CHCF

Strengthening Member Experience

Additional Tools for Engaging People with Complex Needs

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AUTHORS
Gabrielle Ault-Riché, MPH
Ault-Riché Consulting

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About the Author

Gabrielle Ault-Riché, MPH, is an independent consultant with over 15 years of experience serving Medi-Cal eligible, dually eligible, and underinsured Californians. She previously served as the director of customer support for Health Plan of San Mateo, overseeing member-facing efforts.

About the Foundation

The California Health Care Foundation 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.

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This document serves as a companion to *How Health Plans Can Improve the Medi-Cal Experience for Members with Complex Needs*. It contains frameworks with examples and other tools to help managed care plans put the toolkit into action.

Is Member Engagement Just Another Word for Member Outreach?

Some managed care plans (MCPs) consider member outreach to be synonymous with member engagement. Although outreaching to members to inform them of a benefit or to provide health education is vitally important, it is different from seeking input from members. During outreach, information is flowing only from the MCP to the member. When engaging with members, we are seeking to learn from members, ideally creating a dialogue where information and insights can flow both ways. This distinction is important when considering the level of influence you are inviting members to have, as deeper engagements will lead to deeper levels of influence.

Spectrum of Member Influence

One of the key questions to ask yourself when planning to engage members is, "What level of influence are we inviting members to have over our managed care plan's priorities and decisions?" Some engagement activities, like surveys, do not give members any decisionmaking or priority-setting power, while others, like voting seats on a board, invite members to have significant influence. Table 1 outlines four levels of influence: feedback, consultation, collaboration, and co-ownership. Each of these levels is useful in achieving specific goals.

Table 1. Spectrum of Member Influence

	FEEDBACK	CONSULTATION	COLLABORATION	CO-OWNERSHIP
Level of member influence	Seeks one-way member input	Seeks in-depth member insights through dialogue	Seeks member ideas through dialogue and enables members to influence decisions	Seeks member ideas through dialogue
	Does not give members power to make decisions			Does give member representatives power to help make decisions
Plan goal	Gather member input (the "what")	Gather member insights and ideas (the "why")	▸ Collaborate with members to design solutions (the "how")	Share priority setting and decisionmaking with members
Examples of engagement activities	▸ Survey	▸ Focus group ▸ Listening session ▸ Data walk ▸ Ad hoc advisory group ▸ Member journey map	▸ Project or quality improvement workgroup that includes members ▸ Outreach strategy or outreach materials developed with members ▸ Former or current members hired as consultants or navigators	▸ Voting seats on a board of directors ▸ Member Advisory Committee with power to shape priorities and make decisions ▸ Cofacilitated meeting or group ▸ Former or current members hired as plan staff, including leadership positions

Source: Adapted from the Center to Advance Consumer Partnership's Stages of Engagement (not publicly available) and *Engaging Community Members in Medicaid Policy and Program Design*, Center for Health Care Strategies, June 2024.

What Does Co-Ownership Look Like?

Co-ownership typically involves members having voting seats on an advisory committee or board. For member representation to be meaningful, the proportion of health plan members on a committee must mirror that of other decisionmaking stakeholders, such as direct-service providers, community-based organizations, and local government representatives. Proportional voting rights enable member representatives to elevate and influence MCP priorities and avoids tokenism.

In addition to creating member seats on a board of directors, MCPs can designate member seats on internal committees that report to the board, such as quality, utilization management, finance, or member experience committees. These internal committees, along with workgroups and action committees, can also be cochaired by members to elevate members' influence over agendas and follow-through.[1]

