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6 EXAMINING INITIATIVES TO ADVANCE PUBLIC

7 HEALTH

8 WEDNESDAY, MAY 17, 2017

9 House of Representatives

10 Subcommittee on Health

11 Committee on Energy and Commerce

12 Washington, D.C.

13
14
15
16 The subcommittee met, pursuant to call, at 10:15 a.m., in
17 Room 2322 Rayburn House Office Building, Hon. Michael Burgess
18 [chairman of the subcommittee] presiding.

19 Members present: Representatives Burgess, Guthrie, Upton
20 Shimkus, Murphy, Lance, Griffith, Bilirakis, Bucshon, Mullin,
21 Collins, Carter, Walden (ex officio), Green, Schakowsky,
22 Butterfield, Matsui, Castor, Sarbanes, Schrader, Kennedy,
23 Cardenas, Eshoo, and Pallone (ex officio).

24 Staff present: Ray Baum, Staff Director; Paul Edattel, Chief

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25 Counsel, Health; Blair Ellis, Digital Coordinator/Press
26 Secretary; Jay Gulshen, Legislative Clerk, Health; Katie
27 McKeough, Press Assistant; Kristen Shatynski, Professional Staff
28 Member, Health; Danielle Steele, Policy Coordinator, Health;
29 Hamlin Wade, Special Advisor, External Affairs; Jacquelyn Bolen,
30 Minority Professional Staff; Jeff Carroll, Minority Staff
31 Director; Waverly Gordon, Minority Health Counsel; Tiffany
32 Guarascio, Minority Deputy Staff Director and Chief Health
33 Advisor; Una Lee, Minority Senior Health Counsel; Samantha
34 Satchell, Minority Policy Analyst; and C.J. Young, Minority Press
35 Secretary.

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36 Mr. Burgess. Please take your seats. The Subcommittee on
37 Health will now come to order.

38 The chair will recognize himself for 5 minutes for the
39 purpose of an opening statement. And Mr. Collins, I will be
40 coming to you at the end of my opening statement to recognize you.

41 This subcommittee has the responsibility of advancing
42 legislation to improve and strengthen public health policy for
43 all Americans. Today, we will examine four bipartisan bills
44 intended to improve public health for some of our most at-risk
45 populations.

46 In 2015, a 5-year study of nearly 30,000 firefighters found
47 that firefighters had a greater number of cancer diagnoses and
48 cancer-related deaths than the general population. While this
49 built upon prior studies that have examined the link between
50 firefighting and cancer, our understanding of this connection is
51 still limited.

52 To improve upon our ability to alleviate the health risks
53 that these public servants face, Representatives Collins and
54 Pascrell introduced H.R. 931, the Firefighter Cancer Registry Act
55 of 2017.

56 [The Bill H.R. 931 follows:]

57
58 *****INSERT 1*****

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59 Mr. Burgess. This bill would authorize funding for the
60 Centers of Disease Control and Prevention to create a national
61 registry for the collection of data pertaining to cancer incidence
62 among firefighters.

63 We are anxious to hear more from our witnesses about how H.R.
64 931 will fill the void in our understanding of the health risks
65 that our nation's firefighters face.

66 Another bill being considered today seeks to ensure that
67 victims in federally-declared disasters have access to medical
68 care by establishing uniform good Samaritan standards for
69 volunteer healthcare professionals.

70 Federal and state laws have developed to encourage
71 healthcare professionals to volunteer by providing limited
72 liability protection and recent events have exposed gaps in those
73 laws that led to delays in the ability of volunteers to provide
74 care. To prevent this from happening in the future,
75 Representatives Blackburn and Ruppersberger have introduced H.R.
76 1876, the Good Samaritan Health Professionals Act of 2017.

77 [The Bill H.R. 1876 follows:]

78

79 *****INSERT 2*****

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80 Mr. Burgess. This bill would provide limited civil
81 liability protection to licensed healthcare providers during a
82 declared disaster.

83 I certainly want to hear from our witness today about the
84 importance of H.R. 1876 to disaster victims.

85 We will also discuss legislation to strengthen the ability
86 of our healthcare workforce to recognize and care for victims of
87 human trafficking. Identifying victims of trafficking is a
88 crucial first step in getting them the support that they need but
89 it is an incredibly challenging task. A reported 68 percent of
90 trafficking victims end up at a healthcare setting at some point.
91 And this can serve as an important chance for providers to step
92 in and help.

93 Having spent my time practicing medicine, I know that feeling
94 prepared to handle difficult situations does require adequate
95 training and protocols. However, the vast majority of providers
96 do not have access to such resources.

97 To address this gap, Representatives Cohen and Kinzinger
98 have introduced H.R. 767, the SOAR to Health and Wellness Act of
99 2017.

100 [The Bill H.R. 767 follows:]

101
102 *****INSERT 3*****

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103 Mr. Burgess. This bill would build upon a pilot program
104 underway at the Department of Health and Human Services that has
105 enhanced the capacity of communities to identify victims and
106 survivors.

107 I certainly also want to hear from our witness today about
108 how this bill will address an unmet need for trafficking victims
109 and help healthcare providers throughout the United States of
110 America.

111 Finally, we will learn about the Action for Dental Health
112 Act of 2017 authored by Representative Kelly, who has joined us
113 this morning.

114 [The Bill H.R. ____ Action for Dental Health Act of 2017
115 follows:]

116

117 *****INSERT 4*****

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118 Mr. Burgess. Welcome to you.

119 This bill would take several steps to support and improve
120 dental health for some of our most vulnerable populations,
121 including children and the elderly. I look forward to learning
122 more from our witness about the importance of the initiatives of
123 this bill to the dental health of all Americans but especially
124 those known to be underserved.

125 I thank all of our witnesses for being here. I look forward
126 to hearing from each of you and I will yield the balance of my
127 time to the Gentleman from New York, Mr. Collins.

128 [The statement of Mr. Burgess follows:]

129

130 *****COMMITTEE INSERT 1*****

131 Mr. Collins. Thank you, Mr. Chairman, for holding this
132 hearing today and thank you to all our witnesses and particularly
133 Kevin O'Connor from the International Association of Fire
134 Fighters for being here today.

135 One bill up for discussion is legislation that I introduced,
136 H.R. 931, the Firefighter Cancer Registry Act of 2017. This
137 thoroughly bipartisan effort takes the first step towards
138 addressing the detrimental health effects of fighting fires.

139 While common sense tells us that firefighters frequently
140 inhale smoke and other harmful substances, we must know more about
141 the link between specific chemicals and diseases in order to
142 reduce their prevalence.

143 H.R. 931 requires the CDC to establish a voluntary cancer
144 registry so we can better understand the correlation between
145 serving as a firefighter and the incidence of cancer. The
146 registry will allow the CDC to compile a large database of cancer
147 incidence amongst firefighters and, through this research, we
148 will hopefully be able to develop new protocols and safeguards
149 for these brave men and women.

150 Thank you again, Mr. Chairman, for holding this hearing and
151 I yield back.

152 Mr. Burgess. The gentleman yields back. The chair thanks
153 the gentleman.

154 The chair recognizes the subcommittee ranking member, Mr.

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155 Green, for 5 minutes for an opening statement, please.

156 Mr. Green. Thank you, Mr. Chairman. And thank you to our
157 witnesses for being here this morning.

158 Today we are examining four pieces of legislation aimed at
159 improving our nation's health, H.R. 767, the SOAR to Health and
160 Wellness Act would help healthcare professionals identify and
161 assist human trafficking victims. Far too many victims of
162 trafficking have a contact with a healthcare professional while
163 they are in captivity, yet go undetected.

164 According to research, a large portion of healthcare
165 professionals have not received specific training on human
166 trafficking or are poorly equipped to recognize a sign or respond.
167 This legislation builds on work initiated by the Administration
168 of Children and Families in the Office of Women's Health in 2014
169 known as the Stop, Observe, Ask, and Respond or SOAR to the health
170 and wellness training programs that train providers to better
171 recognize and respond to victims of human trafficking.

172 H.R. 767 would authorize a program, as well as grants to train
173 healthcare providers in diverse care settings.

174 H.R. 931, the Firefighter Cancer Registry Act, would help
175 advance scientific understanding and response to increased
176 incidence of cancer among our nation's heroic firefighters and
177 I am proud to be a co-sponsor.

178 Several studies have identified that firefighters are at

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179 elevated risk of certain cancers, yet little beyond that is
180 well-understood. H.R. 931 will direct the Centers for Disease
181 Control and Prevention to develop and maintain a voluntary cancer
182 registry for firefighters. This registration would collect
183 relevant information to determine the risk of develop various
184 cancers and inform efforts to advance interventions.

185 The identified data from the registry would be made available
186 to researchers so we can spur scientific study and, ultimately,
187 better protect our nation's first responders.

188 The Action for Dental Health Act seeks to improve and promote
189 oral health care. Millions of Americans, will never see a
190 dentist, yet half of individuals over the age of 30 suffer from
191 gum disease and a quarter of young children have cavities. The
192 Action for Dental Health Act would reauthorize the CDC's oral
193 health promotion of disease prevention grants and allow volunteer
194 dental programs that provide free care to underserved populations
195 to apply directly for these grants.

196 Finally, we are considering H.R. 1876, the Good Samaritan
197 Health Professionals Act. The legislation would enable
198 providers to better respond to disasters. Specifically, the
199 legislation would limit the civil liability of healthcare
200 professionals who volunteer to provide healthcare services during
201 the response to a disaster.

202 I have long-supported encouraging volunteerism through

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203 protections from civil liability for actions taken in good faith
204 in the professional's capacity but the solution should be covered
205 by the Federal Tort Claims Act in these declared disaster areas.

206 Houston has tragic experience with hurricanes, floods, and
207 it is critical that our medical professionals who want to help
208 are empowered to do so. I look forward to learning more about
209 these worthy proposals and I want to thank the bills' sponsors,
210 and the chairman for this hearing, and our witnesses for their
211 testimony.

212 And I would like to yield the remainder of my time to
213 Congressman Butterfield.

214 Mr. Butterfield. I thank the gentleman for yielding and Mr.
215 Chairman, thank you for holding this hearing today.

216 This hearing is certainly an important first step in
217 reviewing bills that are bipartisan, can benefit all of our
218 constituents, and I certainly hope it will not be the last.

219 There are many other important public health bills, Mr.
220 Chairman, that we must consider, including my bills like the RACE
221 for Children Act and the National Prostate Cancer Plan Act, and
222 importantly, my colleague, Hakeem Jeffries' bill called the
223 Synthetic Drug Awareness Act. I hope these bills will be taken
224 up very soon.

225 The four bills that we are considering today all have
226 significant potential to improve public health. I am grateful

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that the committee is considering the Action for Dental Health Act introduced by my friend and colleague, Robin Kelly from Illinois. As many of you certainly know, my father was a 50-year dentist in a rural community in Wilson, North Carolina, Meharry Medical College Class of 1927. So, I have always understood the need for good oral health care and the barriers that prevent people from accessing it. Many people do not know that tooth decay is the most common chronic disease among U.S. children, according to the Pew Charitable Trust. Adequate dental care is especially lacking for individuals in low-income, minority, and rural communities. The Pew Trust estimates that more than 18 million low-income children went without dental care in 2014.

This bill, Mr. Chairman, would reauthorize important CDC oral health programs that provide grants to communities to expand health coverage. And I am glad. I am delighted that we are considering it today.

And I thank the gentleman for yielding. I yield back.

Mr. Burgess. The chair thanks the gentleman. The gentleman yields back.

The chair now recognizes the chairman of the full committee, Mr. Walden of Oregon, 5 minutes for an opening statement.

The Chairman. Thank you, Dr. Burgess. I appreciate the good work you are putting into these bills and our colleagues on both sides of the aisle keeping up with our bipartisanship over

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251 the years on initiatives to advance solid public health in
252 America.

253 There are four bills before us today we have heard a bit
254 about. I especially want to draw attention to H.R. 931, the
255 Firefighter Cancer Registry Act of 2017, which requires Centers
256 for Disease Control and Prevent to develop a voluntary registry
257 of firefighter occupational information that can be linked to
258 state cancer registries.

259 Kevin, your testimony is especially pointed, given your own
260 personal situation, and really speaks to the importance of the
261 need for these types of registries, especially when it comes to
262 our firefighters. As you point out, we have learned a lot over
263 the years and what to do and not do in terms of best practices
264 and we have got to get ahead of this one.

265 Certainly in Oregon, we know the bravery our first responders
266 not only for traditional firefighting, but also in the West, where
267 the kind of fires we get in the summers in our forests, where they
268 face intense smoke and flames and are frequently breathing in
269 dangerous fumes and carcinogens on the job.

