

HONORING AIR FORCE SECRETARY
SHEILA E. WIDNALL

HON. JANE HARMAN

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Thursday, October 23, 1997

Ms. HARMAN. Mr. Speaker, at the end of the month, a distinguished leader of the Air Force will leave office and begin a new chapter in her life.

Sheila E. Widnall, the first woman to serve as a Service Secretary, will leave her position and I want to join her other friends and colleagues in commending her for a job well done.

During her tenure, Dr. Widnall led the Air Force through a critical period of post-cold-war consolidation and modernization. She directed a time-phased modernization program to shape the future of the Air Force and further integrate space systems into military operations.

Dr. Widnall championed the Department's revolution in business practices with unprecedented acquisition reform initiatives and outsourcing and privatization ventures which have assured that scarce taxpayer dollars are wisely spent. And, she helped lead the Nation's stewardship of space by partnering the Air Force with the National Reconnaissance Office, NASA, and the commercial space sector.

Most notably, Dr. Widnall took care of the individuals who serve in the Air Force. She focused on core values of respect and dignity, assured opportunity for men and women, and pursued tirelessly quality of life issues during a period of personnel reductions and increasing operations temp. She made tough, but courageous decisions during her 4-year tenure, particularly a recent one involving Air Force Lt. Kelly Flynn.

A sailor, jogger, and friend, I regret that I was not able to join Sheila on a trip we often discussed—a transcontinental flight aboard a C-17 cargo plane—an Air Force procurement we both worked to reform and save.

I join my colleagues on behalf of a grateful nation in thanking Dr. Widnall and her husband, Bill. Dr. Widnall set a high standard of leadership and vision, and has prepared the U.S. Air Force for the challenges of the 21st century.

INTRODUCTION OF LEGISLATION
TO SAVE MEDICARE MONEY AND
LIVES

HON. FORTNEY PETE STARK

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Thursday, October 23, 1997

Mr. STARK. Mr. Speaker, on behalf of Representative BECERRA and myself, I am today introducing legislation which will save Medicare money—and save the lives of many of its beneficiaries.

The bill we are introducing passed the House in the Budget reconciliation bill (H.R. 2015) and was known as the Centers of Excellence proposal. CBO scored the provision as saving \$300 million over the 5 years and \$800 million over 10 years.

To quote from the Department of Health and Human Service's justification:

The Center of Excellence proposal originated as a result of a demonstration conducted in the early 90's under which certain facilities, referred to as "Centers of Excellence," were paid a single fee to provide all of the facility, diagnostic and physician services associated with coronary artery bypass graft [CABG] surgery. The facilities were selected on the basis of their outstanding experience, outcomes, and efficiency in performing these procedures. Medicare achieved an average of 12 percent savings for CABG procedures performed through the demonstration.

The House provision would have made the Centers of Excellence program a permanent part of Medicare by authorizing the Secretary to pay selected facilities a single rate for all services, potentially including post-acute services, associated with a surgical procedure or hospital admission related to a medical condition. As with the CABG demonstration, selected facilities would have to meet special quality standards and would be required to implement a quality improvement plan.

The amendment was dropped in conference because of resistance from the Senate. Some Senators from States where no hospitals were designated felt that the program tended to cast into doubt the quality or excellence of non-designated hospitals. Mr. Speaker, the name of this program is not important—what is important is that it can save money and by encouraging beneficiaries to use hospitals that have high volume, quality outcomes, it can save lives. Therefore, I am dropping the term "centers of excellence" and just using the phrase "contracting entities."

Like Lake Wobegon, where all the children are above average, it is human nature for all Members of Congress to want their local hospitals to be above average. But not all hospitals are above average—and this is a serious matter. In fact, it is a matter of life and death. Hospitals which do large volumes of a certain type of procedure tend to have better outcomes and quality. Indeed, really good health policy in this Nation would prohibit hospitals from doing sophisticated procedures if they do not do a certain volume per month. This principle is applied to liver transplants, for example, and ought to be applied to some other procedures as well. We may all have pride in our local hospitals, but the fact is: some of them are killing people because they do not do enough of certain types of procedures and therefore are not skilled in those procedures.

Medicare should be able to contract with certain hospitals for quality and volume—both to save money and to deliver better health care.

We are about to begin a commission to make recommendations for the long-term survival of Medicare. Many on that commission will want to cut back benefits and ask beneficiaries to pay more—but before they do, they should explore every possible cost saving in the system. This bill is a two-fer: it saves money while improving quality.

I regret this provision was not included in this summer's budget bill. I hope it will be included in the next Medicare bill that moves through Congress.

As further explanation of why this legislation makes great sense, I am including below "Extracts from the November, 1995 Research Report" on the Centers of Excellence Demonstration.

CENTERS OF EXCELLENCE DEMONSTRATION—
EXTRACTS FROM NOVEMBER 1995 RESEARCH
REPORT

Rational for the Demonstration: Physicians operate under different payment incentives than hospitals, so hospital managers have difficulties implementing more efficient practice patterns. A global fee that includes physician services aligns incentive and encourages physicians to use institutional resources in a more cost effective.

