INTRODUCTION OF THE CHRONIC ILLNESS CARE IMPROVEMENT ACT OF 2000

HON. FORTNEY PETE STARK

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Wednesday, July 26, 2000

Mr. STARK. Mr. Speaker, in our aging society, it is beginning to dawn on millions of Americans across the country that chronic illnesses are now America's number one health care problem. Yet because our health care system has been designed around meeting the needs of acute, not chronic illness, our system of services for those with Alzheimer's, diabetes, and other major conditions is both fragmented and inadequate.

To be successful, 21st century health care must be reorganized to maximize the intelligent use of those protocols and procedures that can most effectively control and slow the rate of chronic illness progression. This can only be accomplished if treatment for chronic conditions is consciously and carefully integrated across a range of professional providers, caregivers and settings.

This integration of services for chronic illness care is at the heart of the Chronic Illness Care Improvement Act of 2000 that I am introducing today.

It is a major bill, designed to focus debate on the need to provide comprehensive and coordinated care for people with serious and disabling chronic illness. I am introducing this Medicare measure this summer to invite comments, ideas and suggestions for refining this bill so that it can be re-introduced at the beginning of the 107th Congress, with bipartisan sponsorship. The bill I am introducing today is the result of months of consultation and work with numerous senior, illness, and health policy groups. I hope that it will receive the endorsement of many groups in the days to come.

The bill has four titles and is phased in over a number of years. Why? Because we know a lot about the management of chronic illness—but in truth, the comprehensive national program that is so desperately needed will require long range planning and implementation in phases.

Therefore, Title I creates a temporary Commission to study and recommend solutions to the complex issues involved in coordinating and integrating the diversity of healthcare services for the chronically ill.

Title II lays the groundwork for a full, comprehensive care program by establishing the databases and infrastructure we will need to provide high quality care to those with chronic illness.

Title III launches two major prototype chronic disease management programs-one for diabetes and the other for Alzheimer's disease. Once we learn from the experience of these two prototypes, the Act calls for expansion to a high quality national program for management of other serious and disabling chronic illnesses.

Title IV promotes coordination of care for dually eligible beneficiaries by streamlining the processes of obtaining waivers and determining budget neutrality of combined Medicare and Medicaid programs.

WHY A PROGRAM TO IMPROVE THE CARE OF CHRONIC ILLNESS IS NEEDED

Do you know someone who has diabetes, high blood pressure or a heart condition? Perhaps someone who is important to you suffers from arthritis, asthma or Alzheimer's disease. All of these problems have one thing in common-they are chronic illnesses. Once these problems begin, they stay with you and many of these problems inevitably progress over time. What most people don't know is that chronic illness is America's highest-cost and fastest growing healthcare problem accounting for 70 percent of our nation's personal healthcare expenditures, 90 percent of all morbidity and 80 percent of all deaths.

Yet while chronic disease is America's number one healthcare problem, care for those with chronic illness is provided by a fragmented healthcare system that was designed to meet the needs of acute episodes of illness. We cannot deliver 21st century healthcare with a system that was designed a half century ago, before angioplasty or bypass surgery for heart disease and before L-dopa for Parkinson's disease.

Medical discoveries like these have transformed many illnesses from rapidly disabling conditions to chronic conditions that people live with for a long time. But the healthcare system that works for a devastating heart attack does not work for chronic illnesses that need a totally different group of services, including long range planning, prevention, coordination of care, routine monitoring, education, and self-management.

The acute care model is a mismatch for the needs of chronic disease and the result is that people with chronic conditions receive healthcare that responds to crises rather than preventing them. The fact is we know a lot about the natural course of chronic illnesses like diabetes and arthritis. We have learned the all-too-common scenarios that result in complications such as an amputation in the diabetic or a stroke in the person with uncontrolled hypertension. Delaying stroke by 5 years would yield an annual cost savings of 15 billion dollars, yet we continue to shortchange the ounce of prevention that is worth a pound of cure.

The patients know what is wrong with the system—they tell us our healthcare system is disjointed and a nightmare to navigate. They want more information about their condition, more emotional support, and more control of their care. They deserve better communication and integration of care amongst their many healthcare providers who currently function to deliver separate and unrelated services, even though they are providing care to the same person.

But none of this will happen in a medical system that does not reward quality of care for chronic illness. Our healthcare system does not reward preventive care or continuity of care. Neither do we reward early diagnosis, interdisciplinary care, emotional counseling or patient and caregiver education.

The cornerstone of quality healthcare for chronic illness is long-range planning and prevention, yet the Congressional Budget Office currently has no mechanism to measure cost-effectiveness over extended periods of time. Unless we recognize that an upfront investment in the early and middle stages of chronic illness will pay dividends over the long term, we will continue to be caught in the vicious cycle of responding to crises rather than anticipating and preventing them.

There is increasing recognition of the looming problem of providing long-term care to the growing number of senior citizens, but little awareness that better care of chronic illness beginning at the time of diagnosis is the most effective strategy to prevent the progression of disability and loss of independence. Join me in supporting The Chronic Illness Care Improvement Act of 2000 to bring excellence to the care of chronic illness, just as Medicare has already achieved for acute illness. This legislation will put our emphasis where it belongs—on proactive strategies that will prevent complications and disability before they happen.

