

CCO Criteria, Question 1: What Are The Issues

Name, City	Comment
Ron Unger LCSW, Eugene	I am concerned that in the integration of mental and physical health, medical doctors will be given excess authority, resulting in even more reliance on medication, and less on psychosocial approaches, than what currently exists. I think integration is a good idea in the sense of making sure that care is integrated and coordinated, but not if it means that care is dominated by people who really do not understand or value psychological approaches to issues which really are much broader than the areas medical or psychiatric expertise addresses.
fred abbe, Reedsport	survival and quality of life.
Steve McCrea, Portland	Patient rights MUST address REAL informed consent and patient empowerment. I would put this at the top of the agenda. Health equity needs to also include distribution of financial resources - people should not get worse health care just because they are poorer. We'll also save lots of bucks if we take care of people's health issues at an early time, so another topic not mentioned would be how to provide healthcare to the uninsured effectively and efficiently to avoid much larger costs that will occur if we don't.
Anonymous	Discussion should be limited to solving the problem of delivering medical care. There is a reasonable and as yet unaddressed question of whether it is even responsible for these discussions to be distracted from the real problems we need to solve now by range of issues that don't squarely address those problems.
Penny York, Corvallis	Access to full spectrum of services.
Nancy MacDonald, Portland	concerned that everyone is talking about health equity without having a broad enough context or understanding of it. other issues - These 5 seem most important, but in addition they could discuss 1) how to address people who move in/out of Medicaid eligibility - will there be continuity of care through the CCO? 2) how to assure care for people who have guardians/conservators or others working with them or making care decisions on their behalf; 3) managing care across care settings (which may expand the organizations who are/become part of hte CCO); 4) simplifying how much patients need to know/digest about payment and programs.
tom wilson, Springfield	
Marjorie D Crawford, Portland	Parents need to have the right to make their adult child get help when they cannot do this for themselves..Families should not have to go broke because of mental illness.

Melissa, Eugene	I fear the CCO model. I believe that it sweeps a lot of the proper role and duty of government under a profit driven rug, at the expense of the rights and safety and dignity of a specially protected class of citizens. This is wrong. I know how often hospital dump patients back to the street too soon, or HMOs balk and delay providing care just to save a few bucks. They cannot be trusted to make important decisions based on the individual's right to choose, they will be focused on saving money. I sincerely hope I am wrong, but 12 years in the field tells me this is a big mistake
Stephanie Soares Pump, Lake Oswego	Assuming CCO's are huge corporations, what strategies or incentives can be employed that prioritize person-centered services over the "bottom line?"
Rich Standiford, Langlois	Mental health as a co-occurring issue with physical health treatment, especially in treating chronic health issues. I feel that this should be given a relatively high priority. It is easy for providers to just focus on symptoms and sometimes forget to 'step back' to look at what physical issues may be contributing to mental health issues a client reports, just as it may be for physical health providers to be focussed on symptom presentation and not 'step back' to evaluate if there are possible mood/psychiatric issues impacting physical health.
Larry Burnett, Portland	<p>Part of the Global Budget for the CCO will go toward the responsibility of oral health care. The present treatment of childhood caries would result in certain bankruptcy of the system if the CCO were responsible for the lifetime of breakdown and repair of teeth being needlessly filled now.</p> <p>The alternative is to establish an Oral Health Wing of the CCO. This wing will be supervised by a dental hygienist who can treat and prevent the two most common diseases of dentistry; tooth decay and periodontal disease. The hygienist pay is lower than a dentist's while the resultant outcomes will be far superior than those produced any other way.</p>

