Withdrawal/Redaction Sheet
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. resume	Re: B. Thomas Leahy (partial, p. 4 of 4) (1 page)	n.d.	b(6)
002a. letter	To candidate from Hillary Rodham Clinton re: commission (1 page)	08/10/1993	b(6)
002b. draft	Draft of letter to candidate (1 page)	08/26/1993	b(6)
002c. note	Re: candidate (1 page)	07/20/1993	b(6)
002d. note	To Hillary from supporters and re: candidacy for commission (1 page)	n.d.	b(6)
002e. letter	To Bob Nash from candidate re: commission position (1 page)	07/20/1993	b(6)
002f. letter	To Samuel Phipps from candidate for commission (1 page)	03/10/1993	b(6)
002g. resume	Re: candidate (2 pages)	n.d.	b(6)
002h. envelope	To Hillary Rodham Clinton (1 page)	07/20/1993	b(6)

COLLECTION:
Clinton Presidential Records
First Lady's Office
Melanne Verveer
OA/Box Number: 10252

FOLDER TITLE:
MV Correspondence 1993 [loose] [2]

2013-0534-S
ry1703

RESTRICTION CODES

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

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

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

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

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

Clinton Presidential Records
Digital Records Marker

This is not a presidential record. This is used as an administrative marker by the William J. Clinton Presidential Library Staff.

This marker identifies the place of a tabbed divider. Given our digitization capabilities, we are sometimes unable to adequately scan such dividers. The title from the original document is indicated below.

E

Divider Title: _____

THE WHITE HOUSE

WASHINGTON

November 16, 1993

Douglas S. Eakeley, Esq.
Riker, Danzig, Scherer, Hyland & Perretti
Headquarters Plaza
One Speedwell Avenue
P.O. Box 1981
Morristown, NJ 07962-1981

Dear Doug:

Hillary thanks you for your kind invitation to address the Essex County Bar Association. Unfortunately, she will not be able to attend. However, I will refer the invitation to our surrogate desk.

It was wonderful seeing you recently at the breakfast. Congratulations again on being elected Chairman. I know that under your leadership the LSC will once again vigorously meet the challenge it was established to address.

With best wishes,

Sincerely,

Melanne Verveer
Deputy Chief of Staff
to the First Lady

Happy Thanksgiving!

12/7/93

THE WHITE HOUSE
WASHINGTON

Doug-

I'm sorry this letter never went out. As you can see, Melanne signed it quite a while ago. Thanks for sending the Legal Services list.

Happy Holidays-

Madge

RIKER, DANZIG, SCHERER, HYLAND & PERRETTI

HEADQUARTERS PLAZA
ONE SPEEDWELL AVENUE
PO BOX 1981
MORRISTOWN, NEW JERSEY 07962-1981
(201) 538-0800
FAX (201) 538-1984

744 BROAD STREET
NEWARK, NEW JERSEY 07102-3867
(201) 622-7700

170 WEST STATE STREET
TRENTON, NEW JERSEY 08608-1102
(609) 396-2121
FAX (609) 396-4578

WILLIAM F. HYLAND
PETER N. PERRETTI, JR
WILLIAM C. CONNELLY
EDWARD A. ZUNZ, JR.
PETER F. ELD
PETER L. BERKLEY
BENJAMIN P. MICHEL
GERALD A. LILOIA
JOHN P. SHERIDAN, JR.
ROBERT FISCHER III
JAMES S. ROTHSCHILD, JR.
VINCENT J. SHARKEY, JR.
DOUGLAS S. EAKELEY
DENNIS J. O'GRADY
MICHAEL K. FUREY
MICHAEL R. COLE
GARY E. WALSH
SUSAN SCOTT
ROBERT D. BORTECK

NANCY STEWART
STEVEN P. BENENSON
GLENN D. CURVING
MICHELLE ROSEN SILVERMAN
ROBERT D. TOWEY
STUART M. LEDERMAN
PATTI S. LIBERMAN
JEFFREY B. WAGENBACH
ROBERT J. GILSON
JEFFREY J. MILLER
JANET FALLETTI MOSS
LINDA H. PRENTISS
ROBERT C. DALEO
WARREN J. MARTIN JR.
MARK J. WARSHAUER
MARILYNN R. GREENBERG
BARBARA SCHEADER
DAVID P. ARCISZEWSKI
SABRINA H. PEREL
IVAN M. BARON
EDWARD J. McCARTIN III
STEPHANIE SHERMAN
GAIL E. GOVELITZ
LYNNE ANNE ANDERSON
MICHAEL J. CALLAHAN
LORI A. CIARROCCA
SARAH L. MONAGHAN

EDWARD K. DeHOPE
SHAWN L. KELLY
MARK S. RATTNER
DENNIS J. KRUMHOLZ
ALAN E. KRAUS
GLENN A. CLARK
ROBERT J. SCHOENBERG
STUART PEIM
MARYANN P. KICENUIK
SAMUEL P. MOULTHROP
VICTORIA A. MORRISON
ANDREW J. STAMELMAN
KENNETH M. VAN DEVENTER
JAN L. BERNSTEIN
SIGRID S. FRANZBLAU
ANNE M. PATTERSON
JOHN M. PELLECCHIA
ANTHONY J. SYLVESTER
PETER C. HARVEY

JAMES C. MEYER
MICHAEL J. ROSSIGNOL
BEATRIX W. SHEAR
SUSAN MORGAN FOSTER
ABBY H. LANDAU
MICHAEL R. O'DONNELL
KAREN PATRUNO SHEEHY
CONRAD G. CYRIAX
BRIAN W. MOORE
NICHOLAS RACIOPPI, JR
DAVID L. OSSAM
JAMES A. RABORN
KENNETH O. BRADLEY
MICHAEL A. PELLINI
CAROL T. WORTMANN
ANTHONY J. ZARILLO, JR
VITO A. GAGLIARDI, JR
MARK W. MUSSER
KATHRYN STOPPELLO
WILLIAM C. CAREY
DONALD F. MACMASTER
BRIAN E. O'DONNELL
LOUISE A. JOHNSON
ANTHONY J. TOMARI
SETH D. GELDZAHLER
SHELLY A. DEAN

IRVING RIKER (1921-1969)
CHARLES DANZIG (1934-1992)

EVERETT M. SCHERER
NICHOLAS deB. KATZENBACH
SIDNEY M. SCHREIBER
HOWARD F. CASSELMAN
OF COUNSEL

CRAIG J. DONALDSON
CHARLES F. WASKEVICH, JR.
SANDRA BROWN SHERMAN
CHARLES E. REUTHER
COUNSEL

LIZA M. KIRSCHENBAUM
J. ALEX KRESS
ROBERTA N. SAMUELS
JOHN G. VALERI, JR.
KATHLEEN D. WEST
KEVIN G. SMITH
DEBORAH J. FENNELLY
STELLA M. STRELZIK
DEBRA H. AZARIAN
DAVID A. WOLFF
ESTHER S. BONDY
NANCY C. EBERHARDT
HAROLD L. KOFMAN
BARBARA LACZYNSKI
MILENA S. QUAGLIETTA
THOMAS BYRNE
LAURA M. MASSAIA
JEFFREY M. SIMINOFF
CHARLES A. WEISS
NADINE M. SARAJIAN
SCOTT A. OHNEGIAN
GLORIA L. BUXBAUM
JEFFREY A. DURNEY
CATHLEEN H. GIULIANA
BRUCE A. HARRIS
MERI-BETH ROBERTSON
MARCI L. SACCO
CRAIG L. STEINFELD

October 8, 1993

Response
We cannot do, will refer to our Managed Care desk

Hon. Hillary Rodham Clinton
First Lady of the United States
The White House
Washington, D.C. 20500-2000

Dear Hillary:

The Essex County Bar Association is the largest and most civic-oriented of all of New Jersey's bar associations. Rudy Coleman, its President, and Maureen McCully, its Executive Director, are also good friends of mine and caring people.

As you will see from the attached letter from Rudy Coleman, the Association would like to host a joint program in Newark with the Essex County Medical Society, thereby providing a wonderful forum for a discussion of the Administration's health care initiative. Would you have any interest in speaking? If you are unable to make it, who might be a good proxy? Although November 17th and December 1 are possible dates for the event, the schedule is flexible.

The reverberations continue from the President's national address and appearance on the Ted Koppel show, as well as from your

own bravura performances in the Congress last week. Congratulations and best wishes on this most important of initiatives.

Yours truly,

Douglas S. Eakeley

dse/cw

Enclosure

cc: Ms. Melanne Verveer
Rudy B. Coleman, Esq.
Ms. Maureen McCully

O:\SSDATA\DEA\LET1\192117.1

RIKER, DANZIG, SCHERER,
HYLAND & PERRETTI

HEADQUARTERS PLAZA
ONE SPEEDWELL AVENUE
PO BOX 1981
MORRISTOWN, NEW JERSEY 07962-1981
(201) 538-0800
FAX (201) 538-1984

744 BROAD STREET
NEWARK, NEW JERSEY 07102-3867
(201) 622-7700

170 WEST STATE STREET
TRENTON, NEW JERSEY 08608-1102
(609) 396-2121
FAX (609) 396-4578

October 8, 1993

Hon. Webster L. Hubbell
Associate Attorney General
U.S. Department of Justice
Room 5214
10th St. and Constitution Ave. NW
Washington, DC 20530

Administrator, Office of Juvenile Justice and Delinquency Prevention

Dear Mr. Hubbell:

I am writing to commend former New Jersey Superior Court Judge B. Thomas Leahy for Administrator of the Office of Juvenile Justice and Delinquency Prevention. In my opinion, Judge Leahy would be an ideal candidate for this critical position.

As you will note from the enclosed resume, Judge Leahy currently serves as chairperson of the New Jersey Juvenile Justice and Delinquency Prevention Committee. He has been active in the National Council of Juvenile and Family Court Judges, serving as President in 1983-84, and the National Coalition of J.J.D.P. Advisory Groups, among many others. He is a leader in our community and an outspoken advocate for early and effective intervention programs to address the problems of youths at risk. He is also an extremely capable, intelligent, caring, energetic and

personable individual who has dedicated his entire career to serving the public In short, he would be a wonderful asset for the Administration.

Yours truly,

Douglas S. Eakeley

dse/cw

Enclosure

cc w/encl.:
John Dwyer, Esq.
Melanne Verveer

O:\SSDATA\DEA\LET1\192025.1

B. THOMAS LEAHY

2 East Maple Avenue, Bound Brook, New Jersey 08805 (908) 356-0001

JUDICIAL EXPERIENCE

Somerset County Court Judge 1969-1978
Appointed 1969 by Governor Richard J. Hughes; Re-appointed 1970 by Governor William Cahill; Re-appointed 1975 by Governor Brendan Byrne.

New Jersey Superior Court Judge 1978-1991
County Courts absorbed into the Superior Court by Constitutional Amendment, November 1978. Re-appointed to Superior Court 1980 by Governor Brendan Byrne (Tenure Appointment) Retired April 30, 1991.

JUVENILE JUSTICE AND DELINQUENCY PREVENTION ACT EXPERIENCE

Chairperson:	March 1992 to date Designated by Governor Jim Florio
Member:	Since formation of New Jersey J.J.D.P. Committee, April 1976 Appointed by Governor Brendan Byrne
Vice-Chairperson:	Elected such by J.J.D.P. Committee Members, May 1976, and annually thereafter
Acting Chairperson:	April 1976, until designation of Chairperson by Governor Byrne December 1977 Again from February 1988, due to illness of Chairperson until designated Chairperson in 1992

National Coalition of J.J.D.P. Advisory Groups
Member Annual Conference Planning Committee for 1992 and 1993 Conferences

NATIONAL JUVENILE JUSTICE/FAMILY COURT RELATED ACTIVITIES

National Council of Juvenile and Family Court Judges
President 1983-1984; President-elect 1982-1983; Vice-President 1979-1982; Secretary 1978-1979; Member Board of Trustees 1975-1978

National Association of Foster Care Reviewers
Board Member 1987-1989

National Center for Juvenile Justice, Pittsburgh Pennsylvania
Member Board of Fellows 1982-1984

Secretary of Health and Human Services' Child Support Enforcement Task Force
Member 1984-1986

ELECTED OFFICE AND DEMOCRATIC PARTY ACTIVITIES

Board of Freeholders, Somerset County, New Jersey 1965-1967 (county governing body comparable to County Commissioner or County Supervisor)

Third Democrat elected to that five-member Board since elections started being conducted on a county-wide basis in 1922. There have been a total of six Democrats elected to that position in seventy years.

Alternate Delegate Democratic National Convention 1964

Democratic Candidate for New Jersey Assembly 1967 (unsuccessful)

COMMUNITY ACTIVITIES

New Jersey Council of Family Court Judges
President 1977-1978, Officer 1972-1977

Somerset County Welfare Board
Member 1966 and 1967

Somerset County Planning Board
Member 1966 and 1967, Board Secretary 1967

St. Joseph's Roman Catholic Church
Elected to Parish Council 1975-1981, Vice-Chairman 1978-1979, Chairman 1980-1981

Bound Brook Lodge, B.P.O. Elks
Officer 1963-1971, Exalted Ruler 1967-1968, Trustee 1968-1971

Family Counseling Service of Somerset County
Member, Board of Directors 1965-1969

Member of Kiwanis, Rotary Club, Jaycees, Chamber of Commerce

NEW JERSEY SUPREME COURT COMMITTEE ASSIGNMENTS

Juvenile and Domestic Relations Court Committee, 1975-1983 (Chaired 1979-1983)

Family Court Committee, 1984-1986

Committee to Assess Success of Family Court and Plan for It's Future, 1989-1991

Committee on Sentencing, 1990-1992

NATIONAL COUNCIL OF JUVENILE AND FAMILY COURT JUDGES COMMITTEE RESPONSIBILITIES

Juvenile Court Effectiveness Committee, (First) Chair 1979-1983
(created to promote more effective use of research findings by Courts)

Learning Disabilities and Delinquency Committee, 1977-78, 1989-91

Cooperation with National Association of Counties Committee, Chair 1984-1986

Cooperation with National Conference of State Legislatures Committee, 1985-1986

Community Organizations Committee, 1979-1981

Constitution and By-Laws Committee, Chair 1975-77, 1977-81, 1985-86

Resolutions Committee, Chair 1978-79, 1985-86, 1989-92

Planning Committee, 1978-1982, 1982-83 (Chair), 1985-1986

Finance Committee, 1978-1983

Membership Committee, 1980-1981 (Chair), 1984-1985

INVITED APPEARANCES

Research & the Serious Juvenile Offender Conference, University of Nevada, Reno, Nevada - January 9-12, 1983,
Panelist: "Juvenile Justice System Data and Response"

Tenth National Conference on Juvenile Justice, Hilton Head, South Carolina - February 21, 1983
Speaker: "Positive Aspects of Juvenile Justice"

46th Annual Conference, N.C.J.F.C.J., Richmond, Virginia - July 11, 1983
Panelist: "Research and Delinquency - What is the Story"

Eastern Regional Conference on URESA, Boston, Massachusetts - June 24, 1983
Panelist: "Child Support Enforcement"

Blue Ridge Conference for Southern Court Judges, Black Mountain, North Carolina - August 7, 1983
Dinner Speaker: "Child Support Enforcement"

New Jersey Judicial Child Support Enforcement Conference, New Brunswick, New Jersey - September 27, 1985,
Panelist: "Child Support Enforcement Techniques and Judicial Procedures"

Secretary of Health & Human Services Symposium on Child Support Enforcement, Washington, D.C. - August 16-17, 1984, *Speaker at General Session*

New Jersey Teachers Annual Conference, Atlantic City, New Jersey - October 28, 1976
Speaker: "The Relationship between Learning Disabilities and Delinquency"

Judicial Concerns: Issues in Family Law & Family Court, University of Nevada, Reno, Nevada - October 29, 1982,
Lectured: "The Relationship between School Failure and Delinquency"

Ninth National Conference on Juvenile Justice, New Orleans, Louisiana - February 18, 1982
Panelist: "Goals for the Juvenile Justice System - The Judge, The Public, The Media - Are We Marching to the Same Drummer?"

50th Annual Conference, N.C.J.F.C.J., Cincinnati, Ohio - July 14, 1987
Panelist: "The Media/Court Partnership - Help or Headache"

The Violent Youthful Offender, San Antonio, Texas - January 11, 1977
Panelist: "Secured Treatment Programs"

Post Placement/Children in Placement Project Seminar, Cherry Hill, New Jersey - April 20, 1977
First Regional Seminar: "Concern for Children in Placement"
(N.Y., N.J., Del., Penn., Maryland and Washington, D.C.)
Conference Moderator - Presiding Officer

Withdrawal/Redaction Marker
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. resume	Re: B. Thomas Leahy (partial, p. 4 of 4) (1 page)	n.d.	b(6)

COLLECTION:
Clinton Presidential Records
First Lady's Office
Melanne Verveer
OA/Box Number: 10252

FOLDER TITLE:
MV Correspondence 1993 [loose] [2]

2013-0534-S
ry1703

RESTRICTION CODES

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

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

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

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

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

International Juvenile Officers 22nd Annual Training Conference, Niagara Falls, New York - June 22, 1978
Speaker: "Standards and Goals for the Juvenile Justice System"

Seventh National Conference on Juvenile Justice, Orlando, Florida - March 17, 1980
Panelist: "Juvenile Justice in the Decade Ahead"
Panelist: "Assertiveness Training for the Adjudicated Delinquent: Dealing with Peer and Gang Pressure"

American Society of Criminology, Washington, D.C. - November 11, 1981
Speaker: "Trends in De-institutionalization"

National Conference on Court Technology, Chicago, Illinois - April 28-29, 1983
Panelist: "Use of Computers by Juvenile Court Systems"

48th Annual Conference N.C.J.F.C.J., Point Clear, Alabama - July 15, 1985

Panelist: "Family Courts Revisited - Should They Be Our Model?"

Fourteenth National Conference on Juvenile Justice, San Francisco, California - March 17, 1987
Panelist: "Intensive Probation for Juveniles"
Panelist: "Do We Need to Reaffirm Rehabilitation"

Sixteenth National Conference on Juvenile Justice, Sparks, Nevada - March 15, 1989
Panelist: "Guardians Ad Litem and Review Boards - C.A.S.H. and Volunteers"

United Nations International Symposium on Juvenile Justice Issues, Newark, New Jersey - November 2-8, 1983,
One of 17 invited participants

National Family Court Symposium, Las Vegas, Nevada - October 14-16, 1990
One of 5 participants invited from New Jersey

PERSONAL DATA

Date of Birth: (b)(6)

Married: Mary W. - June 6, 1955

[001]

Children: Ann Elizabeth, DOB (b)(6)
Patrick W., DOB (b)(6)

Education: Juris Doctor, New York University School of Law, 1955, Root-Tilden Scholar

Bachelor of Science, Cum Laude
Holy Cross College, 1952

THE WHITE HOUSE

WASHINGTON

August 3, 1993

Ralph Ebersole
1110 By the Shore Drive
Huron, Ohio 44893

Dear Mr. Ebersole:

Mrs. Clinton thanks you for your recent letter regarding a health care stamp to generate revenue to meet the requirements of national health care reform. We appreciate hearing your views on this important challenge that we face as a nation.

Thank you again for sharing your recommendations. Best wishes.

Sincerely,

Melanne Verveer
Deputy Chief of Staff
to the First Lady

THE WHITE HOUSE

WASHINGTON

June 8, 1993

The Economic Alliance for Michigan
150 W. Jefferson, Suite 1501
Detroit, MI 48226-4415

Dear Members of the Economic Alliance of Michigan:

I regret that I will be unable to attend the June 10th Board of Directors meeting of the Economic Alliance. However, because your meeting is so important, I have asked Bob Valdez, who has been a senior member of our health care team, to be with you in my stead.

I want you and your members to know that the Administration is taking the concerns of business and labor very seriously as we put together our health reform proposals. We recognize that our nation's economic vitality is directly related to controlling skyrocketing health care costs. The President's overriding goals are to control costs, provide universal access, and to maintain quality.

If we keep these overriding objectives in mind, I'm confident we can work out the details. We want you to be involved in helping us work out these details, because there are a number of issues on which your experience can be extremely beneficial.

The President's plan hopes to control costs and increase efficiency in the following ways:

We are going to stop micro-managing and over-regulating the health industry. Instead, we will move to outcome-based total quality management for health providers.

We will insure administrative simplicity. We are going to go from hundreds of different insurance forms to one insurance form. Overall, the paperwork load for hospitals, doctors and nurses will be dramatically reduced, as will the attendant costs.

