the first week they were on the agenda, and there is the established right of any member to hold over anybody for a 1-week period.

The people's business needs to be conducted, and the long discussion which ensued over the blue slip, which is an arcane procedure where Senators can have a lot to say or perhaps the controlling determination about U.S. district court judges, is not of much interest to the American people.

The input and status of the American Bar Association, while I think it is important, and I think there ought to be some input at least to district court judges, is not of great interest. I think the American people are concerned about what happens in the Department of Justice.

Again, I say, regrettably, it is not senatorial to have this kind of gridlock spill out into the public arena and into the public press. But I think the American people need to know what is happening.

Not too long ago, someone said on a controversial issue, ''Where is the outrage? Where is the outrage?'' This is one of those items where I think there may be some outrage, once America knows that there is gridlock on a great many collateral issues which do not affect at all the confirmations of the Deputy Attorney General, a very able man, Larry Thompson, or the confirmation of the Solicitor General, a very able man, Ted Olson. On that there has been no disagreement. Nobody has questioned that those people ought to be confirmed. But they are not being confirmed, and the business of the Department of Justice cannot be conducted. I think once there is focus on that, we may see a little change in the practices in the Judiciary Committee.

I yield the floor.

Mr. REID. Mr. President, there has been some talk on the floor today about things going on in the Judiciary Committee. I want to report that Senators ENSIGN and HARRY REID are setting an example of what we believe is the right way to approach judicial nominations.

Yesterday, Senator ENSIGN sent to President Bush four judicial selections. Senator ENSIGN went over these with me and asked me what I thought of the selections. When the day comes for the blue slip, I will sign in very large letters my name. These are very good people to be nominated.

James Mahan, district court judge in Las Vegas, practiced law when I was there. He is an outstanding trial lawyer. He did not only trial work but he did business law work.

Larry Hicks, who is from an excellent law firm, almost became a Federal judge. The elections came and interfered with him being a Federal judge some 7½ years ago.

You cannot find two better lawyers than James Mahan and Larry Hicks.

In addition to that, Senator ENSIGN sent two persons just as capable as the other two. Walt Cannon practiced law in Las Vegas during the same period of time as I did. He is an outstanding lawyer. He has done a tremendous amount of trial work. He has appeared before juries on numerous occasions. He knows what a courtroom is all about. He has a perfect demeanor to be a judge.

Finally, Senator ENSIGN sent the name of another district court judge by the name of Mark Gibbon who practiced law in Las Vegas at the same time as I did. He is a fine lawyer. But he has been a better judge than he was a lawyer.

I want the work of Senator ENSIGN, with my acceptance, to be the model for what we need to do with judicial nominations. Both of us agree that we should report them out very fast, get the work done as quickly as possible, and get them on the bench so they can do the work.

The blue slip has worked very well in the past. I think we should continue with the example that Senator ENSIGN and I have done in the State of Nevada.

I compliment Senator ENSIGN for the fine people he nominated to be Federal district court judges. I look forward to working with him in the future. I think we have a routine that will work well for this Congress, and hopefully thereafter.

COMMUNITY-BASED OUTPATIENT CLINICS IN THE DEPARTMENT OF VETERANS AFFAIRS

Mr. ROCKEFELLER. Mr. President, Congress transformed the landscape of health care delivery for veterans with the Veterans' Health Care Eligibility Reform Act of 1996. This law eliminated barriers to outpatient care and encouraged the Department of Veterans Affairs, VA, to offer health care services to veterans in the most clinically appropriate setting. VA responded by shifting its emphasis from hospital-based treatment to outpatient care, and in just a few years has opened more than 250 new community-based outpatient clinics.

I am enormously pleased that VA has opened community clinics in West Virginia and throughout the country. It is critical to bring health care services closer to veterans, especially as our veterans population continues to age. But it is not sufficient merely to increase the accessibility of care, we must also ensure that veterans receive the highest quality of care possible. Just as I fought to secure outpatient clinics for veterans, I will fight to ensure that these clinics are the very best that they can be.

