Community Advisory Council (CAC) Member Responses to CCO 2.0 Policy and OHP Questions

1) Should the data be monitored annually? Should the CAC membership reflect the CCO demographics?

**Responses were received from four CACs.*

Yes – support for policy:

- Yes, the more data the better
- Yes, policy is sound

Yes – support for policy, with changes:

- Targeted outreach could occur to diversify CAC
- Do data review every two years, instead of every year. Gives more time for CCO and less burden of work. Especially given that data may not change dramatically year to year.
- Organizational chart should be clear
- Mission: communication to public, acronyms are an issue, explain a CAC and its work could be clearer, clear language

Concerns with the policy:

- Haven't talked about: challenge of getting a diverse group of people to the table with a true voice (tokenism? Stronger voices in some communities may have an agenda, travel time and ability are difficult in rural communities).
- Can the under 18 barrier guidelines be removed? This works to exclude youth voice which is very important.
- Problems with recruitment are real, i.e. rural issues, "working poor" challenge of attending meetings
- It is still very difficult to recruit, and many challenges will exist to mirror the membership
- Meeting a specific demographic is very complicated, particularly in rural areas
- Staff are often working hard to manage the CAC, but it is still hard to keep them engage.
- Downside: collecting data is complicated
- Number of people who are on a CAC may already be full
- CAC membership, no matter what, isn't inclusive of the full membership voice. What other ways can count to do this work?
- What incentives will there be to fill this need (for members and CCOs?)
- It is already hard to recruit, will there be disincentives if the CAC can't fill this requirement?
- Is there a metric to the CCOs to also measure the values and concerns from all members?
- Are there other ways to ensure a broad input? Would examples of outreach count? Our CCO does member meetings on regular voices and gets good input and attendance at those.

2) Require the CCOs to show org/connection to the board.

**Responses were received from two CACs.*

Yes – support for policy:

- It's good to show structure on how things work in a CCO
- This makes sense, is easy to do

Yes – support for policy, but with changes:

- Show how recommendations form the CAC are considered, not just how they connect
- CCOs should also be required to give examples of how input is given
- Require more information on this in the CHP report (not just more boxes to check)

Concerns with the policy:

- Create a mega CAC from all CACs. Though there is a monthly recruitment call, and there is an annual meeting, it was recommended that this happen more often and be more formalized.

- How can we ensure that we have a good flow of communication between governing bodies? Organizational structure doesn't necessarily do that.

3) Requirement to spend money on SDOH-E related to the CHP.

**Responses were received from four CACs.*

Yes – support for policy:

- Yes. Our CCO already does this. Others should too.
- Yes, to being required to spend on SDOH/Equity
- There is a lot of value to spending money locally
- CCOs are already doing this
- Examples of already supported SDOH funding: youth drop, One key question work, tobacco cessation work
- Support state "seed money" to help show improvements
- CHP grants to committee work = good work with minimal funding at our local CAC
- Need money to continue to implement CHP identified priorities: more priorities = more money, less priorities = how to spread money

Yes – support for policy, but with changes:

- Reportable +D9dollars spent on SDOH-E should be separate from administration dollars so it can be better tracked and reported.
- Yes, to seed money, but it should be more than just 2 years' worth
- Incentivize providers to collect SDOH data via screenings. Link directly to provider collection and recommendations for client.
- Should this be scripted or flexible by OHA? A combination of both.

Concerns with the policy:

- Discussion regarding what "savings" at the CCO level are, how much they are and what they mean for the OHA vs the CCO
- How does the CCO know best data on expenditures and reduction of health issues?
- How do we identify barriers to health and how to gauge outcomes of SDOH?
- Problem is how to sustain programs in the community (and partnerships) after the seed money is gone. This could set the CCO up for a difficult situation if they cannot sustain work at the same level.
- All are for the "seed money" from OHA, but does it become an unfunded mandate after the seed money?
- There is a sustainability issue in this: example is like Transformation Fund dollars the state gave before, and then CCOs couldn't keep up that spending level and the community is disappointed

4) Should there be shared CHAs and CHPs with public health and hospitals?

**Responses were received from three CACs.*

Yes – support for policy:

- This is already done in Curry County
- This is critical for the sharing of resources
- Shared CHPs are best for all of the work to get done with partners
- Already happening locally
- Advantage: pool resources
- Seems like a good idea

Yes – support for policy, but with changes:

- Makes sense to do this, but only where it aligns
- Recommend including FQHCs in work too
- Sounds okay if it is not a scripted amount or % so the CCO can make that decision

- There is a great need for this, but CCOs need to be adequately funded for this.

