Certain SBA offices have been denying loan applications based upon the possibility that qualified individuals may divorce resulting in joint ownership of the small business.

Section 603. HUBZone Eligibility. This section includes a provision extending eligibility for HUBZone Small Business Concerns for an additional year if they are located in areas that recently were removed from HUBZone status.

Section 604. Subcontracting Preference for Veterans. This clarifies that the language included in subcontracting plans for small business concerns owned and controlled by veterans and used for the purpose of data collection also includes small business concerns owned and controlled by service disabled veterans. Apparently, there is confusion over the fact that the group of veteran owned businesses also includes service disabled veteran owned businesses.

Section 605. Small Business Development Center funding. This section reforms the formula for funding Small Business Development Centers.

Section 606. Surety Bond program. Reauthorizes the Surety Bond financing program.

SALT RIVER PIMA-MARICOPA INDIAN COMMUNITY IRRIGATION WORKS OWNERSHIP

SPEECH OF

HON. J.D. HAYWORTH

OF ARIZONA

IN THE HOUSE OF REPRESENTATIVES

Tuesday, October 3, 2000

Mr. HAYWORTH. Mr. Speaker, during House floor consideration and passage of H.R. 2820, a draft resolution was inserted into the RECORD that was to have been a signed version of the resolution from the Salt River Pima-Maricopa Indian Community approving certain amendments to the Community's water code, as contemplated, and, indeed, as required by the bill. To correct this admission, I ask unanimous consent that the attached signed copy of the Community's resolution approving the requisite amendments to its water code be inserted into the RECORD and be included in the RECORD of the proceedings of the House with regard to H.R. 2820.

SALT RIVER PIMA-
MARICOPA INDIAN COMMUNITY,
Scottsdale, AZ.

RESOLUTION NO. SR–2031–2000

Whereas, the Salt River Pima-Maricopa Indian Community (''SRP–MIC'') Council has the authority pursuant to Article VII, Section 1(d)(5) of the Constitution of the SRP–MIC to provide for the proper use and development and prevent the misuse of the lands, natural resources and other public property of the SRP–MIC; and

Whereas, the Congress of the United States has under consideration the passage of H.R. 2820 to convey to the SRP–MIC the irrigation works formerly owned and operated by the Bureau of Indian Affairs and located on SRP–MIC tribal and allottee land; and

Whereas, as a result of negotiations that led to the development of H.R. 2820, and amendments thereto, the legislation's language contemplates that the Community will adopt certain amendments to its Surface Water Management Code prior to enactment of the legislation: Now, therefore, be it

Resolved, That the SRP–MIC hereby adopts the attached amendments to its Surface Water Management Code, attached hereto as Exhibits ''A'' and ''B'' respectively; and be it further

Resolved, That, if substitute legislation for H.R. 2820 (1) is not passed by the Congress prior to the adjournment sine die of the 106th Congress, or (2) if so passed by Congress, but it is not signed into law during the 106th Congress, the approval by the Community of these amendments shall become null and void.

CERTIFICATION

Pursuant to the authority contained in Article VII, Section 1(d)(5) of the Constitution of the Salt River Pima-Maricopa Indian Community, ratified by the Tribe, February 28, 1990, and approved by the Secretary of the Interior, March 19, 1990, the foregoing resolution was adopted this 19th day of September 2000, at a duly called meeting held by the Community Council in Salt River, Arizona at which a quorum of 5 members were present by a vote of 5 for, 0 against, and 4 excused.

Salt River Pima-Maricopa Indian Community Council.

MERMA LEWIS,
Vice President.

MEDICARE COMPREHENSIVE QUALITY OF CARE AND SAFETY ACT OF 2000

HON. FORTNEY PETE STARK

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Thursday, October 5, 2000

Mr. STARK. Mr. Speaker, in March of 1998, the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry (Quality Commission) issued its final report, raising concerns about medical errors and recommending steps to reduce the incidence of medical errors. The Quality Commission urged that measuring and improving quality of care be made a national priority.

In June of 1998, the Congressional Medicare Payment Advisory Commission (MedPAC) reported on quality of care in Medicare, and in June of 1999, MedPAC made specific recommendations for improving quality of care in Medicare. MedPAC recommended:

That quality of care goals for Medicare, including minimizing preventable errors and increasing participation by patients in their care should be established, reviewed and revised through a public process; that systems be established in Medicare for monitoring, improving and safeguarding quality of care; that the Secretary work with the private sector to develop and use common, core sets of quality measures for monitoring quality; and that to the extent possible, quality of care systems in the traditional Medicare fee-for-service program and Medicare+Choice be comparable.

In July of last year, the Inspector General issued four reports citing major deficiencies in the accreditation of hospitals to ensure that quality of care provided in hospitals for Medicare by the Joint Commission on the Accreditation of Health Care Organizations (JCAHO). The Inspector General made a series of recommendations for improving the accreditation of hospitals to ensure that quality of care provided in hospitals met Medicare standards. Also last year, the General Accounting Office issued reports citing major deficiencies in the accreditation of nursing facilities.