270 So, this is really important legislation. And while we know
271 somewhat about the cancer risk, we don't know everything we need
272 to know. And so I thank you for your support of this bill and
273 Congressman Collins for introducing it, along with his
274 colleagues.

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Legislation offered by Representative Robin Kelly, known as the Action for Dental Health Act of 2017 would help increase access to dental care in underserved communities, by allowing the CDC to award grants for volunteer oral health projects and free dental services to underserved populations.

This bill would also improve outreach, prevention, and education in oral health. We have heard from colleagues on both sides of the aisle about the extraordinary importance of appropriate dental health, especially in underserved areas.

We will also consider H.R. 1876, the Good Samaritan Health Professionals Act of 2017 authored by Chairman Marsha Blackburn, which would provide limited liability protections for health practitioners providing care to those in a natural disaster, terrorist attack, or other emergency. I think we have learned a lot over the years, as these disasters have struck our citizens, just the importance of breaking through some of the barriers when emergencies happen and to try and get ahead of them with legislation like this.

Finally, we will examine H.R. 767, the SOAR to Health and Wellness Act of 2017 authored by Representative Steve Cohen. This bill would expand and codify the Stop, Observe, Ask, and Respond program at HHS, which provides health professionals training on how to identify and treat human trafficking victims.

Human trafficking is a crime. It is a violation of human

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299 rights. Health providers are uniquely positioned on the front
300 lines to interact with suspected trafficking victims and get them
301 the help that they need and deserve.

302 So I want to thank my colleagues on both sides of the aisle
303 for bipartisan work in these efforts and look forward to the
304 testimony from our witnesses.

305 I would say in advance I am being triple-teamed right now,
306 in terms of this hearing, one downstairs, and some other meetings
307 I have to attend to. But I appreciate your testimony, which I
308 have read and look forward to our committee's actions on these
309 important pieces of legislation.

310 I don't know if there is anybody else on the other side that
311 would like the remainder of my time but, if not, I would yield
312 back to the chairman and look forward to the hearing.

313 [The statement of Chairman Walden follows:]

314

315 *****COMMITTEE INSERT 2*****

316 Mr. Burgess. The chair notes the chairman's attendance and
317 is very appreciative because I know it is a busy morning for you
318 and I thank you for being here.

319 The chair now recognizes the gentleman from New Jersey, the
320 ranking member of the full committee, Mr. Pallone, 5 minutes for
321 an opening statement please.

322 Mr. Pallone. Thank you Mr. Chairman. I believe that we can
323 all agree on the importance of supporting our country's public
324 health system. A strong public health response is one of the
325 first lines of defense when our nation is faced with a health
326 crisis. It is also an important tool when addressing
327 longstanding healthcare issues, including the prevention of
328 harmful and closely chronic conditions. And today we will hear
329 from our witnesses on the four public health bills.

330 Mr. Chairman, I am not going to repeat what is in the bills
331 but I do want to comment on them.

332 With regard to H.R. 767, the SOAR to Health and Wellness Act,
333 I wanted to say that a doctor's visit or emergency department trip
334 is a critical point of intervention for victims, as it may be a
335 rare moment in which they can detach from traffickers. Teaching
336 providers to recognize the signs of trafficking and providing them
337 with the resources to assist victims can truly be the difference
338 between life and death. So I want to thank Congressman Cardenas
339 for his work on this bill.

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340 With regard to H.R. 931, the Firefighter's Cancer Registry
341 Act is another bill which we will discuss that creates a voluntary
342 cancer registry of firefighters to collect data related to their
343 cancer risk and outcomes. And firefighters may be exposed to
344 carcinogens and other hazardous chemicals that impact their
345 health while they are on the job. The registry would help CDC
346 collect and monitor information from firefighters over time to
347 inform the best prevention and intervention practices.

348 H.R. 1876, the Good Samaritan Health Professionals Act,
349 again, our volunteer health professionals are a crucial resource
350 in major disasters. I remember 9/11 and the bravery of medical
351 volunteers from all over the nation, especially from my home state
352 of New Jersey, as they headed across the water to help the victims
353 in New York City. I also think of the response to Hurricane Sandy
354 and how many people survived the storm, due to the action of
355 medical volunteers.

356 While I am always concerned about preempting strong state
357 laws, I look forward to learning more about this bill and
358 understand what we can do as lawmakers to support medical
359 volunteers at the federal level.

360 And finally, I want to thank Congresswoman Robin Kelly, who
361 I see is here, for her work on H.R. 767, the Action for Dental
362 Health Act of 2017. Oral health is often thought of as separate
363 from a person's medical care but the truth is that oral health

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is vital to overall health, ensuring access to affordable dental care would lower the number of emergency department visits for preventable oral conditions and reduce the risk of chronic disease. In short, it would lead to an improved quality of life.

And again, I thank our witnesses. I look forward to the discussion.

I would like to yield the remainder of my time to Mr. Cardenas.

Mr. Cardenas. Thank you very much. I want to thank the chairman and also the ranking member for holding this hearing today.

Human trafficking is an issue that really hits home for us in Los Angeles. Unfortunately, we are one of the largest trafficking cities in the world. I have been involved in combatting human trafficking efforts since my days on the city council.

For example, while I was on the city council, the case occurred where 12 women were forced to work as prostitutes in South Los Angeles in a brothel to pay off debts to their smugglers. It was a wake-up call for me and the entire city. We can and should be doing more to prevent human trafficking and we can.

That is why I am proud to join Congressmen Cohen, Kinzinger, and Wagner in introducing H.R. 767, the SOAR to Health and Wellness Act -- Stop, Observe, Ask, and Respond. This bipartisan bill

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creates a pilot program at the Department of Health and Human Services to ensure that more healthcare professionals are trained to identify and assist victims of human trafficking.

Victims of forced sex and labor trafficking are often incredibly difficult to identify. Over 20 million human beings are victimized by traffickers worldwide every single year. And more than 85 percent of trafficking victims end up in a healthcare setting at some point. Despite this, fewer than 60 hospitals around the country have been identified as having a plan for treating patients who are victims of trafficking. Only five percent of emergency room personnel are trained to treat trafficking victims.

This bill is part of the solution to the bigger issue of human trafficking. I urge my colleagues to join me in the fight against human trafficking by supporting this common sense legislation.

And when we did identify that in Los Angeles, we actually did something at very, very little cost. All of the law enforcement agencies throughout LA city and county from the federal level to the state level came together with the not-for-profit service providers and we created a human trafficking task force. And the identification of human traffic victims went up incredibly high and the identification rate didn't have misses. They were all positive hits. So many lives were saved.

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412 And I thank you very much. I yield back.

413 Mr. Burgess. The chair thanks the gentleman. The
414 gentleman yields back.

415 That concludes member opening statements. The chair would
416 like to remind members that pursuant to committee rules, all
417 members' opening statements will be part of the record.

418 And we do want to thank all of our witnesses for being here
419 this morning and taking time, their time to testify before the
420 subcommittee. Each of our witnesses will have the opportunity
421 to give a summary of their opening statement, which will be
422 followed by a round of questions for members.

423 So today, we have with us Mr. Kevin O'Connor, Assistant to
424 the General President of the International Association of Fire
425 Fighters; Dr. Cheryl Watson-Lowry, the American Dental
426 Association; Dr. Martin Levine, Interim Clinical Dean, Touro
427 College of Osteopathic Medicine; and Dr. Jordan Greenbaum, the
428 Director of the Global Child Health and Well Being Initiative from
429 the International Center for Missing and Exploited Children. We
430 appreciate all of you being here today.

431 And Mr. O'Connor, you are now recognized for 5 minutes to
432 summarize your opening statement. Thank you.

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STATEMENTS OF KEVIN O'CONNOR, ASSISTANT TO THE GENERAL PRESIDENT,
INTERNATIONAL ASSOCIATION OF FIRE FIGHTERS; CHERYL WATSON-LOWRY,
D.D.S., AMERICAN DENTAL ASSOCIATION; MARTIN LEVINE, D.O., M.P.H.,
INTERIM CLINICAL DEAN, TOURO COLLEGE OF OSTEOPATHIC MEDICINE; AND
V. JORDAN GREENBAUM, M.D., DIRECTOR, GLOBAL CHILD HEALTH AND WELL
BEING INITIATIVE, STEPHANIE V. BLANK CENTER FOR SAFETY AND HEALTHY
CHILDREN, CHILDREN'S HEALTHCARE OF ATLANTA

STATEMENT OF KEVIN O'CONNOR

Mr. O'Connor. Thank you, Chairman Burgess, Ranking Member
Green, full committee Chair Walden, and Ranking Member Pallone,
distinguished members.

I am Kevin O'Connor and I head the Governmental Affairs and
Public Policy Division for the International Association of Fire
Fighters. I am here today on behalf of over 305,000 members who
provide fire, rescue, and emergency medical services to every
congressional area in the country.

Cancer is a scourge that plagues the fire service of people
of all ages and in every region of the country. It is a disease
that impacts both men and women, young and old. It is a sad truth
that when people join the fire service, they knowingly recognize
that they will incur a higher chance than the general public of
contracting and dying from cancer.

Firefighters respond to every conceivable disaster,

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emergency, or hazardous incident. The environments to which our members are exposed are laden with carcinogens, biohazards, and other chemical formulations and compounds. Under any circumstances, these products are hazardous but, under combustion, they emit byproducts that can be fatal, both at the emergency scene and years later through the accumulation of occupational diseases.

Every year, the IAFF honors our fallen heroes at a memorial service in Colorado Springs. For the past generation, more firefighters have died of occupational cancers than those who are killed on the fire scene, at building collapses, and vehicular accidents, and all other incidents combined. In fact, over 60 percent of our deaths are cancer-related.

There are three principle studies that track elevated incidence of cancer among firefighters. The first is a University of Cincinnati analysis which combine data from over two dozen other studies and classify the heighten risk of firefighters into several categories.

Secondly, NIOSH tracked cancer data in over 30,000 firefighters over a 59-year period from large metropolitan regions and compiled data demonstrating increased risk of firefighters of dying from seven specific cancers.

Lastly, a 40-year 16,000 firefighter cohort study in the Nordic countries largely mirror the results found by NIOSH.

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Here are some of those collective findings: Firefighters contract testicular cancer at a 102 percent greater rate than the general public; mesothelioma, 101 percent more; non-Hodgkin's lymphoma, 51 percent; multiple melanomas 53 percent; rectum cancer, 45 percent; and sadly, the list continues.

Cancer is an epidemic in our industry. To eliminate or reduce cancer risk, we need data. It is problematic but there is only three major studies that track these statistics. The IAFF and our members applaud Representative Chris Collins for introducing H.R. 931 and those who have co-sponsored the legislation. The measure already has over 165 bipartisan co-sponsors and, as stated, would establish a voluntary cancer registry through the Center of Disease Control exclusively for firefighters, career, volunteer, part-time, wildland, all measures of firefighters. This information could be accessed by researchers, epidemiologists, and physicians to track cancer in our profession and use the findings for more advanced or targeted research. Simply put, it will be a centralized data collection point.

The registry would be structured in a fashion that will track various demographic and employment information, including years of service, call volume, risk factors, and more but protect the confidentiality and privacy of the responders. The national registry would provide a trove of useful data and information.

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505 I have a personal interest in H.R. 931. I am a cancer
506 survivor. Before assuming my current post, I served as a
507 firefighter in Baltimore County for 16 years, a career much
508 shorter than many other firefighters. I won't embellish my
509 service. I responded. I did my job just like everyone else.

510 Last year, I developed prostate cancer. The statistics say
511 that firefighters between 30 and 49 years of age have a 159 percent
512 greater chance at contracting prostate cancer than other men.
513 Was my cancer job-related? I don't know the answer to that. But
514 I do know that both my grandfathers lived past 80 and my father
515 is still a very vibrant 85-year-old. I had the prostate removed
516 last year and, as of today, I am cancer-free.

517 Knowledge and information are very powerful tools. We need
518 those tools to track, treat, and prevent cancer. The firefighter
519 cancer registry does just that.

520 I encourage this committee and the entire body to act
521 favorably and expeditiously on this legislation.

522 I thank you for the opportunity to testify today and am
523 willing to answer any questions. Thank you very much.

524 [The statement of Mr. O'Connor follows:]

525

526 *****INSERT 5*****

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527 Mr. Burgess. The chair thanks the gentleman for his
528 testimony.

529 Dr. Watson-Lowry, you are recognized for 5 minutes, please.

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STATEMENT OF CHERYL D. WATSON-LOWRY

Dr. Watson-Lowry. Good morning. Mr. Chairman and members of the subcommittee, thank you for the opportunity to testify this morning in support of the Action for Dental Health Care Act 2017 introduced by Representative Robin Kelly. Thank you very much.

