RPTR GENEUS

EDTR HUMKE

EXAMINING LEGISLATION TO IMPROVE HEALTH CARE AND TREATMENT

WEDNESDAY, DECEMBER 9, 2015

House of Representatives,

Subcommittee on Health,

Committee on Energy and Commerce,

Washington, D.C.

The subcommittee met, pursuant to call, at 9:59 a.m., in Room 2322, Rayburn House Office Building, Hon. Joseph R. Pitts [chairman of the subcommittee] presiding.

Present: Representatives Pitts, Guthrie, Shimkus, Murphy, Burgess, Blackburn, Lance, Griffith, Bilirakis, Ellmers, Bucshon, Brooks, Collins, Green, Engel, Capps, Schakowsky, Castor, Matsui, Schrader, Kennedy, Cardenas, and Pallone (ex officio).

Staff Present: Leighton Brown, Press Assistant; Rebecca Card, Assistant Press Secretary; Karen Christian, General Counsel; Peter

This is an unedited transcript. The statements within may be inaccurate, incomplete, or misattributed to the speaker.

Kielty, Deputy General Counsel; Carly McWilliams, Professional Staff Member, Health; Katie Novaria, Professional Staff Member, Health; Graham Pittman, Legislative Clerk; Adrianna Simonelli, Legislative Associate, Health; Heidi Stirrup, Health Policy Coordinator; John Stone, Counsel, Health; Jen Brennan, Minority Press Secretary; Jeff Carroll, Minority Staff Director; Waverly Gordon, Minority Professional Staff Member; Samantha Satchell, Minority Policy Analyst; and Arielle Woronoff, Minority Health Counsel.

Mr. Pitts. The subcommittee will come to order. The chair will recognize himself for an opening statement.

Today's hearing will examine several different legislative proposals that will address shortcomings in current law, and reauthorize an important nursing training program.

H.R. 921, the Sports Medicine Licensure Clarity Act sponsored by the Health Subcommittee vice chair, Brett Guthrie, clarifies medical liability rules for athletic trainers and medical professionals to ensure they are properly covered by their malpractice insurance while traveling with their athletic teams to other States.

H.R. 1209, the Improving Access to Maternity Care Act, sponsored by another member of our Health Subcommittee, Dr. Michael Burgess, requires the Health Resources and Services Administration to designate maternity care health professional shortage areas inside existing primary care health professional shortage areas, and review these designations at least annually. The Department of Health and Human Services would also be required to collect and publish data on the shortage areas to better ensure access to maternity care.

H.R. 2713, the Title VIII Nursing Workforce Reauthorization Act, sponsored by Representative Lois Capps, reauthorizes the current nursing workforce development programs to continue nursing education at all levels and provide additional support for nurses practicing in medically underserved communities.

H.R. 3441, the Accurate Education For Prenatal Screening Act,

sponsored by Representative Jaime Herrera Beutler, directs the Centers for Disease Control and Prevention to develop, implement, and maintain programs to educate patients as well as healthcare providers on the purpose of cell-free DNA prenatal screenings. The reasons for such screenings, what conditions may be detected as well as the risk, benefits, and alternatives to such screenings.

H.R. 4152, the Cardiac Arrest Survival Act, sponsored by Representative Pete Olson, expands immunity from civil liability related to the use of automated external defibrillator devices.

H.R. 4153, the Educating to Prevent Eating Disorders Act of 2015, sponsored by Representative Renee Ellmers, yet another Health Subcommittee member, establishes a pilot program to test the impact of early intervention on the prevention, management, and course of eating disorders.

We will hear from a panel of experts and stakeholders as to their ideas and recommendations on these bills.

I now yield to Dr. Burgess. You are seeking recognition.

[The statement of Mr. Pitts follows:]

******** COMMITTEE INSERT ********

Mr. Burgess. Thank you, Mr. Chairman. I do seek recognition.

I just want to comment on the bill we have before the panel today. Across the country, women with the greatest need for maternity care services lack access to providers of such care. This bill introduced with Representative Capps will help place more maternity providers where they are needed and to improve access to maternity care and advance the health of mothers and babies. The National Health Service Corps provides for student loan repayment to physicians and other health professionals in exchange for our commitment to provide care in a designated health professional shortage area.

The program has been effective in reducing provider shortages by inspiring new providers to start where they are needed the most. Maternity care providers currently participate in the program based on a determination in an area that is a primary care shortage area. This bill would more effectively allocate maternity care providers based on an area or population's specific needs.

In other words, a maternity care provider will continue to be able to participate, but their participation will be based on a designation of a maternity care shortage area, not just simply a primary care shortage area. We are continuing to work with HRSA to ensure that this narrow targeted provision will improve access to mothers and the care that they and their babies need.

And thank you, Mr. Chairman. I will yield back.

[The statement of Mr. Burgess follows:]

******** COMMITTEE INSERT ********

Mr. Pitts. The chair thanks the gentleman. The chair now recognizes the distinguished ranking member of the Health Subcommittee, Mr. Green, from Texas, 5 minutes for opening statement.

Mr. Green. Thank you, Mr. Chairman. Today we are here to review six bills aimed at improving our healthcare system. But, first, and since this is, hopefully, our last hearing of the year, I want to start by thanking all of my colleagues on the Health Subcommittee, Ranking Member Pallone, Chairman Upton, and, of course, Chairman Pitts, for all of their work that went into the bills that comprise our shared success. It has been an incredibly productive year, and this subcommittee serves as an example of what we can accomplish when we work together on behalf of the American people.

From the 21st Century Cures Act, which passed with overwhelming support in the House last summer, to the Medicare Access and CHIP Reauthorization Act, which repealed and replaced the SGR and extended funding for the CHIP program in community health centers to dozens of public health bills signed into law, to ongoing efforts along the salient issues such as regulation of laboratory developed tests, the success of undertakings of this subcommittee are numbered in significance. None of this would have happened without the strong leadership on both sides of the aisle and the commitment to bipartisanship and a tireless dedication of staff, House legislative counsel and advocates, including the administration. I want to thank all of you and look forward to seeing what we can accomplish in the

coming year.

Now to our bills today. H.R. 921, the Sports Medicine Licensure Clarity Act, will promote the safety of our athletes by ensuring that sports teams' physicians and athletic trainers who treat their athletes while outside their home State can treat their patients regardless of whether they are home or away. Many medical liability insurance carriers do not offer coverage for care provided outside of the State in which the provider is licensed, making it difficult for team physicians to maintain adequate coverage while traveling throughout a sport season. This legislation would clarify certain aspects of the medical liability and malpractice insurance for those providers to address this issue in a targeted manner.

H.R. 4152, the Cardiac Arrest Survival Act, aims to increase the deployment of automated external defibrillators, or AEDs, by providing a baseline protection from civil liability for persons who own or use AEDs and doing a good-faith medical emergency. Numerous studies have demonstrated the value of prompt use of AED during an out-of-hospital cardiac arrest as the likelihood of survival decreases by 7 or 10 percent for every minute delayed until defibrillation.

H.R. 3441, the Accurate Education for Prenatal Screening Act, aims to advance the use of cell-free DNA prenatal screening. The development and delivery of genetic and genomic health care will continue to transform the practice of medicine and improve the diagnosis, prevention, and treatment of disease. While I thank the

bill sponsors for their commitment to the promise of genetics and the improving care for women with high-risk pregnancies, I have some concern that this legislation is overly prescriptive and premature and that information surrounding these tests is not evaluated by the FDA for their clinical or analytical validity.

H.R. 1209, Improving Access to Maternity Care Act, was introduced to increase access to maternity care services by creating a new designation within primary care health professional shortage areas, HPS designation -- HPSA. As someone who represents an underserved area, I appreciate the bill sponsors, Representative Mike Burgess and Lois Capps, for their commitment to targeting gaps in access and ensuring women can obtain vital maternity care services.

H.R. 2713, the Title VIII Nursing Workforce Reauthorization Act, will extend successful advanced nurse -- education nursing grants to support clinical nurse specialist programs. The Title VIII nursing workforce development programs have a long history of success and bipartisan support in Congress. Continued investment in these programs will ensure we have an adequate nursing workforce in the future. I want to thank Congresswoman Capps, the bill's sponsor, an unwavering champion for her work to reauthorize these critical programs, for her long history of working to improve nursing workforce demand, education, practice, recruitment, and retention.

H.R. 4153, the Educating to Prevent Eating Disorders Act, will create a pilot program through the Agency on Healthcare Research and

Quality to test the efficiency of early interventions on eating disorders. According to the NIH, eating disorders frequently present during teens and early adulthood, affect as many as 25 million Americans.

I look forward to hearing from our witnesses and learning more about the merits of each legislative proposal before the subcommittee.

And I thank you, and I yield back my time.

[The statement of Mr. Green follows:]

******** COMMITTEE INSERT ********

Mr. Pitts. The chair thanks the gentleman.

And now, in lieu of the chairman, Mr. Upton, the chair recognizes the gentlelady from North Carolina, Mrs. Renee Ellmers, 5 minutes for opening statement.

Mrs. Ellmers. Thank you, Mr. Chairman.

And thank you to our panelists for being here today for this subcommittee hearing today. Through my experience as a nurse, I recognize and have witnessed the serious implications that stem from eating disorders.

These disorders impact a person's emotional and physical health. So it is all the more important that we put in evidence-based programs in place to better understand the early warning signs of the disease. Our legislation, H.R. 4153, creates a pilot program within middle schools to begin educating school counselors, teachers, nurses, and parents about the signs and symptoms typically associated with these disorders.