We want to move toward a system of twenty-four hour health coverage, so that people are covered under the same health plan no matter where they get sick or hurt. This will save businesses

on worker's compensation costs; it will bring simplicity and less paperwork to providers, businesses and insurers; and it will save billions of dollars in legal fees.

We are going to have as part of the comprehensive benefits package an emphasis on preventive health measures that not only will ensure better health care but will result in lower costs. Today the health care incentives are all wrong. We pay for expensive procedures to deal with serious health problems but fail to provide coverage for primary and preventive care that could have obviated the need for such treatments in the first place.

By providing universal coverage and preventive benefits, we will stop the cost shifting that happens when uninsured people go to emergency rooms for problems that could have been solved far earlier and far less costly with regular check-ups and other prevention. And it will mean providers will no longer have to cover the costs of charity care by passing those costs along to the rest of us.

We are going to allow states a great deal of flexibility in administering this new program, because we know that the demography and geography of different states are vastly different from one another.

I hope your meeting is a success. I look forward to working with the Economic Alliance and all its member organizations in the coming months.

Sincerely yours,

Hillary Rodham Clinton

Hillary Rodham Clinton

THE WHITE HOUSE

WASHINGTON

July 30, 1993

John J. Egan
DePaul University
Office for Community Affairs
243 South Wabash Avenue
Chicago, IL 60604-2302

Dear Jack:

It was good to hear from you. Belated congratulations on your anniversary!

At this point, Hillary is not releasing her thesis, so I won't be able to respond to your request. Should that change, however, I'll keep you in mind.

I hope all is well and that you're taking care of yourself.

Sincerely,

Melanne Verveer
Deputy Chief of Staff
to the First Lady

When are you coming to Washington again?

Withdrawal/Redaction Marker
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
002a. letter	To candidate from Hillary Rodham Clinton re: commission (1 page)	08/10/1993	b(6)

COLLECTION:
Clinton Presidential Records
First Lady's Office
Melanne Verveer
OA/Box Number: 10252

FOLDER TITLE:
MV Correspondence 1993 [loose] [2]

2013-0534-S
ry1703

RESTRICTION CODES

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

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

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

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

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

Withdrawal/Redaction Marker
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
002b. draft	Draft of letter to candidate (1 page)	08/26/1993	b(6)

COLLECTION:
Clinton Presidential Records
First Lady's Office
Melanne Verveer
OA/Box Number: 10252

FOLDER TITLE:
MV Correspondence 1993 [loose] [2]

2013-0534-S
ry1703

RESTRICTION CODES

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

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

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

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

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

Withdrawal/Redaction Marker
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
002c. note	Re: candidate (1 page)	07/20/1993	b(6)

COLLECTION:
Clinton Presidential Records
First Lady's Office
Melanne Verveer
OA/Box Number: 10252

FOLDER TITLE:
MV Correspondence 1993 [loose] [2]

2013-0534-S
ry1703

RESTRICTION CODES

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

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

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

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

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

Withdrawal/Redaction Marker
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
002d. note	To Hillary from supporters and re: candidacy for commission (1 page)	n.d.	b(6)

COLLECTION:
Clinton Presidential Records
First Lady's Office
Melanne Verveer
OA/Box Number: 10252

FOLDER TITLE:
MV Correspondence 1993 [loose] [2]

2013-0534-S
ry1703

RESTRICTION CODES

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

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

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

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

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

Withdrawal/Redaction Marker
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
002e. letter	To Bob Nash from candidate re: commission position (1 page)	07/20/1993	b(6)

COLLECTION:
Clinton Presidential Records
First Lady's Office
Melanne Verveer
OA/Box Number: 10252

FOLDER TITLE:
MV Correspondence 1993 [loose] [2]

2013-0534-S
ry1703

RESTRICTION CODES

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

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

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

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

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

Withdrawal/Redaction Marker
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
002f. letter	To Samuel Phipps from candidate for commission (1 page)	03/10/1993	b(6)

COLLECTION:
Clinton Presidential Records
First Lady's Office
Melanne Verveer
OA/Box Number: 10252

FOLDER TITLE:
MV Correspondence 1993 [loose] [2]

2013-0534-S
ry1703

RESTRICTION CODES

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

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

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

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

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

Withdrawal/Redaction Marker
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
002g. resume	Re: candidate (2 pages)	n.d.	b(6)

COLLECTION:
Clinton Presidential Records
First Lady's Office
Melanne Verveer
OA/Box Number: 10252

FOLDER TITLE:
MV Correspondence 1993 [loose] [2]

2013-0534-S
ry1703

RESTRICTION CODES

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

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

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

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

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

Withdrawal/Redaction Marker
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
002h. envelope	To Hillary Rodham Clinton (1 page)	07/20/1993	b(6)

COLLECTION:
Clinton Presidential Records
First Lady's Office
Melanne Verveer
OA/Box Number: 10252

FOLDER TITLE:
MV Correspondence 1993 [loose] [2]

2013-0534-S
ry1703

RESTRICTION CODES

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

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

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

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

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

January 28, 1993

Ms. Harron Ellenson
Harron & Associates
229 Berkeley Street
Boston, Massachusetts
02116

Dear Ms. Ellenson,

I am writing on behalf of Mrs. Clinton and Patti Solis to apologize for not getting back to you sooner. I realize that we missed your deadline of January 17th, and though I know that it is little consolation, I just wanted you to know that you had not been completely forgotten. Unfortunately, after the election our offices were so flooded with requests that it became rather difficult to get to each of them promptly.

Mrs. Clinton shares your commitment to children, and perhaps there will be another opportunity in the future for some joint effort on behalf of The Judge Baker Children's Center. In the meanwhile, I hope your event was a success, and that the Center continues to provide such wonderful services.

Sincerely,

Amanda Deaver

THE WHITE HOUSE

WASHINGTON

August 9, 1993

Margaret Engel
The Alicia Patterson Foundation
1001 Pennsylvania Avenue, NW
Suite 1250
Washington, DC 20004

Dear Peggy:

Thank you so much for sharing your Boston Globe article about Pat Nixon with Mrs. Clinton and me. The op-ed was most thought provoking. You captured the side of the First Lady's role that no one writes about or cares to understand. Reading it I felt as though you really understood - and only too well.

Again, thank you for thinking of us. Best wishes to Bruce.

Sincerely,

Thanks again!

Melanne Verveer
Deputy Chief of Staff
to the First Lady

DRAFT

February 23, 1993

Ms. Jan Erickson
Director
National Vaccine Information Center
512 West Maple Avenue
Suite 206
Vienna, VA 22180

Dear Ms. Erickson:

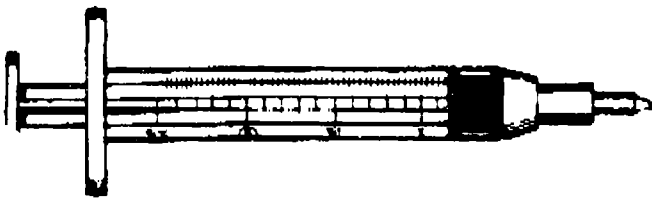
On behalf of Mrs. Clinton, I want to thank you for your thoughts and concerns regarding the problems involved in the proposed mass immunization campaign for pre-schoolers. The office of the First Lady has set up a resource database, and we appreciate people like yourself who keep us up to date on important issues affecting children.

Thank you again for sharing your thoughts. Your offer to work with us in our efforts to bring about health care reform will be forwarded to the Health Care Task Force.

With best wishes,

Sincerely,

Melanne Verveer
Deputy Chief of Staff
to the First Lady



NATIONAL VACCINE INFORMATION CENTER
Dissatisfied Parents Together (NVIC/DPT)
512 W. Maple Ave., Suite 206, Vienna, VA 22180
(703) 938-DPT3 938-0342 FAX: 938-5768

JAN ERICKSON
Director

February 17, 1003

Ms. Hillary Rodham Clinton
The White House
1600 Pennsylvania Ave.
Washington, D.C. 20500

Dear Ms. Clinton:

We appreciate your efforts on behalf of the health of the children of America. In particular, we are interested in working with you on the proposed mass immunization campaign for pre-schoolers. Representatives of our organization, our attorneys, and physicians familiar with our program would like to meet with you soon to discuss how the immunization program may be carried out in the safest manner possible.

Our biggest concern is that physicians and other health care providers must adequately screen at-risk children and be prepared for competent diagnoses and medical interventions when adverse reactions occur. This is not taking place, even now, in the manner that it should. You may be aware that 17,221 vaccine adverse reactions, including 360 deaths, were reported to the federal government for a 20 month period, ending in July, 1992 (the actual numbers are much higher as only a fraction of physicians are reporting). We believe that with a proper educational campaign, parents can become partners with their physicians in screening out high risk children --thereby sparing many unecessary tragedies.

A further concern is that with a mass effort to immunize inner city, poor children --many of whom will be minority children-- there may be increased numbers of adverse reactions. The data is not adequate to safely project any such outcome. However, it would be extremely unfortunate for there to be hundreds, perhaps thousands, of serious adverse reactions in what is otherwise a well-intended effort to help children.

Another major issue to be reviewed relates to a crisis in the federal compensation program for vaccine injuries. Under the Reagan and Bush administrations, the program was not implemented in the manner in which Congress intended. Now, with proposed changes to the Vaccine Injury Table, a lack of funding for compensation of older adjudicated cases, and expiration of a vaccine manufacturer surtax, the program is virtually in its death throes. Other compounding difficulties relate to the continued use of whole cell pertussis vaccine (246 deaths were reported in association with DTP shots in that 20 month period) when there is a safer vaccine and

the long running lack of scientific studies pertaining to vaccine safety that Congress mandated in Public Law 99-660, the National Childhood Vaccine Injury Compensation Act.

These issues are all very urgent, we believe, and must be resolved before an effective mass immunization program can successfully move forward. Please let us know when you may be able to meet with us.

Sincerely,

Jan Erickson

Clinton Presidential Records
Digital Records Marker

This is not a presidential record. This is used as an administrative marker by the William J. Clinton Presidential Library Staff.

This marker identifies the place of a tabbed divider. Given our digitization capabilities, we are sometimes unable to adequately scan such dividers. The title from the original document is indicated below.

F

Divider Title: _____

THE WHITE HOUSE
WASHINGTON

Sent to Agency Liason 12/7/93

November 16, 1993

Ms. Joyce Fisher
8814 Old Spanish Trail
Little Rock, Arkansas 72207

Dear Ms. Fisher:

Thank you very much for your recent letter. The President and Mrs. Clinton greatly appreciate your expression of trust and confidence in them.

To give your concerns the special attention they deserve, I have referred your letter to the Office of Agency Liaison whose mission is to deal with the important casework we receive from constituents.

I appreciate your patience and hope that your situation is resolved satisfactorily.

Sincerely yours,

Melanne Verveer
Deputy Chief of Staff
to the First Lady

May 26, 1993

Donna D. Fraiche, Esq.
Locke Purnell Rain Harrell
Pan American Life Center
601 Poydras Street, Suite 2400
New Orleans, LA 70130-6036

Dear Ms. Fraiche:

Thank you for sending me a copy of your memo regarding your conversation with Mr. Robert Pear of The New York Times. I was pleased that our conversation proved helpful.

Your offer to help the White House Health Care Task Force is greatly appreciated. However, since the Task Force has just about completed its work there really is not a particular need at this time. However, I've passed your offer on to Ira Magaziner.

We do appreciate your support for the First Lady's healthcare reform efforts. We look forward to working with you in the foreseeable future.

Thank you for caring. Best wishes for the important work that you do.

Sincerely,

Melanne Verveer
Deputy Chief of Staff
to the First Lady

faxed 6/14/93 82

THE WHITE HOUSE
Office of the First Lady

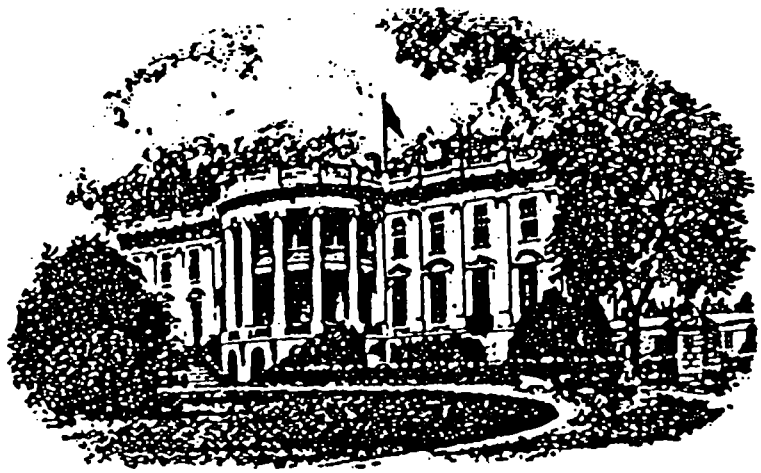
TO: Judy Whittlesey

FROM: Melanne Verveer

RECEIVER FAX: 775-8912

RECEIVER PHONE: 775-8881

NUMBER OF PAGES (INCLUDING COVER SHEET): 2



COMMENTS: Judy - I hope this is OK. If you think it should be changed, * let's let me know.

THE WHITE HOUSE

WASHINGTON

June 14, 1993

Dear Friends of the Women in Military Service for America Memorial Foundation:

I regret that I am unable to join you for the Foundation's Salute to Secretary of Defense Aspin.

Today's event is a wonderful occasion to celebrate the accomplishments of America's servicewomen and women veterans. It is also most appropriate that Secretary Aspin is receiving this well-deserved tribute for his longstanding support in Congress for women in the military and his continuing efforts as Secretary of Defense to help women in the military to achieve equality of opportunity

I would also like to thank you for inviting me to serve as the Honorary Chair of the Women in Military Service American Memorial Foundation. You have done me great honor, and I am very pleased to chair your effort to honor the women who have served or are serving in the nation's armed forces.

This Flag Day reminds us of our obligation as citizens to our nation and to each other. Your contributions deserve the gratitude of all of us.

Sincerely yours,

Hillary Rodham Clinton

Hillary Rodham Clinton

Clinton Presidential Records
Digital Records Marker

This is not a presidential record. This is used as an administrative marker by the William J. Clinton Presidential Library Staff.

This marker identifies the place of a tabbed divider. Given our digitization capabilities, we are sometimes unable to adequately scan such dividers. The title from the original document is indicated below.

G

Divider Title: _____

THE WHITE HOUSE

WASHINGTON

March 26, 1993

Ms. Dorothy H. Gardner
President and Chief Executive Officer
Lutheran General Foundation
1775 Dempster Street - 10 South
Park Ridge, IL 60068-1174

Dear Ms. Gardner:

Thank you for your offer to have Mrs. Clinton utilize the Lutheran Hospital for a health policy-related event when she is in the Chicago area. At this time we are not in a position to accept your gracious invitation. However, we will keep your letter on file and hope there will be an opportunity in the future to visit with you.

With best wishes,

Sincerely,

Melanne Verveer
Deputy Chief of Staff
to the First Lady

THE WHITE HOUSE

WASHINGTON

March 29, 1993

Ms. Doris Lockey Geier
Director, Human Resources
Corporate Secretary
2275 Research Boulevard
Rockville, MD 20850

Dear Doris:

Sue Vogelsinger recently sent me your letter about participating in the Health Care Reform Task Force.

The Task Force includes the Secretaries of the Treasury, Defense, Commerce, Labor, Health and Human Services, and Veterans Affairs; the Director of the Office of Management and Budget; the Assistant to the President for Domestic Policy; the Assistant to the President for Economic Policy; the Chair of the Council of Economic Advisors; and the Senior Advisor to the President for Policy Development.

In addition, the Senior Advisor to the President for Policy Development is leading interdepartmental working groups which are gathering information for, and providing information to, the Task Force. The working groups, which are working closely with Members of Congress and their staffs, are comprised of government employees.

The working groups are in the process of preparing policy options for reforming our health care system. The members of the Task Force are anxious to consult with knowledgeable and concerned people. I am directing your letter to the appropriate working group. Again, thank you for your offer of assistance and your continued support for the success of our endeavor.

Sincerely,

Melanne Verveer
Deputy Chief of Staff
to the First Lady

THE WHITE HOUSE

WASHINGTON

August 9, 1993

Caroline Golab, Dean
Chestnut Hill College
Philadelphia, PA 19118-2695

Dear Carol:

Congratulations on your new position! I'm sure it will offer you many rewards. Chestnut Hill is lucky to have you.

Thank you for your thoughtful letter and offer of service. It was so good to hear from you. Perhaps a collaboration sometime will be possible.

Keep in touch. Best to Edward and the girls.

Sincerely,

Melanne Verveer
Deputy Chief of Staff
to the First Lady

Congrats — what good news! When are you coming to DC?

THE WHITE HOUSE

WASHINGTON

March 25, 1993

Sybil Niden Goldrich
256 South Linden Drive
Beverly Hills, CA 90212

Dear Ms. Goldrich:

Thank you for the information that you sent recently regarding your "Four Step Program". I have passed the materials on to the Health Care Task Force.

Thank you for caring. Best wishes in the important work that you do.

Sincerely,

Melanne Verveer
Deputy Staff Director
to the First Lady

Clinton Presidential Records
Digital Records Marker

This is not a presidential record. This is used as an administrative marker by the William J. Clinton Presidential Library Staff.

This marker identifies the place of a tabbed divider. Given our digitization capabilities, we are sometimes unable to adequately scan such dividers. The title from the original document is indicated below.

H

Divider Title: _____

THE WHITE HOUSE

WASHINGTON

June 5, 1993

John B. Hall
Park College
Wright-Patterson Air Force Base
Ohio

Dear Mr. Hall:

Thank you very much for your invitation to Mrs. Clinton to be a guest speaker at Park College. The courses you teach appear very interesting, and you should be applauded for the effort you are making to inform students about public health issues.

I regret that, due to her extremely demanding schedule, Mrs. Clinton will be unable to speak to your students in the foreseeable future. A resource database has been set up at the White House on national health care reform should you have any ideas or comments to contribute.

Thank you for the good work you do, and best wishes.

Sincerely,

Melanne Verveer
Deputy Chief of Staff
to the First Lady

June 10, 1993

Howard W. Hallman, President
Civic Action Institute
6508 Wilmett Road
Bethesda, MD 20817

Dear Mr. Hallman:

Thank you for your recent letter and items entitled "Local and Federal Coordination of Urban Programs" and "How Urban Coordination Came About."

We appreciate your sharing your expertise in this area with us. It is important information that we will include in our resource database. The President is committed to improving the quality of life in our nation's inner cities, and your comments are vital in our collective effort to do so.

Once again, thank you and best wishes.

Sincerely,

Melanne Verveer
Deputy Chief of Staff
to the First Lady

I am today officially nominating a native of Alabama, Dr. Sheldon Hackney, to be the Chairman of the National Endowment for the Humanities. Dr. Hackney is among the most respected leaders in American higher education. He has served for the past twelve and a half years as the President of the University of Pennsylvania, after serving for five years as the President of Tulane University and three years as Provost of Princeton University. Dr. Hackney has a distinguished record both as a first-rate scholar, author, and educator and as an astute and temperate administrator.

Dr. Hackney is uniquely suited for the challenge of heading the agency and carrying out its mission to support the humanities public programs, education and research. He was, for example, a founding member of the Collaborative for Philadelphia Schools and the Committee to Support the Public Schools, projects which profoundly changed the way the humanities are taught in the Philadelphia public schools.

Dr. Hackney is one of the leading Southern historians of his generation. He has continued to teach courses in American history while serving as President of the University of Pennsylvania, an uncommon practice for executive officers of universities and a measure of the importance he places on teaching. His support for undergraduate education led him to seek a reorientation of the curriculum at Penn to ensure that the teaching mission of the university was granted the same priority as the research mission.

"In a democratic society," a recent NEH Report to the President stated, "the humanities -- those areas of study that bring us the deeds and thoughts of other times -- should be part of every life." Throughout his twenty-five year career as a historian and teacher, Dr. Hackney has worked tirelessly to meet that goal, and, if confirmed by the Senate, will build upon his record of achievement in advancing the humanities and making them more accessible to all Americans.

THE WHITE HOUSE

WASHINGTON

Sent 8/27

August 25, 1993

Howard W. Hallman
6508 Wilmett Road
Bethesda, MD 20817

Dear Mr. Hallman:

Thank you very much for sending information regarding Methodist United's ideas on nuclear disarmament. Mrs. Clinton appreciates the book and other materials and looks forward to reading them.

Best wishes in the important work that you do.

