

Withdrawal/Redaction Sheet

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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. note	Note re: Potential Parent to Speak at June 29 Children's Health Event (partial) (1 page)	01/26/1999	P6/b(6)
002. fax	Post-It Fax note re: phone number (partial) (1 page)	01/27/1999	P6/b(6)
003. fax	Post-It Fax note re: phone number (partial) (1 page)	01/27/1999	P6/b(6)
004. list	Suggested Attendees for the White House Mentoring Event (partial) (7 pages)	01/27/1999	P6/b(6)

COLLECTION:

Clinton Presidential Records
Domestic Policy Council
Eric Morse (Events)
OA/Box Number: 21192

FOLDER TITLE:

Asthma Budget Rollout 1/28/1999

2011-0619-S

rc288

RESTRICTION CODES

Presidential Records Act - [44 U.S.C. 2204(a)]

Freedom of Information Act - [5 U.S.C. 552(b)]

P1 National Security Classified Information [(a)(1) of the PRA]
P2 Relating to the appointment to Federal office [(a)(2) of the PRA]
P3 Release would violate a Federal statute [(a)(3) of the PRA]
P4 Release would disclose trade secrets or confidential commercial or financial information [(a)(4) of the PRA]
P5 Release would disclose confidential advice between the President and his advisors, or between such advisors [(a)(5) of the PRA]
P6 Release would constitute a clearly unwarranted invasion of personal privacy [(a)(6) of the PRA]

b(1) National security classified information [(b)(1) of the FOIA]
b(2) Release would disclose internal personnel rules and practices of an agency [(b)(2) of the FOIA]
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b(4) Release would disclose trade secrets or confidential or financial information [(b)(4) of the FOIA]
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b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

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PRM. Personal record misfile defined in accordance with 44 U.S.C. 2201(3).

RR. Document will be reviewed upon request.

Agency (EPA), together with the Department of Education, will invest \$8.4 million to expand school based programs that teach children how to identify and avoid allergens that trigger an asthma attack, as well as why it is important to use their asthma medication and their inhalers. EPA will also expand programs that educate teachers and building maintenance staff to help them eliminate potential triggers from the school environment. With this investment, over 2 million children will be able to breathe easier in their classrooms.

- **Researching the Link Between Environmental Factors and Asthma.** The Environmental Protection Agency will spend \$5 million to expand its research into the role that environmental hazards (including chemicals, particles, ozone, diesel exhaust, pesticides, tobacco smoke and allergens) play in the onset of childhood asthma and to develop better and more practical strategies for improving the quality of life for children with asthma. The Environmental Protection Agency will also invest \$1 million to conduct a pilot program to expand air pollution monitoring in up to two communities downwind of industrialized urban centers to better understand the relationship between air pollution and asthma.
- **Implementing new disease management strategies to target low income children.** The Department of Health and Human Services will provide \$50 million in competitive grant funds to States who submit disease management programs to identify and treat asthmatic children in their Medicaid fee for service programs in accordance with the new disease management guidelines developed by the National Institutes of Health. These guidelines will help to ensure that children receive the appropriate medication and are taught how to effectively manage their illness.
- **Creating of a new national public information campaign.** The Environmental Protection Agency and the Department of Health and Human Services will invest \$6.2 million in a national public information campaign to reduce children's exposure to environmental tobacco smoke and other indoor asthma triggers through a national public service campaign that uses posters, flyers, and brochures that identify common asthma triggers, such as pet hair or tobacco smoke and simple solutions for eliminating or avoiding them; expands existing in-home education networks, such as the Healthy Indoor Air program, and utilizes Americorps and VISTA volunteers to provide direct assistance to parents in identifying asthma triggers and implementing effective intervention strategies; and using health care providers and managed care organizations to help parents reduce their children's exposure to asthma triggers.

**FIRST LADY HILLARY CLINTON UNVEILS NEW \$72 MILLION INITIATIVE
TO FIGHT CHILDHOOD ASTHMA
January 27, 1999**

Today, First Lady Hillary Rodham Clinton unveiled a new, \$72 million initiative to fight childhood asthma through a comprehensive, Administration-wide strategy to address childhood asthma that includes new efforts to: (1) implement school based programs that teach children how to prevent asthma attacks and how to deal with an attack if they have one; (2) reduce children's exposure to pollutants in our environment that can trigger asthma attacks; (3) provide funds to States and providers to help them implement effective disease management strategies; and (4) conduct a new public information campaign to reduce exposure to asthma triggers.

MILLIONS OF CHILDREN SUFFER FROM ASTHMA

- **Asthma is a serious public health problem.** Approximately 5 million children suffer from asthma, and the incidence of the disease in children under age five has increased 160 percent over the past 15 years. Thousands of children are hospitalized each year because of asthma, making it the leading cause of hospitalization due to chronic illness for children. Asthma is also one of the leading causes of school absenteeism, resulting in over 10 million missed school days each year.
- **Minority children experience disproportionate rates of asthma related deaths.** Although African American children under the age of 18 have only a slightly higher risk of actually having asthma than non-Hispanic white children, they experience a disproportionately high rate of death from asthma attacks. In 1995, the rate of death from asthma for African Americans was over four times the rate for white children.
- **Many asthma sufferers are unaware that there is help for them.** Many asthma patients remain chronically impaired because their physicians and others involved in the management of their asthma are not sufficiently familiar with the new guidelines for treating asthma. Still others lack support systems that enable them to effectively manage their own disease or access sufficient medications or equipment.

LARGEST EVER FEDERAL INVESTMENT TO FIGHT CHILDHOOD ASTHMA

The President's Task Force on Children's Environmental Health and Safety Risks has prepared a comprehensive, Administration-wide strategy to fight childhood asthma. Today, in response to the Task Force recommendations, the First Lady announced new investments in:

- **Implementing school based asthma programs.** The Environmental Protection

Agency (EPA), together with the Department of Education, will invest \$8.4 million to expand school based programs that teach children how to identify and avoid allergens that trigger an asthma attack, as well as why it is important to use their asthma medication and their inhalers. EPA will also expand programs that educate teachers and building maintenance staff to help them eliminate potential triggers from the school environment. With this investment, over 2 million children will be able to breathe easier in their classrooms.

- **Researching the Link Between Environmental Factors and Asthma.** The Environmental Protection Agency will spend \$5 million to expand its research into the role that environmental hazards (including chemicals, particles, ozone, diesel exhaust, pesticides, tobacco smoke and allergens) play in the onset of childhood asthma and to develop better and more practical strategies for improving the quality of life for children with asthma. The Environmental Protection Agency will also invest \$1 million to conduct a pilot program to expand air pollution monitoring in up to two communities downwind of industrialized urban centers to better understand the relationship between air pollution and asthma.
- **Implementing new disease management strategies to target low income children.** The Department of Health and Human Services will provide \$50 million in competitive grant funds to States who submit disease management programs to identify and treat asthmatic children in their Medicaid fee for service programs in accordance with the new disease management guidelines developed by the National Institutes of Health. These guidelines will help to ensure that children receive the appropriate medication and are taught how to effectively manage their illness.
- **Creating of a new national public information campaign.** The Environmental Protection Agency and the Department of Health and Human Services will invest \$6.2 million in a national public information campaign to reduce children's exposure to environmental tobacco smoke and other indoor asthma triggers through a national public service campaign that uses posters, flyers, and brochures that identify common asthma triggers, such as pet hair or tobacco smoke and simple solutions for eliminating or avoiding them; expands existing in-home education networks, such as the Healthy Indoor Air program, and utilizes Americorps and VISTA volunteers to provide direct assistance to parents in identifying asthma triggers and implementing effective intervention strategies; and using health care providers and managed care organizations to help parents reduce their children's exposure to asthma triggers.

Date: _____

FAX**Health Division**

Office of Management and Budget
Executive Office of the President
Washington, D.C. 20503

To: Neera Tandon**Fax:****Phone:** 6x2878**From:** Cindy Smith**Number of Pages (not including cover):** 1**Subject:**

Budget summary of Asthma proposal (Medicaid only)

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5. STRENGTHENING HEALTH CARE

7

sands of high-risk youth, families moving from welfare to work, and other underserved Americans. To help communities address gaps in substance abuse treatment for emerging areas of need, the budget proposes \$76 million for Targeted Capacity Expansion grants. This proposed funding level is triple the 1999 funding level and will provide treatment for another 18,000 individuals.

- *Improving asthma treatment for Medicaid beneficiaries:* The budget proposes \$50 million in demonstration grants to States test innovative asthma disease management techniques for children enrolled in Medicaid, to help these children receive the most appropriate care, and keep their asthma in check. To judge the success of the project in improving asthmatic children's quality of life, participating States would measure the program's success in averting asthma related crises—such as decreased emergency room visits and hospital stays. To complement these efforts, the budget provides \$28 million for the Environmental Protection Agency's (EPA) childhood asthma initiative for education and outreach, research, and expansion of EPA's outdoor pollution air monitoring network.
- *Creating superior public health surveillance:* The budget proposes \$65 million to develop and implement a new National Electronic Disease Surveillance Initiative at the Centers for Disease Control (CDC). A standardized national system to collect and analyze epidemiological information on communicable disease outbreaks is a critical missing link in the Nation's public health infrastructure, and will help address similar problems such as the emergence of the drug-resistant bacteria—so called superbugs—as well as food safety and bioterrorism.

The budget also proposes an increase of 17 percent, or \$190 million, over the 1999 level for FDA to: 1) ensure the timely review of important drugs, medical devices, and food additives; 2) expand inspection coverage of facilities under their jurisdiction (e.g., registered blood banks); and 3) improve the quality of information on inju-

ries and product defects associated with FDA-regulated products. The budget proposes an increase of \$178 million, on a comparable basis, for the CDC to improve public health surveillance, expand immunization coverage for children, promote additional occupational health and safety research, and increase research and prevention efforts on violence against women.

- *Improving public health's response to bioterrorism threats:* The budget proposes a \$71 million, or 45-percent, increase for medical and public health response and preparedness related to potential terrorist use of biological and chemical weapons. At this level, HHS will expand research and development activities on potential biological and chemical terrorist agents, including research on smallpox and anthrax vaccines and therapeutics and expedited regulatory review to facilitate these activities. This increase would improve public health surveillance of these threats and expand epidemiological and laboratory capacities to address such incidents, at the national, State and local levels. The proposed increase would also support more than 25 new local health care response systems (Metropolitan Medical Response Systems). These funds will be in addition to investments in the Departments of Defense and Justice.
- *Enhancing food safety:* The budget increases funding by \$72 million, or 24 percent, over the 1999 level for the Administration's inter-agency food safety initiative. The additional funds would increase the frequency of inspections of high-risk domestic establishments, double inspections and evaluations of foreign food establishments, improve science-based inspections of meat and poultry plants, and expand food safety research, risk assessment, education and surveillance activities. In 1998, the President's Council on Food Safety was formed to develop a comprehensive strategy for Federal food safety activities, including coordinating research efforts and budget submissions among the various food safety agencies.
- *Promoting childhood immunizations:* The budget proposes \$1.071 billion for the



UNITED STATES ENVIRONMENTAL PROTECTION AGENCY
WASHINGTON, D.C. 20460

OFFICE OF
THE ADMINISTRATOR

TO:

Neera Devnani X65557
456 2878

FROM:

Stephanie
260 7960

COMMENTS:

Attached is a draft
fact sheet -- it does
not include HHS

Number of Pages to follow: _____

Date: _____

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DRAFT

A NATIONAL STRATEGY TO FIGHT CHILDHOOD ASTHMA

Assumes \$50 million budget for this

Today, the First Lady is unveiling the Clinton Administration's national strategy and the largest ever federal investment to fight childhood asthma. Building on the Administration's 6-year effort to protect children's health, the Clinton Administration is dedicating \$72 million in FY 2000 to address the growing asthma rates among the nation's children. This Administration-wide effort -- to be lead by the U.S. Environmental Agency and the Department of Health and Human Services -- will fund important efforts to determine the cause of childhood asthma, reduce children's exposure to pollutants in our environment that can exacerbate asthma, and implement initiatives for education, outreach and air monitoring in communities across the nation.

A Dramatic Increase in Asthma Rates. Recent reports have found an alarming rise of childhood asthma in the United States. Approximately five million children now suffer from asthma; even more troubling, the incidence of asthma in children under age five has increased 160 percent from 1980 to 1994. With 150,000 children being hospitalized each year from asthma, it is now the leading cause of hospitalization for children due to chronic illness, at a cost of \$1.9 billion in medical expenses every year. And children are hospitalized more than any other age group. Asthma is also the leading cause of school absenteeism among school children due to chronic illness, costing 10 million missed school days each year.

A National Strategy. Recognizing the importance of fighting childhood asthma, the President's Task Force on Children's Environmental Health and Safety Risks prepared a comprehensive, Administration-wide strategy to address environmental factors that play a crucial role in causing and worsening childhood asthma. This strategy calls on the U.S. Environmental Protection Agency, the Department of Health and Human Services and other agencies to work together to strengthen and accelerate research into the environmental factors that cause of worsen childhood asthma, implement public health programs to reduce environmental exposures to asthma triggering pollutants, and establish a coordinated nationwide asthma surveillance system to track asthma rates, identify high risk populations and environmental risk factors, and develop community-tailored plans to alleviate asthma risks.

Assumes \$50 million for this

The Largest-Ever Federal Investment. The President's FY2000 budget includes \$72 million to fight childhood asthma. This includes \$22 million for the U.S. Environmental Protection Agency to address environmental factors that contribute to the rising rates of asthma. These funds will help reduce children's exposure in the home, schools, and day care facilities to known asthma triggers such as secondhand smoke and indoor allergens (e.g. dust mites, animal dander, insects, and mold) by:

Implementing School-based Programs: The U.S. Environmental Protection Agency, in cooperation with the Departments of Health and Human Services and Education, will invest \$8.4 million to expand outreach and educational programs to inform parents, teachers, and children about how to improve indoor air quality for children with asthma and manage potential asthma triggers. With this investment, 2 million children across the nation will breathe cleaner air in their classrooms.

Creating a New National Public Information Campaign: The U.S. Environmental Protection Agency and the Department of Health and Human Services will work together to develop and implement a national public information campaign to reduce children's exposure to secondhand

smoke and other indoor asthma triggers. This campaign will include: a \$4 million dollar national public service campaign and expanded community-based outreach programs; a \$1 million dollar expansion of existing in-home education networks to provide direct in-home assistance to help parents identify asthma triggers and implement effective strategies to reduce health risks; and \$1.2 million dollars to better equip health care providers to educate children and their parents about ways to reduce exposure to asthma triggers.

Researching the Link Between Environmental Factors and Asthma: The U.S. Environmental Protection Agency will spend \$5 million to expand its research into the role that environmental hazards (including chemicals, particles, ozone, diesel exhaust, pesticides, tobacco smoke and allergens) play in the onset of childhood asthma and to develop better and more practical strategies for improving the quality of life of children with asthma. EPA will also invest \$1 million to conduct a pilot program to expand air pollution monitoring in up to two communities downwind of industrialized urban centers to better understand the relationship between air pollution and asthma.

(NEED INFO ON HHS BUDGET)



EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF MANAGEMENT AND BUDGET
WASHINGTON, D.C. 20503

*Hope you
got this*

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Name

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X 6557

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Neera Tanden

X 6287B

From:

Claudia Magdalena Abendroth

Message:

DRAFT EPA write-up

*Sections w/ asterisks are questionable and are
going through OMB clearance now.
I will let you know when we
have cleared the entire document.*

Number of Pages to Follow:

2

Date:

26 Jan '99

Time:

DRAFT

The Environmental Protection Agency's Children's Asthma Initiative

Asthma is reaching epidemic proportions among American children today, especially in poor urban communities. Nearly 6 million children suffer from asthma ~~and many more children have the disease but simply have not been diagnosed~~. The number of children with asthma has doubled over the past fifteen years and is spreading most rapidly among young children. In fact, the incidence of asthma increased 160 percent for children under 5 years old from 1980 to 1994.

The health implications of asthma are significant. With 150,000 children being hospitalized each year, asthma is now the leading cause of hospitalization for children due to chronic illness. Even when asthma symptoms are not severe enough to cause hospitalization, they can still be severe enough to prevent an asthma sufferer from living a normal life. For example, children with asthma miss twice as many school days as other children and asthma has become the leading cause of school absenteeism due to chronic illness. In total, there are 10 million missed days of school as a result of asthma symptoms. The overall cost of asthma to the U.S. economy was estimated to be \$6.2 billion in 1990 (not just children). *Minority children & children living in poverty bear a disproportionate burden from asthma, suffering a much higher rate of hospitalization & death from asthma.* Scientists do not understand the reasons for the worsening trends in asthma or why lower socio-economic groups are more severely impacted. However, there is consensus that reducing children's exposure to known asthma triggers, such as secondhand smoke and indoor allergens, will reduce the frequency and severity of asthma attacks.

Recognizing the importance of asthma, the President's Task Force On Environmental Health Risks and Safety Risks to Children prepared a comprehensive and coordinated cross-government initiative to address environmental factors that play a crucial role in causing and worsening childhood asthma. The guiding principles of the initiative include an emphasis on: reducing the disproportionate burden of asthma on the poor and minorities; community-based programs; partnerships between government, non profits and the private sector, and evaluation of programs.

The Clinton Administration is committed to reducing the burden of asthma on children, their families and society. Over the next three months, EPA, HHS and other Federal partners will work with the private sector to develop a final ~~an~~ action plan that will prepare us to move expeditiously in FY 2000 to implement the initiative in close partnership with all interested government and non-government organizations.

EPA already has invested \$5 million in this fiscal year (FY99). EPA proposes to invest an additional \$17 million in FY2000 to address environmental factors that contribute to the worsening asthma trends. These investments will be a significant step toward reducing children's asthma. The focus of these investments is to reduce children's exposure in the home, schools, and day care facilities to known asthma triggers such as secondhand smoke and indoor allergens (e.g. dust mites, animal dander, insects, and mold). These investments include:

Implementing School Based Programs. EPA, in cooperation with DHHS and the Department of Education, will invest \$8.4 million to expand implementation of EPA's Indoor Air Quality Tools for Schools program, and to substantially expand the

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availability of the "Open Airways" and "A is for Asthma" elementary and pre-school asthma management programs, developed by the American Lung Association. EPA's Indoor Air Quality Tools for Schools program provides practical information in a checklist format for school personnel to improve the quality of indoor and make air our schools safer for children with asthma by managing potential asthma triggers. With this investment, EPA hopes to help more than 2 million children breathe cleaner indoor air in their schools and to be better equipped to manage their asthma, for those children with the disease.

Creation of a new national public information campaign-- EPA and DHHS will work together to conduct a national public information campaign to reduce children's exposure to environmental tobacco smoke and other indoor asthma triggers which will include:

--\$4 million in funding for a national public service campaign and community based programs.

[--\$1 million to expand existing in-home education networks such as the USDA Extension Service's Healthy Indoor Air for America's Homes program to provide direct in-home assistance to parents in identifying asthma triggers and assisting parents in implementing effective intervention strategies.] *

--\$1.2 million to better equip health care providers, including managed care organizations, to educate children and their parents about ways to reduce exposure to asthma triggers.

Improving our understanding of the link between environmental factors and asthma. EPA will also spend \$5 million to expand its research into the role which environmental pollutants (including chemicals, particles, ozone, diesel exhaust, pesticides, tobacco smoke and allergens) play in the onset of asthma in children and to develop better and more practical strategies for improving the quality of life of children with asthma. EPA will also invest \$1 million to conduct a pilot program to expand **ambient ozone and particulate monitoring** in 1-2 communities downwind of industrialized urban centers to better understand the relationship between ambient air pollution and asthma.

Clinton Targets Childhood Asthma

Associated Press

President Clinton will ask Congress for \$68 million to attack childhood asthma and \$40 million to subsidize the training of pediatricians by children's hospitals, according to the White House.

Both initiatives will be included in the proposed fiscal 2000 federal budget Clinton will submit next week, said the official, speaking on the condition of anonymity.

The asthma plan, to be announced today at the White House,

was billed as the "first-ever comprehensive, administration-wide strategy" to fight the disease. Most of the money—\$50 million—would be used for competitive state grants to identify and treat poor children who have asthma and are served by Medicaid.

First lady Hillary Rodham Clinton was scheduled to unveil the proposed new subsidies for training pediatricians in a speech at the National Press Club.

The government helps pay for the training doctors receive by reim-

bursing hospitals through the Medicare program for the elderly. But that system is based on the number of Medicare patients a hospital sees, creating a disadvantage for hospitals that mainly treat children.

Children's hospitals lose money each year, more so than other teaching hospitals partly because of this inequity, the administration contends. The \$40 million would come through an existing grant program and would amount to about \$9,380 per resident. The average hospital would receive \$689,000.

Light Linked to Gamma Ray Burst

Eruption Originated About 10 Billion Light-Years Away

Associated Press

For the first time, astronomers have recorded visible light from the source of a gamma ray burst, a mysterious deep space eruption more powerful than the energy of 10 million billion stars, researchers report.

The gamma ray burst was detected at 4:47 a.m. EST Saturday by two orbiting observatories. News of the event was relayed through a network to astronomers. Ground-based telescopes were able to capture optical light from the fading afterglow that followed the 110-second peak of the burst.

Gamma ray bursts are common, happening several times a week. But they come and go so swiftly that astronomers have never before been able to link optical observations with the gamma ray detection.

Officials said the stellar eruption originated about 10 billion light-years away but was so powerful in visible light that it could have been sighted from the ground with binoculars if, by chance, someone had been looking.

NASA said that the burst appeared to originate from near the constellation Corona Borealis, visible in the predawn northern sky.

The gamma ray burst phenomenon was discovered in 1967. They occur randomly across the sky several hundred times a year, with the peak of each burst lasting from a few milliseconds to a few minutes. Astronomers do not know their origin or precise cause; some speculate that the bursts originate from black holes. Since gamma rays are invisible to the eye, the eruptions were unknown until the development of gamma ray detectors.

The burst last Saturday was detected by NASA's Compton Gamma Ray Observatory and by the Italian-Dutch satellite BeppoSAX. Both satellite observatories regularly monitor the sky in search of such stellar events.

The satellites pinpointed the sky location of the burst, and the data were relayed quickly to other observers. Visible light was then detected by teams from the California Institute of Technology using a telescope at the Mount Palomar Observatory in California and by observers from Washington's Carnegie Institute, using the Keck II telescope in Hawaii.

Based on the measured intensities of the light and the gamma rays, experts estimated energy released from the explosion could have been equal to the energy of 10 million billion stars like the sun.

The Washington Post

THURSDAY, JANUARY 28, 1999

Senators Exploring a Form of Censure Are Bumping Into Obstacles

By ERIC PLANIN and JOAN BISKUPIC
Washington Post Staff Writers

With conviction of President Clinton now seemingly out of reach, many senators of both parties are anxious to ensure that Clinton does not emerge unscathed and unpunished from his Senate trial.

"The president's behavior was inexcusable, not impeachable," Senate Minority Leader Thomas A. Daschle (S.D.) said yesterday. "The president should not and will not be removed from office. The president should and will receive sanction and rebuke."

There is no consensus on how the trial should happen, but several approaches have been floated. One would be to censure the president after the trial is concluded; another would be to adopt "findings of fact" that would detail his alleged misconduct in the Monica S. Lewinsky affair before a final vote on the two impeachment articles.

Yet there are serious political and legal obstacles to each. The findings-of-fact proposal, proposed by Republicans, has drawn sharp attacks from some Democratic leaders and the White House.

"It's a crass political cheap shot, that's all it is," one Clinton adviser said.

And while House and Senate Democrats overwhelmingly favor censuring the president once the trial is over, many conservative Republicans argue that censure is unconstitutional and say they would oppose it.

Legal experts say any proposal for

separate votes on whether Clinton is actually *guilty* of particular charges and whether he should be removed from office likely would be forbidden.

While the Constitution gives little guidance on how to run an impeachment trial, it makes clear that if the president is convicted of "high crimes and misdemeanors" he must be ousted. Article II, which deals with the executive branch, says the president "shall be removed from office on impeachment for, and conviction of, treason, bribery, or other high crimes and misdemeanors." Article I, which covers the Senate's part, says that the penalty for impeachment "shall not extend further than to removal from office."

