Your Oregon, Your Health

Community Meetings | May & June, 2008

Final Report
To the
Oregon Health Fund Board
July 24, 2008

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Your Oregon, Your Health
Community Meetings | May & June, 2008

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Executive Summary

During the months of May and June 2008 fifteen community meetings were convened across Oregon to solicit input on health reform in advance of the Oregon Health Fund Board preparing its draft report for the 2009 Oregon Legislative Session. Many community agencies were involved in outreach and getting people to attend the meetings. After receiving generous funding from the Northwest Health Foundation, Oregon Health Forum and Oregon Health Decisions led the process of arranging the meetings and designing the meeting process and creating the structure for gathering and analyzing input.

The meetings occurred in the following communities: Gresham, Salem, Eugene, Coos Bay, Corvallis, Medford, Klamath Falls, Bend, La Grande, Ontario, Astoria, Newport, Beaverton and Portland. More than 1300 Oregonians participated in the meetings, spending two hours talking to others in their communities about what they'd like to see – or not see – out of a health reform effort.

Each meeting began with brief comments by a member of the Oregon Health Fund Board, framing the partnership that would be needed by policy makers and constituents in order to achieve the reform that would result in universal access to care, controlled costs and improved health. Participants then spent more than an hour in small groups discussing issues that were of the most importance to them. The small group discussions were facilitated, and notes were taken on the suggestions, recommendations and concerns expressed. Then each group was asked to identify what was most pressing to them, and those were shared with the entire group of participants and captured on flip chart pages that were visible to all.

The report which follows summarizes 30 hours of discussion and input. It is not quantitative in nature. There is no weighting of issues, nor will the reader find numbers that say how often or how urgent participants were about specific issues. Instead the report is intended to give readers a way – a checklist – to hear the values of Oregonians, so that those values become a part of the final report produced by the Oregon Health Fund Board.

This report has two primary audiences – the Oregon Health Fund Board and the participants who attended and took part in the meetings. The Board can use the report to help steer them as they determine the future of health care for Oregonians. It can serve as a touchstone as they wonder "what is most important to Oregonians as we move forward." For those who participated in the meetings, they may hear their own voice or that of a person who sat at a table with them. In consolidating the input the emotion and stories are not included so it is important that participants stay engaged as the process moves forward, that they share their stories at public hearings, local town halls and with their own legislators. The Community Meetings do not replace those other methods of input. Rather this report shows the overwhelming importance of listening to Oregonians and their stories.

Participants came to the meeting ready to give input. There was not 100% consensus on any one strategy, but there was agreement on the underlying values that should shape how Oregon proceeds – values of responsibility, universal access, fair and equitable financing, stability and sustainability over time.

Participants talked about:

- Their readiness for a clear vision and agenda for the new system that will replace the one that we have today. Even those participants with coverage described their limited access, and the need to control costs and make some tough choices in the years to come.
- Whether it's time to move away from health coverage that is tied to employment;
- What they would trade off in order to get to a guaranteed core benefit that was affordable and accessible to all;
- How Oregon has been a leader in health care in the past and can be so again;
- The need to focus on health rather than solely on health insurance;
- The amount of profit in health care and health insurance, and that at a minimum there should be an alternative for Oregonians who wanted to choose something other than a private health insurance plan;
- Accepting limits;
- The call for a model based on a 'single-payer' premise – a system that is broad-based, is administratively simple, has a core benefit, and where everyone equitably shares responsibility for financing;
- How to balance 'health care is a right' with the need to acknowledge limits and identify priorities explicitly and transparently;
- That geography and demographics matter – and ways to maximize consistency while allowing for regional variation and innovation;
- Even though there were differences in opinion about how to address illegal immigration, there were voices in every community saying that everyone must get care when they need it;
- We have to share responsibility for how we finance the system <u>and</u> how we use it;
- Education and prevention were key components and we have to start educating about health choices when kids are in school;
- Discussion of how to use providers other than physicians to maximize efficiency, control cost and be creative about workforce shortages and allocation across the state;
- How to create a system that is bold in scope and yet has tangible steps that are achievable;
- How to design a sustainable solution that works in the long term, not just the short term.

The insights and values described in the report are critical to the successful work of the Oregon Health Fund Board and others who work toward health reform in Oregon. The Community Meeting participants are an indication that Oregonians are ready to work together with policy makers to craft a plan that moves Oregon towards a sustainable health reform solution.

The Community Meetings: Structure and Analysis

The information presented in this report reflects the input from structured conversations among meeting participants. We have reported the key ideas expressed by engaged citizens who took time out to come to the meetings, attracted by the opportunity to contribute their ideas to a pool of ideas and concerns which would be made available to the Oregon Health Fund Board. The participants came up with a large number of ideas expressed in a wide variety of terms. This report provides an analysis of that longer list organized into categories that cluster similar ideas that were variously expressed at the meetings.

The information from the community meetings provides insights to answer the question, "What's important to us (the Oregon community)?" This report can then partner with the information available from experts about facts, strategies and tactics that respond to the question, "How can we get the most of what's important to us?" The Oregon Health Fund Board can then interpret the values of the community and mobilize the intellectual resources of experts to produce a plan for improving Oregon's common good.

The community meetings used small group discussions to encourage expression of values by participants.[1] While the meetings were not made up of a random sample of Oregonians, we sought geographic and ideological diversity to help correct for systematic bias that can color the perceptions of homogeneous segments of the larger community.

The input from this process can function in three ways:

- Confirmation: the public input might confirm the present insights of the Oregon Health Fund Board regarding the desirable path toward health reform.
- Warning: the input might warn the Oregon Health Fund Board that its current insights may run into significant opposition as the public learns of its policy recommendations.
- Innovation: the community input might capture some innovative idea or combination that the Oregon Health Fund Board has not yet considered or not yet paid attention to.

Input for policy decisions

The product of the fifteen community meetings is a list of community values derived from the dialogues. The list serves as a touchstone or "checklist" that the Oregon Health Fund Board can use while producing its recommendations for health care reform in the following ways:

- To aid the Board's internal critique as it weighs various options and alternatives;
- To promote the transparency and public accountability of its process.[2]

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[1] Our approach to the design of the meetings adapts ideas of Ralph Keeney, *Value-Focused Thinking, A Path to Creative Decision Making*, 1992, and Daniel Yankelovich, *Coming to Public Judgment, Making Democracy Work in a Complex World*,1991.

[2] Our approach draws on the concept of "accountability for reasonableness" described by Norman Daniels and James Sabin in *Setting Limits Fairly: Can we Learn to Share Medical Resources?* 2002.

- To give the Board information about the way citizens in multiple communities across the state expressed their hopes and concerns about health reform.
- To help frame issues and explain policy decisions.
- To help structure the process the Board will use when it holds public hearings about its recommendations prior to finalizing them for the Oregon Legislature.

Handling contradictory input from the meetings
The community meeting process fosters freedom of expression. That is why there are differences of opinion, ideology, and values present in the checklist. For example, some participants proposed a variety of taxation strategies to fund wider access while others stated that there was enough money currently in the system and they would not want to pay more. Some wanted various insurance reforms while others want to remove private insurers from a reformed health system. Some wanted to keep what they have and add new programs, while others wanted to adopt a single payer model.

This report is not quantitative data – it cannot show how widely distributed a particular opinion might be, or with what intensity it was held. The report does allow the Board to compare its own insights with what these community members have said about health care reform. Using this input is one of the ways the Board can stay connected to the public. Understanding why the Board makes the choices it does is one of the ways the public can stay connected to the health reform process. These connections are essential to the Board's public accountability for the reasonableness of its health policy recommendations.

Short Form Pages for Each Category

1. Responsibility

It is important to encourage people to exercise personal responsibility for their own health and for their role as participants in a health care system shared by all.

