THE SECRETARY OF HEALTH AND HUMAN SERVICES
THE SECRETARY OF HOUSING AND URBAN DEVELOPMENT
WASHINGTON, D.C.

NOV 6 2000

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MEMORANDUM FOR THE PRESIDENT

On August 11, 2000, you issued an Executive Memorandum that focused on helping teen parents take responsibility for their lives and their children's future. You specifically directed that we take actions to create awareness of Second Chance Homes--places where teen parents who cannot live with their parents or other relatives can have access to a supportive, adult-supervised living arrangement. While these homes differ, they typically offer parenting skills, job counseling, education, and services to reduce the chance of repeat pregnancies.

In addition to the already successful efforts made under your leadership, we will continue to work toward promoting personal responsibility, preventing teenage pregnancy, and providing young people with educational and employment opportunities. The actions both our Departments will take under this Executive Memorandum will build on this progress and provide useful information to states and communities about developing and implementing Second Chance Homes.

Enclosed are two documents which will serve as guidance to nonprofit organizations and state and local governments to create awareness about the Second Chance Home model.

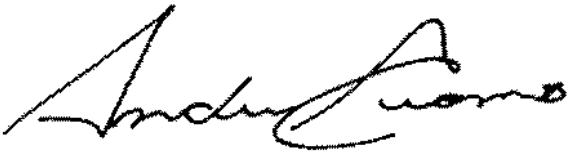
- The first is a brochure that was jointly prepared by the Departments of Health and Human Services and Housing and Urban Development (HHS/HUD) which briefly describes what Second Chance Homes are, why they are important, and what resources are available. We plan to use this brochure to provide technical assistance to our grantees, their associations, and various advocacy groups. We will also provide this brochure to various clearinghouses that serve our constituencies.

- The second document is a White Paper on Second Chance Homes. This paper describes second chance homes and what decision makers at the state and local level need to consider as they start or implement a second chance home program, including issues regarding service delivery, evidence of effectiveness, and challenges to rigorous evaluation. We plan to use this paper as technical assistance to associations, advocacy groups, and state agencies, as well as distribute to these groups and various clearinghouses.

In addition to being widely distributed, both documents will be placed on the HHS and HUD web sites, and in some cases presented at major conferences.

HHS and HUD will continue to work together to ensure that we implement your directive in a timely fashion.

Donna E. Shalala



Andrew Cuomo

Second Chance Homes

Providing Services for Teenage Parents and Their Children

U.S. Department of Health and Human Services
Office of the Assistant Secretary for Planning and Evaluation

October
2000

Second Chance Homes

WHAT ARE THEY?

Second Chance Homes are adult-supervised, supportive group homes or apartment clusters for teen mothers and their children who cannot live at home because of abuse, neglect or other extenuating circumstances. Second Chance Homes can also offer supports to help young families become self-sufficient and reduce the risk of repeat pregnancies. They provide a home where teen mothers can live, but they also offer program services to help put young mothers and their children on the path to a better future. Several federal resources are available to help state and local governments and community-based organizations create Second Chance Homes that provide safe, stable, nurturing environments for teen mothers and their children.

> *"I have to say Visions (a Second Chance Home in Massachusetts) helped me quite a bit, I loved them. I wanted to go somewhere [with my life], and the staff respected me for that."*
>
> *Tara, age 18*

Second Chance Homes programs vary across the country, but generally include:

- An adult-supervised, supportive living arrangement
- Pregnancy prevention services or referrals
- A requirement to finish high school or obtain a GED
- Access to support services such as child care, health care, transportation, and counseling
- Parenting and life skills classes
- Education, job training, and employment services
- Community involvement
- Individual case management and mentoring
- Culturally sensitive services
- Services to ensure a smooth transition to independent living

WHY ARE THEY IMPORTANT?

Second Chance Homes offer a nurturing home for some of society's most vulnerable families — teen mothers and their children with nowhere else to go. Almost half of all poor children under six are born to adolescent parents. Children of teen mothers are 50 percent more likely to have low birthweight, 33 percent more likely to become teen mothers themselves, and 2.7 times more likely to be incarcerated than the sons of mothers who delay childbearing. Teen mothers are half as likely to earn their high school diplomas or GEDs and are more likely to be on welfare than mothers who are older when they give birth.[1] In addition, research shows that over 60 percent of teen parents have experienced sexual and/or physical abuse, often by a household member.[2] Limited early findings indicate that residents of Second Chance Homes have fewer repeat pregnancies, better high school/GED completion rates, stronger life skills, increased self-sufficiency, and healthier babies.[3]

[1] Rebecca Maynard, *Kids Having Kids*, Robinhood Foundation's Special Report on Cost of Adolescent Childbearing, 1996.
[2] Debra Boyer and David Fine, *Victimization and Other Risk Factors for Child Maltreatment among School Age Parents: A Longitudinal Study*, US Department of Health and Human Services, 1990.
[3] Evaluation of Programs for Teen Parents and Their Children, Boston University School of Social Work, June 1998.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Chief of Staff

Washington, D.C. 20201

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November 7, 2000

MEMORANDUM TO THURGOOD MARSHALL, JR. 6 copy

- In response to the President's August 11, 2000, Executive Memorandum which focused on helping teen parents take responsibility for their lives and their children's future, Secretary Shalala and Secretary Cuomo, by the attached joint memorandum, are forwarding documents to the President for his information.

These guidance documents are the fruits of HHS/HUD actions to create awareness of Second Chance Homes, as the President specifically directed.

I can be reached at 202/690-7431 if any additional information is required. Please do not hesitate to call me.

Mary Beth Donahue

Attachment

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

OCT 18 2000

MEMORANDUM TO THE PRESIDENT

I am pleased to transmit to you a letter announcing the Sunset of the National Action Plan on Breast Cancer (NAPBC), coordinated by the Office on Women's Health and funded by the National Cancer Institute in the Department of Health and Human Services.

In the enclosed letter, the NAPBC Steering Committee recognizes your role in creating the NAPBC, summarizes the accomplishments of the Working Groups in catalyzing efforts to address priority issues in the fight against breast cancer, and reports that the evolution of the public-private partnership will remain part of the legacy of your Administration.

Thank you for your vision and leadership in establishing the NAPBC, and for your continued interest in and support of the Department's programs to improve the health of American women.

