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Date: July 16, 1993

To: The Comptroller General's Health Advisory Committee

From: Chief Health Policy Advisor - Sheila M. Smythe

Subject: Some Writings and Awards

Robert H. Brook, M.D., Sc.D., F.A.C.P., received the Association of Health Services Research (AHSR) Award for Outstanding Contributions in Health Services Research at its June 28 annual meeting held in Washington, D.C.

I've attached three articles authored or co-authored by three of our members:

Mark Chassin, M.D.

Harold Luft, Ph.D.

David Mechanic, Ph.D.

Attachments - 3

MEDICAL CARE
Volume 31, Number 5, pp YS37–YS44, *Supplement*
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Explaining Geographic Variations

The Enthusiasm Hypothesis

MARK R. CHASSIN, MD, MPP, MPH

The causes of geographic variations in the use of health care services continue to puzzle researchers. Some have proposed that physicians in geographic areas with high rates of use provide proportionally more unnecessary care than those in other areas. Available research does not support this hypothesis. Others contend that uncertainty about the effectiveness of health services leads physicians to differing conclusions about when to perform various services and is the primary cause of geographic variations. Available research also does not support this hypothesis. This article proposes a different explanation, i.e., the enthusiasm hypothesis. Currently, research data suggest that geographic differences in the use of health care services are caused by differences in the prevalence of physicians who are enthusiasts for particular services. This analysis explores the validity of the enthusiasm hypothesis using previously published data on carotid endarterectomy. (Med Care 1993; 31:YS37–YS44)

For more than one-half century, researchers have puzzled over an increasing body of data that document large differences in the utilization of health care services among different geographic areas.[1–18] These data have established that large differences exist in the use of diverse health services among geographic areas large and small, within the United States and between the United States and other countries. The health services studied include surgical procedures,[1–12] lengths of hospital stays,[13,15] hospital admissions for medical conditions,[14,16] office visits,[18] and home health visits.[17]

Many hypotheses have been advanced to explain these differences. Some have focused on patient factors (e.g., socioeconomic characteristics, illness behavior, and illness prevalence). Others have investigated factors related to the people and institutions that provide services (e.g., physician and hospital characteristics). The American and Canadian literature on small area analysis has been well summarized by Paul-Shaheen et al.[19] Relatively few studies have taken a clinical perspective and compared the clinical characteristics of patients who receive specific health care services in high- and low-use areas.[6,10–12,14,20–22] These studies attempt to answer the question, "Which rate is right?" This article reviews the clinical hypotheses that might explain geographic variations, assesses them against the available evidence, and proposes a new hypothesis that best fits the current data.

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Current Hypotheses: Inappropriateness and Uncertainty

Two popular hypotheses have been propounded to explain geographic variations.

The first is that variations are caused by inappropriate overuse of services in high-use areas. The Health Services Utilization Study (HSUS), conducted by researchers at the RAND Corporation and the University of California at Los Angeles investigated this hypothesis directly. The study first documented large differences among geographic areas in the population-based rates of use of 123 medical and surgical procedures to treat elderly patients.[8,18] More than 75 million physician claims for payment submitted to Medicare formed the data base for measuring the rates of use in 13 large geographic areas that averaged 340,000 elderly Medicare enrollees each. The study then created detailed clinical criteria to measure the appropriateness with which six common procedures were done in 1981: carotid endarterectomy, coronary angiography, upper gastrointestinal (GI) endoscopy, coronary bypass surgery, colonoscopy, and cholecystectomy.[23] The first three of these procedures were selected for a field study of clinical practice.

The criteria and the process by which the clinical appropriateness criteria were developed are described in detail elsewhere.[24–26] Briefly, after comprehensively reviewing the clinical research literature on the efficacy of the each procedure studied, HSUS constructed detailed lists of possible reasons for doing the procedures ("indications"). The indications included all important clinical factors physicians ordinarily consider in making recommendations to patients concerning these procedures.

A panel of nine expert clinicians was assembled to judge the appropriateness for each procedure. Appropriateness was defined as the extent to which the expected health benefits of doing a procedure for a particular indication exceeded the expected negative consequences by a sufficiently wide margin that the procedure was worth doing. Panelists used a nine-point scale to rate appropriateness, with nine indicating extremely appropriate, five indicating benefits and harms approximately equal, and one indicating extremely inappropriate. Panelists rated the initial set of indications by mail. Then, they came together and discussed the indications and initial ratings and rated all the indications again. The final indications numbered 864 for carotid endarterectomy, 300 for coronary angiography, and 1,058 for upper GI endoscopy.

The consensus process did not force panelists to agree. Indeed, significant disagreement persisted for certain indications after the meetings.[23] Based on the final panel ratings, HSUS classified indications into three categories: appropriate, equivocal, and inappropriate. Indications were considered appropriate if their median ratings were from seven to nine without disagreement. Inappropriate indications had medians from one to three without disagreement. Equivocal indications had medians from four to six or met the study's definition of disagreement. An indication was defined as demonstrating disagreement if three (or more) panelists rated it one to three and three (or more) rated it seven to nine.

Using these criteria, HSUS assessed the clinical practices of physicians in disparate geographic areas representing high, average, and low use of the three study procedures. The medical records of 4,564 randomly selected Medicare enrollees were reviewed to define the reasons they underwent the study procedures. Physicians did these procedures for clearly inappropriate reasons the same proportion of the time in both high- and low-use areas.[21] The level of inappropriate care was substantial, averaging 17% of cases for coronary angiography and upper GI endoscopy and 32% for carotid endarterectomy.

The study that produced these conclusions examined the use rates in large geographic areas; each was approximately the size of an average state. The analysis was repeated for small areas in the largest site with the same results.[22] For two of the three procedures studied, there was no significant

correlation between the proportion of inappropriate cases and the population-based rate of use of the procedure among small areas (counties). For the third procedure (coronary angiography), inappropriateness explained 28% of the variance in the rates of use. This finding was, however, driven largely by a single outlier. When this one outlier county was eliminated from the analysis, no significant correlation remained.

These findings were consistent with the results of others. Roos et al.[6] used claims data to assess variations in tonsillectomy and adenoidectomy rates in Manitoba. They found more than twofold differences among nine regions. Less than 30% of cases overall met simple criteria for appropriateness (three episodes of upper respiratory infection or one peritonsillar abscess). No relationship existed between the rates of use and the proportion of cases meeting these criteria.

The second hypothesis that has been advanced to explain geographic variations is that physicians face great uncertainty concerning which health services are effective under which clinical circumstances.[27,28] Proponents of the "uncertainty hypothesis" maintain that the great lack of data on effectiveness permits reasonable physicians to come to different conclusions regarding when to use various health services. This hypothesis implies that, whereas physicians may agree on indications for procedures that are clearly appropriate and on those that are clearly inappropriate, there is a large "gray area" in the middle over which much disagreement exists.

The uncertainty hypothesis would predict that a substantial share of the difference in rates of use between high- and low-use areas would be explained by differences in the use of procedures for reasons falling into that gray area between appropriate and inappropriate. If true, the uncertainty hypothesis might explain why HSUS found no difference in the proportion of inappropriate use between high- and low-use areas. This hypothesis suggests that physicians agree on these inappropriate indications, and we would not expect their behavior to differ much from one area to another. It is difficult to see how the hypothesis can explain the large proportion of inappropriate cases found by HSUS; if physicians agree on inappropriate indications, then presumably few procedures would be done for such reasons. This objection notwithstanding, one key finding of HSUS could be explained.

The HSUS method of developing appropriateness criteria measures uncertainty. As discussed previously, the equivocal category in this classification scheme contains all indications for which risks and benefits are approximately equal (i.e., the procedure is of uncertain net benefit) and those that exhibit significant disagreement among the panel of experts whose judgments created the criteria.[23]

If the uncertainty hypothesis were correct, HSUS should have observed a greater proportion of equivocal cases in high-use areas compared with areas of low use. Neither the large-area studies[21] nor the small-area studies[22] found any such relationship. High-use areas exhibited about the same percentage of equivocal cases as low-use areas.

The Enthusiasm Hypothesis

The existing evidence is most consistent with a different explanation of the geographic differences in health service use, i.e., the enthusiasm hypothesis. This proposal suggests that these differences are caused primarily by variability in the prevalence of physicians who are "enthusiasts" about the use of the services whose use varies. Let us examine the available evidence, using carotid endarterectomy as an example.

Carotid endarterectomy is a commonly done, usually elective procedure about which little rigorous efficacy data existed in 1981, the year in which HSUS assessed its use. Two new studies have recently filled some of this void.[29,30] Of the three procedures HSUS studied, carotid endarterec-

tomy exhibited the greatest variation; physicians in the high-use area performed 3.8-fold as many of these procedures per capita as physicians in the low-use area.

To our surprise, we found that patients were selected for the procedure in similar ways in these two regions. There was no significant difference between the two areas in appropriateness. The high-use area had 37% appropriate, 34% equivocal, and 30% inappropriate cases. The corresponding percentages for the low-use area were 42%, 29%, and 29%, respectively.[21]

Similarly, no differences existed between the two areas in the degree of surgical risk of the operated patients or in the extent of obstruction of the operated carotid arteries.[31] Slightly fewer patients in the high-use area underwent carotid endarterectomy for transient ischemic attacks than in the low-use area (44% versus 53%), and slightly more were asymptomatic in the high-use area (28% versus 23%).[18] The first difference was statistically significant; the second was not. Both were small.

In retrospect, we should not have been surprised. After all, the great majority of physicians who do this procedure are specialists in vascular surgery. They read the same journals, belong to the same societies, and go to the same meetings. It should not be a surprise that they behave similarly with regard to patient selection for carotid endarterectomy.

What, then, distinguishes the high-use area for this procedure? We examined data on the availability of surgeons and their practice volumes to address this question. Both areas had ample numbers of surgeons. The high-use area was 12% above the national average of 426 surgeons per 100,000 Medicare enrollees; the low-use area was 22% below it.[32] In both areas, however, only a small fraction of those surgeons who could possibly have been trained to do the procedure (general or thoracic surgeons) actually did carotid endarterectomy in 1981. In the high-use area, 15% of such physicians did this procedure; only 11% did it in the low-use area. The higher number of surgeons per capita and the higher percentage of surgeons performing carotid endarterectomy combined to produce a higher number of surgeons per capita who did carotid endarterectomy in the high-use area (25 per 100,000 Medicare enrollees versus 12).

The data on practice volumes are even more striking. The two areas differed markedly in the distribution of physicians by practice volume.[32] The data in Table 1 show that nearly equal numbers of physicians in both areas did only one procedure in 1981 (3.8 surgeons per 100,000 Medicare enrollees in the high-use area and 4.1 in the low-use area). As the practice volume increased, however, the relative prevalence of surgeons in the high-use area increased dramatically, with more than eightfold as many surgeons in the highest volume category practicing in the high-use area than in the low-use area. This strikingly geometric relationship suggests the effect of a powerful systematic force. That force is best characterized as enthusiasm for carotid endarterectomy.

The impact of this marked difference between areas emerges in another analysis. Table 2 shows the number of carotid endarterectomies per 100,000 Medicare enrollees done by physicians at each level of practice volume. To explain all the difference in rates

TABLE 1. Practice Volumes of Carotid Endarterectomies in 1981[a]

Volume of Cases Per Surgeon	High-Use Area	Low-Use Area	Ratio (High/low)
1	3.8	4.1	0.9
2–9	14.6	7.2	2.0
10–14	2.6	0.65	4.0
15+	3.7	0.45	8.2
Any number	24.7	12.4	2.1

[a] Figures are number of surgeons per 100,000 Medicare enrollees who performed the specified number of operations in 1981. This Table is adapted from previously published data[32].

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TABLE 2. Rate of Operations by Practice Volumes for Carotid Endarterectomies in 1981[a]

Volume of Cases Per surgeon	High-Use Area	Low-Use Area
1	3.8	4.1
2–9	58.3	28.5
10–14	30.9	7.9
15–	84.9	7.0
All cases	177.8	47.5

[a] Figures are number of carotid endarterectomies per 100,000 Medicare enrollees performed by surgeons who did the specified number of operations in 1981. This Table is adapted from previously published data[32].

of use between the two areas, we must account for the 130.3 more operations per 100,000 Medicare enrollees done in the high-use area (177.8 − 47.5 = 130.3). The difference between areas in the number of cases done by the highest-volume surgeons explains 60% of the overall difference between areas (84.9 − 7.0 = 77.9 and 77.9/130.3 = 0.60). The difference for the two highest-volume categories explains 77% of the overall difference.

These data are consistent with the hypothesis that geographic differences arise when larger numbers of physicians in one area become enthusiastic about a procedure. This enthusiasm may originate in a major local physician training program, in which a particularly influential teacher communicates enthusiastic views to residents and fellows. The enthusiasts must then persuade the primary care physicians who refer patients that their views are correct. If the enthusiasts are successful, large differences in the use of procedures can be created simply because one area has a greater number of enthusiasts than another. In the carotid endarterectomy example, the high-use area had approximately sixfold the number of enthusiasts as the low-use area, as measured by surgeons who did at least ten carotid endarterectomies in 1981.

Other studies have examined the relationship of rates of use of health services to physician supply. In apparent contradiction of the enthusiasm hypothesis, most often no correlation has been found.[9,10,14,19] Two factors may account for this apparent discrepancy. First, most previous work has tried to relate aggregate measures of use (e.g., admissions per 1,000 population or, sometimes, surgical admissions per 1,000) to aggregate measures of physician supply (physicians or surgeons per 1,000 population). These measures of use are too general to pick up the highly service-specific enthusiasm phenomenon. Our previous work showed that geographic areas with high rates of use of one procedure were likely to have low rates of use for other procedures, even ones done by members of the same specialty.[8,18]

Furthermore, as the data on physicians doing carotid endarterectomy show, the information on the total available numbers of physicians is too aggregate to measure the enthusiasm phenomenon. For all surgeons, the ratio of supply between our high- and low-use areas for carotid endarterectomy was 1.4:1.[32] For the highest-volume enthusiasts, the ratio was 8.2:1 (Table 1).

The second explanation resides in the methodology of small area analysis. Rates of use are calculated by attributing cases to geographic areas based on patient residence. Physician supply data are usually based on practice locations. Although this approach produces an excellent data base for asking epidemiologic questions, it is less helpful in analyzing relationships between rates of use and physician characteristics because physicians attributed to one region in the supply measure may provide services to patients attributed to other regions based on their residence. This factor may explain why, in the study cited, Roos et al.[6] found no relationship between physicians doing tonsillectomies per 10,000 population and small area rates of tonsillectomies. The carotid endarterectomy data avoid this problem because we studied large geographic areas selected to minimize border crossing for health care, ex-

cluded patients who migrated into an area for their operations, and excluded operations done out of the area.[8]

Implications

This analysis has suggested a hypothesis. Clearly, additional research is needed to test it. Currently, it is the one hypothesis that is most consistent with the existing evidence concerning the explanation of geographic variations in the use of health care services. It is also the one hypothesis that can explain why such a large fraction of procedures in both high- and low-use areas were done for inappropriate reasons. Enthusiasm can seduce the practitioner into believing in the effectiveness of a procedure where no data exist to document it. If the enthusiasm hypothesis is true, at least two important implications arise.

The hypothesis implies that underuse is more prevalent in low- than in high-use areas. Let us assume that 50 patients with appropriate indications for carotid endarterectomy reside in each of two geographic areas of equal size. Assume that one area has more enthusiasts than the other and that the rate of carotid endarterectomy is fourfold higher in that area, similar to what HSUS observed. HSUS also found that physicians used the same imperfect patient selection process regardless of whether they practice in high- or low-use areas. If physicians in the high-use area did 60 operations compared with 15 in the low-use area and if one third of cases in each area fell into each of the three appropriateness categories (appropriate, equivocal, and inappropriate), then 20 of the cases in the high-use area would include patients with appropriate indications compared with five in the low-use area. Table 3 presents these hypothetic data.

One important effect of this pattern of practice is to leave a larger number of patients with appropriate indications without surgical treatment in the low-use area (50 − 5 = 45) compared with the high-use area (50 − 20 = 30). In the high-use area, 60% of patients with appropriate indications will not undergo the procedure, but 90% of such patients will not receive the appropriate treatment in the low-use area. Failing to receive appropriate care is a good working definition of underuse. Thus, other things being equal, underuse is more prevalent in the low-use areas if the enthusiasm hypothesis is true and if the HSUS results are generalizable.

The other major implication of this hypothesis is that better data on the efficacy of procedures, although eminently desirable in their own right, will not solve the major quality problems that accompany geographic variations, i.e., overuse and underuse. If little inappropriate care existed and most variation were caused by uncertainty about the efficacy of procedures done for gray area indications, then we might expect new efficacy data to lead to more effective patterns of care after the rational incorporation of such data into the practices of physicians

TABLE 3. Enthusiasm and Underuse: Hypothetical Example

	High-Use Area	Low-Use Area
Number of patients with appropriate indications for carotid endarterectomy	50	50
Number of carotid endarterectomies	60	15
Appropriate operations (%)	33	33
Equivocal operations (%)	33	33
Inappropriate operations (%)	33	33
Number of operations on patients with appropriate indications	20	5
Number of patients with appropriate indications who *do not* receive surgery	50 − 20 = 30	50 − 5 = 45
Patients with appropriate indications who *do not* receive surgery (%)	60	90

thirsting for new information on effectiveness.

The enthusiasm hypothesis suggests otherwise. Enthusiasts are not uncertain. They are believers. They see individual patients who benefit from their procedures. Perhaps they discount complications as "inevitable." They extrapolate the indications for their procedures by logical extension rather than by adherence to scientific data. If, for example, doing a carotid endarterectomy on a patient with multiple transient ischemic attacks and a 90% stenosis is effective, then operating on an asymptomatic patient with a 90% stenosis must be similarly beneficial. If 90% stenoses should be treated surgically, what about 80% or 60% lesions?

Their faith might be shaken by a large study that conclusively showed a lack of benefit for the procedure under all circumstances, but randomized trials rarely address all uses of a procedure. In addition, research more often demonstrates usefulness for some patients and not for others. Such is the case with the recent data on carotid endarterectomy,[29,30] which demonstrated efficacy for patients with ischemic symptoms and stenoses of 90% or greater but not for those with less than 30% stenosis. Because research cannot study every possible use of a procedure, many plausible uses will always exist, the efficacy of which research has not directly addressed. These gray areas will always be fertile ground for enthusiasts to till. Other methods than producing more efficacy data will likely be required to rein enthusiasm in.

This exposition of the enthusiasm hypothesis uses carotid endarterectomy as an illustrative example. Are the lessons drawn from studying it generalizable? I believe they do apply to other procedures for which referral from a primary care physician to a specialist must occur before the procedure. We might think that this procedure is unique because there is so little rigorous scientific data on its efficacy. On the contrary, all six of the procedures reviewed by HSUS had similar findings.[33] Lack of efficacy data is by no means limited to carotid endarterectomy.

Other procedures may be even more susceptible to enthusiasm. Such might be the case if no referral is needed and a single physician both evaluates the patient's need for a procedure and does it. The rapid growth of percutaneous transluminal coronary angioplasty might be attributable in part to this phenomenon.

Conclusions

This analysis proposes that geographic differences in the use of particular health services may arise when more physicians in one region become enthusiastic about the potential usefulness of those services. This enthusiasm may also lead some to employ these services for inappropriate reasons because their faith in the utility of the procedure or service exceeds the reasonable bounds of existing data and clinical common sense.

This hypothesis is more consistent with existing health services research data than the other commonly propounded explanations. Additional research will be required to confirm or refute it.

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Choice of Hospital for Delivery: A Comparison of High-Risk and Low-Risk Women

Ciaran S. Phibbs, David H. Mark, Harold S. Luft, Deborah J. Peltzman-Rennie, Deborah W. Garnick, Erik Lichtenberg, and Stephen J. McPhee

Objective. This article tests whether or not the factors that affect hospital choice differ for selected subgroups of the population.

Data Sources. 1985 California Office of Statewide Health Planning and Development (OSHPD) discharge abstracts and hospital financial data were used.

Study Design. Models for hospital choice were estimated using McFadden's conditional logit model. Separate models were estimated for high-risk and low-risk patients, and for high-risk and low-risk women covered either by private insurance or by California Medicaid. The model included independent variables to control for quality, price, ownership, and distance to the hospital.

Data Extraction. Data covered all maternal deliveries in the San Francisco Bay Area in 1985 (N = 61,436). ICD-9 codes were used to classify patients as high-risk or low-risk. The expected payment code on the discharge abstract was used to identify insurance status.

Principal Findings. The results strongly reject the hypothesis that high-risk and low-risk women have the same choice process. Hospital quality tended to be more important for high-risk than low-risk women. These results also reject the hypothesis that factors influencing choice of hospital are the same for women covered by private insurance as for those covered by Medicaid. Further, high-risk women covered by Medicaid were less likely than high-risk women covered by private insurance to deliver in hospitals with newborn intensive care units.

Conclusions. The results show that the choice factors vary across several broadly defined subgroups of patients with a specific condition. Thus, estimates aggregating all patients may be misleading. Specifically, such estimates will understate actual patient response to quality of care indicators, since patient sensitivity to quality of care varies with the patients' risk status.

Keywords. Hospital choice, quality of care, maternity care, conditional choice models, socioeconomic factors

In choosing a hospital to enter for treatment, a number of factors may enter an individual's thinking. For instance, which hospital, from among the possibilities, has the most up-to-date facilities? Where does my physician suggest I go? Do I anticipate the need for special intensive services? Where will I feel most comfortable? Where do many of the people I know go? Will my insurance coverage allow me to choose this hospital? How far away is the hospital? For each person, each of these factors varies in relative importance. Some people may prefer proximity while others may value backup intensive care services.