Concern with the policy:

- Shared CHIP can be very challenging in areas where there are multiple CCOs
- Disadvantage: someone copies others work but doesn't play well together
- Due to changes in spending levels for a small CCO (on pharmacy, etc.) there is less wiggle room for additional dollars
- This could affect the actual clinical staffing needs and support, if money is mandated to SDOH, and therefore staff from clinical programs are removed to meet it.
- CCOs also need to be involved in local policy development, so that could be a non-financial resource that is valuable

5) What are the three things that OHP could do that would help you stay healthier?

**Responses were received from seven CACs.*

Health classes or gym memberships:

- Offer on-line health education modules or lessons
- Offer gym and/or pool memberships
- "Power Clean" (a local initiative that combines Crossfit, group support incentives) for everybody and not those just in recovery from addiction
- Gym or pool memberships at no cost
- Gym memberships
- Recreation pass/Gym membership (either close to me or with covered transportation)

Transportation:

- Ride Vouchers for specialty care
- A way to reimburse gas/mileage or provide transportation to obtain food
- Provide transportation to AA and other peer support groups
- Provide transportation for members to peer support groups or AA or other things that help them but are not traditional billable medical services

Food:

- Veggie Rx, a mobile produce bus that comes to a local clinic
- Increase access to healthier (organic) foods
- Quote from OHP member on SNAP: "$135/month of SNAP for a couple doesn't last. We end up using the food bank for the last half of the month."
- Increase their efforts on healthy food access, opportunities for exercise (the Social Determinants of Health)

Mental health:

- Psychiatry consult especially for management of Psych. medications.
- Increase access to MH services/decrease the barriers for entry into MH services
- Therapy for my child if it was needed (PT/OT/MH); not time limited or number of visits limited but until he was better.

Access to care:

- "First available" appointment. may be months out to access care
- Make the entire prior authorization process clearer. Members need help understanding the path to get referred to a specialist, why some procedures are considered cosmetic vs. medically necessary, why their PA was denied, what their appeal rights for a denial are, how Oregon's prioritized list was applied to the decision on their case and where their condition appears on the prioritized line list.
- Phone wait times for OHP have been at 5 hours; I can't be on hold for 5 hours.

Peer support:

- Investing in peer support organizations or other community supports that could help members
- Change the requirements that a service needs to be billed to count; peer support organizations don't work on that model.

Child care:

- Child Care so I can go to the gym + Child Care so I can make/keep appointments for myself
- Special needs child care

Ombuds:

- The OHP Ombuds information should appear on every document I am sent.
- Define what the OHP Ombuds can do to help me with my case.

Other:

- Offer incentives for healthy behavior (for both adults and teens)
- Send me a monthly newsletter
- Provide a searchable provider directory so I can find a provider I like and want to see
- I never get anything about the cost of my services. That might help people make better decisions about care.
- An increased focus on prevention instead of treatment
- Acknowledge the stress of living in poverty and provide supports related to that stress…acknowledge the cumulative effects of stress.
- Acknowledge and respect the rights of an authorized rep. of an OHP member to communicate and be part of decision making. One member reported being threatened with benefits being reduced/eliminated when acting as an authorized rep. for her grown child if she didn't allow the child to speak. Her child's disability affects her ability to speak for herself, which is why the authorized rep. status was in place.
- Intake rules at some clinics or for some services are excessive and require multiple visits before services can start.
- Contracts with alternative care providers (acupuncture, PT, yoga, massage therapy)
- Improve/create business relationships and projects with community agencies that can impact the Social Determinants of Health
- Care Coordination is in the name of every CCO but needs improvement; how I get handed from one provider to another, and how my information and past/current tests and procedures get from one provider to another.

6) Have you ever needed a health service but had to "give up" on the idea? Why was that?

**Responses were received from seven CACs.*

Oral health:

- Orthodontia. It is not just a cosmetic issue, but a self-esteem issue and can make a child a target of bullying.
- Orthodontia for more than severe bone/face deformities
- Many months delay to see a dentist, only to be given a referral to another dentist which took months.
- The dentist only treats 1 cavity in a child at a time. Too many appointments. to get everything that is needed done.
- A root canal; they told me the only thing they could do was pull my tooth.
- Denied a referral to a specialist.
- Dental access requires travel to distant community; we have no pediatric dentist
- No on-site oral health services for SNF, ALF and adult foster home residents
- Dental access: process too complicated and took too long
- I went months without teeth while waiting for dentures.
- Why do we insist on pulling teeth instead of repairing them?

Mental health:

- MH services: can’t get into services in Linn and Lincoln counties
- Our pool of available MH providers has decreased and there seems to be no supply of new providers.
- There is a wait list for MH services
- MH provider refused to recognize the guardian’s right to make a decision in behalf of family member.
- MH counseling that is preventative instead of when I am in crisis
- 1:1 MH counseling
- Choice of provider for MH counseling
- MH Counseling with a choice of provider (versus the local MH agency staff).