The Community Meeting participants described ways to build the value of responsibility into the policy recommendations the OHFB will produce, including:

- Include educational components that promote understanding of personal responsibility for one's own health—beginning in childhood. This includes helping individuals understand how to prevent disease, how to achieve and maintain health, how to manage chronic disease effectively, and how to use the health system resources appropriately and effectively.
- Frame health care financing recommendations as a joint responsibility where we all play roles (i.e., taxpayers, patients, employers, employees, government) that must work together to produce a functioning system.
- Assure that everyone participates in financing the system with reasonable, equitable adjustments for various income levels (both for individuals and employers).
- Design clear lines of accountability into the system. Include transparency that will support informed consumer behavior and promote appropriate understanding of policy issues.
- Frame reform recommendations in terms of investment – in community well-being and social justice—even when it involves making personal sacrifices.
- Include multiple ways to foster the sense of community participation and contribution, such as volunteering to provide health-related community services in lieu of financial contributions.
- Consider a single payer strategy as an optimum way to achieve inclusiveness, participation, and efficiency.

2. Universal Access

It is important for a community to include all its members in a system of access to needed health care.

The Community Meeting participants described several ways to build the value of universal access into the policy recommendations the OHFB will produce, including:

- Participants used multiple concepts to explain their belief that all members of the community should have access to health care, describing it as:
    - "A human right."
    - "The proper response to human dignity and human needs."
    - "A matter of social justice and common good."
    - "A means to good health."
- Participants saw including everyone as a goal that justified tradeoffs of other aspects of the system, such as:
    - setting limits on services,
    - balancing compassion and efficiency,
    - making participation in the program mandatory
- Participants expressed differing views on whether legal residence should be a requirement for participation, such as:
    - For some, "Everybody means no exceptions."
    - For some, "Legal residence is essential for inclusion."
- Participants expressed several concepts about aspects of the benefit and delivery system, including:
    - Design system with seamless coverage across time and life circumstances
    - Guarantee access to a core group of health services emphasizing prevention and promoting healthier communities
    - Require services to meet standards of quality and affordability
    - Include educational efforts and financial incentives to support healthy behaviors
    - Be transparent and explicit about decisions to prioritize services, ration services or to use waiting lists
    - Specify a clear rationale for the role of government in securing universal access
    - Address current problems of workforce and resource distribution
    - Take advantage of strengths of current system and opportunities for innovation
    - Pay attention to regional differences
    - Consider a single payer strategy as an optimum way to achieve inclusiveness, participation, and efficiency

3. Fair Financing

It is important to design financing mechanisms that serve the goal of universal access to affordable care focused on health and emphasizing prevention.

The Community Meeting participants described several ways to build the value of fair financing into the policy recommendations the OHFB will produce, including:

- Base recommendations on an assumption that everyone will participate in sharing the costs of financing a system with universal access.
- Select financing strategies that produce an equitable distribution of the financial burden among households with differing levels of wealth and differing needs for health care.
- Consider a single payer strategy as an optimum way to achieve inclusiveness, participation, and efficiency.
- Consider innovative ways to moderate the financial impact of health insurance and health services on households.
- Consider various taxing strategies to raise adequate funds for public components.
- Include strategies for coordination among public and private entities.
- Reallocate existing health resources for improved efficiency and expanded access.
- Build financing recommendations that focus on outcomes and effectiveness.
- Frame cost control and efficiency strategies in relation to the social function of health care—to express compassion and respect human dignity.
- Identify the role and focus of public leadership in transition to new system.
- Explore tradeoffs among various public sector activities, not just among components of the health care system.
- Target issues of excess profits, duplication of services, and the need for local flexibility.
- Include fair compensation of providers and support for provider education among cost considerations.
- Look for ways to use financial incentives to affect both consumer and provider behavior.
- Support the function of informed consumers by respecting choice and assuring access to needed information.

4. Stability, Sustainability

It is important for members of the community to trust that there will be continuity of both function and funding in health care during and after transition to the reformed system.

The Community Meeting participants described several ways to build the values of stability and sustainability into the policy recommendations the OHFB will produce, including:

- Identify clearly articulated process steps for transition from the present to the new system.
- Account for regional differences and include opportunities for regional innovation when defining problems and developing solutions.
- Include support for health care provider education in designing sustainability solutions.
- Consider the role of incentives, payment levels, and malpractice reform in maintaining adequate access to services.
- Consider the single payer strategy as an optimum strategy for stable and sustainable funding and functioning.
- Focus on prevention, primary care and chronic disease management in order to achieve improvements in overall population health.
- Improve education about health, healthy behaviors and the most appropriate way to use the health system, beginning with education during youth and continuing into adulthood.

Detailed Response Lists for Each Category[3]

1. Responsibility – Detailed List

Meaning: It is important to design health reform recommendations that encourage people to exercise personal responsibility for their own health and for their role as participants in a health care system shared by all.

- **Include educational components that promote understanding of personal responsibility for one's own health – beginning in childhood. This includes helping individuals manage chronic disease effectively and economically.**

    Mutual/shared responsibility for own health
    Personal education – a stake in your health
    Personal responsibility – understand how circumstances and community reinforce/encourage choices
    Involve K-12 education; have health education over life span; inform youth about 'good choices'
    Emphasis on raising healthy kids as much as there is emphasis on end of life
    We need Consumer Education in order for consumers to be accountable for health
    Education on chronic disease
    Choice of provider / course of treatment / responsibility for own health
    It is essential to have responsibility for personal behavior
    Might be willing to trade off autonomy to stay unhealthy
    Might be willing to pay more taxes to improve healthcare (reduces stress)

- **Frame health care financing recommendations as a joint responsibility where we all play roles (i.e., taxpayers, patients, employers, employees, government) that must work together to produce a functioning system.**

    Shared/mutual responsibility (taxpayers, employers, providers, government)
    Fundamental system reform needs all stakeholders at table
    Live within means personal responsibility for system costs
    Consumer education regarding needs vs. "wants"
    Employers and employees share cost
    Pool where everyone contributes
    Would pay tax for healthcare
    Might trade off lower taxes and some choice
    Sacrifice
    It is not negotiable – it's too important to have an accountable payer
    (providers, hospitals) Accountability to individual and community as a whole
    Need trust in who controls the money

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[3] The Detailed List is made up of ideas expressed in the terms used by participants at the Community Meetings. Ideas that were expressed at multiple meetings have been listed only once, using a representative statement from one of the meetings.

- **Assure that everyone participates in financing the system with reasonable, equitable adjustments for various income levels.**

  Financial responsibility comes with health care = insurance
  Essential that there is a known amount/everyone pays something
  People with limited or no income should make graduated contribution
  Primary care/prevention as community task/job/responsibility + sickness care as an insurance product
  [Not giving up] paying for it
  Sliding scale – but avoid stigma
  Everyone participates through a sales tax dedicated to healthcare
  Shared personal & financial responsibilities
  All parties – consumers, practitioners should follow guidelines
  Might be willing to pay $ to assure everyone is "in" – local delivery
  Payment could come from individual contribution mandatory $/hour + employer match + sliding scale for small employers
  Might give up choice to not participate or option to purchase insurance and agree to mandatory participation
  Single payer = everyone participates

- **Design clear lines of accountability into the system. Include transparency that will support informed consumer behavior and promote appropriate understanding of policy issues.**

  Cost Accountability – Stakeholders involved with checking one another
  System accountability
  Cost containment / accountability – price controls – specialists
  Education on need for more revenue – "make the case" for what $ are needed for
  Transparency – costs + understandable
  Educate providers
  Educate employers about options
  Requirements are enforced and required across the board
  No surprises on cost

- **Frame reform recommendations in terms of investment – in community well-being and social justice – even when it involves making personal sacrifices.**

