Withdrawal/Redaction Sheet
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. letter w/attach.	Ned and Jan Shure to Chris Jennings Re: Approval process for I-DOX (12 pages)	12/16/96	P6/b(6)

COLLECTION:
Clinton Presidential Records
Domestic Policy Council
Chris Jennings (Health Security Act)
OA/Box Number: 8993

FOLDER TITLE:
Correspondence [2]

gf67

RESTRICTION CODES

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

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

C. Closed in accordance with restrictions contained in donor's deed of gift.
PRM. Personal record misfile defined in accordance with 44 U.S.C. 2201(3).
RR. Document will be reviewed upon request.

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

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

Withdrawal/Redaction Marker
Clinton Library

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This marker identifies the original location of the withdrawn item listed above. For a complete list of items withdrawn from this folder, see the Withdrawal/Redaction Sheet at the front of the folder.

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THE WHITE HOUSE

June 23, 1994

C. Everett Koop, M.D.

P6/b(6)

Dear Dr. Koop:

Thank you for sharing with me the concerns of Dr. Billy Melvin, Executive Director of the National Association of Evangelicals. The religious community provides desperately needed health care services for so many people, including the most disadvantaged in this country. The President and I are committed to preserving the essential role of religious institutions under health care reform.

Nothing in the President's proposal for health care reform will limit the ability of churches to sponsor nursing homes and lifetime care centers. Instead, the plan will support hospitals and nursing homes with religious affiliations by continuing to provide tax exemption to non-profit health care providers that serve their communities. In addition, as you know, universal coverage will relieve religious health care institutions of the burdens of uncompensated care.

The Christian community has been tireless in its advocacy for health security. I look forward to continuing to work with them to pass health care reform legislation that will make that goal a reality for all American families.

With best wishes, I am

Sincerely yours,

Hillary Rodham Clinton

Hillary Rodham Clinton

I'm looking forward to another visit soon. Thanks too for making the huge effort to appear on the NBC special. I believe it will help inform millions who watch. Hillary

THE WHITE HOUSE

August 8, 1996

Ms. Mary Ellen Schattman

P6/b(6)

Dear Mary Ellen:

Thank you for sharing your thoughts about health care in Tarrant County, Texas. I have forwarded your letter to Bruce Vladeck, Administrator of the Health Care Financing Administration.

As you noted in your letter, the President and I have fought long and hard over the past few years for health care reform. We are pleased that Congress has taken the first steps by passing legislation that will help as many as 25 million Americans, who today live in fear of losing their health insurance when they change or lose their jobs.

It provides a strong foundation to begin to address a number of other health care challenges that face this country. It is important that we continue our efforts on behalf of the millions of Americans who are still in need of better health care.

Again, I thank you for your words of encouragement and wish you the best of luck in your ongoing efforts in Tarrant County.

Sincerely yours,

Hillary Rodham Clinton

cc: Bruce Vladeck

October 3, 1996

Mr. Jeffrey S. Crowley
Consortium for Citizens
with Disabilities
Seventh Floor
1413 K Street, N.W.
Washington, D.C. 20005-3405

Dear Jeffrey:

Thank you for sharing your thoughts about Medical Savings Accounts. I appreciate hearing from you.

As you probably know, the Kennedy-Kassebaum bill included a compromise provision on MSAs calling for a four-year demonstration period with limits on the number of people who can join. This will allow us to study the advantages and disadvantages of MSAs without delaying the effects of the bill's underlying health insurance reforms.

Until this bill was signed, some 25 million Americans lived in fear of losing their health insurance when they changed jobs or were laid off. The Kennedy-Kassebaum bill provides a strong foundation from which to address the health care challenges that face this country. We must continue our efforts on behalf of the millions of Americans who still need better health care.

Thank you for your input. I'm glad you took the time to write.

BILL CLINTON

Sincerely,

BC/ODP/SF/RSM/RLM/DWB/efr-efr-ws (Corres. #3160831)
(10.crowley.js)

cc: Chris Jennings ODP, Rm. 212R
cc: Sarah Freeman, Rm. 93

THE WHITE HOUSE

WASHINGTON

August 9, 1996

Ms. Susan L. Swinderman
President
Wee Care Therapy, Ltd.
1501 Joliet Street (Rt. 30), Unit B
Dyer, IN 46311

Dear Ms. Swinderman:

Thank you for sharing your support of the Domenici/Wellstone mental health parity compromise.

You will be pleased to know that the President strongly supported this legislation. Enclosed please find a copy of a letter that Leon Panetta, the White House Chief of Staff, sent to all Conferees. Unfortunately, the Domenici/Wellstone compromise was not included in the final version of the health insurance reform bill. Please be assured, however, that the President will work to find an appropriate vehicle for this issue in the near future.

Again, I appreciate your support of those in need of mental health care.

Sincerely,

Christopher C. Jennings
Special Assistant to the President for
Health Policy Development

MARY ELLEN SCHATTMAN

501 High Woods Trail • Fort Worth Texas 76112-1111 • Telephone 817-496-6088

July 18, 1996

Dear Hillary,

Don't ever give another thought to your health care plan. No regrets. No might have beens. I can assure you, even if it had passed, the forces of evil would have found a way to gut it, circumvent it, and steal the promise of health care from the middle class and the working poor.

For three long years Texans have worked to design a system better and kinder than TennCare. We succeeded. Last year we passed legislation and submitted an 1115 waiver. Ever since we have watched Governor Bush thwart the intent of the Legislature and sell out to the lobby. Last week , my public hospital district lost in state court in an attempt to force the governor's health commissioner to <u>just follow the law</u>!! This week another group lost in federal court. I have heard more lies on the stand and seen more cupidity and stupidity than I dreamed possible.

Like Chief Joseph, we in Tarrant County can fight no more. We have been to HCFA which seems perfectly willing to abandon the counties to the state just to grant more 1915b waivers. Because counties in Texas are responsible for indigent health care and many help fund Medicaid, Lubbock County will unwillingly become the poster child for unfunded mandates inflicted by a Republican governor. Under a 1915b waiver pending before HCFA, Texas will save $1 million, the US $2 million and Lubbock County will need to raise taxes by $8 million to make up for the lower revenue after the new HMO layer siphons off its share. Since it will be well nigh impossible for Lubbock to raise taxes by such an amount, health care services to the uninsured working poor will be cut to close the gap.

On the federal end, HCFA has between 90 and 180 days to approve a state waiver request which can irrevocably harm the existing health care delivery system for the poor and working uninsured. HCFA just assumes that the states do not lie. If the state says that there are over 2000 primary care doctors in Lubbock, how is HCFA to know that there are under 300 ? If the state represents that the counties around Lubbock are "urban", how is HCFA to know that they are sparsely populated rural counties, some with only one doctor ?

None of this was supposed to happen. We passed legislation to allow local communities to design systems with state approval to address local needs. But Governor Bush, who had campaigned on local control, even turned his back on Republican county judges and with the 1915b waiver process threw the local taxpayers to the wolves. And when local taxes go up to cover this folly, I am sure that our governor will blame the feds.