Many constitutional scholars say that means if the Senate were to find Clinton guilty of the House charges, he automatically would be expelled. "The sanction for conviction is removal from office," said University of Virginia law professor John C. Jeffries Jr. "That is not 'if the Senate wishes.' That's the constitutional command."

Yesterday a GOP task force headed by Sens. Pete V. Domenici (N.M.) and Olympia J. Snowe (Maine) met twice to complete a draft of a proposed "findings of facts" resolution, one that closely parallels the details of the House's allegations of perjury and obstruction of justice against Clinton but that lacks the force of the impeachment articles themselves.

"We have a number of senators who have said they abhor what has happened... but that they don't think they could vote to remove him," Domenici said.

Senate Majority Leader Trent Lott (R-Miss.) and other leaders have indicated that the resolution might be offered for consideration prior to the Senate's final vote on the two articles of impeachment. Republicans, who hold a 55 to 45 vote edge, believe they could push it through with a simple majority. However, the White House contends it would take a two-thirds majority to pass the measure, and Democrats are expected to mount vigorous opposition.

"That's not going anywhere," Sen. Tom Harkin (D-Iowa) said. "And I don't think it will fly with all the Republicans either."

The proposed findings would cover certain elements of perjury and obstruction of justice but would not present any conclusions regarding the offenses, according to Domenici.

"Many of us are very concerned about the message that would be sent to the American public and to the White House if there is a vote to acquit the president in the face of evidence that he may have, in fact, committed some obstruction of justice," said Sen. Susan Collins (R-Maine), an advocate of this approach. "So we are looking for ways to separate the issue of whether or not the president committed offenses such as obstruction of justice from the issue of whether or not the offenses are sufficient to warrant his removal from office."

At the same time, Sens. Dianne Feinstein (D-Calif.) and Robert F. Bennett (R-Utah) are promoting a harshly worded censure resolution that condemns the

president for wrongful and willful misconduct but that carries no sanctions. The resolution, which requires neither the concurrence of the House nor the signature of the president, would be offered immediately following the conclusion of the trial.

During last month's House impeachment debate, GOP leaders blocked Democrats from offering a censure resolution as an alternative to impeachment.

Conservative GOP leaders have dismissed the censure proposal as a Democratic excuse for not facing up to the president's wrongdoing. They also argued that it would be unconstitutional for Congress to attempt to punish the president for his conduct in the event the Senate concluded the impeachment charges were not justified.

"There's going to be reservations on both sides of the aisle," said Sen. Tim Hutchinson (R-Ark.). "It's got a lot of problems attending it."

Feinstein contends that a Senate censure resolution that neither fines the president nor requires his signature would pass constitutional muster, and others on both sides of the aisle agree.

William and Mary law professor Michael Gerhardt, who has written a book on impeachments, said, "it's going to be difficult to have it both ways." He said any language that implies guilt or endorses the House articles could cross a constitutional line. "I find this approach of a separate vote unnecessary and clearly motivated by an effort to add something to the impeachment and to take

away from any acquittal," he said.

But Brigham Young University law professor Frederick Mark Gedicks said that while there is no precedent for the "findings of fact" approach, there is nothing in the Constitution that would prevent it. "The Senate could say, 'We find that the president lied under oath but we also find that this act does not rise to the level of high crimes and misdemeanors.' That would not be unlike a censure measure."

TODAY IN CONGRESS

SENATE

Meets at 1 p.m.

Committees:

Armed Services—9:30 a.m. Open but will close. U.S. policy toward Iraq. Gen. Anthony Zinni. 106 DSOB.

Budget—10 a.m. Long-term fiscal outlook for U.S. economy. Federal Reserve Chairman Alan Greenspan. 608 DSOB.

Energy & Natural Resources—9 a.m. Oversight hearing on state of petroleum industry. 216 Hart Senate Office Bldg.

Finance—9:15 a.m. U.S. trade policy. Labor Secretary Alexis M. Herman. 215 DSOB.

Judiciary—9:30 a.m. Satellite issues. 226 DSOB.

HOUSE

Not in session.

Committees:

Education & the Workforce—9 a.m. Implementing school reform in states & communities. 2175 Rayburn Office Bldg.

—LEGI-SLATE Inc.

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OFFICE OF THE ADMINISTRATOR

401 M St., SW
Washington, DC 20460

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FROM: DOUG TSAO

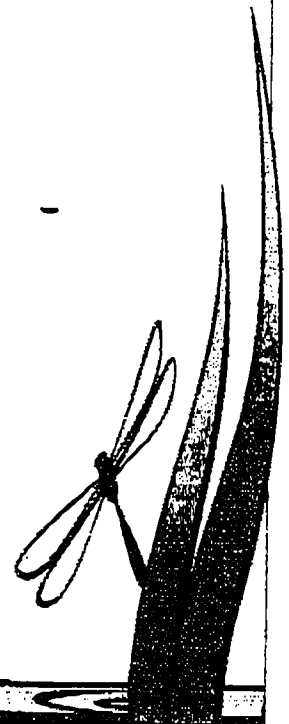
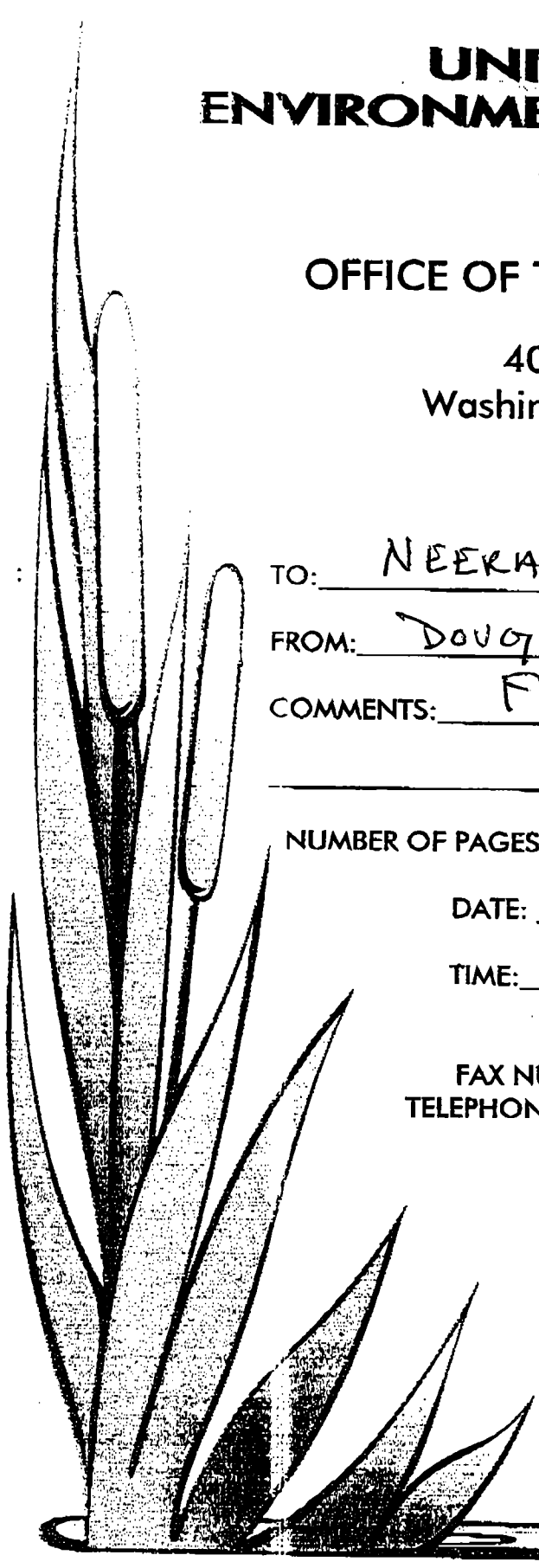
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**Carol M. Browner, Administrator
U.S. Environmental Protection Agency
Budget Announcement of the Asthma Initiative
with First Lady Hillary Rodham Clinton**

**Washington, DC
January 28, 1999**

Welcome all, and thank you for coming today. I am delighted to join Jacy Haas, a mother who knows first hand how asthma affects the daily lives of millions of our nation's children. I am also delighted to be here with Secretary Shalala, and especially First Lady Hillary Rodham Clinton for this important announcement. Today, this administration is taking children's health protection into the 21st Century.

Since the day they came to office six years ago, the President and Vice President have led the way for children's health. They have given this nation's children the strongest environmental and public health protections in the world.

This administration knows that too many of our children get sick by breathing unhealthy air. We know that poor air quality has been linked to many respiratory ailments, including asthma, the leading cause of hospital admissions for children in this country. About five million children now suffer from this debilitating disease. And what's even more troubling -- the incidence of asthma in children under age five has increased *160 percent* from 1980 to 1994.

Clearly, we must do more to protect our children.

President Clinton announced the toughest action in a generation to protect our children from air pollution -- new, updated public health air standards for smog and soot. These new standards together will protect 125 million Americans, including 35 million children, from the adverse health effects of breathing polluted air. Each and every year, they will prevent approximately 15,000 premature deaths, 350,000 cases of aggravated asthma, and nearly a million cases of significantly decreased lung functioning in children.

Breathing polluted air hurts our children's health -- plain and simple. And the danger exists indoors as well as outside.

Twenty nine percent of the country's children live in a house where one or more adults smoke, leading to increased respiratory ailments, ear infections, and aggravated asthma. No adult, no parent should smoke around their young child.

Pound for pound, children drink more fluids, eat more food, and breathe more air. Our young ones crawl on the floor, the older ones spend more time outdoors.

That's why we have led the charge in Congress for new, stronger food safety and drinking water laws. Both require, for the first time ever, that children be protected.

It is why this administration is protecting our children from lead poisoning by stepping up efforts to rid the nation's housing of old lead paint.

It is why today, we are cleaning up the nation's toxic waste dumps faster, and more efficiently. No child should have to grow up near a Superfund site. We've cleaned up nearly three times more toxic waste sites in the last six years than the previous administration did in 12.

It is why this administration is providing parents with more information than ever before about toxic pollution being released into their community's air, land, and water -- because this administration believes that's the best way for families to make the most informed decisions about how to protect themselves from environmental hazards. Last year in May, the First Lady announced an important right-to-know tool that will give people real time information about smog levels in their communities -- a significant step to protect our children who suffer from asthma.

But can we rest? Is our work done? Not until we can say that every neighborhood is free from toxic dumps; that every child is free from lead poisoning -- that childhood asthma rates are falling, not rising.

Today, the First Lady has another important announcement, which will make great progress for the nation's asthmatic children.

When we take steps to protect our children, we are taking steps to protect every American.

As a mother and as a person whose job it is to protect the American people from environmental hazards, I thank the President, the Vice President, and the First Lady for all that they have done to ensure a safe, healthy environment for our children, our children's children, and all the generations to come. Thank you.

And now I would like to turn the floor over to Secretary Shalala -- a leader in our efforts to protect children's health and the health of all Americans. Secretary Shalala...

January 27, 1999

**ANNOUNCING A NEW BUDGET INITIATIVE
TO ADDRESS CHILDREN'S ASTHMA**

Date: Thursday, January 28, 1999
Time: 3:00 - 3:45 PM
Location: Roosevelt Room
The White House
From: Neera Tanden

I. PURPOSE

To announce the President's new, comprehensive initiative to address childhood asthma as part of the FY 2000 budget.

II. BACKGROUND

Overview

You will announce a new initiative that invests funds in research, management and treatment of asthma. This policy initiative is the product of the President's Task Force on Environmental Health Risks and Safety Risks to Children, co-chaired by Secretary Shalala and Administrator Browner. The Task Force was created by the President's Executive Order 13045 and was charged with recommending strategies to protect children's environmental health, and more specifically, with making recommendations for appropriate federal action to address asthma.

The new \$68 million initiative to fight childhood asthma that you will announce is in large measure a response to the recommendations of the Task Force. This initiative forms a comprehensive strategy that includes new efforts to: (1) promote public health at the local level through school-based programs that teach children how to effectively manage their asthma; (2) invest in research to determine environmental causes of asthma and to develop new strategies to reduce children's exposure to asthma triggers; (3) provide funds to states and providers to help them implement effective disease management strategies that will ensure fewer hospitalizations, emergency room visits and deaths from asthma; and (4) conduct a new public information campaign to reduce exposure to asthma triggers and dust mites.

New Announcements

New Report

Today, you will first release "Asthma and the Environment: A Strategy to Protect Children," authored by the President's Task Force on Environmental Health Risks and Safety Risks to Children, which lays out the rationale for this budget initiative and outlines recommendations for an Administration-wide strategy to fight childhood asthma. The Task Force has made four recommendations for federal action that will reduce the incidents of asthma in children,

as well as hospitalizations, and emergency room visits that result from the disease. The recommendations are: to strengthen and accelerate research efforts to better understand the environmental factors that exacerbate childhood asthma, expand programs to improve public health at the community level through school-based and other programs, collect better data at the local level to track asthma incidents, and educate health care providers serving low income children about the most effective course of treatment for asthma.

The FY 2000 Budget of \$68 Million -- The Largest Investment Ever in Childhood Asthma School-Based Asthma Programs. The Environmental Protection Agency (EPA), together with the Department of Education, will invest \$8.4 million to expand school-based programs that teach children how to identify and avoid allergens that trigger an asthma attack, as well as why it is important to use their asthma medication and their inhalers. EPA will also expand programs that educate teachers and school staff to help them eliminate potential triggers from the school environment. With this investment, over 2 million children will be able to breathe easier in their classrooms.

Research on the Causes and Triggers of Asthma. The EPA will invest \$5 million to expand its research into the role that environmental hazards (including chemicals, particles, ozone, diesel exhaust, pesticides, tobacco smoke and allergens) play in the onset of childhood asthma. The EPA will also invest \$1 million to conduct a pilot program to expand air pollution monitoring in up to two communities downwind of industrialized urban centers to better understand the relationship between air pollution and asthma. This additional research will build upon NIH's current investment in research into the onset and exacerbation of asthma in young children, which the President's budget proposes to increase by \$2 million, to reach \$117 million in FY 2000.

New Disease Management Strategies to Target Low Income Children. The Department of Health and Human Services (HHS) will provide \$50 million in competitive grant funds to States who submit disease management programs to identify and treat asthmatic children enrolled in the Medicaid program in accordance with the new disease management guidelines developed by the National Institutes of Health. These guidelines will help to ensure that children receive the appropriate medication and are taught how to effectively manage their illness. Through this initiative, participating states will collect data on asthma incidents so that we may better understand asthma and its possible causes as well as triggers. In addition, HHS will invest almost \$2 million to work with providers nationwide to help them integrate these new strategies into their current patterns of practice.

New National Public Information Campaign. EPA and HHS will invest \$5.2 million in a national public information campaign to reduce children's exposure to environmental tobacco smoke and other indoor asthma triggers. As part of this campaign, these agencies will invest \$3 million in a national public service campaign that uses posters, flyers, and brochures that identify common asthma triggers, such as pet hair or tobacco smoke and simple solutions for eliminating or avoiding them. It will also invest \$1 million to expand existing in-home education networks, such as the Healthy Indoor Air program, and utilizes AmeriCorps and

VISTA volunteers to provide direct assistance to parents in identifying asthma triggers and implementing effective intervention strategies. Finally it will invest \$1.2 million to use health care providers and managed care organizations to help parents reduce their children's exposure to asthma triggers.

Recent Asthma Data

In April of 1998, CDC issued a report titled "Surveillance for Asthma -- United States, 1960-1995" which reported new data on the increased incidence of asthma. First, self-reported asthma cases have increased 75% between 1980 and 1994, and by 1993-1994, an estimated 13.7 million people reported asthma. And for children under five, asthma increased 160%, which was the most substantial increase of any age group. In addition, the number of doctor's office visits for asthma treatment has more than doubled between 1975 and 1995 from 4.6 million to 10.4 million. There were a total of 1.8 million emergency room visits for asthma in 1995. In addition, between 1979-1980 and 1993-1994, the estimated national number of asthma-related hospitalizations increased from 386,000 to 466,000 - a 17% increase and was highest for those under age 5. While the increase in asthma increases and deaths affect all racial groups, age levels and both sexes, blacks reported higher rates of emergency visits, hospitalizations and deaths. Many children with asthma remain chronically impaired because they lack support systems that enable them to effectively manage their own disease or access sufficient medications or equipment.

III. PARTICIPANTS

- The First Lady
- Carol Browner, Administrator of the Environmental Protection Agency
- Donna Shalala, Secretary of Health and Human Services
- Jacy Haas, the parent of Niki Haas, an eleven year old girl with asthma (see attached bio)

V. SEQUENCE OF EVENTS

- You will enter the Roosevelt Room with Administrator Browner, Secretary Shalala and Jacy Haas, a parent of a child with asthma;
- Carol Browner will open the program, make brief remarks and introduce Secretary Shalala;
- Secretary Shalala will make brief remarks and introduce Jacy Haas;
- Jacy Haas will make brief remarks and introduce you;
- You will make remarks and depart.

V. PRESS PLAN

Open press/WH photo.

VI. REMARKS

Provided by Christy Macy.

ASTHMA EVENT

January 28, 1999

List of Attendees

Ruth I. Quartey, Howard University College of Medicine

Carol Wilson Garvey, Montgomery County Department of Health and Human Services

Christine Burch, National Association of Public Hospitals and Health Systems

Suzanne Gaynor, Mount Sinai School of Medicine

Elizabeth J. Noyes, American Academy of Pediatrics

Timothy F. O'Leary, Association of State and Territorial Health Officials

Beverly Malone, American Nurses Association

Jane Lipscomb, University of Maryland, Association of Occupational Health Nurses

Robert K. Musil, Physicians for Social Responsibility

Barbara Santamaria, American Nurses Association

Elizabeth Sword, Children's Health Environment Coalition

Phillip Bouton, National Association of County and City Health

Walter Eric Juzenas, American Public Health Association

Mary Elizabeth Worstell, Asthma and Allergy Foundation of America

Carol Stroebel, Children's Environmental Health Network

Barbara Sattler, Environmental Health Education Center

Morris A. Ward, Environmental Health Center

Lani Smith Mayer Wheeler, Pediatrics and School Health, Anne Arundel County Health Department

Fleming Family

Barry Fleming

Vickie Fleming

Barri Jacqueline Fleming

Lugis Fleming

Haas Family

Charlotte Marie Haas

Louise C. Grady

Jacy Penny Haas

Regina Nichole Haas

Robert William Haas

Charles Edward Haas

Stephanie Marie Haas

Dharma Rose Haas

Fay Family

Lindy Fay

Rebecca Fay

Louviere Family

Kathy Louviere

Kyle Louviere

Jacy Haas

Ms. Haas is a stay-at-home mother whose daughter, Niki Haas, is an asthmatic. Niki is eleven years old, who has experienced relatively severe activity limitations as a result of her asthma. She has made several trips to the emergency room and has been hospitalized on a number of occasions as a result of her disease. Niki has attended an asthma camp sponsored by the Maryland Lung Association, and is well educated about asthma, including ozone and its effects on her.

ASTHMA Qs and As

January 27, 1999

Q: What is asthma? (DHHS)

A: Asthma is a chronic lung disease characterized by recurrent episodes of breathlessness, wheezing, coughing, and chest tightness. The severity of asthma attacks can range from mild to life threatening.

Q: What causes asthma? (DHHS)

A: Why some people develop the chronic airway inflammation that is the hallmark of asthma is not well understood. Genetic factors seem to play a strong role, as do events early in life - such as respiratory infections, exposures to allergens and tobacco smoke - and other factors such as the diets of mother and child and the child's exercise level. Among those who incur the chronic airway inflammation, environmental triggers and life style have a material influence on how frequently the attacks occur, how severe they are, and how readily they can be suppressed by medication.

Q: What can asthma sufferers do about it? (DHHS)

A: Health care professionals do not know how to prevent asthma from developing. But both the frequency and severity of symptoms can be reduced by the use of medications and by reducing environmental and behavioral triggers of asthma attacks.

Q: Why does asthma warrant attention by the federal government? (DHHS)

A: Three reasons:

1. Asthma has reached epidemic proportions in the United States. Over the past fifteen years, the number of Americans afflicted with asthma has doubled to about 15 million - including over 5 million children. The fastest growing group of asthma sufferers is children under five years old. Asthma affects Americans of all ages, races, and ethnic groups - with low income and minority populations experiencing significantly higher rates of fatalities, hospital admissions, and emergency room visits due to asthma.

2. Asthma's secondary effects are wide ranging. It is a leading cause of school absenteeism, accounting for over 10 million missed school days. Asthma symptoms not severe enough to require a visit to the emergency room or to a physician can still substantially restrict the activities and impair the quality of life. Asthma results in many lost nights of sleep, limitation of activity, and disruption of family and care giver routines, with additional social and economic consequences including lost work days.

3. Asthma care is a huge financial burden. In 1990, the cost of asthma to the U.S. economy was estimated to be \$6.2 billion, with the majority of the expense attributed to medical care. A 1996 analysis found the annual cost to be \$14 billion.

Q: Where do we stand in countering this epidemic? (DHHS)

A: Critical breakthroughs in science in the last decade have generated a body of information that, when effectively translated to patients, enables most people with asthma to live fully active lives. The National Asthma Education and Prevention Program, co-sponsored by the National Heart, Lung and Blood Institute, developed Guidelines for the Diagnosis and Management of Asthma, which translate the scientific findings into recommendations for patient care. By implementing these Guidelines, health care providers, care-givers, and most patients with asthma can work together successfully to control the disease.

The Guidelines contain advice about appropriate medical care, self-monitoring of symptoms, control of allergens and other environmental triggers in the indoor environment, avoidance of triggers that cannot be controlled, and abstention from behaviors that exacerbate asthma symptoms. The Guidelines present a set of practices that, in combination, can reduce the frequency and severity of asthma attacks. However, more research is needed to further refine these guidelines. In particular, better strategies for environmental interventions are needed as well as concerted research efforts to learn enough about the causes of asthma to establish primary prevention guidelines.

Many asthma patients remain unnecessarily ill because of a complex interplay of factors that prevent the Guidelines from being fully implemented. Many health care professionals, teachers, day-care workers, workplace monitors, and others in a position to apply the guidelines are not sufficiently familiar with them. Many people lack access to quality medical care or resources to obtain sufficient medications or equipment. Furthermore, even with high quality care, some patients' asthma is not readily controlled; and others experience adverse side effects for the currently available medications.

Q. What is the relationship between asthma and the environment? (EPA)

Our understanding of the relationship between environmental exposures and the development (i.e., onset) of asthma in non-asthmatic children is limited.

However, the environmental triggers of asthma attacks have become increasingly well-understood. There is strong and convincing evidence that particulate matter and ozone are associated with exacerbation of asthma-related symptoms, increases in hospitalization for respiratory causes for persons with asthma, decrements in lung function and increased medication use. Air pollution also might act synergistically with other environmental factors to worsen asthma and some evidence suggests that exposure to ozone can enhance a person's responsiveness to inhaled allergens.

House dust mites, cockroaches, mold and animal dander have been identified as the principal allergens that trigger asthma symptoms. Reducing exposure to these allergens has been shown not only to reduce asthma symptoms and the need for medication, but also to improve lung

function. Environmental tobacco smoke (also called secondhand smoke) is an important irritant that can trigger an asthma episode and possibly worsen the effects of allergens.

Q: In emphasizing environmental triggers, are you suggesting that people could avoid asthma if they simply cleaned their houses better? (DHHS)

A. Of course not. This is not a matter of blaming the victim. The issue is to help people understand and deal with those things in their day-to-day living environments such as animal dander and tobacco smoke that trigger asthma attacks.

Q. What has the Clinton Administration done to combat asthma? (DHHS & EPA)

A. Although a great deal of work is still ahead of us in the fight against asthma, the Administration is proud of the work it has accomplished to date:

Major Accomplishments of the Department of Health and Human Services (DHHS)

The Department of Health and Human Services supports research, health services delivery, and public health practice to address the growing problem of asthma.

Research. This year, enhancing its investments of recent years, HHS will invest over \$100 million in asthma research. HHS-supported grantees have been responsible for many of the scientific breakthroughs that helped shape the Guidelines for the Diagnosis and Management of Asthma.

