PUBLIC COMMENTS
SUBMITTED VIA E-MAIL
April 2008

COMMENTS ARE ORGANIZED BY BUDGET THEME.
Comments that addressed more than one theme were placed under the theme that seemed most closely related. Comments are listed in the order they were received.

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1. VULNERABLE OREGONIANS HAVE ACCESS TO HEALTH CARE.

None.

2. OREGONIANS HAVE ACCESS IN THEIR COMMUNITIES TO THE MENTAL HEALTH CARE AND ADDICTIONS TREATMENT THEY NEED.

After reading the survey done on the Oregon State Hospital in November of 2007 by the Department of Justice, which cites many deficiencies, I wonder why more money is not put into mental health programs. Further, I wonder why Eastern Oregon Training Center is not used as a resource to aide OSH's needs. There is supposed to be a 16-bed unit opening here in the future with only 16 beds taken out of the 80 beds this facility once had. Why cannot more clients from OSH be moved here? There is another Oregon here on the east side of the state that has employees willing to work for clients who need care as they have since 1912 when Eastern Oregon State Hospital opened. Our facility is full of seasoned employees who do a great job with clients. It is a shame that some of us will have to go back to the private sector as nurses and caregivers when EOTC closes.

In 1955, there were 350 beds per 100,000 people for mental health issues in this country. Now, Oregon has 19 mental health beds per 100,000 people. Where have those other client cases gone after the decentralization of mental health care? They have gone to being homeless, to prisons, or died from lack of resources to care for them.

Therefore, I believe that reinstating mental health care before a client ends up in prison is a step in the right direction for humanity. It is inhumane to go to Portland and see the homeless lined up to check into a mission for the night well knowing that many of them are mentally ill. When the government of the United States decided to deinstitutionalize the mentally ill and put them on the streets to fend for themselves, it was a great mistake.

Moreover, I wish to see more money budgeted for mental health care and less money budgeted for Oregon prisons. Perhaps there would not be so many in our prison systems if proper mental health care was available to all Oregonians, perhaps crime would decrease, and no doubt the clients who need that care would have better lives.

Finally, I encourage you to find alternative measures to continue some type of client care at EOTC because, as evidenced by the Justice Department's survey of November 2007 at OSH, it is severely needed in our state. Hillary Clinton says, "It takes a whole village to raise a child." Well, further, it takes the whole of nurses and caretakers from all of Oregon to help the mentally ill. Why do we continue to guard them after they have committed crimes related to trying to survive on the streets as opposed to treating them as human beings with special needs? Please consider budgeting more money for the many Oregonians locked into a mental health system that just does not have the funds to deal with them appropriately, and instead deals with them inappropriately by turning them out into a society where they just cannot make it on their own accord.

3. SENIORS AND PEOPLE WITH DISABILITIES LIVE SAFELY AND INDEPENDENTLY IN THEIR COMMUNITIES.

This is to urge reinstatement of the General Assistance (GA) program in the 2009-2011 DHS budget. This program, which was discontinued years ago for budgetary reasons, serves disabled adults with no income or assets. It enables these adults to have a small income and health insurance while negotiating the 1-3-year-long process of applying for Social Security disability benefits. Once federal benefits are approved, the state is reimbursed for the income benefits distributed from the GA program.

Our social service agency assists many no-income seniors 55-64 years of age with housing services. The discontinuation of the GA program has made it

much more difficult to obtain housing for this very vulnerable group. Resumption of the GA program would greatly help us meet our community's goal of ending homelessness.

Overall, I am concerned with how the DHS leadership has provided for the seniors and people with disabilities served through DHS. While the level of investment on the surface may appear to support the needs of our populations, this is not true from the community partner perspective. We have not seen recognition of the needs of these growing service groups through the budget process. We have not seen the investment of funds into restoring lost services, programs or staffing, nor have we seen a budget that recognizes the systemic issues we will need to face given the growing demographic.

