



Oklahoma City

August 1, 2006



Citizens' Health Care Working Group
HEALTH CARE
THAT WORKS FOR ALL
AMERICANS

OVERVIEW

"It's good that the issue of our health care system is out in the public and we're talking about it."

The questions, concerns, values, and views expressed in Oklahoma City were consistent with what the Working Group has heard throughout the country in previous meetings. This group of Oklahomans had no reservations about being "straight-up" with their opinions, but they were always respectful of the many different views voiced by their fellow participants. At the conclusion of the meeting, over half of the participants agreed that the Working Group's package of recommendations would improve our health system, about 1 in 4 did not know if the package would lead to improvements, while 1 in 5 thought this package would not lead to improvements. However, all were pleased that the proposed changes were being discussed "out in the open" and valued the opportunity to talk about the problems and be part of the solutions.

Participants agreed that changes in the health care system needed to be made and emphasized the need for these changes to lead to a "simpler" system that has a "continuing review process built in." They valued preventive care and emphasized individual responsibility. They recognized the need to reduce costs, and the benefits of evidence-based medicine, but cautioned that there still needs to be "room for innovation" and competition. Participants expressed a pragmatic and skeptical "show me" attitude regarding the role of various institutional players, including insurance companies, government, and corporations; they recognized that those entities will need to be part of any solution and many voiced support for some sort of collaborative public-private system of finance and delivery.



Citizens' Health Care Working Group Community Meetings

Kansas City, Missouri
Orlando, Florida
Baton Rouge, Louisiana
Memphis, Tennessee
Charlotte, North Carolina
Jackson, Mississippi
Seattle, Washington
Denver, Colorado
Los Angeles, California
Providence, Rhode Island
Miami, Florida
Indianapolis, Indiana
Detroit, Michigan
Albuquerque, New Mexico
Eugene, Oregon
Phoenix, Arizona
Daytona Beach, Florida
Upper Valley, New Hampshire
Hartford, Connecticut
Des Moines, Iowa
Philadelphia, Pennsylvania
Las Vegas, Nevada
Sacramento, California
Billings, Montana
San Antonio, Texas
Fargo, North Dakota
New York, New York
Lexington, Kentucky
Little Rock, Arkansas
Cincinnati, Ohio
Sioux Falls, South Dakota
Salt Lake City, Utah



Oklahoma City, OK

SESSION FINDINGS

Recommendation: Protect everyone from very high health care costs

Guarantee financial protection against very high health care costs.

**No one in America should be impoverished by health care costs.
Establish a national program (private or public) that ensures**

- **Coverage for all Americans,**
- **Protection against very high out-of-pocket medical costs for everyone, and**
- **Financial protection for low income individuals and families.**

"...And if you don't know how to navigate the system, you can't even hang on to your own dignity"

Participants agreed that something had to be done to protect people from being devastated by high health care costs, noting that emergency rooms should not be the sole safety net and that people should not be forced into bankruptcy by an illness. The most remarkable quality of the discussion at the meeting was just how diverse and varied participants' concerns and opinions were regarding financial vulnerability and what was needed to address this problem. While some expressed serious doubt regarding a dominant role for government, others clearly believed that a profit-driven system was not the answer. Participants had a number of questions and concerns regarding who would decide, what constituted "very high health care costs" and how those determinations would be made. A plurality (45 percent versus 41 percent) of the participants agreed that everybody should be required to participate in some form of catastrophic coverage. Some were concerned that the catastrophic health insurance coverage they already had through their employer would not be counted and that they would have to "double-pay" for this protection. Asked how such a system should be financed, a large majority (80%) indicated support for a "public-private mix."

Participants voiced concerns about the ethical and financial issues that could result from this recommendation. Speaking from the premise that budgets will preclude everyone from receiving everything, individuals were concerned about who would be making choices pertaining to the care of their loved ones.

Consistent with what we heard at other meetings, there was disagreement among participants over social responsibility. Some participants stated their reluctance to pay for another person's health care while others expressed their willingness to help others in their time of need, knowing that that same assistance would be available to them when they needed it. One participant stated that she would "resent paying for the health care of someone who lives in a three story house and has an Olympic size swimming pool." Another pointed out that while he has insurance, his children, now adults, do not have that coverage and if something happened to them, he would be responsible for those costs. Another variant on this theme was the suggestion that health insurance companies should reinvest something back into the system in order to improve quality of care. Still another was skeptical that "legislating social responsibility" would decrease the cost of health care. As at other meetings, the issue of health care for illegal immigrants surfaced with no resolution.

