WELCOME TO OLIVIA ALEXANDRA BECERRA

HON. XAVIER BECERRA

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Tuesday, May 9, 1995

Mr. BECERRA. Mr. Speaker, it is with great joy that I inform my colleagues that on April 25, 1995, my wife, Carolina, gave birth to Olivia Alexandra, our second daughter.

Because she was born near the end of the Easter district work period, I elected to remain in Los Angeles during the week of May 1 to be with and help care for her during her first week home. As such, I missed a number of recorded votes when the House met on May 2. I would have voted on each amendment and bill:

On motion to instruct conferees on H.R. 1158, Omnibus Rescissions and Supplemental Appropriations (rollcall 303)—Aye.

On final passage of H. Con. Res. 53, visit by President of Taiwan (rollcall 304)—Aye.

On final passage of H. Res. 135, condemnation of the Oklahoma City bombing (rollcall 305)—Aye.

Olver amendment to H.R. 655, Hydrogen Future Act (rollcall 306)—Aye.

Brown of California amendment to H.R. 655 (rollcall 307)—Aye.

THE SARAH WEBER HOME INFUSION CONSUMER PROTECTION ACT OF 1995

HON. SHERROD BROWN

OF OHIO

IN THE HOUSE OF REPRESENTATIVES

Tuesday, May 9, 1995

Mr. BROWN of Ohio. Mr. Speaker, today, I introduce the Sarah Weber Home Infusion Consumer Protection Act of 1995 in honor of Sarah Weber, a young girl from Ohio.

Unfortunately, many of the most vulnerable patients who depend on home infusion therapy are currently at the mercy of certain unscrupulous home infusion providers. This legislation will ensure that patients are served more appropriately by these providers.

Let me share with you Sarah's story. Sarah was a happy little girl from Cleveland Heights, OH, who suffered from cerebral palsy and a rare digestive disorder that would not allow her to tolerate food. Given her condition, she needed to be fed and medicated intravenously. Wanting to stay with her family at home, Sarah received this treatment with her mother as her nurse. It sounds like the perfect situation. Unfortunately for Sarah and her family, it was not.

Instead, Marie was plagued by bill collectors once her $2 million insurance policy ran out. Sometimes, the wrong medications were delivered. Thankfully, Marie was astute enough to recognize the mistake and resolve the situation before harm could be done. Sarah was dropped by one provider, without notice, left hanging by a thread between life and death, with only a day's worth of life sustaining supplies.

These are just a few of the examples of the lack of quality standards and harmful practices that exist. My bill will require home infusion companies to be licensed according to quality standards included in the law. Further, the bill would crack down on fraud in the industry by extending the current restrictions on physician referrals to companies in which they have a financial interest to home infusion companies and all payers.

I believe this bill will go far to eliminate the abuses and will restore families faith in home infusion. Many seriously ill patients depend on home infusion for their medication or nutrients. In many cases, the available technology has enabled them to remain in the comfort of their own homes while they receive treatment. Yet, what good is treatment at home if it is of questionable quality? We must ensure that the care patients receive at home is of the utmost quality and that the patient's physician is involved in the process.

A summary of the bill follows. I invite all my colleagues to join me in cosponsoring this important legislation.

SUMMARY OF SARAH WEBER HOME INFUSION CONSUMER PROTECTION ACT OF 1995

1. Licensure: Require home infusion providers to be licensed according to the standards defined in the bill.

The language of the bill requires persons providing, or arranging for the provision of services, to hold a license. In this context, persons will apply to individuals or companies, whichever applies.

Further, the bill defines home infusion broadly to encompass all types of home infusion providers.

2. Standards: The bill would require providers: to maintain clinical records; adhere to written protocols and policies; make services available 24 hours a day, seven days a week; coordinate all home infusion therapy services with the patient's physician; conduct a quality assessment and assurance program including drug regimen and review and coordination of patient care; assure that only trained (and licensed if necessary) personnel provide infusion products or services; assume responsibility for the quality of services provided by others under arrangements with the person; establish appropriate protocols and explain protocols clearly to patients prior to the initiation of treatment plan; and, meet other requirements which the Secretary may determine are necessary to assure the safe and effective provision of home infusion therapy services.

