[redacted] - November 26, 1997

1993 Correspondence A-Z	Box 1 of 8	- OA - 10593 - NARA - 8010
1994 Correspondence A-Z	" 2 "	- OA - 10594 - NARA - 8011
1995 Correspondence A-L	" 3 "	- OA - 10595 - NARA - 8012
1995 Correspondence M-Z	" 4 "	- OA - 10596 - NARA - 8013
1996 Correspondence A-K	" 5 "	- OA - 10597 - NARA - 8014
1996 Correspondence L-Z	" 6 "	- OA - 10598 - NARA - 8015
103rd Congress	" 7 "	- OA - 10599 - NARA - 8016
104th Congress	Box 8 of 8	- OA - 10600 - NARA - 8017

FIRST LADY FILES
FROM PAM CICETTI
picked up from 2nd fl WW 11/25/97 -
LEE

Doug Thurman
will store in 2W2
per telcon 11/25/97

regular oversize Attachents per Terry Good and
Lee Johnson 11/26/97 rr

10593 → 10600

ENCLOSURES FILED OVERSIZE ATTACHMENTS
8 boxes filed 11/26/97 rr

[redacted]

Brown, Hank

SS/MRS

SA

Congressional Biotechnology Caucus

2241 Rayburn House Office Building
Washington, D.C. 20515

(202) 225-2815

March 30, 1993

Honorable Hillary Rodham Clinton
Chair, Task Force on Health Care Reform
Room 287
Old Executive Office Building
Washington, D.C. 20501

Dear Mrs. Clinton:

I write to you as a founding co-chair of the Congressional Biotechnology Caucus. I ask that as you address the issue of pharmaceutical pricing, you consider the views of those that work in the field of biotechnology. In this regard, I attach for your review a position paper jointly prepared by the Industrial Biotechnology Association and the Association of Biotechnology Companies, the two principal trade associations representing the biotechnology industry.

Biotechnology has been singled out as a critical industry vital to America's long term national security and economic prosperity. It is in position to provide job opportunities here at home, and diagnosis, treatment and cure of life threatening and seriously debilitating diseases for patients around the world.

In recognition of the need for responsible pricing of pharmaceuticals, I understand that the biotechnology industry has indicated its support for federal action which would create strong incentives to limit future price increases.

Within this developing industry, the vast majority of biotech firms do not have a stream of product revenues to finance their research and development. In the attached position paper, the industry argues that government-imposed controls on introductory drug prices may adversely impact investment in the development in new technology.

In drafting the Administration's health care reform package for submission to Congress, I would appreciate your consideration of this information.

Sincerely,

Hank Brown

Hank Brown
United States Senator

Attachment

THE BIOTECHNOLOGY INDUSTRY RECOGNIZES THE NEED FOR RESPONSIBLE PRICING OF PHARMACEUTICALS: IBA/ABC POSITION ON DRUG PRICING[1]

I. Statement of a Critical Problem

The biotechnology industry strongly believes that government-imposed controls on introductory drug prices would strangle investment in our companies. Just the fear that such price controls might be imposed has already undermined investment in our industry, with biotechnology stock prices plunging by 40% since the election.

The opportunity to raise capital by small independent biotechnology companies is now virtually nonexistent. The major remaining method of obtaining capital is to partner with, or be acquired by, large multinational pharmaceutical companies. If the situation does not change, the biotechnology industry as it now exists will be gone within two or three years.

II. Background on a Growing U.S. Industry

The biotechnology industry focuses on discovering new ways to prevent, diagnose, treat, and cure the dozens of life-threatening and seriously debilitating diseases and conditions for which no satisfactory medical therapies currently exist. Biotechnology companies do not develop new, slightly improved versions of existing products and we do not make "me too" drugs: we attempt to redefine the treatment and prognosis for critically ill patients with severe genetic and acquired diseases for which there are no cures.

Our industry has invested at least $10 billion -- almost $5 billion in 1992 alone -- to develop the advanced molecular biology techniques that offer powerful new tools for understanding the mechanisms of human disease and for precisely designing therapies that supplement or complement our bodies' natural disease-fighting processes. R&D alone accounts for 38% of all costs incurred by biotechnology companies, and when the cost of administering that R&D is added, the percentage exceeds 50%. At least 90% of biotechnology R&D funds came directly from investors, most of whom are middle income individuals participating through mutual funds and pension funds.

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[1]This statement represents the considered views of the Industrial Biotechnology Association (IBA) and the Association of Biotechnology Companies (ABC), which have announced an agreement in principle to merge this year to speak with one voice about myriad issues, including the danger we perceive to the growth and, indeed, to the continued existence of our industry. Our combined association, which will become the Biotechnology Industry Organization (BIO) on July 1 of this year, represents over 90% of U.S. investment in biotechnology.

As a result of this extraordinary commitment to R&D, the biotechnology industry lost $3.4 billion last year and at least $9 billion since its inception. But this R&D intensiveness, which is unmatched by any other industry in the world, is a prerequisite to making meaningful therapeutic progress against intractable and devastating diseases and to creating jobs and maintaining U.S. leadership in an internationally competitive world of critical technologies. Our industry has directly created 87,000 jobs and indirectly created perhaps 100,000 more. We have the potential for creating over a million new jobs within the next ten years.