Health Services Delivery. Medicaid and Medicare expenditures for treatment of asthma are estimated to exceed one billion dollars per year. In addition, thousands of people each year receive care for their asthma at HHS-funded facilities such as community health centers and hospitals of the Indian Health Service.

Public Health Practice. Current spending on public health programs, apart from direct patient care, is approximately \$5 million. The Department supports model programs and partnerships that convey information about asthma management to public health officials, health care providers, patients, and their family members.

Major EPA Accomplishments

Air Pollution. In July 1997, EPA updated the public health standards for smog (ozone) and particulate matter (soot). These standards were based on protecting sensitive populations such as children. These standards will prevent approximately 15,000 premature deaths, about 350,000 cases of aggravated asthma and nearly a million cases of significantly decreased lung function in children.

Research. In August 1998, EPA and DHHS established the first-ever federal research centers dedicated solely to studying children's environmental health hazards. Jointly funded by EPA and DHHS, these Centers for Children's Environmental Health Research were created at eight leading research institutions. Five of these centers are focusing on asthma. They will better our understanding of the link between secondhand smoke, smog, and other pollutants and the rise in asthma rates.

Secondhand Smoke. EPA completed a landmark risk assessment in 1993 on the health effects of secondhand smoke on adults and young children, including strong conclusions on the relationship between secondhand smoke and the frequency and severity of asthma attacks. This report has led to major public policy changes resulting in substantial reductions in exposure of children and adults to secondhand smoke.

Public Health Education. EPA has led the effort to provide practical solutions to problems associated with indoor air pollution and has published extensive guidance for the public and building managers to help reduce exposure to asthma triggers in schools, homes, and day care facilities.

Q: What are DHHS' priorities in countering asthma? (DHHS)

A: The Department has four priorities:

- to determine the causes of asthma and develop interventions to prevent it from developing in the first place;
- to reduce the burden of asthma for people with the disease;
- to eliminate the disproportionate health burden of asthma in minority populations and those living in poverty; and
- to track the disease and assess the effectiveness of asthma programs.

Q: What will DHHS do to reduce the burden of asthma? (DHHS)

A: The Department, in collaboration with public and private partners, will continue to foster public health programs that improve access to quality medical care and foster widespread use of current medical and scientific knowledge to prevent and/or reduce the severity of asthma attacks. The Department also will expand research with a view to discovering and developing improved means of managing asthma, including determining more about the triggers of asthma attacks and the variability among patients with respect to their response to these triggers.

Q. What are EPA's priorities in countering asthma? (EPA)

The President's FY2000 budget includes \$22 million for the U.S. Environmental Protection Agency to address environmental factors that contribute to the rising rates of asthma. These funds will help reduce children's exposure in the home, schools, and day care facilities to known asthma triggers such as secondhand smoke and indoor allergens (e.g. dust mites, animal dander, insects, and mold) by:

Implementing School-based Programs: EPA will invest \$8.4 million to expand outreach and educational programs to inform parents, teachers, and children about how to improve indoor air quality for children with asthma and manage potential asthma triggers. With this investment, 2 million children across the nation will breathe cleaner air in their classrooms.

Creating a New National Public Information Campaign: EPA and DHHS will work together to develop and implement a national public information campaign to reduce children's exposure to secondhand smoke and other indoor asthma triggers. This campaign will include: a \$4 million dollar national public service campaign and expanded community-based outreach programs; a \$1 million dollar expansion of existing in-home education networks to provide direct in-home assistance to help parents identify asthma triggers and implement effective strategies to reduce health risks; and \$1.2 million dollars to better equip health care providers to educate children and their parents about ways to reduce exposure to asthma triggers.

Researching the Link Between Environmental Factors and Asthma: EPA will spend \$5 million to expand its research into the role that environmental hazards (including chemicals, particles, ozone, diesel exhaust, pesticides, tobacco smoke and allergens) play in the onset of childhood asthma and to develop better and more practical strategies for improving the quality of life of children with asthma. EPA will also invest \$1 million to conduct a pilot program to expand air pollution monitoring in up to two communities downwind of industrialized urban centers to better understand the relationship between air pollution and asthma.

Q: What will DHHS do to reduce the disproportionate burden of asthma upon racial and ethnic minorities and disadvantaged populations? (DHHS)

A: The Department will foster research and other activities toward

understanding of the causes of the disproportionate impact of asthma; for example, distinguishing the roles in asthma incidence and prevalence of location-specific, and, in cooperation with EPA, environmental factors (e.g., air pollution, occupational exposures) from those of ethnicity, cultural variables, and genetics;

assessing the impact of managed care on Medicaid children and adults with asthma; and

determining the relative influences of poverty, race, and ethnicity on the use of emergency room services for asthma.

Q: How will DHHS track the asthma epidemic to determine the effectiveness of its programs? (DHHS)

A: Current surveillance capability permits the Centers for Disease Control and Prevention to track asthma prevalence, asthma physician office visits, asthma emergency room visits, asthma hospitalizations, and asthma mortality at a national level and in four geographic regions. Except for mortality data, this type of information generally is unavailable at the state or local level. In future years, the Department will be seeking to improve the scope and depth of asthma surveillance. The Department also will seek to complement surveillance – e.g., with studies designed to identify populations with high or low asthma prevalence that might shed light on factors that influence the development of asthma. EPA will also utilize data available through DHHS programs to the extent possible to help it evaluate the effectiveness of environmental interventions in reducing the impact of childhood asthma.

Q. What will the Children's Asthma and the Environment strategy accomplish? (EPA)

This strategy is important for several reasons:

- It consolidates federal resources and expertise to focus on this epidemic.
- It establishes four principles for Federal efforts in this area:

A focus on efforts to:

—eliminate the disproportionate impact of asthma in minority populations and those living in poverty;

--emphasize partnerships and community based programs;

--commit to setting measurable and consistent goals for childhood asthma under the Healthy People 2010 program;

--invest in evaluation to identify those strategies that are most effective in reducing the burden of asthma so that they may be replicated.

- The strategy also calls for action in four areas:

Research: Research will be conducted to understand the role environmental pollutants (including chemicals, fine particles, ozone, diesel exhaust, pesticides, tobacco smoke and allergens) play in the onset of asthma episodes in children and what causes asthma. This research will help us develop practical strategies for improving the quality of life of children with asthma.

Public Health Programs: Using our current scientific knowledge, DHHS and EPA will implement public health programs that reduce environmental exposures to asthma triggers to prevent and reduce the severity of asthma attacks. This will include: promoting national guidelines to reduce environmental factors that worsen asthma; expanding support for state and local public health action; establishing school-based asthma programs in communities to help reduce and eliminate allergens and other environmental risk factors in schools; and reduce children's exposure to environmental tobacco smoke and other indoor asthma triggers in their homes.

Surveillance: Establish a coordinated, integrated, systematic nationwide asthma surveillance system for collecting and analyzing health outcome and risk factor data at the state, regional and local levels.

Addressing disproportionate impacts on the poor and minorities: We plan to eliminate the disproportionate burden of asthma among different racial groups and those living in poverty. We will conduct research and surveillance to better understand the scope of the problem and implement activities designed to reduce and eventually eliminate this disproportionate impact.

Q. What is the initiative on disease management? (DHHS)

DHHS proposes to conduct a demonstration to test the use of innovative disease management techniques for children enrolled in the Medicaid fee-for-service program. The Department will provide \$50 million for competitive start-up grants to states that submit meritorious disease management programs to identify and treat children with asthma using the most appropriate care - the NHLBI guidelines for Diagnosis and Management of Asthma. Participating states would be required to measure the success of the program.

Q. What is Disease Management? (DHHS)

Disease management combines the use of the most-up-to-date treatment protocols ("best practices") with a prevention component -i.e., disease-specific education programs and health screening; an intensive case management component -i.e., close monitoring of patient care and treatment compliance; and a self-care component -i.e., empowering patients and their families to identify symptoms and care for their own chronic disease.

**FIRST LADY HILLARY CLINTON UNVEILS NEW, \$68 MILLION INITIATIVE
TO FIGHT ASTHMA
January 28, 1999**

Today, First Lady Hillary Rodham Clinton unveiled a new, \$68 million initiative to fight childhood asthma through a comprehensive national strategy that includes new efforts to: (1) implement school based programs that teach children how to effectively manage their asthma; (2) invest in research to determine environmental causes of asthma and to develop new strategies to reduce children's exposure to asthma triggers; (3) provide funds to states and providers to help them implement effective disease management strategies that will insure we lower hospitalizations, emergency room visits and deaths from asthma; and (4) conduct a new public information campaign to reduce exposure to asthma triggers and dust mites.

MILLIONS OF CHILDREN SUFFER FROM ASTHMA

Over the past 15 years, the number of children afflicted with asthma has doubled to total about 6 million. The most rapid increase in prevalence over this time period has occurred in children under the age of 5, with rates increasing over 160 percent. Over 100,000 children are hospitalized each year because of asthma, making it the leading cause of hospitalization due to chronic illness for children at a cost of \$1.9 billion in medical expenses annually. Asthma is also one of the leading causes of school absenteeism, resulting in over 10 million missed school days each year. Minority children are disproportionately affected by asthma. Although African American children under the age of 18 have only a slightly higher risk of actually having asthma than non-Hispanic white children, they experience a disproportionately higher rate of death from asthma attacks, over four times the rate for white children. Many children with asthma remain chronically impaired because they lack support systems that enable them to effectively manage their own disease or access sufficient medications or equipment.

DEVELOPMENT OF A NEW NATIONAL STRATEGY

Today, the First Lady will release "Asthma and the Environment: A Strategy to Protect Children," authored by the Children's Environmental Task Force on Environmental Health Risks and Safety Risks to Children, which is co-chaired by the Environmental Protection Agency and the Department of Health and Human Services. This report outlines the first-ever comprehensive, Administration-wide strategy to fight childhood asthma. The Task Force makes four recommendations for asthma that will reduce the incidents of asthma in children, as well as hospitalizations, and emergency room visits for asthma. The four steps for federal action are: strengthening and accelerating research efforts to better understand the environmental factors that exacerbate childhood asthma, expanding school based programs that reduce environmental exposures to asthma, collecting better data at the local level to track asthma incidents, and educating health care providers serving low income children about the most effective course of treatment for asthma.

LARGEST EVER FEDERAL INVESTMENT TO FIGHT CHILDHOOD ASTHMA

Today, the First Lady announced a new \$68 million initiative to address asthma. This package of investments responds to Task Force recommendations and includes:

- **IMPLEMENTING SCHOOL-BASED ASTHMA PROGRAMS.** The Environmental Protection Agency (EPA), together with the Department of Education, will invest \$8.4 million to expand school-based programs that teach parents and children how to identify and avoid allergens that trigger an asthma attack, as well as why it is important to use their asthma medication and their inhalers. EPA will also expand programs that educate teachers and school staff to help them eliminate potential triggers from the school environment. With this investment, over 2 million children will be able to breathe easier in their classrooms.
- **INVESTING IN NEW RESEARCH TO REDUCE CHILDREN'S EXPOSURE TO ASTHMA TRIGGERS.** The Environmental Protection Agency will invest \$2 million to expand its research into the role that environmental hazards (including chemicals, particles, ozone, diesel exhaust, pesticides, tobacco smoke and allergens) play in the onset of childhood asthma. The Environmental Protection Agency will also invest \$1 million to conduct a pilot program to expand air pollution monitoring in up to two communities downwind of industrialized urban centers to better understand the relationship between air pollution and asthma. These new investments builds on the Administration's long-standing committment to asthma research. This year, the National Institutes of Health will invest over \$110 million dollars in research to explore the cause of asthma and develop strategies to better manage the disease, and plans to continue this significant investment in FY2000.
- **IMPLEMENTING NEW DISEASE MANAGEMENT STRATEGIES TO TARGET LOW INCOME CHILDREN.** The Department of Health and Human Services will provide \$50 million in competitive grant funds to States who identify and treat asthmatic children enrolled in the Medicaid program in accordance with the new disease management guidelines developed by the National Institutes of Health. These guidelines will help to ensure that children receive the appropriate medication and are taught how to effectively manage their illness. Through this initiative, participating states will collect data on asthma incidents so we can better understand asthma and effects. In addition, HHS will invest almost \$2 million to work with State officials and other providers nationwide to help them integrate these new strategies into their current patterns of practice.
- **CREATING A NEW NATIONAL PUBLIC INFORMATION CAMPAIGN.** The Environmental Protection Agency and the Department of Health and Human Services will invest \$5.2 million in a national public information campaign to reduce children's exposure to environmental tobacco smoke and other indoor asthma triggers through a national public service campaign that uses posters, flyers, and brochures that identify common asthma triggers, such as pet hair or tobacco smoke, and simple solutions for eliminating or avoiding them; expands existing in-home education networks, such as community based lead prevention programs, and utilizes Americorps and VISTA volunteers to provide direct assistance to parents in identifying asthma triggers and implementing intervention strategies; and using health care providers and managed care organizations to help parents reduce their children's exposure to asthma triggers.

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Today, First Lady Hillary Rodham Clinton unveiled a new, \$68 million initiative to fight childhood asthma through a comprehensive national strategy that includes new efforts to: (1) implement school based programs that teach children how to effectively manage their asthma; (2) invest in research to determine environmental causes of asthma and to develop new strategies to reduce children's exposure to asthma triggers; (3) provide funds to states and providers to help them implement effective disease management strategies that will insure we lower hospitalizations, emergency room visits and deaths from asthma; and (4) conduct a new public information campaign to reduce exposure to asthma triggers and dust mites.

MILLIONS OF CHILDREN SUFFER FROM ASTHMA

Over the past 15 years, the number of children afflicted with asthma has doubled to total about 6 million. The most rapid increase in prevalence over this time period has occurred in children under the age of 5, with rates increasing over 160 percent. Over 100,000 children are hospitalized each year because of asthma, making it the leading cause of hospitalization due to chronic illness for children at a cost of \$1.9 billion in medical expenses annually. Asthma is also one of the leading causes of school absenteeism, resulting in over 10 million missed school days each year. Minority children are disproportionately affected by asthma. Although African American children under the age of 18 have only a slightly higher risk of actually having asthma than non-Hispanic white children, they experience a disproportionately higher rate of death from asthma attacks, over four times the rate for white children. Many children with asthma remain chronically impaired because they lack support systems that enable them to effectively manage their own disease or access sufficient medications or equipment.

DEVELOPMENT OF A NEW NATIONAL STRATEGY

Today, the First Lady will release "Asthma and the Environment: A Strategy to Protect Children," authored by the Children's Environmental Task Force on Environmental Health Risks and Safety Risks to Children, which is co-chaired by the Environmental Protection Agency and the Department of Health and Human Services. This report outlines the first-ever comprehensive, Administration-wide strategy to fight childhood asthma. The Task Force makes four recommendations for asthma that will reduce the incidents of asthma in children, as well as hospitalizations, and emergency room visits for asthma. The four steps for federal action are: strengthening and accelerating research efforts to better understand the environmental factors that exacerbate childhood asthma, expanding school based programs that reduce environmental exposures to asthma, collecting better data at the local level to track asthma incidents, and educating health care providers serving low income children about the most effective course of treatment for asthma.

LARGEST EVER FEDERAL INVESTMENT TO FIGHT CHILDHOOD ASTHMA

Today, the First Lady announced a new \$68 million initiative to address asthma. This package of investments responds to Task Force recommendations and includes:

- **IMPLEMENTING SCHOOL-BASED ASTHMA PROGRAMS.** The Environmental Protection Agency (EPA), together with the Department of Education, will invest \$8.4 million to expand school-based programs that teach parents and children how to identify and avoid allergens that trigger an asthma attack, as well as why it is important to use their asthma medication and their inhalers. EPA will also expand programs that educate teachers and school staff to help them eliminate potential triggers from the school environment. With this investment, over 2 million children will be able to breathe easier in their classrooms.
- **INVESTING IN NEW RESEARCH TO REDUCE CHILDREN'S EXPOSURE TO ASTHMA TRIGGERS.** The Environmental Protection Agency will invest \$2 million to expand its research into the role that environmental hazards (including chemicals, particles, ozone, diesel exhaust, pesticides, tobacco smoke and allergens) play in the onset of childhood asthma. The Environmental Protection Agency will also invest \$1 million to conduct a pilot program to expand air pollution monitoring in up to two communities downwind of industrialized urban centers to better understand the relationship between air pollution and asthma. These new investments builds on the Administration's long-standing commitment to asthma research. This year, the National Institutes of Health will invest over \$110 million dollars in research to explore the cause of asthma and develop strategies to better manage the disease, and plans to continue this significant investment in FY2000.
- **IMPLEMENTING NEW DISEASE MANAGEMENT STRATEGIES TO TARGET LOW INCOME CHILDREN.** The Department of Health and Human Services will provide \$50 million in competitive grant funds to States who identify and treat asthmatic children enrolled in the Medicaid program in accordance with the new disease management guidelines developed by the National Institutes of Health. These guidelines will help to ensure that children receive the appropriate medication and are taught how to effectively manage their illness. Through this initiative, participating states will collect data on asthma incidents so we can better understand asthma and effects. In addition, HHS will invest almost \$2 million to work with State officials and other providers nationwide to help them integrate these new strategies into their current patterns of practice.
- **CREATING A NEW NATIONAL PUBLIC INFORMATION CAMPAIGN.** The Environmental Protection Agency and the Department of Health and Human Services will invest \$5.2 million in a national public information campaign to reduce children's exposure to environmental tobacco smoke and other indoor asthma triggers through a national public service campaign that uses posters, flyers, and brochures that identify common asthma triggers, such as pet hair or tobacco smoke, and simple solutions for eliminating or avoiding them; expands existing in-home education networks, such as community based lead prevention programs, and utilizes Americorps and VISTA volunteers to provide direct assistance to parents in identifying asthma triggers and implementing intervention strategies; and using health care providers and managed care organizations to help parents reduce their children's exposure to asthma triggers.

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facsimile transmittal

To: NEERA TANDEN Fax: 62878
From: Robert HAAS Date: 1-27
Re: 1-28-99 event Pages: 2
CC:

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Notes:

It seems as though with every new person I meet, we have one thing in common, A CHILD WITH SOME FORM OF ASTHMA. Asthma in young children is growing at an alarming rate. When we were children, Asthma was not such a prevalent disease. Now at least two kids in each class have been diagnosed with some form of Asthma.

Every child has their own story; our is our 12 year old daughter, Niki, who was diagnosed with Asthma at the age of 3 months. She has been in and out of Emergency Rooms all her life. She is on a daily retromin of medications that seem like an endless series of swallowing pills and taking machines. These problems follow her through her school day as well as through the night. She has had to change her school schedule to avoid Shop Class because of dust and fumes; as well as limiting her physical education exercises, depending on her daily condition.

When Niki started school, they had little procedures and knowledge on dealing with an asthmatic child that may need emergency medication during the school day. Through my research and sharing my findings with the school I have been lucky in negotiating a procedure with her teachers that provide some assurance of her safety from Asthma during the school day.

With more and more children being diagnosed with Asthma; it is so important that we get more research and programs to help find a cure for this disease that robs our children of a joyful childhood.

Thank you very much.

It is now my privilege to introduce the First Lady: Hilary Rodman

Clinton,

That's why I've taken it upon myself to help educate the school about asthma. My worries will be safe.

Some took it too seriously - promoting misconceptions & sometimes they didn't take it seriously enough - denying her easy access to her inhaler.

She simply can't take part in these things, so many other children & parents take for granted.

While other children can play sports after school, like soccer or track, Niki's activities have been limited to the point that even an inhaler isn't enough for her.

her teachers and the school staff didn't know how to handle her asthma. They didn't know.

a woman who is an unrelenting advocate for our children's health and welfare.

Mrs. Clinton, Administrator Browner, Ms. Hass, distinguished guests.

Earlier this week I was doing an event with the Vice-President celebrating the progress we've made with Head Start. Two young Head Start children decided to join in the action. They stood on chairs next to the Vice-President. One calmly. The other with a bit more enthusiasm. He was climbing on the podium. Playing with the mic. Reordering the Vice-President's note cards. And generally delighting everyone in the room – especially Vice-President Gore.

I mention this because as I was watching these two wonderful children, I couldn't help but think: This is what childhood should be all about. Uninhibited. Curious. Adventurous. Fun. And for most children it is.

But for children with asthma, life can be anything but fun.

Here is how one mother describes her family's ordeal: "My son has had chronic asthma since he was 18 months old. That means we ask the same questions again and again. Did you do your second puff? Did you rinse your mouth? Have you packed the nebulizer? Do you have the prescription? It means his dad and I stay watchful because every season brings its own danger. Pollen in the spring. Heat in the summer. Mold in the fall. Infection in the winter. It means that every day events, like visits with friends who have cats, require vigilance. Most of all, it means a cough is not just a cough."

The number of families living a similar nightmare is growing.

In fact there's an epidemic of asthma in the United States. Between 1980 and 1994, the number of Americans with asthma increased 75 percent, and percentage of pre-school children with asthma increased 160 percent. Today, almost 5 million children have asthma – which makes asthma the number one chronic disease of childhood.

Asthma has a ripple effect too. Not only does it keep children in fear and pain – it keeps them out of school. In every classroom with 30 children, there are likely to be at least two with asthma. That adds up to over ten million school days lost to asthma each year. And, again, the problem is not just children. Over the past 15 years, the number of Americans suffering from asthma has doubled to 15 million. This disease kills over 5,000 Americans every year – and sends almost a half million to the hospital. As serious as asthma is, it doesn't strike evenly. Minorities and the poor are hit especially hard.

We still don't know exactly what causes this chronic lung disease – although it's likely be a combination of genetic and environmental factors. But under the leadership of the President and First Lady, we're fighting back – with more money, more research, and more teamwork to prevent and treat asthma. That's why in addition to the President's Task Force that Administrator Browner and I co-chair, the Department of Health and Human Services is investing more than \$120 million in asthma research – up almost 100 percent since 1993.

This money will be used to understand what causes asthma, to carry out important clinical studies that focus on the prevention and treatment of asthma, and to get new knowledge to schools, families and asthma sufferers.

We've also brought together the best minds from NIH, FDA, CDC, the Health Care Financing Administration, the Agency for Health Care Policy and Research, the Indian Health Service and other HHS agencies to work on a comprehensive strategy for researching asthma and unlocking its secrets.

We're partnering with many private organizations to raise awareness – and educate families and communities about how to manage asthma.

Simply put, we must find the cause of asthma – and learn how to prevent it.

We must reduce the burden of people living with asthma

We must eliminate the disparities in who falls victim to asthma.

And we must track the disease and measure the progress we're making against asthma.

I already mentioned one family's day to day struggle with asthma. But there are millions of others. One of them is Jacy Hass and her daughter Niki. Niki and her mom are both fighters. They know this struggle is far from over. But they also know that with education, effective medication and support from their community they will win this fight.

It's my pleasure to introduce a real hero in the battle against asthma, Jacy Hass

Jacy . . .

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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. note	Note re: Potential Parent to Speak at June 29 Childrens's Health Event (partial) (1 page)	01/26/1999	P6/b(6)

COLLECTION:

Clinton Presidential Records
Domestic Policy Council
Eric Morse (Events)
OA/Box Number: 21192

FOLDER TITLE:

Asthma Budget Rollout 1/28/1999

2011-0619-S

rc288

RESTRICTION CODES

Presidential Records Act - [44 U.S.C. 2204(a)]

Freedom of Information Act - [5 U.S.C. 552(b)]

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POTENTIAL PARENT TO SPEAK AT JUNE 29 CHILDREN'S HEALTH EVENT

- ✓ 8 1) Jacy Haas is an articulate stay-at-home mother whose daughter, Niki Haas, is an asthmatic. Niki is eleven years old. She has had to go to the emergency room because of asthma attacks. Her asthma is now pretty well controlled through medications and proper routines. Niki has attended an asthma camp sponsored by the Maryland Lung Association, and is well educated about asthma, including ozone and its effects on her. She has spoken before to the media, if that is desired again. The Haas's live in Keymar, MD. The home number is

P6/(b)(6)

P6/(b)(6)

[001]

good contact to
find parents with
asthmatic kids:

Cassandra Yutzy
MD Lung Assoc.

