

health professions students by giving them a combined exposure that has not been available to them before. It would also bring a greater awareness and understanding of differences in the two beneficiary populations for new and experienced health care professionals alike.

Congress has made efforts in the past to promote specific sharing. At best, the results have been modest. For example, we authorized the Mike O'Callaghan Federal Hospital at Nellis Air Force Base outside Las Vegas. It is a 96-bed Air Force managed hospital with 52 VA-dedicated beds. This facility still has significant potential to serve as a model for sharing, but the VA and the Air Force made the decision to maintain separate budgets, financial, human resources, patient care records and data management systems. This facility, spending combined appropriations of over \$46 million, is really operating as two independent federal facilities within the same walls, with needless duplications of systems and services and inefficient use of resources.

Another example is the VA Medical center and Kirkland AFB Hospital in Albuquerque, New Mexico. Albuquerque is a VA–Air Force partnership that provides admitting privileges to Air Force physicians. The relationship between the VA and Air Force at these facilities is an example of a good beginning to sharing. What was once a 40-bed Air Force hospital occupying VA space has evolved to a contractual relationship today. Now the Air Force purchases inpatient care services from the VA, rather than operating less efficiently as a separate hospital within the confines of the Albuquerque facility.

While many of the lost opportunities to share observed in Las Vegas do not pertain to the situation in Albuquerque, some do. For example, the Air Force and VA needlessly maintain separate dental clinics, central dental laboratory functions and separate supply chains. Also, the Air Force continues to maintain a management presence as though it were still operating as an independent facility, even though most of its activities duplicate those of VA.

The Committee has also examined sharing in VA and DoD health care facilities in San Diego, CA; Fayetteville, NC; Charleston, SC; and San Antonio and El Paso, TX. It appears that substantial benefits could be achieved on both sides of the sharing equation if sharing became more of a standard operating policy between VA and DoD. Obviously, sharing is more likely to occur if one potential partner has something perceived to be valuable or useful to offer the other and if the right incentives are in place to encourage follow-through on sharing arrangements. VA Medical Centers have been successful in fields such as rehabilitation, prosthetics, treatment of spinal cord injuries and geriatrics, but DoD medical facilities treat a broader base of patients, which provides opportunities for the medical staff to broaden its experience.

Some of these facilities that could share or share more are close neighbors, and close proximity clearly makes sharing much easier to achieve. For some of these essentially collocated facilities, a joint facility would almost certainly reduce administrative costs as well as staffing needs. With such savings, additional resources would be made available for patient treatment and technological improvements. For instance, at the San Diego VA

Medical Center, the fiscal year 2001 budget is \$202 million, and at the Balboa Naval Medical Center, the fiscal year 2001 budget is over \$338 million. Although these facilities are only a few miles apart, no sharing occurs between them. The most recent clinical sharing between VA and the Navy in the San Diego area appears to have ended in 1989. It appears that Congress must be more vigorous or this deplorable situation will continue.

For too many neighboring VA and DoD health facilities, separate management and operations have become the only way they can conceive of doing business, even when another federal medical facility, also supported by tax dollars, may be little more than a stone's throw away. This separateness is mostly about ingrained habits, organizational cultures and protecting turf, and is not about promoting the best quality medical treatment for veterans and military patients, extending specialty care to more federal beneficiaries, or conserving scarce resources and funding.

Our bill would require, among other things, no later than two years after its enactment, the Secretaries of both Departments must submit to Congress a prospectus for the construction of a new joint federal medical facility. The two Secretaries would jointly select the location with two options to consider. They could select a location where both a current VA medical center and DoD military treatment facility are in need of replacement, such as in Charleston, SC, or they could provide improved access to eligible veterans and military beneficiaries in a location where only one VA medical center or DoD military treatment facility is currently serving one of the two beneficiary populations, such as in Los Angeles, CA. We intend that this new facility, once constructed, could develop, refine and demonstrate the practical health resources of sharing that we are confident is possible.

Importantly, Mr. Speaker, this bill would make VA–DoD health sharing mandatory. This change in the law would require jointly located facilities, beginning with those participating in the demonstration project, to actively engage in developing and implementing meaningful and sustainable plans for sharing. We understand that DoD and VA health facilities do not always operate in the same fashion, and that even a small change in policy or procedure can have large consequences. That is why in order to fully test the principles of this sharing legislation, the Secretaries of DoD and VA would be granted the authority to waive certain administrative regulations and policies otherwise applicable within their respective Departments. This bill includes provisions for close monitoring of any administrative regulations and policies that the Secretaries would deem appropriate for waiver, and would require them to report to the Committee on Veterans' Affairs and the Committee on Armed Services on their use of such waiver authority.

In summary, this bill reflects the Committee's belief that veterans and military beneficiaries deserve the best health care a grateful Nation can offer. Through the creation of this demonstration project and other provisions of this bill, we hope to improve health resource sharing by providing stronger incentives for both departments to join forces and make VA–DoD sharing a reality.

When I assumed the Chairmanship of this Committee I promised to do what is right for veterans. I am convinced that the Department

of Defense—Department of Veterans Affairs Health Resources Improvement Act of 2001 would be good for veterans and the military community alike. I urge my colleagues to come on board and support this bill.

HONORING JAMES GLOVER

**HON. BARBARA LEE**

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

*Friday, July 27, 2001*

Ms. LEE. Mr. Speaker, I rise today to honor James Henry Glover for his role as an inspirational African-American family-man, friend and colleague.

James Glover was born in Kansas City, Missouri. In 1942, he enlisted in the United States Army and was stationed in New York, where he met his wife, Carrie Hunley.

Mr. & Mrs. Glover moved to San Francisco and began a family. As a husband, Mr. Glover worked hard to provide his wife a secure and stable home. As a father, he ensured that his children received the best education possible. He instilled in them and all that knew him the importance of an education.

Mr. Glover believed that people can continue to learn beyond the academics of the classroom. He believed that life itself taught lessons. From his experiences, he educated his family, friends and colleagues to the importance of tolerance, compassion for human beings and the power of love.

Mr. Glover was active in the NAACP and in the National Kidney Foundation. He contributed his services to these organizations, because he believed in the empowerment of people and service to his community.

I will always remember Mr. Glover as a proud father, always at the side of his son, Danny, with a smile on his face. Mr. Glover touched us with his love, his warmth, his compassion, his wisdom and his insight. He was an incredible human being who served as a wonderful role model and an inspiration for young African-American men.

Mr. Glover was an extraordinary and honorable man, who will be dearly missed. His memory will be cherished by his three sons, Danny Glover, Rodney Glover and Martin Glover, and to his daughter Connie Grier. I Join his family and friends to salute James Henry Glover.

THE LITTLE SANDY WATERSHED  
PROTECTION ACT

**HON. PETER A. DeFAZIO**

OF OREGON

IN THE HOUSE OF REPRESENTATIVES

*Friday, July 27, 2001*

Mr. DEFAZIO. Mr. Speaker, I'm proud to be an original cosponsor of H.R. 427, the Little Sandy Watershed Protection Act. This bill extends the boundaries of the Bull Run Watershed to include the Little Sandy Watershed, ensuring quality drinking water for the Portland Metropolitan area for many years to come. It will also protect water quality and vital habitat for wildlife, including endangered species of steelhead and chinook salmon.

The Bull Run Reserve was established in 1892 to provide clean and safe drinking water