How We Did Our Work

Hearings

In the Summer and early Fall of 2005, the Working Group held hearings in Crystal City, Virginia; Jackson, Mississippi; Salt Lake City, Utah; Houston, Texas; Boston, Massachusetts; and Portland, Oregon to learn about the nation's health care system. At the first hearings, health policy experts provided a common foundation on topics including employer-based and other private insurance, public programs including Medicare and Medicaid, health care costs, and public and private initiatives to control costs and expand insurance coverage. At the subsequent hearings topics included: the uninsured and underserved, health care quality, geographic variation in health care utilization, health information technology, rural health issues, mental health, health care disparities, long term care, end of life care, community based care, and Oregon's experience in public engagement on health care issues.

We also heard of many private and public programs trying to expand access to care, improve quality, and reduce costs. Some of the programs we heard about were state and local programs to expand health insurance coverage; employees and employers working together to expand access by holding costs down and getting the right care at a good price; using health care technology to reduce medical errors, monitor patient care, and choose the most appropriate care for patients; providing more information to providers and patients for making choices about health care; encouraging people to use less expensive but equally effective care such as generic drugs; adjusting payments to doctors, hospitals, and other health care providers based on the quality of care they provide; and improving people's access to care and insurance coverage through more effective use of current programs or new programs that will allow small business and self employed individuals to obtain coverage.

Many of the programs are new, so we don't know yet how well they will work over the long-term. And, because these programs were designed to work in particular places, we don't know whether the programs would fit, or work successfully, in other locations or settings. However, the hearings reinforced our conclusion, as stated in the *Health Report to the American People*, that we need to address the entire health care system, not just specific problems in cost, quality, or access, no matter how urgent they may seem from our different perspectives. Ideally, savings gained from improving efficiency and quality in the system could be used to make other needed changes. Some of the proposed health care initiatives could help to keep the amount and type of some health care services we receive the same, while controlling costs and improving quality. But we also concluded that none of the initiatives that we reviewed could provide all the answers to our health care system's problems. Rather, the hearings helped lay the groundwork for the search for solutions described in this report.

A complete list and brief description of the 61 presentations made by experts at these hearings is found in Appendix E.

Public Dialogue

The Working Group conducted community meetings throughout the United States to hear from, and begin a dialogue with, the American people. As stated in the statute, these meetings constitute the primary source of input that the Working Group has used in developing its preliminary recommendations. In addition, however, a variety of complementary forms of input (described below) have been important. These different types of input were designed to engage a broad segment of the American public in an informed discussion, using formats that allowed both

- free expression of all views, and
- sufficient structure to allow the Working Group to characterize and compare different views in order to reach conclusions based on the dialogue.

Working Group Community Meetings

The Working Group conducted 31 Community Meetings in 28 states between January and May 2006 (see Appendix A). These meetings ranged in size from about 35 to approximately 500 participants. At least one Working Group Member attended each meeting. Each meeting was organized using one of a set of formats designed for meetings of different lengths, but all were based on discussion of the four questions to the American people posed in the legislation. The discussion guides, as well as other background materials developed for the meetings (videos, slides, etc.) were all based on the analysis of issues confronting the American health care system presented in the Working Group's publication, *The Health Report to the American People*, with some updated facts and figures. Audience generation for the community meetings consisted of outreach through both earned and paid media, involvement of national and local organizations, associations, and other groups, and the participation of various leaders and government officials at the local, state and national level. Professional meeting facilitators led the meetings.

The basic structure of the meetings involved discussion among participants sitting in small groups, and a structured process for reporting the views of the groups. At the 31 Community Meetings, electronic devices allowed individuals to provide responses to all or some of the same questions included in the poll posted on the Working Group Internet site (see Appendix C), and used in other polls and surveys. The responses to each question were then displayed on a screen, providing immediate feedback to the participants. As discussed in "The Dialogue with the American People", there was some variation in the wording of the "standard" questions from meeting to meeting, in response to the preferences of the groups. The format therefore allowed participants to alter the discussion when they felt it was important to do so, while providing enough consistency to allow for comparisons on key issues. Attendees were also encouraged to provide written comments, and many did so. Staff of the Working Group also considered these comments in their review of the meetings.

Additional Meetings

Another important set of discussions took place at the University town hall meeting sponsored by the Big Ten Conference and the Association of Schools of Public Health, and hosted by the University of Michigan on March 22, 2006 (Appendix D). This virtual town hall provided a forum for individuals gathered at 22 separate public meetings organized by the participating universities, along with the host meeting at the University of Michigan, as well as people viewing the live webcast across the country. Interactive technology allowed various locations to call in with questions and comments, and individuals submitted their feedback about health care in America through email to be read to participants during the live event.

