FOIA Number: 2018-0756-F

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[Miscellaneous Memos and Correspondence 1993] [loose] [1]

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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. resume	[Personally Identifiable Information] [Partial] (1 page)	00/00/0000	b(6)

COLLECTION:
Clinton Presidential Records
National AIDS Policy Office
Kristine Gebbie
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FOLDER TITLE:
[Miscellaneous Memos and Correspondence - 1993] [loose] [1]

2018-0756-F
jp4858

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]
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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]

TO: National AIDS Policy Coordinator

FROM: Director, External Liaison Staff Office

SUBJECT: International AIDS Meetings

Attached is a schedule of upcoming international AIDS meetings. This schedule is from "Global AIDS News", a publication of the World Health Organization/Global Programme on AIDS.

I will continue to send information on upcoming meetings.

Nancy A. Hazleton, MPH

Laboratory Technology and Blood Safety, the International Federation of Red Cross and Red Crescent Societies, the United Nations Development Programme and the International Society of Blood Transfusion.

As a result of new developments in transfusion medicine and technology, the need for blood and blood products in many parts of the world is increasing. At the same time, the spread of AIDS has led to a fall in the level of blood donation and threatened the safety of the blood supply, especially in countries where HIV prevalence is high.
The purpose of this joint consensus statement is to aid countries to establish and maintain safe and adequate supplies of blood and blood products. The internationally recognized principle on which the recommendations are based is simply that the way to achieve such a safe and adequate supply is through the effective motivation, recruitment, selection and retention of voluntary community-based, non-remunerated blood donors.

With this central principle the statement goes on to provide a broad package of recommendations, arranged in seven sections, dealing with issues ranging from the establishment of blood donor programmes to the selection of safe donors, and from the selection and training of blood service staff to the evaluation and monitoring of blood donor programmes.

Such a comprehensive package of recommendations, supported by the resolutions of several previous international meetings and by the International Society of Blood Transfusion's code of ethics for blood donation and transfusion, represents a usable and highly authoritative guide as countries work towards ensuring the adequacy and safety of the blood supply. ■

DIARY

25-27 May
Geneva
Ninth Meeting of the GPA Management Committee (GMC)

28 May
Geneva
Second Meeting of the GMC Task Force on HIV/AIDS Coordination

7-11 June
Berlin
Ninth International Conference on AIDS
Fourth STD World Congress
Contact: Congress Organization, Bundesallee 56, D-1000 Berlin 31, Germany. Tel: (49 30) 85 79 03 0. Fax: (49 30) 85 79 03 27.

12-13 June
Tunis
Second Maghreb Conference on AIDS and STDs
Contact: Professor A. Zahar, Service Dermatologie, CHU Hédi Chaker, BP 65-3069 Sfax, Hached, Tunisia. Tel: (216 4) 42 627. Fax: (216 4) 41 384.

20-26 June
Oñate, Guipuzcoa, Spain
Children and HIV/AIDS: Medical, Ethical and Legal Issues (international conference)
Contact: Professor Emilio Viano, School of Public Affairs/DJLS, The American University, Washington, DC 20016-8043, USA. Tel: (1 202) 885 2953. Fax: (1 202) 885 1292 or 885 *2353*.

29 August - 1 September
Helsinki
Tenth International Meeting of the International Society for STD Research
Contact: ISSTDR-93, P.O. Box 151, 00141 Helsinki, Finland. Tel: (358 0) 175 355. Fax: (358 0) 170 122.

1-3 September
Tempe, Arizona
Consortium for Retrovirus Serology Standardization
Registration: Sheri Cyrus, Blood Systems Laboratory, 6220 East Oak Street, Scottsdale, Arizona 85257. Tel: (1 602) 946 4201. Fax: (1 602) 946 3823.

7-10 September
Edinburgh, United Kingdom
Second International Conference on HIV in Children and Mothers
Contact: HIV Conference Secretariat, Index Communications, 19 The Hundred, Romsey, Hampshire SO51 8GD, UK. Tel: (44 794) 511 331/332. Fax: (44 794) 511 455.

23-28 September
Acapulco, Mexico
Sixth International Conference for People with HIV/AIDS: "Communication and Solidarity for a Better Quality of Life"
Contact: Rodney Jones, PPS Europe Ltd, Wicker House, High Street, Worthing BN 11 1DJ, West Sussex, United Kingdom. Tel: (44 903) 205 884. Fax: (44 903) 234 862.
Note: this conference is open only to people with HIV/AIDS.

5-6 October
Geneva
Third Meeting of the GMC Task Force on HIV/AIDS Coordination

5-8 October
Lyon, France
First International Conference on Home Health Care for AIDS Patients
Organizing Secretariat: Hussard Organization, 8 rue Waldeck Rousseau, 69006 Lyon, France. Tel: (33) 72 74 06 03. Fax: (33) 72 74 05 79.

12-17 December
Marrakech, Morocco
Eighth International Conference on AIDS in Africa
Contact: Professor A. Benslimane, Société Africaine anti-SIDA, 4 Place Charles Nicolle, Casablanca, Morocco. Tel: (21 22) 29 53 25/6. Fax: (21 22) 29 53 27/8.

7-13 August 1994
Yokohama, Japan
Tenth International Conference on AIDS
Contact: Secretariat for the Tenth International Conference on AIDS, Congress Corporation, Namiki Building, 5-3 Kamiyama-cho, Shibuya-ku, Tokyo 150, Japan. Tel: (81 3) 3466 5812. Fax: (81 3) 3466 5246.

need to find out who from HHS & HUD are — lead —

Bob / Tim → See me if you have Q's

Need to be sure HIV/AIDS issues get included / mentioned —

~~CONFIDENTIAL~~ DRAFT

FEDERAL PLAN TO BREAK THE CYCLE OF HOMELESSNESS both problem & solution

Foreword.

- o Build on points from "putting people first" and other campaign statements
- o May 19, 1993 Executive Order
- o Development of a Federal plan--methods: outreach, interactive forums, mail solicitations.

Homeless Summit — Feb 24/25 — VA?, are some HIV/homeless groups tied in?

I Background and History.

1. Causes of homelessness

- o There is no one single cause of homelessness and many types of homeless persons who should not be pigeonholed into certain stereotyped classes. That only confuses a very complex issue.
- o The rise of homelessness in the 1980s is very complex but may have two major causal streams:

  --The first stream was the increased crisis of poverty in the U.S.

  --The second stream is the growing number of persons in American society who are not receiving adequate treatment for drug addiction, alcoholism, and mental illness.

- o In any one city during a given period of time the residents of the shelters constitute a complex mix of the homeless coming from both groups.

2. Past efforts to deal with homelessness

a. Local pioneering efforts largely through private nonprofit social service agencies and a few progressive local governments predated Federal or state involvement.

b. State efforts minimal.

c. Federal efforts late in coming, focusing initially on emergency care.

3. Current Federal policies and programs

a. McKinney Act programs

dealing with mentally ill in the street and developing adequate institutional discharge procedures so that new homeless persons are not continually created.

- o Pass health care reform to help meet needs of homeless individuals suffering from mental illness, alcoholism, or substance abuse.

3. Improve coordination and improve homeless programs.

- o Improve coordination of homeless job training and education programs.
- o Improve coordination of weatherization programs.
- o Improve coordination and streamline existing targeted Federal homeless assistance programs which fund emergency shelters and services.

4. Improve homeless prevention activities. Promote coordination and cooperation among Federal agencies to ensure that their mainstream programs support State and local prevention efforts.

5. Promote continuum of care beyond emergency services.

- o Redirect Federal funding to require links between housing and support services for homeless.
- o Encourage creative and cost-effective local approaches, including integrating emergency shelter with long-term housing assistance, education and employment opportunities through technical assistance and training.
- o Federal agencies should encourage applicants to demonstrate a fully coordinated and comprehensive approach to addressing the identified needs of homeless people.
- o Develop additional interagency collaborative efforts, including joint review of applications for competitive grant programs, memorandum of understanding, special technical assistance, etc.

III CONCLUSIONS--STEPS TO IMPLEMENTATION

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III CONCLUSIONS--STEPS TO IMPLEMENTATION

I think we're working on this — how is it coming?

June 2, 1993 3:45 am

Dear President and Mrs. Clinton,

I am writing to you at the suggestion of a friend; I am an HIV treating physician in Los Angeles plagued by the recurrent absurd situation I find my patients in and thought you might benefit from my thoughts on this situation.

The horror of HIV infection in human beings is disabling to behold. One of my more pleasant patients, Fred, was just placed in the hospital yesterday with both lower extremities swollen beyond recognition and bloody fluid dripping from wounds that opened spontaneously in his flesh - this is from his Kaposi's sarcoma which was brought into his life by his HIV infection. To be sure, there are treatments; yet the best treatment - little more than fat mixed with an already approved form of chemotherapy, daunarubicin - is not available for him, but has been under clinical investigation for the last 4 years and running.[1] Who are we protecting?

A ten year old boy that I cared for died from starvation Saturday, caused by Mycobacterium Avium infection in his intestines; but he didn't just die, he died of diarrhea - chronic, unremitting, embarrassing, foul diarrhea which was brought into his life by his HIV infection.

These poignant examples are but of few of my daily frustrations and my friend suggested that I need to express my concerns over our current drug approval process as it relates to terminally ill patients, especially AIDS patients, and offer a suggestion which could improve your political standing on health issues in general, and most especially my patient's afflicted with AIDS. I feel, with a slight addendum to the FDA's mandate, you could accelerate the finding of a cure for this disease and others. I will try for brevity, but clearly could go on for hours.

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[1] Lipisomal daunarubicin (LD), manufactured by Vestar in California, rumored to be approved this month? In actuality Fred could have enroll in a randomized controlled clinical study in which he would have a 50/50 chance of receiving the drug, and when he failed to get better on the alternative treatment (AVB) he would be eligible for the trial drug (LD) - remember daunarubicin is already approved for use in humans in the US by the FDA, and lipisomal technology is nothing more than putting the drug in a fat globule, which increases the drugs half life in circulation and may facilitate its up -take by tumor! I have enclosed Fred's pictures so you might have some idea as to what he is dealing with. Incidentally, he has already had the alternative treatment (AVB) and it failed.

Problems concerning the drug approval process: minimizes the risk of harm, but maximizes the delay; the risk of missing potentially curative treatments.

The current drug approval process (as I understand it) is based on a wish to prevent medical mishaps such as occurred with thalidomide in Europe. It is structured to insure that no medication/device used in the US will ever cause similar untoward events. This model is quite correct when it comes to wrinkle creams, cosmetic disorders and other treatments for self-limiting illnesses: clearly these individuals are essentially healthy and can, in reality, only be harmed by the use of untested, poorly tested, or poorly understood agents used in the treatment of these conditions; hence all medications must be tested to the fullest extent possible prior to their approval/use in the United States.

Unfortunately, for critically ill individuals with less than weeks or months to live, the underlying premises for drug approval are patently false. These individuals are most certainly going to die, and accordingly, the tolerance for side effects and adverse events caused by drugs is much greater in these individuals' minds, and these individuals can, in reality, only be helped by the use of untested, poorly tested, or poorly understood agents, provided there is some rationale for the agent's use, and more importantly provided that we learn from the use of these agents. Many of my patients would suffer willingly if there was some chance of improving their lot, or even if there was some chance of advancing our knowledge - I would go further and say that several of my patients have said to me that they only wished that someone would learn from their deaths so that others might be helped. What I have learned from their deaths is an infuriated frustration at the knowledge that potentially curative agents sit on the shelves of many laboratories and pharmaceutical companies in this great country while my patients continue to die. That my patients would gladly allow themselves to be experimental subjects, with little more than the expectation of death at the hands of unknown agents, was initially surprising; that they would do this with only the expectation of helping someone else avoid that same agent or extend our knowledge in the treatment of HIV, is heroic and must represent the best of our human nature; unfortunately for these noble souls, little is tried, less learned. [2]

Currently two very promising agents for the treatment of HIV/AIDS are under clinical trials in Europe; both agents are made by United States companies and both companies independently have decided to go to Europe to start human trials on their compounds: GEM-91 by Hybridon corporation and the Protease inhibitor by Abbott Labs Chicago IL. Why? Because of the barriers set-up by our drug approval process/tort system. By all indications both treatments look efficacious if not curative and non-toxic. The reason given by both companies for not initiating United States trials[2] was that it is easier to start clinical trials in Europe as the FDA, in essence, is demanding that the agents be proven non-toxic prior to use. Obviously, at least for the FDA, the best way to do this is to let Europe go first and observe the results, i.e., thalidomide. Unfortunately, when one thinks about it, these results and actions are clearly understandable. Any reasonable

[2]Actually, trials will begin in the US sometime in the future(?) but for now these companies are awaiting FDA approval and completing additional toxicological studies asked for by the FDA

person charged with the task of drug approval in the United States with even a remote interest in keeping their job, home, bank account, reputation etc., would be out their mind to approve any new drug for use in the United States - what could he possibly gain? I maintain a thinking individual would wait on approving any medication/device at least until it had already been approved somewhere else. The risk then being known, he would be assured no harm would come from the use of this medication/device and hence no harm would come to the approver. A thinking individual would do this for two reasons; first, those patients who would need the medication/device on moral grounds (willing to try anything, beyond hope) would by definition be the sickest and undoubtedly have little energy to fight, eventually and shortly dying; thus exerting little or no political pressure on the approver. Secondly, as he would only lose his job if an adverse effect occurred through the use of the new medication he had approved and as this is the substance of the media and the tort courts, which don't die, he would have two very good reasons to delay approval. Clearly, if you want to keep your job in the drug regulatory division, don't approve anything until it is already proven by someone else to be effective and free of side effects. Also, God help the drug company that would push to have any drug approved or used on moral grounds, or try to accelerate approval prior to it being abundantly clear to the regulator that he wasn't going to lose his job by approving a thalidomide- like drug. If one considers the position of the would-be medication/device regulator a little further, one realizes that as a thinking drug regulator, being in the position to make or break any drug company by virtue of control over the approval process, he should have little to contend with from anyone interested in having a medication/device approved for sale or use in the United States; or stated differently, by vindictively delaying approval of a bothersome pharmaceutical company's new drugs one could guarantee not a peep or hint of condemnation would be heard from the drug manufacturers - the only other, directly interested, surviving party in the drug approval process.

What a dilemma, the brightest, most innovative country on the face of the planet isn't using its resources to tame the worst plague of history, is allowing agents like DDI (may substitute DDC, D4T, etc.) to languish for 5 years in clinical studies, only to finally be approved and to be found (or I can tell you will be found) to be poorly effective, at best, in the treatment of HIV; but available to anyone who can afford the cripplingly expensive price[3] (somewhat justified to offset the huge cost of complying with the clinical and toxicological data requirements by the FDA).

Might I suggest the following solution, which is potentially beneficial to my patients, US pharmaceutical manufacturers, our country and you?

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[3] Actually if one speaks with the individuals involved in the early AZT studies, one finds that these physicians saw astonishing results in those patients started on this agent (AZT) and these same physicians pushed for rapid approval of this drug - it was, in fact, approved in a very rapid fashion; unfortunately, although AZT is very effective in the AZT naive user, or first time user, this efficacy quickly disappears in 2-6 months leaving the patient with little continuous benefit, but only growing and continuous toxicity. What we are now seeing in the literature concerning the lack of effect(long term benefit) of AZT on survival in HIV infected patients, i.e., the Concord study out of Europe, and the resultant class action law suits filed against Burrows Wellcome for "poisoning" patients-clearly reaffirms the dismal truth and wisdom employed by the thinking drug approvers approach. Clearly, if you want to keep your job in the drug regulatory division, don't approve anything until it is already proven bysomeone else to be effective and free of side effects.

The Sanctuary Drug Act.

As I understand the FDA to be under the control of the executive branch, and as I understand that its mission and purpose can be changed, amended or appended by executive fiat, I suggest using this power and mandating the following amendment ,creating a separate division, body, committee to the Food and Drug Administration charged with the creation and maintenance of a sanctuary for the human use of currently unproved agents/ devices. As an example: In those individuals deemed and substantiated by their physician as having less than six (6) months of life because of a life - threatening, incurable disease; and having signed all necessary forms of consent and wavers of liability; and being of sound mind, such individuals shall be allowed to have their physician petition the "sanctuary" for the providing of sanctuary agents, to be used by such patients for as long as the providing physicians reports back to the sanctuary on a regular basis to be established by the sanctuary governing board, pays a nominal fee for the agent and is limited to no more than 100 patient requests for any single sanctuary agent in one year. Agents will be placed in sanctuary based on the best judgment of a group of researchers, physicians and community activists and will remain in sanctuary until it is decided that they are dangerous, ineffective or more than 50,000 requests have been processed for the agent. Agents may be removed from sanctuary if no marked improvement in the patients so treated has come to light through anecdotal reporting by the treating physicians and/or as compared with the natural history of the disease itself. Drug manufacturers may submit agents to sanctuary without liability or loss of rights to the compounds and may pursue simultaneously phase one, two, and three protocols as currently recognized by the FDA. The sanctuary will be charged with adding and removing medications/devices from sanctuary status, maintenance and dissemination of a timely account based on the feed-back from physicians using the sanctuary drugs, and in allowing or disallowing physician participation in the sanctuary program based on noncompliance with the sanctuary's reporting requirements. Further, the sanctuary will maintain an acceptable standard of toxicity and ensure such data is present and available on all agents in sanctuary prior to release of compounds from sanctuary to the treating physician: this requirement for limited toxicity shall be judged in, rat, rabbit and dog but no standard on human toxicology will be required on sanctuary agents prior to their release, with all parties being warned as to the limits of the toxicological data. Sanctuary will transmit all toxicological summary data to requesting physicians with the sanctuary drugs. The sanctuary will use the funds it collects from the fee charged for providing agents to physicians/patients to pursue the study of the toxicology on agents decided by committee for use in the sanctuary, but not having drug company sponsorship or prior toxicological data, an example being a natural compound or chemical compound having promise is cell culture studies but not attractive to drug companies for reason of profit, patent etc.

This act would sub-serve several functions:

1) Any agent having tremendous curative power, even if non-patentable or widely available would be immediately obvious to those individuals both in and out of the sanctuary who are familiar with the disease process and would hopefully, having shown such promise in sanctuary, be pursued further in more formal clinical trials.

2) All or most covert use of agents in terminal disease would become public as the sanctuary would have these agents and proponents, or more importantly their patients, could look at the results, or read the anecdotal reports from many physicians who had direct experience with the agent prior to trying it themselves. This would help to limit unsubstantiable claims made for coffee enemas, or some other less/more absurd treatment done exclusively in one place, i.e., in Mexico, etc., and not capable of being refuted, or even analyzed, as no professional would risk losing their license doing something they had no data/faith in. Nevertheless, these same professionals might, at the patient's request, provide such therapy if available in sanctuary and would by definition report back to sanctuary, thus normalizing the reality of the agent and its effect in a broad group of patients and in a broad range of doctor's hands

By not allowing any one group to dominate the anecdotes or spread nonsense amongst desperate patients, the only motivation served by the sanctuary act, and in the requesting of a sanctuary agent, would be for one's patient's health and survival.

