

## Public Input for the Oregon Health Policy Board

March 1 – April 10, 2012

Doc #	Summary	Comment Type	Writer
1	Submitted article: <i>Mercury on the Mind</i> by Donald W. Miller, Jr., MD on the dangers of mercury and dental amalgam.	Letter Received 3/7/2011	John Costa
2	Submitted article on Housecall Providers and the enormous impact they are making on the health and wellbeing of homebound elderly and disabled people in Portland.	Email Submitted 3/1/2012	Barbara Gorman
3	Concerned that under new system, mental health funding for children will be reallocated to physical and adult mental health.	Email Submitted 3/7/2012	Susana Alvarez
4	Thought CCOs are an important step in the right direction, there are numerous unresolved issues, especially in rural areas: provider alignment and interfacing capabilities, communities fitting into CCO model, not enough local input, etc.	Email Submitted 3/7/2012	Jon Schott, MD
5	Recommending implementation of a version of a program used in New Mexico called Get Set For Health. The program provided educational materials for patients and sent teams of providers to low income apartment complexes to check up on seniors once a quarter.	Email Submitted 3/12/2012	Susan Bender Phelps
6	There are ways to prevent kidney failure as well as hypertensive kidney failure and thus prevent people from going on the kidney machine. Please refer to my 2002 paper on <a href="http://www.genomed.com">www.genomed.com</a> .	Email Submitted 3/17/2012	David Moskowitz, MD
7	Medicare-for-all system is the way to go.	Email Submitted 3/18/2012	Dick Noren
8	Doctors should not have to be present when nurses are administering immunology shots.	Email Submitted 3/21/2012	Rita Kiley
9	OHA should ask for a federal waiver on the Telehealth requirement to have the patient be in an “originating site” in order to bill for the Telehealth services. Current CMS rules do not allow providers to access patients unless they travel to a hospital, physicians office, etc (the “originating site”).	Email Submitted 3/17/2012	Michael May, MD
10	I foresee insurance companies artificially raising prices through mutual agreement in the coming insurance exchange. Have there been any safeguards set up around this issue?	Email Submitted 3/27/2012	Sharon Botchway, FNP, CNM
11	The answer is not increasing the number of CCOs, since lack of regulation after certification leads to negligence. I believe managed care by PCPs would be the most economical approach.	Email Submitted 3/28/2012	Joanna Pipes
12	Are employees in the food industry in Oregon required to wear gloves? A fast food manager told me they are not – this needs to be fixed.	Email Submitted 4/2/2012	Alexandra Ramirez

# ***Check out this article titled "Mercury on the Mind" by Donald W. Miller, Jr., M.D.***

## ***Who is Donald W. Miller Jr., M.D.?***

### **Professor**

#### **Faculty Positions:**

University of Washington, Professor, 2003 - present.

University of Washington, Clinical Associate Professor, 1980 - 2003.

University of Washington; Chief, Division of Cardiothoracic Surgery, 1978 - 80.

University of Washington, Associate Professor, 1978 - 80.

University of Washington, Assistant Professor, 1975 - 78.

#### **Education:**

**Residency:** General Surgery: Roosevelt Hospital, 1965 - 70. Cardiothoracic Surgery: Columbia-Presbyterian Medical Center and Harlem Hospital, NYC, 1972 - 74.

**M.D. Degree:** Harvard Medical School, 1965.

**Board Certified:** American Board of Surgery, 1971. American Board of Thoracic Surgery, 1975.

#### **Clinical Interests:**

Coronary artery bypass surgery.

#### **Research Interests:**

Risk assessment.

## Mercury on the Mind

by Donald W. Miller, Jr., MD

by Donald W. Miller, Jr., MD

Although they afflict widely different age groups, autism and Alzheimer's disease share a common cause: mercury. Dr. Boyd Haley, professor and chair of the chemistry department at the University of Kentucky, and Dr. Bernard Rimland, founder of the Autism Research Institute, presented evidence at this year's Doctors for Disaster Preparedness meeting that connects mercury with these diseases.

This heavy metal is highly poisonous. A Dartmouth professor studying the chemical characteristics of an organic form of mercury – dimethyl mercury – spilled two drops of it on her gloved hand. The first sign of mercury poisoning occurred four months later when her speech began to be slurred. This was followed by difficulty walking and loss of vision. She then fell into a coma and died. Another person, attempting to smelt the silver in dental amalgams he obtained (they are 35 percent silver, 50 percent mercury, and 15 percent tin, zinc, and other metals), heated them in a frying pan. The mercury vapor thus generated killed him quickly. The two other family members in the house at the time also died.