Several investigators have used linear versions of conditional-choice models to look at the factors influencing hospital admissions for all patients (Folland 1983; Lee and Cohen 1985; Erickson and Finkler 1985) or for aggregated subgroups (McGuirk and Porell 1984). In all of these models, distance from the patient's home to the hospital was the most important factor. Garnick, Lichtenberg, Phibbs, et al. (1989) have

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This research was supported by Grant Number HS-05411 from the National Center for Health Services Research and Health Care Technology Assessment (NCHSR). Dr. Phibbs was supported, in part, by a postdoctoral fellowship from the National Center for Health Services Research Institutional National Research Award HS00026. Dr. Lichtenberg and Dr. Mark were supported, in part, by postdoctoral fellowships from the Pew Charitable Trust Health Policy Program T87-01210.

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shown that it is preferable to use maximum-likelihood estimators instead of linear approximations. Luft, Garnick, Mark, et al. (1990) used this method to examine hospital choice for 12 diagnoses and surgical procedures. They found differences in the relative influence of the factors affecting hospital choice across different diagnoses and procedures. This finding raises an obvious question: do the factors that influence hospital choice vary across subgroups of patients with the same diagnosis?

We used maternal delivery to test for differences in hospital choice across subgroups of patients with the same medical condition. Delivery is a good choice for examining these differences because of the long time that passes between first knowledge of the need for hospital services and the date when provision is actually required. Expectant mothers have more time to shop around for the hospital that best meets their needs than do patients with most other conditions. The concerted efforts to regionalize perinatal care for high-risk women and infants (McCormick, Shapiro, and Starfield 1985) should also influence the observed hospital choices. Finally, the large number of deliveries yields a sufficient volume of perinatal deaths (despite relatively low mortality rates) to make it feasible to use perinatal mortality as a marker for hospital quality.

The primary purpose of this study was to examine factors that may influence different subgroups of the general population in their choice of a hospital for delivery. We specifically focused on the choices of mothers considered to be at high risk of facing serious complications for themselves or their infants and of mothers considered to be at low risk. In this article we used data from all hospitals in the greater San Francisco Bay Area with delivery services in 1985. Hospital choice was modeled as a function of four types of variables: quality, price and payment, hospital ownership, and geographic access. This model is estimated separately for the high-risk and low-risk groups to compare differences in hospital choice by risk status. For each of these risk groups, we also looked at the effects of payment source on choice by comparing the hospital choice of women covered by California Medicaid (Medi-Cal) with that of women covered by private insurance.

DATA

Hospital discharge abstracts for 1985 from the Office of Statewide Health Planning and Development (OSHPD) were selected for all patients for whom delivery was the listed type of admission. To reduce the data set to a manageable size, deliveries only from zip codes in the greater San Francisco Bay Area were considered.[1] The size of this area

(over 100 miles long and about 30 miles wide) and its number of hospitals were sufficient to mean that fewer than 1.5 percent of all patients residing in the region received hospital care outside of its boundaries. Patients hospitalized in federal, state, or HMO hospitals were excluded since their choice of hospital was more limited than that of other patients. The hospital discharge data included the zip code of patient residence, which we used to determine the geographical origin of the patient. The discharge abstracts also contained data on maternal diagnoses, procedures, age, race, hospital charge,[2] and expected source of payment.

Data on hospital ownership, teaching status, and facilities were obtained from the OSHPD Hospital Disclosure Report. Data on the level of newborn intensive care available at each hospital were obtained from the Maternal and Child Health Section of the California Department of Health Services. Data on the Medi-Cal contract status were obtained from a published report of the California Department of Health Services (1988). Latitude and longitude coordinates for residential zip codes were obtained from commercially available geographic files. Exact coordinates for hospitals were determined from topographic maps plotted by the U.S. Geological Survey. Data on risk-adjusted birth outcomes were obtained from the California Maternal and Child Health Data Base (Rust, Rust, and Williams 1989).

METHODS

STATISTICAL MODEL

Qualitative-choice models are a class of methods used to study situations in which an individual chooses from among a set of alternatives. These models may be estimated using the conditional logit method developed by McFadden (1974). The attractiveness of hospital j to patient m in location i, Y^*_{ijm}, is a linear function of observable attributes of the hospital and patient, X_{ijm}, and random variables, e_{ijm}:

$$Y^*_{ijm} = V(X_{ijm}) + e_{ijm}$$

The probability that hospital j is chosen equals the probability that it is more attractive than all other hospitals in the choice set. If the random components, e_{ijm}, have identical independent Weibull distributions, then the probability of observing the selection of hospital j by patient m in location i, p_{ijm}, is:

$$p_{ijm} = \{\exp[V(X_{ijm})]\} / \{\Sigma_k \exp[V(X_{ijm})]\} \quad k = 1, \ldots, N$$

where N is the number of hospitals. The advantage of this model is that in generating the parameter estimates it explicitly considers the characteristics of the alternatives that were rejected as well as the one that was chosen. We have shown elsewhere that the maximum-likelihood method of estimating the parameters for this particular type of problem is more robust than the other commonly used methods (Garnick, Lichtenberg, Phibbs, et al. 1989).

A key assumption of the conditional logit model is the independence of irrelevant alternatives (IIA). This assumption implies that the addition or subtraction of alternative choices will not affect the estimated parameters. We tested for violation of this assumption using the auxiliary regression method of McFadden (1987).[3] This test is asymptotically equivalent to the test of Hausman and McFadden (1984). This test did not reject the IIA assumption ($\chi^2 = 0.6$, d.f. = 17).[4]

Given that we specifically designate different levels of hospitals, based on the level of care provided, we also considered the possibility that a nested logit model should be used. For this application, a nested logit model would have the first level of analysis examine choice across groupings of comparable hospitals and the second level of analysis examine choice within each grouping. This was of specific concern for this analysis, since high-risk women might consider only hospitals that offered tertiary services. Again, the auxiliary regression to test failed to reject the assumption that the model was not nested ($\chi^2 = 0.4$, d.f. = 16) (McFadden 1987).

PATIENT SUBGROUPS

Deliveries were classified as high- or low-risk based on the American Academy of Pediatrics/American College of Obstetrics and Gynecology Guidelines for Perinatal Care (1988). These guidelines define the level of care appropriate for different maternal conditions.[5] We classified as high-risk deliveries the 23,903 women who had at least one of the guideline conditions for which it is recommended that delivery occur in a hospital with at least an intermediate-level neonatal intensive care unit (NICU). All deliveries not identified as high-risk were classified as low-risk. Our coding scheme was designed to ensure that we captured all high-risk women. With 38.9 percent of the cases classified as high-risk, we almost certainly classified many women who were actually of moderate or nominal risk as high-risk: this admittedly dilutes the observed effects of risk status on choice of hospital.

Many of the conditions that classify a pregnancy as high-risk, such as maternal chronic disease, can be identified in advance. Others, such

as severe hypertensive disorders, surface later in pregnancy, but even then patients and physicians can consider switching hospitals. Conditions, such as preterm labor, that cannot always be predicted are those that the mother or her physician should immediately regard as unstable/precarious. The standard of care in these cases is to transfer or directly refer the high-risk mothers to a site that offers the appropriate level of care if the mother is stable enough to allow the move. Thus, it seems plausible that joint patient-physician preferences about where to deliver will be different for women identified as being high-risk, than for low-risk women—up to the point where transfer of the mother is considered unsafe. Specifically, high-risk women and their physicians who know their risk status, should be more willing than low-risk women and their physicians to travel farther, and should be more concerned about quality and the services available to treat high-risk cases. To test for differences in the choice process between high- and low-risk patients, the model was estimated separately for each group (unrestricted models). These estimates were compared with the estimates of data pooled from both groups, which had forced the parameter estimates to be equal for both groups (restricted model). The difference between the log likelihood of the restricted model and the sum of the log likelihoods of the unrestricted estimates is distributed χ^2 with k degrees of freedom, where k is the number of regressors in the model.

The demographic and socioeconomic characteristics of Medi-Cal–eligible women are quite different from those of the insured population. With respect to choice of hospital, their increased reliance on public transportation is especially important. In addition, the willingness of physicians and hospitals to accept Medi-Cal patients may differ from their willingness to treat insured patients. Therefore, the parameters of the choice model are likely to be different for these two patient groups. For this test, patients with an expected payment source of Medi-Cal were compared with patients whose expected source of payment was some form of private insurance (commercial insurance, Blue Cross, Blue Shield, non-Kaiser HMO or other prepaid plan, or Medicare).[6] Patients not included in these two groups were excluded from the comparison. To focus the comparison on the differences between these two groups, this comparison was made separately for the high-risk patients and the low-risk patients. The unrestricted models were separate estimates for the Medi-Cal patients versus insured patients, and the restricted model was for all patients in these two groups.

VARIABLES IN MODEL

The dependent variable for our estimates was patient-hospital pairs. Since the data elements are identical for all patients in a zip code who chose the same hospital, we aggregated to the zip code–hospital level and weighted the estimates by the number of patients in each pair for computational convenience. Thus, computationally, the dependent variable was the number of patients from a given zip code who chose a given hospital. The independent variables in the model included zip code–specific patient characteristics and characteristics of each hospital. These variables could be categorized into four general groups: quality, charges, ownership, and distance. Table 1, further on, shows the mean values of the variables used in the analysis: by hospital, for all patients, for the high-risk and low-risk patients, and for the low-risk and high-risk private-pay and Medi-Cal patients.

QUALITY

We used both structural and outcome variables to measure the quality of care. The level of neonatal intensive care available is a measure of the range of services the hospital is able to provide to infants. These units should tend to attract more women who anticipate a high-risk delivery. Given that some complications cannot be predicted in advance, giving birth at a hospital with a NICU assures the availability of any level of care that may be required. Therefore, the presence of a NICU may be a feature that attracts some women for low-risk deliveries. We used data from the California Department of Health Services to create categorical variables for the presence of level III (tertiary), high-level II (intermediate), and low-level II NICUs. Teaching affiliation with a medical school may also be interpreted as a marker of quality by some women. Other low-risk women may wish to avoid the "extra attention" commonly associated with the clinical training of house staff and medical students in teaching hospitals.

Hospital characteristics that can affect the birth experience may influence the mother's choice. We included binary variables for the presence of an alternative birth center and the provision of parent training classes. By 1985, the rapid increase of cesarean section deliveries was well documented, and many experts were questioning whether or not all of them were necessary (Bottoms, Rosen, and Sokol 1980; Fraser, Usher, McLean, et al. 1987; Gleicher 1984). On the other hand, it has been shown that cesarean section delivery may improve outcomes, especially for high-risk infants (Williams and Hawes 1979). We included the hospitals' cesarean section rates in the model to control for the fact that

this variable might affect choice of hospital.[7] Cesarean sections were identified by a primary or secondary ICD-9 procedure code of 740–744 or 749. Percentages of cesarean sections were based on all delivery patients in each hospital, including those who lived outside the San Francisco Bay Area.

Although an expectant mother is obviously concerned about her own well-being, the rarity of maternal mortality makes it likely that newborn outcomes are predominant in her assessment of hospital quality. For newborns, the dominant risk factor is birth weight. Since exact birth weight data are not available on the OSHPD discharge data, we used a *Z*-score–based outcome measure derived from vital records data as a hospital-level measure of quality (Williams 1979; Rust, Rust, and Williams 1989). This measure adjusts for birth weight, sex, race, and plurality to calculate an expected perinatal mortality rate for each hospital. Indirect standardization was used to compare the expected mortality rate with the actual mortality rate. The *Z*-score was used to correct for differences in sample size across hospitals, which affects the level of confidence associated with observed outcomes. A *Z*-score of zero implies that the actual number of perinatal deaths equaled the expected number of deaths. *Z*-scores greater than zero imply that actual deaths were greater than expected deaths, with the converse true for *Z*-scores less than zero. This measure has been shown to be a good indicator of the quality of perinatal care independent of socioeconomic status (Williams 1979). Since the *Z*-score takes the birth weight as it is given, and adjusts for this risk accordingly, the potential for omitted-variable bias due to the correlation between lower birth weights and socioeconomic status is reduced. It has been shown that selective maternal referral of cases with congenital anomalies introduces a bias in the *Z*-scores of some tertiary hospitals in California (Rust, Rust, and Williams 1989). To eliminate this bias, we used the *Z*-scores that Rust et al. calculated after deleting all deaths due to congenital anomalies.[8]

CHARGES

Although insurance coverage reduces the effective price for hospital services, relative price has still been found to influence hospital choice for some conditions (Luft, Garnick, Mark, et al. 1990). To capture this effect we used the hospital charge listed on the discharge abstract in the model. To adjust for the effect of case mix on charges, we estimated a regression model where charges were dependent on mother's age, expected payment source, race, cesarean section, emergency room admission, whether the hospital included physician charges in its bill,

and whether the hospital had a Medi-Cal contract. This model was estimated for low-risk deliveries only, to minimize the possibility that unobserved case-mix difference might bias the results.[9] We used the ratio of actual charges divided by expected charges to control for the effect of relative-price differences in the conditional choice model.

MEDI-CAL CONTRACTING

In 1982, California passed legislation switching Medi-Cal to a selective contracting program and enabling formation of preferred provider organizations (PPOs).[10] Both of these changes restricted the options of many patients. To control for the hospital's eligibility for Medi-Cal births (about 20 percent of all births), our model included the number of months in which each hospital had a Medi-Cal contract. Unfortunately, data on PPOs are not readily available; thus, their effect could not be examined.

SOCIOECONOMIC STATUS

The socioeconomic status of patients may influence their choice of hospital. Indigent patients may be concentrated at public institutions and a limited number of other hospitals due to the restrictions of Medi-Cal selective contracting, patient reliance on public transportation, and the unwillingness of some hospitals to accept uninsured or underinsured patients. More affluent patients may prefer well-appointed hospitals that cater to their needs. To test the magnitude of such socioeconomic grouping, we created a variable that combined the percent of each hospital's patients who had private insurance with the percent of the population in each zip code with at least some college education.[11] However, simply multiplying these variables would not have picked up the desired effect, since high education–high percent insured combinations would be near one while low education–low percent insured combinations would be near zero. Under a "likes attract" hypothesis, these two combinations need to be similar. Thus, the interaction term we included is based on the deviations from the mean value of each of the components.

This variable yields large positive values for the high-high and low-low groups. It yields large negative numbers for opposites (low-education zip code paired with a high percent–insured hospital and high education zip code paired with a low percent–insured hospital). A positive coefficient can be interpreted as support for the hypothesis that individuals of high (low) socioeconomic status (SES) tend to concentrate their admissions in hospitals that primarily serve individuals with good (poor) insurance coverage. The subsamples used in the comparison of

Medi-Cal and privately insured patients limit the variance of the SES interaction variable just described; Medi-Cal patients tend to come from lower-education zip codes, and private-paying patients tend to come from higher-education zip codes. Thus, any variance that remains is due mostly to differences in the percentage of each hospital's admissions covered by private insurance. To avoid the reduction in the variance induced by the interaction term, we used the percentage of each hospital's patients covered by private insurance for the models comparing Medi-Cal and privately insured women. Here, the "likes attract" hypothesis would imply a positive coefficient for the private insurance subsample and a negative coefficient for the Medi-Cal subsample.

OWNERSHIP

Ownership status may also influence choice of hospital. The strongest factor is probably local government ownership, since these hospitals, which primarily serve indigent populations, often are less attractive to privately insured patients for this reason. Hospitals operated by local hospital districts, while controlled by a publicly elected board, do not have a special mission to serve the poor. It is unclear how this type of ownership influences choice of hospital. Many individuals wish to avoid for-profit hospitals in the belief that profit making is inconsistent with high-quality care. Depending on one's beliefs, Catholic ownership may be regarded as an attraction or, possibly, detraction. We created binary variables for each of these ownership categories. The excluded category is private, not-for-profit, non-Catholic hospitals.

DISTANCE

Hospital markets are relatively localized (Garnick et al. 1987). Thus, patients tend to prefer hospitals closer to home. Because neither road distance nor travel times were available, straight-line distance was calculated from the location of the patients' zip code to the exact location of each hospital using latitude and longitude coordinates. To account for the bottlenecks associated with travel in the San Francisco Bay Area, we included a variable indicating whether a bridge or tunnel would be used on the most direct route between a zip code and a hospital.

RESULTS

The final data set included 61,436 deliveries. Of these, 37,583 (61.1 percent) were classified as low-risk, and 23,903 (38.9 percent) were

classified as high-risk. Of the low-risk deliveries, 9,329 (24.9 percent) were covered by Medi-Cal and 23,500 (62.6 percent) were covered by private insurance. Medi-Cal covered 6,725 (28.1 percent) of the high-risk deliveries, and private insurance covered 14,987 (62.7 percent) of them. The remaining deliveries were self-pay or HMO, and were not included in the payer source comparisons. Table 1 shows the means of the variables in the model for all deliveries and for each subgroup. Among the data subsets shown on Table 1, most of the variables are similar for all of the groups. There are, however, some notable exceptions. Compared to low-risk patients, many more high-risk patients use teaching hospitals and hospitals that provide level III newborn intensive care. High-risk patients are also concentrated in hospitals with lower risk-adjusted mortality rates. Many fewer Medi-Cal patients cross a transportation bottleneck (bridge or tunnel) than private-pay patients. A much higher percentage of Medi-Cal patients use public and Catholic hospitals. Surprisingly, there was no difference in the cesarean section rate between high-risk and low-risk women.

Table 1 also shows the means for the 48 San Francisco area hospitals. About half of the hospitals are private, not-for-profit hospitals. Most of the hospitals provide parent training classes and have an alternative birth center. Slightly over one-third of the hospitals provide some level of newborn intensive care. Medi-Cal contracts were present at 27 of the hospitals for all 12 months of 1985, and one had a contract for seven months. The remaining 20 hospitals had no Medi-Cal contract at any time in 1985.

Table 2 shows the results for the estimates for all deliveries and the high- and low-risk subsets. Quality, price, ownership, and distance all had significant effects on the choice of hospital, as we have previously found for other types of cases (Luft et al. 1990). Teaching hospitals and hospitals that provide newborn intensive care were preferred, with higher levels of newborn intensive care preferred over lower levels. Better outcomes, as measured by the risk-adjusted Z-score for perinatal mortality, also increased the probability that a mother would choose to deliver at a particular hospital. Patients also preferred hospitals that offered parent training classes and alternative birth centers, and hospitals that had higher cesarean section rates. Holding other factors constant, patients preferred hospitals with lower charges. Having a contract with the state Medi-Cal program reduced the probability that a hospital would be chosen. The SES interaction variable had the expected positive effect. Catholic hospitals were more attractive, as were public hospitals, than proprietary and district hospitals. Straight-line distance from the zip code of patient residence to the hospital had a very strong effect on

Table 1: Mean Values for Variables in Regression Models

		All			Low-Risk		High-Risk	
	Hospitals	*Deliveries*	*Low-Risk*	*High-Risk*	*Private-Pay*	*Medi-Cal*	*Private-Pay*	*Medi-Cal*
N	48	61,436	37,533	23,903	23,500	9,329	14,987	6,725
Z-score of risk-adjusted perinatal death rate	0.02	-0.47	-0.32	-0.70	-0.43	-0.37	-0.72	-0.95
Teaching hospital	16.7%	24.5%	21.0%	30.0%	16.9%	21.1%	23.7%	32.1%
Newborn intensive care unit	12.5%	25.3%	20.4%	33.0%	19.2%	20.6%	29.7%	37.3%
High intermediate newborn intensive care unit	10.4%	18.5%	19.8%	16.4%	20.6%	17.3%	16.6%	14.3%
Low intermediate newborn intensive care unit	14.6%	21.2%	22.0%	20.1%	26.2%	13.0%	23.6%	15.4%
Cesarean section rate	24.5%	23.9%	23.9%	23.9%	25.1%	22.5%	25.1%	22.6%
Parent training classes	70.8%	77.3%	77.3%	77.2%	78.7%	82.8%	80.5%	79.0%
Alternative birth center	81.3%	85.2%	85.6%	84.6%	90.4%	76.1%	91.4%	72.5%
Ratio of actual to expected charges	0.978	1.001	1.004	0.997	0.997	1.015	0.989	1.013
Number of months hospital had Medi-Cal contract 1985	6.9	7.8	7.4	8.3	6.4	9.7	7.1	10.5
SES interaction variable*		0.285	0.286	0.285	0.343	0.175	0.352	0.176
Public	10.4%	16.4%	16.1%	16.8%	6.9%	30.3%	5.7%	30.3%
Proprietary	2.1%	0.3%	0.5%	0.1%	0.6%	0.2%	0.1%	0.2%
District	22.9%	14.1%	14.8%	13.1%	16.7%	11.4%	16.2%	7.5%
Catholic	14.6%	13.5%	14.1%	12.6%	12.6%	20.7%	11.2%	18.4%
Distance (log miles)		1.320	1.297	1.358	1.396	1.069	1.455	1.171
Bridge or tunnel†		0.049	0.044	0.056	0.055	0.018	0.070	0.027

*Percent of hospital's patients who had private insurance multiplied by the percent of the zip code population that had at least some college education; for the high-risk and low-risk private pay and Medi-Cal patients (columns 5–8), this variable is percent of hospital's patients with private insurance.

†Binary variable indicating whether a bridge or tunnel would be used in the most direct route between a zip code and a hospital.