We have already produced bioengineered treatments for diabetes, dwarfism, Kaposi's sarcoma, hairy cell leukemia, hemophilia, Gaucher's disease, anemia, improved cancer therapy, and a dozen other seriously debilitating or deadly ailments. To continue our progress against such diseases as AIDS, Alzheimers, various cancers, multiple sclerosis, and cystic fibrosis, and to maintain our international leadership, the biotechnology industry requires substantial amounts of R&D funding.

While established pharmaceutical companies have ready access to research funds from profits on existing product lines, the vast majority of biotech firms do not have a stream of product revenues from which to finance their research. Instead, biotech companies rely almost exclusively on equity financing to obtain the capital needed for research and development of new drugs. As is true for all industries, the availability of equity capital is directly related to investors' anticipated risks and returns. The availability of risk capital is perhaps the largest reason for U.S. dominance in global biotechnology. Government regulation of the rate of return on new drugs through introductory product price controls would prevent investors from anticipating profits commensurate with the risks of investment. It would result in the industry vanishing.

It is important to stress that investing in a biotech company is inherently risky. Substantial scientific, manufacturing, and regulatory hurdles must be overcome before a new product can be marketed. Experimental therapies fall by the wayside, sometimes accompanied by their corporate sponsors. Recently, investors in one major biotechnology company lost 67% of the value of their shares in a single day because the company announced disappointing clinical trial results on its lead product.

The cost of failure is compounded by the extremely high level of investment required, as well as the ten to twelve year time horizon between drug discovery and FDA marketing approval. Very few firms have achieved profitability, while a substantial number have either folded, merged, or been taken over.

In light of this already risky investment environment, the continuing capital needs of biotechnology companies can only be met if investors can foresee a return commensurate with the risks, costs, and time involved in new biotechnology product development.

Biotechnology continues to be a young and fragile industry with the potential for enormous growth. Although there are hundreds of small, entrepreneurial biotechnology firms, three out of four companies have fewer than 50 employees, and 97 out of 100 have fewer than 300 employees. Most firms are less than ten years old. The collective market capitalization of our industry ($48 billion) is less than that of a single large pharmaceutical company, Merck ($60 billion).

The ability of these emerging companies to fund research and development of critically needed medical therapies is directly proportional to the availability of equity capital which, in turn, is directly related to investors' anticipated risks and returns. If companies' introductory drug prices become regulated by the government, then investors will continue to redirect their funds into other sectors of the economy and the biotechnology industry will become financially incapable of fulfilling its potential to help millions of critically ill patients and to create a million new jobs. New drug development will simply not take place at the same pace or level of intensity and this high tech industry, which is critical to our Nation's future competitiveness, will experience an eroding capital base and eventually lose its lead over its trading competitors.

III. Biotechnology Products: Cost Effective Alternatives in Health Care

In light of the fact that drugs are often the most cost effective way of treating disease, one critical point should not be overlooked: ***a policy that discourages the development and utilization of new drugs to treat diseases for which no satisfactory therapies currently exist would likely increase, rather than reduce, overall health care costs.***

For example, peer-reviewed independent studies on recombinant G-CSF and GM-CSF, bioengineered drugs used to stimulate white blood cell production in chemotherapy and bone marrow transplant patients, showed reduced hospital costs of 35 - 50%, reduced antibiotic requirements, and allowed more effective use of chemotherapy treatments. Another study, on the cost benefits of the use of recombinant alpha interferon instead of conventional chemotherapy for the treatment of progressive hairy cell leukemia, showed that annual direct patient costs for medical care -- which included blood transfusions, antibiotic treatment, splenectomy and chemotherapy -- were reduced by nearly two-thirds.

These products, and products like them, provide not only important therapeutic benefits to patients, but also an additional element of cost-containment to the entire health care system. Appropriate drug utilization review can optimize the usage of these drugs and enhance their benefit to patients and contribution to cost containment.

IV. A Solution

Our industry is committed to achieving profitability through innovation, and not through inflation of existing drug prices. Virtually all of the twenty-two biopharmaceuticals on the market are selling for the same price today as they were on the day of FDA approval, which in one case was 10 years ago. While this has been accomplished by voluntary price restraints in the past, we recognize the need for the new Administration and Congress to ensure that price increase restraint continues and can be objectively calculated for the purpose of achieving and documenting health care system savings.

Accordingly, ***the biotechnology industry is prepared to support federal action which creates strong incentives to limit future price increases in exchange for the right to continue to set introductory prices in accordance with the need to provide vigorous equity capital investment in our industry.***

Biotechnology companies have been, and will continue to be, socially responsible in setting introductory prices for their products. Clearly, a system of managed competition will increase market pressures on companies that are pricing new products. We believe that the reasonableness of U.S. biopharmaceutical prices is illustrated by a comparison to the prices of identical products in Japan, where the government-set price is two to three times higher than the U.S. company-set price. ***Japan has chosen extremely high prices set by its government as the preferred method of subsidizing its biotech industry. Despite its history of losses and fragility, the U.S. biotechnology industry does not seek subsidization.***

We have been gratified by the support that President Clinton and Vice President Gore have shown for maintaining the international competitiveness of emerging high tech industries such as ours, and ask only that we be allowed to continue to raise the funds necessary to invest in the world's most innovative biomedical research and, ultimately, to develop breakthrough therapies for those patients who would otherwise suffer or die. In return, our industry pledges to join the Administration's efforts and to play a constructive role in addressing our Nation's health care crisis.