~~301~~ 301 483 3164

**AMERICAN LUNG ASSOCIATION®***of the District of Columbia*

475 H Street, N.W., Washington, D.C. 20001-2617



Date: January 27, 1999

To: Neera Tanden
American Lung Assoc. of the District of Columbia
Fax: 202-456-2878

From: Rolando A. Andrew
Phone: 202-682-5864 **Ext.:** 17

Pages: 2

Subject: Asthma Campaign

I am writing as per your conversation with Rick Leach. Attached please find the Executive Summary of the Asthma Campaign.

I look forward to tomorrow's briefing on asthma by the First Lady. I hope to meet you there. If you have any questions, please call Rick at 202/659-4050 or me at 202/682-5864.

Thank you.

American Lung Association of the District of Columbia**ASTHMA CAMPAIGN***PREVENTION, TREATMENT & MAINTENANCE***EXECUTIVE SUMMARY*****THE MISSION***

The District of Columbia has the highest rate of asthma in the nation – more than 5% of the District residents have asthma (compared to less than 2% nationally). Therefore, the mission of the Asthma Campaign is to reduce the mortality and morbidity from pediatric asthma through preventive prevention and treatment utilizing collaborative partners.

GOALS & OBJECTIVES

- To improve the quality of life for the asthmatic child and his/her family
- To promote an active partnership between the patient, and the physician
- To identify the barriers to health care access
- To impact on the barriers to health care access
- To promote optimal medical management of the asthma patient
- To reduce environmental hazards in the community which impact asthma

TARGET MARKET

- The Campaign will start in Ward 6, which has the highest asthma mortality rate in the District. In 1996, 8 of the 22 people who died in the District were from Ward 6
- Asthmatic children ages 0 – 11 residing in Ward 6
- Families and parents of asthmatic children in Ward 6

MEASURABLE OUTCOMES

- Reduce the number of emergency room visits due to asthmatic episodes
- Reduce number of asthma related hospitalizations
- Reduce number of school days lost due to asthma illness
- Reduce number of deaths due to asthma

COLLABORATIVE PARTNERS

To carry out the Campaign, the ALA of DC is assembling a broad coalition of organizations including:

- United States Centers for Disease Control & Prevention
- DC Department of Health
- Howard University Hospital
- Glaxo Wellcome
- Capital Community Health Plan
- Asthma & Allegory Foundation

ASTHMA Qs and As
January 27, 1999 (2 PM)

Consolidated DRAFT DHHS and EPA Qs and A's. Department/Agency that prepared each response is identified in () following each question..

Q: What is asthma? (DHHS)

A: Asthma is a chronic lung disease characterized by recurrent episodes of breathlessness, wheezing, coughing, and chest tightness. The severity of asthma attacks can range from mild to life threatening.

Q: What causes asthma? (DHHS)

A: Why some people develop the chronic airway inflammation that is the hallmark of asthma is not well understood. Genetic factors seem to play a strong role, as do events early in life - such as respiratory infections, exposures to allergens and tobacco smoke - and other factors such as the diets of mother and child and the child's exercise level. Among those who incur the chronic airway inflammation, environmental triggers and life style have a material influence on how frequently the attacks occur, how severe they are, and how readily they can be suppressed by medication.

Q: What can asthma sufferers do about it? (DHHS)

A: Health care professionals do not know how to prevent asthma from developing. But both the frequency and severity of symptoms can be reduced by the use of medications and by reducing environmental and behavioral triggers of asthma attacks.

Q: Why does asthma warrant attention by the federal government? (DHHS)

A: Three reasons:

1. Asthma has reached epidemic proportions in the United States. Over the past fifteen years, the number of Americans afflicted with asthma has doubled to about 15 million - including over 5 million children. The fastest growing group of asthma sufferers is children under five years old. Asthma affects Americans of all ages, races, and ethnic groups - with low income and minority populations experiencing significantly higher rates of fatalities, hospital admissions, and emergency room visits due to asthma.

2. Asthma's secondary effects are wide ranging. It is a leading cause of school absenteeism, accounting for over 10 million missed school days. Asthma symptoms not severe enough to require a visit to the emergency room or to a physician can still substantially restrict the activities and impair the quality of life. Asthma results in many lost nights of sleep, limitation of activity, and disruption of family and care giver routines, with additional social and economic consequences including lost work days.

3. Asthma care is a huge financial burden. In 1990, the cost of asthma to the U.S. economy was estimated to be \$6.2 billion, with the majority of the expense attributed to medical care. A 1996 analysis found the annual cost to be \$14 billion.

Q: Where do we stand in countering this epidemic? (DHHS)

A: Critical breakthroughs in science in the last decade have generated a body of information that, when effectively translated to patients, enables most people with asthma to live fully active lives. The National Asthma Education and Prevention Program, co-sponsored by the National Heart, Lung and Blood Institute, developed Guidelines for the Diagnosis and Management of Asthma, which translate the scientific findings into recommendations for patient care. By implementing these Guidelines, health care providers, care-givers, and most patients with asthma can work together successfully to control the disease.

The Guidelines contain advice about appropriate medical care, self-monitoring of symptoms, control of allergens and other environmental triggers in the indoor environment, avoidance of triggers that cannot be controlled, and abstention from behaviors that exacerbate asthma symptoms. The Guidelines present a set of practices that, in combination, can reduce the frequency and severity of asthma attacks. However, more research is needed to further refine these guidelines. In particular, better strategies for environmental interventions are needed as well as concerted research efforts to learn enough about the causes of asthma to establish primary prevention guidelines.

Many asthma patients remain unnecessarily ill because of a complex interplay of factors that prevent the Guidelines from being fully implemented. Many health care professionals, teachers, day-care workers, workplace monitors, and others in a position to apply the guidelines are not sufficiently familiar with them. Many people lack access to quality medical care or resources to obtain sufficient medications or equipment. Furthermore, even with high quality care, some patients' asthma is not readily controlled; and others experience adverse side effects for the currently available medications.

Q. What is the relationship between asthma and the environment? (EPA)

Our understanding of the relationship between environmental exposures and the development (i.e., onset) of asthma in non-asthmatic children is limited.

However, the environmental triggers of asthma attacks have become increasingly well-understood. There is strong and convincing evidence that particulate matter and ozone are associated with exacerbation of asthma-related symptoms, increases in hospitalization for respiratory causes for persons with asthma, decrements in lung function and increased medication use. Air pollution also might act synergistically with other environmental factors to worsen asthma and some evidence suggests that exposure to ozone can enhance a person's responsiveness to inhaled allergens.

House dust mites, cockroaches, mold and animal dander have been identified as the principal allergens that trigger asthma symptoms. Reducing exposure to these allergens has been shown not only to reduce asthma symptoms and the need for medication, but also to improve lung function. Environmental tobacco smoke (also called secondhand smoke) is an important irritant that can trigger an asthma episode and possibly worsen the effects of allergens.

Q: In emphasizing environmental triggers, are you suggesting that people could avoid asthma if they simply cleaned their houses better? (DHHS)

A. Of course not. This is not a matter of blaming the victim. The issue is to help people understand and deal with those things in their day-to-day living environments such as animal dander and tobacco smoke that trigger asthma attacks.

Q. What has the Clinton Administration done to combat asthma? (DHHS & EPA)

A. Although a great deal of work is still ahead of us in the fight against asthma, the Administration is proud of the work it has accomplished to date:

Major Accomplishments of the Department of Health and Human Services (DHHS)

The Department of Health and Human Services supports research, health services delivery, and public health practice to address the growing problem of asthma.

Research. This year, enhancing its investments of recent years, HHS will invest over \$100 million in asthma research. HHS-supported grantees have been responsible for many of the scientific breakthroughs that helped shape the Guidelines for the Diagnosis and Management of Asthma.

Health Services Delivery. Medicaid and Medicare expenditures for treatment of asthma are estimated to exceed one billion dollars per year. In addition, thousands of people each year receive care for their asthma at HHS-funded facilities such as community health centers and hospitals of the Indian Health Service.

Public Health Practice. Current spending on public health programs, apart from direct patient care, is approximately \$5 million. The Department supports model programs and partnerships that convey information about asthma management to public health officials, health care providers, patients, and their family members.

Major EPA Accomplishments

Air Pollution. In July 1997, EPA updated the public health standards for smog (ozone) and particulate matter (soot). These standards were based on protecting sensitive populations such as children. These standards will prevent approximately 15,000 premature deaths, about 350,000 cases of aggravated asthma and nearly a million cases of significantly decreased lung function in children.

Research. In August 1998, EPA and DHHS established the first-ever federal research centers dedicated solely to studying children's environmental health hazards. Jointly funded by EPA and DHHS, these Centers for Children's Environmental Health Research were created at eight leading research institutions. Five of these centers are focusing on asthma. They will better our understanding of the link between secondhand smoke, smog, and other pollutants and the rise in asthma rates.

Secondhand Smoke. EPA completed a landmark risk assessment in 1993 on the health effects of secondhand smoke on adults and young children, including strong conclusions on the relationship between secondhand smoke and the frequency and severity of asthma attacks. This report has led to major public policy changes resulting in substantial reductions in exposure of children and adults to secondhand smoke.

Public Health Education. EPA has led the effort to provide practical solutions to problems associated with indoor air pollution and has published extensive guidance for the public and building managers to help reduce exposure to asthma triggers in schools, homes, and day care facilities.

Q: What are DHHS' priorities in countering asthma? (DHHS)

A: The Department has four priorities:

- to determine the causes of asthma and develop interventions to prevent it from developing in the first place;

- to reduce the burden of asthma for people with the disease;

- to eliminate the disproportionate health burden of asthma in minority populations and those living in poverty; and

- to track the disease and assess the effectiveness of asthma programs.

Q: What will DHHS do to reduce the burden of asthma? (DHHS)

A: The Department, in collaboration with public and private partners, will continue to foster public health programs that improve access to quality medical care and foster widespread use of current medical and scientific knowledge to prevent and/or reduce the severity of asthma attacks. The Department also will expand research with a view to discovering and developing improved means of managing asthma, including determining more about the triggers of asthma attacks and the variability among patients with respect to their response to these triggers.

Q. What are EPA's priorities in countering asthma? (EPA)

The President's FY2000 budget includes \$22 million for the U.S. Environmental Protection Agency to address environmental factors that contribute to the rising rates of asthma. These funds will help reduce children's exposure in the home, schools, and day care facilities to known asthma triggers such as secondhand smoke and indoor allergens (e.g. dust mites, animal dander, insects, and mold) by:

- *Implementing School-based Programs:* EPA will invest \$8.4 million to expand outreach and educational programs to inform parents, teachers, and children about how to improve indoor air quality for children with asthma and manage potential asthma triggers. With this investment, 2 million children across the nation will breathe cleaner air in their classrooms.
- *Creating a New National Public Information Campaign:* EPA and DHHS will work together to develop and implement a national public information campaign to reduce children's exposure to secondhand smoke and other indoor asthma triggers. This campaign will include: a \$4 million dollar national public service campaign and expanded community-based outreach programs; a \$1 million dollar expansion of existing in-home education networks to provide direct in-home assistance to help parents identify asthma triggers and implement effective strategies to reduce health risks; and \$1.2 million dollars to better equip health care providers to educate children and their parents about ways to reduce exposure to asthma triggers.
- *Researching the Link Between Environmental Factors and Asthma:* EPA will spend \$5 million to expand its research into the role that environmental hazards (including chemicals, particles, ozone, diesel exhaust, pesticides, tobacco smoke and allergens) play in the onset of childhood asthma and to develop better and more practical strategies for improving the quality of life of children with asthma. EPA will also invest \$1 million to conduct a pilot program to expand air pollution monitoring in up to two communities downwind of industrialized urban centers to better understand the relationship between air pollution and asthma.

Q: What will DHHS do to reduce the disproportionate burden of asthma upon racial and ethnic minorities and disadvantaged populations? (DHHS)

A: The Department will foster research and other activities toward

understanding of the causes of the disproportionate impact of asthma; for example, distinguishing the roles in asthma incidence and prevalence of location-specific, and, in cooperation with EPA, environmental factors (e.g., air pollution, occupational exposures) from those of ethnicity, cultural variables, and genetics;

assessing the impact of managed care on Medicaid children and adults with asthma; and

determining the relative influences of poverty, race, and ethnicity on the use of emergency room services for asthma.

Q: How will DHHS track the asthma epidemic to determine the effectiveness of its programs? (DHHS)

A: Current surveillance capability permits the Centers for Disease Control and Prevention to track asthma prevalence, asthma physician office visits, asthma emergency room visits, asthma hospitalizations, and asthma mortality at a national level and in four geographic regions. Except for mortality data, this type of information generally is unavailable at the state or local level. In future years, the Department will be seeking to improve the scope and depth of asthma surveillance. The Department also will seek to complement surveillance – e.g., with studies designed to identify populations with high or low asthma prevalence that might shed light on factors that influence the development of asthma. EPA will also utilize data available through DHHS programs to the extent possible to help it evaluate the effectiveness of environmental interventions in reducing the impact of childhood asthma.

Q. What will the Children's Asthma and the Environment strategy accomplish? (EPA)

This strategy is important for several reasons:

- It consolidates federal resources and expertise to focus on this epidemic.
- It establishes four principles for Federal efforts in this area:

A focus on efforts to:

--eliminate the disproportionate impact of asthma in minority populations and those living in poverty;

--emphasize partnerships and community based programs;

--commit to setting measurable and consistent goals for childhood asthma under the Healthy People 2010 program;

--invest in evaluation to identify those strategies that are most effective in reducing the burden of asthma so that they may be replicated.

- The strategy also calls for action in four areas:

Research: Research will be conducted to understand the role environmental pollutants (including chemicals, fine particles, ozone, diesel exhaust, pesticides, tobacco smoke and allergens) play in the onset of asthma episodes in children and what causes asthma. This research will help us develop practical strategies for improving the quality of life of children with asthma.

Public Health Programs: Using our current scientific knowledge, DHHS and EPA will implement public health programs that reduce environmental exposures to asthma triggers to prevent and reduce the severity of asthma attacks. This will include: promoting national guidelines to reduce environmental factors that worsen asthma; expanding support for state and local public health action; establishing school-based asthma programs in communities to help reduce and eliminate allergens and other environmental risk factors in schools; and reduce children's exposure to environmental tobacco smoke and other indoor asthma triggers in their homes.

Surveillance: Establish a coordinated, integrated, systematic nationwide asthma surveillance system for collecting and analyzing health outcome and risk factor data at the state, regional and local levels.

Addressing disproportionate impacts on the poor and minorities: We plan to eliminate the disproportionate burden of asthma among different racial groups and those living in poverty. We will conduct research and surveillance to better understand the scope of the problem and implement activities designed to reduce and eventually eliminate this disproportionate impact.

Q. What is the initiative on disease management? (DHHS)

DHHS proposes to conduct a demonstration to test the use of innovative disease management techniques for children enrolled in the Medicaid fee-for-service program. The Department will provide \$50 million for competitive start-up grants to states that submit meritorious disease management programs to identify and treat children with asthma using the most appropriate care - the NHLBI guidelines for Diagnosis and Management of Asthma. Participating states would be required to measure the success of the program.

Q. What is Disease Management? (DHHS)

Disease management combines the use of the most-up-to-date treatment protocols ("best practices") with a prevention component -i.e., disease-specific education programs and health screening; an intensive case management component -i.e., close monitoring of patient care and treatment compliance; and a self-care component -i.e., empowering patients and their families to identify symptoms and care for their own chronic disease.

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002. fax	Post-It Fax note re: phone number (partial) (1 page)	01/27/1999	P6/b(6)

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Domestic Policy Council
Eric Morse (Events)
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FOLDER TITLE:

Asthma Budget Rollout 1/28/1999

2011-0619-S

rc288

RESTRICTION CODES

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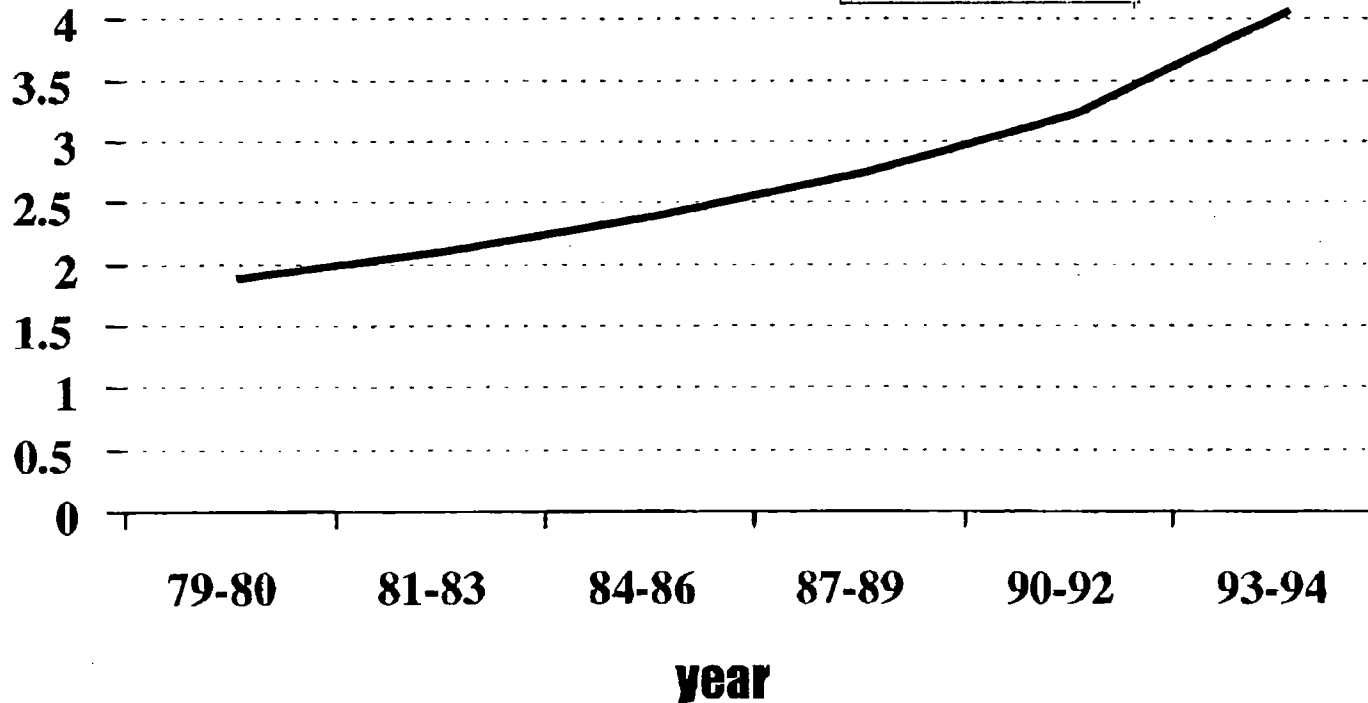
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Prevalence of asthma in children, 0-14 yrs old, 1979-1994

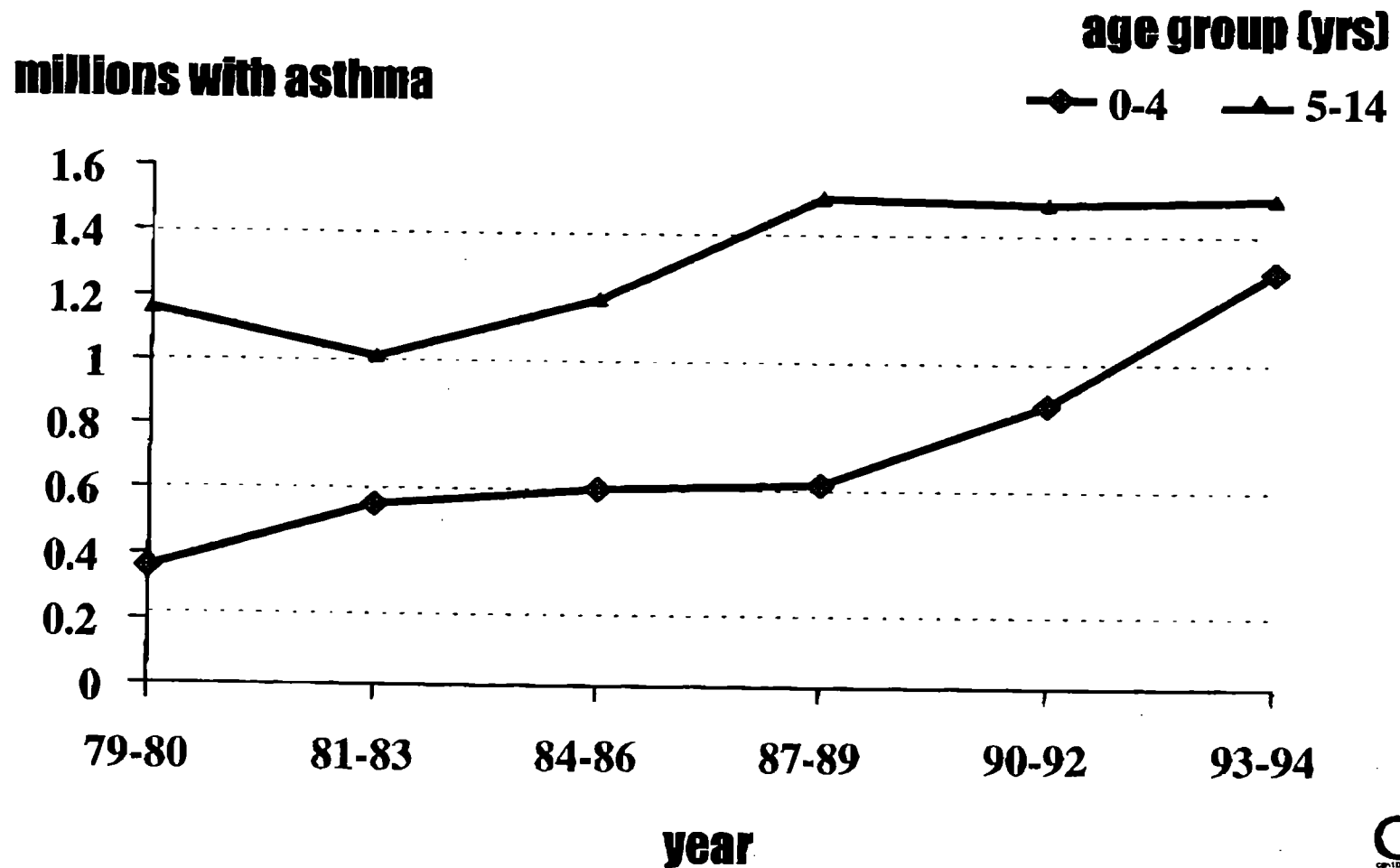
millions with asthma

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Prevalence of Asthma in Children 0-14 years old 1979-1994