Table 2: Regressions Comparing Hospital Choice for High- and Low-Risk Deliveries

	All Deliveries		*Low-Risk*		*High-Risk*	
	Coefficient	*t-Ratio*	*Coefficient*	*t-Ratio*	*Coefficient*	*t-Ratio*
Z-score of risk-adjusted perinatal death rate	-0.0458	-9.50	-0.0373	-6.03	-0.0750	-9.53
Teaching hospital	0.1017	4.52	0.0450	1.54	0.2320	6.49
Newborn intensive care unit	1.5783	56.21	1.2700	35.11	1.9409	42.66
High intermediate newborn intensive care unit	1.3483	72.29	1.3494	58.28	1.3143	41.28
Low intermediate newborn intensive care unit	0.7603	49.95	0.7575	39.94	0.7785	30.18
Cesarean section rate	1.1761	7.91	0.6741	3.63	2.2215	8.94
Parent training classes	0.4818	33.72	0.4214	23.12	0.5584	23.84
Alternative birth center	0.4929	30.05	0.4738	22.95	0.5685	20.69
Ratio of actual to expected charges	-0.4702	-11.87	0.1135	2.21	-1.3562	-21.27
Number of months hospital had Medi-Cal contract 1985	-0.0237	-19.21	-0.0218	-14.12	-0.0271	-13.03
SES interaction variable*	5.9146	41.18	5.5808	29.94	6.4274	28.23
Public	0.1531	7.20	0.0598	2.19	0.3486	10.04
Proprietary	-0.5051	-4.88	-0.2061	-1.78	-1.5283	10.04
District	-0.2093	-12.15	-0.2624	-12.13	-0.1023	-3.56
Catholic	0.3011	13.97	0.2777	10.34	0.3587	9.81
Distance (log miles)	-1.3727	-295.01	-1.3772	-231.59	-1.3692	-181.53
Bridge or tunnel†	-1.8238	-87.17	-1.9480	-69.87	-1.6316	-51.38
Pseudo R^2	0.48		0.49		0.48	

*Percent of hospital's patients who had private insurance multiplied by the percent of the zip code population that had at least some college education.

†Binary variable indicating whether a bridge or tunnel would be used in the most direct route between a zip code and a hospital.

the choice of hospital. The necessity of passing through a major traffic bottleneck (a bridge or tunnel) to reach a hospital also reduced the probability that that hospital would be chosen.

The hypothesis that the high- and low-risk patients made the same hospital choices for delivery was rejected ($p < .001$ $\chi^2 = 800$, d.f. = 17). The third and fifth columns of Table 2 show the estimates of the separate models for the high- and low-risk groups. Low- and high-risk women placed about the same importance on the presence of intermediate newborn intensive care, a hospital's Medi-Cal contract status, and distance. High-risk women had stronger preferences for hospitals with better quality measures (lower risk-adjusted mortality rates, teaching hospitals, and hospitals with level III NICUs), and were more willing to travel through a traffic bottleneck to reach their preferred hospital. Women expecting high-risk deliveries were more willing to go to a public hospital, more likely to deliver at hospitals with high cesarean section rates, and more likely to avoid a proprietary hospital than were women expecting low-risk deliveries. Surprisingly, women in the high-risk category seemed more sensitive to charges than those in the low-risk group.

Table 3 shows the estimates that compare the low-risk Medi-Cal and private insurance subgroups. The hypothesis that low-risk patients covered by Medi-Cal and patients covered by private insurance made the same choices was rejected ($p < .001$ $\chi^2 = 4{,}963$, d.f. = 17). Medi-Cal patients were less likely than women with private insurance to choose a teaching hospital, a hospital with a NICU (any level), a hospital with a high cesarean section rate, a hospital with a higher risk-adjusted mortality rate, a hospital with an alternative birth center, a proprietary hospital, or a hospital that was more difficult to reach. They were more likely to choose a hospital with a Medi-Cal contract, a hospital with higher charges, a hospital that offers parent training classes, or a public hospital. The percentage of a hospital's admissions covered by private insurance has a significant positive effect for the private-pay patients and a significant negative effect for the Medi-Cal patients.

The estimates that compare the high-risk Medi-Cal and private insurance patients are shown in Table 4. The hypothesis that these high-risk subgroups have the same choice model was rejected ($p < .001$ $\chi^2 = 3{,}407$, d.f. = 17). In general, although the magnitude of the differences varied, the direction of the differences between the two subgroups was the same as that of the differences between the low-risk subgroups. The exceptions were (1) the increased aversion of privately insured high-risk patients to proprietary hospitals—now equal to that of Medi-Cal patients; (2) the stronger aversion of patients with private insurance to hospitals with high Z-scores, instead of a weaker aversion; and (3) the

Table 3: Comparison of Hospital Choice by Low-Risk Mothers with Private Insurance and Medi-Cal Coverage

	All Low-Risk		*Private*		*Medi-Cal*	
	Coefficient	*t-Ratio*	*Coefficient*	*t-Ratio*	*Coefficient*	*t-Ratio*
Z-score of risk-adjusted perinatal death rate	-0.0847	-11.88	-0.0492	-5.16	-0.1454	-10.73
Teaching hospital	-0.1493	-4.54	-0.1439	-3.21	-0.3936	-6.70
Newborn intensive care unit	1.1048	26.75	1.6526	27.88	0.6498	9.36
High intermediate newborn intensive care unit	1.2697	51.85	1.6468	54.75	0.7940	14.39
Low intermediate newborn intensive care unit	0.5994	30.19	0.8647	36.07	-0.2832	-5.15
Cesarean section rate	-1.0689	-5.10	-0.0914	-0.35	-0.1445	-0.33
Parent training classes	0.5705	28.78	0.5808	24.78	0.9379	19.69
Alternative birth center	0.1732	7.43	0.2347	7.45	-0.2571	-5.97
Ratio of actual to expected charges	0.1086	1.95	0.1111	1.68	0.6602	5.20
Number of months hospital had Medi-Cal contract 1985	0.0176	9.77	0.0012	0.58	0.0810	16.12
Percent of hospital's patients with insurance	1.7892	35.74	3.0111	46.89	-1.4800	-14.16
Public	0.6217	18.28	-0.0938	-1.92	0.7222	11.01
Proprietary	-0.4988	-3.97	-0.1826	-1.26	-1.5363	-5.35
District	-0.3979	-17.44	-0.3852	-14.36	-0.5521	-10.21
Catholic	0.3351	11.95	0.5593	14.98	0.3629	6.83
Distance (log miles)	-1.4156	-220.77	-1.4690	-187.25	-1.3821	-107.76
Bridge or tunnel*	-1.9318	-65.06	-1.6780	-51.40	-3.0282	-36.05
Pseudo R^2	0.50		0.52		0.59	

*Binary variable indicating whether a bridge or tunnel would be used in the most direct route between a zip code and a hospital.

Table 4: Comparison of Hospital Choice by High-Risk Mothers with Private Insurance and Medi-Cal Coverage

	All High-Risk		*Private*		*Medi-Cal*	
	Coefficient	*t-Ratio*	*Coefficient*	*t-Ratio*	*Coefficient*	*t-Ratio*
Z-score of risk-adjusted perinatal death rate	-0.1190	-13.15	-0.4449	-3.49	-0.2221	-12.42
Teaching hospital	0.1118	2.78	-0.0688	-1.18	0.1916	2.76
Newborn intensive care unit	1.7591	34.58	2.5913	33.47	1.1410	13.00
High intermediate newborn intensive care unit	1.2280	36.72	1.5329	37.21	0.8412	11.28
Low intermediate newborn intensive care unit	0.5783	21.75	0.6852	21.52	0.1425	2.00
Cesarean section rate	0.1890	0.69	1.3857	4.02	-0.7913	-1.36
Parent training classes	0.7086	28.24	0.6987	23.25	1.1652	19.11
Alternative birth center	0.1528	5.02	0.1160	2.73	-0.0299	-0.53
Ratio of actual to expected charges	-1.5299	-22.18	-1.7587	-20.68	-0.5660	-3.81
Number of months hospital had Medi-Cal contract 1985	0.0163	6.74	-0.0007	-0.25	0.1021	14.72
Percent of hospital's patients with insurance	1.9889	30.11	3.6035	40.45	-1.3384	-10.66
Public	0.9785	22.15	0.3970	6.18	0.8124	9.53
Proprietary	-1.8453	-7.72	-1.8252	-5.88	-1.7517	-4.50
District	-0.2951	-9.73	-0.1822	-5.17	-0.7486	-9.79
Catholic	0.3986	10.57	0.7786	15.22	0.1967	2.77
Distance (log miles)	-1.4043	-173.33	-1.4469	-144.87	-1.3970	-87.34
Bridge or tunnel*	-1.6197	-48.16	-1.3429	-35.73	-2.6839	-30.70
Pseudo R^2	0.49		0.51		0.59	

*Binary variable indicating whether a bridge or tunnel would be used in the most direct route between a zip code and a hospital.

finding that Medi-Cal patients are now more likely, instead of less likely, to select a teaching hospital.

DISCUSSION

The results presented here clearly show that the relative influence of various factors affecting patients' choice of hospitals differs for various subgroups of patients with one clinical condition in common: maternal delivery. For almost all of the variables in the model, the effects took the same direction but differed in magnitude. We chose to look at maternal delivery since it was relatively simple to identify the high-risk patients, and the volume of cases made it more likely that we would find statistically significant differences. Further, the relatively long period of advanced notice of the need for hospitalization before delivery increases the ability of the patient to shop around. Additional studies must be done to determine whether differences in choices among subgroups of patients will also be observed for other diagnoses and procedures where patients have less advance notice of the need to be hospitalized.

We have previously shown that differences exist in hospital choices among patients with different conditions (Luft, Garnick, Mark, et al. 1990). The results presented here indicate that the estimates of patients' choice of hospital vary across identifiable subgroups within a defined group of patients. Researchers will need to be sensitive to these potential differences in applying these models. Specifically, when interested in particular subgroups of patients, researchers will have to estimate the models separately for those subgroups. Given that the number of patients in any one zip code who choose a particular hospital for treatment declines rapidly as the subgroup under study is narrowed, such analysis will increase the number of zip code–hospital pairs with zero patients. This implies that such estimates will have to use maximum-likelihood estimates, instead of linear-approximation techniques, to obtain stable parameter estimates (Garnick, Lichtenberg, Phibbs, et al. 1989).

The comparison between the high- and low-risk cases shows that those factors likely to have a strong effect on expected outcome were more influential in the choice of hospital by high-risk women (and/or their physicians). This is consistent with the hypothesis that the sensitivity of demand to quality varies directly with the probability of perinatal death: the greater the risk of perinatal mortality, the more the patient is concerned about the expected quality of care. If this finding holds for other diagnoses, then estimates that aggregate all patients with a given

diagnosis will not accurately measure the quality elasticity of demand unless they include some measure of case mix (i.e., the risk of mortality of each patient).

Most of the results presented here were consistent with expectations. The increased willingness of high-risk women to give birth in hospitals with higher cesarean section rates is consistent, given that for high-risk cases cesarean deliveries have been shown to be associated with improved outcomes (Williams and Hawes 1979). Although low-risk women do not ignore quality, they tend to place less importance on the outcome-oriented quality factors we included, which is consistent with their low-risk status. These mothers seem to place more emphasis on factors perceived to influence the "ambiance" of the birth experience. Specifically, they are less likely to choose a tertiary teaching hospital, and thus can avoid the extra "attention" of house officers and medical students.

Caution must be applied in interpreting some of the differences in the estimated parameters between women covered by Medi-Cal and those covered by private insurance. Although the coefficients for the privately insured patients almost certainly reflect the preferences of those patients and their physicians, we cannot draw the same conclusions for women covered by Medi-Cal. The "choice" estimates for the Medi-Cal sample were also influenced by access restrictions and factors associated with serving large Medi-Cal populations. This may provide a partial explanation for the results that show Medi-Cal patients with a stronger preference for higher-charge hospitals.[12] Similarly, what appears to be a stronger aversion to cesarean sections by Medi-Cal mothers may be due not to patient preference but to the fact that resource-constrained public hospitals simply perform fewer cesarean sections.[13]

A more disturbing finding is that high-risk women covered by Medi-Cal were more likely to choose hospitals with worse perinatal outcomes (higher Z-scores), and were less likely to deliver at hospitals providing any level of specialized care for newborns. These results raise the possibility that high-risk women covered by Medi-Cal face barriers to care at appropriate facilities. We cannot identify the cause of these differences with our model, but this matter merits further investigation.

Most of the observed differences between the Medi-Cal and privately insured groups have more standard explanations. For example, Medi-Cal patients were more likely to be admitted to a public hospital or to a hospital with a Medi-Cal contract, and were less likely to be admitted to a proprietary hospital. As our "likes attract" hypothesis predicts, they were more likely to be admitted to a hospital with a larger propor-

tion of uninsured patients. Although the distance parameters were about the same, the much larger estimate for the bridge-tunnel variable indicates that geographic access is a much more important issue for the poor. It is also the case that in the Bay Area these bridge-tunnel bottlenecks usually signify county boundaries. Since much of the public transit in the Bay Area is county-based, this finding may be capturing more than just a traffic bottleneck.

Although we did observe significant differences in hospital choice between high-risk and low-risk women, our estimates—due to our broad definition of high-risk—probably understate the true effect of risk on hospital choice. We expect that we would find a risk gradient if we refined our definition of high-risk into several groups of increasing risk. We chose not to do so in this analysis since our primary purpose was to see if there were differences in the choice decision across subgroups of patients, not to estimate precisely the magnitude of the effect of risk on hospital choice. Further, such an analysis would have been very difficult to undertake with the data we used, since ICD-9-CM codes indicate only the presence of a diagnosis, not its severity. In spite of these limitations, our results demonstrate that hospital choice is sensitive to patient risk and insurance status. Increased sensitivity to risk factors among high-risk women suggests that referral patterns are at least somewhat rational. The different results for Medi-Cal women reflect the segmented medical markets that influence choices for privately versus publicly insured women.

ACKNOWLEDGMENTS

We thank Ronald Williams and two anonymous reviewers for helpful comments on an earlier draft of this article. Any errors or omissions remain our own.

NOTES

1. For more detail on how these zip codes were selected, see Garnick, Lichtenberg, Phibbs, et al. (1989).
2. For some hospitals, this data field includes some physician charges. The data indicate which hospitals also bill for physician services. We controlled for this in our regression model to calculate risk-adjusted charges.
3. The prediction errors of the original model are used as the dependent variable in a model where the independent variables are the weighted

average of each independent variable in the original model. The weights are the estimated probabilities from the original model.

4. This result is for the model comparing all high-risk deliveries with all low-risk deliveries. The statistic reported below for the nested logit model is also for this data set.
5. The Appendix available from the authors shows these guidelines and lists the ICD-9 codes that were used to classify women as high-risk.
6. Medicare was grouped with private insurance because it is a relatively "good" payer for delivery. Further, Medicare obstetrics patients are very rare, that is, only those women covered under the disability provisions of Medicare, and so forth.
7. We considered, and rejected, the possibility that cesarean section might be endogenous—that it is a function of some of the other independent variables and hospital choice. While a hospital's cesarean section rate may be influenced by the preferences of the women who deliver there, it is likely that most of the variance in cesarean section rates across hospitals is due to differences in the practice styles of the physicians on staff at each hospital. Because of this variation in practice styles, significant variability exists in the cesarean section rates across all of the other factors controlled for in the analysis.
8. Although there is a known volume-outcome relationship for births, we could not include any direct measures of number of hospital beds or patient volume in the model because these variables were highly collinear with several of the other variables in the model. Furthermore, we were attempting to explain choice of hospital based on variations in outcomes, not the reasons for variations in outcomes. In addition, the number of patients choosing a hospital from any one zip code is a small fraction of total volume.
9. For more details on the case-mix adjustments, see Garnick, Lichtenberg, Phibbs, et al. (1989) or Luft, Garnick, Mark, et al. (1990). Copies of these regression results are available from the authors on request.
10. Under selective contracting, Medicaid patients were restricted to receiving hospital care at contract hospitals, except on an emergency basis. By 1985, all of the areas in our study had been incorporated into the selective contracting program.
11. More than 12 years of education is used as a proxy for higher income. Educational level and income are very highly correlated, especially when aggregated to the zip code level.
12. A referee also noted that, since Medi-Cal patients do not pay any coinsurance, this result is consistent with economic theory.
13. A similar, but different explanation would attribute this difference to the fact that physicians who treat a larger number of Medi-Cal patients are less likely to let economics influence their medical decision making. Thus, they are not swayed to perform more cesarean sections by the higher reimbursement for operative deliveries. It may also be the case that some cesarean sections are encouraged by private physicians to end a long labor, while in hospitals using rotating physicians the responsibility for delivering the child is simply passed to the next-shift physician (Fraser et al. 1987).

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THE WHITE HOUSE

WASHINGTON

April 14, 1994

MEMORANDUM TO CAROL RASCO, Assistant to the President for Domestic Policy

FROM: Kristine M. Gebbie, R.N., M.N. Kristine M Gebbie / DBaum
National AIDS Policy Coordinator

SUBJECT: Process for review and comment on National HIV Action Agenda DRAFT

As we had discussed, I had not fully outlined for you a process for getting useful input on the National HIV Action Agenda.

GOAL: An agenda document which outlines the directions I (and others) have been stating for several months and gives a start to specific action plans for agencies and private sector groups.

The following is the process for review and comment:

1) HHS, coordinated by Phil Lee, will have comments on the full draft document by early May.

2) At the same time, I will send to members of the DPC (and selected other agencies) a copy of the **full document** for their review and comment. There will be a discussion between staff at key agencies and my staffers in additon to transmittal of the document. Agency comments will be due by early May. I would like ten minutes at a DPC meeting to review this process.

3) A briefing was held for representatives of 12 national HIV organizations. They have been given an **outline** of the goal statements of the Action Agenda. Given this, they have been asked for comments on the goals or on actions which should be taken to achieve those goals by April 29.

4) Following receipt of comments from both the community and federal agencies, an updated version of the Action Agenda will be available. At this point, a working meeting of both agency staff and advocates may be convened to consider key issues.

5) The Action Agenda will be discussed at the Presidential HIV/AIDS Advisory Council's first meeting.

If you have any questions, please give me a call. Thank you for your advice and support.

THE WHITE HOUSE

WASHINGTON

RECEIVED

OCT - 4 1994

August 2, 1993

Mr. A. Auerbach
Aravaipa Associates Inc.
Design and Manufacturing
P.O. Box 256
Oracle, Arizona 85623

Dear Mr. Auerbach:

Thank you for writing. I agree that condoms will continue to be a major part of our efforts to stop the spread of HIV infection.

Both the National Institutes of Health and the Centers for Disease Control and Prevention are conducting research on improved barrier methods. You many wish to contact them, as well as continue your efforts with manufacturers.

Sincerely,

Kristine M. Gebbie, RN, MN
National AIDS Policy Coordinator

OVER—

ARAVAIPA ASSOCIATES INC.
PO Box 256
Oracle, Arizona 85623 USA

Sept. 28, 1994

Patricia Fleming
Office of AIDS Policy
750 17th St. NW #600
Washington DC 20503

Dear Ms. Fleming:

Be advised that I have a (patented) condom improvement that has been discussed with numerous public health physicians. They agree it appears to be the first basic improvement in many years, and could make condoms both more effective - up to twice as effective! - and more popular.

But the major condom manufacturers are not interested, and people in the business tell me it is simply because they have an easy market today, hence are not motivated to make changes. And perhaps there is also the "not our idea, no good" attitude that inventors often meet. (I am in touch with a small firm that is interested, but short of capital.)

If you wish to know more, I will send a description and sample. I do not know how far your authority reaches, but I should think you would at least want to know what my improvement is. And be advised that I would forego royalties on condoms made for free distribution.

See the other side for the reply I had from Ms. Gebbie. And yes, I have written to other agencies such as the CDC and the Surgeon General. They did not reply or were similarly evasive.

Sincerely,

A. Auerbach

66

A. Auerbach

A. Auerbach
PO Box 256
Oracle AZ 85623

TUCSON AZ 857 PM
TUCSON AZ 85726 23 Dec 1994 17:36



Patricia Fleming
Office of AIDS Policy
750 17th St. NW #600
Washington DC 20503

THE WHITE HOUSE

WASHINGTON

February 28, 1994

Ramon Cortines, Chancellor
New York Public Schools
Board of Education
110 Livingston Street
Brooklyn, NY 11201

Dear Ray:

On February 12, I had the opportunity to meet over 200 young people, students in the New York City school system who were discussing youth-to-youth HIV and AIDS education. They had planned the conference themselves, using expert adults as consultants, and had as well-run a day of workshops and meetings as I have seen in a long time.

The focus of the sessions was on what young people need to know about themselves, their bodies, and HIV in order to stop the spread of this infection, and in order to respond compassionately to those who are infected. It was grounded in the principle which many endorse that in areas such as this, teens teaching each other is one of the most effective approaches possible.

I had the opportunity of answering questions about the development and focus of national policy with a small workshop group, and then addressing the closing plenary session. I was impressed by the seriousness of the students, their maturity, their commitment to making life better for themselves and their peers.

The students developed a platform of concerns which I understand will be forwarded to you and others in positions of authority for response. While some of their suggestions may not be within the realm of possibility, the thrust of the ideas is sound, and I hope you will be able to be responsive.

If I can provide additional comment as this process continues, please let me know. I was most impressed by the Saturday event, and would like to be supportive of appropriate follow up.

Sincerely,

COPY

Kristine M. Gebbie, R.N., M.N.
National AIDS Policy Coordinator

Standard Response

July 19, 1994

Mr. Robert A. Wisnewski
125 S.E. Citadel Drive
Lee's Summit, Missouri 64106

Dear Mr. Wisnewski:

Thank you for sharing your concerns about my participation in the "Youth Teaching Youth About HIV/AIDS" Peer Educators' Conference in New York City last February. Your letter criticizes my participation in this conference, where it was discovered that certain materials inappropriate for younger audiences may have been obtained by students. I believe the following information will address your concerns.

The conference was planned and run by students in the New York City school system, using adult experts as consultants. The focus of the day of workshops and meetings was on what young people need to know about themselves, their bodies, and HIV in order to stop the spread of this infection, and in order to respond compassionately to those who are infected. It was grounded on the principle that in areas such as this, teens teaching each other is one of the most effective approaches to education. I was impressed by the seriousness of the students, their maturity and their commitment to making life better for themselves and their peers.

I attended the meeting as a guest of the student conference organizers. Part of my role as the National AIDS Policy Coordinator is to travel the country and speak to as many groups as possible, including groups of students like those attending the "Youth Teaching Youth" conference, about the development and focus of national AIDS policy, and to hear directly their concerns in the area of HIV/AIDS prevention. I participated in one session and delivered a short closing statement to the meeting.