Still other meetings organized by individual Working Group Members and staff in collaboration with community based health, advocacy, and business groups provided additional insights and opportunities to hear from people with perspectives that might not have been well represented at the other community meetings (see below). Some of these were directly related to issues that were raised in the hearings held by the Working Group (see Appendix E). These special meetings included sessions focusing on mental health, health care at the end of life, chronic illness and disability, a series of meetings in rural areas of Mississippi, a meeting co-hosted with Native American organizations, and a meeting organized by a national association representing realtors.

The Working Group also reviewed data from additional meetings that members as well as other people throughout the country conducted on their own, using materials developed by the Working Group and made available to the public in the “Community Meeting Kit” available on the website. A listing of meetings that have provided data to the Working Group is included at the end of this section. Other organizations have also provided us with information. Among these are: The National Health Care for the Homeless Council (NHCHC), which conducted a nationwide outreach effort to gather the input of homeless persons; data from the responses of 446 homeless persons in 12 cities were provided to the Working Group. The United Church of Christ provided us with about 1,500 hand-written responses from people in about 10 percent of its 5,700 churches across the country to the open-ended questions posted on our Internet site. Additionally, the Area Agency on Aging in Florida provided about 50 poll responses from seniors in Florida. The Catholic Health Association also provided over 1,000 poll responses from its members.

Other Direct Citizen Input

The Working Group solicited input from people across the country via the internet, at www.citizenshealthcare.gov, and by mail.

The Working Group Public Comment Center on its website solicited both structured and unstructured comments from the public.

- “What’s Important to You” sought responses to four broad questions about people’s concerns about health care in America, views on changing the way health care is delivered or paid for, trade-offs that people would be willing to make to improve health care, and recommendations that people would make to improve health care for all Americans. The responses submitted by over 4,500 people from across the United States were coded into response categories and analyzed; the full text of close to 2,000 hand written responses were also provided to the Working Group for review.
- The Health Care Poll posted on the website drew over 10,000 responses from January through May 14 (see Appendix C). In addition to responses submitted through the Working Group web site, other poll responses were collected by partner organizations that posted the poll on their own web sites and then forwarded their data to the Working Group.

Written input, including paper versions of the internet poll as well as written responses to the open-ended questions that were mailed to the Working Group, were also coded and analyzed using the same protocols as the electronic data submitted over the Internet.

Analysis of the Data

Methods

The Working Group reviewed summaries of all the sources described above. The Community Meetings were considered, for analytical purposes, as case studies. In addition to the data on demographics and the votes recorded at each meeting, staff reviewed background information on each location and, in the course of planning each meeting, obtained a great deal of information on the health care, resources, and policy issues in each community. Senior staff members who attended the meetings used a structured format when preparing the meeting reports. The individual reports, including the data recorded at each meeting, are being made available to the public on www.citizenshealthcare.gov. The Working Group compared data across meetings only when it was truly comparable, that is, questions were asked in the same context during the meetings, in the same form. (See Appendix B for more information.)

Data from open-ended and poll responses were coded by staff and analyzed using standard statistical software. The Working Group reviewed summary data, as well as the results of analyses possible differences in response patterns related to demographic differences. The Working Group also reviewed data from relevant national polls and surveys.

Limitations

People attending the Working Group Community Meetings or providing input in writing are more likely than others to be especially interested in health care, either because they, or their family members, have had concerns about their health care or insurance coverage, or because they work in the health care field. The people we heard from were, on average, more likely to be female and in or on the edges of the Baby Boom generation (age 45-64), and the proportion having bachelor degrees or advanced graduate degrees was much higher than in the population as a whole. And, while participation in Community Meetings by minority group members was fairly close to national percentages, representation of people who identified themselves as Latino or as African American among those submitting comments or poll data was lower. The proportion of people who were not covered by any form of health insurance, and the proportion receiving benefits through Medicaid, was also lower than the nation as a whole. Some of these limitations were addressed by holding meetings specifically designed to reach underrepresented populations (see above). And, as noted above, analysis of the data was performed to assess the extent to which demographic factors may have accounted for some of the findings.

A more serious issue is the inability to ensure that people providing input represent the full spectrum of views of all Americans, given that people who are sufficiently interested or motivated to provide input on health care and policy issues may not be typical of the population as a whole. To some extent, consistency of findings across many communities and between the poll data obtained through both the Working Group Internet and the University town hall meeting provides support for the view that we have heard from a significant segment of the American people. The consistency between findings from recent national polls and surveys provides even stronger support for the findings. However, the meetings, as well as the www.citizenshealthcare.gov data were designed to offer information to help frame discussion and responses to questions, whereas national polls and surveys generally do not serve this purpose. Therefore the responses we have analyzed are not exactly comparable to other national poll data, even when the same, or very similar, questions are asked. Consequently, we do not claim that we know, with great certainty, the values and preferences of all Americans. Rather, we are basing our recommendations on a careful assessment of input from as many sources as feasible, from thousands of people from all across the United States, taking into account the gaps or biases that may be reflected in the data to the best of our ability.

