians have the care they need. We focus especially on making sure the system works for Californians with low incomes and for communities who have traditionally faced the greatest barriers to care. We partner with leaders across the health care safety net to ensure they have the data and resources to make care more just and to drive improvement in a complex system. CHCF informs policymakers and industry leaders, invests in ideas and innovations, and connects with changemakers to create a more responsive, patient-centered health care system.

Acknowledgments

The Center for Health Care Strategies (CHCS) would like to acknowledge the Technical Advisory Group (TAG) for devoting time, energy, and thoughtful insights to this effort. Our team greatly admires the TAG's deep dedication to meaningfully engaging Medi-Cal members across California.

CHCS is also appreciative of the Medi-Cal members who were interviewed by our team. Your experiences and stories about serving on consumer advisory committees are at the heart of our recommendations and shaped every aspect of what we consider the path forward. Thank you for sharing your expertise with us.

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Executive Summary

The California Department of Health Care Services (DHCS) announced the launch of its Medi-Cal Member Advisory Committee in February 2023, consisting of diverse Medi-Cal (California Medicaid) members from across the state. This group will provide a mechanism for the agency to receive robust and authentic member feedback and guide opportunities to shape and enhance Medi-Cal policies and programs to better respond to member needs.

The Medi-Cal Member Advisory Committee (MMAC) was created following a design phase, supported by the California Health Care Foundation (CHCF), in which the Center for Health Care Strategies (CHCS) partnered with DHCS and the foundation to develop recommendations to inform the design of the MMAC. CHCS conducted a landscape assessment of existing consumer advisory committee–type groups in California and other states and interviewed stakeholders, including an advisory group of Medi-Cal enrollees and others with expertise engaging Medi-Cal enrollees in advisory groups. Drawing from the landscape assessment and interviews, CHCS developed a set of recommendations to help guide the design of the DHCS MMAC.

This report presents CHCS's recommendations and summarizes the research and advisory group feedback that informed them. It is intended to provide transparency into the design process and outcomes and share insights that could be helpful for other states looking to create an advisory committee of Medicaid members.

Recommendations

Drawing from this design phase, the following are CHCS's recommendations for 10 core elements critical to designing and sustaining an effective MMAC.

1. Composition and Size

Ensure composition reflects the Medi-Cal population. Include a diverse mix of races, ethnicities, gender identities, sexual orientations, and uses of Medi-Cal services (e.g., members on waiver programs, managed care, fee-for-service).

Keep size manageable. A core group of 10–15 to serve as a pilot for one year will allow for a robust and diverse mix of populations without being challenging to convene and facilitate.

2. Recruitment

Use a multipronged approach. Effective recruitment will require a multipronged approach that includes (1) leveraging networks of providers, community-based organizations (CBOs), managed care plans (MCPs), DHCS staff, and others; and (2) use of marketing events, social media posts, flyers/mailers, etc., to get the word out.

3. Compensation

Provide a fair amount. Provide at least a $100 stipend per MMAC member per meeting, regardless of being virtual or in-person. Let MMAC members choose their compensation preference — check or gift card. Also cover additional supports, including (as appropriate) mileage; parking; public transit, Uber or Lyft, or taxi; meals; technology support; and childcare.

4. Meeting Logistics

Be consistent regarding meeting format, length, and cadence. To accommodate MMAC members located across the state, meet virtually for two hours every other month. As possible, meet

in person once or twice per year to build relationships and have more in-depth discussions around certain topics or when important deadlines are approaching (e.g., public comment period, legislative session, etc.).

Recognize the importance of translation. Real-time translation (in person and virtually) is needed at least in Spanish and American Sign Language (ASL). All translators should be native speakers and/or certified (e.g., ASL certified).

5. Meeting Facilitation

Identify a strong meeting facilitator. The ideal meeting facilitator for the MMAC will have rich experience working with community members, a strong understanding of the Medi-Cal program, and background and race/ethnicity reflective of MMAC membership.

Plan the agenda. Keep the agenda light on updates and allow ample time for questions, discussion, and for MMAC members to offer their own topics.

6. Meeting Materials

Send clear meeting materials in advance. Meeting materials should be easy to understand, free from jargon and acronyms, written at a sixth-grade reading level to ensure readability, and translated into MMAC members' primary languages. All materials should be sent to MMAC members *at least* one week before meetings.

7. Building Trust

Treat MMAC members with respect, understanding, and kindness. Actions such as individually greeting each MMAC member at meetings and ensuring everyone has a reliable way home after the meeting will help members feel supported. Create avenues for honest feedback; acknowledge when a mistake was made, apologize, and pledge to make it right going forward.

Establish feedback loops. If a recommendation is made or a concern is raised by a MMAC member, follow up on the status, even for recommendations that cannot necessarily be implemented. MMAC members will appreciate knowing how information is acted on and where their voices are making a difference.

8. Preparing and Supporting Medi-Cal Member Advisory Committee Members

Create a consistent orientation process. Provide new members with clear information regarding the MMAC's purpose; roles and responsibilities; what to expect before, during, and between meetings; list of key terms; how the MMAC will influence policy; how to reach the MMAC contact; and other key details.

Conduct check-in calls for MMAC members. Connect with MMAC members before and after meetings. These conversations can be short but are important to ensure MMAC members have what they need before meetings, and to gather feedback after meetings to ask if members feel heard, supported, and valued.

9. Measuring Success

Measure success for MMAC members. Develop a brief survey for MMAC members to complete after each meeting to gather anonymous feedback on their experiences. Use time at a future meeting to report on responses and work with MMAC members to identify what is going well and what needs improvement.

Measure success for DHCS. Establish three or four measures of success for the MMAC. A guiding question for defining those measures could be: If speaking to leadership about the MMAC two years from now, what would you want to be able to say was accomplished? How did the MMAC help in the process?

10. Sustainability

Commit to the 10 core elements when building the MMAC. Sustainability will naturally occur if the key elements described above are considered when establishing the MMAC.

Embrace the process. Know there will likely be lots of back and forth with MMAC members on certain projects, but it is necessary to ensure their feedback is genuinely being internalized and changes are being made as possible.

Pitfalls to Avoid in Launching the Medi-Cal Member Advisory Committee

As important as knowing what to do when establishing and leading a consumer advocacy committee (CAC) is knowing what *not* to do. Below are a few examples of pitfalls to avoid gleaned from stakeholder interviews, TAG discussions, and the literature.

Overpromising what can be done. Avoid committing to plans or changes that DHCS cannot make. Be open and transparent, but also realistic in what may or may not be possible to change.

Sending meeting materials out too late. Getting meeting materials to MMAC members in advance must be best practice. Otherwise, members do not have time to adequately prepare and are less effective during the meeting.

Not providing culturally and linguistically appropriate meeting materials. MMAC members will be turned off from the start if the materials do not meet them where they are.

Rattling off statistics and jargon. A steady stream of statistics and jargon can be overwhelming and confusing. Instead, share updates and information that will resonate with MMAC members and be explicit about why what is being shared matters to them, and where you need their input.

Conclusion

The DHCS Medi-Cal Member Advisory Committee will be a unique space for state leaders to receive meaningful and authentic input from Medi-Cal members in real time. For the first time, DHCS will have an ongoing channel to gather member feedback to help shape and advance its policy, governance, and strategic priorities as well as its program activities.

Introduction

In California, the Department of Health Care Services (DHCS) has historically worked with community advocates to help the agency shape and redesign Medi-Cal policies and programs. The value that community advocates and community-based organizations (CBOs) bring to these discussions is critically important to ensure policies and programs meet the needs of Medi-Cal members. However, there are untapped opportunities to connect directly with Medi-Cal members as part of the agency's policymaking and implementation process. This effort aligns with a growing trend in which Medicaid agencies across the country are increasingly seeking to meaningfully partner with Medicaid enrollees to help design policies and programs that better serve program participants.[1]

Recognizing this opportunity, in late 2021 DHCS established a Medi-Cal Member Advisory Committee (MMAC). This group is intended to provide a way for the agency to receive robust and authentic feedback from a diverse group of Medi-Cal members and to glean information to shape and enhance policies and programs to respond to identified member needs. DHCS is committed to using the MMAC's guidance in determining how to advance the agency's policy, governance, and strategic priorities with a patient-centered focus.[2] At the outset, DHCS recognized that establishing and leading an MMAC would be unlike any process the agency had undertaken. Building trust with MMAC members would be paramount, and the agency would need to actively listen and be open to change.

With support from the California Health Care Foundation (CHCF), the Center for Health Care Strategies (CHCS) partnered with DHCS and the foundation to develop recommendations to inform the design of the MMAC. CHCS conducted a landscape assessment of existing consumer advisory committee–type groups in California and other states and interviewed stakeholders, including an advisory group consisting of Medi-Cal enrollees and others with expertise engaging Medi-Cal enrollees in advisory groups. Drawing from the landscape assessment and interviews, CHCS developed a set of recommendations to help guide the design of the DHCS MMAC.

This report shares findings from the landscape assessment and stakeholder interviews and outlines CHCS's recommendations for developing a member advisory group. It also outlines pitfalls to avoid in establishing a member advisory group gleaned from stakeholder interviews and the literature. Although CHCS's analysis focused specifically on designing a DHCS-led group with Medi-Cal enrollees, this report outlines universal lessons related to designing and building a successful consumer advisory committee that could inform other settings and states.

