Supporting Meaningful Engagement through Community Advisory Councils

LESSONS FROM THE OREGON HEALTH AUTHORITY

CASE STUDY

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Using evidence to improve population health

COMMUNITY CATALYST

CONTENTS

Abstract

There is growing consensus that person-centered, value-driven health care delivery includes consumers as equal partners in all aspects of decision-making about their health care. State agencies and health care systems are increasingly seeing the value in engaging consumers not only in direct patient care, but also to guide organizational decisions about that care to drive progress on improving health outcomes and stabilizing health costs.
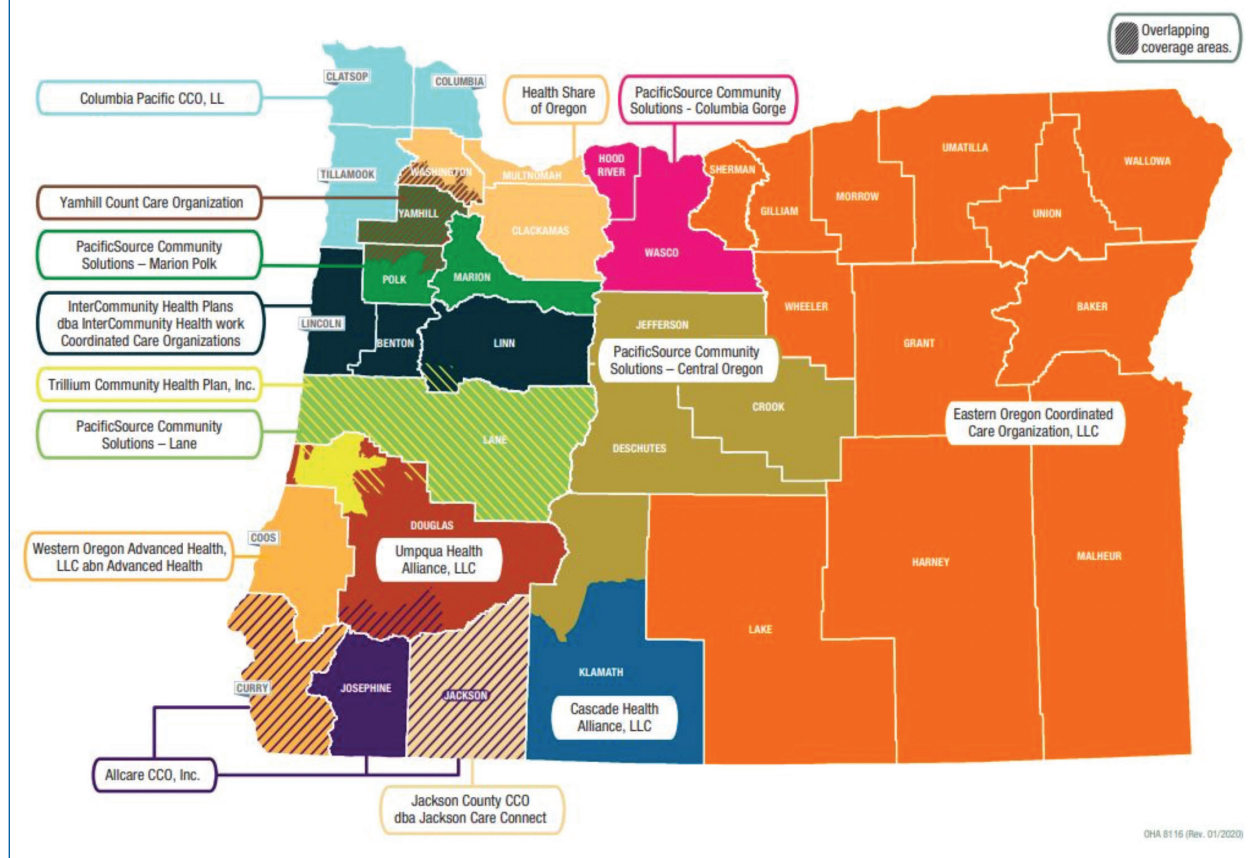
Oregon has made substantial investments in this type of engagement. About a decade ago, the state embarked on an ambitious transformation initiative that established coordinated care organizations (CCOs), local networks of health care providers that receive a global budget to serve Oregon Health Plan (OHP)/Medicaid enrollees. The legislation that created CCOs also required these networks to create at least one community advisory council (CAC) to integrate community and OHP member voices in their work. Since the law's passage, the Oregon Health Authority (OHA), which oversees OHP, has devoted significant time and resources to these councils. This case study takes a look at what has made CACs, and the resulting consumer engagement, so successful. Key takeaways include: devoting state-level staff and financial resources to the program; creating strong lines of communication between OHA, CCOs, and CACs; and providing opportunities, including in-person events, for councils to learn from one another.