Mercury is one proton (neutron and electron) heavier than gold – the atomic number of gold is 79; mercury, 80. It is distributed throughout the earth's crust. Unlike other metals, mercury, in its elemental state, is liquid (molten) at room temperature. And it releases a steady stream of gaseous mercury atoms that linger in the atmosphere for months (eventually falling back to earth and its oceans in an inorganic form in rain drops). Even when in a solid state, combined with other metals as an alloy, mercury atoms continually escape into the atmosphere. Once added to latex paint, put in teething powder, used in making hats, as a fungicide on seeds, as an antiseptic (Merthiolate), and as a treatment for syphilis (the cure was worse than the disease), human exposure to mercury today comes principally from three sources: dental amalgams, vaccines, and fish.

Elemental mercury when released by a dental amalgam is inhaled and (80 percent of it) absorbed by the lungs and retained in the body. Vaccine makers add thimerosal (which is half ethyl mercury) to vaccines to prevent bacterial contamination. This injected organic form of mercury is readily taken up by brain and heart muscle cells. Fish harbor another organic form of mercury – methyl mercury, which is obtained from plankton that synthesize it from inorganic mercury extracted from the sea.

Currently the two most important sources of mercury exposure for Americans are dental amalgams and vaccinations. The Federal government's Centers for Disease Control and Prevention (CDC) and Food and Drug Administration (FDA), for reasons not explained, have chosen to ignore this fact. These agencies and the National Institutes of Health (NIH) focus exclusively on mercury in seafood, to the extent that the NIH will not fund studies that address mercury in amalgams and vaccines.

In lockstep with the government, the American Dental Association (ADA) claims that amalgams are safe, and the mercury in them poses no problem. The (government-funded) Institute of Medicine (IOM) and various specialty societies, notably the American Academy of Pediatrics (AAP), American

Academy of Family Physicians (AAFP), and the American Medical Association (AMA), say the same thing about mercury in vaccines. There is growing evidence, however, that mercury in vaccines and amalgams cause both autism and Alzheimer's disease. The CDC and the FDA and the medical establishment, led by its specialty societies, discount or ignore this evidence -- evidence that includes privately funded epidemiological studies; research on how mercury damages brain cells grown in culture; animal studies in rodents, sheep, and primates; and clinical studies in children and adults.

Autism was discovered in 1943, in American children, twelve years after ethyl mercury (thimerosal) was added to the pertussis vaccine. (The disease was not seen in Europe until the 1950s, after thimerosal was added to vaccines used there.) In a typical case, shortly before his 2<sup>nd</sup> birthday a normally developing, healthy boy stops communicating with others and withdraws into himself. He avoids eye contact and becomes strange and aloof. His vision becomes blurred; and he develops various motor disturbances, such as involuntary jerking of the arms and legs and walking on his toes. In addition to these manifestations, Dr. Sallie Bernard and her colleagues, in a study titled, "Autism: A Unique Type of Mercury Poisoning," describe the speech difficulties, unusual behavior (such as unprovoked crying spells and head banging), various degrees of cognitive impairment, gastrointestinal difficulties, and immune difficulties that these autistic children can have. Mercury is most likely a causative factor in other developmental disorders as well, such as delayed speech and attention deficit hyperactivity disorder.

Investigators have shown that there is a direct relationship between increasing doses of mercury in vaccines and autism. In the 1950s, with an immunization schedule limited to four vaccines (against diphtheria, tetanus, pertussis, and smallpox), 1 in 10,000 children developed this disease. As vaccines for other diseases were added, health care providers began injecting increasingly larger doses of mercury into children. Those born in 1981 were given 135 micrograms of mercury (on average), and one case of autism occurred in every 2,600 children born that year. With the addition of hepatitis B vaccine (injected on the day of birth) and one for *Haemophilus influenzae* Type b, providers injected 246 micrograms of mercury into children born in 1996. Autism occurred in one out of every 350 of these children. Today, providers follow an immunization schedule, prepared by the CDC and approved by the AAP and AAFP, that includes 13 vaccines given, with variable numbers of booster shots, 33 times before a child reaches the age of 2 (when the development of the brain is completed). Autism now afflicts 1 in 100 boys and 1 in 400 girls, and physicians diagnose 100,000 new cases of this disease every year in the U.S (using diagnostic criteria, in the DSM-IV, that is more restrictive than the previous DSM-III-R). Over the last 30 years more than one million children have come down with this disease, and currently one in every 68 families in America has an autistic child.

Mainstream medical journals, like *Pediatrics* and *The New England Journal of Medicine*, only publish studies that claim thimerosal is safe. And it turns out that these articles are written in large part by researchers in the pay of vaccine makers, as the Coalition for Safe Minds (Sensible Action For Ending Mercury-Induced Neurological Disorders), a private nonprofit organization, has shown. Editors of these journals will not publish studies that show a link between thimerosal and autism like "Thimerosal in Childhood Vaccines, Neurodevelopment Disorders, and Heart Disease in the United States" by Mark and David Geier, which documents a strong association between the amounts of mercury injected in vaccines and autism. Such articles can only find acceptance in alternative (i.e., "politically incorrect") journals like the *Journal of American Physicians and Surgeons*, where this one was published.