CCO Criteria, Question 2: CCO Certification Process

Name, City	Comment
fred abbe, Reedsport	let peers certify peers
Steve McCrea, Portland	Focus on genuine accountability for OUTCOMES, especially for mental health. "Symptom reduction" is NOT an outcome - it is an indicator. Outcomes would reflect an improvement in overall social and emotional functioning, including increased employment, school attendance or vocational training, involvement in community activities, effective family relationships, increasing connectedness to friends and supportive groups, and genuine improvements in other quality of life indicators. Feeling "less depressed" is not a worthy goal for mental health care! We don't just want people to feel better, we want them to LIVE BETTER!
Anonymous	credible, responsible model for our medical system in the CCO. To responsibly assert the CCO model should be about more than solving the medical care delivery problem first requires an even more demonstrably sound, clearly
Mike Volpe, Corvallis	I believe that one necessary priority of a CCO is to work with a network of service providers in the CCOs area to provide the best quality services at lower cost. Determining the CCOs financial viability and ability to absorb up front financial realities that will happen at the initiation of a new process will be crucial. This will be especially true for rural areas which have a much lower population spread over a larger area. CCOs must measure their ability to accept risk and serve the population with quality services.
Nancy MacDonald, Portland	Option 4 - it seems critical that the transformation goals be a part of evaluating who becomes a CCO, and that it is more than re-naking existing configurations. There will be challenges (I like that word better than "cons") in any approach, but we need to address the challenges head on, rather than ignore them. The most important thing is that the CCO's look different, act different and have an understanding of what is expected of them as a CCO. They also need to accept this with eyes-wide-open. That won't happen if the process is easy, or curtailed.
tom wilson, Springfield	The biggest question I have is how are the changes to the system going to be implemented when the State is going forward with the Junction City Hospital. Here we are implementing changes at the current hospital in Salem, passed legislation that will positively affect patient population, yet moving forward on the construction based a data before these events. On top of that the hospital model is using general fund monies, when 16 person facilities can access Medicaid dollars. Seems like a no brainer even with the uncertainty in the present political climate about Medicaid.
Marjorie D Crawford, Portland	Coordination with family mmebers most involved with the patient.
Melissa, Eugene	Remove any link between services provided and profit realized. In other words, keep it the responsibility of government

Stephanie Soares Pump, Lake Oswego	Certification: we have one chance to get this right. Option 1 is preferred as it requires accountability + a business approach/delineating sound business practices and principles and it is more "transformative" in nature. Considerations: the process should be as thorough as possible. It should be truly transparent. It should be rigorous for the applicant.
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Global Budget Methodology, Question 1: Global Budget Priorities

Name, City	Comment
fred abbe, Reedsport	AMA,ADA,APA,Big Pharma must forcably be shoved into obscurity and natural modalitys to the forefront.Can you handle this truth?
Steve McCrea, Portland	<p>1) Creating incentives to reduce costs while providing quality care, and eliminating perverse incentives to do the opposite.</p> <p>2) Creating true, outcome-based accountability measures for every area of healthcare, such as reduced C-sec rates, increased rates of nursing at 6 months and 1 year, improved employment outcomes for mental health clients, decrease in use of special ed services, etc. Budgets should be DIRECTLY tied to success in meeting these objectives, and those who do not should lose business or be removed from any contracts.</p>
Anonymous	<p>First the GBM workgroup must prove why the GBM methodology, being nothing more than the latest attempt to repackage a failed managed-care approach to health care that puts costs control ahead of patient needs and desires, is in principle respectful of patient needs and desire. Second the GBM must provide quantitative proof how much it will actually cost under the GBM to deliver medical care that patients define for themselves as meeting their needs. To argue that patient attitudes, values, and expectation can and must be fundamentally changed to make the health care consequences of GBM acceptable to patients and to make GBM financially feasible will of course guarantee that the entire reform effort is a health care and political failure.</p>
Penny York, Corvallis	Can this new methodology be phased in, especiallay in the rural areas where there may not be community organizations that are fully ready to take the full risk immediately?
Nancy MacDonald, Portland	<p>what happens when there is money left over from what was projected?</p> <p>what happens when it appears there won't be enough funds to do what was projected?</p>
Cathy Unis, Troutdale	<p>The Healing of America by TR Reid is a very informative book about 'developed nations' (all except the US of course) health care systems and how they came about. The Canadian Medicare system was set up by one province - Saskatchewan - through the efforts of that state's governor. The rest of the Canadian states came on board when they saw how successful and popular the system was in Saskatchewan. Oregon can do the same - set up Medicare for All in Oregon - or even use the Kaiser system. I believe this is how we have the best chance of a national health care program. It's just like the Bottle Bill - Oregon can be at the forefront again. How to pay for this? I don't have any ideas besides higher taxes and maybe means test co-pays.</p>
Melissa, Eugene	Job training and low income housing

