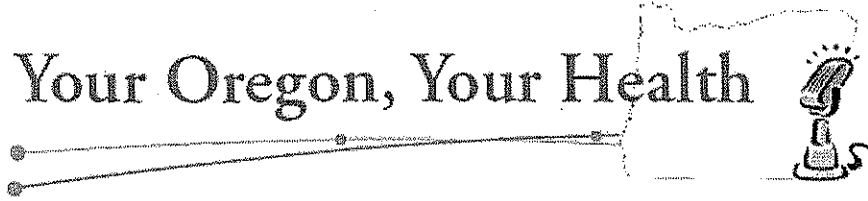


# Your Oregon, Your Health



**Community Meetings | May & June, 2008**

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

Written and compiled by:



**OREGON HEALTH DECISIONS**  
*Giving Oregonians a Voice in Their Health Care*

# Your Oregon, Your Health

## Community Meetings | May & June, 2008

### Table of Contents

Executive Summary .....	1
The Community Meetings: Structure and Analysis.....	3
Short Form Pages for Each Category.....	5
1. Responsibility .....	5
2. Universal Access.....	6
3. Fair Financing.....	7
4. Stability, Sustainability.....	8
Detailed Response Lists for Each Category.....	9
1. Responsibility – Detailed List.....	9
2. Universal Access – Detailed List.....	12
3. Fair Financing – Detailed List.....	17
4. Stability, Sustainability – Detailed List.....	24
Demographic Summary .....	26
Employment.....	28
Acknowledgements.....	29
Appendix A.....	31
Meeting Format.....	31
Discussion Scenarios.....	34
Appendix B .....	36
Earned Media .....	36
Paid Media.....	37
Appendix C.....	38

## 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.

## Your Oregon, Your Health Summary Report Executive Summary

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 and 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.<sup>1</sup> 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.<sup>2</sup>

---

<sup>1</sup> 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.

<sup>2</sup> 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.

## Your Oregon, Your Health Summary Report Community Meetings: Structure and Analysis

- 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<sup>3</sup>

### 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

---

<sup>3</sup> 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.

Your Oregon, Your Health Summary Report  
Detailed Responses for Value of Responsibility

- **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)

Your Oregon, Your Health Summary Report  
Detailed Responses for Value of Responsibility

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 who will be included or left out;
- Rationale for what 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 not 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

Your Oregon, Your Health Summary Report  
Detailed Responses for Value of Universal Access

Essential to have access, 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

Your Oregon, Your Health Summary Report  
Detailed Responses for Value of Universal Access

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 longer (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



Your Oregon, Your Health Summary Report  
Detailed Responses for Value of Universal Access

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
- Health 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

Your Oregon, Your Health Summary Report  
Detailed Responses for Value of Universal Access

- **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

Your Oregon, Your Health Summary Report  
Detailed Responses for Value of Fair Financing

### **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

Your Oregon, Your Health Summary Report  
Detailed Responses for Value of Fair Financing

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 everyone is in
- 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

Your Oregon, Your Health Summary Report  
Detailed Responses for Value of Fair Financing

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

Your Oregon, Your Health Summary Report  
Detailed Responses for Value of Fair Financing

- 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

Your Oregon, Your Health Summary Report  
Detailed Responses for Value of Fair Financing

- **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

Your Oregon, Your Health Summary Report  
Detailed Responses for Value of Fair Financing

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  
- rôle 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



Your Oregon, Your Health Summary Report  
Detailed Responses for Value of Fair Financing

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

Your Oregon, Your Health Summary Report  
Detailed Responses for Value of Stability, Sustainability