3. Authorizes Funds for Start up Grants to the States: The bill provides for the authorization of funds to provide assistance to the states in establishing a licensing system. It further states to require the payment of a fee for the processing and licensing of companies.

4. Restrictions on Referrals: The legislation will ban physicians from referring patients to home infusion providers in which they have a financial interest. This requirement would apply to all payers.

5. Enforcement: The bill would be enforced via civil monetary penalties determined by the Secretary of Health and Human Services but not to exceed $10,000. The Secretary may also file an action to enjoin persons from violating the Act.

6. Study: The bill would require the study of the feasibility and economic impact of coverage of infusion services that may otherwise be covered in a hospital setting.

DR. BARBARA BARLOW, A GUARDIAN ANGEL FOR THE CHILDREN

HON. CHARLES B. RANGEL

OF NEW YORK

IN THE HOUSE OF REPRESENTATIVES

Tuesday, May 9, 1995

Mr. RANGEL. Mr. Speaker, I would like to bring to your attention and to the attention of my colleagues here in the house, a story about a very dedicated doctor committed to helping save the lives of our children in the Harlem community and beyond.

This guardian angel of which I speak is Dr. Barbara Barlow, chief of Pediatric Surgery at Harlem Hospital Center.

Her push for prevention in helping keep our children on the playgrounds and out of emergency rooms, was depicted recently in a story in Parade Magazine, April 16, 1995.

I am proud to have such a remarkable and devoted individual caring for the children in the Harlem community.

HER PUSH FOR PREVENTION KEEPS KIDS OUT OF ER

(By Peter Hellman)

Dr. Barbara Barlow still recalls the 4-year-old boy who arrived at Harlem Hospital Center 20 years ago, soon after she had been appointed chief of pediatric surgery. ''He tumbled head-first out a fourth-floor window while his mother went to answer the phone,'' she told me. ''Multiple fractures. Brain dead. An only child. It was just so incredibly sad.''

Dr. Barlow was then treating an average of one dozen children annually who'd fallen from windows. ''I only saw kids who were still breathing,'' said Barlow. ''Others had been taken directly to the morgue.''

Convinced that ''prevention is better than sewing them up,'' Dr. Barlow decided to get involved. She knew that installing inexpensive window gates would remedy the problem and that a new law required New York City Landlords to install the guards upon request. But compliance was spotty, so Barlow put her energy into a campaign, started by the city's health department, called ''Children Can't Fly.'' Harlem students acted our dramas about window falls. They were sent home from hospital clinics with window-guard request forms. At the culmination of the campaign, ''Children Can't Fly'' balloons were tied to window gates all over Harlem.

The result? Last year, Dr. Barlow treated only one window-fall victim.

If window falls could be so decisively reduced by attacking root causes, reasoned Dr. Barlow, why not also the other kinds of trauma injuries to Harlem's children? Through the mid–1980s, they were being hurt at a rate that was double the national average. Now, thanks to the Injury Prevention Program that Dr. Barlow established in 1988, admissions of children with trauma injuries to Harlem Hospital have been reduced by 44 percent.

Dr. Barlow first focused on Harlem's dirty and dangerous playgrounds. Emergency-room data showed that they caused many injuries. To help upgrade the playgrounds, she persuaded the nonprofit Robert Wood Johnson Foundation of Princeton, N.J., to provide a $240,000 grant. (''A very untraditional use for our money in terms of health care,'' admitted Michael Beachler, a program officer for the foundation.)

Though she was outwardly confident, Dr. Barlow remembers ''lying awake all night and thinking, 'What if we can't get anyone to fix these playgrounds'?'' But it turned out Barlow could put people together as well as

bodies. With the cooperation of city agencies, schools and volunteer groups (she calls her own role ''coalition-building''), more than a dozen playgrounds were made safer. Metal swings—which too often smashed into children, sometimes fracturing skulls—were replaced by soft rubber ones. Broken climbing bars with jagged points also were replaced. Pocked asphalt, which so easily tripped dashing feet, yielded to rubberized surfaces. Graffiti-strewn walls were painted over with cheerful murals by schoolchildren. Five entirely new playgrounds with Harlem motifs were created.