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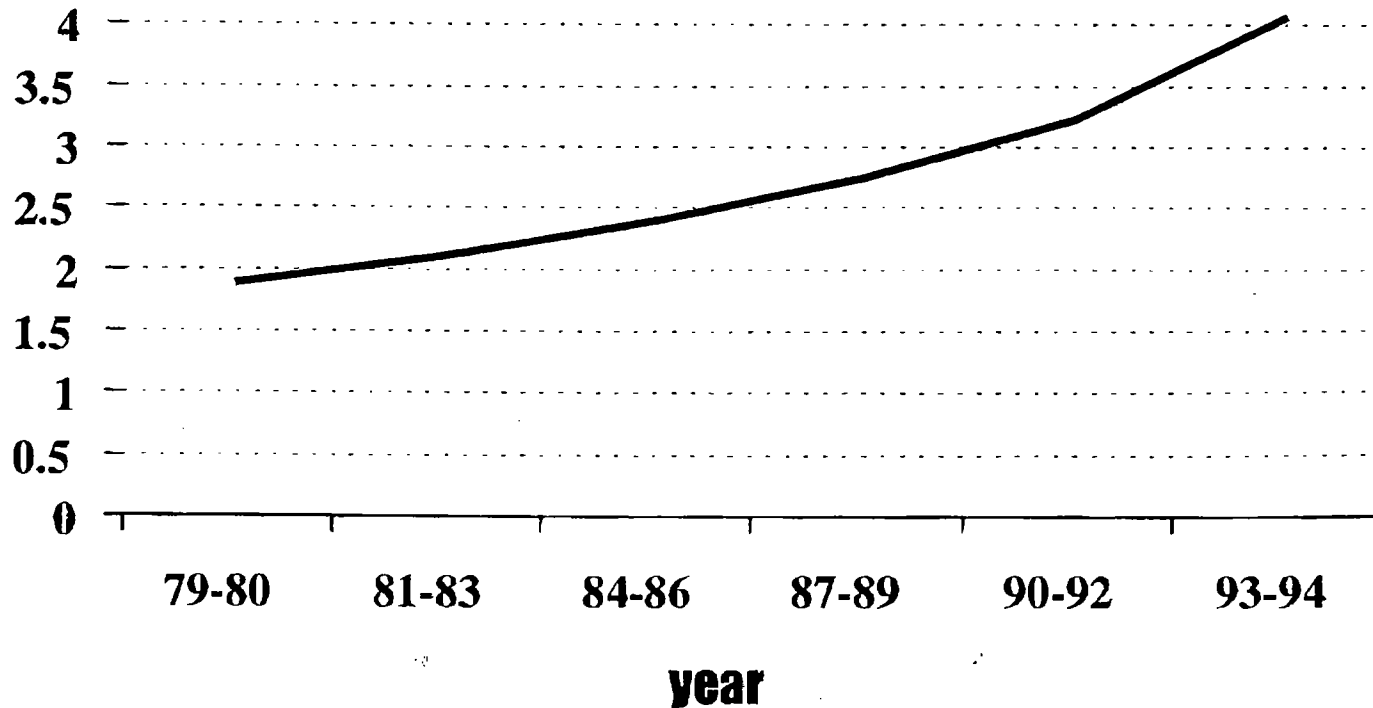
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Prevalence of Asthma in Children 0-14 years old 1979-1994

millions with asthma



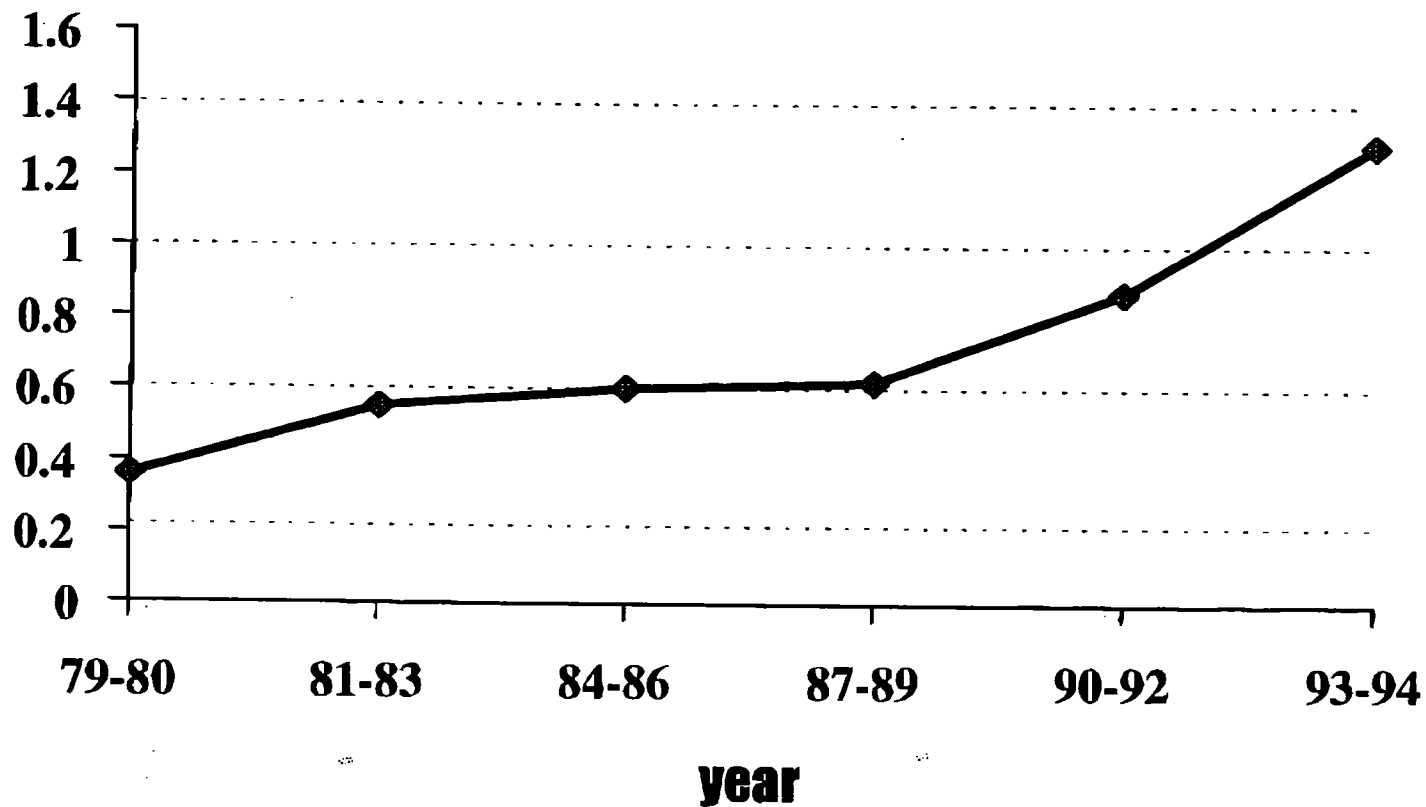
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CDC
CENTERS FOR DISEASE CONTROL
AND PREVENTION

Prevalence of Asthma in Children 0-5 years old 1979-1994

millions with asthma



Asthma and the Environment:

A Strategy to Protect Children



President's Task Force on Environmental Health
Risks and Safety Risks to Children

ABOUT THE PRESIDENT'S TASK FORCE ON ENVIRONMENTAL HEALTH RISKS AND SAFETY RISKS TO CHILDREN

In recognition of the growing body of scientific information demonstrating that America's children suffer disproportionately from environmental health risks and safety risks, President Clinton issued Executive Order 13045 on April 21, 1997, directing each Federal Agency to make it a high priority to identify, assess, and address those risks. In issuing this order, the President also created the Task Force on Environmental Health Risks and Safety Risks to Children, co-chaired by Donna Shalala, Secretary of the Department of Health and Human Services, and Carol M. Browner, Administrator of the Environmental Protection Agency. The



Task Force was charged with recommending strategies for protecting children's environmental health and safety. Two subcommittees were established in the Executive Order to carry out this directive: a subcommittee directed to review and foster public access to federal government sponsored research on environmental health and safety risks to children, and a subcommittee directed to identify priority public outreach activities related to protecting children's environmental health and safety.

In April 1998, the Task Force identified four priority areas for immediate attention: childhood asthma, unintentional injuries, developmental disorders, and childhood cancer. The Task Force created and charged the Asthma Priority Area Workgroup, co-chaired by EPA and DHHS, with reviewing current Federal efforts to address the many facets of the issue and, most importantly, to make appropriate recommendations for action by the Federal government. This strategy is the result of that effort.

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EXECUTIVE SUMMARY

An epidemic of asthma is occurring in the United States. While the epidemic affects people of all ages, children are particularly affected. Nearly 1 in 13 school-aged children has asthma, and the percentage of children with asthma (i.e., prevalence rate) is rising more rapidly in preschool-aged children than in any other age group.

There is no national system to collect data from states specifically on asthma, although several states are developing systems to collect such data. Although national data do not provide the resolution necessary to identify particular geographic areas hardest hit by the asthma epidemic, surveys undertaken in a number of large cities in the United States indicate that the prevalence and severity of asthma are greatest in the large, urban inner cities.

**An epidemic
of asthma is
occurring in
the United
States.**

Asthma is one of the leading causes of school absenteeism, accounting for over 10 million missed school days per year. Asthma also accounts for many nights of interrupted sleep, limitation of activity, and disruptions of family and care-giver routines. Asthma symptoms that are not severe enough to require a visit to an emergency room or to a physician can still be severe enough to prevent a child with asthma from living a fully active life.

In 1990, the cost of asthma to the U.S. economy was estimated to be \$6.2 billion, with the majority of the expense attributed to direct medical expenses. A 1996 analysis found the cost of asthma to be \$14 billion, indicating a rapidly increasing financial burden. These estimates, which are not limited to the costs of childhood asthma, indicate that the direct medical costs of asthma account for between 1% and 3% of all health care expenditures in the United States.

Asthma is a particularly important disease to consider in the context of environmental hazards to which children are exposed. Children breathe more air, eat more food, and drink more liquid in proportion to their body weight than do adults, and their developing respiratory, immunological, and digestive systems may be more susceptible to environmental exposures than those of adults. In a typical day, children may be exposed to a wide array of environmental agents at home, in day care centers, schools and while playing outdoors. There is substantial evidence that environmental exposures, including viruses and allergens, play a major role in triggering asthma symptoms. Indoor airborne allergens include those from house dust mites, cockroaches, mold and animal dander. In addition, exposure to environmental tobacco smoke (ETS), also known as secondhand smoke, has been shown to be a major determinant of asthma symptoms. Elevated levels of outdoor air pollutants, particularly ozone and exposure to outdoor allergens (e.g. pollens, molds), are associated with increased symptoms and an increased risk of emergency department visits for asthma, as well.

In addition, environmental factors such as airborne allergens and environmental tobacco smoke may play a major role in the onset of asthma. Other pollutants may also play a role, although the scientific data are inadequate to offer firm conclusions. Genetic predisposition is the strongest known risk factor for developing asthma, but the rapidly rising number of cases of childhood asthma cannot be solely genetic because the genetic composition of the population changes slowly. Rather, some interaction between genetic predisposition and environmental exposures, and possibly other factors such as diet, increased body weight, or lack of exercise are likely to be responsible for the increase. Further work is essential to clarify how genetic susceptibility and environmental exposures interact to cause asthma.

Reducing exposures of children with asthma to airborne allergens and pollutants will reduce the health burden of asthma and significantly improve their quality of life. It is not yet certain, but it is possible that reducing the exposure of infants and young children at risk of developing asthma may prevent its onset. Environmental control methods and asthma treatments are available now that can help children and their families control asthma and lead healthy, active lives. Yet not all children have access to these measures. Too many children miss school, limit their physical activity, and are seriously ill because of asthma. A child ill with asthma also has an impact on the entire family.



This strategy, prepared by the Task Force, is aimed at developing a further understanding of the role of environmental factors associated with the:

- onset of asthma; and
- triggers of asthma attacks

The efforts of the Task Force resulted in four recommendations for Federal action for addressing childhood asthma, which are presented in this strategy. The strategy also sets forth guiding principles that were used to develop the four recommendations.

GUIDING PRINCIPLES

Federal agency actions can provide leadership and direction in reducing environmental risks to protect children who have asthma or are at risk of developing it. Recommendations for action put forward in this initiative are predicated on the principles that federal action must have:

- A focus on efforts to *eliminate the disproportionate impact of asthma in minority populations and those living in poverty.*
- An emphasis on *partnerships and community based programs.*
- A commitment to setting *measurable and consistent goals* for childhood asthma under the Healthy People 2010 program.

- *An investment in evaluation* to identify those strategies that are most effective in reducing the burden of asthma so that they may be replicated.

RECOMMENDATIONS

RESEARCH

Strengthen and accelerate focused research into the environmental factors that cause or worsen childhood asthma.

- ⇒ Strengthen and accelerate research into the environmental factors that may contribute to the onset of asthma in children.
- ⇒ Expand and accelerate research to develop and evaluate environmental strategies that will improve the quality of life of people with asthma.

This initiative is about protecting children from environmental risks that either cause or worsen asthma...

PUBLIC HEALTH PROGRAMS

Implement public health programs that foster improved use of current scientific knowledge to reduce environmental exposures to prevent and reduce the severity of symptoms for those with asthma.

- ⇒ Promote clinician and patient implementation of national guidelines for reducing environmental risks that worsen asthma.
- ⇒ Expand support for state and local public health action.
- ⇒ Reduce children's exposure to environmental tobacco smoke and other indoor triggers in their homes.
- ⇒ Establish school based asthma programs that help reduce or eliminate allergens and irritants and that promote student's self management of asthma and full participation in school activities.
- ⇒ Continue to reduce outdoor air pollution.

SURVEILLANCE

Establish a coordinated, integrated, and systematic nationwide asthma surveillance system for collecting and analyzing health outcome and risk factor data at the state, regional and local levels.

DISPROPORTIONATE IMPACT ON THE POOR AND MINORITIES

Identify the reasons for and eliminate the disproportionate burden of asthma among different racial and ethnic groups and those living in poverty.

- ⇒ Improve asthma management for children within the medicaid program.



INTRODUCTION

The Growing Problem of Asthma in Children

Asthma is a chronic inflammatory lung disease characterized by recurrent episodes of breathlessness, wheezing, coughing, and chest tightness; these episodes are also known as exacerbations or attacks. The severity of exacerbations can range from mild to life threatening. Both the frequency and severity of asthma symptoms can be reduced by the use of medications and by reducing exposure to the environmental triggers of asthma attacks.

For the past 15 years, an epidemic of asthma has occurred in the United States. By all indications, this epidemic is continuing. Although asthma has become a major public health problem affecting Americans of all ages, races and ethnic groups, children have been particularly severely affected.



National survey data indicate that the number of children with asthma in the United States has more than doubled in the past 15 years. In 1980, 2.3 million American children had asthma. In 1995, the most recent year for which data are available, the number of affected children had risen to 5.5 million. Based on these trends, it is estimated that in 1998 more than 6 million children in the United States have asthma. Prevalence rates of asthma are highest in boys and are increasing in both boys and girls, and in all race and ethnic groups. The prevalence of asthma in children under age 18 is 7.3%. The most rapid increase has occurred in children under 5 years old, with rates increasing over 160% over the past 15 years.

The number of deaths attributed to asthma in children has also increased. In 1977, 84 deaths in children 18 and younger were recorded; the number of deaths has risen to 280 in 1995, a more than 3-fold increase. Although the death rate due to asthma has increased in all racial and ethnic groups, minority populations experience a disproportionately higher death rate from asthma. In 1995, the death rate from asthma in African-American children, 11.5 per million, was over four times the rate in white American children, 2.6 per million. The higher death rates among African-American children are especially troubling.

The number of hospitalizations and emergency room visits for asthma have increased in all population groups. Asthma accounts for one-third of all pediatric emergency room visits and is the fourth most common cause for physician office visits. The variation in the impact of asthma across racial and ethnic groups is significant. African-American children have an annual rate of hospitalization of 74 per 10,000, over 3 times that for white children, 21 per 10,000. In addition, African-American children are approximately 4 times more likely than white children to seek care at an emergency room. In short, African-American children have a slightly higher risk of getting asthma, but have a much higher risk of hospitalization or death due to the disease.

At the present time, surveillance for asthma in children is limited to analyses of ongoing surveys and data systems on health events such as mortality, hospitalization, and outpatient visits. Other than for African Americans, such information is extremely limited for most ethnic groups.

There is no national system to collect data from states specifically on asthma, although several states are developing systems to collect such data. Although national data do not provide the resolution necessary to identify particular geographic areas hardest hit by the asthma epidemic, surveys undertaken in a number of large cities in the United States indicate that the prevalence and severity of asthma are greatest in the large, urban inner cities.

There is no national system to collect data from states specifically on asthma, although several states are developing systems to collect such data.

These measures, particularly for death, hospitalization, and emergency room visits, give an incomplete picture of the true burden of asthma in the United States. For example, one follow-up study of children with asthma in inner city areas found a nearly 10 times higher likelihood of a child suffering symptoms of asthma on a given day than visiting an emergency room. Asthma is one of the leading causes of school absenteeism, accounting for over 10 million missed school days per year. Asthma also accounts for many nights of interrupted sleep, limitation of activity, and disruptions of family and care-giver routines. Asthma symptoms that are not severe enough to require a visit to an emergency room or to a physician can still be severe enough to prevent a child with asthma from living a fully active life.

Estimating the costs of asthma is an indirect way to measure its health burden. In 1990, the cost of asthma to the U.S. economy was estimated to be \$6.2 billion (Weiss, 1992), with the majority of the expense attributed to direct medical expenses. A 1996 analysis (Farquhar, et al, 1998) found the cost of asthma to be \$14 billion, indicating a rapidly increasing financial burden. These estimates indicate that the direct medical costs of asthma for all ages account for between 1% and 3% of all health care expenditures in the United States.

What We Know About Childhood Asthma

Over the past 15 years, there have been major advances in the scientific understanding of asthma. Asthma is now known to be a disease of airway inflammation resulting from a complex interplay between environmental exposures and genetic and other factors. This has implications for the medical treatment and for the environmental management of asthma.

In contrast to the limited understanding of the relationship of environmental exposures to the onset of asthma, the environmental triggers of asthma attacks for children with asthma have become increasingly well characterized. House dust mites, cockroaches, mold and animal dander have been identified as the principal allergens that trigger asthma symptoms. Reducing exposure to these allergens has been shown not only to reduce asthma symptoms and the need for medication, but also to improve lung function. Environmental tobacco smoke is an important irritant that can trigger an asthma episode and possibly worsen the effects of allergens. Upper respiratory viral infections are also recognized as important triggers for asthma episodes.

Children with asthma have long been recognized as particularly sensitive to outdoor air pollution. Many common air pollutants, such as ozone, sulfur dioxide, and particulate matter are respiratory irritants and can exacerbate asthma. Air pollution also might act synergistically with other environmental factors to worsen asthma. For example, some evidence suggests that exposure to ozone can enhance a person's responsiveness to inhaled allergens. Whether long term exposure to these pollutants can actually contribute to the development of asthma is not known. To date, little research has examined the role of other hazardous air pollutants (e.g., metals and volatile chemicals) in the development or exacerbation of asthma, although this is an issue of increasing public concern.

Children with asthma have long been recognized as particularly sensitive to outdoor air pollution.

In addition to improved understanding of appropriate environmental management of asthma, the medical management of asthma has changed significantly. Inhaled anti-inflammatory medications have become the mainstay of medical management to prevent asthma episodes and lessen chronic symptoms of asthma. In addition, improvements in monitoring techniques now permit objective measures of lung function that are easy for patients and physicians to use in assessing asthma severity and monitoring changes in the disease. In a disease like asthma that varies considerably over time and where changes in lung function can occur before symptoms develop, these objective measures are essential tools for making management decisions.

As a result of these advances, the medical and environmental management of asthma is better defined and the knowledge exists to manage asthma better than ever before. One especially important finding is that patient education has been documented to be cost effective. Teaching patients and their families specific management skills improves asthma management, reduces the use of emergency services, and improves quality of life. This is particularly important for asthma management, since the environmental management of asthma requires knowledge of asthma triggers and specific actions that can be undertaken to reduce exposure to these triggers. The treatment goal for almost all individuals with asthma should be for that person to lead a life unrestricted because of asthma.

Reducing exposure to environmental allergens and pollutants will reduce the frequency and severity of attacks for children with asthma, reduce their need for medicine, and improve their lung function. Children are exposed to many environmental agents that could trigger asthma attacks. For example, 25% of children in America live in areas that regularly exceed EPA limits for ozone. Approximately 29% of households still permit exposure of children to secondhand smoke in the home on a regular basis and exposure to environmental tobacco smoke is so widespread that approximately 88% of all children have some level of documented exposure (Pirkle, 1996). A high proportion of children living in the inner city are exposed to high levels of cockroach antigen.

Why Has Asthma Reached Epidemic Proportions in Children?

The causes of the increasing rate of asthma over the past 15 years and the particular role that environmental exposures play are not known, but there are some clues. Atopy, the genetically inherited susceptibility to become allergic, is the most important predictor of a child developing asthma. A substantial research effort is underway to identify the genes that are responsible for susceptibility to asthma. Because the genetic make-up of the population changes slowly, genetic susceptibility alone cannot be responsible for the epidemic of asthma that has occurred in the United States over the past 15 years. Further work is essential to clarify how genetic susceptibility and environmental exposures interact to cause asthma. Factors such as the intensity of environmental exposure and the age of the person being exposed are likely to be important.

Exposure to allergens found indoors is a strong risk factor for developing asthma. Children are spending increasing amounts of time indoors, thus increasing their exposure to indoor allergens.

The causes of the increasing rate of asthma over the past 15 years and the particular role that environmental exposures play are not known

The environmental exposures most strongly suspected of causing asthma to develop include environmental tobacco smoke and allergens such as house dust mites, cockroaches, mold, and animal dander. Exposures that stimulate the immune system may also be significant, such as diet during the prenatal period and early infancy, the pattern of respiratory infections early in life, and even decreasing rates of exercise have all been suggested as risk factors for the development of asthma.

Scope of the Strategy

This strategy is about protecting children from the environmental risk factors that make their asthma worse. Environmental action may also help prevent asthma. To accomplish this goal, the environmental aspects of asthma must be considered in the context of other aspects of asthma prevention and management, such as access to quality medical care and efforts to understand the disproportionate health impact of asthma among minority populations. Childhood asthma is a multi-factorial disease, and efforts to improve its management and to prevent it will require multi-dimensional, multi-disciplinary efforts that must occur simultaneously. This Asthma and the Environment strategy focuses on improving the environment in which children with asthma live, learn, play and work. Environmental action, along with medical care, will help children with asthma live productive, active lives and may spare future generations of children from the disease altogether. The Task Force has prepared the following four goals to be accomplished in the next ten years, guided by the vision that in the 21st century, every child in America will live, learn, work, and play in environments that do not cause or worsen asthma.

GOALS OF THE ASTHMA AND THE ENVIRONMENT STRATEGY

BY THE YEAR 2005, THE NUMBER OF HOUSEHOLDS IN WHICH CHILDREN ARE REGULARLY EXPOSED TO SECONDHAND SMOKE WILL BE REDUCED TO 15%.¹

BY THE YEAR 2010, ASTHMA HOSPITALIZATION RATES IN CHILDREN WILL HAVE FALLEN TO NO MORE THAN 10 HOSPITALIZATIONS PER 10,000 PEOPLE.² (Healthy People 2010 DRAFT)

BY THE YEAR 2010, EMERGENCY DEPARTMENT VISITS WILL BE REDUCED TO NO MORE THAN 46 PER 10,000 PEOPLE.³
(Healthy People 2010 DRAFT)

BY THE YEAR 2010, NO MORE THAN 10% OF CHILDREN WITH ASTHMA WILL EXPERIENCE ACTIVITY LIMITATIONS.⁴
(Healthy People 2010 DRAFT)

1 Baseline: 29% in 1994. Source: Biennial Radon and ETS Survey of the Conference of Radiation Control Program Directors and EPA.

2 Baseline: Hospitalization rate per 10,000 population in 1993-94: 18 for total population; 50 for children 0-4 yrs of age and 18 for children 5-14 yrs. Source: Healthy People 2010 Draft

3 Baseline: Emergency room visits 71 per 10,000 population for total population in 1992-94; 121 for children 0-4 yrs of age and 81 for children 5-14 yrs. Source: Healthy People 2010 Draft

4 Baseline: Activity limitation for persons with asthma; 22 percent for overall population in 1992-94. No children-specific data available. Source: Healthy People 2010 Draft

VISION FOR THE 21ST CENTURY

**Every child in America will
live, learn, work, and play
in environments that do
not cause or worsen
asthma.**

GUIDING PRINCIPLES

Federal agency actions can provide leadership and direction in reducing environmental risks to protect children who have asthma or are at risk of developing it. Recommendations put forward in this strategy are predicated on the principles that federal action must have:

1. A focus on efforts to better understand and eliminate the disproportionate impact of asthma in minority populations and those living in poverty.

Poor and minority children are much more likely than white, non-Hispanic children to visit an emergency room, to be hospitalized, or to die from asthma, although the rising prevalence of asthma has affected all populations. The reasons for this disparity are not known, although environmental exposures and limited access to quality medical care may all play a role.

The focus on eliminating disparities across racial and ethnic groups has to be considered in all efforts to prevent asthma and its health impact; however, because of the importance of this issue the Task Force has included a specific recommendation in this strategy to examine, understand, and ultimately eliminate disparities.

2. An emphasis on partnerships and community based programs.

A successful effort to reduce childhood asthma will depend in part on the level of success achieved in enlisting all sectors of society in efforts to implement effective programs to prevent and manage the disease. Federal agencies have already forged effective partnerships with many health and professional organizations, corporations, and foundations to conduct training, educate health care providers and the public, and to implement a wide range of prevention activities at the national, state, and local levels.