  Acknowledge health as a social justice/social good
  Health care for all (physical, mental, dental, vision)
  Invest in communities
  Balance individual responsibility and community caring for all
  Accept limits/social change
  Free is not a good idea – won't be valued
  Might trade off Entitlement
  Essential to have disease prevention/education/prevention
  Incentives for good health practices
  Basic healthcare – move from individuals to population approach; use pool
  Focus on staying healthier longer (i.e., residences as people age)

Cover basic needs with focus on wellness, i.e., smoking cessation, weight management)
Health is not just health care
Guaranteed health care not guaranteed health insurance
Whole array health – mental/health/dental
Emphasize youth/school based clinics + more active lifestyle for kids
Proactive system versus reactive (fixing illness)
Willing to allow prioritization of services (higher priority to immunizations, primary care, pregnancy, mental health, and care for children)
Willing to give up anything that leads to poor health
Willing to give up care that they are entitled to, in order for others to get care

- **Include various ways to foster the sense of community, such as volunteering to provide health-related community services in lieu of financial contributions.**

Find ways to have partnerships – i.e., seniors helping youth
Willing to give time, volunteer
Might be willing to give/allow community service in lieu of payment
Require a parental license (means of paying)
Education for social, cultural change
Would trade off responsibility for life style choices in order to allow free $ for others
Must have hope & belief in change – don't base thinking on fear
Healthcare for all is a right – comprehensive mental health, social health, vision, and prevention, dental
Ethics committee needed
Willing to trade off low risk care for elderly
Compassion should be throughout the system
Might give up extraordinary end of life care at all ages
Essential, won't give up cost containment
Essential, won't give up sustainable, culturally appropriate, dental, vision, mental health

- **Consider a single payer strategy as an optimum way to achieve inclusiveness, participation, and efficiency.**

Human beings deserve healthcare
Single payer = belongs to everyone
Want guaranteed health care not guaranteed health insurance
Must have accountable payer
Single payer = accountability to public
Choice of publicly funded, publicly accountable not for profit system
Accountability to individual and community as a whole
Need trust in who controls the money

2. Universal Access – Detailed List

Meaning: It is important for a community to include all its members in a system of access to needed health care.

Included two aspects:

- Rationale for <u>who</u> will be included or left out;
- Rationale for <u>what</u> will be included or left out.

Basic concepts participants used to explain their judgments about members of the community having access to health care:

- **"A human right."**

  Everyone deserves healthcare as a basic right
  Healthcare right for all – a matter of fairness
  Health care is a right – How to make this consistent nationally
  Universal coverage – equal, not tied to employer
  Two-tiered is <u>not</u> truly universal care

- **"The proper response to human dignity and human needs."**

  Human beings deserve healthcare
  Human dignity
  Treat people with dignity
  Compassion should be throughout system
  Vulnerable populations – that's where we start

- **"A matter of social justice or common good."**

  Social justice as guiding principal – everyone covered
  Everyone Covered "Health Care is not a luxury"
  Everyone in – fairness
  Essential to have everyone in
  Won't give on – everyone in
  Not giving up Access to health care for all
  Non negotiable – too important – cover everyone
  Subsidies for those who need it
  Need coverage for parents of kids

- **"It's a means to good health."**

  Health & wellness for all as goal not health insurance for all
  Healthcare ≠ health insurance
  Guaranteed health care not guaranteed health insurance

- **Participants saw including everyone as a goal that justifies tradeoffs of other aspects of the system.**

  Balance between increased access and limits

Essential to have **a**ccess, affordability, competition
Balance compassion and efficiency
Would accept some trade-offs in order to have mandatory participation

- **Participants expressed differing views on the issue of using legal residence as a basis for including/excluding people.**

Separate healthcare & immigration issues
Operate within immigration laws – disagreement on what this means
Acknowledge limited resource/pool – how to prioritize – legal status is a requirement
Creating a residency requirement would take us back to cost-shifting
Everyone in means everyone, even those who may not be here legally

Basic concepts participants used to explain their judgments about what members of the community will have access to:

- **Build plans around a comprehensive spectrum of services.**

"Whole array" health/mental health/dental
Comprehensive to cover major conditions + prevention, well child care, screening, education, sex education + dental, mental health
Access to necessary, quality comprehensive healthcare for all (include support for post-trauma post traumatic stress)
Everyone deserves health care – physical, MH, dental, vision (needs definition of level)
Prescription coverage
Mental health services
Too important – prevention
Access to care, medicines regardless of income – right service available, triage
Clinic, primary care home – simplicity for all
Integrate coordinated services – Mental health, addiction, dental, primary care, EMR (like the VA)
Willing to allow prioritization of services (higher priority to immunizations, primary care, pregnancy, mental health, child care)
Health care for all (physical, mental, dental, vision)
Drug/MH/Dental part of core benefit + family planning / families with special needs kids

- **Design system with seamless coverage across time and life circumstances.**

Consistent coverage throughout lifespan – including senior and persons with disabilities
Universal – care for everyone – when it's needed
No waiting periods or gaps in coverage
Lower deductibles, co-pays / shorter waiting periods for coverage
No pre-existing conditions especially after pregnancy or those born with conditions

Portability – not tied to employment (important to migrant and lower-paid workers)

- **Guarantee access to a *core* group of services emphasizing prevention and promoting healthier communities.**

  Will not give up basic level for everyone
  Cover basic needs with focus on wellness i.e., smoking cessation, weight management
  Public benefit is "basic" and people could buy-up
  Basic level – sick care – well care – mental health care – vision
  Universal – equity ("humane floor") for basic care (including revised prioritized list
  Would give up premium frills in exchange for everyone having core benefit
  Willing to trade off wellness benefit
  Universal access = healthier communities
  Will NOT trade off focus on wellness
  Focus on staying healthier <u>longer</u> (e.g., residences as people age)
  Basic Healthcare – move from individuals to population approach – pool
  Screenings and early detection – no barriers
  Essential to have disease prevention/education/prevention
  Basic healthcare – move from individuals to population approach; use pool
  Prevention – want health plan not a sick plan/remove barrier to get to health i.e., deductibles
  Increase prevention – special focus on high sugar/saturated fats
  Preventive care with coordination – learn from HMO successes
  Increase prevention – special focus on high sugar/saturated fats

- **Require services to meet standards of quality and affordability.**

  Everyone with access to quality affordable health care
  Value of evidence related to health outcomes – role in deciding what's covered
  Quality throughout system – Companion to cost and accounting
  Includes accessible affordable preventive focus – i.e., immunization screening & early intervention
  Would trade off extraordinary measures at end of life
  Courage to have difficult conversations re end of life care
  Willing to change presumption about advance directives at end of life
  Can't give up pain management and palliative care
  Choice of provider / course of treatment / responsibility for own health
  Essential to have cost containment – sustainable, culturally appropriate, dental, vision, mental health
  Primary care – patient/provider relationship—choice
  Choice of level of care – alternatives
  Include alternative therapies
  Coordinated database system
  Might give up medically unnecessary procedures

Might be willing to give up experimental technology
Outcomes-based practices
Efficiency – change way services are delivered & reimbursed pay for what has evidence
Value access to care locally (quality, shared efficiency/workforce)
Essential to have quality
Understand issues related to care and workforce issues when crossing borders (into Washington or Idaho as examples)
Manage chronic conditions
Medical records follow person

- **Include educational efforts and financial incentives to support healthy behaviors.**

Involve K-12 – health education increase consistency and education over life span – train youth about 'good choices'
Emphasis on raising healthy kids as much as end of life
Education- patients as partners
Emphasize & reward healthy habits
Prevention is too important – Emphasize youth / school based clinics + more active lifestyles for kids
Prevention and communication in education is critical
Health care includes MH, PE in schools, and dental
Provide incentives to "produce" healthier patients
Incentives for good health practices
Incentives for providers to promote health – pay for performance
Focus on prevention and incentives for healthy behaviors and nutrition