HANK BROWN
COLORADO

COMMITTEES:
BUDGET
FOREIGN RELATIONS
JUDICIARY

United States Senate

WASHINGTON, DC 20510-0604

HG

March 22, 1993

SW

The attached resume is from a nurse - if we end up collecting nurses - we should put her in the file - forward to Sean for database!

Ms. Margaret Williams
Chief of Staff
Office of the First Lady
The White House
1600 Pennsylvania Avenue, N.W.
Washington, D.C. 20500

Dear Ms. Williams:

Enclosed is a copy of the correspondence from Sue Kaufman Brown. The correspondence is in regard to her ideas for health care reform.

Your review of this material and any suggestions for replying to this letter would be helpful. If there are any questions, please contact Gerry Cichon of my staff at 202-224-5941. A reply, in duplicate, to Gerry's attention would be appreciated.

Many thanks for your assistance in this matter.

Sincerely,

Hank Brown

Hank Brown
United States Senator

HB/gwc

WH

55

1993 MAR -5 AM 9:04

February 25, 1993

Ms. Hillary Rodham Clinton
White House
1600 Pennsylvania Avenue
Washington, D.C. 20510

Dear Ms. Clinton,

I would like to introduce myself. I am Sue Kaufman Brown R.N., B.S.N., M.B.A. with thirty years of operational experience as a provider, both in clinical and administrative positions, in acute care hospitals, community based clinics, public health agencies, skilled nursing homes, rural delivery systems, university faculties, Vocational Education programs and a wide variety of community volunteer health agencies.

In 1984 I earned a Masters Degree in Business Administration and Health Care Administration while supporting two children by myself on a nurse's salary. My son completed his law degree in 1984 at the University of Denver and my daughter completed her degree in theater and dance. Following a very long and arduous struggle we all graduated within one week of each other! See attached photo.

During the preceding twenty four years I have not had access to publicly subsidized programs or any financial support from a spouse. Therefore, I have a great deal of respect for the people in middle class America who fall *outside* the system definition of 'need'. However, my children and I learned a great deal about cooperative team efforts which ultimately contributed to our mutual academic and personal success.

My total professional commitment during this extensive learning process has been to the needs of the patient, the family, and the increasing need for community based responsive health care, incorporating promotion and prevention. I believe that currently both the patient and the family have been excluded from the paradigm of health care planning and reform.

While we attempt to find ways to make health care affordable to third party payers and still remain reasonably profitable to providers, the mission of medical care is *lost in the rhetoric of competition, profit, and vested interest.* What is the mission of medical care? Traditionally, it has evolved around the 'medical model' as taught in medical schools and traditional health care administration programs. The medical model involves the following:

OBSERVATIONS OF THE CURRENT MEDICAL MODEL

1. Cure at any cost!

2. Humans cease to be whole, integrated beings with quality of life issues, and become individual anatomic systems and pathologies.

3. A high degree of specialization due to technology has, over the last twenty years, accelerated this dehumanization process. The need to fund this technology has thus lead to the perception of the patient as revenue engendering, insured, uninsured or indigent, rather than as an integrated member of the community deserving the best care available and appropriate for them. The *appropriate care* may not involve cure, as dictated by the medical model, but may instead mean coming to grips with death and aging in a human evolutionary process with the support of the family and community services available largely outside of the acute care facility.

4. Competitive institutions that amount to chauvinistic, self-perpetuating and secluded pockets of high tech acute care that are recognized as the only legitimate delivery system.

5. The patient becomes a pawn, a means to an end; currently in the battle for institutional dominance of the community and the battle for physician support promoted by self-interest dedicated CEO's and their top-heavy executive teams, armed with the same kinds of 'perks' and 'bennies' our President is attempting to eliminate from government in order to reduce waste.

6. Clearly, as the former Governor of Colorado, Richard Lamb, said in his address *The Brave New World of Health Care*, delivered to the University of Colorado Medical School on September 18, 1990, health care is 'an economic cancer'. I submit to you that the host is the invisible patient.

I am suggesting a break with tradition. İ am suggesting that it is time to bring the mission of medical care back to the patient based ethic. It is time for past public policy to be left to the past. Relegate it to the history books for our children to read and turn a new page. I am submitting, for your consideration, the model that I have developed as the result of many years of operational experience. This model includes the following:

ATTRIBUTES OF THE REFORMED HEALTH CARE MODEL

1. This model would be based upon a National Health Insurance - a single payer system. Do away with Medicare and Medicaid and substitute a *Health Care Trust*, funded by the tax dollars that would be saved with the eradication of the attending bureaucratic stagnation and physician/hospital administrative abuse of regulations that is presently destroying the effectiveness of the entire population's health care benefits.

2. All major metropolitan areas would eliminate competitive institutional structures - hospitals, agencies, and policy making boards. These would be replaced by centers of specialty specific *Centers of Excellence*. For instance, one institution becomes all Behavioral Medicines, another Women's and Children's Health, etc. These facilities would be prevention, promotion and treatment oriented.

