

EXTENSIONS OF REMARKS

IN HONOR OF ASTRONAUT JOE
FRANK EDWARDS, JR.

HON. BOB RILEY

OF ALABAMA

IN THE HOUSE OF REPRESENTATIVES

Tuesday, January 27, 1998

Mr. RILEY. Mr. Speaker, I rise today to congratulate the extraordinary accomplishments of one of Alabama's finest, Astronaut Joe Frank Edwards, Jr., of Lineville, Alabama, who is piloting the space shuttle *Endeavor*, which took off on January 22, 1998.

Graduating from Clay County's Lineville High School in 1976, Joe went on to receive a B.S. degree in Aerospace Engineering from the U.S. Naval Academy in 1980 and an M.S. in Aviation Systems from the University of Tennessee in 1994. As a Naval Aviator, Joe has been honored with many medals, including the Distinguished Flying Cross, Air Medal, Defense Meritorious Service Medal, Navy Commendation Medal, Navy Achievement Medal. Joe has also received the Daedalian Superior Airmanship Award in 1992, the Fighter Squadron 143 Fighter Pilot of the Year in 1984 and 1985, the Fighter Squadron 142 Fighter Pilot of the Year in 1990, 1991, and 1992, and the Carrier Airwing Seven Pilot of the Year in 1985, 1990, and 1991.

In December 1994, Joe was selected as an astronaut candidate by NASA. After completing a year of training and evaluation, he has qualified for assignment as a shuttle pilot.

During the STS-89 mission, Joe will be responsible for undocking from the eighth shuttle rendezvous with Russia's Mir Space Station and piloting the flight around the space station. The nine day shuttle mission objectives include replacing astronaut Dr. David Wolf with Andy Thomas who will be the next U.S. crew member on the Mir Space Station. More than 7,000 pounds of experiments, supplies, and hardware are scheduled to be transferred between the two spacecraft.

Clay County, as well as all of Alabama, is very proud of Joe's exceptional hard work and commitment to space flight. I congratulate Joe on this extraordinary honor and am proud to have him represent us on this important mission.

FULFILLING THE PROMISE OF
MANAGED CARE

HON. FORTNEY PETE STARK

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Tuesday, January 27, 1998

Mr. STARK. Mr. Speaker, my bill H.R. 337 establishes consumer protections in managed care plans—just like many other bills currently pending before the Congress.

One unique feature in H.R. 337, however, is the requirement that when a managed care plan enrolls a person, they must soon do a health profile or work-up on that person. Medi-

care and private insurance plans pay an HMO hundreds of dollars a month to "maintenance" an enrollee's health. But how can the HMO provide maintenance or preventative care (such as immunizations, mammograms, etc.), unless it sees the enrollee and establishes a health benchmark on the person?

My legislation is designed to ensure that HMOs really do maintain people's health. By scheduling an appointment and the collection of basic health data, the HMO can truly begin to provide managed care health. It can determine whether the person is a smoker, overweight has high cholesterol, is diabetic, is facing glaucoma, etc. Once these benchmarks have been established, the HMO can begin the counseling or the other services needed to "maintain" or improve health—thus fulfilling the promise of managed care.

The November 5, 1997 issue of the *Journal of American Medical Association (JAMA)* contains an article, "The Relationship Between Patient Income and Physical Health Behaviors," which states, "Although unhealthy behaviors were common among all income groups, physician discussion of health risk behaviors fell far short of the universal risk assessment and discussion recommended by the US Preventive Services Task Force. We conclude that the prevalence of physician discussion of health risk behaviors needs to be improved."

If physicians would do more to counsel their patients especially the lower income, these individuals could receive adequate and informative health care advice. As the *JAMA* article said, "Physicians also need to be more vigilant in properly identifying and counseling low-income patients at risk. Increasing the prevalence of physician discussion of health risk behaviors could greatly affect productivity, quality of life, mortality, and health costs in the United States. If the nation is truly interested in health improvement, a multifaceted approach is required to diminish the social gradients in health related to education, income, housing and opportunity, including a more effective national system for preventive services (Papainicolaou tests, breast examinations, immunizations) as well as improved discussion of health risk behaviors."

For instance in the case of smoking the *JAMA* article states: "Our data indicate that 49% of all patients with whom behavioral discussions occur attempt to cut down or quit smoking based on their physicians' advice and 49% of those who report attempting to change behavior no longer smoke. . . increasing the prevalence of physician discussion of smoking by 50% would result in a 6% decrease in the prevalence of smoking. Based on mortality and cost estimates of smoking, this reduction in smoking could potentially result in 24,000 annual deaths delayed and a \$3 billion annual cost savings to our society."