Methods

Landscape Assessment

Between June and October 2022, CHCS conducted a robust national landscape assessment of community member advisory group structures, activities, and promising practices — both within California and in other state Medicaid agencies. The landscape assessment sought to gain an understanding from key informants in California and other states with direct experience with CACs regarding their design choices, successes, pitfalls, and other important lessons. The landscape assessment consisted of interviews with Medi-Cal enrollees and experts in California and other states and a literature review. Also, representatives of 14 managed care plans (MCPs) in California completed a survey that explored their experiences leading CACs. Survey results are detailed in a supplemental report, *Designing Medi-Cal Consumer Advisory Committees: Insights from a Survey of Medi-Cal Managed Care Plans.*

Key Stakeholder Interviews

From July to September 2022, CHCS conducted 27 stakeholder interviews. All interviewees had experience either serving on or convening a community member advisory group, and the purpose of these conversations was to identify promising strategies for leading these groups effectively. CHCS was also interested in understanding where the challenges lie and potential missteps that can occur in establishing a community member advisory group. Nearly all interviewees were California-based and included Medi-Cal members (8) and staff from managed care plans (6), CBOs (6), California state agencies (3), researcher organizations (2), a Federally Qualified Health Center (1), and another state Medicaid program (1). CHCS received help from staff of DHCS and the California Pan-Ethnic Health Network (CPEHN) to compile a list of interviewees and to conduct outreach (see Appendix A for the interview protocol).

While CHCS used a standard interview protocol, questions were adjusted depending on the different insights interviewees could share. For example:

- **Medi-Cal member interviewees** all serve on a managed care plan CAC. They offered insights on what keeps them coming back to the group; strategies for helping them feel supported, engaged, and valued; and strong meeting facilitation techniques.
- **MCPs** in California are required to establish and lead CACs; thus interviews with MCP staff centered on identifying what works well and what does not doesn't in these groups.
- **Community-based organizations** offered recommendations for effective recruitment and engagement strategies, and ways to ensure CACs are diverse and representative of the community.
- **State agencies** (inside and outside of California) shared insights into the ways they engage community members and the challenges they have faced along the way.
- **Researchers** described their work and summarized findings regarding CACs in Medicaid agencies.

Literature Review

CHCS conducted a literature review, identifying and reviewing 24 articles and resources to understand promising practices for CACs. This research also informed some of the interview questions.

The literature review consisted of a compilation of resources pulled from online search engines, including Google Scholar, Google, and PubMed. Search terms included "involving family voices," "engaging families in their care," "evidence-based practices or strategies for consumer engagement," "consumer led/run programs," "community-based organizations led and staffed by patients or families," "patient family advisory council," "evidence-based consumer engagement within Medicaid," "state-level consumer engagement," "CACs within Medicaid agencies," "Medicaid consumer engagement," and "identifying Medicaid strategies for effective family engagement." CHCS also received resource suggestions from colleagues and external partners, TAG members, and interviewees. (See Appendix B for a summary and key themes of the articles.)

Design

Technical Advisory Group

In partnership with CHCS, CPEHN, and CHCF, DHCS convened a "Technical Advisory Group" (TAG) of consumer advocates, Medi-Cal enrollees (including one parent of a child enrolled in

Medi-Cal), and others with deep professional and personal expertise in community member advisory groups. Diverse representation and perspectives were important criteria for selecting TAG members. (See Appendix C for a list of TAG members and organizations.)

Between July and October 2022, the TAG met four times to review and provide feedback on each DHCS MMAC design element (e.g., size, composition, meeting facilitation, strategies for building trust). The TAG's feedback helped refine CHCS's design recommendations and ensure they were meaningful and relevant for the Medi-Cal population. At the last TAG meeting in October 2022, CHCS presented final DHCS MMAC recommendations to the group.

DHCS Medi-Cal Member Advisory Committee Design Findings and Recommendations

CHCS examined 10 design elements:

1. Composition and Size
2. Recruitment
3. Compensation
4. Meeting Logistics
5. Meeting Facilitation
6. Meeting Materials
7. Building Trust
8. Preparing and Supporting Advisory Group Members
9. Measuring Success
10. Sustainability

The authors' findings and recommendations follow.

1. Composition and Size

Findings

The composition of the DHCS MMAC was imperative to interviewees and TAG members. Given the diversity of the 15 million Californians enrolled in Medi-Cal, all the stakeholders CHCS spoke with emphasized the need to ensure the DHCS MMAC was inclusive and fully representative of the population. Interviewees and TAG members shared that, too often, these types of committees draw from the same small cohort and leave other important groups or communities out, resulting in recommendations or changes that do not necessarily apply or work for all. The DHCS MMAC, however, was an opportunity to represent all Medi-Cal members. With that in mind, interviewees and TAG members recommended including representation from as many of these groups as possible:

- African American*
- Asian American*
- Black*
- Formerly incarcerated individuals
- Indigenous community members
- Individuals experiencing homelessness
- Individuals with behavioral health conditions
- Individuals with chronic conditions
- Individuals with intellectual or developmental disabilities
- Individuals with physical disabilities
- Latina/o/x
- LGBTQ+ individuals
- Native Hawaiian
- Pacific Islander*
- Parents, guardians, and families with children
- Parents, guardians, families, and caregivers of children with special health or complex care needs
- Rural residents
- Seniors or family caregivers, formal caregivers
- Teens, youth, and former foster youth
- Tribal nations
- Undocumented individuals

* Please note that *Black* was intentionally separated from *African American*. It was initially presented to the Technical Advisory Group as *African American/Black*, but several members urged the authors to present these groups separately, as well as *Asian American* and *Pacific Islander*.

In addition to these groups, interviewees and TAG members also noted the importance of geographic diversity, and recommended having representation from throughout the state, regardless of geographic or population size.

In terms of the size of the DHCS MMAC, the literature and interviews uncovered a broad range in the number of participants — anywhere from 10–15 all the way up to 100 (for organizations that host subcommittees or regional committees). For MCPs that cover a large area, some noted having many participants due to leading regional groups or subgroups. In probing on ideal size, interviewees and TAG members noted that large groups of 20–30 can be challenging to convene, facilitate, and gather meaningful input from. While the list of recommended populations to include is large, interviewees and TAG members suggested finding a balance between including as many groups as possible without creating an unmanageable group. Also, many members may represent more than one category.

Recommendations

Ensure MMAC composition reflects the Medi-Cal population. The DHCS MMAC should include a diverse mix of people that fall into as many of the "composition list" populations as possible but would ideally launch in 2023 with representation from these communities, at least:

- African American
- Asian American
- Black
- Individuals with behavioral health conditions
- Individuals with intellectual or developmental disabilities
- Individuals with physical disabilities
- Latina/o/x
- LGTBQ+ individuals
- Native Hawaiian
- Pacific Islander
- Parents, guardians, and families of children with special health care needs
- Rural residents
- Seniors and family caregivers, formal caregivers
- Tribal nations
- Youth

The MMAC should also include representation from different regions of the state and different paths of interaction with Medi-Cal (e.g., members on waiver programs, managed care, fee-for-service). While all the populations on the "composition list" are of equal importance, CHCS recommends this set as a starting place, since these populations were the most often elevated in interviews and TAG meetings.

Keep size of MMAC manageable. A core group of 10–15 DHCS MMAC members to serve as a pilot for one year will allow for a robust and diverse mix of populations without being challenging to convene and facilitate. After establishing rapport and building relationships, DHCS can consider expanding the group to include four or five more people who represent other populations on the composition list and begin to form subcommittees (e.g., subcommittees for youth, behavioral health, rural communities, etc.). After three to four years, DHCS can also consider expanding recruitment significantly to establish regional MMACs.

2. Recruitment

Findings

Recruitment is a critically important part of the process when establishing a CAC. Interviewees and TAG members consistently raised this topic as being central to ensure diversity and sustainability. Interviewees also agreed that recruitment is not a

one-time activity and instead should be ongoing. It would be easy to underestimate the time and effort it takes to recruit, conduct outreach, and onboard MMAC members; DHCS should ensure that staff assigned this responsibility have sufficient capacity to do it well. In terms of how long CAC members may serve, interviewees noted the unforeseen challenges or changes that can sometimes occur in CAC members' lives (e.g., illness or family member illness, relocation, schedule change, childbirth, etc.) and the potential need to cycle members on and off. To account for this, interviewees suggested ensuring there is a strong recruitment pipeline so there is never a lull in identifying new MMAC members.

Interviewees shared the importance of pursuing a variety of avenues to recruit MMAC members, including CBOs, recruitment events, social media, flyers, and mailings. Interviewees also noted the need to ensure language in recruitment materials is clear, thorough, and translated as needed.

Recommendations

Use a multipronged approach. Effective recruitment for the DHCS MMAC will require a multipronged approach that includes leveraging contacts and networks of providers, CBOs, MCPs, TAG members, DHCS staff, and others through a combination of marketing events, social media posts, flyers, mailers, etc., to get the word out as far as possible.

In addition to the demographic composition discussed above, CHCS recommends that DHCS seek people with these traits:

- Enrolled in Medi-Cal (or caring for a Medi-Cal member)
- Able to and interested in working closely with DHCS to advise on policies and programs
- Able to participate in virtual or in-person meetings (or, if barriers are noted, the barriers can be overcome with the help of DHCS or others)

Set term limits. To ensure new perspectives are regularly added to the DHCS MMAC, CHCS recommends instituting a mix of one- and two-year term limits to begin with. This approach ensures ongoing and staggered rotation of membership, so an entire cohort is not turning over at the same time. Term limits present the opportunity to bring on members of populations that have perhaps been underrepresented or previously could not participate. Also, DHCS should seek to establish a strong pipeline of potential MMAC members who could cycle onto the DHCS MMAC to keep sustainability strong and representation current.