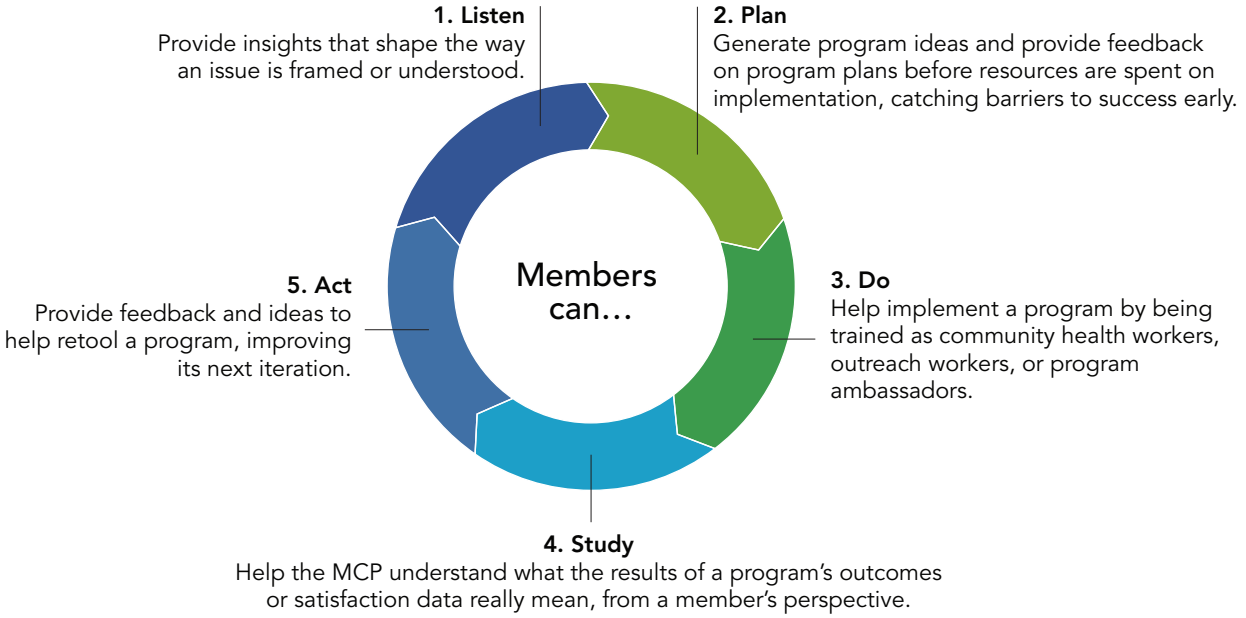
Stages of Member Engagement

Members can bring value to process and quality improvement efforts as well as member engagement efforts. Based on the classic Plan-Do-Study-Act (PDSA) cycle, the Listen-PDSA (L-PDSA) cycle encourages an initial phase of listening to the people impacted by the topic at hand, highlighting the importance of engagement at the beginning of a project.

For a process, program, or quality improvement effort, members can support each stage of the L-PDSA cycle.

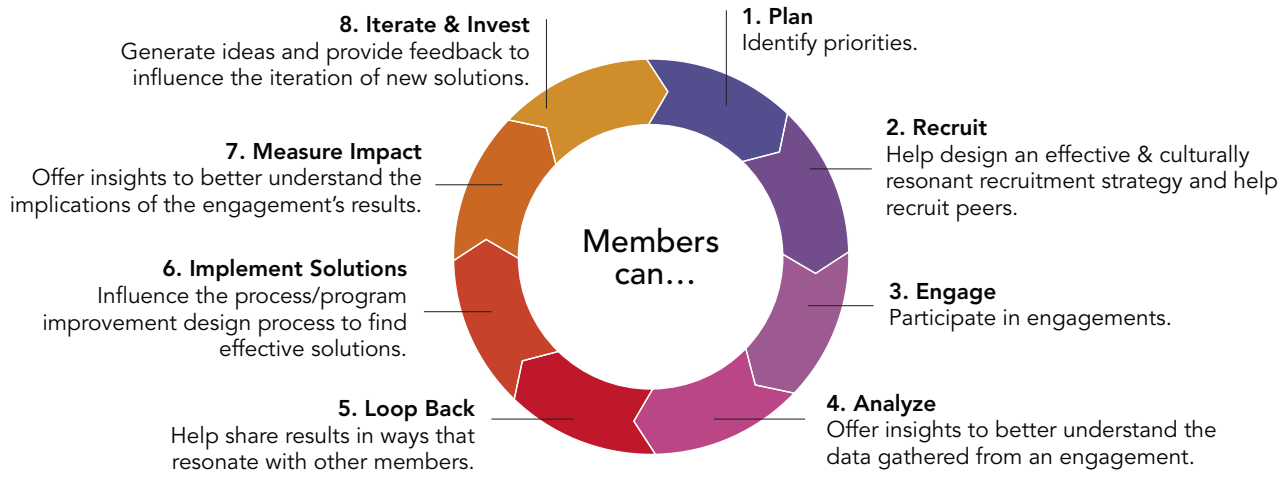
In addition to bringing value to a process, program, or quality improvement initiative, members can also bring value to member engagement efforts themselves. Figure 2 (following page) illustrates the value members can bring to each stage of a member engagement initiative.

Figure 1. Value of Member Engagement in an L-PDSA



Source: Adapted by the author from a framework created by Libby Hoy of Patient and Family Centered Care Partners.