3) This act would provide a restraint on those unscrupulous charlatans who practice beyond and within our borders and drain our citizens/patients of resources. Any physician who cares for the terminally ill can attest that this is very difficult to prevent. By virtue of a sanctuary act a physician could use the same or similar agents as the charlatans. Reports by physicians, all using the same pure agent, could be read by potential sanctuary candidates and physicians prior to embarking on the use of such an agent. Patients would then have many reports to review rather than the one report of cure from one individual with one treatment available only in Mexico, Africa, etc.

4) The great cost of drug development could be brought to a fraction of its current level, as "home-run" agents would be evident and their major toxicities also evident. Small firms with little capital could submit or publish their data as is currently done and the sanctuary committee could select their agent for placement in the sanctuary

5) Agents in the sanctuary would be provided by drug manufacturers at no cost and would be pure, the manufacturer obtaining very rapid data on the agents effect in humans in return for provision of the agent and the toxicological animal data.

6) The sanctuary allows for a rapid evaluation of many agents with potential for cure, as contrasted with the 9 billion dollars we have spent comparing AZT to DDI. through the ACTG's

7) Patients and physicians stop re-inventing the wheel[4].

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[4]One of the truism of medicine is that when a treatment for a disease works, for example the treatment of testicular cancer with 98% cure, there is very little charlatan activity, or alternative medicine in these diseases, however, when current therapy is ineffective there is a burgeoning market in quack cures. Much of the problem with HIV is that we have no effective cure. When one is found, most of the problems surrounding the disease treatment with bizarre agents disappears.

Benefit to United States patients:

1) Untold thousands of patients now go to Mexico, Europe, etc., to seek out "cures" at great expense and untold grief. Given the availability of the same agents through their doctors these same patients (having failed all conventional therapy and with less than 6 months to live) would surely prefer to stay at home and some data could be collected on these agents at the same time.

2) The sanctuary agent might just work. Agents which clearly already work in the test tube could be used in humans in a matter of months rather than years.

Benefit to the United States pharmaceutical manufacturers:

In essence the companies could choose to place drugs in sanctuary and obtain information on its human toxicity and efficacy without spending the 10 million it currently costs to bring an agent through clinical trials. Having such advanced warning on agents under consideration by the drug companies for development is invaluable and for those agents which showed promise in sanctuary, efforts could be accelerated through the normal channels of phase one, two, and three. This would increase the availability of the agent to less ill patients who would not meet the definition of sanctuary users.

Benefit to you:

Clearly more previously healthy young Americans have died from HIV (200K) than have died in W.W.II, Korea and Viet Nam. Recognized or not this is a state of emergency. Each individual who dies of AIDS has on the average 30 years of training spent on him and these same individuals were expected by society to perform for another 30-40 years - what an incredible waste of productive man years. 30 years times 200K men equals 6 million man years of production! These are the individuals who were to pay taxes and take care of society - but now just draw on society and die.

All of those persons infected with HIV- dead or alive - have families that are extremely anxious that something be done and would be extremely grateful to anyone accelerating the process of finding a cure. This addendum to the FDA costs nothing, wins popular support and could dramatically accelerate the discovery of cure. I can think of no greater act that could be done to win popular support for your administration than to allow the terminally ill to go first, and experiment with their and their families' consent and the approval of their physicians, in a situation so
desperate for cure.

Purpose of the Sanctuary

1) To allow the free circulation of information on potentially useful agents, written by the treating physicians, on real persons with AIDS to the community at large.

a) This would discourage the continual pursuit of agents used by prior patients

who died, so that patients don't keep "re-inventing the wheel" [5]

b) Clearly by relying on the anecdotal model small differences of benefit or harm will be missed, but no one needs statistical methods to tell when someone's t cells go up or down by a factor of 3. This change is obvious to all observers - and unfortunately this is the change we need. This sanctuary method would miss small, or in my mind with this disease, inconsequential effects, but large effects would be obvious even if only anecdotally.

c) Patients will continue to seek out quack cures regardless of the laws against them as the preservation of their life would seem a higher good, even if misguided. There isn't enough man-power in the nation to stop a motivated individual told that he is terminally ill from seeking out hopeful alternatives to death -- why waste their experience?

Thank you for hearing me out.

THOMAS J. MAGEE, MD.

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[5]This is quite common in my experience, each new cohort infected with HIV-1 seeks out and tries the same therapies the last, dead, cohort did, e.g. , compound Q, dextran sulfate, ozone, hydrogen peroxide, intravenously hydrochloric acid, passive immunotherapy, etc.. Each desperate cohort attempts to re-invents the wheel which didn't work the first time around. Not only is the lack of efficacy disconcerting but the failure to learn from prior deaths is appalling. This lack of learning is related to two facts: most of the "practitioners of these therapies are either infected physicians themselves or 'alternative healers' and in both cases these data are not made public-the treatments being illegal or the treating physician dying from HIV and with him any information concerning the treatment efficacy or rather obvious lack thereof. During my treating of HIV infected patients I have seen this cycle repeat itself 3 times and I see no end in sight. It has two distressing side effects, one, more effective or even different therapies are not sought out and, two, the burden or proof is placed on the physicians who don't believe these therapies effective. Patients have said to me: "if it can't hurt me don't you think I should do it" or" doesn't it make sense, if ozone, bleach, hydrochloric acid, etc. kills the virus in cell culture won't it kill the virus in my blood" or " I have a friend whose T cells went up 400 by using rectal enemas of bitter melon extracts". How does a physician answer these questions? Scientifically? With what data? In this situation perhaps one can answer an anecdote with another anecdote or several thousand of them. For example, if every one of the individuals who comes to me expressing a desire to do intravenous compound Q could be referred to the Sanctuary data base of 5000 experiences with this agent and if 90% of the patients had died, got worse, did nothing, etc. I would suggest that these same patients initially determined to undertake such therapy would start looking for another treatment modality.

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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]

Thomas J. Magee, M.D.
6464 Sunset Blvd.
Suite 790
Hollywood CA, 90028
213-464-2107
(b)(6)
Age 36

Current Interest: Investigation into the HIV-1 infected human CD4 receptor bearing cells. Effects of anti-P27(NEF) antibodies on disease progression in HIV-1 infected patients. Gastrointestinal manifestations of HIV-1, lipid abnormalities in HIV-1. Skin disease in HIV illness, Anti-sense and viral construct projects. Kaposi's sarcoma, pathophysiology and treatment, cryptosporidium treatments.

EDUCATION

1986-88.....Internal Medical Residency at
Cottage Hospital
Santa Barbara, CA

1985-86.....Internship at L.A. County Hospital
Los Angeles CA
California Medical License

1981-85.....University of Illinois Medical School
Chicago, IL
M.D. Degree

1977-81.....University of Chicago
Chicago, IL
B.A. Degree

Board Certified in Internal Medicine, September 15, 1988
California Medical License since 1987, G59575. DEA BM0973594

[001]

WORK EXPERIENCE

Sept. 1988-Present.....Exclusive AIDS practice with out-patient and in-patient management of HIV-1 infected individuals.

Out patient medicine at Santa Barbara MedCenter.

Undergraduate summer research at University of Chicago: membrane estradiol and prolactin receptor characterization/quantization. Six years (part time) of in hospital Clinical Chemistry work.

RESEARCH PUBLICATIONS

Study: Duplicated research by Lloyd on the effects of bile salts in HIV infected human cells, study showed extreme toxicity in human cells unlike those results published by Lloyd, submitted to Lancet for publication in letter section but was rejected for publication.
G. Lloyd, PM Sutton, T Atkinson. Effect of Bile Salts and of Fusidic Acid on HIV-1 Infection of Cultured Cells. Lancet i,1988; 1418
Letter to Lancet:T. Magee In-vitro study of the effects of bile salts on HIV-1 infected human PBML cells.

ARTICLE TITLE: Follow-up study of patients receiving pentamidine aerosol for prophylaxis of PCP.
ARTICLE SOURCE: Int Conf AIDS (Canada), Jun 4-9 1989, 5 p196 (abstract no. T.B.O.1)
AUTHOR(S): Scolaro MJ; Kennedy P; Kahn B; Magee T; Eggerding F
AUTHOR'S ADDRESS: Los Angeles Oncologic Institute, St. Vincent Medical Center, Los Angeles, California 90057, USA

ARTICLE TITLE: LARGE VOLUME LYMPHOCYTE TRANSFER AS IMMUNE-ENHANCING THERAPY IN A SET OF MONOZYCOTIC TWINS
ARTICLE SOURCE: IXth Int Conf AIDS (Berlin), June 7-11, 1993
AUTHOR(S): Berry, P*; Shaker Irwin, L; Magee, T; Chang, H; Levy, J
AUTHOR'S ADDRESS: SEARCH Alliance 7461 Beverly Boulevard, Suite 304, Los Angeles, California, USA.
*Pacific Oaks Medical Group, Beverly Hills, California, USA

The objectives of this study were: 1) to determine the feasibility of weekly lymphocyte transfusions from a twin who is HIV seronegative to his twin with AIDS; 2) to evaluate the efficacy of less frequent lymphocyte transfers in improving immune function to a level compatible with reduction in risks of opportunistic infections. The results demonstrated improved immunologic function in the HIV (+) twin based on increased CD4 counts and percentages. No additional opportunistic infections occurred and there was a subjective marked improvement in the patient's quality of life.

CURRENT ACTIVITIES

Supported research on published subject matter Kaposi's sarcoma: Chronic retrovirus infection of transformed human T-cells and release of Oncostatin M : Specific stimulation of cultured spindle cells developed from AIDS associated Kaposi's sarcoma.

Member of Search Alliance Medical Research committee, located at 7461 Beverely Boulevard, Suite 304, Los Angeles Ca. 90036. Involved in all research information and dissemination to facilitate trials or other scientific involvement.

Appointed as Clinical Assistant Professor of Internal Medicine for participation in the education of Osteopathic Medical Students at the College of Osteopathic Medicine of the Pacific in Pomona, Ca. 91766-1889.

Member of the Medical Staff at Hollywood Community Hospital and participates in clinical rotations for medical interns from Hollywood Community Hospital located at 6245 De Longpre Avenue, Hollywood, Ca. 90028. He has presented the following lectures at Hollywood Community Hospital:

AIDS Update 7/26/91
Nutritional Assessment and Treatment 6/19/92
New Therapeutic Agents in the Management of AIDS scheduled for 12/04/92

Currently emphasizing rational anti-viral therapy with quantitative markers of HIV-1 viral burden (quantitative DNA/RNA PCR) and its response to therapy. Cell culture systems for testing of agents for in vitro anti-HIV-1 activity.

Participated in the Centers for Disease Control Model Performance Evaluation Program (MPEP): Testing for T-Lymphocyte Immunophenotyping (TLI).

Interviewed by Bill Roberts as a guest speaker for the Michael Howard radio boardcast in San Diego on KCEO (AM 1000) concerning medications and HIV treatment.

Alliances with community and scientific groups to further speed up potential therapy and trial developments.

Addressed AIDS Project Los Angeles Hotline and Speakers Bureau volunteers on recent therapy and research issues, October 27, 1993.

PROFESSIONAL AFFILIATIONS & SOCIETIES

American Medical Association 1982 - present

California Medical Association,
component society Los Angeles County Medical Association 1993 - present

American Society of Internal Medicine,
component society California Society of Internal Medicine 1992 - present

Physicians Association for AIDS Care (PAAC) 1993 - present

REFERENCES

Syed Zaki Salahuddin
Norris Cancer Hospital & Research Institute
818-397-8522
1441 Eastlake Avenue #162
Los Angeles, Ca. 90033

Dr. Ray Aller
Long Beach Community Hospital
310-595-3190
1720 Termino Avenue
Long Beach, Ca. 90804

Darol D. Joseff, M.D.
Santa Barbara Cottage Hospital
805-687-0412 Office
601 E. Arrellaga Street, Suite 103
Santa Barbara, CA. 93102

OUTLINE FOR PROPOSED SANCTUARY DRUG ACT

I. PATIENT QUALIFICATIONS
- A. Life-threatening, incurable disease
- B. Expected to have less than six months to live
- C. Informed consent waivers, liability waivers
- D. Mentally competent
- E. Physician's verification of A through D

II. PHYSICIAN REQUIREMENTS
- A. Agrees to report to Sanctuary board on regular basis on patient status
- B. Pays nominal fee for Sanctuary drugs
- C. Limited to 100 patients/Sanctuary drug/year
- D. Provide Sanctuary drugs to patients at cost

III. SANCTUARY DRUG/AGENT REQUIREMENTS
- A. Meets Sanctuary toxicity standards based on animal studies
- B. Are not deemed dangerous or ineffective by the Sanctuary board
- C. Are supplied to the Sanctuary at no cost by manufacturers
- D. Removal from Sanctuary
  1. No marked improvement in patients, as compared with the natural progression of the disease, has been reported by physicians
  2. Shown to be dangerous
  3. More than 50,000 requests have been received by Sanctuary

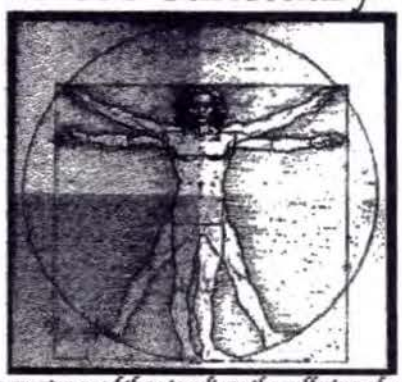
IV. SANCTUARY BOARD
- A. Researchers, physicians, community activists
- B. Maintain an acceptable standard of toxicity
- C. Add to and remove from the Sanctuary medications/devices
- D. Maintenance and dissemination of anecdotal results from participating physicians
- E. Allowing/disallowing physician participation in program based on physicians' compliance with reporting requirements
- F. Transmit toxicological summary data to physicians
- G. Use funds collected from participating physicians to pursue the study of the toxicology of agents chosen by the committee for inclusion in Sanctuary that do not have drug company sponsorship or prior toxicological data (i.e., natural compounds or compounds showing promise in cell culture studies, but unattractive to drug companies for patent or profit reasons)

V. DRUG MANUFACTURERS
- A. May submit agents to Sanctuary without liability or loss of rights to compounds
- B. May simultaneously pursue phase one, two, or three protocols as recognized by the FDA

VI. BENEFITS
- A. Speed in recognizing agents with great potential for cure
- B. Agents without great profit potential would be evaluated/utilized
- C. Alternative therapies scientifically evaluated
- D. Drug development costs could be greatly reduced
- E. Purity and dosageof agents would be standardized, assuring:
  1. Patient safety
  2. A level playing field for comparison of agents
- F. Charlatanism reduced
- G. Tens of thousands of productive lives might be salvaged

Sanctuary Task Force

1-800-Sanctuary



"There is no greater good than to relieve the suffering of another man"

The FDA's mission is to protect the public against harmful drug toxicities. Since the thalidomide scare of the '60's, the FDA has developed stringent guidelines and regulations for drug approval. It currently costs in excess of $190 million and takes four to ten years to bring a single drug to the marketplace. As a result of the high costs and the lengthy approval process, many potentially beneficial drugs are being tested overseas or not at all. In fact, some of the drugs being tested in Europe were developed at the National Institutes of Health at U.S. taxpayers' expense.

We are 13 years into the AIDS epidemic and have only three FDA-approved HIV therapies, all of which have limited benefit. Patients with late-stage, life-threatening diseases are often excluded from U.S. drug trials. Many physicians and their patients have been frustrated in their attempts to gain access to promising experimental therapies. Protecting the general public against harmful side effects is necessary, but we need to adopt a different standard for life-threatening diseases.

The Sanctuary Drug Act offers a solution. By establishing a Sanctuary Board comprised of prominent researchers and HIV-treating physicians as an arm of the FDA, potentially beneficial, non-FDA approved drugs warranting scientific investigation will be identified and evaluated. Those agents deemed to be within the range of acceptable risk will be selected for study inclusion. Study participants will be limited to individuals with less than one year to live. Sanctuary will supply and closely monitor the safety and efficacy of therapeutic agents in a structured, uniform study, wherein data will be collected, interpreted and disseminated to physicians via electronic data transmission. This structure will expedite our ability to recognize treatments with the potential for cure, allow alternative therapies to be scientifically evaluated, and greatly reduce drug development costs. The expanded national access to drugs and information will also eliminate duplication of research on ineffective agents.

In dealing with the AIDS crisis, as with all incurable diseases, we must take bold and determined steps. In response to this, a group of HIV-treating physicians, AIDS activists, and HIV-infected and affected persons have recently formed the Sanctuary task force. Sanctuary can offer hope to the terminally ill -- an opportunity to improve their chances for survival and quality of life, and the opportunity to participate in the search for a cure.

For further information, please call Brian Magee at (213) 993-0433.

I endorse the idea of the Sanctuary Drug Act and authorize the Sanctuary Task Force to use my endorsement in their efforts to promote the creation of the Sanctuary. I understand that my endorsement implies no obligation on my part, but is simply a reflection of my support of the Sanctuary Drug concept.

_____ _____

NAME DATE

Please return to the Sanctuary Task Force at:

Sanctuary Task Force
c/o Knowing, Inc.
6565 Sunset Blvd., Suite 416
Hollywood, CA 90028

or FAX (213) 993-0430

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Secretary

Washington, D.C. 20201

JUN 18 1993

MEMORANDUM

TO: Deputy Assistant Secretary
for Health Communications

FROM: Avis LaVelle
Assistant Secretary for Public Affairs

SUBJECT: Request for Approval to Publish Evaluation and Management of Early HIV Infection: Clinical Practice Guideline

The attached request to publish Evaluation and Management of Early HIV Infection: Clinical Practice Guideline is being returned without action, to allow for a thorough policy review and potential resubmission to OASPA for approval to publish.

The Office of Assistant Secretary for Health (not the Assistant Secretary for Public Affairs) should make the initial determination whether the private sector panel or the AHCPR version should be presented in this Government document. OASH also should determine whether the content should undergo further review and clearance through the Department's Executive Secretariat.

I recommend that the aforementioned reviews be conducted after the swearing-in of a new Assistant Secretary for Health.

Attachment

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Secretary

Washington, D.C. 20201

JUN 17 1993

MEMORANDUM

TO: Deputy Assistant Secretary
for Health Communications

FROM: Avis LaVelle
Assistant Secretary for Public Affairs

SUBJECT: Requests for Approval to Publish (1) HIV and Your Child: A Guide for Parents (English & Spanish), (2) Living with HIV: A Patient's Guide (English & Spanish), and (3) Early HIV Infection: Quick Reference Guide

The attached requests to publish (1) HIV and Your Child: A Guide for Parents (English & Spanish), (2) Living with HIV: A Patient's Guide (English & Spanish), and (3) Early HIV Infection: Quick Reference Guide are approved with the following provision:

Although 2 inks is approved for covers, only one ink is approved for text pages.

Attachment

the guideline panel has worked closely with PHS reviewers to ensure that the clinical guideline accurately presents sound professional opinions on management of HIV infection.

The AHCPR also provided the final draft guideline to Ms. Kristine Gebbie, National AIDS Policy Coordinator, for review and comment. Ms. Gebbie will provide comments to the Office of the Secretary.

I am satisfied that the major differences of professional opinion have been appropriately resolved and, therefore, endorse the AHCPR request for clearance to publish the practice guideline.