Education is a critical step -- first step, if we hope to prevent, identify, manage, and intervene on behalf of the struggling adolescent. It is my hope that this legislation provides school officials and healthcare professionals with the education and resources they need to help thwart this mental illness from taking root. Thirty million Americans will struggle with an eating disorder at some point in their lives.

H.R. 4153 aims to amend the Public Health Service Act to establish

a pilot program to test the impact of providing students with interventions to prevent, identify, intervene, and manage eating disorders. The bill would establish a 3-year pilot program to provide grants to eligible schools for eating disorder screening, which would be implemented based on best practices recommendations from experts in the field of eating disorders. The pilot program would also include educational information and seminars on eating disorders developed by experts in the field for teachers, and parents, and eligible schools.

The intent of H.R. 4153 is to detect risk factors and symptoms so that young people can be directed to help when it is most effective. H.R. 4153 could be the most important proactive piece of legislation for the early intervention and prevention of deadly eating disorders.

I look forward to beginning this important discussion today, and thank you, again.

I yield back the remainder of my time.

[The statement of Mrs. Ellmers follows:]

******** COMMITTEE INSERT ********

Mr. Pitts. The chair thanks the gentlelady.

Is anyone else on this side of the aisle seeking recognition?

The chair thanks the gentlelady, and I now recognize the distinguished ranking member of the full committee, Mr. Pallone, 5 minutes.

Mr. Pallone. Thank you, Mr. Chairman. This morning we will be discussing a wide variety of bills. The first, H.R. 921, the Sports Medicine Licensure Clarity Act, stipulates that if a team doctor or athletic trainer crosses State lines for a game, any care provided at the out-of-State event will be treated as if it were a home game for the purpose of medical licensure and liability.

The second bill, H.R. 4152, the Cardiac Survival Act, expands civil liability protections related to the usage of automated external defibrillator devices, or AEDs. This bill would offer broad protections for both the owners of AEDs and any lay person that may use it. While I strongly support the intended goal of this bill, I do have some concerns surrounding State law preemption, especially as it may relate to various State AED training laws.

Third is H.R. 3441, the Accurate Education for Prenatal Screenings Act, would direct CDC to develop patient and provider education programs and materials to inform them about the use of cell-free DNA prenatal screening tests for genetic conditions such as Down syndrome. These screenings are intended to provide patients with genetic information regarding their pregnancy. However, these

screenings are not regulated by FDA and have a history of false positives and false negatives. Further, these tests are often misunderstood by both patients and providers. More must be done to ensure that the information provided about these tests is accurate and truthful to ensure that patients and providers can better understand these screenings and their limitations.

The fourth bill, H.R. 1209, the Improving Access to Maternity Care Act, as introduced by Representatives Burgess, Capps, and Duckworth, would make changes to the National Health Service Corps definition of a primary care health professional shortage area by creating a subcategory specifically for maternity care providers. This would allow the National Health Service Corps to better target maternity care providers towards the areas with the most need.

And then we have H.R. 2713, the Title VII Nursing Workforce Reauthorization Act as introduced by Representative Capps and Joyce, would reauthorize the Title VIII nursing workforce programs which provide valuable training to our Nation's nursing workforce through 2020. It also provides technical updates that more accurately reflect the current state of the nursing profession.

And, finally, H.R. 2153, the Educating to Prevent Eating Disorders Act, as introduced by Representatives Ellmers, Clark, and Castor, creates a pilot program to test new approaches to early interventions for eating disorders.

I would like to yield the remainder of my time to Mrs. Capps.

[The statement of Mr. Pallone follows:]

******** COMMITTEE INSERT ********

Mrs. Capps. I thank my colleague for yielding.

And I thank you, Mr. Chairman and Ranking Member Green, for holding this hearing. I am particularly pleased that two pieces of legislation I have worked on for a long time are also included in this discussion. Each would help strengthen our healthcare workforce and improve access to care for patients across the Nation.

H.R. 1209, the Improving Access to Maternity Care Act, would help identify and fill gaps in maternity care through the National Health Service Corps. My colleague from Texas has already described this, but I want to underscore the fact that the National Health Service Corps is one of our most effective programs to improve access to care in underserved areas.

Maternity care professionals are already included in the program, but their placement is based on data looking at primary care access shortages, not maternity care data. And this bill would make this more efficient by allowing these professionals to serve in areas with shortages in maternity care access, not just those with primary care deficiencies. It may seem like a small thing, but it is actually pretty significant.

I am pleased to have also co-authored this legislation with Dr. Burgess, and I want to highlight the work of our colleague, Representative Roybal-Allard on this issue over the years. Quality maternal care is vitally important for both the health of women and their future children, and it is our interests to do all we can to break

down barriers to access for this care.

I am also very pleased that we are considering H.R. 2713, the Title VIII Nursing Workforce Reinvestment Act -- Workforce Reauthorization Act. Sorry. Title VIII is the primary program our Nation has to strengthen and grow the nursing workforce. Title VIII has supported the recruitment, retention, and distribution of the highly educated professionals who comprise our Nation's nursing workforce and have been doing so for over 50 years through Title VIII. These programs bolster nursing education at all levels, from entry-level preparation through graduate study, and they provide support for institutions that educate nurses for practice in rural and medically underserved communities. Moreover, these programs are designed to address specific needs within the nursing population -- nursing workforce and America's patient population. The Nursing Workforce Reauthorization Act would ensure that these critical programs are available for years to come.

I want to thank my nursing caucus co-chair, Representative David Joyce, for coauthoring this legislation and the over 50 nursing groups that we have worked with to move this reauthorization forward. It is a great day.

So, again, thank you for including these bills in today's hearing.

And with that, I yield back to my colleague, but I don't think there is any time. Thank you.

[The statement of Mrs. Capps follows:]

This is an unedited transcript. The statements within may be inaccurate, incomplete, or misattributed to the speaker.

******** COMMITTEE INSERT ********

Mr. Pitts. The chair thanks the gentlelady.

As usual, all written opening statements of the members will be made a part of the record.

I have a UC request. I would like to submit the following documents for the record: Statements from Representative Herrera Beutler, from the American Congress of Obstetricians and Gynecologists, from National Nursing Centers Consortium, from the National Association of Clinical Nurse Specialists, from the Nursing Community Coalition, from the Society for Maternal Fetal Medicine, from the National League for Nursing, and the National Athletic Trainers' Association. Without objection, these will be made a part of the record.

[The information follows:]

******** COMMITTEE INSERT ********

Mr. Pitts. I will now introduce the panel. We have six witnesses today. I will introduce them in the order of their testimony.

First of all, Dr. Chad Asplund, director, athletic medicine, head team physician for Georgia Southern University, and Dr. Jonathan Reiner, director, Cardiac Catheterization Laboratory, George Washington University Hospital, and Dr. Anthony Gregg, professor and chief, division of maternal fetal medicine, University of Florida, Department of Obstetrics and Gynecology.

Dr. Ginger Breedlove, president, American College of Nurse Midwives; Dr. Deborah Trautman, president and CEO of American Association of Colleges of Nursing, and Dr. Ovidio Bermudez, chief clinical officer and medical director of Child and Adolescent Services Eating Recovery Center, senior board adviser, National Eating Disorders Association.

Thank you, each, for coming today. Your written testimony will be made a part of the record. You will each be given 5 minutes to summarize your testimony. You have a little series of three lights; green for the first 4 minutes, yellow should kick on for the last minute, red when your time has expired. So thank you for coming.

And at this point, Dr. Asplund, you are recognized 5 minutes for your summary.

STATEMENTS OF CHAD ASPLUND, MD, MPH, FACSM, DIRECTOR, ATHLETIC MEDICINE AND HEAD TEAM PHYSICIAN, GEORGIA SOUTHERN UNIVERSITY; JONATHAN REINER, MD, DIRECTOR, CARDIAC CATHETERIZATION LABORATORY, GEORGE WASHINGTON UNIVERSITY HOSPITAL; ANTHONY R. GREGG, MD, PROFESSOR AND CHIEF DIVISION OF MATERNAL-FETAL MEDICINE, UNIVERSITY OF FLORIDA DEPARTMENT OF OBSTETRICS AND GYNECOLOGY; GINGER BREEDLOVE, PHD, CNM, APRN, FACNM, PRESIDENT, AMERICAN COLLEGE OF NURSE MIDWIVES; DEBORAH E. TRAUTMAN, PHD, RN, FAAN, PRESIDENT, AMERICAN ASSOCIATION OF COLLEGES OF NURSING; AND OVIDIO BERMUDEZ, MD, FAAP, FSAHM, FAED, F.IAEDP, CEDS, CHIEF CLINICAL OFFICER AND MEDICAL DIRECTOR OF CHILD AND ADOLESCENT SERVICES, EATING RECOVERY CENTER SENIOR BOARD ADVISOR, NATIONAL EATING DISORDERS ASSOCIATION

STATEMENT OF CHAD ASPLUND

Dr. Asplund. Thank you, Mr. Chairman, Ranking Member Green, members of the committee.

Mr. Pitts. Is your button on there? You can pull it closer if you would like.

Dr. Asplund. Am I on?

Mr. Pitts. That is good.

Dr. Asplund. Thank you, Mr. Chairman, Ranking Member Green, members of the committee. Thank you for inviting me here to discuss

H.R. 921, the Sports Medicine Licensure Clarity Act. My name is Chad Asplund. I am a family medicine, sports medicine physician, and I am the head team physician at Georgia Southern University.