Figure 2. Value of Member Engagement in a Member Engagement Initiative



Source: Developed by the author with data collected from literature review and interviews conducted March–May 2025.

The Nine Dimensions of Authentic Engagement

Figure 3 illustrates the nine dimensions of authentic engagement as defined by the INSPIRE project (Initiating National Strategies for Partnership, Inclusion, and Real Engagement). For a full explanation of these dimensions, see Inspire's article *The Nine Dimensions of Authentic Community Engagement* (PDF).[2]

Figure 3. Nine Dimensions of Authentic Engagement

Source: INSPIRE and Patient- and Family-Centered Care Partners.

Regulatory Requirements Around Member Engagement

Connecting your member engagement efforts to regulatory requirements is key to driving impact and building sustainability. The 2024 California Department of Health Care Services (DHCS) Medi-Cal Managed Care contract[3] requires more member engagement than previous contracts. Exhibit A, Attachment III, Section 5.2.11.E of the boilerplate contract outlines the requirements for an MCP's Community Advisory Committee. In addition, Exhibit A, Attachment III, Section 5.2.11.D goes beyond the Community Advisory Committee, requiring that plans "develop a policy and procedure for a Member and family engagement strategy that involves Members and their families as partners in the delivery of Covered Services."

DHCS now requires MCPs to have a member engagement strategy that includes (emphasis added):

- "Maintaining an **organizational leadership commitment** to engaging with Members and their families in the delivery of care;
- **Routinely engaging** with Members and families through focus groups, listening sessions, surveys and/or interviews and incorporating results into policies and decision-making . . . ;
- Developing processes and **accountability for incorporating** Member and family input into policies and decision-making;
- Developing processes to **measure and/or monitor the impact** of Member and family input into policies and decision-making;
- Developing processes to **share with Members and families** how their input impacts policies and decision-making;
- **Conducting consumer surveys** and incorporating results in Quality Improvement and Health Equity activities […];
- Partnering with **community-based organizations** to cultivate Member and family engagement;
- Maintaining a **Community Advisory Committee** whose composition reflects [the health plan's] Member population and whose **input is actively utilized** in policies and decision-making. . . ."[4]

In addition to these requirements, MCPs also have the following requirements:

- **DHCS:** All Plan Letter 25-009 outlines MCP requirements around Community Advisory Committees (CACs), including guidance on selection committees, CAC duties, incorporating CAC input into plan operations, and required reporting.[5]
- **National Committee for Quality Assurance:** 2025 Health Plan Standards and Guidelines
  - Member Experience (ME) 3, Element C: Assessing Member Understanding, Factor 1 outlines requirements for surveying or interviewing new members to assess their ability to understand policies and procedures.[6]
  - Member Experience (ME) 7, Element E: Annual Assessment of Behavioral Health Care and Services, Factor 2 outlines requirements for surveying members receiving behavioral health services about their experience.[7]
- **US Centers for Medicare & Medicaid Services:** *CMS Manual System: Medicare Managed Care Manual* (PDF), Section 20.2.9 outlines requirements for a D-SNP Enrollee Advisory Committee.[8]

Engagement Activities by Member Effort and Required Member Abilities

Tables 2a and 2b go deeper on common member engagement activities. Table 2a defines each activity, the level of member effort required, and the recommended compensation range. Table 2b outlines the level of member influence each entails and the abilities members need to successfully engage in each.

Table 2a. Common Member Engagement Activities by Effort and Compensation

ACTIVITY	DEFINITION	MEMBER LEVEL OF EFFORT	MEMBER COMPENSATION	ILLUSTRATIVE EXAMPLE
Survey	A list of predetermined questions to be answered by members. If written, mailed or emailed/web link; if oral, administered by phone or in person.	Low (One time, < 30 min)	$25–$50	To rate members' level of satisfaction with their durable medical equipment provider
Individual Interviews	A one-on-one interview with a member in which they are asked open-ended questions about their experience on a given topic	Medium (One time, 1–2 hrs)	$100–$150	To understand the reasons members elected to accept or decline ECM services
Focus Group or Listening Session	A discussion with a group of members on a given topic. A focus group is often more structured and narrower in scope, while a listening session is less structured with a broad scope or with the topic set by members	Medium (One time, 1–2 hrs)	$100–$150	To understand what is important to members when receiving personal care services to assist with activities of daily living
Data Walk	An interactive visual display of data paired with a discussion about the data	Medium (One time, 1–2 hrs)	$100–$150	To identify what factors may be impacting ED utilization rates for diabetes-related conditions, from a member perspective
Journey Map	A robust process of visually mapping a member's experience, from their perspective, as they progress through various stages of interacting with the MCP or health care system	High (Ongoing, 1–3 hours at a time)	$100–$150 per session	To understand where in the MCP onboarding process members experience friction and what key touchpoints most impact their overall opinion of the MCP
Workgroup	A group of health plan staff and members who meet regularly to understand a process or issue affecting the member experience and to work together to develop solutions	High (Ongoing, 1–3 hours at a time)	$100–$150 per session	To find solutions with members to address high no-show rates for medical appointments