Stephanie Soares Pump, Lake Oswego	You speak of integrating mental, physical and dental health yet one of the most significant drivers of health care costs is substance use. You can not assume that mental health includes substance use. You speak of prevention but you only speak of public health issues and tobacco cessation. What about underage drinking? What about changing the culture from one of pills/alcohol to healthier means of coping or problem solving? What about public education approaches that teach non-substance related approach to everyday living? There are 18 publicly funded agencies/organizations/divisions that are directly impacted by substance use; we will NEVER reduce the cost of health care without reducing and preventing substance use.
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Global Budget Methodology, Question 2: Which Programs to Include

Name, City	Comment
fred abbe, Reedsport	Only those suffering can decide these prioritys.
Steve McCrea, Portland	Mental health programs are the most important inclusion. Decisions on what to include should be based on increasing costs vs. actual outcomes. I'm betting that prenatal/maternity care would be an area with huge cost increases without benefits, and should be considered a separate special area to target for cost reductions and improved financial incentives.
Anonymous	If it is accepted that the GBM must first be shown to be an effective approach to meeting the medical care needs and desires of patients, it is arbitrary and capricious, not to mention bad health care practice, to simply throw whole programs under a GBM. In fact, whether a GBM would be appropriate for financing any program on that list would depend on the needs and desires of each patient. It would even be poorer health care practice for the OHA and the OHPB to make recommendations to the Legislature for including programs in CCO global budget on the basis of poll results.
Nancy MacDonald, Portland	if this is to focus on medicare/medicaid eligibles to start, the notion of not including (integrating?) long term care dollars is concerning. It is critical that these be part of overall planning for achieving best care scenarios.
Melissa, Eugene	Targeted case management, outpatient mental health programs, in school primary care for children,
Stephanie Soares Pump, Lake Oswego	It is not possible to pick just two. The real question is what services and supports will impact the most people and lead to the biggest improvement (both in terms of leading healthier lives and saving costs). By now it will come as no surprise that I believe substance use prevention is the number one priority. Unfortunately, it is no where on your list.

Outcomes and Metrics, Question 1: Principles for Selection and Retirement

Name, City	Comment
Steve McCrea, Portland	Most important principle to me is not directly stated: performance measures should focus on PATIENT-BASED OUTCOMES and should reflect long-term benefits to the patients and the State rather than simply reporting on short-term, institutional objectives such as "efficiency." It's easy to be "efficient" by not providing appropriate treatment, as the C-section rate clearly shows us.
Anonymous	There is only one responsible principle: Has the metric provably caused the CCO to deliver the medical care patients need and desire? Unfortunately there are business interests that have direct or indirect standing in the OHA's deliberations who will benefit financially from the selection of a metric and suffer financially from the retirement of a metric. Because of that there is more than fair reason to be concerned about the potential for harm to the health care of patients by a reliance on metrics to evaluate the GBM unless the it is acknowledged that the only responsible metric of CCO accountability is whether the medical care needs and desires of patients are met at reasonable cost.
Fred Abbe, Reedsport	Tireously and fearlessly looking for truth inspite of cartel influences to the contrary.
Stephanie Soares Pump, Lake Oswego	Yes. Yes. I think the #1 Principle is Feasibility of Measurement. Without that why bother? The next most important to my way of thinking is Relevance and Value. Again, without that why bother!