The amount of damage a given dose of mercury can do to the brain (and also the heart) depends on one's age, sex, and genetically determined ability to excrete mercury. Young children with still developing brains are more susceptible, and males are more vulnerable to a given dose of mercury because testosterone enhances its neurotoxicity. Most important, however, is one's genetically programmed

ability to rid the body of mercury. The brain has a house-cleaning protein that removes dangerous waste products, which comes in three varieties: APO-E2, APO-E3, and APO-E4. The APO-E2 protein can carry 2 atoms of mercury out of the brain; APO-E3, one; and APO-E4, none. The genes we acquire from each parent determine which two we have. People with two APO-E4 proteins (and thus no APO-E2 or -E3) have an 80 percent chance of acquiring Alzheimer's disease. And according to one study, autistic children have a huge preponderance of APO-E4 protein in their brains.

Alzheimer's disease was discovered in 1906, again in America, where dentists used mercury-laden amalgams to fill cavities (dentists in Europe largely avoided them). Today, more than 4 million Americans now have Alzheimer's disease. It afflicts half of people over the age of 85 and 20 percent aged 75 to 84.

The first symptoms of this disease are difficulty concentrating and variable degrees of memory loss, leading ultimately to devastating mental deterioration. The brains of people with Alzheimer's disease shrink by 25 percent and have distinct pathologic hallmarks (neurofibrillary tangles, amyloid plaques, and phosphorylation of tau protein). Brain cells grown in the laboratory develop the same three pathologic findings when exposed to nanomolar ( $3.6 \times 10^{-10}$  molar) doses of mercury, an amount approximating that found in the brains of people who have a lot of amalgam fillings.

Dental amalgams are the main source of mercury in an adult's brain. An average-sized amalgam filling contains 750,000 micrograms of mercury and releases around 10 micrograms a day. Researchers put radiolabelled mercury amalgams in the teeth of sheep and determined where escaped mercury went with a scanner. They showed that mercury atoms exhaled through the nose travel up filaments of the olfactory nerve to the hippocampus, which controls memory, and to other critical areas in the brain. In another study, rats given the same concentration of mercury that people inhale from their amalgams develop the pathologic markers of Alzheimer's disease. People with Alzheimer's disease have mercury levels in their brains that are 2 to 3 times higher than that seen in normal people.

The mercury in flu vaccines also plays a role in this disease. One investigator has found that people who received the flu vaccine each year for 3 to 5 years had a *ten-fold* greater chance of developing Alzheimer's disease than people who had zero, 1, or 2 shots.

Another important factor with regard to mercury on the mind, which officials at the CDC, FDA and the professors in the IOM do not consider, is synergistic toxicity – mercury's enhanced effect when other poisons are present. A small dose of mercury that kills 1 in 100 rats and a dose of aluminum that will kill 1 in 100 rats, when combined have a striking effect: *all* the rats die. Doses of mercury that have a 1 percent mortality will have a 100 percent mortality rate if some aluminum is there. Vaccines contain aluminum.

Why do officials at the CDC, FDA, and leaders of the medical and dental establishment discount or ignore all these important facts? Some of them being in the pay of vaccine makers is one reason. The specter of litigation for having sanctioned thimerosal and amalgams and, in the case of the FDA, not doing appropriate safety studies on them is another. But it is more complicated than that. The hypothesis that mercury causes autism and Alzheimer's disease is a new truth. And as Schopenhauer points out (see my article on him), each new truth passes through three stages: First, it is ridiculed. Second, it is violently opposed. And third, it is accepted as self-evident. The mercury truth is now in the second stage.

In the 1790s Edward Jenner observed that milk maids did not have pock marks on their faces, like people did who had contracted and survived smallpox. Milking cows with cowpox rendered them

immune to smallpox. He took fluid from the pustules of infected cows, injected it into children, and found that it protected them, when exposed, from contracting smallpox. The medical establishment of the day dismissed the idea of vaccinating people with cow pus as nonsense; and Sir Joseph Banks, president of the British Royal Society (the IOM of the day), told Jenner that he would ruin his reputation if he tried to publish these findings, which were so much at variance with established knowledge. When other doctors and informed individuals like Thomas Jefferson recognized that "vaccination" did indeed work, its value was, in time, accepted as self-evident. Jenner's vaccine saved millions of lives and eradicated a disfiguring disease that has a 30 percent mortality rate. (But laboratories in the U.S. and U.S.S.R. preserved the virus that causes smallpox, and we now know that Soviet microbiologists grew vast quantities of it in chicken eggs for use as a biological weapon of mass destruction.)