Sincerely,

Melanne Verveer
Deputy Chief of Staff
to the First Lady

DRAFT EB

Save name: Hallmn2.mv1

You've corresponded with him before. See June file. EB

August 20, 1993

Howard W. Hallman
6508 Wilmett Road
Bethesda, MD 20817

Dear Mr. Hallman:

Thank you very much for sending information regarding Methodist United's ideas on nuclear disarmament. Mrs. Clinton appreciates the book and other materials and looks forward to reading them.

~~The President is committed to making this nation a more peaceful one and to improving relations with other countries.~~ Your ideas are significant as ~~we work toward these important~~ goals.

~~It was good to hear from you again.~~ Best wishes in the important work you do

Sincerely,

Melanne Verveer
Deputy Chief of Staff
to the First Lady

METHODISTS UNITED

for Peace with Justice

421 SEWARD SQUARE, S.E. WASHINGTON, D.C. 20003 202-546-5551

July 29, 1993

Ms. Melanne Verveer
Deputy Chief of Staff
Office of the First Lady
The White House
Washington, DC 20500

Dear Ms. Verveer:

We kindly request you to place the enclosed letter to Mrs. Clinton and the attachments in her "summer reading" pile.

We are offering some ideas on nuclear disarmament, as developed by some United Methodists. We believe that they contain a combination of idealism and practicality that should appeal to the Clinton Administration.

Specifically we are proposing that by August 6, 1995 (the fiftieth anniversary of the bombing of Hiroshima) all strategic nuclear weapons around the globe be deactivated by removing warheads from delivery vehicles, achieved in phases dureing the next two years with proper verification. Dismantlement could occur thereafter.

We have presented our ideas to personnel of the National Security Council, State Department, and Defense Department. We have found them cordial and willing to listen, but they come mostly from the arms control community and would settle for "minimal deterrence" rather than "zero alert" and eventually complete nuclear disarmament. We believe that the latter is possible with creative U.S. leadership.

If you or others on Mrs. Clinton's staff would like to discuss our ideas in greater detail, please let me know.

Sincerely yours,

Howard W. Hallman

Howard W. Hallman
Issues Chair

Telephone -- Mon-Thurs: (301) 694-2859; Fri-Sat: (301) 897-3668

Please reply to 6508 Wilmett Road, Bethesda, MD 20817

METHODISTS UNITED
for Peace with Justice
421 SEWARD SQUARE, S.E. WASHINGTON, D.C. 20003 202-546-5551

July 29, 1993

Mrs. Hillary Clinton
The White House
Washington, DC 20500

Dear Mrs. Clinton:

Knowing your interest in a broad range of issues beyond the ones you are now working on, we would like to share with you some ideas on nuclear disarmament as developed by people associated with the United Methodist Church.

Our own organization is a national association of laity and clergy, originally organized in 1987 by the Peace Mission of the Foundry United Methodist Church, which you are attending. I myself was a member of Foundry (and organizer of the Housing Mission) before my wife entered the ordained ministry in 1985, and I followed her in itinerancy.

Our latest thinking is contained in the enclosed letter to Dr. Anthony Lake in which we propose a global zero alert for all strategic nuclear weapons, achieved by separating warheads from delivery vehicles with proper verification. We propose that this be accomplished in phases, to be completed by August 6, 1995, the fiftieth anniversary of the bombing of Hiroshima.

The rationale for this approach is offered in the enclosed letter of March 1, 1993 to President Clinton.

This idea comes out of a broader resolution on "Nuclear Disarmament: the Zero Option", adopted by the United Methodist General Conference in May 1992. As you know, this is the official governing body of the United Methodist Church. There was so little opposition to this resolution in committee that it was adopted as part of the consent calendar, in effect by unanimous consent.

The 1992 resolution contains policy recommendations that build upon the pastoral letter and foundation document, *In Defense of Creation*, which the United Methodist Council of Bishops adopted in 1986 and the General Conference affirmed in 1988. A copy is enclosed in case you don't have one handy.

We are recommending that the "Methodist option" be given consideration in the comprehensive strategic review which is now underway. We urge you to use your influence to see that this occurs.

If you or your staff would like to discuss our ideas in greater detail, please let us know.

With best regards,

Howard W. Hallman

Howard W. Hallman
Issues Chair

Telephone -- Mon-Thurs: 1-301 694-2859; Fri-Sat: 301 897-3668

Please reply to 6508 Wilmett Road, Bethesda, MD 20817

METHODISTS UNITED
for Peace with Justice

421 SEWARD SQUARE, S.E. WASHINGTON, D.C. 20003 202-546-5551

March 1, 1993

The Honorable Bill Clinton
The White House
Washington, DC 20500

Dear Mr. President:

As you prepare to meet with Russian President Boris Yeltsin next month, we urge you give in-depth consideration to the idea of simultaneously taking the Russian and U.S. strategic arsenals off alert. Just such a proposal was made by Russian Foreign Minister Andrei Kozyrev on February 12, 1992 at the Conference on Disarmament in Geneva. He stated:

> First, we may consider taking off the alert status the strategic forces of Russia, the United States and other nuclear powers, which are targeted on one another's territories or facilities, thus placing nuclear weapons on a "zero alert posture".
>
> Second, keeping nuclear weapon delivery vehicles and warheads apart could prove a useful idea. In other words, ICBMs on launchers would carry no front sections, submarines berthed in home ports would carry no SLBMs or SLCMs, and heavy bomber nuclear weapons including nuclear ALCMs would be kept in central-run storages. In this way, we would be guaranteed against their unauthorized or accidental use. Another benefit of this measure is its verifiability. The details of verification could be agreed upon.

Assuming that all strategic weapons of the former Soviet Union are encompassed in this arrangement (including those still based in Belarus, Ukraine, and Kazakhstan), we think that this would be a great deal for the United States. Among other benefits it would quickly remove all the powerful Russian S-18s and S-24s from active service. Mutual zero alert would vastly increase U.S. homeland security against an unexpected nuclear attack from afar and would safeguard against actively deployed Russian missiles falling into the hands of a reactionary regime should President Yeltsin be overthrown.

Zero alert status can be achieved if the United States will agree to reciprocate by removing the warheads from all of our ICBMS, bringing all our submarines into port and removing their missiles, and continuing to keep nuclear weapons off our strategic bombers (a practice President Bush initiated in the fall of 1991). Once off alert, Russian and U.S. strategic weapons can be dismantled in a staged and balanced manner, beginning with an accelerated START I and START II schedule with latter additions.

We have been advocating this course for a year and a half. Many citizen organizations look favorably upon this approach and so do some leading members of Congress. We have also found persons who are skeptical of this idea, in particular for three reasons. They doubt its practicality. They believe that the United States will always need to keep strategic

submarines at sea for deterrent purposes, if not directed against Russia then some other adversary. And some persons ask whether other possessors, such as China, Great Britain, and France, would be included. I would like to address these three concerns, starting with the second.

Doing without strategic submarines. Having nuclearly-armed, strategic submarines at sea has become a habit for the United States. Yet, their only purpose at this point is to deter Russia and the three other independent states of the former Soviet Union from launching a strategic nuclear attack against the United States. Zero alert would remove that threat. If Russia later reactivated its strategic nuclear weapons, the United States could reciprocate by putting nuclear missiles back on submarines and sending them to sea. Otherwise, the United States has no use for strategic submarines, either as a deterrent or for warfighting purpose for any events likely to occur during the next 10 to 20 years.

To make this determination for yourself, we urge you and your national security advisers to explore the top global security concerns of the United States and determine whether strategic submarines have any utility either for deterrence or warfighting. As a point of departure, we offer the following chart with blanks to be completed.

	Usefulness of U.S. strategic submarines	
Possible event	**Nuclear deterrence** (0=none 5=definite)	**Warfighting utility** (0=none 5=definite)
Ethnic conflict in former Yugoslavia		
Ethnic conflict in states of former Soviet Union		
Russian revanchism (attempts to recover lost territory)		
Terrorist operations of Libya, Syria, Iraq, Iran, any other state or terrorist group		
War between Israel and Arab states		
Aggression of Iraq, Iran, Syria against its neighbors		
Civil war in Africa		
War between India and Pakistan		
Border war between Russia and China		
Chinese invasion of neighboring states		
North Korean invasion of South Korea		
Warfare in Southeast Asia		
Communist insurgency in the Philippines		
Civil war in Latin America		

We believe that the answer is "none" for both questions on all these possible events. That is, U.S. strategic nuclear weapons, including submarines, cannot deter these events from happening and have no warfighting utility if they should occur. We come to this conclusion inductively by reviewing (1) similar events of the past 48 years that actually happened and thus were not deterred by U.S. nuclear might and (2) wars in which U.S. political and military leaders decided that U.S. weapons would not be used. This manner of thinking differs from most nuclear weapons theorists who reason deductively and never test their exotic theories by relating them to real-world experience.

Without going through the entire list, we can note that the 125 wars occurring since the end of World War II reveal that the U.S. strategic force cannot deter civil and ethnic wars and wars between divided nations (Korea, Vietnam). Furthermore, nuclear weapons have no warfighting utility in these situations (as Presidents Truman and Eisenhower concluded in the Korean War and Presidents Johnson and Nixon concluded in the Vietnam War).

U.S. strategic weapons have not deterred small and medium-sized military powers from invading their neighbors, as Iraq did against Iran and then Kuwait. When the United States got involved in the latter situation, it had plenty of firepower without invoking nuclear weapons. Even if nuclear weapons would have been used, they would not have been long-range strategic missiles. If North Korea invaded South Korea, nuclear weapons would not be necessary or useful (among others Admiral Noel Gayler, who was once commander-in-chief of the Pacific Basin including Korea, has so testified).

U.S. strategic weapons did not deter the Soviet Union from sending troops into Hungary (1956), Czechoslovakia (1968), and Afghanistan (1979) and would not deter a reactionary Russian regime from seeking to regain Belarus, Ukraine, the Baltic States, or enclaves of Russian population within those states. This would be true even if Russia no longer had active nuclear weapons, for U.S. national interest in protecting freedom of Russia's neighbors is insufficient to go to war with nuclear weapons. The only event for which the United States might have used nuclear weapons was Soviet invasion of Western Europe, and that is now totally moot.

U.S. nuclear weapons do not deter regional rivals from fighting, such as India and Pakistan, Israel and the Arab states, nations of Southeast Asia. Nuclear weapons do not deter terrorists.

Perhaps, though, you or some of your national security advisers would think that U.S. strategic nuclear weapons have a slight deterrent capacity for a few of these possible events, that is a rating of "1" or even "2". If so, we suggest that you weigh this value against the worth of getting the entire Russia strategic nuclear arsenal completely out of service. This ought to be a supreme objective of the United States and should far outweigh any other minor deterrent value of U.S. strategic nuclear weapons. Moreover, to the extent that the United States wants to deter these other events (and we can't deter everything on Earth), there are other means.

In sum, we are firmly convinced that the United States can safely bring its strategic submarines into port and remove the missiles and take the warheads off all its ICBMs and place them in storage if Russia and the other three independent states do the same thing at the same time.

Practicality. This brings us to the second objection to this proposal which we hear: that it is impractical. For instance, a Hill staffer said, "It may be a good concept, but it can't be accomplished easily. The 'devil is in the details.'" (The latter is a phrase used around town as an excuse for avoidance.) Although we are not military or arms control technical experts, the task doesn't seem that difficult for intelligent people on your staff to figure out.

For instance, we note a description in *The Bulletin of the Atomic Scientists* (May 1992, pp.48-49) on how the U.S. Air Force is retiring Minuteman II missiles.

> Disarming the missiles is the first step in the retirement process. The Mark IIC reentry vehicles (RVs), with W56 warheads inside, are removed from the top of each missile. The RVs are transferred to a special van and, under heavy security, transported back to base. There the warheads are removed from the RVs, put in a special container, and placed in weapon storage igloos. ...Eventually, a C-141 will be used to take a load of these warheads to an air force depot -- in this case, probably to Barksdale, in Louisiana, for temporary storage. When scheduling permits, they will be transported to the Pantex warhead assembly plant in Texas, where they will be disassembled.

It doesn't seem overwhelming to work out similar procedures for all of the former Soviet ICBMs and the remaining U.S. ICBMs. The whole operation could be observed by inspection teams from the other side with surveillance 24 hours a day. In a similar manner, observation teams can watch missiles come off strategic submarines and placed in storage, with or without warheads still attached (preferably the latter). And the stored weapons removed from bombers can similarly be kept under surveillance. Thereafter, warheads can be disassembled in stages. There is already experience with similar operations under the INF treaty, and the START I agreement has applicable procedures.

Other nations. As to the third objection to the off-alert concept -- what about other possessors beyond Russia and the United States, we reply that obviously Belarus, Ukraine, and Kazakhstan have to be part of the arrangement. That doesn't seem overwhelming in spite of the current maneuvering now occurring. They have a self-interest in seeing that the Russian missiles are taken out of service. Their other concerns can be resolved.

Great Britain, France, and China should, of course, be invited to join this deactivation process. But even if they don't do so immediately, there would be no great danger. They would know that the United States and Russia would retain much of their strategic arsenal in reserve and would have plenty of missiles available to rearm in the event of a surprise attack by one of the other nuclear powers. Any other nation producing nuclear weapons would likewise know that they could not safely attack the United States or Russia without risking retaliation by rearmed strategic missiles.

In addition, it is exceedingly important for the United States to carry out a vigorous nonproliferation campaign on nuclear weapons and long-range ballistic missiles so that other nations do not join the nuclear weapons club.

Celebration. We are convinced that achieving mutual zero-alert status for Russian and U.S. strategic weapons is quickly achievable. Bringing this about is the kind of creative leadership we and other Americans are expecting of you. It requires some new thinking and discarding outgrown habits. You are the one to lead the nation in this direction.

We believe that it might be possible to achieve zero alert by July 4 this year. Then Independence Day could have a second significant meaning: independence from the fear of nuclear attack. Or maybe it would take until August 6 to complete the task: the 48th anniversary of the bombing of Hiroshima.

As the submarines come in and the warheads come off the ICBMs, there can be local celebrations. When it's all accomplished, there could be a parade down Pennsylvania Avenue with personnel who have served in the deterrent force.

We have an opportunity this year to remove the threat of nuclear attack on the U.S. homeland. We urge you to use your meeting with President Yeltsin to bring this about.

With best regards,

Howard W. Hallman

Howard W. Hallman
Issues Chair

Please reply to 6508 Wilmett Road, Bethesda, MD 20817

March 1-14: (301) 897-3668. Thereafter:
Mon-Thurs: (301) 694-2859; Fri-Sat: (301) 897-3668

January 11, 1994

Mr. Howard W. Hallman
Issues Chair
Methodists United for Peace with Justice
6508 Wilmett Road
Bethesda, MD 20817

Dear Mr. Hallman:

Please forgive my delay in responding. I want to thank you for sending me copies of the materials on the "Methodist Option" which you sent to Mrs. Clinton. We appreciate being kept informed on what the United Methodists are doing.

Your organization, and those of others, provide the President with a better understanding of the complex issues involved in nuclear disarmament. I can assure you that he is apprised of the views expressed by concerned individuals like yourself and the members of your organization before making policy decisions.

Thank you again for taking the time to make your voice count. Good luck in the important work you do.

Sincerely yours,

Melanne Verveer
Deputy Chief of Staff
to the First Lady

March 16, 1993

Ms. Angela Harrington
Riverview Cablevision
4007 Park Avenue
Union City, New Jersey 07087

Dear Ms. Harrington:

Thank you for sharing the story of Bob Brand which you produced for Riverview Cablevision's North Hudson News. This story, like so many we are hearing from Americans across the country, underscores the compelling need for health care reform. I have forwarded your letter and video to the health working group. I am confident it will inform their deliberations.

With best wishes,

Sincerely,

Melanne Verveer
Deputy Chief of Staff
to the First Lady

Riverview Cablevision
Associates

February 9, 1993

Angela Harrington
ANCHOR/REPORTER
NORTH HUDSON NEWS

RIVERVIEW CABLEVISION
YOU'LL LOVE THE VIEW

(201) 866-9521 FAX (201) 866-4876
4007 PARK AVENUE
UNION CITY, NEW JERSEY 07087

Ms. Melanne Verveer
Deputy Chief of Staff
Office of the First Lady
Old Executive Office Building
Rm 134
Washington, D.C. 20500

Dear Ms. Verveer:

One of the greatest challenges facing our nation is developing a health care system that is accessible to all Americans - rich and poor.

As First Lady Hillary Rodham Clinton takes on this challenge, I would like to share the story of Bob Brand which I produced for Riverview Cablevision's North Hudson News.

Mr. Brand's struggle with Lou Gehrig's disease and his wife Helen's battle with their insurance company to get his home care paid, inspired me to raise public awareness about the need for health insurance companies to change their policies and exercise some common sense.

In his fight to stay alive, Mr. Brand has chosen to be cared for at home, among those who love him, and not in the aseptic world of a hospital. But his insurance company, Empire Blue Cross and Blue Shield of New York, has refused to pay for his home care, even though it is more than two times cheaper than being in a hospital.

Mrs. Brand and her attorneys have numbers that prove it is more economically feasible for Mr. Brand to be home, yet Empire Blue Cross maintains it is more cost effective for him to stay in a hospital or a skilled nursing facility.

Mrs. Brand has already spent $65,000 out of her own pocket for her husband's care.

It is inconceivable that insurance companies opt for the more costly plan, instead of seeking alternative ways to care for patients, where the rewards are measured not only by the money saved, but by the preservation of human dignity.

The enlcosed tape contains the two-part series, "In Sickness and In Health: Common Sense Health Care," which aired last week. It details the Brands' personal struggle and their court battle against Empire Blue Cross.

I hope you will take 11 minutes of your time and Mrs. Clinton's time to view the tape, for it took great courage for Mr. Brand to bare his soul in front of the camera. His courage should be a symbol for the rest of the nation - the symbol that serves as a catalyst for change.

Respectfully yours,

Angela Harrington

AH: ac
encls.
cc: Rep. Robert Menendez
13th District, New Jersey

THE WHITE HOUSE

WASHINGTON

August 2, 1993

Judy Harris
Reed Smith Shaw & McClay
1200 18th Street, NW
Washington, DC 20036

Dear Judy:

Thank you for your recent fax recommending Gloria Sachs to the NEA council. She certainly appears to be a candidate for a position on the council.

I will forward your recommendation to the appropriate officials in Presidential Personnel, who are currently reviewing applications to the NEA.

I hope all is well. I enjoyed hearing from you. Best wishes.

Sincerely,

Melanne Verveer
Deputy Chief of Staff
to the First Lady

Always good to hear from you
Hi to Norm

draft NR

August 26, 1993

fine!

Mr. Melton Harrison
1220 Marie Street
Hattiesburg, MS 39402

Dear Mr. Harrison:

Thank you very much for sending me your notebook presentation on the issue of health care costs and waste in Hattiesburg. I also received and included the two follow-up letters you have since sent. I deeply appreciate the time and energy you have spent preparing the report, taking the photographs, and researching. Mrs. Clinton and I have read your report with interest.

The questions which you raise certainly epitomize a pervasive trend, in which Americans are questioning and challenging the status quo of the health care system in the country. As the President moves forward toward the release of his plan for health care reform, he hopes to create a national dialogue on the subject, so that questions such as those you raise in your report can be addressed.

Thank you again for writing to me and the First Lady.

Sincerely,

Melanne Verveer
Deputy Chief of Staff
to the First Lady

DRAFTbz

November 19, 1993

Dr. James S. Harrold, Jr.
Partial Hospital Institute of America, Inc.
501 Bel Air Blvd., Suite 200
Mobile, Alabama 36606

Dear Dr. Harrold:

Thank you for your recent ~~letter~~ request to Secretary Shalala regarding ~~the~~ reimbursement of Medicare ~~reimbursement~~ as it affects your institution. Mrs. Clinton greatly appreciates your sharing your ~~ideas about an issue that is important to you and to many other people~~.

Your comments, ~~and those of other writers,~~ provide The President ~~Clinton~~ and Mrs. Clinton with a better understanding of the complex issue of health care reform. I can assure you that they carefully consider the views of concerned ~~individuals like you before making policy decisions.~~ citizens like yourself

Mrs. Clinton regrets she was unable to attend the open house of your new facility early this month.

Thank you again for taking the time to ~~make your voice count~~ share your experience in the delivery of health care.

Sincerely,

Melanne Verveer
Deputy Chief of Staff
to the First Lady

involved in

Partial Hospital Institute of America, Inc.

DAY HOSPITAL/DAY TREATMENT PROGRAMS with tracks for PSYCHIATRY, CHEMICAL DEPENDENCY, DUAL DIAGNOSIS, PAIN MANAGEMENT and MEDICAL REVIEW OFFICER SERVICES

JAMES S. HARROLD, JR., M.D.