Outcomes and Metrics, Question 2: Domains of Accountability

Name, City	Comment
Fred Abbe, Reedsport	If you deal with the first question honestly the rest will fall in place.
Steve McCrea, Portland	Be careful in defining what is "safe" and "effective." It's way too easy to say that a treatment (especially in mental health) is "effective" because it makes the institution's life easier. Effective should be defined BY THE RECIPIENTS of the service, and not by the convenience of the provider!
Anonymous	<p>This slide is simply too many buzzwords. What does "patient-centered" specifically mean in this context? What does "patient engagement and activation" specifically mean and what is the proof that whatever that metric means actually is respectful of patient needs and desires? To assert these domains have sufficient, relevant meaning to even solicit comments is to improperly terminate the debate about the propriety of the GBM and the role of CCOs. At the bottom line, if there is a role for CCOs, they should only be accountable for cost effectively delivering the direct health care services that patients need and desire. This is not a case where experts have an understanding of system needs that patients and the public generally don't. This is a political situation in where many mainly wanting to find a role for meaningless and unnecessary expertise are being invited to put that ahead of what we must do to effectively and directly meet the care needs of patients that we need to address now. To assert that the transformation process needs first and foremost to change the public's expectations of the medical care system, and that the metrics should b</p>
Nancy MacDonald, Portland	<p>These are probably a good start. Concerned that these measures may vary if I am dual diagnosis and you're measuring any of these domains from a medical standpoint alone. The vantage point of examining the system is incredibly important.</p> <p>one note - the three boxes on the right note a shift in describing controlling cost. The notion that we will control cost so that care is affordable for everyone seems unrealistic. There will always be people who cannot afford care. The better measure is whether we, as a society, can afford to take care of us, as a community. The triple aim stayed at a population and per capita level, and it makes sense for the cco's to be there as well. Yes, they need to pay attention to the individuals who receive care, but the overall measure cannot be affordability for the individual. that tells us that cost to the individual should be close to zero to accommodate all.</p>
Melissa, Eugene	Why are access and equity not equally valued with cost containment?
Stephanie Soares Pump, Lake Oswego	Yes but.... Historically, the penetration rates for addictions is woefully inadequate (.07 ish to 2.3 ish). Penetration should be another domain of accountability.

Medicare-Medicaid Integration of Care, Question 1: Successes and Challenges

Name, City	Comment
Ruby Smirl, Portland	Medicare and Medicaid have been successful in delivering services by giving Clients access to outside services and programs. The more intergrated and comprehensive this can be and hopefully 100% intergrated by including all services available within each municipality. This involves research and moderate upgrading of websites and printed material. I realize this costs money but it's money best spent since more people can become self suffcient. Better access to jobs and healthcare will bring relief from the standard agencies customers have been using for decades
Steve McCrea, Portland	Costs for mental health care are rising dramatically. This is at least in large part due to the over-reliance on long-term maintenance on psychotropic medications, despite emerging evidence that these medications may create more chronic problems in the long run, including an increase in the chronicity of the very problem they are intended to treat. Read "Anatomy of an Epidemic" by Robert Whitaker for the latest research on this topic. A move to more social-emotional treatment, including peer-based, recovery-focused programs will save a great deal of money while yielding better long-term outcomes.
Anonymous	The success of the Medicare and Medicaid programs are in delivering medical care to those who otherwise cannot afford it. The fundamental problem with this effort is that it is mainly about controlling costs where patients are seen as faceless cost drivers. Terms like "patient-centered" have become propagandist buzzwords without a working definition commensurate with popular understanding of those words. The greatest challenge is standing up to all the advocates for other agendas and nonsense that is leveraging the cost argument for their own purposes to focus solely on the delivery of medical care that people need and to leave all the other judgmental agendas out of it. The OHA can start by providing it's working definition of "person-centered" since that would determine what's within the bounds of discussion (and how the definition of "person-centered" and the bounds that implies should be changed.)
Mike Volpe, Corvallis	I am currently enrolled in Medicare/Medicaid. I have no voluntary movement below my neck due to Multiple Sclerosis. I live in my own home with assistance. The services Medicaid helps me with include homecare workers that are necessary for me to live in my own home, services provided by the local senior and disability office that administers these services, at a central office in Salem that administers these services statewide. It is well known that Oregon has one of the best in home service programs in the country. Medicaid also provides wrap around coverage to Medicare which helps to make up for services that Medicare that does not pay for. The high quality wheelchair I have was mostly paid for by Medicare. During the eight years I've owned this chair the repairs and service has also been paid for by Medicare. Both the wheelchair and the upkeep are necessary for me to live in my own home. I also receive other Durable Medical Equipment items which help to keep me in my own home through Medicare. I do receive regular doctor visits which are necessary to maintain my health with a substantial disability