Donna E. Shalala

Enclosures

DEPARTMENT OF HEALTH & HUMAN SERVICES

Chief of Staff

Washington, D.C. 20201

October 19, 2000

MEMORANDUM FOR THURGOOD MARSHALL, JR.

I am forwarding herewith Secretary Shalala's Memorandum to the President, announcing the Sunset of the National Action Plan on Breast Cancer (NAPBC). The enclosures forwarded with the Secretary's memorandum chronicle the remarkable journey of the NAPBC to advance progress against breast cancer, a legacy of the Administration.

If I can be of any assistance or provide anything further, please do not hesitate of phone me at 202/690-7431.

Mary Beth Donahue

Attachment

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MEMORANDUM FOR THE PRESIDENT

On October 12, 1999, you directed the Secretaries of Health and Human Services, Education and Agriculture to develop a set of recommendations for making outreach to enroll children in Medicaid and the State Children's Health Insurance Program (SCHIP) an integral part of school business. During the past nine months, staffs from our agencies have worked together to gather information about school-based outreach from national, regional, State and local health and education sources.

Our findings indicate that school systems are indeed the critical link in successful outreach for children's health insurance programs in many States. Schools are an accepted conduit for important information for families and schools have a variety of mechanisms already in place to communicate with families. School outreach activities vary widely, from providing information for children to take home to direct on-site enrollment assistance. Many schools partner with States, community-based organizations or provider groups to conduct outreach. Unfortunately, there is widespread recognition that schools face multiple constraints in these efforts. Schools lack the funding, expertise or time it takes to conduct effective outreach campaigns. Privacy issues make sharing information across programs difficult. To build effective campaigns in schools, it will be important to remove these barriers through collaboration and partnerships around child health. Yet at all levels, there is a shared recognition that America's children face many compelling educational, health and developmental challenges that affect their lives and their futures. To help children meet these challenges, education and health must be linked in partnership.

We are pleased to forward to you our *Report on School-Based Outreach for Children's Health Insurance Programs*. The Report outlines our findings, describes barriers and promising approaches to school-based outreach and makes recommendations for ensuring that health insurance outreach for children is a customary part of school activity. To foster school-based outreach efforts, we must encourage collaboration and cooperation between schools and other organizations that can assist schools to capitalize on their unique positions to reach families of uninsured children. The workgroup has made recommendations for Federal actions and prepared an action plan for assisting States and schools in outreach efforts. The Report also identifies promising outreach practices for State governments and for school districts and schools. "How to" guides for distribution to school districts and schools, State administrators, providers and community groups are also in development.

Donna E. Shalala
Secretary of
Health and Human Services

Richard W. Riley
Secretary of Education

Dan Glickman
Secretary of Agriculture

Attachment

HCFA/KEN

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
AND
U.S. DEPARTMENT OF LABOR

SEP 15 2000

MEMORANDUM FOR THE PRESIDENT

We are writing to inform you of the concrete steps the Quality Interagency Coordination Task Force (QuIC) is taking to reduce medical errors and improve patient safety. In December 1999, you directed the QuIC to review the Institute of Medicine's (IOM) report, *To Err is Human*, which called attention to the harm caused by medical errors, and to report back to you regarding actions the Federal agencies could take to improve patient safety. In February, you received the QuIC report, *Doing What Counts for Patient Safety: Federal Efforts To Reduce Errors And Their Impact*. It outlined more than 100 actions that Federal agencies will take to improve patient safety.

In its report, the QuIC agencies promised to foster activities that would improve patient safety by:

- raising awareness of the problem of medical errors and establishing a national focus to enhance knowledge about safety;
- identifying and learning from medical errors through reporting systems and analysis of incidents;
- raising standards and expectations for improvements in safety through the actions of oversight organizations, purchasers, and professional groups; and
- implementing safe practices at the delivery level.

Our plan to accomplish these goals requires the development of partnerships among public and private sector organizations. We are moving ahead in all four of these areas as well as continuing to develop additional activities. We believe that you will be encouraged by how much progress has been made in the six months since you received our report. In addition to this brief summary of our activities, we have appended a more detailed description of our accomplishments (Tab A).

Raising Awareness and Providing Leadership on Patient Safety
The IOM called for leadership and a national focus on medical errors. In its report, the QuIC described its plan to foster broad discussion of errors in health care and improving patient safety.

AHRQ/Reading

Hold National Summits. One concrete step toward taking this leadership role is the QuIC's promise to conduct three national summits --- one to identify the priority areas for research, one to showcase practices that are effective in reducing errors, and one to focus on drugs and medical devices. The Agency for Healthcare Research and Quality (AHRQ) is taking the lead for the QuIC in organizing the first of these national summits – the National Summit on Medical Errors and Patient Safety Research on September 11, 2000 in Washington, DC. This summit will provide an opportunity for stakeholders (i.e., consumers, health care professionals, health care delivery organization leaders, purchasers, policy-makers, etc.) to tell Federal research funding agencies and private, patient-safety-funding foundations what the stakeholders need to know about medical errors and how to prevent them.

On October 17-18, 2000, QuIC is holding a conference entitled *Enhancing Working Conditions and Patient Safety: Best Practices* in Pittsburgh, PA. The conference is being organized by the Centers for Disease Control and Prevention (CDC)/National Institute for Occupational Safety and Health (NIOSH), Occupational Safety and Health Administration (OSHA), National Center for Infectious Diseases (NCID), AHRQ, and the Veterans Health Administration (VHA) in cooperation with the National Patient Safety Foundation, labor unions, and other stakeholders. It will identify ways in which the work environment has and can be improved through programs, processes, or policies to enhance both worker and patient safety.

Foster Public Attention to Errors. The public is concerned about medical errors and is looking for information on how they and their family members can reduce their risk of being the victim of an error. The QuIC agencies, under the leadership of the Office of Personnel Management (OPM) and the Health Care Financing Administration (HCFA), recognized that broad collaboration in articulating and disseminating public messages would reduce confusion and improve the effectiveness of our communication efforts. Working in close collaboration with the Department of Labor's Health Benefits Education Campaign, the QuIC developed five core messages that all QuIC agencies and interested private purchasers can use to promote public behavior to reduce medical errors (Tab B). These short messages are distillations of the "20 Tips for Patient Safety," developed by AHRQ and based on available research findings about common causes of and steps to reduce medical error. The Department of Labor (DOL) has worked with the partners of its Health Benefits Education Campaign to use these core messages and to encourage their use by private employers, patient and consumer groups, providers, etc. OPM will use these messages in its open enrollment information this fall. QuIC agencies will share these research-based messages with other purchasers, providers and the mass media.