3. Since the philosophy of these centers would *not be acute care based* but community responsive prevention, health care maintenance and education based, these centers would integrate acute care in its proper perspective to preventative and specialty specific rehabilitation disciplines covering the entire evolving constellation of patient and family needs.

4. All major technology would be available in these centers only, thus cutting tremendous amounts of cost through duplication of expensive equipment and human resources. I also believe that this type of concentration of resources would promote much improved training systems for the health care providers, which in turn would promote greater productivity. Each of these centers would be technologically accessible to outlying rural communities via *Rural Care Pods*.

5. The Rural Care Pods would be staffed by clinically specialized nurse practitioners and other health care providers who would have technological, transportation, and specialized staff support from the Centers of Excellence in the major communities. The Centers of Excellence would be the support to the nurse practitioners via state-of-the-art, computer-aided communication tools, thus guiding the course of the patient's care during their acute episodes under the direction of the appropriate physicians. Once stabilized, if necessary, the patient would be transported into the Center of Excellence for further care. This would extend a much needed and improved level of care to the rural areas.

In addition, groups of doctors and other professionals would be expected to travel out into rural communities periodically for the purpose of teaching, offering community-based preventive care and patient follow-up. (See model diagram.)

6. Physicians, as with all health care providers, would be salaried and integrated as *members* of the entire team of health care personnel.

INFRASTRUCTURE OF THE REFORMED HEALTH CARE MODEL

1. With the conversion of the old competitive institutional structures into *NOT FOR PROFIT* Centers of Excellence, the governing boards making hospital policy that previously existed would be eliminated and each community would have a total community health board made up of representative members of discipline occupations and all levels of social strata. For instance: homemakers, policemen, teachers, clergy, lawyers, bankers, physicians, community leaders, patients and *grass roots citizens*.

2. This design would then offer a sensitive forum to be responsive to the changing community demands of health boards in urban and rural districts voicing and identifying the needs of their specific areas. These boards would function autonomously from interest groups, lobbies and long distance federal intervention. These groups would form the primary monitoring apparatus for Total Quality Management (TQM), cost control, health care consumer protection - advocacy would be mandated at this level - and community access to the common pool of information, services and intervention.

3. Rather than a central agency, such as Medicare/Medicaid, dictating an apathetic, chaotic and inappropriate standard for individual communities, the communities would be responsible for setting their own policy based upon their constantly changing and idiosyncratic community needs. The Medicare and Medicaid systems would be eliminated with their economic proceeds pooled into the total *Health Care Trust*.

4. In addition, each multi-disciplined clinical team, from Centers of Excellence nationwide, would develop standards of care, interdependent protocols, and case management care plans for individual diagnosis-related groupings. This would enhance the clinical quality of care for the patient and family, and eliminate the inefficiency, costly duplication, and negligence of practitioners who are allowed to set their own standards of care based upon vested interest rather than their patient's need.

I believe this would be a much needed first step toward eliminating the highly profitable *medical malpractice phenomena* that exists in our current system. There would be an ongoing program of exchange of clinical and technological progress among all Centers throughout the country that would be research based.

As a professional caregiver, the most ethically despicable component of the current system, from my experience, is the for-profit nursing home. Among the Centers of Excellence and in the Rural Care Pods, this model will provide an acceptable alternative to the degradation of the elderly for profit and design Home Health Care support for the elderly in their own environment via community support services.

In this Brave New World of Health Care, we can no longer afford to compromise quality, ignore the paramount needs of prevention and rehabilitation, and the natural processes of the life cycle, including death, in dealing with our patient population. We must recognize the whole human process if we are to stem the tide of crisis in health care. This means taking a realistic and sane view of our own mortality and recognizing that while birthing centers are needed to bring us into the world, death centers are also needed when it is time for use to leave.

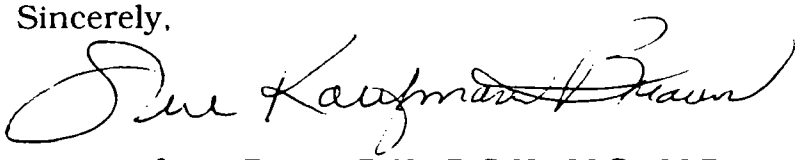
In conclusion, your advisory groups seem to me to be retracing the old halls of a familiar maze. There is a demonstrated need for new architects with new visions and with the education and training to look at 'caring' and the entire human life cycle. I am suggesting that among your architects you include more registered nurses and other health care providers who have had hands-on operational educational experience, and who recognize from their immediate involvement with the patient, that rhetoric posturing vested interest and arrogance won't help now.

You might be interested to know that Florence Nightingale wrote and published the first book on hospital administration and the delivery of care, which included health education and health promotion and prevention as well as acute care intervention. Perhaps we should take another look at this volume.

I am an impassioned reformer. I have witnessed thirty five years of abuse, and I have fought it. In the twilight of my career, I want to bring that fight to a successful conclusion. This year, I am publishing a book, documenting the abuse of privilege, power and public trust that has infected the health care industry, and has now reached the point of sepsis. I am dedicating that book to my grandchildren, in the hope that their world will be braver and better and in all ways more ethical and kinder than mine. I would like to join you in laying the foundation of change upon which they will build that world.