Develop a short application. DHCS should develop a short application for interested Medi-Cal members to complete for DHCS MMAC consideration. CHCS recommends the application focus on getting to know prospective candidates and their interest in being an MMAC member. In addition to meeting logistics (e.g., dates, times, locations), application questions could include:

- Have you served on a CAC type of body before?
- How did you learn about the DHCS MMAC?
- How long have you been a Medi-Cal member?
- Would you be able to work closely with DHCS to advise policies and programs?
- Do you see any potential barriers to participating in MMAC meetings?
- Would you be interested in serving a one-year or a two-year term?
- What is your primary language? What language do you prefer to speak? Read? Hear at meetings?

The application should include the composition list from the "Composition and Size" section above and ask that applicants indicate the populations with which they identify.

The application should be provided to the potential MMAC in accessible formats, ideally a PDF that can be filled in electronically on a mobile device. Other accommodations should be considered as well, including large print versions of the application and versions translated into other common languages (e.g., Spanish and Mandarin).

Invest in dedicated staff. A successful DHCS MMAC will require dedicated staffing and resource investment from the agency. DHCS will need to create a position that will be the contact for the DHCS MMAC and be responsible for recruitment efforts, meeting planning, drafting and sending meeting materials, attending all meetings, and preparing and supporting MMAC members. The authors recommend that DHCS either adjust an existing position to allow for the additional responsibilities needed to run a DHCS MMAC or create a new position dedicated to leading the DHCS MMAC. Ideally, this person will have experience in recruitment, community outreach, supporting individuals with lived experience, etc.

3. Compensation

Findings

Providing compensation to MMAC members is essential. MMAC members are offering their time and expertise and should be compensated for their contributions as professionals would be. Interviewees and TAG members described providing compensation as a "must" and discussed the types of compensation that could be offered, including stipends and gift cards. While Medi-Cal member interviewees shared that they do not participate in CACs for the compensation, it is deeply appreciated and helpful in building trust and strong relationships.

Ideally, DHCS MMAC members would be offered flexibility regarding the compensation options, such as choosing between checks or gift cards. Interviewees and TAG members urged DHCS (and other agencies that may pay community members) to offer support though eligibility counselors to ensure the compensation received from participating in the MMAC does not impact benefits that may be tied to income.

As for the amount of compensation offered, most interviewees recommended $50–$100 per meeting, with an equal split between checks and gift cards. (The most popular types of gift cards were groceries or Visa.) See the supplemental report *Designing Medi-Cal Consumer Advisory Committees: Insights from a Survey of Medi-Cal Managed Care Plans* for details on compensation averages for MCPs. However, compensation is not necessarily only monetary. Interviewees noted they offer transportation for in-person meetings, meals or snacks during meetings, technology support for virtual meetings, and reimbursement for childcare. At the heart of the compensation discussion is removing as many barriers to participation as possible for MMAC members.

Recommendations

Provide a fair amount. Based on the literature, interviews, and the MCP survey, CHCS recommends DHCS provide at least a $100 stipend per MMAC member per meeting, whether the meeting is virtual or in-person (about six per year). The $100 per meeting recommendation is in line with or exceeds examples reviewed for this report but is not too high to impact income levels for eligibility.[3]

Offer flexible payment methods. CHCS recommends mailing checks to MMAC members' home addresses as the most efficient method of payment. However, as noted in interviews, it is important to ask DHCS MMAC members their preferences around payment. For example, a universal Visa gift card or grocery gift card may be a better option for those who lack a permanent address or bank account.

Consider additional compensation and supports. In addition to the stipend (either check or gift card), the following supports should also be covered for each MMAC member:

- Mileage to and from meeting location
- Parking for meeting
- Public transit to and from meeting location
- Uber, Lyft, or taxi to and from meeting location
- Meals (e.g., provided if meeting in person; DoorDash, UberEats, or CraveBox if meeting virtually)
- Technology support (e.g., hot spots, instructions for joining a Zoom call, etc.)
- Childcare could be available on-site for MMAC members who need to bring children in order to attend, or a separate childcare stipend should be provided (e.g., the DHCS MMAC member would receive a stipend to cover the expense of hiring a childcare provider for the time needed for meeting time and round-trip travel).

Related to the above, DHCS could consider having benefits counseling available to ensure compensation related to MMAC participation does not impact members' benefits.

Provide timely compensation. Compensation should be provided to DHCS MMAC members promptly following a meeting. DHCS should clearly communicate upfront with members the time frame in which compensation will be received (e.g., checks will arrive within two weeks of the meeting date), and DHCS MMAC members should reach out to their DHCS MMAC contact if there are issues or questions regarding the compensation.

4. Meeting Logistics

Findings

Key logistical considerations for MMAC meetings include in-person versus virtual, meeting location if in-person, meeting frequency, time and length of meeting, and availability of translation services. In discussions, interviewees and TAG members mainly focused on virtual versus in-person meetings. Most interviewees (including Medi-Cal members, especially) appreciated the flexibility and accessibility that virtual meetings allow, as well as the opportunity for the most robust participation. However, a few important cautions were noted:

- Do not assume that everyone knows how to join a virtual meeting — take time to provide clear directions and prep members in advance.
- Some areas in California do not have strong access to broadband. One health plan noted in an interview that it mailed out lists of local Wi-Fi hotspots to help ensure MMAC members could connect at meeting times.

When discussing in-person meetings with interviewees and TAG members, some shared that meeting in person one or two times per year is helpful for building relationships and for trying to focus on a particular topic. Some interviewees, however, cautioned that travel and meeting in person may be too difficult or complicated for some MMAC members. Interviewees and TAG members mentioned several key considerations for in-person meetings:

- Hold meetings when MMAC members will have the best chance of participating (e.g., lunch hour, after 5:00 PM).
- Recognize that some members may want or need to bring a family caregiver or other caretaker with them to effectively participate, so accommodations may be needed for extra people.
- Choose neutral meeting locations within communities (e.g., not a government building or space).
- Rotate meeting locations to spread out the travel burden for members.
- Ensure the meeting space and refreshments are equitable and work for everyone. For example, one health plan mentioned that not providing vegetarian and vegan options during a past meeting set the wrong tone.

Findings from the MCP survey and interviews indicate the majority of CAC meetings last about two hours (sometimes with lunch for 30 minutes before) and occur quarterly (see the supplemental report *Designing Medi-Cal Consumer Advisory Committees: Insights from a Survey of Medi-Cal Managed Care Plans* for more survey results).

Also, Medi-Cal member interviewees noted the CACs they serve on meet quarterly and many felt that was often not enough. With three months between meetings, momentum could be lost, and some felt there was just too much work to do to wait. Furthermore, some noted that if a CAC member misses a meeting, it will be six months between meetings for that member.

An additional topic raised in *all* interviews was that real-time translation is needed at MMAC meetings. One state agency suggested that at a minimum, translation should be offered for American Sign Language (ASL) and Spanish. A health plan recommended having breakout sessions at MMAC meetings where members may join a small group speaking their native language. This both builds trust and ensures those who may not be as comfortable conversing in English (particularly about their health or health care experiences) may do so in their native language.

Recommendations

Be consistent regarding meeting format, length, and cadence. CHCS recommends the DHCS MMAC meet virtually for two hours every other month. This format, length, and cadence would best accommodate a group of 10–15 members located across the state. As possible, meet in person once or twice per year at a neutral location (e.g., local community center, conference center, CBO with meeting space) to build relationships and to have more in-depth discussions around certain topics or when important deadlines are approaching (e.g., public comment period, legislative session). As noted in interviews, it is important to make sure any in-person meeting venue allows enough space for all to convene (including additional space for MMAC members who may want or need to bring a family member or other caregiver to comfortably participate).

In terms of cadence, given what was heard from Medi-Cal member interviewees regarding the desire to meet more often than quarterly to maintain momentum, CHCS suggests meeting every other month.

Recognize the importance of translation. Based on interviewee feedback, the need for real-time translation (in person and virtually) cannot be overemphasized and is needed at least in Spanish and ASL. As the group continues to build rapport and relationships, more languages could be added, as needed. If subcommittees and regional groups are eventually established, DHCS could consider identifying translators to participate in the group (both virtually and in person) to build relationships with DHCS MMAC members. Additionally, all translators

should ideally be native speakers and/or certified (e.g., ASL certified). Conducting brief premeetings before DHCS MMAC meetings for translators can ensure they know how to use the platform and can seamlessly participate. (Note that translation services will need to be scheduled ahead of time and included in the budget.)

Plan for lunch-hour meeting times. Per interviews and the literature, meeting over a lunch hour is preferred (11:30 AM–1:30 PM or 12:00–2:00 PM). If meeting in person, catered lunch should be provided, making sure all dietary restrictions are accommodated. If meeting virtually, DHCS could consider offering either credit on a food service delivery app for members to order lunch or have snacks sent to members' homes.

5. Meeting Facilitation

Findings

Meeting facilitation is critical for effective CAC meetings. Interviewees and TAG members suggested the DHCS should seek to provide neutral facilitation that respectfully and effectively engages MMAC members in ways that cultivate trust and safety. While facilitation tends to be an internal role taken on by the MCP, agency, or other organization, interviewees shared that the meeting facilitator needs to be "the right person" and is often the most important part of CAC meetings. If a facilitator lacks an understanding of and sensitivity to the unique needs of the Medi-Cal population or is in any way unsupportive or insensitive, trust could be lost before it is gained. The language and tone used when talking about equity and poverty matters — so all must be sensitive in how conversations are framed and worded in ways that are welcoming and respectful.

In terms of meeting format, Medi-Cal member interviewees shared that meetings with packed agendas of presentations, jargon, and statistics can be overwhelming and are not the ideal format for a CAC. Instead, meetings that were lighter on presentations and updates and focused primarily on time for discussion and input were considered most productive and appreciated.