So as I said, mourn not for what might have been. You would have had to compromise excruciatingly just to get it passed. Once passed, your enemies would have found new ways to thwart it clause by clause and state by state. There is just no antidote for greed.

Except maybe a good licking. So lets just give'em one. I am really looking forward to seeing you in Chicago.

As ever,

Mary Ellen

August 7, 1996

Mr. Gene Kimmelman
Ms. Cathy Hurwit

P6/b(6)

Dear Cathy and Gene:

Thank you for writing to express your opposition to H.R. 2925, the Antitrust Health Care Advancement Act of 1996. It's always good to hear from you, and I appreciate knowing your views on this legislation.

While I believe that health care providers need clarification on antitrust law so that they can establish competitive alternatives to traditional insurance plans, I am concerned that statutory changes could have unintended consequences. I share your strong support for the development of new guidelines by the Federal Trade Commission and the Department of Justice, and while the FTC and the Department have yet to release such guidelines, it is my hope that they will strike an adequate balance between addressing providers' need for clarification and avoiding interventions that undermine competition in the marketplace.

I welcome your involvement in this important issue, and I'm glad you took the time to write.

Sincerely,

BILL CLINTON

BC/SEM/JFB/RSM/ws-lynn-ws-emu (Corres. #3042799)
(7.hurwit.c)

cc: Chris Jennings, OEOB, 212R,ODP
cc: Sandy Bublick-Max, ODP
cc w/copy of incmg. to Jen Klein, WW

THE WHITE HOUSE

WASHINGTON

July 30, 1996

The Honorable Howard L. Berman
Congress of the United States
House of Representatives
Washington, D.C. 20515-0526

Dear Mr. Berman:

Thank you for your recent letter regarding the cochlear implant and its Medicare fee schedule. I appreciate being apprised of the challenges the manufacturer of the product faces.

I have forwarded your letter to Dr. Bruce Vladeck, Administrator for the Health Care Financing Administration (HCFA) and have asked him to respond directly to your concerns. As you requested, I will review HCFA's response with your views in mind.

Please do not hesitate to contact me again on this or other issues of importance to you or your constituents. Again, thank you for writing.

Sincerely,

Christopher C. Jennings
Special Assistant to the President
for Health Policy Development

cc: Ms. Debbie Chang

THE PUBLIC FORUM INSTITUTE

1215 17th Street, N.W. • Washington, DC 20036 • 202 547-2470 FAX 202 547-1893 • email foruminst@aol.com

July 17, 1996

Mr. Chris Jennings
The White House
OEOB
Room 213
Washington DC 20500

Dear Chris:

After nearly 20 years it is time for a change! On behalf of all the staff of the Columbia Institute, I am pleased to announce that we have re-structured to form a new organization, "**The Public Forum Institute**".

Over the nine years that I have served as Executive Director of the Columbia Institute, I have had the privilege to oversee a wide range of public policy research and education initiatives in all fifty states and overseas. After reviewing where we have made the greatest contribution to the development of good public policy, I have concluded that our resources and experience should be more sharply focused on public education and the development of comprehensive public policy forums.

The sound-bite revolution along with more and more elaborate "message campaigns" have left less room for impartial and comprehensive public analysis of national policy issues. To address this, **The Public Forum Institute** will be dedicated to developing techniques that facilitate non-partisan, independent public forums. As an Institute, it will share these ideas with both elected officials and other public and private leaders. It will serve the public on the premise that if decisions made in Washington are to be sustained, they must be based on an informed public.

All the staff from the Columbia Institute have formed the new organization bringing years of experience in health care, tax and trade policy, economic development and other community issues, energy and environmental policy, education and labor issues, and, of course, all the corresponding fund raising, media, and logistics skills so essential to an "event" planning group. In addition to moving forward with our own initiatives, these services will remain available to corporate public affairs offices, trade associations and public affairs firms.

I am proud to announce that we will be moving to a new building on August 1, 1996 and have attached a new card for your rolodex. If you want to learn more about the leading edge services we now offer, or if we can serve as a resource to you, please do not hesitate to contact us.

Sincerely,

Jonathan Ortmans
President

What can I do to help between now and November!

AUG - 5 1996

WEE CARE THERAPY, Ltd.

1501 JOLIET ST. (RT. 30) UNIT 6B, DYER, IN 46311 (219) 322-1415 or (708) 946-9069
PEDIATRIC THERAPY SPECIALISTS

July 19, 1996

Dear Honorable:

I'm writing to express my support for the Domenici-Wellstone "parity amendment". Please vote in favor of this amendment as it is a long overdue health benefit desperately needed today.

As an occupational therapist, as well as president of Wee Care Therapy, Ltd., I have seen discrimination against the mentally ill for far too many years. A mental illness is as real as any physical problem and should rightfully be given more consideration. Many sick individuals could make significant strides in their recoveries if this amendment is passed.

Concern for all sick people, mentally ill as well as physically ill, is an obligation which the world needs to be reminded of. Please vote in favor of the Domenici-Wellstone "parity amendment".

Sincerely,

Susan L. Swindeman

Susan L. Swindeman, OTR/L
President

SUSAN L. SWINDEMAN, OTR/L, BCP
PRESIDENT

California Medical Association

221 Main Street, P.O. Box 7690, San Francisco, CA 94120-7690 • (415) 541-0900

Physicians dedicated to the health of Californians

John C. Lewin, M.D.
Executive Vice President
Chief Executive Officer
TEL: (415) 882-5100
FAX: (415) 882-3349

July 24, 1996

Chris Jennings
Special Assistant to the President
for Health Policy Development
The White House
1600 Pennsylvania Avenue NW
Washington, DC 20500

Dear Chris:

It was a distinct pleasure having the opportunity to hear your reflections on the key healthcare issues and priorities of the Clinton Administration at this point in our nation's history. I have long respected your excellent work in Washington in these regards, and I hope that as the CEO and Executive Vice President of California Medical Association, that I will have the opportunity of bringing "the most democratic-inclined" group of physicians in the country to the task of participating with the Administration and Congress in the development of solutions to the nation's access and quality issues in healthcare.

As you undoubtedly know, I am personally dedicated to resolving the access problems in a way that will also enhance the health status of Americans through a strengthened public health and community health infrastructure. I am heartened that the President and First Lady have always ascribed to these kinds of goals. That is why it has been such a pleasure to work with them in the past and hopefully in the future.

If the California Medical Association can be of significant assistance to you in any way over the coming months or in the course of the next four years, please don't hesitate to call on me at any time.

Very truly yours,

John C. Lewin, MD

JCL:ai

July 15, 1996

Ms. Ann B. Howard
Executive Director
American Federation of
Home Health Agencies, Inc.
Suite 100
1320 Fenwick Lane
Silver Spring, Maryland 20910

Dear Ann:

Thank you for sharing your views regarding the proposal to move the home care benefit from Part A to Part B of Medicare. I appreciate knowing of your concerns.