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

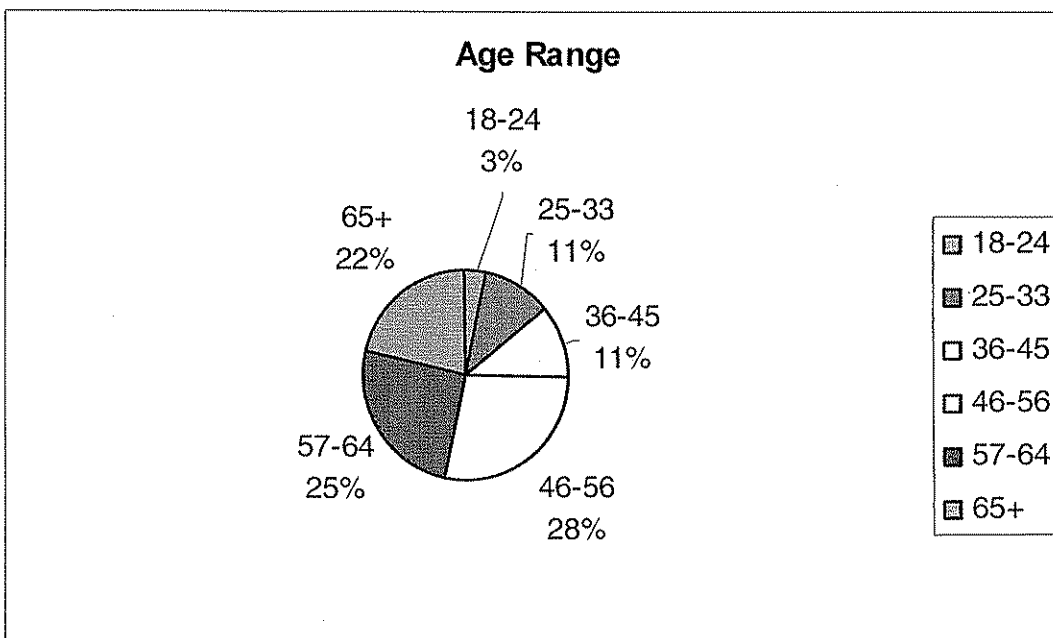
Oregon is a state with a broad spectrum of diverse communities, each facing different challenges within the context of health care access, affordability and quality, as well as many differences in political and economic climates. It was an essential priority of the Community Meeting planners to provide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

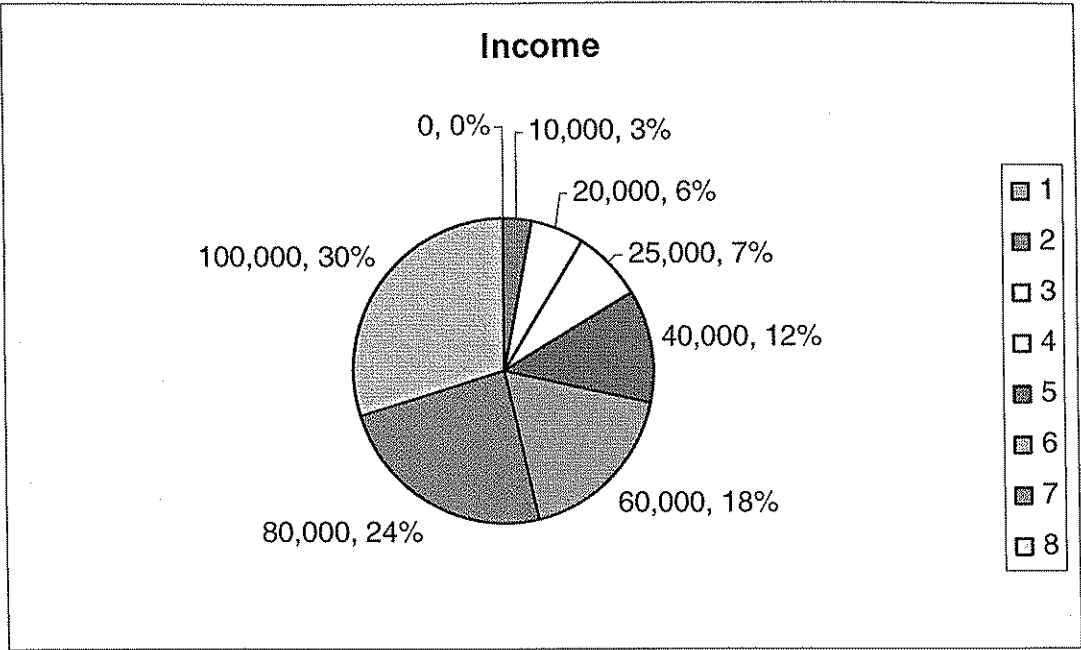
Using extensive grassroots organizing efforts within communities, as well as the earned media techniques of letters to the editor, editorial board meetings, public service announcements, radio interviews and media advisories, there were nearly 1,300 Oregonians in attendance for the 15 Community Meetings. 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 ethnic 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)**