Design of the Demonstration: Under the demonstration, Medicare paid each of the hospitals a single global rate for each discharge in DRGs 106 and 107 bypass with and without catheterization. This rate included in all inpatient and physician services. The standard Medicare hospital passthroughs were also included, i.e., capital and direct medical education, on a prorated basis. Any related readmissions were also included in the rate. Pre- and post-discharge physician services were excluded except for the standard inclusions in the surgeon's global fee. All four hospitals agreed to forego any outlier payments for particularly expensive cases. The hospitals and physicians were free to divide up the payment any way they chose.

Medicare Savings under the Demonstration: From the start of the demonstration in May 1991 through December 1993, the Medicare program saved \$15.3 million on bypass patients treated in the four original demonstration hospital. The average discounted amount to roughly 14 percent on the \$111 million in expended spending on bypass patients, including a 90-day post-discharge period.

90 percent of the savings came from HCFA-negotiated discounts on the Part A and B inpatient expected payments.

8 percent came from lower-than-expected spending on post-discharge care

Beneficiary Savings under the Demonstration: Beneficiaries (and their insurers) saved another \$2.3 million in Part B coinsurance payments.

Total Savings under the Demonstration: Total Medicare savings estimated to have been \$17.6 million in the 2.5 year period.

Also included is an article from the October 23 Washington Post entitled "Turning to a Specialist [Hospital] to Curb Rising Health Care Cost." It is an excellent explanation of how contracting with quality hospitals for a high volume of services can help both the Medicare trust fund and the patient.

TURNING TO A SPECIALIST TO CURB RISING
HEALTH CARE COSTS

(By Steven Pearlstein)

Legal Sea Foods. The Cap. Federal Express. Nucor Steel.

One of the things common to all of these successful companies is focus. Rather than try to be all things to all people, they do one thing and do it very well. And by virtue of their high volume and specialization, they have raised quality and lowered prices for their consumers and made a nice profit beside.

But will the same formula work in health care? In small way, it already has.

At the Shouldice Hospital in Toronto, which performs only hernia operations, the average price of \$2,300 was more than a third less than the cost of the same operation at the typical general hospital in the United States. And yet despite the lower cost, only one-half of 1 percent of Shouldice patients need to have the procedure repeated, compared with 10 percent of patients at general hospitals.

And at surgeon Denton Cooley's famed Texas Heart Institute in Houston, a coronary bypass operation cost \$26,000, compared with

a national average of \$30,000. More than 90 percent of Cooley's patients lived five years beyond their surgery; patients elsewhere didn't do nearly as well.

According to Regina Herzlinger, a professor at the Harvard Business School who collected the statistics, these early moves toward specialization are almost sure to be replicated as market forces continue to reshape the health care industry.

Herzlinger notes that a dozen or so medical conditions now account for as much as two-thirds of the nation's health care bill—things such as heart disease, depression, asthma, diabetes, arthritis, cancer and pregnancy. That means that if ways can be found to shave even 15 percent off the cost of treating those conditions, the nation's health care tab could be reduced by \$100 billion each year.

Specialization, of course, is nothing new to medicine. There have long been mental hospitals and children's hospitals, rehab centers and eye and ear infirmaries. But for the most part, these centers have specialized in the hardest-to-treat cases, coupling care with medical research and training in ways that have tended to raise costs rather than lower them.

The new genre of speciality facilities—"focused factories," Herzlinger calls them—tend to be much more entrepreneurial, hoping to leverage their lower prices and higher quality to win contracts from big insurers and health and maintenance organizations.

In a sense, these facilities represent the second phase of the effort to rationalize the nation's health care system. In the first phase, competition forced doctors and nurses and hospital administrations to accept higher workloads and less pay while patients were forced to accept less choice and convenience. Now, that process has pretty much reached its limit.

In the next phase, experts say, the way in which doctors and hospitals go about delivering care will be reengineered, disease by disease. Hospitals and doctors that come up with standard treatments that generate the best medical outcomes at the lowest prices will become the preferred providers of the big health care plans. And look for these specialists to roll out their successful model nationwide, driving local suppliers out of the business in much the same way that Subway has trounced the local sandwich shop and Home Depot the local hardware store.

The high-volume specialists will gain some advantage from the fact that they can buy sutures more cheaply or because they can better afford the cost of sophisticated medical equipment. But more important, according to Herzlinger, is that by doing the same thing over and over again, they gain expertise and efficiency.

At Shouldice Hospital, for example, each surgeon performs an average of 600 to 700 hernia operations each year. That means Shouldice surgeons do more hernia operations in two years than most of their counterparts do in a lifetime.

So promising are these results that big HMOs, such as Oxford Health Plans in the New York area, are working with specialists and hospitals to put together their own focused factories in key markets.

General hospitals look at all this with some apprehension. Right now, the "profits" they earn from high-volume procedures such as heart bypasses and baby deliveries are used to make up for "losses" they suffer or running emergency rooms and neonatal units. But if the profitable business is taken away by the lower-cost specialists, hospital administrators warn that they will have no choice but to raise the price of the services they are left with.