The AHCPR would like to schedule a public release press event on the Clinical Practice Guideline on Evaluation and Management of Early HIV Infection, for January 1994. With prompt clearance to publish, this can be accomplished.

If you need additional information on this matter, please contact J. Jarrett Clinton, M.D., AHCPR Administrator, on (301) 594-6662.

Philip R. Lee, M.D.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Office of the Assistant Secretary
for Health
Washington DC 20201

TO: The Assistant Secretary for Public Affairs

FROM: Assistant Secretary for Health

SUBJECT: Clearance to Publish the AHCPR-supported Clinical Practice Guideline on HIV Infection

This memorandum transmits my endorsement of the Agency for Health Care Policy and Research (AHCPR) request to publish the Clinical Practice Guideline on Evaluation and Management of Early HIV Infection. You approved for publication the Patient Booklets and the Clinician's Quick Reference for the Clinical Practice Guideline on HIV Infection, by memorandum dated June 17, 1993.

The AHCPR convened a private sector expert panel, co-chaired by Wafaa El-Sadr, M.D., Harlem Hospital Center, and James Oleske, M.D., New Jersey Medical School, to develop the clinical guideline and related products. The draft guideline has undergone extensive external peer review as well as review with the Public Health Service (PHS) by experts in the Centers for Disease Control and Prevention (CDC), the Food and Drug Administration (FDA), the Health Resources and Services Administration (HRSA), and the National Institutes of Health (NIH).

In May 1993, AHCPR submitted an earlier draft version of the guideline to the Office of the Assistant Secretary for Public Affairs (OASPA) and requested approval to print the guideline as submitted by the panel with the exception of the panel's declarations on issues related to inclusion of pregnant women in clinical trials and access to care. The AHCPR asked OASPA to approve for publication the AHCPR version of these issues.

By memorandum dated June 18, 1993, the ASPA stated that the Office of the Assistant Secretary for Health should determine whether the AHCPR or panel version of the issues should be printed and also determine whether the content needed to undergo further review and clearance. Since your June 18 memorandum, AHCPR and the guideline panel have reached consensus on an appropriate presentation of the medicosocial issues. Further,

Attachments

Tab A: Memorandum to the Assistant Secretary for Public Affairs
Tab B: HIV Clinical Practice Guideline
Tab C: June 17, 1993 memorandum from the Assistant Secretary for Public Affairs approving the Patient Booklets and the Clinician's Quick Reference
Tab D: June 18, 1993 memorandum from the Assistant Secretary for Public Affairs returning the Clinical Practice Guideline for OASH decisions.

In May 1993, we submitted an earlier draft version of the guideline to OASPA and requested approval to print the guideline as submitted by the panel with the exception of the panel's declarations on issues related to inclusion of pregnant women in clinical trials and access to care. We asked OASPA to approve for publication the AHCPR presentation of these issues.

By memorandum dated June 18 (Tab D), the ASPA stated that the Office of the Assistant Secretary for Health should determine whether the AHCPR or panel version of the issues should be printed and also determine whether the content needed to undergo further review and clearance. Since that June memorandum, we and the guideline panel have reached consensus on an appropriate presentation of medicosocial issues. Further, the guideline panel has worked closely with PHS reviewers to ensure that the clinical guideline accurately presents sound professional opinions on management of HIV infection.

The draft also has been provided to Ms. Kristine Gebbie, National AIDS Policy Coordinator, for review and comment. Ms. Gebbie will provide her comments to you and to the Office of the Secretary.

With prompt clearance to publish, we would plan a public release press event for January 1994. We have had press events for release of the earlier six clinical practice guidelines.

Because of the Departmental clearance requirement for publication of information related to HIV infection, we would appreciate your approval of its publication by signing and transmitting the memorandum to the Assistant Secretary for Public Affairs.

RECOMMENDATION

We recommend that you approve publication of the AHCPR-supported Clinical Practice Guideline on Evaluation and Management of Early HIV Infection by signing and transmitting the memorandum to the Assistant Secretary for Public Affairs requesting that the guideline be cleared for publication.

DECISION

Approved_____ Disapproved_____ Date_____

/s/ J. Jarrett Clinton, M.D.

J. Jarrett Clinton, M.D.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Agency for Health Care Policy and Research
Rockville MD 20857

Kristine Gebbie

Kristine: Jim is preparing today that Dr. Lee forward the approval to print for the guideline, for both the department, your positive support is critical and essential.

OCT 21 1993

TO: The Assistant Secretary for Health
Through: ES/PHS_____

FROM: Administrator

SUBJECT: Approval of the AHCPR-supported Clinical Practice Guideline on HIV Infection--ACTION

ISSUE

Attached for your signature is a memorandum to the Assistant Secretary for Public Affairs (ASPA) (Tab A) which endorses our request for clearance to publish the AHCPR-supported Clinical Practice Guideline on Evaluation and Management of Early HIV Infection. Our formal request to ASPA for clearance to publish the clinical guideline has been submitted through the appropriate channels. A copy of the final draft guideline, on which our request for clearance is based, is attached for your reference (Tab B).

The ASPA previously approved for publication the Guideline's Patient Booklets (in English and Spanish) and the Clinician's Quick Reference Guide (Tab C).

DISCUSSION

The AHCPR convened a private sector expert panel, co-chaired by Wafaa El-Sadr, M.D., Harlem Hospital Center, and James Oleske, M.D., New Jersey Medical School, to develop the clinical practice guideline on management of early HIV infection.

The draft practice guideline has undergone extensive external peer review and has been reviewed within the Public Health Service (PHS) by experts in the Centers for Disease Control and Prevention (CDC), the Food and Drug Administration (FDA), the Health Resources and Services Administration (HRSA), and the National Institutes of Health (NIH).

~~CONFIDENTIAL~~

22 June 1993

Recommendations for United States Government Action
to Assist International Efforts in Prevention and Control of
HIV/AIDS

1. Make HIV/AIDS Prevention and Care a top national priority. Over one million Americans have been infected with HIV since the start of the HIV/AIDS pandemic. Nevertheless, millions of Americans are still not aware of the magnitude of the problem in their own country. Recent surveys indicate that the majority of American youth have inadequate knowledge and unsafe sexual practices. There is thus a need to elevate the priority and commitment given to national HIV/AIDS prevention and care activities. AIDS and other sexually transmitted diseases should be discussed more openly in society, including in schools. Information needs to focus on the risk of unsafe sexual behaviour and means of avoiding infection rather than on whether behaviour is morally "right" or "wrong". More efforts must be carried out to counter discrimination against HIV-infected persons, which include conveying a better understanding of persons with different life styles. Priority must be given to inner cities.

   Presidential leadership is required for this effort. Many countries look to the United States for guidance on major policy issues. There can be no doubt that such presidential leadership in the United States would not only be of great benefit to the health of the American people; it would also provide a positive example to other world leaders. President Clinton should make a major policy speech on AIDS on World AIDS Day (1 December).

2. Ensure that HIV/AIDS prevention and care activities are given appropriate priority in international settings. Worldwide, 14 million persons have been infected with HIV since the start of the pandemic. In some African cities one in three adults is infected. In parts of Asia the disease is spreading as it did in Africa a decade ago with a tripling of infections in the past year. Worldwide, 5 000 new infections are occurring daily. At least 40 million persons will be infected by the year 2000 and 10 million children will be orphaned by the death of their parents. Despite the magnitude of the HIV/AIDS problem in their countries, leaders of many developed and developing countries continue to deny its importance and are reluctant to talk openly about the problem. This has contributed in part to the insufficient national and international responses to the pandemic.

   The United States Government should ensure that top priority is given to HIV/AIDS prevention and care efforts in all international fora concerned with health and development issues e.g., the UN General Assembly and the World Bank Annual Meeting. When speaking with world leaders, President Clinton could inquire about their

HIV/AIDS situation and encourage them to undertake greater efforts. One bold step would be for him to call for support of a global plan of action by Heads of State at an upcoming G-7 meeting. Such action is justified by the enormous economic impact the pandemic is likely to have during the next two to three decades (cost will be in the trillions of dollars), if significant steps are not taken during the next two to three years to greatly increase prevention efforts in all countries. The political stability of some nations is likely to be threatened by such an economic impact.

3. Provide global leadership in raising the financial resources needed to support prevention efforts in third world countries. WHO conservatively estimates that $2.5 billion is required annually now by third world governments to carry out essential prevention activities. Such resources could decrease the number of new infections by half by the turn of the century and save $90 billion in direct and indirect costs. Developing country governments must provide some of the resources, but there is no doubt that outside assistance is needed. The United Sates Government can play a major role in increasing the availability of these resources by:

   - increasing US Government contributions to the World Health Organization Global Programme on AIDS and HIV/AIDS activities of other UN agencies;

   - supporting the establishment of a United Nations Programme on HIV/AIDS as proposed in WHA resolution WHA46.37 and decision 1993/14 of the Governing Council of UNDP;

   - advocating the giving of more soft loans to governments by the Breton Woods institutions (World Bank, regional banks) for HIV/AIDS activities;

   - increasing the support given to private voluntary organizations (PVOs) working in HIV/AIDS related areas in developing countries;

   - increasing the funds provided by USAID for bilateral HIV/AIDS activities in prevention and care; and, most importantly,

   - encouraging "Corporate America" to provide support for international HIV/AIDS efforts (despite the great threat the pandemic poses to the economies of many nations, American multi-national companies have been very reluctant to date to support HIV/AIDS control activities).

4. Provide better direction and coordination of United States HIV/AIDS international research activities. The United States Government has provided billions of dollars for

support of research by government institutions and universities in the United States and abroad to find a preventive vaccine or cure for HIV/AIDS. At times overall priorities for funding have been unduly influenced by specific interest groups. Procedures for funding international research projects have resulted in competition and subsequently duplication among different government agencies pursuing the same objectives. United States-funded research, especially in developing countries, could more effectively meet the needs of these countries and could be better coordinated with research supported by non-USA agencies (international agencies as well as agencies of other nations). To solve these problems, an operational mechanism or structure should be established, which sets clear priorities for United States support of international research and ensures that this support is coordinated among United States funding agencies as well as between these agencies and non-USA agencies.

5. Reverse legislation that requires foreigners visiting the United States to declare their HIV-positive status. There is no public health risk in allowing HIV-positive persons to visit the United States. As noted above, over one million Americans are already HIV-infected. One's chance of becoming infected is dependent on one's own sexual behaviour, and not on the number of HIV-infected persons in the country. In fact, only four countries in the world require that visitors declare their HIV-positive status - China, Iraq, Philippines and the United States. This practice has resulted in a decision by international agencies not to participate in any international AIDS meetings in the United States. More importantly, it contributes to a climate of discrimination against HIV-positive persons which has hampered control efforts worldwide. It is remarkable that an enlightened nation such as the United States should follow such a practice. This practice should be reversed as a signal to the world that the United States is fully committed to the fight against AIDS. This would also allow the United States to show the importance it truly places on human rights and personal freedom.

Possible
site
visit
in
~~NY~~

This should be put with his resume —

—

FROM

FINTAN R. STEELE Ph.D
5300 28th St NW
WASHINGTON DC
20015

WASHINGTON, DC 200
PM
6 JUL
1993

29 Lilac
USA

TO

DR. KRISTINE GEBBIE
"AIDS CZAR"
% The White House
1600 PENNSYLVANIA AVE.
WASHINGTON DC
20500

PERSONAL

Dear Dr. Hebbie,

Please pardon an intrusive and maybe even self-serving note, but I want to wish you great luck and good things in your new job. As a long time AIDS "buddy"-volunteer, a gay man who has lost a number of friends, and more recently, a molecular biologist working in AIDS related research, I can appreciate the formidable hurdles you face.

I have recently decided to leave active research and try to work with more "politically" oriented groups on AIDS issues. Though I will likely join one of the established activist organizations, I am sending separately a resume to you; if my background and experience are valuable, or meet your needs, let me know. Again, best wishes! Sincerely,

Tristan R. Stiles

HOUSING & SERVICES, INC.
902 BROADWAY • SUITE 1512 • NEW YORK, NEW YORK 10010 • 212-529-6000 • FAX:212-529-9084

July 1, 1993

Kristine M. Gebbie
White House AIDS Coordinator
The White House
Washington, DC 20005

Dear Ms. Gebbie:

Congratulations on your recent appointment as White House AIDS Coordinator. As president of a not-for-profit organization which develops housing for formerly homeless persons with special needs, including persons with AIDS, I appreciate your background in public health and your support for prevention and education programs.

Our organization, Housing and Services, Inc. (HSI), is the largest provider of housing for persons with AIDS in the United States. We developed and currently manage a model facility, the Highbridge Woodycrest Center, for formerly homeless single persons and families with AIDS. Our care program at Highbridge Woodycrest is unique in that it offers a comprehensive approach to living with HIV disease. We provide each resident with an individualized health care and social service program. Our approach to health care is holistic, including traditional medications and alternative treatments such as acupuncture and vitamin and herbal therapies. In conjunction with health care, we offer a broad range of services. We provide counseling for substance abuse and offer courses in independent living, symptoms and infection management, and educational and vocational training.

Our residents do get better. Most outlive their initial prognoses for survival. Recognizing that most residents live longer, we have developed a concept and program called the Continuum of Care in which residents of all of our facilities participate. Residents can move freely within our range of facilities depending on the status of their

health. If they have stabilized, they can move from a long-term care facility into a supported independent living apartment and function as contributing members of their community. If their illness flares up, they can return to one of our long-term care facilities. Through our Continuum of Care, we provide for our residents at all stages of the HIV illness cycle.

I have enclosed information on the Highbridge Woodycrest Center, the Continuum of Care, and HSI. We would be honored if you could the Highbridge Woodycrest Center in the near future. attend/visit

I commend you on your appointment. With your experience and commitment, I have confidence that you will strive to implement the kind of comprehensive AIDS policy our nation needs.

Best regards,

Claire

Claire Haaga

President

Retire

Thank you for writing. [redacted] & sharing info on the Highbridge Woodycrest Center.

I will be in NYC from time to time, and will try to schedule a visit to the center.

Best wishes to you in your continuing work — sincerely

July 7, 1993

NOTE TO: Kristine Gebbie
National AIDS Policy Coordinator

FROM: Buck Buckingham

SUBJECT: First thoughts on strategic planning for staff support to the Office of the National AIDS Policy Coordinator

Here's a summary of where I think we are so far, and what the logical next steps should be. If I've misinterpreted anything, please let me know. I look forward to your response.

ASSIGNMENT:

Make recommendations for organization and deployment of staff to the National AIDS Policy Coordinator (APC), including the future mission of the National AIDS Program Office (NAPO)

PARAMETERS:

- The APC White House office will have a core staff of 3-4 individuals with skills related to
  --strategic planning
  --congressional liaison
  --Federal budgeting (calendars, procedures, relationships to OMB), and
  --community/consumer-level impact of Federal policies
- The APC will have line authority for NAPO personnel
- FTEs assigned to NAPO will not increase; may decrease
- "Policy support" (to be defined) to OASH and the Secretary will be continuing functions of NAPO
- All other current functions of NAPO are subject to review; and to ultimate reaffirmation, revision, or rejection

SUGGESTED PROCESS (see Attachment One for details):

[1] Conduct a thorough assessment of needed support to ensure the highest possible levels of program and policy coordination. The assessment should secure input and recommendations from four broad constituencies:

- **Policy makers** (APC, ASH, others as named),
- **Internal** (DHHS),
- **Interdepartmental**, and
- **External** (Capitol Hill, NGOs, associations, States, people living with HIV/AIDS).

[2] Assess and categorize Federal resources currently committed to AIDS/HIV policy coordination and support through:

A. NAPO
- Personnel
- Budget
- Other (including computer hardware/software, etc.)

B. Other PHS Efforts

C. Other DHHS Efforts (agency Associate Administrators for AIDS, etc.)

D. Other Federal Department/Agency Efforts

[3] Summarize findings and recommendations for review with APC at scheduled intervals. At same time, report on any process problems; course-correct as necessary. Recommendations, consistent with your memo of July 6 to Art Lawrence, will be made within the framework of establishing

- an "interdepartmental group"
- an "HHS-wide group", and
- a "PHS-wide group".

While not specifically addressed in your memo, I suggest I bring you policy options for "being in consultation" with community-level folk. There's potential for a bad rap if we don't deal with it directly in the context of how you organize to meet your mandate.

[4] Develop strategic, organizational, and operational recommendations for personnel accountable to the APC, including a DHHS-based "HIV/AIDS Office for Policy Support." (HOPS? I don't think so . . . HOOPS is probably more like it!)

LOCUS of PROJECT: This effort must be unmistakably positioned as one undertaken on behalf of the APC, rather than "one more attempt by NAPO to justify its existence."

PERSONNEL and ACCOUNTABILITY: Buckingham accountable to Gebbie for all phases of this work. Buckingham and Gebbie should meet weekly on this subject. Gebbie, Buckingham, and Lawrence meet as needed to discuss progress against workplan and timetable; reinforce or realign assignments where necessary.

CAVEATS:

- Detailed workplan (my task for Friday) must clearly define roles for other personnel in this process (I can't do this alone!).
- APC may need to enforce accountability to the *process*, as well as the individual coordinating it
- Must avoid even the appearance of a "repackaging" of NAPO. Current NAPO personnel should help inform the process, but should not directly staff it.

ATTACHMENT - PRELIMINARY WORKPLAN

Workplan presumes a four week process, with week one starting July 12, 1993. Next step will be getting more precise about the order in which things happen, and who does what. Tasks are **not** presented in priority order and are numbered for reference only.

[1] Assess and analyze perspectives on support needed to ensure highest levels of program and policy coordination

TASKS:

1.1 . . . . . Interviews w/ APC, ASH, other policy makers identified by APC
1.2 . . . . . Interviews w/ all current NAPO personnel
1.3 . . . . . Focus Group at scheduled 7/20 Executive Task Force meeting
1.4 . . . . . Focus group or other effort to get interdepartmental perspective
1.5 . . . . . Focus group w/ people with HIV disease
1.6 . . . . . Focus Group w/ key National AIDS/HIV organizations
1.7 . . . . . Focus Group w/ key Associations
1.8 . . . . . Interviews w/ selected Hill staffers
1.9 . . . . . Interviews w/ others as identified

[2] Assess and categorize current Federal resources

TASKS:

2.1 . . . . . NAPO
- 2.1.a. . . . . Review; analyze current FTE situation
- 2.1.b. . . . . Do trend analysis, etc. on budget
- 2.1.c. . . . . Obtain, analyze inventory of other resources

2.2 . . . . . PHS Efforts
- 2.2.a. . . . . Summary report on FTEs, budgets, etc.
- 2.2.b. . . . . Prepare trend analysis

2.3. . . . . Other DHHS Efforts
- 2.3.a. . . . . Summary report on FTEs, budgets, etc.
- 2.3.b. . . . . Prepare trend analysis

2.4. . . . . Other Department Efforts
- 2.4.a. . . . . Summary report on FTEs, budgets, etc.
- 2.4.b. . . . . Prepare trend analysis

[3] Report status and findings/recommendations at scheduled intervals.