At my request, the Democratic staff of the Senate Committee on Veterans' Affairs surveyed more than 200 VA community-based outpatient clinics nationwide to evaluate the success, capacity, and quality of care in these clinics. This self-reported information from individual clinics offers Congress and VA an opportunity to assess services provided by the various clinics, and to determine where improvements can be made to ensure that veterans receive the best possible care. The Democratic committee staff report concludes that, although all clinics reported offering primary care, services varied markedly by clinic and by geographic location.

VA's 22 regional network directors, rather than VA Headquarters, hold responsibility for activating, operating, and overseeing the community clinics. Although this provides flexibility to local VA managers, the variations in services described by clinic staff appear to result from varied management practices rather than deliberate adaptations to community needs.

For example, staffing levels did not appear to be related to the number of patients seen, and varied among clinics and among networks. Some clinics served about 5,000 patients in the first half of fiscal year 2000 with the equivalent of 15 full-time health care providers, while others served the same number of patients with only six full-time staff. Some clinics operated with fewer than two full-time employees.

Variations in staffing translated into differences in the types and levels of services provided, including basic mental health care. Less than half of the clinics surveyed offered even minimal mental health care, an issue of concern as VA continues to close its inpatient mental health care clinics. In several areas of the country, waiting times for an appointment for primary care ranged from 30 to 150 days. More than 60 percent of the community clinics lacked equipment and personnel to respond to a cardiac emergency, an issue of patient safety.

VA's lack of a consistent, nationwide system for collecting and analyzing information on health care outcomes and treatment costs is an obstacle to measuring the success of VA's outpatient clinics. VA must develop tools to allow community clinics to monitor health outcomes, so that veterans can depend on a system that not only meets their needs but continues to improve their health status. Clinics must be able to combine this information on health outcomes with accurate data about costs of treatment, so that VA can ensure the effective and efficient use of resources at all clinics.

I certainly do not expect community clinics to offer the full range of services available in a large medical center. However, it is reasonable to assume that a veteran seeking primary care through a VA outpatient clinic should be able to expect a minimum standard package of services and an acceptable quality of care, regardless of geographic location. Oversight by VA headquarters and by Congress is essential to ensuring consistency in the services and quality of care offered to veterans through community clinics.

I have forwarded a copy of this report to VA Secretary Anthony Principi, and I look forward to working with him to

make certain that veterans who turn to VA's community care clinics can expect not just access, but excellence.

I ask unanimous consent that the text of the executive summary of the Democratic committee staff report be printed in the RECORD.

There being no objection, the summary was ordered to be printed in the RECORD, as follows:

STAFF REPORT ON COMMUNITY-BASED OUTPATIENT CLINICS IN THE VETERANS HEALTH ADMINISTRATION, DEPARTMENT OF VETERANS AFFAIRS

(Prepared by the Democratic staff of the Committee on Veterans' Affairs, United States Senate, for Senator John D. Rockefeller IV, Ranking member, May 3, 2001)

EXECUTIVE SUMMARY

Background—In 1996, Congress broke down the barriers to developing an outpatient care network within the Department of Veterans Affairs (VA) health care system. The Veterans' Health Care Eligibility Reform Act of 1996 (Public Law 104–262) simplified eligibility rules, mandated uniformity in services offered to veterans, and eliminated legal barriers to the sharing of health care resources with other providers. In response, VA has shifted emphasis from providing hospital-based care to treating more veterans in outpatient clinics. Much of the new outpatient care is being provided in Community-Based Outpatient Clinics (CBOCs), local, often small clinics, some operated by VA staff, others managed by contractors for VA.

Responsibility for activation, operation, and oversight of CBOCs rests with VA's 22 Veterans Integrated Service Networks (VISNs) directors, contingent upon congressional approval. Between 1996 and 2001, more than 250 CBOCs have been activated, with the goal of improving access to care for many veterans. CBOC staff may treat veterans in the community clinic or refer them to the parent VA medical center for more intensive treatment and then provide followup care through the clinic.

As a consequence of the establishment of the CBOCs and other changes in response to the Eligibility Reform Act of 1996, more veterans are accessing primary care in the outpatient setting. VA estimates that the total number of annual outpatient visits (in all facilities) has increased from 26 million to 42 million in the last 5 years. Of the 229 clinics that completed surveys for this report, total outpatient visits in the first half of FY 2000 increased more than 20% over the equivalent period in FY 1999.