Be assured that this transfer plan does not call for any additional co-payments. Moreover, the shift has the benefit of reducing -- by some $50 billion over the next seven years -- the amount of traditional Medicare cuts that would otherwise have to be taken from hospitals, nursing homes, and home health agencies.

As we seek to protect the long-term stability of the Medicare Trust Fund, I will certainly keep your views in mind. Meanwhile, I have shared your letter with my staff.

Sincerely,

BILL CLINTON

BC/SEM/JFB/bws-ws (Corres. #3024454)
(7.howard.ab)

cc: w/inc Chris Jennings, ODP
cc: w/inc Jen Klein, WW
cc: w/inc Marilyn Yager, OPL

AMERICAN FEDERATION OF HOME HEALTH AGENCIES, INC.
1320 Fenwick Lane • Suite 100 • Silver Spring, MD 20910
Phone (301) 588-1454 Fax (301) 588-4732

June 6, 1996

President William J. Clinton
The White House
1600 Pennsylvania Ave.
Washington, D.C. 20500

Dear Mr. President:

The American Federation of Home Health Agencies is strongly opposed to the Administration's and Congressional Democrats' proposal to transfer part of the Medicare home health benefit from Part A to Part B of the Medicare program.

It does not matter that the Republicans have made similar proposals in the past. Their proposals were equally misguided.

The shift of over 70 percent of the home health benefit to Part B is nothing more than budgeting by legerdemain. It is a gimmick to give the appearance of savings when in truth it represents a massive cost shift to the American taxpayers, who will have to contribute more in general tax revenues to pay for the transferred home health services, and to Medicare beneficiaries, who will be forced to pay higher Part B premiums.

The proposal also puts beneficiaries on the slippery slope to imposition of home health copayments. How long will it be before the Administration and Congress succumb to the inevitable pressure to impose such cost sharing on Part B home health visits, to be consistent with other Part B services subject to copayments? Not long.

We suspect that home health beneficiaries and their family members will not be pleased to learn that other sectors of the health care industry, such as hospitals, are eager to offer the bifurcation of the Medicare home health benefit and additional financial burdens on Medicare beneficiaries as "savings" that should be enacted in lieu of adjustments to their own rates of reimbursement.

Medicare beneficiaries, their family members, and American workers and employers have already paid for these home health services through the Medicare taxes we pay on every dollar we earn or pay to our employees. Now beneficiaries and taxpayers would be forced to pay again.

This transfer proposal is not progress. It is a throwback, to an outmoded model which Congress discarded in 1979. Congress itself set in motion an expanded role for home care that year by removing the old three-day prior hospitalization requirement and the one hundred visit per beneficiary annual limit.

In the years since these changes, home health providers have responded to the challenge of implementation of hospital diagnostic related groups (DRGs), enabling hospitals to discharge patients more quickly and in a poorer state of health. In addition, because home health agencies can provide all services short of surgery in the home, they have prevented the hospitalization or institutionalization of countless very sick Medicare beneficiaries, at great savings to the American taxpayer.

Does it make any sound policy sense to send beneficiaries who have a three-day hospital stay home to Part A services and those with a two-day stay home under Part B? Does it make sense to take two patients with the same diagnoses, circumstances, and treatment requirements and place one in Part A because of a prior hospitalization, and the other in Part B because a home health agency has succeeded in preventing a hospitalization in the first place? This artificial splintering of the home health benefit fails to recognize that home care often constitutes acute care that substitutes for higher cost hospitalization.

When will the Administration and Congress recognize that home health care is not the problem? Rather, it is a big part of the solution.

Sincerely,

Ann B. Howard

Ann B. Howard
Executive Director

THE WHITE HOUSE

WASHINGTON

August 9, 1996

Mr. Jonathan Ortmans
President
The Public Forum Institute
1215 17th Street, NW
Washington, DC 20036

Dear Mr. Ortmans:

Thank you for your letter informing me of the recent changes in your organization. It sounds like some wonderful things are happening over there.

I appreciate your keeping me up to date. Good luck with this new endeavor.

Sincerely,

Christopher C. Jennings
Special Assistant to the President for
Health Policy Development

Institute for Research of Food-related Disease
Director Patrick Wright, Ph.D.
P.O. Box 150 007, San Rafael, CA 94915-0007
Tel. (415)453-1709

July 7, 1996

Mr. Bob J. Nash
Assistant to the President
Director of Presidential Personnel
The White House
WASHINGTON, D.C. 20500

Re: New European information for solving the health crisis

Dear Director Nash:

Please find enclosed a copy of the first two chapters of my new book, Food for Humans. It introduces to the U.S. European dietary and health knowledge that has been practiced and proven for more then 20 years. It has, unfortunately, not yet found its way into American publications and American medical practices. Making use of this knowledge would save many Americans a lot of money as well as their health and their lives.

In Chapter 1a (Americ a's annual death toll from food-related diseases) I try to quantify on page 8 that the U.S. loses each year five times as many years of potential life because of the boycott of the knowledge of cause and cure of food-related diseases as the nation has lost in one year of WW II.

Please find enclosed also as an example a copy of Chapter D2 "Cancer." In Chapter D1 I introduce Dr. Wendt's 1948 discovery of cause and cure of heart disease. The application of the knowledge of Parts D and E could make Medicare feasable again without any cuts.

I have compiled further ideas of how to solve America's health crisis in a Plan. It focuses on Presidential decisions that do not necessarily involve Congress in order to exclude lobbying. Do you see a chance to discuss these ideas for a reform? It should be possible to move health care toward a system of real health assurance and away from a system that waits until people get sick and then makes payments for medical treatments.

I look forward to hearing from you.

Sincerely,

Patrick Wright

Patrick Wright

THE WHITE HOUSE

WASHINGTON

August 9, 1996

Mr. John C. Lewin, M.D.
Executive Vice President
Chief Executive Officer
California Medical Association
221 Main Street, P.O. Box 7690
San Francisco, CA 94120-7690

Dear Jack:

I wanted to take this opportunity to thank you for your kind note. It was good to see you too.

I know the First Lady and the rest of the Administration representatives at the meeting were equally impressed with the California delegation and their approach to health care reform.

Again, thanks for your support. As always, I look forward to working with you in the coming months and years (hopefully).

Sincerely,

Christopher C. Jennings
Special Assistant to the President for
Health Policy Development

THE WHITE HOUSE

WASHINGTON

July 30, 1996

The Honorable Howard L. Berman
Congress of the United States
House of Representatives
Washington, D.C. 20515-0526

Dear Mr. Berman:

Thank you for your recent letter regarding the cochlear implant and its Medicare fee schedule. I appreciate being apprised of the challenges the manufacturer of the product faces.

I have forwarded your letter to Dr. Bruce Vladeck, Administrator for the Health Care Financing Administration (HCFA) and have asked him to respond directly to your concerns. As you requested, I will review HCFA's response with your views in mind.