Lead by Example. The QuIC agencies have also taken significant steps to lead by example as providers, purchasers, and oversight organizations. The OPM has taken important steps as a purchaser to signal that patient safety is an important consideration for the Federal Employees Benefit plans by requiring plans that they report patient safety efforts to OPM and to their plan members. The VHA has taken critical steps to signal their increasing attention to safety by introducing multiple patient safety systems and measures within their delivery systems. These actions, described below, have been touted by others. Many purchaser and provider organizations are considering whether they can take similar steps.

Understanding Consumer Information Needs. Further efforts will be informed by continued work to understand how the public is thinking about the patient safety issue. For example, in an exciting collaboration, the Kaiser Family Foundation will field a nationwide survey about the public's use of healthcare quality information, which will include questions on medical errors. The survey will be analyzed and results shared at a December conference on *Informing Consumers About Health Care Quality: New Directions for Research and Action* which is designed to promote discussion on how to effectively talk to consumers about quality. Sponsors of the consumer conference include AHRQ, HCFA, CDC, OPM, The Henry J. Kaiser Family Foundation, and the California HealthCare Foundation.

Identifying And Learning From Errors

Efforts to improve patient safety are dependent on gathering reports on errors and analyzing them for important underlying causes. Currently, there are no nationally representative data on errors. To begin to understand what data exist at the State level, the QuIC initiated a process to evaluate States' error reporting systems. This evaluation is being conducted by the National Academy for State Health Policy with support from AHRQ, the Robert Wood Johnson Foundation, and the Commonwealth Fund. QuIC agencies are also developing or augmenting their own reporting systems.

Federal Error Reporting Systems. Reporting systems provide the information that identifies systems vulnerabilities so that appropriate corrective actions can be implemented that will prevent future negative events. The VHA has implemented an internal mandatory, non-punitive, comprehensive root cause analysis and corrective action system complete with computer assisted analysis and human factors tools to improve patient safety in all of its facilities. Outside health care providers and other organizations (e.g., Joint Commission on the Accreditation of Healthcare Organizations (JCAHO), American Hospital Association (AHA), Department of Defense (DoD), University of Texas, Baylor, Kaiser-Permanente, Jefferson Medical College, Government Accounting Office (GAO), Food and Drug Administration (FDA)) have sent their personnel to be trained by these methods.

On May 30, 2000 the VHA announced the development of a Patient Safety Reporting System (PSRS). This complementary system of de-identified error reporting for learning, developed in cooperation with National Aeronautics and Space Administration (NASA), is patterned after the Aviation Safety Reporting System (ASRS). The PSRS will begin accepting data by January 2001. The information from the PSRS and the internal mandatory system provide a more complete picture than either could alone, and thus, enabling the best preventive strategies to be implemented.

Recently, the DoD has directed its facilities to report medical errors to a confidential, central data base at the Armed Forces Institute of Pathology. The DoD is working to create the processes by which these data will be analyzed and information fed back to practitioners. It will pilot test this system in the fall of 2000 and implement it worldwide after testing.

The FDA, through its voluntary reporting system (MedWatch) and mandatory reporting by manufacturers, continues to receive reports of errors with medical products. The FDA is now classifying all reports of medication errors for types, causes, outcomes, and contributing factors

associated with the events in a researchable format. The FDA expects to release information in the near future on the causes of medication errors that have resulted in patient deaths.

Developing Knowledge to Improve Safety. The VHA has developed four patient safety research centers in White River Junction, VT; Cincinnati, OH; Palo Alto, CA; and Tampa, FL. The VHA is currently working to disseminate the best practices from those centers into all of its health networks. AHRQ continues to foster patient safety research; recipients of the latest research grants will be announced in September.

Raising the Expectations for the Delivery System

In addition to developing knowledge about the causes of error, the QuIC is aware that providers must be encouraged to implement these systems. The QuIC agencies are using many different means to encourage this attention to safety.

Calling for Safety Systems. To provide an impetus to improve safety, the OPM has instructed carriers in the Federal Employee Health Benefits Program (FEHBP) that they must implement patient safety activities. OPM issued a call letter instructing carriers to report on their current initiatives that relate to patient safety, and to provide plan members with information about medical errors.

Implementing Safety Systems for Prescription Drug Administration. Because the misadministration of drugs is one of the most common types of medical error, the FDA is improving the management of and communication about the risks of prescription drugs. By implementing user-friendly labeling, it is anticipated that these errors can be greatly reduced. The FDA is spearheading labeling reforms and proposing new regulations and guides to improve the format and content of labeling and due in October or November.

Implementing Blood Safety Systems. The FDA is developing two key blood safety regulations: 1) to extend error and accident reporting to all U.S.-registered blood establishments and transfusion centers and 2) to facilitate a standardized method for labeling blood products. The new error and accident reporting regulations will be finalized in the Fall, but the FDA has already issued a guidance for the blood which conforms to international standards.

Engaging the Private Purchaser Community. The DOL has been working with partners to identify and develop products that will provide information on health benefit quality and safety. The first product underway is the "Employers' Quality Briefcase." This will be a web-based repository of links to information on quality and safety that employers can use when choosing health benefits for their employees. The "Briefcase" will also serve as a vehicle for future dissemination of information and resources on quality and safety in the context of employer provided health benefits.

Implementing Safe Practices in Federal Delivery Systems

The Federal delivery systems, particularly the VHA, have been leaders in implementing safety improvements in care delivery. All the QuIC agencies recognize that we must continuously strive to improve on our current level of performance. Thus, safer processes are being tried and implemented.

Upgrading the Electronic Interface. The DoD is making computerized medical record order entry improvements, and is testing Pharmacy Data Transaction System (PDTS), which will allow pharmacists and physicians to know what medications a beneficiary has been given, regardless of where or when the patient received the prescription. This will help to prevent drug interactions for DoD beneficiaries worldwide. Implementation of the PDTS is expected by the end of this year.