TASKS:

3.1. . . . . Final workplan; assignments OK by 07/13
3.2 . . . . . 1st status report 07/16
3.3. . . . . 2nd status report 07/20
3.4. . . . . 3rd status report 07/25
3.5 . . . . . 4th status report 08/02
3.6. . . . . 5th Status report; FINAL draft of recommendations 08/11

Note: status reports 1-3 will be about how the process is going and what course correcting is necessary. I'll write up first draft of recommendations while on vacation and come in for the day on August 2nd to review them with you then return to the woods (or my cave or wherever I'm hiding out. . .).

[4] Produce final strategic, organizational, and operational recommendations for organizing personnel and other resources to meet the mandates of the National AIDS Policy Coordinator

TASKS:

4.1. . . . . Interdepartmental Group
    4.1.a. . . . . Strategic Recommendations (relationships, etc.)
    4.1.b. . . . . Organizational Recommendations
    4.1.c. . . . . Operational Recommendations
4.2. . . . . HHS Group
    4.2.a. . . . . Strategic Recommendations (relationships, etc.)
    4.2.b. . . . . Organizational Recommendations
    4.2.c. . . . . Operational Recommendations
4.3. . . . . PHS Group
    4.3.a. . . . . Strategic Recommendations (relationships, etc.)
    4.3.b. . . . . Organizational Recommendations
    4.3.c. . . . . Operational Recommendations
4.4. . . . . Extra-Federal Consultation/Participation
    4.4.a. . . . . Strategic Recommendations (relationships, etc.)
    4.4.b. . . . . Organizational Recommendations
    4.4.c. . . . . Operational Recommendations

KRISTINE M. GEBBIE, R.N., M.N., F.A.A.N.
NATIONAL AIDS POLICY COORDINATOR
DEPARTMENT OF HEALTH & HUMAN SERVICES
Room 729H Humphrey Building
200 Independence Ave., S.W.
Washington, D.C. 20201

DAY Wednesday DATE July 7, 1993

TIME 1:00 pm LOCATION Room 1332, Switzer Bldg.

SUBJECT Public Health Care Reform Meeting

PARTICIPANTS:
Participants list is enclosed with the agenda.

CORE PUBLIC HEALTH FUNCTIONS

- Health-related data, surveillance, and outcomes monitoring
- Investigation and control of diseases and injuries
- Protection of environment, housing, food, and water
- Laboratory services
- Public information and education
- Targeted outreach and linkage to personal services
- Quality assurance
- Training
- Research, demonstration, and evaluation
- Leadership, policy development, and administration

CORE FUNCTIONS PROJECT

Tasks

1. Validate the estimates for Federal, State, local investments in population-based services.
2. Develop estimates of the potential returns on the investment.
3. Clarify the data responsibilities.
4. Review the issues attendant to categorical v. core function funding patterns.
5. Others?

Upcoming Meetings

1. Joint Council -- July 22
2. Public Health Linkages Group -- TBD
3. Foundations -- TBD
4. Others?

CORE PUBLIC HEALTH FUNCTIONS

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DRAFT

CORE PUBLIC HEALTH FUNCTIONS

Health-related data, surveillance, and outcomes monitoring

Public Health Agencies	Health Plans
• Establishing enrollment procedures • Issuing health security cards • Setting data reporting requirements • Conducting capacity assessments • Setting criteria and performing risk ratings of health plans • Developing an electronic data network • Collecting data from health plans • Analyzing health outcomes and trends in plans, communities and States • Establishing quality of care measures • Assessing provider performance • Providing the public and health plans with timely reports • Publishing information about communities/States including subgroups of the population • Identifying fraud and abuse • Setting safeguards and confidentiality standards • Undertaking community surveys	• Compiling data required by alliances and public health agencies: for risk ratings; on enrollment; utilization; costs; outcomes • Participating in development of an electronic data network • Analyzing health outcomes and trends • Collaborating with public health agencies on whether service capacity addresses the population needs

Investigation and control of diseases and injuries

Public Health Agencies	Health Plans
• Working with other governmental agencies, e.g. jails, schools, to control diseases and to prevent injuries • Promptly identifying new and emerging diseases • Establishing procedures reporting and investigation procedures • Conducting investigations • Developing an electronic data network • Collecting data and analyzing health outcomes and trends • Reporting back to plans and communities • Undertaking community control measures • Assessing capacity to respond and control diseases and injuries	• Reporting diseases and injuries to the appropriate public health agencies • Participating in development of an electronic data network • Analyzing health outcomes and trends

Protection of environment, housing, food, and water

Public Health Agencies	Health Plans
• Establishing prevention programs and control procedures with other government agencies with responsibility, e.g. environmental protection agencies, housing departments, and public works. • Issuing regulations on reporting and investigation procedures • Conducting investigations and enforcing code requirements • Setting reporting requirements • Developing an electronic data network • Collecting data and analyzing health outcomes and trends in communities and States • Pursuing community-based prevention efforts with community organizations, including health plans • Undertaking community control measures • Supporting community-based organizations in their prevention programs	• Reporting diseases that are a result of environmental/housing (lead poisoning)/food or water contamination to the appropriate public health agencies • Participating in development of an electronic data network • Analyzing health outcomes and trends • Collaborating on community prevention programs to protect the environment, improve housing, and ensure the safety of food and water

Laboratory services

Public Health Agencies	Health Plans
• Establishing measures to assess laboratory capacity • Ensuring the development of sufficient laboratory capacity to meet community needs • Establishing quality control measures in public and private laboratories • Providing community-based laboratory services • Setting data reporting requirements • Collecting data from laboratories • Analyzing health outcomes and trends from laboratory data • Providing technical assistance and consultation to private labs • Identifying fraud and abuse	• Conducts personal laboratory procedures • Participates with public agencies in developing measures to assess lab capacity, quality assurance, etc. • Reports to public health agencies

Public information and education

Public Health Agencies	Health Plans
• Identifying public health problems that need to be addressed • Developing materials that provide culturally sensitive and linguistically appropriate messages • Conducting public information campaigns • Targeting messages to particular health problems or population groups • Distributing materials for health plans to provide their clients • Developing meaningful ways of measuring the effectiveness of public information activities • Evaluating the effectiveness of public information campaigns	• Distributing information on their services • Recruiting enrollment • Collaborating on the development and dissemination of health messages • Participating in community information and education efforts • Reporting on the plans' health outcomes and trends

Targeted outreach and linkage to personal services

Public Health Agencies	Health Plans
• Identifying communities/population groups' health problems • Developing targeted outreach to communities/population groups with health problems • Monitoring the extent to which linkages occur as a result of outreach efforts • Assessing plans' capacity to absorb new enrollees or to render specific services • Establishing reporting requirements • Analyzing health outcomes and trends	• Distributing information on the plans' services • Recruiting enrollment • Establishing linkages with other providers to render services • Reporting on the plans' outreach efforts

Quality assurance

Public Health Agencies	Health Plans
• Establishing case-mix enrollment requirements • Ensuring access to health plans for all population groups, particularly persons with disabilities, persons with chronic diseases, the elderly, etc. • Developing measures for capacity assessment • Setting criteria for risk rating • Performing risk ratings of health plans • Establishing quality of care measures • Assessing provider performance • Identifying fraud and abuse • Setting safeguards and confidentiality standards on data • Providing consultation/technical assistance for private labs • Regulating laboratories, health providers • Enforcing code requirements	• Distributing to the public information on the plan's services and quality • Distributing to the public health agencies information on the plans' enrollment, services and costs • Establishing linkages with other providers to render services that a plan does not provide • Reporting on the plans' outcomes and trends

Training

Public Health Agencies	Health Plans
• Collaborating with schools and training programs to assure a core of properly trained health professionals • Ensuring that there is a trained cadre of public health professionals to perform the core public health functions within the public health agency • Assessing the labor force to address the community's current needs and projecting labor force needs • Identifying labor shortages • Establishing continuing education requirements for health professionals	• Sharing with public health information difficulties in recruiting personnel • Collaborating on continuing training and education requirements • Establishing linkages with schools and training programs

Research, demonstration, and evaluation	
Public Health Agencies	**Health Plans**
• Conducting and supporting economic analyses of health promotion/disease prevention and other population-based programs • Developing a knowledge base which links risk behaviors and environmental exposures with health promoting behaviors and health outcomes • Developing meaningful measures to assess the effectiveness of prevention • Developing new technology and tests to accurately identify in a more timely manner new, emerging and existing diseases • Supporting the development of new drugs and medical devices	• Sharing with public health agencies difficulties and limitations in knowledge • Collaborating on research, demonstration and evaluation projects • Developing linkages with schools and research institutions
Leadership, policy development, and administration	
Public Health Agencies	**Health Plans**
• Collaborating with other governmental agencies to ensure community-based protection and to pursue community prevention strategies • Developing, maintaining and supporting an mechanism for communications with providers/plans and consumers • Providing a framework for achieving the Healthy People 2000 objectives • Examining the policies and opportunities in schools, worksites and other settings for prevention and protection • Regulating and enforcing as necessary • Providing technical assistance and support	• Providing leadership and guidance from a community provider's perspective about needs and capacity • Participating in development of policies, plans and programs with public health agencies • Translating information into useful reports to influence health policies

FOREWORD

Timely and reliable data is a critical component of public health surveillance and assessment, policy development, and program management and evaluation within the Public Health Service (PHS) and within the public health community generally. Accordingly, PHS sponsors a wide variety of data systems, projects and activities in support of agency missions to protect and promote public health. Similarly, PHS collaborates with the States in the development of data for mutual public health needs.

Planning for health care reform data affords an opportunity to plan systematically for public health data needs as well. Health care reform will increase financial access to health services, but a variety of population-focused core public health programs will continue to be needed to protect the public health, each with associated data requirements. New public health data systems may be needed as health reform is phased in, while other data systems may need to be strengthened or modified, and others phased out.

Accordingly, PHS has initiated a process to review its current and planned public health data systems and activities in the context of health reform. As the first stage of the review, PHS is developing an inventory of current and planned public health data projects and systems. The inventory is being developed by the PHS Task Force on State and Community Data. In the next stage, PHS will review the inventory of current and planned public health data activities in the framework of health reform and public health data needs, and develop recommendations to the Assistant Secretary for Health concerning future directions.

The PHS data inventory is currently in the developmental phase. Based on a review of agency program plans, budgets and information collection plans, a variety of current and planned data projects, systems and activities have been identified. For each public health data project or system identified, a one page description is being developed. In the current draft, complete project descriptions are shown where available. If the complete project description is not yet available, a title or an annotated entry is included.

Even in its current developmental stage, the PHS Inventory of Public Health Data Projects and Systems provides a reference guide to the wide variety of public health data systems supported by PHS, as well as a framework for assessing future public health data needs. The following types of public health data activities are included in the Inventory:

- Block grant application and reporting requirements
- Categorical program reporting requirements
- Disease and risk factor surveillance systems
- Periodic general purpose health surveys

- Vital statistics systems; disease and treatment registries; environmental health registries
- Training, technical assistance and State capacity building arrangements for public health data;
- Public health analytic data bases; public health computer-based information systems, and public health telecommunications systems.

AGENDA

PUBLIC HEALTH AND HEALTH CARE REFORM

July 7, 1993

1:00 p.m.

1. Introductions and Update

2. Data Activities
   Presentation on the State and Community Data Task Force and the PHS Data Inventory

3. Discussion of Core Functions

4. Upcoming Meetings/Opportunities for Further Discussion
   Joint Council
   Schools of Public Health Linkages
   Foundations
   Others

5. Next Steps

INVITED PARTICIPANTS

William McBeath
Associate Executive Director, Professional Affairs
American Public Health Association

Catherine Hess, M.S.W.
Executive Director
Association for Maternal and Child Health Programs

Michael K. Gemmell
Executive Director
Association of Schools of Public Health

George K. Degnon
Executive Vice President
Association of State and Territorial Health Officials

Nancy Rawding
Executive Director
National Association of County Health Officials

Byron J. Harris
Deputy Executive Director
U.S. Conference of Local Health Officers

James T. Dimas
Executive Director
Public Health Foundation

Martha F. Katz
Associate Director for Policy, Planning, and Evaluation
Centers for Disease Control and Prevention

Edward L. Baker, M.D.
Director, Public Health Practice Program Office
Centers for Disease Control and Prevention

Douglas S. Lloyd, M.D.
Associate Administrator for Public Health Practice
Health Resources and Services Administration

Eric Goplerud, Ph.D.
Director, Division of Planning and Policy Implementation
Office of Policy and Program Coordination
Substance Abuse and Mental Health Services Administration

Kristine Gebbie

Founded in 1911 as the Massachusetts Society of Examining Physicians
and Incorporated as the ASLM in 1972

AMERICAN SOCIETY OF
LAW, MEDICINE & ETHICS

ASLME FAX NO: (617) 437-7596

ASLME FAX TRANSMITTAL FORM

FROM: Larry Gostin DATE: 7-9-93

TO: Kristine Gebbie TEL: ( )

NAPO

FAX: (202) ~~670 4422~~ 202 690-[redacted] 7054 Total # of pages: 6
(This is page #1)

Additional INFO:

Founded in 1911 as the Massachusetts Society of Examining Physicians
and Incorporated as the ASLM in 1972

AMERICAN SOCIETY OF
LAW, MEDICINE & ETHICS

July 8, 1993

To: James Curran, MD; Kristine Gebbie; Raymond S. Greenberg, MD, PhD; Margaret Hamburg, MD; Robert Kingdon; Jennifer Klein; Joyce Lashoff, MD; Joanne Lukomnik, MD; William H. McBeath, MD; J. Michael McGinnis, MD; Michael Osterholm, PhD, MPH; Helen Rodriguez-Trias, MD; Allan Rosenfield, MD; Alfred Sommer, MD

From: Lawrence O. Gostin, JD

Re: Task Force on Health Care Reform & Public Health

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Mark Barnes, in consultation with me, drafted the enclosed letter which is intended to provide a record of our discussions. We thought that such a letter could be helpful to the Department of Health and Human Services and the Task Force on National Health Care Reform as the Bill went through Congress. We are inviting each member of the public health group that met to sign the letter. Could you phone (212) 788-5261 or fax (212) 964-0472, Mark Barnes' office by Monday, July 12, 1993 5:00 PM if you wish to have your name on the letter?

Again, thanks for all your help with the public health aspects of health care reform.

765 Commonwealth Avenue, 16th Floor • Boston, Massachusetts 02215 • 617-262-4990 • fax 617-437-7596

July 7, 1993

Philip R. Lee, M.D.
Acting Assistant Secretary for Health
United States Department of Health and Human Services
HHH Building, Room 716G
200 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Dr. Lee:

We are grateful for your time and attention during our meeting on June 25, in which we shared our common concerns regarding the fate of public health programs under the health care reform proposals. As you know, many of us have worked for several months with the Health Care Reform Task Force. During that time and during our meeting with you, particular concerns emerged about how public health programs and policies will be treated as health care reform proceeds. These concerns include, of course, the fate of preventive clinical services in the basic benefits package, but also include other public health interventions, both population-wide (such as education and prevention) and patient-specific (such as treatment for sexually-transmitted diseases and tuberculosis, directly-observed therapy for tuberculosis patients, contact tracing and partner notification, and lead testing and abatement efforts).

The concerns that we discussed with you, and that we know you and many members of the Public Health Service share, fall into six categories, as outlined below:

1. Public Health Representation on the National Health Board

Public health issues, from clinical preventive services to population-wide prevention interventions to patient-specific interventions (e.g., screening, contact tracing, directly-observed therapy, environmental hazards abatement) must be front and center in the agenda of the National Health Board that is expected to be formed as the decisional body for the health care reform plan. This goal can be accomplished in several different ways within the Board structure, either (1) by statutory language directing the

Board to take all actions with a view toward public health consequences and preventive effects, (2) by requiring in the enabling legislation that public health expertise be represented in specific ways in the membership of the Board, and/or (3) by establishing in the implementing legislation a separate public health panel of the Board, whose responsibility would be to advise and consent on Board decisions with significant public health impact.

2. Funding for Public Health Programs

Public health functions should be funded in some set-aside or percentage way in the health care reform package. According to information compiled by both the Public Health Service and by the Council of State and Territorial Epidemiologists, core public health functions, including the most basic function of disease surveillance, have been drastically underfunded. The goal here should be to fund core and cost-effective public health functions from some modest set-aside from premium collections, while requiring maintenance of effort on the state and local levels as a precondition for receipt of any new funds.

3. Quality Assurance for Public Health Programs

In order to justify enhanced expenditures for public health efforts, public health interventions on both the population and patient-specific levels should be subject to quality assurance measures, which might include outcomes measures. Developing such measures will be difficult, since public health success is measured by disease that does not occur, and is therefore defined by phenomena that are extremely difficult to capture. At the same time, however, public health should begin to develop these measures, in order to assure efficiency and effectiveness, and in order to develop cost-effectiveness comparisons with patient-specific health care delivery. It may well be, for example, that directly-observed therapy for tuberculosis patients, partner notification for HIV/AIDS, or environmental inspections for sources of lead poisoning in children are more cost-effective than funding for various other tuberculosis, HIV, or lead poisoning-related services in the basic benefits package. If so, funding clearly should be shifted toward such public health programs and away from less effective, patient-specific health care delivery. For these reasons, health care reform legislation, if it includes set-asides for public health funding, should require quality assurance processes for public health interventions that are funded from premiums.

4. Public Health Measures for Quality Assurance of Health Plans

Public health indices, such as overall measures of the health of various populations, should also be included in the quality assurance mechanisms for health plans. In other words, the aggregate effectiveness of individual health plans may be gauged, at least partially, by the health status and health trends of their

patient populations. In this way, public health statistics and disease surveillance processes can assist quality assurance mechanisms for health plans.

5. Survival of Essential Community Providers (ECPs)

Public health departments have developed and continue to offer an array of clinical services targeted toward interrupting infectious disease and abating sources of environmental and occupational disease. These services include tuberculosis clinics (linking patients to contact notification, directly-observed therapy, and drug-susceptibility testing), HIV counseling and testing (linking HIV-infected persons to partner notification, prevention counseling, and HIV primary care), sexually-transmitted disease clinics (linking patients to contact tracing services), school nursing and child health programs (ensuring immunizations, screening children for disease, and where appropriate, linking children and families to environmental inspection and abatement programs), and contraceptive and prenatal care programs (often treating patients anonymously or pseudonymously). It is essential that these public health clinical services survive the enactment of health care reform legislation, since they are vital, proven links to disease prevention.

The rationales for ensuring the continuation of these services and ensuring that these services are paid for through health alliance premiums include: (1) economies of scale, (2) disease-specific expertise not otherwise readily available in primary care settings (e.g., tuberculosis), (3) the essential linkages to public health interventions, (4) the special need to serve undocumented persons who apparently will not otherwise be covered by health plans, and (5) the likelihood that if not reimbursed through premiums, unscrupulous health plans will "dump" their own patients onto this fragile service delivery system. These services should be protected and funded in the health care reform package, most easily by requiring health plans to reimburse for the services that their members receive at these clinics, or by direct flow of adequate funds from health alliances to public health departments for these patient-specific clinical services.