Please do not hesitate to contact me again on this or other issues of importance to you or your constituents. Again, thank you for writing.

Sincerely,

Christopher C. Jennings
Special Assistant to the President
for Health Policy Development

cc: Ms. Debbie Chang

26TH DISTRICT, CALIFORNIA

COMMITTEES:

INTERNATIONAL RELATIONS

RANKING MEMBER, SUBCOMMITTEE ON ASIA AND THE PACIFIC

JUDICIARY

Congress of the United States

House of Representatives

Washington, DC 20515-0526

HOWARD L. BERMAN

96 JUL 26 P6 : 09

2231 RAYBURN HOUSE OFFICE BUILDING
WASHINGTON, DC 20515-0526
(202) 225-4695

DISTRICT OFFICE:
10200 SEPULVEDA BLVD.
SUITE 300
MISSION HILLS, CA 91345
(818) 891-0543
(818) 764-1206

July 23, 1996

Mr. Christopher Jennings
Special Assistant to the President for Health Policy
The White House
212R OEOB
1600 Pennsylvania Ave., N.W.
Washington, DC 20500

Dear Mr. Jennings:

I am writing to ask that you review HCFA's pending proposal to develop a fee schedule for the cochlear implant when it is provided in the Part B setting, and request HCFA to put this proposal on hold until a review has been completed. It is my understanding that HCFA intends to implement this policy in early August. As outlined below, I believe that this proposal may be unwise and should be re-evaluated.

The cochlear implant is a surgically implanted, bio-medical device which enables the profoundly hearing impaired to hear. Cochlear implant patients receive no benefit from hearing aids. Implant users are often able to use the telephone, go to school with their peers, maintain demanding jobs, and be more involved in their community and family life. The implant is designed to last the lifetime of the patient, while the external sound gathering device and sound processor are upgraded as technology improves. If HCFA implements the fee schedule it now contemplates, I am told that many cochlear implant programs will cease to be financially viable and will be terminated by their hospitals. The effect would be to eliminate access to this life enhancing technology for some of the fewer than 200 Medicare patients a year who need it.

The two U.S. manufacturers of this technology, one of which is in my congressional district, have worked for the past nine months with HCFA in an effort to resolve this matter. As a result, HCFA has agreed not to use pricing data for the development of the fee schedule that the manufacturers demonstrated was inaccurate. Notwithstanding this cooperation from HCFA, I am told the resulting fee schedule payment for the cochlear implant is likely to be substantially below the cost of acquisition.

I am concerned about HCFA's interpretation of congressional intent in OBRA 86 regarding the development of fee schedules for prosthetic devices. Congress has required HCFA to use fee schedules for many areas of medical technology in order to bring greater efficiency and cost savings to the Medicare program. HCFA has responded to OBRA 86 by developing fee schedules for wound dressings, ostomy supplies, and other relatively low-tech, high volume supplies. However, the cochlear implant is not a health care commodity item routinely used hundreds of times a day in hospitals across America. Only 50 or so hospitals have cochlear implant programs. The device actually re-establishes a link between the outside world and the hearing center of the brain bringing a lifetime of hearing to an otherwise totally deaf individual.

Extensive pre-surgical and post-surgical work with the patient is required, and each device must be calibrated to the needs and physiology of the patient. It is worth noting that HCFA has actually refrained from imposing fee schedules on other devices which require customization. These pre and post surgical activities require many patient visits to the surgeon and audiologist over a period of several months. Thus, it would be an unacceptable hardship on patients and their families for HCFA policy to force the closing of the low-volume centers, nor would a "centers of excellence" concept work.

To conclude, I hope you will ask HCFA to suspend efforts to implement a Part B fee schedule and allow the manufacturers to meet with you to explain their position.

Sincerely,

Howard L. Berman

HOWARD L. BERMAN
Member of Congress

HLB/ir

cc: Mr. John Hilley

fax to Bruce Vladeck

cc: Debbie Chang

THE WHITE HOUSE

WASHINGTON

December 30, 1996

Ms. Susan Pascoe
Director, Home Care Services
Daughters of Charity
4600 Edmundson Road
St. Louis, Missouri 63134

Dear Ms. Pascoe:

Thank you sharing with me your thoughts on the potential effects of the regulation 42 CFR 424.22 on home health agencies. Your concerns about this regulation's unintended consequences absent the final regulations of the "Stark II" law are understandable.

I have forwarded your letter to Dr. Bruce Vladeck, Administrator of the Health Care Financing Administration (HCFA) and asked him to respond directly to your concerns.

I appreciate having the benefit of your views.

Sincerely,

Christopher C. Jennings
Special Assistant to the President
for Health Policy

DAUGHTERS
OF
CHARITY
NATIONAL HEALTH SYSTEM

4600 Edmundson Road
St. Louis, Missouri 63134
314-253-6700

Post Office Box 45998
St. Louis, Missouri 63145-5998

December 12, 1996

Mr. Chris Jennings
The White House
1600 Pennsylvania Ave., N.W.
Washington, D.C. 20500

Dear Mr. Jennings:

The Health Care Financing Administration (HCFA) issued a letter on the interpretation of several regulations in response to a consultant's request. This letter has created concern about an interpretation that would bar physicians from referring patients to hospital owned home health agencies when the physician is employed by, or has a significant financial arrangement with that hospital.

As Director of Home Care Services for the Daughters of Charity National Health System, many of our agencies are uncertain of what are acceptable practices. I am contacting you to express my apprehension that this interpretation would prevent organizations with capitated Medicare contracts from providing home health services; bar integrated delivery systems from coordinating care for Medicare beneficiaries; prevent medical residents paid by hospitals from establishing treatment plans for hospitals' home health agencies; and interrupt access to care in rural areas where hospitals frequently provide a seamless continuum of home health care.

I understand that the final decision to issue a moratorium on enforcement of the regulation 42 CFR 424.22 rests with Secretary Shalala. I ask you on behalf of the 35 Daughters of Charity home health care agencies to urge her to do so.

Sincerely,

Susan Pascoe

Susan Pascoe
Director, Home Care Services

C:\WPDOCS\SISP\SHALALA.MEM

Aug. 13, 1996

Dear Hillary,

I am writing to request your support of a very exciting project that has long range consequences for Arkansas and the nation as a whole. As you may be aware, the University of Arkansas for Medical Sciences has had a major interest in caring for our rapidly aging population. UAMS has been a leader in providing direct patient care for older Arkansans, delivering education to health care professionals working throughout the state, and conducting both basic and applied research in the field of aging. UAMS advanced its activities in geriatrics in July, 1995, when Dr. Ward, Chancellor, officially established the Center on Aging and appointed Dr. David Lipschitz as its director.

A community advisory board, chaired by Jo Ellen Ford, was formed and I accepted an invitation to serve on it. I must say I am truly excited about the Center's work and I think anyone who is affiliated with the Center is astonished at the positive response to it.