Today the medical establishment, led by the AAP, AAFP, AMA, CDC, and IOM, has gone to the other extreme. The accepted wisdom now is that vaccines are a panacea. Health care providers start injecting them in infants on the day of birth, and government officials seek to have them made mandatory for all Americans. But some little-discussed facts belie their value. Deaths from diphtheria, for example, declined 90 percent from 1900 to 1930, due to better sanitation and nutrition, before there was a vaccine for this disease. Likewise, the death rate for measles declined 95 percent (13.3 to 0.03 deaths per 100,000 population) between 1915 and 1958, before the vaccine for measles was introduced in 1963. Viewed from a risk/benefit perspective, providers and government officials downplay the deleterious effects that vaccines can have on one's health and inflate their benefits. The top medical textbook on the subject is Vaccines, edited by Drs. Plotkin and Orenstein. In the 1999 3<sup>rd</sup> Edition that I reviewed (a slightly longer 4<sup>th</sup> Edition was published last year), its authors confine their discussion of mercury in vaccines to two short paragraphs in this 1,230-page book. They do not address concerns that have been raised about its neurotoxicity.

Vaccine manufacturers have started removing thimerosal from vaccines. And for the first time since the state began keeping records on this disease, California has had a *decrease*, of 6 percent, in the annual number of children over the age of 3 who have been diagnosed with autism. This occurred in children born in 2000, when the phase-out of thimerosal in vaccines began. Iowa has passed a law banning thimerosal in that state, and California has done the same thing for pregnant women and children under 3 (the bill awaits the governor's signature). But pharmaceutical companies still add thimerosal in their Flu vaccines; and pediatricians are vaccinating children with their remaining supply of thimerosal-containing vaccines, which the FDA has chosen not to recall.

Taking mercury out of vaccines would substantially reduce the incidence of autism, but this alone will not eliminate the disease. Giving too many vaccines over too short a time to infants whose nervous system is not yet fully developed can also trigger autism and its spectrum of disorders. As Dr. Blaylock has shown (see Recommended Reading below), multiple vaccines given close together over-stimulate the brain's immune system and, via the mechanism of "bystander injury," destroy brain cells.

Much more research needs to be done on the neurotoxicity of mercury and excessive vaccination. Dr. Haley terms autism Mad Child Disease. Finding one cow in the U.S. with Mad Cow Disease, from Canada, prompted the Federal government to spend millions of dollars examining other cows to see if they had contracted it. With regard to Mad Child Disease, however, the government spends \$59.00 in research for every case of autism diagnosed in this country.

Avoiding flu shots that contain thimerosal; and having dentists stop implanting mercury amalgams in people's mouths would lower the incidence of Alzheimer's disease. If you have amalgam fillings, particularly if there is a family history of Alzheimer's disease, you might consider having them removed. Be sure to have a dentist do it who follows the protocol established by The International

Academy of Oral Medicine & Toxicology for safely removing them.

For the third source of mercury, follow the CDC's advice and don't eat mercury-contaminated fish, especially if you are pregnant because mercury in your bloodstream crosses the placenta and is concentrated in the fetus' brain.

**Recommended Reading** – in addition to the online links provided above

An excellent review of thimerosal and autism, titled "Mercury in Medicine – Taking Unnecessary Risks," is to be found, of all places, in the *Congressional Record*. Prepared by its Subcommittee on Human Rights and Wellness, this report was presented to the Committee on Government Reform, chaired by Congressman Dan Burton (who has an autistic grandson). *Congressional Record*, May 21, 2003, E1011–E1030.

SafeMinds president, Lyn Redwood, presented testimony at a Congressional hearing held on September 8, 2004 that exposes malfeasance by the CDC and FDA related to thimerosal. It is titled "Truth Revealed: New Scientific Discoveries Regarding Mercury in Medicine and Autism" and is posted on their website, [safeminds.org](http://safeminds.org). See also this organization's 84-page Report to Congress titled, "A Brief Analysis of Recent Efforts in Medical Mercury Induced Neurological and Autism Spectrum Disorders" (September 8, 2004).

"The Three Modern Faces of Mercury" – in fish, vaccines, and dental amalgams – by Thomas Clarkson in *Environmental Health Perspectives* Volume 110 | Supplement 1 | February 2002 | pages 11–23. This study provides an current-day perspective on mercury exposure, post Calomel, Merthiolate, and Mad Hatters.

If your dentist parrots the American Dental Association stance on this subject and says that "silver" – i.e., mercury – amalgams are perfectly safe, insist that he or she read Dr. Boyd Haley's response to the president of the ADA on his defense of dental amalgams. It is posted on this website. I sent it to my dentist who I had been going to for a number of years. When he chose to ignore it, I changed dentists – to a mercury-free one and had him remove all my amalgam fillings.

"Mercury: the Silent Killer," Chapter 3 in *Health and Nutrition Secrets That Can Save Your Life* by Russell L. Blaylock, M.D. As a board-certified neurosurgeon, Dr. Blaylock, like me, is a member of the medical establishment. He now, however, studies and writes about wellness and complementary/alternative medicine on a full-time basis.