Background

Following the adoption of the Affordable Care Act, the Oregon legislature passed bipartisan, enabling legislation establishing coordinated care organizations (CCOs). In 2011, the legislature enacted HB 3650, which directed the Oregon Health Authority (OHA) to create a plan for a "Coordinated Care Delivery System for Medicaid." After a year of gathering public input—including at more than 75 public meetings or tribal consultations—the legislature passed SB 1580 in 2012. That law formally established CCOs as local networks of health care providers (including physical, mental health and addiction, and dental) that serve approximately 600,000 enrollees in the Oregon Health Plan (OHP), the state's Medicaid program.[1] In addition to delivering a comprehensive suite of medical and related services, CCOs focus on prevention and community health. The state pays each CCO under a global budget, providing a risk-adjusted, prospective payment intended to cover total expected spending of the CCO's patient population over a broad continuum of care for a defined period.[2]

SB 1580 also required each CCO to create at least one community advisory council (CAC), an advisory body made up of OHP members and community representatives. CACs are responsible for overseeing a community health assessment and developing a community health improvement plan.[3] This requirement is consistent with growing recognition among policymakers and health care organizations that consumer engagement is an important contributor to the success of accountable care entities.[4]

Coordinated Care Organization 2.0 Service Areas

Oregon Health Authority

Overlapping coverage areas.

Columbia Pacific CCO, LL

Health Share of Oregon

PacificSource Community Solutions - Columbia Gorge

Yamhill Count Care Organization

PacificSource Community Solutions – Marion Polk

InterCommunity Health Plans dba InterCommunity Health work Coordinated Care Organizations

Trillium Community Health Plan, Inc.

PacificSource Community Solutions – Lane

Western Oregon Advanced Health, LLC abn Advanced Health

PacificSource Community Solutions – Central Oregon

Eastern Oregon Coordinated Care Organization, LLC

Umpqua Health Alliance, LLC

Cascade Health Alliance, LLC

Allcare CCO, Inc.

Jackson County CCO dba Jackson Care Connect

OHA 8116 (Rev. 01/2020)

Counties shown: CLATSOP, COLUMBIA, TILLAMOOK, WASHINGTON, MULTNOMAH, HOOD RIVER, SHERMAN, GILLIAM, MORROW, UMATILLA, WALLOWA, UNION, YAMHILL, CLACKAMAS, WASCO, POLK, MARION, JEFFERSON, WHEELER, GRANT, BAKER, LINCOLN, BENTON, LINN, CROOK, DESCHUTES, LANE, HARNEY, MALHEUR, COOS, DOUGLAS, LAKE, CURRY, JOSEPHINE, JACKSON, KLAMATH

While the legislature provided a solid framework for meaningful consumer engagement, the Oregon Health Authority (OHA) Transformation Center has breathed life into it by devoting significant staff and resources to making CACs work as well as possible—and encouraging participating CCOs to do the same.[5]
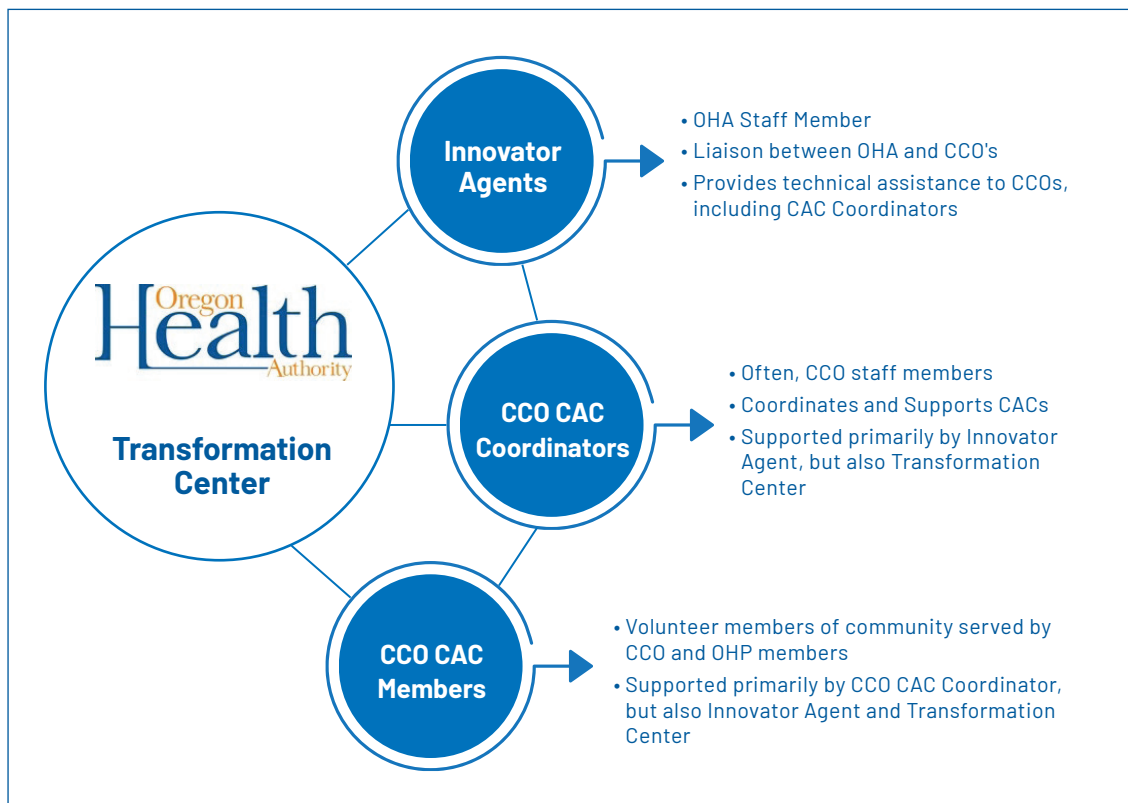
The OHA Transformation Center continued its support of CACs as the state entered into the next five-year phase of health system transformation, known as "CCO 2.0." Launched in 2020, CCO 2.0 focuses on:

- improving the behavioral health system,

- increasing value and pay for performance,

- focusing on social determinants of health and health equity, and

- maintaining sustainable cost growth.

Under the CCO 2.0 framework, OHA strengthened CAC requirements. For example, CCO governing boards are now required to have at least two CAC members,[6] at least one of whom is an Oregon Health Plan (OHP)/Medicaid beneficiary.[7]

Methods

Fifteen individuals were interviewed, either in person or by phone, to provide insight into OHA's support for CACs. Interviewees included leadership and staff of the Transformation Center, including OHA Innovator Agents, CAC coordinators and OHP members serving on CACs from three CCOs: Columbia Pacific CCO, Eastern Oregon CCO and PacificSource Community Solutions–Columbia Gorge CCO. These CCOs were selected based on their geographic diversity and experience operating CACs, following discussions with Transformation Center staff and Innovator Agents. In addition to these interviews, this case study was informed by a review of CAC-related materials provided by the Transformation Center and CCOs, as well as content on the Transformation Center website. The interviews were recorded, transcribed and coded.

Snapshot of Three CCOs' CAC Structures			
CCO Name	**Columbia Pacific CCO**	**Eastern Oregon CCO**	**PacificSource Community Solutions–Columbia Gorge CCO**
Region	3 counties in Northwest Oregon (Clatsop, Columbia and Tillamook)	12 counties in Eastern Oregon (Baker, Gilliam, Grant, Harney, Lake, Malheur, Morrow, Sherman, Umatilla, Union, Wallowa and Wheeler)	Hood River and Wasco counties
Number of CACs	3—one for each county	12—one for each county	1
Regional CAC	Yes	Yes	No
CAC Meeting Structure	Local CACs (LCACs) meet monthly; Regional CAC meets quarterly; chair and co-chair from each LCAC attends the regional meeting	Local CACs (LCACs) meet monthly; Regional CAC meets quarterly with LCAC chairs in attendance	Monthly meetings
CAC Coordinator(s)	2—one is responsible for the Clatsop and Tillamook CACs; the second is responsible for the Columbia CAC	12—LCAC coordinators 4—CCO field staff from behavioral health care organization; each one is responsible for 3 LCACs	2

Oregon Health Authority Support for CACs

In September 2012, OHA was awarded a four-year, $45 million State Innovation Model grant from the Centers for Medicare and Medicaid Services. The state used a portion of these funds to establish the Transformation Center as a "hub for innovation and quality improvement for Oregon's health system transformation efforts to achieve better health, better care and lower costs for all."[8] Broadly speaking, the Transformation Center "identifies, strategically supports and shares innovation at the system, community and practice levels"[9]—or, as one interviewee said, "to make good ideas spread faster." Once CCOs were formed, the Transformation Center received outside resources to support CAC development. The Northwest Health Foundation provided a $75,000 grant for start-up activities such as key meetings for all CACs.

Transformation Center support for CCO CACs includes:

1. Transformation Center staff;

2. Innovator Agents;

3. in-person events;

4. monthly technical assistance calls; and

5. webinars, training and materials.

1. Transformation Center Staff

Since its creation, the Transformation Center has employed between 14 and 30 staff members, depending on the point in time and organizational structure. Three staff members support CACs with a range of responsibilities including:

*   strategic planning for CAC technical assistance/supports;

*   identifying partnership opportunities to support CACs;

*   facilitating monthly meetings of the CAC Learning Collaborative and CAC coordinators;

*   planning and implementing an annual CAC conference;

*   regularly updating the CAC Supports webpage of the Transformation Center with relevant resources;

*   developing targeted technical assistance in response to feedback from CACs;

*   responding to requests for information from CCOs and CACs; and

*   developing policies to strengthen CACs.