Improving Medication Delivery. A multi-year medication bar coding project at one medical center resulted in cutting medication errors by two-thirds. Beginning in 1999, the VHA began national implementation of the bar coding throughout its entire medical system.

Improving the Delivery System Environment. The Emergency Medical Services for Children (EMSC) program in the Health Resources and Services Administration (HRSA), Maternal and Child Health Bureau is color-coding medications and equipment for pediatric resuscitation so that it is easy to identify the appropriate supplies during emergency situations.

Reducing Errors in High Hazard Environments. The QuIC, led by efforts in the VHA and DoD, is sponsoring a breakthrough series with the Institute for Healthcare Improvement to explore ways to achieve a significant reduction in errors in healthcare environments that involve both a fragile individual and setting which requires quick decisions. Typical "high hazard" environments include intensive care units, trauma units, emergency rooms, etc.

QuIC's collaborative work ensures that the Administration's patient safety initiatives are clear and well coordinated, and indicates to the public that we are committed to quality improvement in the health care system. We welcome your feedback on these actions.

Donna E. Shalala
Secretary
Department of Health and Human Services

Alexis M. Herman
Secretary
Department of Labor

Attachments
Tab A – Summary of QuIC's Current and Proposed Patient Safety Activities
Tab B – 5 Steps to Safer Health Care

Tab A

SUMMARY OF QuIC'S CURRENT AND PROPOSED PATIENT SAFETY ACTIVITIES

Disseminating Patient Safety Information to the Public, Purchasers, and Providers

Well-informed patients, providers, and purchasers are key participants in the effort to enhance the quality and safety of Americans' health. Quality Interagency Coordinating Task Force (QuIC) is conducting the aggressive information and education effort needed to increase these stakeholders' understanding of how medical errors occur and what steps they can take to prevent such errors.

ACTIONS:

- This fall, the Office of Personnel Management (OPM) will make patient safety information available to over 4 million enrollees in the Federal Employees Health Benefit Program. OPM also asked health plans to help provide consumer information and education about patient safety and consulted them regarding consumer messages.

- The Agency for Healthcare Research and Quality (AHRQ) published "20 Tips For Patient Safety" that patients can use to improve their safety in the health care system.

- The QuIC worked closely with the Department of Labor's (DOL) Health Benefits Education Campaign and its private partners to refine and shorten the "20 Tips" into five core messages for patient safety that purchasers and others will disseminate to their constituencies. The DOL is working through its Health Benefits Education Campaign as a forum for the dissemination of patient safety information through the Campaign's partners, including the National Association of Insurance Commissioners (NAIC). DOL maintains regular communications with its Campaign partners, such as discussing progress and issues of concern regarding patient safety at the NAIC's quarterly meetings.

- The Food and Drug Administration (FDA) has completed development of a brochure targeted to consumers to educate them in making safe choices when medical devices are to be used in the home—"Making Sure the Medical Device You Choose is Designed for You." This can be used as a checklist by health professionals when recommending a device for a patient.

- The FDA, National Institute for Occupational Safety and Health (NIOSH), and National Aeronautics and Space Administration (NASA) worked in collaboration to complete a videotape, "Hidden Dangers: Safe Handling of Oxygen Regulators" to address the common goal of patient and user safety. Federal Emergency Management Administration's (FEMA) US Fire Administration is distributing this videotape to all fire/emergency rescue department heads in each state, state fire marshals, and the fire publications (e.g., "Fire House"). The FEMA Satellite Network will downlink the videotapes several times to all linked firehouses around the country. To alert consumers to the potential hazards, FDA published information about safe handling of oxygen regulators in the FDA Consumer publication (August 2000).

- The Health Care Financing Administration (HCFA) conducted research on consumer awareness and conceptualizations of medical errors. HCFA, AHRQ, and OPM will follow-up with consumer research on the measurement and reporting of medical errors.

Patient Safety Research Initiatives and Pilot Projects

Research on the epidemiology and prevention of errors is still in its infancy. QuIC is helping to expand the medical error knowledge base by sponsoring and conducting patient safety research projects in areas

where information is lacking. QuIC is using these research findings to develop and field test error reduction programs. QuIC is actively collecting feedback from providers and other users of patient safety tools to refine and improve the usability of these methods.

ACTIONS:

- HCFA solicited proposals for projects on medical errors and patient safety from its Peer Review Organizations. There is particular interest in reducing medication errors/prevention of adverse drug events, identifying states that have mandatory reporting, and developing collaborative efforts with interested parties to identify standardized data reporting and collection elements. Many of these projects include working with volunteer hospitals. HCFA is currently reviewing these proposals and will select several.

- AHRQ is working on projects for its Evidence-based Practice Centers to focus on areas where there is currently no research and developing RFAs (request for applications) for patient safety research which will begin in FY 2001. If AHRQ receives the amount of funding requested in the President's budget, then AHRQ will fund significant new patient safety research and work to develop Patient Safety Centers of Excellence.

- AHRQ and HCFA are contracting with the National Forum for Health Care Quality Measurement and Improvement (NQF) to perform several critical research tasks related to medical errors and patient safety. The NQF will perform the following tasks: 1) Develop a compendium of evidence-based safety practices necessary in preventing and reducing healthcare errors in hospitals (to include identifying safety practices that are proven to effectively reduce adverse healthcare events in hospitals, establishing criteria for evaluating these, and developing a process for updating and augmenting them); and 2) Identify a core set of standardized, avoidable, serious adverse events that should never occur (to include developing a process for updating and augmenting this list).

- The FDA is conducting research on computerized searches of medical records to find evidence of adverse events. The results of this research could be used to develop software to help detect and hopefully prevent adverse events.

- HRSA's Bureau of Primary Health Care is piloting an *Internet Medical Errors Reporting System* in four primary care grantee sites. This anonymous system will test the feasibility of tracking and documenting medical incidents in ambulatory care centers as part of a quality improvement system.

- On October 17-18, 2000, the National Institute of Occupational Safety & Health (NIOSH), Occupational Safety & Health Administration (OSHA), CDC, AHRQ, and the Veterans Health Administration (VHA) are co-sponsoring a QuIC conference entitled *Enhancing Working Conditions and Patient Safety: Best Practices* in Pittsburgh, PA on October 17-18, 2000. Programs that have improved working conditions for health care employees (e.g., effective ergonomics programs, reduced workplace violence, etc.) that simultaneously have improved patient outcomes (e.g., fewer falls, fewer patient assaults, fewer medication errors, etc.) will be featured. Additionally, there are a number of non-federal "partners" in the conference such as Service Employees International Union, American Nurses Association, Kaiser Permanente, American Hospital Association, National Patient Safety Foundation, and representatives from the OSHA/Insurance Roundtable.