Are Vaccines Safe and Effective? by Neil Z. Miller (2002). This 78-page (paperback) book is well worth reading, especially if you have children or if you are being pressured to get a flu shot.

For a comprehensive review, with 167 scientific references, on how vaccines damage infants' and soldiers' brains (Gulf War Syndrome) when given too close together, see Dr. Blaylock's "Interaction of Cytokines, Excitotoxins, Reactive Nitrogen and Oxygen Species in Autism Spectrum Disorders" in the *Journal of the American Nutraceutical Association* (JANA 2003;6[4]:21–35). See also his study, "Chronic Microglial Activation and Excitotoxicity Secondary to Excessive Immune Stimulation: Possible Factors in Gulf War Syndrome and Autism" in the *Journal of American Physicians and Surgeons* (JAPS 2004;9[2]:46–52). Dr. Blaylock has written a simplified version of these studies for the general public titled "Vaccines: the Hidden Dangers," in his Blaylock Wellness Report (Vol. 1, No. 1), which is published monthly and can be purchased online.

September 29, 2004

*Donald Miller (send him mail) is a cardiac surgeon and Professor of Surgery at the University of Washington in Seattle and a member of Doctors for Disaster Preparedness and writes articles on a variety of subjects for LewRockwell.com, including bioterrorism. His web site is [www.donaldmiller.com](http://www.donaldmiller.com).*

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### Donald Miller Archives

**Find this article at:**

<http://www.lewrockwell.com/miller/miller14.html>

Check the box to include the list of links referenced in the article.

**From:** Barbara Gorman <bgorman@housecallproviders.org>  
**Sent:** Thursday, March 01, 2012 12:47 PM  
**To:** OHPBInfo@state.or.us  
**Subject:** Michael Bonetto, PhD, MPH, MS,  
**Attachments:** Terri\_BizJournal.pdf

**Categories:** OHPB Comments

Hello Michael,

I thought you might be interested in the article about Housecall Providers that was recently published in the Portland Business Journal. Housecall Providers is making an enormous impact on the health and wellbeing of homebound elderly and disabled people in the Portland Metropolitan area.

Thank you,

Barb Gorman  
fund development coordinator  
Housecall Providers  
housecallproviders.org

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# Housecall Providers aids fragile seniors, the disabled

The nonprofit's health care staff last year made more than 12,000 patient visits

BY ROBERT GOLDFIELD  
SPECIAL SECTIONS EDITOR

*The doctor's house call is far from dead in Portland. The nonprofit Housecall Providers sends physicians to the homes of medically fragile seniors and disabled adults.*



*Its roster of physicians and other health care providers are paid employees, not volunteers. Last year that staff made more than 12,000 patient visits.*

*The Portland-based organization also offers hospice services and advocates on behalf of its patients, their caregivers and families.*

*The Business Journal recently asked Housecall's executive director, Terri Hobbs, how the organization works and what benefits it delivers.*

**1. Describe your business model:**

As members of a growing nonprofit medical practice, our physicians, nurse practitioners, physician assistants and support staff provide much needed primary care to a severely underserved population. Wherever our patients choose to receive care — that is where we deliver that care, be it in a home, group residential setting or adult foster care.

Our model of health care means our patients don't have to make difficult trips to physician offices for routine medical care. They receive quality medical care in the residence of their choice.

Our patients' caregivers value our ser-

We continue to see our patients to the end of life; therefore, it made sense from a continuity of care standpoint to add hospice to our model.

vices because our support allows them respite from their hard work, and they know our professional team truly listens to them when they talk about the patient.

Our service model saves money: A survey of 40 percent of our patients in 2011 showed an average annual cost of care per patient of \$10,593, compared to the Medicare benchmark for a comparable group of \$16,083.

In addition to our primary care practice, we offer hospice services where our patients can complete their lives with dignity, respect and compassion.

We currently have 1,300 patients under our care, compared to 972 patients in 2009, when we first started to serve hospice patients. We have sustained rapid growth in the last year, adding 702 new patients in 2011 compared to 522 in 2010. Our clinicians made 12,185 patient visits in 2011, compared to 10,785 in 2010.

**2. How is your organization funded?**

We have two primary revenue sources: fundraising and fee for service for our medical services. Fundraising comprises about 6 percent of total revenue. The reason our services do not cover all of our costs is that we are not reimbursed for all the services we offer, and we turn no patient away for an inability to pay.

**3. Why did the organization add a hospice?**

Adding hospice services was a natural progression of our mission. We continue to see our patients to the end of life; therefore, it made sense from a continuity of care standpoint to add hospice to our model. We only accept current Housecall Providers patients onto our hospice plan.