Democratic Staff Project—At the direction of Ranking Member John D. Rockefeller IV, the Democratic staff of the Senate Committee on Veterans' Affairs undertook an oversight project to determine whether CBOCs have fulfilled their potential to deliver high quality care to veterans in an effective and efficient manner.

To carry out this project, staff members designed a survey questionnaire intended to obtain information regarding capacity and performance directly from the clinics. This survey requested information on operation and management issues, staffing, hours of operation, patient load, availability and timeliness of care, costs, and quality of care. Staff mailed surveys directly to the 257 congressionally approved clinics for which valid mailing addresses could be obtained—rather than to VISN offices or to parent medical center directors—and compiled the results for federal FY 1999 (October 1, 1998–September 30, 1999) and the first two quarters of federal FY 2000 (October 1, 1999–March 31, 2000).

Based on this self-reported information from individual clinics, this report is intended to offer an opportunity to assess services provided by the various clinics and to determine where improvements can be made to ensure that veterans receive the best possible care.

Data Collection and Validity—VA programs frequently suffer from flawed data collection and monitoring, and outpatient care provided by CBOCs is no different. No single VA source could provide Committee staff with accessible and objective information on clinic services systemwide. Thus, the validity of the information received via the surveys must rely solely upon the precision and accuracy with which clinic staff completed the questionnaire. Despite Committee staff efforts to design unambiguous questions regarding basic operational parameters, the responses lacked uniformity. Some respondents indicated that the requested data for specific questions had never been properly collected or could not be accessed. Because a site audit of each clinic was beyond the scope of Democratic Committee staff resources, this report relies solely on self-reported data, with caveats for incomplete or subjective responses noted.

Findings and Conclusions—While community-based clinics appear to offer an appropriate avenue for increasing veterans' access to care, the unevenness of responses to the staff survey precludes any generalized conclusions on the collective success, capacity, and quality of these clinics. The available data show wide variety in every possible parameter of clinic function, both within and among networks. This variability, which suggests a significant lack of uniformity among the CBOCs, prevents easy summaries or simple solutions for possible deficits.

The flexibility inherent in the decentralized VA health care system has allowed network and medical center directors, rather than VA Headquarters, to map the course of VA's community-based outpatient care. While this arrangement does not preclude provision of excellent health care in individual clinics and does present the opportunity to tailor services to each community's demands, the significant variations in operational standards described by clinic staff appear to reflect varied management practices rather than deliberate adaptations to community needs.

Based on the variability in services—and in the vocabulary for describing operational standards—the Democratic Committee Staff can only infer that VA has not established a systemwide baseline for the minimum acceptable service levels in CBOCs. Community clinics should not be expected to offer identical or completely inclusive services. However, veterans accessing primary care through VA outpatient clinics should be able to depend upon a minimum standard package of services, regardless of geographic location, and on an acceptable level of quality of care. Also, the Congress should be able to expect an effective and efficient use of resources at all CBOCs.

Specific findings include the following: The number of FTEE (full-time employee equivalents) providing primary care varied markedly among clinics and did not appear to be linked consistently to the patient load. Staffing levels for clinics serving about 5,000 patients in the first half of FY 2000 ranged from 6 to 15 FTEE. Some clinics operated with fewer than two FTEE, raising significant concerns about the ability of such a limited staff to offer high quality health care while performing administrative tasks and monitoring quality of care.

VA does not provide the same services in all clinics. Variations in staffing translate into variations in the types and levels of services provided, including basic mental health care, both preventive and counseling services, and overall hours of service. Veterans in different regions should be able to expect a standard basic package of services.

Community clinics have not eliminated long waiting times to obtain an appointment and to receive treatment in every network in accordance with VA goals. The longest actual waiting time for an appointment exceeded 30 days in 18 networks. Only a few clinics reported having a defined policy for accepting and scheduling ''walk-ins.''