Specifically, the following need your attention in this process:

1) Replace the lost General Funds into the OPI Program and increase the budget so that we can begin to serve more seniors as well as people with disabilities.
2) Fund the remaining 5 percent of Equity for the Transfer AAAs.
3) Fund the workload standards that have been developed and recommended by outside consultants.
4) Develop a funding plan that will address the investment in a pre-Medicaid system of services consistent with SB 1061 and The New Front Door concept.
5) Develop a budget that clearly partners with state housing programs to help local communities plan for and develop housing that is safe, accessible and affordable for our older adults and people with disabilities.

I am a disabled senior who has been designated disabled since 1997 at age 52. I have attempted many times to get services through Washington County Senior Disabled Services up to 2004 to no avail. I was placed on Social Security disability from 1999, back to August 1997.

In 1997 I was permanently disabled from work through multiple workplace injuries that affected my walking, lifting, housework, shopping, etc. I was

diagnosed later in the year with a congenital heart valve defect, scleroderma, lupus, IBS, fatigue, chronic pain and osteoporosis, to name a few. Preserving my strength and health was and is paramount, including undue energy exertion. I catch infections very easily such as colds and flu, I strain my muscles and connective tissue in my arms, hands, legs and joints with over-lifting and repetitive motions. I have injured my back repeatedly doing housework chores, and have to wear braces for my hands, hips, and back to remedy the pain and spasm cycles in addition to being on inadequate medications, requiring extended bedrest, down time and inactivity to restore my health.

In January 2000 I had to have emergency gall bladder surgery, a heart valve replacement in October and emergency double lumpectomies in June 2001, when I had not even fully recovered from the heart surgery. Unbelievably, I still could not get any services from this office.

In 2005 I was given light housekeeping assistance through the Oregon Project Independence program and continued with that program through November 2007.

I was eliminated at that point because I was not requiring “feeding, being bedridden or bathing assistance.” It didn’t seem to matter that with the well-documented illnesses I have, as well as being down all last summer from multiple injuries to my left foot and hip, and torn muscles and connective tissue to my left abdomen, that I was in no position to be dropped from the program and its assistance. I am still dealing as of this date with possible surgery soon to repair that damage. I have suffered the flu and cold with numerous relapses starting in September 2007 to March of this year.

I told the caseworker in November 2007 that I can’t carry my laundry baskets to the laundry room for muscle strain, do vacuuming, move furniture or even tuck in bedding when changing my bed. I have difficulty preparing meals, and many times will go without a decent meal due to fatigue. Cutting foods is hard for me, including slicing cheese, ironically. Standing for extended periods for food prep is a problem for me.

So, since the last housekeeper in September 2007, I have continued to strain my abdomen, increased bladder drop due to my strained abdomen, my other personal tasks have gone by the wayside, and will only get worse with the possible upcoming surgery.

And this is all in early 2008.

Funds need to be restored to OPI for my age group – seniors – for which the program was created in the first place. As in my case I feel having lost the services in November, I have had a very hard time medically. As a senior I am aging and have less energy in general.

I need this service at minimum. And I may not be the only one in my county as well as throughout the state.

4. CHILDREN ARE SAFE AND HEALTHY.

None.

5. FAMILIES ARE SAFE AND STABLE.

None.

6. DHS PROMOTES PREVENTION, PROTECTION AND PUBLIC HEALTH.

I was very pleased to hear from the Oregon Toxics Alliance about your plans for the forums and discussion about toxics in our communities. However, we were surprised to see you did not include the toxics we are breathing in our airshed, especially when we live near industrial polluters. Can you include this item in your planning?

I understand that you are planning your 2009-2011 budgets and would like to advocate for funding for birth defects surveillance. Surveillance is necessary to track the incidence of birth defects and identify communities and populations at higher risk. State-based surveillance systems will help health officials evaluate needs, deliver services, and implement and evaluate prevention programs. Research into the cause of birth defects is a critical step in developing cost-effective strategies to prevent them. All babies

should be given a chance to be born healthy and given a fighting chance if not.

We are one of only four states that do no currently have some type of birth defects surveillance systems. That is unacceptable.