**4. What kind of growth do you expect for Housecall?**

We expect potentially rapid growth in the next year if we become a demonstration site for Independence at Home and if we are awarded a \$2.7 million grant we recently applied for. This could add as many as 12 employees to our staff of 66, and up to 1,000 new patients. Our revenue would grow considerably if either of these events takes place.

We have been on a steady growth trajec-

**The Hobbs File**

• **Joined Housecall Providers** on Sept. 17, 2001.

• **Became CEO** in July 2011.

• **Almost 30 years' experience** in many capacities in health care.



is why we are in a recruiting mode currently; we have a patient waiting list of about 150 but cannot add them until we hire more clinicians.

**5. How do you recruit physicians and health care professionals?**

To date, most of our recruiting has been by word of mouth, Craig's List and some national advertising. We are about to launch a more aggressive recruiting campaign.

Our success has made it possible to offer wages and benefits for most of our positions that are competitive within our industry. The only exception to that is compensation for physicians. The trade-off for them is we offer a lot of flexibility and the opportunity to provide care to a drastically underserved population.

tory since 1996, the year Housecall Providers was incorporated. However, our patient census varies depending on the number of physicians we have on staff. This is because we are limited by the number of clinicians because each one can only handle so many patients. This

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**From:** ALVAREZ Susana V <susana.v.alvarez@state.or.us>  
**Sent:** Wednesday, March 07, 2012 9:27 AM  
**To:** 'ohpb.info@state.or.us'  
**Subject:** Assistance in finding out how Mental health for children will be funded with new system

**Categories:** OHPB Comments

Dear Board,

I am concerned that with the prior system in place there were 35% of the mental health funding was going to children services and slated for that use. With the information I am reading I can't find where children's mental health services will still continued to receive this funding and how there are any safe guards to making that the funds will not all be tied to physical health and adult mental health. Could you direct me to the information on how this is going to be handled?

Sincerely  
Susana Alvarez

**From:** Jon Schott, MD <jschott@eoma.net>  
**Sent:** Wednesday, December 21, 2011 3:32 PM  
**To:** OHPBInfo@state.or.us  
**Subject:** CCO

**Categories:** OHPB Comments

To Whom it Concerns

Though the philosophy of care surrounding CCO's is undoubtedly the logical course that healthcare needs to take as we approach the financial and clinical challenges in our near and distant future, as a rural family physician I have not been sold after attending two sessions you've held as to how you plan to implement CCOs at least in rural areas. First of all, the sessions seem to have been informational but not designed to seek input. It appears the state has decided what they want to do and will push forward. That does not build alignment. Second, in rural areas what defines a community as it relates to a CCO seems to be a big problem. In frontier areas where communities are small in number and geographically separate, the function of a CCO will have to be different than in the Portland area. That does not appear to have been considered at least in the presentations I've attended. Perhaps most importantly, in rural areas where there aren't large systems of care already in place, alignment of providers and hospitals into one system that achieves triple aim is going to be a big project. Hospitals and providers that are on electronic health records systems typically don't interface. Many providers are still on paper charts. Building a system where participants agree on chronic disease markers to work towards and health maintenance goals are met and the financial benefit and cost of coordinated care given the logistics of a rural setting is going to be different than in the Willamette Valley. It seems premature to push forward on implementation of the state's CCO model at least in rural areas, until these issues have been thought through carefully.

Jon Schott MD

**From:** Ettinger Ari A <ari.a.ettinger@state.or.us>  
**Sent:** Monday, March 12, 2012 2:48 PM  
**To:** ohpb.info@state.or.us  
**Subject:** FW: CCOs & cutting healthcare costs

**Categories:** OHPB Comments

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**From:** Susan Bender Phelps [mailto:susanbb2901@yahoo.com]  
**Sent:** Wednesday, March 07, 2012 1:11 PM  
**To:** CCO.Info@state.or.us  
**Subject:** CCOs & cutting healthcare costs

Dear members of the Board,

I moved to Oregon about 11 years ago from New Mexico. At the time we had a program that decreased emergency room usage by about 30 percent without compromising overall health or immediate outcomes. It also helped low-income seniors to be healthier. I think a similar program could be very effective in the CCO's.

It was called Get Set For Health New Mexico. I cannot find it online, so I don't believe it is happening any longer. I could be wrong.

The program was a collaboration of local businesses, hospitals and volunteers. It had two parts

1. A book was created that could be used by anyone who can read. It outlined the most common health concerns that caused people to use the ER for services. Described the symptoms and what conditions needed to go to the ER, to Urgent Care, to a docto's office and what could be treated at home. Free workshops to teach people how to use the book were led by volunteer nurse practitioners and physician assistants at schools, pre-schools and in low-income neighborhoods at libraries. Each participant was given a book, a certificate and a shoe box filled with everything youb need for a basic first aid kit. The books were in English and Spanish. The shoe boxes were donated by shoe stores and department stores. The first aid supplies were donated by chain drug stores, and other local businesses. It was a three hour class. Afterward, the women and men who had been through the class, carried the books with them wherever they went and shared their knowledge.