My name is Dr. Cheryl Watson-Lowry. I am a practicing dentist from Chicago, Illinois and a member of the American Dental Association.

As you may have seen from my bio, I am a second generation dentist. My dad went to Meharry. I started working with my dad when I was 11 years old and I started working chair-side when I was 15 years old.

My practice is in the inner city and my patients range in age from 6 months to 107 years old. My patients include professionals, politicians, teachers, police officers, students, fast food workers, and even one patient that sells incense on the train to pay his bills, including for his dental services.

The Action for Dental Health Bill you are considering could positively affect every patient in my practice, which is why I am so passionate about it.

This bill is important because healthy teeth and gums aren't a luxury. They are an essential for good oral health and good overall health. As a practicing dentist, I know the causes of

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dental disease can be varied and complex. So the solutions for the dental health crisis facing America today needs to be wide-ranging. The American Dental Association is very proud to support H.R. 2422 because the legislation helps to address the numerous barriers to accessing care and oral healthcare services. The ADH bill does this by providing funding for organizations engaged in volunteer dental projects that provide free dental care directly to those in need but it also establishes a second grant program to promote oral health initiatives design to facilitate private-public partnerships collectively called Action for Dental Health Initiatives.

A good example of a successful volunteer project, the ADA's Give Kids A Smile program, which has provided free oral healthcare services for over 5.5 million children since 2003. While pro bono programs serve as an important safety net for individuals who cannot afford coverage, we all know that offering free oral health services is not a long-term solution. That is why in 2013, the ADA launched the Action for Dental Health Initiative.

The ADA initiative is a nationwide community-based movement aimed at ending the dental crisis. It is composed of eight initiatives designed to address specific barriers to care. This morning, I would like to focus on just two of the ADH Initiatives: emergency room referrals and community dental health coordinators.

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578 A key initiative in the ADH program is reducing the number
579 of people who visit the emergency room for dental conditions by
580 referring them to dental practices. These emergency room visits
581 for dental problems cost more than providing regular care by oral
582 health professionals. It is estimated that the U.S. spent nearly
583 \$3 billion on E.R. dental visits between 2008 and 2010. Also,
584 most E.R. visits only provide patients with pain medication and
585 antibiotics. They do not treat the underlying problem.

586 While recent research indicates that hundreds of E.R.
587 referral programs in virtually every state are working and the
588 use of emergency room for dental conditions have been decreasing,
589 we cannot let up now. More still needs to be done to expand E.R.
590 referral programs and H.R. 2422 will help.

591 The ADA also believes that the use of community dental health
592 coordinators, also called CDHCs can continue this positive trend
593 by connecting patients to dental homes and ensuring that the care
594 is delivered in the most appropriate and cost-effective venue
595 possible. The ADA's commitment to improving America's oral
596 health has led us to invest more than \$7 million in the CDHC
597 program. This program trains individuals to provide patient
598 navigation, oral health information, and preventative self-care
599 for patients who typically do not receive dental services.

600 The CDHCs work in inner cities, remote rural areas, and
601 Native American lands. They help people who might otherwise

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through the cracks of what can be a complicated delivery system. Most CDHCs grew up in these communities, so they better understand the problems that affect the access to dental care.

The CDHC model has been adapted to numerous community settings, including clinics, schools, Head Start programs, institutional settings, churches, and other venues. It is important to note that an evaluation based on 88 case studies of CDHC programs demonstrated the real-world value of the CDHC in making the dental team more efficient and effective. Before the end of this summer, the CDH program will have over 100 graduates working in 21 states. With the help of H.R. 2422, we hope that the number will continue to grow and help our nation's vulnerable find dental homes.

Mr. Chairman and subcommittee, thank you for the opportunity to share with you why the ADA believes the Action for Dental Health Act of 2017 will enhance ongoing efforts to reduce the barriers to oral health care facing Americans today.

Thank you.

[The statement of Dr. Watson-Lowry follows:]

*****INSERT 6*****

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622 Mr. Burgess. Thank you and thank you for your testimony.
623 Dr. Levine, you are recognized for 5 minutes for a
624 summarization of your opening statement, please.

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STATEMENT OF MARTIN LEVINE

Dr. Levine. Thank you, Chairman Burgess, Ranking Member Green, and -- Chairman Burgess, thank you. Ranking Member Green and members of the subcommittee, on behalf of the American Osteopathic Association and the nearly 130,000 osteopathic physicians and osteopathic medical students we represent, thank you for the opportunity to testify this morning on the Good Samaritan Health Professionals Act of 2017.

My name is Martin Levine, D.O. I am a board-certified osteopathic family physician from New Jersey and I also have the distinct privilege of having served as the 115th President of the AOA in the 2011-2012 term.

I have practiced osteopathic family medicine and osteopathic manipulation as well as sports medicine for 34 years. Throughout my career, I have always worked with students and I am now the Interim Clinical Dean at the Touro College of Osteopathic Medicine in Harlem.

I have also served as a team physician at every level of sports, including local college, Olympic, and professional sports teams. In addition, I have been proud to serve as a volunteer physician at the New York City Marathon for over 20 years and also as the Elite Athlete Recovery Area physician at the Boston Marathon for the past 18 years.

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649 On April 15, 2013, after finishing my duties with the Elite
650 Athletes, I was triaging runners in front of the main medical tent
651 just after the finish line of the Boston Marathon when the first
652 of two bombs exploded on Boylston Street. We heard the explosion
653 and I saw the plume of smoke begin to rise. And the first thing
654 I noticed with it, there were no people standing in that area
655 anymore.

656 I immediately told the staff inside the tent to make room
657 and to clear out anyone that was able to leave, as it was clear
658 we were going to have casualties. And then I turned and ran to
659 the site of the explosion.

660 As I arrived at the scene, the second bomb went off further
661 up Boylston Street. As one of the first responders at the site
662 of the first blast, I saw blood everywhere and dozens of victims
663 on the ground with severe wounds, mostly below the waist. Many
664 of the victims were missing lower limbs and bleeding profusely.
665 So I and other responders improvised tourniquets with our belts
666 and identification badge lanyards to staunch the bleeding. We
667 transported victims to ambulances using stretchers, backboards,
668 wheelchairs, whatever was possible.

669 Thanks to the quick work of the EMS, other first responders,
670 and the ambulances, the first casualty to arrive at the hospital
671 was there in 14 minutes and they were in the operating room within
672 22 minutes of the blast. In seconds, we had gone from helping

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runners recover from the race to treating spectators with severe trauma -- horrific injuries inflicted by a bomb.

The medical team at the Boston Marathon is always prepared to treat mass casualties, just not the type of wounds we saw on that day. As part of the medical responders, I didn't feel the chaos of the moment; we were simply doing what we had to do in that situation and most important was that we were able to save lives.

I am grateful that the committee is holding the hearing today to examine the Good Samaritan Health Professionals Act, legislation that will help provide professional healthcare volunteers with much needed certainty when serving as volunteers during federally-declared disasters. The desire to help save lives drives many physicians and healthcare professionals from all over the country to volunteer when disaster strikes.

While the scale of the disaster and the scope of needs will always vary, providing uniform federal standards for professional liability will help ensure that a sufficient healthcare workforce can be mobilized without unnecessary delays or confusion. In our case of the marathon, the race's liability coverage would have protected as volunteers for treating the runners. But we had to shift to treating spectators in a much different capacity which would not be covered under that policy.

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697 This legislation will help fill in the existing gaps in our
698 liability protection laws. While many states have such
699 protection in place, the current patchwork of laws does not
700 provide healthcare professionals with the certainty they need and
701 the inconsistency in understanding the application of these laws
702 has resulted from physicians being turned away from disaster
703 areas, when they attempt to volunteer their services. A uniform
704 federal standard narrowly focused to apply to federally-declared
705 disaster areas will ensure that qualified medical professionals
706 can contribute their services to provide communities with the
707 medical assistance they need.

708 As an osteopathic physician, I am trained to treat the whole
709 person, addressing not just the body but the mind and spirit.
710 Disaster victims require the need for emotional support, comfort,
711 and empathy, as they receive the care needed to address their
712 physical wounds. In this case, it was an act of terrorism. In
713 other instances, it might be a natural disaster or public health
714 outbreak. Regardless, this legislation would provide healthcare
715 professionals with the comfort and emotional well-being of
716 knowing that they are not at financial risk when voluntarily
717 treating victims of federally-recognized disasters.

718 Thank you once again for the opportunity to provide my
719 testimony before the subcommittee today. On behalf of the nearly
720 130,000 osteopathic physicians and students across the country,

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721 we appreciate your attention to the important issue and thank the
722 committee members for taking steps to advance public health.

723 Thank you.

724 [The statement of Dr. Levine follows:]

725

726 *****INSERT 7*****

727 Mr. Burgess. The chair thanks the gentleman for his
728 testimony.

729 Dr. Greenbaum, you are recognized for 5 minutes for an
730 opening statement, please.

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STATEMENT OF JORDAN GREENBAUM

Dr. Greenbaum. Thank you. Good morning Chairman Burgess, Ranking Member Green, and subcommittee members. I appreciate the opportunity to testify in front of you today.

I am a child abuse physician and the Medical Director of the Institute for Human Trafficking at Children's Healthcare of Atlanta. The purpose of the Institute is to improve the lives of children and families affected by human trafficking by enhancing mental health and medical care through research, training, and education.

I am also the Medical Director of the Global Initiative for Child Health and Well Being at the International Center for Missing and Exploited Children and a HEAL Trafficking member, a national organization dedicated to ending human trafficking using a public health approach.

A 15-year-old girl was admitted to Children's Healthcare of Atlanta a few years ago for a suicide attempt. She had ingested alcohol and a narcotic. It was only after she woke up in the intensive care unit and was interviewed by one of our social workers that we learned her depression existed in the context of human trafficking.

What if we had never asked her about her depression or the circumstances of her life? She probably would have been admitted

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briefly to a psychiatric institution and then, in all likelihood, discharged back to her life of exploitation.

For the next 4 minutes, I would like to make three essential points: human trafficking is a healthcare issue; healthcare professionals need training in order to be able to recognize and respond to human trafficking; and the SOAR to Health and Wellness Act is a very effective strategy for addressing this widespread need for education and training.

As you know, reliable estimates of the incidence and prevalence of human trafficking are lacking but the best estimates suggest that millions of adults and children around the world are impacted by human trafficking and the United States is a major destination country. Victims of trafficking may experience a plethora of physical and mental health adverse consequences ranging from physical assault injuries, sexual assault injuries, sexually-transmitted diseases, HIV/AIDS, tuberculosis, major depression, and post-traumatic stress disorder. In a recent study of youth sex trafficking victims, 47 percent reported attempting suicide within the past year.

Despite the criminal nature of human trafficking and the desire of traffickers to elude detection, research consistently shows that victims do have contact with medical professionals. In a study of female survivors, nearly 88 percent had been seen by a medical professional during their period of exploitation but

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we also know that victims rarely self-identify when they seek medical care. I believe that every day hundreds of victims across the United States are coming to our clinics and our emergency departments and presenting for symptoms, being treated for conditions, and discharged with no one ever asking about the possibility of exploitation.

Consider a 14-year-old trafficked boy who comes to a clinic with symptoms of a sexually-transmitted infection. He might easily be treated for his symptoms and sent on his way, without anyone ever asking about the possibility of exploitation or the circumstances of his life. Subsequently, that same unidentified victim may become HIV-positive or experience major traumatic injuries from a physical assault.

This medical visit represents a critical missed opportunity. Health and services are within arm's reach but go untouched. To prevent lost opportunities such as these, to offer exploited persons help in leaving their situation, it is imperative that healthcare professionals recognize signs of high-risk youth and adults, ask questions appropriately and provide trauma-sensitive care.

The SOAR to Health and Wellness Act would address the critical need for training of healthcare providers. This training would be specific to the needs of varied professionals, ranging from medical and mental health practitioners, social

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workers, and public health professionals. And importantly, the training would be based on research, not emotion; on facts, not speculation. It would use well-established adult learning strategies to facilitate changes in practitioner attitude, knowledge, and behavior. And the training would be formally evaluated to make sure it is effective.

Essential to facilitating lasting change in any medical practice is to support the newly trained practitioners and this can be facilitated through good protocols for providers to use whenever they suspect a patient has been trafficked. H.R. 767 addresses this need by including protocols in the program development -- protocols for offices, clinics, and hospitals, and provision of technical assistance to those who want to implement the protocols.

Training and technical support of healthcare professionals are critical components of the U.S. effort to curb the tide of human trafficking. Healthcare professionals have a unique role in preventing exploitation and identifying victims, as well as assisting them in escaping their plight. But without evidence-based, high-quality, easily accessible training, and technical assistance, the very large, complex, and unwieldy healthcare sector may well lose track of the human trafficking issue and give up its role in fighting the battle against exploitation. We cannot allow that to happen.