Nancy MacDonald, Portland	While the programs overlap, Medicaid allows for long term care and community based care that Medicare should, but does not provide. Many seniors confuse the two programs, and think one picks up the cost that the other does not cover. As long as the two programs operate under two sets of rules, with different billing and expectations, the administrative complexity will outweigh the gains of having two programs.
Tom Wilson, Springfield	People get well and maintain recovery by making connections with others. Sitting alone taking medications does not make people well, so the more resources that help people connect with community provide the supports necessary to function and maintain wellness and should receive a higher priority for funding. Also key is quality training programs especially in interpersonal communication skills for staff directly involved in person-centered care. That is a breakdown in the mental system I have experienced.
Marjorie D Crawford, Portland	I have a niece who has been diagnosed with schizophrenia. She is 20 yrs. old, Her mother is at her wits end because her daughter had taken medication, but goes off of it because of its side effects as well as thinking she is well now. The diagnosis comes with an inability to see that you need help..T Three times her daughter has left home without telling my sister where she is..My sister cannot find ANYONE who can help her get her daughter to get back on meds...She is deeply worried about her as is worn out. My sister's only option is to take her on a plane to IRAN where they used to live, where they will force her to get mediated.\$3-4000 The state/federal does not allow a person with severe mental illness to be taken into custody, brought to a Psychiatric ward in a hospital and kept until she is on a stable level of meds. Nor do they have a program that oversees the welfare of the patient after leaving the hospital. WE DESPERATELY NEED NEW LAWS TO KEEP PATIENTS WITH MENTAL ILLNESS STAY SAFE AND WELL...AND TO REALLY HELP FAMILIES WITH THIS LIFE THREATENING DISEASE>>>Not just allow them to
Anonymous	Providers that refuse to accept Medicare patients. Providers that require payment up front for any Medicare patient even though the patient is covered by Oregon Health Plan as well. Difficulty in finding providers who will see a Medicare patient.
Belinda Sauer, Salem	Successes increasing the number of people we serve. Challenges not letting go of insurance to address chronic illnesses of the elderly. Continue and promote preventive treatments and allow more forms of non-traditional costs. Challenges in person-centered care is not being prescriptive of all with a formula of treatment.
Melissa, Eugene	Oregon has been a shining example of using scarce federal Medicaid dollars to simultaneously improve the quality of life for the elderly and disabled and save money by the OSIPM program. However, the DHS and OAA case managers provide a fundamental check and balance to the profit driven private sector partners. The state's responsibility to focus on the mandated respect for these vulnerable citizens' right to preference, maximum independence and equity cannot be shifted to the private sector.

Stephanie Soares Pump, Lake Oswego	First question: Beyond the fact that we have the two programs, I don't know. Second Q: That there's too much bureaucracy; that not enough education is done to the general public leading to a lack of understanding about what's available; that the "system" is too big and impersonal; that we continually fail to put resources into substance use prevention.
Rich Standiford, Langlois, OR	A success in Coos Co. for delivery of crisis services was opening of a crisis resolutions center as an alternative to psychiatric hospitalization. Unfortunately, we can only offer this to individuals on Medicaid only or to someone deemed indigent. Medicare will not pay for this type of service at this time.
Larry Burnett, Portland	The challenge is to get the incentives right for the treating staff. This is the best way to assure the highest quality care.