Expanded partnerships both within government and between government and the private sector are needed. With increasing knowledge about the primary causes of asthma and triggers of asthma attacks, the challenge for the 21st century will be to integrate new research findings into effective environmental, medical and educational programs. Partnerships will be critical to implementing this broad vision of asthma control. In particular, community-based programs should integrate asthma control activities into existing systems such as schools, child care, youth programs, workplaces, primary health, and job training programs.

The challenge for the 21st century will be to integrate new research findings into effective environmental, medical and educational programs.

3. A commitment to setting measurable and consistent goals for childhood asthma under the Healthy People 2010 program.

Health objectives are now being developed for the year 2010 and represent a significant revision of the goals set for the year 2000. These objectives will set the nation's health agenda for increasing years of healthy life and reducing disparities among the entire American population. Draft objectives currently encompass an expanded set of asthma-related objectives for improved clinical management as well as a series of environmental objectives addressing known asthma triggers such as indoor allergens, secondhand smoke and outdoor air pollution. The goals embodied in the final Healthy People 2010 document will serve as the tools to measure progress towards control of asthma.

4. Investment in evaluation of programs to identify those strategies that are most effective in reducing the burden of asthma so that they may be replicated.

Asthma intervention programs and related activities need to be fully evaluated to determine those techniques which are successful and should be replicated. Evaluation should be incorporated in the planning of all programs and should include:

- identification of desired health outcomes of the program;
- measurement of effectiveness of the intervention activities and processes used to implement them;
- identification of unforeseen obstacles;
- assessment of the cost-effectiveness of the program;
- a prediction of long term sustainability of the program.

RECOMMENDATIONS

I. RESEARCH

Strengthen and accelerate focused research into the environmental factors that cause or worsen childhood asthma.

EXPAND RESEARCH INTO THE ENVIRONMENTAL FACTORS THAT CONTRIBUTE TO THE ONSET OF ASTHMA IN CHILDREN.

Though progress has been made in understanding what causes asthma, there is currently insufficient scientific information to establish specific guidelines and recommendations for public health practices to prevent the onset of asthma in children (i.e. primary prevention).

In order to establish primary prevention guidelines, the top priority for research is to determine the causes of asthma in children and particularly the role of the environment. To understand what causes asthma, research must identify the basic cellular and molecular mechanisms that cause airway inflammation and sensitization and, in particular, the interaction of environmental exposures and genetic susceptibility. In addition, clinical and epidemiologic studies are needed to examine the relationship between environmental exposures and the onset of asthma.



Because of promising preliminary work on the relationship of indoor allergens and asthma onset, as well as the much greater proportion of time that children spend indoors, greater emphasis on examining the relationship of indoor exposures to the development of asthma is warranted. Exposures to high levels of allergens in the indoor environment have been shown in some studies to be associated with the subsequent development of asthma. However, few studies have examined the importance, by geography, of particular allergens. In studies evaluating the role of indoor allergens on exacerbations of asthma, different allergens, such as those associated with cockroaches, dust mites, and mold, have been implicated in different cities. This suggests that different allergens can exacerbate asthma, and that different allergens may be capable of inducing the new onset of asthma.

In one study (Hyde, et al, 1997) avoiding exposure to dust mite and food allergens early in life was found to reduce the risk of developing asthma in the first year of life. However, this effect was not statistically significant at 2 to 4 years of age. Whether such allergen avoidance strategies are feasible and effective in reducing the development of asthma is not known.

The complex interactions between outdoor air pollutants and allergens and the development of asthma have not been adequately evaluated. Some epidemiologic studies have suggested a relationship between exposure to volatile organic compounds and prevalence rates of childhood asthma. Because adult-onset asthma is known to be associated with occupational exposures to volatile organic compounds including formaldehyde, ethylene oxide, and isocyanates, further work to assess the possible etiologic role of specific pollutants in childhood asthma is appropriate.

EXPAND AND ACCELERATE RESEARCH TO DEVELOP AND EVALUATE ENVIRONMENTAL STRATEGIES THAT WILL IMPROVE THE QUALITY OF LIFE FOR CHILDREN WITH ASTHMA.

It is well established that inhaled allergens and irritants and outdoor pollutants provoke asthma symptoms. Research is needed to identify if other environmental exposures are significant. Further, the relative importance of various exposures is not well understood. Cost effective strategies for reducing exposures are not well developed.

Patient education strategies in certain populations have profound impacts on reducing the frequency and severity of exacerbations and improving the quality of life for children. But many of these programs are not responsive to the cultural, ethnic, and economic diversity of the American population. Innovative strategies are urgently needed for reaching a wide range of children and their families, for tailoring recommendations for reducing environmental exposures to their needs, and for providing support to follow the recommendations.

2. PROGRAMS TO IMPROVE PUBLIC HEALTH

Implement public health programs that improve use of scientific knowledge to prevent and reduce the severity of asthma symptoms by reducing environmental exposures.

PROMOTE CLINICIAN AND PATIENT IMPLEMENTATION OF NATIONAL GUIDELINES FOR REDUCING ENVIRONMENTAL RISKS THAT WORSEN ASTHMA.

Despite uncertainty about the causes of the increase in asthma prevalence rates, much can and should be done to prevent severe illness and death from asthma and improve the quality of life of persons with asthma. Experts convened by the National Asthma Education and Prevention Program (NAEPP) coordinated by the National Institutes of Health (NIH) have reviewed the

scientific literature and produced guidelines for managing asthma. These include specific recommendations for controlling environmental factors that contribute to asthma severity.

While there is consensus that NAEPP guidelines define the best diagnosis and management practices for asthma, dissemination of the guidelines must be expanded and adoption improved. Many clinicians do not include advice about environmental control in their patient education. Among families who do receive recommendations, adherence is generally low. Asthma is highly variable, and families need help establishing priorities for environmental control measures that will be suitable for their individual child's asthma and their family circumstances. Effective public health programs can provide this education and support.

For children without access to quality health care, appropriate instruction on the environmental triggers of asthma is impossible or severely limited. Emergency rooms or urgent care facilities may serve as the only source of primary care for such children. These settings should be recruited to provide the kind of education and links to chronic disease management services that are essential to reducing the severity and frequency of asthma attacks.

EXPAND SUPPORT FOR STATE AND LOCAL PUBLIC HEALTH ACTION.

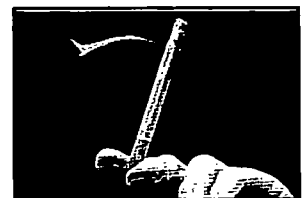
Recent advances in the treatment of asthma and in identifying the environmental triggers of asthma attacks make it possible to control and prevent symptoms at a level unheard of just ten years ago. But these gains have not been realized by many of our children. Public health agencies have a critical role in helping to reduce environmental factors affecting asthma and the human and financial toll of the disease. These programs should include the following components:



- (1) Education and training
- (2) Asthma surveillance
- (3) Coalitions for prevention

REDUCE CHILDREN'S EXPOSURE TO ENVIRONMENTAL TOBACCO SMOKE AND OTHER INDOOR TRIGGERS IN THEIR HOMES.

Secondhand tobacco smoke and indoor allergens are major contributors to the incidence of wheezing in young children and play a significant role in the number and severity of asthma attacks. Reducing smoking in homes with young children will improve the health status of the estimated 2 million children with asthma who are exposed to secondhand smoke. In addition, exposure to allergens such as cockroach, house dust mite, mold, and animal dander causes many attacks of asthma that are preventable.



ESTABLISH SCHOOL BASED ASTHMA PROGRAMS IN EVERY COMMUNITY.

The educational system is a critical component of effective efforts to reduce illness due to asthma in children. Programs will be implemented in schools to assure a healthy physical environment at the school and to promote improved self-management of asthma through education.

CONTINUE TO REDUCE OUTDOOR AIR POLLUTION

The U.S. EPA set national ambient air quality standards (NAAQS) for six air pollutants in 1971, in part based on evidence of associations between air pollutants such as ozone, particulate matter, and sulfur dioxide and asthma. Since that time substantial new epidemiological evidence has been published supporting the association between levels of ozone and particulate matter and increased hospitalization for respiratory causes, such as childhood asthma. In 1997, NAAQS for both ozone and particulate matter were strengthened to improve the protection afforded by these standards and to help reduce the risk of ambient exposures that aggravate asthma in children.

Federal, State, local, and private sector efforts to implement the original NAAQS resulted in substantial improvements in air quality, yet notable problems remain. Following the 1990 Clean Air Act Amendments, efforts were expanded to improve nationwide air quality and reduce related health effects. In conjunction with the strengthening of the ozone and particulate matter NAAQS, EPA has taken steps to integrate implementation measures for these pollutants and to improve the effectiveness of control programs. EPA has also taken steps to inform the public about air pollution that may affect children.



3. SURVEILLANCE

Establish a coordinated nationwide asthma surveillance system for collecting and analyzing health outcome and risk factor data at the state, regional and local levels.

Current national surveillance permits tracking of asthma prevalence, asthma physician office visits, asthma emergency room visits, asthma hospitalizations and asthma mortality at a national level and in four geographic regions (i.e., Northeast, Midwest, South, and West) through surveys conducted by the National Center for Health Statistics. Surveillance information on asthma, with the exception of mortality data, are not available at the state or local level. This information is needed to identify high risk populations and environmental risk factors of

relevance to particular communities and to design and implement interventions that will be most suitable for, and therefore most likely to succeed, in that community. State and local health agencies also need this information to evaluate the impact of local sources of air pollution on childhood asthma in specific communities. A significantly enhanced and expanded surveillance program will be essential to study issues related to race and gender differences in asthma morbidity and mortality among children, identify gaps in providing comprehensive care, and monitor trends in asthma morbidity and mortality at the community level.

4. DISPROPORTIONATE IMPACTS ON THE POOR AND MINORITIES

Identify the reasons for and eliminate the disproportionate burden of asthma among different racial and ethnic groups and those living in poverty.

Poor and minority children are disproportionately affected by asthma, which has reached epidemic proportions in many American inner cities. Prevalence rates vary only by a few percentage points among different race and ethnic groups, yet emergency room use, hospitalization, and mortality rates vary 3- to 4-fold. Understanding the factors that contribute to the disproportionate impact of asthma on minority and lower income populations is the critical first step to reducing and eventually eliminating the disparities between rich and poor, minority and non-minority children. Such factors may include differing intensities of environmental exposures, such as exposure to cockroach antigen and access to and quality of care, among others.

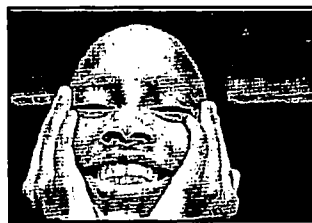
Poor and minority children are disproportionately affected by asthma, which has reached epidemic proportions in many American inner cities.

IMPROVE ASTHMA MANAGEMENT FOR CHILDREN WITHIN THE MEDICAID PROGRAM.

Disease management combines prevention, intensive attention to treatment and patient compliance, and guidance for self-care. This concept has considerable promise for reducing the frequency and severity of asthma attacks. Integrating an asthma disease management initiative within the fee-for-service component of Medicaid would demonstrate the efficacy of this approach in improving children's health.

Asthma and the Environment:

A Strategy to Protect Children



President's Task Force on Environmental Health
Risks and Safety Risks to Children

ABOUT THE PRESIDENT'S TASK FORCE ON ENVIRONMENTAL HEALTH RISKS AND SAFETY RISKS TO CHILDREN

In recognition of the growing body of scientific information demonstrating that America's children suffer disproportionately from environmental health risks and safety risks, President Clinton issued Executive Order 13045 on April 21, 1997, directing each Federal Agency to make it a high priority to identify, assess, and address those risks. In issuing this order, the President also created the Task Force on Environmental Health Risks and Safety Risks to Children, co-chaired by Donna Shalala, Secretary of the Department of Health and Human Services, and Carol M. Browner, Administrator of the Environmental Protection Agency. The



Task Force was charged with recommending strategies for protecting children's environmental health and safety. Two subcommittees were established in the Executive Order to carry out this directive: a subcommittee directed to review and foster public access to federal government sponsored research on environmental health and safety risks to children, and a subcommittee directed to identify priority public outreach activities related to protecting children's environmental health and safety.

In April 1998, the Task Force identified four priority areas for immediate attention: childhood asthma, unintentional injuries, developmental disorders, and childhood cancer. The Task Force created and charged the Asthma Priority Area Workgroup, co-chaired by EPA and DHHS, with reviewing current Federal efforts to address the many facets of the issue and, most importantly, to make appropriate recommendations for action by the Federal government. This strategy is the result of that effort.

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EXECUTIVE SUMMARY

An epidemic of asthma is occurring in the United States. While the epidemic affects people of all ages, children are particularly affected. Nearly 1 in 13 school-aged children has asthma, and the percentage of children with asthma (i.e., prevalence rate) is rising more rapidly in preschool-aged children than in any other age group.

There is no national system to collect data from states specifically on asthma, although several states are developing systems to collect such data. Although national data do not provide the resolution necessary to identify particular geographic areas hardest hit by the asthma epidemic, surveys undertaken in a number of large cities in the United States indicate that the prevalence and severity of asthma are greatest in the large, urban inner cities.

**An epidemic
of asthma is
occurring in
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States.**

Asthma is one of the leading causes of school absenteeism, accounting for over 10 million missed school days per year. Asthma also accounts for many nights of interrupted sleep, limitation of activity, and disruptions of family and care-giver routines. Asthma symptoms that are not severe enough to require a visit to an emergency room or to a physician can still be severe enough to prevent a child with asthma from living a fully active life.

In 1990, the cost of asthma to the U.S. economy was estimated to be \$6.2 billion, with the majority of the expense attributed to direct medical expenses. A 1996 analysis found the cost of asthma to be \$14 billion, indicating a rapidly increasing financial burden. These estimates, which are not limited to the costs of childhood asthma, indicate that the direct medical costs of asthma account for between 1% and 3% of all health care expenditures in the United States.

Asthma is a particularly important disease to consider in the context of environmental hazards to which children are exposed. Children breathe more air, eat more food, and drink more liquid in proportion to their body weight than do adults, and their developing respiratory, immunological, and digestive systems may be more susceptible to environmental exposures than those of adults. In a typical day, children may be exposed to a wide array of environmental agents at home, in day care centers, schools and while playing outdoors. There is substantial evidence that environmental exposures, including viruses and allergens, play a major role in triggering asthma symptoms. Indoor airborne allergens include those from house dust mites, cockroaches, mold and animal dander. In addition, exposure to environmental tobacco smoke (ETS), also known as secondhand smoke, has been shown to be a major determinant of asthma symptoms. Elevated levels of outdoor air pollutants, particularly ozone and exposure to outdoor allergens (e.g. pollens, molds), are associated with increased symptoms and an increased risk of emergency department visits for asthma, as well.

In addition, environmental factors such as airborne allergens and environmental tobacco smoke may play a major role in the onset of asthma. Other pollutants may also play a role, although the scientific data are inadequate to offer firm conclusions. Genetic predisposition is the strongest known risk factor for developing asthma, but the rapidly rising number of cases of childhood asthma cannot be solely genetic because the genetic composition of the population changes slowly. Rather, some interaction between genetic predisposition and environmental exposures, and possibly other factors such as diet, increased body weight, or lack of exercise are likely to be responsible for the increase. Further work is essential to clarify how genetic susceptibility and environmental exposures interact to cause asthma.

Reducing exposures of children with asthma to airborne allergens and pollutants will reduce the health burden of asthma and significantly improve their quality of life. It is not yet certain, but it is possible that reducing the exposure of infants and young children at risk of developing asthma may prevent its onset. Environmental control methods and asthma treatments are available now that can help children and their families control asthma and lead healthy, active lives. Yet not all children have access to these measures. Too many children miss school, limit their physical activity, and are seriously ill because of asthma. A child ill with asthma also has an impact on the entire family.



This strategy, prepared by the Task Force, is aimed at developing a further understanding of the role of environmental factors associated with the:

- onset of asthma; and
- triggers of asthma attacks

The efforts of the Task Force resulted in four recommendations for Federal action for addressing childhood asthma, which are presented in this strategy. The strategy also sets forth guiding principles that were used to develop the four recommendations.

GUIDING PRINCIPLES

Federal agency actions can provide leadership and direction in reducing environmental risks to protect children who have asthma or are at risk of developing it. Recommendations for action put forward in this initiative are predicated on the principles that federal action must have:

- A focus on efforts to *eliminate the disproportionate impact of asthma in minority populations and those living in poverty.*
- An emphasis on *partnerships and community based programs.*
- A commitment to setting *measurable and consistent goals* for childhood asthma under the Healthy People 2010 program.

- *An investment in evaluation* to identify those strategies that are most effective in reducing the burden of asthma so that they may be replicated.

RECOMMENDATIONS

RESEARCH

Strengthen and accelerate focused research into the environmental factors that cause or worsen childhood asthma.

- ⇒ Strengthen and accelerate research into the environmental factors that may contribute to the onset of asthma in children.
- ⇒ Expand and accelerate research to develop and evaluate environmental strategies that will improve the quality of life of people with asthma.

This initiative is about protecting children from environmental risks that either cause or worsen asthma...

PUBLIC HEALTH PROGRAMS

Implement public health programs that foster improved use of current scientific knowledge to reduce environmental exposures to prevent and reduce the severity of symptoms for those with asthma.

- ⇒ Promote clinician and patient implementation of national guidelines for reducing environmental risks that worsen asthma.
- ⇒ Expand support for state and local public health action.
- ⇒ Reduce children's exposure to environmental tobacco smoke and other indoor triggers in their homes.
- ⇒ Establish school based asthma programs that help reduce or eliminate allergens and irritants and that promote student's self management of asthma and full participation in school activities.
- ⇒ Continue to reduce outdoor air pollution.

SURVEILLANCE

Establish a coordinated, integrated, and systematic nationwide asthma surveillance system for collecting and analyzing health outcome and risk factor data at the state, regional and local levels.

DISPROPORTIONATE IMPACT ON THE POOR AND MINORITIES

Identify the reasons for and eliminate the disproportionate burden of asthma among different racial and ethnic groups and those living in poverty.

- ⇒ Improve asthma management for children within the medicaid program.



INTRODUCTION

The Growing Problem of Asthma in Children

Asthma is a chronic inflammatory lung disease characterized by recurrent episodes of breathlessness, wheezing, coughing, and chest tightness; these episodes are also known as exacerbations or attacks. The severity of exacerbations can range from mild to life threatening. Both the frequency and severity of asthma symptoms can be reduced by the use of medications and by reducing exposure to the environmental triggers of asthma attacks.

For the past 15 years, an epidemic of asthma has occurred in the United States. By all indications, this epidemic is continuing. Although asthma has become a major public health problem affecting Americans of all ages, races and ethnic groups, children have been particularly severely affected.



National survey data indicate that the number of children with asthma in the United States has more than doubled in the past 15 years. In 1980, 2.3 million American children had asthma. In 1995, the most recent year for which data are available, the number of affected children had risen to 5.5 million. Based on these trends, it is estimated that in 1998 more than 6 million children in the United States have asthma. Prevalence rates of asthma are highest in boys and are increasing in both boys and girls, and in all race and ethnic groups. The prevalence of asthma in children under age 18 is 7.3%. The most rapid increase has occurred in children under 5 years old, with rates increasing over 160% over the past 15 years.

The number of deaths attributed to asthma in children has also increased. In 1977, 84 deaths in children 18 and younger were recorded; the number of deaths has risen to 280 in 1995, a more than 3-fold increase. Although the death rate due to asthma has increased in all racial and ethnic groups, minority populations experience a disproportionately higher death rate from asthma. In 1995, the death rate from asthma in African-American children, 11.5 per million, was over four times the rate in white American children, 2.6 per million. The higher death rates among African-American children are especially troubling.

The number of hospitalizations and emergency room visits for asthma have increased in all population groups. Asthma accounts for one-third of all pediatric emergency room visits and is the fourth most common cause for physician office visits. The variation in the impact of asthma across racial and ethnic groups is significant. African-American children have an annual rate of hospitalization of 74 per 10,000, over 3 times that for white children, 21 per 10,000. In addition, African-American children are approximately 4 times more likely than white children to seek care at an emergency room. In short, African-American children have a slightly higher risk of getting asthma, but have a much higher risk of hospitalization or death due to the disease.

At the present time, surveillance for asthma in children is limited to analyses of ongoing surveys and data systems on health events such as mortality, hospitalization, and outpatient visits. Other than for African Americans, such information is extremely limited for most ethnic groups.

There is no national system to collect data from states specifically on asthma, although several states are developing systems to collect such data. Although national data do not provide the resolution necessary to identify particular geographic areas hardest hit by the asthma epidemic, surveys undertaken in a number of large cities in the United States indicate that the prevalence and severity of asthma are greatest in the large, urban inner cities.

There is no national system to collect data from states specifically on asthma, although several states are developing systems to collect such data.

These measures, particularly for death, hospitalization, and emergency room visits, give an incomplete picture of the true burden of asthma in the United States. For example, one follow-up study of children with asthma in inner city areas found a nearly 10 times higher likelihood of a child suffering symptoms of asthma on a given day than visiting an emergency room. Asthma is one of the leading causes of school absenteeism, accounting for over 10 million missed school days per year. Asthma also accounts for many nights of interrupted sleep, limitation of activity, and disruptions of family and care-giver routines. Asthma symptoms that are not severe enough to require a visit to an emergency room or to a physician can still be severe enough to prevent a child with asthma from living a fully active life.

Estimating the costs of asthma is an indirect way to measure its health burden. In 1990, the cost of asthma to the U.S. economy was estimated to be \$6.2 billion (Weiss, 1992), with the majority of the expense attributed to direct medical expenses. A 1996 analysis (Farquhar, et al, 1998) found the cost of asthma to be \$14 billion, indicating a rapidly increasing financial burden. These estimates indicate that the direct medical costs of asthma for all ages account for between 1% and 3% of all health care expenditures in the United States.

What We Know About Childhood Asthma

Over the past 15 years, there have been major advances in the scientific understanding of asthma. Asthma is now known to be a disease of airway inflammation resulting from a complex interplay between environmental exposures and genetic and other factors. This has implications for the medical treatment and for the environmental management of asthma.

In contrast to the limited understanding of the relationship of environmental exposures to the onset of asthma, the environmental triggers of asthma attacks for children with asthma have become increasingly well characterized. House dust mites, cockroaches, mold and animal dander have been identified as the principal allergens that trigger asthma symptoms. Reducing exposure to these allergens has been shown not only to reduce asthma symptoms and the need for medication, but also to improve lung function. Environmental tobacco smoke is an important irritant that can trigger an asthma episode and possibly worsen the effects of allergens. Upper respiratory viral infections are also recognized as important triggers for asthma episodes.

Children with asthma have long been recognized as particularly sensitive to outdoor air pollution. Many common air pollutants, such as ozone, sulfur dioxide, and particulate matter are respiratory irritants and can exacerbate asthma. Air pollution also might act synergistically with other environmental factors to worsen asthma. For example, some evidence suggests that exposure to ozone can enhance a person's responsiveness to inhaled allergens. Whether long term exposure to these pollutants can actually contribute to the development of asthma is not known. To date, little research has examined the role of other hazardous air pollutants (e.g., metals and volatile chemicals) in the development or exacerbation of asthma, although this is an issue of increasing public concern.

Children with asthma have long been recognized as particularly sensitive to outdoor air pollution.

In addition to improved understanding of appropriate environmental management of asthma, the medical management of asthma has changed significantly. Inhaled anti-inflammatory medications have become the mainstay of medical management to prevent asthma episodes and lessen chronic symptoms of asthma. In addition, improvements in monitoring techniques now permit objective measures of lung function that are easy for patients and physicians to use in assessing asthma severity and monitoring changes in the disease. In a disease like asthma that varies considerably over time and where changes in lung function can occur before symptoms develop, these objective measures are essential tools for making management decisions.