The printed materials in question were apparently brought to the meeting by mistake by a worker associated with one of the sponsoring agencies. These materials were not intended for participants in the conference and were left on a table that was unattended. I understand that the organization has acknowledged this error.

As you may know, the current administration is committed to taking the steps necessary to stop the spread of HIV. We base our efforts in this area on sound research which demonstrates that linguistically specific, culturally based materials are the most effective means of changing risky behavior among individuals at risk for HIV infection. It is also our

policy that prevention materials must be technically accurate, appropriate for the intended audience, and contain information about abstinence. I have been very explicit in my

advocacy for linguistically specific materials that are appropriate for the age group for which they are intended.

Sensational commentaries attempting to depict the "Youth Teaching Youth" conference as a Board of Education sponsored event designed to encourage sexual activity and drug use in our school age youth, are false and misleading. The conference was planned and sponsored by the young people themselves as a forum for peer education. We should be proud that many of our young people are so strongly concerned about the AIDS epidemic that they want to do something constructive about it.

As a mother of three children, I share many of your concerns and appreciate your taking the time to write me.

Sincerely,

Kristine M. Gebbie, R.N., M.N.
National AIDS Policy Coordinator

THE WHITE HOUSE
WASHINGTON

RECEIVED
JUL 22 1994

July 12, 1994

Mrs. Catherine Mueller
2925 Charleston
Albuquerque, New Mexico 87110

Dear Mrs. Mueller:

Thank you for taking the time to write. It is certainly true that the epidemic of HIV is related to other issues, especially those of prejudice and discrimination. I will continue to advocate for HIV and AIDS policy based on sound public health science, while listening to the voices of all Americans.

Sincerely,

Kristine M. Gebbie, R.N., M.N.
National AIDS Policy Coordinator

Kristine, prejudice and discrimination are very minor issues in addressing the AIDS plague. As a fellow Lutheran you know that we learned already in first grade from Luther's Catechism that adultery, fornication, and sexual perversions such as sodomy and lesbianism are wrong and a transgression against the Sixth Commandment.

Perhaps the HIV is a judgment against those who will not obey God's moral absolutes. In that event, billions spent yearly on finding a cure will be to no avail. The answer is not in the laboratory but in the lifestyle!

The Gay Rights movement is extremely powerful and well-funded and is intimidating those of us who are calling for a change in behavior. The more those folks rant and rave, the stronger the rest of us - 80% of the population -

become in fighting this perversion. The morals of America have become so disgusting that the biblical Sodom and Gommorah would be a Disneyland in comparison.

Call for a return to morality and you will see an end to the many health and social problems which face our nation.

Praying for toughness "tough love" as all Americans confront AIDS, a deadly disease.

Sincerely,

Kathy Hueller

PHOTOCOPY
PRESERVATION

POZ Magazine
349 West 12th Street
New York, NY 10014
Tel: 212-242-1900 • Fax: 212-242-1963

July 8, 1994

Ms. Kristine Gebbie
750 17th Street, NW #1060
Washington, DC 20500
Fax: 202-632-1096

Dear Ms. Gebbie,

This must be a tough time for you and I am sure you are hurt and angry.

I want to say that my call for your resignation was not a challenge to your compassion, sympathy or sincere desire to really make a difference.

We've not met, but I believe you to be a nice person, an honest person and probably as much as anyone else, disappointed in how difficult it has been for your office to move as quickly and effectively as needed.

It wasn't working. The position was poorly structured and destined to fail from the beginning.

But right now, as you are dealing with pain and frustration, I want you to know that your resignation was the difficult, but right thing to do. It is going to help people with AIDS, because it gives us a chance for a fresh start. The office must be reconfigured to make it *possible* for the next coordinator to be more effective.

I am an aggressive activist. But having been on the receiving end of criticism from this community, I know how it can often become personal, or be taken personally. That's not what my call for your resignation was about and I want to tell you so.

I am hopeful you will continue your personal commitment to fight AIDS, and support people with AIDS, in whatever new capacity you pursue.

Sincerely and good luck,

Sean Strub, Publisher

American Nurses Foundation, Inc.

Suite 100 West
600 Maryland Avenue, S.W.
Washington, DC 20024-2571
(202) 554-4444
FAX: (202) 554-2262

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July 6, 1994

JUL 25 1994

Kristine M. Gebbie, MSN, RN, FAAN
National AIDS Policy Coordinator
Executive Office of the President
750 17th Street, NW
Suite 1060
Washington, DC 20003

Dear Ms. Gebbie:

On behalf of the Board of Trustees and staff of the American Nurses Foundation, I want to thank you for participating as the speaker at ANF's Century Club Luncheon held recently as part of the activities at the American Nurses Association convention in San Antonio, Texas.

I sincerely appreciate your efforts at working your schedule so as to accommodate our request. Your presentation was excellent and right on target.

I have always enjoyed participating in smaller, informal activities that you attended. However, this was the first time I had the privilege of listening to a formal presentation. I was struck by your broad knowledge base of the subject matter as well as your devotion and passion for the challenges that HIV/AIDS brings to each of our lives.

Thank you again. I hope we will have other opportunities to work together. Best regards in your future endeavors.

Sincerely,

O. Kent Nordvig
Coordinator

/okn

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Executive Director

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JUL 27 1994

ANIN
AIDS NATIONAL
INTERFAITH NETWORK

July 12, 1994

Kristine Gebbie
National AIDS Policy Office
750 17th Street, NW
Washington, DC 20003

Dear Kristine:

Just a quick note to explain the "full" plan to recognize Ken on his 5th anniversary with ANIN:

The Board and staff are holding a "surprise" dinner for Ken during our Board meeting this coming weekend. Kay Dowhower was part of the "plot" to concoct an excuse to get Ken to show up at the hotel...she was drawn into the plot by Bishop Sherman Hicks, all of this in an effort to keep Ken from becoming suspicious. She may have given you the impression that this dinner was some sort of "public" event; rather, it's just for Board and staff.

At Skills Building in October, we plan to publicly recognize Ken at the ANIN reception, awards and dinner on Halloween night. As part of that celebration, we want to present him with the letters in a nice portfolio. So, my request of you pertained to this, and I wouldn't need those letters until October 1 or so.

I didn't want you to misunderstand via Kay that this weekend was any "official, public" recognition of Ken.

Thank you for your help on this.

Sincerely,

Joseph P. McGinty
Associate Director

110 Maryland Avenue, N.E. Suite 504 Washington, D.C. 20002
VOICE: 202-546-0807 FACSIMILE: 202-546-5103

SHARP LEGISLATIVE RESOURCES
8819 RIDGE ROAD
BETHESDA, MARYLAND 20817
TELEPHONE 301.469.7150

Retire - can we fit this in?

August 18, 1993

Kristine Gebbie
White House AIDS Advisor
HH Humphrey Building
200 Independence Ave, SW
Washington, DC 20201

Dear Ms. Gebbie:

Congratulations on your White House appointment as AIDS advisor! The whole nursing world is excited about your appointment. Please let us all know how we can be of assistance to you in your new position.

I am writing, also, to request that you meet with the 75-100 members of the National Association of Health Care Recruitment who will be here for their first annual "Washington Public Policy Institute." They will be here from Saturday, September 18 through Thursday, September 23. The general sessions will be at the Grand Hyatt Hotel at 1000 H Street, NW, but they will also have a White House briefing, visit several Federal Agency offices, and keep appointments with their own Senators and Representatives. All this during the week of the unveiling of President Clinton's health care plan!

Specifically, we would like you to be our dinner speaker on Wednesday, September 22, 1993 at the Grand Hyatt Hotel. Dinner will be from 7:00pm - 8:00pm. We would like you to make a presentation to the group from 8:00pm-8:30pm.

The National Association of Health Care Recruitment is a 2000 member non-profit organization composed primarily of nurse and health care recruiters employed by hospitals nationwide. About 70% of the members are themselves registered nurses.

I will call your office next week to discuss the details further. I look forward to meeting you soon!

Sincerely yours,

Nancy Sharp

Nancy J. Sharp, MSN, RN
Program Director
Washington Public Policy Institute

UNIVERSITY OF CALIFORNIA, SAN FRANCISCO

CONFIRMATION

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THE GEORGE WILLIAMS HOOPER FOUNDATION
and the
Karl Friedrich Meyer Laboratories

SAN FRANCISCO, CALIFORNIA 94143-0552
FAX: (415) 476-6185

August 25, 1993
FAX

Retina

Christine Gebbie, R. N.
National AIDS Policy Coordinator
750-17th Street, N. W.
Suite 1060
Washington, D.C. 20503

Dear Ms. Gebbie:

I was delighted to learn that you will participate in the Biomedical Research Caucus on September 20. Elizabeth Marincola from The American Society for Cell Biology will contact you with further details, including how to contact the other speakers in order to coordinate the program. My colleagues and I are very grateful for your help.

Sincerely yours,

J. M. Bishop

J. Michael Bishop, M.D.
Professor, Microbiology and Immunology,
Biochemistry and Biophysics;
Director, The G. W. Hooper Research Foundation

JMB/v

cc: E. Marincola, ASCB
Dr. M. Kirschner

FOUNDED 1950

MARTIN E. JANIS & COMPANY, INC.
PUBLIC RELATIONS
919 NORTH MICHIGAN AVENUE • CHICAGO, ILLINOIS 60611
(312) 943-1100

replied by phone — gave him FDA# —

4/29/93

Kristine Gebbie, R.N.
c/o HHS/PHS/OS
2132 Switzer Bldg.
330 C St. SW
Washington, D.C. 20201

Dear Madame Czarina (to be);

I know this is going to sound kind of crazy .... but before I get involved in promoting the enclosed, I was wondering if you've ever heard of it ... and if it really works!

I'm not about ready to turn over years of work and contacts to a company that may be talking out of its " ____ ".

Hope to see you (and speak to you) soon.

Thanks,
Frank

P.S.: of this stuff is legit and it works, I'm going to suggest they donate the gloves to St. Clare's Hospital in New York as a test case. Somehow or another, I don't think O'Connor would approve the contraceptive.

FROM: MARTIN E. JANIS & COMPANY, INC.
PUBLIC RELATIONS
919 North Michigan Avenue
Chicago, ILLINOIS 60611

CONTACT: Darcy Bretz
(312) 943-1100

FOR: **FUTURE MEDICAL PRODUCTS, INC.**

FOR IMMEDIATE RELEASE

PATENT FOR HIV CONTRACEPTIVE AGENT GRANTED TO

FUTURE MEDICAL PRODUCTS, INC.

Hauppauge, NY - April 13, 1993 -- FUTURE MEDICAL PRODUCTS, INC. (NASDAQ:FMPI) a fully-integrated medical products company specializing in the prevention of AIDS and other diseases, announced that the U.S. Department of Commerce's Patent and Trademark office granted patent protection for use of the AIDS inhibitor Butylurea (BU), a member of the alkylurea group of chemicals, as a contraceptive agent.

Independent studies by an FDA-approved laboratory demonstrated the effectiveness of BU as a spermicide, either alone or in combination with much lower concentration of the current commercially used spermicide, Nonoxinol 9. BU, which demonstrated antiviral potency against AIDS-causing HIV, inactivated free viral particles as well as HIV particles associated with the white blood cells, when used in HIV-contaminated blood.

Furthermore, toxicology studies of the AIDS inhibitor BU were successfully completed, including both acute and sub-acute topical sensitization and irritation studies. No side effects were observed at an efficacious HIV killing dosage (0.2 Molar and up to 0.4 Molar) with intravaginal BU foam with or without Nonoxinol 9. Histologic tissue evaluation also showed no apparent damage after exposure to BU with or without low dosages of Nonoxinol 9 (Nonoxinol 9 at commercially used concentration did show histologic changes in the same model system).

Dr. Yair Devash, Chairman of the Board of Future Medical Products, Inc., stated that "the dual activity of BU as an HIV killer and sperm killer results in an attractive contraceptive reagent."

FMPI, which owns the rights to BU antiviral potency, is aggressively pursuing strategic alliances with pharmaceutical companies concerning the BU.

- 30 -

FROM: MARTIN E. JANIS & COMPANY, INC.
PUBLIC RELATIONS
919 North Michigan Avenue
Chicago, ILLINOIS 60611

CONTACT: Darcy Bretz
or Frank Hagan
(312) 943-1100

FOR: **FUTURE MEDICAL PRODUCTS, INC.**

FOR IMMEDIATE RELEASE

FUTURE MEDICAL PRODUCTS, INC. TESTS OF BUTYLUREA AS VIRUCIDE IMPREGNATED IN LATEX GLOVES, SUCCESSFUL

Hauppauge, New York, April 27, 1993 - FUTURE MEDICAL PRODUCTS, INC. (NASDAQ:FMPI) announced that Butylurea (BU), a member of the alkylurea group of chemicals, was coupled to surgical latex gloves in a patented methodology allowing its immediate and protracted release upon contact with body fluids containing the AIDS virus.

Studies with glove prototypes have been completed successfully, showing that predetermined doses of BU resulted in 100% kill of free AIDS virus and AIDS virus in white blood cells. Toxicology studies of the AIDS inhibitor were successfully completed in an FDA-approved independent laboratory, showing that at efficacious concentrations BU showed no dermal irritation or sensitization and no mucosal (eye, vagina) irritation.

FMPI, which owns the rights to BU antiviral potency, is aggressively pursuing strategic alliances with pharmaceutical companies concerning the BU.

- 30 -

6/30

Kristine,

When I read that "damned" article IN USA Today, I fired off the enclosed.

I'm sorry, but I can't stand the media when it "decides" to create situations ... or blow situations so out of porportion.

To hell with the Olympian -- it's "onward and upward", and you have my full support. Clinton chose the best person for the job.

Frank

FAX FAX FAX FAX FAX FAX

TO: BOB PARTLOW
or
JOEL COFFIDIS

THE OLYMPIAN

FROM: FRANK HAGAN JR.

RE: Integrity - or lack of it.

PAGES: 2 (inc. cover)

NOTES:

THE ATTACHED LETTER IS NOT AN EDITORIAL REPLY AND CANNOT BE REPRINTED WITHOUT CONSENT.

FRANK J. HAGAN JR.

FAX #: (206) 754-5408

6/30/93

FRANK HAGAN JR.
60 East Scott St.
Chicago, IL 60610

BOB PARTLOW
JOEL COFFIDIS
"THE OLYMPIAN"

VIA FAX

Gentlemen,

(And I use that term loosely) .... I just finished reading the article you wrote about Kristine Gebbie's administration as Health Secretary in Washington. It will go down in journalistic history along with such great items as the Chicago Tribune's "DEWEY DEFEATS TRUMAN" and the New York Post's "HEADLESS WOMAN FOUND IN TOPLESS BAR". One had the facts all wrong, the other exploited in the name of sales.

Where in your report is the balance? Where are the people who say she isn't racist. Where are the statistics to show the racial balance of her department. What I see is 5 cases, four of which were dismissed. How many charges of racist practices were filed by Health workers in Illinois, California or New York during the same period? Were these people fired because of bad work habits and then charged racism to fight back because they had no defense? Also, where are the quotes from minorities who did work for her that call these "unleveled" charges false and misleading?

I have worked for Kristine Gebbie. I was the media coordinator for the Reagan Presidential Commission on the HIV Epidemic. She was an shining star on that Commission because of her unbiased attitudes and openness. I've seen her in action and she is no racist .. nor is she homophobic or a poor administrator.

When I left the Commission, I returned to a TV career producing hundreds of hours of national and local "Talk TV." I had to book guests on those shows that created balance -- "both sides of the coin" -- because it is not my job to lead a viewer in any direction. After reading your piece on Kristine, I had to write this letter because you say "no one has charged her with racism" ... but you all but did.

Shame on you. You are both an embarrasment to journalism and to anyone who (by their job) is in the position to reach the public through the media.

Frank Hagan Jr.
(312) 943-1100

Frank Hagan Jr.

National Alliance of State and Territorial AIDS Directors

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US Virgin Islands

Executive Director

Julie M. Scofield

July 1, 1993

Kristine M. Gebbie
AIDS Policy Coordinator
c/o Office of Disease Prevention
and Health Promotion
Department of Health and Human Services
Room 2132 Switzer Building
330 C Street, S.W.
Washington, D.C. 20201

Dear Ms. Gebbie:

On behalf of the National Alliance of State and Territorial AIDS Directors (NASTAD), we are writing to extend our congratulations on your appointment by the President as the nation's first AIDS policy coordinator. From the perspective of front line public health officials combatting this epidemic, your appointment is extremely welcome and gives us confidence that a more aggressive federal response to the HIV epidemic is forthcoming.

We are particularly pleased that the President has appointed someone to this critical position with your distinguished record of leadership on HIV issues including work at both the federal and state levels. Your knowledge of the issues and of the critical role of state and local public health officials will help provide the vision and leadership we sorely need.

Your address at our annual meeting in April reminded us of the need to view HIV in the broad context of community public health. This global perspective will be essential to ensuring the implementation of a full continuum of HIV prevention and care services. Of course, we hope that the needs of people with HIV disease are recognized in the President's forthcoming health care reform proposal and that the range of related health needs such as substance abuse and TB are addressed as well.

444 North Capitol Street NW, Suite 617, Washington, DC, 20001 Phone: (202)434-8090 Fax: (202)434-8092

We hope that you will consider us a resource and an ally as you begin the task of forging consensus and building support for a comprehensive national action plan for addressing the HIV epidemic.

We would like to meet with you at your earliest convenience to discuss the challenges we face as state AIDS directors. A small contingent of NASTAD members, including John Auerbach and Bob McAlister, our Chair and Chair-elect, will be in Washington on July 14 and John will be returning on July 19 and 20 in the event these dates are convenient for you. We would be delighted to meet at any future time that can be arranged.

We look forward to working with you on these complex issues. You have our enthusiastic support.

Sincerely,

John Auerbach
Chair

Theodore D. Northup
Vice Chair

Julie M. Scofield
Executive Director

Work with Julie to schedule for Aug or Sept.

Waiting for callback

Outlines

Lambda Publications

Publishers of:

OUTLINES — *A monthly newsmagazine for the gay and lesbian community.*

OUT! — *A twice-yearly resource guide of gay and lesbian supportive businesses, professionals and organizations.*

Nightlines — *A weekly Chicago area calendar, sports, entertainment and humor guide.*

July 9, 1993

Kristine Gebbie
"AIDS Czar"
(fax) 202-690-7054

Dear Ms. Gebbie,

Congratulations on your appointment from President Clinton. From what I've been told by some people who have worked with you in the past, you are an excellent choice for the position.

Our newspaper is a national lesbian and gay publication. Because of the importance of your post to the gay community, I'd like to request a one-on-one interview with you during your next visit to Chicago. If you have only a half-hour, we'll hit at least the major topics and let the community get to know you better.

Frank Hagen has been helping to keep me informed about your appointment and suggested you and I might have a chance to meet when you make it into town. Please let me know if you are open to the idea.

Again, my sincere congratulations. I look forward to talking with you.

Yours truly,

Cathy Seabaugh

Cathy Seabaugh
Staff Writer

Lambda Publications, Inc. ▼ 3059 N. Southport, Chicago, IL 60657 USA
(312) 871-7610 ▼ FAX (312) 871-7609

(312-588-6397)(H)

COURTYARD
Marriott
Dulles South
3935 Centerview Drive
Chantilly, VA 22021
(703) 709-7100

DATE: _____

TO: ATT: KATINA FAX: TO: 202-690-7054

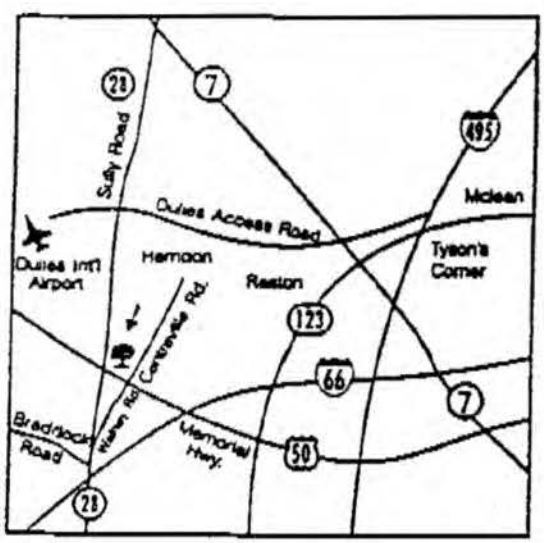
FROM: DR. GREENSPAN FAX: (703)709-8672

Number of pages: 2 (including cover sheet)

DULLES SOUTH

Directions

495 to I-66 West to Rt. 50 West Exit. Proceed
5 miles to Courtyard on right.



LGD BIOMEDICAL GROUP
23 Spring Hill Road · Annandale, NJ 08801 · Tel: (908) 730-8717 · Fax: (908) 735-6842

July 9, 1993

Kristine Gebbie
National AIDS Policy Office
Room 738G
200 Independent Ave. SW
HHH Building
Washington, DC 20201

Dear Ms. Gebbie:

Pardon my informal approach, but I find that that sometimes gets things done in a more appropriate time frame.

I understand that you will be out of your office for most of next week and that Friday, the 16th, might be the only date that you would be available. With that in mind, I am faxing this letter today in an attempt to arrange a short meeting with you for next Friday while I am in Washington for an NIH committee meeting.

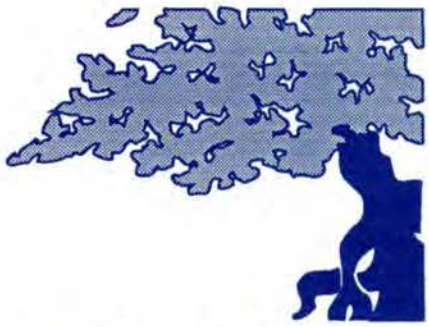
The purpose of getting together would be to discuss your interest in participating in an upcoming workshop/seminar at the NIH regarding some new approaches to treatment for HIV/AIDS.