Finally, both the literature and interviewees acknowledged that the discussions during CAC meetings can be challenging when the feedback being shared is unexpected or even negative (e.g., a member may share a story about a difficult Medi-Cal interaction they had that week because it was top of mind). Interviewees noted that DHCS staff must commit to being active listeners, try to be flexible, and be open to making changes.

Recommendations

Identify a strong meeting facilitator. The DHCS MMAC will need a skilled meeting facilitator with deep experience working with community members. Ideally, the facilitator will have these skills and background:

- Have a strong understanding of the Medi-Cal program from a policy perspective or lived experience with Medi-Cal. (Medi-Cal policy and program expertise could be supported by having DHCS staff participate in meetings to answer questions and explain programs and policies as needed.) DHCS MMAC members may ask questions beyond the scope of a Medi-Cal program, for example, and a facilitator with a strong knowledge base — plus staff — can respond without leading on or setting up DHCS MMAC members for disappointment.
- Have a background that reflects the racial/ethnic populations served by Medi-Cal (e.g., the DHCS MMAC members will want to "see themselves" in the group and in the facilitator).
- Use an affirming and inclusive communication style. (Traditionally, those in charge often use formal titles, lead or dominate the conversation,

and focus heavily on timelines, deadlines, and productivity. Those practices are likely intimidating or offputting for MMAC members.)

- Know the common power dynamics that appear in typical meeting formats.
- Convey that DHCS MMAC meetings are a collaborative space.
- Codevelop meeting norms with DHCS MMAC members.

Be intentional about the meeting format. DHCS should plan to set two or three agenda items but leave ample open time for MMAC members to raise questions, concerns, and topics of highest importance to them and be open to the discussion that follows.

A sample meeting structure may include the following agenda items:

- Welcome, introductions, ice breaker
- Review of meeting norms and agenda
- Recap of previous meeting, including the status of outstanding items (e.g., update on the status of suggestions and recommendations made during the last meeting)
- Two or three new agenda items (e.g., overview of a new program or policy and soliciting input, reviewing meeting materials for literacy, accuracy, readability, etc.)
- Open time for questions, discussion, feedback, and other important topics MMAC members want to raise
- Next steps and reminders for the next meeting (e.g., date, location, reminder about point of contact, expecting a debrief call, etc.)

As the DHCS MMAC comes together as a group and builds trust, CHCS recommends moving to a codesign model where members are asked for agenda items in advance, and DHCS ensures those items are on the agenda for the next meeting and comes prepared to discuss them. For the first few months of the DHCS MMAC, the group may want to ease into agenda setting by raising topics within the meeting.

Prepare featured speakers. Featured guest speakers at MMAC meetings are typically appreciated by CAC members, but preparing those speakers in advance is critical to ensure they feel comfortable presenting. One recommendation is to work with staff before a DHCS MMAC meeting to develop a few discussion questions about their program or service as opposed to a long report out (e.g., a guest speaker would say, "I just described our new planned program regarding smoking cessation. Does what we have proposed seem like it would be helpful to you, your neighbors, your family?").

Establish meeting norms and procedures. Establishing meeting norms and procedures in partnership with DHCS MMAC members is an effective strategy for convening meaningful and productive meetings. Some CACs follow formal guidelines, while others choose fewer formalities. At a minimum, however, everyone participating in the DHCS MMAC should know the agreed-upon method for sharing feedback in and outside of meetings; how to indicate wanting to speak (e.g., raising name cards, hand-raising function in Zoom); and the standard meeting procedures (e.g., meetings will start and end on time, a timekeeper will keep the meeting on track, translation services will be available, questions are welcome throughout the meeting, etc.).

6. Meeting Materials

Findings

Clear, concise, accurate, and culturally and linguistically accessible meeting materials for DHCS MMAC members are critically important. Meeting materials set the stage for the upcoming meeting and play a key role in ensuring DHCS MMAC members are ready to participate and know what to expect. For example, one state agency noted the most pushback they ever received from their CAC members was when they sent meeting materials shortly before the meeting. CAC members reported feeling disrespected and not valued, since the agency did not give them enough opportunity to properly prepare.

Interviewees and TAG members emphasized the need to plan ahead when it comes to meeting materials, and to ensure ample time is set aside for DHCS staff to think through, draft, finalize, and send materials. DHCS MMAC meetings will not be effective or productive if members do not understand the meeting materials.

When talking specifically about agendas, Medi-Cal members shared that the most important part of agenda setting in CAC meetings is to ensure ample time for questions, discussion, and for CAC members to raise their own topics.

Recommendations

Plan the agenda. DHCS MMAC agendas could start with a couple of standing items, such as reviewing meeting norms and providing status updates on earlier suggestions. Having standing items will help everyone know there are certain items they can always count on discussing and is a nice way to open or close each meeting. DHCS could add two or three items to the agenda (e.g., proposed programs coming out, draft correspondence going out to members, feedback on implementing an existing program, etc.). Add no more than two or three major topics to the agenda to avoid overpacking the meeting and overwhelming MMAC members. Thus, focus on items most relevant to the DHCS MMAC and community members and most time sensitive. After covering the items mentioned above, the rest of the meeting should be open for discussion, and the meeting facilitator and staff should engage in active listening.

Send meeting materials in advance. Meeting materials must be sent to DHCS MMAC members *at least* one week before the meeting. DHCS MMAC members should be asked their preference for how they want to receive meeting materials (e.g., mail, email, or both). For virtual meetings, place links to meeting materials in the chat function or, if in person, copies of meeting materials should be provided to all DHCS MMAC members.

Consider readability. To ensure readability and understanding, meeting materials should be written at a sixth-grade reading level and distributed in formats accessible to those with visual impairments, and jargon and acronyms should be avoided. Check-in calls with DHCS MMAC members are a great opportunity to review draft materials and ensure members' understanding.

Allow enough time for translation. Meeting materials should be translated at least into the languages requested by DHCS MMAC members on their applications. Additionally, a native speaker community member should review draft meeting materials to ensure accurate translation and clarity. Even with the best of intentions, professional translation services can be inaccurate or use terms not used in day-to-day conversation. CAC members will immediately pick up on poorly translated materials, which has the potential to damage trust. (Note that translating materials will affect meeting timelines and will need to be accounted for as soon as meeting dates are set.)

7. Building Trust

Findings

Interviewees and TAG members consistently expressed that building trust with CAC members will "make or break" the group. Community members may be somewhat distrustful of government agencies and could harbor significant trauma and frustration, making them wary to participate. The guidance CHCS heard was that DHCS should start its MMAC understanding that trust will need to be earned, but there are many ways it can be built right away and continue to strengthen. Several of those strategies have been mentioned — intentional meeting facilitation, culturally and linguistically appropriate meeting materials, and creation of a collaborative space.

One additional critical strategy is establishing a strong and purposeful feedback loop. This was the most frequently mentioned way interviewees noted to build trust. DHCS MMAC members will want to be heard and know their input is being used. A couple of interviewees shared their own experiences with hearing from frustrated CAC members without a clear sense of how, or whether, their suggestions were used.

Additionally, ensuring members have a contact they may reach out to with questions, concerns, or to talk with is critical. Knowing there is a trusted person they can connect with goes a long way toward building trust.

Recommendations

Treat DHCS MMAC members with respect, understanding, and kindness. Simple acts of kindness and respect will be paramount for the DHCS MMAC. For example, practices such as individually greeting each DHCS MMAC member at meetings and checking at the end of the meeting to make sure everyone has a reliable and safe way home will help them feel welcome and supported.

Avoid implicit bias. Be aware of and acknowledge implicit bias and address it when it affects the conversation. Aim to choose an implementation consultant and facilitator open to discussing potential biases with MMAC members as needed. Additionally, strive for the facilitator's background and race/ethnicity to reflect the MMAC membership.

Establish feedback loops. If a recommendation is made or a concern is raised by a DHCS MMAC member, DHCS should try to follow up on the status of those items, even for recommendations that cannot necessarily be implemented in the exact way they were suggested. One health plan noted it records all recommendations and concerns in the meeting minutes and reviews them all at the next meeting with either updates or reasons some items may need to change, wait, etc. CHCS recommends DHCS end each meeting sharing a rundown of follow-up items and start each meeting with a brief status update on each. DHCS MMAC members will appreciate knowing how information is acted on and where their voices are making a difference.

Work with community-based organizations. CBOs often have long-standing trusting relationships with community members. One consistently successful recruitment strategy is to look to CBOs to find community members to participate in CACs. Hearing about the opportunity from a trusted source within the community can help some potential CAC members take the first step in reaching out and applying. CHCS recommends partnering with CBOs (e.g., contracting with them and paying to support their efforts), such as the California Pan-Ethnic Health Network, Asian Health Services, Painted Brain, SCOPE LA, The Children's Partnership, etc., to recruit, support MMAC members, and identify translators.

Establish a contact. DHCS should identify who the contact will be for the DHCS MMAC before the

group's launch, and let all members know who it is and how to contact that person.

Acknowledge missteps. Particularly initially, mistakes may be made with the DHCS MMAC. A comment may be made that could be deeply offensive to someone. Someone may feel their feedback was glossed over. Meeting materials may be late or hard to understand. This is a new journey for DHCS — and some bumps in the road are expected. The best way to build trust with DHCS MMAC members, however, is to create avenues for honest feedback and to acknowledge when a mistake was made, apologize, and pledge to make it right going forward.

8. Preparing and Supporting Medi-Cal Member Advisory Committee Members

Findings

The literature suggests — and interviewees confirmed — the importance of preparing and supporting CAC members before, after, and between meetings. Doing so helps CAC members effectively participate and feel comfortable and empowered in their roles. Preparing and supporting DHCS MMAC members will require staff time and resources, ideally with a dedicated position for this effort, as noted.