I graduated from the United States Coast Guard Academy, completed medical training at the University of Pittsburgh, family medicine residency at DeWitt Army Community Hospital at Fort Belvoir, and my sports medicine fellowship at Ohio State University. Additionally, I completed a master's of public health degree at the University of Florida.

In my experience as a sports medicine physician, I have had the opportunity to take care of athletes at all levels; Olympic, professional, NCAA division 1, 2, and 3, as well as recreational and high school athletes. I am here today representing the American Medical Society for Sports Medicine, the largest organization of team physicians in the world, which I serve as its chair of the practice and policy committee. I would not be here also without the support of the National Athletic Trainers' Association, the American Academy of Orthopedic Surgeons, and many others.

Nearly every day in this country, athletic teams travel across State lines to compete in their contests. Every day those athletes are out on the field they are subject to danger and to harm. And because of this, physicians and athletic trainers are there to ensure their safety. In the United States there is approximately 14,000 athletic trainers and physicians that are dedicated to team care, and each week

in America 300 to 500 of these professionals travel across State lines to provide care to the teams that they support.

What you may not realize is that in many cases by doing this, by crossing State lines to perform their jobs, they are risking their professional licenses and personal assets to make sure that those athletes have the best care by the medical professionals who know them best.

H.R. 921 would protect medical professionals that keep these athletes safe. H.R. 921 has three main components. First, to ensure medical professionals' licenses are valid when crossing State lines when they travel with their teams for sanctioned events as long as the care they provide is within the confines of the bill.

Second, to ensure that the Medical Practice Act in the medical professional's home State dictates their scope of practice, licensure requirements, laws, rules, and regulations governing their actions. And third, to ensure that a medical professional's medical malpractice and liability coverage can and will cover them while they were traveling to support their teams.

As you are aware, it is college football playoff time. It is college football bowl season. Many teams will travel across State lines to play football, which at times can be a violent and dangerous sport. Athletic trainers and physicians travel with these teams in order to ensure their safety. I would like to share a personal story of an incident that happened to us.

During this football season, during a game at Troy University, one of our Georgia Southern football players received a hit to the head and was laying unconscious, face down on the football field. Our medical team ran onto the field, and upon finding him, he was found to be unconscious and unresponsive. It was determined that he would need to be spine boarded and transported to the nearest emergency medicine facility.

The complex choreography of stabilizing the cervical spine, managing the remainder of the spine while rolling the patient and placing him on a backboard is something that takes lots of training and lots of practice between physicians and athletic trainers that work together all the time. Our athlete was placed on a spine board and was transported to EMS. Thankfully, his further evaluation was all negative. He was diagnosed with a concussion, and has since made a full recovery.

At the beginning of this incident, the Georgia Southern University medical team provided the medical care to this patient, which was then transferred to the emergency medical services when he was placed in the ambulance. Had there been an adverse event and a lawsuit had been filed, the protection of those members that provided that care would be uncertain. Their medical licenses and their personal assets would be at risk.

But there is no need to put medical professionals continued at risk. Today you can take a significant step to solve this problem.

You can choose to protect athletes and medical professionals by supporting and passing H.R. 921. I urge you, again, to support and pass this bill. And thank you very much for your time today.

[The statement of Dr. Asplund follows:]

******** INSERT 1-1 ********

Mr. Pitts. The chair thanks the gentleman.

And, Dr. Reiner, you are recognized 5 minutes for your summary.

STATEMENT OF JONATHAN REINER

Dr. Reiner. Mr. Chairman, Ranking Member Green, members of the committee, thank you for the opportunity to testify on behalf of the Cardiac Arrest Survival Act and the many thousands of lives this bill has the potential to save. I am a professor of medicine and cardiologist at the George Washington University, and I have spent most of my adult life treating people with heart disease. This is a topic I care about deeply.

Every year approximately 350,000 Americans experience an out-of-hospital cardiac arrest. Sudden cardiac arrest, or SCA, is a condition that results most often from the abrupt onset of a heart rhythm abnormality called ventricular fibrillation. This extremely rapid and chaotic arrhythmia causes the heart to quiver, effectively blocking its ability to pump. With no heart function, blood pressure drops to zero, breathing stops, and organs, most quickly the brain, begin to die. Without immediate measures, the victim has just a few minutes to live. SCA is a supremely lethal event that results in the death of about 90 percent of those it afflicts.

Sudden cardiac arrest is an equal opportunity killer. It kills the young and the old, the rich and the poor, those suffering from

chronic heart disease, and those who have never before been sick. It kills our husbands and our wives, our parents, and our partners, our friends, and neighbors, and our children. The annual death toll from sudden cardiac arrest is about twice the number of those who die from breast cancer, lung cancer, and HIV-AIDS combined.

Defibrillation with an automated external defibrillator, an AED, is the only effective treatment for sudden cardiac arrest. An AED is a small device, about the size of a lunch box, that can deliver a therapeutic shock to essentially reset the electrical circuitry of the heart. Contemporary AEDs, the type you see throughout airports and here in the hallways of the Capitol, have algorithms that automatically determine whether a shock is indicated and step-by-step audio prompts that guide the rescuer through the surprisingly simple process of saving a life.

This is time-tested technology designed for use by people who have had no prior medical training. In the late 1990s, when clinical studies proved unequivocally that public access to defibrillation saved lives, States began to enact AED laws. Over the next several years, all 50 States and the District of Columbia passed such legislation. Unfortunately, the unintended consequence of this effort was that the enacted AED measures were all different, creating a confusing patchwork of regulatory requirements and liability provisions.

The American Heart Association has stated that the variations and

complexities of State laws have complicated efforts to disseminate AEDs around the country. For example, more than 30 States require the registration of AEDs with local authorities, a process that is different in each State and can be quite cumbersome. Despite the fact that AEDs are designed to be used by lay rescuers, several States still prohibit AEDs by untrained operators.

Forty States require oversight of an AED program by a licensed physician. Although all 50 States have enacted some form of Good Samaritan protection for AED responders, the laws differ as to who in particular is eligible for immunity. Collectively, the varied State laws create a confusing series of bureaucratic hurdles that must be crossed before an AED program can commence. While individual State laws make the process of instituting a single AED program cumbersome, State to State regulatory heterogeneity and differences in Good Samaritan protections create an air of liability uncertainty for national corporations considering enterprise-wide AED programs.

The Wall Street Journal, noting that hotels around the United States have been reluctant to deploy defibrillators, describe their liability concerns as the, quote, "no good deed goes unpunished exposure." American retail stores have been similarly reluctant to deploy defibrillators. For example, you can purchase an AED from Walmart for about $1,000, however, should you experience a cardiac arrest while shopping in most stores, resuscitation will have to wait until the paramedics arrive.

To facilitate the placement of AEDs in businesses and public places across the United States, there must be a single unambiguous nationwide platform of liability protections. This is what the Cardiac Survival Act of 2015 does. The bill essentially decouples liability protection from the very State requirements for AED implementation, and in so doing, creates a national uniform baseline of civil liability protection for Good Samaritan rescuers and the entities that own the device. Reducing the current uncertainty surrounding AED acquisition and use will encourage the deployment of additional AEDs across the Nation and ultimately, this will save lives that otherwise that would have been lost.

In conclusion, Mr. Chairman, the current jumble of State AED provisions creates great uncertainty regarding liability exposure and has become a virtual speed brake on the dissemination of the simple, irreplaceable, decades-proven therapy. Congress has the ability to remedy this problem with the passage of the Cardiac Arrest Survival Act. Thank you.

[The statement of Dr. Reiner follows:]

******** INSERT 1-2 ********

Mr. Pitts. The chair thanks the gentleman, now recognizes Dr. Gregg, 5 minutes for your summary.

STATEMENT OF ANTHONY GREGG

Dr. Gregg. Good morning, Mr. Chairman, members of the subcommittee. I am Anthony Gregg, professor and chief of the Division of Maternal-Fetal Medicine at the University of Florida. I am board certified in obstetrics and gynecology, maternal-fetal medicine, and clinical genetics. I have been in practice for over 20 years specializing in high-risk pregnancies. I am here today as a representative of the American College of Medical Genetics and Genomics.

ACMG is a specialty society representing U.S. clinical and laboratory medical geneticists, who are certified by the American Board of Medical Genetics and Genomics. There are nearly 2,000 ACMG members, including genetic counselors, nurses, and public health geneticists. Delivery of genetic and genomic health care is an exciting area that has transformed and continues to alter the practice of medicine.

Medical genomics refers to the knowledge of human DNA organization and structure along with an appreciation of the environmental impacts that lead to health and disease. Medical genomics is now applicable in the delivery of prenatal and postnatal patient care, including fetal and neonatal screening for genetic

conditions.

I am also here today in the capacity as lead author of the May 2013 ACMG policy statement on noninvasive prenatal screening for fetal aneuploidy. The genetics and genomics world is fast moving. Noninvasive prenatal screening, NIPS, using cell-free DNA was introduced clinically in the United States about 4 years ago. The ACMG statement on this technology outlines test limitations and major issues to consider with regards to test limitations. It emphasizes the screening nature of this test and states clearly that false positive and false negative results occur. In fact, ACMG introduced the name, noninvasive prenatal screening, NIPS. The S in the acronym is meant to emphasize the screening nature of this test.

The ACMG document addresses the importance of clear language when conveying laboratory test results and recommends that laboratories offering this testing adhere to accepted standards and guidelines for practice. Uniquely, the statement includes a number of information resources available to patients and providers.