The workshop itself will be sponsored jointly by Fogarty International Center and the Office of AIDS Research at NIH, AMFAR and possibly CDC. It will be a "closed" session assembly of 25-30 researchers from the NIH, CDC, Harvard, Rockefeller, Pasteur, and others, to discuss mutual interests in these new approaches. Ideally, this meeting will result in establishment of collaboration for ongoing investigations.

I will follow this letter up with a phone call, if not today, then early next week, regarding your availability for a Friday meeting.

Respectfully,

Dr. Howard C. Greenspan
Director, R&D
LGD Biomedical Group



KITSAP COUNTY HIV/AIDS FOUNDATION

109 AUSTIN DRIVE • BREMERTON, WA 98312 • (206) 478-5235

July 12, 1993

Christine Gebbie
200 Independence Avenue SW
Room 738-G, HHH Building
Washington, DC 20201

Dear Ms. Gebbie:

First of all, I would like to say WELCOME ABOARD, and y'all are doing an outstanding job! It makes me very proud to be an American, when such a capable and caring administration is in place. It also gives us PWA's a great sense of hope...to know that you and your staff are ready, willing and able to walk with us, through this crisis. I also find it particularly thrilling that you are from my home state. Your support is very strong here, in "America's Most Livable City (and County)."

Sadly, as with practically every other county in America, Kitsap County has the HIV/AIDS crisis to deal with. All of us, even in the smaller, rural counties of western Washington are doing what we can to educate the public and to take care those of us who are dealing with HIV/AIDS...and their families. So far, we are doing an excellent job. Our caseloads have yet to completely overwhelm the system, but then again we have only seen the proverbial tip of this insidious iceberg. The projected statistics are just as frightening as ever, and that accounts for our solid commitment to quality health-care and specialized services, and to effective HIV/AIDS education and prevention. Our grassroots approach is just about on a one-to-one basis in Kitsap County, thanks to the wonderful HIV/AIDS staff at the Health District, our HIV Speaker's Bureau, and the many *dozens* of volunteers we've been so very blessed with. In Kitsap County, it's People Helping People. We feel that our Kitsap-style is unique, and we hope we have set examples for other smaller counties to learn from.

As you may know, one of our major annual fundraising and educational projects, is the 10K AIDS Pledge Walk, entitled, *"Kitsap County WALKS Against AIDS 1993,"* and it is outlined in the enclosed FYI's and brochure. It is truly a great day of family fun and education, with lots of exercise, music, speeches from many elected officials, the Bremerton Sunday Farmer's Market, local and national celebrities, donating, volunteering, and most importantly, AIDS Awareness. Last year saw our first AIDS Walk, and we were astonished by a turnout of over *forty* teams! The Kitsap County AIDS Foundation takes pride in its community-wide, health-issue focus, and although the awareness is for everyone, our primary target groups are young adults and teenagers. It seems as though we all took the Clinton campaign seriously when, at a Seattle rally last summer, he stated that "we all have to stop thinking of AIDS as a 'dirty word' and deal with it for what it is...a health crisis." Well said, Mr. President. A new slogan to be incorporated into our team and sponsor recruitment and general advertising this year will be a rewording of an often-used old adage, and I'd like your opinion, *"Awareness = Life."*

Teams from school and church groups, civic and social organizations, stores and businesses, and sports clubs have signs, caps or tee shirts printed for the event, walk with their friends and family, and raise pledges for the Foundation. People of all age groups, and from all walks of life, help us get the message to the public, that being...that HIV/AIDS is *preventable!*

We always invite special guests from show-biz, sports and politics to help us out. Our guests last year included that legendary northwest TV clown, J.P. Patches, KING-TV's Pat Cashman, the Seahawks Seagals, six great bands, local health officials, and a great showing by County Commissioners Win Granlund and John Horsely, State Rep. Paul Zellinsky, and Congressman Norm Dicks, just to name a few. This year's guest list is about the same, with the addition of a few film stars, AND the Bremerton Sunday Farmer's Market.

It is my personal wish that some of our leadership, from Olympia to the *other* Washington, join up with our forty-plus teams again this year. Indeed, many of our supportive elected officials, or their representatives, showed up last year, to say a few words and to meet and greet with the public, and some did the Walk as well.

Not surprisingly, political responses for this year's event have been great, with interest expressed by those named above, and from Rep. Maria Cantwell, Rep. Cal Anderson, Governor Mike Lowry, and even a very sweet letter of support from Tipper Gore. We have requested a phone call, or a brief prerecorded audio cassette from The White House, to give a last-minute pep talk for our walk participants. Such a call would mean so much to us out here "in the trenches," and would really top-off an otherwise perfect speech schedule.

You are also cordially invited to attend our event if at all possible, or to share support via the phone link or cassette or letter. And of course, you'd be invited to say a few words, should you have the time to attend our wonderful event.

Who am I? I'm a pretty regular guy of 41, a retired musician and sales rep, a father, soon to be a grandpa, a regular with the Bremerton-Kitsap County Health District HIV/AIDS Speaker's Bureau, a volunteer, and an eight-year AIDS survivor. My story is just one out of 1.5 million. I care passionately about HIV/AIDS education and health-care issues that affect America, but unfortunately I only have enough energy to help out around here...and there's certainly plenty to do.

Thanks for your time and consideration, take good care, and keep up the great work! I hope to shake your hand one day, and look forward to your participation with *"Kitsap County WALKS Against AIDS 1993."*

Respectfully,

Herb B. Deisler
Fundraising Coordinator
The Kitsap County AIDS Foundation
(206) 373-1262 res.

Walk date on next page
for: Sept. 12th

(res.) 92-I McNeal Avenue
Bremerton, Washington 98312

Dear 1992 Team Leaders & Friends Of The Kitsap County AIDS Foundation:

The Kitsap County AIDS Foundation is pleased to announce KITSAP COUNTY WALKS AGAINST AIDS 1993 will be taking place SUNDAY, SEPTEMBER 12th, 1993. EVERYONE did such AN OUTSTANDING JOB last year, and we are sure 1993 will be even BIGGER & BETTER!

But in order to do so, we need YOUR help! It was YOU who set the precedent with the 1992 Walk. YOU made it such a GREAT SUCCESS! HIV/AIDS Awareness, Education, Prevention & Services in Kitsap County were so greatly enhanced by YOUR pledges, YOUR compassion & concern, and by YOUR 1992 WALK THROUGH BREMERTON! Please, let's all get together for an ENCORE PERFORMANCE!

Betty Griggs
President
Kitsap County AIDS Foundation



Kitsap County WALKS Against AIDS 1993

- *WE ARE BIGGER & BETTER FOR 1993! The Kitsap County AIDS Foundation is extremely happy to be sharing the beautiful Bremerton Waterfront Boardwalk Park & Marina with the Bremerton Mainstreet Association's Sunday FARMER'S MARKET, SUNDAY, SEPTEMBER 12TH, 1993!*
- *The BREMERTON SUNDAY FARMER'S MARKET is always a delightful variety of Food and Beverage Booths; Local & Northwest Artists & Craftspeople creating and displaying their unique one-of-a-kind clothing, jewelry; folk art; local specialty food products; informational booths; exhibits & demonstrations.*
- *A Variety Of Attractions & Entertainment; Live Music & Fun For The Whole Family; Meet & Greet VIP Guest Speakers; Television, Sports, Film & Radio Personalities.*
- *A Great Time, A Good Cause, An Outstanding Day!*

Here's How YOU Can Participate:

- *BECOME A TEAM LEADER! Get your health-conscious friends together to DO THE WALK; each walker is asked to raise as much money as they can! GATHER PLEDGES from friends, family, neighbors, co-workers, friends from your church or school, your civic, sports & social organizations, people you do business with. Challenge Each Other...Challenge Yourself...Challenge HIV/AIDS.*
- *We are starting to recruit for Teams NOW...to give us all summer to build our TEAMS, provide trainings for Leaders, if they wish, and to reach more SPONSORS. (This year's prize structure will be announced at trainings).*
- *MAIL this RSVP in TODAY for a Complete Team Leader Kit and Team Leader Training Information! It's good to organize early, but day-of-event entrants and singles are always welcome! Please return the coupon to get on our Team Leader Kit Mailing List, or give us a call. Then call your friends...*

Won't You Please Join Us Once Again As Kitsap County WALKS Against AIDS?

KITSAP COUNTY WALKS AGAINST AIDS 1993 ~ TEAM RECRUITMENT & TRAINING ~ BKCHD OFFICE
109 Austin Drive, Bremerton, WA 98312 ~ Or Call 478-5235 or 1-800-874-2437 for more info.

□ *Mail My 1993 Team Leader Kit To:* □ *Check Here If New Address & Phone.*

Name _____ *Address* _____ *Phones* _____

Team Name? _____ *Representing?* _____ *How Many?* _____

✓ *Please Vote For Your Favorite Team Leader Training Dates:* □ *June*_____ □ *July*_____ □ *August*_____ □ *September*_____

✓ *Several Team Leader Training Sessions Based On Your Votes Will Be Announced & Held At The Health District During The Summer.*

Would Your Organization Or Company Like A Speaker To Come Talk About The Walk With Your Staff? Just Give Us A Call...

Event Time & Place:
SUNDAY, SEPTEMBER 12TH, 1993
Registration & Speakers Begin At 8:30AM
10K AIDS Pledge Walk Begins At 10:00AM
BREMERTON WATERFRONT BOARDWALK PARK
Adjacent To The Bremerton Farmer's Market

Please Clip & Return Your RSVP Coupon TODAY!
KITSAP COUNTY WALKS AGAINST AIDS 1993
TEAM RECRUITMENT & TRAINING STAFF
Bremerton-Kitsap County Health District Office
109 Austin Drive ~ Bremerton WA 98312
(206) 478-5235 ~ 1-800-874-2437

©1993 KCAF

KCAF
109 Austin Drive
Bremerton, Washington 98312

You're Invited!

RSVP Today!



So far we're staying ahead of the game in Kitsap County...and we're doing an excellent job...and so are YOU!

→ *Every dollar raised in 1992 has been well-invested in the healthy future of Kitsap County, and has helped to fund...*

→ *Client Services: Things such as medical & dental needs not covered by other health-care programs; help with unforeseen living expenses; child care; help with transportation & chores; "Meals That Heal." So many things, both large & small, others may take for granted are often just too much for many clients & their families to afford.*

→ *Community Services: Multi-level educational & prevention programs; public informational presentations; volunteer trainings. And that's only the beginning...*

→ *Kitsap County offers support groups for clients, families, friends, spouses, bereavement, and a wide range of counseling is available. The Bremerton-Kitsap County Health District offers complete confidential STD testing & counseling.*

→ *The Kitsap County AIDS Task Force works closely with the public at all levels to meet the growing needs of our citizens. AIDS has the unfortunate ability to bankrupt its sufferers physically, emotionally, spiritually & financially. Sadly, here in Kitsap County, across the USA, and indeed, throughout the World, We Are ALL Living In The Age Of AIDS.*

→ *The statistics are grim, but the forecast holds promise... There is HOPE for a healthy future...for our kids, our friends & others who are about to come face-to-face with the Health Crisis Of The Century...AIDS IS PREVENTABLE...and after we WALK about it, we TALK about it!*

July 12, 1993 **Press Release/FYI #3**

"KITSAP COUNTY WALKS AGAINST AIDS 1993

A 10K Pledge Walk To Benefit The Kitsap County AIDS Foundation
And To Emphasize Community HIV/AIDS Awareness, Education & Prevention
Team Registration & Guest Speakers Begin 8:30AM ☆ Walk 10:00

PLUS! The Kitsap County AIDS Foundation Is Proud To Hold This Year's Event In Conjunction With...

☆ **THE BREMERTON SUNDAY FARMER'S MARKET** ☆

The Craftspeople & Artisans, The Food & Beverage, The Produce, And
The Waterfront Atmosphere Of The Fabulous Weekly Market! BIGGER THAN EVER!

...AND...

☆☆☆ **"ROCK AROUND THE DOCK '93"** ☆☆☆

A Variety Of Live Music at the 1st St. Dock "Electric" Stage & the Market "Unplugged" Stage;
VIP Guest Speakers, & Personal Appearances By TV, Radio, Politics, Film & Sports People,
Meeting & Greeting The Public All Day ☆ Produced By The Foundation As A BIG THANK-YOU!

☆☆☆ **Entertainers & Personal Appearances To Date:** ☆☆☆

Acoustic Allstars *Some of the NW's Finest "Unplugged" Music*
Sonick Blue *Classic & Contemporary Rock & Roll*
Bill Brown & The Kingbees *Rocking Rockin' Rhythm & Blues*
That Legendary Northwest TV Clown **J.P. Patches**
Actor/Author of Newly-Published "Here On Gilligan's Isle" **Russell Johnson**
From KING-TV's "Almost Live!" and KING-AM's "Morning Show" **Pat Cashman**
The NW's #1 Cheerleading Squad **The Seattle Seahawks Seagals**

NEW ADDITIONS FOR FYI #3 (as of 7/10/93)

KITSAP TRANSIT
Offers Free Fares To Everyone
En Route To The Boardwalk
Wearing The Red Ribbon
CAR POOLING IS SUGGESTED!
Old Bremerton JC Penney Lot Is Open
Teams! Use Park & Ride Lots!
BKCHD INFO BOOTH
AIDS Quilt Panels: The NAMES Project
HIV/AIDS Education, Information & Brochures
Public & Staff One-On-One Discussions All Day
Autographs/Book Signings/Tee Shirts/Pins/Buttons
HONORARY 1993 CO-CHAIRMAN:
State Senator Betti Sheldon
SCHEDULED SPEAKERS TO DATE:
State Senator Betti Sheldon
Bremerton Mayor Louis Mentor
Kitsap County Commissioner Win Granlund
Dr. Melvin E. Belding, Kitsap Physician's Service
Dr. Willa Fisher, BKCHD Director
Speakers From The Congress Of The United States
And The Washington State Legislature - TBA In August
(A Half-Dozen VIP's Are On Tap, Schedules Permitting)

We do not advertise politician's attendance, we just Hope

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Christine Gebbie
200 Independence Avenue SW
Room 738-G, HHH Building
Washington, DC 20201

355 21st Place
Santa Monica, CA 90402-2503
July 20, 1993

Kristine M. Gebbie
606 Lilly Road N.E., Apt. 723
Olympia, Washington 98506

Dear Kris,

It was a great pleasure to hear that you have been appointed as Coordinator of AIDS Programs and Services. You are so well qualified and have the ability to change the course of this epidemic. I am glad that you will be there to meet this challenge.

I can't help but offer a thought for the day. As a microbiologist, I appreciate the safety that good barrier systems can offer in preventing contact with contamination. Surely our nation can build a better flexible barrier for use in condoms, gloves for health care professionals, etc. For those who want to stop the spread of AIDS from person to person, a better barrier system could save lives. It is ridiculous to have to fear contact with HIV because of too porous, easily torn condoms and gloves. While I see a major thrust in research on the virus, the patients' immune system, prevention by education, I see much less work on developing better simple barrier systems.

On the UCLA front, we have our own challenge. Vice Chancellor Andrea Rich has proposed a "health sciences initiative" which would cut the budget of our school by 40-50% beginning in 1994. She proposes that we cut the undergraduate program and downsize the graduate program. This happens just as we are the fifth ranked school of nursing in the U.S. News and World Report national survey. We find ourselves becoming more political and outspoken daily. All of this comes as President Clinton appears to be ready to announce a national health plan which includes a strong role for nursing. I know that our school of nursing is not alone, nationally, in being the target for budget cuts. These are difficult times.

We are so proud of your accomplishments and President Clinton's recognition of your leadership ability in this new appointment. You have our very best wishes for success. If ever I can help you in any way, please feel free to call upon me. Very best wishes in your new role.

Sincerely yours,

Donna

Donna Vredevoe

July 22, 1993

Ms. Kristine Gebbie
National AIDS Policy Office
200 Independence Avenue, SW
Washington, DC 20201

Dear Ms. Gebbie:

Thank you for speaking to me on the phone today. I hope that you will be able to make it to AIDSWALK/Washington, and be able to speak briefly, as well as use your influence to get the President, Vice President or First Lady to speak at the Walk.

As you know, AIDS is a terrible crisis facing our nation. The only way to meet this disease head on is to combat it through education to the uninfected and services for those who are infected. I believe AIDSWALK/Washington accomplishes both goals

AIDSWALK/Washington, which will be held on September 18th in Washington, DC. raises over a million dollars and benefits over 20 AIDS service organizations throughout the metropolitan Washington area. This year, we anticipate over 30,000 individuals to participate. The Walk will begin and end this year on the Ellipse. Last year there were over 65 print and broadcast placements about the walk, including national coverage on CNN.

We have already requested consideration by the President for participation in the Walk because we believe that his participation will send an important message concerning AIDS to the nation in addition to underlining his commitment to health care reform. We would be grateful if you and the President could speak briefly at the beginning of the Walk at 9:45 AM on September 18th or at the end of the Walk at 2:00 PM.

Mr. Clinton's participation could make a difference in thousands of dollars for AIDS services in the Washington, DC, area. As a resident of this community, we do hope Mr. Clinton will join his fellow

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Washingtonians at AIDSWALK. You may reach me at 202-797-3508.

Thank you so much,

John Miles
Director
AIDSWALK/Washington

STATE OF TEXAS
OFFICE OF THE GOVERNOR
AUSTIN, TEXAS 78711

ANN W. RICHARDS
GOVERNOR

July 26, 1993

PHOTOCOPY
MISC. HANDWRITING

Kristine Gebbie, Ph.D
National AIDS Policy Coordinator
Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Dr. Gebbie:

Medical students at the University of Texas Health Science Center at Houston have asked me to pass along to you their invitation to speak in September.

I join them in welcoming you to Texas!

But because you have one of the most important jobs in the federal government, if you cannot come at this time, we will certainly understand about the pressing demands on your calendar.

Please know how much we all support your efforts to coordinate the fight against AIDS and HIV disease.

Sincerely,

Ann Richards

ANN W. RICHARDS
Governor

AWR/dt

enclosure

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John D. Brown
2111 Hollyhall #4811
Houston, TX 77054
(713) 795-4662

re: will be in San Antonio in August; anyway to coordinate for that date.

July 19, 1993

GOVERNOR ANN RICHARDS
% JANET ALLEN-SHAPIRO
Executive Office of the Governor
P.O. Box 12428
Austin, TX 78711

Dear Governor Richards:

I am a second-year medical student at The University of Texas Health Sciences Center at Houston and the seminar director for our medical school's AIDS Awareness/Education committee for the 1993-1994 school year. We are coordinating a series of 10 lectures covering diverse topics regarding the HIV virus and its associated immunodeficiency syndrome ranging from its biochemistry to its socio-economic impact.

I am writing for your assistance in procuring President Clinton's newly appointed AIDS Czar, Kristine Gebbie, Ph.D. to open this series of lectures here at the medical school. I am coordinating the series with Dr. Nancy Hansel, Ph.D., Vice-Chair, Dept. of Family Practice (713)792-5862. We would like to request her presence the second week of September to lecture on the state of the epidemic and how we as the physicians of the next century can hope to prepare our profession and our patients. However, we are flexible and any time during the month of September would be fine. For your convenience, Ms. Gebbie may be reached at the following address and telephone number:

Kristine Gebbie Ph.D.
AIDS CZAR
Dept. of Health and Human Services
200 Independence Avenue S.W.
Washington, DC 20201
(202)619-0257

Please forward a copy of the Governor's signed request for my records.

Sincerely,

John D. Brown

For: Sept. Second Week



STATE OF TEXAS
OFFICE OF THE GOVERNOR
AUSTIN, TEXAS 78711



Kristine Gebbie, Ph.D
National AIDS Policy Coordinator
Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

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A Project of the PWA Coalition of Dallas, Inc.

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July 27, 1993

Mr. Keith Harlin
Grants Manager
Dallas County Welfare Department
2377 Stemmons Freeway, Suite 200
Dallas, TX 75207-2710

Dear Mr. Harlin:

This letter acknowledges your letter of July 22, 1993 citing a response from an individual with the Health Resources and Services Administration (HRSA), and your subsequent transmittal of that correspondence, and your demand for the revision of our sliding scale fee schedule. We have reviewed the letter from Ms. Libby Hartnett, Grants Management Specialist, and conclude that it states absolutely nothing concerning our rental schedule, which meets all requirements established by the Department of Housing and Urban Development (HUD) as established by the Texas Department of Housing and Community Affairs. The response wholly ignored the issues that I raised to her in my letter of June 11, 1993, which has not been acknowledged. We want no part of a systemic disempowerment of persons living with AIDS, and we will not make programmatic changes without further clarification from HRSA and HUD.

Once again we are torn between government bureaucrats pulling us in two directions. Our attempts to meet the growing need for housing with assisted living facilities and other programs that stress empowerment of people living with HIV/AIDS and their families are imperiled by a complete lack of coordination between HRSA and HUD government agencies. The failure of our community to engage in any serious long term strategies that would provide a framework and perspective for dealing with the many short-term challenges housing providers and developers face will bear fruit only in the collapse of community based service delivery.



• Housing
• Education
• Advocacy

I find it completely ironic that on the same day I received your letter mandating our transformation from an assisted living facility to a welfare motel, to have received a copy of HRSA's Technical Assistance Topic 4, *Housing and Residential Services for People With AIDS* (May 1993) disseminating information on HUD programs "intended as a primer for Ryan White CARE Act Title I and Title II grantees and their service providers" [1] in order to acquaint them with programs that they cannot possibly qualify for because of your conclusion based on Ms. Hartnett's letter.

Your posture on this issue directly impacts the development of our Shelter Plus Care/Hillcrest facility, our SPNS multi-family project, our HOPWA award and upcoming application, and our Section 8 set asides with the Dallas Housing Authority, not to mention the programmatic consequences that result. We are in suspense until this matter is resolved, once and for all.