Citizens’ Health Care Working Group Meetings through June 1, 2006

Community Meetings

Kansas City, MO	January 17, 2006
Orlando, FL	January 24, 2006
Baton Rouge, LA	January 26, 2006
Memphis, TN	February 11, 2006
Charlotte, NC	February 18, 2006
Jackson, MS	February 22, 2006
Seattle, WA	February 25, 2006
Denver, CO	February 27, 2006
Los Angeles, CA	March 4, 2006
Providence, RI	March 6, 2006
Miami, FL	March 9, 2006
Indianapolis, IN	March 11, 2006
Detroit, MI	March 18, 2006
Albuquerque, NM	March 20, 2006
Phoenix, AZ	March 25, 2006
Hartford, CT	April 6, 2006
Des Moines, IA	April 8, 2006
Philadelphia, PA	April 10, 2006
Las Vegas, NV	April 11, 2006
Eugene, OR	April 18, 2006
Sacramento, CA	April 19, 2006
San Antonio, TX	April 19, 2006
Billings, MT	April 21, 2006
Fargo, ND	April 22, 2006
New York, NY	April 22, 2006
Lexington, KY	April 25, 2006
Cincinnati, OH	April 29, 2006
Little Rock, AR	April 29, 2006
Tucson, AZ	May 4, 2006
Sioux Falls, SD	May 6, 2006
Salt Lake City, UT	May 6, 2006

Special Topic Community Meetings

Hanover, NH Last Days	March 31, 2006
Redwood Valley, CA Native Americans	April 20, 2006
Washington, DC National Association of Realtors	May 16, 2006
Atlanta, GA Mental Health	May 22, 2006

Meetings Organized by Individual Members

Washington, DC Ascension Health CEOs	December 5, 2005
Daytona Beach, FL Bethune-Cookman College	March 26, 2006
Deltona, FL Florida CHAIN (Community Health Action Information Network) and MS-keteers Multiple Sclerosis Support Group	May 6, 2006
Palm Beach Gardens, FL Area Agency on Aging	May 10, 2006
Boca Raton, FL Area Agency on Aging	May 11, 2006
Lake Worth, FL Area Agency on Aging	May 12, 2006
Thousand Oaks, CA City of Thousand Oaks Conejo Recreation and Park District	May 18, 2006

National Webcast, March 22, 2006

Participating Institutions[#]

Boston University	Boston, MA
Drexel University	Philadelphia, PA
Emory University	Atlanta, GA
George Washington University	Washington, DC
Indiana University	Indianapolis, IN
Johns Hopkins University	Baltimore, MD
Louisiana State University	Baton Rouge, LA
Michigan State University	East Lansing, MI
Northwestern University	Evanston, IL
Ohio State University	Columbus, OH
Penn State University	Harrisburg, PA
Purdue University	West Lafayette, IN
Tulane University	New Orleans, LA
University at Albany	Albany, NY
University of Arkansas	Fayetteville, AR
University of Illinois	Urbana, IL
University of Iowa	Iowa City, IA
University of Louisville	Louisville, KY
University of Michigan (Host)	***Ann Arbor, MI***
University of Minnesota	Minneapolis, MN
University of South Carolina	Columbia, SC
University of Wisconsin	Madison, WI

Not all meetings took place at main campuses.

Self-Initiated Meetings

Crossville, TN The Learning Community	January-March, 2006
Starkville, MS	March 21, 2006*
Verona, MS	March 27, 2006*
Wesson, MS	March 29, 2006*
Hattiesburg, MS	March 30, 2006*
Clarksdale, MS	April 11, 2006*
Palm Beach Gardens, FL Human Resource Association of Palm Beach County	April 11, 2006
Greenville, MS	April 18, 2006*
Newton, MS	April 20, 2006*
Eau Claire, WI Chippewa Valley Technical College	April 29, 2006
Seattle, WA Association of Advanced Practice Psychiatric Nursing	April 29, 2006
Galveston, TX Center to Eliminate Health Disparities, University of Texas Medical Branch	May 1-3, 2006
McKeesport, PA Mon Valley Unemployed Committee	May 11, 2006

* Held under the auspices of the Mississippi State University Extension Service.

Citizens’ Health Care Working Group Meetings, January – May, 2006