The December 3, 1997 issue of *JAMA*, contains an article, "Cost-effectiveness of the Clinical Practice Recommendations in the AHCPR Guideline for Smoking Cessation," which states that "Tobacco use has been

cited as the chief avoidable cause of death in the United States, responsible for more than 420,000 deaths annually. Despite this, physicians and other practitioners fail to assess and counsel smokers consistently and effectively." Again, an HMO would be the ideal setting to help a person stop smoking, but they can't do it if they don't see the patient—and that's why we need H.R. 337.

As we start to pay HMOs thousands of dollars a year for maintaining health, let's make sure that they at least see the individual and do something to earn these payments. If the premise of managed care is correct, then H.R. 337's early profiling and subsequent counseling will save the HMOs money in the long run by avoiding future expensive acute care services.

IN RECOGNITION OF THE ORANGE
COUNTY SCHOOL OF THE CULINARY
ARTS

HON. LORETTA SANCHEZ

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Tuesday, January 27, 1998

Ms. SANCHEZ. Mr. Speaker, I would like to take this opportunity to recognize a remarkable culinary school that was recently established in Orange County, CA, the Orange County School of Culinary Arts.

The school is sponsored by the Regional Occupation Program (ROP) of North Orange County. ROP is responsible for rehabilitating and re-training underprivileged and unemployed citizens and high school students to compete and succeed in a competitive work environment.

The Orange County School of Culinary Arts offers a wide variety of culinary classes that is as good, if not better, than that of the larger culinary institutes in America. While the cost of tuition at one of the big three Culinary Arts schools often exceeds \$27,000 per year, a course at the Orange County School of the Culinary Arts costs \$40 per class, a \$65 uniform fee and the cost of the food that is prepared and consumed.

There is currently a shortage of professionally trained chefs in the United States by 2 million. By the turn of the century, this number is expected to increase dramatically with the expansion of the cruise industry and the resort business throughout the United States. In Orange County alone, there are 8 positions available for every qualified applicant, and existing programs have not been filling the void.

The community has already flocked to the program. Almost 500 students have already enrolled when the student body was only projected to be 120 students. The courses range from beginner and advanced levels of preparation for a variety of foods, to restaurant management, nutrition, and sanitation. All courses are instructed by chefs with an extensive training in internationally-renown culinary academies and working backgrounds from the finest resorts and cruise ships around the world.

• This "bullet" symbol identifies statements or insertions which are not spoken by a Member of the Senate on the floor.

Matter set in this typeface indicates words inserted or appended, rather than spoken, by a Member of the House on the floor.

I would like to recognize the Orange County School of Culinary Arts as a benchmark for other programs to follow. This program will not only alleviate the shortage of professionally-trained chefs, it will open a world of opportunities to neighboring citizens. From now on, a student can now pay for a professional training equal to those of the finest academies for a fraction of the cost. The Orange County School of Culinary Arts stands before us as a shining example of success for other communities to follow in the coming years.

A CENTURY OF EXCELLENCE—THE
YORK COUNTY CHAMBER OF
COMMERCE TURNS 100

HON. WILLIAM F. GOODLING

OF PENNSYLVANIA

IN THE HOUSE OF REPRESENTATIVES

Tuesday, January 27, 1998

Mr. GOODLING. Mr. Speaker, January 13, 1997 marked the 100th anniversary of one of south central Pennsylvania's most important and prolific organizations. Originally established in 1898 as the York Merchant's Association, the York County Chamber of Commerce has continued to faithfully carry out its mission to expand economic opportunities for commercial, mercantile, and industrial companies while enhancing accessibility to area products.

York County has benefitted immeasurably from the existence and activity of the Chamber. Ranging from the \$1.5 million raised by the Chamber in 1925 to connect the neighboring communities in Lancaster County via the Wrightsville Bridge, to the development of a communications link between Chamber members and worldwide customers via the Internet, the Chamber has always been working to bring people together in the best interest of our community. They have succeeded over and over again in making York a better place to live.

But York is not the only beneficiary of the Chamber's efforts. During its early years, the York County Chamber of Commerce helped lead the national effort to recognize and promote business interests by becoming the eighth charter member of the nearly formed Chamber of Commerce of the United States in 1908. This grassroots leadership has not only helped to propel the U.S. Chamber of Commerce to the prominent place it holds today as one of the top voices for the business industry, but also to place the York Chamber among the top 10 percent of chambers nationwide.

Despite a few changes in name and location, the York County Chamber of Commerce has remained the guiding force for local businesses for 100 years. That is why we should take the time to recognize this important milestone in the history of York County and its business community. Without their efforts, York County would not have achieved the level of prosperity we enjoy today. I am pleased to associate myself with this important organization and join them as they celebrate their centennial.

IMPROVING MEDICARE QUALITY—
SAVING MEDICARE LIVES: SUP-
PORT FOR H.R. 2726

HON. FORTNEY PETE STARK

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Tuesday, January 27, 1998

Mr. STARK. Mr. Speaker, the AARP Public Policy Institute issued a paper in December of 1996 by Dr. David Nash, entitled "Reforming Medicare: Strategies for Higher Quality, Lower Cost Care." It is an excellent paper on a number of ways to improve and extend the life of Medicare.