2. A team of volunteers would visit low-income apartment complexes for senior adults once a quarter. The team was comprised of a physician, P.A. or nurse practitioner, a pharmacist, a massage therapist, a nutritionist and someone from the city's senior affairs office. They would take blood pressures and pulses, compare meds for side affects and combinations, talk to them about their eating habits and access to food, give them a chair massage, answer questions about assistance or services. They were able save people from strokes, drug interactions and other common problems. The visit became a social opportunity for the seniors. A lot of the men were malnourished and began eating with the women and doing much better. They also found that the residents began to order the special buses and go shopping together.

I think a component like this could accomplish a lot of what the CCO's are intended to do. I am not a medical practitioner. I do volunteer on the Washington County Commission for Children and Families, so these issues are close to my heart.

Sincerely,

Susan Bender Phelps

*If you're not mentoring, you're not leading.*

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**From:** David Moskowitz <dwmoskowitz@hotmail.com>  
**Sent:** Saturday, March 17, 2012 4:32 AM  
**To:** oha.directorsoffice@state.or.us; ohpb.info@state.or.us  
**Cc:** Nick Budnick; Nick Budnick  
**Subject:** Dialysis is expensive but obsolete; why not make Oregon dialysis-free?  
**Attachments:** GenoMed's\_COIP(r)--6-2-2011.ppt; CV 3-5-12.odt

**Categories:** OHPB Comments

Dear Oregon Health Authority,

I've been reading Nick Budnick's articles about the unconscionable fees (\$300K) being charged to the Oregon Medical Insurance Pool for dialysis for the 70 dialysis patients in the pool, and about these patients' virtual imprisonment on hemodialysis, since the American Kidney Fund won't help if the patient gets a transplant.

Such shenanigans are common in the hemodialysis world.

I'm writing because I worked out how to prevent diabetic kidney failure as well as hypertensive kidney failure, i.e. 90% of why people go on the kidney machine. I see no reason why Oregon shouldn't eliminate dialysis altogether, and have the few remaining kidney failure patients go directly to transplant.

The first step might be to publicize the existence of my 2002 paper, which is here:

Moskowitz DW. From pharmacogenomics to improved patient outcomes: angiotensin I-converting enzyme as an example. *Diabetes Technol Ther.* 2002;4(4):519-32. PMID: 12396747.  
(<http://www.genomed.com/pdf/diabetes.technology.therapeutics.pdf>).

I've attached a slide show that further explains my paper.

Although my paper was published in 2002, you obviously never heard of it. You're certainly not alone. I consider this an even bigger story, which speaks volumes about what healthcare has become in the past 50 years. Details are at [http://www.genomed.com/images/guyot\\_dec09nl.pdf](http://www.genomed.com/images/guyot_dec09nl.pdf). From the public health point of view, it's ***a modern day Tuskegee***: a cure exists, but the people who most need to know, the patients, are being kept in the dark.

Hope you'll let me help you avoid dialysis in Oregon. Puedo hablar (y escribir) español. Para seis años trabaje un día a la semana en La Clínica para gente que no tenía dinero ni Inglés.

Best regards,  
Dave

PS. My CV is also included.

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**From:** Dick Noren <dnoren@upwardaccess.com>  
**Sent:** Sunday, March 18, 2012 11:29 PM  
**To:** ohpb.info@state.or.us  
**Subject:** single payer health care system

**Categories:** OHPB Comments

To the Board,

What you have proposed will not work and everyone knows it. It is time to put on your big boy pants and get serious about how to address health care cost in Oregon! A Medicare for all system is the way to go.

Regards,  
Dick Noren

**From:** Rita <tkiley5@aol.com>  
**Sent:** Wednesday, March 21, 2012 10:36 AM  
**To:** ohpb.info@state.or.us  
**Subject:** Health Care Plan for Oregon

**Categories:** OHPB Comments

Dear Representative Prozanski:

I just had a conversation with my allergist who mentioned to me that there is a provision in the new Oregon Health Plan that requires a doctor to be present when nurses are administering immunology shots. The nurses are very competent and well-trained to handle any reactions from the shots. This imposes a hardship on our clinic which often serves other areas.

If there is anything you can do to change this provision, I would be very grateful. I have been served by my allergy center for over 30 years and trust the entire staff.

Sincerely,  
Rita B. Kiley  
Eugene 97405

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**From:** Mike May <MikeM@samhealth.org>  
**Sent:** Wednesday, March 21, 2012 1:05 PM  
**To:** OHA.DirectorsOffice@state.or.us  
**Subject:** Telehealth

OHA should (if you already have not) ask for a federal waiver on the Telehealth requirement to have the patient be in an "originating site" in order to bill for the Telehealth services. The current CMS rules do not allow providers to access patients unless they travel to a hospital, physicians office etc (originating site). In addition, the originating site can charge a fee. So now the Telehealth service has two charges not one and the patient has to travel needlessly.