This is a systems problem that requires a systems solution. Disease management of chronic illness will only succeed if financial, administrative and information systems are developed to support it. Our current healthcare system locks into place fragmentation and duplication of services. We must strive to align financial incentives among healthcare providers to achieve common care, quality and cost objectives. We can improve the quality of care while reducing costs by reducing duplicative and unnecessary services and by preventing complications and loss of independence.

The healthcare challenge of this new century is to design a Medicare system that meets the needs of persons with serious and potentially disabling chronic illness. The medical discoveries of the 20th century have dramatically prolonged the life expectancy of persons with all types of chronic conditions. In the 21st century, our challenge is to reduce the progression of disability and to improve the functional status and quality of life of persons with chronic illness.

INVITATION FOR COMMENTS

Mr. Speaker, reforming our health care delivery system to improve the care of chronic illness is a complex and major undertaking. Therefore, I want to repeat my comments that I am introducing this bill today to solicit comments and ideas from across the Nation. Today's bill is just the first round in a major initiative to improve this part of our health care system. I look forward to additional ideas and suggestions.

Following is a section-by-section description of the proposal.

THE CHRONIC ILLNESS CARE IMPROVEMENT ACT OF 2000 BILL SUMMARY

1. The bill charges a congressionally-appointed National Commission with development of a Medicare policy agenda that provides for an integrated, comprehensive continuum of care for serious and disabling chronic illness. Among its responsibilities, the National Commission on Improving Chronic Illness Care will:

Raise public awareness about how and why chronic illness care should be improved;

Investigate the barriers preventing integration of care for the chronically ill and establish baseline data for benchmarking future progress in reducing the prevalence of chronic conditions and healthcare costs;

Establish direction for integrating the delivery, administration and finances of chronic care services.

III. The bill lays the groundwork for a national program of coordination and integration of care for serious and disabling chronic illness through initiatives addressing:

Prevention of Disease and Progression of Disability: Preventive services under Medicare are expanded. Research is also expanded into risk factors associated with the progression of disability. A public awareness campaign on prevention of chronic illness is established and bonus payments are offered to reward plans and providers that meet targets for reducing disability.

National Targets for Improving Chronic Care: HHS will develop a national database for long-term planning and measurement of outcomes; will set national goals to reduce the prevalence of chronic illness; and will develop outcomes measures for analysis of

long-term effectiveness of interventions that prevent chronic illness, complications and disability.

Coordination and integration of health services across different care settings: Common patient assessment instruments-are developed to integrate care across settings. Medicare and Medicaid-services for dually eligible beneficiaries are coordinated by streamlining the processes of obtaining waivers and determining budget neutrality for these programs.

Adequate manpower, education and expertise in chronic illness: Expand training opportunities where shortages of physician's with chronic illness expertise exist and HHS-sponsored, Internet-based national resource centers are set up to serve chronic illness patients and providers.

Managed care bonus programs for excellence in integration of chronic illness care:, Bonus payments are provided through Medicare for the development of comprehensive programs serving chronically ill beneficiaries. Specifically, disability prevention programs that achieve prevention goals, improve quality or perform research into delaying the progression of disability or preventing disease-related complications are funded.

Development of methods of cost assessment that make sense for long goals and outcomes: Methodologies to measure long range costs of comprehensive disease management programs that prevent chronic illness, delay disability, and prolong independence are developed and implemented by HHS.

III. The bill implements a nationally Phased-in program of comprehensive integration 'and coordination of care for serious and disabling chronic illness by:

Establishing-Prototype models for comprehensive disease management of two chronic illnesses, diabetes and Alzheimer's disease in 2003, that will be used as the basis for expanding in 2007 to other serious and disabling chronic illnesses, including hypertension, heart disease, asthma, arthritis, multiple sclerosis and Parkinson's disease.

These comprehensive disease management programs known as The National Initiative to Improve Chronic Illness Care include these key components: Best practices and evidence-based clinical guidelines, Interdisciplinary care, Case management, Disability prevention, Patient and caregiver education to foster self-management, Medication monitoring, Integrated administrative and financial services, Integrated information systems.

THE SCIENTIFIC CERTAINTY IN SENTENCING ACT OF 2000

HON. F. JAMES SENSENBRENNER, JR.

OF WISCONSIN

IN THE HOUSE OF REPRESENTATIVES

Wednesday, July 26, 2000

Mr. SENSENBRENNER. Mr. Speaker, today I introduce the ''Scientific Certainty in Sentencing Act of 2000.'' As the Chairman of the House Science Committee, I have had the opportunity to see first hand the amazing changes that take place each day in various fields throughout the science world. Advancements in DNA testing are no exception. Each advance brings a new degree of accuracy.

The legislation I am introducing today will allow convicted federal criminals the use of DNA testing. This would be allowed for those who did not have the opportunity to use DNA testing during trial or those who can show that a new technologically advanced DNA test would provide new evidence in their case.