- **Be explicit about priorities.**

Prioritize care for children
Heath care should have emphasis on children
Essential that kids are covered
Too important – Kids, Mental Health
Essential to have prioritization/limits
Willing to allow prioritization of services (higher priority to immunizations, primary care, pregnancy, mental health, child care)
Willing to have explicit rationing
Can accept limits to heroic interventions at any stage/age
Can give up least life-threatening benefits in lean financial times
Willing to accept queuing for non-urgent care
Would give up cosmetic surgery, unneeded healthcare services
Would accept that not everything would be local
Can accept limits on prescription drugs
Can accept limits on high tech/imaging
Can accept limits on experimental procedures

- **Specify clear rationale and role for government in securing universal access.**

  Government to play strong role in creating all-inclusive system
  Choice of publicly funded, publicly accountable health plan that is not-for-profit
  Create a single payer plan
  Look at quasi-public or universal coverage

- **Address current problems of workforce and resource distribution.**

  Provider shortage – look for ways to find more tied to incentives and liability
  Provider / workforce shortage
  Incentives for providers to care for everyone
  Workforce shortage impacts access – use incentives for placement and retention; adjust payment inequities

- **Take advantage of current strengths and innovations.**

  Resources – school nurses/school based health care – volunteer doctors – public health for health education and prevention – volunteer and community organizations

- **Pay attention to regional differences.**

  Value access to care locally (quality, shared efficiency/workforce)
  Address barriers – cultural, etc.
  Don't want different standards for different communities
  Cross border issues: standards, common benefits
  Acknowledge demographic differences

- **Consider a single payer strategy as an optimum way to achieve inclusiveness, participation, and efficiency.**

  Human beings deserve healthcare
  Single payer = belongs to everyone
  Want guaranteed health care not guaranteed health insurance
  Must have accountable payer
  Single payer = accountability to public
  Choice of publicly funded, publicly accountable not for profit system
  Accountability to individual and community as a whole
  Need trust in who controls the money
  Single payer = simplified bureaucracy and administration

3. Fair Financing – Detailed List

Meaning: It is important to design financing mechanisms that serve the goal of universal access to affordable care focused on health and emphasizing prevention.

- **Base recommendations on an assumption that everyone will participate in sharing the costs of financing a system with universal access.**

  System must be affordable for all – individuals & employers
  Find balance between affordable, necessary & outcomes/evidence
  It is essential to have and sustain affordability
  Affordable low co-pay, low deductibles
  Affordable/balanced out of pocket costs
  Statewide pool for employers with varied options
  Decrease/eliminate burdens on small businesses
  Fair pricing for everyone

- **Consider innovative financing strategies that produce an equitable distribution of the financial burden among households with differing levels of wealth and differing needs for health care.**

  Sliding scale for premiums and health services
  Sliding scale – but avoid stigma
  Equitable payment for system services – % of income
  Everyone has a financial stake even if it's a small amount
  Free is not a good idea – won't be valued
  Subsidies for those who need it
  People with limited or no income should make graduated contribution
  Means testing for Medicare
  Eligibility for public services for health care for self employed based on net instead of gross
  Willing to pay more in order for all to be covered

- **Consider a single payer strategy as an optimum way to achieve inclusiveness, participation, and efficiency.**

  Single payer – creates cost savings
  - Individual contribution
  - Mandatory employer contributions

  Use employers as an org place – i.e., for a wage/payroll tax
  Willing to trade off having insurance tied to employment
  Move away from job based coverage
  Not an employer-based plan
  Single payer – efficiency and moral issue – look at other countries
  Single pool/spreads risk
  Single payer = easy management/lower cost
  Essential to move to single payer
  Publicly owned universal plan
  Remove private insurance companies

Healthcare publicly funded
Single payer = efficiency
Single payer system run by government
Publicly financed system but delivered privately (a la Medicare)

- **Consider innovative ways to moderate the financial impact of health insurance and health services on households.**

Sliding scale for premiums and health services
Essential to have sliding scale
Can give/be negotiable on co-payments
Incentives for consumers/providers

- **Consider various taxing strategies to raise adequate funds for public components.**

Tax reform is part of healthcare reform
Reform tax system (a la Medicare tax) – flat tax
Need a tax structure that allows consistent funding and stabilized revenue
Willing to pay clearly defined individual health care tax
Taxes based on gross income and corporate revenue for financing
Increased income tax
Willing to pay progressive taxes if <u>everyone is in</u>
Sin taxes – "out of state" wines
Tax – fast food – pharmaceutical advertisements
Taxes instead of higher premiums; tax drug ads; tax providers to cover uninsured
Percent of luxury salaries (i.e., athletes)
Percent of current taxes
Eliminate kicker, individual/corporate
Sales tax
Tax junk food
Value added tax (VAT)
Trade employer based system for payroll tax
Pay or play
Dedicated tax on non-essential goods
Tax/regulate medical marijuana

- **Include strategies for coordination among public and private components.**

Use state funds to expand OHP; allow buy-up
Public/private partnership
Public dollars for core benefit
Small businesses can buy into public plan
Consider rate payer based public utility model
Not-for-profit public corporation rather than private insurance – driven by community values
Publicly managed, publicly accountable health plan that is not for profit

Fed and State – regulations impair rural healthcare because they are from an urban perspective
Might trade off Medicare/Medicaid for a universal system
Single price for services using Medicare rates
Willing to trade off regulation at regional level i.e., construction
Maximize federal match

- **Consider various regulations to reform private health insurance.**

Public regulation of health care/insurance
Eliminate private insurance
Have catastrophic coverage with prevention covered, leaving off everything in between
Willing to give up uncontrolled increases to employers for insurance
Willing to give up insurance tied to employment
Need urban/rural equity in relation to insurance options
Health insurance that is not profit driven

- **Examine a wide range of regulatory interventions focused on outcomes and effectiveness of care; invest in developing data that demonstrate effectiveness.**

Value of evidence re: health outcomes – role in deciding what's covered
Quality throughout system – companion to cost and accounting
Evaluation of system – cost, outcomes
Include alternative therapies
Coordination of care, including technology
Training, scope of practice
Manage chronic conditions
Examine over use in the system
Willing to give up unproven, experimental care
"Whole array" health/mental health/dental
Might trade off expensive procedures that are not effective
Willing to give up duplicative tests and services (defensive medicine)
Might trade off private funded research; invest in public funded research
Might trade off excessive end of life care
Would give up necessity of having medical doctors treat every aspect – use other levels of providers
Need coordinated database system
Essential that medical records follow person
Advertise programs that work – i.e., RX pool
System Accountability/Consumer Education to be accountable for health

- **Frame cost control and efficiency strategies in relation to the social function of health care – to express compassion and respect of human dignity.**

Human beings deserve healthcare
Compassion and efficiency
Compassion should be throughout system

Treat people with dignity
Education- patients as partners
Courage to have difficult conversations re end of life care
Might give up extraordinary end of life care
Health care advance directives
Willing to change advance directive presumption (from current presumption that everyone wants extraordinary measures unless it's in writing)
Run healthcare like a business but not for profit
Provide incentives for providers to promote health – pay for performance
Might trade off immediacy of non-urgent care with queuing & willing to pay
Willing to trade off convenience of care for assured access
Can't give up pain management and palliative care
Willing to trade off care for all intensive need for preemies – heroic care at end-of-life regardless of age

- **Identify the role and focus of public leadership in transitioning to a new system.**

Government to play strong role in creating all-inclusive system
Willing to give up excess profits and pharmaceutical advertising
Willing to trade off drug company incentives for research
Control pharmacy companies' access to providers
Limited advertisements – drugs – facilities
Cap for what's charged for drugs
Willing to give up paying for high-end exec salaries
Limit profit in new system
Eliminate profit
Need a delivery system free from one-sided and unbalanced influence of profit motive
Oregon play national policy leadership role as it did with original OHP