Diplomate: American Board of Psychiatry & Neurology (ABPN) American Academy of Pain Management (AAPM)
Certified: Addictionologist, American Society of Addiction Medicine (ASAM).
Medical Review Officer (MRO), American Association of Medical Review Officers (AAMRO)

October 25, 1993

First Lady Hiliary Clinton
The White House
Washington, D. C. 20500

Dear Mrs. Clinton:

Thank you for your letter of August 6, 1993, through your assistant, Ms. Rasco, it was very gratifying to hear from you on behalf of the President and Mrs. Clinton. This is evidence that hard work is not in vain.

I am writing again, as we now need your help if our program is to remain viable. We believe strongly that if health care is to be controlled, it will be based on collaborative efforts between state, federal government and the private sector. Having extensive experience in academia in the federal health care system, as well as, involvement in state health care and now in private practice, I feel I am in a position to truly know the problems that presently exist in health care and certainly have strong feelings about how they can be resolved. I have written a detailed letter to Secretary of Health & Human Services, Donna Shalala, that will outline in detail our present dilemma and my strong feelings about it.

Any assistance would be extremely helpful. I feel strongly that it will be the private sector showing goals and incentives with federal and state government that will lead the way to true reform. I believe strongly in the President and First Lady's initiatives on this issue, and can see numerous areas where joint ventures can be struck between business and government to this end.

After reviewing my letter to Secretary Shalala, we would appreciate any assistance you can offer us. As outlined in the letter, we are only asking that we not be hindered in our efforts. If possible, I would also like you, or a representative of your staff, to visit our facility. We are having an open house on November 4, 1993, which would offer a first-hand opportunity to view our facility. Of course, we realize that your schedule and that of your staff is very complex and hectic, but we

501 Bel Air Blvd., Suite 200, Mobile, Alabama 36606
Telephone: (205) 473-6700 / FAX: (205) 476-0111

truly believe that we can show you a model of cost-effective care at its best. We feel a comprehensive partial hospital program such as ours, is the future of mental health care, chemical dependency (substance abuse), and chronic pain management with superimposed mental health or chemical dependency issues. I also feel this will be the treatment of choice with addiction in the federal/private workplace, based on urine drug screenings.

Respectfully,

James S. Harrold, Jr., M.D.
Founder, President, C.E.O & Medical Director
Partial Hospital Institute of America

DIPLOMATE: American Board of Psychiatry and Neurology (ABPN), American Academy of Pain Management (AAPM)
CERTIFIED: Addictionologist, American Society of Addiction Medicine (ASAM), Medical Review Officer (MRO), American Association of Medical Review Officers (AAMRO)

JSH:cr

Enclosure

Partial Hospital Institute of America, Inc.

DAY HOSPITAL/DAY TREATMENT PROGRAMS with tracks for PSYCHIATRY, CHEMICAL DEPENDENCY, DUAL DIAGNOSIS, PAIN MANAGEMENT and MEDICAL REVIEW OFFICER SERVICES

JAMES S. HARROLD, JR., M.D.

Diplomate: American Board of Psychiatry & Neurology (ABPN) American Academy of Pain Management (AAPM)
Certified: Addictionologist, American Society of Addiction Medicine (ASAM), Medical Review Officer (MRO), American Association of Medical Review Officers (AAMRO)

October 25, 1993

Donna Shalala
Secretary of Health & Human Services
200 Independence Ave., S.W.
Washington, D.C. 20201

Dear Secretary Shalala:

This is a follow up of my letter to you of February 22, 1993. I outlined at that time our recent opening of the Partial Hospital Institute of America, Inc. As I mentioned in my February letter to you, this is a comprehensive program, established specifically to cut inpatient psychiatric hospital costs. The program is also designed to cut inpatient costs for chemical dependency treatment and for the treatment of chronic pain on an inpatient basis. The chronic pain aspect is for people who are nonsurgical candidates, with chronic pain syndromes and who, often through prescription medications, may have a secondary addiction as well. The program is thus for "dual diagnosis, to include major psychopathology, chemical dependency, and chronic pain".

As I mentioned, the program is divided into Day Hospital and Day Treatment, with five tracks, as outlined above, psychiatry, chemical dependency (addictions), dual diagnosis, chronic pain management and medical review officer services (MRO). The MRO aspects of the program are very important as well. As you know, a Medical Review Officer is a physician specialized in the diagnosis of drug dependency, the clinical interpretation of addiction and an expert in the analysis of drug screening tests. Through the Partial Hospital Institute of America, we have the diversity to act as an MRO in screening for drugs in the work place, to include federal, state and private sector, who use random drug testing, as well as, the subsequent treatment of addiction as found through various programs.

501 Bel Air Blvd., Suite 200, Mobile, Alabama 36606
Telephone: (205) 473-6700 / FAX: (205) 476-0111

Since I talked with you, we have received certification through Joint Commission of Accreditation of Health Care Organizations (JCAHO), as well as the State of Alabama. We are also institutional members of the American Association for Partial Hospitalization, Inc. (AAPA), the International Association for Psychosocial Rehab Services (IAPSRS), National Consortium on Alcoholism and other drug dependency, psychiatric organizations.

We are accredited under the 1993 guidelines for Joint Commission, including all addendums (appendices used to indicate the degree of intensity of services offered). This is specifically designed to indicate the scope, depth and breadth of a partial hospital program and as using the language indicated in the JCAHO manual, to indicate the program is "like inpatient". All of these appendices are used for our program and we were evaluated as such. There was a similar accreditation for the State of Alabama, where we were also evaluated on par with an inpatient psychiatric unit. In the partial hospital nomenclature, our program would be considered an "ambulatory psychiatric hospital".

Since opening in February of 1993, we have treated over 100 patients. The patients have included a full range, including patients on chronic renal dialysis, wheelchair-bound patients, patients with advanced metastatic cancer to the brain, and geriatric patients over the age of 65, but with cognition and ambulatory skills which made them very suitable for an intensive outpatient ambulatory program such as we offer. We have been gratified by the fact that patients, as well as their families, have derived a high degree of satisfaction from our program and have recommended it through word of mouth.

An inpatient psychiatric hospitalization is now used by us as a crisis triage situation. Patients are discharged from inpatient to the partial hospital after only several days of stabilization. Many patients now with our program are never on an inpatient unit, but come directly to the partial hospital and then back to a traditional outpatient practice. For inpatient stay, we have averaged approximately four days. This is compared to three to four weeks of inpatient treatment prior to our program. We have also found that our program offers several distinct advantages over inpatient:

1. We have a truer index of patient progression. As the patient returns home each night and, on weekends, he/she returns to the program with data from their environment and their family setting that is readily fed back into their treatment plan. This means the treatment plan is shaped realistically during the course of treatment and there are no unknown variables to lead to relapse after discharge from the partial hospital program.

2. We also have the opportunity to treat a significantly higher number of patients with family involvement. As the patients are going home each evening, families can readily see their improvement. We also view families as collaborators and openly-elicit their involvement.

3. We offer a very detailed family psychoeducational program once weekly, to include psychoeducational group, multiple family groups and a social period for families to interact informally. We have a similar program for our chemically dependent patients, "chemical dependency aftercare group", which is also used for identified patients and spouses.

To date, we have saved literally thousands of dollars for insurance companies, Medicare, Champus and for the identified patient and his/her family in copays. Our total price for treating a patient for one month in the Partial Hospital Institute of America, averages just under $12,000.00. This includes facility charges, physician charges, all other multidisciplinary staff charges, to include psychological testing. We offer our family program and chemical dependency aftercare program free for patients who go through the partial hospital program.

The least expensive inpatient program in the Alabama area, as well as the Southeast, is anywhere from $25,000 to $45,000, when physician, psychologist and other charges are included. Of note, the cost for inpatient treatment varies widely across the country but, historically, has been lowest in the Southeast.

For many patients in our program, we have been able, during the latter stages of treatment, to have them come less than five days per week, and actually phase them back to work while still in the program. The patients in this category, are charged below $10,000 for one month of treatment. We can cut costs by a variety of mechanisms. First, we have a 20-day month. The patients come five days a week, the program is closed on weekends and holidays, compared to traditional inpatient treatment, where the patient has on average, 30-day month, and the patient is still charged facility fees, as well as, in many cases, physician charges for the weekends and holidays as well.

We also see patients actually progress faster, as they enter the program immediately with the support of their family members. This is compared to traditional inpatient hospitalization, where the patient, by program design, is kept away from their family members for, on average, 72-hours (3 days), due to acclimating the patient to the inpatient milieu.

Lastly, as mentioned earlier, the patient is actually receiving intensive treatment on par or greater than an inpatient psychiatric unit, without the guilt or anxiety of being away from children, spouses or significant others. Patients and their families also, do not have the added expense of making arrangements for the care of their children, the spouse or significant other missing valuable days from work to aid in caring for children, and/or loss of job due to lack of contact with employers for extensive periods while hospitalized on inpatient units.

With our program hours, 9:00 am to 3:30 pm, Tuesday through Friday, and from 1:00 pm to 7:30 pm on Monday (to accommodate family night), we essentially allow a situation for our patients where children can be dropped off at school, picked up at school by the spouse or identified patient when more stable, and a mother can spend the evenings with their children and, when more stable, even be home in time to prepare dinner for the family. We find this is a situation much more readily accepted by male spouses, who traditionally have been either uninvolved in inpatient treatment of their female spouse, or has felt alienated from the hospital. Attending a partial hospital on a daily basis with weekends, holidays and evenings covered by physicians, has proven to be a very powerful median for improvement in our patients. This is also contrasted to inpatient hospitalization, where if a family member calls, they may or may not be able to talk to the patient, based on restrictions due to the early part of admission, or other issues. The first person at the other end of the phone in such an instance is usually a nurse whose function is to attempt to contact the attending physician. This often leads to frustration on the part of the patient, as they are not allowed to talk to their doctor, and statistics clearly indicate they end up using higher amounts of medication, with more frequent doses of "prn" medications (medications as used as needed, when the patient indicates a escalation and/or intensity of pathology). Of note, this usually happens in the late evenings, or on weekends, when the physicians are not at the hospital, as well as the major treatment staff, Social Workers, etc.

As stated, our program was designed specifically to cut health care costs on the <u>INPATIENT SIDE</u> which is the most expensive aspect of psychiatric and chemical dependency health care. We have clearly established the ability to do this. Along with this, we have seen a much lower rate of recidivism and when recidivism does occur, the patient is referred back to the partial hospital program, rather than an inpatient psychiatric unit. It is important to indicate this is the first program of this type in the State of Alabama. Partial hospitalization has been traditionally been used as "glue between outpatient and inpatient treatment". When the patient really becomes sick, they are referred 100% of the time to an

inpatient psychiatric unit. Our program is structured so that from the start of illness, there is an alternative. We have found, and this is supported by literature, that 85% or more of our patients previously hospitalized not only can be treated in our partial hospital setting, but show a faster recovery, greater stability, and more family involvement. We are also able to be much more "therapy-intensive" than traditional inpatient units, based on the fact that the patients spend evenings, weekends and holidays with their families, and sleep in their own beds. After program hours, when they call with problems, they reach a physician on the other end of the line (Board Certified Psychiatrist). This is an important aspect of our program because when patients and/or their family members call, they are talking to a physician with the power to provide treatment of a full range, to include prescriptions, as needed, that can be called in to a pharmacy as needed, and, if indicated, hospitalization. We have had many instances where we will hospitalize a patient on a Friday afternoon and discharge the patient back to the partial hospital program on Monday morning.

I, as Founder, President, C.E.O and Medical Director of Partial Hospital Institute of America, Inc. (PHIA), feel very strongly that if health care costs are to be lowered, the initiative will have to come from physicians. Our predecessors have justifiably often left a poor image in the eyes of consumers and insurance companies. This is based on prolonged hospital stays, unnecessary procedures, etc. The American Psychiatric Association, in particularly the American Association of Partial Hospitalization, Inc. (which I have been a member of for over nine years), is committed to cost containment. I am a member of numerous organizations for physicians involving psychiatry, chemical dependency, chronic pain, medical review officer services and many multidisciplinary groups which are all dedicated to the end of providing cost effective, yet high quality care. I would venture to say that our program provides a higher intensity of care than any inpatient unit in the State of Alabama. We do this in the following way. Every patient has an individual clinician (case manager), to coordinate their treatment plan. I have found the most common complaint of patents, particularly hospitalized patients, is that they have no one to talk to about their difficulties. When they cannot talk to someone, the supplement is usually medication. Every clinical person in the Partial Hospital Institute of America acts as a primary clinician (case manager) for patients. It is important to note here that this is not to say that we have nurses, mental health clinicians or others at or below the Masters level, conducting "psychotherapy". This is all done by masters level social workers, psychology, psychiatry and trained certified chemical dependency rehab counselors who are credentialed to do so. An individual clinician (case manager) is important because there are many functions that can be achieved by a person at or below the masters level, trained and supervised. This includes

calling the patient in the morning to help get them to the program, following up if patients miss a day, meeting with them daily to aid in coordinating family meetings and calling agencies needed by the patient for support, ranging from food stamps, consults and state vocational rehabilitation, or physical rehabilitation. This allows for much more efficient use of social workers at the masters level, psychology and psychiatry. We have also found that having a full-time activities/leisure therapist is vital, as well as that of having a full-time dietitian (leisure activities therapist at the masters level, and dietitian, registered through both the American Dietetic Association and State Dietetic Association). We find use of leisure time and eating habits are key variables to both good physical and psychological well-being. Active involvement of these disciplines in our program, to include group, individual consultations, monitoring the lunch program and all outings and other activities of a leisure nature in the program, we find our patients making much better use of their leisure time, finding quality time with their families. Through our family programs, we are educating spouses on mental illness and, very importantly, how to recognize early warning signs. As one example, a major focus of the program at present is to focus on the upcoming winter holidays (Thanksgiving, Christmas and New Years). This is traditionally a difficult time for psychiatric patients and a time for relapse. The strongest weapon against relapse of any type, especially what is referred to as "holiday blues", and "anniversary reactions", is specific education to the identified patient and his/her family, and a structured program closely monitors patients around these difficult times.

Also, unlike most partial hospital programs in the southeast and most in the country for that matter, our program includes all full-time salaried staff. This is an important consideration for the stability of a program and, in fact, to have a true partial hospital program. The Joint Commission for Accreditation of Health Care Organizations is beginning to look critically at this issue, as many programs who call themselves partial, literally consist of a core staff of a nurse and an on-call physician, who may or may not be a psychiatrist, and all other disciplines consulted. An example would be a program which uses consultants, such as psychology to come in and do a group once a week, a consulting dietitian to maybe give a lecture once a week, and the physician, essentially seeing the patient briefly around medication issues.

In the Partial Hospital Institute of America, within the prices quoted above, we provide our patients psychotherapy, as well as pharmacological therapy. The psychotherapy is done in the way of individual psychotherapy by social work, psychology and psychiatry, as well as, individual family therapy, as frequently as families can make time for in their schedule. We have reached the point in our program where we actually receive most help from family members in getting patients to the program on a daily basis and, if they fall off in attendance, a simple call to the family can readily get the patient back.

Our program is located in approximately 11,000 square feet of space. It includes two nursing stations, offices for every clinical person, including mental health workers, chemical dependency counselors, social work, psychology, psychiatry, dietary therapy, recreation and leisure therapy and chemical dependency counselors. This is important, because when a patient is seen individually, we feel an office is critical, where the patient can sit down with their clinician or therapist, in privacy, and discuss their issues. We feel this allows for the greatest dignity in patients with severe psychopathology. I would note that this is often not the case on inpatient units.

Despite our dedication to controlling health care costs without sacrificing quality of care, we have become totally frustrated with the state and federal systems, in regard to Medicare and Champus reimbursement. We are also finding in the State of Alabama, that based on the strong private hospital lobby, insurance companies, including Blue Cross and Blue Shield of Alabama, have been very reluctant to fully endorse this treatment model. We have had our patients write, specifically requesting this treatment modality for the reasons outlined above, only to be told that partial benefits are not included in their healthcare package. In many situations, and I would say the majority at this point, we have literally taken a patient out of an inpatient unit after 3 to 4 days, treated them totally in the partial hospital program, with successful remission and/or resolution of their symptomatology, and have them now doing well in structured outpatient, saving thousands of dollars for Medicare, Champus and private health insurance carriers. Our reward for this has been for Medicare, Champus and private carriers, such as Blue Cross and Blue Shield of Alabama, to deny reimbursement on the inpatient side and reimburse only through outpatient benefits. This is extremely harmful in a number of ways. As you know, for private insurance, as well as Medicare and Champus, outpatient benefits are reimbursed at a much lower level than inpatient benefits. Our program, as stated, was designed to significantly cut inpatient costs based on receiving reimbursement

on the inpatient side, as we are doing the work that would usually have been done during an inpatient admission of several weeks. Our patients need their outpatient benefits. If outpatient benefits are used for partial hospitalization, we are using a programmatic model with the intensity of the Partial Hospital Institute of America, Inc., they have essentially eroded their outpatient benefits quickly while in the partial program. They are left with the following situation: They have a calendar year maximum for inpatient and outpatient benefits. The outpatient benefits have been totally exhausted. The inpatient benefits have hardly been touched based on our treating the patient in a partial hospital setting. The patient thus finishes the year with no outpatient benefits, necessitating out-of-pocket treatment for outpatient benefits, with a deep pool of inpatient benefits that have not been touched. Having worked in the area of partial hospitalization for a number of years, as well as being well-versed in public and administrative psychiatry and chemical dependency issues (I completed a fellowship in public and administrative psychiatry at Yale University School of Medicine after my residency in psychiatry), I find this a gross injustice not only to the patient, but to organizations such as ours that are legitimately attempting to bring down the cost of health care. As indicated earlier, unlike other partial hospital programs, all our employees, both clinical and administrative, are salaried employees. They receive health care benefits (Blue Cross & Blue Shield, including dental), and other benefits such as term life insurance, and ample vacation/sick time and mental health days. I also believe strongly in family leave. We, thus, offer maternity leave for employees, or other leaves around family needs.

I cannot keep my program open without appropriate reimbursement. At present, we have thousands of dollars in Medicare reimbursement in accounts receivable, Champus reimbursement in accounts receivable and, as stated earlier, insurance companies capitalizing on the effectiveness of this model by literally pocketing money that is designated for insurance coverage for psychiatric, mental health and other issues. As stated earlier, we were evaluated by JCAHO and the State of Alabama as a hospital. I paid for liability coverage as a hospital. I have the appropriate staff with the required credentials to operate as a hospital. Lastly, we treat patients at the severity of illness that of a hospital. In most instances, offering more services with a greater intensity of service.

Managed Care in the Southeast has essentially been used to purchase the cheapest coverage without any thought to quality. The way a physician or physician group is rewarded in this area, is to essentially run medication mills in hospitals, as well as through outpatient treatments. Large numbers of patients have come to our program frustrated with the managed care system, indicating "I never saw a doctor", or "I never knew who my doctor was". We also commonly hear from family members "I never got a chance to talk to the doctor", "they discharged him too soon, he is still sick, or he is still drinking". When I am on inpatient units, I am often in the awkward position of patients literally approaching me, requesting to change from their present physician to become involved in our program, based on seeing patients in our program with what they feel are distinct advantages that they also want.

If administration is truly serious about cutting health care costs and if as administration states, they also see the need for mental health and chemical dependency benefits, I am now asking that you help us. I have established two previous partial hospital programs of this type in academic settings, as I indicated to you in my letter of February 22, 1993. Our present program is larger, more complex, and offering more services than the previous ones. As I also stated to you in my February letter, both previous programs are still operative and functioning well, with census' in the 30's to 50's.

Without appropriate reimbursement for our services, I cannot pay my federal taxes for employees, I cannot pay for employee services and I cannot repay loans received as start up money for our program. Of note, $150,000 was through an SBA (small business), $160,000 was through private sources, and over $200,000, of my own money has been used. As any good employer should, I pay my employees before myself. I am to the point now where my own financial situation is in jeopardy. This not only hurts me personally, but also prevents me from securing finances through other sources for the program. At present, we now have over $300,000 in accounts receivable. Over $200,000 of that is hard and monies appropriately due for services rendered. Of note, we are approaching close to $100,000 in Medicare, based on usual, reasonable and customary charges. Based on my knowledge of other partial programs across the country, offering only a fraction of our services, are receiving Medicare reimbursement greater than our usual and reasonable customary charges ($400 per day for Day Hospital, and $350 per day for Day Treatment). As stated, these are all inclusive charges, with the exception of psychiatrists and psychologist charges. This is no different from the inpatient model, where physician and psychologist charges are separate.