- The National Academy of State Health Policy is examining existing state reporting systems to determine what information is currently being provided by those systems and how that information is being used.

- The VHA has developed four patient safety research centers in White River Junction, VT; Cincinnati, OH; Palo Alto, CA; and Tampa, FL. The VHA is currently working to disseminate the best practices from those centers into its health network.

Health Care Professional Education Initiatives

Introducing patient safety best practices to health care professionals early on in their training will improve their ability to recognize and prevent medical errors in the future.

ACTIONS:

- The VHA has just completed the implementation of its internal comprehensive patient safety system which required training personnel (ranging from top management to the front-line personnel) in all of its 172 hospitals. This training addressed topics including information on performing root cause analysis utilizing computer-aided analysis and human factors tools, formulation of corrective actions, and general patient safety issues.

- The VHA has developed a patient safety educational program involving both the federal and private health care sectors, which has been praised by attendees and emulated by other health delivery organizations.

- The HRSA Bureau of Health Professionals (BHPr) supported Council on Graduate Medical Education and the National Advisory Council on Nurse Education Practice are convening a joint meeting to develop recommendations on physician-nurse collaborative education and practice activities leading to enhanced safety in caring for patients.

Bringing Together Stakeholders to Improve Patient Safety

For several years, researchers, health system and hospital administrators, providers, and policymakers have unilaterally explored and implemented effective patient safety programs. QuIC is creating forums for the sharing and exchange of patient safety information between developers of patient safety research and those who implement patient safety practices.

ACTIONS:

- On behalf of QuIC, AHRQ is coordinating the *National Summit on Medical Errors and Patient Safety Research*, scheduled for September 11, 2000. The Summit will serve as a forum for discussion and debate among medical errors experts, consumer advocates, and Federal agencies and will enable AHRQ to further refine its patient safety research agenda.

- OPM asked Federal Employee Health Benefit Plans to work with their providers, independent accreditation agencies, and others to implement patient-safety improvement programs and to implement accountability systems and ensure that sound practices are noted and rewarded. OPM encouraged them to consider strategies endorsed by other purchasers, such as computerized physician order entry systems, evidence-based hospital referral, and intensive care unit physician staffing.

- On June 21, 2000, the FDA and the American Society for Healthcare Risk Management (ASHRM) co-sponsored a satellite video teleconference, "Preventing Errors Using Medical Products," to help

healthcare professionals identify, understand, prevent and resolve errors related to the use of medical products.

- On October 11, 2000, the FDA is presenting a live video teleconference that will focus on the role of the medical device industry and the FDA in reducing medical device errors by addressing user needs. Not only will the discussion center on how individuals innately respond to their physical environment, but it will allow the development of ways in which those factors should be considered in the area of new medical device design and development.

- The DOL is working with partners to identify and develop products that will provide information for participants and employers on issues of health benefit quality and safety. The first product underway is the "Employers' Quality Briefcase." This will be a web-based repository of links to information for employers of all sizes who are looking for data and materials on issues of quality and safety when choosing health benefits for their employees. The "Briefcase" will also serve as an outlet for those developing information and resources on issues of quality and safety in the context of employer provided health benefits who are looking for a national forum to disseminate those materials.

- HRSA formed an internal task force on patient safety, comprised of representatives from HRSA, the National Association of Community Health Centers, the Joint Commission on Accreditation of Health Care Organizations, and the Institute for Healthcare Improvement. Task force activities focus on the issue of incident reporting systems and provider credentialing and privileging procedures.

- AHRQ and the Medical Group Management Association (MGMA), an association of small to medium-sized physician group practices, are working together to begin to identify practices by which ambulatory care settings may be altered to reduce medical errors. Building on that information from the physician's viewpoint, HCFA is researching how purchasers might be supportive of changes within the ambulatory care setting to improve patient safety. HCFA's activities will involve setting up demonstration projects and helping to identify best practices. Other members of the QuIC, such as the OPM, are supporting and participating in these efforts.

- The HRSA and National Highway and Traffic Safety Administration will be co-funding research centered on reducing errors when caring for children in emergency situations.

Technological Initiatives to Improve Patient Safety

QuIC agencies are recognized leaders in the application and implementation of information technology in health care. Although the success of health care informatics models is well known and their applicability to patient safety is evident, they have not been widely adopted. QuIC members are combating this trend by developing and testing several computer-based patient safety initiatives, capitalizing on the growing usage and accessibility of the Internet, and creating software applications to reduce medication errors.

ACTIONS:

- The DoD is making computerized record/ order entry improvements. It is testing the Pharmacy Data Transaction System (PDTS), which will allow for identification of drug interactions on all DoD systems worldwide. Implementation of this system is expected by the end of the year.

- The FDA is developing a regulation that will adopt an international standardized method for labeling blood products that will computerize labeling and incorporate the use of bar codes. The adoption of

this standard, which is already being allowed under agency guidance to industry, will help reduce the chance of patients receiving the wrong blood product.

- HRSA is piloting an *Internet Medical Errors Reporting System* in four primary care settings. The anonymous system will test the feasibility of tracking and documenting incidents in ambulatory care centers as part of a quality improvement system. Data can be used for benchmarking at both the local site as well as regionally or nationally with aggregate data analysis.

Collection and Analysis of Medical Errors Reporting Data

Research has shown that when error-reporting systems are non-punitive, staff are far more likely to report adverse events. QuIC is launching several pilot non-punitive error reporting systems with the intention of collecting and analyzing data to determine the root causes of error.

ACTION:

- The VHA instituted, across all of its 172 facilities, a comprehensive program for root cause analysis and corrective action analysis in its mandatory reporting systems. The program not only identifies causes and corrective actions, but also verifies whether corrective actions are effective, and will be implemented throughout the VHA. This program not only identifies errors, but also "adverse events" and "close calls." On May 30, 2000 the VHA announced the development of a Patient Safety Reporting System (PSRS). This system of de-identified error reporting for learning, developed in cooperation with NASA, is patterned after the Aviation Safety Reporting Systems (ASRS). The PSRS will begin accepting data by January 2001.

