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NUCLEAR MEDICINE WEEK

Mr. BOND. Mr. President, I rise today to remind my colleagues that this week, October 3 through October 9, is Nuclear Medicine Week. Nuclear Medicine Week is the first week in October every year and is an annual celebration initiated by the Society of Nuclear Medicine. Each year, Nuclear Medicine Week is celebrated internationally at hospitals, clinics, imaging centers, educational institutions, corporations, and more.

I am particularly proud to note that Dr. Henry Royal, a physician practicing nuclear medicine at the Mallinckrodt Institute of Radiology in St. Louis, is a constituent and immediate-past president of the Society of Nuclear Medicine. The Society of Nuclear Medicine is an international scientific and professional organization of more than 15,000 members dedicated to promoting the science, technology and practical applications of nuclear medicine. I commend him and his colleagues for their outstanding work in the field of nuclear medicine and for their dedication to caring for people with cancer and other serious and life-threatening illnesses that can be diagnosed, managed, and treated with medical isotopes via nuclear medicine procedures.

With nuclear medicine, health care providers can use a safe, noninvasive procedure to gather information about a patient's condition that might otherwise be unavailable or have to be obtained through surgery or more expensive diagnostic tests. Nuclear medicine procedures often identify abnormalities very early in the progression of a disease—long before some medical problems are apparent with other diagnostic tests. This early detection allows a disease to be treated early in its course, when there may be a more successful prognosis.

An estimated 16 million nuclear medicine imaging and therapeutic procedures are performed each year in the United States. Of these, 40 to 50 percent are cardiac exams and 35 to 40 percent are oncology related. Nuclear medicine procedures are among the safest diagnostic imaging tests available. The amount of radiation from a nuclear medicine procedure is comparable to that received during a diagnostic x-ray.

Nuclear medicine tests, also known as scans, examinations, or procedures, are safe and painless. In a nuclear medicine test, small amounts of medical isotopes are introduced into the body by injection, swallowing, or inhalation. A special camera, PET or gamma camera, is then used to take pictures of your body. The camera does this by detecting the medical isotope in the target organ, bone or tissue and thus

forming images that provide data and information about that area of your body. This is how nuclear medicine differs from an x-ray, ultrasound or other diagnostic test—it determines the presence of disease based on function rather than anatomy.

Recently, the Centers for Medicare & Medicaid Services' announced its decision to approve coverage of positron emission tomography or PET for Medicare beneficiaries who have suspected Alzheimer's disease. This decision will allow physicians to obtain an early and more definitive diagnosis and to begin treatment at the time when it provides the best chance of prolonging cognitive function for our Medicare beneficiaries. Some of the more frequently performed nuclear medicine procedures include: bone scans to examine orthopedic injuries, fractures, tumors or unexplained bone pain; heart scans to identify normal or abnormal blood flow to the heart muscle, measure heart function or determine the existence or extent of damage to the heart muscle after a heart attack; breast scans that are used in conjunction with mammograms to more accurately detect and locate cancerous tissue in the breasts; liver and gallbladder scans to evaluate liver and gallbladder function; cancer imaging to detect tumors and determine the severity—staging—of various types of cancer; treatment of thyroid diseases and certain types of cancer; brain imaging to investigate problems within the brain itself or in blood circulation to the brain; renal imaging in children to examine kidney function.

Unfortunately, the field of nuclear medicine is not attracting enough incoming students to fill the current demand for nuclear medicine technologists—usually called NMTs. Currently, there is approximately an 18-percent vacancy of NMTs as determined by the American Hospital Association, AHA. By 2010, the Bureau of Labor Statistics, BLS, projects that the U.S. will need an additional 8,000 NMTs to fill the projected demand created by the aging workforce and expanding senior population. Over the next 20 years, the BLS expects that there will be a 140-percent increase in the demand for imaging services. The use of diagnostic imaging services has been increasing by approximately four percent a year, even as the number of certified NMTs and registered radiologic technologists has remained stable. As a result, imaging technologists often work longer shifts, and patients can face weeks of delay for routine exams.

A similar situation is developing for nuclear medicine physicians. According to the American Board of Medical Specialties, there currently are 4,087 certified nuclear medicine physicians in the United States. At the same time, the number of physician training programs is also declining, exacerbating the future shortage.

Over the next 20 years, the number of people over the age of 65 is expected to

double at the exact same time when the nation will face shortages of medical personnel—including nurses, NMTs, physicians, laboratory personnel, and other specialists. With an increasing number of people needing specialized care—such as nuclear medicine—coupled with an inadequate workforce, our Nation quickly could face a healthcare crisis of serious proportions with limited access to quality cancer care, particularly in traditionally underserved areas.

I encourage my colleagues to support Nuclear Medicine Week, to support policies such as the newly released CMS decision, and to support increased funding for programs so that our Nation will have a sufficient supply of nuclear medicine physicians and technologists to care for all patients in need of nuclear medicine procedures and related care.

CHIP PROTECTION AND IMPROVEMENT ACT

Mr. CHAFEE. Mr. President, I introduced S. 2759, along with my colleague, Senator ROCKEFELLER, to help States with healthy State Children's Health Insurance programs remain strong, so that they may continue to provide high-quality health care coverage to the children they serve. Our bill achieves this objective by allowing States to keep \$1.1 billion in expiring funds in the SCHIP program and continuing current law redistribution rules through 2007.

Concerns have been expressed that S. 2759 would not reallocate SCHIP funds in an effective manner and that States cannot utilize their current SCHIP allotments. Proponents of this view believe the expiring SCHIP funds could be more effectively used for outreach and enrollment in the program. We fully support greater outreach and enrollment, but do not believe that it should come at the expense of providing adequate health insurance to children currently served by the program. In 2003, due to State budget deficits, seven States capped enrollment in their SCHIP. Over the next few years, unless we extend the availability of existing SCHIP funds and target them to the States with the most need, many States will lack adequate funds to meet their existing need, much less enroll more eligible but uninsured children. It is also important to note that ten percent of the amount States spend on coverage can be spent on administrative costs, including outreach. Consequently, an increase in coverage would also increase the funding States have for outreach and enrollment. Moreover, the Robert Wood Johnson Foundation currently provides SCHIP outreach grants to community health centers, hospitals, and faith-based organizations through its Covering Kids & Families Initiative.

Another criticism of S. 2759 deals with the amount of money States will have available in fiscal year 2005.