We need help **NOW.** We have gone through extensive efforts with Champus. We were initially told the root was through the Wisconsin group. This was after my reviewing the partial hospital regulations issued by Champus in November, 1992, only to find they had been rescinded after initiated. Initially, we found the Wisconsin Group only accredited partial hospital programs that were a part of a hospital setting, whether medical/surgical, or free-standing psychiatric hospitals. By definition, a partial hospital to be effective, should be as far away from an inpatient unit as possible. In our area, partials are being reimbursed as part of inpatient free-standing psychiatric hospitals, such as the Charter Medical Corporation system. These are programs where the patients supposedly come to partial, but attend the same milieu of groups they attended while hospitalized, they are treated by the same nurses who treated them as inpatients, and who are clearly treating inpatients and seen by the psychiatrist who is currently seeing inpatients. In essence, these are programs without any designated staff or space. The partial patients are mixed with inpatient, receive the same thing, with the only difference being that the partial patients leave and go home. In our view, this is not treatment and certainly not what a partial hospital program is meant to be. After seemingly, finally winning the battle with the Wisconsin group and receiving facility and provider applications, filling them out and sending them to Health & Human Services, we received a letter back from HHS, stating "these are the wrong forms". Again, the criteria for a partial reimbursement under Champus had apparently changed. Rather than sending us the appropriate forms, we were told we were on a waiting list for forms. This was over four months ago. We called constantly and we just received the appropriate forms for Champus today. Please note, the forms allow us to apply for Champus inclusion as a partial hospital program and we have no idea how long this process will take.

For Medicare, we are apparently at the mercy of the State of Alabama, as Medicare is tied to state certification and licensure. This has also been a long and arduous task, constantly receiving misinformation. It is also important to note that the certifying body for the state is the Department of Mental Health & Retardation, with the reimbursement body being Health & Human Services through HCFA, which I am sure you know. The Alabama Department of Mental Health and Mental Retardation also actively now solicits contracts from Blue Cross & Blue Shield and other entities, to cover groups such as teachers, and other state employees, to include State Troopers, office workers, etc. We have a number of patients in this category who we have traditionally seen as outpatients who I have been involved over the last several years, admitting to the designated hospitals required by the state. Of note, this is limited to one hospital in Mobile, and one hospital on the Eastern Shore of Mobile (Baldwin county), which are often inconvenient for patients and are certainly far below the

best facilities in the area. The patients literally, due to the fact that there has been no attempt to screen out geriatric patients with severe dementia, from younger patients with extreme depressive, anxiety disorders or schizophrenia, when admitted, feel the hospital treatment is worse than no treatment at all. We have also been told by the state that they have partial services. Having been a consultant for the state psychiatric system for several years now, it is evident there are no true partial hospital services offered. In fact, the state only has an adult day program, which is essentially a program for patients with severe mental retardation or chronic intractable schizophrenia with cognitive decline. It is also important to note that while attempting to get a patient into the state system from my practice, or even indicating to the state, I will continue to treat the patient in my practice, if the state will only supply medications for the patient through the state pharmacy, as they are unable to afford them themselves, and I have been repeatedly told the answer is no. I have had patients who have been unable to afford private treatment, and I have carried them as long as possible, transferred them to the state with extreme difficulty, given an appointment time for six months down the line, and on at least one occasion, by his family's choice, wanting to wait for their appointment with the state, the patient unfortunately committed suicide. As you can see, it makes it quite difficult for me to accept the fact that the state wants all lucrative contracts, but yet is unwilling to treat the indigent patients. Based on a number of years in academia, and as stated in my February letter, a former chief of psychiatry for a large regional VA Medical Center, I am familiar with the operations of the federal and state systems. One initiative those systems were leaning towards when I left them in 1989, was joint ventures between state and federal systems and the private sector. I have approached the State of Alabama on these initiatives as well.

To close, as indicated, we need help and we need help now. I feel if health care costs are to be controlled, we will need collaborative efforts between federal and state agencies with the private sector. Based on years of working with this model, I feel we can do it better and more cost effective than the state. Rather than reinvent the wheel, allow programs such as ours to go under, only to mean more suffering and a lower quality of care for the residents of this state, as well as others, we are asking for your help. Please understand, we are not asking you to give us anything, but rather, based on policies for Medicare and Champus, not to tie our hands behind our backs and, in the case of private insurance, in my view, to allow them to violate antitrust legislature, in order to screen out systems that will offer real competition and continue to hold to the old models that have certainly proven not to work, to be too costly and clearly not with the best interest of the patient in mind.

I hope you will get to read this letter personally, Secretary Shalala. We need a prompt response from you, as I see with no change over the next 30 to 45 days, our program will cease to exist. There are many other private physicians, as well as mental health professionals watching us, also eager to engage in cost effective models of this kind. The failure of our program will surely send a negative message to other health professionals in our area. This will lead back to the status quo.

Lastly, I am speaking also as a business man, who is attempting to establish a small business. I am providing jobs for twenty-five (25) employees. These are jobs with good benefits, with a future and with a significant tax load. The failure of my program will also mean another failure of a very much needed small business in my state, contributing to both the state and federal treasury, in the way of taxes and other benefits.

I cannot stress strongly enough my statement earlier that if we are to solve the healthcare crisis, it will take the efforts of physicians and other health professionals. I feel I am in the best position to monitor the health care benefits of the patients I serve and to scrutinize those benefits in a way that provides the highest quality of health care for the least amount of benefits used, both for the agencies involved (Medicare, Champus, private insurance, etc)., as well as out-of-pocket expenses for my patients. I believe strongly that the private sector, working collaboratively with state and federal government in a true team approach, can solve this very complex problem. My program is testimony to that fact. I have literally put my resources and efforts into what I believe. If the administration is truly committed to healthcare reform, our program should be a tailor-made example of what has been indicated by the president, Ms. Clinton and yourself, in speeches and written material.

We would very much like someone through your office, if not yourself, to be able to view our program first hand. We feel it is truly revolutionary for this area and, as stated, the first program in the State of Alabama, designed specifically to cut cost on the inpatient side, by treating patients on par or more intensively than on inpatient units.

Respectfully,

James S. Harrold, Jr., M.D.
Founder, President, C.E.O & Medical Director
Partial Hospital Institute of America, Inc.

DIPLOMATE: American Board of Psychiatry and Neurology (ABPN), American Academy of Pain Management (AAPM)
CERTIFIED: Addictionologist, American Society of Addiction Medicine (ASAM), Medical Review Officer (MRO), American Association of Medical Review Officers (AAMRO)

JSH:cr

cc: Senator Howell Heflin
Senator Richard Shelby
Representative Sonny Callahan
Mrs. Hiliary Clinton
Tipper Gore
Carol H. Rasco

THE WHITE HOUSE

WASHINGTON

May 26, 1993

Mr. Dirk P. Hein
416 1/2 East Harrison Street
Seattle, WA 98102

Dear Mr. Hein:

Thank you for your thoughts and suggestions regarding the critical issues facing the delivery of health care in this country. Thank you also for the book, Acupuncture, by Professor Worsley. The White House Health Care Task Force has set up a resource database, and we appreciate people like yourself who take the time to apprise us of ideas concerning health care reform.

Thank you for caring. Best wishes,

Sincerely yours,

Melanne Verveer
Deputy Chief of Staff
to the First Lady

draft NR

We should also attach HRC's speech to the Catholic Health [illegible] & have a copy [illegible]

August 31, 1993

Rev. Msgr. George Higgins
Curley Hall
The Catholic University of America
Washington, D.C. 20064

Dear Rev. Msgr. Higgins:

Thank you very much for your letter and column regarding Father Philip S. Keane's ~~recent~~ book about health care reform. As the Clinton Administration ~~approaches the release of the National Health Security Plan,~~ it is crucial to keep abreast of ~~the national dialogue which has been growing on health care reform~~. Father Keane ~~was~~ is on target when he described health care reform as a "social moral issue." To secure affordable, attainable, quality health care for all Americans ~~remains a firm commitment~~ is a priority of this Administration.

Thank you again for your recommedendations, and for thinking of me and the Health Care working group.

Sincerely yours,

Melanne Verveer
Deputy Chief of Staff
to the First Lady

grapples with the issues surrounding national health care reform,

literature in this field. The Task Force had a working group that considered ethical questions & how considerable Catholic participation.

MSGR. GEORGE G. HIGGINS

Curley Hall The Catholic University of America Washington, D.C. 20064 202-319-5660

P/S rec'd

August 24, 1993

Ms. Melanne Verveer
Deputy Assistant to
the Chief of Staff
Office of the First Lady
1600 Pennsylvania Avenue, N. W.
Washington, D. C. 20220

Dear Melanne:

It occurs to me that the new book about health care reform which I have "plugged" in the enclosed column might be of interest to the members of the White House Taskforce on Health Care, if it hasn't already come to their attention.

Written in haste.

With every best wish, I remain,

Cordially yours,

George G. Higgins

Rev. Msgr. George G. Higgins

Enclosure

GGH:mh

DRAFT

February 23, 1993

Dr. Peter G. Hill
President, Greater Boston
Chiropractic Society
Director, Massachussets
Chiropractic Society
Copley Square Chiropractic Office
304 Columbus Avenue
Boston, MA 02116-5116

Dear Dr. Hill:

We regret that you were not included in the health care meeting held at Bunker Hill Community College on February 22nd, but the invitations for this meeting were issued by ~~Senator Kennedy~~ others.

However, we certainly want the benefit of your experiences and thoughts as it is important that we hear from all branches of the medical profession in order to achieve our goal of health care reform. Please send us what you would have said at the meeting. We want to hear from you.

With best wishes,

Sincerely,

Melanne Verveer
Deputy Staff Director
to the First Lady

BOSTON
Copley Square
Chiropractic Office

Peter G. Hill, D.C., M.F.A.

104 Columbus Avenue
One Block From Copley Place

Boston, MA 02116
Telephone (617) 536-9119

FAX TRANSMISSION
FAX # (617) 536-9177

Date: Feb 22, 1993

To: Ms. Melanne Verbeer

Voice Phone: _____

Fax Phone: 2028456 6344

From: Dr. Peter Hill
Office of Dr. Peter G. Hill

Fax Phone (617) 536-9177
Voice Phone (617) 536-9119

RE: URGENT

IMMEDIATE ACTION REQUIRED, PLEASE

This FAX transmission consists of 3 pages, including this page. Please call (617) 536-9119 if you do not receive all transmitted pages.

BOSTON
Copley Square
Chiropractic Office

Peter G. Hill, D.C., M.P.A.

304 Columbus Avenue
One Block From Copley Place

Boston, MA 02116-5116
Telephone (617) 536-9119

Need to do a reply. Sen Kennedy had issued invitations. Pls send us what you would have said had he participated. Update his input

February 22, 1993

Ms. Melanne Verbeer
White House
Schedule Department
Fax: 202-456-6244

Dear Ms. Verbeer:

I am writing you this letter to request that I can attend the meeting at 11:30 A.M. at Bunker Hill Community College to represent the chiropractic profession.

As my resume indicates, I am President of the Greater Boston Chiropractic Society, and I am also one of the Directors of the Massachussets Chiropractic Society. I think that it is very important that a representative of the chiropractic profession be included in any discussion among health care providers for health care reform.

If I can provide you with any information to assist you in getting me security clearance for this meeting today, I would be more than happy to assist.

Thank you very much for your prompt attention to this matter.

Note saying — but write it better Sen Kenn issued the invitations and we certainly want the benefit of your experience & thots.

Very truly yours,

Dr. Peter G. Hill
President, Greater Boston Chiropractic Society
Director, Massachussets Chiropractic Society

Pls send us ~~that~~ what you would have said at the meeting. We want to hear for you —

Dr. Peter G. Hill
Boston/Copley Square Chiropractic Office
304 Columbus Avenue
Boston, MA 02116
(617) 536-9119

EXPERIENCE

1986-PRESENT BOSTON CHIROPRACTIC OFFICE BOSTON, MA
* Board of Director for Massachusetts Chiropractic Society.
* Greater Boston Chiropractic Society.
  a) President 1990 - present
  b) Vice President 1989 - 1990
* Independent Review Consultant
  Lectured to the following:
* Medical Director for Boston's Emergency Service Department.
* Occupational Health Physicians at Boston University.
* Orthopedic Department of Boston University.
* Orthopedic Department at Children's Hospital, headed by Dr. John Hall.
* The Neurosurgeons at Boston University, headed by Dr. Spats.
* The Resident's at St. Elizabeth's Hospital.

Have developed professional relationship with the above as well as with the following:
* Back Clinic of Boston University.
* Medical Care Affiliates.
* Deaconess Orthopedic.
* Dr. Albert England, neurologist.
* Somerset Diagnostic Center.
* Boston University EMG.
* Boston University Bone Scan Unit.
* Other Internists and Family Practitioners.

Chiropractor to the Downtown Boston Health and Swim Club as well as Chiropractic Consultant to Pete's Power Gym in the South End.

TECHNIQUES EMPLOYED
Sports Chiropractic, Muscle therapy, Motion Palpation, Diversified Technique, Sacro-Occipital Technique, Cox (Flexion-Distraction)

LICENSES
Massachusetts, New York, Connecticut, N.B.C.E.

EDUCATION
1983-1986 NEW YORK CHIROPRACTIC COLLEGE - D.C.
1978-1980 NEW YORK UNIVERSITY - MPA (Health Care)
1974-1978 STATE UNIVERSITY OF NEW YORK AT BUFFALO - B.A.

PUBLICATION
LINKS TO JOB HURT HEALTH CARE SYSTEM, WALL STREET JOURNAL
MEDICAL TECHNOLOGY IS OVERUSED, NEW YORK TIMES
ATTITUDE TOWARDS CHIROPRACTIC, LAWYERS WEEKLY

REFERENCES
Will be furnished upon request.

DRAFTbz OK

November 19, 1993

Mr. Michael h. Hodgson
2748 West 64th
Anchorage, AK 99502

Dear Mr. Hodgson:

Thank you for your thoughtful letter. I appreciate your sharing with me your ideas about an issue that is important to you and to many other people.

Your comments, and those of others writers, provide the Clinton administration with a better understanding of the importance of a healthy diet to maintaining general health care.

Thank you again for taking the time to make your voice count.

Sincerely,

Melanne Verveer
Deputy Chief of Staff
to the First Lady

Rep 1

Dear Melanne Berveer,

Hello. I have sent you a copy of my latest physical/12 test blood examination for one simple reason: DIET CURES MORE THAN MEDICINE. I am a Vegan (vegetarian), meaning, I abstain from any and all products and by-products, both in my diet and my clothing, etc., of animal origin. There is more to being Vegan than this, though for the purpose of this letter (since a book can be written on the word "Vegan" alone, and many have already been), this simple definition is all there is necessary to say.

Vegetarians, especially strict vegetarians, live a lifestyle which reduces the likelihood of, and even prevents: illness, allergies, degenerative diseases, addiction/ compulsive behavior, stress, bone demineralization, fatigue, constipation, etc. (these are facts which are well documented), and therefore deserve some type of compensation for such a commitment. Though I sincerely doubt a person who heals h/er self with food is likely to ever require medical assistance, I think that the Task Force can take into account the benefits of a strict vegetarian diet, and act accordingly, by providing citizens who choose a vegetarian lifestyle, or, in other words, sustain their health on a diet at least mostly consisting of plants, with health insurance benefits (such as are now provided for non-smokers).

This nation, this World, can neither afford nor accept any longer the myths and misconceptions supported by the American government, and sanctioned by the Animal Industries' lobbyists.

Please give what I have said some consideration. If at all my words appear in any way cynical to you, please also accept my apology. Health is very important to me, and so is education and social reform.

Sincerely,

Michael H. Hodgson

P.S. There is also an irony here. When I took the test I had just recently moved, so I was eating more processed food than usual. I have since reduced/replaced the processed foods mostly with more raw vegetables and more fresh fruits.

Michael H. Hodgson
2748 W. 64th
Anchorage, AK
99502

5/18/93
15:41

ROCKWOOD CLINIC
EAST 400 FIFTH AVENUE
SPOKANE, WA 99204

ID: 513384 NAME: HODGSON,MICHAEL SEX: M AGE: 20

REG: 2660 DATE DRAWN: 5/18/93 TIME DRAWN:
REVIEWED BY: JP
COMMENT: 14.5 HR PP

TEST	RESULT	ABNORMAL	UNITS	--EXPECTED--	
12 TEST					
TOTAL PROTEIN	7.2		G/DL	6.0	8.0
ALBUMIN	4.6		G/DL	3.5	5.2
CALCIUM	9.2		MG/DL	8.4	10.2
PHOSPHORUS	3.6		MG/DL	2.5	4.5
CHOLESTEROL		139.0	MG/DL	140.0	200.0
GLUCOSE	83.0		MG/DL	75.0	115.0
URIC ACID	5.9		MG/DL	2.4	7.6
CREATININE	1.1		MG/DL	0.8	1.4
T BILI	0.8		MG/DL	0.3	1.3
ALK PHOS		92.0	U/L	30.0	80.0
LDH	87		U/L	45	94
SGOT(AST)	19.0		U/L	9.0	26.0
HDL	40.2		MG/DL	30.0	90.0
TRIGLYCERIDE	83.0		MG/DL	30.0	170.0
CHO/HDL	3.5			0.0	4.5
LDL/HDL	2.0			0.0	3.2
LDL	92.2		MG/DL	62.0	185.0

Great !

ID:513384 HODGSON,MICHAEL LOC:- DR:CRITSL

THE WHITE HOUSE

WASHINGTON

September 30, 1993

Gregory Hood
211 Addle Street
Apt. 3
Pismo Beach, CA 93449

Dear Mr. Hood,

Thank you for your comments concerning health care reform and nutrition. We do appreciate your taking the time to write us with your concerns and ideas.

With best wishes,

Sincerely yours,

Melanne Verveer
Deputy Chief of Staff
to the First Lady

Save name:
Hordes_mVl

DRAFT EB

August 20, 1993

Jess N. Hordes, Director
Anti-Defamation League
Washington, D.C. Office
1100 Connecticut Avenue, NW
Suite 1020
Washington, D.C. 20036

Dear Mr. Hordes:

Thank you very much for sending the new ADL report on neo-Nazi Skinhead violence in America. ~~I was very~~ disturbed ~~by the findings of growing membership and increasing acts of violence, and~~ I appreciate your sharing ~~that~~ the information with ~~Mrs.~~ Clinton ~~and me~~.

One of the President's top priorities is to improve the state of crime prevention in this nation. He is committed to change, and to that end, he is working along with the Department of Justice and other groups to outline important next steps. Your organization is vital ~~in~~ this effort.

Again, ~~thank you for sharing the report with us. Good luck in the important work that you~~ do.

Sincerely,

Melanne Verveer
Deputy Chief of Staff
to the First Lady

Anti-Defamation League
Washington, D.C. Office

1913 - 1993 ADL 80
Anti-Defamation League®

JESS N. HORDES
Director

MICHAEL LIEBERMAN
Associate Director/Counsel

STACY BURDETT
Assistant Director

August 12, 1993

Ms. Melanne Verveer
Deputy Assistant to the President
Deputy Chief of Staff to the First Lady
Office of the First Lady
Old Executive Office Building
Washington, D.C. 20501

Dear Melanne:

I am pleased to share with you the attached copy of an important new ADL report on neo-Nazi Skinhead violence in America. The report, the seventh in a series of ADL reports on neo-Nazi Skinheads, reveals a growing membership and an increasing resort to violence, including homicides.

The current report, with its finding that Skinhead crime is on the rise, makes clear that when tough law enforcement was not applied persistently, it indeed provided only temporary relief. Unless the law enforcement community now develops a plan to address this problem, and gets the resources needed to implement it, there is every likelihood that Skinhead crime will continue unabated.

Please do not hesitate to contact our office if you have any questions about this report or if we can be of assistance to you in any way.

Sincerely,

Jess N. Hordes
Washington Representative

1100 Connecticut Avenue, N.W., Suite 1020, Washington, D.C. 20036
Tel: 202/452-8320, FAX: 202/296-2371

THE WHITE HOUSE

WASHINGTON

June 22, 1993

Leonard Hudson
2324 Brookwood Drive, SE
Decatur, Alabama 35601

Dear Mr. Hudson:

Thank you for your recent letter regarding the inadequate labeling of drugs and the often serious consequences that result to our citizens. I appreciate your taking the time to share your views with Mrs. Clinton, and I am happy to have the views of pharmaceutical professionals like yourself.

As you know, the health care working group has completed its charge from the President. We expect that he will soon make his proposal to Congress. Your advice is helpful as we work toward this important national initiative.

Mrs. Clinton enjoys having the comments of all Americans. I know that she is happy to have your input.

Best wishes.