2. Innovator Agents

The Innovator Agent role was created by CCO enabling legislation as a resource for CCOs and a bridge between CCOs and OHA to help achieve the goals of health system transformation: better care, better health and lower costs.[10] The five current Innovator Agents have diverse and extensive backgrounds in community development, public health, behavioral health and/or social work.

Among the Innovator Agents' responsibilities is supporting the formation and ongoing role of CACs, including attendance at every CAC meeting.[11] They provide updates, as needed, from OHA; answer questions that arise on topics such as quality improvement projects; share information from other communities across the state; and field (and resolve) individual OHP member issues.

Between meetings, Innovator Agents communicate primarily through CCO CAC coordinators[12] to share relevant information, answer questions, review document drafts, develop CAC meeting agendas, and help with special projects.

3. In-Person Events

The Transformation Center has held an annual, in-person CAC conference since 2014. It brings together representatives from all CCOs and their CACs for one to two days to discuss strategies for their work. The events are planned by Transformation Center staff, with input from Innovator Agents, CAC coordinators, CAC members who participate in monthly CAC Learning Collaborative meetings and, typically, several consultants. Transformation Center staff also process all travel reimbursements for CAC members attending the events and cover hotel lodging expenses for these members.

Almost uniformly, interviewees named these face-to-face events as the single most useful type of CAC-related technical assistance. As one interviewee observed, "for consumer members, that consumer conference, to be able to be around other consumers and hear their stories and share their experiences, is really, really helpful."

The Transformation Center measures the impact of their in-person events using an online, immediate post-event survey and a six-month retrospective survey. In 2019, the six-month retrospective survey asked attendees to look back over the past six months to assess:

- how helpful the support/technical assistance provided at this conference was in meeting CAC's needs (54% reported the assistance was either extremely helpful or very helpful);
- how helpful the support/technical assistance provided at the conference was in improving their knowledge, skills or abilities (nearly 60% reported the assistance was either extremely helpful or very helpful); and
- the session/type of information/experience from the conference they found to be the most useful in their role (common responses included: networking with others in the same role, sharing best practices across CACs, learning strategies for engaging people in rural areas and learning about CCO 2.0).

> "[The CAC conference] started a conversation about how we can better launch efforts to involve more non-English speakers, and inspired us to create [meeting ground rules], as well as have acronym abbreviations on the back of the monthly agendas."
>
> ~ CAC Conference Attendee

4. Monthly Technical Assistance Calls

The Transformation Center facilitates the CAC Learning Collaborative, a monthly conference call among CAC coordinators and members. This call

serves as a forum for peer-to-peer sharing among participants and gives Transformation Center staff an opportunity to tailor support to CAC needs. Staff also facilitate a monthly meeting with CAC coordinators for similar purposes.

In addition to these monthly calls, Transformation Center staff periodically conduct one-on-one telephone calls with CAC coordinators and periodically send out an online (or paper) needs-assessment survey to CAC members.

5. Webinars, Training and Materials

The Transformation Center offers webinars throughout the year on topics related to CAC meeting management, CAC member recruitment and engagement, and other best practices. Many interviewees knew about and utilized these webinars, but others did not. Identified barriers to webinar use include finding time to watch them, making sure that all CAC members received notice about them, and perceptions that the content is irrelevant to their role.

Staff and consultant-led, in-person training sessions are available to CCOs on issues such as the Community Health Assessment (CHA) and the Community Health Improvement Plan (CHP), areas for which CACs are responsible.

In addition, the Transformation Center maintains an online resource library of webinar recordings, editable templates and presentations on topics such as planning effective CAC meetings and onboarding CAC Members.

One of the most valuable and frequently used resources in the library is the *CCO Community Advisory Councils: Handbook of Best Practices.* This is a "living document" of recommendations and specific examples relevant to recruiting and engaging OHP members as active CAC members. This handbook reflects the variation across CCOs in their approach to recruiting and selecting OHP members—for example, using fliers, hosting booths at health fairs and relying on referrals from community partners—and providing OHP members with an array of supports, such as transportation, stipends, meals and child care reimbursement, to enable them to participate meaningfully.

CHAs and CHPs

CCOs are required, by law and state contract, to complete a Community Health Improvement Plan (CHP) based on a Community Health Needs Assessment (CHA) at least every five years.

Community Health Needs Assessments (CHA) identify key health needs and issues through systematic, comprehensive data collection and analysis. CCOs must develop a CHA in collaboration with local public health authorities, hospitals, tribes and other CCOs that share the service area.

Community Health Improvement Plans (CHP) are long-term, systematic efforts to address community health issues, needs and priorities. CCOs must develop a shared CHP using the findings documented in their CHA, including any health disparities data. The CHP serves as a strategic plan for population health and health care systems to serve the communities within the CCO's service area.

CACs are responsible for overseeing a CHA, adopting a CHP and publishing an annual report on the progress of the CHP.

Sources: 2020 ORS 414.575 (community advisory councils); CCO Guidance: Community Health Assessments and Community Health Improvement Plans.