The financial integrity of this agency and the responsibility we have toward individuals we presently serve is more important than risking additional entanglements with competing governmental entities that provide such mixed signals which threaten our mission and our fiscal viability. Unfortunately, the delays this situation will cause on these projects will impact people's lives - - but this appears to be just another tragedy in the history of AIDS in America, and AIDS in Dallas.

We appreciate the leadership and advocacy demonstrated by our Administrative Agent in this matter. We have grown accustomed to indifference.

Very truly yours,

Don Maison

DJM:m

c: Ms. Libbie Hartnett, HRSA
Mr. David Vos, HUD
Mr. Steven Young, HRSA
Ms. Eda Valero Figueria, HRSA
✓ Ms. Kristine Gebbie, AIDS Policy Coordinator

---

1 Technical Assistance to Ryan White CARE Act Grantees, *Housing and Residential Services for People with AIDS/HIV,* May 1993, p 1.

THE WHITE HOUSE
WASHINGTON

8/2/93

To: Retina Holmes
From: Pam Barnett
Spec. Asst. to
First Lady
456-2369

Please be sure Dr. Gebbie gets this copy of Mrs. Clinton's letter to Mary Fisher.

thanks

Pam

[redacted]

THE WHITE HOUSE

WASHINGTON

July 30, 1993

Ms. Mary D. Fisher
3075 Hampton Place
Boca Raton, Florida 33434

Dear Ms. Fisher:

Thank you for taking the time to write to me. I apologize you didn't receive a response to your letter earlier, but the high mail volume sometimes means important letters like yours don't receive the prompt attention they deserve.

Thank you also for including your remarks to the University of Michigan Social Work Conference. Your eloquent reminder of the dignity and recognition due everyone no matter what his or her circumstance in life is a message that needs to be heard and understood widely.

As the health care reform debate moves forward, one of our goals is to remove the obstacles that HIV/AIDS patients must overcome before they receive health care services. HIV/AIDS related illnesses should be treated like any other disease with respect to insurance co-payment plans and health care providers. But, most importantly, the AIDS crisis simply can't be left to those stricken to fight this disease alone -- it is a fight we must all join.

I appreciate your generous offer to share your experience and wisdom. I hope that in the near future we'll have that opportunity. In the meantime, if you would be willing, I would appreciate your meeting with Kristine Gebbie, President Clinton's new AIDS Policy Coordinator. Retina Holmes can be reached at (202) 690-5471 to set up the meeting.

I admire your courage and honesty in facing the many ugly realities of AIDS and the dignity with which you've handled it all.

Sincerely yours,

Hillary Rodham Clinton

Hillary Rodham Clinton

bcc: Kristine Gebbie

B.P.S. My friend, Elizabeth Glazer, loved her meeting with you. I hope you'll be able to meet with Mary Fisher, also. I, too, look forward to a visit.

KANSAS HEALTH FOUNDATION

August 2, 1993

Kristine Gebbie
National Aids Policy Coordinator
Office of National Aids Policy
Executive Office of the President
Washington, D.C. 20500

Dear Kristine:

Wanted to let you know that, per your recommendation to Marni Vliet, I have contacted Dr. Lester Wright regarding serving as a consultant on strategic planning for the Kansas Department of Health and Environment.

Dr. Wright is sending me his vitae and I'll be meeting with Bob Harder, Secretary of the Kansas Department of Environment soon to discuss this possibility.

Enjoyed meeting you last month and wish you the best of luck in your new position.

Sincerely,

Steve Coen

Steve Coen
Program Officer

SC:nm

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THE GAY AND LESBIAN COMMUNITY'S PRESIDENTIAL TRANSITION PROJECT

**********COALITION '93**********

August 5, 1993

Kristine Gebbie
Director, Office of AIDS Policy
Executive Office of the President
750 17th Street, NW Suite 1060
Washington, DC 20500

Dear Ms. Gebbie,

Thank you for meeting with me in regards to the four candidates we are recommending for consideration as members of your staff. We would also like to offer our support in any other way we can in order to help you achieve your goals.

Please feel free to let me know if there is anything I can personally do or a volunteer role I could play in any advisory body you set up.

Below is my personal contact information. I look forward to seeing you again in the near future.

Sincerely yours,

Andrew E. Barrer, Ph.D.
1712 22nd Street, NW
Washington, DC 20008
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Volume 17 Number 2 August 1993

Clinical Infectious Diseases

AN OFFICIAL PUBLICATION OF THE INFECTIOUS DISEASES SOCIETY OF AMERICA

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Rapid Response of AIDS-Related Bacillary Angiomatosis to Azithromycin

Luis G. Guerra, Carlos J. Neira, Darius Boman, Hoi Ho, Paul R. Casner, Marc Zuckerman, and Abraham Verghese

From the Divisions of General Internal Medicine and Infectious Diseases and the Department of Pathology, Texas Tech University Health Sciences Center, El Paso, Texas

A 28-year-old male with AIDS and a CD4 cell count of 100/mm^3 presented with fever, hepatosplenomegaly, weight loss, and multiple, polypoid, angiomatous lesions on his face. It was determined by means of biopsy that the lesions were due to bacillary angiomatosis. The patient was treated with oral azithromycin (1 g daily as a single dose). Rapid resolution of the skin lesions was noted. After 1 week of therapy, diminution in the size of the liver and spleen was noted. The only significant side effect noted was diarrhea, which was controlled with symptomatic therapy.

Bacillary angiomatosis is a newly described bacterial infection most commonly seen in patients with AIDS [1, 2]. Clinical manifestations include a variety of cutaneous lesions, typically multiple subcutaneous nodules or papules. Disseminated bacillary angiomatosis with involvement of the liver, spleen, and bone marrow has also been described [3–5]. Recently, Spach et al. reported the case of a patient with AIDS and intracerebral bacillary angiomatosis [6].

A number of antimicrobial agents have been used with variable clinical success. Stoler et al. [7] successfully treated a patient with oral erythromycin. Others have used doxycycline [4, 5] and isoniazid and rifampin [8], resulting in resolution of skin lesions and improvement of constitutional symptoms.

Azithromycin, a new macrolide, has the unique property of achieving a concentration within macrophages that is many times that achieved in serum [9]. Azithromycin is being studied and appears promising for treatment of infections characterized by intracellular parasitism, such as *Mycobacterium avium–Mycobacterium intracellulare* infections and toxoplasmosis [10]. We report a case of bacillary angiomatosis in which the cutaneous and visceral lesions responded rapidly to azithromycin.

Case Report. A 28-year-old homosexual male with a 1-year history of AIDS presented to the Texas Tech HIV Clinic in El Paso, Texas, with complaints of fever, night sweats, fatigue, and a 10-kg weight loss over an 8-month period. Two months before admission the patient had noted an erythematous papular rash over his face as well as several pedunculated lesions on the back of his ear. On admission he had a temperature of 103.5°F, heart rate of 120, and blood pressure of 109/51 mm Hg. Multiple polypoid, angiomatous lesions were concentrated around his lips. Pedunculated angiomatous lesions were seen on the back of his ears (figure 1). Examination of his oral cavity showed evidence of candidiasis, and findings on examination of the heart were normal except for tachycardia. Decreased vocal fremitus and dullness to percussion were noted over the left lung base. The liver was palpable 5 cm below the right costal margin, with a total span of 20 cm. The spleen was readily palpable 4 cm below the left costal margin.

Laboratory examination revealed the following values: peripheral leukocytes, 6,300/mm^3; platelets 154,000/mm^3; hematocrit, 20.7%; CD4 lymphocytes (absolute count) 100/mm^3; alkaline phosphatase, 469 IU/L. A chest roentgenograph showed left pleural effusion, with some underlying infiltrate in the left base. A computed tomographic study of the abdomen demonstrated hepatomegaly and splenomegaly with multiple rounded, low-attenuation lesions in both organs (figure 2, *left*). Blood cultures were done by means of the lysis centrifugation method and did not reveal any growth after prolonged incubation. Warthin-Starry staining of a shave biopsy specimen of one of the cutaneous angiomatous lesions and of bone marrow and liver biopsy specimens revealed bacillary organisms that were consistent in appearance with organisms seen in previously reported cases of bacillary angiomatosis and AIDS.

After we obtained informed consent and approval from the institutional review board, the patient received azithromycin (1 g daily, as a single oral dose). Within 3 days of the institution of therapy, rapid resolution of the skin lesions was noted. Despite subjective clinical improvement, the patient continued to have a temperature of up to 104°F during the 2 weeks in which he received azithromycin. By this time no trace of the skin lesions was visible, the liver was barely palpable below the costal margin, and the spleen had regressed in size. Four weeks after admission, computed tomography revealed that the areas of low attenuation in the liver and spleen had resolved (figure 2, *right*).

An extensive search for other causes of fever by means of multiple blood cultures, stool cultures, bone marrow examination and cultures, sputum culture, sputum silver stain,

Received 28 October 1992; revised 27 January 1993.

Reprints or correspondence: Dr. Abraham Verghese, Department of Internal Medicine, 4800 Alberta Avenue, Texas Tech University Health Sciences Center, El Paso, Texas 79905-1298.

Clinical Infectious Diseases 1993;17:264–6
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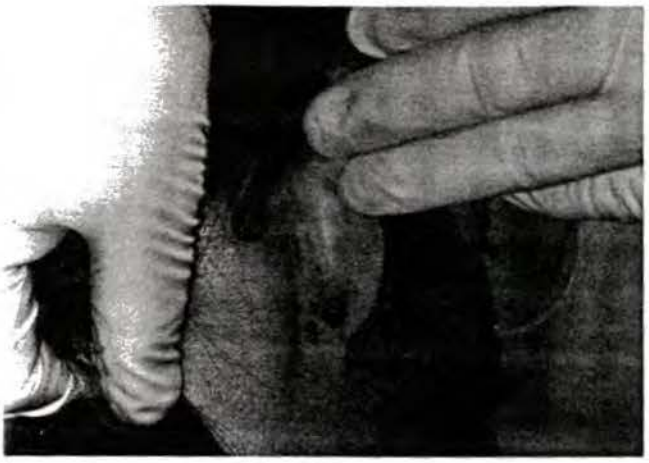


Figure 1. Multiple pedunculated angiomatous lesions on the back of the ears before treatment with azithromycin.

fungal and mycobacterial cultures, and pleural fluid cultures revealed nothing. His fever subsided after 2 months.

At a 10-month follow-up, there was no trace of skin lesions suggestive of bacillary angiomatosis, and neither the liver nor the spleen was palpable. Repeated blood cultures performed by lysis centrifugation have continued to yield no growth.

Bacillary angiomatosis is a vascular proliferative disease with both cutaneous and visceral manifestations that occurs in patients with AIDS as well as in other immunosuppressed hosts. A rickettsia-like bacillus, *Rochalimaea henselae*, has been identified as the causative agent [10]. If not treated, the condition can be rapidly fatal [2].

The fact that case reports have described response to erythromycin therapy [3, 8, 11–13] suggested that a response would likely be seen to therapy with azithromycin. For the majority of patients with bacillary angiomatosis who are described in the literature, the condition involves the skin, although a few cases with visceral involvement have occurred. The skin lesions reportedly disappear from within 3 days to several weeks after institution of antimicrobial therapy. Responses noted in patients with disseminated bacillary angiomatosis have included a decrease in the size of the liver and spleen and complete resolution of the low-attenuation defects [3, 4].

Our patient responded promptly to treatment with azithromycin; we noted complete resolution of the skin lesions, diminution in the size of the liver and spleen, and resolution of the low-attenuation abnormalities seen on imaging of the liver and spleen. Azithromycin was well tolerated. Diarrhea, the only side effect, responded to symptomatic therapy. Despite the response of skin and visceral lesions, no remission of fever was noted for 2 months. These findings are similar to those in the case reported by Schwartzman et al. [5] in which gradual resolution of skin lesions and a decrease in the size of the liver were noted but the patient remained febrile.

Since bacillary angiomatosis is a relatively uncommon condition, a clinical trial for comparing different antibiotic treatments will be exceedingly difficult unless it is a multicenter study. Single case reports that describe response (or lack of response) to particular therapeutic agents are of importance to the clinician. The response of our patient's skin lesions and organ enlargement to therapy was prompt. Azithromycin may be considered as an alternative agent for treatment of bacillary angiomatosis; there are theoretical advantages to its use by virtue of its ability to concentrate in tissue.

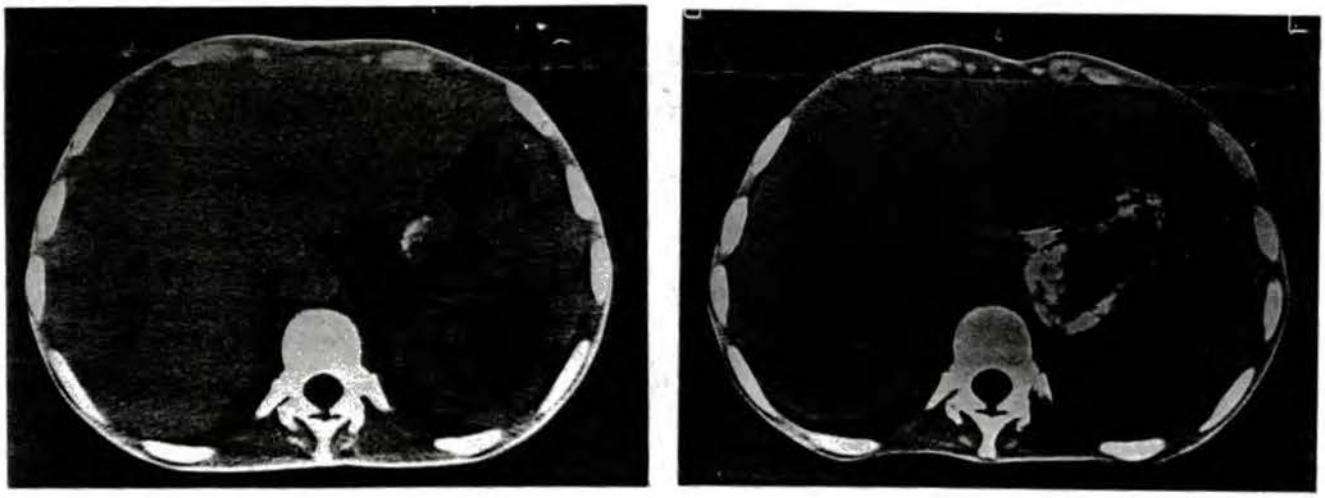


Figure 2. Computed tomography of the abdomen demonstrating hepatic and splenic enlargement with multiple rounded, low-attenuation lesions in both organs (*left, before treatment*) and resolution of attenuation lesions in the liver and spleen (*right, 4 weeks after initiation of treatment*).

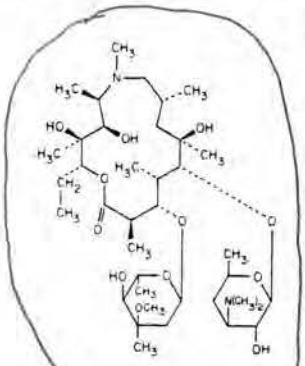
Acknowledgments

The authors thank Della Nabhan, P.A., Patricia Bayles, R.N., the staff of the Texas Tech Virology Clinic, and the Southwest AIDS Committee for their assistance. We also thank Maria Morales for secretarial help.

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Azithromycin



azithromycin

Description

Azithromycin is a semisynthetic macrolide antibiotic. The drug differs structurally from erythromycin by the addition of a methyl-substituted nitrogen atom into the lactone ring, and thus is a member of the macrolide subgroup of azalides. Azithromycin is commercially available as the dihydrate; potency is calculated on the anhydrous basis.

Uses

Azithromycin is used orally for the treatment of mild to moderate upper and lower respiratory tract and skin and skin structure infections caused by susceptible organisms. The drug also is used for the treatment of nongonococcal urethritis or cervicitis caused by *Chlamydia trachomatis*.

In the treatment of mild to moderate upper respiratory tract infections (e.g., pharyngitis, tonsillitis) caused by susceptible *Streptococcus pyogenes*, azithromycin is an alternative to first-line therapy (e.g., a natural penicillin) and generally is reserved for patients who are intolerant of such therapy. For mild to moderate lower respiratory tract infections, azithromycin is used for the treatment of acute bacterial exacerbations of chronic obstructive pulmonary disease secondary to susceptible *Branhamella* (*Moraxella*) *catarrhalis*, *Haemophilus influenzae*, or *Streptococcus pneumoniae* and for mild cases of community-acquired pneumonia caused by susceptible *S. pneumoniae* or *H. influenzae* when oral therapy is considered appropriate. The drug also is used for the treatment of uncomplicated skin and skin structure infections caused by *Staphylococcus aureus*, *S. pyogenes*, or *S. agalactiae*; abscesses usually require surgical drainage.

The manufacturer warns that azithromycin should *not* be used for the treatment of pneumonia that is considered unsuitable for outpatient oral therapy because of the severity of the infection (e.g., moderate to severe) or when risk factors such as nosocomially acquired infection, known or suspected bacteremia, or a clinically important underlying health problem that might compromise the patient's ability to respond adequately (e.g., immunodeficiency, asplenia) is present. In addition, the manufacturer warns that the drug should *not* be used for the treatment of pneumonia in patients requiring hospitalization or in geriatric or debilitated patients.

When used for the treatment of mild to moderate chlamydial nongonococcal urethritis or cervicitis at the usual dosage, azithromycin alone should not be relied on for effective therapy against possible concomitant syphilis or gonorrhea. In addition, the possibility that the drug may mask or delay development of the signs and symptoms of incubating gonorrhea or syphilis should be considered, and appropriate serologic tests for syphilis and cultures for gonorrhea should be performed prior to initiating azithromycin therapy. Appropriate antiinfective therapy and follow-up should be initiated if either infection is confirmed.

Dosage and Administration

■ Administration

Azithromycin is administered orally. Because food decreases both the rate and extent of GI absorption of the drug, azithromycin should be administered at least 1 hour before or 2 hours after a meal.

■ Dosage

Dosage of azithromycin, which is commercially available for oral use as the dihydrate, is expressed in terms of anhydrous azithromycin. Azithromycin is recommended for use in adults and children 16 years of age or older; the manufacturer states that safety and efficacy in younger patients have not been established.

The usual dosage of azithromycin for the treatment of mild to moderate pharyngitis or tonsillitis (as second-line therapy) or acute bacterial exacerbations of chronic obstructive pulmonary disease, mild community-acquired pneumonia, or uncomplicated skin and skin structure infections is 500 mg given as a single dose on the first day of therapy, followed by 250 mg once daily for 4 additional days of therapy (total cumulative dose: 1.5 g administered over 5 days). For the treatment of chlamydial nongonococcal urethritis or cervicitis, the usual dosage of azithromycin is 1 g administered as a single dose.

Azithromycin dosage adjustment does not appear to be necessary for geriatric patients with normal renal and hepatic funtion.

■ Dosage in Renal and Hepatic Impairment

While the manufacturer makes no specific recommendations for azithromycin dosage adjustment in patients with hepatic impairment, caution should be exercised in such patients since the drug is eliminated principally via the liver. Caution also should be exercised in patients with renal impairment since experience with azithromycin use in such patients is limited.

SumMon® (see Users Guide). For additional information on this drug until a more detailed monograph is developed and published, the manufacturer's labeling should be consulted. It is *essential* that the labeling be consulted for detailed information on the usual cautions, precautions, and contraindications.

Preparations

Azithromycin

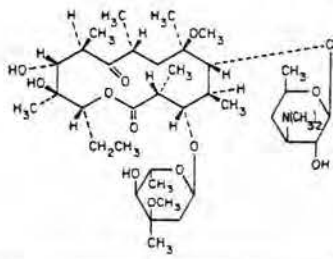
Oral

Capsules	250 mg (of anhydrous azithromycin)	**Zithromax®**, Pfizer

Selected Revisions January 1993, © Copyright, May 1992, American Society of Hospital Pharmacists, Inc.

Clarithromycin

A-56268
6-*O*-Methylerythromycin
TE-03



Chemistry and Stability

■ Chemistry

Clarithromycin is a semisynthetic macrolide antibiotic. The drug differs structurally from erythromycin only by the methylation of a hydroxyl group at position 6 of the lactone ring. The presence of a methyl group at this position minimizes acid-catalyzed degradation of clarithromycin to the inactive 8,9-anhydro-6,9-hemiketal and subsequently the 6,9,9,12-spiroketal products; some erythromycin degradation products (e.g., the anhydrohemiketal form) have been shown to increase GI motility and may contribute to the adverse GI effects of that drug.

Clarithromycin occurs as a white to off-white crystalline powder. The drug is practically insoluble in water and slightly soluble in alcohol, having solubilities of approximately 12 mg/mL in water and 4.7 mg/mL in alcohol at room temperature. The solubility of clarithromycin reportedly is pH dependent, increasing with decreasing pH.

■ Stability

Commercially available clarithromycin tablets should be stored in tight containers at 15–30°C and should be protected from light. When stored as directed, the commercially available tablets have an expiration date of 2 years following the date of manufacture.

Mechanism of Action

Clarithromycin usually is bacteriostatic, although it may be bactericidal in high concentrations or against highly susceptible organisms. Bactericidal activity has been observed against *Streptococcus pyogenes*, *S. pneumoniae*, *Haemophilus influenzae*, and *Chlamydia trachomatis*.

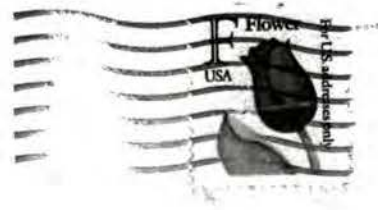
Clarithromycin inhibits protein synthesis in susceptible organisms by penetrating the cell wall and binding to 50S ribosomal subunits, thereby inhibiting translocation of aminoacyl transfer-RNA and inhibiting polypeptide synthesis. The site of action of clarithromycin appears to be the same as that of erythromycin, clindamycin, lincomycin, and chloramphenicol.