Many community clinics lacked equipment and personnel to respond to a cardiac emergency, an issue of patient safety. Each clinic should have, at minimum, an automated external defibrillator and staff trained in its use. Only 38% of clinics reported having the staff and equipment necessary in the case of a cardiac emergency.

Community clinics have not offered sufficient outpatient mental health care to compensate for the loss of VHA impatient programs. The number of VA medical facility beds available for impatient mental health care has declined steadily over the last two decades. By the end of FY 2001, VA anticipates reducing the numbers of patients treated in inpatient psychiatric care programs by 56% from the level treated in FY 1995. Outpatient mental health care programs provide a complement to (although not a substitute for) acute inpatient care, and can serve as a valuable community-based tool in a comprehensive mental health care maintenance regimen.

If outpatient programs are to play a part in maintaining systemwide capacity for mental health care treatment of veterans, they must be accessible to veterans at the sites of outpatient care. Yet, less than half of the clinics surveyed reported offering any mental health care. Of the 229 clinics that responded to the staff survey, only 50 reported that they provided PTSD treatment, and only 42 reported offering substance abuse treatment of any kind. Mental health care FTEE constituted only a small fraction of the total clinic staff in most networks.

Clinics report a range of costs per patient visit, with the average cost per visit within a network in FY 1999 ranging from $27 to $290. Calculating the cost-effectiveness of outpatient treatment requires a uniform method of calculating actual costs, which VA currently lacks. Whether the variation in patient visit costs reported by clinics represents varying staff efficiency or differences in treating ''revenue-generating'' insured patients cannot be determined from the data here.

The lack of a coherent system for collecting, monitoring, and analyzing quality of care data prevents evaluation of community care success. Almost all clinics reported that they document and monitor the quality of health care provided, but the clinic staff who completed the surveys had widely varying perceptions of what constituted a quality of care assessment. The materials presented for documenting quality of care ranged from medical checklists to patient satisfaction surveys that focused largely on aspects of patients' physical and emotional comfort in the clinic setting, rather than health care-related criteria. None documented health outcomes. Only 130 clinics reported sending any quality of care reports (regardless of content) to the parent facilities, and none received written feedback specific to that clinic from the parent facilities. The complete lack of a shared vocabulary for measuring quality of care prevented any compilation of the data. One clinic operated by a contractor responded that monitoring quality is not part of its contract.

The poor or absent measures of quality of care make the effectiveness of the care provided by the clinics, variations between contracts- and VA-operated clinics, and the effect of staffing inequities impossible to judge. VA needs a consistent set of tools that can be employed in outpatient clinics systemwide to obtain meaningful quality of care outcomes.

VICE PRESIDENT'S TORONTO SPEECH ON ENERGY POLICY

Mr. BINGAMAN. Mr. President, on Monday of this week, the Vice President gave a speech in Toronto laying out some of the broad themes of the Administration's developing energy policy.

Some of the points made by the Vice President were valid. I want to comment on some of those. I obviously realize that we are now in the middle of the debate on the Elementary and Secondary Education Act. I intend to come back to the floor either later today or next week to talk about that legislation and to commend the sponsor of it and the Democratic ranking member, Senator KENNEDY. Senator JEFFORDS and Senator KENNEDY have done yeoman's work in putting that legislation together.

I want to take the opportunity this next week to go through that in some detail. But today I wanted to take a few minutes to talk about energy issues since the Vice President is clearly focused on this and is speaking out strongly on it.

I agree with much of what the Vice President has said.

For example:

I agree with him that we face some serious long-term issues in national energy policy.

I agree with him that our response must have comprehensive and long-term focus.

I agree with him that we are very dependent on coal and nuclear power for electricity generation, and this dependence will probably continue into the future.

There are a number of other points, however, where I fear he may have overstated a particular point of view or missed the mark. Let me just cite some of those.

The Vice President seemed to equate energy conservation with rationing for something like rationing. I don't know of anyone advocating energy conservation who supports rationing. He also stated that ''some groups are suggesting that government step in to force Americans to consume less energy.''

That is certainly not any proposal I have made or seen here in the Congress.