Medicare-Medicaid Integration of Care, Question 2: Incentives

Name, City	Comment
Ron Unger LCSW, Eugene	<p>In mental health care, excess authority is given to psychiatrists who make their money off prescribing medications and who fail to take note of data that indicates that in the long term, use of medication is usually associated with worse rather than better outcome. (See Robert Whitaker's book, Anatomy of an Epidemic, for more detail on this.)</p> <p>People in crisis entering the mental health system often encounter hospitals who see their role as getting people on lots of medication quickly, rather than making any attempt to offer a choice of alternatives or attempt other ways of resolving the crisis. In particular for those with psychosis, a better approach would be that of the Open Dialogue program in Northern Europe, which deliberately delays medication to see if other approaches will work: this method results in dramatically lower rates of disability and long term costs. See http://recoveryfromschizophrenia.org/2010/10/finding-out-more-about-the-open-dialogue-approach-on-the-web/ One current barrier to carrying out the Open Dialogue approach in Oregon is rules against having more than one mental health professional bill for attending the same meeting: Open Dialogue meetings do have more than one team memb</p>
Fred Abbe, Reedsport	<p>The AMA is only effective concerning physical trauma all else it does in every other area is better done by natural and preventive modalities like traditional naturopathy,homeopathy,yuen method,chiropactic and other bodywork.Google this.....TheTruthAboutVaccinesAndModernMedicine.....Goggle this.....MercuryJustice.org.....read,study and watch the videos.....Google this.....RobertKennedyJr.com....read his report on childrens health.....Quit playing around kowtowing to vested interests stretch yourselves out ,seek the truth with all your heart and you will find it.Among those who have suffered most in a given area or with a certain ailment are those that have recovered.Humble yourselves and let them teach you.Sincerely, Fred Abbe p.s. Be brave follow the truth wherever it leads.By the way the ADA causes great damage as well as the APA.</p>
Fred Abbe, Reedsport	<p>Read the book "Sick and Tired" by Robert Young to understand the foundational disfunction of the entire health care system and how to correct it at a founndational level.If the foundation is rotted the structure will collapse.Also read "War Against The Weak" a book by Edwin Black to understand some little known precisely documented history of "health care" in the USA.There are so many superior alternative modalitys to consider and implement.I'd be glad to advise you more extensively ,for the sake of the people.Sincerely ,fred abbe.....fabbe@charter.net</p>

Steve McCrea, Portland	Doctors are paid more for doing more invasive procedures rather than letting nature take its course. Nowhere is this more clear-cut than in the field of birth. Doctors get more money for Caesarian sections and spend less time than at a normal births. The C-section rate now exceeds 30% in Oregon and nationally. This is a crime against mothers and babies and also adds huge, avoidable costs to our healthcare system. If the incentive were to encourage a normal birth with minimal intervention, we'd get a lot more of them. Early inductions, automatic ultrasounds on a monthly basis, routine Pitocin augmentation, and other interventions are encouraged financially and normalized when they create greater prematurity, increased postnatal morbidity for mother and baby, and ongoing increased costs through the life of the new baby. Add to that then irrational prohibitions against V-BACs (once a C-section, always a C-section), and you have a very expensive waste of time, money, and human energy that is used to create tragedy and pain rather than health and well-being.
Anonymous	There are some problems with this question. First, it does not acknowledge how, on balance, the Medicare system is the reason most people, or at least those who haven't gotten themselves into Medicare Advantage managed care plans, get high quality care because the system protects their right to determine the medical care they believe is right for them. The Medicaid system presents a completely different set of issues because of how it is financed and the shameful politics that politicians of all stripes have play with that program. On top of that, the major problem blue Oregon like many small red states actually suffers from most are regional disparities in funding that our leadership for years has failed to have the competence to respond to properly. Finally, there is a big difference in the situation of a Medicaid single eligible who "ages-out" to become a dual-eligible and a single eligible Medicare who "spends-down" to become a dual-eligible. To date the entire process generally has been disrespectful to the former and condescending to the latter. Therefore the discussion mixes apples and oranges and inappropriately limits the range
Nancy MacDonald, Portland	Medicare pays for things as long as a person is sick, instead of paying for anything to keep them well. Medicaid requires spending down before providing supportive services. The biggest barrier is the requirement that someone spend 3 days in a hospital before they can be considered for out of home placement options. Sometimes the need is so clear and the hospital stay seems like both a waste of time and money. Not always, for sure, but often enough.
tom wilson, Springfield	Murphy's Law at work, often middle management fails to implement the training that is offered. I have had extensive training as a mental health support specialist with sheets filled with the appropriate boxes checked off. The system will change when agencies place high value on the skills of the trainers, supplemented with a management systems that actually implements what is learned. The facilities where I have volunteered or worked show little adherence to trainings because there was no one to oversee that the lessons were put in place. Yes, extend the training to the workplace in helping staff get practical experience on methods taught. Unfortunately that means many currently in the system have to be taught also.