Spectrum

Clarithromycin generally displays in vitro activity similar to or greater than that of erythromycin against erythromycin-sensitive organisms and also exhibits activity against some organisms (e.g., atypical mycobacteria, *Toxoplasma*) for

J.T. SIMONIELLO
55 PETERS PL-2C
RED BANK NJ. 07701-1720-555





MS. KRISTINA M. GERRIBBIE RN.-MS.
THE WHITE HOUSE
1600 PENNSYLVANIA AVE.
WASHINGTON DC. 2001

not in WHMC

National Academy for State Health Policy

50 Monument Square, Suite 502, Portland, Maine 04101
207-874-6524 • Fax 207-874-6527

August 17, 1993

EXECUTIVE COMMITTEE

Barbara D. Matula, Chair
North Carolina

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North Carolina

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Utah

Alternative Systems & Cost Management
Sally Richardson
West Virginia

Executive Director
Trish Riley

Kristine Gebbie
Office of the Assistant Secretary
DHHS-Room 2132, Switzer Building
330 C St., SW
Washington, DC 20201

Dear Kristine:

Thank you for your contribution to the success of this year's annual state health policy conference! I have just completed a review of the evaluations and conclude that the one theme that runs through them is praise for the quality and preparation of the speakers and the provocative and timely topics you addressed. It would appear that this year we also were able to provide sufficient time for dialogue and questions which participants greatly appreciated. As one commented, "nothing is better than the direct interaction with such decision makers" as were represented in our sessions.

As we were reminded by so many speakers, the work of health reform happens through a series of small steps and incremental achievements which often lead to great changes. We deeply appreciate your role in that progress and your willingness to make the time in your schedule to so actively participate in the conference. Thank you so much for your work. It is deeply appreciated by all of us who participated in the conference. Thank you.

Sincerely,

Trish

Trish Riley
Executive Director

Sorry we missed the chance to speak

LUCILLE ROYBAL-ALLARD
33D DISTRICT, CALIFORNIA

Committee on Banking, Finance, and Urban Affairs
Subcommittee on Housing and Community Development
Subcommittee on Consumer Credit and Insurance

Committee on Small Business
Subcommittee on SBA Legislation and the General Economy
Subcommittee on Minority Enterprise, Finance, and Urban Development

Congress of the United States
House of Representatives
Washington, DC 20515-0533

Mailing Address:
324 Cannon House Office Building
Washington, DC 20515
Telephone: 202-225-1766

DISTRICT OFFICE:
255 East Temple St.
Suite 1860
Los Angeles, CA 90012
Telephone: 213-628-9230

August 17, 1993

Ms. Christine Gebbie
National AIDS Policy Coordinator
Executive Office of the President
750 17th Street, N.W., Suite 1060
Washington, D.C. 20500

Dear Ms. Gebbie:

I was so pleased to hear that you will be joining us at the National Latina Education Leadership Council breakfast meeting on Wednesday, September 15, in Room 2359 of the Rayburn House Office Building.

As you may know, Dr. Jocelyn Elders will also be joining us. Your presence and remarks, together with Dr. Elders', will provide the full dimension of the Administration's commitment to improve our health care delivery system.

While Dr. Elders will focus on women's health issues in general, we would appreciate hearing your perspective on HIV/AIDS issues impacting women and the involvement of Latinas in addressing those issues.

The ELC has been holding a series of regional meetings throughout the country involving over 500 community leaders in public health. As a result, the ELC will be issuing a series of recommendations and action items focusing on women's and family health needs. Your perspective would be extremely helpful.

We have allowed up to 8-10 minutes for your remarks, to be followed by Q&A.

The breakfast will start at 8:30 a.m. and end at 9:30 a.m. The program will begin approximately at 8:45 a.m. We hope you can stay throughout the program.

We look forward to your participation.

Sincerely,

Lucille Roybal-Allard

LUCILLE ROYBAL-ALLARD
Member of Congress

PRINTED ON RECYCLED PAPER

THE WHITE HOUSE

WASHINGTON

7254

August 18, 1993

Mr. Frank Beadle
National Hispanic/Latino AIDS Coalition
300 I Stret N.E., Suite 400
Washington, D.C. 20002

Dear ~~Mr. Beadle:~~ Frank

Thank you for caring to share with me the National Hispanic/Latino AIDS Coalition concerns and priorities. The Coalition has done an impressive amount of work, and I look forward to collaborating with you over the coming months.

Please contact me any time if you have concerns or questions.

Sincerely,

Kristine M. Gebbie, RN, MN
National AIDS Policy Coordinator

THE WHITE HOUSE

WASHINGTON

August 18, 1993

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Sincerely,

Kristine M. Gebbie, RN, MN
National AIDS Policy Coordinator

Prepared by: APO: KMGebbie: gw: 8/12/93: 690-5471: b:\beadle

FILE COPY

OFFICE	SURNAME	DATE	OFFICE	SURNAME	DATE	OFFICE	SURNAME	DATE

7253

THE WHITE HOUSE

WASHINGTON

August 23, 1993

William W. Reece, M.D.
The Hopkinson House - Suite 1505
604-36 South Washington Square
Philadelphia, PA 19106-4115

Dear Dr. Reece:

Thank you for writing, I appreciate your letter.

Dr. Fennel is correct that proper use of barriers such as gloves is essential to their effectiveness. That is one of the points made in occupational training for health personnel.

Thank you for taking the time to write.

Sincerely,

Kristine M. Gebbie, RN, MN
National AIDS Policy Coordinator

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National AIDS Policy Coordinator

Prepared by: APO: KMGebbie: gw: 8/20/93: 690-5471: b:\reece

FILE COPY

OFFICE	SURNAME	DATE	OFFICE	SURNAME	DATE	OFFICE	SURNAME	DATE

William W. Reece
The Hopkinson House - Ste 1505
604-36 South Washington Square
Philadelphia, PA 19106-4115
922-5417

Kristine Gebbie, RN

7/17/93

Dear MS Gebbie,

I am writing to you because of the article written by a dentist, Dr. Perry Fennel of Philadelphia, Pennsylvania.

A reading of his article will make clear to anyone, layperson or professional, the exact method of transfer of the HIV virus by Dr. Acer. (This is assuming, of course, that Dr. Acer did not deliberately transfer AIDS to his patients).

Briefly, Dr. Fennel's theory is this. A dentist with HIV and a small traumatic ~~[illegible]~~ on his finger puts on his gloves to examine or inject an analgesic into the patient's gingiva. While awaiting the analgesic to take effect, the dentist removes his gloves - to temporarily perform other duties - then a short time later puts the same gloves on to resume his procedures. (If you notice, in order to take latex gloves off, they are turned inside-out. This leaves any microscopic blood droplets containing HIV now on the outside of the gloves. When the dentist puts the gloves on again all the bacteria and viruses, etc., that were at first on the inside now on the outside and of course touches the patient.

I feel strongly that Dr. Fennel is right and what we must teach dentists and other professionals in the dental/medical field is that once they have put on a pair of gloves and examine or treat a patient the gloves must be discarded and another pair used. Even if we examine or treat the same patient before we examine/treat another patient.

The purpose of this letter then is to bring to your attention the work and theory of Perry Fennel, DDS.

Would you examine his ideas carefully and let me know what you think?

Thank you,

William W. Reece

William W. Reece, M.D.

Copies to other interested persons -

BEWARE ! Improper use of rubber gloves may be hazardous to your health and that of your patients.

The Federal Center for Disease Control (CDC) reported on July 26, 1990 that there was a case of a Florida dentist passing on his HIV infection to his patients, still pending investigation. The CDC report stated that the patient tested positive for the AIDS virus having been diagnosed two years after having an oral surgery procedure. The patient's history revealed that the oral surgery procedure was the only event that took place in the intervening two years that could have led to her aquiring the HIV virus.

Morbidity Mortality Weekly Reports (MMWR) of the CDC dated January 18, 1991 vol 40/no 2 was used for background information. The bulletin stated that after extensive investigation by the CDC, four of the dentist's patients had tested positive for the HIV antibody. Three of these patients were sero-positive with a virus which had a similar genetic pattern as the dentist. For identification purposes, the report identified the patients as Patient A, Patient B and Patient C. Patient A was the young lady first identified and seen on television. The single common procedure that they all had was extractions, an invasive procedure. The CDC's investigation of the dentist's appointment book showed Patient A and Patient B were seen on the same day. On that day, Patient A had an extraction, and Patient B was seen for a toothache. The MMWR report stated, "at this time, higher titers of virus may have been present in the dentist's blood, and he may have been more likely to transmit the virus than earlier in the course of his HIV infection".

I surmise that the dentist infected Patient A during oral surgery on the same day he saw Patient B. Patient B had a toothache, was examined and returned on a subsequent day for the extraction. I propose the dentist transmitted his HIV infection to Patient B when she returned for surgery, and Patient C was infected on the date of his surgery. The CDC remains unclear as to how the disease was transmitted to the patients, since the dentist was wearing a mask and gloves.

We may never know the complete story, since the dentist has died. There is however, a very logical explanation of the circumstances that may have created this tragic accident. One explanation may not have been readily apparent since the investigation was probably done by physicians, scientists and technicians. Questioning active dentists with busy practices would have been most helpful. Individuals in most fields, after donning their gloves, proceed to work and discard their gloves when finished. The CDC investigation was probably based on this work pattern. However, the practice of Dentistry has elements not used in traditional areas.

Dental students are taught in school to keep non-productive time to a minimum. In dental practices, after the administration of local anesthesia, the dentist must wait ten to fifteen minutes before proceeding. During this time delay, an opportunity for many things, including lethal mistakes can take place. Busy dentists make use of this time productively. In my practice, I see other patients, return calls, read mail or go to the lab. Before leaving the patient area, the dentist removes his/her gloves and places them on the tray which is usually behind the patient's head.

Here is where the problem begins. The removal of rubber gloves is quite different than the removal of gloves made of other materials. After removing gloves made of cotton, silk, etc. the external surface remains external. However, while removing rubber gloves, since they fit so tightly, many pull them off at the wrist thereby leaving the gloves inverted or inside out. The external surface now appears the same as the internal surface. Many dentists, upon returning to the patient, wash their hands, re-invert their gloves and proceed to work. If the dentist has an infection, perhaps an open wound or injury in the skin, then blood, exudate or serum may soil the internal surface of the gloves. After rubber glove removal, these body fluids may be exposed on the outer surface of this now inverted glove. Upon resuming work and redonning gloves, if the dentist fails to re-invert the gloves, he/she might unwittingly introduce his body fluids directly into the blood stream of the patient. Contrarily, the dentist may also be at risk. If the patient has an infectious disease, the dentist could unknowingly place contaminated material right into his own blood stream through a break in his skin. We will never know the technique the dentist used, since his office glove policy varied according to MMWR. I believe the dentist may have used improper glove donning and removal techniques at least sometimes, since presently, three of his patients have tested positive for the HIV virus.

Even if the dentist were alive today, he might not remember since the dentist was engaged in a very active practice. The MMWR report stated that there were 14 persons on staff. Patient A testified that the dentist was wearing gloves while performing surgery. It would be highly unusual for a busy dentist to spend ten to fifteen minutes standing in front of a patient with gloves on.

In many instances, the tray is behind the patient's head, and I don't think the patient has the knowledge of whether the doctor keeps the gloves on continuously. They probably assume this fact. Patients don't understand the significance of proper gloving techniques, and unfortunately, many dentists don't either. The dentist treated many patients and only three of them so far have tested HIV positive. I surmise certain conditions had to be present, all working in concert to make transmission possible:

1. The dentist, probably in haste, failed to re-invert his gloves and proceeded to work.

2. The dentist would have had to be highly infectious with a high titer of HIV virus and may have been highly contagious for a limited period of time.

3. There would have been improper glove usage techniques. The MMWR states the dental staff used different gloving methods at different times.

4. The dentist had to perform an invasive procedure. Transmission of the HIV virus occurs when body fluids come in contact with the blood stream.

5. The dentist would have to have had an open wound or lesion on the skin of his hands to seep inside his gloves. I don't know the nature of what could have caused a break in his skin integrity, however, he must have had some type of lesion that permitted escape of his body fluids.

6. When exposed to air for an extended period, the substrate that holds the virus would air dry and transmission would be very difficult or impossible to take place. Therefore, the dentist would have to return to work, donning his gloves in a short period of time.

I believe that although he saw many patients, there was probably a limited amount of time when all these factors were at work at the same instance. Thus only three persons so far are sero-positive.

In the old tv sit-com, it seems Dr. Welby had just one patient a day. Dentists must treat many patients a day to survive. Dentists must be made aware that when they go back and forth between patients, they must either get new gloves each time they re-enter, or they must re-invert the gloves previously used on that same patient. Let me hasten to add that gloves are discarded after each patient is completed in my practice. I may have two to three patients, each having different pairs of gloves at their individual chairs. Because of economy, I don't get a new pair of gloves every time I touch the same patient. I merely re-invert them. I make sure that the external side is always outside which is not a problem for physicians, since they don't go back and forth between the same patients. Dentists should be aware of this potential problem. We must make it part of our higher consciousness to remember to use gloves properly.

Perry C. Fennell Jr. DDS
Temple University School of Dentistry, 1959
General Practioner

Contributions made by Wesley Anderson, New Jersey Medical and Dental School.

7249

THE WHITE HOUSE

WASHINGTON

August 23, 1993

Barbara R. Kelley, EdD, MPH, CPNP
Eastern Massachusetts Chapter of National Association of
Pediatric Nurses
10 Loring Avenue
Salem, Massacusetts 01970

Dear Dr. Kelley:

Thank you for sharing a copy of your recent letter to the President.

I very much appreciate the support of my nursing colleagues, and look forward to working with nurses from across the country as I go forward.

All the best to you and your associates in eastern Massachusetts.

Sincerely,

Kristine M. Gebbie, RN, MN
National AIDS Policy Coordinator

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National AIDS Policy Coordinator

Prepared by: APO: KMGebbie: gw: 8/20/93: 690-5471: b:\kelley

FILE COPY

OFFICE	SURNAME	DATE	OFFICE	SURNAME	DATE	OFFICE	SURNAME	DATE

Dear Dr Kelley

Thank you for sharing a copy of your recent letter to the President

I very much appreciate the support of my nursing colleagues, and look forward to working with nurses from across the country as I go forward.

All the best to you & your ~~ABBE~~ associates in Easton Massachusetts

Sincerely

Eastern Massachusetts Chapter of National Association of Pediatric Nurse Associates & Practitioners

July 25, 1993

President Bill Clinton
The White House
Washington, D.C.

Dear President Clinton:

The Eastern Mass Chapter of NAPNAP is writing in strong support for your choice of Kristine Gebbie to be the nation's first AIDS policy coordinator. Her expertise and long history of working to implement public health programs to combat the transmission of HIV and to serve the AIDS community will serve the country well. It is especially gratifying to have Ms Gebbie, a nurse, in this position. In addition to the vital aspects of prevention and cure, her leadership will provide the needed dimension of care to one of the nation's most pressing health problems.

Thank-you for your choice of Ms Gebbie. As pediatric nurse practitioners and primary care providers, we look forward to working with both Ms Gebbie and your administration in the proposed health care reform.

Sincerely,

Barbara R. Kelley

Barbara R. Kelley, EdD, MPH, CPNP
Eastern Mass Chapter President

cc Kristine Gebbie
Donna Shalala

Ms Gebbie,
Congratulations
and good luck!
We are very proud
of you —
Barbara Kelley

7250

THE WHITE HOUSE

WASHINGTON

August 25, 1993

Thomas A. Cosgrove
3535 Quail Road
Pinion Hills, California 92372

Dear Mr. Cosgrove:

My apologies for the slow response. I'm delighted to learn of your congregation's plans for an HIV education network.

I have asked the National AIDS Clearinghouse to send you a current packet of information. Your local health department should also have pertinent materials.

Best wishes.

Sincerely,

Kristine M. Gebbie, RN, MN
National AIDS Policy Coordinator

THE WHITE HOUSE

WASHINGTON

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National AIDS Policy Coordinator

Prepared by: APO: KMGebbie: gw: 8/20/93: 690-5471: b:\cosgrove

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Best wishes.

Sincerely

CC. Clearinghouse

(aids02)

7 July 1993

3535 Quail Road
Pinon Hills, CA.
92372

(619) 868 4461

Ms. Kristine Gebbie
AIDS Czar (or whatever)
c/o The White House
1600 Pennsylvania Avenue
Washington, D.C. 20500

Dear Ms. Gebbie:

Through the local Lutheran Church in Phelan, Pastor Duane Seibert and I plan to initiate an AIDS information network on facts relative to this disease.

Will you please have your staff:

1) Add me to your mailing list.

2) Send me whatever materials you have for distribution relative to AIDS.

Any information, suggestions or advice you have will be appreciated.

Sincerely,

Thomas A. Cosgrove

cc Duane Seibert

7257

THE WHITE HOUSE

WASHINGTON

August 25, 1993

Marsha H. Harris
4206 Whippoorwill Drive
Greensboro, NC 27407

Dear Ms. Harris:

Thank you for writing. I am asking the Centers for Disease Control and Prevention to send you a copy of their recent materials on condom use and effectiveness. I'm sorry you've felt frustrated in trying to locate this information.

Sincerely,

Kristine M. Gebbie, RN, MN
National AIDS Policy Coordinator

cc: Centers for Disease Control and Prevention

THE WHITE HOUSE

WASHINGTON

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National AIDS Policy Coordinator

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Prepared by: APO: KMGebbie: gw: 8/20/93: 690-5471: b:\harris.ltr

FILE COPY

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locate this information

Sincerely,

CDC

4206 Whippoorwill Drive
Greensboro, NC 27407
July 22, 1993

Kristine Gebbie
Attn: AIDS policy Director
1600 Pennsylvania Avenue
Washington, D.C. 20500

Dear Ms. Gebbie,

I would like to know how to get a report recently published by the White House and available to the public. It is a newly published report about research that was done to help stop the spread of aids. It tells the proper use of the condom so it is about 100% effective.

The News show said copies of this report are available to the public if they request one.

I checked with my local health

department they do not have copies of the report.

Could you please either tell me how to get a copy of such a report or send me a copy in the mail.

Thank you very much for your time.

By the way, this may help you to know which report I am talking about. The research done, began under the Bush administration, but was not available at that time to the public. Now it is available to the public, but the News should went on to say that, President Clinton would not mail it to people's homes unless they requested it because it would upset conservatives to have the report send to everyone in the country.

PHOTOCOPY
PRESERVATION

Thank you again for your time.

Sincerely,
Marsha H. Harris
Marsha H. Harris

7252

THE WHITE HOUSE

WASHINGTON

August 25, 1993

Greg Moody
Rt. 1 Box 365
Big Sandy, TX 75755

Dear Mr. Moody:

The office is so new we do not have a formal packet of information.

As National AIDS Policy Coordinator I am responsible for working across all Executive Branch agencies to develop and deliver effective HIV/AIDS related programs.

This great challenge will also require nationwide efforts to improve our response in all sectors.

Thank you for your interest.

Sincerely,

Kristine M. Gebbie, RN, MN
National AIDS Policy Coordinator

THE WHITE HOUSE

WASHINGTON

August 25, 1993

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As National AIDS Policy Coordinator I am responsible for working across all Executive Branch agencies to develop and deliver effective HIV/AIDS related programs.

This great challenge will also require nationwide efforts to improve our response in all sectors.

Thank you for your interest.

Sincerely,

Kristine M. Gebbie, RN, MN
National AIDS Policy Coordinator

Prepared by: APO: KMGebbie: gw: 8/20/93: 690-5471: b:\moody.ltr

FILE COPY

OFFICE	SURNAME	DATE	OFFICE	SURNAME	DATE	OFFICE	SURNAME	DATE

August 23, 1993

Greg Moody
Rt. 1 Box 365
Big Sandy, TX 75755

Dear Mr. Moody:

The office is so new we do not have a formal packet of information.

As National AIDS Policy Coordinator I am responsible for working across all executive branch agencies to develop and deliver effective HIV/AIDS related programs.

This great challenge will also require nationwide efforts to improve our response in all sectors.

Thank you for your interest.

Sincerely,

Kristine M. Gebbie, RN, MN
National AIDS Policy Coordinator



August 27, 1993

Kristine Gebbie, MSN, RN, FAAN
National AIDS Policy Coordinator
Hubert H. Humphrey Building
Room 729 H
200 Independence Avenue, SW
Washington, D.C. 20201

Dear Ms. Gebbie:

On behalf of the Ohio Nurses Association Task Force on Issues Related to AIDS, I would like to congratulate you on your appointment to the position of National AIDS Policy Coordinator. Your important contributions to Public Health and HIV management makes you uniquely qualified for this new role.

I appreciate the opportunity we had to discuss nursing issues that relate to HIV care at the August 23, 1993 luncheon at the American Nurses Association. I look forward to sharing the information with our task force members.

We are certain that our clients with AIDS will benefit from your expertise. Please do not hesitate to contact our task force for any assistance in your work.

Sincerely,

Deborah Coleman

Deborah Coleman, MS, RN
Chair, ONA Task Force on Issues Related to AIDS
Director, AIDS Program-Columbus Health Department

Task Force Members:
Judy Neidig, MS, RN-Columbus
Ann Whitlatch, MS, RN-Columbus
Terry Donner, BSN, JD, RN-Cleveland
David Feldt, BSN, RN-Cleveland
Karen Krause, MPH, RN-Toledo
Louise Stewart, BSN, RN-Dayton
Janice Wagner, BSN, RN-Dayton
Jennifer Vonnahme, MA, RN-Cincinnati
Jean Scholz, MS, RN, C-Columbus (ONA Staff)

ohio nurses association
4000 east main street • columbus, ohio 43213-2983 • 614/237-5414
an equal opportunity and affirmative action organization

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service
Region II

Memorandum

Date: August 31, 1993

To: Audrey F. Manley, MD, MPH
Deputy Assistant Secretary for Health

From: Raymond L. Porfilio
Regional Health Administrator, Region II

Subject: Funding for Regional AIDS Coordinator (RAC)

In regard to a conversation with Kristine Gebbie yesterday, I was disappointed to learn that the RAC positions will no longer be funded by NAPO as this in all likelihood will result in a diminution of the cross-cutting impact which have made the RACS so effective.