James Bentley, vice president of the American Hospital Association, warns that what

appears at first blush to be cost *saving* may, in the end, turn out to be nothing more than cost *shifting*.

But a Georgetown University Medical Center, Kenneth D. Bloem, the new chief executive, believes that the trend toward specialization is inevitable—and that general hospitals like his will have to begin preparing for it.

That might require Georgetown to develop one or two focused factories of its own, he said, while closing down some of its departments that cannot achieve minimum economies of scale. Or it might involve a new arrangement under which management of Georgetown's departments—the coronary surgery unit, say—is turned over to one of the specialty companies.

Right now, says Bloem, officials at a hospital such as Georgetown still think of it as more like a medical department store. In the future, he says, it may have to operate more like a mall made up of a number of market-tested specialty boutiques.

In a small way, that process already has begun. The coffee cart in the lobby of the hospital is run by Starbucks.

FIVE ALARMS FOR FIRE MARSHALL GARY T. CONNELLY

HON. JAMES A. BARCIA

OF MICHIGAN

IN THE HOUSE OF REPRESENTATIVES

Thursday, October 23, 1997

Mr. BARCIA. Mr. Speaker, whether it is putting out a multiple alarm fire in a major life-threatening situation, providing emergency first aid in the event of an accident, or the more image-laden activities of rescuing the family cat from a tree or taking the shiny engine to an elementary school for fire safety day, each and every one of us has had a very positive encounter with our local fire departments. The people of my home town of Bay City have been the fortunate benefactors of the 30-year career of our recently retired fire marshal, Gary T. Connelly.

From June 1, 1967, when he started at the Central Fire Station and worked for several years with the first emergency rescue squad within the Bay City Fire Department, to his last 5 years as fire marshal, Gary Connelly has let it be known that he cares about the people he serves, the citizens of Bay City, and the many outstanding men and women of the department who report to him.

His outstanding career as a firefighter, a State-certified emergency medical technician, relief driver, and fire awareness officer, is the result of his ongoing professional training throughout his years. With training at Delta College for programs offered with the accreditation of the National Fire Academy, and other programs offered by the Michigan State Police, Macomb College, Eastern Michigan University, Central Michigan University, and the National Fire Academy itself, Fire Marshal Connelly is living testimony to the fact that one never stops learning, and that there are always opportunities to make even outstanding service even better.

The key element to his successful career, however, is the outstanding support that Gary has received from his family. His brother Kenneth also served as a member of the Bay City Fire Department for 32 years. Until his retirement as assistant chief in 1987. And without doubt, Gary's wife, Rosalyn, and his children

Gary Jr. and Sherry, have been most supportive of his career. The dangers of being a firefighter are known to many of us, but are a very real daily fear for the families of these brave men and women. The people of Bay City probably own as much of a debt to Fire Marshal Connelly's family as they do to him.

Mr. Speaker, I know how important leadership is within a demanding organization like a fire department. Gary Connelly has provided service beyond what right any of us may have had to expect. I urge you and all of our colleagues to join me in wishing him a most pleasant and well-earned retirement, and the best for all that his future holds for him.

TRIBUTE TO UNION TOWNSHIP VOLUNTEERS

HON. MICHAEL PAPPAS

OF NEW JERSEY

IN THE HOUSE OF REPRESENTATIVES

Thursday, October 23, 1997

Mr. PAPPAS. Mr. Speaker, on Saturday, September 20, 1997, over 60 parents, teachers and other volunteers gathered together to help build a playground at the Union Township School in my district.

The cost of the equipment was raised by carnivals, book fairs and other projects. Area contractors, builders and merchants all joined forces to donate their skills, supplies, food and support. The parent-teacher association raised money for the project for 3 years.

When all was ready, the volunteers went to work, constructing the new playground which was ready in time for the start of the school year for the children to enjoy.

Mr. Speaker, this demonstration of community service and volunteerism is characteristic of our Nation's growing effort to help one another. It is heart-warming to hear of efforts like this that bring parents and area residents together for the common good of their children. I want to congratulate the residents of Union Township for coming together for such a worthwhile cause. They are truly an inspiration to us all.

THE ENHANCEMENT OF TRADE, SECURITY, AND HUMAN RIGHTS THROUGH SANCTIONS REFORM ACT

HON. PHILIP M. CRANE

OF ILLINOIS

IN THE HOUSE OF REPRESENTATIVES

Thursday, October 23, 1997

Mr. CRANE. Mr. Speaker, I have long been concerned about the growing resort to unilateral trade sanctions to enforce foreign policy or other nontrade goals. I have always believed that before we impose sanctions, we should think long and hard about the effect of such sanctions on the U.S. economy and our businesses, workers, and consumers. There is little evidence that these sanctions have changed the behavior of the targeted government. Instead, the use of sanctions has translated into billions of dollars of lost opportunities here. In my view, the better policy is to pursue our goals with our trading partners through multilateral fora in an attempt to achieve consensus.