What I think would be helpful to the discussion is perhaps to identify the questions that need to be asked about energy policy as we proceed over the next few weeks with consideration of the energy policies that the administration is going to recommend as well as those that have been introduced here in the Congress.

Let me cite essentially five questions and elaborate on them slightly.

The first question that I believe should be asked is whether the energy policy, the one that the Vice President is going to advocate, or that any of us here are advocating, adequately recognizes the enormous differences between energy markets in the 1970s and 1980s and those that we face today.

Back in the 1970s, there was a lot of talk about eliminating our dependency on foreign imports with increased domestic production through ''Project Independence.'' Electricity markets were local, electricity suppliers were largely confined within State boundaries and regulated by State public utility commissions. Because a State public utility commission could guarantee its utilities fixed rates of return on their investments in infrastructure, such as large nuclear power plants, there was a market for them.

We now face a very different situation. Electricity markets have become regional, and increasingly they are beyond the ability of State public utility commissions to regulate. The nationwide electrical grid is being called upon to transmit large amounts of electrical power across enormous distances, something it was not really designed to do. State regulation of electricity has given way to a system that relies more on market forces, even though electricity markets are far from perfect ones. The old model of a protected and regulated monoply environment for utility investments in new generation has been transformed into a ''wild wild west'' of decentralized generation by a welter of new actors.

No where do the changes in energy markets manifest themselves more clearly than in the situation facing energy infrastructure. Attempts to blame Federal environmental regulations for the difficulties of siting and building energy infrastructure are severely off the mark. The most serious obstacle to building new energy infrastructure has been not at the Federal level, though, but at the local level and in capital markets. For example, the Vice President and other Administration officials have often observed over the last several weeks that it has been 20 years since a large refinery has been built in the United States. But the main reason has not been the Clean Air Act. It has been the low rates of return on capital in the refining sector and the refining overcapacity that existed up to a few years ago. You are not going to build a new refinery when there are already too many to serve the market, and up until recently, that was the case.

The need for energy infrastructure has provoked serious local concern and opposition. One example, which has been in the news, is the Longhorn pipeline from the Gulf Coast to El Paso, Texas. It has been tied up for nearly 5 years addressing community opposition to its construction. If the energy industry can't build pipelines in Texas, I don't think we should assume it will be any easier to build them anywhere else.

The result of these factors—economic and local—have been cited at a hearing before the Energy and Natural Resources Committee last week by a witness from ExxonMobil, who testified that our largest U.S.-based oil company does not believe that any new refineries will be built in the United States. He predicted that the only additions to U.S. refining capacity would come from expansions at existing facilities. Expanding that capacity will not be easy regardless of federal policies. Most refineries are located in heavily industrialized areas with significant environmental issues regulated at the State and local levels of government.

Instead of looking for ways to blame the Federal Government for an energy infrastructure problem which has not been of the Federal Government's making, I think we need to look for creative new ways to respond to the challenges of working with State and local communities on these siting issues. Effective mechanisms for greater regional cooperation are critical to ensure adequate infrastructure investments are made on a timely basis to meet energy demand. Coordinated regional efforts on energy infrastructure can reduce the impact on communities by optimizing infrastructure use and reducing price volatility.

If the Vice President's energy policy recognizes this complex reality and starts to address it, then it will be helping the country to make a positive step forward. If the answer from the Vice President's study is simply to try to pit energy needs against environmental protection, then we won't be looking at a comprehensive and balanced energy policy.

The second question to ask of the Vice President's comments this week is how this so-called energy policy that we are envisioning will connect planned actions related to energy with climate change policy.

Science has been developed showing fairly clearly today that there is a connection between human activity and climate change. We may not be able to prove the exact amount of human causation in the global warming that we see, or to model its precise regional impacts. But we know enough now to realize that our ever-increasing emissions of greenhouse gases pose substantial risks both to critical and fragile ecosystems around the world and to future generations of humans. The world will have to deal with the issue, and the United States must be a leading contributor to negotiations on any international framework to address global warming. A leadership role for the United States is required not only because we are a major emitter of greenhouse gases, but also because we have the leading capability to harness science and technology both to understand climate change and to respond to it.

We, as a country, need to have a climate change policy. We need to put in