ACTIVITY	DEFINITION	MEMBER LEVEL OF EFFORT	MEMBER COMPENSATION	ILLUSTRATIVE EXAMPLE
Advisory Committee	A formal group of health plan staff, members, and other stakeholders who meet regularly to review operational reports from functional areas of the health plan and to uplift member feedback	High (Ongoing, 1–3 hours at a time)	$100–$150 per session	To collaborate with members to prioritize among the MCP's process improvement efforts based on what is most important to members

Source: Developed by the author with data collected from literature review and interviews conducted March–May 2025.

Table 2b. Engagement Activities by Required Member Abilities

DEGREE OF MEMBER INFLUENCE	FEEDBACK	CONSULTATION				COLLAB-ORATION	CO-OWNERSHIP
ACTIVITY	SURVEY	INDIVIDUAL INTERVIEWS	FOCUS GROUP OR LISTENING SESSION	DATA WALK	JOURNEY MAP	WORK-GROUP	ADVISORY COMMITTEE
Member Abilities							
Has personal experience with the topic	X	X	X	X	X	X	X
Able to provide feedback on their own experience	X	X	X	X	X	X	X
Able to extrapolate from their own experience to a larger context when providing input		Maybe	Maybe	Maybe	Maybe	X	X
Able to read and understand written material	Maybe			X		X	X
Able to engage one-on-one (in person, by phone, or by web)	Maybe	X			X		
Able to engage in a group setting (in person or by web)			X	X	Maybe	X	X
Able to learn and understand some background information about disucssion topic		Maybe	Maybe	X		X	X
Able to understand graphs and basic data or information visualization				X		Maybe	X

DEGREE OF MEMBER INFLUENCE	FEEDBACK		CONSULTATION			COLLAB-ORATION	CO-OWNERSHIP
ACTIVITY	SURVEY	INDIVIDUAL INTERVIEWS	FOCUS GROUP OR LISTENING SESSION	DATA WALK	JOURNEY MAP	WORK-GROUP	ADVISORY COMMITTEE
Member Abilities							
Able to think critically about data or information presented				X		X	X
Able to understand background information from reports on a range of health plan topics							X
Able to participate in tracking improvements over time (e.g., remembering information from a previous session)						X	X

Source: Developed by the author with data collected from literature review and interviews conducted March–May 2025.

Types of Member Input and Corresponding Engagement Activities

Table 3 outlines which engagement activities to consider given the type of member data and the frequency of your planned engagements.

Table 3. Types of Member Input and Corresponding Engagement Activities

EXPLANATION	EXAMPLE	ENGAGEMENT ACTIVITY
The What vs. The Why		
What/whether. These data tell you the "what" about a topic (i.e., what percentage or number) or whether something occurred. They generally need to be statistically significant to be meaningful, requiring much data gathering and, likely, quantitative data. Note that since these data are self-reported, they can still be subjective.	What percentage of members with approved authorizations for Enhanced Care Management (ECM) think they received those services timely?	▸ Member surveys
Why/how. These data tell you the "why" and the "how." They can engage a smaller number of members but will require more in-depth conversation, yielding richer qualitative data.	How do members think the ECM services they received impacted their overall health and well-being?	▸ Listening session ▸ Focus group ▸ Individual interview ▸ Data walk ▸ Journey map
Onetime vs. Ongoing Input		
Onetime engagements involve members by eliciting their feedback during a point in time.	Do members think the health plan's printed flier about ECM is enticing and answers their key questions? Do members receiving ECM services think their care manager treats them with respect and dignity?	▸ Member survey ▸ Listening session ▸ Focus group ▸ Individual interview ▸ Data walk ▸ Journey map

Ongoing engagements involve members by either eliciting their input at multiple points in time or creating ongoing opportunities for members to codesign solutions or co-own decisions.	Members who graduated from ECM participate in a workgroup to help streamline processes between the health plan and community providers.	▸ For gathering input across time, use the same activities for eliciting onetime input (above).
		▸ For collaboration or co-ownership, use a:
		  ▸ Workgroup
		  ▸ Advisory committee

Worksheet for Identifying Metrics of Success

To identify the metrics you will use to measure your engagement, start at the top of Figure 4 and work your way down. Ask yourself each question and write down metrics for each of your answers, using the example metrics on the right as inspiration.