The most common support strategy used by interviewees was holding brief prep and debrief conversations with CAC members. These calls were typically used to ensure CAC members receive and understand meeting materials and to answer any questions, check in on any logistical or technology needs to ensure participation is smooth, and answer questions or discuss concerns after meetings. Debrief calls in particular allow CAC members an additional opportunity to share any feedback they may not have thought of during the meeting or were uncomfortable sharing in front of the entire group.

Recommendations

Create a consistent orientation process. To become acclimated to the group and start off on a solid foundation, every DHCS MMAC member should participate in an orientation process. The orientation process should include slides or other materials describing the following, at least:

- The purpose of the DHCS MMAC
- Roles and responsibilities of DHCS MMAC members and DHCS staff
- What to expect before, during, and between meetings
- List of key terms or glossary
- How the DHCS MMAC will shape and influence policy
- Contact information for the DHCS MMAC contact
- Overview of key DHCS MMAC details including translation, compensation, term-limits agendas, timing of meeting materials, etc.

An orientation session should be offered to DHCS MMAC members before the first meeting and could be conducted as a small group session if several new members are joining together, or as individual sessions.

Establish a DHCS MMAC mentor system. After the DHCS MMAC has been in place for one year and new members are being added (either to the main group or to subcommittees), CHCS recommends establishing a mentor system to help new members learn about their roles and the expectations of the group. DHCS could pair new DHCS MMAC members with a mentor — ideally, a DHCS MMAC member who has been participating for at least one year and understands the details of the role. The mentor would then consistently check in with the new member and help with preparation responsibilities along with DHCS staff.

Check in with MMAC members. The contact for the DHCS MMAC should check in with all DHCS MMAC members before and after meetings. The check-in calls should be placed a few days after meeting materials are sent out, and the purpose of the call will be to ensure the DHCS MMAC member understands the materials and the agenda, answer any questions, and confirm the meeting date, time, and location. During debrief calls one or two days after the meeting, DHCS MMAC members should be asked for their feedback on how the meeting went; if they felt heard, valued, and supported; if there are more ways their participation in the meeting could be supported; and if they have more questions or feedback to share. They should also be reminded of the date, time, and location of the next meeting (if known).

9. Measuring Success of the Medi-Cal Member Advisory Committee

Findings

A noticeable gap identified in the literature — also confirmed by researcher interviewees — is that leaders of CACs rarely consider measures of success for the group, either for the organization or agency or for the CAC members themselves. Organizations and agencies are often eager to start their CACs and do not necessarily think about what success will mean to them. If DHCS could establish a few key measures or benchmarks for its CAC, that data could be collected and analyzed over time to support course corrections, develop deeper relationships with DHCS MMAC members, and support conversations with leadership and stakeholders about impact and return on investment.

Recommendations

Measure success for DHCS MMAC members. DHCS could develop a brief survey (eight to 10 questions) for DHCS MMAC members to complete after each meeting to gather feedback (anonymously) on their experiences with the group. For example:

- Do they feel heard?
- Do they feel valued and have a sense of belonging in the group?
- What are their reactions to the meeting format, facilitator, meeting frequency, etc.?
- Do they feel comfortable in their role?
- Are they getting the support they need from DHCS and their fellow MMAC mwembers?

After gathering this feedback, DHCS could dedicate time at the next meeting to report back on responses and work with DHCS MMAC members in real time to acknowledge what seems to be going well and to explore solutions for areas of improvement.

Measure success for DHCS. In partnership with the DHCS MMAC and select CBOs with experience in this area, DHCS could establish three or four measures of success for the MMAC. A guiding question for thinking about those measures could be: If speaking to leadership about the DHCS MMAC two years from now, what would you want to be able to say was accomplished? How did the DHCS MMAC help in the process? Then, with those potential measures in mind, DHCS could consider discussing this concept with DHCS MMAC members as an agenda item during an upcoming meeting to solicit the group's feedback on what success means.

10. Sustainability

Findings

When asked how to maintain and sustain a DHCS MMAC, interviewees and TAG members noted that all the key elements — composition and size, recruitment, compensation, logistics, meeting facilitation, meeting materials, building trust, preparing and supporting DHCS MMAC members, and measuring success — play a role in developing a strong and long-standing CAC. The message CHCS heard from interviewees and TAG members on sustainability was essentially that if the DHCS MMAC is established based on these promising practices, the group and its members will continue to thrive.

Recommendations

Commit to the key elements when building the DHCS MMAC. Sustainability will naturally occur if the key elements described in this report are considered when establishing the DHCS MMAC.

Embrace the process. One CBO noted that once established, CACs can be iterative and take time as they work through projects and issues. There will likely be lots of back and forth with DHCS MMAC members on certain projects, but that is necessary to ensure member feedback is genuinely being internalized and changes are being made to the extent possible. Timelines are important, but so is the need to recognize when being patient and flexible is the best approach. MMAC members will be more inclined to remain part of a group that agrees that getting it "right" is more important than getting it done quickly.

Pitfalls in Launching the Medi-Cal Member Advisory Committee

As important as knowing what to do when establishing and leading a CAC is knowing what *not* to do. Below are a few examples of pitfalls to avoid gleaned from stakeholder interviews, TAG discussions, and the literature.

Overpromising what can be accomplished. Avoid committing to plans or changes that DHCS cannot make. One CBO interviewee shared that their CAC members dedicated their time and energy to partner with them on shaping a project that never came to fruition due to lack of funding. The CAC members were disappointed and felt their time had been wasted. Be open and transparent but also realistic in what may or may not be possible to change.

Sending meeting materials out late. Nearly all interviewees mentioned that sending materials out in advance must be best practice. Otherwise, MMAC members will not have time to adequately prepare and could be less effective during meetings. Also, sending out materials without ample lead time will send the wrong message to MMAC members (e.g., we expect you to come to the meeting but are not giving you adequate time to prepare).

Having multiple leaders of the MMAC. Interviewees recommended that a few staff should lead the group and those roles should be clearly defined. There is value in having one or two strong relationships versus confusing MMAC members with too many staff members, roles, and voices.

Providing meeting materials that are not culturally and linguistically appropriate. One health plan noted the importance of having its Cultural and Linguistics Team review all meeting materials in advance to ensure they are free of jargon, are at the appropriate literacy level, are translated correctly, etc. MMAC members will be turned off from the start if the materials do not meet them where they are.

Assuming everyone can easily access and use technology, such as Zoom or Microsoft Teams. Do not assume everyone has the same command of or access to virtual technology. Confirm that members are familiar with the platform being used. One health plan shared that they made this mistake and lost a lot of time in a CAC meeting trying to help a translator join the meeting virtually.

Assuming because someone is quiet, they have nothing valuable to contribute. People have different styles of communication, and not all people feel comfortable raising issues in a group setting. Offer a variety of vehicles for offering feedback — one-on-one discussions directly after meetings, debrief calls a few days after meetings, voicemail line, email follow-up, survey, etc.

Rattling off statistics and jargon. Medi-Cal members interviewed noted that a steady stream of statistics and jargon can be overwhelming and confusing. Instead, share updates and information that will resonate with MMAC members and be explicit about why what is being shared matters to them and where you need their input.

Conclusion

With the launch of its Medi-Cal Member Advisory Committee, DHCS has committed to creating a unique space for state leaders to receive meaningful and authentic input from Medi-Cal members in real time. For the first time, DHCS will have an ongoing channel to gather member feedback to help shape and advance its policy, governance, and strategic priorities as well as its program activities. By largely adopting the recommendations in this report, which reflect the experience of other consumer advisory committees and incorporate feedback from an advisory group of Medi-Cal enrollees and stakeholders with CAC experience, DHCS has built on the experience of others and is laying a solid foundation for success.

Appendix A. DHCS Consumer Advisory Committee Research and Design: Interview Tool

Interviewee(s):

Organization:

Date of Interview:

Good morning/afternoon. Thank you so much for taking the time to speak with us today.

As you likely know, the California Department of Health Care Services (DHCS) is deeply committed to strengthening approaches to engage Medi-Cal members and people with lived experience to drive policy change. To that end, the agency has identified the need for a DHCS Consumer Advisory Committee (CAC) to be housed at DHCS and is aiming to convene its first meeting by the end of 2022. The Center for Health Care Strategies (CHCS) and California Pan-Ethnic Health Network (CPEHN) have received support from the California Health Care Foundation (CHCF) to support DHCS in conducting research and developing a proposed design for a **DHCS CAC of Medi-Cal members**.

As part of the research and design phase of the project, CHCS is conducting interviews with key stakeholders in the Medicaid and community engagement communities to better understand the landscape, where the challenges lie, bright spots of innovation and success, and what is needed when thinking about designing a CAC at DHCS.

We will talk through the questions below with you but welcome you going "off script" and sharing thoughts and insights that may not be included in these questions. We're also happy to focus on the areas where you have specific expertise. **We would like to record this call for note-taking purposes only (and we will destroy the recording after). Do we have your permission to do so?**

Definition of Key Terms

Community engagement. Integrating Medi-Cal members and other people with lived experience and expertise in navigating public benefit programs, like Med-Cal, into all aspects of state agencies to shape and drive policy change.

DHCS Consumer Advisory Committee (CAC). To date, DHCS has done well integrating advocates into its stakeholder processes but now would like to focus more intentionally on Medi-Cal member voices. Thus, DHCS plans to launch a CAC made up of diverse Medi-Cal members from across the state who will advise on DHCS policy and programs. The CAC will focus on the priorities cited by the members and will coordinate and inform existing groups such as the current Stakeholder Advisory Committee.