A birth defects surveillance system will:

- Identify the incidence and clusters of birth defects,
- Establish a database to contribute to improved health status of infants and children,
- Expand access and linkages to existing programs and services for children with special health care needs,
- Increase prevention activities related to these special conditions, and
- Assist in the development of public health programs to enhance community prevention initiatives.

This will not only help our public health system offer more effective services, it helps our community by helping ensure all children are given the care they need to live a healthy life.

When considering the 2009-2011 budget planning, please budget for a Policy Option Package on birth defects surveillance! It is so important.

I write in support of proposals to institute a birth defects surveillance system in Oregon. I serve on the board of the Greater Oregon Chapter of the March of Dimes. Our organization is totally devoted to finding the causes of premature birth and fighting birth defects.

Surveillance is necessary to track the incidence of birth defects and identify communities and populations at higher risk. State-based surveillance systems help health officials evaluate needs, deliver services, and implement and evaluate prevention programs. Research into the cause of birth defects is a critical step in developing cost-effective strategies to prevent them.

Currently 46 states, the District of Columbia, and Puerto Rico have some type of birth defects surveillance systems. Oregon needs to join this list.

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Our organization has grant money available for these programs, but we need to be able to identify where it can best be put to use. Please consider adding this to the department's budget for the next biennium. I think you will find the benefit to cost ratio is very high.

I am writing to strongly recommend that Oregon develop a birth defects surveillance system. It is essential for epidemiologic research so that we can figure out high-risk areas and groups, and determine cost-effective ways to reduce the incidence of birth defects.

I can only speak with moderate authority about budgeting for Public Health. I understand that there are many competing services in Oregon that fall under the DHS umbrella.

Public Health has been grossly under-funded for some time. In addition, the funding that comes to LPHAs does not provide enough resources to meet the demands in program elements.

DHS:

1) Must prioritize PH as a necessary component of public safety,
2) Must develop a model of minimum capacity to achieve the required objectives, and
3) Must have a funding formula that first provides adequate base funding for minimum capacity in ALL public health departments.

After adequate base funding, per capita allotments are required.

1) Every possible dime that may come to LPHAs must be allocated by DHS – and not held at the state level. In times of diminishing resources, one must weigh the need for statewide trainings/meetings against providing funds to deliver direct services. These resources are used more effectively at the local level – DHS must shrink if dollars are to flow to local communities. DHS is finding that they cannot provide the level of service with the dollars typically allocated to LPHAs.
2) Without changes in funding/program requirements, I have great fears that my county – and many others – will attempt to relinquish LPHA. This does not bode well for Oregon
3) DHS must decide if PH is truly important. In small communities like ours (Coos County) it has been disastrous to allow a competing FPEP program. The promise of FPEP was to help build capacity and assist in loss of revenue due to the Title X program. This worked well in Coos County until a competing program – without the requirements of Title X – began to bleed off only FPEP clients. If this does not change, Coos County Public Health will have to severely restrict the FP program, which will result in the loss of public health nurses, affecting our ability to respond in general to public health issues. THIS IS NOT GOOD PUBLIC HEALTH POLICY. So, if family planning is an important component of public health, LPHAs should be given first consideration when plans of expanding are being discussed. If there will be a negative impact, DHS must refrain from allowing competing programs.

I have been at many meetings discussing the potential need to contract out Public Health services. PH is a system – and it works because it is a system. If one starts carving out services to non-PH agencies (e.g., WIC, Family Planning, Immunizations, OHP outreach), the most vulnerable populations will be negatively affected. Most clients need a variety of PH services. Putting people in a position to have to travel to several different agencies or providers – especially with limited financial and transportation resources – will likely result in their failing to get all the needed services.

I work for Lane County Public Health's Tobacco Prevention and Education Program. I recently attended the Community Forum held in Eugene and felt it might be useful to submit my comments in writing as well. I'd like to address specifically DHS's role in keeping people healthy because we know that preventing disease is the best way to reduce costs and improve quality of life.

In Oregon, the two biggest risk factors for chronic disease are tobacco use and obesity.