Figure 4. Worksheet for Identifying Metrics of Success

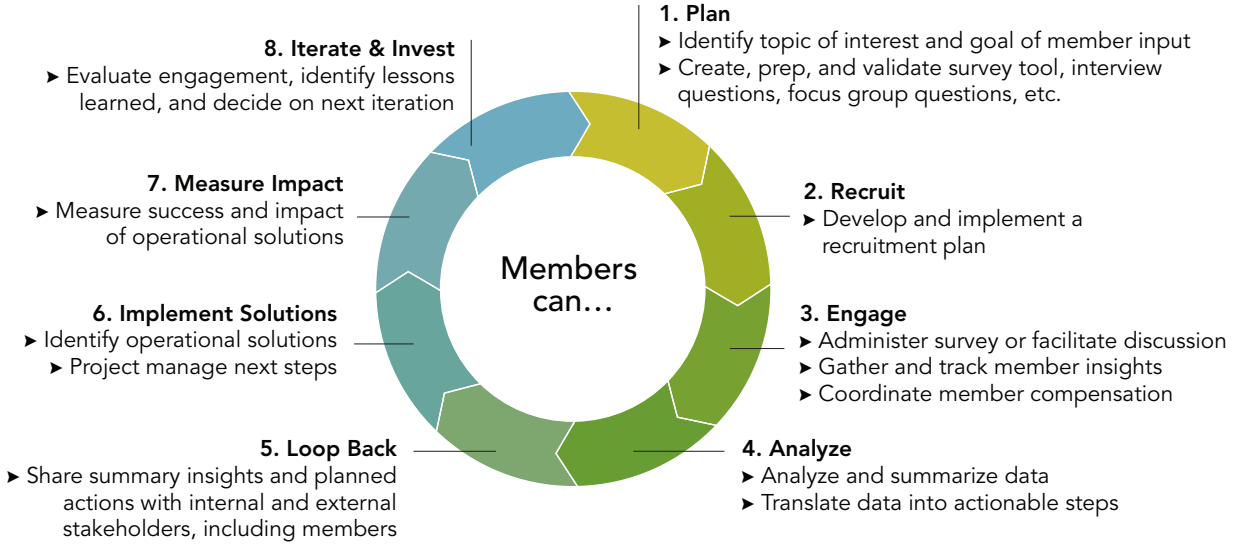
Source: Developed by the author with data collected from literature review and interviews conducted March–May 2025.

Notes: *DHCS* is California Department of Health Care Services, *DMHC* is California Department of Managed Health Care, *HEDIS* is Healthcare Effectiveness Data and Information Set, *HOS* is Health Outcomes Survey, *MCAS* is Managed Care Accountability Set, *NCQA* is National Committee for Quality Assurance, and *PDSA* is Plan-Do-Study-Act.

Staff Skills Required at Each Stage of Engagement

When evaluating the skills of your internal teams, consider which tasks are needed for each stage of an engagement. Use Figure 5 to help guide these considerations. For skills you do not already have internally, consider the pros and cons of training internal staff, hiring an external contractor, or collaborating with a community partner to meet those needs.

Figure 5. Tasks Required at Each Stage of Engagement



Source: Developed by the author with data collected from literature review and interviews conducted March–May 2025.

Indicators of Member Trust

Determining how much members trust your health plan can be a challenging exercise of introspection. To ground your self-assessment, consider the questions in Table 4 on reliability, transparency, and follow-through from a member's perspective. Also, determine which of the assessment activities listed in the rightmost column you already conduct and which you could begin implementing.