- **Reallocate existing health resources for improved efficiency and explore tradeoffs among public sector finances, not just among components of the health care system.**

Reallocation of existing resources
Limit duplication – technology, equipment, facilities
Local provision of coverage, no out-of-state, non-profit organization
Need different economic model – no financial burden
Run healthcare like a business but not for profit
Limit interventions by special interest
Encourage involvement of non-profits
Might trade off defense (national) spending
Might trade off Kicker checks/stimulants
Might trade off amount of money spent on war
Maximize the federal match
Use finances from the lottery

- **Design efficiencies into Administrative Rules and use savings from efficiencies to help pay for expanded access.**

  Savings projected
  Demonstrate lowering costs prior to asking for more $
  Less Bureaucracy/paperwork
  Integrate medical records
  Must have standard benefit/administration
  Cost controls – decrease administration, consistent benefits, simplify payments, avoid duplication, and increase collaboration
  Cost controls that favor consumers rather than creating barriers
  Would give up higher payments to insurers
  Decrease complexity of benefits/options/plans for simplicity/streamlining
  Streamline/simplify administration
  Consistent billing/transparency/accountability – including knowing what things cost/changes – reimbursement, compare providers and quality
  Shared information systems
  Use DRG concept for more services
  Over use examined
  Leverage prices/costs/eliminate middle-men
  Money should go where it's supposed to go
  Coordination and advocacy at primary care level

- **Target issues of excess profits, duplication of services and the need for local flexibility.**

  Might trade off brand names for generics
  Eliminate profits/pharmaceutical ads
  Willing to give up duplicative tests and services (defensive medicine)
  Need flexibility to do things differently depending on geographic characteristics
  Community needs are different because choices are already limited
  Keep community focus on local needs – administration & delivery decisions

- **Include fair compensation of providers and support for provider education among cost considerations.**

  Workforce shortage impacts access – [use] incentives [for] placement [and] retention – [adjust] payment inequities
  Fair compensation for providers/equity for primary and prevention
  Might trade off providers income levels if they are willing to serve anyone
  Incentives – recruit providers
  Incentives for providers to care for everyone
  Need to acknowledge work of providers who are trying to make a living/run a business
  Incentives for providers to promote health – pay for performance
  Physicians on salary
  Transparency – cost & what providers are paid
  Willing to give up certificate of need

Willing to give up the ‘blank check’
Workforce changes – acknowledge complexities, cost, change in culture/expectations – medicine has changed from a calling to a “job”
Support for provider education (nurses, medical doctors)
Willing to give up reimbursement for mistakes/errors
Look at alternative providers/practices to reduce cost
Increase community based clinics as alternative to hospitals
- triage/screening
- role of PH, mental health services
- increased home visits; “treat and release” with home follow-up

Value access to care locally (quality, shared efficiency/workforce)
Willing to give up preferred provider network
Willing to give up decision making by distant providers
Cost containment / accountability – price controls – specialists
Use innovative sources – e.g., Walgreen’s
Advice system, remove pressure from medical providers
Willing to use other practitioners in place of MDs

- **Look for ways to use financial incentives to affect both consumer and provider behavior.**

Incentives – motivation for health is quality
Incentives for health
Might trade off use-it-or-lose-it sick benefits

- **Build transparency and accountability into proposed reform.**

Transparent costs that are equitable
Decrease fraud/waste
System Accountability/Consumer Education to be accountable for health
Trade offs knowledge needed
Lower hospital overhead; use that money for increased access.
Eliminate gatekeepers
Money should go where it’s supposed to go

- **Support the function of informed consumers by respecting choice and assuring access to needed information.**

Employee/patient/consumer is real customer not employer
Choice for employers/employees rather than requirements for employers to go a specific way
Blended public/private system CHOICE!
Willing to only have catastrophic coverage with prevention covered, leaving off everything in between
Allow option for private insurance or services purchase
Essential – Choice of plan/provider
Might be willing to give up provider choice in order to get to universal access
Incentives & disincentives – personal choices

Balance consumer choice with priority of universal access
Standards with choice
Healthcare advance directives
Need more information easily shared about resources
Must have transparency about healthcare costs e.g. portion of taxes that goes to health care
Willing to trade off consumer advertisements – drugs
Advertise programs that work – RX pool
System Accountability/Consumer Education to be accountable for health
Education needed

4. Stability, Sustainability – Detailed List

Meaning: It is important for members of the community to trust that there will be continuity of both function and funding in health care during and after transition to the reformed system.

- **Identify process steps for transition from the present to the new system.**

  Reallocation of existing resources
  Start with small steps – i.e., public education, pooling, buy into OHP
  Increase awareness of cost among providers
  Utilize federal $
  Move away from job based coverage
  Need a tax structure that allows consistent funding--stabilize revenue
  In interim reform state tax code
  Will NOT trade off Incremental vs. transformation
  Use other models to learn what works
  MAY agree to start with basic plan, grow from there
  Insurance via other routes besides [in addition to] employment (keep)
  Single price for services using Medicare rates
  Simplification of admin bureaucracy
  Coordination – care, including technology
  System Accountability/Consumer Education to be accountable for health
  Public regulation of health care/insurance
  Consider rate payer based public utility model
  Use state funds to expand OHP, allow buy-up
  Government to play strong role in creating all-inclusive system
  Can accept turmoil during change
  Use free market competition, minimize government

- **Include regional differences when defining problems and developing solutions.**

  Regional Characteristics
  - Lack of drug and mental health resources, especially for youth and teens
  - Provider retention impacts access
  - Families don't understand how to get help
  - Provider shortages – Providers are coming to Astoria but don't take Medicare/Medicaid

  Coast demographics
  - Almost 10% students are homeless
  - 21% senior deaths exceed births
  - More low-income jobs (hospitality)

  Statewide plan with local flexibility
  Fed and State – regulations impair rural healthcare because they are from an urban perspective
  Might accept regionalized care in order to achieve equity
  Keep community focus on local needs – administration & delivery decisions
  Flexibility – local community differences/different needs

Need urban/rural equity in relation to insurance options

- **Include support for health care provider education in designing sustainability solutions.**

Workforce changes – acknowledge complexities, cost, change in culture/expectations – medicine has changed from a calling to a “job”
Provider / workforce shortage
Support for provider education (nurses, medical doctors)
Public funding for med schools

- **Consider the role of incentives, payment levels, and malpractice reform in maintaining adequate access to services.**

Incentives increase motivation for health quality
Incentives for providers to promote health– pay for performance
Workforce shortage impacts access – use incentives for placement and retention –adjust payment inequities
Need to acknowledge work of providers who are trying to make a living/run a business
Willing to give up high end exec salaries
Willing to give up the ‘blank check’
Willing to give up reimbursement for mistakes/errors
Provider shortage – look for ways to find more tied to incentives and liability
Essential – Won’t give up malpractice protection
Willing to accept changes to malpractice – willing to have a cap or arbitrated system
Decrease liability – may add incentives

- **Consider the single payer strategy as an optimum strategy for stable and sustainable funding and functioning.**

Single payer – efficiency and moral issue – look at other countries
Single pool/spread risk
Single payer = easy management/lower cost
Non negotiable/too important – Single Payer
Publicly financed system but delivered privately
Essential/won’t give up – free market competition, minimize government