Tobacco is costing Oregonians $2.1 billion in medical expenses and lost productivity every year. We know that adults on OHP are almost twice as likely to smoke (36 percent) as compared to other Oregon adults (19 percent). As a result, Oregon's Medicaid program spends $278 million every single year on tobacco-related illnesses – many of the them chronic diseases such as cancer, heart disease, stroke and asthma.

In 1996 Measure 44 increased the cigarette tax by 30 cents, with 10 percent of those funds being dedicated to tobacco prevention and cessation. These funds created Oregon's Tobacco Prevention and Education Program (TPEP), which is based on CDC Best Practices and continues to demonstrate remarkable success in saving lives and saving the state money it would otherwise use to treat smokers.

In Lane County our local TPEP-funded program has worked to reduce the number of youth who start smoking, increase quit rates among smokers, and protect everyone from the dangers of secondhand smoke. Working with community coalitions, we've been able to pass a comprehensive smoke-free workplace ordinance in the City of Eugene, establish tobacco-free hospital campuses, reduce youth access to tobacco through local retail licensing laws, and promote tobacco-free events like the U.S. Olympic Trials.

As a result of programs like ours across the state, adult smoking has decreased 22 percent in Oregon. Cigarette smoking has declined almost 60 percent among Oregon's 8th graders and 46 percent among Oregon's 11th graders. Without these reductions, Oregon would have roughly 38,000 additional young smokers today. Overall cigarette consumption in Oregon has declined by 41 percent, compared with 31 percent across the nation. The effectiveness of tobacco prevention in Oregon is clear. It is also clear, however, that when tobacco prevention funding decreases, as it did in 2003,

decreases in cigarette consumption slow. Fortunately, funding was restored in 2007.

The CDC recommends that Oregon invest $43 million a year to comprehensively address tobacco use in the state. Current Oregon funding is $8 million annually, which is only 19 percent of the CDC's recommended investment level. Funding at the CDC-recommended level would allow Oregon to serve more communities and individuals using comprehensive evidence-based targeted interventions outlined by the CDC. I strongly encourage DHS to continue to advocate for and commit resources to preventing chronic disease through local research-based programs like TPEP. These programs have been proved effective and will save not only money, but lives.

Is there budget availability to have preventive oral care pilot programs for high school students, middle school, food assistant sites, shelters and convalescent care, with assessments, triage, cleanings, fluorides, oral care instruction, etc.? Thanks.

I am writing to request support and consideration for a birth defects surveillance program for Oregon. Oregon is one of just four states without a similar program. Surveillance is a necessary component for tracking, evaluation and research. As a family that lost a child due to a birth defect, we feel strongly that a system needs to be in place to help find answers for these difficult situations. Thank you for your consideration.

PLEASE REMEMBER THE Birth Defects Surveillance in Oregon WHEN PLANNING FOR YOUR BUDGET! THANK YOU!

Currently, Oregon does not have a birth defects surveillance system and simply collects data from birth certificates and has no mechanism for systematic confirmation and follow-up. Oregon is one of only four states that have no birth defects surveillance system in place.

A birth defects surveillance system will:

- Identify the incidence and clusters of birth defects,
- Obtain information to determine whether environmental hazards are associated with birth defects and poor reproductive outcomes in communities in Oregon,
- Establish a database to contribute to improved health status of infants and children,
- Expand access and linkages to existing programs and services for children with special health care needs,
- Increase prevention activities related to these special conditions, and
- Assist in the development of public health programs to enhance community prevention initiatives.

Thank you.

7. Services are safe and available in communities when they are needed.

I am writing as the representative of a private not-for-profit provider of residential services to adults with developmental disabilities. Oregon Mennonite Residential Services (OMRS) has been in operation since 1986. We provide services in eight group homes to adults who require significant supports in Yamhill and Linn counties.

We are very grateful for the increase that went into effect February 1 of this year. We are, however, reluctant to pass it on in the form of higher wages to our 85 employees, based on our previous experience of no COLAs for four years while the minimum wage continued to increase. Our staff members are not adequately paid for the work they do, and our turnover rate is very high.