Introductions and Organizational Overview

1. Could you share a high-level overview of your organization and your specific role?
2. Does your organization have or work with a consumer advisory committee? Is your organization engaged in other activities that involve consumers?

Consumer Advisory Committees: Promising Practices, Lessons Learned, Innovations

1. How would you define a strong and effective consumer advisory committee?
2. Have you seen any strong consumer advisory committees in practice? If so:
   a. What strategies seem to work well?
   b. What hasn't worked?
3. Any bright spots or exciting innovations to share around developing a CAC, promising practices, outcomes and accomplishments, etc.?

DHCS Consumer Advisory Committee: What Is Needed?

1. CHCS is supporting DHCS in designing a CAC that will be housed at the agency. With that in mind:
    a. What do you picture when thinking about a CAC at DHCS?
    b. Which populations, communities, etc., should be represented?
    c. What is the ideal standard for the following CAC "must haves":
        i. Composition, size, and term limits
        ii. Trust building
        iii. Logistics
        iv. Comensation
        v. Agenda setting
        vi. Sustainability
        vii. Support and prep for CAC members
        viii. Governance structure
        ix. Measuring success
        x. What else would be on your "must haves" list?
    d. What pitfalls should be avoided?
    e. What is most important to consider in designing a CAC that ensures participants feel safe and supported?
    f. What elements are needed for a CAC to have the greatest positive impact on policymaking?
    g. Are there design considerations for a CAC unique to Medi-Cal?
2. A consultant will be chosen (via an RFP process) to recruit for and implement the CAC. Do you have any suggestions for potential consultants who may have experience in this area?

Wrap-Up

1. Do you have any other comments, thoughts, or recommendations we didn't already cover?
2. Do you have any reports, research, or resources on CACs or community engagement in California or nationally that you'd be willing to share with us?
3. <If applicable> Do you have consumer contacts (e.g., Medi-Cal members participating on a CAC) that you would recommend we speak to?

Appendix B. Literature Review: Promising Practices for Community Engagement and Consumer Advisory Committees

The following document is a compilation of research focused on promising practices for community engagement and, more specifically, consumer advisory committees (CACs). The articles are organized in two ways in the charts below: (1) summary of article and best practices and key lessons and (2) key theme and/or CAC design element. The **bolded text** signifies points in the research that *CHCS has heard mentioned in either Technical Advisory Group meetings or key stakeholder interviews.*

Much of the research highlighted below will strengthen and confirm the recommendations to be made in CHCS's recommendations for the DHCS MMAC.

ARTICLE INFORMATION	STATE	EVIDENCE-BASED	BEST PRACTICES AND KEY LESSONS	CHALLENGES	OUTCOMES
Increasing Consumer Engagement in Medicaid: Learnings from States Summarized key lessons from conversations with 50 leaders of state Medicaid programs across 14 states. Source: Jane M. Zhu and Ruth Rowland, *Increasing Consumer Engagement in Medicaid: Learnings from States* (PDF), Oregon Health Sciences University, December 2020.			**Support for engagement** ▸ **States connect with members through technology beneficial for those hard to reach.** ▸ **Ensure engagement opportunities are accessible.** ▸ **Provide compensation in return for member participation, along with food, transportation, and childcare for participants who see these as obstacles to attendance.** ▸ Offer opportunities for member engagement in various formats (e.g., town halls, focus groups, committee seats). ▸ **Provide training to members on technical language and policy details.** **Feedback loop** ▸ **Communicate consistently about how their input was used to inform decisionmaking.**		
	CA	N	Partner with community foundations for financial support of engagement functions (technical support, meeting facilitation, and atendee travel and per diem) that cannot be easily provided through government contracting.		
	CO	N	▸ Offers a handbook and is developing a video orientation on Medicaid policy for members participating in its benefits collaboratives to facilitate productive engagement. ▸ Medicaid agency uses a "benefits collaborative" process to solicit member priorities when deciding on Medicaid covered benefits by documenting input.		
	MN	N	**Leverage community partnerships to provide a neutral, safe space for engagement (e.g., hosting sessions at a community center).** One session started with members sharing personal stories before discussing Medicaid program design. This helped to root the policy discussion in the context of members' lived experiences.		
	NY	N	Conducted 25 focus groups in several languages to understand members' knowledge of health systems and experiences with care. The findings were used to design educational messages and to provide insight to shape demonstration projects designed to improve care provided to Medicaid patients.		
	PA	N	Maintain a member-only subcommittee, focused entirely on members' needs, facilitated by a leader with the Pennsylvania Health Law Project. The group generates member-initiated policy ideas and provides input on state-led policy initiatives.		
	VA	N	Virginia lets members participate through a telephone town hall in which committee members dial in to ask questions and to offer comments.		

ARTICLE INFORMATION	STATE	EVIDENCE-BASED	BEST PRACTICES AND KEY LESSONS	CHALLENGES	OUTCOMES
Key Learnings for Strengthening Partnerships Study highlights key learnings and recommendations to provide practical guidance to the field for strengthening partnerships with patients and families. Source: Deborah L. Dokken, Pam Dardess, and Beverley H. Johnson, *Key Learnings for Strengthening Partnerships* (PDF), Institute for Patient- and Family-Centered Care, November 2021.	CA	N	Key lessons: ▸ Leadership commitment is necessary for success. ▸ Pay ongoing attention to relationship and trust building. ▸ Establish a defined infrastructure. ▸ Work to expand involvement of patient and family advisors (PFAs). ▸ Have planned opportunities for onboarding PFAs, mentoring, and continuing education. ▸ Design a mechanism to ensure coordination and synergy of efforts. ▸ Stay nimble and adaptable to emerging issues. ▸ Commit to measurement, evaluation, and reporting. ▸ Use technology effectively.		
It Takes a Family Report offers recommendations for how California could fulfill its articulated commitment to coordinated, family-centered care by including families in decisionmaking. Source: Maryann O'Sullivan, *It Takes a Family* (PDF), Lucile Packard Foundation for Children's Health, May 2014.	CA	N	▸ Maximize the value of family participation at the agency level. ▸ **Assure that family representation reflects California's diverse population.** ▸ **Provide supports to allow family members to participate (e.g., translation services, ability to join meetings by web or phone).** ▸ Support activities related to work on the government policy entity, including outreach to gather input from other families. ▸ **Consider travel issues when setting meeting locations.** ▸ **Reimburse for childcare and travel expenses.** ▸ **Provide stipends for attending meetings.**		

ARTICLE INFORMATION	STATE	EVIDENCE-BASED	BEST PRACTICES AND KEY LESSONS	CHALLENGES	OUTCOMES
Working with Patient and Families as Advisors: Implementation Handbook The purpose of this tool was to help hospitals implement and develop effective partnerships with patients and family members at the organizational level Source: *Working with Patient and Families as Advisors: Implementation Handbook* (PDF), Agency for Health Care Research and Quality, January 2013.	IL MD SC	N	**Identify and hire a staff liaison** — designate a staff member to put in place the infrastructure for advisor engagement: ▸ Prepares staff and clinicians to work with patient and family advisors. ▸ **Recruits, orients, trains, and supports advisors.** ▸ Facilitates partnerships. ▸ **Ensures that advisors are ready to participate** and that staff are ready to engage in partnerships. Staff liaisons have these qualities: ▸ Passion for patient- and family-centered care ▸ Ability to listen and be open to new ideas ▸ Ability to build a strong rapport with hospital leadership, clinicians, staff, and with patients and family members ▸ Willingness to both learn and educate ▸ Well-connected within the hospital ▸ Patience and perseverance ▸ Ability to see strengths in all people in all situations and to build on these strengths ▸ Flexibility and a sense of humor **Recruitment process** ▸ Develop a set application and interview processes. ▸ Advertise; place brochures in easily accessible locations (i.e., discharge packets, informational materials, welcome packets, patient satisfaction survey mailings). ▸ **Most effective method for recruiting advisors is with a personal invitation.** **Support** ▸ Work with advisors to develop or revise written and audiovisual materials, such as patient and family handbooks, informational videos, or care instructions. ▸ To get the most of advisor input, bring advisors into the process when their ideas and input can have the biggest impact. ▸ Ensure a personal understanding of the hospitals culture, policies, and decisionmaking. ▸ **Provide advisory training.** ▸ **Pair advisors closely with a mentor.** **Advisors need to understand the responsibilities associated with the role before they can decide whether they are ready to serve. The staff liaison can hold an information session** for potential advisors to cover: ▸ **The role of patient and family advisors,** including **responsibilities** and the benefits of participation **Orientation** ▸ Background information ▸ Organizational structure of the department ▸ Responsibilities and expectations ▸ Tips for being an advisor ▸ How the staff liaison will support the advisor **Logistics** ▸ Time commitments, whether reimbursement or compensation is provided, what kind of training and support is available, and how the application process works **Term limits** ▸ **1- to 2-year commitment** **Feedback loop** ▸ **Provide feedback to and solicit feedback from patient and family advisors.** ▸ **Conduct periodic check-ins.** ▸ For advisors who are council members, staff liaisons may want to schedule a quarterly meeting to talk about how the experience is going and to identify any areas in which the advisor needs or wants to develop their skills.		

