April 17, 2018 Community Advisory Council (CAC) Event
CCO 2.0 Gallery Walk Notes

SDOH & Equity Spending Requirements

Potential Strategies:

- Require CCOs to spend portion of savings on SDOH & health equity disparities:
  - State provides two years of seed money to help CCOs meet spending requirement on social determinants of health & equity in partnership with community social determinants of health providers.

Question: How might CACs be involved in this work with their CCOs?

- Each CCO is different and careful of how "swings" is interpreted. Seed money is helpful.
- Encourage CCO's to change requirements on having CBIR Funds to be spent on incentive measures rather than CHP priorities.
- Need to define what expenditures would apply to SDOH. CAC could help and prioritize.
- Missing strategies: Require representatives of SDOH fields at CCO boards.
- Keep local control. Don't micro-manage from "on high".
- Allow funding for food.
- Global warming – air conditioners.
- CAC's, CAP's, all CCO board members required to have equity training.
- Seed money is unnecessary. The CCOs (I imagine) already have plenty of money – why spend more state dollars on "seed money".
- Focus more on wellness care rather than health care.
- Provide CACs with the resources to make the decisions, trainings, data, etc.
- We should do what our community needs and make over the long-term health better.
- Allow funds to be spent on housing supports.
- Seed money is required to make this happen. Our work stalled without funding.
- Gym memberships. Cooking classes especially on how to use food boxes from food banks.
- Give clarity around whether this money is intended for clinics or non-clinic community partners.
- Great idea.
- Flexible funds to address SDOH.
- Allow and encourage nonprofit CHW programs and develop billing mechanism.
- What about using SDOH data in rate-setting?
- What about CCOs that are apart of larger health plans with different reserve requirements?
- Provide technical support.
- CACs should have direct control over at least some of money for SDOH.
- Being forceful, coming up with the ideas also meeting with our CCO once every six months.
- This would make the CAC more meaningful to its members.
- Having an expectation that CACs and communities are informed about SDOH. Having a clear definition.
- Are we training our staff and CACs thoroughly in cultural competency to avoid tokenizing people?

- This is especially important for housing. Bankers and developers are ready to fund projects. Funds need to be available.
- Have each CCO have at least one SDOH focus area in CHP to ensure funding.

Question: If your CAC has experience supporting this type of work (for example, deciding how to spend some CCO funding on community-based work), what has worked and what hasn't?

- Important to maintain flexibility within the CCO – don't penalize CCO if the funds are not spent in 12 months. Sometimes it takes time to circle the wagons and innovate.
- CAC could help with prioritizing. Would need clear definitions on what would qualify.
- Community engagement.
- Need to utilize an application form similar to grant funders for projects. CAC members develop guidelines on evaluating them. Must get following reports on outcomes.
- Simplified process for allocating funds.
- Getting information to the community.
- Determining best practice, promising practices.
- Help create buy-in by siloed community partners.
- Leadership opportunities for CAC members.
- We need more data. Needs/new project will be "obvious" from here.
- You must keep stipends, child care, and transportation flowing and stigma-free. Our time is valuable.

SDOH&E: Community Health Improvement Plans

Potential strategies:

- Require CCOs to submit their CHA to OHA
- Require CCOs to developed shared CHAs with local public health authorities and non-profit hospitals; also encourage shared CHPs to the extent feasible
- Require that CHPs align with 1-2 State Health Improvement Plan (SHIP) priorities.
- Other?

Question: Is there anything missing when it comes to CACs and your role in the CHA and CHP?

- Yes, please have legislation that requires more alignment between non-profit hospitals and CCOs and public health in CHA/CHP process!
- CHP/SHIP alignment – timelines don't match up well, particularly with public health departments that started early on accreditation.
- Keep local control – don't micro-manage on high!
- Alignment with SHIP is a "top down" requirement. Communities should be able to decide this for themselves.
- Local control – standardize data collection, not priorities.
- Alignment doesn't have a ton of space or capacity to implement strategies to address what we learn in the CHA. We only have four CHP areas, for example.
- How much rural voice is invested in development of SHIP?
- More rural areas may have different needs than the SHIP.
- It's important to remember that as this CAC is growing, changing evolution of ideas, that new people coming aboard would benefit with definition of CHA and CHP and what the purpose is, and who is reading it.

- Thinking big for the long term and overall health.
- Great idea to streamline! As long as all partners are willing to cooperate and coordinate.

SDOH&E: Health-related services (HRS)

Potential strategies:

- Encourage HRS investments to align with community priorities, such as those from CHA/CHPs and CACs, and identify a role for the CAC in making decisions about how HRS investments are made.

Question: What feedback do you have about involving CACs in this work?