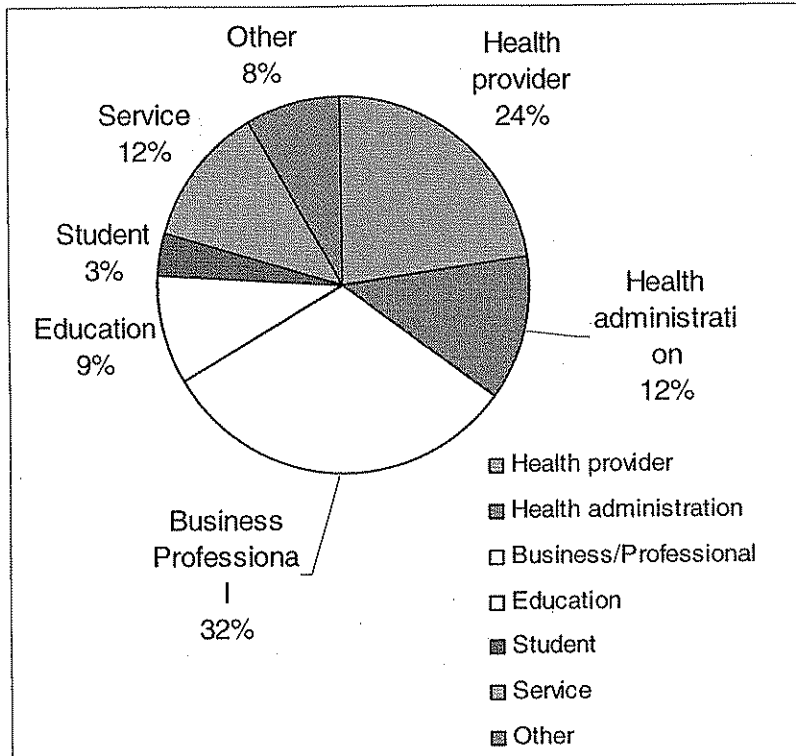
- 67% live in 1- or 2-person household
- 15% live in 3-person household
- 12% live in 4-person household
- 5% live in 5+ person household

**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 Aschenbrenner 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, Terry 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

## Your Oregon, Your Health Summary Report Acknowledgements

- 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.

Your Oregon, Your Health Summary Report  
Appendix A

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 1<sup>st</sup>- June 19<sup>th</sup>

**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**



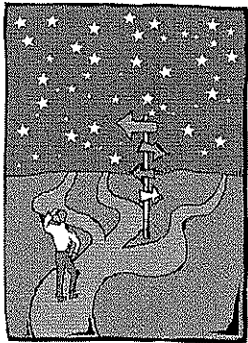
Felicia Ward and Andrea Foley are single mothers of young children. They both work full-time as housekeepers in different motels at the coast. If the new law is passed, their income levels would be low enough to qualify them for full state subsidy to pay for private health insurance for themselves and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

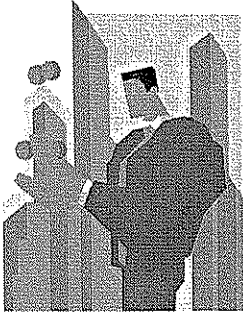


Albert Haley owns a small vineyard that relies heavily on immigrant workers. A new state law requires him to offer his workers health insurance or pay into a state pool where they can buy health insurance individually. Albert doesn't much like the requirement, but he likes having a choice. He doesn't 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](http://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 • Lips • Metropolitan Alliance for Common Good

Family Care Association of Oregon • Health Advocates of Oregon • Oregon Working Families • Oregonians for Health Security • Health Care for All - Oregon • OSHPD • PacificSource Health Plans • Providence Health & Services

Northwest Health Foundation • Office for Oregon Health Policy & Research • Oregon Academy of Family Physicians • Oregon Ad Hoc • Oregon Association of Hospital and Health Systems • Oregon Business Council • Health Care Task Force

# 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](http://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](mailto:staff@healthforum.org). Thank you!

Visit [www.healthforum.org](http://www.healthforum.org) for more information.  
*You're an Oregonian, and your health matters.*

Brought to you on behalf of the Oregon Health Fund Board by:



Family Care Association of Oregon • Health Advocates of Oregon • Oregon Working Families • Oregonians for Health Security • Health Care for All - Oregon • OSHPD • PacificSource Health Plans • Providence Health & Services