ACMG supports H.R. 3441, the Accurate Education for Prenatal Screenings Act. H.R. 3441 recognizes that NIPS is unique. It has better screening test metrics than any technology which has preceded it and any other currently in use. It is a technology that is easy to implement. It is noninvasive, which means it requires only a blood draw from a patient's perspective. These features within a rapidly changing genetics and genomic medical practice environment creates

challenges for many patients and providers of obstetric care.

NIPS has seen rapid uptake by providers and their patients, and it is increasingly offered to a large proportion of pregnant women. This has caused a paradigm shift in the way prenatal genetic screening takes place. Every aspect of screening is impacted, including pretest counseling, sample collection and shipping, laboratory testing, and post-test counseling, and follow-up.

Counseling patients is at the heart of the clinical utility of NIPS. Nondirective, but informed counseling requires training and skill. Patient aids, literacy level, spoken language, and baseline anxiety varies among patients. Medical geneticists are uniquely trained to address patient heterogeneity. ACMG agrees with the goal of H.R. 3441. Clinicians are going to provide patients with both pretest and post-test counseling when offering NIPS in order to avoid any potential harm or confusion.

There are nearly 4 million U.S. births annually, and it is imperative that obstetric care providers, including obstetricians, family medicine doctors, nurse midwives, and practitioners have access to accurate educational materials that ensure patients receive accurate pretest counseling. Pretest education and counseling leading to informed decisionmaking are critical components of any genetic screening process. The great majority of normal results are communicated to patients by the provider or their designee that counseled and offered the test. However, abnormal results may not be

easy for nongenetics trained professionals to interpret. Sometimes these must be put into the context of personal and medical family history in order for patients to receive accurate information. A deep understanding of genomic medicine is required.

We applaud Congressmen Herrera Beutler and Roybal-Allard for including provisions in H.R. 3441 that emphasize the importance of both pretest education and counseling as well as the need for accurate and patient-specific follow-up when results point to a possible fetal genetic condition.

Mr. Chairman and members of the committee, thank you for focusing on this important issue for women and families. ACMG looks forward to working with you to ensure access to accurate, reliable, and up-to-date information. Thank you.

[The statement of Dr. Gregg follows:]

******** INSERT 1-3 ********

Mr. Pitts. The chair thanks the gentleman and now recognizes Dr. Breedlove, 5 minutes for your summary.

STATEMENT OF GINGER BREEDLOVE

Ms. Breedlove. Chairman Pitts, Ranking Member Green, and members of the Subcommittee on Health, it is truly my honor to be with you today to discuss the status of maternity care in the United States and the need for Congress to work with maternity care providers, including midwives, to improve a woman's access to these essential services.

I am a certified nurse-midwife with 37 years of clinical experience and a professor of graduate nursing and nurse-midwifery at Shenandoah University in Winchester, Virginia. Today I join you as president of the American College of Nurse-Midwives.

ACNM is the professional organization for certified nurse-midwives and certified midwives, and our vision is a midwife for every woman. Our mission is to support midwives and advance the practice of midwifery in order to achieve optimal health for women through their lifespan with expertise in well-women and gynecologic care promoting optimal pregnancy, physiologic birth, postpartum care, and care of the newborn through the first 28 days of life. CNMs are licensed, independent healthcare providers with prescriptive authority in all 50 States, the District of Columbia, American Samoa,

Guam, and Puerto Rico.

Medicare, Medicaid, and all other Federal programs provide access to midwifery services. Approximately 82 percent of CNMs have a master's degree, and as of 2010, a graduate degree is required to entry into our practice. As president of ACNM, I am proud to fully support the Improving Access to Maternity Act, H.R. 1209, as authored by Representative Michael Burgess and Representative Lois Capps. I thank them for championing this important public health initiative on behalf of women in rural and urban areas experiencing shortages of qualified maternity care providers.

I also wish to thank the American College of Obstetricians and Gynecologists, which has been a strong partner supporting this legislation along with numerous nursing and maternal health groups.

H.R. 1209 would establish a maternity care shortage designation within existing designated health professional shortage areas. The goal of this legislation is to identify areas in the U.S. experiencing significant shortages of full scope professionals, including midwives. Such information will enable Congress and the administration to better understand and address needs of women of child-bearing age and allow appropriate resources to be focused on those unique needs.

ACNM believes enabling access to maternity care professionals in underserved areas can reduce overall maternity care costs by ensuring women have access to necessary prenatal and delivery options. For example, we know nearly half of the 4 million annual births in the U.S.

each year are covered by the Medicaid program. Thus, both Federal and State governments have a clear financial stake in ensuring high-quality care is being provided at a reasonable cost. Too many of these births require expensive interventions that could double the cost of a birth and, in fact, increase a woman's risk for maternal mortality. The CDC reports that the rate of maternal mortality has more than doubled in the past few decades.

Today, women giving birth in our country are at a higher risk of dying than those giving birth in China or Saudi Arabia. This tragedy must be addressed. While there are several causes, one solution is better access to maternity care providers, including midwives, who can monitor a woman's pregnancy, provide prenatal care, adequate postnatal care, and promote a healthy transition to parenthood without complications.

Research shows that in 2011, some 40 percent of counties had neither a certified nurse midwife nor an OB-GYN to provide direct patient care services. For millions of women, shortages in maternity care providers can result in long waiting times for appointments, and long travel times to their prenatal care or site of their birth. We know inadequate prenatal care is associated with increased risk of prematurity, stillbirth, and neonatal death.

H.R. 1209 will ensure policymakers have necessary information on maternity care shortage areas. Midwives and OB-GYNs are already full participants in the National Health Service Corps, which places

practitioners in underserved areas, yet, no maternity care shortage designation exists. Allowing the National Health Service Corps to place them where their unique skills are most needed will benefit the women of our country.

Thank you for your consideration of this legislation today.

[The statement of Ms. Breedlove follows:]

******** INSERT 1-4 ********

Mr. Pitts. The chair thanks the gentlelady, now recognizes Dr. Trautman, 5 minutes for your summary.

STATEMENT OF DEBORAH E. TRAUTMAN

Ms. Trautman. Good morning. My name is Deborah Trautman, and I am the chief executive officer for the American Association of Colleges of Nursing. I want to thank the chairman for hosting this important meeting today, also recognizing Ranking Member Green and the opportunity to speak to you all about a very important issue for our Nation's health.

On behalf of H.R. 2713, Title VIII Nursing Workforce, I would also like to extend my gratitude to Representatives Capps and Joyce for introducing this legislation and for their work as the nursing caucus. Both of them are fierce champions for the nursing profession and for improving health in our Nation.

Additionally, I wish to thank House Energy and Commerce Committee members who have cosponsored this legislation, including Representatives Castor, Kennedy, Loebsack, Matsui, Schrader, and Yarmuth. AACN, as you may know, represents 781 schools of nursing across the country in all 50 States and the District of Columbia. Our membership extends to 475,000 individuals, 18,000 full-time faculty, 457,000 nursing students, and deans who lead these institutions.

Healthcare delivery models are not static, as you know, neither

is nursing education. This legislation would modernize the Title VIII nursing workforce development programs, thus creating alignment with transformational efforts underway in nursing and health care. With over 3 million licensed providers, registered nurses are the largest healthcare workforce in America and essential members of the healthcare team.

As we continue to ensure that all communities have access to care, it is essential that Title VIII nursing workforce development programs be reauthorized. This will ensure a continued pipeline of support for providers who spend the most time with patients, our Nation's nurses.

AACN, along with 51 other nursing organizations, collaborated with Representatives Capps and Joyce to identify four technical changes. The mutually agreed-upon changes promote the clinical nurse specialist role, which employs expertise to specific patient populations, nurse managed health clinics, which provide essential primary care, and the clinical nurse leader role, which is vital to care coordination.

Title VIII programs have supported the nursing profession for over five decades. In 2015, the Title VIII programs awarded 1,166 new and continuing grants. These grants bolster the nursing workforce, address nursing workforce diversity, improve and increase nursing faculty, improve quality, promote inter-professional education and training, and help meet the needs of our aging population.

Today, regional demands for nurses reflect some of the barriers

to recruitment and retention, particularly in areas of nursing shortage. One Title VIII program, the advanced education nursing traineeship, helps us address this. In a study HRSA did recently, this program supported 5,650 students, of which 56 percent of these students received training in medically underserved areas, and 48 percent received training in primary care settings.

One future nurse, who is a recipient of this traineeship, Britney Keplera, a doctor of nursing practice student at the University of Pittsburgh, students like Britney are prime examples of how this program reaches those who provide care to the underserved. Britney, as others, look forward to serving their local community, and Title VIII funding allows students to prioritize their future practice settings over choosing an area where salary will help offset their loans.

Another nurse, Lisa Van Cleave, a Ph.D. student at Hardin-Simmons University in Abilene, Texas, is supported through the nurse faculty loan programs. Lisa states that this financial aid will assist her in becoming a doctorally prepared faculty member. There is a critical demand for doctorally prepared faculty across the country.

Each year, hundreds of students like Britney and Lisa share with AACN how the nursing workforce development programs have provided them financial opportunity to work towards their ultimate career goal, providing high-quality, cost-effective care, and for many of them that includes becoming the faculty of the future who will teach tomorrow's

nurses.

I thank the subcommittee for the opportunity to share the tremendous impact that Title VIII programs have had and how its recipients and their careers have and will continue to improve the health of our Nation.

I applaud the subcommittee for bringing H.R. 2713 to a hearing, as it is the necessary legislative step to support America's patients, their families, and the communities in which they live.