I have enclosed my resume and would like to be actively involved in the development of 'The Brave New World of Health Care' policy. I have exceptional analytical, strategic, pragmatic and political skills and have many years of experience as a public speaker and health care consultant. Mark Twain once said, "Truth is stranger than fiction, after all, fiction must make sense." We must begin to make sense. I am sure that you can appreciate the sensible value of a woman who has lived long and hard enough to know the difference between truth and fiction.

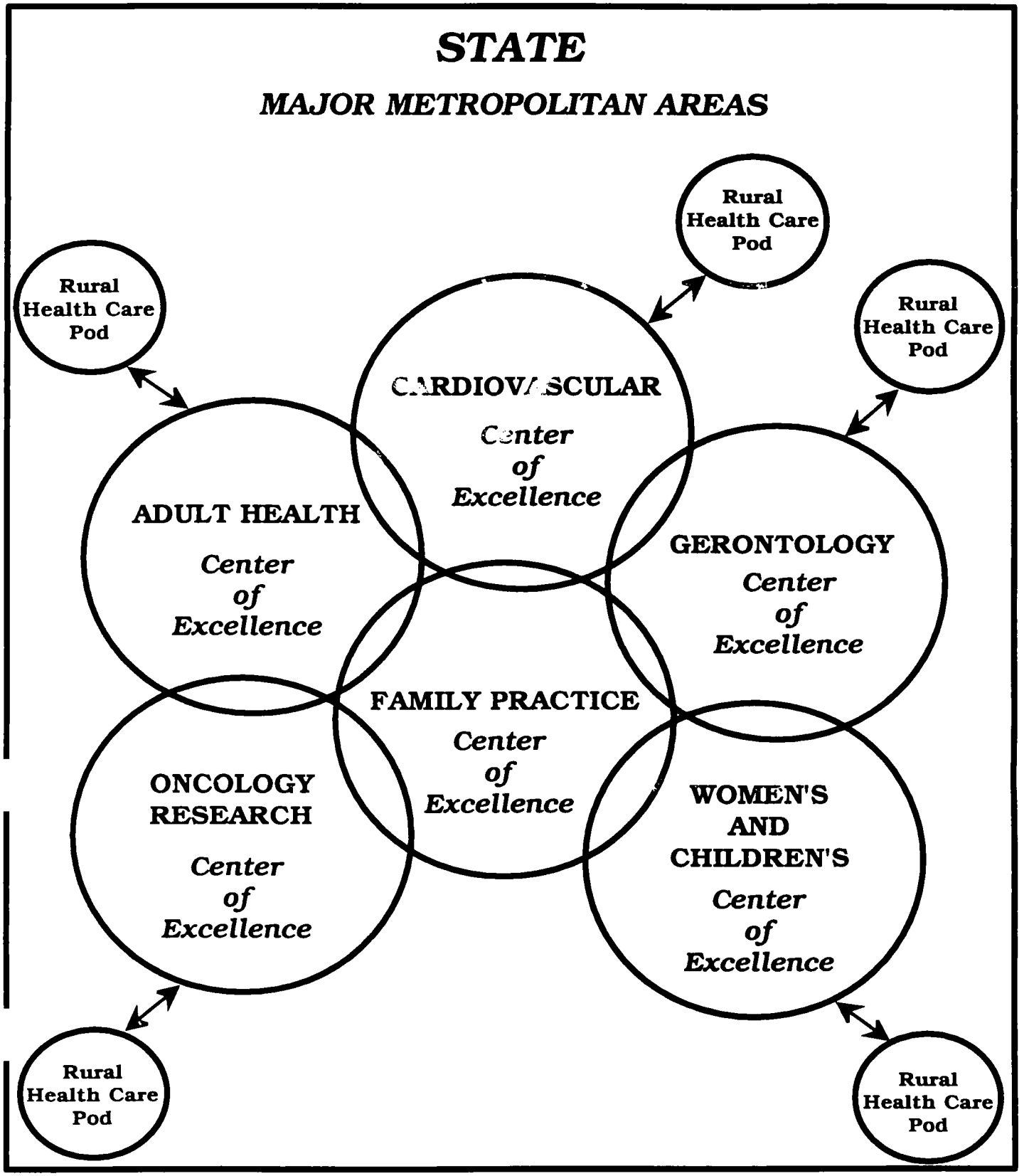
Sincerely,



Sue Kaufman Brown R.N., B.S.N., M S., M.B.A.
7451 S. Odessa Circle
Aurora, Colorado 80016
(303) 693-5215

REFORMED HEALTH CARE MODEL

Centers of Excellence



Sue Kaufman Brown, R.N., B.S.N., M.S., M.B.A. February 27, 1993

.cc

Senator George Mitchell
U.S. Senate Office
Washington, D.C. 20510

Senator Nancy Johnson
U.S. Senate Office
Washington, D.C. 20510

Senator Henry Waxman
U.S. Senate Office
Washington, D.C. 20510

Senator David Pryor
U.S. Senate Office
Washington, D.C. 20510

Senator Ron Wyden
U.S. Senate Office
Washington, D.C. 20510

Secretary of the Treasury
Lloyd Bentsen
White House
1600 Pennsylvania Ave.
Washington, D.C. 20510