Marjorie D Crawford, Portland	<p>Make a seamless plan in Northwest States(IN case they move out of state)that actually helps patients with mental illness stay on track..not putting the TOTAL EMOTIONAL BURDEN on parents/ families,who do not have the special skills needed to interact in therapeutic ways with them.</p> <p>Have funds easily accessible for this as well as flexibility in the system to address special needs.Provide support team for families..</p>
Anonymous	<p>If funds are set aside for long-term supports and service systems then they will be used for that purpose because that is all they can be used for. But if the funds were more flexible then other uses that may reduce these supports can be used which may save funds overall</p>
Belinda Sauer, Salem	<p>I think follow-up is cost saving and should be made a priority with clients so they do not get to far down the road where the costs would be even greater.</p>
Melissa, Eugene	<p>We have to motivate specialists in the medical sector to become generalists, or at least take on the primary care duties for patients whose main medical issue is that practitioner's specialty, perhaps at a lower rate for primary or maintenance than emergent patients. We have to provide convenient free health clinics as an alternative to costly emergency room care. Too many Oregonians without access to medical care go to the ER for problems even they know are not true emergencies, but because it is their ONLY treatment option for conditions they cannot ignore but cannot afford to pay for. State and local government employees should be docked for failing to manage their own weight and health problems adequately, and rewarded for reducing their use of more expensive medical care. Hospitals that use a so-called charity care program to maintain their non profit status should expand their programs to include ER physician bills, lab bills, anesthesia bills, etc. or not be able to count that.</p>
Stephanie Soares Pump, Lake Oswego	<p>Q 1: Beyond the dynamics listed in the previous question....I don't know.</p> <p>Q 2: Emphasize prevention, substance use as well as the typical health prevention strategies. Financial strategies that encourage health care providers to deliver broad-based prevention services.</p>
Larry Burnett, Portland	<p>The answer would be too long. Lets just take the example of childhood tooth decay - the most common chronic disease in children. The incentives are directed for the dentists to fill teeth with early decay. There are no incentives for the dental hygienist to go, even with mobile access to the young children them and treat that same early decay with simple medical treatments and sealants that reverse the early decay.</p> <p>The result is a plethora of disadvantaged children with mouths full of fillings which deteriorate over time. To a person of means, each drilled and filled tooth is destined to a lifetime of breakdown and repair costing thousands of dollars per tooth. To a person without means, each filled tooth is destined to a lifetime of breakdown and despair because of inability to pay for the ever increasing larger fillings, crowns, and root canal treatments that have become necessary.</p> <p>The results of incentivising the elimination of the decay problem results in large numbers of children having a lifetime free of decay. The research literature all attests to the accuracy of what i write here.</p>