- The DoD is working on several information technology initiatives to improve patient safety. DoD is putting together a patient safety reporting system based on the current VHA system, and a pilot test of the system is expected to be held in the fall of 2000.

- The FDA continues its efforts to determine the underlying causes of product errors that are reported to MedWatch.

- Public discussion of the principles of a Medical Error Reporting System for Transfusion Medicine has been ongoing at the PHS Advisory Committee for Blood and Safety Availability. A model system has been identified and its utility may be further evaluated under support from NIH.

- The FDA is working with an Internet-based, consumer survey company to explore sending web-based surveys to consumers about usage experiences of home medical devices.

- The U.S. Coast Guard is committed to reducing medical errors and has established a working group to evaluate available data to determine what measures should be monitored to detect and then reduce medication errors in Coast Guard clinics.

- For contract year 2001, OPM directed its Federal Employees Health Benefits Plans to report on their current patient safety and error-reduction initiatives, as well as how they will strengthen their patient safety program for the future. Those reports are part of each Plan's 2001 rate and benefit proposal. OPM staff will analyze and consolidate the reports over the summer, and share them with the Plans before the start of the new contract year.

Tab B

Five Steps to Safer Health Care

1. **Speak up if you have questions or concerns.** Choose a doctor who you feel comfortable talking to about your health and treatment. Take a relative or friend with you if this will help you ask questions and understand the answers. It's okay to ask questions and to expect answers you can understand.

2. **Keep a list of all the medicines you take.** Tell your doctor and pharmacist about the medicines that you take, including over-the-counter medicines such as aspirin, ibuprofen, and dietary supplements like vitamins and herbals. Tell them about any drug allergies you have. Ask the pharmacist about side effects and what foods or other things to avoid while taking the medicine. When you get your medicine, read the label, including warnings. Make sure it is what your doctor ordered, and you know how to use it. If the medicine looks different than you expected, ask the pharmacist about it.

3. **Make sure you get the results of any test or procedure.** Ask your doctor or nurse when and how you will get the results of tests or procedures. If you do not get them when expected -- in person, on the phone, or in the mail – don't assume the results are fine. Call your doctor and ask for them. Ask what the results mean for your care.

4. **Talk with your doctor and health care team about your options if you need hospital care.** If you have more than one hospital to choose from, ask your doctor which one has the best care and results for your condition. Hospitals do a good job of treating a wide range of problems. However, for some procedures (such as heart bypass surgery), research shows results often are better at hospitals doing a lot of these procedures. Also, before you leave the hospital, be sure to ask about follow-up care, and be sure you understand the instructions.

5. **Make sure you understand what will happen if you need surgery.** Ask your doctor and surgeon: Who will take charge of my care while I'm in the hospital? Exactly what will you be doing? How long will it take? What will happen after the surgery? How can I expect to feel during recovery? Tell the surgeon, anesthesiologist, and nurses if you have allergies or have ever had a bad reaction to anesthesia. Make sure you, your doctor, and your surgeon all agree on exactly what will be done during the operation.

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THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

AUG 24 2000

MEMORANDUM TO THE PRESIDENT

On October 19, 1987, a ceremony was held in the Great Hall of the Hubert H. Humphrey (HHH) Building to unveil a bust of the former Vice President and Senator after whom the headquarters building of the Department of Health and Human Services is named (Public Law 95-141). The bust, which has resided in the Great Hall since that time, was a gift from Mrs. Frances Humphrey Howard, the sister of Mr. Humphrey, and Joseph John Jova, former Ambassador to the Organization of American States.

I recently met with Mrs. Howard, who expressed concerns about whether the artwork would remain on permanent display in the Humphrey Building throughout future administrations. I assured Mrs. Howard that I believed it was the objective of the government to retain the sculpture in the HHH building.

However, to ensure that the bust will remain as part of the HHH Building for as long as the Federal government maintains ownership, I ask that you sign a letter (draft enclosed) to Mrs. Howard that explicitly expresses the government's intent to keep the bust as an integral and implicit part of the facility.

Donna E. Shalala

Enclosure

10/2 loc/2

Amc/Bd

SUGGESTED DRAFT TEXT OF LETTER FROM THE PRESIDENT TO MRS. HOWARD

Mrs. Frances Humphrey Howard
2801 New Mexico Avenue, NW
Washington, D.C. 20007

Dear Mrs. Howard:

Secretary Shalala relayed your concern to me regarding the permanent retention of the bust of your brother, the Honorable Hubert H. Humphrey, which is located in the Great Hall of the Hubert H. Humphrey Building in Washington, D.C.

I would like to assure you that the bust is considered an integral part of the Department of Health and Human Services Headquarters building, and that it is the Federal government's intent to permanently retain the artwork in its current place. The American people will always be grateful for your brother's distinguished service to this country. Both his bust and the building that bears his name are appropriate tributes to his memory.

I want to thank you personally for the sculpture, and for the many public services you and your family have given this country.

CC: Secretary of Health and Human Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

Chief of Staff

Washington, D.C. 20201

August 24, 2000

MEMORANDUM FOR THURGOOD MARSHALL, JR.

In her memorandum to the President, Secretary Shalala asks the President to sign a letter to Frances Humphrey Howard, reassuring her that the bust of her brother, Hubert H. Humphrey, will remain through future Administrations as a legacy in the Great Hall of the Hubert H. Humphrey Building.

I am forwarding herewith the Secretary's memorandum to the President and a draft letter to Ms. Howard for the President's consideration. As always, if I can be of any assistance or provide further information, please do not hesitate to phone me at 202/690-7431.

Mary Beth Donahue

Attachments

Memorandum to the President

Draft letter to Ms. Howard

cc: Karen Tramontano

Maria Echaveste

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

AUG 24 2000

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Donna E. Shalala

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I want to thank you personally for the sculpture, and for the many public services you and your family have given this country.