Representative Jim Cooper
U.S. Senate Office
Washington, D.C. 20510

Senator Edward Kennedy
U.S. Senate Office
Washington, D.C. 20510

Representative Pete Stark
U.S. Senate Office
Washington, D.C. 20510

Senator Thomas Daschle
U.S. Senate Office
Washington, D.C. 20510

Senator Ben Knighthorse Campbell
380 Russel Senate Office Bldg.
Washington, D.C. 20510

Senator Jay Rockefeller
U.S. Senate Office
Washington, D.C. 20501

Senator Hank Brown
717 Hart Senate Office Bldg.
Washington, D.C. 20501

Senator Dan Schaefer
2448 Rayburn House Office Bldg.
Washington, D.C. 20501

Governor Roy Romer
136 State Capitol
Denver, Co. 80203

Sue Kaufman Brown, M.B.A., B.S.N., R.N.

7451 South Odessa Circle
Aurora, Colorado 80016

Telephone
(303)693-5215

OBJECTIVE: Seeking a challenging position in Health Care Services to improve patient outcomes. Position preferred should provide opportunities for professional growth.

EDUCATION:

UNIVERSITY OF NORTHERN COLORADO, GREELEY, COLORADO
Masters Degree - Business Administration and Health Care Administration, January 1984

DENVER UNIVERSITY, DENVER, COLORADO
Bachelor of Science Degree in Nursing

Colorado and California Professional Nurse Licensure

SUMMARY OF QUALIFICATIONS: Consistently demonstrated management abilities in the following relevant areas:

- Reorganization and structure Patient Centered/Focused Models.
- Consistently demonstrated sound organizational, financial planning, budgeting and controlling with a dramatic improvement in the "bottom line."
- Developed a consistent "systems approach" to accurate financial analysis, ratios and productivity measurement tools for an effective evaluation of the organization's financial position. Implemented system with middle managers, holding them accountable and responsible for their unit financial management.
- Developed a new and proactive approach to organizational design, flattening upper management structure, decentralized unit structure reducing layers of management positions with a reduction in total F.T.E.
- Redesign of the workplace environment, demonstrating positive results with "new governance" models increasing staff accountability, responsibility, commitment and involvement in professional practice standards.
- Creative and innovative approach to redesign patient delivery systems with consistent improvement in patient outcomes and reduction in "human resource" costs.
- Record of consistently demonstrating positive relationships with physicians, all professional staff and ancillary departments.
- Creative with adapting marketing principles demonstrating positive results in nurse retention recruitment, new program development and patient satisfaction.
- Consistently maintained a respect for subordinates and others in the organization, recognizing and rewarding their contributions.
- Designed and presented national seminars in all major metropolitan areas- "Business and Leadership Skill for Nurse Leaders" with very positive results.
- Participated in "Planetree Project," Pacific Presbyterian Hospital, San Francisco, California.

PROFESSIONAL EXPERIENCE:

9/90 to Present

UNIVERSITY PHOENIX, DENVER ,COLORADO
Faculty Member - in Masters and Bachelors program in Nursing and Business Administration.

- Responsible for curriculum development and classroom facilitation of the following classes:
  - Organizational Management and Leadership Skills
  - Negotiations, Change and Conflict in Health Care Organizations
  - Health Care Policy and Politics

8/90 to Present

IMPACT SYSTEMS INCORPORATED
President -

- Responsible for the total operations of this health care consulting service.

ACCOMPLISHMENTS:

- Coordination of all activities of this Consulting Service.
- Developed, implemented and evaluated national Marketing program with expansion of services.
- Developed entire Infrastructure and system for the organization.
- Established master plan of action for annual goals, objectives, budget and marketing projections for Health Care Consulting Services.
- Decrease of operational costs with improved monitoring of budget and controls in all areas.
- Establish quality improvement survey process for all consulting contracts.
- Expanded consulting service to include coliaborative practice, shared governance Focused Centered reorganizational design.

12/87 to 9/90

MERLE WEST MEDICAL CENTER, KLAMATH FALLS, OREGON
Director Department of Nursing/Director Departments of Social Services, Discharge Planning and Utilization Review-
In 250 bed regional full-service hospital accountable and responsible for the following departments: Emergency Room, Ambulance Service, Operating Room, Recovery Room, Day Surgery, Maternal Child Health, Pediatrics, Orthopedics-Neurological, Critical Care, Telemetry, Medical-Surgical and Oncology, Home Health, Behavioral Medicine. Responsible for seven Clinical Managers, three Clinical Specialists, Quality Assurance Standards Coordinator, Project Coordinator, and seven off-shift Administrative Supervisors. Total of 450 plus F.T.E.

As Division Director of Social Service, Discharge Planning, and Utilization Review, responsible for four social workers, three RN's, Discharge Planners and Utilization Review, plus support staff.