Demographic Summary

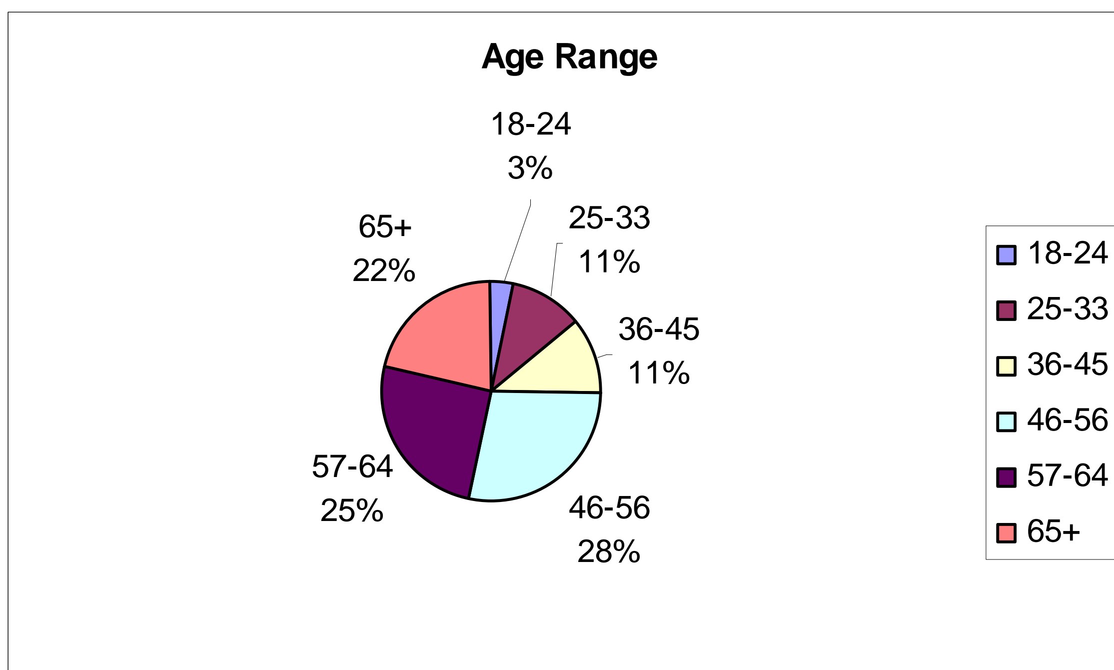
Oregon is a state with a broad spectrum of diverse communities, each facing different challenges within the context of health care access, affordability and quality, as well as many differences in political and economic climates. It was an essential priority of the Community Meeting planners to provide the OHFB with a broad geographical representation of Oregonians, spanning as much demographic diversity as possible within the budgetary limitations of the project.

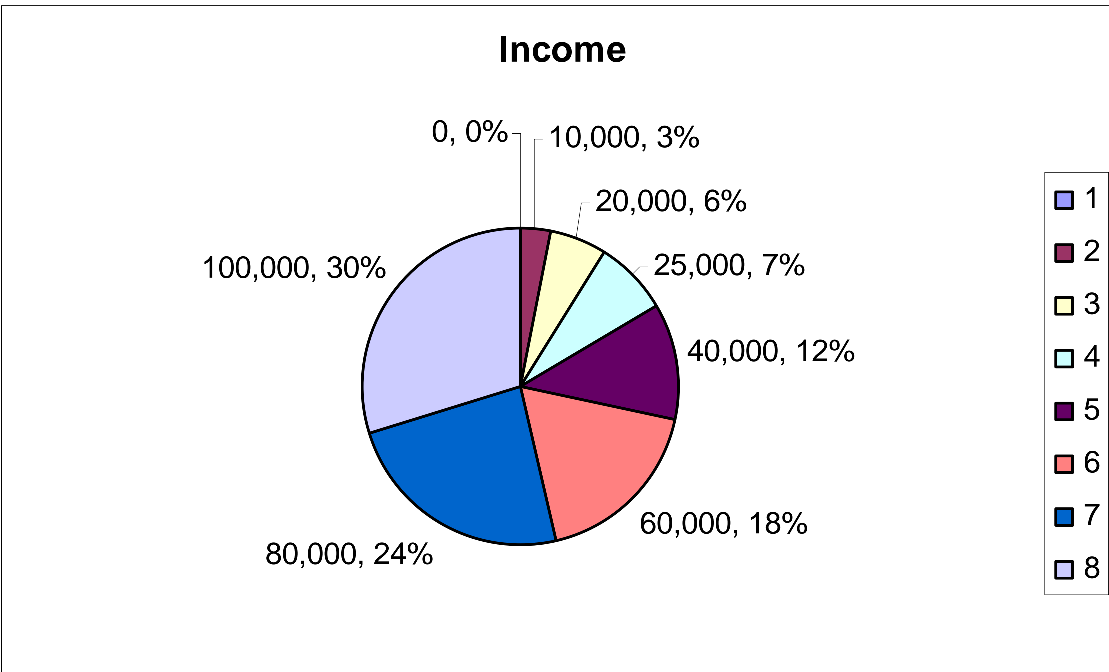
Using extensive grassroots organizing efforts within communities, as well as the earned media techniques of letters to the editor, editorial board meetings, public service announcements, radio interviews and media advisories, there were nearly 1,300 Oregonians in attendance for the 15 Community Meetings. Paid media was also employed in some targeted communities, in the form of postcard mailings, newspaper and bus advertisements.

A network of organizations assisted in notifying their members of the Community Meetings, and project organizers took to the phones prior to every meeting, calling schools, business groups, health care organizations and communities of faith, as well as local government entities, service organizations and neighborhood associations (see Acknowledgements, page 29).

The substantial outreach efforts resulted in broad demographic representation, reflecting age, income and employment diversity, however due to the topic, a natural predominance of health workers were in attendance. Race and ethnicity were not surveyed, though meeting organizers worked through a variety of means to be inclusive and welcoming of all communities of color and ethic backgrounds, including the provision of translators and translated materials and outreach through a network of multicultural organizations.

The following demographic data reflects a 64% response rate of the meeting attendees; a total of 828 surveys were received from the 1,285 meeting attendees.





Number of Persons in Household (sharing stated income)

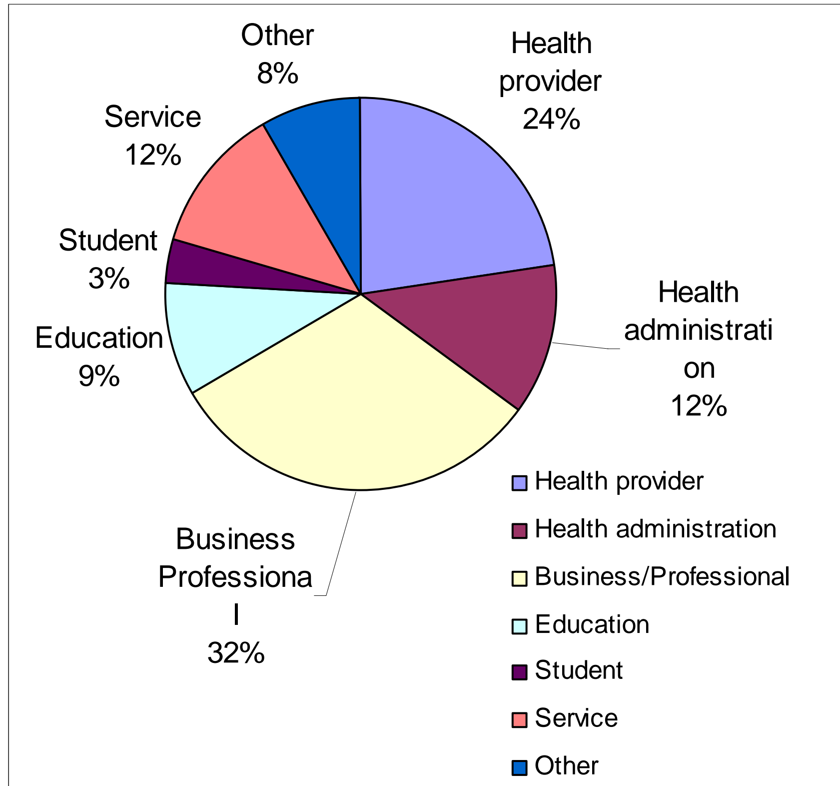
- **67% live in 1- or 2-person household**
- **15% live in 3-person household**
- **12% live in 4-person household**
- **5% live in 5+ person household**

Employment

- **64% employed currently**
- **26% retired**
- **10% unemployed**

Professional classifications

Health provider	147
Health administration	78
Business/Professional	202
Education	61
Student	22
Service	79
Other	54



Acknowledgements

Loosely defined, community engagement is the process of working collaboratively with and through groups of people affiliated by geographic proximity, special interest, or similar situations to address issues affecting the well-being of those people. It is a powerful vehicle for bringing about environmental and behavioral changes that will improve the health of the community and its members. *It often involves partnerships and coalitions that help mobilize resources and influence systems, change relationships among partners, and serve as catalysts for changing policies, programs, and practices* (Fawcett et al., 1995).