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827 Thank you very much for allowing me to testify in front of
828 you today.

829 [The statement of Dr. Greenbaum follows:]

830

831 *****INSERT 8*****

832 Mr. Burgess. And thank you. We appreciate your testimony.
833 And I thank all the witnesses for their testimony.

834 We are now going to move into the question portion of the
835 hearing.

836 Just before we do that, I do want to recognize Dr. David
837 Scott, who was a lead co-sponsor on the Good Samaritan Health
838 Professionals Act. So, I certainly want to acknowledge his good
839 work on that.

840 I will get in trouble for doing this but I want to recognize
841 the presence of Dr. Laura Sirott in the audience. She is a McCain
842 Fellow from the American College of OB/GYN. She practices I think
843 in Los Angeles, California and we are very grateful to have her
844 attention this morning as the good folks at ACOG sponsor the McCain
845 Fellowship to foster a greater understanding of public policy as
846 it relates to health care.

847 Dr. Levine, thank you so much for being here this morning.
848 Thank you for your work.

849 You know it was shortly after Hurricane Katrina struck on
850 Labor Day weekend and I am sitting in my office a little bit north
851 of Dallas, Texas, as a Member of Congress, but clearly there was
852 a need. And I was somewhat startled to find out that if I made
853 myself available down at Reunion Arena in Dallas, Texas, where
854 I had a state license but I no longer carried liability insurance,
855 I could be at risk. But if I traveled to Louisiana, where I didn't

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856 have a medical license, I could volunteer all day long.

857 Now, it turns out I was probably more useful as a triage
858 individual, helping people get placement in nursing homes in the
859 Metroplex who were in trouble in Louisiana but it struck me that
860 day that there is kind of a patchwork that governs this. Is that
861 correct?

862 Dr. Levine. Yes, sir and it is hard for the physicians who
863 may want to travel, for whatever reason, out of state but also
864 within their own state. It is difficult when you are telling your
865 insurer, liability insurer for your own practice, that if you are
866 working outside of your practice spots, you may not be covered.
867 So even if I am in the same state, some of the states will not
868 -- some of the liability will not cover you within your own state.

869 Mr. Burgess. So just as a matter of course, a physician who
870 wishes to volunteer in one of those types of situations, do they
871 need to call their liability carrier first before they volunteer?

872 Dr. Levine. Obviously, that would be very difficult and
873 with the chaos of disasters, it is almost impossible to find out
874 immediately what you would be covered by.

875 Mr. Burgess. Yes, in your situation in Boston, obviously,
876 that would have been impossible in that chaotic moment.

877 And I want to thank you for being there and responding. I
878 will tell you, having watched that drama unfold on the television
879 here on Capitol Hill, it was very, very difficult. And it really

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880 wasn't until the medical professionals came out that night and
881 gave the press conference that I had a sense that things were back
882 under control. So, clearly, the people who respond in events like
883 that provide, in addition to taking care of the people that are
884 injured at the scene, it also provides care to those of us who
885 are not on the scene, that somebody competent is in charge and
886 taking care of those who were injured.

887 Mr. O'Connor, I want to thank you for your presence today.
888 You have provided us information on something which I was unaware,
889 was the dramatic increase, and if I understand your testimony
890 correctly, that started around calendar year 2002, or is that just
891 when we started keeping statistics?

892 Mr. O'Connor. Well, the statistics have been kept longer
893 than that. My testimony was germane to the IAFF's fallen
894 firefighter, when we started tracking statistics internally.
895 That is just for those who actually have perished in our
896 organization. That is not comprehensive of the entire fire
897 service.

898 Mr. Burgess. I see.

899 Mr. O'Connor. Statistics started being collected in 1950.
900 The one study that I referenced began then and ended in 2009. The
901 problem, unfortunately, has been the gathering of information has
902 not been complete. There has been certain aspects in terms of
903 risk factors, how long people served as firefighters, a lot of

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904 that other type of demographic data has not been collected. It
905 has just basically been review of death certificates.

906 Mr. Burgess. Well, you certainly added good evidence to why
907 the collection of data is important.

908 Dr. Greenbaum, let me ask you. In your testimony you talked
909 about a 14-year-old who came to an emergency room. When I
910 practiced in Texas, if there was even any evidence of child abuse,
911 I was required to call Child Protective Services. It wasn't
912 optional. It was an obligation in which case, I could perhaps
913 incur legal liability if I didn't do that. Would that not have
914 been the case for this child that you referenced in your testimony?

915 Dr. Greenbaum. In many states, commercial sexual
916 exploitation falls under the child abuse mandated reporting laws.
917 It is not uniformly so. And I think all too often, people don't
918 ask the questions about the background and what led to that
919 sexually-transmitted infection. So, they don't get the
920 information that would tell them the child has been exploited,
921 requiring a report.

922 Mr. Burgess. Well, I thank you for your testimony and for
923 your work on this.

924 It wasn't in this committee but on the Helsinki Commission
925 a year and a half ago, we had a very compelling hearing on this
926 issue of human trafficking and both of the women who testified
927 -- it was very courageous for them to come forward -- it was their

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interactions with the healthcare system, where the evidence and clues were missed. One of the things that just struck me during that hearing was each of those witnesses stated that their trafficking was done by a family member. So merely the fact that it is a family member who brought someone in for care does not mean you don't have to worry about that. In these two cases, it was a direct result of their family member doing the trafficking that caused them to be in the emergency room or the clinical setting where they were that day.

And the other thing that struck me is the length of time that it went on before there was actually recognition. So I suspect that is what you have brought to us today is extremely important and something the committee clearly needs to look at.

I am going to yield back my time and recognize the ranking member of the subcommittee, Mr. Green from Texas for 5 minutes for questions, please.

Mr. Green. Thank you, Mr. Chairman.

Mr. O'Connor, welcome to our committee and I want to thank you and your fellow firefighters across the country. If I hadn't gotten into politics, I would probably have been a firefighter since my grandfather and my two uncles were.

But cancer continues to be a devastating effect on individuals throughout our country. The American Cancer Society estimates that 692,000 Americans will die from this horrible

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952 disease. And these efforts -- last Congress we passed the Beau
953 Biden Cancer Moonshot, which was part of our 21st Century Cures
954 in support in improving the lives of all Americans.

955 The Firefighter Cancer Registry, though, is really important
956 because there is an incidence of firefighters, even though
957 nowadays they have a lot better equipment, when they go into a
958 fire, they don't know what they are breathing. It could be
959 chemicals, particularly in an area like I come from because we
960 have a chemical industry.

961 What is currently known about the link between firefighter
962 occupation and cancer?

963 Mr. O'Connor. Well I mean that is a very good question and
964 there is multiple answers for it.

965 First, their industry has changed so much in the 31 years
966 I became a firefighter. You are absolutely right. If this room
967 itself caught on fire, there is carcinogens in just about
968 everything, toxic flame retardants. For wildland firefighting,
969 people just think that it is the trees and it is nature burning.
970 In many cases, it becomes a conflagration, like what occurred in
971 Colorado Springs, where 200 houses went up. The World Trade
972 Center, the collapse, the particulates.

973 Firefighters are exposed to it from almost the minute they
974 walk into a fire station. One of the problems we encounter is
975 diesel exhaust just in the station from the equipment starting

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and shutting off. Obviously, when they get on the scene, they have exposure through inhalation, through breathing. Certainly, the technology of self-contained breathing apparatus has improved and lung cancer has actually diminished a little bit over the last generation because it was a known risk.

But what we are finding now is that people are getting exposed through, essentially, their sweat, basically through their clothing absorbing into the skin, through so many different sources. It isn't just the inhalation risk. It is almost every aspect of it.

The other aspect is the type of fires have changed so much and the responsibilities of firefighters. Many years ago, it was simple construction. People understood the risk. But today it is hazardous materials response, it is EMS. There are so many different things, every measure of disaster. It was referenced the situations down on the Gulf Coast, the same thing with Super Storm Sandy.

We are exposed and what this registry does differently than any other study is it takes almost every factor into account, not just people contracting and dying, but it will actually take how long somebody is a firefighter, what type of firefighter. Are they large city firefighters, where they may have more responses and more varied responses? Are they volunteer, paid on call, wildland? All those demographics are going to be taken into

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1000 account. So, hopefully, over a period of time, we will actually
1001 be able to assimilate the information and digest it and make it
1002 useable to prevent cancers in the future.

1003 Mr. Green. Thank you. Thank you all for bringing the bill
1004 before us.

1005 Dr. Levine, because our chair coming from Houston, I remember
1006 very well Hurricane Katrina. And at the Astrodome in Houston we
1007 received a quarter of million folks from Louisiana. They brought
1008 us good gumbo, too, and we sent them back with good barbeque.

1009 My concern about the bill that would just give protection
1010 from lawsuits and we have a patchwork of laws with states.
1011 Louisiana is different from Texas, for example, maybe. But on
1012 the federal level, if we could give these tort claims protections
1013 under a federal act, would that solve the same problem?

1014 Dr. Levine. I believe it might and I am saying might. I
1015 mean there are still state laws that are fairly strong in this
1016 area so, they would still be there for protection. But I would
1017 think that having one overarching one is what we are after here,
1018 one overarching federal law that would tell the first responders
1019 it is okay to be there and do what you need to do.

1020 If you are relying on state law, you may or may not know what
1021 is going on at the moment and that time is really the key to any
1022 act and any treatment of an individual.

1023 I mentioned that 14 minutes, and 22 minutes, and minutes to

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1024 get somebody to the OR, when we are talking about a large loss
1025 of blood, either you do it or you don't. There is no questions.
1026 There is no -- you know you don't have time anything except to
1027 respond.

1028 Mr. Green. An example is we worked for years for the
1029 Federally Qualified Health Clinics to have volunteer doctors so
1030 they could provide for the underserved in giving them federal tort
1031 claims protection by volunteering in those clinics. So that was
1032 just an example.

1033 Mr. Chairman, I would like to yield my last 2 seconds to my
1034 colleague, Congressman Sarbanes from Maryland.

1035 Mr. Sarbanes. I thank the gentleman for yielding. I don't
1036 know that I am going to be here when it comes time.

1037 I just wanted to thank you, Kevin. You mentioned your 16
1038 years of service to the residents of Baltimore County. I
1039 represent those folks and, on their behalf, I want to thank you
1040 and for your extraordinary advocacy on all of these issues.

1041 And I yield back.

1042 Mr. Burgess. The chair notes the gentleman's time had
1043 expired when he yielded time that didn't exist.

1044 Mr. Green. Well, I had 5 seconds.

1045 Mr. Burgess. So, it comes off future time.

1046 I do now want to recognize the gentleman from Virginia, Mr.
1047 Griffith, for 5 minutes for your questions, please.

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1048 Mr. Griffith. Thank you very much. I do appreciate it. I
1049 appreciate all of you all being here. These are all important
1050 topics. I was talking earlier, I had carried legislation related
1051 that also dealt with hypertension but also cancer, when I was in
1052 the state legislature.

1053 The dental program, let me start there, although I have got
1054 lots of questions and I tend to be somebody that reads, looks at
1055 things, and tries to sort things out. One of the things that it
1056 said is that among the groups that can get some assistance from
1057 this bill would be ones that are affiliated with an academic
1058 institution and that are exempt under the taxes and offer free
1059 dental programs to underserved populations.

1060 We have, in my district, a group that sets up weekend medical
1061 clinics at a large field and they have a dental component with
1062 a number of dentists who come in and give their entire weekend,
1063 and they bring all the equipment, and they have a mobile unit,
1064 and so forth but they are not affiliated, as far as I know, with
1065 any academic institution. Is that something that is critical,
1066 you think, to the bill or can we maybe carve out an exemption if
1067 they are long-standing providers of free medical, or in this case,
1068 dental care to an underserved area?

1069 Dr. Watson-Lowry. This bill does not say that you have to
1070 be associated with an institution. It is basically providing
1071 local solutions to local problems.

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1072 So if that particular group wanted to be able to apply for
1073 funding, they could apply for funding also.

1074 Mr. Griffith. All right, I do appreciate that.

1075 I have got an issue on the Good Samaritan Section 2 if I might
1076 ask a couple of questions on that. And I guess the first one is
1077 is that, I don't think there would be any problem with it, I think
1078 the language might need to be tightened up just a little bit
1079 because it appears that it might actually say that if they are
1080 on their way to the scene and if they are driving 85-90 miles an
1081 hour and they run over a pedestrian they might be covered. You
1082 wouldn't have any problem -- you are trying to get to the folks
1083 who are providing medical care, once they get there, as I
1084 understand it. It think that is the intent of the bill. Would
1085 you not agree that is the intent of the bill? Just to make sure
1086 we are not getting folks in trouble who are trying to be good guys.