6. Integration of Public Health Interventions into Health Care Delivery

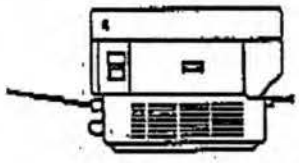
In defining the range of clinical services to be included in the basic benefits package, the health care reform legislation should make clear the responsibility of health plans to integrate public health measures into the delivery of clinical services. This does not mean that health plans themselves must conduct contact tracing, partner notification, lead abatement inspections, and directly-observed therapy. It does mean, however, that quality assurance processes should measure how well health plans have integrated linkages to these public health services into clinical care. State and local public health departments, depending on local needs and disease prevalence, must retain the ability to

require clinical service providers (health plans) within their jurisdictions to integrate public health measures into clinical care.

We hope that this summary of our discussions with you proves useful as you continue work on the health reform issues. We are happy to provide further assistance on these or other issues, and we thank you again for your time and interest in these public health concerns.

With warm regards,

THE CITY OF NEW YORK
DEPARTMENT OF HEALTH
OFFICE OF THE COMMISSIONER



125 WORTH STREET
NEW YORK, NY 10013

Margaret A. Hamburg, M.D.
Commissioner
Tel (212) 788-5261
Fax (212) 964-0472

TO: Ms. Kristine Gebbie

FROM: *OFFICE OF THE COMMISSIONER/* Mark Barnes

VIA: TELEX (212)964-0472 TO: _____

DATE: 7/9/93

7 pages (including cover sheet) are being telexed to the above person(s).

ACTION(S) TO BE TAKEN:

AS REQUESTED

PLEASE CALL UPON RECEIPT (212)788-5261 

AS PER OUR CONVERSATION

FOR YOUR INFORMATION

DELIVER IMMEDIATELY

COMMENTS:

_____

_____

_____

_____

_____

_____

MARK BARNES
Office of the Commissioner
Room 331, (212) 788-5258
New York City – Department of Health

TO: Kris Cebble DATE:

	INITIALS	DATE
Margaret Hamburg		
Wilfredo Lopez		
Bill Spadaro		
Clarence Gadsden		
Michael Baker		
Mary Ann Chiasson		
E. Randy Dupree		
Tom Frieden		
Kelly Henning		
Richard Nasdor		
Stanley M. Reimer		
Ann Sternberg		
Steve Matthews		
Sheldon Landesman		
June Binney		
Shawn LaFrance		

- ☐ ACTION
- ☐ APPROVAL
- ☐ AS REQUESTED
- ☐ COMMENT
- ☐ FILE
- ☐ FOR CLEARANCE
- ☐ FOR CORRECTION
- ☐ FOR YOUR INFORMATION
- ☐ NOTE AND RETURN
- ☐ PER CONVERSATION
- ☐ PREPARE REPLY
  - ☐ DRAFT
  - ☐ FINAL
- ☐ SEE ME
- ☐ SIGNATURE

REMARKS:

7/9/93

Kristine –

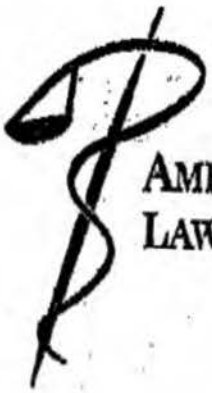
Do you want to sign on to this letter? Please let me know ASAP –

thanks –

MARK BARNES

212/788-5258

Founded in 1911 as the Massachusetts Society of Examining P...
and Incorporated as the ASLM in ...



AMERICAN SOCIETY OF
LAW, MEDICINE & ETHICS

July 8, 1993

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Public health functions should be funded in some set-aside or percentage way in the health care reform package. According to information compiled by both the Public Health Service and by the Council of State and Territorial Epidemiologists, core public health functions, including the most basic function of disease surveillance, have been drastically underfunded. The goal here should be to fund core and cost-effective public health functions from some modest set-aside from premium collections, while requiring maintenance of effort on the state and local levels as a precondition for receipt of any new funds.

3. Quality Assurance for Public Health Programs

In order to justify enhanced expenditures for public health efforts, public health interventions on both the population and patient-specific levels should be subject to quality assurance measures, which might include outcomes measures. Developing such measures will be difficult, since public health success is measured by disease that does not occur, and is therefore defined by phenomena that are extremely difficult to capture. At the same time, however, public health should begin to develop these measures, in order to assure efficiency and effectiveness, and in order to develop cost-effectiveness comparisons with patient-specific health care delivery. It may well be, for example, that directly-observed therapy for tuberculosis patients, partner notification for HIV/AIDS, or environmental inspections for sources of lead poisoning in children are more cost-effective than funding for various other tuberculpsis, HIV, or lead poisoning-related services in the basic benefits package. If so, funding clearly should be shifted toward such public health programs and away from less effective, patient-specific health care delivery. For these reasons, health care reform legislation, if it includes set-asides for public health funding, should require quality assurance processes for public health interventions that are funded from premiums.

4. Public Health Measures for Quality Assurance of Health Plans

Public health indices, such as overall measures of the health of various populations, should also be included in the quality assurance mechanisms for health plans. In other words, the aggregate effectiveness of individual health plans may be gauged, at least partially, by the health status and health trends of their

patient populations. In this way, public health statistics and disease surveillance processes can assist quality assurance mechanisms for health plans.

5. Survival of Essential Community Providers (ECPs)

Public health departments have developed and continue to offer an array of clinical services targeted toward interrupting infectious disease and abating sources of environmental and occupational disease. These services include tuberculosis clinics (linking patients to contact notification, directly-observed therapy, and drug-susceptibility testing), HIV counseling and testing (linking HIV-infected persons to partner notification, prevention counseling, and HIV primary care), sexually-transmitted disease clinics (linking patients to contact tracing services), school nursing and child health programs (ensuring immunizations, screening children for disease, and where appropriate, linking children and families to environmental inspection and abatement programs), and contraceptive and prenatal care programs (often treating patients anonymously or pseudonymously). It is essential that these public health clinical services survive the enactment of health care reform legislation, since they are vital, proven links to disease prevention.

The rationales for ensuring the continuation of these services and ensuring that these services are paid for through health alliance premiums include: (1) economies of scale, (2) disease-specific expertise not otherwise readily available in primary care settings (e.g., tuberculosis), (3) the essential linkages to public health interventions, (4) the special need to serve undocumented persons who apparently will not otherwise be covered by health plans, and (5) the likelihood that if not reimbursed through premiums, unscrupulous health plans will "dump" their own patients onto this fragile service delivery system. These services should be protected and funded in the health care reform package, most easily by requiring health plans to reimburse for the services that their members receive at these clinics, or by direct flow of adequate funds from health alliances to public health departments for these patient-specific clinical services.

6. Integration of Public Health Interventions into Health Care Delivery

In defining the range of clinical services to be included in the basic benefits package, the health care reform legislation should make clear the responsibility of health plans to integrate public health measures into the delivery of clinical services. This does not mean that health plans themselves must conduct contact tracing, partner notification, lead abatement inspections, and directly-observed therapy. It does mean, however, that quality assurance processes should measure how well health plans have integrated linkages to these public health services into clinical care. State and local public health departments, depending on local needs and disease prevalence, must retain the ability to

require clinical service providers (health plans) within their jurisdictions to integrate public health measures into clinical care.

We hope that this summary of our discussions with you proves useful as you continue work on the health reform issues. We are happy to provide further assistance on these or other issues, and we thank you again for your time and interest in these public health concerns.

With warm regards,

DATE: 7/20/93

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NO. OF PAGES TO FOLLOW: 3

___*For your information* ___*Please call upon receipt*

X *As requested* ___*For review and comment*

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6/21/93

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DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Office of the Assistant Secretary
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Washington DC 20201

JUL 21 1993

Notified not attending 7/23

NOTE TO KRISTINE GEBBIE

SUBJECT: MEETING ON STATE REFORM AND PUBLIC HEALTH

I am pleased that you will be able to join the Assistant Secretary for Health for a meeting on State health care reform and the public health system. The meeting is scheduled for Thursday, July 29, 1993, from 1:00 until 5:00 P.M. in the OASH Conference Room (Room 729G), Hubert H. Humphrey Building, 200 Independence Avenue, S.W., Washington, D.C.

As you are aware, States are currently enacting a broad range of initiatives to achieve the goals of health care reform. These differ in terms of coverage, benefits, cost controls, insurance reforms, delivery system reforms, and data system enhancement. If national reform is enacted, certain elements (e.g., coverage, benefits, insurance reforms, and data standards) are likely to be uniform across the country. But if States are given flexibility in other areas, there will probably be substantial differences in the way costs are controlled and the delivery system is structured.

The purpose of this meeting is to get a better understanding of how different constructs for reform effect the extent to which public health objectives can be met and the ways in which these objectives can best be achieved. The meeting will begin with representatives of various States briefly describing their reform initiatives, focusing on elements related to improving the health of the population or reducing differences in health status across various segments of the population. Areas of particular interest include whether the reform:

- changes the organization or funding for State and local agencies responsible for meeting public health needs;
- improves data systems or the supply and training of personnel needed to meet public health objectives;
- achieves universal access to care or comprehensive coverage (including preventive services, mental health services, and services related to alcohol and drug abuse);

- establishes local entities responsible for meeting the health care needs of defined populations of patients (e.g., regional purchasing alliances, health care plans, or community-based organized systems of care); or

- sets explicit standards for public health objectives and holds local entities accountable for meeting them.

Following these presentations, analysts with expertise in health care reform and public health will join State representatives in discussing the relationship between these different constructs for reform and the public health infrastructure. As part of this discussion, participants will be asked to address the following issues:

- To what extent can individual- and population-based public health functions be met by the mainstream delivery system under each type of reform? Which reform elements facilitate moving in this direction?

- How will/should the roles of State and local public health agencies change under each type of reform? What will be required to make them most effective?

- Which roles of State and local public health agencies are likely to be the same under all constructs for reform? Which are likely to vary?

- To what extent are public health infrastructure needs likely to be the same under all constructs for reform? To what extent are they likely to vary?

- How can the public health infrastructure can be made more effective in helping States meet public health objectives under reform?

We look forward to seeing you on July 29. An agenda for the meeting and a list of participants is attached. If you have any questions, please do not hesitate to call me at (202) 690-7163.

Roz Lasker (NS)

Roz Diane Lasker, M.D.
Senior Advisor

Attachments

U.S. PUBLIC HEALTH SERVICE
MEETING ON STATE REFORM AND PUBLIC HEALTH

July 29, 1993
1:00-5:00 P.M.

OASH Conference Room 729G
Hubert H. Humphrey Building

AGENDA

1:00 WELCOME AND INTRODUCTIONS

1:15 HEALTH CARE REFORM AND PUBLIC HEALTH

- -- Overview of Issues
- -- Objectives of the Meeting

2:00 STATE REFORM INITIATIVES

- -- Minnesota
- -- Vermont
- -- Hawaii
- -- Florida
- -- Oregon
- -- Oklahoma
- -- South Dakota

3:15 BREAK

3:30 ACHIEVING PUBLIC HEALTH OBJECTIVES UNDER DIFFERENT CONSTRUCTS FOR REFORM

- -- Role of the Mainstream Delivery System
- -- Role of Public Health Agencies
- -- Infrastructure Needs

5:00 ADJOURN

U.S. PUBLIC HEALTH SERVICE
MEETING ON STATE REFORM AND PUBLIC HEALTH

July 29, 1993
1:00-5:00 P.M.

OASH Conference Room 729G
Hubert H. Humphrey Building

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The Secretary of Energy
Washington, DC 20585

August 2, 1993

Ms. Kristine M. Gebbie, RN, MN, FAAN
Office of the National AIDS Policy Coordinator
Hubert Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Dear Ms. Gebbie:

It is with regret that I accept your resignation as Chair of the Environment, Safety and Health Advisory Committee. Your contribution to improving the Department of Energy environment, safety, and health programs is very much appreciated. We welcome your continued interest in the Department of Energy public health-related activities and will continue to solicit your advice.

Best wishes for success with your appointment as the National AIDS Policy Coordinator.

Sincerely,

Hazel R. O'Leary

THE JOHNS HOPKINS UNIVERSITY

Program of Infectious Disease

DEPARTMENT OF EPIDEMIOLOGY

SCHOOL OF HYGIENE AND PUBLIC HEALTH

624 North Broadway Suite 763 • Baltimore, Maryland 21205

Put with her resume

August 4, 1993

Christine Gebbe
National AIDS Policy Coordinator
750 17th Street N.W.
Washington D.C. 20503

Dear Ms. Gebbe:

Thank you for your time on Monday. I enjoyed having the opportunity to meet you and discuss the exciting work of your office. As I mentioned, I hope you will not hesitate to let me know if I can be of any help to you.

I understand that you are in the midst of determining what your future staffing needs will be. To give you some additional information concerning my work I am enclosing a list of references.

Please call me if I can provide any additional information.

Sincerely yours,

Liza Solomon

Liza Solomon DrPH

JOHNS HOPKINS
UNIVERSITY

Liza Solomon

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1993

Ms. Christine Gebbe
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750 17th Street, N.W.
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KRISTINE M. GEBBIE, R.N., M.N., F.A.A.N.
NATIONAL AIDS POLICY COORDINATOR
DEPARTMENT OF HEALTH & HUMAN SERVICES
Room 729H Humphrey Building
200 Independence Ave., S.W.
Washington, D.C. 20201

DAY Thursday DATE August 19, 1993

TIME 1:00 p.m. LOCATION Rm. 716-G, HHH Bldg.

SUBJECT Meeting on Health Care Reform

PARTICIPANTS:
Drs. Lee, Elders, Henderson, Lasker, Biles and Cliff Gaus will be participating.

Note to participants in 8/19/93 reform meeting

From: Roz Lasker

Subject: Public Health Initiative/Underserved

Date: 8/18/93

Attached, please find a draft of the revised underserved paper (now called Public Health Initiatives to Ensure Health Care Access) as well as a brief overview of all of the draft Public Health Initiatives, which puts the proposed access programs into a broader context.

The draft paper reflects the discussion during our meeting last week and is intended to be a springboard for discussion at tomorrow's meeting. The strategy was developed by a cross-cutting group representing many perspectives, who all look forward to your comments to guide their future efforts.

OVERVIEW OF PUBLIC HEALTH INITIATIVES UNDER REFORM

GOAL: Reinvent public health to work efficiently and in concert with the reformed personal care delivery system to:

- improve the health of the American public at an affordable cost;
- reduce disparities in health status across different sectors of the population (e.g., socioeconomic status, geographic region);
- address community health problems.
- Assure services to ~~traditi~~ underserved & hard to reach populations.

BUILD ON THE STRENGTHS OF THE NEW DELIVERY SYSTEM:

- access to comprehensive services for all;
- regional alliances and health plans responsible for providing services to defined populations;
- alliances and plans capable of reaching out to consumers and providers in their populations, providing them with information about prevention and appropriate use of services, and facilitating coordination of care;
- financing and payment system that rewards alliances and plans for keeping their populations well.
- the capacity of the states to flexibly match services to local needs

STRENGTHEN AND REORIENT PUBLIC HEALTH TO PROVIDE VITAL SUPPORT FOR THE REFORMED DELIVERY SYSTEM THROUGH THE FOLLOWING PROGRAMS:

I. Formula grants to states to strengthen public health core functions

Purpose: (1) to enable communities to maintain a strong defense against preventable diseases and conditions; (2) to work with the delivery system to address local problems as they arise; (3) to monitor and assure that all segments of the local population have access to needed services.

Functions supported:

-- Health data collection, surveillance, monitoring
-- Accountability for service delivery; quality assurance
-- Protection of environment, housing, food, water
-- Investigation/control of diseases and injuries

-- Community information, education, mobilization
-- Laboratory services
-- Training and education of public health professionals
-- Leadership, policy development, administration

(Note: does NOT include outreach services)

II. Competitive grant program to support innovative strategies for addressing priority health needs of regional and national significance

community assessment of HP2000 goals, by

Purpose: to support the development, testing, and dissemination of interventions that link public health and the personal care delivery system in reducing the incidence/prevalence of high priority conditions (such as infectious diseases, chronic and environmentally-related diseases, health related behavior, etc.)

especially those

Recipients: funds go to State and local government agencies, not-for-profit organizations, and research institutions, targeting the most needy geographic areas and population groups.

III. Federal funds to support the development of a uniform information system.

Purpose: (1) to consolidate currently fragmented public health data systems and integrate these systems with the regional and national data network derived from the personal care delivery system; (2) to assure that the elements and refined codes/definitions included in the data network from the delivery system support public health functions to the greatest extent possible.

IV. Federal programs to ensure access to needed services

A. Mandated reimbursement to designated **essential community providers** (ECPs) for services provided to plan enrollees. Mandate in place for five years, during which time ECPs integrate with health plans or form new community-based plans.

B. Federal grants and technical support to expand capacity in underserved areas through the **development of practice networks and health plans.**

C. **Expansion of the National Health Service Corps** and related programs to reduce the shortage of primary care providers in medically-underserved areas.

D. Formula grant program to States to ensure **access to**

* for any one state, funds for existing categorical access services continue until the state becomes an alliance, & then are gradually folded into the formula access grant (see D) over a 3 year period, assuming that the state meets access standards

needed services in sparsely-populated areas and for hard-to-reach populations (As current categorical programs and formula grants are phased-out, those funds will shift to this program).

Services supported:

-- outreach and enabling services
-- personal health services at first contact
-- linkage to providers and health plans
-- linkage to community health and social services
-- advocacy and follow-up

Targeting of populations/conditions: Funds used to correct disparities in access and health status according to population subgroups in each State. Accountability linked to monitoring and improvement in access and health status indicators.

Recipients of funds: States can allocate funds to free-standing public and community-based organizations (including school-linked clinics), providers, health plans, or regional alliances.

E. **Mental health/substance abuse**

F. **Indian Health Service**

G. **Undocumented persons**

V. Formula grant to States (funded through HHS and Department of Education) to support comprehensive health education in grades K-12 in high-risk schools

Grants given to State Departments of Education with a requirement to contract with State Health Departments. Focus of curricula and accountability linked to Healthy People 2000 objectives.

Other components of school health initiative funded through other PHS programs:

community health education -- covered in formula grant to strengthen core functions

school-based service delivery -- funded through formula grant to ensure access to needed services

research, development, and dissemination of curricula geared toward specific problems or population groups -- funded through competitive grants addressing priority health issues.

PRELIMINARY DRAFT -- AUGUST 18, 1993

PUBLIC HEALTH SERVICE INITIATIVES TO ENSURE HEALTH CARE ACCESS

I. Current situation

A. Currently, major financial and non-financial barriers to health care reduce access for a number of population groups in American society. Access barriers are disproportionately experienced by populations defined by income or education; by their culture, ethnicity, language or race; by place of residence (e.g. rural and frontier); by their lack of a stable residence (e.g. migrants and the homeless); by age (e.g. adolescents); or by the nature and severity of the health problems they face (e.g. HIV/AIDS, chronic mental illness, substance abuse, or serious disability).

B. Populations facing such access barriers often have reduced health status and quality of life. In response, the Public Health Service, as well as state and local government and charitable organizations, have funded or carried out a wide range of programs to address access barriers, provide personal health services, and reduce disparities in health status. (See Appendix for a brief description of current DHHS access-related programs.)