Then, in November of last year, the Institute of Medicine issued a report, ''To Err is Human'', which reported that almost 100,000 people may be killed each year by medical errors. The IOM recommended that improving health care safety be made a national priority and that a nationwide mandatory reporting system of medical errors by providers should be established. The IOM also called for a ''culture of safety'' in health care organizations. On February 10, 2000, the Ways and Means Health Subcommittee held hearings on the IOM report.

And yesterday, October 4, 2000, the Journal of the American Medical Association (JAMA) published an article reporting on the findings of a study on quality of care furnished to Medicare fee-for-service (FFS) beneficiaries. The study examined Medicare hospital claims by State for 24 quality of care performance indicators. The study found wide variation in quality of care both among States and among performance indicators.

The authors state: ''Available data suggest that providing the services measured here could each save hundreds to thousands of lives a year.'' The authors report that ''there has been no systematic program for monitoring the quality of medical care provided to FFS

Today, I along with Mr. NEAL and Mr. JEFFERSON, am introducing legislation that would address the recommendations made by these distinguished organizations. For the first time since the Medicare program was enacted, my bill would establish quality of care as a major emphasis in Medicare.

The ''Medicare Comprehensive Quality of Care and Safety Act of 2000'' would for the first time in the history of Medicare establish a comprehensive quality of care and safety system in Medicare for setting quality of care goals and priorities, conducting research and setting standards for quality of care, monitoring quality, safeguarding quality, and establishing systems to improve information and education of patients and providers concerning quality of care issues.

Perhaps most important of all, my legislation will create a ''culture of safety and quality'' in health care by requiring every provider to establish a ''Medicare Quality of Care and Safety Program'' (MQCSP). Based on model fraud and abuse compliance plans developed and implemented by the HHS Inspector General, every Medicare provider would be required to implement a quality monitoring and error reduction program—''Medicare Quality of Care and Safety Program''—and to report serious failures to meet quality standards and medical errors. The Secretary would be required to establish a national database of medical errors, as called for by the Institute of Medicine.

This legislation would establish a Medicare Quality and Safety Advisory Committee, which would be charged with recommending annual goals and priorities on quality of care. In the Medicare comprehensive quality of care system, the Secretary would be required to establish quality standards, including performance measures. The Secretary would be required to coordinate Medicare quality of care activities with those in other Agencies of the Department. As an example, the Centers for Disease Control and Prevention have for many years established and implemented performance standards for certain aspects of care; the CDC

Medical Infection Disease System (MIDS) provides performance standards for limiting the spread of infectious diseases in hospitals. My legislation would require Medicare to make use of these standards and others already developed either in government or in the private sector. The Secretary would be required to establish systems to adopt these standards in Medicare and educate providers on their use.

Providers would be required to report quality of care and medical error data in a completely confidential system, and the Secretary would be required to establish data systems to monitor the performance of providers regarding quality of care and medical errors. The Secretary would be required to use standard data so that comparisons could be made across providers.

My legislation does not evision a punitive system, but rather a system of working together to achieve improvements in quality and error reduction. I believe that most medical errors are the result of systems failures, and my legislation would focus on correcting these systems errors. I also believe that improvement must come from within health care organizations, rather than being imposed from outside. That is why my legislation would focus on identifying and correcting systems failures from within. However, I also believe that information on best practices and standards must be collected at the national level and shared with health care providers.

This legislation would build on the organizations that are already charged with sharing information and helping to improve quality of care are the Peer Review Organizations (PROs). The Secretary would be required to develop standards and train the PROs regarding those standards. PROs, in turn, would train health care providers in implementing those standards. PROs would also be required to investigate serious failures by providers to meet quality standards, including serious medical errors, and work with providers to implement corrective action plans to modify systems or take other actions to improve quality and minimize errors.

As a way of increasing the confidence of providers in the PROs, fraud and abuse activities of the PROs would be phased out, and their work would be limited to quality related activities. The legislation would change the name of the PROs to ''Quality Improvement Organizations'' in keeping with their new emphasis in Medicare.

The Secretary would be required to monitor quality and safety though a national data system, as recommended by virtually all of the organizations reporting on quality of care. To help providers feel more comfortable in reporting problems with quality or medical errors, the Secretary would be required to establish a confidential reporting system so that physicians, employees of providers, and others would be able to report errors or other failures on a confidential basis. Employees would be provided whistle blower protection for reporting quality failures and errors. Providers who achieve outstanding results in meeting quality standards and minimizing errors would be rewarded with the designation of ''Medicare Provider of Excellence.''