A proposal was submitted to the Don W. Reynolds Foundation for a building to house the Center, and funds to develop a Department of Geriatrics in the University. We think both of these proposals would benefit significantly if it included a letter from you, addressed to Dr. David Lipschitz, the reflects your continuing interest in the State of Arkansas and the work to which UAMS has committed itself. I know you are deeply concerned about the health of all Americans, but particularly with this segment of our population.

I am enclosing several documents that can more fully explain the Center on Aging. I certainly would be glad to try to answer any questions you may have. Also, I know, Dr Dowd Lipschitz will be happy to speak with you or a member of your staff to clarify or expand on any points.

I will be in Chicago for the Convention - I would not miss it!!! I hope I will have a chance for a quick visit.

Thank you for your Consideration,

Love

Lissy

CENTER ON AGING
4301 West Markham, Slot 748
Little Rock, Arkansas 72205-7199
501/296-1475

August 13, 1996

UAMS MEDICAL CENTER

The University of Arkansas for Medical Sciences has had a major interest in caring for our rapidly aging population. UAMS has been a leader in providing direct patient care for older Arkansans, delivering education to health care professionals working throughout the state, and conducting both basic and applied research in the field of aging. UAMS advanced its activities in geriatrics in July, 1995, when Dr. Ward, Chancellor, officially established the Center on Aging and appointed Dr. David Lipschitz as its director.

Two excellent opportunities to receive significant funding for the Center's aging initiative have recently developed. Both opportunities are from the Don Reynolds Foundation. This Foundation has determined that an area in which they feel they will have the greatest impact is in aging and especially in the training of health professionals specializing in or sensitive to the special needs of the growing elderly population. Further, the Foundation will only support activities in one of three states: Arkansas, Nevada, and Oklahoma. The two opportunities available to us consists of $12-15 million to build and equip a Center on Aging facility, and to award an endowment of between $10-30 million to develop a Department of Geriatrics in the College of Medicine.

In early June, UAMS received notice that the proposal we submitted for a building to house the UAMS Center on Aging merited further consideration. Accordingly, we are in the process of developing a proposal due September 30, 1996. The goals of the Center on Aging Building are to promote functional independence of older adults, and to prepare for the baby boomer generation. Specifically we intend to develop a Center of Excellence that supports the latest in communication technology that will:

- Provide a network capable of providing for the education of geriatric health professionals, health care professionals in practice, older adults, their families, and the general public, and to prepare practitioners and consumers of health care to use state-of-the-art equipment and technologies
- Conduct basic and clinical research
- Deliver geriatric health care that encompasses primary care, care of individuals with cognitive related disorders, and provide health promotion and disease prevention, and
- Develop a public policy institute designed to address key health, social, and economic concerns critical to an aging society.

The second initiative is to develop a Department of Geriatrics in the College of Medicine. The goal of this Department is to train geriatric physicians and other health care providers including nurses, pharmacists, and nutritionists. This endowment will provide much needed support to increase the number of geriatric health professionals to care for the burgeoning number of older adults. We will be meeting with a team from the Don Reynold's Foundation, August 27, to informally discuss this particular proposal.

Goal: TO DEVELOP A WORLD CLASS CENTER ON AGING

INTRODUCTION

Increases in life expectancy and reductions in childbearing have transformed the age-structures of the population. This trend has increased significantly the number of elderly Americans. It is estimated that the number of people 65 years or older will double between 1990 and 2030 bringing their total number to about 70 million. On an average people have approximately 16.4 years of life remaining at age 65, however, only about 12 of these years will be spent in a condition of good health.

Arkansas is no exception to this trend. It ranks sixth in the nation in the percentage of its residents that are 65 years of age and over. The fastest growing segment of Arkansas' population is the 85+ group. The need for health care and personal social services rises rapidly for this group because many of its members are physically disabled and can no longer function independently.

CENTER ON AGING

The University of Arkansas for Medical Sciences has taken a major step in addressing the needs of older Arkansans. In July 1995 Chancellor Harry Ward officially established the Center on Aging (COA) and appointed Dr. David Lipschitz as its director. The Center's orientation follows closely that of the University. The COA has defined its mission as follows:

> The mission of the Center on Aging is to deliver quality health care for older persons, provide educational programs on aging for health care professionals and the public, conduct research on aging and age-related diseases,and influence public policy on aging issues.

The Center acts as a clearinghouse to coordinate efforts, publicize ongoing programs in a systematic manner and develop venues for collaboration on age-related projects for faculty members, not only from UAMS but from the University of Arkansas system. The COA serves as a broad-based resource, enhancing faculty and their institutions' abilities to successfully compete for exogenous funding. Another major

focus of the Center is the development of programs that are unique to older persons, especially minorities, in the rural areas of Arkansas.

Existing Programs

Age-related activities at UAMS, developed over the past decade and a half, serve as the foundation for the COA. The University is fortunate to have several outstanding institutions and research facilities nearby that have developed robust aging programs. In the area of service and clinical work it has an outstanding partner in the John L. McClellan Memorial Veterans' Hospital in Little Rock. This VA hospital became the site in 1976 of the first Geriatric Research, Education and Clinical Center (GRECC) in the country. Its mission is threefold: 1) design and develop model clinical programs that improve care to older veterans, 2) increase knowledge through basic and applied research on aging and 3) provide educational and training opportunities for health care professionals in geriatrics and gerontology. The Little Rock GRECC developed the first *Geriatric Evaluation Unit* (GEU). Today, it is a nationally-recognized paradigm for the team concept in health care delivery. Each GEU, consisting of physicians, nurses, pharmacists, social workers and other health care professionals, provides comprehensive assessments of older patients and their often complex problems. These assessments provide the mechanisms through which treatment plans are developed with an aim at maintaining functional independence. This program has not only improved older patients' quality of life but has also proven to be cost effective. Its utilization has reduced the odds that many older veterans will be placed in nursing homes. As a direct result of the Little Rock example there is now a GEU in almost every VA hospital.

In addition, the Little Rock VA is a pioneer in the field of adult day health care. Its program provides care and rehabilitation for functionally dependent older persons during the day allowing them to return home at night usually to households whose residents are employed outside the home. The LRVA also developed the first home-based program wherein hospital care is provided to frail patients in their own residences. Another innovation is the respite care program that admits functionally dependent older patients to hospitals for short periods giving needed relief to caregivers.

Following the lead of its neighbor and partner, UAMS has developed programs that include interdisciplinary ambulatory care clinics that evaluate and provide primary care to older persons, the Pennebaker Center that provides adult day health care and the innovative geriatric rehabilitation and recuperative care programs in nursing homes. In the latter, patients who have experienced acute illnesses are admitted to nursing homes' transitional care units where they receive intensive rehabilitation targeted toward their regaining sufficient health and independence to return to their homes. UAMS has also developed a center for Alzheimer's disease and related disorders that provides comprehensive assessment and care for patients with memory disorders.