The following organizations and individuals deserve recognition and acknowledgment for their efforts in making the Your Oregon, Your Health Community Engagement Meetings possible:

- Northwest Health Foundation, under the leadership of Thomas Aschenbrener and with the guiding support of Chris DeMars
- Oregon Health Decisions—Michael Garland, Liz Baxter and Paige Sipes-Metzler
- Oregon Health Forum—Carol Robinson, Jennifer Smith, Melanie Miller, Anne Morrill, Curtis May and Rhonda Morin
- American Leadership Forum—Robin Teater, Dawn Bonder, Carol Turner, Kathleen Saadat, Joe Gallegos, Susan Massey, Susan Densmore, Terryl Ross
- The Archimedes Movement—Liz Baxter and team
- Oregonians for Health Security—Maribeth Healey, Steve Dixon and team
- Oregon Action—Jo Ann Bowman, Rich Rhode and team
- Oregon Health Action Campaign—Ellen Pinney, Bud Thurston and team
- The Staff of Oregon Health Policy and Research—Heidi Allen and team
- AARP—Jerry Cohen, Joyce DeMonnin and team
- LIPA—Terry Coplin, Rhonda Busek and team
- Mid-Valley Health Care Advocates—Betty Johnson and team
- Physicians for a National Health Program
- League of Women Voters
- Barry Anderson, Portland State University
- Coalition for a Healthy Oregon
- Metropolitan Alliance for the Common Good
- Oregon Association of Hospitals and Health Systems
- Oregon Business Association
- Oregon Latino Health Coalition
- Oregon Medical Association
- OSPIRG
- CareOregon
- Community Health Advocates of Oregon
- Ecumenical Ministries of Oregon
- Oregon Academy of Family Physicians
- Oregon Business Council—Health Care Task Force
- Oregon Nurses Association

- Oregon Primary Care Association
- PacificSource Health Plans
- Providence Health & Services
- Working Families Party
- Klamath Health Partnership—Bob Marsalli and team
- Lane County Community College President's Office
- Klamath Falls Senior Center
- Southwest Oregon Community College
- Access Services Northwest
- Passport to Languages
- National Federation of Independent Businesses
- Members of the Oregon Legislature and other elected leaders who served as local hosts
- Many, many others who served as table leaders, provided child care and interpretation services and spread the word about the meetings

Appendix A

Meeting Format

Summary:

Oregon Health Forum, together with Oregon Health Decisions and Northwest Health Foundation, will host a public engagement process within 13 communities between May 1, 2008 and June 19, 2008 to discuss elements of health reform in an unbiased, nonpartisan atmosphere. These meetings will be designed to inform the work of the Oregon Health Fund Board by asking Oregonians about values that should shape policy recommendations from the Board to the Oregon Legislature.

In a community meeting format, utilizing large group and small group discussion techniques, participants will be asked to consider elements of health reform from two perspectives; that of the individual and that of the community (defined as both local and state).

From the individual frame, the meetings will be designed to tap into personal values around health care for oneself and one's family, eliciting both hopes and fears around health care costs and access to quality care.

From the community frame, the meetings will provoke discussion on potential changes to the healthcare system that would make the community a more desirable place to live. Within this perspective, discussion will occur around the reform issues of health care financing and equity.

Multiple partner organizations will participate in building awareness of the meetings and in recruiting attendees in each community and Oregon Health Forum will utilize staff, volunteers and college interns to mount a grassroots effort to inform a broad swath of organizations typically unfamiliar with health reform about issues of the value and importance of the public participation opportunities. Earned media such as editorial board meetings and local news stories will be sought, and paid media will be developed and purchased as funding allows.

Follow-up communications will be sent to participants via electronic means, surveying for effectiveness of engagement process and willingness to receive additional information. A report for OHFB will be prepared by Oregon Health Forum and Oregon Health Decisions with a summary of meeting results and resulting qualitative and quantitative data collected. Depending on financial resources available, focus group data may also be collected and analyzed.

Agenda	Who/How	Objectives	Tools/Strategies
7:00 pm Welcome and introductions	Local community leader will introduce Health Fund Board members and committee members in attendance	Provide a local host to lead the meeting to elicit a sense of community ownership of the process	Collect anonymous demographic information
7:10-7:30 A brief summary framing the problem, what the passage of SB 329 is set out to accomplish and how; questions that need input from the public	Barney Speight, OHFB members, Committee Chairs	Create understanding of the issues and why public sentiment is essential to inform the reform proposal	Introductory PowerPoint slides or video with handouts showing committee themes in brief bullets
7:30-8:15 Small group discussions (tables of 8-10 depending on space available)	Intro instructions by Meeting staff; Table discussions led by a facilitator at each table with 2-3 questions for discussion, and a facilitator's guide; questions are focused on individual and community values; examples will be about health care access/delivery, cost/financing and equity	Ensure that everyone gets to discuss what matters to them Receive authentic responses based on values	Assigned note-takers will record themes Table facilitator instructions will be basic and at each table Group leader will check in periodically to ensure progress Record results in visual format – to see consensus and differences at each table
8:15-8:50 Reports back from small table facilitators; As time allows large group discussion horizontal question/answer period	Led by local leader/ host; flip chart notes taken by Meeting staff (visible to all)	Opportunity for OHFB members to listen and ask questions Opportunity to see shared values and consider other ideas	Record table results in a visual format for all (illustrate common values)
8:50-9:00 Conclusion/ Wrap-up	Barney/ Board members	Express gratitude for participation Inform on next steps and information access	Collect survey on meeting process, contact information

Details:

What: Community meetings to discuss changes to Oregon's health care systems

When: May 1st- June 19th

Where: 14 communities in Oregon (2 meetings in Portland for a total of 15 meetings)
Locations:
Eugene, Bend, Astoria, Newport, Portland, Beaverton, Gresham, Salem
Klamath Falls, Medford, Coos Bay, LaGrande, Ontario, Corvallis

How: Grassroots efforts, combined with partner will work with civic groups, schools, churches and synagogues, chambers of commerce and other business groups, Rotary, Lions, health organizations, physicians groups, clinics, etc. to recruit an audience of engaged and interested citizens for the public discussions.

Who: The geographic selection of locations for community meetings will provide demographic diversity related to urban/rural community differences. Additional diversity of participants will be sought through recruiting efforts to include ethnicity; age; gender; socio-economic status; businesses, small and large; labor organizations; health and insurance status; employment status.

Why: Qualitative reporting to the Oregon Health Fund Board following the 12 community engagement meetings will serve several useful goals:

- Confirm insights of the OHFB about the direction of their work through its first draft phase
- Bring early warning about potential lack of congruence between community values and work of the Board
- Uncover hopes, fears and ideas of Oregon citizens that may have not yet caught the attention of the Board, providing opportunities for adjustments and for specific message development with resonance with general citizenry.
- Allow for a sense of ownership in the development of health reform within many sectors of Oregonians; diminishing the Us/Them reaction to government-directed solutions.