As a result of these advances, the medical and environmental management of asthma is better defined and the knowledge exists to manage asthma better than ever before. One especially important finding is that patient education has been documented to be cost effective. Teaching patients and their families specific management skills improves asthma management, reduces the use of emergency services, and improves quality of life. This is particularly important for asthma management, since the environmental management of asthma requires knowledge of asthma triggers and specific actions that can be undertaken to reduce exposure to these triggers. The treatment goal for almost all individuals with asthma should be for that person to lead a life unrestricted because of asthma.

Reducing exposure to environmental allergens and pollutants will reduce the frequency and severity of attacks for children with asthma, reduce their need for medicine, and improve their lung function. Children are exposed to many environmental agents that could trigger asthma attacks. For example, 25% of children in America live in areas that regularly exceed EPA limits for ozone. Approximately 29% of households still permit exposure of children to secondhand smoke in the home on a regular basis and exposure to environmental tobacco smoke is so widespread that approximately 88% of all children have some level of documented exposure (Pirkle, 1996). A high proportion of children living in the inner city are exposed to high levels of cockroach antigen.

Why Has Asthma Reached Epidemic Proportions in Children?

The causes of the increasing rate of asthma over the past 15 years and the particular role that environmental exposures play are not known, but there are some clues. Atopy, the genetically inherited susceptibility to become allergic, is the most important predictor of a child developing asthma. A substantial research effort is underway to identify the genes that are responsible for susceptibility to asthma. Because the genetic make-up of the population changes slowly, genetic susceptibility alone cannot be responsible for the epidemic of asthma that has occurred in the United States over the past 15 years. Further work is essential to clarify how genetic susceptibility and environmental exposures interact to cause asthma. Factors such as the intensity of environmental exposure and the age of the person being exposed are likely to be important.

Exposure to allergens found indoors is a strong risk factor for developing asthma. Children are spending increasing amounts of time indoors, thus increasing their exposure to indoor allergens.

The causes of the increasing rate of asthma over the past 15 years and the particular role that environmental exposures play are not known

The environmental exposures most strongly suspected of causing asthma to develop include environmental tobacco smoke and allergens such as house dust mites, cockroaches, mold, and animal dander. Exposures that stimulate the immune system may also be significant, such as diet during the prenatal period and early infancy, the pattern of respiratory infections early in life, and even decreasing rates of exercise have all been suggested as risk factors for the development of asthma.

Scope of the Strategy

This strategy is about protecting children from the environmental risk factors that make their asthma worse. Environmental action may also help prevent asthma. To accomplish this goal, the environmental aspects of asthma must be considered in the context of other aspects of asthma prevention and management, such as access to quality medical care and efforts to understand the disproportionate health impact of asthma among minority populations. Childhood asthma is a multi-factorial disease, and efforts to improve its management and to prevent it will require multi-dimensional, multi-disciplinary efforts that must occur simultaneously. This Asthma and the Environment strategy focuses on improving the environment in which children with asthma live, learn, play and work. Environmental action, along with medical care, will help children with asthma live productive, active lives and may spare future generations of children from the disease altogether. The Task Force has prepared the following four goals to be accomplished in the next ten years, guided by the vision that in the 21st century, every child in America will live, learn, work, and play in environments that do not cause or worsen asthma.

GOALS OF THE ASTHMA AND THE ENVIRONMENT STRATEGY

BY THE YEAR 2005, THE NUMBER OF HOUSEHOLDS IN WHICH CHILDREN ARE REGULARLY EXPOSED TO SECONDHAND SMOKE WILL BE REDUCED TO 15%.¹

BY THE YEAR 2010, ASTHMA HOSPITALIZATION RATES IN CHILDREN WILL HAVE FALLEN TO NO MORE THAN 10 HOSPITALIZATIONS PER 10,000 PEOPLE.² (Healthy People 2010 DRAFT)

BY THE YEAR 2010, EMERGENCY DEPARTMENT VISITS WILL BE REDUCED TO NO MORE THAN 46 PER 10,000 PEOPLE.³
(Healthy People 2010 DRAFT)

BY THE YEAR 2010, NO MORE THAN 10% OF CHILDREN WITH ASTHMA WILL EXPERIENCE ACTIVITY LIMITATIONS.⁴
(Healthy People 2010 DRAFT)

1 Baseline: 29% in 1994. Source: Biennial Radon and ETS Survey of the Conference of Radiation Control Program Directors and EPA.

2 Baseline: Hospitalization rate per 10,000 population in 1993-94: 18 for total population; 50 for children 0-4 yrs of age and 18 for children 5-14 yrs. Source: Healthy People 2010 Draft

3 Baseline: Emergency room visits 71 per 10,000 population for total population in 1992-94; 121 for children 0-4 yrs of age and 81 for children 5-14 yrs. Source: Healthy People 2010 Draft

4 Baseline: Activity limitation for persons with asthma; 22 percent for overall population in 1992-94. No children-specific data available. Source: Healthy People 2010 Draft

VISION FOR THE 21ST CENTURY

Every child in America will
live, learn, work, and play
in environments that do
not cause or worsen
asthma.

GUIDING PRINCIPLES

Federal agency actions can provide leadership and direction in reducing environmental risks to protect children who have asthma or are at risk of developing it. Recommendations put forward in this strategy are predicated on the principles that federal action must have:

1. A focus on efforts to better understand and eliminate the disproportionate impact of asthma in minority populations and those living in poverty.

Poor and minority children are much more likely than white, non-Hispanic children to visit an emergency room, to be hospitalized, or to die from asthma, although the rising prevalence of asthma has affected all populations. The reasons for this disparity are not known, although environmental exposures and limited access to quality medical care may all play a role.

The focus on eliminating disparities across racial and ethnic groups has to be considered in all efforts to prevent asthma and its health impact; however, because of the importance of this issue the Task Force has included a specific recommendation in this strategy to examine, understand, and ultimately eliminate disparities.

2. An emphasis on partnerships and community based programs.

A successful effort to reduce childhood asthma will depend in part on the level of success achieved in enlisting all sectors of society in efforts to implement effective programs to prevent and manage the disease. Federal agencies have already forged effective partnerships with many health and professional organizations, corporations, and foundations to conduct training, educate health care providers and the public, and to implement a wide range of prevention activities at the national, state, and local levels.

Expanded partnerships both within government and between government and the private sector are needed. With increasing knowledge about the primary causes of asthma and triggers of asthma attacks, the challenge for the 21st century will be to integrate new research findings into effective environmental, medical and educational programs. Partnerships will be critical to implementing this broad vision of asthma control. In particular, community-based programs should integrate asthma control activities into existing systems such as schools, child care, youth programs, workplaces, primary health, and job training programs.

The challenge for the 21st century will be to integrate new research findings into effective environmental, medical and educational programs.

3. A commitment to setting measurable and consistent goals for childhood asthma under the Healthy People 2010 program.

Health objectives are now being developed for the year 2010 and represent a significant revision of the goals set for the year 2000. These objectives will set the nation's health agenda for increasing years of healthy life and reducing disparities among the entire American population. Draft objectives currently encompass an expanded set of asthma-related objectives for improved clinical management as well as a series of environmental objectives addressing known asthma triggers such as indoor allergens, secondhand smoke and outdoor air pollution. The goals embodied in the final Healthy People 2010 document will serve as the tools to measure progress towards control of asthma.

4. Investment in evaluation of programs to identify those strategies that are most effective in reducing the burden of asthma so that they may be replicated.

Asthma intervention programs and related activities need to be fully evaluated to determine those techniques which are successful and should be replicated. Evaluation should be incorporated in the planning of all programs and should include:

- identification of desired health outcomes of the program;
- measurement of effectiveness of the intervention activities and processes used to implement them;
- identification of unforeseen obstacles;
- assessment of the cost-effectiveness of the program;
- a prediction of long term sustainability of the program.

RECOMMENDATIONS

I. RESEARCH

Strengthen and accelerate focused research into the environmental factors that cause or worsen childhood asthma.

EXPAND RESEARCH INTO THE ENVIRONMENTAL FACTORS THAT CONTRIBUTE TO THE ONSET OF ASTHMA IN CHILDREN.

Though progress has been made in understanding what causes asthma, there is currently insufficient scientific information to establish specific guidelines and recommendations for public health practices to prevent the onset of asthma in children (i.e. primary prevention).

In order to establish primary prevention guidelines, the top priority for research is to determine the causes of asthma in children and particularly the role of the environment. To understand what causes asthma, research must identify the basic cellular and molecular mechanisms that cause airway inflammation and sensitization and, in particular, the interaction of environmental exposures and genetic susceptibility. In addition, clinical and epidemiologic studies are needed to examine the relationship between environmental exposures and the onset of asthma.



Because of promising preliminary work on the relationship of indoor allergens and asthma onset, as well as the much greater proportion of time that children spend indoors, greater emphasis on examining the relationship of indoor exposures to the development of asthma is warranted. Exposures to high levels of allergens in the indoor environment have been shown in some studies to be associated with the subsequent development of asthma. However, few studies have examined the importance, by geography, of particular allergens. In studies evaluating the role of indoor allergens on exacerbations of asthma, different allergens, such as those associated with cockroaches, dust mites, and mold, have been implicated in different cities. This suggests that different allergens can exacerbate asthma, and that different allergens may be capable of inducing the new onset of asthma.

In one study (Hyde, et al, 1997) avoiding exposure to dust mite and food allergens early in life was found to reduce the risk of developing asthma in the first year of life. However, this effect was not statistically significant at 2 to 4 years of age. Whether such allergen avoidance strategies are feasible and effective in reducing the development of asthma is not known.

The complex interactions between outdoor air pollutants and allergens and the development of asthma have not been adequately evaluated. Some epidemiologic studies have suggested a relationship between exposure to volatile organic compounds and prevalence rates of childhood asthma. Because adult-onset asthma is known to be associated with occupational exposures to volatile organic compounds including formaldehyde, ethylene oxide, and isocyanates, further work to assess the possible etiologic role of specific pollutants in childhood asthma is appropriate.

EXPAND AND ACCELERATE RESEARCH TO DEVELOP AND EVALUATE ENVIRONMENTAL STRATEGIES THAT WILL IMPROVE THE QUALITY OF LIFE FOR CHILDREN WITH ASTHMA.

It is well established that inhaled allergens and irritants and outdoor pollutants provoke asthma symptoms. Research is needed to identify if other environmental exposures are significant. Further, the relative importance of various exposures is not well understood. Cost effective strategies for reducing exposures are not well developed.

Patient education strategies in certain populations have profound impacts on reducing the frequency and severity of exacerbations and improving the quality of life for children. But many of these programs are not responsive to the cultural, ethnic, and economic diversity of the American population. Innovative strategies are urgently needed for reaching a wide range of children and their families, for tailoring recommendations for reducing environmental exposures to their needs, and for providing support to follow the recommendations.

2. PROGRAMS TO IMPROVE PUBLIC HEALTH

Implement public health programs that improve use of scientific knowledge to prevent and reduce the severity of asthma symptoms by reducing environmental exposures.

PROMOTE CLINICIAN AND PATIENT IMPLEMENTATION OF NATIONAL GUIDELINES FOR REDUCING ENVIRONMENTAL RISKS THAT WORSEN ASTHMA.

Despite uncertainty about the causes of the increase in asthma prevalence rates, much can and should be done to prevent severe illness and death from asthma and improve the quality of life of persons with asthma. Experts convened by the National Asthma Education and Prevention Program (NAEPP) coordinated by the National Institutes of Health (NIH) have reviewed the

scientific literature and produced guidelines for managing asthma. These include specific recommendations for controlling environmental factors that contribute to asthma severity.

While there is consensus that NAEPP guidelines define the best diagnosis and management practices for asthma, dissemination of the guidelines must be expanded and adoption improved. Many clinicians do not include advice about environmental control in their patient education. Among families who do receive recommendations, adherence is generally low. Asthma is highly variable, and families need help establishing priorities for environmental control measures that will be suitable for their individual child's asthma and their family circumstances. Effective public health programs can provide this education and support.

For children without access to quality health care, appropriate instruction on the environmental triggers of asthma is impossible or severely limited. Emergency rooms or urgent care facilities may serve as the only source of primary care for such children. These settings should be recruited to provide the kind of education and links to chronic disease management services that are essential to reducing the severity and frequency of asthma attacks.

EXPAND SUPPORT FOR STATE AND LOCAL PUBLIC HEALTH ACTION.

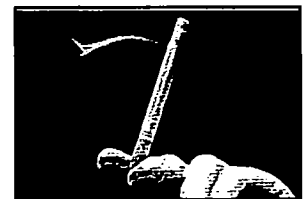
Recent advances in the treatment of asthma and in identifying the environmental triggers of asthma attacks make it possible to control and prevent symptoms at a level unheard of just ten years ago. But these gains have not been realized by many of our children. Public health agencies have a critical role in helping to reduce environmental factors affecting asthma and the human and financial toll of the disease. These programs should include the following components:



- (1) Education and training
- (2) Asthma surveillance
- (3) Coalitions for prevention

REDUCE CHILDREN'S EXPOSURE TO ENVIRONMENTAL TOBACCO SMOKE AND OTHER INDOOR TRIGGERS IN THEIR HOMES.

Secondhand tobacco smoke and indoor allergens are major contributors to the incidence of wheezing in young children and play a significant role in the number and severity of asthma attacks. Reducing smoking in homes with young children will improve the health status of the estimated 2 million children with asthma who are exposed to secondhand smoke. In addition, exposure to allergens such as cockroach, house dust mite, mold, and animal dander causes many attacks of asthma that are preventable.



ESTABLISH SCHOOL BASED ASTHMA PROGRAMS IN EVERY COMMUNITY.

The educational system is a critical component of effective efforts to reduce illness due to asthma in children. Programs will be implemented in schools to assure a healthy physical environment at the school and to promote improved self-management of asthma through education.

CONTINUE TO REDUCE OUTDOOR AIR POLLUTION

The U.S. EPA set national ambient air quality standards (NAAQS) for six air pollutants in 1971, in part based on evidence of associations between air pollutants such as ozone, particulate matter, and sulfur dioxide and asthma. Since that time substantial new epidemiological evidence has been published supporting the association between levels of ozone and particulate matter and increased hospitalization for respiratory causes, such as childhood asthma. In 1997, NAAQS for both ozone and particulate matter were strengthened to improve the protection afforded by these standards and to help reduce the risk of ambient exposures that aggravate asthma in children.

Federal, State, local, and private sector efforts to implement the original NAAQS resulted in substantial improvements in air quality, yet notable problems remain. Following the 1990 Clean Air Act Amendments, efforts were expanded to improve nationwide air quality and reduce related health effects. In conjunction with the strengthening of the ozone and particulate matter NAAQS, EPA has taken steps to integrate implementation measures for these pollutants and to improve the effectiveness of control programs. EPA has also taken steps to inform the public about air pollution that may affect children.



3. SURVEILLANCE

Establish a coordinated nationwide asthma surveillance system for collecting and analyzing health outcome and risk factor data at the state, regional and local levels.

Current national surveillance permits tracking of asthma prevalence, asthma physician office visits, asthma emergency room visits, asthma hospitalizations and asthma mortality at a national level and in four geographic regions (i.e., Northeast, Midwest, South, and West) through surveys conducted by the National Center for Health Statistics. Surveillance information on asthma, with the exception of mortality data, are not available at the state or local level. This information is needed to identify high risk populations and environmental risk factors of

relevance to particular communities and to design and implement interventions that will be most suitable for, and therefore most likely to succeed, in that community. State and local health agencies also need this information to evaluate the impact of local sources of air pollution on childhood asthma in specific communities. A significantly enhanced and expanded surveillance program will be essential to study issues related to race and gender differences in asthma morbidity and mortality among children, identify gaps in providing comprehensive care, and monitor trends in asthma morbidity and mortality at the community level.

4. DISPROPORTIONATE IMPACTS ON THE POOR AND MINORITIES

Identify the reasons for and eliminate the disproportionate burden of asthma among different racial and ethnic groups and those living in poverty.

Poor and minority children are disproportionately affected by asthma, which has reached epidemic proportions in many American inner cities. Prevalence rates vary only by a few percentage points among different race and ethnic groups, yet emergency room use, hospitalization, and mortality rates vary 3- to 4-fold. Understanding the factors that contribute to the disproportionate impact of asthma on minority and lower income populations is the critical first step to reducing and eventually eliminating the disparities between rich and poor, minority and non-minority children. Such factors may include differing intensities of environmental exposures, such as exposure to cockroach antigen and access to and quality of care, among others.

Poor and minority children are disproportionately affected by asthma, which has reached epidemic proportions in many American inner cities.

IMPROVE ASTHMA MANAGEMENT FOR CHILDREN WITHIN THE MEDICAID PROGRAM.

Disease management combines prevention, intensive attention to treatment and patient compliance, and guidance for self-care. This concept has considerable promise for reducing the frequency and severity of asthma attacks. Integrating an asthma disease management initiative within the fee-for-service component of Medicaid would demonstrate the efficacy of this approach in improving children's health.

UNITED STATES ENVIRONMENTAL PROTECTION AGENCY

OFFICE OF THE ADMINISTRATOR

401 M St., SW
Washington, DC 20460

TO: NEERA

FROM: DOUG

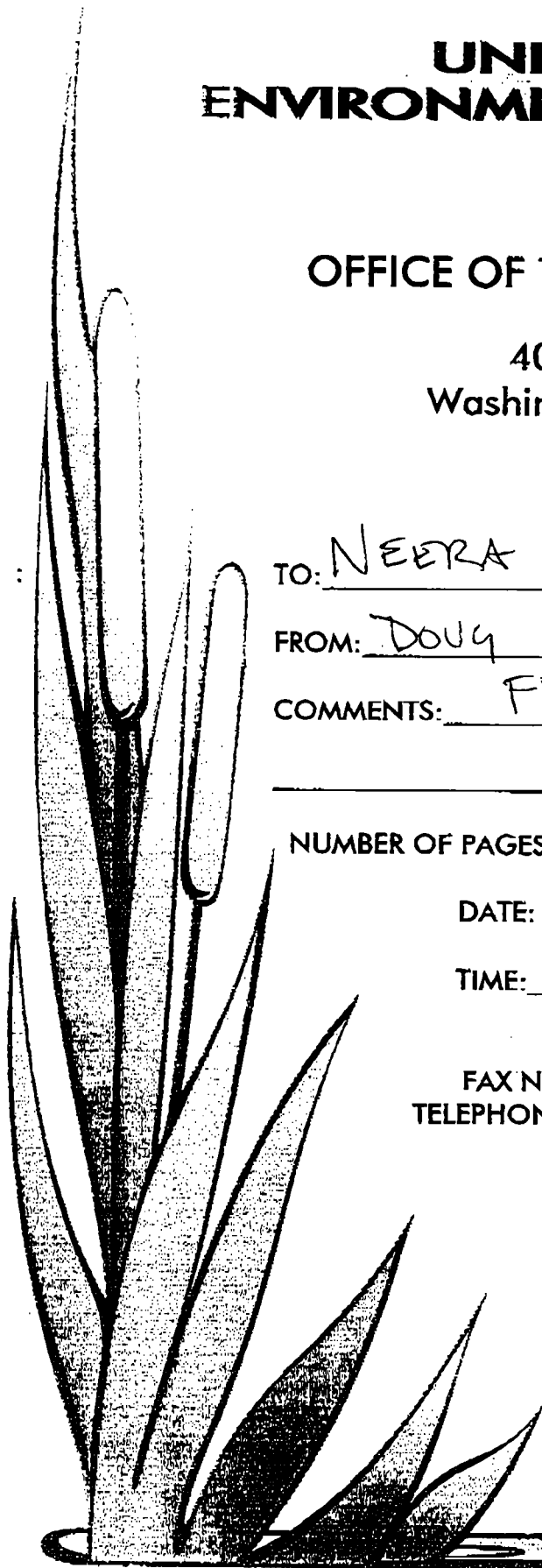
COMMENTS: FYI

NUMBER OF PAGES TO FOLLOW: _____

DATE: _____

TIME: _____

FAX NUMBER: (202)260-4852
TELEPHONE NUMBER: (202)260-4724



CHILDREN'S

FINAL *

	FY99 Base	FY00 - OMB	FY00 - OVER	Totals
Science				
Base	\$27,961			\$27,961
Data Collection		\$1,986 6.0		\$1,986 6.0
Research Centers		\$2,000		\$2,000
Research		\$3,000		\$3,000
Endocrine Review		\$5,305 5.0		\$5,305 5.0
	\$27,961	\$12,291 11.0	\$0 0.0	\$40,252 11.0
Asthma				
Base (Centers, IAQ)	\$4,850			\$4,850
Indoor Air Outreach		\$4,500		\$4,500
G8 Implementation (ETS)		\$500		\$500
Asthma Research		\$1,953 13.0		\$1,953 13.0
Buy Clean - Markets		\$500		\$500
Buy Clean - Research		\$481 1.0		\$481 1.0
Enforcement		\$465 5.0		\$465 5.0
Indoor Air Outreach (Exp)			\$7,500	\$7,500
Air Monitoring	~~\$4,850~~	~~\$8,399~~ 19.0	~~\$1,500~~ 0.0	~~\$1,500~~
		\$9,000	\$9,000 0.0	\$22,249 19.0
Total Children's	\$32,811 37.2	\$20,690 30.0	\$9,000 0.0	\$62,501 67.2

* Includes payroll costs

**Office of Juvenile Justice and Delinquency Prevention
U.S. Department of Justice**

OFFICE OF THE ADMINISTRATOR

TO:

Name:

Neera Tanden

Organization:

Fax Number:

456-2878

FROM:

*Sarah Ingersoll, Special Counsel
Office of Juvenile Justice and Delinquency Prevention
U.S. Department of Justice
800 K Street, NW
Washington, DC 20531
PH: (202) 616-3650
FAX: (202) 307-2093*

Number of pages, including cover sheet:

8

Please call to confirm receipt:

Yes

No

Additional comments:

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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
004. list	Suggested Attendees for the White House Mentoring Event (partial) (7 pages)	01/27/1999	P6/b(6)

COLLECTION:

Clinton Presidential Records
Domestic Policy Council
Eric Morse (Events)
OA/Box Number: 21192

FOLDER TITLE:

Asthma Budget Rollout 1/28/1999

2011-0619-S

rc288

RESTRICTION CODES

Presidential Records Act - [44 U.S.C. 2204(a)]

- P1 National Security Classified Information [(a)(1) of the PRA]
- P2 Relating to the appointment to Federal office [(a)(2) of the PRA]
- P3 Release would violate a Federal statute [(a)(3) of the PRA]
- P4 Release would disclose trade secrets or confidential commercial or financial information [(a)(4) of the PRA]
- P5 Release would disclose confidential advice between the President and his advisors, or between such advisors [(a)(5) of the PRA]
- P6 Release would constitute a clearly unwarranted invasion of personal privacy [(a)(6) of the PRA]

C. Closed in accordance with restrictions contained in donor's deed of gift.

PRM. Personal record misfile defined in accordance with 44 U.S.C. 2201(3).

RR. Document will be reviewed upon request.