AACN is dedicated to working with this subcommittee and Congress to advance this legislation.

Thank you for the opportunity to comment.

[The statement of Ms. Trautman follows:]

******** INSERT 1-5 ********

Mr. Pitts. The chair thanks the gentlelady, now recognizes Dr. Bermudez, 5 minutes for your summary.

STATEMENT OF OVIDIO BERMUDEZ

Dr. Bermudez. Thank you, Mr. Chairman, and members of the Subcommittee on Health for the opportunity to testify before you today to support H.R. 4153, the Educating to Prevent Eating Disorders Act of 2015.

My name is Dr. Ovidio Bermudez, and I serve as chief clinical officer and medical director of child and adolescent services for the Eating Recovery Center, a treatment facility in Denver, Colorado.

I also serve as senior advisor for the board of the National Eating Disorders Association, which is a not-for-profit organization that supports both families and individuals who have been impacted by eating disorders.

I applaud this subcommittee for their consideration of this legislation, and in particular Congresswoman Ellmers for her leadership in championing this very important cause. As a medical doctor working in the field of eating disorders now for over 25 years, I would like to emphasize the importance of screening and early recognition and intervention in the prevention of eating disorders.

Over the last two and a half decades, I have treated thousands of children and adolescents suffering from eating disorders and have

learned a few things about them that I would like to share with you. First, those who suffer from an eating disorder and their families bear a heavy burden of disease. However, many of the personality characteristics that have rendered them at risk for the development of these illnesses also render them productive members of society once they have recovered from their illness.

Second, those in touch with the daily lives of young people, meaning parents and school personnel, specifically teachers, are in the best position for early detection. There are attitude changes in a young person that often precede the development of eating related pathology and behaviors, and thus can clue us into the needs for assessment and further intervention.

Third, eating disorders are curable mental illnesses, but the later the diagnosis and the institution of appropriate intervention, the harder the course of illness and worse the outcome. So early recognition and early intervention are essential to improve treatment outcomes and avoid the chronicity and early death often associated with eating disorders.

In the U.S., 20 million women and 10 million men suffer from a clinically significant eating disorder at some point in their lives, including anorexia nervosa, bulimia nervosa, or binge eating disorder. Eating disorders are real; they are complicated, complex, and devastating conditions and can have serious consequences for health, productivity, and relationships. They are not a fad. They are not

a phase. They are not a lifestyle choice. In fact, they are not a choice at all.

Eating disorders are serious, potentially life-threatening conditions that affect a person's emotional and physical health and can impact every organ of their body, including the brain. If left untreated they can damage the brain, the liver, kidneys, gastrointestinal tract, teeth, skin, hair, bones, and heart. They can result in serious medical conditions such as retarded growth, osteoporosis, kidney problems, gastrointestinal dysfunction, and heart failure.

In fact, eating disorders have the highest mortality rate of any mental illness, yet, due to the lack of awareness and education about them, many people do not receive the treatment they need and deserve. Due to this lack of information, eating disorders are often not recognized or diagnosed until the physical health of an individual is compromised, at which point irreversible damage may have already occurred. But the good news is that eating disorders are treatable conditions. Early recognition may prevent the development of eating disorders and subsequent chronic physical and mental conditions, including a high risk of suicide.

Studies have demonstrated a link between early intervention and better treatment outcomes. The American Academy of Pediatrics has recommended the screening questions about eating patterns and body image be asked of all preteens and adolescents to detect the onset of

eating disorders early and halt their progression. The cost of treating a full-blown eating disorder is quite expensive, and so prevention really pays.

H.R. 4153 aims to amend the Public Health Act to establish a pilot program to test the impact of early intervention through screenings, under-prevention management, and course of eating disorders that would establish a 3-year pilot program to provide grants to eligible schools for eating disorders screenings. The screenings would be implemented based on best practices from recommended experts in the field of eating disorders.

To me, the reality is, is that this is an important opportunity to protect one of the most valuable sectors of our population, which is young people.

So I want to thank you for hearing this testimony and for the consideration of supporting this H.R. 4153 to improve the health and well-being of youth across our Nation by helping to prevent eating disorders. Thank you.

[The statement of Dr. Bermudez follows:]

******** INSERT 1-6 ********

Mr. Pitts. The chair thanks the gentleman. That concludes the oral presentations of the witnesses. We will now begin questioning.

I will recognize myself 5 minutes for that purpose.

Dr. Asplund, has your organization discussed H.R. 921 with any medical malpractice insurers, and if so, what are their thoughts on the need to clarify lines of jurisdiction when a team physician or trainer is providing care for an athlete outside the State which they are licensed or insured?

Dr. Asplund. Thank you for the question. A group of colleagues from the American Medical Society for Sports Medicine contacted 20 of the Nation's largest medical malpractice providers and asked them the question, would you cover a team physician practicing across State lines?

Approximately 25 to 30 percent said that they would regardless of the place where a care was covered, 45 to 50 percent said it would depend, and 30 percent outright said that they would not cover that medical professional who provided that care outside of the State. So there is a potential for anywhere from 30 to 80 percent of medical providers who may not be covered by their malpractice, simply for traveling with their team and doing their job.

Mr. Pitts. Thank you.

Dr. Reiner, you mentioned in your testimony that all 50 States have passed legislation, including the liability protection for citizens that use a defibrillator on someone during the course of an

apparent medical emergency, and for businesses that have defibrillators installed for such purposes. Can you speak to how these laws vary and the impact such variation is having on increased deployment of lifesaving devices? And how would H.R. 4152 lead to more widespread deployment, and how many lives could they save?

Dr. Reiner. Mr. Chairman, in Pennsylvania, for instance, if a business wants to institute an AED program, they can do so, but they are required to train their employees in the use of the device.

Mr. Green, in Texas, there is no such training requirement. In Virginia, there are no requirements at all. So if you want to purchase a defibrillator for your coffee shop or your hardware store, you can buy one on Amazon and put it on the wall.

So the essential problem is that although all States have enacted some form of legislation, the legislation differs from State to State. So if you are a national corporate entity that wants to do business around the United States, you have the problem of getting 50 different State laws correct. And they differ just enough to create an uncertainty in your mind that, you know, if I don't get this right, then this is my problem.

Imagine if you have a hotel and your State requires a trained employee on duty 24/7, and that night someone dies in your hotel and somehow the resuscitation doesn't go well. Well, now, that is potentially your problem. And the owner of the hotel might say, gee, it might have been better for me just not to have a defibrillator at

all.

So simply what this bill does is decouple all of the State provisions, training, supervision. If the States find an interest in those, that is great. But it just decouples those different training and supervision requirements from liability protection. If you have a working defibrillator that is kept in good order, you are protected from liability.

Mr. Pitts. Thank you.

Dr. Gregg, does the training OB-GYNs receive in genetics prepare them to interpret cell-free DNA prenatal screening results and communicate them effectively to patients?

Dr. Gregg. I think this is the fundamental problem and probably what brings this bill to this body today. The obstetrician, gynecologist can certainly read a report where the report says normal and can read a report that says the patient has an abnormal test result. What follows is a detailed discussion on post-screening test results in the context of what does an abnormal test result really mean.

Patients have taken that test result to mean that they definitely have a child that has Down Syndrome, and in some cases due to time constraints, fear has led them in directions that, as we have heard through the lay press, were directions that weren't what they would have expected.

The problem, then, becomes in understanding that this is a screening test and what types of tests need to follow. In addition,

understanding the positive and negative predictive value of the results at hand.

Mr. Pitts. The chair thanks the gentleman. My time is expired. The chair recognizes the ranking member, Mr. Green, 5 minutes for questions.

Mr. Green. Thank you, Mr. Chairman.

Dr. Trautman, we appreciate you joining to discuss the Title VIII nursing workforce programs. Title VIII programs have long enjoyed bipartisan support, and I am glad that it has continued with the introduction of H.R. 2173. The Title VIII Nursing Workforce Reauthorization Act by Representative Capps and Joyce, like many, I am concerned about the nursing shortage facing the U.S. and baby-boomer generations further exaggerating the great need for more healthcare providers.

According to a report, the United States registered nurse workforce report card and shortage forecast published in the American Journal of Medical Quality in January of 2012, the shortage of registered nurses is projected to spread across the country to 2030 with the most intense shortages in the South and the West. I understand that one of the contributing factors in the shortage of nursing facilities. In fact, in 2012, nursing undergraduate and graduate programs turned away 80,000 qualified applicants due to the lack of capacity.

Doctor, could you elaborate on the difficulty in attracting

students and professionals entering in the nursing faculty workforce?

Ms. Trautman. Yes, thank you, Chairman. That is a very good question. And I want to thank you, again, for the support that has occurred over the decades that has allowed us to attract individuals to nursing programs.

We have a strong desire to continue to advance those who are interested in not only the sciences but in caring for individuals to join the nursing profession. And we have done more with respect to these programs and recognizing that it is important to get to our youth earlier and speak to them about the profession, educate them.

Title VIII funding, as you know, has been targeted recently, some of the advance practice work in serving the underserved areas. As you mentioned, it is correct that the nursing workforce, like the American public is aging, so while our past efforts have been successful, we must do more. A part of doing more, which Title VIII supports, is advancing doctoral education for nursing because we need doctorally prepared nurses to be faculty to teach the future nurses. It is an extraordinary profession, and we will continue to work with our colleagues in Congress and outside to educate others about the benefits of being a member of the nursing profession.