Table 4. Indicators of Member Trust

PLAN ATTRIBUTE	QUESTIONS TO ASK YOURSELF	EXAMPLES
Reliability As a member, I can count on the plan to provide me the information I need, cover my medically necessary care, and connect me with high-quality care when I need it.	Can members rely on the MCP to consistently provide clear and accurate information when they need it?	Call centers: ▸ Ensure high first-call resolution scores to avoid repeat requests for information. Communications and health education: ▸ Conduct website usability testing. ▸ Assess fulfillment speed of member requests for printed materials. ▸ Translate into threshold languages all member materials, including website. ▸ Ensure that literacy level of all member materials is at sixth grade or lower and excludes or explains jargon. ▸ Conduct readability testing of materials by members.
	Can members rely on the MCP to consistently fulfill its essential functions of covering medical services and managing a robust provider network?	Utilization management (UM): ▸ Review UM data to identify low-risk areas where UM requirements could be removed, to avoid delays in patient care and to maximize same-visit care. ▸ Identify patterns in overturned appeals and update UM policies accordingly to avoid inappropriate UM denials. Provider services: ▸ Reach out to providers to close gaps between provider expectations of coverage and UM denials. ▸ Ensure timely-access standards are met. ▸ Meet provider network requirements around geographic access, provider-to-patient ratios, and availability of telehealth. ▸ Assess provider merit through timely credentialing and review of member grievances against providers.

PLAN ATTRIBUTE	QUESTIONS TO ASK YOURSELF	EXAMPLES
Transparency As a member, I can trust the plan to be honest with me and not to obfuscate known issues.	Do you regularly bring members into the problem-solving process or acknowledge that a given area needs improvement?	Call centers and appeals and grievance: ▸ Identify standard practices of call center and appeals and grievance staff as they relate to staff transparency with members about known issues. Member outreach / member services: ▸ Review Community Advisory Committee agendas to identify instances in which members were asked for input on an issue or the committee was advised of an area for improvement in the plan's operations. ▸ Review member engagement activities to determine how often input is sought from members.
	Do you regularly share goals and outcomes with your members, even if they are not successful?	Member outreach / member services: ▸ Review member materials (e.g., newsletter) and committee agendas to see if they highlight known access gaps, waitlists, etc.
	When an error is made within the organization that impacts a given member, does the organization acknowledge the error, take responsibility, and apologize to the member?	Call centers and appeals and grievance: ▸ Identify standard practices of call center and appeals and grievance staff as they relate to owning and apologizing for health plan errors. ▸ Review appeals and grievance resolution letters to identify whether root causes are identified and shared with members.
Follow-through As a member, I can count on my plan to proactively follow up with me and provide me a reasonable resolution to my concerns.	In cases of both one-on-one problem-solving (e.g., a grievance) and in larger settings (e.g., a new program announced at a Community Advisory Committee), do MCP representatives follow through to close the loop with members?	Appeals and grievance: ▸ Review appeals and grievance resolution letters to identify whether members are "made whole" by resolutions. Call centers: ▸ Review call center data for instances in which members called multiple times about the same issue. Member outreach / member services: ▸ Review external committee agendas to track updates provided across meetings, with particular attention to questions posed by plan members on the committee.
	Is follow-through completed within the time frame given to members?	Call centers and appeals and grievance: ▸ Assess timely resolution rate of call center and appeals and grievance. ▸ Review call center recordings to identify if members receive time frame updates. ▸ Review appeals and grievance time frame extensions taken and whether letters are sent to members to inform them of time frame extensions when applicable.

Source: Developed by the author with data collected from literature review and interviews conducted March–May 2025.

Factors for Recruiting Strategically

When building your recruitment strategy, you need to identify the ideal outreach scope, source, and method to reach your recruitment goals. Use Table 5 to help you consider each of these elements.