Recommendation: Support integrated community health networks

The federal government will lead a national initiative to develop and expand integrated public/private community networks of health care providers aimed at providing vulnerable populations, including low income and uninsured people, and people living in rural and underserved areas, with a source of high quality coordinated health care by:

- **Identifying within the federal government the unit with specific responsibility for coordinating all federal efforts that support the health care safety net;**
- **Establishing a public-private group at the national level that is responsible for advising the federal government on the nation's health care safety net's performance and funding streams, conducting research on safety net issues, and identifying and disseminating best practices on an ongoing basis;**
- **Expanding and modifying the Federally Qualified Health Center concept to accommodate other community-based health centers and practices serving vulnerable populations; and**
- **Providing federal support for the development of integrated community health networks to strengthen the health care infrastructure at the local level, with a focus on populations and localities where improved access to quality care is most needed.**

Participants supported the idea that integrated community health networks would go beyond being a place primarily for "vulnerable populations," functioning as a system that would respond to public health concerns, including immunization, nutrition counseling, exercise education, and smoking cessation clinics. Some also noted the role that the government could play in creating a coordinating body, saying that "if that cooperation and integration was going to take place on its own, then we'd have it by now."

Participants discussed the need to "do a better job of telling people what is available and going out into the communities." However, they recognized that "many of us don't want to look and learn about these things until they are actually a problem for us" and suggested having one place that people could call for information (such as a "211" community services number). One person noted the role Community Health Centers play in many communities and the need to support other community organizations providing similar services: federal leadership could help make this happen. Reflecting the conflicting views, one participant indicated that they did "have concerns about the federal government but one of the best features we have is the public health system. Preventive health care, women and children's health, vaccines, have all done well.

We need to remember how to share. Our fear of losing what we've got is clouding our thoughts about how to get what we all need." Regarding how to improve the integration of local community care, another participant indicated that "sometimes change has to happen at the top; conflicting rules at the top prevent programs from working well at the local level. The rules need to be more flexible so that local entities can work together more effectively."

Recommendation: Promote efforts to improve quality of care and efficiency

The federal government will expand and accelerate its use of the resources of its public programs for advancing the development and implementation of strategies to improve quality and efficiency while controlling costs across the entire health care system.

- **Using federally-funded health programs such as Medicare, Medicaid, Community Health Centers, TRICARE, and the Veterans' Health Administration (VA), the federal government will promote:**
 - **Integrated health care systems built around evidence-based best practices;**
 - **Health information technologies and electronic medical record systems with special emphasis on their implementation in teaching hospitals and clinics where medical residents are trained and who work with underserved and uninsured populations;**
 - **Reduction of fraud and waste in administration and clinical practice;**
 - **Consumer-usable information about health care services that includes information on prices, cost-sharing, quality and efficiency, and benefits; and**
 - **Health education, patient-provider communication, and patient-centered care, disease prevention, and health promotion.**

Despite apprehension expressed by some over “turning anything over to the feds,” there was general support among the participants for asking the federal government to use their considerable financial clout in the market to foster and support efforts to improve quality and efficiency. Several individuals noted that local communities, whether the business community or the health care provider community, haven’t been able to “tame the beast” and this type of government backing could be very helpful.

Participants recognized that “the federal government could set a very good example in the area of assuring quality care, and we wish they would.” They noted that “consumers can be empowered and act on cost and quality and that competition helps control costs” and valued the increased implementation of evidence based practices and electronic health records. At the same time, some participants expressed reservations about consumer-driven health care, one attendee noting, “You’re a consumer until you get sick. Then you become a patient.” Finally, they talked about the need to “take control back from the insurance companies to be effective” and create positive incentives for increasing quality and effectiveness in health care delivery.

A telling, though indirect, exchange took place between a patient-participant commenting on the fact that his health care provider has to “flip through a paper medical chart to see what my prior health care has been,” and a physician-participant who observed that the cost to a private practice physician to set up an electronic health record system was several thousands of dollars – a cost that could be prohibitive for small practice health care providers.

Recommendation: Restructure end-of-life care

Fundamentally restructure the way that palliative care, hospice care and other end-of-life services are financed and provided, so that people living with advanced incurable conditions have increased access to these services in the environment they choose.

Individuals nearing the end of life and their families need support from the health care system to understand their health care options, make their choices about care delivery known, and have those choices honored.

- **Public and private payers should integrate evidence based science, expert consensus, and culturally sensitive end-of-life care models so that health services and community-based care can better deal with the clinical realities and actual needs of chronically and seriously ill patients of any age and their families.**
- **Public and private programs should support training for health professionals to emphasize proactive, individualized care planning and clear communication between providers, patients and their families.**
- **At the community level, funding should be made available for support services to assist individuals and families in accessing the kind of care they want for last days.**

"Sometimes insurance drives health care decisions. I had this situation with my father in the last week of his life and they wanted to do open heart surgery because it was paid for- but we didn't want that."