Mr. Green. Okay. Since we had so many applicants, qualified applicants who couldn't get in, does this legislation help in that lack of capacity?

Ms. Trautman. Yes, it does. It helps in two regards. The

problem is primarily related to either clinical placements and/or faculty. Although, again, there is regional variation, some areas of the country have no problem. But in those areas that do, Title VIII helps support, as well as some other programs, but it helps support, again, preparing doctorally prepared faculty. And the clinical placements are not a part of Title VIII, but the nursing community and other stakeholders recognize the importance.

The nurse managed clinics, though, which are in Title VIII, do provide an opportunity for additional clinical settings, and that will help us accept more students.

Mr. Green. Okay. Great, thank you.

RPTR MAAR

EDTR SECKMAN

[10:59 a.m.]

Mr. Green. Okay. Great. Thank you.

We also have all heard about the difficulty in accessing maternity care services in certain areas and where there is certain populations. It is surprising that we do not have good data to understand the problem.

Dr. Breedlove, what do we know about the existing shortage in maternity care providers?

Ms. Breedlove. We know there is an increasing shortage of OB/GYNs graduating from residency programs. And ACOG has supported data on the critical workforce shortage of OB/GYNs, I believe, in their testimony. We also know that 40 percent of counties in our country have no maternity care provider, whether that be an OB/GYN or a midwife. So it is astounding that so much of the geographic region of our country can provide services through the National Health Service Corps through primary care providership, which both these professions are a part of. However, the specialty they provide often is not identified in the primary care shortage definition. So a physician, OB, or midwife may go to one of these primary care shortage areas but not be able to deliver the services they are uniquely trained for.

Mr. Green. Okay.

Will H.R. 1209, Improving Access to Maternity Care, help us

collect that information?

Ms. Breedlove. Absolutely. This directs HRSA to create definitions and collect data that can help us place particularly new graduates in these professions and setting where they are most needed.

Mr. Green. Okay.

Thank you, Mr. Chairman. I yield back.

Mr. Pitts. The chair thanks the gentleman and now recognizes the gentleman from Illinois, Mr. Shimkus, for 5 minutes for questions.

Mr. Shimkus. Thank you, Mr. Chairman.

Welcome. This is a great panel, great issues. The challenge of health care is apportionment of costs because everyone is really there to serve the public. And it is just a great aspect of being on this committee. I just have two -- I think, Dr. Reiner, so in the 108th Congress, we passed the Adam's Memory Act, which allowed emergency auxiliary defibrillators to be placed throughout in public areas. And it was based upon an act of young boy who got hit in the chest with a baseball at a diamond and went down. And just, fortunately, there was a policeman there and had one in the truck of the car. And that caused us to move a year or two later to help place these throughout open-access areas. And they have changed quite a bit since technologically. So I think a good way to really kind of reinforce the language of this bill is to just have one here because they just -- they tell you what to do. I mean, it is like: Open the case; grab these little wires; put them here; press start. Right? So that

is kind of the basic -- that is what you basically need, to be able to follow instructions and listen to them to use one of these auxiliary emergency defibrillators today. Isn't that correct?

Dr. Reiner. That is right, sir. The devices were really made to be used by people with no training. And the favored study that I point to is a study that compared sixth grade kids, basically 12-year-olds, to trained paramedics. So they set up a mock cardiac arrest. And they told the kids outside the room -- who had never seen a defibrillator -- that all you have to do is open it because, as you said, there are audio prompts that talk you through. And, importantly, the device cannot deliver a shock to a person who would not benefit from it. So they compared 20 kids to 20 paramedics. And, obviously, the paramedics knew how to do it. And the paramedics beat the kids by only about 20 seconds, 20 seconds. Every kid could do it. Every kid did it properly. Every kid did it right the first time.

But the laws are confusing, and they are intimidating. I travel through O'Hare from time to time. And signage on the defibrillators is terrifying. The signage says "to be used only by trained responders." Well, why should it say that? The devices are designed to be used by anyone, trained or untrained. It says that because there is a piece of Illinois law that makes that necessary.

So all that this bill says is if you have a working defibrillator and it is used with good intent to try and save the life of somebody, that the owner of the defibrillator is protected, as is the Good

Samaritan. It doesn't change the requirements that some States may have for training or supervision. It simply says that whatever the State rules are, if you are using it with good intent and you have a working device, everyone is protected.

Mr. Shimkus. Excellent. Thank you.

And I will just finish up with Dr. Gregg. And I appreciate this bill too. There is going to be a continued debate, I mean, between those who consider ourselves pro-life and believe life begins at conception and should be protected and then the challenges that we face under medical ethics, under genomic testing, and then decisions that are made because of that which may not sometimes -- as you pointed out, we need to make sure that they are an accurate as possible description to inform the family of what may or may not be. If you want to comment on that, you can. That is a challenge that I think the healthcare community has to work on.

Dr. Gregg. Sure. Let me just say that noninvasive prenatal screening, or NIPS, has the best test metrics for screening available today, better than anything we have used over the last 30 years, the best positive predictive value, negative predictive value, sensitivity, and specificity. In a New England Journal of Medicine paper published last spring, this best testing metrics was confirmed across all reproductive age groups, so not just what is classically defined as advanced maternal age patients, but all reproductive age groups.

Having said this, it is imperative that patients and the providers understand that it is still a screening test and that there is a need for follow up.

As far as women and their reproductive choices, I will say that the American College of Medical Genetics and Genomics has as a fundamental ethics tenet that counseling is performed in a nondirective fashion. And screening takes place today. This is not adding screening to a healthcare system that doesn't already have it, but it is trying to refine the educational piece. And, to me, that is what this bill does. It brings the educational piece to the forefront, not screening or not what women do with the screening.

Let me say that the false positive rate with this particular test is less than 1 percent -- in fact, in some studies, less than a half a percent. Other screening tests that have been in play now for now more than 25, 30 years have a false positive rate of 5 percent. That brings more people to the high-risk obstetrician with anxiety. And it brings more people potentially to diagnostic procedures that have some small but real measurable risk associated with them.

So it is these educational aspects -- I will just say one more thing, that this is becoming an increasingly complex testing environment as we move from common aneuploidies, Down syndrome being one of the most commonly talked about, to now other aspects of genomics. Other aspects where small pieces of DNA are deleted or duplicated, we are now able to identify these. These have a different positive and

negative predictive value. And different things are done in response to these test results. And that is the educational piece, not sort of the simpler aneuploidy piece. I think that can be done in a paragraph. But it is how to keep in front of the evolution of this technology as it comes forward.

Mr. Shimkus. Thank you.

Thank you, Mr. Chairman.

Mr. Pitts. The chair thanks the gentleman.

I now recognize the ranking member of the full committee, Mr. Pallone, for 5 minutes for questions.

Mr. Pallone. Thank you, Mr. Chairman.

I want to ask Dr. Trautman some questions and then, if I have time, Ms. Breedlove.

Dr. Trautman, as you know, there are four advanced practice registered nurse roles: Nurse practitioner, certified registered nurse anesthetist, certified nurse midwife, and clinical nurse specialist. And I am interested in learning more about the role of the clinical nurse specialist. Could you explain the role of the clinical nurse specialist within the healthcare system, and what are the education and training requirements of clinical nurse specialists?

Ms. Trautman. Thank you. As you have described, there are four advanced practice roles in nursing. The clinical nurse specialist is a role that is focused on a specialty, so a specialty area. The education for a clinical nurse specialist is a graduate degree. There

are master's prepared clinical nurse specialists. And there are increasingly more doctorally prepared clinical nurse specialists.

Mr. Pallone. Okay. Now, the advanced nurse education grant program supports projects that develop and test innovative academic practice partnership models for clinical training and prepare primary care and advanced practice registered nurses to provide safe, quality care. Can you explain why this program is important to supporting the nursing workforce?

Ms. Trautman. Certainly. Thank you. That is an excellent question. Academic practice partnerships are critically important. Gone are the days where the academic community can be separate from the practice community. As we as a Nation move forward in all of our efforts to improve health and health care, those partners and leaders and practitioners in practice, as well as our educators, must come together. And when we do, we benefit from the expertise of both of those very important disciplines to not only advance the profession, but we have had significant examples in the VA and in other settings of how we improve the experience of care for individuals and their families.

Mr. Pallone. Okay. Now, currently only three of the four advanced practice register nurse roles are eligible for this program. Could you elaborate on why it is important to include the clinical nurse specialists in the advanced nursing education program?

Ms. Trautman. Certainly. The request for the change, the

technical change in the reauthorization, is to allow us to standardize, as you have just mentioned, across all advanced practice nursing roles. And because the education, as I have shared, is similar, at graduate level and above, the competencies of the clinical nurse specialist, it will, by making this technical change, it allows us to create parity within all of the advanced practice roles.

Mr. Pallone. Okay. Thank you.

So let me go to Ms. Breedlove, I wanted to ask some questions about the increase in maternal mortality. According to the CDC, the rate of maternal mortality has more than doubled in the past few decades, increasing from 7.2 deaths per 100,000 births in 1987 to 17.8 deaths per 100,000 births in 2011. Could you explain some of the reasons leading to this increase?

Ms. Breedlove. Absolutely. Thank you for the opportunity to comment.

Just this morning, the World Health Organization released a statement related to maternal mortality with a specific focus on issues related to pre and postnatal care. Most specifically, contributors include preeclampsia, lack of early diagnosis, post partum hemorrhage, and post partum infection. And when you think about the provider shortage challenging the ability for pregnant and postdelivery women to access immediate care for evaluation and referral to appropriate services, particularly in rural areas of our country, we know there are ways to address this. But we have to have providers who are

accessible to the women who need that care.