Table 5. Factors for Recruiting Strategically

MEMBER IDENTIFICATION METHOD *How should the MCP identify members to recruit?* Consider whether the lived experiences you are seeking to learn about require members to have specific identity markers, such as specific health conditions, demographics, geographies, etc. If so, you will need to employ a targeted approach to identifying which members you will recruit.	
Targeted Identification, via Data: Members are identified through data sources such as health plan utilization, claims, and demographic data. This assumes the health plan has access to accurate data about the markers of interest.	▸ Adults with 5+ emergency department visits in the last 6 months > Identified via encounter data ▸ Members authorized for ECM who have no encounters for ECM > Identified via utilization management and encounter data
Targeted Identification, via Relationships Members are identified by people or groups who know them. Use this option when you wish to identify members who have lived experiences that are not captured in available health plan data. The MCP must first identify which groups have relationships with members who meet the desired recruitment criteria. These groups can then identify members who both have the desired lived experiences and who are a good fit for the engagement activities being planned.	▸ Family caregivers of Medi-Cal members who have experienced difficulty navigating the authorizations process > Identified by a community organization that runs a support group for family caregivers ▸ Members who experienced housing instability during pregnancy or postpartum > Identified by a local provider (medical or housing)
Broad Identification This approach can be used if you are seeking to engage with members around a general topic that most members have experienced.	▸ MCP is seeking input on how to improve their onboarding experience > Since all members have an experience of the onboarding process, no targeted identification is required.
MEMBER INVITATION SOURCE *Who should invite members to participate?* If an MCP is seeking to recruit members with certain diagnoses or for input on a stigmatized topic, invitations to members will be more effective if they come from a trusted messenger. Consider whether members can be invited to participate through a broad channel or whether a more targeted approach is needed.	
Targeted Recruitment based on Trusted Messengers Identify who is likely a trusted source of information for the identified member population you are seeking to recruit. Consider trusted providers, community partners, and health plan staff.	▸ Members who have received substance use disorder treatment are invited to participate by the clinic that provided them treatment *(Note: not the specific clinician)* ▸ Members experiencing homelessness or housing instability are invited to participate by the community-based organization providing housing navigation services. ▸ Members who are frequent callers to the MCP call center are invited to participate by specific call center representatives with whom they have built relationships over time.

Broad Recruitment

For broader-based recruitment, general invitations from the health plan can be effective.

In-person efforts that create a health plan presence in the community can also be considered.

MCP Invitations:

- Invitation flyer from the health plan mailed to a sample of members

Community Presence

- MCP staff tabling at a laundromat, community resource center, playground, grocery store or farmer's market to recruit members

Source: Developed by the author with data collected from literature review and interviews conducted March–May 2025.

Member Accommodations

Think through the accommodations you are prepared to offer members and then check in with members to identify which accommodations they need. Taking a comprehensive approach to this step will help you build trust with members by showing them you honor their needs and comfort. Use Table 6 to help you think through possible options. You do not need to offer every one of the accommodations listed. The key here is to check in with members to identify what their needs are and to do your best to meet the needs they identify.

Table 6. Member Accommodations

ACCOMMODATION CATEGORY	SPECIFIC MEMBER ACCOMMODATIONS
Trauma-informed approach	▸ Facilitate engagements using a trauma-informed approach, which includes both how facilitators communicate with members and considerations for the physical space, like seating members near an exit if needed. Hire partners trained in trauma-informed facilitation or provide training to MCP staff to ensure facilitators are equipped with these skills.
Alternative participation pathways	▸ Offer alternative options for meeting attendance (e.g., video attendance; one-on-one sessions that can be rescheduled more easily than group sessions). Such alternatives can enable participation from members with complex care needs who cannot attend an ongoing meeting due to unexpected changes in their health status.
Physical space and logistic factors	▸ Ensure buildings are accessible per Americans with Disabilities Act requirements and spaces are large enough to accommodate members who use a wheelchair, breathing device, or other durable medical equipment or who have a service animal. ▸ Offer free transportation to and from engagements and try to host at locations accessible by public transit, walking, and biking. ▸ Offer meals or refreshments for all engagements. Ask about and provide for dietary restrictions. ▸ Disclose if the location is near a law enforcement facility.
Linguistic inclusion	▸ Offer sign language, closed captioning, or both. ▸ Coordinate language interpretation as needed. ▸ Consider creating language-specific engagements (e.g., a group dedicated to speakers of a given language). ▸ Offer printed materials in large-print and avoid color combinations difficult to distinguish for people with color blindness.

ACCOMMODATION CATEGORY	SPECIFIC MEMBER ACCOMMODATIONS
Medical precautions	▸ Implement precautions to avoid the spread of viruses and amplify as needed for at-risk populations. ▸ Ask members if accommodations are needed around allergies, sensitivities to scents, or other medical conditions.
Family-centered considerations	▸ Offer childcare to parents and guardians. ▸ Offer safe and comfortable lactation spaces for perinatal members. ▸ Defer to member availability, offering hours in evenings or on weekends.
Considerations for lesbian, gay, bisexual, trans, and queer (LGBTQ+) members	▸ Offer a gender-neutral bathroom option to support an inclusive environment for trans and nonbinary members. ▸ Use inclusive, gender-neutral language and share chosen names and pronouns. ▸ If engaging members on a topic specific to LGBTQ+ interests, use LGBTQ-identifying facilitators or those familiar with LGBTQ+ identities.

Source: Developed by the author with data collected from literature review and interviews conducted March–May 2025.