ON THE INTRODUCTION OF THE VETERANS COMMEMORATION ACT OF 2000

HON. JAY INSLEE

OF WASHINGTON

IN THE HOUSE OF REPRESENTATIVES

Thursday, October 5, 2000

Mr. INSLEE. Mr. Speaker, today I introduce the Veterans Commemoration Act of 2000. This piece of legislation will help to alleviate a serious impediment to adequate health care for our veterans.

Many veterans have trouble getting to and from VA hospitals. The legislation that I am introducing today would create a coin commemorating Executive Order 5398, signed by President Herbert Hoover on July 21, 1930, which established the Veterans Administration. The proceeds from the sale of this coin would fund a transportation program for veterans, provided by the Disabled American Veterans.

This program provides a much-needed service to our nation's veterans. The DAV provides transportation services to veterans to and from VA hospitals. Considering the fact that many veterans live far away from VA hospitals and are disabled, the lack of transportation can be a very serious impediment to adequate health care.

In my home state of Washington, the Veterans Administration hospital in Seattle serves the entire Pacific Northwest. Many of the patients who rely upon the care provided by the VA have severe disabilities that prevent them from easily accessing the clinic. Public transportation serves those veterans that live in the Metropolitan area, but for the thousands of veterans without access to public transportation, the DAV steps in to provide door to door services. This essential program is truly the missing link for veterans' health care.

The DAV has recognized this need by creating the transportation program. This program has been very successful so far. But it only operates in a few select areas and serves only a handful of veterans. This program should be available to all veterans, but the DAV simply cannot afford to fund a project of that magnitude. This bill would create the funds necessary to expand this program.

With no cost to the taxpayer, we can help our nation's veterans and show them that their needs are important. We must show our support to the brave men and women who have risked their lives to serve this country. This unique program, provided by the DAV, deserves our support.

Today I stand with over 150 of my colleagues to introduce this legislation. This bipartisan bill has diverse and broad support. We have the time and the support to pass this bill now. We should not wait for the next Congress to take action when we have the ability and the will to do so now. I urge my colleagues to stand with me and with the Disabled American Veterans to pass this bill and support our veterans.

THE CHILDREN OF SIERRA LEONE

HON. JOHN F. TIERNEY

OF MASSACHUSETTS

IN THE HOUSE OF REPRESENTATIVES

Thursday, October 5, 2000

Mr. TIERNEY. Mr. Speaker, if you are paying attention to the House floor at this moment, please listen very closely to what some of my colleagues and I are discussing. Because we are talking about saving children who are being savaged and we desperately need your help.

If you can, please stop what you are doing for a second—I know we're all very busy right now, but again this is important. So, please, stop what you are doing and remember for a moment what you felt like when you were a child, especially if you had moments in which you felt very vulnerable in any way.

Now, take that feeling, and try to imagine living in a community ripped by the throes of war—your parents are missing, friends, sisters and brothers beaten, broken and battered, if even still alive.

And as you imagine this life, now look down at your arms and legs. Imagine an arm or a leg or more mutilated and even severed from your body. Think about that. Can you even bear to imagine it?

As hard as it is to believe, there are children today who don't have to imagine this horror because they live it. They see where their arms and legs once were. They know that their family has been destroyed.

They are the children of Sierra Leone.

And no matter what your politics are, humanity calls us to act. Support funding for peacekeeping now. Support Tony Hall's bill to halt the illegal diamond trade that funds this butchering now. Don't wait. Support ending the horrific suffering of these children now.

CELEBRATION IN PITTSBURGH

HON. WILLIAM J. COYNE

OF PENNSYLVANIA

IN THE HOUSE OF REPRESENTATIVES

Thursday, October 5, 2000

Mr. COYNE. Mr. Speaker, I rise today to call my colleagues' attention to an upcoming ceremony that will be held in Pittsburgh on October 13, 2000, to commemorate the 100th anniversary of the founding of the Homestead Grays and the 40th anniversary of Bill Mazeroski's World Series-winning home run. The joint ceremony serves to highlight Pittsburgh's long history of outstanding professional baseball.

The Homestead Grays was a Negro League baseball team that was originally formed by local African American steelworkers. The Homestead Grays played baseball from 1900 until Major League baseball teams were integrated 50 years ago, and the club won a number of pennants. The Grays, incidentally, played the first night game in Pittsburgh baseball history—against the Kansas City Monarchs at Forbes Field on July 25, 1930.

The Homestead Grays were known for several outstanding players who could compete with the best baseball players of the time, white or black. A number of these players were eventually inducted into the Baseball Hall of Fame. Oscar Charleston, first baseman and manager for the Grays—with a lifetime batting average of .357, the ranking of fourth on the all-time home run list for the Negro Leagues, and fielding that was deemed superior to that of his white contemporary Ty Cobb—was inducted into the Baseball Hall of Fame in 1976. Smoky Joe Williams, who pitched for the Grays, was voted the greatest pitcher in Negro League history in 1952, beating out Leroy