UAMS has a robust, internationally known program in aging research. Total grant support from government and industry now exceeds $17,000,000.

In the area of basic research Dr. Lipschitz leads a large group that studies the fundamental changes that lead to declines in cell function with age; Sue Griffin, PhD, guides a group of colleagues that investigates the basic biology of Alzheimer's Disease; and Stavros Manolagas, MD, PhD, leads a large number of scientists that studies the causes of osteoporosis. Just as the presence of the VA has been a boon also has the National Center for Toxicological Research (NCTR) in nearby Jefferson, AR. Ronald Hart, PhD and colleagues explore the effects of food intake restriction upon longevity. This NCTR program provides an ideal opportunity for collaboration with UAMS researchers.

In the clinical research realm, Dennis Sullivan, MD, heads a group of clinical investigators that studies the role that malnutrition plays in increasing the risk of complications and death in frail hospitalized older persons. Additional studies are examining the role of strength training, nutrition and hormonal therapy in improving strength and independence in the most frail hospitalized older persons. Cornelia Beck, PhD, RN, leads a large group of investigators who are studying approaches to the management of disruptive behavior in patients with Alzheimer's disease and to the special needs of their caregivers. Additional age-dependent disease research includes approaches to falls prevention in older persons, cause and prevention of strokes, and basic and clinical research programs on causes, treatment and prognosis of cancer in the elderly.

In the area of education, UAMS has developed several programs with geriatric/gerontologic tracks. Programs include a geriatric fellowship and residency program in the College of Medicine, a geriatric residency in the College of Pharmacy and a masters degree in the College of Nursing. In addition, when the College of Nursing inaugurates its PhD program in fall 1997 a concentration in geropsych nursing will be offered. Many courses throughout UAMS have a geriatric/gerontologic content. In addition, the VA offers specialized training programs in aging to physicians, nurses, social workers, pharmacists, physical and occupational therapists and psychologists. The GRECC and UAMS offer a series of courses and seminars on aging for health care professionals, e.g., annual symposia on nutrition and aging attracting over 200 registrants from throughout the United States.

COA Strategic Plan

Consistent with its goal and mission statement, the following Five-Year Strategic Plan was developed based upon input from representatives from all UAMS colleges, Institutional Advancement, University Hospital, the VAH and the External Advisory Board.

1. Develop new and expand existing interdisciplinary healthcare programs at UAMS and the VA.

As described above UAMS in concert with the VA continues its development of an outstanding clinical program that evaluates, educates and treats older patients. Employing state of the art technology, an interdisciplinary team, including physicians, social workers, pharmacists, nutritionists, registered nurse practitioners and psychologists, performs an initial evaluation that leads to accurate diagnosis and assessment and a rational approach to management of older patients' health care needs. This includes treatment of medical conditions, advice regarding inappropriate medication use, and treatment of behavioral/social problems that may accompany age-dependent diseases and frailties. A major focus is the diagnosis and treatment of patients with Alzheimer's disease and other memory disorders. Accurate diagnosis, optimization of medical management and treatment of complications will improve the quality of life of the patient and decrease the family burden. In selected patients, specific therapies aimed at retarding progression of disease may also be prescribed. An intensive education effort is an important component of the program that provides essential insights and support to patients and their families. Patients are followed regularly to monitor progress and manage problems if they develop.

The COA hopes to expand the scope of services provided. These include closer collaboration with community clinics, the Pennebaker Center, and development of strategies to improve care to minorities and elderly in rural areas. Currently, the staff required to meet the increasing number of older persons requesting care at the University Medical Center is insufficient.

- 1.1 Expand interdisciplinary team
  - a. home
  - b. clinic
  - c. hospital
  - d. nursing home/transitional care
  - e. establish core of case managers
- 1.2 Establish linkages with all UAMS programs that deliver care to the elderly
  - a. incontinence
  - b. osteoporosis
  - c. falls and frailty
  - d. impotence
  - e. stroke
  - f. rehabilitation medicine
  - g. Pennebaker Center
  - h. Argenta highrises
  - i. AHECs
- 1.3 Develop programs for informal caregivers
  - a. system for long distance caregivers
  - b. Jr. League/CD-Rom
  - c. conduct needs assessment on caregiving

1.4 Establish programs that promote positive approaches to successful aging
   a. develop wellness programs
   b. develop innovative programs for the frail elderly
   c. develop health promotion and disease prevention programs
   d. explore alternative medicine programs in aging
   e. develop health maintenance programs in chronic disease management and prevention
   f. develop community-based programs

1.5 Promote the use of volunteers to assist patients in clinics and in their homes

Specifically:

- Expand clinic staff, including two physicians, one social worker, two advanced practice nurses, one neuropsychologist and one data manager.
- Name a coordinator for services targeted at rural and minority elderly. This person will be responsible for the design and development of model service programs, identification of grant support opportunities and implementation of funded programs.

Develop COA-affiliated programs to provide primary care geriatric clinical services for local residents and education and research opportunities for health care professionals throughout the state. Development of these affiliations will be in concert with the Arkansas Area Health Education Centers (AHEC). This effort will rely heavily upon teleconferences and telemedicine in program development.

1.6 Develop affiliated Centers
   a. El Dorado
   b. Hot Springs Village
   c. Northwest Arkansas

2. Provide educational opportunities for healthcare professionals and the public.

In many areas of the state, 20 percent or more of the population is elderly. In some regions the older population is affluent while in others poverty and poor access to health care are serious concerns. The COA plans to increase educational opportunities at UAMS and affiliated colleges and universities across the state and for the public. The interdisciplinary nature of care and research provides a unique opportunity to educate health care professionals in many disciplines including medicine, nursing, social work, physical and occupational therapy, audiology, and speech pathology.

The Center plans to use state-of-the-art telemedicine and teleconference technology. The Center will be linked to sites across the state and also the nation. In addition programs designed and developed on aging will be disseminated to universities, and vocational and community colleges. Education efforts directed toward the public of all ages are a high priority. This effort will lead to the development of novel and

effective programs that target underserved and functionally dependent older persons. The strategies in education are:

2.1 Work with organizations to educate public, e.g., Alzheimer's Association
2.2 Sponsor courses
  a. professional/providers
  b. community
2.3 Strengthen existing programs
2.4 Develop teleconferencing courses for healthcare professionals
2.5 Educate primary care providers to recognize age-dependent diseases and conditions including cognitive impairments
2.6 Develop Internet program, e.g., web page, on eldercare
2.7 Establish speakers bureau
2.8 Develop in conjunction with AETN a four-part series on aging
2.9 Publicize success stories

To meet these objectives resources must be identified to recruit an education director, an associate director and administrative personnel. This group will assume responsibility for identifying sources of support to assist in the design and development of these education strategies.