Freedom of Information Act - [5 U.S.C. 552(b)]

- b(1) National security classified information [(b)(1) of the FOIA]
- b(2) Release would disclose internal personnel rules and practices of an agency [(b)(2) of the FOIA]
- b(3) Release would violate a Federal statute [(b)(3) of the FOIA]
- b(4) Release would disclose trade secrets or confidential or financial information [(b)(4) of the FOIA]
- b(6) Release would constitute a clearly unwarranted invasion of personal privacy [(b)(6) of the FOIA]
- b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
- b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
- b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

Suggested Attendees for the White House Mentoring Event

Mentoring Experts

Ethel Simon-McWilliam/CEO
Northwest Regional
Educational Laboratory
JUMP Training & Technical Assistance Provider
PH: (503) 275-0121
SS: [REDACTED] [004]
DOB: [REDACTED]
(She's on the list submitted by Jay and Diana)

Elaine Diepenbrock
Principal Investigator
Information Technology International
JUMP Evaluator
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SS: [REDACTED]
DOB: [REDACTED]

Elizabeth Mertinko
Program Analyst, Information Technology International
JUMP Evaluator
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SS: [REDACTED]
DOB: [REDACTED]

Jim Lang
Co-Investigator
Information Technology International/JUMP Evaluator
PH: (301) 564-4200
SS: [REDACTED]
DOB: [REDACTED]

Gary Walker, President
Public/Private Ventures
One Commerce Square
2005 Market Street, Suite 900
Philadelphia, PA 19103
PH: 215/557-4402
(P/PV did the seminal study on mentoring)

Mark Freedman, Vice President
Public/Private Ventures
1422 Bonita Avenue
Berkeley, CA 94709
PH: 510/526-4302

(Mr. Freedman wrote an important report on mentoring for the Administration and is now running mentoring with elderly)

Reverend Geoffrey Brown
Executive Director
National Ten Point Leadership Foundation
Ella J. Baker House
411 Washington Street
Boston, MA 02124
PH: 617/822-1832

Sandra McBrayer (The Attorney General has requested that Sandra recommend the leader of mentoring colation in San Diego -- this is forthcoming)

P6/(b)(6)

Mentoring Grantees

Roxeanne Spillett, President
Boys and Girls Clubs of America
230 W. Peachtree Street
Washington, DC 20004
PH: 404/815-5792

* * *

Rev. Alice Davis
JUMP Project Director
Shiloh Family Life Center
Washington, DC
PH: 202-232-7081

SS: P6/(b)(6)

DOB: P6/(b)(6)

Rev. Barry Hargrove
JUMP Project Coordinator
Shiloh Family Life Center
Washington, DC

SS: P6/(b)(6)

DOB: P6/(b)(6)

Jacquelyn Thompson-Shiloh/Mentor

SS: [REDACTED] P6/(b)(6)

DOB: [REDACTED] P6/(b)(6)

Danisha Gravitt-Shiloh/Mentee-age 11

* * *

Barbara Cooper Miller

JUMP Program Director

St. John Baptist Church

Columbia, MD

PH: 410-992-5054

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DOB: [REDACTED] P6/(b)(6)

Carol Elizabeth Turner

JUMP /Program Coordinator

St. John Baptist Church

Columbia, MD

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DOB: [REDACTED] P6/(b)(6)

Lamont English

St. Johns Baptist Church/ Mentor

SS: [REDACTED] P6/(b)(6)

DOB: [REDACTED] P6/(b)(6)

Jeffrey Joshua Flagg (Age 15)

St. Johns Baptist Church/Mentee

SS: [REDACTED] P6/(b)(6)

DOB: [REDACTED] P6/(b)(6)

* * *

Henrietta Parker

JUMP Project Coordinator

Wicomico County Board of Education

Salisbury, MD

PH: (410) 860-0002

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DOB: [REDACTED] P6/(b)(6)

Bonnie Walston
Supervisor/Special Instructional Programs
Wicomico, County Board of Education
Salisbury, MD

SS: P6/(b)(6)

DOB: P6/(b)(6)

Nancy Evans-Wicomico/Mentor

SS: P6/(b)(6)

DOB: P6/(b)(6)

Karen Muller-Wicomico/Mentee
(10 Th Grade, Parkside Senior High)

SS: P6/(b)(6)

DOB: P6/(b)(6)

* * *

Richard Rowe
Project Director
Project RAISE
101 Baltimore Mentoring Partnership
(410) 685-8316

Dawniece L. Roberts
RAISE - Mentee
DOB: P6/(b)(6)

Cynthia L. Etheridge
RAISE - Mentor
SS: P6/(b)(6)
DOB: P6/(b)(6)

Federal Agency Representatives

Marianne Klink, Federal Liason
National Endowment for the Arts
202/682-5613

Bob Denniston, Director
HHS Secretary's Initiative on Youth Substance Abuse Prevention
Center for Substance Abuse Prevention
301/443-7072

Joan Quinlan
HHS Secretary's Initiative on Youth Substance Abuse Prevention
Center for Substance Abuse Prevention
301/443-5592

(Someone from) America Reads
U.S. Department of Education

Colonel Tom Bowman,
Challenge Grant Program
U.S. Department of Defense
703/693-5371

Richard Sauer, President and CEO
National 4-H Council
301/961-2894

Annette Hayes
U.S. Department of Navy
703/693-4957

DOJ Representatives

Laurie Robinson, Assistant Attorney General
Office of Justice Programs
SS: [REDACTED] P6/(b)(6)
DOB: [REDACTED] P6/(b)(6)

Shay Bilchik
Administrator, OJJDP
SS: [REDACTED] P6/(b)(6)
DOB: [REDACTED] P6/(b)(6)

Travis A. Cain
Juvenile Mentoring Program (JUMP) Coordinator
Special Emphasis Division/ OJJDP
SS: [REDACTED] P6/(b)(6)
DOB: [REDACTED] P6/(b)(6)

Miracle Howard
Travis Cain's Mentee-age 15
[REDACTED] P6/(b)(6)

Sandra Susan Brunson
Juvenile Mentoring Program(JUMP)Assistant Coordinator
Special Emphasis Division/ OJJDP

[REDACTED]
P6/(b)(6)

Cora Roy-Stevens
Special Emphasis Division
JUMP Team Member/OJJDP

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DOB: [REDACTED] P6/(b)(6)

Eric Peterson
Program Manager
Research & Program Development Division/OJJDP

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DOB: [REDACTED] P6/(b)(6)

Sarah Ingersoll, Special Counsel

SS: [REDACTED] P6/(b)(6)
DOB: [REDACTED] P6/(b)(6)

OJJDP Staff Alternates

Eileen Garry
Information Dissemination Unit/OJJDP

SS: [REDACTED] P6/(b)(6)
DOB: [REDACTED] P6/(b)(6)

John Wilson, Deputy Director
OJJDP

SS: [REDACTED] P6/(b)(6)
DOB: [REDACTED] P6/(b)(6)

Douglas C. Dodge/ Director
Special Emphasis Division/OJJDP

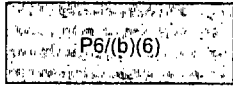
SS: [REDACTED] P6/(b)(6)
DOB: [REDACTED] P6/(b)(6)

Third Tier OJJDP Alternates

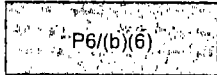
Gloria Rovira
Program Manager
Special Emphasis Division/OJJDP

[REDACTED]
P6/(b)(6)

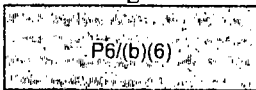
Eric Stansbury
Program Manager
Special Emphasis Division
JUMP Team Member/OJJDP



Debbie Oldenettel
Program Manager
Special Emphasis Division
JUMP Team Member/OJJDP



Janine Muller
Program Manager
Training & Technical Assistance Division/OJJDP



You may also want to ask ONDCP if they think we need to invite:
Dennis Windscheffel, Coordinator
Prevention Through Civic Service Alliance
1604 Siwanoy Drive
Alhambra, CA 91803
626/289-1564

F A C S I M I L E**DATE:** 1/25**TO:** Neera Tandon**FAX#:** 456-2878

FROM: Elizabeth Summy
Deputy Chief of StaffPhone: 202/690-7431 Fax: 202/401-5783

COMMENTS:

11 ~~10~~ Pages [including this cover]

To: Elizabeth Summy@IOS.IO
From: "STACEY KATZ" <skatz@OSASPE.DHHS.GOV>
Cc: ISMTP@B11WDC-OV08B@Servers[<phoppin@OSASPE.DHHS.GOV>],
ISMTP@B11WDC-OV08B@Servers[<wraub@OSASPE.DHHS.GOV>]
Bcc:
Subject: info on the FEB 9th meeting in Atlanta
Attachment: Headers.822
Date: 1/25/99 2:26 PM

I just returned from our 1:00 meeting and received a phone message from Jim Rifenberg of CDC (Even Steve Redd eventually answered his page. He called me from "Splash Mountain" --Disney World)

More info on the Feb 9th meeting in Atlanta "Pub. Health Response to Asthma"

The number of people attending the meeting likely to be about 250. About 75 of those are likely to be "state and local policy implementers" on asthma. Others will represent a variety of backgrounds including: academicians, Federal government representatives, public interest groups/state and local asthma coalitions, pharmaceutical industry representatives, etc.

As for big names, these tend to be big names in the research or asthma community context. For example:

1) Noreen Clark, dean of the University of Michigan School of Public Health (and I believe one of the originators of a very successful asthma public health program called "Open Airways");

2) Kevin Weiss - Coordinator of one of the country's largest and best known asthma coalitions -- "the Chicago Consortium on Asthma" (bringing together partnerships of every kind in Chicago to tackle the city's asthma problem and improve quality of care for those who need it most

3) The Deputy Director of the American Lung Association

Asthma Prevention Program of the National Center for Environmental Health, Centers for Disease Control and Prevention

AT-A-GLANCE 1999



*Asthma is one of the most common and costly diseases in the United States.
More than 5% of the US population has asthma and the numbers are growing.
The need to respond to this problem is increasingly urgent.*

CDC
Centers for Disease Control and Prevention

NCEH

NCEH Pub. No. 98-0367

A Public Health Response to Asthma

February 9-11, 1999 + Sheraton Colony Square Hotel + Atlanta, Georgia

*1 P.m. Conference will open
on 2/9 in Atlanta.*

Purpose:

The conference will provide a forum for increasing knowledge regarding asthma prevention and control and an update of current asthma surveillance and intervention activities in state and local health agencies. It will also provide opportunity for interaction with colleagues from across the country.

Who should attend:

This conference is designed for staff of state, local and territorial public health agencies who currently work with asthma surveillance and intervention activities or who plan to do so in the future.

Format for the conference:

A series of "Master Lectures" presented by asthma experts will focus on topics designed to increase knowledge and stimulate dialogue.

Break-out sessions will provide opportunity for in-depth consideration of specialized topics, presentation of papers by conference participants, and discussion in smaller group settings.

The poster session, "topic tables", generous break time, and an evening reception will provide time for considerable interaction with colleagues from across the country. "Round table" discussions will provide additional opportunity for discussion allowing participants to plan for the future with colleagues in geographic proximity to their jurisdiction and to help define needed support for their activities.

Please Register in Advance on the Attached Form!

DRAFT AGENDA

A PUBLIC HEALTH RESPONSE TO ASTHMA February 9-11, 1999 Atlanta, Georgia

Tuesday, Feb. 9

- 1:00-1:15** Opening comments, introductions
- 1:15-1:30** Official welcome
- 1:30-2:15** Using Data to Set the Stage - Dr. Peter Gergen
- 2:15-3:00** Coalitions - Dr. Fran Butterfoss
- 3:00-3:30** Break
- 3:30-5:00** Concurrent Sessions:
 - (1) Surveillance and Data Use
 - (2) Coalitions
- 6:00-7:30** Gala reception; (exhibitors, posters available for first time)

Wednesday, Feb 10

(exhibitors present all day, posters remain up all day)

- 8:30-9:00** The National Cooperative Inner City Asthma Study - Dr. Peter Gergen
- 9:00-10:00** Community Interventions for Asthma Control - Dr. Noreen Clark
- 10:00-10:30** Break
- 10:30-12:00** Concurrent Sessions:
 - (1) Getting an Asthma Program Started
 - (2) Interventions for Asthma Control
- 12:00-1:30** Lunch
- 1:30-2:30** A community's approach to addressing asthma - Dr. Kevin Weiss
- 2:30-3:00** Legislation and Asthma Control - Ms. Fran DuMello
- 3:00-3:30** Break
- 3:30-4:30** Topic tables

Thursday, Feb 11

- 8:30-9:20** Round table discussions in geographic groups
- 9:30-10:30** Round table discussions: where do we go from here?
- 10:30-11:00** Break
- 11:00-11:50** The Cost of Asthma - Dr. Kevin Weiss
- 11:50-12:00** Closing

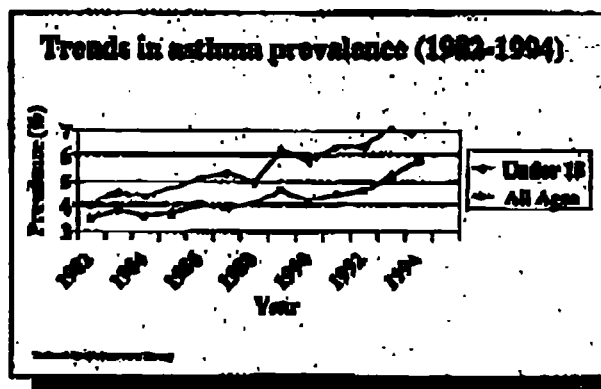
Scope of Problem

Asthma currently cannot be cured, only controlled. Asthma is a long-term, often progressive disease in which the airways become temporarily blocked. Those affected have episodes of breathing difficulty when their airways become inflamed, and they are more sensitive to a variety of "triggers" for breathing problems. These triggers include dust, tobacco smoke, cockroaches, and

some chemicals. A long-term, multifaceted approach is required to prevent and manage asthma. This includes educating, treating, and providing continual medical care and monitoring for people who have asthma; changing behaviors that lead to asthma or worsening of asthma; and eliminating or avoiding asthma triggers.

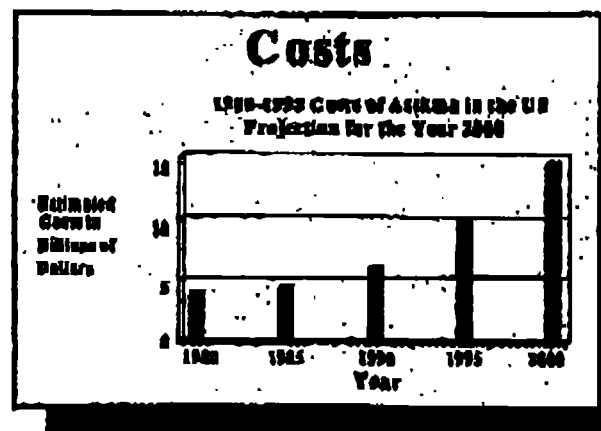
Asthma's Impact is Large

The number of asthma sufferers has more than doubled from 6.7 million in 1980 to 17.3 million in 1998. An estimated 4.8 million are children. Asthma is hitting hardest and disproportionately among poor, inner city dwellers. Collectively, people who have asthma experience well over 100 million days of restricted activity each year, and asthma is believed to be the most common reason that students miss school. In 1995, more than 5,000 Americans died from asthma.



Asthma's Costs are Large

Asthma accounts for nearly 500,000 hospitalizations each year. Asthma deaths have tripled over the past two decades. Despite improvements in clinical treatment, visits to emergency rooms and hospitalizations due to asthma are increasing. It is estimated that by the year 2000, asthma-related costs will exceed \$14.5 billion.



CDC's Asthma Prevention Program

The National Center for Environmental Health of the Centers for Disease Control and Prevention (CDC) is leading CDC's efforts to prevent and control asthma in partnership with state and local health departments. This program includes (1) using surveillance data to target resources and evaluate prevention efforts; (2) educating health care providers, school personnel, and people who have asthma and their families about asthma;

(3) building partnerships to conduct local initiatives for controlling asthma; and (4) conducting research to increase understanding of asthma and identify new strategies to control it. An important part of controlling asthma is to stop people who have asthma from coming into contact with things in the indoor and outdoor environments that trigger asthma. This means modifying the environment to remove or reduce triggers.

Benefits of Preventing and Managing Asthma

When existing asthma is controlled through better use of available knowledge and technology, individuals and society benefit in numerous ways.

Decreased Emergency Room Visits and Hospitalizations. Better asthma management could reverse the increasing numbers of emergency room visits and hospitalizations due to asthma. Use of emergency facilities for asthma attacks is an indication that people are not adequately controlling their asthma and need quality, routine medical care and instruction.

Increased school and work attendance. Asthma is the single largest reason children miss school. And it is not only the children who must stay home—their parents must take time off to care for them. In addition, asthma accounts for an estimated 3 million lost workdays annually for workers over 18 years of age who have asthma

themselves, according to the American Lung Association. Better control of asthma will increase our nation's productivity.

Healthier environment. Air pollution and tobacco smoke can aggravate asthma symptoms. If we reduce exposure to "trigger" substances such as these, not only will people who have asthma benefit, but everyone else will as well.

Improved quality of life. If not managed properly, asthma can cause coughing, wheezing, inability to breathe, and even death. But it doesn't have to be that way. People with asthma can have better control of their lives if they receive proper, ongoing medical treatment; come into less contact with triggers; and have a clear asthma management plan.

Barriers to Preventing and Managing Asthma

There are a number of barriers to preventing and managing asthma.

Missed diagnosis. There is anecdotal evidence that not enough primary health care providers are using the clinical guidelines for diagnosing asthma that were issued by an expert panel of the National Asthma

Education and Prevention Program (National Heart, Lung and Blood Institute of the National Institutes of Health). These guidelines provide a means of interpreting what is and isn't asthma. Not using these guidelines may lead to misdiagnosis of asthma, for example, as a temporary respiratory infection.

Behavior change constraints. The lifestyle changes needed to control asthma in indoor environments are time-consuming. Controlling or eliminating exposure to tobacco smoke, dust mites, cockroaches, pet dander, mold, and other indoor triggers requires a significant commitment from an asthma sufferer's entire family, schools, and businesses to be effective.

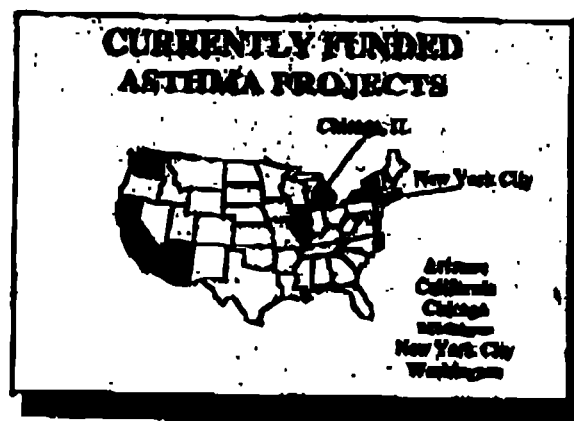
Limited or no access to primary care. Not everyone has access to medical treatment, especially ongoing preventive treatment. Some of the poorest inner city children who have severe asthma do not receive the routine primary care that could reduce asthma's impact on their lives.

Embarrassment. Many children feel different because they have asthma. They may be hesitant to use inhalers and feel ostracized if their asthma causes them to miss gym classes or other activities. Adults may be embarrassed to tell their coworkers that they have asthma or to use inhalers on the job.

Misinformation and stereotypes. Misconceptions such as "People who have asthma are weak" or "It is bad for people to use so much medicine" may inhibit people from managing their asthma. Some school districts' "no drugs" policies are inappropriately applied to prescription medication, including asthma inhalers.

Strategies for Preventing and Managing Asthma

Surveillance. Public health professionals use surveillance—the ongoing collection, analysis, and interpretation of outcome-specific data—to plan, carry out, and evaluate activities for protecting public health. In collaboration with the National Heart, Lung, and Blood Institute and the US Environmental Protection Agency's Office of Children's Health, CDC has funded four state health agencies and two local health agencies to develop model asthma surveillance programs (see figure). This project is the first step in building state- and local-based asthma surveillance programs nationwide.



Tracking and studying asthma cases and severe episodes (e.g., hospitalizations and emergency room visits due to asthma) can help us understand how many people have asthma, who is at high risk, who has more severe asthma, and if any of these measures change over time. Surveillance is essential for understanding the extent of the problem, knowing how to address the problem, and assessing the success of intervention efforts.

Most of what is currently known about asthma distribution, severity, and changes in occurrence over time is based on surveys of the national population or mortality data. Little is known about patterns of asthma occurrence in state or local areas.

National Partnerships and Outreach. CDC understands the importance of educational and outreach efforts for preventing asthma and improving the quality of life of those already suffering with it. A successful national campaign to reduce asthma incidence and better control existing cases would be impossible without the active involvement of a coalition of committed partners.

There is already a common forum. Agencies and organizations share materials and information related to asthma control through the National Asthma Education and Prevention Program. CDC is an active member of this national program and uses its clinical practice guidelines in developing educational materials for various audiences.

CDC and the American Lung Association are currently identifying asthma-related activities they might jointly sponsor. Opportunities include developing standardized asthma education programs; recommending legislative actions that benefit people who have asthma (e.g., letting children carry asthma medication on themselves at school and third party payment for asthma education); and making indoor environments more "friendly" for people with asthma. CDC actively promotes American Lung Association education programs such as "Open Airways for Schools" among its state and local health professional partners.

State and Local Asthma Partnerships and Outreach. CDC is working with state and local partners to implement and evaluate the success of comprehensive asthma prevention programs. These programs monitor communities to identify local disease trends; conduct asthma prevention activities; conduct intervention and evaluation research; and educate health care practitioners, people who have asthma, and community organizations about asthma.

Projects cosponsored by CDC and its state and local partners include the following:

1. The California Community-Based Asthma Intervention Demonstrations Project (Fresno, CA): The goal of this project is to study whether reducing exposure to secondhand tobacco smoke reduces hospitalization of children due to asthma-related problems.

2. The Wisconsin Community-Based Asthma Intervention Project (Madison, WI): The goal of this project is to reduce exposure of children who have asthma to indoor allergens and document any reduction in asthma-related problems. CDC's partners are the Wisconsin Department of Health and Social Services; the American Lung Association of Wisconsin; Fight Asthma Milwaukee; and the Medical College of Wisconsin.

3. Investigation Characteristics and Circumstances Surrounding Asthma Deaths (New York, NY): In this study, CDC and the New York City Department of Health are reviewing medical examiner cases of death due to asthma to help identify and understand factors that may be causing an increase in asthma death rates in this population. Death rates from asthma among 25- to 45-year-old adults are substantially higher in New York City than in other metropolitan areas and the nation as a whole.

4. Wisconsin Asthma Education for Welfare-to-Work Project (Milwaukee, WI): The Wisconsin Department of Health and Social Services (DHSS) will develop and pilot an asthma education and management program for Milwaukee area families enrolled in Wisconsin Works (the Wisconsin welfare-to-work program). DHSS will provide families with information about asthma in general, indoor and outdoor allergens, and tools for treating and monitoring asthma (e.g., metered dose inhalers and peak flow meters).

5. ZAP Asthma Project (Atlanta, GA): CDC and 16 public, private, and community organizations formed ZAP Asthma, Incorporated, a community-based coalition to improve the lives and health of children who have asthma. The goal of the ZAP Asthma program is to determine if reducing exposure to known triggers in the home and educating families about asthma will decrease the number of asthma attacks and the costs associated with treating and managing asthma. The project is being pioneered with children 5 to 12 years old living in Atlanta's Empowerment Zone, a cluster of inner-city, low-income neighborhoods with a high rate of asthma among children.

6. CDC/Health Department Interaction (all states and territories): To build capacity in preventing and managing asthma, CDC provides staff of state, local, and territorial health agencies with training and networking opportunities. In collaboration with its national partners, CDC currently provides funding to six state and city health agencies for evaluating their asthma surveillance efforts. Based on the results, the partners will make recommendations to others about effective approaches to asthma surveillance.

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What More Can Be Done?

Controlling asthma as a public health problem will require a variety of initiatives.

Surveillance. State surveillance activities will help define asthma incidence and severity. CDC has developed asthma-related questions for its 1999 Behavioral Risk Factor Surveillance System survey for use by states. These questions will help determine which groups of people are engaging in behaviors that may increase their risk of asthma-related problems and who is most at risk. States and others can use this data to target intervention programs to those who need them the most, refine programs so that they are more effective, and evaluate the progress and results of programs.

Education. People who have asthma, their families, health care providers, school administrators, teachers, coaches, and community partners need to learn more about how to prevent and manage asthma. Professional and community educators can help reduce the economic and personal burdens of asthma by sharing information about asthma triggers, diagnosis, and treatment options. If funded, CDC could provide initial and continuing training for staff of state and local health agencies to ensure ongoing professional development in preventing and managing asthma.

Partnerships. For asthma prevention and control activities to flourish, dedicated partners in government agencies, nonprofit groups, and the private sector, including health maintenance organizations and hospitals, must coordinate their efforts. They can also work together on appropriate legislation related to asthma control, such as legislation allowing better access to asthma medication in drug-free schools or third party payment for asthma education.

Research. To further reduce asthma-related illness and costs, an applied research program is needed to refine and develop strategies for preventing and controlling asthma. To separate asthma causes from asthma triggers, accurate measures of asthma incidence need to be developed. To provide a basis for policies that offer the greatest benefit for available resources, the factors that make an asthma prevention program more effective need to be better understood.

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