ACCOMPLISHMENTS:

- Responsible for a complete operational analysis of Nursing and Social Service departments with total restructuring resulting in improved quality care and decrease in operational costs.
- Multi-skilling and training within three major department.
- Flattened organizational structure with reduction of 7 supervisory F.T.E. New structure has increased communications and responsiveness of the department.
- Implemented, with success, Professional Practice Model with strong staff commitment in a union environment.
- Decentralized organizational structure to unit level with revision staffing model appropriate with modular units and with a reduction in staffing cost.
- Complete revision of department infrastructure resulting in successful JCAHO accreditation survey.
- Implementation of modular patient care units (10 bed patient pods) with 90% improved patient outcomes and reduction F.T.E. staffing.
- Implementation decentralized Quality Assurance, Standards Care, Policy Procedures, Protocols, and revision of nursing documentation on unit level with positive staff involvement.
- Facilitated clinical ladder development with strong staff involvement.
- Very successful Recruitment and Retention Program with staff "Nurse Ambassadors," resulting in 79% reduction in licensed staff vacancies.
- Active participation with Board of Directors, Medical Staff Committees facilitating improvement in Nurse/Physician relationships.
- Revision of all staffing systems, budget planning and controls developing these skills with Nurse Managers, resulting in a marked increase in the department's productivity.
- Increased visibility and accessibility of all nursing management team members improving staff and ancillary department communications.
- Implementation multi-disciplinary discharge planning system with patient and family rounds to facilitate compliance to D.R.G.

12/87 - Present *RESOURCE APPLICATIONS, BALTIMORE, MARYLAND*
Nursing Consultant, National Seminar Leader-
Accomplishments: Research, preparation and presentation of national seminars and hospital consultations with emphasis on "Business and Leadership Skills for Nurse

NORTHRIDGE HOSPITAL, NORTHRIDGE, CALIFORNIA
Administrative Director Nursing - Division Medicine, Surgery and Rehabilitation-
In a very active 485 bed hospital, responsible for management of six nurse managers; six nursing divisions; short-stay surgery, 32 beds; telemetry, 47 beds; oncology, 32 beds; orthopedics, 32 beds; rehabilitation, 50 beds, inclusive of spinal cord, head trauma, stroke and pain program.

ACCOMPLISHMENTS:

- Implementation decentralized organizational structure to unit level with development unit based, quality assurance, Standards Care and revised nursing documentation.
- Redesign nursing care delivery system to total patient care model with improved patient outcomes.
- Responsible for all budget planning and control with each nurse manager in relationship to patient population, acuity with an increase in overall productivity.
- Developed and chaired nursing department Quality Assurance Program as well as medical staff, safety, pharmacy and therapeutics, hospital-wide quality assurance committee.
- Successfully completed California Title 22 and JCAHO accreditation programs, March 1987.
- Assisted with design of three new nursing units in new building project.
- Developed transport team to reduce professional staff involvement in "non-nursing duties."
- Participated in revision of all job descriptions and performance standards.
- Technical and operational consultant for three graduate students at U.C.L.A. School Health Care Administration in "Planetree Project" at Pacific Presbyterian Hospital, San Francisco, California.
- Responsible for coordination of five new graduate nurse programs.
- Developed strong support and commitment with middle managers, physicians and staff by being highly visible and accessible.

SPALDING REHABILITATION HOSPITAL, DENVER, COLORADO
Director Education Department-
Implemented the development of this new department of education. Coordinating all disciplines in this effort in addition to actively participating as member of the Nursing Administration Executive Council.

ACCOMPLISHMENTS:

- Coordinated the first formalized nursing education program, extending this to other members of the multi-disciplinary rehabilitation staff.
- Implemented a comprehensive orientation program involving all departments consistent with multi-disciplinary rehabilitation philosophy.

ACCOMPLISHMENTS CONTINUED:

- Participated in medical staff education under direction of medical director.
- Member of Nurse Executive Council instrumental in planning implementation of departmental growth in satellite facilities as well as budget, policy and standards development in department nursing.
- Developed "Modular" patient care and primary nurse model for improved delivery of care.
- Established quality assurance program and chaired nursing committee.
- Participated in C.A.R.F. accreditation.
- In consort with Craig Rehabilitation, Swedish Hospital, participated as faculty on four statewide education seminars.

METROPOLITAN STATE COLLEGE, UNIVERSITY OF COLORADO, DENVER, CO
Faculty Member-

- Faculty (part-time) in the Division of Health Care Management.
- Instructor for "Past and Future Health Care Trends."
- Reported to Assistant Dean in the Department of Nursing and Health Care Administration.

DENVER GENERAL HOSPITAL, DENVER, COLORADO
Assistant Director of Nursing Critical Care-
In a very active 380 bed trauma city hospital, responsible for management of patient outcomes in Medical I.C.U., C.C.U., Surgical I.C.U., Surgical Intermediate, Neurological I.C.U. and Neuro Intermediate and Recovery Room. Managed four head nurses, professional and ancillary staff.

ACCOMPLISHMENTS:

- Coordinated all activities with active participation of physician directors.
- Established individual unit objective and goals to gain commitment of managers and staff involved in process.
- Decreased budgetary expenditures through increased staff awareness and accountability for staffing, equipment and supplies.
- Established and expanded responsibilities for unit manager to relieve head nurse of clerical functions and other "non-nurse" functions.
- Increased total number Intensive Care Unit beds available without increasing full-time equivalent staff.
- Established new orientation for all nursing personnel in Critical Care Units with active participation of staff and managers and Department Education.