1087 Dr. Levine. Yes, I would agree. Thank you.

1088 Mr. Griffith. All right and I do want to work on that.

1089 Likewise, and it may need to be tweaked a little bit, it might
1090 be in there, would you have any problem if we made it clear that
1091 the medical care they were providing was at least within the scope
1092 of their license, so that -- I mean I know, obviously, the health
1093 -- you mentioned mental health, which I think is important and
1094 a lot of folks can do that but I am not sure I want my chiropractor
1095 trying to reattach my fingers.

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1096 Dr. Levine. I would agree always with the scope of practice
1097 within their license, yes.

1098 Mr. Griffith. All right and I do appreciate that.

1099 And one thing that I think because of your background, Dr.
1100 Greenbaum, that might have been misunderstood but my reading of
1101 the bill does not say it is just for minors who are sexually
1102 trafficked, it is looking for adults who you know they might be
1103 18 or 19 who are being sexually trafficked, too. Is that your
1104 understanding as well?

1105 Dr. Greenbaum. Absolutely, the bill includes both adults
1106 and minor sex and labor trafficking, yes.

1107 Mr. Griffith. And obviously, theoretically, minors are
1108 probably more vulnerable but if you had somebody that has been
1109 in the system as a person who has been trafficked or enslaved in
1110 that industry, they could be an adult but have been in for a while
1111 or it could be somebody with diminished -- some forms of diminished
1112 capacity.

1113 Dr. Greenbaum. Absolutely. You make a very good point. A
1114 lot of the children that we see age out and so they are 19, 20,
1115 21 but they started when they were 15. So a lot of adults were
1116 kids when they started. And then a lot of adults are very
1117 vulnerable because of disabilities, mental health issues, other
1118 reasons. And so yes, but this bill will cover everything.

1119 Mr. Griffith. This bill will cover everything.

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1120 Well, I appreciate it and these are all, I think, bills that
1121 are trying to do good things for the American people and I
1122 appreciate you all's testimony here today.

1123 And Mr. Chairman, I yield back.

1124 Mr. Burgess. The gentleman yields back. The chair thanks
1125 the gentleman.

1126 The chair recognizes the gentlelady from Florida, Ms.
1127 Castor, 5 minutes for questions, please.

1128 Ms. Castor. Well, thank you, Mr. Chairman for organizing
1129 this hearing and thanks to all of our witnesses who are here today.
1130 These are all very positive ideas and bills.

1131 And Mr. O'Connor, thank you for your long-term service.

1132 And Dr. Levine, thank you. I am so grateful that you were
1133 in the right place at the Boston Marathon and that is quite a story.
1134 So, thank you for being there.

1135 I wanted to focus on Congresswoman Kelly's bill. I think
1136 it is such an important reauthorization. And I want to thank her
1137 and Congressman Simpson and ask Dr. Watson-Lowry a few questions
1138 because I have seen dentists in Florida, the Florida Dental
1139 Association, they really do a wonderful job of providing free
1140 care. In fact, I have a few statistics here that kind of blew
1141 me away.

1142 The Florida Dental Association's Mission of Mercy Event,
1143 just over the past couple of years in Pensacola, that is a pretty

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1144 small town in the Panhandle, their events saw more than 1,800
1145 patients and provided more than \$1.4 million in donated care just
1146 in March. Similar, in Jacksonville, saw 2,800 patients, where
1147 they provided \$2.75 million in donated care and there were almost
1148 2,500 volunteers.

1149 In my hometown of Tampa, there are some outstanding dentists
1150 with the public service interest, along more with more health.
1151 Their event saw more than 1,600 patients; 8,000 treatment
1152 procedures worth over \$1 million; more than 350 dentists,
1153 registered dental hygienists who volunteered; and there were
1154 1,000 support volunteers.

1155 So there are very serious gaps in dental care in America.
1156 And I wanted to ask you to talk about that, this troubling lack
1157 of access to dental services and how we have to rely on these
1158 volunteer initiatives and describe your experience with providing
1159 free dental care in your community.

1160 And as we talk to our colleagues about the importance of
1161 making this investment through the CDC to local communities, what
1162 are the long-term benefits? Isn't there a return on investment
1163 here?

1164 Dr. Watson-Lowry. Well, thank you for your question. I
1165 just want to say last year I went to the Florida Dental Association
1166 meeting, and it was wonderful, in Orlando. I met some new friends
1167 down there.

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1168 But yes, it is a wonderful question. In Illinois we have
1169 a MOM's Event approximately every 2 years because it takes so much
1170 to set it up and it costs so much. We have to get sponsors and
1171 that type of thing. Our last event we saw about 2,000 -- we had
1172 about 2,000 patients visits and did more than \$1 million worth
1173 of service. So, that is something that is going on across the
1174 country.

1175 What this bill does is bring the CDHCs online a little bit
1176 more and increasing their numbers. What we have is it kind of
1177 bridges that gap. There are a lot of patients that don't know
1178 where to get care. There has been an increase in Medicaid funding
1179 but if a patient has a problem but they don't know where to go,
1180 then the first place they go is to the emergency room.

1181 And so we are trying to -- this bill helps to cut down on
1182 those emergency room visits so that patients can receive care at
1183 a dental office, or in a practices, an FQHC. That care may cost
1184 \$70 versus an emergency room visit that is \$700 or more. And when
1185 they go to the emergency room, as I mentioned in my testimony,
1186 they just get a prescription for an antibiotic and a pain
1187 medication and then they are back in the emergency room in a couple
1188 of months or a month or so and they haven't gotten that care.

1189 So, this addresses that situation. It puts the CDHC in place
1190 so that they can help those patients find the proper place to
1191 receive care, make sure they have transportation for that, and

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1192 also talk to them about maybe if they have some anxieties about
1193 going to the dentist and help them through those issues, and teach
1194 them about prevention.

1195 That is one of the key things that I see in my practice. One
1196 of the first visits I talk to them about well, you have this cavity;
1197 it is not just about treating that cavity. How did that cavity
1198 get there? And a lot of my patients are one peppermint on Sunday
1199 in church every Sunday and that is causing them to lose all of
1200 their back teeth. And it is costing them, especially seniors,
1201 it is costing them a lot of money.

1202 So, everything that we have in here is going to help bridge
1203 that gap.

1204 Ms. Castor. And there is an important education element
1205 that comes with all of this --

1206 Dr. Watson-Lowry. Huge. Huge.

1207 Ms. Castor. -- so that they are not returning patients.

1208 Dr. Watson-Lowry. Exactly. Exactly. I don't know if I
1209 have the time but I have a friend that was in Alaska and saw the
1210 Native Americans. And he went to the grocery store and three of
1211 the four rooms were stacked from floor to ceiling with pop. The
1212 children were drinking pop all day. They weren't drinking milk
1213 because that was \$7 for a half a gallon of milk. And so all of
1214 their cavities -- they were losing their front teeth because they
1215 had cavities in their front teeth from drinking the pop.

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1216 And so just the education, letting them know this is what
1217 is causing the problem and helping them find a solution to that
1218 and teaching the parents, teaching the kids what to do and what
1219 not to do. That is a huge component.

1220 Ms. Castor. Thank you very much. I yield back my time.

1221 Dr. Watson-Lowry. Thank you.

1222 Mr. Burgess. The chair thanks the gentlelady. The
1223 gentlelady yields back.

1224 The chair recognizes the gentleman from Kentucky, Mr.
1225 Guthrie, the vice chairman of the subcommittee, 5 minutes for
1226 questions.

1227 Mr. Guthrie. Thank you, Mr. Chairman. I appreciate the
1228 recognition.

1229 And first to Mr. O'Connor. Should this legislation be
1230 enacted, the CDC will be tasked with collecting data from all over
1231 the United States. Can you please share how the publicity for
1232 firefighter's data solicitation will take place and how do you
1233 foresee the data collection taking place?

1234 Mr. O'Connor. Well, the bill addresses that. The CDC,
1235 along with NIOSH, will get with stakeholders from the fire
1236 service. I would imagine that would include organizations
1237 representing professional firefighters, a managerial component
1238 of the fire service, the International Association of Fire Chiefs,
1239 the National Volunteer Fire Council. Collectively, we have about

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1.1 million firefighters across the country. I imagine that they will be sitting down with the CDC, based on the direction articulated in the bill and try and come up with a process whereby the data can be aggregated, probably department by department, in terms of if a department chooses to participate, they would be able to essentially provide the data from their employees, their retirees, because that is a huge component of it as well, to make sure that you have got length of service of all the people involved and do it in a fashion that essentially people are de-identified; that you are able to basically get the data, the information on people but protecting their confidentiality.

I could envision that you know if there needs to be a deeper dive in terms of direct information, that there may be a process in place whereby the researchers at CDC or the people keeping the database would be able to contact these people but it would be on a voluntary basis.

Mr. Guthrie. Okay, thanks.

Let me go to Dr. Watson-Lowry. You mentioned in your testimony that most Medicaid dental programs fall short of providing the amount and extent of care needed by low-income patients. According to Kaiser Family Foundation, even states with extensive adult dental benefits, patients have a difficult time finding a dentist.

I know a lot of dentists don't accept private insurance and

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1264 some accept private but not Medicaid. And could you kind of walk
1265 through why it is hard to find a dentist that does Medicaid?

1266 In Kentucky, I have visited some. We do pediatrics and,
1267 although they are not celebrating their reimbursements, don't get
1268 me wrong, but the biggest issue that they talk about is booking
1269 chair time and having no-shows. That is one of their biggest
1270 issues.

1271 Dr. Watson-Lowry. Thank you for that question.

1272 Yes, this bill addresses that with the community health
1273 coordinators. They help them navigate those situations so they
1274 help them find someplace that takes -- in Illinois we have like
1275 three different kinds of coverage for Medicaid, which makes it
1276 very complicated in the paperwork with the doctors. So but when
1277 they can find one, they have to be able to find transportation.
1278 So the CDHC helps so that that chair time doesn't go empty and
1279 so that improves the utilization of the participators that are
1280 functioning there. It helps that whole situation and improves
1281 care and it also cuts the cost because you can see more patients
1282 in less time.

1283 Mr. Guthrie. Good. Thank you. Because the issue is that
1284 we have to overbook, therefore, it is not good for our patients
1285 who come in and have to wait --

1286 Dr. Watson-Lowry. Exactly.

1287 Mr. Guthrie. -- because they don't distribute themselves,

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1288 the no-shows, and sometimes there is just no one there and they
1289 are not using their chair. So, it is a thing they are trying to
1290 thread the needle on.

1291 Dr. Watson-Lowry. There are some studies that have shown
1292 that they have reduced the no-show rate by 18 percent, the CDHCs.

1293 Mr. Guthrie. Perfect. Perfect.

1294 I am going to get a couple more questions in. So, Dr. Levine,
1295 why is it not sufficient to require medical volunteers to present
1296 their medical license on-site?

1297 Dr. Levine. Well, I assume this is a combination of two
1298 things. One is your medical license --

1299 Mr. Guthrie. I mean if it is a large disaster, not just
1300 general. Go ahead, I am sorry. Go ahead, please.

1301 Dr. Levine. Your license is one thing but liability
1302 coverage is a separate issue. Here, we are just dealing with the
1303 liability issue as to whether or not the physician is there to
1304 respond only if he or she is covered potentially. It has nothing
1305 to do with presenting their license only. What does that mean
1306 and who is going to verify that license, at the time of the
1307 disaster? That is very difficult and it is so chaotic that it
1308 is hard to do. And sometimes that will even take a few days in
1309 a normal situation.

1310 Mr. Guthrie. Right.

1311 Dr. Levine. That is the difficulty.

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1312 Mr. Guthrie. Okay, thanks for that.

1313 And then Dr. Greenbaum, in your testimony you say that
1314 research consistently shows that victims of trafficking do have
1315 contact with medical professionals. Are there certain health
1316 providers and certain health settings who are more commonly in
1317 contact with suspected trafficking victims?

1318 Dr. Greenbaum. There has been a limited amount of research
1319 but probably the most relevant research shows that about
1320 two-thirds show up to emergency departments in hospitals but a
1321 quarter of them also go to public health clinics, Planned
1322 Parenthood, sexually-transmitted infection clinics, and some to
1323 their own doctors like their gynecologists or their
1324 pediatricians. So it really runs the gamut but I would say that
1325 probably emergency departments and public health clinics are the
1326 biggest.

1327 Mr. Guthrie. Okay, thank you. I appreciate that.

1328 My time has expired and I yield back.

1329 Mr. Burgess. The gentleman yields back. The chair thanks
1330 the gentleman.

1331 And the chair recognizes the gentleman from Maryland, Mr.
1332 Sarbanes, for 5 minutes for questions, please.

1333 Mr. Sarbanes. Thank you, Mr. Chairman. I want to thank the
1334 panel for being here today on these very important proposals that
1335 I think you see broad agreement of support for.