Observations

Positive Outcomes

Health and Wellness Resources

When asked about their CAC successes, interviewees were most likely to cite their administration of tens of millions of dollars in community reinvestment funds paid by the state to CCOs for reaching quality targets.[13] CCOs then allow CACs to make decisions about how these payouts will be reinvested to address community health priorities, as identified in the CHP. Interviewees pointed to programs that provide fresh vegetable "prescriptions," initiatives aimed at promoting adolescent well-care visits, and gym memberships that encourage wellness. CACs have approved funding to create a life jacket station at a local lake, cleats for walking on snow and ice, and walking poles to promote exercise among older adults while preventing falls.

Collaborative Health Planning

"After attending the conference, one of our [CAC] members initiated a strategy, with the help of our staff, to outreach and recruit from areas of our county where there are more transportation and distance barriers. We have since conducted three informational sessions in those more rural areas and are doing a fourth one this month. It has helped raise awareness of the CAC and the overall work of the CCO in these areas and helped strengthen connections with various partners (schools, churches, community-based organizations) in outlying areas, allowing the CAC and staff to hear regularly the different strengths and barriers to health that people living there experience."

~ CAC Conference Attendee

The CAC creates a space where people from many community entities, such as schools or churches, can come together to have conversations about the health system. As one CCO representative put it, "our CAC has become the one place in the region where all these partners meet. There's not really another regular meeting where all these various cross-sector organizations meet, and....look to get more information on how to best serve our clientele." This point was illustrated by an example in which the executive director of a local health clinic sought the CAC's opinion on its priorities for a planned new building.

Improving CCO Policies and Procedures

By including OHP members in the CAC, CCOs have an important avenue to learn how their policies and procedures are impacting members and make any necessary adjustments. For instance, nonemergency medical transportation (NEMT) services are a covered Medicaid benefit for Columbia Pacific CCO members who, depending on their needs, can receive rides, bus passes or help paying for gas.

The Tillamook CAC began hearing that those who were receiving help paying for gas had to complete a complex process for reimbursement, thereby making it difficult for OHP members to pay for other necessities. As a result of the CAC's recommendation, the CCO changed the procedure to streamline the reimbursement process.

Making Health Planning More Inclusive

Another area of success has been making materials and meetings more accessible to community members. The Columbia Gorge CAC strongly influenced the regional CHA's development by creating an 11-page "plain language," more accessible and visual summary that provides key highlights of the 63-page assessment. Its members also advocated successfully for translating the summary document into Spanish, the region's dominant non-English language. Finally, OHP members of the Columbia Gorge CAC were able to get the CCO to invest in simultaneous Spanish-English translation, making meetings fully accessible to Spanish-speaking residents.

The Transformation Center also found examples where outreach was improved to better understand the experience of CCO members in outlying areas. For instance, one CAC started holding monthly meetings in outlying areas of its county. Other CACs adopted new meeting tools and approaches to help OHP members participate in more meaningful ways.

Challenges
Recruiting and Supporting OHP Members

Recruiting and supporting OHP members to serve on CACs were by far the most common barriers. Challenges related to outreach and recruitment included: varying level of interest across CCO regions, ensuring CACs have the supports needed to meaningfully include members once they join CACs, and properly funding supports for CAC member attendance.

> "[It's important to] have those 'mover and shaker' people that are community partners sitting in the same room with and building good relationships with and friendships with people that we're serving on our health plan, because they're equals, and frankly, if anybody should be in the hierarchy it should be our members, because they're the ones that are being impacted directly, and they should be the ones voting on those things."
>
> ~ CAC Coordinator

Several interviewees said it was challenging to identify specific and meaningful ways for CAC members to help CCOs reach their two key outcomes: limiting increases in per capita spending and improving health care access and quality.[14] Additionally, some interviewees said cultivating an environment in which member voices were respected was an ongoing challenge.

Representing the Diversity of Communities Served

While progress has been made to create more language access for individuals whose first language is not English, translation and interpretation still remain a barrier to full member participation. In addition, CAC staff said there are not sufficient supports for meeting CAC diversity requirements. CAC members and staff both mentioned that CAC operating practices (meeting times, location, etc.) may hinder more diverse membership.

Measuring Impact

The OHA has a sophisticated and widely published approach to evaluate the CCO program's progress in achieving its outcomes.[15] To date, however, with the exception of capturing the structure and process outcomes noted above, the OHA has not otherwise measured the

impact of the CACs in achieving these outcomes. That said, as of the publication of this case study, the OHA was developing a CCO 2.0 evaluation plan that will include measuring CACs' impact.

Acknowledging Differences Among Regions

Some interviewees mentioned a lack of flexibility in how CACs and their activities are implemented and acknowledged that the differences between CCO regions could influence a council's efficacy. Others identified challenges in staffing CACs, procuring space for CAC meetings, and identifying the best communication methods for CAC members (in-person meetings or phone meetings). An OHA staff member said one of the biggest internal challenges is traveling to all regions of the state to interact in-person with all CACs.