Access to care and services:

- Specialty referrals take too long (example of a referral from April resulting in a July appointment)
- All members should have an assigned care navigator or THW/CHW to help them figure things out.
- I feel like everyone is “covering things up” (the CCO/Samaritan/Local MH) and won’t tell us why services had to be reduced and why care is so hard to get.
- Prior authorizations for exceptional needs are a barrier.
- There is no neurologist in our area; I was referred to Salem for an appointment 4 months out.
- We have very limited choices for women's health care/GYN
- I have been denied for services without any written notice provided.
- I want to have a choice in my provider (for example, a male or female provider, cultural or religious choices).

Eye health:

- Punctal plugs for an eye condition that was denied.
- Limits on glasses for my 6 year old child (who breaks them often)
- Eyeglasses; got many answers that were not consistent. Legally blind without them.

Medication:

- Multiple stories of prescribed medication being denied at the pharmacy level. “Why can’t my doctor and the pharmacy be on the same page?”
- My doctor is reducing my pain medication (long term prescribed opioids) but hasn’t provided me with any other way to manage my pain.
- Medications ordered by my provider that are not on the formulary for the CCO.

Care integration:

- Co-location of services. Not just an integrated behaviorist in a medical clinic, but my MH service provider in my medical clinic.
- Greater care integration

Phone use:

- Courtesy phones for those who can’t afford a cell phone.
- The ability to use a clinic phone to make a call if needed.

Other:

- Communication between social service and medical providers. I have to tell my story over and over.
- I was told by a provider that I just needed to “live with it” when denied a cardiac procedure that would extend my life.
- I have known providers who refuse to see a patient or has been “fired” by a provider
- NEMT: Reimbursement after the expense doesn’t work. I don’t have money to make the trip in the first place
- Treatment for my melanoma BEFORE it becomes cancerous was denied
- I have a medical condition and am required to wear compression garments on my arms and legs. I have a prescription from my doctor, but the CCO wouldn't pay.
- Interpretation is almost never provided; patients are told to bring someone with them.

7) What do you wish your health plan could do for you that it doesn't already do?

**Responses were received from seven CACs.*

Mental health:

- MH providers at school; perhaps on a ratio number of students
- Preventative MH services specific to teens. We have had a lot of teen suicides lately.
- Put MH Therapists in our schools
- Equine therapy. Pet therapy.
- EMDR Therapist
- Those with SPMI (serious and persistent mental illness) have so many needs and consume so much of the resources.
- Not enough MH Res. beds in our state (none in local area)
- People in small communities have little or no provider choice (esp. in MH)
- State hospital resources; > 6 month wait to get a bed

Access to care:

- Provide quicker access to care. Help providers figure this out or find providers who can do this better.
- Decrease wait time for everything (phone calls on hold, appointments when needed, referrals)
- Increase access to care in rural areas

Transportation:

- Rides for family members that need to travel with someone who has an appointment.
- NEMT access so my husband or child can go with me to appointments; I can't leave them home alone.
- NEMT solutions when someone doesn't live on a bus line
- Supports to help me navigate the NEMT system
- A way to pay for gas to go to out of area specialist appointments.

Gym memberships:

- Gym membership or park and rec facility access
- A gym membership and good options for regular exercise

Community health workers:

- Hire Community Health Workers.
- Provide a patient navigator to help me advocate for myself; "a warm body" or someone to fill this role in person. This could be a THW or CHW or peer-support role.

Massage therapy:

- Massage for a member with Lymphadema
- Massage Therapy

Provider recruitment:

- Consider using incentives to recruit providers (including housing, coordination with spouse employment opportunities, etc.).
- Recruit medical school graduates from other countries (i.e. Cuba) so that we can have enough providers.

Care coordination:

- Give me more information about how integration and care coordination is happening here
- My care coordination should not be coming via a contract with a contracted company based in Florida. They don't know our local area, our local resources or my challenges. My care coordination should be from my CCO.

Other:

- Help with weight loss surgery (member denied) or wt. loss program
- A safe way to dispose of my used needles (diabetes); the cost to do so is a barrier.

- Bilingual support and professional interpretation (phone interpretation not adequate)
- Scholarships to my kids can participate in sports programs (maybe with a community service obligation)
- More affordable food outlets (only Safeway and Fred Meyer here, need WinCo or Walmart
- Board Meetings should be public meetings; this should be required for all CCOs.
- Could our CCO have an ombudsman?
- Compression garments for someone with Lymphadema
- I wish OHP could require that a member have “skin in the game” or make their own commitment to improve their health.
- Be aware of ACE scores and increase investments in those with high ACE scores; become more trauma-informed as a system.
- One-stop shopping for my care. I have to go multiple places for physical health, oral health, behavioral health, pharmacy, etc.
- Local specialty providers