Sincerely,

Melanne Verveer
Deputy Chief of Staff
to the First Lady

THE WHITE HOUSE

WASHINGTON

May 22, 1993

Mr. Howard Huenergardt
3603 Wallace Road
Santa Rosa, CA 95404

Dear Mr. Huenergardt:

Thank you for you letter containing your "Ten Practical Remedies" for the health care problems facing the country. Your views are very helpful as we work to formulate the reform of our national health care system.

The White House Health Care Task Force has set up a resource database, and we appreciate people like yourself who take the time to apprise us of ideas concerning health care reform.

Thank you for caring. Best wishes,

Sincerely,

Melanne Verveer
Deputy Chief of Staff
to the First Lady

THE WHITE HOUSE

WASHINGTON

March 9, 1993

Mr. James E. Hug
Executive Director
Center of Concern
3700 13th Street, N.E.
Washington, DC 20017

Dear Jim:

Thank you for forwarding the materials on health care reform. I found your "Concluding Reflections" piece very solid. It will require much public education if health care reform is to become a reality.

Thank you also for your good wishes and offer of support.

Sincerely,

Melanne Verveer
Deputy Staff Director
to the First Lady

Hope all is well!

CENTER OF CONCERN

3700 13th STREET, N.E. • WASHINGTON, D.C. 20017

TEL: (202) 635-2757
FAX: (202) 832-9494

February 26, 1993

Ms. Melanne Verveer
Office of Hillary Rodham Clinton
The White House
1600 Pennsylvania Ave., N.W.
Washington, DC 20500

Dear Melanne,

How are things at the White House! Congratulations. I'm sure it is a challenging and exciting time for you.

I am enclosing some materials on healthcare reform for your review. Are you working on this issue? Perhaps you will know who might find them of use. The first is a short article for our last newsletter -- which you may have seen. The second is a more extensive discussion of some of the key moral issues, written as the concluding chapter for a healthcare reform primer to be published this Spring by the Catholic Health Association for its membership.

I also want to call your attention to two recent pieces given by a Canadian health leaders on the impact of the Canada-US Free Trade Agreement on the Canadian Health System. They are sobering and should raise even further cautions about NAFTA.

I have some time to give to the moral/justice dimensions of the healthcare reform debate in the next few months. If you have some sense of the hot issues along those lines that I could be of help on, let me know.

Blessings! My best to Phil.

Sincerely,

Jim

James E. Hug, S.J.
Executive Director

I found your "Concluding Reflections" piece very solid. For will require much public education if health care reform is to become a reality

DRAFT EB

Save name:
Hughes.hrc

August 20, 1993 letter sent 8/25

Ruth A. Hughes, Executive Director
International Association of Psychosocial
Rehabilitation Services
10025 Governor Warfield Pkwy, #301
Columbia, MD 21044-3357

Dear Ms. Hughes:

Thank you for your thoughtful letter regarding your interest in the inclusion of psychiatric rehabilitation and case management in the national health care reform package.

The President is committed to providing Congress with a health care proposal that is considerate of the needs of mental health patients. We are confident that your recommendations will be addressed.

Again, thank you for taking the time to share your expertise in this area. Good luck in the important work that you do.

Sincerely yours,

~~Hillary~~ Rodham Clinton

your letter makes a number of important points and ~~will~~ member is receiving full careful consideration.

VIP R

IAPSRS INTERNATIONAL ASSOCIATION OF PSYCHOSOCIAL REHABILITATION SERVICES

10025 Governor Warfield Pkwy, #301 Columbia, Maryland 21044-3357
Phone: 410-730-7190 FAX: 410-730-5965

July 21, 1993

Hillary Rodham Clinton
The White House
1600 Pennsylvania Avenue
Washington, DC 20500

Dear Mrs. Clinton,

As a participant in the meeting of the Mental Health Liaison Group with Ira Magaziner and Judy Feder, on Tuesday, July 19th, I was distressed to hear the consideration of eliminating psychiatric rehabilitation and case management from the Administration's mental health package, and further troubled to hear the Administration considers these services as social services instead of essential health care services for people with serious and persistent mental illnesses. If, in the final deliberations, the Administration does delete these services from coverage, the ramifications for persons with serious mental illnesses are catastrophic. It also means that more expensive mental health services will be utilized at a much higher rate, with less effective outcomes for the persons treated. This is exactly the inefficiency health care reform was to prevent. Before making this potentially devastating decision, I urge you to learn more about mental illness and the role of psychiatric rehabilitation and case management.

Psychiatric rehabilitation and case management <u>are not social services</u>. Clinical symptoms for an illness like schizophrenia may include slow and confused thinking (poverty of thought), an inability to experience pleasure (anhedonia), a lack of emotional responsiveness (apathy), social withdrawal, slowness of movement, impaired attention and memory, and a damaged ability to think abstractly. These symptoms are created by the biochemical disorder in the brain. Given our current state of knowledge of the brain, the most effective interventions to compensate for these symptoms are a combination of medication, psychiatric rehabilitation and case management. A person with mental illness may have a combination of symptoms which are not controlled by medication. For those people who cannot tolerate psychiatric medications or for whom they have limited effectiveness, psychiatric rehabilitation and/or case management services may provide the only assistance in controlling or relieving the symptoms.

The interventions in psychiatric rehabilitation and case management are designed to help compensate for or promote recovery from these symptoms, and to help manage the effects of the illness.
A growing body of research studies consistently finds that psychiatric rehabilitation and case management:

- significantly reduce utilization of psychiatric hospitals
- increase the level of functioning, management of the illness and the level of independent living
- increase the quality of life for service participants

At the same time, these services cost less than any other category of psychiatric services. While a range exists across regions, a typical day (6 to 8 hours)in a psychiatric rehabilitation program may only cost $55 to $75, significantly less than one hour of psychotherapy.

Psychiatric rehabilitation and case management have grown dramatically as states have realized it is the most effective expenditure of the mental health dollar, as well as providing better quality outcomes for persons with serious mental illness. The National Institute of Mental Health and the Center for Mental Health Services have strongly endorsed these services and were responsible for the initial growth of this field through grants to states to develop a system of rehabilitation and case management services (the Community Support Program). The Health Care Financing Administration has approved funding of these services in Medicaid, and recently reaffirmed the appropriateness of continued coverage of psychiatric rehabilitation. Private insurance companies have just begun to recognize the advantages of including coverage of psychiatric rehabilitation and case management, and a small but growing number of plans cover these services.

Some serious misconceptions about psychiatric rehabilitation sometimes arise because the field embodies a holistic approach to treatment of mental illness. Psychiatric rehabilitation agencies <u>also</u> frequently provide social services, vocational rehabilitation, housing, and education. While these non-health services are funded from other sources, the mental health interventions are more effective because these needs are also addressed.

The current assumption that states will supply these additional services if they are not included in health care reform is suspect at best. Most states are operating under adverse financial situations, and will be under enormous pressure to maximize the utilization of services in the health care reform package, even when those services are not the most appropriate and effective for the person with a serious and persistent mental

illness. Unless there are very strong incentives for states to continue funding psychiatric rehabilitation and case management services, the current system of care will be adversely affected and the recovery process for millions of people with serious mental illnesses will be interrupted. More importantly the federal government is sending a message to states which legitimizes the discrimination of those with the most serious mental illnesses, and circumvents the spirit of the Americans with Disabilities Act.

The current proposals for long term care will also not provide adequate services for this population. The eligibility requirements now under consideration would eliminate most people with mental illness. A residual Medicaid program for those who are disenfranchised by poor coverage in health care reform is also a poor solution. Most current Medicaid services for persons with mental illness are covered in the clinic, case management and rehabilitation options. As states move to utilize health care reform, the likelihood of continuing to fund any Medicaid options is low. Without a major incentive from the federal government for states to provide services, people with serious mental illnesses may end up with very inadequate services from all sources.

A better solution to the present dilemma of the Administration, would be to offer a comprehensive benefit package of mental health services, including psychiatric rehabilitation and case management, under the managed care plan of benefits. The mental health services recommended by the Mental Health Liaison Group and the Mental Health Committee of the Health Care Task Force, were designed to meet the medical needs of people with the most serious mental illnesses as well as the mental health needs of the general population. Health providers would have the flexibility to use the funds for the most clinically appropriate and cost effective services, <u>based on the needs of the individual patient</u>. This solution would be in the spirit of health care reform, provide much more effective services for people with serious mental illnesses, and be cost effective. In addition, the actuarial data on the wider array of services would be generated for further modifications of the mental health benefit package. The Administration's current proposal does not meet any of these goals.

A diabetic receives insulin because of an impaired ability to process sugar. A person with schizophrenia receives case management and psychiatric rehabilitation because of an impaired ability to process information. Both are illnesses which affect a major organ of the body and are chronic in nature. To consider one an illness requiring comprehensive treatment in health care reform, and not the other is simply overt discrimination against people with mental illness.

I urge you to read the enclosed documents about the effectiveness of psychiatric rehabilitation and case management and to visit an agency which provides these services before making your final decision. If I can supply you with further information or arrange for a visit to an agency, please let me know. I challenge you to be clear about the serious implications of these decisions on the lives of millions of people with serious mental illnesses. To base these decisions on actuarial data which does not include data on psychiatric rehabilitation or case management is an insufficient rationalization to preclude services which have proven to be effective, cost efficient and are on the cutting edge of mental health treatment.

Sincerely,

Ruth A. Hughes

Ruth A. Hughes, Ph.D.
Executive Director

enc PSR in HCR
Facts About PSR
Impact on Rehospitalization

Impact of Psychiatric Rehabilitation Programs on Rehospitalization

RESEARCH PROGRAM	DECREASE IN NUMBER OF READMISSIONS	DECREASE IN NUMBER OF DAYS HOSPITALIZED	PROPORTION OF CLIENTS READMITTED
Arana, Hastings, & Herron (1991).	significantly fewer	63 to 19 days	n/a*
Bond, Witheridge, Dincin, Wasmer, Webb, & DeGraff-Kaser (1990).	from 3 admissions to 1 admission	54 to 26 days	n/a
Bond, Witheridge, Wasmer, Dincin, McRae, Mayes, & Ward (1989).	n/a	n/a	participants' rates dropped 50%
Bond, Miller, Krumwied, & Ward (1988).	n/a	31 to 9 days	n/a
Ryan & Bell (1985, May).	n/a	n/a	nonparticipants = 61% participants = 26%
Bell & Ryan (1984).	n/a	n/a	nonparticipants = 48% participants = 33%
Bond (1984).	from 3 admissions to 1 admission	134 to 52 days	n/a
Cannady (1982).	n/a	n/a	participants' rates dropped 74-92% overall
Dincin & Witheridge (1982).	n/a	87 to 36 days	nonparticipants = 44% participants = 14%
Witheridge, Dincin, & Appleby (1982).	n/a	87 to 37 days	n/a
Stein & Test (1980). *Test & Stein (1980).* *Weisbrod, Test, & Stein (1980).*	significant reductions	significantly fewer days	significant reductions
Beard, Malamud, & Rossman (1978).	n/a	n/a	nonparticipants = 77% participants = 37%
Becker & Bayer (1975).	n/a	n/a	nonparticipants = 50% participants = 12%
Wolkon, Karmen, & Tanaka (1971).	n/a	n/a	clients attending 50+ sessions/yr. = 0% clients attending < 10 = 22%

*n/a = not measured in the study

Prepared by: Lisa Razzano, Ph. D., Thresholds National Research & Training Center, Chicago, Illinois.

FACTS ABOUT PSYCHIATRIC REHABILITATION

There is a growing body of evidence that psychiatric rehabilitation (also known as psychosocial rehabilitation) is both an effective and cost efficient treatment for persons with serious and persistent mental illness. These services have grown rapidly over the last 15 years and have become an integral part of our nation's mental health system. Health care reform legislation needs to include psychiatric rehabilitation services, if we are to address the health needs of one of the most vulnerable segments of our society, people with serious and persistent mental illness.

Serious and Persistent Mental Illness

Approximately 2.1% to 2.6% of the population of the United States experience a serious mental illness which has affected the individual's ability to function effectively. Today most people with a mental illness live in the community, rather than in an institution. Schizophrenia, affective disorders and depression often have a cyclical nature, with changes in functioning and symptoms occurring over time. The intensity and the type of health care services also vary over time, depending on the needs of the individual. The symptoms of a mental illness, such as schizophrenia may include:

* **Hallucinations, delusions and bizarre behavior**
* **Apathy, withdrawal, blunting of emotions, slowed motor activity**
* **Cognitive deficits including impaired attention and memory, poor generalization of learning, impairment of logic, and a damaged ability to think abstractly**

While medications are effective in reducing some of the symptoms, the residual symptoms have a direct impact on a person's ability to function and live independently. Frequent hospitalizations, emergency room visits, and even incarceration or homelessness have been the outcome for those most severely affected by the mental illness. In an attempt to address this problem, psychiatric rehabilitation services developed and have become an integral part of our nation's mental health system.

What is Psychiatric Rehabilitation?

The goal of psychiatric rehabilitation is to restore the individual's ability for independent living, socialization and effective life management. Psychiatric rehabilitation services are designed to help an individual with a serious and persistent mental illness to:

* **Develop coping strategies to manage the symptoms of the illness**
* **Develop behaviors and skills to compensate for the functional deficits in activities of daily living , interpersonal relations, problem solving , and cognition**
* **Develop a supportive environment in which to function as independently as possible**
* **Build on personal strengths to offset the effects of the illness**
* **Coordinate all treatment, rehabilitation and support services**
* **Manage crises and relapses of the mental illness**
* **Utilize community alternatives to psychiatric hospitalization when clinically appropriate**

There is a strong emphasis on activities which are integrated into the normal life of the individual and the community, and have real, tangible outcomes. Through this process an individual learns and practices coping strategies which help to offset the effects of the mental illness and allow a person to live more independently. The services may be provided within in a facility or they may be provided off site, integrated into the normal community settings of the individual. Coordination with other mental health treatment services, both inpatient and outpatient, is provided. In addition to the treatment services, many psychiatric rehabilitation agencies also offer housing services, education, and vocational rehabilitation services to address the effects of the illness in all aspects of the individual's life.

Outcome Research and Cost Effectiveness

Outcome research in psychiatric rehabilitation consistently demonstrates the effectiveness of this approach. A number of studies examining the impact of participation in psychiatric rehabilitation services have reported consistent findings:

*** Significant reductions in psychiatric hospitalizations**
*** Increased level of functioning and level of independent living**
*** Increased client satisfaction**
*** Increased rate of employment**

In a review of 35 studies, Dion and Anthony (1987) found psychiatric rehabilitation interventions reduced rehospitalization, and positively affected employment, skill development, client satisfaction and the amount of time spent in the community. The reduction of hospital utilization, as subjects participate in psychiatric rehabilitation and case management services, is a particularly well documented and consistent finding in many studies (Arana, Hastings and Herron, 1991; Bond et al, 1990; Bond et al, 1989; Bond et al, 1988; Ryan and Bell, 1985; Bell and Ryan, 1984; Bond, 1984; Cannady, 1982; Dincin and Witheridge, 1982; Witheridge et al, 1982; Stein and Test, 1980; Beard, Malamud and Rossman, , 1978; Becker and Bayer, 1975; Wolkon, Karmen and Tanaka, 1971.)

Psychiatric rehabilitation serves those persons most at risk of long term institutionalization. The cost effectiveness of these services is demonstrated not only in significantly lower hospitalization rates, but in reduced utilization of community treatment over time, and increased employment. Savings in other federal programs, such as Supplemental Security Income, also result when an individual is able to go to work.

Psychiatric rehabilitation is a necessary component of health care for persons with serious and persistent mental illness. It is an effective and cost efficient treatment intervention. Without psychiatric rehabilitation services, persons with serious and persistent mental illness are at higher risk for institutionalization, incarceration, and homelessness.

More information on psychiatric rehabilitation is available from:
International Association of Psychosocial Rehabilitation Services
10025 Governor Warfield Parkway, #301
Columbia, MD 21044-3357
(410) 730-7190

Psychiatric Rehabilitation is an Essential Health Service for Persons with Serious and Persistent Mental Illness

Introduction

As our health care system is undergoing massive changes, it is important for us to consider those who are most vulnerable and most in need of a safety net of health care services. Persons with serious and persistent mental illness have historically been high utilizers of expensive health care services. Over the last 20 years, a concerted effort to find more effective and lower cost alternatives to long term institutionalization has led to the development of psychiatric rehabilitation services. This field of services has developed to respond directly to the high risks that many persons with serious and persistent mental illness experience of repeated hospitalizations, high utilization of emergency room services, low levels of functioning in the community, homelessness, and unemployment.

There is a growing body of evidence that psychiatric rehabilitation, also known as psychosocial rehabilitation, is an effective and cost efficient alternative to other forms of mental health treatment. Research in psychiatric rehabilitation services has demonstrated lower hospitalization rates, higher levels of functioning, higher levels of client satisfaction, and higher rates of employment than patients not receiving psychiatric rehabilitation services. The strong indications are that psychiatric rehabilitation services make a crucial and positive difference in the functioning and independence of persons with serious and persistent mental illness. Medicaid currently funds psychiatric rehabilitation services under either the rehabilitation or the clinic options in most states, providing essential safety net services for hundreds of thousands of persons with serious and persistent mental illnesses. Today there are more than 2000 agencies providing psychiatric rehabilitation services in the United States, as well as programs throughout much of the world.

The services and terminology of psychiatric rehabilitation are not always well understood. This is a short description of the needs of the population served, and the impact of psychiatric rehabilitation services on these needs, a summary of outcome and cost effectiveness research, and the importance of psychiatric rehabilitation in health care reform for persons with serious and persistent mental illnesses.

The Needs of Persons with Serious and Persistent Psychiatric Disabilities

Approximately 2.1% to 2.6% of the population of the United States experiences a serious mental illness which has affected the individual's ability to function effectively (Barker et al, 1992). More hospital beds are used for psychiatric illnesses than any other diagnosis, despite a significant

reduction in state hospital beds over the last decade. Not all people with serious mental illness need psychiatric rehabilitation services. A frequently used method of defining the population in need of at any given time is to look at a combination of diagnosis, duration and level of disability.

The most frequent diagnoses of persons needing psychiatric rehabilitation services are schizophrenia, manic depressive disorders and depression, and severe personality disorders. Duration refers to the chronicity of the disorder and usually means a series of hospitalizations, a series of relapses of the illness, or symptoms which remain over a period of years. The last criterion, disability, is particularly important for assessing the need for psychiatric rehabilitation services and refers to the impaired functioning of an individual due to the illness. Each of the major mental illnesses has a significant impact on functioning. A description of the effects of schizophrenia on functioning will highlight how the symptoms and functioning interact.

In schizophrenia there are two groups of symptoms, acute symptoms and residual symptoms. The acute or positive symptoms are so called because they describe symptoms that are additions to normal behavior. These symptoms may include hallucinations (hearing or sensing something that does not exist), delusions (false beliefs), and bizarre behavior. Acute symptoms are most frequently treated with medications. The residual or negative symptoms describe those things which are losses to the individual with schizophrenia and include anhedonia (diminished ability to experience pleasure), apathy (lack of feeling), social withdrawal, poverty of thought (slow and confused thinking), blunting of emotion (emotional insensitivity), slowness of movement, lack of drive, and vulnerability to stress. Much of the pharmacological treatment of schizophrenia has had little effect on these residual symptoms. There may be a number of cognitive deficits as well, including impaired attention and memory, a handicapped ability to transfer learning from one situation to another, impairment of logic, and a damaged ability to think abstractly. These symptoms have serious impact on the ability of a person to function effectively in every day life.

In addition to the acute and residual symptoms, there are secondary symptoms related to the individual's and to the community's reaction to the illness, which may interfere with recovery and treatment. These secondary symptoms include a sense of hopelessness and helplessness, low self esteem, and a fear of taking risks (as in resuming normal life activities). The stigma of mental illness is so pervasive and harmful that most people diagnosed with a serious mental illness must also cope with rejection, misunderstanding and fear from those around them.

While medication and other treatment services may affect some of the symptoms of the illness, the functional deficits are best addressed by psychiatric rehabilitation. The functional limitations frequently seen in a person with a mental illness may include deficits in daily living, impaired social interactions, ineffective problem solving, a diminished ability to maintain relationships, and a marked impairment in role functioning.

Psychiatric rehabilitation is designed to help an individual capitalize on his personal strengths, develop coping strategies to deal with deficits and the symptoms of the illness, and develop a supportive environment in which to function as independently as possible. Most serious mental illnesses are cyclical in nature, and a combination of medication and psychiatric

rehabilitation can help diminish the likelihood and impact of relapses and rehospitalizations.