- HRS: CC's are not making HRS an accessible option. Processes are too complicated. Need to give more local community control over spending/approval process.
- HRS are so unique and specific it may create barriers if they must align w/ CHP.
- Our CAC currently puts out a call for applications, reviews them? Makes funding recommendations. This works really well. The biggest problem is finding a meeting time for everyone. Although sometimes it seems like the people with the loudest voices get their passions funded.
- CAC should most definitely make the financial choices.
- Require CCOs to train providers how to effectively use the funds.
- Have OHP recipients on the board that gets to decide HRS spending.
- Use similar strategies/process we use for the CHP grant and identify disparities.
- Sustainability for community-based work.
- Require CCOs to demonstrate how CAC proposals, committees, etc. are giving input into how SDH dollars are being spent.
- Should be thinking long-term about health.
- If your CAC is truly representative of the OHP member this will be helpful.
- The CHA is personal to CCOs and their community. Works well.
- In our organization, everything is top-down. The CAC is at the bottom. Our CEO sees our whole CCO in this way. It should be more focused on bottom-up.
- Public input – focus groups.
- HRS are still a mystery to OHP/CAC members. They need CCO leadership to explain their policies and how to access HRS.
- Share how SDOH&E are impacting members (from conversation).
- Begin with SDOH 101 education.
- Don't tie to rates! Allow a nimble model for the use of this resource.
- Identify a role for the CAC is vague. CACs need explicitly defined authority so CCOs take their council seriously.
- Report to CAC w/ data around what is being funded/how many requests come in and how many are approved vs. denied.
- Regular CCO reports about use of HRS across all areas.
- If CAC's truly govern then give them the platform and leadership roles.
- Great!!
- Be clear with CAC members (new and current) what their roles and expectations are.

Question: If your CAC already has a role in your CCO's health-related services work, what has worked and what hasn't?

- Giving CAC funds and autonomy to make decisions about community investment.
- We kind of already do this with CWIF funding. They love it. They get to review applications, then vote. It then goes higher up the ladder for further review. Our CAC also votes on PIP and incentive metrics.
- Local decision-making by CACs and SDOH investments.

SDOH&E Community Advisory Councils

Potential strategies:

- Require CCOs annually review member data and align with CAC representation (e.g. race, ethnicity, age, language, geography, ability, gender, sexual orientation, etc.) and CHP priorities
- Require CCOs report annually to OHA (to be shared publicly) on CAC member composition compared to member data, including percentage of OHP consumers on CAC and how they define OHP consumer
- Require CCOs share with OHA (to be shared publicly) a clear organizational structure that shows how the CAC connects to the CCO

Question: Are we missing any important strategies to reach our policy goals?

- Provider support to achieve this – training, education, funding.
- The strategies need to be rewritten to not sound intimidating.
- Build in incremental steps to avoid tokenism.
- Frequent training for CAC/board/CCO.
- Require/encourage CCOs to stop term limits.
- Thinking overall long-term or what's coming because what's happening and how the overall effects are going to be – drugs to mental health, eye sight and neck pain from phones.

Question: Do you have any significant concerns or feedback on the potential strategies?

- 1st strategy: OHA member data is currently available when it comes to race/ethnicity so tying it to requirements won't be meaningful until/unless this is fixed.
- 1st strategy: Great, but it will be difficult to maintain (membership matching population). What % of population needs to be represented?
- 2nd strategy: Potential to give up disability/health status info that's identifiable in small communities.
- 2nd strategy: Shows how the CAC connects to the CCO is vague. CACs need more power within CCOs, it's not just about CCOs explaining their governance to OHA.
- Worries about CAC members not wanting to be identified by their data – small numbers on these committees makes people easily identifiable.
- Add board and staff representation. Aligning CAC demographic representation with member data is a very different requirement from aligning with each CHP goal → split into two?
- Keep local voice/control – don't micro-manage from OHA "on high".
- Could be difficult to find community representatives who meet the required categories and who are willing to serve. Some may not wish to self-identify in a quasi-public forum.
- CAC composition does not necessarily mirror the OHP/CCO composition.
- What is the accountability (of aligning CAC population w/ CHP and CCO membership)?
- Perhaps at least make them show/document their efforts to recruit CAC members to achieve appropriate member composition based on member data.
- Involve more diversity
- When spending on SDOH don't limit things to OHP only all people need help.

- One still fails to capture race/ethnicity on 40% of members. How can we expect to do this at the CCO level?
- How does OHA plan to enforce requirements related to CAC member composition? We have had the 51% requirement for ~6 years but without consequence it isn't happening.
- We need to have a clear definition of consumer. A community agency is a proxy for an OHP member.
- Having or requesting data from CAC might be concerning – individuals might not want to share their private information.
- Concerns on how and what information needs to be collected from potential CAC members. Also privacy issues and if potential CAC members discourage from applying.
- The SDOH requirements are funded during the planning and development phase (before outcomes will be seen).
- When the board has to approve the CAC decision it takes a long time.
- Transparency is a good thing.
- Having conversations during the process instead of bringing a couple of choices that were decided on w/out the CAC voice.
- CAC involvement in process for requesting help. Share challenges of ensuring the funds are spent wisely.
- Does the state share the demographic data with the CCO? How do you deal with those who don't answer?
- Partnership w/ SDOH providers; what if there aren't these resources available? These funds shouldn't be given to the org's already – there's monopoly – CHMP.