Oregon Health Fund Board members will commit to:

- Attending (at least one Health Fund Board member will attend each meeting)
- Active listening
- Open sharing
- Full consideration of follow-up report

Planning Partners:

This proposal was developed with advice from members of the Oregon Health Reform Collaborative Outreach Team, comprised of Northwest Health Foundation, Archimedes Movement, Oregonians for Health Security, Oregon Action, Oregon Health Action Campaign, Oregon Health Policy Research, Oregon Health Decisions and Oregon Health Forum. Oregon Health Reform Collaborative is a coalition of 27 organizations convened by the Northwest Health Foundation and Oregon Health Policy Commission.

Discussion Scenarios

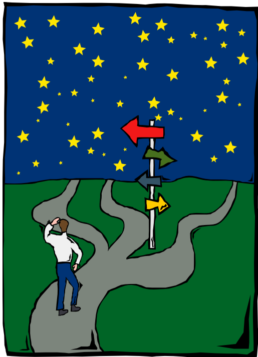
Felicia Ward and Andrea Foley are single mothers of young children. They both work full-time as housekeepers in different motels at the coast. If the new law is passed, their income levels would be low enough to qualify them for full state subsidy to pay for private health insurance for themselves and their children. This would mean that the workers and their children would have health coverage.

Is this the kind of change you would like to see in Oregon's future health care system?

◯ I like the idea

◯ Subsidies have too many problems

If Oregon does subsidize the purchase of private health insurance, what would be a fair way for the state get the necessary money?

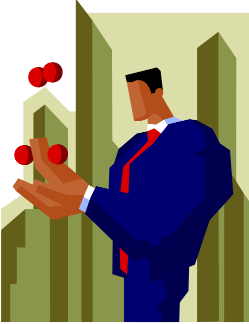


Albert Haley owns a small vineyard that relies heavily on immigrant workers. A new state law requires him to offer his workers health insurance or pay into a state pool where they can buy health insurance individually. Albert doesn't much like the requirement, but he likes having a choice. He doesn't want to shop around for health insurance. Paying into the pool works for him. But he's not sure the arrangement will really help all of his workers. A lot of them can't afford to pay the premiums and he heard that immigrants who have been in the country for less than five years aren't eligible for public subsidies.

Suppose Oregon's health reform required employers to provide health insurance or pay into a pool where workers could purchase health insurance individually. Would you feel our health reform efforts were headed in the right direction?

◯ Right direction

◯ Wrong direction



Mary Harper is 27 and has a 2 month-old baby. Her husband, Joe, had family health insurance while she was pregnant. Two months after she gave birth, Joe's employer decided to close the business. Luckily, Joe found a job almost immediately, but his new health insurance plan has a 90-day waiting period before he can use it. It also has a large deductible and 20% co-insurance for most services. Mary has complications from the delivery and needs several more follow-up visits. The Harpers will have to pay directly for these visits until the waiting period is over and their deductible limit is reached.

Waiting periods are common in health insurance today. Some advocates for health reform say large deductibles and coinsurance are important because paying out of pocket keeps people from overusing health care. Others say it is a dangerous practice that can keep people from getting useful care.

What do you think policy makers should keep in mind when they decide to use or not use financial incentives as part of health reform?

Anne and Mark Johnson are driving home from a community meeting about health reform. Mark says, "I had to bite my tongue a lot tonight. Tons of wishful thinking. Everybody wants more. No one wants to give up anything. Who's supposed to pay for all that?" "For once, Mark, I wish you had spoken up. I really would like to have heard people talk about what we could give up and what's too important to give up. And how should we pay for it? Wow! Three things we agree on. What a night!"

If Mark and Ann were here, how would you respond to their questions? "What's too important to give up?" "What could we give up?" "How should we pay for it all?"

Thank you for participating. Please stay involved.
Updated Information and links at www.HealthForum.org

Appendix B

Earned Media

- Portland/Gresham – *The Oregonian*
  - Op-ed April 30
  - Health briefs listing April 30
- Newport – *Newport News Times*
  - Article and event notice May 2
  - Article after May 7 meeting
- Newport – Oregon Public Broadcasting
  - Live taping of May 7 meeting
  - On-air interview and discussion, "Think Out Loud," May 8
- Astoria – *The Daily Astorian*
  - Article May 5
  - Resident letter to the editor May 6
  - Article May 9
- Medford
  - Local television announcement prior to May 15 meeting
- Coos Bay – *The World*
  - Article May 28
  - "What's Ahead" listing June 2
  - Article June 4
- Eugene
  - *Oregon Family* – event listing June 2008 issue
  - Lane County Medical Society – flyer insert
  - Bulletin boards around Eugene
- Bend
  - Calendar listing bendbulletin.com (*The Bulletin*)
  - Article June 3
  - Article June 4
  - Local television coverage of June 5 meeting
- Portland
  - KBOO radio appearance April 28
  - *The Oregonian* – Resident letter to the editor after June 10 meeting
  - KBOO radio appearance June 12
- Salem – *Statesman Journal*
  - Article June 11
  - Letter to editor after June 11 meeting
- Corvallis – *Gazette Times*
  - Sidebar and mentioned in article June 14
  - Article June 15
  - Article June 20
  - Resident letter to the editor June 19 to promote meeting
  - Resident letter to the editor June 23 in response to meeting

Paid Media

- Eugene – partnership with Lipa
    - *Blue Chip* (Lane County's monthly business magazine published by *Register Guard*) – advertisement June 2008 issue
    - *Eugene Weekly* – advertisement May 29 issue
    - *Oregon Daily Emerald* – advertisement June 4 edition
    - City Bus advertisement
- AARP
    - Targeted mailing of 70,000 postcards to 50-65-year-olds in select communities
- Oregonians for Health Security
    - Targeted mailings to 2,861 in selected communities

Appendix C

AARP Oregon • The Archimedes Movement • CareOregon • Coalition for a Healthy Oregon • Ecumenical Ministries of Oregon • Lipa • Metropolitan Alliance for Common Good • Northwest Health Foundation • Office for Oregon Health Policy & Research • Oregon Academy of Family Physicians • Oregon Action • Oregon Association of Hospitals and Health Systems • Oregon Business Council - Health Care Task Force • Oregon Business Association • Oregon Health Action Campaign • Oregon Latino Health Coalition • Oregon Medical Association • Oregon Nurses Association • Oregon Primary Care Association & Community Health Advocates of Oregon • Oregon Working Families Party • Oregonians for Health Security • Health Care for All - Oregon • OSPIRG • PacificSource Health Plans • Providence Health & Services •

Your Oregon, Your Health

We Want to Hear From You About Health Care!

Health care is on everyone's mind. Health insurance costs, quality of care, access in our communities – there are many concerns that affect all of us. While the health care system is broken, there's a process in place to fix it. Oregon leaders are developing a proposal for quality, affordable health care for Oregonians. **But what does that mean for you?**

Join us at a community near you for an important public discussion on health care in Oregon.

Everyone's voice matters:

- people with or without health care
- employers
- seniors
- people with disabilities

These events are free and interpreters and child care are available.* Your input will help shape the future of health care in our state.

You can also get involved in the conversation online at a new website on health reform in Oregon. Share your views at www.talkhealthreform.org.

All 7 – 9 p.m.
Thursday, May 1, Gresham
Wednesday, May 7, Newport
Thursday, May 8, Astoria
Wednesday, May 14, Klamath Falls
Thursday, May 15, Medford
Tuesday, May 20, Washington County
Wednesday, May 28, La Grande
Thursday, May 29, Ontario
Tuesday, June 3, Coos Bay
Wednesday, June 4, Eugene
Thursday, June 5, Bend
Tuesday June 10, Portland
Wednesday, June 11, Salem
Thursday, June 19, Corvallis

* If you need an interpreter and/or child care, please contact Oregon Health Forum so they can make arrangements. **Call 503-226-7870 or toll free 800-501-4220, or email staff@healthforum.org.** Thank you!

Visit **www.healthforum.org** for more information.
You're an Oregonian, and your health matters.

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