A number of persons with serious and persistent mental illnesses also have other illnesses or disabilities. Other health problems such as epilepsy, diabetes, or high blood pressure are not uncommon because of the poor health care received by many persons with mental illness. The incidence of substance abuse is growing dramatically in this population. Mental retardation is a common second disability. The frequency of HIV positive is also growing. Psychiatric rehabilitation services must coordinate and provide care to meet the broad range of needs.

Psychiatric Rehabilitation Services

The goal of psychiatric rehabilitation is to enable individuals to compensate for, or eliminate the functional deficits, interpersonal barriers and environmental barriers created by the disability, and to restore ability for independent living, socialization and effective life management. Interventions help the individual learn to compensate for the effects of the symptoms of the illness through the development of new skills and coping techniques, and a supportive environment. They also counteract the effects of the secondary symptoms by restoring a sense of confidence and building on the strengths of each person, emphasizing wellness rather than illness.

An assessment process helps define the specific areas of functioning that have been affected by the symptoms of the mental illness and the strengths which can be used to counteract any functional deficits. The assessment process is usually situational --- observing the individual in activities of the every day life and identifying areas of daily living, social relationships, problem solving, etc. which are difficult for the individual to manage. Once the functional deficits and strengths are identified, a rehabilitation or treatment plan is developed with the individual who has a mental illness.

Through the activities of the psychiatric rehabilitation treatment program, the individual then works on restoring and/or learning the skills needed to compensate for the functional deficits, as well as accentuating the strengths he brings to the rehabilitation process. Those deficits frequently fall into several categories --- daily living skills, social interactions, and problem solving (cognitive processes). For instance, problems with daily living might include poor personal hygiene, difficulty with cooking and caring for the home, or inability to use public transportation. Problems with socialization might include isolation and withdrawal, inappropriate social behavior, and poor verbal skills. Cognitive deficits often lead to difficulty in thinking through and planning tasks, making decisions, following directions, clarifying the intent of others, and completing activities.

Activities of a psychiatric rehabilitation program are designed to be the real activities one engages in every day. There is a strong emphasis on activities which are normal, integrated into the regular life of the community and have real, tangible outcomes. There is often a poor transfer of learning from one situation to another for a person with a serious mental illness. Therefore, it is crucial that the rehabilitative process take place in the real community in which an individual lives. For this reason, psychiatric rehabilitation may be provided both in a psychiatric rehabilitation facility and "off site" in the community or in an individual's home. By tailoring the psychiatric

rehabilitation to the individual's needs, rather than to a location, the effectiveness of rehabilitation is enhanced. This experiential learning process is one of the most effective ways to address functional deficits.

Some psychiatric rehabilitation programs design their activities to focus on the various aspects of running the program (clerical unit, food unit, maintenance unit, etc). Other psychiatric rehabilitation agencies design activities with a more educational emphasis such as groups or classes in problem solving. The activities are almost always group oriented to allow for peer support, feedback and assistance. The development of competence and successes are celebrated by the groups.

The psychiatric rehabilitation staff may coordinate the care given across a range of providers through case management, as well as providing treatment and rehabilitation services directly to the client. This case management is essential if the broad range of needs of persons with serious and persistent mental illness are to be met. Case managers do whatever is needed to make sure the gaps in services are filled effectively, and that services meet the actual needs of the individual.

Another psychiatric rehabilitation service offered in some areas is residential treatment and/or crisis residential services, which provide an effective and low cost alternative for those individuals who would otherwise be hospitalized or placed in other institutions (skilled nursing facilities, nursing homes, jails, etc). These programs provide intensive treatment and rehabilitation in a home-like setting, integrated into the normal community. Such programs offer a low cost alternative to inpatient settings, while providing the intensive services needed to assist an individual with a crisis or relapse, and help him in reintegrating into the community.

Other services may be offered such as substance abuse treatment, family support groups, medication management, crisis intervention services, etc. The bottom line for psychiatric rehabilitation services is to do whatever it takes to ensure the needs of the client are being met.

Psychiatric Rehabilitation Terminology

While the activities used to learn and practice new coping strategies may appear to be vocational or educational activities, it should be clear that work or education is not the goal of such activities any more than learning to swim is the goal in hydrotherapy of a physical injury. For example, a young woman with schizophrenia may participate in the food unit preparing lunch. The effect of the mental illness is evident in her slow movement and disinterest in the activities around her (apathy), in her withdrawal from interactions with others (isolation and withdrawal), and in the difficulty she has understanding and communicating with others (cognitive deficits). The intent of rehabilitation is not to teach her to cook or to find a job in a restaurant. Rather she is learning to follow directions, to ask for clarification when she does not understand, to complete tasks, to relate to others appropriately, to control bizarre behavior, etc. Most importantly, she is learning to manage the symptoms of her illness in a normal setting. Such activities also raise self esteem, combat hopelessness, and provide a testing ground for new coping skills in a supportive and caring environment.

Early in the development of psychiatric rehabilitation, it was recognized that the role of the "patient" can be counterproductive to the rehabilitative process. For many people who have had long or frequent periods of institutionalization, the primary identifications of themselves as a mentally ill patient has contributed to passivity, acceptance of bizarre behavior, low tolerance for risks, and low self esteem. Efforts have been made to diminish the patient role and to strengthen the individual's commitment to the rehabilitative process. It is typical to find an informal, first name relationship between practitioners and clients. Rather than clients or patients, the recipients of services are frequently called members or associates to underscore the working partnership. The language used to describe services (skills training, clubhouse activities, support groups, classes) is purposefully non-medical.

The terminology used to describe the rehabilitative process has led to much confusion by health care policy makers which separate long term support services, vocational rehabilitation services and educational services from health care. While psychiatric rehabilitation agencies may also offer long term support, vocational rehabilitation and educational services, the psychiatric rehabilitation process is an essential component of the treatment of the mental illness and the restoration of functioning. It is important to understand that the deemphasis of medical and clinical terminology is an intentional effort to help the individual overcome the disabling effects of the mental illness in his or her life and to underscore the productive, coping abilities that are developing.

Community Support System

In recognition of the diverse needs of persons with serious and persistent mental illness when they leave psychiatric institutions, the National Institute of Mental Health developed the Community Support Program in 1977 to foster the growth of community support systems for the care of persons with serious and persistent mental illness. A community support system is defined as "an organized network of caring and responsible people committed to assisting persons with long term mental illness to meet their needs and develop their potentials without being unnecessarily isolated or excluded from the community."

To address the range of needs, community support systems need to include treatment, rehabilitation, housing, vocational rehabilitation, case management, income supports, crisis response, case management, health and dental care, peer support, and family and community support. In concert with the goal to work with the whole person, psychiatric rehabilitation facilities frequently offer services that are not necessarily considered health services. The provision of these related services has a direct impact on reducing utilization of health care services. The most common services include housing, vocational rehabilitation and education. These services are funded through sources other than Medicaid, Medicare or insurance. Only by working with all aspects of the person can psychiatric rehabilitation be as effective as possible.

Housing - One of the most fundamental needs for every person is a place to call home. Room and board are not considered part of health care services. Many programs combine the room and board with psychiatric rehabilitation services to assist an individual to live in a much

more independent living situation. Rehabilitation agencies frequently offer a range of housing services including group homes with intensive rehabilitation, supervised apartments, and supported housing. Supported housing programs assist each individual in finding a home of their own and then provide the rehabilitation services necessary to assist the person to function effectively at home. Supervised apartments are usually apartments shared by several people, with varying levels of staff supervision and rehabilitation services. Group homes and halfway houses usually include a larger number of residents and the most intense level of psychiatric rehabilitation services.

Education - Because the onset of mental illness frequently occurs in adolescence, many people with serious mental illnesses have had interrupted educations. For those persons who live in areas where education is frequently limited, there is the secondary effect of limited education. Rehabilitation agencies frequently offer literacy and GED classes. Members may also be assisted in attending college or specialized training programs (supported education).

Vocational Rehabilitation - The characteristic that most defines us in our culture is our work. People with mental illness describe getting a job as one of their top priorities. Rehabilitation agencies usually offer vocational rehabilitation services which might include supported employment, transitional employment, group placements, agency run businesses, and sheltered workshops. In supported employment, a job coach continues the psychiatric rehabilitation process on the job by providing the training and support an individual needs to work effectively. In transitional employment, a person may work at a series of part time placements with the assistance of a staff member, and them move on to full time, permanent work. Many programs also have group placements which work in competitive jobs with staff supervision. Agency run businesses which hire workers with psychiatric disabilities provide a range of opportunities. Consumer run businesses are also a growing alternative.

An example of the interrelatedness of health care and these support services was demonstrated by a recent study by Bob Drake (1992). The study examined two similar partial hospitalization programs for treatment of mental illness. When one was converted into a vocational rehabilitation service, the researcher found the converted program led to a significant reduction in health care services utilization, and a significant increase in employment of clients, without any increase in mental health risk factors between the two groups. Health care utilization can be significantly reduced by ensuring access to these other crucial support services.

Outcomes Research

While outcome research in psychiatric rehabilitation is a relatively new initiative in mental health research, there is a growing body of evidence that psychiatric rehabilitation, including case management services, has a positive impact on the lives of people with serious and persistent mental illness, as well as a reduction in hospitalizations. In a review of 35 studies, Dion and Anthony (1987) found psychiatric rehabilitation interventions reduced hospital recidivism, and positively affected employment, skill development, client satisfaction, and the amount of time spent in the community. The reduction of hospital utilization as subjects participate in psychiatric rehabilitation and/or case management services is well documented and a consistent finding in many studies (Bond et al, 1984; Bond, 1988; Dincin and Witheridge, 1982; Fairweather and

Fergus, 1988; Hammaker, 1983).

Assertive community treatment is one of the most widely researched approaches in psychiatric rehabilitation. In a Stein and Test study (1980), experimental subjects had significantly less time in psychiatric hospitals, higher occupational functioning and were less symptomatic after 12 months than control patients. In a similar study over 30 months, the control patients have been hospitalized nearly 5 times as often as the patients receiving assertive community treatment (Mulder, 1985). In a study by Hoult (1984), after 1 year the experimental patients were less symptomatic, higher functioning, and more satisfied with their care, as well as experiencing fewer and shorter hospital stays, than the control subjects. In a 5 year study (Borland et al, 1989) hospital admissions were reduced between 19 and 32 percent from the annual average for two years before assertive community treatment. Recipients of case management services demonstrate more stable community adjustments than those persons not receiving the services (Taube et al, 1990).

Similar results have been found with other models of psychiatric rehabilitation. Participation in a club house program is associated with higher life satisfaction by participants (Rosenfield and Neese-Todd, 1992). Skills training, a common psychiatric rehabilitation intervention, has been found to reduce clinical symptoms and relapse rates, as well as improve social skills (Wallace and Liberman, 1985). Participants in Fairweather Lodge programs show significantly reduced hospitalization rates and increased rates of employment (Fairweather and Fergus, 1988). Participation in psychiatric rehabilitation leads to an increased level of independent living (Bond et al, 1984).

The National Institute of Mental Health has made a commitment to increase research in rehabilitation. In the National Plan of Research to Improve Services (1991), NIMH has included a special section on rehabilitation research as well as outcome research in rehabilitation. The strong indications are that psychiatric rehabilitation services make a crucial and positive difference in the functioning and independence of persons with serious and persistent mental illness.

Cost Effectiveness

In addition to the clinical effectiveness of psychiatric rehabilitation, the cost effectiveness needs to be noted. In a review of cost effectiveness studies of Schizophrenia, Goldberg (1991) found community care was generally less expensive than care in a hospital. In an economic analysis of psychiatric rehabilitation, Bond (1984) reported savings in hospitalization costs, costs of community treatment and an increase in earnings in competitive employment related to participation in psychiatric rehabilitation services.

In another study examining intensive case management as an alternative service for those at risk of hospitalization, the intensive case management services were found to be a cost effective alternative to hospitalization (Weisbrod, 1983). In a review of the cost effectiveness of assertive community treatment programs, Taube and his colleagues (1990) demonstrated the cost effectiveness of assertive community treatment as an alternative to hospitalizations and standard after care treatment, particularly for those patients who were at high risk of repeated

hospitalizations.

Most individuals served in psychiatric rehabilitation programs are former residents of state and private psychiatric hospitals, or would likely be long term patients in hospitals if psychiatric rehabilitation services were not available to them. For example, in a recent study of the Maryland Association of Psychiatric Support Services (MAPPS), an IAPSRS chapter, it was calculated that the cost of a state hospital bed in Maryland now exceeds $100,000 per year, while a comprehensive array of community treatment and rehabilitation services -- including psychiatric rehabilitation, outpatient clinic visits, housing, and vocational rehabilitation -- is less than $50,000 a year. The psychiatric rehabilitation component in that state costs $54 a day, while state hospital care is $275 a day and inpatient care in a private or general hospital is $300 to $500 a day. Even the most intensive forms of community treatment and rehabilitation provide less costly alternatives to hospitals.

Clinical effectiveness and cost effectiveness go hand in hand in this field. Good psychiatric rehabilitation not only reduces reliance on expensive hospitals, but also assists individuals with psychiatric disabilities to reduce their dependence on all public services and ultimately the taxpayer --- and achieve levels of productivity and independence considered impossible only a decade ago.

Conclusion

Serious and persistent mental illnesses can result in significant functional deficits that effect a person in every aspect of his life. Effective psychiatric rehabilitation services are aimed at minimizing these impairments in functioning and role performance, and restoring the individual to maximum functioning. By increasing functioning, the likelihood of relapse is diminished and hospitalizations prevented. The interaction of psychiatric rehabilitation, vocational rehabilitation, educational services and housing helps underscore the rehabilitation process in every aspect of the individual's life. Psychiatric rehabilitation, in all its many aspects, coupled with medication is the treatment of choice for many individuals with a serious and persistent mental illness, and must be included in any health care reform initiative if these citizens are to break the cycle of institutionalization, decrease the use of expensive, less effective treatments and participate actively and productively in community life.

More information on Psychiatric Rehabilitation is available from:

International Association of Psychosocial Rehabilitation Services
10025 Governor Warfield Parkway, #301
Columbia, MD 21044-3357
(410) 730-7190

Bibliography

Anthony, W.A. and Liberman, R. P. "The Practice of Psychiatric Rehabilitation: Historical Conceptual and Research Base", Schizophrenia Bulletin, Vol. 12, 1986.

Barker, P.; Manderscheid, R.; Hendershot, G.; Jack, S.; Schoenborn, C. and Goldstrom, I. "Serious Mental Illness and Disability in the Adult Household Population: United States, 1989", Advance Data, No. 218, September 16, 1992.

Bond, G. R. "An Economic Analysis of Psychosocial Rehabilitation", Hospital and Community Psychiatry, Vol. 35, 1984.

Bond, G. R.; Dincin, J.; Setze, P.; and Witheridge, T. "The Effectiveness of Psychiatric Rehabilitation: A Summary of Research at Thresholds" Psychosocial Rehabilitation Journal, Vol VII, No. 4, April, 1984.

Bond, G. R.; Miller, L.; Krumwied, R.; and Ward, R. "Assertive Case Management in Three CMHCs: A Controlled Study" Hospital and Community Psychiatry, Vol. 39, No. 4, April, 1988.

Borland, A.; McRae, J. and Lycan, C. "Outcome of Five Years of Continuous Intensive Case Management", Hospital and Community Psychiatry, Vol. 40, pp 369-376, 1989.

Dincin, J. and Witheridge, T. "Psychiatric Rehabilitation as a Deterrent to Recidivism", Hospital and Community Psychiatry, Vol 33, 1982.

Dion, G. and Anthony, W. "Research in Psychiatric Rehabilitation: A Review of Experimental and Quasiexperimental Studies", Rehabilitation Counseling Bulletin, Vol 30, pp 177 - 203, 1987.

Drake, Robert and Becker, D. Presentation "The Individual Placement and Support Model of Vocational Rehabilitation for Persons with Severe Mental Disorders" Presented at the Hospital and Community Psychiatry Conference in Toronto, 1992.

Fairweather, G. and Fergus, E. "The Lodge Society: A Look at Community Tenure as a Measure of Cost Savings". Michigan Lodge Dissemination Project, Michigan State University, 1988.

Goldberg, D. "Cost Effectiveness Studies in the Treatment of Schizophrenia: A Review", Schizophrenia Bulletin, Vol 17, No 3, 1991.

Hammaker, R. "A Client Outcome Evaluation of the Statewide Implementation of Community Support Services" Psychosocial Rehabilitation Journal, Vol. VII, No., 1, July, 1983.

Hoult, J. and Reynolds, I. "Schizophrenia: A Comparative Trial of Community Oriented and Hospital Oriented Psychiatric Care", Acta Psychiatrica Scandivavica, Vol 69, 1984.

Mulder, R. "Evaluation of the Harbinger Program, 1982 - 1985", Lansing, Michigan Department

of Mental Health, 1985.

National Institute for Mental Health, Caring for People with Severe Mental Disorders: A National Plan of Research to Improve Services. DHHS Pub. No. (ADM)91-1762. Washington, DC: Supt of Docs., US Government Printing Office, 1991.

Neese-Todd, S. and Weinberg, J. "Public Academic Liaison: On Clubhouse Approach to Research and Program Evaluation," Psychosocial Rehabilitation Journal, Vol. 16, No. 2, 1992.

Olfson, M. "Assertive Community Treatment: An Evaluation of the Experimental Evidence", Hospital and Community Psychiatry, Vol 41, No 6, 1990.

Rosenfield, S. "Factors Contributing to the Subjective Quality of Life of the Chronic Mentally Ill," Journal of Health and Social Behavior, Vol. 33, 1992.

Rosenfield, S. and Neese-Todd, S. "Elements of a Psychosocial Clubhouse Program Associated with a Satisfying Quality of Life," Hospital and Community Psychiatry, Vol. 44, 1993.

Stein, L. and Test, M. "Alternative to Mental Hospital Treatment: I. Conceptual Model, Treatment Program, and Clinical Evaluation", Archives of General Psychiatry, Vol 37, 1980.

Taube, C.; Morlock, L.; Burns, B. and Santos, A. "New Directions in Research on Assertive Community Treatment", Hospital and Community Psychiatry, Vol 41, No 6, 1990.

Wallace, C. and Liberman, R. "Social Skills Training for Patients with Schizophrenia: A Controlled Clinical Trial", Psychiatry Research, Vol 15, pp 239-247, 1985.

Weisbrod, B.A. "A Guide to Benefit-Cost Analysis, as Seen Through a Controlled Experiment in Treating the Mentally Ill", in Helpman E. (Ed), An Economic Perspective. San Diego, CA: Academic Press, 1983.

Witheridge, T.; Dincin, J. and Appleby, L. "Working with the Most Frequent Recidivists: A Total Team Approach to Assertive Resource Coordination", Psychosocial Rehabilitation Journal, Vol 5, 1982.

5/18/93

THE WHITE HOUSE

WASHINGTON

February 23, 1993

Swanee Hunt
500 East Eighth Avenue
Suite 100
Denver, Colorado 80203

Dear Swanee,

Thank you so much for all the time and effort which you and Lila put into your paper on international organizations and appointments that most directly affect women and children. Your paper, along with the supporting materials, will be of great value to us in achieving our mutual goals for women and children.

Please extend my appreciation to Susan Andross, Judith Bruce, and Nadine Hack. Their knowledge and experience are invaluable and I am grateful that they were willing and able to contribute so much to this project.

Thank you again for your outstanding paper. It was good to see you recently in our office. Please give my best to Charles.

With best wishes,

Sincerely,

Swanee -
I hope all goes
well for you

Melanne Verveer
Deputy Chief of Staff
to the First Lady

January 23, 1993

Ms. Reanetta Hunt-Craft
R.C. Hunt and Associates
P.O. Box 770155
Memphis, Tennessee
39177

Dear Ms. Hunt Craft,

On behalf of Mrs. Clinton, I am writing to thank you for your note and resume, and to apologize for not getting back to you sooner. As you can imagine, things have been very busy since the election, but we are beginning to catch up.

I have taken the liberty of forwarding your resume to the Office of Personnel, as they are better situated in the whole process. Hopefully something will turn up there that can match your talent and media experience with a rewarding opportunity to serve the country in this new administration.

In the meanwhile, thank you for taking the time to offer your skills and commitment to this new administration.

Sincerely,

Melanne Verveer
Deputy Chief of Staff
to the First Lady

Clinton Presidential Records
Digital Records Marker

This is not a presidential record. This is used as an administrative marker by the William J. Clinton Presidential Library Staff.

This marker identifies the place of a tabbed divider. Given our digitization capabilities, we are sometimes unable to adequately scan such dividers. The title from the original document is indicated below.