One proposal in Dr. Nash's paper is the "centers of excellence" concept, in which Medicare can contract with certain hospitals to provide a high volume of complicated procedures in exchange for a lower global payment. The results of Medicare's "demonstrations" of this concept shows that Medicare can save money while increasing quality for beneficiaries.

Following is Dr. Nash's discussions of the Heart Bypass Center Demonstration. The Administration had proposed legislation in the FY 97 Budget Reconciliation bill to implement this type of proposal nationwide. The House passed the proposal, but it was dropped in Conference. I hope that Congress will revisit this issue in 1998 and enact this concept.

It is not just a matter of dollar—it is a matter of lives.

Medicare, like most private insurance, has historically paid hospitals and doctors separately. Since 1983 with the introduction of the Prospective Payment System (PPS), Medicare has paid hospitals a fixed price for most care based on the patient's diagnosis. Doctors, whose medical decisions still affect nearly 80 percent of hospital costs, continue to be reimburse on a fee-for-service basis that rewards them for doing more, not less.

The Medicare participating Heart Bypass Center Demonstration project is an experimental project implemented by Medicare in early 1992. Two primary events drove the planning for this important demonstration project: namely, the results of numerous studies showing a strong correlation between relatively higher volume, lower cost, and better outcomes in open heart surgery services, and unsolicited proposals from individual hospitals willing to provide coronary artery bypass graft (CABG) services for a fixed price.

This demonstration project was implemented to answer four basic questions: 1) Is it possible to establish a managed care system with Medicare Part A and Part B payments combined, including all pass throughs for capital, medical education, etc., and pay a single fee to the hospital for treating patients? 2) Would it be possible to decrease the Medicare program's expenditures on CABG surgery while maintaining or improving quality? 3) What is the true relationship between volume and quality in CABG surgery, and can hospital procedure volume be increased without decreasing the level of appropriateness? and 4) What is involved at a hospital operational level—can such a program be sustained over a period of time without draining financial resources and dragging the organization down?

Preliminary results evaluating the Medicare participating Heart Bypass Center Demonstration project, I believe, strongly sup-

port its immediate national expansion to appropriately realign the incentives between hospitals and their physicians. By creating a strong financial incentive to be more cost effective in their use of resources, hospitals and doctors will be able to implement the tools of continuous quality improvement, practice guidelines, critical pathways, and the nonpunitive feedback of information about performance. In a word, they will utilize many of the tools mentioned throughout the body of this report to improve quality and lower costs.

For example, the seven experimental heart surgery site institutions have reported numerous operational changes resulting in lower costs and improved quality as a result of the HCFA demonstration project. Quick transfers out of intensive care, shorter patient stays after surgery, fewer laboratory and radiology tests, and the use of care management and critical pathways, are some of the cost cutting measures being employed at each of the participating institutions. Expensive consultations with other physicians were also targets for cost saving. Participating institutions report a nearly 20 percent decrease in the use of consultation with no demonstrable changes in overall case outcomes. At four demonstration sites, doctors and administrators together are challenging long-standing patterns of care and scrutinizing the use of everything from \$5 sutures to intensive care unit beds at \$800 per day. At St. Joseph's Hospital, in Atlanta, Georgia, neurologists were charging between \$364 and \$1,676 for a neurologic consultation before the program began; now the hospital pays them a flat rate of \$371. In the post-operative period, physicians are removing particular chest drainage tubes in certain patients within 24 hours rather than waiting the customary 48 hours, a strategy that even may foster quicker healing. Physicians describe the demonstration project as making them rethink each step along the patient care continuum. If each step is not supportable on a scientific basis, and is not in the patient's best interest, it is removed, and, as a result, costs are reduced.

Of course, many managed care organizations and some specialty practices have often charged a global fee for procedures or for a specified time period of care such as one calendar year. A growing number of managed care companies have negotiated special package price deals for expensive or high-tech procedures including organ transplantation, maternity care, and cancer care. The Medicare program should proceed quickly with preliminary plans to expand the participating Heart Bypass Center Demonstration project and begin a 'National Centers of Excellence' program on other high-cost, high-volume procedures. The literature is clear that practice makes perfect and an expansion of this program, which would realign incentives, reduce costs, and inevitably improve quality, ought to be implemented quickly.

Finally, consideration should be given to expanding the current prospective payment system to include outpatient care. Studies ought to be undertaken to link inpatient and outpatient claims for particular procedures and particular diagnoses such as congestive heart failure, pneumonia, diabetes and other high-cost, chronic illnesses. With the availability of improved outpatient case mix systems, HCFA has an opportunity to provide national leadership and use its evaluative capacity to realign incentives between doctors and hospitals.