Whether this new testing results in an exoneration, reduced sentence, or a reaffirmation of the conviction, we can all rest assured that the rule of law is upheld and that truth and justice have prevailed.

This legislation allows the great strides that have come, and will come, in the field of biological science to be utilized so that we may ensure that we are keeping the correct people behind bars. The bill is not a vehicle for frivolous appeals, but rather to allow all relevant facts to be shown in each case, which can only benefit all parties involved.

I encourage my colleagues to join me in promoting the use of the best technological advances in regards to convicted federal criminals.

PERSONAL EXPLANATION

HON. JERRY WELLER

OF ILLINOIS

IN THE HOUSE OF REPRESENTATIVES

Wednesday, July 26, 2000

Mr. WELLER. Mr. Speaker, due to unavoidable circumstances, I was forced to take a medical leave of absence from the House of Representatives after 7:00 p.m. on July 20, 2000. I respectfully request that how I would have voted had I been able to be present for votes be submitted and accepted into the CONGRESSIONAL RECORD at an appropriate place as follows:

On Rollcall Vote 421, an amendment offered by Representative VITTER, Adding $25 Million to the High Intensity Drug Trafficking Areas Program, had I been able to be present I would have voted aye.

On Rollcall Vote 422, an amendment offered by Representative DELAURO to allow federal funds to pay for abortions under the Federal employee health benefit program by striking Section 509, had I been able to be present I would have voted no.

On Rollcall Vote 423, an amendment offered by Representative TOM DAVIS of Virginia to add a new section prohibiting funds from being used to carry out the amendments to the Federal Acquisition Regulation relating to responsibility considerations of Federal contractors and the allowability of certain contractor costs, had I been able to be present I would have voted aye.

On Rollcall Vote 424, an amendment offered by Representative RANGEL to add provisions to the bill prohibiting funds from being used to implement Public Law 104–114 which codifies the economic embargo of Cuba, as in effect on March 1, 1996, had I been able to be present, I would have voted no.

On Rollcall Vote 425, an amendment offered by Representative SANFORD to add provisions to the bill which prohibit the use of funds from being used to enforce part 515 of the Code of Federal Regulations (the Cuban Assets Control Regulations) with respect to any travel or travel related transaction, had I been able to be present, I would have voted aye.

On Rollcall Vote 426, an amendment offered by Representative MORAN of Kansas to prohibit funds in the bill from being used to implement any sanction imposed by the United States on the private commercial sale of medicine, food, or agricultural product to Cuba, had I been able to be present, I would have voted aye.

On Rollcall Vote 427, an amendment offered by Representative HOSTETTLER to prohibit the use of funds to enforce, implement, or administer the provisions of the settlement document dated March 17, 2000, between Smith and Wesson and the Department of the Treasury, had I been able to be present I would have voted aye.

On Rollcall Vote 428 for final Passage of the Fiscal Year 2001 Treasury Postal Appropriations, had I been able to be present I would have voted aye.

TRIBUTE TO THE LATE BARBARA ROSE ISLEY

HON. ELTON GALLEGLY

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Wednesday, July 26, 2000

Mr. GALLEGLY. Mr. Speaker, today I pay tribute to the memory of Barbara Rose Isley, who died last week after decades of dedicated community service in my district.

Mrs. Isley and her late husband, Mason, were founding members of the Camarillo Citizen Patrol, a citizens organization that helped the Camarillo Police Department with stakeouts, traffic control, crowd control, searching for lost or missing people and Kid Prints.

She was known by her handle ''Ding-Dong Lady'' because she sold Avon products, an occupation she pursued for 35 years and for which she had achieved the honor of being a member of the President's Club.

Through the years Mrs. Isley helped transform the Citizen Patrol from members patrolling in their personal vehicles wearing civilian clothes to the currently marked Citizen Patrol cars and uniforms. She was the unit's secretary from its founding until her death last week. During that time she guided eight Deputy Advisors as they took over the helm of the Citizen's Patrol.

The Camarillo Citizen Patrol was the first disaster assistance team for Camarillo. Mrs. Isley and other members received training in first aid; shelter management; damage assessment surveys of fires, floods and earthquakes; and aiding the victims. One of Mrs. Isley's favorite stories about the Citizen's Patrol occurred in mid-1999.

A series of vehicle burglaries were committed at a Camarillo hotel from February to July 1999. A two-month surveillance was launched. Mrs. Isley and another member, who were armed with binoculars and a two-way radio and stationed in a hotel room overlooking a parking lot, watched as three suspects broke into a van and took a computer case. She radioed to deputies who were nearby in unmarked cars. The suspects were quickly captured and booked into jail on multiple counts of burglary, conspiracy and possession of stolen property. A further investigation revealed that the three suspects were responsible for approximately 40 similar crimes along Highway 101 from Los Angeles to Santa Barbara.

Mrs. Isley graduated from the Citizen's Academy in November 1998 and was honored as the Camarillo Citizen Patrol Member of the Year for 1998.