Best Practices

OHA's approach to prioritizing and supporting meaningful consumer and community engage-ment through CAC structures offers several lessons for other state agencies, health plans and accountable care entities seeking to better engage their Medicaid beneficiaries in health system transformation. Many of these best practices reflect current thought leaders' views on key elements of successful engagement initiatives.[16]

Prioritize Engagement

The years of careful and thoughtful work that OHA put into empowering CACs, and making them relevant and visible, have paid off. As a result, when planning CCO 2.0 was underway, stakeholders prioritized CACs and assigned them a more significant role in achieving the overall aims of the statewide CCO initiative.

Invest Staff Time and Financial Resources

Creating and sustaining meaningful consumer engagement takes significant time and resources. A key part of the CACs' success is the staff dedicated to their operation. This includes OHA Transformation Staff, Innovator Agents and consultants. Additionally, it could not be successful without the network of CCO CAC coordinators, whose job it is to recruit and support members, guide them in executing their responsibilities and handle meeting logistics.

"You give people meaningful work to do. They have a real role. Often times, with these [advisory groups], it's 'come on in, have some lunch with us, we'll show you some marketing materials that are two seconds from going to print. You tell us what you think and we'll say we consulted the community.' By statute and by rule, [CACs] have real important work to do, and I think that's empowering."

~ Innovator Agent

Give Beneficiaries Meaningful Work

The single most effective way to engage Medic-aid beneficiaries in health system transforma-tion efforts is to provide them with meaningful and important work. Advisors can readily tell if they are just "window dressing" or a means to satisfy externally imposed requirements for consumer engagement. They can also tell if they are being asked for input on issues that have already been decided upon or communi-cations materials that are about to go to print. CACs' roles in developing CHPs and in deciding

how to allocate community reinvestment funds are examples of "co-design," in which benefi-ciary advisors are equal partners in tackling complex challenges.[17]

Measure and Communicate Outcomes

It is essential to communicate CACs' success to a broader audience to underscore their importance. Although OHA collects data from

CCOs on a wide variety of measures, it does not collect information on outcomes related to CAC activity. That said, individual CACs collect some information—e.g., how many people have been helped, what changes were made—about projects supported by their CCOs' community reinvestment funds. OHA has used its quarterly e-newsletter, among other communication vehicles, to highlight these and other results of CAC activities.

Support an Inclusive Environment

Several interviewees identified inclusive approaches to engaging CAC members—especially those that are OHP members—as a key reason CACs are so successful. This engagement is not only cultivated through member participation on CACs, but also by their establishment and operations. Some CACs make space in their agendas for members to bring up new business or comment on old business, and some employ popular education techniques to make sure everyone's voice is heard and respected. Despite challenges in reaching this level of meaning-ful consumer engagement, it is seen as a critical component of the CAC program's success.

Share "What Works"

Whether through in-person events, conference calls, webinars or online materials, the Transformation Center has prioritized sharing best practices across CACs on topics ranging from recruitment and retention techniques to successful meeting habits. This allows CACs to learn from one another and to avoid spending limited time creating approaches from scratch.

Looking Ahead

CCO 2.0 was launched in early 2020[18] to meet new CAC requirements designed to ensure that CACs better represent the communities served by CCOs, and that CCO spending to address social determinants of health is consumer-informed. (See Appendix 1 - New CAC Requirements Under CCO 2.0). CAC members and CAC coordinators identified needs to fulfill the new requirements, and Transformation Center staff have begun developing CAC-related supports.[19] They are also creating (or updating) templates specific to CCO 2.0 reporting, including an Annual CAC Demographic Report Template and a CAC Member Diversity Assess-ment Worksheet.

> **CACs Role in Addressing Disparities**
>
> Under CCO 2.0, CACs have an essential role in addressing disparities in histori-cally excluded communities. By contract, CCOs are required to increase their strategic investments in activities aimed at addressing the social determinants of health, health equity, and health dispar-ities. And, CACs will have a distinct role in determining how those investments are made. (*See Appendix 1 for additional detail.*)

Conclusion

The Oregon Health Authority works in varied and intentional ways to ensure CCOs not only meets the law's minimum community engagement requirements, but also that their engagement is meaningful, inclusive and transparent. With a deeper understanding of OHA's infrastructure and supports, state agencies—as well as managed care plans, accountable care organizations and other health care organizations—can adopt similar engagement strategies to drive progress on improving health outcomes and stabilizing health costs.