While I fully appreciate the fact that the positions will continue via funding from HRSA, I firmly believe that optimum use of the RACS could be made through conjoint funding (with accountability) from CDC, SAMHSA, and NIH as well. With new leadership coming on board at the agencies, coupled with a renewed national emphasis on the HIV epidemic, the time appears opportune for such an arrangement. This would strengthen the RO ability to integrate and link HIV/AIDS program activities and at the same time be an enhancement of the RAC functions at no additional cost to PHS.

Raymond L. Porfilio

Post-it™ brand fax transmittal memo 7671	# of pages ▸ 1
To K. Gebbie	From RHA
Co. OA	Co. PHS, Region 2
Dept.	Phone # (212) 264 2560
Fax # (202) 6907054	Fax (212) 264 1324

cc: K. Gebbie
A. Fitzpatrick

UNIVERSITY OF WASHINGTON
SCHOOL OF NURSING

FAX TRANSMISSION COVER SHEET

FAX Number: (206) 543-3624

To: Kristine, Gebbie-, Nat'l Acad Sciences Comm Coord.

From: Anne Levine

Number of pages sent (excluding cover sheet): 2

Comments:

Problems? Call the School of Nursing Business Office at (206) 543-9175.

University of Washington
School of Nursing
SC-72
Seattle, Washington 98195

UNIVERSITY OF WASHINGTON
SCHOOL OF NURSING

OFFICE OF THE DEAN

September 14, 1993

Ms. Kristine Gebbie
National AIDS Policy Coordinator
National AIDS Office
FAX# 202/632-1096

Dear Ms. Gebbie:

The UW School of Nursing's newsletter, *Connections*, has a ***BRIEFLY*** section in which we list the accomplishments of faculty, students, and alumni. Since you are one of our clinical faculty, I am interested in listing your appointment as National AIDS Policy Coordinator, and requested your photograph and curriculum vitae from your communications office.

Not knowing how closely affiliated you feel with us as a clinical faculty member at this time, Dean Sue Hegyvary asked that I ask your permission before printing the information. A draft is attached for you. Will you please call (206/543-8732) or FAX (206/543-3624) any changes or comments to me by the end of this week? The issue is set up on PageMaker, and we can delete or change any information quite easily.

Thanks very much.

Sincerely yours,

Anne Devine

Anne Devine
Assistant to the Dean and
Director of Communications

Attachment

Let her know this is fine — pve

BRIEFLY



Dr. Nancy F. Woods



Dr. Jeanne Q. Benoliel,



Dr. Frances M. Lewis



Dr. Marjorie A. Muecke

Kristine Gebbie, clinical assistant professor, Department of Community Health Care Systems, has been appointed the nation's first AIDS Policy Coordinator. Gebbie will be a full member of the Domestic Policy Council and will work closely with the Department of Health and Human Services to develop national AIDS policy.

Dr. Nancy Fugate Woods has been elected to the prestigious Institute of Medicine, a branch of the National Academy of Sciences. She is among 50 new active members elected to begin their terms on July 1 and the only new member from the UW. Members join forces to study a broad range of health policy issues. Woods joins two other UW School of Nursing faculty who are Institute of Medicine members: Drs. Rheba de Tornyay and Kathryn Barnard.

Woods also received the 1993 Distinguished Research Lectureship Award from the Western Institute of Nursing and will serve on the Women's Health Initiative Program Advisory Committee of the National Institutes of Health.

Dr. Kris Swanson will serve on the advisory boards of SHARE (Source of Help in Airing and Resolving Experiences) and CLIMB (Center for Loss in Multiple Birth) and the executive committee of the Council of Nurse Researchers.

Dr. Martha Price is secretary for the National Organization of Nurse Practitioner Faculty.

Dr. Jeanne Quint Benoliel, professor emeritus, received the University of Pennsylvania's honorary doctor of science degree. Others who received honorary degrees included Hillary Rodham Clinton. The Oncology Nursing Society awarded the Distinguished Researcher Award to Benoliel during their 1993 Annual Congress.

Dr. Frances M. Lewis will serve on the Clinical Investigation Review Committee of the National Cancer Institute. Lewis also presented information on cancer's impact on families to the 1993 President's Cancer Panel. Her policy recommendations will be incorporated into a report to President Clinton.

Dr. Rheba de Tornyay has been named as one of 19 members of the Pew Health Professions Commission for a second three-year phase, after also serving in phase one. Administered by the Center for the Health Professions at the University of California, San Francisco, the commission will work directly with health professions schools, professional associations, and state and federal legislators to remove barriers to health care reform that are grounded in health professions training and practice.

Ms. Martha Tyler completed a three-year term as a founding board member of the Respiratory Nursing Society.

Dr. Marjorie Muecke is the new program officer for Reproductive Health and Population with the Ford Foundation. She will work globally to promote women's health through applied social science research, addressing ethical and legal issues, and empowering women to improve their reproductive health. She will take a three-year leave from the University to assume her new position at Foundation headquarters in New York. Muecke, a nurse and anthropologist, will pursue a comparative perspective on the socio-cultural constraints on women's health.

Ms. Faith Claman chairs the special interest group on school-based and school-linked health centers for the National Association of Pediatric Nurse Associates/ Practitioners.

The American Association of Occupational Health Nurses appointed **Dr. Mary Salazar** to their Professional Affairs Subcommittee on Research and Ethics.

Dr. Phyllis Schultz will chair the Research Committee of the Council on Graduate Education for Administration in Nursing and serve on the American Academy of Nursing's Expert Panel on Cultural Competence in Health Care.



Ms. Kristine Gebbie

File

Alaska State Legislature

While in Fairbanks
119 N. Cushman St.
Suite 203
Fairbanks, AK 99701
907-456-3161

While in Juneau
State Capitol
Juneau, AK 99801-1182
907-465-2327
907-465-4713

Representative Joe Sitton

Aug

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To Ms. Kristine Gebbie	From Dr. Peter NAPO
Co. Attn: Patricia	Co. Attn: Paula
Dept.	Phone # 907 465-2845
Fax # 202-690-7054	Fax # 907-586-1877

Ms. Kristine Gebbie
National AIDS Policy Coordinator
750 17th Street NW, Suite 1060
Washington, D. C. 20503

Dear Ms. Gebbe:

First and foremost, may I offer my congratulations on your recent appointment with the Clinton Administration. Your past and present work in the public health field is well-known in Alaska and we welcome the priority which President Clinton has placed on the HIV/AIDS problem.

Over the years, I have become extremely concerned about the lack of any coherent public health policy for Alaska. Although Alaska's Constitution mandates the Legislature to "provide for the promotion and protection of public health," our public health problems have taken a back seat to other issues. The State has not done its job. I want to see a policy established which ensures that every child in Alaska will be carried by a healthy mother into a healthy environment where he/she can grow and play in an environment free of external threats.

On September 15 and 16, I am sponsoring a public health policy conference in Fairbanks, Alaska. This will be the first time that legislators and members of the public health community will be getting together to begin a dialogue and establish some principles which will lead to a long-term comprehensive public health policy for Alaska. This is but the initial step and I look forward to some exciting accomplishments. There will be discussion of our public health problems (HIV/AIDS, Tuberculosis, sanitation, substance abuse, suicide, etc.)and discussion of a process to be followed to define solutions.

In view of your work in the public health field with both Oregon and Washington and your present position as the nation's AIDS policy coordinator, I would like to invite you to be the keynote speaker for the conference. I recognize that you must have a very busy schedule but I am hopeful that you may be able to address this conference on September 15, although we would certainly accomodate your schedule for either day.

I look forward to hearing from you.

Sincerely,

Joe Sitton

Representative Joe Sitton

JS:pt

K.G.:

This Conference may cause you to be 5-10 min late for your 5:30 w/Pamela.

Please advise me if you want me to come along or not to the tele-conference. JL

P.S.

Ted Foor is already planning on attending. So, you may not need another person with you.

JL

September 15, 1993

SCHEDULED TELECONFERENCE
FOR
KRISTINE M. GEBBIE
NATIONAL AIDS POLICY COORDINATOR

DATE: TODAY
TIME: 4:30 P.M.
DURATION: 45 minutes

LOCATION: Keystone Studios
400 North Capitol Street, N.W.
Washington, D.C.

ONAPC CONTACT: John Paul Gurrola

SITE CONTACT: Grant Oines, Keystone Studios @ 737-4440

REMARKS REQUIRED: You will be expected to give a brief intro about yourself. The focus they desire is your experience in Washington State, specifically your role and your advice in reference to setting up their State Public Health Policy. Next, you may give an overview of your role as NAPC, as the conference will be discussing AIDS. Questions will be asked of you.

BACKGROUND: This conference is being sponsored by the Alaska State Legislature in conjunction with the Alaska Public Health Association. The Speaker of the Legislature, Ramona Barnes has been involved in supplying support and funds for the event.

The concept for this conference is spearheaded by AK State Rep. Joe Sitton. His concern has stemmed from the lack of a comprehensive public health policy for Alaska. He wants this conference to be the initial step in the formulation of a public health policy for Alaska. He has great concerns about the spread of HIV/AIDS, TB and hepatitis.

Of Alaska's 60 Legislator's, 12-15 will be present. Other government officials will also be present and one-third of the participants will be from the private sector (regional health coordinators, NPO's, and members of the public).

OTHER PARTICIPANTS: Burt Hall, former Alaska Commissioner of Public Health, will be the moderator; Alaska's First Lady Ermalee Hickel will be present at the conference and will be speaking prior to you.

PH / ~~Health Reform~~

The issue of infrastructure —
PH related to illness care
most vulnerable part

The process —
identify / understand core fx
~~Mod's available~~ -

~~self assessment~~

talk through what it would be like if
all insured

The time needed / the fears —
~~present staff concerned (threatened~~
people don't understand the continued need
the $'s are real —
building expectations $'s ~~dangerous~~
of concern

~~to state PH improvement plan~~

Biggest gaps
DATA
Epidemiology
trained staff

Ties to HR / AIDS —

August 23, 1994

Mr. Jacques T. Garon
Apartment 210
92-16 Whitney Avenue
Elmhurst, New York 11373-2281

Dear Jacques:

Please accept my congratulations on the successful Tenth Annual Candlelight AIDS Vigil that you recently coordinated in New York City.

I am pleased that my Administration had the opportunity to be represented and join in such a momentous occasion. I am committed to fight against AIDS until we stop losing Americans to this tragic epidemic. Thank you for your efforts in helping to raise awareness and to remember those whom we have lost.

I appreciate your efforts and wish you continued success.

Sincerely,

BILL CLINTON

BC/AIDSPOLICY/MM/emu (Corres. #1765873)
(8.garon.jt)

cc: John Paul Gurrola, Aids Policy

August 23, 1994

The Reverend Ken South
AIDS National Interfaith Network
Suite 504
110 Maryland Avenue, N.E.
Washington, D.C. 20002

Dear Ken:

Congratulations on your fifth anniversary with the AIDS National Interfaith Network.

The Network has been an important part of our national response to the HIV epidemic. You have provided a focal point for religious communities interested in being a positive, active force at the local level, and have brought their voices to the national table.

Best wishes to you as you continue your work.

Sincerely,

BILL CLINTON

BC/AIDSPOLICY/MM/emu (Corres. #1765782)
(8.south.k)

SEND TO:

Mr. Joseph P. McGinty
Number 42
1322 15th Street, N.W.
Washington, D.C. 20005

cc: John Paul Gurrola

THE WHITE HOUSE

WASHINGTON

AUG 25 1994

Mr. Martin Delaney
Founding Director
Project Inform
1965 Market Street
Suite 220
San Francisco, CA 94103

Dear Martin:

Thank you for your letter concerning Dr. Yanto Lunardi-Iskandar, a Visiting Scientist from France who is working at the National Cancer Institute.

Dr. Lunardi currently has valid visa status and is not under any formal INS deportation proceedings. Although his J-1 visa will expire in September, I understand that NCI plans to request a sixth and final year under the Exchange Visitor Program that would extend his visa for another year. During this period, at the discretion of the NCI, a decision may be made to request a waiver of the two-year foreign residence requirement of the Exchange Visitor Program for Dr. Lunardi.

I hope this information is helpful.

Sincerely,

Patsy

Patricia S. Fleming
National AIDS Policy Coordinator
(Interim)

PROJECT inform

Ms. Patsy Fleming
Acting National AIDS Policy Coordinator

August 15, 1994

Dear Patsy,

I am writing today to inform you of our serious concern about possible immigration actions against a critically important researcher at the National Institutes of Health. Dr. Yanto, who works in Dr. Gallo's lab, is the architect of recent studies which have identified key factors in the growth of Kaposi's Sarcoma. He has been working for the last two years on a surprise finding regarding a possible role for HCG, a hormone associated with pregnancy, and KS. That research is currently at a critical phase and was reported on in Yokohama. Similarly, I understand that he has recently made important discoveries which may be relevant to the understanding and treatment of Multiple Sclerosis.

Despite Dr. Yanto's importance to this work, he now faces deportation, possibly due to delays on the part of NCI officials to file necessary papers with the INS in a timely fashion. I am not fully conversant in the details, but I'm sure someone in Dr. Gallo's office could apprise you further of the details.

I urge you to look into this matter and take action as quickly as possible. I know that matters of immigration are especially complex, but it seems to us that the needs of AIDS research should somehow be morally and ethically elevated above such concerns. If government is unable to manage bureaucratic details of this nature properly, unable to set reasonable priorities of principle, there would seem little hope that we will ever see an end to this epidemic.

Thank you for your attention.

Sincerely,

Mark Delaney

Founding Director, Project Inform

cc: Victor Zonana

1965 MARKET STREET, SUITE 220
SAN FRANCISCO, CALIFORNIA 94103

ADMINISTRATIVE OFFICES
415-558-8669

FAX:
415-558-0684

LOCAL HOTLINE
415-558-9051

NATIONAL HOTLINE
800-822-7422

FAX TRANSMITTAL SHEET

National Institutes of Health, DHHS
Fogarty International Center
International Services and Communications Branch
Building 16A, Room 101
Bethesda, Maryland 20892
Telecopier #: (301) 496-0847
Telephone #: (301) 496-6166

August 17, 1994

TO: Joyce Jones, OIA, DHHS

Telecopier #: 202/690-7127
Telephone #: 202/690-6174

FROM: Claudie Pifer

NOTES: Re: Dr. Yanto Lunardi-Iskandar, Visiting Scientist from France in Dr. R. Gallo's lab in NCI.

NCI had requested and received approval from the Office of Intramural Affairs, OD, NIH, to proceed with a waiver through your office and a change of status to H-1B in June 1993. Our office met with Dr. Lunardi and staff of Dr. Gallo's lab on July 9, 1993 to discuss the procedures for filing a waiver request with EVWRB. From July 1993 through April 1994, the NCI developed their waiver package. In April or May 1994, it became unclear whether Dr. Broder, Director, NCI, would sign the evaluation cover letter that accompanies the waiver application. I do not know why the letter has not been signed. Dr. Lunardi currently has valid visa status, and, to the best of my knowledge, is not under any formal INS deportation proceedings.

Our last communication with NCI on this case was 8/10/94. Dr. Broder still has not signed the waiver letter. NCI has indicated that a 6th and final year under J-1 Exchange Visitor sponsorship will be requested, however, our office has not received the renewal request from NCI. Dr. Lunardi's current stay in the U.S. and his appointment expire on September 11, 1994.

NUMBER OF PAGES SENT: 1 **(including cover sheet)**

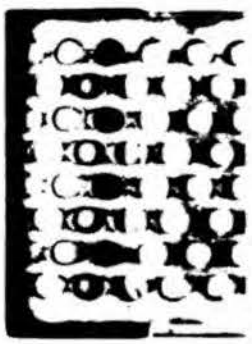
THE WHITE HOUSE

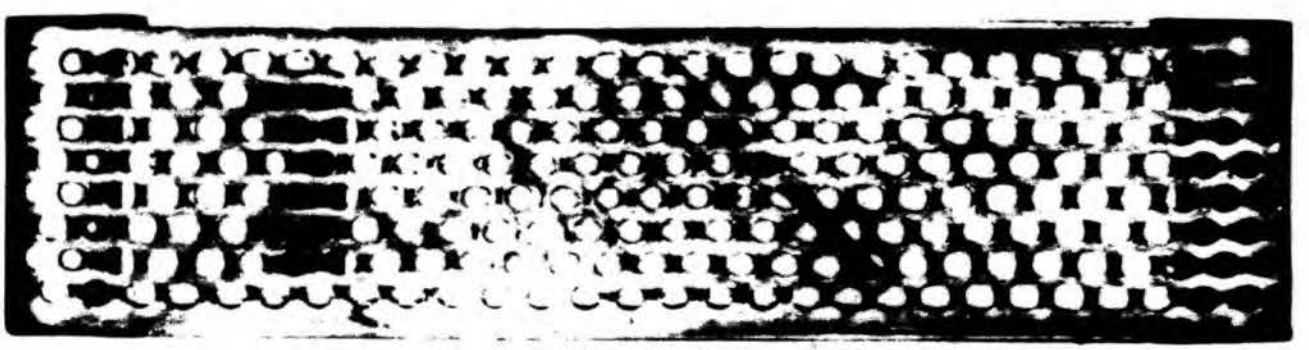
1995

Dear Bob —

Thanks for writing — the Chair date's on the calendar! I'm already looking forward to it —

Cheers





the ST. OLAF CHOIR
NORTHFIELD
MINNESOTA
U S A

Anton Armstrong

B.J. Johnson

Northfield, MN 55057
Ph. 507 646-3179
Fax. 507 646-3549

28 June 1993

Kristine Gebbie
606 Lily Rd., N.E. Apt. 723
Olympia, WA 98506

Dear Kris:

Congratulations on your appointment! And best wishes as you continue to undertake a daunting task in your new role. The campus was abuzz this morning about the news of your appointment.

The 10 p.m. Twin Cities news covered the story as well as National Public Radio. I presume you will be moving to Washington, D.C. and if so let me be among the first to give you a date to put on your calendar.

The St. Olaf Choir will be singing at the Kennedy Center on Sunday, February 5, 1995, in a benefit concert for Lutheran Social Services of the National Capital Area. We hope you can join us.

Although the concert is 1 1/2 years away, we already have a committed sponsor and the ground work is set for a grand concert.

With all best wishes.

Sincerely yours,

Manager

BJJ/mla

THE WHITE HOUSE

WASHINGTON

March 6, 1994

Mr. Steve Fein
6911 Bonnie Ridge Drive
Baltimore, Maryland 21209

Dear Mr. Fein:

This letter confirms the appearance of Kristine M. Gebbie, National AIDS Policy Coordinator, at the Johns Hopkins School of Medicine chapter of the American Medical Association on Wednesday, May 4, 1994.

Ms. Gebbie plans to arrive at 1:00 p.m. to discuss health care reform and public health, followed by a period for questions and answers. Ms. Gebbie will be available for approximately 1 hour and 15 minutes. Please call me at (202) 632-1090 at your earliest convenience to provide me with the location of the meeting, and with any questions or for further clarification. I am enclosing a biographical sketch and curriculum vitae for your reference.

I also appreciate your patience in getting this meeting scheduled.

Sincerely,

W. Steve Lee

W. Steve Lee, Executive Assistant
and Scheduler to the
National AIDS Policy Coordinator

Enclosures

2/10

NOV 22 1993

Steve Fein
6911 Bonnie Ridge Dr.
Baltimore, MD 21209

Kirk Chan-Acle
550 6317

November 9, 1993

Ms. Kristine Gebbie
National AIDS Policy Coordinator
750 17th Street, N.W.
Suite 1060
Washington, D.C. 20503

Dear Ms. Gebbie:

On behalf of the Johns Hopkins School of Medicine chapter of the American Medical Association, I would like to invite you to speak to the medical students as part of our continuing series on controversial issues in medicine.

This talk would take place at one of our chapter meetings, which occur on Thursdays at 1:00 pm, and are open to all medical students-I would expect 60-80 students to attend. Following some brief announcements, I would ask you to give a 25-30 minute presentation of an issue about which you would like to heighten our awareness, followed by 20 minutes for open discussion.

Some dates I have in mind include December 9, January 6, or January 13, though we are flexible with dates. I appreciate your consideration and look forward to hearing from you. I can be reached at 410-653-8727, or at the above address.

Thank you.

Sincerely,

Steven Fein

Steven Fein
Vice President
JHU Chapter of A.M.A.

5/2/94

Spoke with Steven and he cancelled the event because the students could not attend.

Steve - we should get a typing of this speech (from the Galveston Conference) & consider having it for distribution (a transcript, not the tape!)

3/3/94
Galveston

Shaping a New Era in HIV/AIDS Policy

Where we are in the epidemic
- #'s grow - not just new case definition
- demographics change -
  - gay men = largest #
  - recognition of gay men of color, young men
  - women as fastest growing #
  - substance abuse overlap

(the overlap of circles becomes evident)

- don't be thrown off by stories, #'s
  - Chicago / children
  - SFO / "peak"
- Global reminder - large #, equal men & women

Why is this a new era?
- Exec. branch "ownership" of policy
  - coherence to individual agency work
  - "bully pulpit" to the nation

Policy directions have been there from Nat'l Commission / private groups

Who's at the table changes -
- holiday dinner vinegar
- partners, not antagonists to Congress, advocates

Kristine,

The attached note was sent to Dr. Lee on 9/7/93. I will follow-up next week with PHS Executive Secretariat. As of today, 9/28 the Conference Report has not been forwarded.

Sandy Bart