Consistent with other community meetings, there was significant support for rethinking care at the end of life. Those who had previous experience with hospice care shared their view that this "unbelievably loving" service should be made available to more individuals. Participants offered suggestions on how to make changes, including "changing Medicare's 6-month rule for hospice care because it is very difficult to determine." They also requested changes that would facilitate a more seamless transition into palliative care as curative care stopped working. They felt there was room for systemic improvement in how the health care system handles death, noting that an expert on this subject, Joanne Lynn of RAND, in a visit to Oklahoma had observed "at almost any ER, a woman can drop in and have a baby and have good quality care- everyone knows how to do that. But it isn't the same way when someone is dying, and it should be." There also is a need for more attention to the non-medical assistance that many people need.

Participants voiced their experiences with "futile care" in the health care system, and desired to see changes that would "de-incentivize" this type of end-of-life treatment. Some individuals challenged their fellow participants to "follow the money" surrounding futile end-of-life care. They were careful to note that end-of-life care is not only for the elderly and is an important consideration whether a person is aged 3 months or 93 years.

Recommendation: It should be public policy that all Americans have affordable health care.

All Americans will have access to a set of core health care services. Financial assistance will be available to those who need it.

Across every venue we explored, we heard a common message: *Americans should have a health care system where everyone participates, regardless of their financial resources or health status, with benefits that are sufficiently comprehensive to provide access to appropriate, high-quality care without endangering individual or family financial security.* This message was echoed in Oklahoma City.

“Everybody here that has a job and has employer sponsored health insurance should be grateful for that. But let’s say you are get ill, and cannot work- how long will your employer be able to maintain your coverage? We have to find a balance of both public and private simply to meet the needs of real people with real problems.” Participants suggested increasing incentives for people to enter the medical field and, at the same time, the utilization of nonphysician providers, suggesting that in many instances a physician is not required. They suggested following the examples of other countries that have made health care available, expressed frustration that the United States had not yet found a way to make health care work for everyone.

Recommendation: Define a ‘core’ benefit package for all Americans

Define a ‘core’ benefit package for all Americans.

Establish an independent non-partisan private-public group to identify and update recommendations for what would be covered under high-cost protection and core benefits.

- **Members will be appointed through a process defined in law that includes citizens representing a broad spectrum of the population including, but not limited to, patients, providers, and payers, and staffed by experts.**
- **Identification of high cost and core benefits will be made through an independent, fair, transparent, and scientific process.**

The set of core health services will go across the continuum of care throughout the lifespan.

- **Health care encompasses wellness, preventive services, primary care, acute care, prescription drugs, patient education, treatment and management of health problems provided across a full range of inpatient and outpatient settings.**
 - **Health is defined to include physical, mental, and dental health.**
 - **Core benefits will be specified by taking into account evidence-based science and expert consensus regarding the medical effectiveness of treatments.**

Participants at this meeting were frustrated that many people in the current system have little or no access to health care outside of an emergency room. While many participants felt that people in the United States have an “ethical, moral, and social”

responsibility to look out for the well being of their fellow Americans, others wanted to stay away from a system that would require them to pay for “someone else’s poor health decisions.”

There was strong support for making core services available to everyone. As we have heard at other meetings around the country, participants compared health care to the public school system. They noted that “we can guarantee everyone some basic health care coverage, just like we guarantee a basic K-12 education. We don't guarantee a college education. That may mean that people have the responsibility to have an examination every year, or follow certain parameters that are set, but it is feasible.”

CONCLUSION

Individuals shared ideas about how to engage everyone in the health care system. Participants cautioned that regardless of what measures are enacted, “consumers need to stay in the game.” They suggested financial incentives that would make it advantageous for young adults to join and that would reward people of all ages for not over-utilizing health care services.

They questioned “who’s going to pay for all these goodies” and offered a number of suggestions. Participants recommended options that provide “a lot of bang for the buck, like primary care” or that affect a large number of people. Participants noted the need for mental health services and argued for widespread access to preventive care. Funding suggestions included payroll taxes, sales taxes, repealing tax deductions, sin-taxes, and incentives for healthy behaviors. Participants also questioned government priorities, saying “if we can spend billions of dollars overseas, they why can’t we take care of our own people here?” They recognized that change will require “health insurance companies, pharmaceutical companies, hospitals, and doctors to come to the table. If maximization of profits remains the goal of health care, then changes won’t happen.”