Acknowledgements

APPENDIX 1 – New CAC Requirements Under CCO 2.0

Topic	Details	Goals
CAC Membership	**CAC Selection Committee:** CCO must convene a CAC Selection Committee comprised of (in equal numbers): (a) individuals who sit on the CCO's Governing Board; and (b) individuals who are representatives of each county within the CCO's service area. The Selection Committee is responsible for selecting members of the CAC and will ensure the CAC includes representatives from the community, including, but not limited to consumer representatives (at least 51%) and is representative of the diversity of populations within CCO's service area.	**Goal:** CCOs have a representative CAC. This builds trust and relationship with members. Systems are designed with the OHP member in mind.
	Definition of Consumer Representative: A Consumer Representative must be at least 16 years old and either (a) a person serving on a CAC who is on (or was within the previous six months) the Oregon Health Plan (OHP), or (b) a parent, guardian or primary caregiver of an individual who is on (or was within the previous six months) the OHP.	
	Tribal Participation: In CCO service areas where only one tribe exists, the tribe will be responsible for choosing one tribal representative to serve on the CAC; in CCO service areas where more than one tribe exists, each tribe will choose a tribal representative to serve on the CAC; in the Portland tri-county metropolitan area, CCOs shall also reach out to the Urban Indian Health Program to identify a representative to serve on the CAC.	
CCO Governing Body: CAC Member Representation	Each CCO's governing body must include at least two members of the CAC. At least one of the CAC representatives on the CCO's governing body must be a current CAC consumer representative.	
Annual CAC Demographic Report	The report (due 6/30/21) will show how CAC membership is representative of the communities in a CCO's service area.	
CAC Duties: CCO Spending Decisions	CAC members will have a role in reviewing Social Determinants of Health and Equity (SDOH-E) spending under the future (2021) Supporting Health for All through Reinvestment (SHARE) Initiative. They will also have a role in determining how Health-related Services (HRS) Community-Benefit Initiative Investments are made.	**Goal:** Increased strategic spending by CCOs on social determinants of health and health equity/disparities. Decision-making is inclusive and consumer-informed.

Sources: *Transformation Center, CCO 2.0 Policies Impacting CCO Community Advisory Councils (CACs) – Pulled from Appendix A: CCO 2.0 recommended policies and implementation expectations; Transformation Center, CCO 2.0 and CACs: What's New for CAC Members?; Transformation Center, CCO 2.0 & Community Advisory Councils (CACs) v4: Frequently Asked Questions*

Notes

[1] The passage of the CCO law was the culmination of several years of work by then Governor Kitzhaber, key legislators and the Oregon Health Reform Collaborative, a multi-stakeholder group of over 25 organizations representing providers, insurers, underserved populations, businesses, consumers and faith-based communities. Consumer representatives were the driving force behind the inclusion of CAC provisions in the law.

[2] In 2014, the state awarded contracts to 16 organizations to serve as CCOs for a period of five years. Those contracts were extended for an additional year, to December 31, 2019, to allow the state to develop the new, five-year CCO 2.0 contracts.

[3] 2020 ORS 414.575 community advisory councils

[4] See e.g., White R, Kocot SL, Mostashari F, McClellan MB. Improving the Medicare ACO Program: The Top Eight Policy Issues. *Brookings Issue Brief.* June 2014. https://www.brookings.edu/blog/up-front/2014/06/17/improving-the-medicare-aco-program-the-top-eight-policy-issues/. Accessed July 29, 2020.

[5] Picture from https://sharedsystems.dhsoha.state.or.us/DHSForms/Served/le8116.pdf.

[6] 2017 ORS 414.625(2)(o)(D)–(E)

[7] 2017 ORS 414.625(2)(o)(E) as amended by Chapter 529 Oregon Laws 2019 (HB 2267). https://www.oregonlegislature.gov/bills_laws/lawsstatutes/2019orLaw0529.pdf.

[8] About the Transformation Center. Oregon Health Authority website. https://www.oregon.gov/oha/HPA/dsi-tc/Pages/About-Us.aspx. Accessed July 29, 2020.

[9] About the Transformation Center. Oregon Health Authority website. https://www.oregon.gov/oha/HPA/dsi-tc/Pages/About-Us.aspx. Accessed July 29, 2020.

[10] The Innovator Agent role was modeled on the role of agricultural extension workers, as described Gawande A. Testing, Testing. *The New Yorker.* Dec. 7, 2009. Available at https://www.newyorker.com/magazine/2009/12/14/testing-testing-2. Accessed July 29, 2020.

[11] 2017 ORS 414.628(2)

[12] CAC-related issues are only one part of the CAC coordinator's job. Estimates of how much of their time is spent on CAC issues ranged from 40 to 70%. CAC coordinators' have a wide array of responsibilities that include: recruiting CAC members, helping to develop meeting agendas and organize meeting logistics, writing the meeting minutes, and writing applications for community reinvestment funds.

[13] While the reinvestment funds come almost entirely from CCOs themselves, in 2016, OHA provided CHP implementation grants of up to $30,000 to each CCO to implement strategies identified in their CHPs.

[14] See e.g., OHSU Center for Health Systems Effectiveness. Evaluation of Oregon's 2012-2017 Medicaid Waiver. December 2017. https://www.oregon.gov/oha/HPA/ANALYTICS/Evaluation%20docs/Summative%20Medicaid%20Waiver%20Evaluation%20-%20Final%20Report.pdf. Accessed July 29, 2020.