I am aware that people don't do what our employees do for the money, but the fact that the turnover rate among the staff of state-operated group homes is much lower suggests that pay and benefits do make a difference. OMRS does a great job of ensuring that the people we serve have their needs met, but we do it at the expense of our staff.

We know there is a lot of competition for Oregon's dollars. We appreciate efforts to ensure that the needs of individuals with developmental disabilities, as well as the people who care for them, are met. Thank you.

I believe there are certain things that should be taken into consideration. I have listed these in no particular order.

1. There are competing interests and forces at play. There is pressure for efficiency, for expansion, for more services to more people. More bang for the buck! And there is pressure for quality, for evidence-based activities, for wraparound, community-based services. These cost more. So one area of competing interest is efficiency vs. quality. Which is the higher value in Oregon????
2. We need to have an adequately reimbursed work force. Currently we are not able to attract, employ and retain quality staff. Governmental employees are paid and benefited way better than non-profit contractors, and government is able to hire staff from non-profit agencies. It is this private non-profit sector that is on the verge of not being able to sustain programs as their costs continue to increase. The historically high quality of the service sector in Oregon is on the verge of collapse because non-profit organizations cannot support themselves with government contracts.
3. In particular it seems like the drug and alcohol treatment system and parts of the mental health system are grossly under-resourced.
4. Prevention can reduce costs in the future. While we know this, it is still hard to fund quality prevention services. We need to have budget people take a 25-year perspective.
5. Prevention will never eliminate all high-cost services. Available funding needs to be allocated across the continuum of services so that no particular type or level of service is funded more than others, or there will be an imbalance in the system that will create a little wobble that may result in eventual system collapse.
6. Perhaps we are committed to a little too much incarceration and should fund other services as well – diversion, A&D treatment, job preparedness, mental health tax, etc.
7. Foster parents are community heroes. They raise kids who need additional life supports. Foster parents need a lot more recognition in the form of supports and resources, including higher monthly payments.
8. Supporting enrollment on OHP is a good thing. State funds are stretched by matching with federal funds. Resources are provided throughout the health care system that reduce the challenges

associated with un/underinsured citizens. This can extend health care coverage until we have universal coverage and will help support health care providers.

9. People with disabilities have huge challenges in supporting themselves, finding employment, accessing housing and living in the community. They often are dependent on governmental support. SSI is absolutely inadequate. There is some evidence that this population may increase in the future, particularly with mental health and autism-type conditions. We need to begin building a system of supports for these folks in the future so we are not caught completely unprepared.
10. We need to fully fund the brokerage system for people with developmental disabilities.
11. We should increase the tax on all alcohol and use this for treatment costs. A tax might reduce teenage drinking a little bit.
12. It would also be good to find a way to tax illegal drugs. Again, to reduce demand and pay for treatment. But do you tax the seller or the purchaser??? I don't know.

My mother, sister and I came from Romania in 1969, not knowing a word of English. As a result, life was hard, especially for a few months until I was able to learn enough English. However, we would not have survived if we would not have had the help of some very good people. Help took the form of financial, moral, as well as instructions in the ways and laws of the U.S. In Oregon there are volunteer agencies to help refugees, but no such situation existed in 1969 in Illinois. For us it was like landing on another planet, but in the end we were able to adapt.

We were extremely lucky because we were healthy, so not knowing the language and not having health insurance did not affect us as it would have otherwise.

I have worked as a Health Assistant/Romanian interpreter for Multnomah County Health department for five years (when I was not there no one could communicate), and have experienced the importance of providing interpretation in a health care setting. It's also a requirement of Title VI.

Currently I am in the position of hiring interpreters as well as managing interpretation contracts with private and non-profit agencies to provide interpretation for our clients.

I cannot emphasize enough the importance of providing quality interpretation for LEP individuals. Of course, quality interpretation means that interpreters need to be paid, so we need funding.

Thank you for your time and consideration.

8. DHS HAS THE CAPACITY TO MEET CLIENTS' NEEDS.

None.

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