Dr. Barlow didn't stop there. When a child was raped in the darkness of unkempt Jackie Robinson Park in northern Harlem, where the lights had long been out, she demanded that city officials get the lights back on. Now, Little League teams once again play on the park's renovated fields, and two of the teams are sponsored by Harlem Hospital.

While sports have their place, they can't give a child what gardening can, according to Bernadette Cozart, a gardener for the city parks department. Her ''Greening of Harlem'' project works in cooperation with the Injury Prevention Program. Under Cozart's eye, children fill vacant lots and playground plots with flowers and vegetables. Typical is the garden at P.S. 197, an elementary school. Roses, lilies, tomatoes, eggplants, even collard greens thrive there. ''I have kids who wouldn't eat anything green until they started growing it,'' said Cozart.

Like gardening, the hospital's popular dance program might seem far afield from injury prevention. But time spent dancing is time away from the mean streets of the inner city. ''Why shouldn't these children be loaded up with afterschool activities, just like suburban children are?'' asked Dr. Barlow.

No Harlem child, however, can avoid the streets: 48 percent of pediatric trauma injuries at Harlem Hospital involve motor vehicles. So ''Safety City,'' a course for third-graders on how to be a safe pedestrian, is part of the Injury Prevention Program (aided by the city's department of transportation). Another part of the program is the Urban Youth Bike Corps, which provides helmets and bicycle-repair instruction, while the KISS (Kids, Injuries and Street Smarts) project educates teens about gun violence.

So varied has the Injury Prevention Program become that it's easy to assume Dr. Barlow has little time left for old-fashioned doctoring. That would be a mistake. She still takes a turn of duty every fourth night, though, as a department chief, she doesn't have to.

Dr. Barlow's pioneering program is now going national, thanks to a new $1.1 million grant from the Robert Wood Johnson Foundation. Pittsburgh, Chicago and Kansas City, Mo., are the first cities to replicate it. At Harlem Hospital, meanwhile, the surest sign of the continuing downward trend in trauma injuries is a dark corner of the pediatric ward. ''We used to have patients hanging off the rafters when I first came here.'' said Dr. Barlow. ''Now I've closed off six beds. We don't need them anymore.''

SOCIAL SECURITY COURT OF APPEALS ACT OF 1995

HON. ANDREW JACOBS, JR.

OF INDIANA

IN THE HOUSE OF REPRESENTATIVES

Tuesday, May 9, 1995

Mr. JACOBS. Mr. Speaker, I am today introducing the Social Security Court of Appeals Act of 1995 which creates a court to adjudicate appeals from Federal district court related to Social Security. A summary prepared by the minority staff of the Subcommittee on Social Security follows:

The past decade has witnessed increasing regional variation in the standards of eligibility used by the Social Security Administration [SSA] to evaluate applications for disability benefits. A significant cause of this variation is the Federal courts' increased role in reviewing SSA decisions and interpreting agency regulations. Court intervention has been, and continues to be, vitally important in protecting the right of claimants. However, the regional nature of court jurisdiction can also serve to fragment Social Security disability standards along geographic lines and result in disparities in treatment of similarly situated claimants.

To address this problem, this legislation would establish a single, national Social Security Court of Appeals. This court would be modeled after the court of appeals for the Federal circuit, which has jurisdiction over patent and trademark law, international trade, and the Court of Claims. The new court would replace the 12 Federal circuit courts of appeal in adjudicating Social Security and Supplemental Security Income [SSI] benefit appeals from Federal district courts. The court would consist of five judges with lifetime appointments. It would render appeal decisions in panels of three judges, as is the case at present with Federal circuit courts of appeal. The new court would be located in Washington, DC, but would have authority to travel as it deemed necessary. As the single body to adjudicate Social Security and SSI appeals from Federal district courts, this court would be positioned to articulate a consistent body of case law and to eliminate regional discrepancies in SSA policy.