II. The Opportunity and Challenge of Health Care Reform

A. Under health care reform, we can expect significant reductions in financial barriers to access for Americans

1. All Americans will ultimately have health care coverage

2. A standard package of comprehensive benefits will include treatment services, clinical preventive services, and some mental health and substance abuse services

3. Regional alliances and health plans will be responsible for making the full range of benefits covered in the benefits package accessible to all population groups.

B. However the reform is unlikely to affect and eliminate all current barriers to health care and assure access to quality care, even when fully implemented:

1. Certain populations will remain uncovered (e.g., undocumented persons)

2. Certain services will remain uncovered or only partially covered

3. Health plans will be responsible for providing services to populations with whom they have little experience or expertise

4. Health plans will not have financial incentives to expand into low-population areas or to ensure that hard-to-reach populations get access to care

5. Many barriers to accessing covered services will persist, including:

   a. Lack of providers and health plans in both rural and low-income urban areas

   b. Providers who find certain populations difficult or undesirable to serve

   c. Absence of integration and coordination between primary care and other providers and facilities

   d. Geographical barriers

   e. Lack of transportation

   f. Cultural/linguistic barriers

   g. Lack of understanding among consumers/patients of the need for or availability of services

   h. Resistance to use of services (which may reflect problems with providers, patients or both)

   i. Care not available at convenient times

6. At the same time, many skilled, committed providers will not have the expertise and resources needed to participate effectively in a reformed delivery system based on insurance payments rather than grants

7. Depending upon risk adjustment of premiums and mechanisms to assure accountability, it will be difficult to hold health plans, health alliances and states accountable for assuring access, quality and improved health outcomes for historically vulnerable populations. This is particularly true in regions where such groups are only a small fraction of the general population.

C. In response to these opportunities and challenges, the proposed PHS initiative is designed to work in concert with the reformed delivery system to improve health care access for previously underserved populations, thus achieving national health objectives that we know will not be met if differential levels of access persist. The proposed PHS initiatives are designed to:

1. Support health alliances and health plans by providing critical outreach to and expertise in addressing previously underserved groups

2. Assure that health plans do their part in enrolling underserved populations and meeting their personal health care needs

3. Integrate organizations and professionals currently supported by public sector funds with health plans, which will benefit these providers by giving them support (administration, information systems, coordination of care) and ready access to consultations (in person or via telecommunications) and specialized services

4. Continue and expand programs to increase the availability of quality providers in underserved areas

5. Utilize existing programs to ensure continuation and improvement of current levels of access during the transition period before the reform is fully implemented and operational

6. Gradually shift the emphasis of public, non-premium funding streams away from delivery of personal health services covered in the benefit package and toward:

   a. Activities designed to enable, enhance and ensure access to care by addressing persistent barriers, especially those faced by hard-to-reach populations

   b. Services not covered in the benefit package but essential for constructive participation in society

These steps will set the stage for public health agencies at the national, state and local level to turn their resources, expertise and creativity to carrying out the core functions of public health, described in a companion document. Linking the access initiative with strengthened core public health activities will lead to solid improvements in health at the community level.

PRELIMINARY DRAFT -- AUGUST 18, 1993

III. Proposed PHS health access initiatives

A. To achieve these goals, the PHS will undertake several key initiatives. Some are initiatives designed for immediate implementation to support transition to a reformed delivery system. Others initiatives will be phased in gradually, as implementation proceeds and the reformed system is consolidated.

1. To assure access and continuity of care for underserved populations and residents of areas in which shortages of physicians and facilities exist, established health providers (including Federal grantees, providers supported by State and local government, as well as independent practitioners and facilities operating in underserved areas) may apply to the HHS for designation as essential providers.

   a. Designation of quality facilities and professionals as essential community providers will assure payment for needed, covered services they provide to health plan enrollees. The reimbursement rates will coincide with Medicare payment principles applied to federally qualified health centers and rural health clinics.

   b. This designation process and reimbursement policy will be in effect for 5 years. During this time, such providers will either be incorporated into health plans, or join together to create new, community-based health plans. (Note: Designation for less than 5 years is likely to result in incomplete integration of such providers and set the stage for a "self-fulfilling prophecy" regarding the impossibility of such integration.)

2. The integration of essential providers and the expansion of new providers into medically-underserved regions will be further enhanced and ensured through a new program of Federal grants and technical support to expand capacity by developing practice networks and health plans (including Federal grants and direct or guaranteed loans for capital infrastructure development for public and non-profit facilities).

3. Expansion of the National Health Service Corps and related programs to reduce the shortage of primary care providers in medically underserved areas

PRELIMINARY DRAFT -- AUGUST 18, 1993

4. During the early years of reform implementation, continued funding of Federal categorical programs and formula grants providing personal health services to specific populations facing barriers to care will continue.

   a. These programs include:

      i. Community/migrant health centers

      ii. Ryan White CARE programs

      iii. Health care programs for the homeless and residents of public housing

      iv. Family planning programs

      v. Demonstration programs and special initiatives (e.g. healthy start)

      vi. Maternal and child health block grants

      vii. Rural health outreach program

      viii. Transition grant program

      ix. Essential access community hospital and primary care hospital program

      x. Rural health clinics

   b. The need for Federal categorical funding of personal health services will decline as covered services are paid for by plans and as providers become integrated into the mainstream delivery system. As these categorical programs are phased out, funding will be shifted to the proposed PHS access initiative below.

Note that related papers cover initiatives addressing support for core public health functions; basic services for American Indians/Alaskan Natives; mental health and substance abuse services; and services for undocumented persons.

5. The PHS will develop a long-term formula grant program to States to ensure access to needed services for hard-to-reach populations.

   a. This formula grant will cover

i. Outreach and enabling services (e.g. transportation, translation/interpretation, child care)

ii. Personal health services needed at first contact

iii. Linkage to health plans and providers (e.g. enrollment, information and referral)

iv. Linkage to needed community health and social services

v. Advocacy and follow-up services

b. Formula allocations will be based on demographic and need factors

c. To encourage maintenance of current State and local efforts addressed to underserved populations, States will be required to match Federal funds on the basis of a formula to be developed

d. To assure accountability, State and local public health departments (overseen by PHS) will follow local indicators measuring access to needed services for population subgroups as well as health status measures from Healthy People 2000 that are closely linked to access to care

e. To obtain funds, States must submit plans showing how they will address disparities in access and health status according to population subgroups in their area, and demonstrate improvement in these measures over time

f. This initiative will be funded by a combination of set-asides from premiums and grant revenues previously allocated to categorical programs or program-specific formula grants. Funding for the long-term access initiative increases as funding for categorical programs declines over time

g. States will be able to allocate resources from the formula grant to free-standing public and community-based organizations, and to health alliances, health plans, or specific providers. These resources can be used to supplement and enhance those flowing from premium dollars, in a

manner most strategic and appropriate for the circumstances in a given community.

B. Rationale for a transition from categorical to formula grant funding

1. Categorical programs have been initiated to assure that the special needs of a particular population are being adequately served. The unreformed delivery system was seldom held accountable for performance. Unlike other constructs for health care reform, the Administration's proposal makes it possible to hold specific entities accountable both for overall community health and for addressing special needs and special population groups. With strong accountability and quality assurance systems, categorical funding will no longer be required to assure that needs are being met.

2. In common with the current specialty-dominated personal care system, the extant categorical based programs that have dominated public health programs are wasteful of resources. Both personal care and public health have encouraged unnecessary duplication of infrastructure while lacking an integrated approach to patient- and population-based problem solving. A formula grant system will

   a. Allow State and local health departments and community-based organizations to tailor their programs and activities to the varied health needs and problems of different areas of the country

   b. Provide health departments the flexibility to respond promptly and vigorously to the emergence of a new health problem (e.g. HIV/AIDS) or the recrudescence of a long-term problem (e.g. MDR/TB).

   c. Encourage centralized planning and management structures within health departments to support common application procedures, data collection, and reporting systems

PRELIMINARY DRAFT -- AUGUST 18, 1993

APPENDIX

CURRENT DHHS PROGRAMS PROVIDING PERSONAL HEALTH SERVICES TO POPULATIONS FACING BARRIERS TO CARE

1. Community and Migrant Health Center (C/MHC) program provides preventive and primary care, and case management of specialty and hospital services in underserved urban and rural communities

   a. Each C/MHC is governed by a community board to ensure it meets community needs

   b. In 1993, 586 not-for-profit and public organizations received grants to operate 1,547 clinics that served 6.6 million people

   c. FY 93 funding - $616 million; FY 94 request - $681 million, with an expected 7.1 million people served

   d. Adding the Health Services in Public Housing Program, with $9 million requested, 7.2 million people would be served

   e. The C/MHC authority is used to support infrastructure as well as services

   f. In FY 94, $8 million is expected to be used for major capital projects, an additional $6 million for planning and community development, primarily through State or Regional Primary Care Associations

2. Family Planning grants are authorized by Title X of the Public Health Service Act to provide family planning services, including counseling and clinical services necessary to prescribe contraceptives

   a. FY 93 funding - $159 million for 84 continuing grants to State and local governments and not-for-profit organizations serving about 4 million women; FY 94 request - $209 million

PRELIMINARY DRAFT -- AUGUST 18, 1993

3. Maternal and Child Health Formula Grant, with its related set-asides, serves as the principal means of Federal support for States to improve the health of mothers and children

   a. FY 93 grants - $664 million, served 8.2 million women and children; FY 94 request - $704 million

4. Ryan White CARE Act of 1990 authorizes assistance to metropolitan areas with large numbers of reported AIDS cases

   a. To meet emergency service needs

   b. To improve the availability and organization of health care and supplemental services for individuals infected with HIV

   c. To provide early intervention services at community-based organizations

   d. FY 93 funding - $348 million; FY 94 request - $658 million

5. Health Care for the Homeless Program improves access of homeless persons to health care resources

   a. In 1993 over 525,000 people were served by 119 grantees in areas that are easily accessible to homeless persons

   b. FY 93 funding - $58 million; FY 94 request - $58 million

6. National Health Service Corps (NHSC) provides health care professionals to serve underserved areas and populations

   a. Health professions students are eligible to receive NHSC scholarships and graduates are assisted with loan repayments in return for service in designated areas

   b. The NHSC authority also supports grants to State Offices of Rural Health and State Primary Care Cooperative Agreements to promote State needs assessment, planning, and coordination of primary care activities

   c. In FY 93 the NHSC supported over 388 scholarships and 495 loan repayments. The total field strength was over 1,500 health care providers.

   d. FY 93 funding - $74 million; FY 94 request - $92 million

   e. An additional $45 million is requested in FY 94 for NHSC

field programs for site development, recruitment, mentoring, travel and transportation costs of assignees and technical assistance

7. Rural Health Outreach Program supports new and innovative models of integration and coordination of rural health services

   a. Its 127 grantees are found in all rural States

   b. FY 93 funding - $25 million; FY 94 request - $25 million

8. Transition Grant Program (HCFA program) assists rural hospitals in altering their missions from general acute care to other services needed by their communities, such as long-term care

   a. FY 93 funding - $23 million; FY 94 request - $10 million

9. Essential Access Community Hospital and Primary Care Hospital (EACH/PEACH) Program (HCFA program) provides grants both to States and to individual hospitals to develop networking systems for hospitals that serve rural areas

   a. FY 93 funding - none; FY 94 request - $11 million, by Presidential request

10. Rural Health Clinics (HCFA program) are specially designated to receive cost-based payments for the health care services they provide to Medicare and Medicaid patients. They must utilize non-physician practitioners, provide specified services, and be located in an underserved rural area. There are currently about 1,000 rural health clinics.

School of
Health Professions

SWT

Schedule appt for after this date

August 24, 1993

Kristine M. Gebbie, R.N., M.N.
National AIDS Policy Coordinator
The White House
Washington, D.C.

Dear Ms. Gebbie:

Thank you so much for your very kind letter of congratulations regarding my appointment as Executive Director of the American Public Health Association. I am well aware of your many years of service to APHA and I welcome your generous offer of assistance.

I wish to congratulate you on your well deserved appointment as the National AIDS Policy Coordinator. You bring a wealth of public health experience to the position and I look forward to providing whatever assistance APHA and/or I may provide you in your new role.

I will assume my new position effective October 12. I look forward to meeting you and wish you every success. Best wishes.

Sincerely,

Fernando M. Treviño, Ph.D., M.P.H.
Dean

Southwest Texas State University
601 University Drive San Marcos, Texas 78666-4616
Telephone: 512-245-3300 Fax: 512-245-3791
SWT is a member of the Texas State University System.

fwb

can we change name vs. abolish?

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Public Health Service

Office of the Assistant Secretary for Health

Statement of Organization, Functions and Delegations of Authority

Part H, Public Health Service (PHS), Chapter H, of the Statement of Organization, Functions, and Delegations of Authority for the Department of Health and Human Services (DHHS) (42 FR 61318, December 2, 1977, as amended most recently at 58 FR 7140-41, February 4, 1993), is further amended to abolish the National AIDS Program Office (HAA), Office of the Assistant Secretary for Health, and to establish a new Office of National AIDS Policy (HAH) within the Office of the Assistant Secretary for Health. These changes are being made to reflect the major responsibilities in AIDS policy and planning and a heightened role in collaborative coordination among Federal, State, local and private organizations.

Office of the Assistant Secretary for Health

Under Section HA-10. Office of the Assistant Secretary for Health - Organization, delete item 1. National AIDS Program Office (HAA), and following item 4. Office of Research Integrity (HAG), add a new item 4. Office of National AIDS Policy (HAH), and renumber items 2 through 4 as 1 through 3.

Under Section H-20, Office of the Assistant Secretary for Health (HA) - Functions, delete the title and statement for the National AIDS Program Office (HAA).

Following the statement for the Office of Research Integrity (HAG), add the following title and statement:

Office of National AIDS Policy (HAH). Under the direction of the Assistant Secretary for Health ~~and the National AIDS Policy Coordinator~~, the Director of the Office of NAP shall serve as 1) Deputy National AIDS Policy Coordinator and ~~serves as the day to day~~ 2) director of the Office of National AIDS Policy, ~~which:~~ NAP shall (1) Provides PHS liaison with and support to the Office of the National AIDS Policy Coordinator, Executive Office of the President; (2) serves as the principal HIV/AIDS staff to the National AIDS Policy Coordinator and the Assistant Secretary for Health; (3) identifies critical national and PHS issues, including inter-and intra-agency coordination needs, and advises on how to resolve the issues; (4) directs and/or ~~conducts~~ coordinates HIV/AIDS policy planning processes and monitors progress toward achieving established goals; (5) provides liaison with other Federal organizations, State and local entities, and non-governmental organizations involved in AIDS activities; (6) assists in the preparation of responses to inquiries related to HIV/AIDS activities as appropriate; (7) provides analytic and administrative support to national HIV/AIDS advisory bodies, cross-Departmental coordinating groups, and other subsidiary or independent task forces, work groups, or subgroups; (8) maintains direct relationships with State and local agencies involved with HIV/AIDS activities; (9) provides guidance on the cooperative

dissemination and exchange of accurate scientific, prevention, and educational information and clinical guidelines with and between public health interest groups and professional and private sector organizations; (10) guides and promotes methods of dissemination and exchange of information to and among the public and (11) reviews and makes recommendations on budget requests and on research and prevention priorities as incorporated in planning documents or budget proposals.

_____ _____

Date Donna M. Shalala
Secretary

Draft Thu Sep 2, 1993 - 2:15pm

KRISTINE M. GEBBIE, R.N., M.N., F.A.A.N.
NATIONAL AIDS POLICY COORDINATOR
DEPARTMENT OF HEALTH & HUMAN SERVICES
Room 729H Humphrey Building
200 Independence Ave., S.W.
Washington, D.C. 20201

DAY Thursday **DATE** September 2, 1993

TIME 4:00 p.m. **LOCATION** 729-G, HHH Bldg.

SUBJECT Phone Interview with Comprehensive Health Education Foundation

PARTICIPANTS:
Ms. Robyn Rockstad will be doing and taping the interview. The interview is scheduled for 20 minutes.

KG:
I advised WH Press of this interview.

J

— File

August 25, 1993

NOTE TO KRISTINE GEBBIE

SUBJECT: Press Interviews Scheduled
FROM: Rayford Kytle 202-690-6867
Fax: 202-690-6608
202-232-4363 (Home)

1. **Thursday, September 2, 1993, 4:00 pm - 4:20 pm**
By phone, she'll phone you at 202-690-1090
They will tape the interview.

Robyn Rockstad, editor of C.H.E.F. Magazine
Tel: 1-800-323-2433

The Comprehensive Health Education Foundation (C.H.E.F.) promotes health education in schools and communities. They are starting up a magazine which will be published mid-January, 1994, as a resource for health educators and trainers.

Their questions on AIDS prevention and education are attached.

Questions for Kristine Gebbie

You've had extensive experience in advocating for AIDS education and research at the state level and as chair of CDC's external advising committee on AIDS. Which of your experiences have most prepared you for your position as national AIDS policy coordinator?

What do you believe about AIDS prevention programs for children and youth? When should they start? What should they consist of?

How can the federal government assist schools in making sure every American child has access to excellent AIDS education? Do you think they will make this commitment?

What statistic are you most concerned about regarding the spread of AIDS nationally?

What tactics do you see useful in preventing the spread of AIDS in our society?

Since the position of national AIDS policy coordinator has been newly created, how do you feel you'll be able to shape it?

What are your key goals for the next few years?

How committed do you feel the Clinton administration is to the direction you'd like to take?

Do you think there will be additional federal support in the next year or two to help schools obtain materials and train teachers for AIDS education? If not, where do you see the money coming from?

What advice can you give health educators and other teachers who want to give their students the information they really need but may be afraid to because of local mores, lack of resources, or limited knowledge about AIDS?

How can educators (and parents, community members, and students) affect national AIDS policies?

DENNY MILLER ASSOCIATES, INC.
400 N. CAPITOL STREET, N.W.
SUITE 363
WASHINGTON, D.C. 20001
(202) 783-0280

MEMORANDUM

Tape record into
Z's coming

TO: RAYFORD KYTLE

FROM: TIM LOVAIN

RE: INTERVIEW WITH KRISTINE GEBBIE

DATE: 8/9/93

Thank you for speaking with me today about the possibility of an interview with Ms. Gebbie in C.H.E.F. Magazine.

Ms. Gebbie is probably acquainted with the Comprehensive Health Education Foundation (C.H.E.F.), a national leader in the promotion of health education in schools and communities. Their drug education program, Here's Looking at You, 2000, is the most widely used commercially-prepared drug education program in the U.S. and their Natural Helpers program is the most widely used peer helper program. They use their "profits" to endow their foundation which promotes health education efforts especially in Washington State.

Their AIDS education program, Here's Looking at AIDS and You, has earned top marks from the Centers for Disease Control and Prevention. C.H.E.F. would like to see an effort equal to the Drug-Free Schools and Communities Act that focuses attention on AIDS and empowers local schools to have meaningful AIDS education programs.

I am enclosing an internal C.H.E.F. memorandum which answers most of the questions you raised. They estimate that the interview would consist of 8-10 questions and take no more than 20 minutes. C.H.E.F. Magazine will be a new 24-page glossy magazine designed to be a resource for health educators and trainers.