ACCOMPLISHMENTS CONTINUED:

- Developed Community-based training program to establish internal pool to cover vacation, holidays and sick coverage in more cost effective manner.
- Expanded the Intensive Care Committee to include middle managers, chief physicians from University of Colorado Medical School Faculty, resulting in much improved physician/nurse relationships.
- Prepared all units for J.C.A.H.O. accreditation in consort with Assistant Directors of Medical, Surgical, Operating Room, Obstetrics, Pediatrics and Emergency Room Services.
- Increased staff nurse "retention" by designing committee for decision making, and staff participation in change process on unit level.
- Opened a Coronary Care Unit without increase in F.T.E. staffing by designing nurse rotation from Medical I.C.U.
- Acted as Administrative Supervisor for entire hospital for one weekend out of four in monthly rotation schedule.
- Redesign of Neurological I.C.U. equipment to allow for more cost effective function of staff and improved patient outcomes.
- Established first unit-based audit to evaluate nursing process and patient outcomes increasing staff accountability.

Reported to Chief of Surgery, Medicine, Neurology and Assistant Director Inpatient Services. Supervised 64 I.C.U. patients and over 200 staff members.

SWEDISH MEDICAL CENTER, ENGLEWOOD, COLORADO
Head Nurse-
Responsible for 52 bed telemetry medical unit initially demonstrating severe organizational, staff and physicians' problems.

ACCOMPLISHMENTS:

- Developed staff-physician relationship committee with positive results.
- Decreased full time equivalent staff 25% by reorganization of unit into total patient care model and redesign patient acuity system.
- Participated on Pharmacy Therapeutics Committee, Medical staff Committees, as well as Nursing Department "Clinical Ladder."
- Designed patient family education program with active staff participation.
- Responsible for total budget preparation. Decreased expenditures by design and implementation unit inventory controls and improved staff utilization supplies and equipment.

ADDITIONAL EXPERIENCE:

CONSULTANT
Institutional Representative for Medical Planning Associates, Malibu, California
Responsible for complete operational analysis of hospital facilities with emphasis on total restructure of Nursing and associated Departments. Active in physical restructure and design with architectural division.

ADMINISTRATIVE CONSULTANT
Nursing Service Consultants, Denver, Colorado-
Consulting services for hospital and long-term care facilities inclusive of complete operational analysis, implementation of new organizational structure consistent with multi-disciplinary team approach to client care. Emphasis on facilities qualification JCAHO, Federal and state regulations. Five years experience as D.O.N./Consultant skilled Nursing facilities.

ADMINISTRATIVE
Director Nursing Services, three years in 100 plus bed acute care facilities. Faculty position; two years A.D.N. program and five years Vocational education, including Administrative Director Licensed Practical Nurse Programs. Functioned as Nursing Home Administrator, Skilled and Intermediate Care facilities, over 150 beds.

EDUCATIONAL:
Pharmacology and Drug Administration, Instructor-
Administrative Instructor - Developed professional and nonprofessional staff training programs in coordination with Neighborhood Health Center and Denver General Hospital.
Administrative Instructor - In-service Education - Denver General Hospital
In-service Educational Department .
Staff Nurse - with experience in Public Health, Emergency Service, Home Health, Obstetrics, Psychiatry, Pediatrics, General Medicine and Surgery, V.A. Hospital, Denver, Colorado
Open Heart Surgery and General Medicine; Surgery.

PUBLICATIONS:

"Guidelines to Transdisciplinary Approach to Client Care." Policy and Procedure Manual for Skilled Nursing Home Facilities.

CERTIFICATIONS/ ORGANIZATIONS:

Health Occupations/ADN Programs
National Speakers Association
California and Colorado State Nurses Association
American Organization Nurse Executives
Colorado State Board of Community Colleges and Occupational Education
Type "E" Education Certifications - Colorado State Board of Education
Practical Nurse Association - Past Faculty Advisor
Denver University Alumna
University of Northern Colorado Alumna

REFERENCES:

Will be furnished upon request

THE WHITE HOUSE

June 13, 1993

Sue Kaufman Brown, R.N., B.S.N., M.S., M.B.A.
7451 South Odessa Circle
Aurora, Colorado 80016

Dear Ms. Brown:

Thank you for sharing your health reform model with members of the President's Task Force on National Health Care Reform. The Task Force, which has completed its work, benefitted from the suggestions of thousands of people like you, who have firsthand experience with the health care system. I think you will find that when the President's proposal is made final, it will address many of the points you raise: community health boards, emphasis on prevention, and elimination of bureaucracy and paperwork.

Again, thank you for contacting me.

Sincerely,

Hillary Rodham Clinton

Hillary Rodham Clinton

THE WHITE HOUSE

June 4, 1993

Honorable Hank Brown, Co-Chairman
Congressional Biotechnology Caucus
2241 Rayburn House Office Building
Washington D.C. 20515

Dear Senator Brown:

Thank you for your letter in support of biotechnology as a way to limit cost increases in pharmaceutical drugs.

Copies of your report have been provided to the President's health care advisors for further consideration. The President's health care reform initiative will include provisions to reduce the skyrocketing costs of prescription drugs and control other health care costs.

Again, thank you for sharing this information. I look forward to our continued work together to ensure that every American family has access to quality, affordable health care.

Sincerely,

Hillary

Hillary Rodham Clinton

9/29 To Wan Brown with best wishes – Hillary Rodham Clinton

wife of Sen. Hank Brown