CC: Secretary of Health and Human Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

Chief of Staff

Washington, D.C. 20201

August 24, 2000

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Mary Beth Donahue

Attachments

- Memorandum to the President
- Draft letter to Ms. Howard

cc: Karen Tramontano
Maria Echaveste

DEPARTMENT OF HEALTH & HUMAN SERVICES Office of the Secretary

Washington, D.C. 20201

AUG 14 2000

MEMORANDUM TO: The Secretary

THRU : DS
COS
ES

FROM: : John J. Callahan
Assistant Secretary for
Management and Budget

SUBJECT : Draft Letter to Ms. Frances Humphrey Howard for the President's Signature -- Action

Attached for your signature is a memorandum to the President requesting him to send a letter (draft also attached) to Frances Humphrey Howard concerning the bust of her brother, Hubert H. Humphrey. As you may recall, Ms. Howard previously expressed her concern to you that the bust may be removed from the Great Hall of the Hubert H. Humphrey Building during future changes in administrations.

We are asking the President to reassure Ms. Howard that the bust is considered an integral part of the facility and that it is the Federal government's intent to always retain the artwork in its current place. Hopefully, this will provide some comfort to Ms. Howard and also eliminate any questions in the future about the permanence of the bust.

In the meantime, we are pursuing other aspects of your commitment to Ms. Howard to affirm the tribute to her brother in the building named for him. Please let me know if I can be of further assistance in this matter.

Attachments

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

AUG 4 2000

MEMORANDUM FOR THE PRESIDENT

You issued Executive Order 12994 on March 21, 1996, updating and continuing the President's Committee on Mental Retardation (PCMR). This letter is requesting your consideration for a minor amendment to the Executive Order.

The request for an amendment of Executive Order 12994 consists of changing the number of years for a term of service on the President's Committee on Mental Retardation from two-year terms to three-year terms. The requested amendment of one word is located in Section 2(a), paragraph (10), in the last sentence.

President Johnson established the PCMR on May 11, 1966, by issuing Executive Order 11280. President Nixon superseded the Executive Order on March 28, 1974, with Executive Order 11776 by setting new goals. During the period of these two Executive Orders, a span of 30 years, three-year terms of service existed. The original rationale for a three-year term was to have seven members (one-third of the total 21 members) turnover each year, so as to create an orderly continuity and effectiveness of the Committee. In the beginning, rather than have complete change of 21 members every 3 years, seven members were appointed to a one-year term, seven to a two-year term and seven to a three-year term. Thereafter, every appointment of seven new members was for a three-year term. This avoided major changes in membership.

It is desirable to have first year members serve with second and third year members to discuss a variety of complex issues in the areas of health, education, human services, social security, housing, transportation, employment, civil rights and justice.

It has been the experience of current members that two-year terms have been too brief. To assure sufficient experience and continuing effectiveness among members of the Committee, reappointments have often been recommended.

The full membership of the current Committee has carefully considered the question of a change in length of term of service for members appointed to the Committee. They discussed and voted as a body and unanimously agreed that the term of service should be for three years. They recommended that the President give consideration to an amendment of Executive Order 12994.

The members of the PCMR are very grateful to you for your issuing Executive Order 12994 updating the continuation of the Committee and would like the amendment to occur during your Administration.

The members requested that I, as the Secretary of Health and Human Services and an ex officio member, forward a letter to you requesting that you consider and approve the change in length of service for future members by amending the Executive Order.

I recommend that you give consideration to making the amendment to Executive Order 12994. Attached are copies of the current Executive Order (Tab A) and the proposed amendment to the specified section and paragraph of Executive Order 12994 (Tab B).

Thank you for your consideration of this matter.

Donna E. Shalala

2 Attachments:
Tab A - Executive Order 12994
Tab B - Proposed Amendment to the Executive Order

Presidential Documents

Executive Order 12994 of March 21, 1996

Continuing the President's Committee on Mental Retardation and Broadening Its Membership and Responsibilities

The President's Committee on Mental Retardation, established by Executive Order No. 11280 on May 11, 1966, as superseded by Executive Order No. 11776 on March 28, 1974, has organized national planning, stimulated development of plans, policies and programs, and advanced the concept of community participation in the field of mental retardation.

National goals have been established to:

(1) promote full participation of people with mental retardation in their communities;

(2) provide all necessary supports to people with mental retardation and their families for such participation;

(3) reduce the occurrence and severity of mental retardation by one-half by the year 2010;

(4) assure the full citizenship rights of all people with mental retardation, including those rights secured by such landmark statutes as the Americans with Disabilities Act of 1990, Public Law 101-336 (42 U.S.C. 12101 *et seq.*);

(5) recognize the right of all people with mental retardation to self-determination and autonomy, to be treated in a nondiscriminatory manner, and to exercise meaningful choice, with whatever supports are necessary to effectuate these rights;

(6) recognize the right of all people with mental retardation to enjoy a quality of life that promotes independence, self-determination, and participation as productive members of society; and

(7) promote the widest possible dissemination of information on models, programs, and services in the field of mental retardation.

The achievement of these goals will require the most effective possible use of public and private resources.

NOW, THEREFORE, by the authority vested in me as President by the Constitution and the laws of the United States of America, including the Federal Advisory Committee Act, as amended (5 U.S.C. App. 2), it is hereby ordered as follows:

Section 1. *Committee Continued and Responsibilities Expanded.* The President's Committee on Mental Retardation (the "Committee"), with expanded membership and expanded responsibilities, is hereby continued in operation.

Sec. 2. *Composition of Committee.* (a) The Committee shall be composed of the following members:

(1) The Secretary of Health and Human Services;

(2) The Secretary of Education;

(3) The Attorney General;

(4) The Secretary of Labor;

(5) The Secretary of Housing and Urban Development;

(6) The Chief Executive Officer of the Corporation for National and Community Service (formerly ACTION);

(7) The Commissioner of Social Security;

(8) The Chair of the Equal Employment Opportunity Commission;

(9) The Chairperson of the National Council on Disability;

(10) No more than 21 other members who shall be appointed to the Committee by the President. These citizen members shall consist of individuals who represent a broad spectrum of perspectives, experience, and expertise on mental retardation, and shall include self-advocates with mental retardation and members of families with a child or adult with mental retardation, and persons employed in either the public or the private sector. Except as the President may from time to time otherwise direct, appointees under this paragraph shall have two-year terms, except that an appointment made to fill a vacancy occurring before the expiration of a term shall be made for the balance of the unexpired term.

(b) The President shall designate the Chair of the Committee from the 21 citizen members. The Chair shall advise and counsel the Committee and represent the Committee on appropriate occasions.