If you have any more questions, please let me know. As the C.H.E.F. memo indicates, they would like to conduct the interview this month, but their deadline could slip if necessary.

We look forward to hearing from you.

Fax 206 824 8217
800 323 2433
Robynn Rockstad
ed.
- 30 min
2 pm
9/2
4 pm

Julie Peterson
Gov't rel3

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To Rayford Kytle	From Tim Lovain
Co.	Co.
Dept.	Phone #
Fax #	Fax # 640-6608

Enclosure

Ph call coming from West Coast

Inter/Office Memo

To: Julie

From: Robynn

Date: July 27, 1993

Subject: Interview for the new C.H.E.F.® Magazine

The Editorial Team met last Thursday and expressed interest in a leading feature that would be an interview with either Kristine Gebbie or Lee P. Brown. I was wondering if you could help me in contacting either of these two people and in shaping the interview questions. Following is some information about the new magazine:

Publication Date:	Mid-January, 1994
Article Due Date:	End of August
Circulation:	Approximately 8,000 health educators and trainers
Audience:	Customers of our health education programs *(teachers, district health education coordinators, school administrators, public health educators, trainers)*, participants of our conferences and trainings
Word Count:	1100 to 1400, plus photo (total: 2 pages)

A telephone interview would be fine, but I would like to be able to tape it to ensure accuracy. I'm open to allowing Gebbie or Brown review the final draft of the interview if this would make either of them more comfortable with accepting. Also, we would like a photo (color) we could use for the cover and perhaps another photo (black and white) for the article.

If we know we can have the interview for sure, the deadline can slip. Sue and I are firming up the time line next week, so I'll know more then.

Thank you in advance for your help and expertise!

CHEF®
Comprehensive Health
Education Foundation

July 23, 1993

Kristine Gebbie, National AIDS Policy Coordinator
National AIDS Policy Office, U.S. DHHS
200 Independence Avenue, Room 738G
Washington, DC 20201

Dear Ms. Gebbie,

As CEO of Comprehensive Health Education Foundation--C.H.E.F.®--I'd like to congratulate you on being confirmed as National AIDS Policy Director. It's nice to see someone with Northwest experience in national AIDS policy-making.

C.H.E.F.® is a nonprofit organization located in Seattle, Washington; we develop and publish health education materials. One of our products is *Get Real about AIDS*™, a comprehensive AIDS prevention curriculum for students in grades 4-12. The curriculum comprises teacher's guides, books, videotapes, posters, and audiotapes; we try to use as many different teaching strategies as possible. (I've enclosed a *Get Real about AIDS*™ brochure and pin.)

Through the use of this curriculum, through the training of hundreds of teachers and of trainers of teachers, and through the technical assistance we give every day, I feel that our office and yours are allies in trying to prevent the spread of AIDS.

Like you, like former Surgeon General Koop, like many others in the forefront of AIDS education, we believe strongly that education is the most important tool in fighting AIDS. I don't have to emphasize to you the importance of educating young people--in giving them accurate information and in giving them useful skills so that they can reduce the risks of getting sexually transmitted diseases. The money we spend on prevention is well spent if we save children's lives. I'd like to work together with you on a strong, comprehensive AIDS prevention effort. Please give me a call here at C.H.E.F.® if you'd like to talk over some of the ways we can do that.

Sincerely,

Clay Roberts
CEO
CR:ns

22323 Pacific Highway South
Seattle, Washington 98198
Telephone 206-824-2907
Facsimile 206-824-3072

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Announcing the most comprehensive AIDS prevention program available today:

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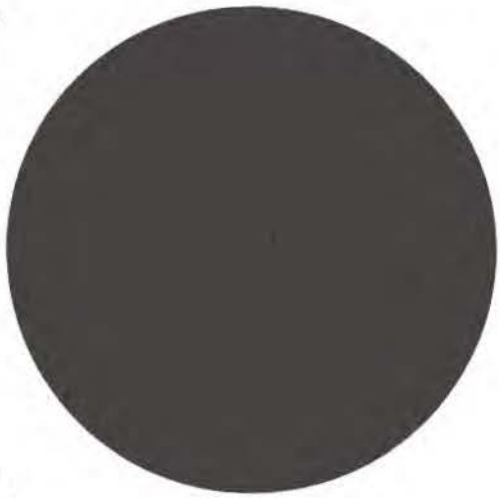

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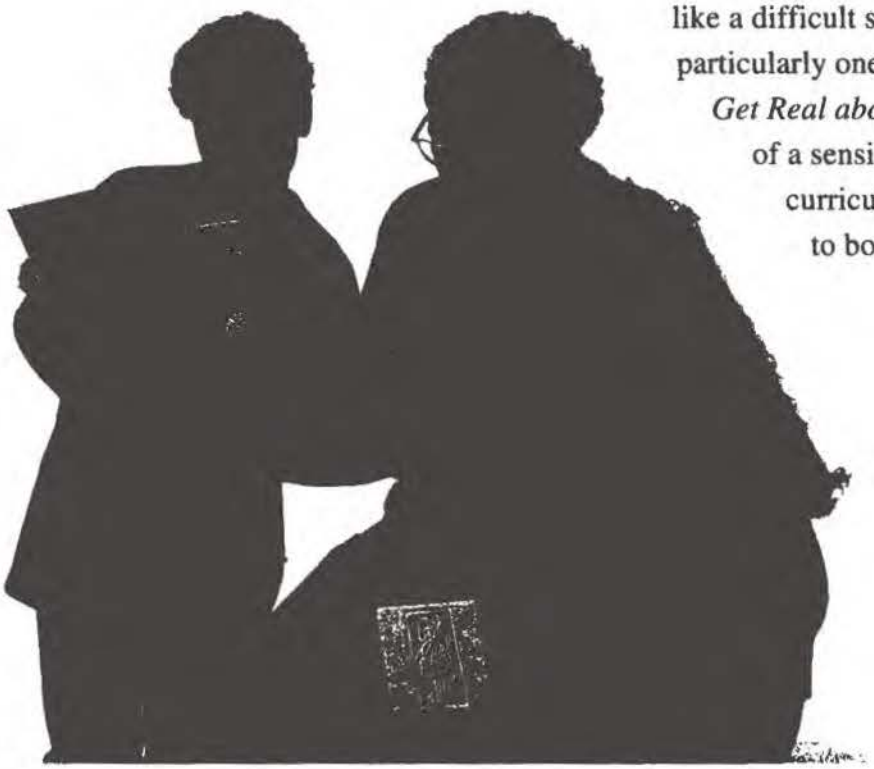

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☐ Grades 4-6 ☐ Grades 6-9 ☐ Grades 9-12

Phone (____)_____. The best time to reach me is_____ am/pm.

☐ Please have a C.H.E.F.® sales representative call me.

☐ I have previewed *Get Real about AIDS*™, and am ready to place my order. Please contact me at the number above.

☐ Please send my pin and keep me on your mailing list for more information about *Get Real about AIDS*™ and other C.H.E.F.® products.

(Please make any necessary corrections to label.)

Questions? Need assistance?
Call C.H.E.F.® at 1-800-323-2433.

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September 16, 1993

SCHEDULED INTERVIEW
FOR

KRISTINE GEBBIE
NATIONAL AIDS POLICY COORDINATOR

ONAPC STAFFER:	John Paul Gurrola
DATE/TIME OF EVENT:	4:00 p.m., September 17, 1993
LOCATION:	750 17th Street Office
ORGANIZATION:	Sigma Theta Tau International, Inc.
CONTACT:	Julie Goldsmith 317/634-8171
PURPOSE:	To give Sigma Theta Tau International (Honor Society of Nursing) an opportunity to interview the NAPC.
OTHER PARTICIPANTS:	Dr. Tim Porter-O'Grady, RN, FAAN will be interviewing the NAPC.
MEDIA COVERAGE:	NONE
REMARKS REQUIRED:	Please see attached questions.
BACKGROUND:	Sigma Theta Tau is the only national news show for nurses and it is broadcasted in 350 cities across the U.S. and Canada. They are scheduled to arrive at the office at 3:30 p.m. for set-up. You will actually be interviewed at 4:00 p.m. for 15 minutes.

Sigma Theta Tau International, Inc.
HONOR SOCIETY OF NURSING

International Headquarters
550 West North Street
Indianapolis, IN 46202-3157
(317) 634 8171

Fax (317) 634-8188

NURSING APPROACH TAPED INTERVIEW QUESTIONS FOR FRIDAY SEPT. 17

1. Nursing Science is increasingly important to the nation's health. There is no greater example of this than your appointment. How do you think your nursing background contributes to the effectiveness of this new post as AIDS Czar?

2. The face of AIDS if changing, from the gay community to heterosexual populations, to children and teen-agers. Given these changes, are national priorities changing too? What will you be focussing on in the next few years?

3. What would you like nurses to do in their own communities to respond to the AIDS crisis?

4. Are health care professionals responding differently to this epidemic than to others?

4. What is the most difficult part about this job for you?

THE WHITE HOUSE

WASHINGTON **September 16, 1993**

MEMORANDUM TO DISTRIBUTION LIST

FROM: MACK McLARTY, CHIEF OF STAFF Mcl

SUBJECT: Health Care Briefing

The President will address a Joint Session of Congress on Wednesday, September 22, on his proposed health care reform legislation. All senior staff must be briefed on the details of the President's proposed plan before then.

To that end, there will be a senior staff briefing tomorrow, Friday, September 17, in the Room 100 conference room in the Old Executive Office Building. The briefing will begin promptly at 9 a.m. and should be concluded no later than 10:30 a.m. All senior staff listed below are expected to attend.

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KRISTINE M. GEBBIE, R.N., M.N., F.A.A.N.
NATIONAL AIDS POLICY COORDINATOR
DEPARTMENT OF HEALTH & HUMAN SERVICES
Room 729H Humphrey Building
200 Independence Ave., S.W.
Washington, D.C. 20201

DAY Wed DATE Sept. 22, 1993

TIME 12 Noon-4:30p LOCATION Humphrey Bldg. Auditorium

SUBJECT Health Care Reform

PARTICIPANTS:

Secretary Shalala
Judith Feder
Kenneth Thorpe
Dr. Helen Smits
Dr. Phil Lee

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Assistant Secretary
for Public Affairs

Washington, D.C. 20201

September 20, 1993

TO INVITEES, "HHS Health Care University:"

A "Health Care University" (similar to the seminars being presented on Capitol Hill today and tomorrow) will be held for key HHS staff on Wednesday, September 22, from noon to 4:30. The session will be held in the Humphrey Building Auditorium.

Following introductory remarks by the Secretary, there will be four presentations, with opportunity for Q and A following each presentation:

Secretary Shalala -- Introduction
Judith Feder -- Overview and Coverage
Kenneth Thorpe -- Financing
Dr. Helen Smits -- Medicare and Medicaid roles
Dr. Phil Lee -- Public Health Aspects

Invitees are those who will need to have good general knowledge of the administration's health care reform proposal. This includes senior staff and others who will need to represent the plan to the public, or who have other key policy or administrative roles connected with the plan.

Lunch cannot be provided -- attendees should eat beforehand.

Please confirm attendance with the Secretary's press office. Contact Martha Henneghan, (202) 690-6343.

Put on Schedule for Kris Art will be attending

Avis LaVelle

Avis LaVelle
Assistant Secretary for Public Affairs

Contacts Made for Kristine Gebbie Reception
at Mercy Hospital and Medical Center

Columbus Hospital
2520 N. Lakeview Ave.
Chicago, IL
(312) 883-1331
Laurie Stevens, Director of Public Relations

Cook County Hospital
1835 W. Harrison St.
Chicago, IL 60612
(312) 633-6000
Contact: Ruth Rothstein, director

Illinois Masonic Medical Center
836 Wellington
Chicago, IL 60657
(312) 975-1600
Contact: Nancy Rosenberg, director of public relations

Loyola Medical Center
2160 South First Avenue
Maywood, IL 60153
Administration Bldg. 4th floor
(708) 216-4203
Contact: Weldon Rougeau, associate vice president of government and community affairs

Lutheran General Health System
1774 Dempster Street
Park Ridge, IL 60068
(708) 696-8589
Contact: Anne McGrath, director of government affairs
Bob Iickes, Executive Director, HIV Coalition

Mercy Hospital and Medical Center (hosts)
Stevenson Expressway at King Drive
Chicago, IL 60616
312-567-2000
Contact: Sister Marie Moore, President
Mr. Winkle Lee, executive vice president
Judy Traynor, director of public relations

Mount Sinai Hospital and Medical Center
California Ave. at 15th Street
Chicago, IL 60608
(312) 542-2000
Contact: Roberta Raycoff, director of government relations

Northwestern Memorial Hospital
Superior Street and Fairbanks Court

Chicago, IL 60611
(312) 908-1302
Contact: Lisa Tofil, director of government relations

Provident Hospital
500 East 51st Street
Chicago, IL 60615
(312) 572-2977
Contact: Mercedes Melette

Rush-Presbyterian-St.Luke's Medical Center
1653 W. Congress Pkwy.
Chicago, IL 60612
(312) 942-7091
Contact: Avery Miller, v.p. inter-governmental affairs

THE WHITE HOUSE
WASHINGTON

PRESS RELEASE

FOR IMMEDIATE RELEASE

FOR MORE INFORMATION:
JOHN GURROLA 202/632-1090
TOM RYAN 312/996-8279

HEALTH CARE REFORM DISCUSSED AT UNIVERSITY OF ILLINOIS AT CHICAGO

September 23, 1993 - CHICAGO, IL -- President Clinton's National AIDS Policy Coordinator, Kristine M. Gebbie, participated in a Town Hall Meeting discussion today concerning the President's Health Care Reform proposals at the University of Illinois at Chicago Medical School. Joining Ms. Gebbie were State Senators Judy Baar Topinka (R-22) and Gary La Paille (D-11), Ruth Rothstein, Chief Officer of Cook County Hospital, and Chicago City Health Commissioner Sheila Lyne. The meeting was hosted by the University of Illinois at Chicago (UIC) and approximately 350 of their students and faculty participated in the event.

Ms. Gebbie stated that "the time is now for health care reform" and discussed that her experience in health care over the past two decades has made her long for the day a President would take the lead in fixing our current health care system. She said "These principles work - they cover what we need". State Senator La Paille, who also chairs the Democratic Party in Illinois, announced "this is a campaign and it starts today". He went on to share the toll free phone number for health care reform involvement and questions (800)933-8683. Republican State Senator Topinka said "It's time to come together" to help build a system of universal health coverage.

Ruth Rothstein stated "we need to talk about public health issues" and discussed various local health needs. Commissioner Lyne read a letter from Mayor Daley that stated "I share your fundamental goals of making health care more affordable and accessible to everyone." She went on to say that "preventive care must be there to make a difference in primary care."

The Town Hall Meeting attracted many different groups from across Chicago and the panel answered many questions from the audience.

##

HISTORY OF MERCY HOSPITAL AND MEDICAL CENTER, CHICAGO

Mercy Hospital and Medical Center has a long history. A history of caring and concern that spans 130 years. It has a history of people searching for the best answers to the difficult questions of quality health care. It has a history of very dedicated people who are not satisfied with anything but giving the best services; people who are anxious to prevent/alleviate/cure illnesses that have long plagued mankind. Because of this, patients come to Mercy... and find mercy.

In 1849, Chicago's first hospital, Illinois General Hospital of the Lakes, was located at Michigan and Rush. In 1852, the Mercy Sisters obtained a charter for the hospital and re-named it Mercy Hospital and Orphan Asylum. In 1853, because the owners of the building which housed Lake House would not renew the lease, Mercy moved to Tippecanoe Inn/Hall on Kinzie Street fronting the Chicago River. In August of 1863, Mercy grew too large for this Hall and moved to St. Agatha's Academy at the corner of 26th and Calumet. The people of Chicago thought it folly, for 26th and Calumet was outside the city limits. After the Chicago fire, when Mercy did so much to help injured and homeless people, the "folly" complaints disappeared.

By the late forties, Mercy was fast becoming obsolete. In 1947, the friends of Mercy joined forces and organized multi-fund-raising events in the hope of building a new Mercy Hospital. Because of many factors which had an adverse effect on Mercy's financial viability, and because of repeated stalemates associated with decisions regarding the Medical School and site determination, the new facility did not become a reality until twenty years later.

In 1963, thanks to the 1.5 million dollar gift from the Frank J. Lewis Foundation, the way was cleared to launch a capital fund drive by the Men of Mercy, under the leadership of the Knights of Mercy. There were two prominent men who figured significantly in Mercy Hospital remaining on the near southside. They were Mayor Richard J. Daley, who provided the urban renewal program, and Morgan F. Murphy of Commonwealth Edison, who showed us how to raise funds.

In 1968, a 526-bed, 26 million dollar facility, known as Mercy Hospital and Medical Center, came into being. The Hospital stands tall at the crossroads of Chicago's vast expressway system. Officially, the address is Stevenson Expressway at King Drive. Mercy is near McCormick Place, South Commons, and Prairie Shores. Transportation to and from the Loop is accomplished within minutes.

In 1974, it became apparent that outpatient services, with a greater accent on preventive medicine, needed more room. Increased educational facilities were needed for the Residency programs. Better arrangement of interior department areas was also vital. An Intensive Care Unit was needed in closer proximity to surgery, so that life-support systems for the patient could be maintained in a more flexible manner. This expansion was dedicated in 1977.

It is difficult to highlight all of the events of 130 years, but one of its rich traditions should be mentioned. . . its role as and education institution:

1850-1859	Mercy was affiliated with Rush Medical College
1859-1864	Mercy was affiliated with the Medical Department of Lind University
1864-1920	Mercy was affiliated with Chicago Medical School, the Medical Department of Northwestern University
1920	At the request of George Cardinal Mundelein, Mercy severed its relation with Northwestern and became the teaching hospital of Loyola University Medical School (later known as Stritch School of Medicine)
1970	Mercy Hospital and Medical Center became affiliated with the College of Medicine of the University of Illinois

This year the campus is being updated further with the refacing and interior remodeling of the Research Building. Mercy continues to enjoy a respectable reputation in the field of research.

Many stages of growth have taken place; many hundreds of people have contributed to the success of this hospital. . . many hundreds have continually invested their loyalties, and monies in Mercy.

The Hospital's affiliations in 1979 include. . .
accreditation by:
The Joint Commission on Accreditation of Hospitals (JCAH);

endorsement by:
The Chicago Association of Commerce and Industry,
Blue Cross Plan of Hospital Service Corporations, and
Blue Shield Plan of Illinois Medical Services;

membership in:
American Hospital Association,
Catholic Hospital Association,
Archdiocesan Conference on Catholic Hospitals, and
Illinois Hospital Association;

affiliation with:
University of Illinois College of Medicine,
St. Xavier College School of Nursing

and, approval for residency training by:
American Medical Association and Specialty Boards.

MERCY HOSPITAL AND MEDICAL CENTER

Background Information

Mercy Hospital and Medical Center is a 477-bed teaching hospital affiliated with the University of Illinois and University of Chicago Perinatal Network. Established in 1852, it is Chicago's oldest hospital and is accredited by the Joint Commission on Accreditation of Health Care Facilities. Mercy provides comprehensive health services that include ambulatory, acute, rehabilitative and extended care. Services range from sophisticated diagnostic procedures to basic family health care. Mercy has a residency program which enhances medical education and improves patient care. Its full-fledged research department is actively pursuing research on breast cancer and has been the recipient of major funding from the National Institute of Health and the American Cancer Society.