Mr. Pallone. And specifically how would the creation of the maternity care health professional shortage areas help reduce maternal mortality?

Ms. Breedlove. By placing the most qualified providers of the unique services to women during the childbearing years in the areas where the need is more clearly defined. Right now, we have no ability to designate maternity shortage areas under the Health Service Corps definition, nor do we have any idea what that shortage area percentage might be. But we are aware from many stories and the poor outcomes that we are facing that health care is needed in those areas. So it would be a very simple way to introduce a new definition without changing those who already exist in the Health Service Corps.

Mr. Pallone. Thank you very much.

Mr. Pitts. The chair thanks the gentleman.

I now recognize the gentleman from Pennsylvania, Dr. Murphy, 5 minutes for questions.

Mr. Murphy. Thank you, Mr. Chairman.

And thank you to the panel for being here.

Dr. Breedlove, let me continue on with some of those areas that Mr. Pallone was asking. With regard to the number of OB/GYNs available, do we have any idea of the cost we would encounter from having them involved in this?

Ms. Breedlove. There would not be additional costs. We are

talking about providers who already qualify in the National Health Service Corps. So what we are talking about in this bill is enabling the right provider to be at the right place at the right time.

Mr. Murphy. But it comes out of the funding for the medical corps, medical service that is existing. So does that mean it takes away from -- the current areas designated for shortage are primary care, dental care, and mental health care. So it would pull from the same amount of money, not additional?

Ms. Breedlove. I am not exactly sure how to answer your question, other than these provider types which we currently have already fulfill the primary care opportunities.

Mr. Murphy. I am aware of their -- I am just trying to think in terms of funding. There is a certain block of money. So we add them to that list, and then they all pull from that same list. Am I correct in terms of --

Ms. Breedlove. I am not able to answer your question.

Mr. Murphy. That is okay. All right. I just want to make sure because given that -- I don't know what the cost savings would be and maybe you could get us some estimates. I know we went to Dr. Tom Insel here, the immediate past head of the National Institute of Mental Health. He said the current cost in our mental health system is $444 billion. That does not include the justice system, which is probably another $50 billion to $100 billion, so half a trillion dollars per year. I just want to make sure we are not cutting other services for

a group that we already have a massive shortage on. But I agree with you; we need to do this part too.

Dr. Bermudez, welcome. I want to ask you about some of the aspects you brought out about eating disorders. And thank you for talking about that. You said that there are perhaps tens of millions of mostly women and some men who are affected by this. But in your testimony, you really emphasized the role of the family and the role of teachers to early identification and facilitate treatment. And toward the end of your testimony, you also said basically once an eating disorder takes hold, it is very difficult to reverse. The physical, emotional, and financial toll it takes on families is devastating.

I am a psychologist by training so that you know. And in this, would you say -- and I have seen this in other studies too, first of all -- that a person who has an eating disorder can sometimes be so deeply involved in their psychiatric problems that they may resist treatment, true?

Dr. Bermudez. True.

Mr. Murphy. And under those circumstances, I read another study that says whether a person is involuntarily or voluntarily committed, that the outcome is good if you get them in treatment. It is much better if they are in treatment versus not in treatment. Is that correct?

Dr. Bermudez. The data is clear on that.

Mr. Murphy. Okay. That is very important because sometimes people say, "Well, we shouldn't involuntarily commit someone," but a

person's mind may be so disturbed from the psychiatric illness, they are not cognitively aware of what they need. Further, some people with eating disorders may also be in the category of severe mental illness -- schizophrenics, bipolar -- so they have dual diagnoses on top of that, which makes it even more complicated. Am I correct?

Dr. Bermudez. Absolutely.

Mr. Murphy. So in this getting a family member involved, one of the big dilemmas that oftentimes occurs are HIPAA laws, where if you are treating someone with bulimia or anorexia and the issue is if they are not even going to their appointments and the family member doesn't even know their diagnosis or the treatment plan or where they are supposed to go or a change in appointment or the medication, very often providers say, by HIPAA laws, I am not even allowed to tell you information to facilitate treatment. Am I correct?

Dr. Bermudez. So what I wanted to tell you is that that is completely -- I agree with that for adults. Now, that is part of the beauty of the opportunity here is that we are talking about a group of illnesses that generally presents in early adolescence and toward the latter part of adolescence. So the opportunity of the involvement of the family at a very meaningful level is clearly there, in spite of HIPAA laws and wanting to work and respect --

Mr. Murphy. And during that time, a provider could certainly build a relationship with family members and understand who to trust, who is part of the team. So even when that person turns 18, for example,

severe mental illness, 50 percent of severe mental illness emerges by age 14; 75 percent by age 24. It is a critical time. They are no longer in school. They are past 18. HIPAA dynamics change. But from what I hear you saying, from your testimony, it is very important that, for the prognosis of that person, to keep the family member involved and find ways to make sure the HIPAA law doesn't get in way so that person can be involved. Would that be fair to state?

Dr. Bermudez. That is a fair statement. And we have clearly shifted as a field in our understanding of eating disorders and moving away from really blaming families to really partnering with families. Families are critical as agents of change, not only to be aware early on and recognize in a timely fashion and bring their loved ones to care, which secures better outcomes, but I think, at the same time, to remain involved and continue the appropriate followup of these illnesses. As you know, from a psychological perspective, these are not things that change overnight. And, therefore, involvement of a support system -- i.e., the family -- is critical in the success of treating these illnesses.

Mr. Murphy. Thank you. I appreciate it.

I yield back.

Mr. Pitts. The chair thanks the gentleman.

I now recognize the gentlelady from California, Mrs. Capps, 5 minutes for questions.

Mrs. Capps. Thank you, Mr. Chairman.

Thank you all for your testimony.

And before I begin, Dr. Trautman, I would like to ask my first question of you. But I want to clarify, my colleague, Mr. Murphy, just raised an issue about funding for maternal-child health. And I just want to clarify this money is already being spent, to my colleague. Mr. Murphy?

Mr. Murphy. I am sorry?

Mrs. Capps. I just want to clarify something to you as I started because of the statement that you made regarding funding and allocations coming. This is money that is already now being spent. So there are no new providers being added or taken into the program for maternal-child health or for any of these nursing programs. It would just help to drill down within the existing programs for primary care designations to place these maternity care professionals where they are needed most.

Mr. Murphy. I understand.

Mrs. Capps. I just want to make sure --

Mr. Murphy. Make sure we are robbing from Peter to pay Paul. We need to do more. Not less.

Mrs. Capps. Exactly. So, Dr. Trautman, as you well know more than most of us, the Institute of Medicine's 2010 Future of Nursing Report is a landmark study for our profession. In it, the IOM laid out the current state of our nursing workforce and a roadmap of what needs to happen to prepare for the healthcare system of the future.

Just last week, IOM's evaluation committee released a followup report reviewing the progress made on the Future of Nursing's recommendations. One of their recommendations was an increased focus on nursing workforce diversity. Title VIII Nursing Workforce Diversity program has supported increasing diversity. No one is arguing with this.

So, Dr. Trautman, can you discuss what progress you see being made in nursing school enrollments regarding diversity? And how does the title VIII program, for all of us to understand it better, how does this program support this goal?

Ms. Trautman. Thank you very much, Representative Capps. And thank you again for your fierce, strong commitment to the profession and what ultimately again is going to improve the health of our Nation. Thank you.

The importance of diversity in all health professions, most certainly in nursing, is clearly understood. And title VIII has been very effective in helping us make improvements. In the years, looking at the data, from 2010 to 2014, we have improved the diversity of the nursing student population at all levels. At the baccalaureate, at the master's, and at the doctoral level, we are now at 30 percent of those students represent diversity. And while that is significant progress, it is not yet enough. Much more needs to be done. Some of that, most certainly, has within the past been directly related to title VIII and so will the future in these programs that are specifically targeted to help us not only to bring diverse individuals into the

profession but, as you know, equally important that we are serving areas of the country most in need.

Mrs. Capps. Yes.

Ms. Trautman. So that is very important. We will also do other things beyond the law, the legislation, the changes that are proposed in the health professions. One example that you are aware of, I know, is this holistic review, which is an approach to looking at individuals who enter the profession, and it includes the individual as a whole. So you look -- we look at personal attributes, in addition to the academic metrics that, in the past, most health professions had solely relied upon.

Mrs. Capps. I appreciate that. Thank you very much.

Switching gears here, the goal of the Improving Access to Maternity Care Act is to better target the maternity care professionals to the communities that need it most. We know that prenatal care is so critical to pregnant women. But far too many women are not getting the recommended care, as you know.

So, Dr. Breedlove, from your perspective as a certified nurse midwife -- I am big supporter of that program, of course -- and an educator of midwives, what impact does proximity to prenatal care -- that, I think, is something we really want to zero in on -- and post partum care, maternity care have on the quality of a pregnancy for a woman and for the child?

Ms. Breedlove. Thank you so much for your fierce support of our

profession but also of access to prenatal care for women in our country. The issue really is around whether or not there can be adequate screening, which we have heard a little bit about today, whether there is an opportunity to assess women for potential risk, could be preconception, early pregnancy, as well as routine prenatal visits, which we know have a huge impact on the ability to diagnose early signs of preeclampsia, again, one of the problems of maternal mortality in our country. So it really is critical that if women are driving, you know, an hour and an hour and a half to find prenatal care, the likelihood of her having routine care and not missing visits, in addition to driving even longer than that for the birth facility is a very challenging thing for our families and really is clearly evident of some of the challenges that we have in all women in our country having in the prenatal care they need in a timely fashion.