I

Divider Title: _____

Clinton Presidential Records
Digital Records Marker

This is not a presidential record. This is used as an administrative marker by the William J. Clinton Presidential Library Staff.

This marker identifies the place of a tabbed divider. Given our digitization capabilities, we are sometimes unable to adequately scan such dividers. The title from the original document is indicated below.

J

Divider Title: _____

THE WHITE HOUSE

WASHINGTON

July 6, 1993

Mr. Greg Jarres
Bibb County Department of Family and Children Services
Staff Development/Training Coordinator I
456 Oglethorpe Street
Macon, GA 31298

Dear Mr. Jarres:

Thank you for the description of the Bibb County Department of Family and Children Services EPSDT Clinic which you sent through Beth Zimmerman of Health Systems Research.

Mrs. Clinton regrets that she will be unable to accept the invitation to visit your wonderful facility in the forseeable future. She appreciates learning about your valuable program.

Thank you for taking the time to share it with us. Best wishes in the important work you do.

Sincerely yours,

Melanne Verveer
Deputy Chief of Staff
to the First Lady

THE WHITE HOUSE

WASHINGTON

June 5, 1993

Beth A. Jacobson
6009 Cobalt Road
Bethesda, MD 20816

Dear Ms. Jacobson:

Thank you for your recent letter. Currently, the Office of the First Lady does not have any staff vacancies. However, we do have several full and part time volunteers working with us. If you wish to volunteer with our office, please contact Diane Limo, our Office Manager, at (202) 456-6266. We will also forward your resume to the White House Personnel Office for consideration.

Best wishes.

Sincerely,

Melanne Verveer
Deputy Chief of Staff

to the First Lady

THE WHITE HOUSE

WASHINGTON

June 5, 1993

Wayne L. Johnson
Thomas Claggett Elementary School
Parent-Infant Program for the Hearing Impaired
2001 Addison Road
Forestville, MD 20747

Dear Mr. Johnson:

Thank you for your thoughts and suggestions regarding the critical issues facing the delivery of health care in this country. I appreciate your views on universal newborn hearing screening. The President intends to include primary and preventive health care as a cornerstone of his reform initiative. We greatly appreciate your taking the time to lend your important advice concerning health care reform.

Thank you also for your own effort toward our cause. Best wishes.

Sincerely,

Melanne Verveer
Deputy Chief of Staff
to the First Lady

June 30, 1993

Shirley Jones
Southwest International Wine and Food Review
Route 2, Box 20-A
Sapello, NM 87745

Dear Ms. Jones:

Thank you for your recent letter and information regarding wine and health.

As you may know, the health care task force has completed its charge from the President. We expect that he will soon make his proposal to Congress. Your suggestions are helpful as we work toward Congressional consideration of this important national initiative.

Thank you again for sharing your views. Mrs. Clinton appreciates hearing from you. Best wishes.

Sincerely,

Melanne Verveer
Deputy Chief of Staff
to the First Lady

THE WHITE HOUSE

WASHINGTON

March 5, 1993

Ms. Rosemary Jordano
President
Children First Inc.
60 State Street
Boston, MA 02109

Dear Ms. Jordano:

On behalf of Mrs. Clinton, I want to thank you for forwarding the letter and background materials on Children First which you sent the President. The office of the First Lady has set up a resource database, and we appreciate people like yourself who keep us up to date on important issues affecting children.

Your thoughtfulness in enclosing the "official attire" of Children First is also greatly appreciated.

With best wishes,

Sincerely,

Melanne Verveer
Deputy Staff Director
to the First Lady

CHILDREN
FIRST
INC.

Sixty State Street
Boston, MA 02109
617.742.2828
Fax: 617.742.4959

W/ t-shirt
Send Thank you letter

BY FEDERAL EXPRESS

February 24, 1993

Ms. Hillary Rodham Clinton
The White House
1600 Pennsylvania Avenue, NW
Washington, D.C. 20500

Dear Ms. Clinton:

It is with great pleasure that I forward to you a copy of the letter and materials sent to the President. As a fellow Wellesley alumnae (class of 1984), I am thrilled to know a Wellesley woman is in the White House!

As mentioned in my letter to the President, Children First is dedicated exclusively to the design, development and operation of world class, backup child care centers. Corporations in America, such as Ropes & Gray (as your friend Eleanor D. Acheson may know) and Goldman, Sachs & Co. (as Robert Rubin may also know), already realize the importance of providing their employees with state of the art, backup child care options.

I write to you in hopes of making Children First the "Official Backup Child Care Option" of the White House. For your information, I have enclosed background materials on Children First as well as a business plan that I am currently in the midst of presenting to banks and the Small Business Administration. In addition, I would love to speak with you on how to better promote children and why they should come first! In the interim, I am enclosing the "official attire" of Children First! Wear it in good health! Best regards.

Respectfully yours,

Rosemary Jordano
President

NATIONAL PUBLIC RADIO®

Mary Lou Joseph
Director, National Affairs

2025 M Street NW
Washington, DC 20036

202 822-2747

Melanne -
We thought the Clinton's might enjoy these!
ML

February 23, 1993

Ms. Mary Lou Joseph
Director, National Affairs
National Public Radio
2025 M. Street, NW
Washington, DC 20036

Dear Mary Lou:

Thank you very much for sending the aural souvenir of PERFORMANCE TODAY's program recorded on January 20th. I will see to it that the President and Mrs. Clinton receive it. I am sure they will enjoy hearing the thoughtful and inspiring music which your program selected in honor of the President's Inauguration.

With best wishes,

Hope all is well!

Sincerely,

Melanne Verveer
Deputy Chief of Staff
to the First Lady

February 18, 1993

President Bill Clinton
The White House
Washington, DC

Dear Mr. President:

I know that you've got more pressing issues on your mind today, but I wanted you to have this aural souvenir of the day four weeks ago when you became President. PERFORMANCE TODAY is National Public Radio's daily program of what's new and news in the world of classical music. On January 20th, we featured performers who figured prominantly in your home state and in your Inauguration Day festivities.

The show includes a performance by the Philander Smith College Choir, recorded in concert in Little Rock. The orchestra of the Music Festival of Arkansas performs the Symphony No. 3 by Aaron Copland at a summer concert in Fayetteville. Marilyn Horne is heard in a recital of American songs from a concert she gave in Spain last year. There's an interview with James Earl Jones about his new recording of Copland's "Lincoln Portrait." And there's even music by American composer Alan Hovhannes to welcome Socks to Washington.

PERFORMANCE TODAY is heard on 150 stations across America, including KUAR-FM in Little Rock and KUAF-FM in Fayetteville, and WETA-FM here in Washington. I hope that, in the busy days you have in front of you, you'll find the time to enjoy what the country heard from Arkansas on January 20, 1993.

Respectfully and sincerely,

Martin Goldsmith

Martin Goldsmith
Host

NATIONAL PUBLIC RADIO 2025 M STREET, N.W. WASHINGTON, D.C. 20036 202 822 2370

Clinton Presidential Records
Digital Records Marker

This is not a presidential record. This is used as an administrative marker by the William J. Clinton Presidential Library Staff.

This marker identifies the place of a tabbed divider. Given our digitization capabilities, we are sometimes unable to adequately scan such dividers. The title from the original document is indicated below.

K

Divider Title: _____

THE WHITE HOUSE

WASHINGTON

Acct 9/13

September ~~8~~ 13, 1993

Ms. Robin F. Kaufer, Esq.
228 Wayland Street
Los Angelos, California 90042

Dear Ms. Kaufer:

Thank you very much for your letter regarding health care reform. It is both a highly complex issue and a very personal one for most Americans. I appreciate your taking the time to express your views.

Very shorty, the President will announce ~~its~~ his Health Security Plan. The fundamental aim of the initiative is to provide affordable, quality health care to every American. Preventative medicine and education will play critical roles in his proposal.

Thank you again for making your voice count. I assure you that the President and the Administration carefully consider the views of concerned individuals like yourself before making policy decisions.

Sincerely,

Melanne Verveer

Melanne Verveer
Deputy Chief of Staff
to the First Lady

THE WHITE HOUSE

WASHINGTON

May 26, 1993

Edward G. Kaufman, D.D.S.
Dean
New York University School of Dentistry
345 East 24th Street
New York, NY 10010

Dear Dr. Kaufman:

Thank you for sending me the information from your recent conference on "Dentistry's Role in National Health Reform". We regret that we cannot attend the numerous meetings and conferences to which we are invited and therefore appreciate your taking the time to apprise us of your ideas and suggestions.

Best wishes for the important work that you do.

Sincerely yours,

Melanne Verveer
Deputy Chief of Staff to
the First Lady

DRAFT

June 5, 1993

Herbert H. Keyser, M.D.
318 Foxhall Lane
San Antonio, TX 78213

Dear Mr. Keyser:

Thank you very much for your recent letter. We regret that we were unable to respond sooner, because we do welcome the comments and ideas people like you contribute.

The White House Health Care Task Force has set up a resource database, and we appreciate that you have taken the time to apprise us of your valuable ideas concerning health care reform. This is an important time for the nation, and it is essential that we work together.

Sincerely,

Melanne Verveer
Deputy Chief of Staff
to the First Lady

Robin F. Kaufer, Esq.
228 Wayland Street
Los Angeles, CA 90042

August 26, 1993

Ms. Melanie Berveer,
Chief of Staff
Health Task Force
100 Old Executive Office Bldg.
Washington, D.C. 20500

Dear Ms. Berveer:

I am writing to express my thoughts on aspects of the health care system in this country. I feel strongly that we can save a lot of tax dollars by emphasizing prevention, and rewarding people for healthy behavior.

First, medical doctors and other health professionals need to be much better educated on the effects of diet and exercise on chronic diseases. We are paying much too much for conditions that are often easily controlled by our own behavior.

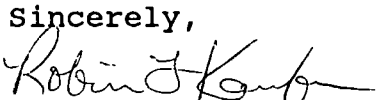
Second, medical consumers themselves need to be better educated, so as to make the most of their access to health care. It does not take a nutritionist to understand that the old "four basic food groups" are an outdated concept, and the new food pyramid would be a good learning tool for this.

Also, it seems that many people are ignorant when it comes to visiting the doctor for a cold or the flu. Although for the vast majority, these are not life-threatening situations, involving common viruses, they march to their physicians and demand antibiotics. I resent having to pay for such waste.

Finally, I really feel that it is unfair for those who take very good care of their health to pay the same for health insurance as those who do not take the same effort. I have learned to keep to a strict vegetarian diet, and keep in top aerobic condition. Why should I subsidize someone who is overweight, with high cholesterol, and out of shape? If they had a financial incentive to improve their condition, it would save everyone money, and they would feel better on top of it.

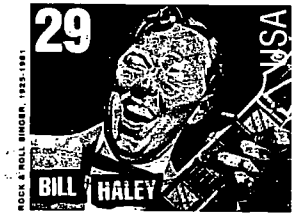
John A. McDougall, M.D., has some very good ideas as far as practical solutions in these areas. I hope his and my thoughts are taken into account in preparing a plan for the country.

Sincerely,



Robin F. Kaufer

R. Kaufer
228 Wayland St.
Los Angeles, CA 90042-3540



Ms. Melanie Berveer
Chief of Staff
Health Task Force
100 Old Executive Office Bldg.
Washington, D.C. 20500

Clinton Presidential Records
Digital Records Marker

This is not a presidential record. This is used as an administrative marker by the William J. Clinton Presidential Library Staff.

This marker identifies the place of a tabbed divider. Given our digitization capabilities, we are sometimes unable to adequately scan such dividers. The title from the original document is indicated below.

L

Divider Title: _____

THE WHITE HOUSE

WASHINGTON

June 4, 1993

Jayne La Grande, Chair
Regional volunteer Summit Task Force
Accounting Supervisor, USAA
Post Office Box 15506
Sacramento, CA 95852

Dear Ms. La Grande:

Thank you for inviting Mrs. Clinton to serve as a keynote speaker for your "Regional Volunteer Summit: Empowering our Communities for Change." It appears to be a most interesting and important program.

Unfortunately, due to a probable conflict in her demanding schedule, Mrs. Clinton will be unable to speak at the summit. You are right that the First Lady has a personal commitment to volunteerism and believes in the importance of teamwork to better the nation as a whole. We regret that she cannot accept your kind invitation.

We have forwarded your invitation to Mrs. Gore's office for consideration.

Thank you for the contribution you make. Best wishes.

Sincerely,

Melanne Verveer
Deputy Chief of Staff
to the First Lady

March 16, 1993

Ms. Karen Storek Lange
Director
New Parets Network
P.O. Box 44226
Tucson, AZ 85733-4226

Dear Ms. Lange:

On behalf of Mrs. Clinton, I want to thank you for sending us the packet on New Parents Network. Mrs. Clinton shares your concern for children and their well-being. The office of the First Lady has set up a resource database, and we appreciate people like yourself who keep us up to date on important issues affecting children.

We applaud your efforts in setting up the New Parents Network databank and wish you lots of luck.

With best wishes,

Sincerely,

Melanne Verveer
Deputy Chief of Staff
to the First Lady

NEW PARENTS NETWORK™

A SOCIAL & SERVICE INFORMATION PROVIDER

March 3, 1993

Office of the First Lady
The White House
First Lady Hillary Clinton
Room 100-OEOB
Washington, DC. 20500

Dear Ms. Clinton:

I send you the enclosed packet to introduce you to a national, non-profit organization - New Parents Network (NPN). New Parents Network has coordinated the nation's first databank designed to link and fully describe all agencies concerned with children and parenting. These agencies are invited to have a full file description as part of our databank at no cost. The gathered educational files are disseminated through 1) NPN software, 2) our telecommunications network, and 3) the international telecommunications network Delphi.

A few examples from the hundreds of files we have are: - health information (the immunization schedule, breastfeeding help, etc.) car seat and toy recalls, safety information (what plants are poisonous, pool safety, CPR info, etc.), disability information (Downs Syndrome, Cleft Palate, Epilepsy, etc.), support groups that help parents (Depression After Delivery, ICU Care Parents, Entrepreneurial Mothers, etc.), child care information, and government programs that assist parents and children (W.I.C., Head Start, etc.).

By coordinating this databank and inviting all agencies to participate, New Parents Network can help families learn about crucial information and services available to help them become better parents.

Under the current Surgeon General, Mr. Steve Sepe (National Director of Immunizations in Atlanta) lead a multi-department task force that has been exploring New Parents Network and looking at the concept of installing our software on computers in Head Start, WIC, and county health departments.

I send you this information so that you would be aware the program's presence and perhaps help NPN get a coordinated effort of government agencies (Federal & State) listed and described on the network.

Sincerely,

Karen Storek Lange

Karen Storek Lange
Director

P.O. Box 44226 • Tucson, Arizona 85733-4226
Voice: (602) 327-1451 • Computer BBS: (602) 326-9345 • FAX: (602) 881-8474
New Parents Network, Inc. is a non-profit organization

THE WHITE HOUSE

WASHINGTON

June 11, 1993

Edward P. Lawrence, Esq.
Ropes & Gray
One International Place
Boston, Massachusetts 02110-2624

Dear Mr. Lawrence:

Thank you most sincerely for your recommendation to the Office of the First Lady of Dr. Isadore Meschan, prominent radiologist currently associated with the Bowman Gray School of Medicine.

My office left a message in your absence today regarding our disposition of the material you enclosed, which defines a most distinguished career about which we are pleased to know. While the Health Care Task Force was officially over on May 30 and the next phase is now underway, I want to assure you of my personal gratitude for your effort on behalf of Dr. Meschan. We will apprise our health care staff of his availability to serve as advisor.

Sincerely,

Melanne Verveer
Deputy Chief of Staff
to the First Lady

THE WHITE HOUSE

WASHINGTON

May 11, 1993

Mr. Fred Lawrence
9017 Doris Drive
Ft. Washington, MD 20744

Dear Mr. Lawrence:

Thank you for your thoughts and suggestions regarding the critical issues facing the delivery of health care in this country. Your views are very helpful as we work to formulate the reform of our national health care system.

Thank you for caring. Best wishes,

Sincerely,

Melanne Verveer
Deputy Chief of Staff
to the First Lady

DRAFTbz

January 7, 1994

Mr. John M. Lawson
2032 Belmont Road, N.W. #518
Washington, DC 20009

Dear John:

It has taken far longer to catch up with my correspondence than I expected! It was so nice to hear from you ~~in September~~ and learn of all the exciting things you are doing in telecommunications.

I want to wish you much success with your new company. ~~Thanks for keeping me informed.~~ Let's stay in touch.

With best wishes,

Sincerely,

Melanne Verveer
Deputy Chief of Staff
to the First Lady

John M. Lawson

September 21, 1993

Ms. Melanne Verveer
Office of the First Lady
The White House
1600 Pennsylvania Avenue, NW
Washington, DC 20500

Dear Melanne:

I wanted to give you a quick update on what I've been doing since we last talked. Basically, there's a telecommunications revolution taking place, and I'm very happy to be part of it.

After more than three productive years as Director of National Affairs for public television, I've started a consulting company. My focus is helping clients plan and secure funding for "information highways" and "convergence technology" applications.

My business, after several months, is considerably ahead of my expectations. The cellular industry has retained me to help them launch an initiative to provide communications technology for schools. I'm working with PBS on a number of projects, including a proposal with a major electronics company for defense conversion funding. We want to develop a low cost transmitter for digital, high definition television (HDTV). I'm helping WNET/New York find funding to produce educational software. Higher education and health care are other industries I hope to be working with soon.

I'll soon send you an announcement of the new company, Convergence Services, Inc., located at 1101 Vermont Ave, NW, Suite 400, Washington, DC 20005. Office number is 202-289-3633.

I hope you're doing well. Please stay in touch.

M- I know you're busy these days.

John

2032 Belmont Road, NW #518
Washington, DC 20009
(202) 232-3121

January 28, 1993

Ms. Jeanne Lenzer
National Child Rights Alliance
P.O. Box 422
Ellenville, New York
12428

Dear Ms. Lenzer,

On behalf of Mrs. Clinton, I am writing to thank you for your letter and the information you sent on your organization, the National Child Rights Alliance. As you know, children and their well-being has been and will continue to be a priority in Mrs. Clinton's work. She values the efforts and dedication of people like yourself, and she sympathizes with your funding difficulties. Unfortunately her schedule does not provide her the time to meet with all of the organizations working on behalf children.

I will share your letter with Mrs. Clinton, and we will be sure to include your information in our resource collection. Thank you again for taking the time to share your thoughts with Mrs. Clinton, and for your good wishes.

Sincerely,

Melanne Verveer
Deputy Chief of Staff
to the First Lady

THE WHITE HOUSE

WASHINGTON

March 5, 1993

Ms. Regina A. Loughran
Special Counsel
The Special Commissioner of
Investigation for the New York
City School District
25 Broadway
8th Floor
New York, NY 10004

Dear Ms. Loughran:

On behalf of Mrs. Clinton, I want to thank you for forwarding a copy of your recent report on a most unfortunate situation which occurred in a New York City public school. The office of the First Lady has set up a resource database, and we appreciate people like yourself keeping us up to date on important issues which affect children.

Thank you again for sending the report and for your good wishes.

Sincerely,

Melanne Verveer
Deputy Chief of Staff
to the First Lady

CITY OF NEW YORK
THE SPECIAL COMMISSIONER OF INVESTIGATION
FOR THE NEW YORK CITY SCHOOL DISTRICT
25 BROADWAY, 8TH FLOOR • NEW YORK, NEW YORK 10004
(212) 510-1400
FAX: (212) 510-1550

ED STANCIK
SPECIAL COMMISSIONER

February 12, 1993

Mrs. Hillary Clinton
c/o Melanne Verveer
Deputy Chief of Staff
Office of the First Lady
The White House, Rm. 100-OEOB
Washington, D.C. 20050

Dear Mrs. Clinton:

Because of your interest in the welfare of America's children, I have enclosed a copy of a report recently issued by this office. The report describes the alarming failure of the principal, a teacher and a physician's assistant in a New York City public school to respond to an abused child's cry for help.

The Special Commissioner of Investigation for the New York City School District investigates crime, corruption and any other misconduct in the nation's largest public school system. Unfortunately, all too many of our cases involve sexual abuse of children or, as in this case, the failure of school personnel to deal with suspected abuse in a way that minimizes harm to the child.

As a result of our findings, Chancellor Fernandez has promised to take measures to ensure that school personnel are properly trained to detect signs of abuse and to report suspected abuse to authorities.

Best of luck in your new position as First Lady. We hope that you will make great strides to protect children from abuse and neglect.

Sincerely,

Regina A. Loughran
Special Counsel

RAL: tk