Just two miles south of the Loop, Mercy Hospital is located between the two community areas of the Near South Side and Douglas Community. According to the 1980 Census, both these are among Chicago's ten lowest income areas with annual median incomes of $7,231 for the Near South Side and $8,578 for the Douglas Community.

Although Mercy draws patients from a wide geographical area of the south and southwest sides of the city and south and southwestern suburbs, its commitment to serve the needy and racially/ethnically diversified populations residing in the inner city - its immediate neighborhood - has never wavered. This commitment is fulfilled through the Hospital's Diagnostic and Treatment (D&T) Center, popularly known as the Clinic, which serves recipients of medicaid and medicare as well as the working poor who pay fees on a sliding scale. Annually, nearly $1.5 million is spent on free and/or subsidized health care services for the needy.

In the past six years, Mercy Hospital reached out to the Chinese and Hispanic communities by establishing the Mercy Medical in Chinatown, manned by Chinese-speaking personnel, and by sponsoring, in collaboration with six other agencies, the Alivio Medical Center - a community-based health care center in Pilsen. The Hospital's medical staff and other health care personnel reflect the racial/ethnic mix of the patients served.

During its 139 years of service, Mercy Hospital has had a rich history of accomplishments and has been recognized for its commitment to quality care and concern for the needy. Given below are just a few examples:

1866: Dr. Edmund Wyllis Andrews, Mercy's chief surgeon, studied Joseph Lister's new "germ theory" in London and returned to introduce antiseptic techniques in Chicago.

1933: The largest therapeutic x-ray machine in the world - the first in the Midwest - was installed at Mercy under the direction of Dr. Henry Schmitz, Sr., a pioneer in cancer treatment. He also established the Institute of Radiation Therapy.

1949: Mercy Hospital became the first private hospital in Chicago, and one of the few in the United States, to offer treatment with radioactive medicine.

1952: Mercy Hospital Clinic established a home medical service, providing continuity of care for those who are unable to come to the clinic or cannot afford a private physician.

1969: The Mercy Research Department is formally established to conduct investigations for better patient care and to enhance the Hospital's medical education programs.

1970: Along with five other area hospitals, Mercy forms the Metropolitan Group of Hospitals, University of Illinois (Metro-Six) to provide the best in contemporary clinical experience for undergraduate and graduate medical students.

1980: The Mercy Health Care and Rehabilitation Center in Homewood, Illinois is established to provide residential care for the elderly and rehabilitative care for patients of all ages.

Mercy Health Care Center in Justice, Illinois is acquired to provide combined facilities for outpatient surgery, minor emergency care, and appointments with personal physicians.

1986: The A.C. Buehler Foundation awards a five-year grant to establish a Center for Cochlear Implant (surgical implantation of an electronic device to aid the profoundly deaf).

1987: Mercy is awarded a grant of $1 million by The Chicago Community Trust for establishment of the Alivio Medical Center.

1990: Opening of the LaVerne and Dan Rostenkowski Outpatient Surgery Center.

Award of a $660,000 grant from New Jersey-based Robert Wood Johnson Foundation for initiation of a Patient-Driven System of Health Care Delivery.

1991: Award of a grant of $325,000 from The Chicago Community Trust for initiation of a comprehensive program of early intervention in maternal and child health, with special focus on serving women and children at high risk.

RECEPTION WITH KRISTINE GEBBY 9/23/93

MERCY HOSPITAL - STEVENSON EXPRESSWAY @ King Dr 567-2000

Room 203 5:00 - 6:00

✓	Mary Ellen Krens	Chicago House	248-5200
	Joanne Trapanni		448-9354
	Anita Loomis	Horizons Community Service	472-6469
	Mike Brickman	AIDS Alternative Health Project	327-6437
	Karen Fishman	AIDS Foundation of Chicago	642-5454
	Bradley Vander	AIDS Legal Counsel	427-8990
	Carol Reese	AIDS Pastoral Care Network	334-5333
	Brian David	Impact	528-5868
	Greg Salvistro	Howard Brown Clinic	871-5777 x302
	Tom Tunney		348-2378
	Fred Eychaner & Marsha Lipetz	Melony Sovine	975-0400
	Monica Sotranko	Harbor Home Support Services	886-1195
✓	Steve Wakefield	Test Positive Awareness Network	404-8726
	David Loy	Erie House	489-6060
	Amy Maggio	Stop AIDS Chicago	871-3300
	Linda Branson	Kupona Network	536-3000
	Cathy Christeller	Chgo Fs AIDS Project	271 9070
	Sam Clark	Open Hand Chicago	665 1000
	Paul Hook	Cook Co Hosp - AIDS prevention	633-3004
	Shelley Fried	AIDS Services, Chgo Health Outreach	281-4288

THE WHITE HOUSE

WASHINGTON

NATIONAL HEALTH SECURITY ACT
TOWN HALL MEETING
CHICAGO

DATE/TIME:	Thursday, September 23, 1993 1:00 P.M.
DURATION:	60 to 90 minutes
LOCATION:	University of Illinois at Chicago Chicago Illini Union - Chicago Rooms 828 South Wolcott Avenue Chicago, IL
ADMINISTRATION REPRESENTATIVE:	Kristine Gebbie, RN, MN National AIDS Policy Coordinator, The White House
AUDIENCE:	300 - 500 individuals from: Illinois State Legislature City of Chicago Representatives Students from Northwestern University and The University of Illinois at Chicago

MEETING FORMAT:

Welcome-	Mayor Richard Daley (tentative) (10 min)
NHSA overview-	Ms. Kristine M. Gebbie (20 min)
Comments-	State Senator Gary La Paille (3 minutes) 11th District/Chair Dem Party
Comments-	State Senator Judy Baar Topinka (3 minutes)
Comments-	Cook Cnty. Rep. Ruth Rothstein (3 minutes)
Comments-	Health Commissioner Sr. Lyne, Chicago

QUESTIONS FROM THE AUDIENCE (20 - 30 minutes)

Moderator- R.K. Dieter Haussmann, Ph.D.
Vice Chancellor of Health Services,
University of Illinois

1973 **Chicago Chapter National Black Nurses' Association**

Contact : Azella Collins
(219) 882-1201 (Day)
(312) 288-3642 (Evening)

PRESS RELEASE

BLACK NURSES VIEW HEALTH CARE REFORM WITH CAUTION

Any health care reform movement must address the inequities in the health care system for black patients. states **Azella C. Collins**, RN, MSN, President Chicago Chapter National Black Nurses' Association. Blacks live five (5) to seven (7) years less than whites, their life expectation is 69.2 years. Compared to 76 years for whites.

In addition blacks are dying excessively from seven (7) preventable diseases such as hiv/aids, hypertension, diabetes, infant mortality, violence, cancer and substance abuse. Although Clinton's Health Care Reform Package does mention prevention, blacks will need additional dollars during the transition period for health education in order to use a prevention health model.

Access to health care has always been evasive for blacks, often forcing them to rely on public institutions such as Cook County Hospital and the Board of Health Clinics. Under the Clinton Plan poor people will be able to receive health services at other facilities. **Margaret A. Davis**, RN, MSN, President of the African-American Aids Network is fearful that health care dollars will be taken from the traditional public facilities and now be shifted to the private clinics.

Currently blacks own very few health care facilities which also impede access. When asked where black patients get most of their care, historically its been with the Black Health Care Professional.

Clinton's Health Care Plan does not adequately address this insolvbility of culturally competent/sensitive health care professionals.

Lastly President Clinton's Health Reform Package allows for states to have the flexibility to develop their own health plans, **Zina Simmons**, RN, BSN, Health Policy Chairman of CCNBNA states where racism is prevalent blacks may not receive their fair share of the funding allocation.

The majority of the Black Nursing Organizations are supportive of the inclusion of the intercultural health coalition principles which are:

1. Universal coverage for all residents.
2. Affordable health services without financial barriers.
3. Basic benefit package for all medical conditions.
4. Program that is accountable to the public.
5. Consumer and provider empowerment.
6. Assurance of high quality care efficient available, adaptable and acceptable for all.
7. A payment mechanism to ensure desired health outcomes.
8. Support for provider education and training.
9. Affirmative action for workers consumers, providers and managers.
10. Expansion of consumer education.
11. Reforms in malpractice insurance and tort and anti-trust laws.

In conclusion, whereas many black nurses are excited about the Health Care Reform movement we will remain forever vigilent in advocating for the needs of African Americans in receiving quality, affordability and accessible health care.

*GUIDING PRINCIPLES FOR HEALTH CARE REFORM**

1 **Universal coverage for all residents**

- Every American is entitled to basic health service coverage.
- Every American is entitled to access to a benefit package of basic health care services.
- Every American is entitled to the highest quality of health care services, delivered by culturally-sensitive health care providers.

2 **Affordable health services without financial barriers**

- Access to the health care system should not be limited by a person's ability to pay for services which may be long-term and expensive.
- Access to the health care system should not be determined by whether a person is employed, unemployed, or under-employed.
- Access to the health care system should begin with an extensive program of health promotion and disease prevention.
- Access to the health care system is enhanced when patients are made active participants in the promotion of good health and the prevention of disease.

3 **A national health program that includes a basic benefits package for all medical conditions**

- A national health care program should provide basic benefits, incorporating diagnostic, therapeutic, and reasonable services for every medically necessary condition, including dental care, mental health, long-term care, and pharmaceutical products and services.
- A national health care program should be based on health promotion and disease prevention.

4 **A national health care program that is accountable to the public**

- A national health care program should be monitored by all levels of government to insure quality, access, and standards for cost.
- A national health care system should be accountable to the public by involving the public to insure that the system responds to community needs.
- A national health care system should clearly define the roles and relationships of public hospitals in the broad health care system.

5 **Consumer and provider empowerment**

- Health care consumers and health care providers must be involved in the design of any reformed health care system.
- Health care consumers and health care providers must be involved in the implementation of any reformed health care system.
- Health care consumers and health care providers must be involved in the decision-making and evaluation of a reformed health care system that promotes family-oriented, community-based care.

* Adopted by the Planning Coalition for Summit '93: African American Prescription for Health/Intercultural Health Coalition.

6 **Assurance of high quality and efficiency, as well as availability, adaptability, and acceptability of the national health care program**

- Availability must include full and equal access to and participation in health care plans for all Americans, with the inclusion of health care providers who are culturally-sensitive.
- Adaptability of the national health care program must focus on the diverse and serious health care concerns of the nations' underserved population and the delivery of high quality health services to that population.
- Acceptability of the national health care program must be based on meeting the health care needs of all Americans.

7 **A payment mechanisms to insure desired health outcomes**

- A payment mechanism for health care services should be efficient and provide incentives for prevention, primary care, and the continuity of care and service to the underserved.
- A payment mechanism for health care should place emphasis on health promotion and disease prevention.

8 **A national health care program that supports education and training**

- A national health care system should provide incentives for the training of African American health professionals and other persons committed to serving underserved populations.
- A national health care system should provide additional incentives to historically black colleges and universities.

9 **A national health care program that encompasses the principle of affirmative action**

- A national health care program must provide for full and equal access by all health care workers, consumers, and trainees.
- A national health care program must include the establishment of African American-owned and operated networks that provide health-related services.

10 **Expansion of consumer education**

- Consumer education must focus on the individual, family, and community institutions.
- Consumer education must focus on health promotion and disease prevention.
- Consumer education must be responsive to cultural diversity in the American population.

11 **Reform of malpractice insurance, tort procedures, and anti-trust laws**

- The delivery of affordable health care services should not be limited by the high cost of malpractice insurance.
- The delivery of affordable health care services should be enhanced by the reform of legal procedures which produces a system which is responsive both to the needs of the patient and the health care provider.

Please share this message with family friends, colleagues, neighbors, church members, public officials , and others!

The White House

Health Care Reform Today

September 23, 1993

◆ "Now, it is our turn to strike a blow for freedom in this country. The freedom of Americans to live without fear that their own nation's health care system won't be there for them when they need it. It's hard to believe that there was once a time in this century when that kind of fear gripped old age. When retirement was nearly synonymous with poverty, and older Americans died in the street. That's unthinkable today, because over a half a century ago Americans had the courage to change -- to create a Social Security system that ensures that no Americans will be forgotten in their later years."

◆ "Forty years from now, our grandchildren will also find it unthinkable that there was a time in this country when hardworking families lost their homes, their savings, their businesses, lost everything simply because their children got sick or because they had to change jobs. Our grandchildren will find such things unthinkable tomorrow if we have the courage to change today."

◆ "This is our chance. This is our journey. And when our work is done, we will know that we have answered the call of history and met the challenge of our time." With that...President Clinton began a historic debate with the American people...a debate to reform health care.

◆ The Republican's who responded to the President's speech must not have been listening. As the President made a national call to arms and a bi-partisan appeal to join together to solve this crisis, the Republicans failed to respond in the same spirit. That is disappointing and unfortunate. We know there are many Republicans who want to work with the President and have heard the public demand that health care form take place now. Today, we start that process.

Ful
Invites.

U.S. Department of Health and Human Services
Public Health Service
Office of the Surgeon General
200 Independence Avenue, S.W., Room 736-E
Washington, DC 20201

Telephone: 202-690-8335
Fax: 202-690-6498

DATE: 10/27/93

TO: Steven Lee

FAX: 202-632-1096

FROM: JAMES JOHN BEMBERG
202-690-8335

ADDITIONAL MESSAGE:

Please leave a message that you received this FAX

Thanks
James

Total number of pages this transmission (including cover): 2

FIRST IN THE FIGHT
AGAINST AIDS

GMHC

CY

TCT 11/4
left message w/
David Engel
T-A Richardson

October 13, 1993

Dr. Joycelyn Elders
United States Surgeon General
Office of the Surgeon General
200 Independence Avenue SW
Room 736E
Washington, D.C. 20201

Dear Dr. Elders:

On September 22nd, I wrote to request your participation in a national media briefing on the prevention of AIDS-related *pneumocystis carinii* pneumonia (PCP), one of the leading killers of people with AIDS. To maximize the impact and coverage of your participation, I would now like to propose that the media briefing take place on Monday, November 8th, to be followed by our 1993 President's Lunch. The annual President's Lunch is GMHC's most important gathering of top funders and community leaders in the fight against AIDS. Approximately 100 people will attend this year's lunch at the Four Seasons Restaurant in Manhattan. As you know, Gay Men's Health Crisis is the world's oldest and largest AIDS service, education and advocacy organization.

Our hope is that you would consent to participate in the media briefing at 10:30 A.M. and stay on to be the keynote speaker at the President's Lunch at 12:30 P.M. You would be able to leave no later than 1:30 P.M. Your presence at these two critical events would allow your visit to affirm the Administration's commitment to the needs of this epidemic to the media, as well as to opinion leaders in New York City. Your visit would also be an important affirmation of your personal leadership in the fight against AIDS.

Publicity about PCP prevention, when it has existed at all, has been extremely limited. For this reason, GMHC has launched a groundbreaking, first-ever public awareness campaign on the city subways and airwaves. The campaign has also provided information about PCP prevention to more than 7,000 AIDS organizations and health departments across the nation.

The proposed media briefing will carry the PCP prevention message beyond the city borders to the hundreds of thousands of Americans currently at risk for PCP, and comes at a time when many seem to have lost hope of early, effective treatment. The whole briefing session will last one and a half hours at a midtown New York City hotel, with breakfast served -- you would be asked to speak for ten minutes or so on the importance of PCP prevention. Other members of the panel would include Ernesto Hinojos, GMHC's Deputy Executive Director of Education; Dr. Gabriel Torres, head of the AIDS Unit of St. Vincent's Hospital; David Barr, GMHC's Director of Treatment Education and Advocacy, and a person with AIDS who will talk about how he could have avoided PCP if he had been provided with prevention information.

Each year GMHC has invited a noted spokesperson to address the President's Luncheon, which again will be held in midtown Manhattan at the Four Seasons restaurant. Last year, Dr. David Rogers provided the keynote address. We would like your keynote address to last approximately 10-15 minutes, and to deal with AIDS in whatever way you felt appropriate.

Although your participation in both events is ideal, we are aware of your busy schedule. If participation on November 8th is not possible, we would still welcome your participation in the media briefing about PCP on a date of your convenience. GMHC's Assistant Director of Communications, David Eng, will be contacting your office shortly to coordinate this effort.

Thank you for your attention to this matter. We look forward to meeting you soon.

Sincerely,

Jeff Richardson

Jeff Richardson
Executive Director

(8d)

FIRST IN THE FIGHT
AGAINST AIDS

GMHC

September 22, 1993

Ms. Jean Santucci
Office of the Surgeon General
200 Independence Avenue SW
Room 736E
Washington, D.C. 20201

Dear Ms. Santucci:

I am writing to request the participation of Dr. Elders in a national media briefing on the prevention of AIDS-related *pneumocystis carinii* pneumonia (PCP), one of the leading killers of people with AIDS. Although largely preventable, more than 19,000 Americans were diagnosed last year with the debilitating AIDS-related infection.

The briefing will highlight the important role that the media can play in informing the American public about PCP prevention. PCP is ten times cheaper to prevent than to treat, and free or low-cost prophylactic medications are available in many states. Yet PCP continues to strike down Americans with HIV in record numbers. Nearly a third of all Americans diagnosed with AIDS in 1992 suffered a bout of the AIDS-related pneumonia.

Publicity about PCP prevention, when it has existed at all, has been extremely limited. For this reason, Gay Men's Health Crisis, the nation's oldest and largest AIDS organization, has launched a groundbreaking, first-ever public awareness campaign on the city subways and airwaves. The campaign has also provided information about PCP prevention to more than 7,000 AIDS organizations and health departments across the nation. (Copies of our campaign materials are enclosed.) The proposed media briefing will carry the PCP prevention message beyond the city borders to the hundreds of thousands of Americans currently at risk for PCP, and comes at a time when many seem to have lost hope of early, effective treatment.

We would like Dr. Elders to speak for ten minutes or so on the importance of PCP prevention. The whole briefing session will last one and a half hours at a midtown New York City hotel, with luncheon served. The date and site have not been set and are contingent upon Dr. Elders' availability. We would like the briefing to take place during the weeks of October 18th or 25th in order to coincide with the first flight of the campaign's subway and radio advertising.

Dr. Elders will be part of a panel to include Ernesto Hinojos, GMHC's Deputy Executive Director of Education; Dr. Gabriel Torres, head of the AIDS Unit of St. Vincent's Hospital; David Barr, GMHC's Director of Treatment Education and Advocacy, and a person with AIDS who will talk about how he could have avoided PCP if he had been provided with prevention information.

We are eager to welcome Dr. Elders to GMHC. In addition to featuring her participation in the PCP media briefing, we hope we can provide her with a tour of our facilities and the opportunity to meet our staff and representatives of other leading New York AIDS organizations. GMHC's Assistant Director of Communications, David Eng, will be contacting you shortly to coordinate this effort.

Thank you for your attention to this matter. We look forward to speaking with you soon.

Sincerely,

Jeff Richardson
Executive Director