3. Conduct and support basic and applied research.

The COA offers a unique opportunity for researchers on campus to interact with each other and develop collaborative efforts that will make UAMS more competitive for federal research funding, independent research programs and support as designated center of excellence. These include being able to compete for federal monies to establish a Claude Pepper Older Americans Independence Center, a Nathan Shock Center of Excellence in the Basic Biology of Aging and to be designated by the National Institute on Aging as an Alzheimer's Center, supporting basic and clinical research. in addition, independent research grant support for program projects that provide mechanisms for scientists to study common problems, e.g., basic biology of aging an age-dependent disease such as Alzheimer's, will be sought.

Becoming competitive for these centers and programs will require greater cooperation among existing faculty as well as the recruitment of new faculty to increase critical mass and competitiveness. Strategies for research are:

3.1 Support research activities
  a. grant preparation and editing
  b. identify potential funding sources
3.2 Apply for research grants
  a. Claude D. Pepper Older Americans Independence Center
  b. Alzheimer's Disease Core Center
  c. Nathan Shock Center of Excellence in Basic Biology of Aging

d. graduate/postgraduate training
e. individual initiated projects

3.3 Establish ongoing review process for grant applications
3.4 Create systematic publicity program for research projects and accomplishments
3.5 Provide funding for pilot studies

4. Ensure the COA's Financial Viability.

The COA must strive to ensure its fiscal stability. It must work closely with the University Hospital and develop mechanisms to constantly monitor public and private funding sources.

4.1 Enhance care revenues
a. identify all reimbursable clinical charges
b. explore organizational structures that permit additional billings
c. participate in managed Medicare program development
d. identify programs/services eligible for block grant funding (if enacted)

4.2 Seek support from state
a. establish rapport with Arkansas legislators
b. secure dedicated revenue sources

4.3 Establish fund raising programs
a. develop case statement and identify potential donors
b. create COA foundation
c. involve adult children/grandchildren of patients in fund raising activities
d. educate COA patrons/patients on estate planning and planned giving
e. seek endowments for specific programs
f. conduct one major public event per year

5. Build a Facility to House the Center on Aging.

The overall theme of the work conducted in the proposed facility will be *"the promotion of functional independence in older persons through closely linked and interdependent research, education and clinical programs."* Although people are living longer it is not necessarily a given that they are living better. That is, many older persons find their quality of life compromised. UAMS, in general, and the COA, in particular, is dedicating itself to finding ways to keep older citizens independent.

A building housing the COA will permit on-site linking of clinical care to clinical research. Patients can be evaluated and observations made that can assist in developing new and novel approaches for improving older persons' quality of life. Three distinct older population groups have been identified: 1) healthy elderly, 2) physically impaired elderly (including frail elderly) and 3) cognitively impaired (including

Alzheimer's disease). Health promotion and disease prevention activities will be delivered to healthy persons whereas maintenance and improvement in independence is the goal for the physically disabled and the cognitively impaired.

It is envisaged that the proposed COA building, occupying a block of land on the southeast corner of the UAMS campus, will be four stories tall. The two lower floors will be dedicated to clinical service and research activities. The third floor will house basic research programs and the fourth floor will be devoted to education and a public policy institute plus the Center's administrative offices.

5.1 Donald W. Reynolds Foundation proposal
   a. preproposal/letter
   b. proposal
5.2 Secure funding for facility operations

6. Establish a Public Policy Institute.

Leaders from Arkansas have played key roles in developing the national public policy on aging. Much of this effort has been spearheaded by the Honorable David Pryor. Throughout his career, whether serving in the House of Representatives or the Senate, he has championed the needs of older Americans. The Center on Aging at UAMS can provide an excellent environment from which to continue Senator Pryor's work. Thus, a major thrust of the COA will be the creation of a Public Policy Institute on Aging. The Institute will address key health, social and economic concerns critical to an aging society. The Institute will become a local, regional, national and international forum where aging issues and their consequences are addressed. Resident staff plus invited leaders will develop research studies, white papers and scholarly articles. Special emphasis will be given to community programs that need to be developed for "quality of life" issues facing the elderly as they live within their community. Such programs and interactions may include transportation, work opportunities, intergenerational family issues and housing. The preparation of our communities for the graying of America will be emphasized.

6.1 Define objectives
6.2 Seek funding
6.3 Staff

7. Develop a teaching longterm care facility.

A longterm care teaching facility will be developed in collaboration with an established provider of extended nursing home care. In 1990, 4.3% of Arkansans 60 years of age or older lived in nursing homes. This percentage increases markedly with age, ranging from 0.7% for the 60-64 age group to a high of 21.8% for persons 85 or older. The presence of a teaching nursing home will provide a unique resource not only for the COA and UAMS but for the entire state.

A critical aspect of geriatric care is the provision of a continuum of care that includes ambulatory, inpatient, transitional, nursing home and home health care services. It is anticipated that this site will be used extensively for the education of health care professionals in long term care in general and in nursing home care in particular. This academic site will be used to develop novel, high quality, cost effective programs to provide for the special needs of institutionalized older persons. Services provided will include general nursing home care, dementia patient care and subacute care. Intensive rehabilitation and disposition planning will be a high priority in the latter, i.e., subacute care. The academic nursing home will also conduct high quality, appropriate research that, hopefully, will be well supported by both private and public funds.

7.1 Identify an extended care provider with whom to affiliate
7.2 Commence planning/feasibility study
7.3 Staff

8. Expand the Scholars Program.

This program will continue to provide and seek endowed positions for junior faculty addressing the problems of aging. The Center already has in place one program, i.e., the Inglewood Scholar Program. In 1993, UAMS was the recipient of a $1,000,000 endowment from the Inglewood Foundation to finance research on Alzheimer's disease. Proceeds from the investment of the money are currently providing startup salary and support for Dr. Steven Barger who joined the Center on September 1, 1995. He has been given salary support and funds to develop his research program through August 31, 1998. During this time he will compete for independent funding that will provide him with ongoing support beyond this initial period. After Dr. Barger's tenure another scholar will be recruited. This mechanism will increase the critical mass of scientists on campus conducting research on Alzheimer's disease.

Additional resources will be sought to maintain four more scholars. It is envisaged that one young faculty member will conduct interdisciplinary clinical research. In addition, one scholar will be named in each of the following colleges: nursing, pharmacy, and health related professions.

8.1 Establish an endowed Scholars Program in each UAMS college
8.2 Explore sources of funding

STEVE ANDERSON
Trustee

DONALD W. REYNOLDS FOUNDATION

August 5, 1996

RECEIVED
AUG - 6 1996
Chancellor's Office

Dr. Harry Ward
Chancellor
University of Arkansas for Medical Sciences
4301 West Markham
Mail Slot 541
Little Rock, AR 72205-7199

Dear Dr. Ward,

The Board of Trustees of the Donald W. Reynolds Foundation decided in January of 1996 to investigate initiatives for possible funding in addition to our current on-going Capital Grants Program. The Board formed two committees to investigate the areas of interest expressed by the Trustees during that meeting. Our committee, the Committee on Aging and Quality of Life, spent the Spring of this year investigating the areas of greatest need in issues dealing with aging and the elderly. Since the three members of our committee had no expertise in this area we retained the services of Dr. Robert Butler, the director of the International Longevity Center, professor in geriatrics and past director of the Henry L. Schwartz Department of Geriatrics and Adult Development, Mt. Sinai School of Medicine to advise us.