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1336 I wanted to ask you, Kevin, and again, thank you for not just
1337 your service in Baltimore County but your advocacy on these issues
1338 and being a terrific resource for so many of here on the Hill when
1339 it comes to issues that affect firefighters of all categories
1340 across the country.

1341 I think I have a pretty decent understanding of what the
1342 registry offers and, obviously, we support it. I was wondering
1343 if you could speak a little bit to what kinds of advances, in terms
1344 of technology, and equipment, and other things are available to
1345 firefighters when they are going into these situations that can
1346 help to reduce some of the risks for cancer and other diseases.
1347 Because I imagine, as you become more and more aware of the
1348 heightened risk for these things, that you are thinking about that
1349 as you come on to the scene and that there has probably been some
1350 advances with respect to that.

1351 Mr. O'Connor. The best way to answer that question is
1352 through example. When I came to the fire service in 1985, I was
1353 issued a helmet, a turnout clip coat, and three-quarter rubber
1354 boots. So what that meant is every time I went into a fire, large
1355 portions of my body were exposed. If something happened below
1356 the waist, essentially, any type of water, wash off contamination,
1357 could go down into those boots.

1358 Over the years, we made a determination that because of some
1359 of the diseases, cancer and other diseases were being caused by

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1360 those type of exposures, that it made sense to more fully
1361 encapsulate a firefighter.

1362 So, we came up with hoods that protect the neck and the ears.
1363 But unfortunately, technology hasn't advanced to the point that
1364 it is a complete coverage, a complete shield. You still, as I
1365 said in my testimony, you can absorb materials, toxic soups, if
1366 you will, in your sweat, things of that nature going into your
1367 pores. That serves as a single example.

1368 A successful story is with respect to lung cancer. Many
1369 years before I came to fire service, people went into buildings
1370 without self-contained breathing apparatus. They were inhaling
1371 everything. Over the years, the advancement in that technology
1372 has been marked in terms of the duration with which people can
1373 stay in that type of an environment. But even that has -- it is
1374 not drawbacks but its limitations. For years, people thought
1375 that once the fire was done, you took your breathing mask off and
1376 you walked around. But the residual smoke and toxicity that was
1377 there continued to cause diseases.

1378 Within the fire station itself, the diesel exhaust, which
1379 I referenced, now we have what is called a Nederman exhaust system
1380 that actually attached to the exhaust.

1381 So as things manifest and we are able to make determinations,
1382 the technology ultimately catches up to it. The problem is, the
1383 way that people are being exposed to these toxins now is very

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different than it was even 15 years go. So, essentially what we need, we need the information and data on these different types of cancers. It is not just a simple cancer. It is like a prostate cancer or a colon cancer. We are having clusters of cancer of firefighters that are exposed to benzene, for example, and they develop a very specific type of liver cancer which occurred, actually, in Baltimore many years ago.

So this information really allows us to take a deep dive and look at it and essentially work with our partners that manufacture clothing, the researchers to come up with things to better protect firefighters and, essentially, try to de-risk it as much as possible.

Mr. Sarbanes. Well, thank you for that answer and I think what it shows is the attention, through this registry, to the issue can heighten the awareness so that we can have more technologies developed but also points to the need for investing the resources that can allow for better protection and better protective equipment and so forth. And actually even potentially extends to -- I know there is issues around sort of flame retardant and other kinds of things that are put onto furniture. And in theory, that is supposed to help the situation when a fire breaks out. But to extend its generating smoke and other things that can be inhaled that are even more toxic than if you didn't have those retardants in place.

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1408 So it gets a conversation going. I don't know if you want
1409 to respond to that.

1410 Mr. O'Connor. Yes, very quickly. Our organization has
1411 been in the forefront of trying to expose some of the problems
1412 with flame retardants and the potential health hazards they pose
1413 not just to firefighters but to ordinary citizens, as well. I
1414 think, at the last count, 26 states have enacted some type of law,
1415 either regulating, forcing disclosure on flame retardants.
1416 Legislation was just passed in Maryland with respect to its impact
1417 on children. So, it is something that we are very involved in.

1418 But you are absolutely right. That is a hazard not just to
1419 firefighters but to the general public.

1420 Mr. Sarbanes. Thank you. I yield back.

1421 Mr. Burgess. The gentleman yields back. The chair thanks
1422 the gentleman.

1423 The chair recognizes the gentleman from New York, Mr.
1424 Collins, 5 minutes for questions, please.

1425 Mr. Collins. Thank you, Mr. Chairman. I ask unanimous
1426 consent to enter into the record letters of support for H.R. 931
1427 from the International Association of Fire Chiefs, the
1428 Congressional Fire Services Institute, the National Volunteer
1429 Fire Council, International Association of Fire Fighters, and the
1430 National Fall Firefighters Foundation.

1431 Mr. Burgess. Without objection, so ordered.

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1432 [The information follows:]

1433

1434 *****COMMITTEE INSERT 4*****

1435 Mr. Collins. Thank you.

1436 So, Mr. O'Connor, I mean we touched on this briefly but I
1437 know we have, just in my one county alone, 99 volunteer fire
1438 companies. And when we look back at what was the standard
1439 procedures 20-30 years ago versus today, I always think back when
1440 firefighters would tell me they would keep their turnout gear in
1441 their car, in the trunk. So they would be fighting a fire today
1442 and God knows what chemicals they could be associated with. And
1443 we certainly had a lot of chemical fires in the Niagara Falls area.
1444 You know they would finish the fire and just throw the turnout
1445 gear into the trunk of the car and drive their kids to baseball
1446 games and the like, having no clue that there could be an
1447 association of what was on that turnout gear then exposing their
1448 families to where we are today with a lot of protocols. Some
1449 stations follow these protocols better than others.

1450 But if you could comment just a little bit. And I have got
1451 a sign in my office that says in God we trust; all others, bring
1452 data. And where this data will be taking us, especially with the
1453 manufacturers of some of this gear, as we are learning and,
1454 certainly, with the data, we will continue to learn more to produce
1455 safer equipment and better apparatus.

1456 If you could maybe just where we have gone just in the last
1457 10 years and where this might take us.

1458 Mr. O'Connor. Well, first, I again really want to thank you

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1459 for your stalwartship on this issue. It is very important. And
1460 as you have indicated, data is what really matters with respect
1461 to being able to do this tracking and making these determinations.

1462 And you are absolutely right. I mean part of it you can't
1463 get around of it, is resources as well. You know I mentioned my
1464 ensemble when I first went to the fire department. You are 100
1465 percent right. We did not adequately clean our turnout clothing.
1466 We were afforded one set of turnout clothing. If you were busy,
1467 you went from one fire immediately to the next fire and the
1468 aggregation occurred.

1469 You were consistently wearing it, whether it was a fire call
1470 -- if you were going out on a cold evening for an EMS call, what
1471 did you put on? You put on your turnout coat. Your previous
1472 calls might have been at a chemical plant. It might have been
1473 at a fire where you were exposed to different things. So people
1474 were consistently re-exposed to the carcinogens and the toxins
1475 that they encounter on their calls.

1476 Beyond that, you are also correct in the volunteer fire
1477 service but also in a career fire service. If you were detailed
1478 from one station to another, you took your turnout clothing, you
1479 threw them in the car, and you were continuing re-breathing in
1480 all of that. It is a real hazard.

1481 The sad aspect, though, unfortunately, is we have not been
1482 able to quantify that. We have not been able to really make any

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1483 direct determination. We know it is hazardous but, in the absence
1484 of good data, we haven't been able to do that.

1485 All the studies that I have mentioned are very comprehensive
1486 studies in terms of just one simple analysis. They looked at the
1487 death certificates and they made their determinations. What your
1488 bill, hopefully, will be able to do is provide enough data, enough
1489 demographics in terms of work and risk, what people actually do
1490 that we can factor that into the equation and try to make these
1491 determinations.

1492 I do believe that a lot of the companies that do manufacture
1493 this type of equipment are partners with the fire service.
1494 Certainly, we do have some issues at times but, at the end of the
1495 day, they can only design equipment that is safe and healthy if
1496 they have the data to recognize how we can better avoid these
1497 hazards.

1498 Mr. Collins. So another question is we have seen the cancer,
1499 the prevalence of cancer. Are we seeing it while a firefighter
1500 is currently serving or after they have left the service?

1501 Mr. O'Connor. Both. Some of it manifests early. The one
1502 statistic that I put out was a 159 percent increase of men
1503 firefighters between 30 and 49 years of age. Most of those people
1504 are still in the service but a lot of these diseases are
1505 manifesting afterwards.

1506 A good example is in your home state, the aftermath of 9/11.

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1507 We lost 343 people that day. Unfortunately, in the days since
1508 9/11, 1,590 firefighters have contracted some form of cancer.
1509 Many of those people have retired from the service and the symptoms
1510 are just coming now. And that is one example. It is a very
1511 graphic example but the same thing is applicable throughout the
1512 country in departments large and small, where you will see the
1513 aggregation and accumulation of people, the hazards that they have
1514 encountered over the years, manifest in terms of developing some
1515 type of cancer years after retirement.

1516 Mr. Collins. Thank you for your testimony. My time has run
1517 out and I yield back.

1518 Mr. Burgess. The gentleman yields back. The chair thanks
1519 the gentleman.

1520 The chair recognizes the gentlelady from California, Ms.
1521 Eshoo, 5 minutes for questions, please.

1522 Ms. Eshoo. Thank you, Mr. Chairman, and thank you to the
1523 witnesses, not only for being here today but the work that you
1524 have done over your entire adult life in key areas; great
1525 contributions to the country.

1526 I also want to compliment my colleagues that are sponsoring
1527 the four bills today for their work because I think that they are
1528 offering a good legislation.

1529 I want to start with Dr. Watson-Lowry first. You are aware
1530 that the House recently passed legislation that would allow states

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1531 to pick and choose which essential benefits, health benefits they
1532 require insurance plans to cover. Pediatric oral care is
1533 currently one of the ten essential health benefits covered in the
1534 Affordable Care Act. The House-passed bill also makes cuts to
1535 Medicaid, which currently requires coverage of early and periodic
1536 screening, diagnostic treatment, the EPSDT -- we have
1537 abbreviations for everything here -- including dental screening.

1538 So what I would like to ask you to at least touch on is the
1539 continuing need for programs like these to be funded by the CDC's
1540 oral health promotion and disease prevention grants for people
1541 who are currently served by these programs.

1542 And, also, touch on the benefits that people will be -- you
1543 know on what people are going to be forced to make changes to
1544 Medicaid that could result in the elimination of these benefits.
1545 I think that we have members here that may not even realize that
1546 that is in the bill that passed the House. But nonetheless, it
1547 is one of the essential health benefits.

1548 So, would you comment on that please?

1549 Dr. Watson-Lowry. Thank you for your question.

1550 Just one point is the children being covered in the essential
1551 health benefits that almost slipped out. And the ADA noticed that
1552 and it was like the 11th hour and we were able to get that back
1553 in.

1554 That is critical for children to receive care. When

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1555 children lose their teeth at an early age, that can affect their
1556 self-esteem in school. Another thing is that that is the highest
1557 reason that children missed school and a lot of people don't
1558 realize that. That is the most common chronic disease is dental
1559 cavities. And so when children are missing school, the other
1560 problem is now, at least in Illinois, the schools don't get the
1561 funding for that child for that day. So, it has repercussions
1562 that --

1563 Ms. Eshoo. There are repercussions.

1564 Dr. Watson-Lowry. Exactly -- that follow behind those
1565 things.

1566 As far as funding for adults, patients that have diabetes,
1567 there is a clear connection between diabetes and periodontal
1568 diseases.

1569 Ms. Eshoo. There is.

1570 Dr. Watson-Lowry. So even some of the insurance companies
1571 have started covering the adults that have diabetes for them to
1572 come in three times a year instead of twice a year because they
1573 found the savings in that. You can save thousands of dollars a
1574 year with patients that have chronic conditions like diabetes.
1575 And when we reduce their chronic dental conditions, it helps to
1576 improve their overall health.

1577 So, it is critical that patients receive care and also these
1578 preventative care issues that we have. And we are hoping that

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1579 those things will help the whole population of the United States,
1580 along with, as I mentioned before, the educational piece, helping
1581 prevent --

1582 Ms. Eshoo. Thank you very, very much.

1583 To Dr. Martin Levine, first, I want to thank you for your
1584 service as a first responder during the Boston Marathon bombing
1585 in 2013.