Given the current advances in videoconferencing capabilities within peoples' homes, it only make sense that we access patients in their home for some telemedicine services. Oregon should be a leader in developing and piloting this shift in healthcare provision within the patient's home. CCOs will want to do this since it just makes sense. And, if we can get a federal waiver then it will be easier to get the commercial insurers to follow.

Case in point; it's now snowing outside and our clinic should be seeing patients. Many of our scheduled patients had to cancel today because of the snow. If we could bill for the service we could be accessing them in their home or at any secure computer site that had webcam and internet access. There is a severe psychiatrist shortage on the coast and many of our patients have to travel the coastal range to get care here in Corvallis. It seems like a no-brainer to be able to provide needed services in a way that is actually convenient to patients, doesn't waste gas and doesn't put Oregonians at risk by driving in bad weather.

Please add this to your list of things to do.

mm

*Michael A. May, MD*  
**Chief of Psychiatry, Psychiatry Residency Training Director**  
**VP/Medical Director, Samaritan Mental Health**  
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**From:** sharon botchway <grateful50@live.com>  
**Sent:** Tuesday, March 27, 2012 2:16 PM  
**To:** ohpb.info@state.or.us  
**Subject:** health care concern

**Categories:** OHPB Comments

Hi There,

I wanted to communicate a concern I have had over the coming health care changes. There is talk of these insurance exchanges, and how the competition will naturally drive down the health insurance costs. So, I'm really concerned that that will not actually happen. What would stop the insurance companies basically all agreeing that they won't lower cost? I would expect them to pull SOMETHING that will keep the costs high. What is being done to address this? Am I the only one concerned about it? I haven't heard anyone, anywhere talk about this.

I just lost my health insurance from work. I now need to buy individual policies for myself and my 2 kids. We do have pre-existing conditions. COBRA will cover us for \$1600/month. Or I can buy our own for around \$900/month, but pre-existing excluded for me, and deductible of 2000+. WHO can afford that????? Who? I am very discouraged and don't trust these insurance companies for 2 seconds. I am all for the changes that are coming, I just believe we are in for a shock at what it turns out to really cost. I hope we can do something proactively to prevent this. I work as a nurse practitioner and really feel we need a system something similar to Canada's.

Thanks,

Sharon Botchway, FNP, CNM

**From:** Joanna Pipes <joanna.pipes@pcc.edu>  
**Sent:** Wednesday, March 28, 2012 2:27 PM  
**To:** OHPB.info@state.or.us  
**Subject:** I'd like to take part in a public meeting  
**Attachments:** Timeline.docx

**Categories:** OHPB Comments

Since the signing of **Senate Bill 1580**, I have become increasingly interested in sharing my perspective as a recipient of OHP mental health care. I recently contacted the citizens representatives regarding difficulty in accessing care through the cco's in Wa. County. As of now although I have received a call back, I have had no increase in access to care through Lifeworks. I must say that I believe increasing the number of cco's isn't the answer. I think the best most economical answer is to have care managed by pcp's. I have attached the same report I have submitted to the Governor's office and Senator Merkley's office. I think it outlines that the failure is not from the number of cco's but the lack of regulation once the insurance companies pass all governance of cases to the negligence of the cco's.

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**From:** alex Ramirez <smiles4u08@yahoo.com>  
**Sent:** Monday, April 02, 2012 7:51 AM  
**To:** OHPB.info@state.or.us  
**Subject:** ATTENTION PLEASE READ VERY CONCERNED.

**Categories:** OHPB Comments

Hello there:

My Name is Alexandra Ramirez and I am currently living in Springfield Oregon. Being out here I was really bothered with a Fast Food Restaurant (Jack in the Box) and ALL the employees were not wearing any gloves. Now I been working in the food industry for five years now and I haven't lived in any state that requires you NOT to wear gloves, so my QUESTION: is Oregon really not a state yet that has passed that rule?

With no gloves just because you wash your hands does not mean you are clean. The young lady was touching her face moving from position to position and then touching food which is not acceptable. I just know this because like I said I been trained. The answer the Manager on the shift excuse was they are new, AND OREGON IS NOT REQUIRED TO WEAR GLOVES. I don't care if your new you are handling people's food. People's nails are dirty you don't know what they really do and only washing your hands every hour is nasty. You should be constantly washing your hands. Not only that but you it's not sanitary. It is just plain out nasty.

My concern was brought to his attention, but if people knew that their food was being made like that who would want to eat it. I do hope if this state does not require it, it really needs to get it started so eating out can be clean, and sanitary and that you can feel safe eating there.

Hoping to hear back from you

Very Concerned and I hope you can give me some answers

Thank You,

Alexandra Ramirez