Under Dr. Butler's guidance the committee has determined that the area where our Foundation can have the greatest impact is in the training of health professionals specializing in or sensitive to the special needs of the growing elderly population. We realize that a number of institutions are already involved and doing significant work in the field, however, we feel the current need for doctors and the projected future needs are not being met. We believe that we can be a part of the resolution of that problem by working in partnership with a selected institution to develop a program that will meet the Foundation's goals of:

1. training new physicians in the field of geriatrics
2. training educator-scientists to teach in geriatrics departments
3. underwriting and endowing research in diseases related to aging
4. training allied health professionals
5. retraining established physicians in geriatric-related issues

In order to accomplish these goals we believe an institution is going to have to make a major commitment to the establishment of a department of geriatrics within its medical school's curriculum. The role of the Foundation in the development of this department will be to provide initial and on-going funding and professional resources that the institution might not otherwise have access to. We understand that there might be some concern from the existing departments in the school about competition for funding and space. It is our intent for the proposed department of geriatrics to be supported by the Foundation financially until it can support itself without having to compete for existing funding that is currently available to other departments.

The Donald W. Reynolds Foundation currently makes capital grants in the states of Arkansas, Oklahoma and Nevada. Therefore, the committee has limited its search for a potential site to those three states.

REPLY TO: P.O. BOX 2206 · FORT SMITH, ARKANSAS 72902 · (501) 646-9720 · FAX (501) 646-9762

As I told you by telephone, we are making site visits during the week of August 26th to the University of Arkansas, the University of Oklahoma and the University of Nevada. The purpose of these site visits will be to allow our team to meet your staff and see your current facilities. We will also answer any questions that you might have that would be helpful in preparing your proposal for funding. Our team will consist of two trustees of the Foundation, Dr. Butler and Malvin Schechter, a colleague of Dr. Butler's. We would like to meet with your key decision-makers and the appropriate staff leaders. We are not expecting you to make a formal presentation to this committee. Most of the time may be spent answering questions and discussing our expectations for the formal proposal. I would anticipate the visit to last no more than 4 to 6 hours depending on the amount of questions you have and the amount of time required to view your existing facilities.

After the site visit is concluded we are going to ask you to prepare a formal written proposal for presentation to the Foundation on or before November 1, 1996. The proposal would include the criteria listed in the attached ***Rationale and Plan; Building Geriatrics Departments in Medical Schools*** that was prepared by Dr. Butler for the Foundation's use. It will include an outline of required funding, a proposed schedule for implementation of the program and the resources required to implement the program you would propose. From November through January the proposals will be evaluated by the committee and our consultants. A synopsis of all three proposals and a recommendation of the proposed site will be presented to the Trustees during our regular meeting in January, 1997. With the approval of the Board, we will contact the successful institution and begin further development and refinement of the proposal by February 1, 1997.

Our committee is developing a list of nationally-known individuals to serve us as an advisory group. This group will consist of three or four geriatricians with broad backgrounds, an epidemiologist, a behavioral psychologist, a sociologist and possibly leaders from the private and public sector. This advisory group will continue meeting through the Spring with our committee and the selected institution during negotiations to formalize the initial agreement and implementation strategy. Our time goal for completion of the agreement phase is June, 1997. This coincides with the next regularly scheduled meeting of the the Board of Trustees. With Board approval, funding for the program could begin immediately.

Once the agreement is finalized our committee will provide assistance to the institution in whatever way necessary to meet the original Foundation goals. We expect the relationship to be a partnership and will not take a heavy-handed or highly prescriptive approach in dealing with the institution. Foundation support will be long-term as well as flexible. If desirable the Foundation will provide for continuing consultation with outside experts or the advisory board.

I am sure that this letter and attached document will create more questions than they have answered. If you would like to discuss any of the points prior to our meeting please don't hesitate to give me a call. In order to avoid confusion or possible conflicting information I would ask that you direct all questions through my office and provide a single source of contact for us to communicate with in your institution. If there are specific questions that Dr. Butler is more qualified to answer I will see that he contacts you prior to the meeting.

We will handle all of the travel arrangements and hotel accommodations for our team. We would ask that you make arrangements on campus for the meeting place. We would like to start the meeting at 9:00 A.M. and be complete in the early afternoon on Tuesday, August 27, 1996.

Our committee is excited about this program and anxious to meet you and see your facilities. This is a learning experience for us, therefore, some of the details will be developed as we go. I can assure you that the Board of Trustees has agreed that this initiative will receive substantial support and we are committed to support any program we start for the long term. As we also discussed on the phone, this initiative will not affect your qualifications to be considered in the capital grants program or any other application the University of Arkansas might have under current consideration. However, if your institution is selected as the site for funding under the Aging and Quality of Life initiative we might want to reevaluate your need for space and include funding for a new building as part of this initiative instead of the capital grants program.

Sincerely,

Steve Anderson

Steven L. Anderson

Encl.

Cc: Fred Smith
Donald Pray

DONALD W. REYNOLDS FOUNDATION

May 30, 1996

RECEIVED
JUN 3 1996
Chancellor's Office

Harry P. Ward, M.D.
Chancellor
University of Arkansas for Medical Sciences
4301 West Markham
Little Rock AR 72205-7100

Dear Dr. Ward:

We have reviewed your April 9, 1996 proposal for a building to house the Center on Aging and believe your plans merit further consideration. Accordingly, we have enclosed a Donald W. Reynolds Foundation statement of policies and grant application form.

The Donald W. Reynolds Foundation awards program is *extremely competitive*. To be considered, applicants must demonstrate that the proposed project:

- is well developed and based on objectives identified in your strategic plans,
- will benefit your clients and community,
- is appropriate for the program(s) to be housed in a new facility,
- is cost effective and,
- can be maintained, along with the programs to be housed in the proposed facility, beyond the support of the Donald W. Reynolds Foundation.

Proposals must be *received* prior to 12 Noon (CDT) on Monday, September 30, 1996. Applications postmarked or otherwise sent (i.e., FedEx, UPS) prior to the due date but received after the deadline will not be considered. Nor can we accept proposals submitted by facsimile transmission or electronic mail. Since a large number of proposals are expected, *applicants are urged to submit materials as much in advance of the deadline as possible.*

The Foundation will entertain only one proposal per applicant organization. We ask that you take great care to submit a complete and accurate application. While we normally do not conduct pre-application visits, David Zemel, Senior Program Officer, or I will be happy to answer your grant application questions by phone or letter.

Sincerely,

Margaret Skyles

Margaret Skyles
Grants Administrator

Enc.

7130 SOUTH LEWIS · SUITE 900 · TULSA, OKLAHOMA 74136 · (918) 496-0033 · FAX (918) 496-1777