ARTICLE INFORMATION	STATE	EVIDENCE-BASED	BEST PRACTICES AND KEY LESSONS	CHALLENGES	OUTCOMES
Five Top Tips for Engaging Families in Advisory Roles: Advice from a Family Leader Source: *Five Top Tips for Engging Families in Advisory Roles: Advice from a Family Leader* (PDF), Lucile Packard Foundation for Children's Health, December 2018.	CA		Top tips 1. Organization values families' time and input 2. Organization offers ongoing training and support to family members 3. Organization provides support to committee chair 4. Chair models appropriate facilitation and behavior 5. Chair builds community, cohesion, and trust		
Leading by Convening: A Blueprint for Authentic Engagement This guide revealed three state approaches to how leaders at the school, district, and state level grapple with the challenges of implementing practice change. Source: J. Cashman et al., *Leading by Convening: A Blueprint for Authentic Engagement* (PDF), Natl. Assn. of State Directors of Special Education, 2014.v	GA	Yes	C.A.F.E. (Circles of Adults Focusing on Education): A diversified group of school, family, and community stakeholders were invited to "coalesce" around alarming school data (declining test scores, high absenteeism, little parent involvement, low graduation rates). Transparency of leaders (principal). Practices and strategies ▸ Dialogue Guide process ▸ Communities of Practice ▸ By inviting the full range of partners to learn from and with each other, Meriwether County leaders committed to making the necessary practice changes.		Graduation rate increased by over 30% (general population); graduation rate increased by over 30% (students with disabilities).
	IN		Initial sharing of information, building administrators in collaboration with teachers and specialized instructional support personnel, dialogue between parents and community members The Partnership Way: ▸ *Coalescing around issues* describes a habit of practice in which groups come together around shared concerns or problems of practice they want to resolve. ▸ *Ensuring relevant participation* involves making sure the right mix of stakeholders is identified and participating. ▸ *Doing the work together* focuses on the work being done and the interactions between and among the participants.	Primary teachers raised concern regarding research, best practice, and materials to support student acquisition and decided they needed more help to research best practice and delineation of appropriate sequence of skill instruction.	
	CO		Colorado Response to Intervention (RTI) Community of Practice brought together staff and local practitioners to engage in monthly discussions around problems of practice related to successfully implementing RTI.	State Advisory Council for Parent Involvement in Education "review best practices and recommend to policy makers and educator's strategies to increase parent involvement."	Colorado Dept. of Education was awarded a grant that gave birth to new partnerships.

ARTICLE INFORMATION	STATE	EVIDENCE-BASED	BEST PRACTICES AND KEY LESSONS	CHALLENGES	OUTCOMES
A Guide to Replicating and Adapting an Innovative Youth Development Program This guide is designed to provide organizations with the information they need to replicate, adapt, and implement a leadership academy in their area similar to Bay Area Leadership Academy. Source: *A Guide to Replicating and Adapting an Innovative Youth Development Program* (PDF), Bay Area Leadership Academy (BAYLA), November 2018.	CA		▸ Youth are paired with coaches to further explore concepts from the trainings and to plan projects for change. ▸ Youth develop relationships with BAYLA facilitators, coaches, staff, guest speakers, and externship hosts. ▸ At the end of the training period, youth are placed in four-week externships to implement the projects they have developed. ▸ Youth, coaches, and externship sites are recruited through outreach. ▸ Coaches and externship sites commit to the 10-week program. ▸ Youth leaders complete six full days of training. ▸ Networking with their coaches, youth leaders plan projects for change. ▸ Youth leaders develop their projects for change during their four-week externships. **Compensation** Youth receive $75 for each training they attend, $45 for each assignment they complete and each meeting with their coach, and $15 per hour (up to 10 hours per week) for working on their projects during that phase. **Support** ▸ Coaches have a network of youth to call on to participate in policy initiatives. ▸ Cultural field trips that connect participants with local events and history provide a visual, one-on-one experience.		Built membership base by engaging current and former foster youth with an interest in advocacy work.
Partnering with Youth, Families, and Patients in Research: A Standard of Compensation for Youth, Family, and Patient Partners Guide provides recommendations to youth, families, and patients for collaborating with researchers on studies and outlines fair compensation for the work done as part of the research team Source: Charlene Shelton, Clarissa Hoover, and Carolyn Allshouse, *Partnering with Youth, Families, and Patients in Research: A Standard of Compensation for Youth, Family, and Patient Partners* (PDF), CYSHCNet, 2021.	CO	Y	**Active engagement** ▸ Youth, family, and patient partners work with funders to focus on and design research projects, advising about or recruiting participants, helping to develop materials, carrying out aspects of research such as conducting interviews with study participants. ▸ CBOs led and staffed by patients or families such as Family Voices and Family-to-Family Health Information Centers. ▸ Participating in training events, receiving support, and mentoring around research terms and processes. ▸ Interviewing participants or leading a focus group. ▸ **Coproducting reports, articles, and other dissemination materials.** **Representation** **Diversity — in addition to racial and ethnic diversity, socioeconomic status, education, geography, rural/urban, culture, nationality, language, religion, and other aspects of the human** **Develop a contract or scope of work that outlines duties and compensation.** CYSHCNet recommends that payments begin at $25 per hour with a $100 minimum payment.		Compensation shows a commitment to excellence in research and helps make sure the findings represent the population being studied.

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Family Engagement in Systems Toolkit: Strategies and Resources The Family Engagement in Systems (FES) Toolkit can be used as a standalone resource or as a companion document to the Family Engagement in Systems Assessment Tool (FESAT). The FESAT is a tool that organizations can use to assess and improve family engagement in systems-level initiatives, helping to ensure that the voices of the individuals, families, and communities who receive services are included in the creation of the policies and practices that govern those services. The FES Toolkit and FESAT are based on a framework of four strategic domains. Family Voices encourages organizations to use the strategies and resources in this toolkit to promote, strengthen, and improve family engagement in systems-level initiatives. Source: *Family Engagement in Systems (FES) Toolkit: Strategies and Resources* (PDF), Family Voices, June 2020.	MA	N	▸ Commitment ▸ Transparency ▸ **Engaged families reflect the diversity of the community served (race/ethnicity, culture, language, and geography)** ▸ **Diversity not only in race/ethnicity, but also in socioeconomic status, education, geography, rural/urban, culture, nationality, language, religion, and other aspects of the human condition**		
"Engaging Consumers and Communities to Meaningfully Transform Care" Project gathers best practices for: ▸ Identifying community priorities ▸ Obtaining and integrating patient input ▸ Designing and implementing sustainable community-based efforts to address patient-identified health and social needs ▸ Understanding and collectively addressing equity challenges Source: Anna Spencer, "Engaging Consumers and Communities to Meaningfully Transform Care," Center for Health Care Strategies, September 12, 2019.	CA	N	**Integrating patient experience and voice into health system interventions is crucial to making sure health care systems design and deliver services that meet community needs.**		
"Convening a Consumer Advisory Board: Key Considerations" Key considerations to help guide health care systems in creating successful community advisory boards. Source: Anna Spencer, "Convening a Consumer Advisory Board: Key Considerations," Center for Health Care Strategies, December 2019.	NJ	N	▸ Laying the groundwork ▸ Recruiting members ▸ Supporting meaningful participation ▸ Reducing barriers to participation ▸ Compensating members for expertise		

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Supporting Meaningful Engagement Through Community Advisory Councils: Lessons from the Oregon Health Authority This case study examines what has made CACs — and the resulting patient engagement — successful. Source: Renée Markus Hodin and Madison Tallant, *Supporting Meaningful Engagement Through Community Advisory Councils: Lessons from the Oregon Health Authority* (PDF), Center for Consumer Engagement in Health Innovation, August 2020.	OR	Yes; case study	Training Staff and consultant-led, in-person training sessions are available on issues such as the Community Health Assessment (CHA) and the Community Health Improvement Plan, areas for which CACs are responsible. Policies feedback loop Coordinated care organizations have an important avenue to learn how their policies and procedures are impacting members and to make any necessary changes. Accessible materials ▸ The Columbia Gorge CAC strongly influenced the regional CHAs' development by creating an 11-page "plain language," more accessible and visual summary that provides key highlights of the 63-page assessment. ▸ Translated the summary document into Spanish.	Recruiting and supporting members to serve on CACs. Challenges included varying level of interest across regions; ensuring CACs have the supports needed to meaningfully include members once they join; and properly funding supports for CAC member attendance.	
Key Findings from the Medicaid MCO Learning Hub Discussion Group Series and Roundtable — Focus on Member Engagement and the Consumer Voice Challenges with member and family engagement, strategies for better engagement, and how COVID-19 affected engagement efforts were discussed. After assessing key themes, the team convened a roundtable with partners to discuss findings and identify insights and opportunities to address those findings Source: *Key Findings from the Medicaid MCO Learning Hub Discussion Group Series and Roundtable — Focus on Member Engagement and the Consumer Voice*, NORC at the University of Chicago, January 2021.	CA	N	Managed care organizations reach out to members to provide multiple types of important information via mailings, phone calls, face-to-face interactions, text messages, interactive voice response, and social media. **Compensation** ▸ Incentives can include stipends, lunch, transportation, gift cards, childcare, etc. ▸ Incorporating celebrations like annual dinners and awards ceremonies also encourages participation and shows members and their families that their input is valued.		
"Engaging Consumer Voices in Health Care Policy: Lessons for Social Work Practice" To better understand the quality of patient participation. Source: Kristi Lohmeier Law and Jeanne A. Saunders, "Engaging Consumer Voices in Health Care Policy: Lessons for Social Work Practice," Health and Social Work 41, no. 1 (Feb. 2016): 9–16.	CA	Qualitative study	To ensure that health centers meet the needs of their patients, they uniquely engage them in their organizational decisionmaking and policy-development processes by requiring that their boards of directors encompass a 51% patient majority.		