Claimants' rights to appeal SSA decisions to Federal district courts would be unaffected by this legislation. Moreover, decisions of the Social Security Court of Appeals would be appealable to the U.S. Supreme Court, just as Social Security decisions by the circuit courts of appeal are under current law.

DOD INCREMENTAL COSse member.TS IN SUPPORT OF U.N. PEACEKEEPING

HON. LEE H. HAMILTON

OF INDIANA

IN THE HOUSE OF REPRESENTATIVES

Tuesday, May 9, 1995

Mr. HAMILTON. Mr. Speaker, many members have expressed interest in the scope and nature of incremental costs incurred by the Department of Defense in support of peacekeeping operations conducted or authorized by the United Nations. This issue was the subject of some confusion during the debate in the House on H.R. 7, the National Security Revitalization Act.

On January 13, I wrote to Secretary of Defense William Perry requesting detailed information on these costs. On February 15, I received an interim response from Under Secretary of Defense Walter Slocombe, followed by further clarification in a letter from Under Secretary Slocombe on April 18.

The Department of Defense now estimates its voluntary incremental costs in support of nonassessed U.N. peacekeeping operations at $1.41 billion in fiscal year 1994. As Under Secretary Slocombe points out in his latest letter:

Were the United States to credit amounts of this size against our annual U.N. peacekeeping assessment, it would cancel out our entire yearly contribution, thereby seriously impairing the U.N.'s capability to conduct peacekeeping operations.

Because these are now the latest official Department of Defense estimates of these costs, I ask that this correspondence be included in the RECORD.

COMMITTEE ON INTERNATIONAL RELATIONS,
Washington, DC, January 13, 1995.

Hon. WILLIAM J. PERRY,
Secretary of Defense, Department of Defense, The Pentagon, Washington, DC.

DEAR SECRETARY PERRY: I write concerning the Committee on International Relations impending markup of H.R. 7, the foreign affairs portion of the ''Contract with America'', and information we need prior to that markup in order to defend the Administration's position.

Two provisions in H.R. 7, if enacted as currently drafted, would cripple the ability of the United States to support U.N. peacekeeping operations, and might well shut down such operations altogether. Sections 501 and 508 of that legislation, taken together, would prohibit effectively the ability of the Defense Department to support U.N. peacekeeping operations, and off-set any DOD support for U.N. authorized actions against the U.S. peacekeeping assessment to the U.N.

I believe that these provisions stem from a political perception that DOD participation in or support for U.N. peacekeeping operations and related activities has had a negative impact on U.S. military readiness. While I anticipate a lengthy debate this year in Congress on the subject of U.S. military readiness generally, my problem is that we in Congress do not have the necessary information to have an informed debate on whether and how DOD support for U.N. peackeeping operations might contribute to the readiness issue.

I therefore would urge you to provide at your earliest possible convenience the following information:

How does DOD differentiate between direct and indirect support for ''Contingency Operations'', and for direct and indirect support for U.N. peackeeping operations?

What costs has DOD incurred in Fiscal Year 1994 for contingency operations for U.N. authorized operations, such as the no-fly zone in Iraq? For ''Blue Helmet'' operations such as UNSOM II?

How much was DOD reimbursed by the U.N. in Fiscal Year 94 for support of U.N. peacekeeping operations? In each case, at what time were DOD costs incurred, on what date did DOD request each such reimbursement, and when did each such U.N. reimbursement occur?

How much of these costs in Fiscal Year 1994 have been covered by U.S. supplemental appropriations? In cases where supplemental appropriations have been provided and the U.N. has subsequently reimbursed those costs, how much has DOD returned to the U.S. Treasury?

Who within DOD compiles information on incremental costs associated with U.N. peackeeping operations? Is it done by each service, then collated by the Office of the Secretary of Defense? Or some other way?

I look forward to your prompt response.