Sec. 3. *Functions of the Committee.* (a) The Committee shall provide such advice and assistance in the area of mental retardation as the President or Secretary of Health and Human Services may request, and particularly shall advise with respect to the following areas:

(1) evaluating and monitoring the national efforts to establish appropriate policies and supports for people with mental retardation;

(2) providing suggestions for improvement in the delivery of mental retardation services, including preventive services, the promulgation of effective and humane policies, and the provision of necessary supports;

(3) identifying the extent to which various Federal and State programs achieve the national goals in mental retardation described in the preamble to this order and have a positive impact on the lives of people with mental retardation;

(4) facilitating liaison among Federal, State, and local governments, foundations, nonprofit organizations, other private organizations, and citizens concerning mental retardation;

(5) developing and disseminating such information as will tend to reduce the incidence and severity of mental retardation; and

(6) promoting the concept of community participation and development of community supports for citizens with mental retardation.

(b) The Committee shall make an annual report, through the Secretary of Health and Human Services, to the President concerning mental retardation. Such additional reports may be made as the President may require or as the Committee may deem appropriate.

Sec. 4. *Cooperation by Other Agencies.* To assist the Committee in providing advice to the President, Federal departments and agencies requested to do so by the Committee shall designate liaison officers to the Committee. Such officers shall, on request by the Committee, and to the extent permitted by law, provide the Committee with information on department and agency programs that do contribute to or could contribute to achievement of the President's goals in the field of mental retardation.

Sec. 5. *Administration.* (a) The Department of Health and Human Services shall, to the extent permitted by law, provide the Committee with necessary staff, administrative services, and facilities and funding.

(b) Each member of the Committee, except any member who receives other compensation from the United States Government, may receive compensation for each day he or she is engaged in the work of the Committee, as authorized by law (5 U.S.C. 3109), and may also receive travel expenses, including per diem in lieu of subsistence, as authorized by law (5 U.S.C. 5701-5707), for persons employed intermittently in the Government service.

Committee members with disabilities may be compensated for attendant expenses, consistent with Government procedures and practices.

(c) The Secretary of Health and Human Services shall perform such other functions with respect to the Committee as may be required by the provisions of the Federal Advisory Committee Act, as amended (5 U.S.C. App. 2), except that of reporting to the Congress.

Sec. 6. *Construction.* Nothing in this order shall be construed as subjecting any Federal agency, or any function vested by law in, or assigned pursuant to law to, any Federal agency, to the authority of the Committee or as abrogating or restricting any such function in any manner.

Sec. 7. *Superseded Authority.* Executive Order No. 11776 is hereby superseded.

William J. Clinton

THE WHITE HOUSE,
March 21, 1996.

[FR Doc. 96-7401
Filed 3-25-96; 8:45 am]
Billing code 3195-01-P

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

PROPOSED AMENDMENT TO EXECUTIVE ORDER 12994, SECTION 2(a), PARAGRAPH (10)

Proposed amendment to Section 2 (a), paragraph (10), with the word, "two," deleted, and the word, "three," substituted in its place. The proposed amendment is identified in the last sentence of paragraph 10.

(10) No more than 21 other members who shall be appointed to the Committee by the President. These citizen members shall consist of individuals who represent a broad spectrum of perspectives, experience, and expertise on mental retardation, and shall include self-advocates with mental retardation, and members of families with a child or adult with mental retardation, and persons employed in either the public or private sectors. Except as the President may from time to time otherwise direct, appointees under this paragraph shall have *three*-year terms, except that an appointment made to fill a vacancy occurring before the expiration of a term shall be made for the balance of the unexpired term.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Chief of Staff

Washington, D.C. 20201

Exec Sec

August 7, 2000

MEMORANDUM TO THURGOOD MARSHALL, JR. Goody

I am forwarding herewith a request from Secretary Shalala to amend Executive Order #12994. The Executive Order updates and continues the President's Committee on Mental Retardation (PCMR). Please feel free to call me at (202) 690-7431, if I can be of any assistance.

Mary Beth Donahue

Attachment

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

MAY 2 2000

MEMORANDUM FOR THE PRESIDENT

I encourage you to sign the attached proclamation regarding World Asthma Day on May 3.

The increasing incidence of asthma in recent years is striking, as is the need to bring about up-to-date care for all those who suffer the disease. While there are many unknowns surrounding asthma, we in fact already have the knowledge in hand to reduce its severity and help prevent attacks, hospitalizations and deaths.

A proclamation by you in support of World Asthma Day would be important in recognizing and promoting the opportunities that exist for ameliorating the burden of this disease, especially for low income and minority populations.

Donna E. Shalala

Attachment

THE WHITE HOUSE

Office of the Press Secretary

For Immediate Release May 3, 2000

WORLD ASTHMA DAY 2000

BY THE PRESIDENT OF THE UNITED STATES OF AMERICA

A PROCLAMATION

Asthma is a worldwide problem, affecting between 100 and 150 million people around the globe and killing more than 180,000 annually. In the last 15 years, its prevalence has doubled worldwide.

In the U.S., asthma ranks among the most common chronic conditions, affecting more than 15 million Americans, including nearly 5 million children. It takes a particularly high toll in low-income and minority individuals, who account for significantly higher rates of emergency department visits, hospitalizations, and deaths.

This is unacceptable. We have made substantial progress in developing effective treatments for asthma and now know that when people with asthma are taught to manage it effectively, they can lead full, active lives. By increasingly working with groups at the community level, we are trying to ensure that this information reaches the health care professionals and patients who need it most.

May 3, 2000 is the second annual World Asthma Day. More than 80 countries around the world are participating this year. This is an important occasion because it brings together health care groups and asthma educators from around the world to raise awareness about the burden of asthma and to work together to improve asthma care.

NOW, THEREFORE, I, WILLIAM J. CLINTON, President of the United States of America, by virtue of the authority vested in me by the Constitution and laws of the United States, do hereby proclaim May 3, 2000 as World Asthma Day in the U.S. I encourage all citizens to recognize the importance of this opportunity to forge partnerships to raise awareness about asthma and its impact on communities and to use the power of our knowledge to defeat this disease.

IN WITNESS WHEREOF, I have hereunto set my hand this third day of May, in the year of our Lord two thousand.