METHODOLOGY

The meeting format was a combination of table-level discussions and full audience involvement. Attendees participated in table-level discussions, assisted by the table facilitator, and reported their findings to the entire audience. The attendees also participated in moderated discussions involving the full group. During the full group discussions, key points raised by individuals and tables were compiled and displayed on the screens. Participants then used their key pads to answer questions and the results were displayed as received. Key findings from these instant polls formed the basis for additional full group discussion. Complete polling data from this meeting is available at www.citizenshealthcare.gov/register by selecting “Oklahoma City.”

PARTICIPATION

Over 300 individuals gathered at the Express Event Center in Oklahoma City on August 1, 2006 to discuss the Interim Recommendations of the Citizens' Health Care Working Group. Oklahoma Insurance Commissioner Kim Holland welcomed participants to the meeting and acknowledged the other meeting co-hosts: the State Chamber, Integris Health, and Care ATC. In her opening comments, Ms. Holland noted the challenging health issues facing Oklahoma, including very high rates of uninsurance, obesity, stroke, heart disease, diabetes, and teen pregnancy and very low rates of immunization and early entry into prenatal care. Catherine McLaughlin represented the Working Group.

The demographics of the audience were similar to those of the state - predominantly white non-Hispanics, roughly evenly split between men and women. Almost all were high school graduates and about half were college graduates or higher. Participants were from many parts of the state and represented a good mix of occupations and views on health care reform. There was a sizable and diverse contingent of health care providers, including physicians, nurses, home health aides, hospice workers, and adult day care workers. One table consisted of self-identified union representatives; there were also insurance agents and brokers, entrepreneurs and small business owners, various state government employees, and a relatively small number of health reform "advocates."

DATA

Are you male or female?

46%	1	Male
54%	2	Female

How old are you?

2%	1	Under 25
29%	2	25 to 44
59%	3	45 to 64
10%	4	Over 65

Are you Hispanic or Latino?

3%	1	Yes
94%	2	No
4%	3	No Response

Which of these groups best represents your race?

84%	1	White
6%	2	Black or African American
1%	3	Asian
0%	4	Native Hawaiian or Pacific Islander
4%	5	American Indian or Alaska Native
3%	6	Other
2%	7	Decline to answer

What is the highest grade or year of school you completed?

0%	1	Elementary (grades 1 to 8)
1%	2	Some high school
1%	3	High school graduate or GED
17%	4	Some college
6%	5	Associate Degree
36%	6	Bachelor's Degree
38%	7	Graduate or professional degree
1%	8	Decline to answer

What is your primary source of health care coverage?

78%	1	Employer-based insurance
9%	2	Self-purchased insurance
9%	3	Veterans'
0%	4	Medicare
0%	5	Medicaid
4%	6	Other
0%	7	None
0%	8	Not sure

STAYING INVOLVED

Through the Citizens' Health Care Working Group website, we have made it possible for you to stay involved in the discussion – and to encourage others to get involved as well. Visit the website at www.citizenshealthcare.gov and:

- Download a **Community Meeting Kit** to plan a meeting for your family, friends, neighbors and co-workers.
www.citizenshealthcare.gov/community/mtg_kit.php
- Find a list of other cities hosting meetings and spread the word to friends and family in those cities to **Register for a Community Meeting** near them.
www.citizenshealthcare.gov/register
- Add your opinions to three different polls in the **Public Comment Center**
www.citizenshealthcare.gov/speak_out/comment.php
- Read what members of the Working Group and other Americans have to say by following the link on the homepage to the **Citizens' Blogs**.
www.citizenshealthcare.gov
- Share your opinions on the future of health care by creating your own blog by following the link on the homepage to the **Citizens' Blogs**.
www.citizenshealthcare.gov
- Join a growing group of individuals engaging in back-and-forth discussions on the **Discussion Forums** by following the link on the homepage.
www.citizenshealthcare.gov
- Read **Community Meeting Reports** from other cities to see how opinions are shaping up across the country.
www.citizenshealthcare.gov/community/mtng_files/complete.php
- Stay tuned to the homepage for the Citizens' Health Care Working Group **Preliminary Recommendations** (available in early June) and get involved in the 90-day public comment period.
www.citizenshealthcare.gov
- Stay tuned to the homepage for information on the **Final Recommendations** and the schedule of **Congressional hearings** to address those recommendations.
www.citizenshealthcare.gov

If you have additional ideas on how to get others involved, we would love to hear them. Please contact Jessica Federer at 301-443-1521 or jessica.federer@ahrq.hhs.gov.