Pitfalls and Countermeasures for Sharing Engagement Results with Members

Closing the loop with members by sharing the results of an engagement and planned actions is a critical step in building trust and accountability with members. While it seems simple, this step is often overlooked for the reasons outlined in Table 7. Implement each countermeasure listed to keep members informed.

Table 7. Pitfalls and Countermeasures for Sharing Engagement Results with Members

COMMON PITFALL	ISSUE	COUNTERMEASURE
Organizational shift in focus	Initiatives at MCPs move fast, and before the ink has dried on one report we are often hopping to the next deadline. When moving quickly and juggling many balls, it is easy to forget to loop back with members.	**Assign accountability** Just as you would assign a responsible party to brief the CEO, identify who will be responsible for informing members of the results and planned actions after an engagement.
Unknown member preferences	Not knowing whether members are interested in hearing results can lead to an assumption of lack of interest. Remember instead that members are more likely to stay engaged if they see the impact their ideas can have.	**Assume interest and ask** Before or during an engagement, ask members whether they would like an update on the summary of what the MCP learns from the engagement and what changes are planned as a result. If you miss this step, assume interest and notify members anyway.

COMMON PITFALL	ISSUE	COUNTERMEASURE
Fear of transparency	It can feel deeply uncomfortable for an organization to loop back with members when it does not have a concrete change or solution to offer. If the suggestion from members conflicts with a regulatory requirement, a difficult financial constraint, or simply a lack of political will, you may not have a "feel good" solution to share.	**Acknowledge inaction** Explain what you heard, the implications you considered, and why you have chosen not to take a given action. Members do not expect that every piece of their feedback will be implemented, but they do expect to feel heard. **Solve an individual problem** For systemic issues that will take a long time to remedy, try to solve a member's individual issue in the meantime. Perhaps a systems-level fix requires a lengthy implementation, but an individual fix could be completed in a reasonable time frame.

Source: Developed by the author with data collected from literature review and interviews conducted March–May 2025.

Additional Online Resources

For further guidance and tools on community engagement, see the following comprehensive resources from leaders in the field:

- Center for Health Care Strategies' Community Member Engagement Resource Center[9] is a searchable online tool with a treasure trove of briefs, fact sheets, and articles about various elements of implementing member engagement efforts.
- Community Commons's Engaging People with Lived Experience Toolkit[10] similarly offers a searchable online toolkit with guidance for each stage of engagement.
- *Engaging People with Lived Experience of Inequities: Meeting Facilitation Guide* (PDF)[11] from 100 Million Healthier Lives includes tangible, how-to guidance for facilitating meetings with community members.

For further guidance on specific topics, see the following resources:

- **Engaging meaningfully at each level of engagement:** CHCS's tool "Meaningfully Engaging People with Lived Experience in Behavioral Health Reform: A Guide for States"[12] and State Health & Value Strategies' brief *Transformational Community Engagement to Advance Health Equity* (PDF).[13]
- **Assessing organizational readiness for engagement:** PFCCpartner's *Readiness Tool* (PDF).[14]
- **Building and facilitating Consumer Advisory Committees:** Center for Health Care Strategies' companion reports *Designing Medi-Cal Community Advisory Committees: Insights from a Survey of Medi-Cal Managed Care Plans*[15] and *Medi-Cal Member Advisory Committee: Design Recommendations for the California Department of Health Care Services*.[16]
- **Building trust with members:** Center for Health Care Strategies' technical assistance brief *Building a Culture of Engagement for Medicare-Medicaid Enrollees: Health Plan Approaches* (PDF).[17]
- **Member engagement's return on investment:** Inspire's article *Making the "Business Case" for Sustained Investment in Community Engagement* (PDF).[18]
- **Quality improvement tools for iteration:** Institute for Healthcare Improvement's *Quality Improvement Essentials Toolkit*.[19]
- **Building buy-in with senior leaders:** Center for Health Care Strategies' brief *Making the Case for Engaging People with Lived Experience and Expertise in State Behavioral Health Reforms*.[20]

Endnotes

1. Some ideas on co-ownership gathered from Stephen Hoy, Chief Operating Officer, Patient- and Family-Centered Care Partners, interview with author, April 2, 2025.
2. Evelyn Kane and Taylor Brown, *The Nine Dimension of Authentic Community Engagement* (PDF), INSPIRE.
3. *2024 Managed Care Boilerplate Contract* (PDF), California Department of Health Care Services (DHCS).
4. 2024 Contract, DHCS, exhibit A, 367–8.
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