1586 What I want to ask you is does current liability law, in your
1587 view, actually discourage health professionals from volunteering
1588 during times of emergency? I mean is that even on their mind or
1589 do they know and not go, or know and be hesitant, or just go?

1590 Dr. Levine. Thank you for the question.

1591 Unfortunately, I think it is on their mind. I think they
1592 do react to it. There were several articles in the New England
1593 Journal of Medicine following the Boston event. One of them was
1594 from an individual who texted his mother. He was working in the
1595 medical tent as a volunteer for the first time as a physician.
1596 And his mother texted him back: Get out of there as quickly as
1597 possible. And as he was leaving, it was only because the
1598 individual who was on the microphone in the tent, who is not a
1599 physician, said please don't leave your patients at a time of
1600 crisis that he turned around and said maybe I shouldn't leave.

1601 But one of the things that was on their minds was my
1602 responsibility is in the medical tent, where the runners are, not

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1603 anywhere else. So, I am not leaving the tent to see what happened
1604 outside. So there were physicians in the tent who did not go
1605 elsewhere.

1606 By the time I got back into the medical tent, most of the
1607 triage was finished on the site but a lot of the physicians were
1608 no longer there. So, yes, it is absolutely on their minds.

1609 Ms. Eshoo. There is the answer. I am going to submit
1610 further questions to the witnesses, as members are allowed.

1611 And with that, I want to thank you again for what you do.
1612 I yield back.

1613 Mr. Burgess. The chair thanks the gentlelady. The
1614 gentlelady yields back.

1615 The chair recognizes the gentleman from New Jersey, Mr.
1616 Lance, 5 minutes for questions, please.

1617 Mr. Lance. Thank you, Mr. Chairman, and good morning to the
1618 distinguished panel. And I will ask several questions and if they
1619 have already been answered, I apologize. We are between two
1620 subcommittee hearings this morning.

1621 To Mr. O'Connor, I understand that there has already been
1622 an in-depth study of cancer in over 30,000 participants in three
1623 major U.S. cities. Mr. O'Connor, can you tell me which cities
1624 have been studies and are additional studies necessary?

1625 Mr. O'Connor. Let me answer your second question first.

1626 Mr. Lance. Yes.

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1627 Mr. O'Connor. Yes, additional study is definitely needed.

1628 Mr. Lance. That is Mr. Collins' bill.

1629 Mr. O'Connor. Absolutely.

1630 Mr. Lance. Yes.

1631 Mr. O'Connor. The three cities that were utilized were San
1632 Francisco, California; Chicago, Illinois; and Philadelphia,
1633 Pennsylvania.

1634 Mr. Lance. I see.

1635 Mr. O'Connor. They were chosen, I imagine, by the
1636 researchers at that point in time because they represented
1637 different parts of the country --

1638 Mr. Lance. I see.

1639 Mr. O'Connor. -- and the call volumes there were
1640 substantial.

1641 But what I would note and one of the reasons why additional
1642 study is needed, they are three relatively similar type fire
1643 departments, large metropolitan areas. Certainly, there is
1644 different hazards between cities but very, very extensive call
1645 volume during the time of the study.

1646 Park of what we are trying to -- what Mr. Collins' bill is
1647 trying to accomplish is looking at the broad fire service, where
1648 people work in smaller communities; where people have a higher
1649 number of call volumes, where perhaps they have a greater
1650 incidence of hazardous materials response; whether they are

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1651 responding to wildland fire; the whole aspect of it. Those three
1652 cities, essentially are relatively homogenous in terms of their
1653 call load.

1654 The other aspect that I had mentioned a little bit earlier
1655 is that a lot of the employment demographics weren't taken into
1656 account in terms of how long people remained a firefighter, where
1657 they were assigned, what their specific duties were, ages when
1658 they were employed, et cetera, and that is what we are hoping to
1659 accomplish in the cancer registry.

1660 Mr. Lance. In the part of New Jersey I represent, not
1661 exclusively but predominately, firefighters are volunteers.

1662 Mr. O'Connor. Correct.

1663 Mr. Lance. I represent 75 municipalities. If we each
1664 represent three-quarters of a million people, that is roughly
1665 10,000 in each of the municipalities. And so it is different from
1666 large metropolitan areas.

1667 Should any study include the effect on volunteer
1668 firefighters?

1669 Mr. O'Connor. That is included in this, volunteer as well
1670 as paid on-call.

1671 Mr. Lance. Yes.

1672 Mr. O'Connor. So, absolutely. And in fact, your colleague
1673 read into the record a letter from the National Volunteer Fire
1674 Council, which represents volunteer firefighters supporting

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1675 legislation for that reason.

1676 Mr. Lance. Thank you.

1677 To Dr. Levine, I understand your practice is in Bayonne in
1678 Jersey City. Is that right?

1679 Dr. Levine. That is correct, sir.

1680 Mr. Lance. You ought to move to Westfield or Somerville in
1681 the district I serve.

1682 Dr. Levine. I live in your district.

1683 Mr. Lance. Where do you live?

1684 Dr. Levine. Short Hills.

1685 Mr. Lance. Short Hills. Do you want me to wash your car
1686 or mow your lawn?

1687 Dr. Levine. That won't be necessary, sir.

1688 Mr. Lance. That won't be necessary. I am pleased to hear
1689 that since the last time I mowed a lawn was sometime in the middle
1690 of the last century.

1691 Many states have reciprocity agreements with their
1692 neighboring states, Dr. Levine. Perhaps wouldn't it be easier
1693 for states experiencing a large-scale disaster to ask their
1694 neighboring states to send medical volunteers? And I am
1695 interested in your expertise, based upon what you have done,
1696 including at the Boston Marathon.

1697 Dr. Levine. The bill explicitly recognizes the state laws
1698 that provide a stronger protection to the volunteer health

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1699 professionals but, as you know, some of those states are not as
1700 strong.

1701 And as an example, we spoke about 9/11 in another context
1702 but having, unfortunately, been involved, I guess in some ways
1703 in that disaster as well --

1704 Mr. Lance. Yes, of course.

1705 Dr. Levine. -- I was at Liberty State Park after being at
1706 Bayonne Hospital that had some of the first wounded.

1707 Mr. Lance. Yes.

1708 Dr. Levine. But there was a group of surgeons who were
1709 taking a course, a CME course to pass their recertification boards
1710 at the Meadowlands. They took a bus over to Liberty State Park
1711 and set up a triage unit that would have been very valuable, had
1712 there been more injured personnel because they were coming over
1713 by boat to Liberty State Park to evacuate lower Manhattan. They
1714 were from all over the country.

1715 And the problem, potentially, with neighboring states is
1716 that the reciprocity is usually one neighboring state to another
1717 like New York and New Jersey.

1718 Mr. Lance. Yes.

1719 Dr. Levine. They were from Oklahoma, et cetera.

1720 Mr. Lance. Yes, of course. Very good. Thank you.

1721 I won't have time to ask questions of Dr. Watson-Lowry or
1722 of Dr. Greenbaum but I admire your fine work in your areas of

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1723 expertise, the dental health of this country and also, of course,
1724 identifying missing and exploited children. Thank you for your
1725 public service in what you do, as well as the rest of the panel.

1726 Thank you, Mr. Chairman.

1727 Mr. Burgess. The gentleman yields back. The chair thanks
1728 the gentleman.

1729 The chair recognized the gentleman from Georgia, Mr. Carter,
1730 5 minutes for questions, please.

1731 Mr. Carter. Thank you Mr. Chairman and thank all of you for
1732 being here. These are very important pieces of legislation and
1733 I appreciate your interest in them.

1734 I want to start with Dr. Greenbaum. Dr. Greenbaum, I am from
1735 Georgia as well and served in Georgia State Legislature and
1736 certainly, human trafficking a problem in a lot of urban areas
1737 but particularly in Atlanta.

1738 When I served in the Georgia State Senate, we addressed this
1739 and it is something that we passed legislation on. In fact, a
1740 great champion of this has been State Senator Renee Unterman, who
1741 has passed Rachel's Law and the Safe Harbor Law and those are very
1742 important.

1743 And you know human trafficking is horrific and it is
1744 widespread and it is in our urban areas. We think it is not there
1745 but it is there. And oftentimes, the only people that these
1746 victims will see will be healthcare professionals, while the

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1747 victims are in captivity. And I say captivity and I mean they
1748 are in captivity. I think you all understand that. But how can
1749 nurses and doctors; how can they identify? Are we doing any
1750 training to help them to identify victims?

1751 I know it is very difficult but are we doing anything? Are
1752 there any telltale signs that we can point toward?

1753 Dr. Greenbaum. We are doing a lot of training for healthcare
1754 providers in looking for possible indicators and red flags and
1755 there are some well-known ones. We are also doing some research
1756 to actually come up with a screening tool that can be used in a
1757 very busy healthcare setting to identify children who are at risk
1758 and we are validating that in a multi-site study out of Children's
1759 Healthcare of Atlanta.

1760 But we do try very hard to make healthcare providers, nurses,
1761 and doctors, and physician assistants aware of the red flag
1762 indicators that might suggest that person is high-risk.

1763 Mr. Carter. Do you concentrate on emergency rooms or just
1764 --

1765 Dr. Greenbaum. We do a lot of work with emergency rooms but
1766 also with general internists, and pediatricians, and just about
1767 any specialist, especially gynecologists also will see a fair
1768 number of victims as well. So really, we try to educate everybody
1769 in the healthcare system.

1770 Mr. Carter. What about the Children's Hospital of Atlanta;

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1771 have they done anything that you are aware of? Have they got any
1772 programs like this?

1773 Dr. Greenbaum. Yes, I think the Institute for Human
1774 Trafficking was just funded this year and we are doing the research
1775 I talked about earlier, as well as doing a lot of training of
1776 healthcare providers and people who work in the healthcare sector.
1777 We do a lot of webinars and on-site trainings, as well as the
1778 research into a screening tool for children.

1779 Mr. Carter. And results, have you seen positive results as
1780 a result of this education and efforts?

1781 Dr. Greenbaum. Yes, we have tracked the results of our
1782 webinars and there were large improvements in knowledge and
1783 skills, as well as the use of the materials that we trained people
1784 on in their practice. So people began screening. People began
1785 talking to other healthcare providers about human trafficking,
1786 which is exactly what we wanted.

1787 Mr. Carter. Well, I want to thank you for your work because
1788 -- and I want to make sure my colleagues all understand what a
1789 big problem this is. It is a serious problem, particularly in
1790 international cities, if you will, like Atlanta, where you have
1791 so many people coming in like that. It is something we have really
1792 struggled with and I think we have made progress and I am very
1793 proud of that.

1794 Dr. Greenbaum. Yes, I think that Georgia has done a whole

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1795 lot with the issue of human trafficking, partly because Atlanta
1796 is such a major hub.

1797 Mr. Carter. Exactly. Exactly.

1798 Dr. Watson-Lowry, I wanted to ask you about the dental bill.
1799 I know that CDC works with a lot of the local communities, and
1800 they have state partners in local communities, and they do a lot
1801 to help with water fluoridation and making sure that they have
1802 monitoring systems to help the communities monitor their water
1803 systems and all. And they also send funds to health departments
1804 for oral education and for different things.

1805 So if they are doing this, explain to me the purpose of the
1806 partnerships or the contracts that are outlined in this
1807 legislation. I mean are we duplicating things here? Is this
1808 necessary or how is this going to complement that?

1809 Dr. Watson-Lowry. Thank you for your question.

1810 It is necessary because this is more grassroots. It is local
1811 solutions to local problems. Sometimes the CDC is flying up here.
1812 We need things on the ground. We need to be able to address the
1813 issues that are local in those particular areas and be able to
1814 take care of those problems efficiently.

1815 The CDHCs are able to -- a lot of those CDHCs are from those
1816 particular areas so they know exactly what the situations are,
1817 what the problems are. They can get the patients to those
1818 locations, make sure they receive the services, make sure they

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1819 receive the care that they need. Sometimes it is just difficult
1820 finding the exact location to get the particular service that you
1821 need.

1822 Mr. Carter. Great. Well, thank you for your work. Thank
1823 all of you for being here today. This is most important
1824 legislation that we are talking about.

1825 And Mr. Chairman, I yield back.

1826 Mr. Burgess. The gentleman yields back. The chair thanks
1827 the gentleman.

1828 The chair would like to recognize the ranking member of the
1829 subcommittee, Mr. Green, 5 minutes for redirect questioning.

1830 Mr. Green. Well, thank you, Mr. Chairman for letting me go
1831 first.

1832 Dr. Watson-Lowry, in your testimony you talk about the
1833 elderly face the greatest barriers in accessing dental care for
1834 any group population. I know in our district our seniors, we have
1835 a lot of dual eligibles, so Medicaid does cover it but Medicare
1836 doesn't.