[15] See e.g., OHSU Center for Health Systems Effectiveness. Evaluation of Oregon's 2012-2017 Medicaid Waiver. December 2017. https://www.oregon.gov/oha/HPA/ANALYTICS/Evaluation%20docs/Summative%20Medicaid%20Waiver%20Evaluation%20-%20Final%20Report.pdf. Accessed July 29, 2020.

[16] The National Academy of Medicine, in its Guiding Framework for Patient and Family Engage Care, points to making engagement a strategic priority, allocating appropriate resources to engagement efforts, creating an inclusive culture and creating feedback loops as key criteria for successful initiatives. Frampton SB, Guastello S, Hoy L, Naylor M, Sheridan S, Johnston-Fleece M. Harnessing evidence and experience to change culture: A guiding framework for patient and family engaged care. *NAM Perspect*. National Academy of Medicine, Washington, DC. doi:10.31478/201701f. Similarly, the American Institutes for Research referred to engagement as "the blockbuster drug of the century" and emphasized the importance of using inclusive, collaborative engagement strategies. American Institutes for Research and The Gordon and Betty Moore Foundation. A Roadmap for Patient and Family Engagement in Healthcare: Practice and Research. https://www.air.org/sites/default/files/Roadmap-Patient-Family-Engagement.pdf. Accessed July 29, 2020.

[17] See e.g., Fucile B, Bridge E, Duliban C, Law MP. Experience-based co-design: A method for patient and family engagement in system-level quality improvement. *Patient Exp. J.* 2017;4(2):53-60. doi:10.35680/2372-0247.1209

[18] OHA sought the views of CACs while developing CCO 2.0 policies.

[19] New materials on CAC requirements under CCO 2.0 are available at the Transformation Center's CAC Supports webpage. https://www.oregon.gov/oha/HPA/dsi-tc/Pages/CAC-Learning-Community.aspx.

The Authors

Renée Markus Hodin, JD, is deputy director of Community Catalyst's Center for Consumer Engagement in Health Innovation. In this role, she works to establish a powerful and effective consumer voice at all levels of the health care system in order to make it more responsive to consumers, particularly those who are most vulnerable. Prior to joining the Center, Ms. Hodin served as the director of the *Voices for Better Health* project, which brought a consumer voice to the design and implementation of new programs aimed at providing better coordinated, comprehensive, high-quality care to Medicare-Medicaid beneficiaries ("dual eligibles"). Her expertise extends to other areas of health care including hospital free care and community benefits and health care conversions. Before joining Community Catalyst in 1998, Ms. Hodin served as a special assistant attorney general in the civil litigation department of the Vermont Attorney General's Office. She holds a bachelor's degree from the State University of New York at Binghamton and a Juris Doctor degree from the University of Maryland School of Law.

Madison Tallant, MSW, joined Community Catalyst's Center for Consumer Engagement in Health Innovation in 2018 as a program associate. In this role, she provides research and project management support for the Center's policy and client-based work. Ms. Tallant recently graduated from the Boston College School of Social Work where she studied health and mental health policy and programming. While a graduate student, Madison interned with the National Alliance on Mental Illness of Massachusetts and the Technical Assistance Collaborative, Inc. She holds a bachelor's degree in psychology from Rhodes College.

About Community Catalyst

Community Catalyst is a national, non-profit consumer advocacy organization founded in 1998 with the belief that affordable, quality health care should be accessible to everyone. We work in partnership with national, state and local organizations, policymakers, and philanthropic foundations to ensure consumer interests are represented wherever important decisions about health and the health system are made: in communities, courtrooms, statehouses and on Capitol Hill. For more information, visit communitycatalyst.org. Follow us on Twitter @healthpolicyhub.

About The Center for Consumer Engagement in Health Innovation

The Center for Consumer Engagement in Health Innovation (CCEHI) at Community Catalyst is a hub devoted to teaching, learning and sharing knowledge to bring the consumer experience to the forefront of health innovation in order to deliver better care, better value and better health for every community, particularly vulnerable and historically underserved populations. The Center engages in investments in state and local advocacy, leadership development, research and evaluation, and consultative services to delivery systems and health plans. For more information visit healthinnovation.org. Follow us on Twitter @CCEHI.

About the Milbank Memorial Fund

The Milbank Memorial Fund is an endowed operating foundation that works to improve the health of populations by connecting leaders and decision makers with the best available evidence and experience. Founded in 1905, the Fund engages in nonpartisan analysis, collaboration, and communication on significant issues in health policy. It does this work by publishing high-quality, evidence-based reports, books, and The Milbank Quarterly, a peer-reviewed journal of population health and health policy; convening state health policy decision makers on issues they identify as important to population health; and building communities of health policymakers to enhance their effectiveness.

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