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Creating a Consumer Advisory Council This fact sheet outlines a set of best practices to help guide you as you create any form of a consumer advisory council. Source: *Creating a Consumer Advisory Council: Fact Sheet* (PDF), National Partnership for Women & Families, January 2014.	N/A	N	▸ **Secure buy-in from existing board members and senior leadership to create a consumer advisory council.** ▸ **Identify council members and together determine roles and responsibilities.** ▸ **Formalize the role of the CAC by creating a written document to outline its principal functions.** ▸ **Ensure the CAC is integrated within the greater organization.** ▸ **Orient all stakeholders to the goals of the CAC.** ▸ **Orient members of the consumer advisory council to the goals, mission, and vision of the larger organization.** ▸ **Designate staff to support and maintain the membership of the CAC.**		
"Engaging Consumers in Medicaid Program Design: Strategies from the States" Early evidence on how state Medicaid agencies are integrating members' experiences and perspectives into their program design and governance. Source: Jane M. Zhu et al., "Engaging Consumers in Medicaid Program Design: Strategies from the States," Milbank Quarterly 99, no. 1 (Mar. 2021): 99–125.	OR	Y	▸ Holding telephonic "town halls" for members who could not attend in person. ▸ Tapping foundations to fund members' participation costs, meals, and meeting facilitation. ▸ Building member research into budget requests for federal programs. ▸ Using short-term workgroups regarding specific benefits to optimize member interest and impact. ▸ Using advocacy groups to identify representative member participants. ▸ Implementing application and selection processes for member' committee membership. ▸ Incorporating activities across different Medicaid subpopulations. ▸ Educating new committee members on Medicaid and how to use it. ▸ Encouraging members to start policy discussions via an all-member medical care advisory committee (MCAC) subcommittee. ▸ Closing the loop: sending out detailed agency responses to all public comments, making sure members see their impact. ▸ Showing respect for members' input by having Medicaid director attend MCAC sessions. **Engagement** ▸ Hold standing meetings with advocacy organizations and other constituents, town halls, and focus groups. ▸ Partner with a regional nonprofit to gather member experiences as part of the case management service redesign. ▸ Medicaid leaders highlighted that providing some minimal compensation for participation was a factor in successful engagement. **Feedback loop** **Ensure an effective feedback loop by reporting (through public minutes or reports) how members' feedback was used, invested time and staffing resources to help with effective member interactions.** **Supports** ▸ **Provided training for patient participants to better understand technical language and policy complexities.** ▸ One-on-one orientations for new committee recruits to familiarize them with the Centers for Medicare & Medicaid Services, the role of the council, and the work that it does.	▸ Keeping members engaged ▸ Overcoming resource constraints ▸ Ensuring engagement is productive	

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Engaging Youth with Special Health Care Needs and Families of Children with Special Health Care Needs: Recommendations for Medicaid Agencies Key findings from the survey and interviews, including engagement themes, challenges, and recommendations for Medicaid agencies, youth with special health care needs and families of children with special health care needs, and funders to strengthen engagement that can have lasting impact on outcomes, quality, equity, and cost. Source: Courtney Roman, Hannah Gears, and Madeline Pucciarello, *Engaging Youth with Special Health Care Needs and Families of Children with Special Health Care Needs: Recommendations for Medicaid Agencies*, Center for Health Care Strategies, July 2021.	CO CT DC DE ND OH OK RI TX	N	**Trust building** ▸ **Systematically checking in (e.g., establishing a consistent feedback loop) with youth and family advisors and representatives, and refining engagement strategies based on their input.** ▸ **Reliable feedback loop between Medicaid agencies and family representatives encourages prolonged engagement and mutual trust.** **Sustainability** **Offer training, onboarding, coaching, and compensation to ensure members understand their roles and can participate effectively.** **Engagement** ▸ **Dedicate staff time and resources to conduct intensive recruitment.** ▸ **Conduct outreach and provide a virtual option for participation to help yield a much more diverse and rich representation.** ▸ **Consider cultural and linguistic competencies when partnering with youth and families.** ▸ Understand deeply rooted cultural needs and preferences for participation. **Compensation** ▸ **Stipend, childcare, meals**	Majority of state Medicaid agencies do not meaningfully engage youth and teens with special health care needs (focus is more often on parents).	
Youth Advocates Program California Children's Trust and California Coalition for Youth have partnered with youth leaders to create the Youth Advocates Program. Source: "Youth Advocates Program," California Coalition for Youth.	CA	N	▸ Support youth in building their advocacy skills. ▸ Offer youth opportunities to change and influence the systems that impact them. ▸ **Acknowledge the wisdom and experience young people bring to complex issues by compensating them for their advocacy.**		
Family Engagement and California's Whole Child Model Source: Caroline Davis, *Family Engagement and California's Whole Child Model: Lessons Learned from the Implementation of Family Advisory Committees*, Lucile Packard Foundation for Children's Health, September 9, 2021.	CA	N	**Compensation** The health plans provide a stipend of between **$50** and **$100** per meeting to their family advisory committee family representatives.		
Y.O.U.T.H. Training Project YTP is the first child welfare training program developed and delivered entirely by current and former foster youth. Source: "Y.O.U.T.H. Training Project," California Youth Connection.	CA	N	YTP has trained, employed, and supported more than 140 youth who have in turn trained over 7,500 child welfare professionals on the needs of foster youth and the practices that best support them.		

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Issue Brief: Framework for Assessing Family Engagement in Systems Change Summarizes barriers to effective family engagement and identifying four domains and corresponding key criteria that provide a framework for considering how well organizations and agencies are engaging families. Source: Clarissa Hoover et al., *Issue Brief: A Framework for Assessing Family Engagement in Systems Change* (PDF), Lucile Packard Foundation for Children's Health, April 2018.	CA	Y	**Representation and recruitment** Reflect the diversity of the community (race/ethnicity, language, income, education level, and geography). **Collaborate with family-led and community-based organizations for recruitment, training, and support of participants.** **Support** ▸ **Provide peer mentors to help family leaders learn the skills to participate effectively and address barriers to their participation.** ▸ **Make meeting minutes and other key materials available to family leaders, in formats they can access, in language they can understand, and in a timely way.** ▸ **Provide both families and professionals opportunities for training and support in understanding their roles and the process of engagement.** **Transparency** ▸ Provide access to relevant knowledge. ▸ Practice partnership in all parts of the process. **Engagement** ▸ Promote engagement as a core value. ▸ Establish engagement at all levels, in all systems of care. ▸ **Hold meetings that accommodate everyone's schedules to encourage regular attendance. In-person meetings help with relationship building between families and professionals.** **Diversity** **Ensure that family participants represent the race/ethnicity, language, income, education level, and geography.** **Compensation** ▸ **Compensate family organizations and family leaders for their time, expertise, and the costs of participation, such as travel expenses and childcare.** ▸ **Family engagement should be adequately funded and included in the budget.** **Language** ▸ **Spell out acronyms and explain their meaning.** ▸ **Use plain language when writing and speaking.**		
Family Voices Matter: Listening to the Real Experts in Medi-Cal Children's Health This report describes parents' experiences with their children's Medi-Cal coverage and their recommendations for improving children's health care, as well as how health plans can collaborate with families on systems change. Source: *Family Voices Matter: Listening to the Real Experts in Medi-Cal Children's Health* (PDF), Children's Partnership, June 2022.	CA	N	**Engagement** **Build a family engagement infrastructure: Provide families financial, transportation, translation, child care.** **Meaningfully incorporate family input into DHCS decisionmaking.**	Suggestions for improvement: Codesign, with parents, information materials to be more relevant, and provide the materials to parents with coordinators available to help them navigate and understand information they receive.	

Appendix C. DHCS Medical Member Advisory Committee Design — Technical Advisory Group Roster

Participants

NAME	ORGANIZATION
Jimina Afuloa	Empowering Pacific Islanders Coalition
Seciah Aquino	Latino Coalition for a Healthy California
Dannie Cesena	California LGBTQ Health and Human Services Network
Sarah Coombs	National Partnership for Women & Families
Jack Dailey	Legal Aid Society of San Diego
Auleria Eakins	L.A. Care Health Plan
Janette Robinson Flint	Black Women for Wellness
Tiffany Huyenh-Coh	Justice in Aging
Kausha King	Family Resource Navigators
Rod Lew	Asian Pacific Partners for Empowerment, Advocacy, and Leadership
Nancy Netherland	California Children's Trust / Parent and Consumer Partner
Hector Ramirez	Consumer Partner
Andrea Wagner	California Association of Mental Health Peer Run Organizations
Jevon Wilkes	California Coalition for Youth
Elizabeth Zirker	Disability Rights California

Staff

NAME	ORGANIZATION
Michelle Baass	California Department of Health Care Services
Palav Babaria	California Department of Health Care Services
Alissa Beers	Center for Health Care Strategies
Kelly Church	Center for Health Care Strategies
Brian Hansen	California Department of Health Care Services
Tricia McGinnis	Center for Health Care Strategies
Chris Perrone	California Health Care Foundation
Courtney Roman	Center for Health Care Strategies
Cary Sanders	California Pan-Ethnic Health Network
Kiran Savage-Sangwan	California Pan-Ethnic Health Network
Madeline Steward	Center for Health Care Strategies

Endnotes

1. Courtney Roman, Hannah Gears, and Madeline Pucciarello, "**Engaging Youth with Special Health Care Needs and Families of Children with Special Health Care Needs: Recommendations for Medicaid Agencies**," Center for Health Care Strategies, July 2021; and Jane M. Zhu and Ruth Rowland, ***Increasing Consumer Engagement in Medicaid: Learnings from States*** (PDF), Oregon Health and Sciences Univ., December 2020.
2. California Dept. of Health Care Services, "**DHCS Launches New Medi-Cal Member Advisory Committee**," press release, February 17, 2023.
3. Note that for CAC members paid $600 or more during one calendar year, a 1099 tax form will likely be required and the compensation reported for tax purposes.