1837 How are the Action for Dental Health Programs currently
1838 increasing access to dental care for the vulnerable elderly?

1839 Dr. Watson-Lowry. Thank you for that question.

1840 One of the tenets of the plan trains dentists to treat
1841 patients in the nursing homes. It is very difficult for patients
1842 in the nursing home to get out and get access to dental care and

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1843 get to dental offices. Some of them don't have mobility. I have
1844 a patient, in particular. She is able to get transportation to
1845 our practice but now she has had surgery, she can't get back to
1846 get her services.

1847 I have done some care in nursing homes and gone out but there
1848 are certain procedures I have to have equipment to go to those
1849 areas. So we are trying to train dentists to do procedures in
1850 those nursing homes and maybe have the availability to have
1851 equipment so that they can take it with them and go take care of
1852 those patients.

1853 But they are a very vulnerable population and they have
1854 served us very well. We don't want to see them be neglected.

1855 Mr. Green. I am also interested in the Medicare. Do you
1856 know of any Medicare Advantage programs that offer dental?
1857 Because so many of them, we have a lot of competition between
1858 plans.

1859 Dr. Watson-Lowry. There are. It depends. Some
1860 situations depend on the state. We can get more information to
1861 you from the ADA. But some of those plans get to be complicated
1862 so it makes it very difficult for the dentists to be able to
1863 navigate what they can do, what they can't do, what is covered,
1864 and what is not covered. And some of those crossovers cause
1865 paperwork barriers.

1866 So some of this helps with some of that paperwork but we can

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1867 get more information to you in writing from the ADA.

1868 Mr. Green. Okay. And today we are hearing more and more
1869 evidence that chronic conditions, such as diabetes and heart
1870 disease have impact from bad oral health. Would you discuss the
1871 evidence and educate us on how the oral health and general health
1872 are linked?

1873 Dr. Watson-Lowry. Well, I am going to give you a situation.
1874 I had a particular patient that was coming in and he was doing
1875 fine for a while and then all of sudden he was losing a tooth every
1876 year. I looked in his mouth and I told him you know I am looking
1877 at some things and it looks like you have diabetes. And he went
1878 to his physician and he said well, no, you don't have diabetes.

1879 And I kept telling him something is not right and his doctor
1880 looked again. But he was borderline. He was just flying under
1881 the radar. Over a 10-year period, he lost 12 teeth.

1882 He retired from the police force. He went to another
1883 physician and then they told him, yes, you do have diabetes. He
1884 came in to me and he said you were right, Doc, all along. But
1885 by this time, he was having problems with his eyes. He was having
1886 a lot of other problems, threatening losing a foot, a lot of other
1887 things that were going on.

1888 So, it is really important that we address these issues with
1889 patients. Periodontal disease is a silent killer. A lot of
1890 patients don't even realize they have it and they just notice their

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1891 teeth loosening. So it is really important that we talk to the
1892 patients, educate them, and get these things under control so that
1893 they can, their overall health can be improved.

1894 Mr. Green. Do you have any information regarding cost
1895 savings of dental case management for patients who have chronic
1896 medical diseases such as diabetes or special conditions that we
1897 can say show the before and after that you actually have?

1898 Dr. Watson-Lowry. Well, one study shows that there was a
1899 reduction of \$1,300 per patient that had diabetes. Also, these
1900 patients, we can reduce them going to the emergency rooms when
1901 they are having other medical problems when we keep their dental
1902 conditions under control. So, there are cost savings there, as
1903 far as emergency room situations are concerned and all their other
1904 healthcare issues, keeping that blood sugar under control when
1905 their periodontal disease is under control.

1906 Mr. Green. Okay, thank you.

1907 Dr. Greenbaum, I want to thank you for your work. Coming
1908 from the Houston area international airports like L.A. and Miami,
1909 and New York, we have terrible situations.

1910 You discussed in your testimony the need to focus on trauma,
1911 and form, and culture in appropriate care. Can you explain some
1912 of the evidence-based techniques that should be used when caring
1913 for human trafficking victims that are trauma-sensitive and
1914 culturally appropriate?

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1915 Dr. Greenbaum. Yes, thank you. We all know that human
1916 trafficking victims have experienced complex trauma before they
1917 were trafficked and, certainly, during their period of
1918 trafficking. And so that likely impacts the way they see the
1919 world, the way they see us, as healthcare providers, and the things
1920 they say and do, and the way they interpret what do.

1921 So we have to, as healthcare providers, be able to stand back
1922 and say okay, that person may be acting belligerent, or may be
1923 acting aggressive, or maybe very socially withdrawn. That is not
1924 reflecting on me. That is their trauma talking and it is really
1925 important that I don't rise to that and that I sit and be very
1926 nonjudgmental because that is going to build the rapport that
1927 allows them to find out more information and provide services.

1928 So until you can really get beyond that, that trauma
1929 exterior, it is very hard to get to the real issues and provide
1930 care.

1931 Mr. Green. To get through that ice.

1932 Thank you, Mr. Chairman.

1933 Mr. Burgess. The gentleman yields back. The chair thanks
1934 the gentleman.

1935 I will now recognize myself for 5 minutes for redirect. I
1936 won't use all of the time.

1937 But Dr. Greenbaum, I think Ranking Member Pallone, in his
1938 opening statement, talked about the interaction with the

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healthcare system, giving an opportunity for the victim to detach from their trafficker. And in that other hearing that I referenced in the Helsinki Commission, the chairman, Chairman Smith from New Jersey ran, one of the things that impressed me was how not only was the trafficker a family member but they would never leave the patient. And he even detailed multiple E.R. physician visits. At least one time through labor and delivery, the naming of the child was done by the trafficker. I mean these were clearly clues that fall outside the norm. So, I recognize that what you are talking about doing can be very important, and very impactful, and clearly, it is an area where we need to make a difference.

And understanding that people coming in in that situation are not always going to be truthful about their situation but there can be other clues that lead to the correct assignment of what is actually happening.

So I am grateful that you are here today. And again, although that hearing was in a different committee in the Helsinki Commission, that has bothered me since that hearing occurred. So I am grateful to see that we are taking some tangible, measurable steps towards solving that problem and I believe next week is the week that we focus on human trafficking. So it is appropriate that we are doing the hearing this week to do that.

And to every other member of our witness panel today, I can't

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1963 thank you enough. Dr. Levine, again, you provided, whether you
1964 knew it or not, reassurance to the country that night and I was
1965 grateful for the participation of all of the medical professionals
1966 in Boston that day. I think it was an important part of the
1967 healing of our country.

1968 Dr. Watson-Lowry, thank you for what you do in helping
1969 provide services to people who need them so desperately.

1970 And Mr. O'Connor, my patron saint back home in Louisville,
1971 Texas was Chief Latzky of my fire department. He has now gone
1972 on to a different department, a trophy club. But certainly before
1973 I ever ran for public office, it was his example of giving back
1974 in public service that has always -- it has been a North Star for
1975 me, something to help guide me through my time in public service.
1976 So, I thank you for being here today and what you brought to the
1977 committee.

1978 I see that we have been joined by Mr. Bilirakis, who I would
1979 be happy to recognize 5 minutes for questions.

1980 Mr. Bilirakis. Thank you very much. I appreciate it. I
1981 had the V.A. full committee meeting and TELCOM. So, I apologize
1982 for being late.

1983 Dr. Levine, Florida is bracing for the next big one each
1984 hurricane season and its implications, especially for a state with
1985 a significant population growth over the last few years, a
1986 sizeable portion age 55 and older. A huge concern and God forbid

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1987 we get it but we have got to be prepared.

1988 Can you walk us through the Volunteer Protection Act and why
1989 it is so -- I mean what is your opinion and why is it not sufficient?
1990 Yes, please.

1991 Dr. Levine. I believe it goes to a certain point but,
1992 unfortunately, a healthcare professional providing medical care
1993 specifically. There is a difference between just doing first
1994 aid, doing triage, but actually providing medical care goes to
1995 another level that I don't believe would be covered for that
1996 physician from a liability perspective.

1997 At the Boston Marathon, we deal with mass casualties every
1998 year. It could be hyponatremia. Approximately 20 to 30 people
1999 have that. It is life-threatening.

2000 We deal with cardiac disease; again, it could be two to five
2001 a year. With 38,000 runners, typically we are going to get one
2002 cardiac event per 100,000; also life-threatening.

2003 We also deal with hyperthermia, in which people have body
2004 temperatures, core temperatures of 104 to 109 every year. This
2005 past year was not as bad as 2012, in which we had 24 people who
2006 had to be in the dunk tank for almost 30 minutes. Those are
2007 life-threatening conditions that you must have medical care and
2008 get their temperatures down within 30 minutes.

2009 In a disaster situation, you don't have time to understand
2010 whether, at the moment, you are going to have the capability of

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2011 evacuating someone to a hospital immediately. You may have to
2012 actually render the care immediately.

2013 One of the things at the Boston Marathon was, when I got to
2014 the site, there were a lot of people with their shirts off, who
2015 were trying to staunch the bleeding by putting a cotton shirt up
2016 against, unfortunately, a limb stump. What that did was, it
2017 actually increased the amount of flow into the shirt. Now, these
2018 were people that were volunteers but they were not medically
2019 trained. So they didn't know that they probably should have torn
2020 the shirt, tied it around and used tourniquets.

2021 So, if a medical personnel is not going to be on the site
2022 because they are not covered by the Volunteer Act, this is why
2023 this act I think is necessary.

2024 Mr. Bilirakis. Thank you very much.

2025 Dr. Watson-Lowry, in preparation for this hearing, I reached
2026 out to the dental community to get a sense of the cost impact of
2027 dental issues in my district. I know it is significant.

2028 In 2014, there were at least 163,906 E.R. visits in Florida
2029 for dental problems, almost none of which were cured in the E.R.,
2030 obviously, and the hospital bills exceeded \$243 million.

2031 In Pasco County, and I represent all of Pasco County, but
2032 in Pasco County alone, it accounted for approximately \$10.9
2033 million in E.R. expenses -- \$10.9 million in E.R. expenses.

2034 Can you explain how the E.R. referral works and how does it

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2035 provide cost savings?

2036 Dr. Watson-Lowry. Thank you for your question.

2037 Mr. Bilirakis. Sure.

2038 Dr. Watson-Lowry. There are approximately 200 E.R.
2039 diversion programs that we have going right now. There are
2040 approximately six different models, so they work differently in
2041 different situations. So, we can get information to you
2042 specifically on that.

2043 But suffice it to say, when you have someone going to the
2044 emergency room, that can cost over \$700 for that one emergency
2045 visit and, as we mentioned before, it doesn't cure the problem.
2046 We can take care of that issue in a dental practice or a dental
2047 clinic for one-tenth of that cost.

2048 So there is one particular program that the patients go in,
2049 they receive the service, and to pay for that service, they
2050 actually volunteer in different areas. So there have been
2051 situations where they have decreased the E.R. visits by 50 percent
2052 and increased the volunteer hours in other settings by like 9,000
2053 different volunteer setting visits.

2054 So there are a lot of different programs that are there and
2055 we can get more information to you about those different ones.

2056 Mr. Bilirakis. Yes, please do. Please do. I am very
2057 interested.

2058 One more question, Mr. Chairman or -- can I go to one more?

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2059 What do you think?

2060 Mr. Burgess. The gentleman is testing the patience of the
2061 chair.

2062 Mr. Bilirakis. Okay. All right, I will yield back and
2063 submit. Thank you very much, Mr. Chairman.

2064 Mr. Burgess. The chair thanks the gentleman for yielding.

2065 Mr. Bilirakis. I want my bills passed.

2066 Mr. Burgess. The chair thanks the gentleman for yielding
2067 back his time.

2068 Seeing that there are no further members wishing to ask
2069 questions, I do want to thank all of our witnesses for being here
2070 today.

2071 We have received outside feedback from a number of
2072 organizations on these bills and I would like to submit statements
2073 from the following for the record:

2074 Representative Simpson of Idaho, a co-sponsor of H.R. 2442,
2075 the American Association of Neurological Surgeons, and the
2076 Congress of Neurological Surgeons, the American College of
2077 Surgeons, and the American Hospital Association, PIAA, and the
2078 International Association of Fire Chiefs.

2079 Without objection, so ordered.

2080 [The information follows:]

2081

2082 *****COMMITTEE INSERT 5*****

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2083 Mr. Burgess. Those will be added to the record.

2084 Pursuant to committee rules, I remind members they have 10
2085 business days to submit additional questions for the record. I
2086 ask that the witnesses submit their response within 10 business
2087 days upon receipt of the questions.

2088 Without objection, the subcommittee stands adjourned.

2089 [Whereupon, at 12:07 p.m., the subcommittee was adjourned.]

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