Mrs. Capps. Thank you very much both of you.

And I yield back my time.

Mr. Pitts. The chair thanks the gentlelady.

I now recognize the gentleman from Texas, Dr. Burgess, 5 minutes for questions.

Mr. Burgess. Thank you, Mr. Chairman.

And, Ms. Breedlove, forgive me, Dr. Bucshon had eclipsed you temporarily.

Thank you, Doctor. You are so kind to me.

Let me ask you a question because, I mean, because in your

statement, your testimony, the suggestion that the maternal mortality rate has increased over the last 10 to 12 years' time, can you give us -- I know you have been asked this previously -- but can you give us the breakdown of where those deaths have occurred?

Ms. Breedlove. We are collecting data under the guidance of CDC and the Maternal Mortality Commission. I attended an all-day workshop at the ACOG annual meeting in San Francisco last year. It is very clear that not only is it based on prenatal and postnatal adequacy of care but also in systems of care within the hospital setting itself so that there are clearly defined clinical pathways and the management of women who are at risk of stroke, who are at risk for hemorrhage, and who are at risk for hypertension that is poorly managed. So there are a variety of projects that are interdisciplinary in nature going on around the country, developing we call them bundles for care that are collaborative in nature and codeveloped by all the disciplines within healthcare maternity services.

So we know more about some of the challenges. But we also are keenly aware that if you have no one available to help diagnose and early screen and provide services prior to hospital admission, you have increased risk of those families.

Mr. Burgess. I think that is the lesson we are in danger of overlooking when we have this discussion. The drop in maternal mortality, not just in this country but worldwide, was dramatic. And it occurred about 1937. It is important to me because my grandfather

was an academic obstetrician at the Royal Victoria Hospital in Montreal. So he was part of that generation of doctors. These are doctors who practiced before antibiotics were widely available, before anesthesia was as reliable or survivable as it is today. Certainly the same could be said about blood banks. If you were fortunate enough to get a blood transfusion, the likelihood that you would survive it was certainly problematic before modern blood banking techniques emerged. And all of that coalesced around 1937, and the numbers dramatically dropped. So it is the presence of a trained attendant at birth that really probably has made more difference in maternal mortality than anything else, which is why your testimony intrigued me because, you know, we shouldn't forget the lessons of the past. So one of the things that this will do, with all deference to my friend from Pennsylvania, we are not taking his money, but we are trying to make certain that the money that is available in the primary care space goes where it is most needed. And the other thing that, interestingly enough, has been found over the years is that doctors tend to go or stay, rather, where they train. We are not terribly imaginative, as it turns out. And so we don't wander far from where it is that we took our -- generally our residency training, perhaps subspecialty training. We tend to marry people who are in that area. And, as a consequence, we don't move from there unless our spouses give us permission. We tend to establish referral patterns: who you can trust, who you can't. So the degree of professional comfort is greatest in

the area in which you train. It certainly was true for me and a great number of my cohort. The significance there is if we can bring to the medically underserved from a maternal standpoint, if we can bring practitioners to the medically underserved area, the likelihood that they will then populate those areas is higher than if we try to entice them with other inducements. So that is why this change in designation, although it is really not more money and we are not taking money from someone else, this is really an important thing to accomplish and why I am grateful that Representative Capps has partnered and that we are now having the legislative hearing, and we are working on getting it done.

And, Dr. Gregg, I just want to say to you -- and thank you for your testimony -- we are struggling -- I shouldn't say "we" are struggling. I am struggling -- the committee seems, everyone else seems comfortable with letting the FDA have further regulatory ability over what are called laboratory-developed tests. And I am nervous about that. And people on this committee know that. But I was encouraged by some of your comments. I mean, a screening test is a screening test. No one takes someone to the operating room because of a screening test. You do the confirmatory test.

Now, it is one of the idioms or one of the axioms of medicine that the confirmatory test will always be equivocal. But, nevertheless, you don't start a clinical action based on a screening test. So I appreciate your testimony on that very much.

Mr. Chairman, thank you. I will yield back.

Mr. Pitts. The chair thanks the gentleman.

I now recognize the gentleman from Oregon, Dr. Schrader, 5 minutes for questions.

Mr. Schrader. Thank you, Mr. Chairman.

A question on the Cardiac Survival Act for Dr. Reiner. I am familiar with the use of the devices. And you indicated in the testimony some of the queries that anyone can pretty much use those. So the device discerns between like atrial fibrillation and ventricular fibrillation. So it is not up to the individual using the device?

Dr. Reiner. That is right. And, in fact, there is really no way to deliver a shock to someone who doesn't have what is programmed into the system as a, quote, shockable rhythm, which is basically ventricular fibrillation or a very fast ventricular tachycardia. So if someone has just passed out, for instance, but they don't have one of those rhythms, you cannot actually deliver a shock.

Mr. Schrader. Okay. Good to know.

For Dr. Gregg, I guess, on the cell-free DNA testings, screenings, those can be ordered by anybody, anywhere, any time? It is not through a physician?

Dr. Gregg. It can be, these can be ordered by advanced practice nurses, yes, sir.

Mr. Schrader. I mean, just laypeople.

Dr. Gregg. No.

Mr. Schrader. Okay. Okay.

Dr. Gregg. You would have to have an MPI number.

Mr. Schrader. And there is a concern that advanced practice nurses and physicians are unclear about how to interpret the results on these and, therefore, would advise people perhaps incorrectly?

Dr. Gregg. On the pre-test side, there is a concern that patients may not and are not getting the adequate information to understand well the tests that they are having done and what that test is actually doing.

Mr. Schrader. But if that is done in concert with the physician or advanced nurse practitioner, wouldn't that take care of that potential problem?

Dr. Gregg. Again, the concern here is that the advanced practice nurse and/or physician is -- does not have the depth of knowledge to completely understand what it is they are ordering. And then when results come back, this becomes an even more complex problem when the result is abnormal. When the result is abnormal, it is not simply reading an abnormality is here, and then there is an algorithmic next step. In interpreting abnormal results, there are many subsequent steps that should take place following.

Obstetric care, as you know, is provided by people that range in their knowledge base. Midlevel providers provide obstetric care under the direction of physicians and so forth. Midwives provide obstetric care independently.

Mr. Schrader. Would be they interpreting these results too? Is that what you are --

Dr. Gregg. That is exactly right, that there is a wide variety of people interpreting these results.

Mr. Schrader. Okay. I understand.

Then, I guess, for Dr. Breedlove, if I may, on the Maternity Care Act, my understanding from some of the information we have gotten is that primary care shortage areas, of which this is one, is already recognized. And the reason for this is to draw even more attention to it? Or I am not exactly clear why it is called that.

Ms. Breedlove. Actually, no. The maternity care designation is not listed under the primary care scope. So what we are asking is that there be a definition within primary care.

Mr. Schrader. Okay. Great. I misinterpreted that then. And then, I guess, last but not least our nursing person here, talk a little bit about title VIII and how we can develop the next generation of nursing educators so critical to improving the number of nurses out there and why there is such a shortage.

Ms. Trautman. Well, thank you very much. Title VIII has made a contribution already. We have improved significantly the number of doctorally prepared nurses. We now have had in both the research doctorate as well as the practice doctorate an increased number of enrollees that is unprecedented. What we now also need to do beyond quantity is also start earlier in the nurse's career. And so we have

begun to create programs that facilitate earlier attainment of the knowledge and skills that are necessary for one to be competent and practice at the doctoral level. So it is a very exciting time and unprecedented in our Nation's history how the schools across the country are responding to assure that we have quality, high standards in education programs but that we facilitate ease of access and progression.

Mr. Schrader. Thank you, Doctor.

With that, I yield back, Mr. Chairman.

Mr. Pitts. The chair thanks the gentleman.

I now recognize the gentleman from Virginia, Mr. Griffith, 5 minutes for questions.

Mr. Griffith. Thank you very much, Mr. Chairman.

I appreciate all of you being here today. I want to start with Dr. Asplund and just say I am a cosponsor of the bill. I think it is a good concept. My reading of the bill, and I think it goes in a good direction, but my reading of the bill indicates this would also apply not only to college and professional athletes, but it would also apply to those folks who have trainers with high school teams if they are competing in a nationally sanctioned or sponsored event, something that some national organization puts on. Is that your understanding of the reading as well?

Dr. Asplund. Thank you for your question. So with the National Federation of High Schools being a sanctioning body of all high school

athletes, it was the intent in our language for high school athletes to be covered by this bill as well. As many people are aware, there are far more high school athletes in America than at any other time. There are far more contests across State lines in the high school level. I live in Augusta, Georgia. We frequently cross the river to South Carolina pretty much weekly to do that and, as such, are crossing into a State where many of my colleagues do not have licensure. So, yes, high schools were intended to be included through the line with the national sanctioning body being the National Federation of High Schools.

Mr. Griffith. I represent a district that borders four other States. And we have lots of high school competition going on. So I appreciate that. And I think that is a very good aspect of the bill. And I do appreciate that.

Dr. Reiner, I have got concerns about the AEDs or the bill at least. I think that the Federal policy does need to be looked at just simply because the good news is the bill that was passed in 2000, one of the criteria was you notify the local EMS. I think that at the time that made a lot of sense. Today, those AEDs are in a lot more places than they were in 2000. I think now it is impractical, in fairness, to notify local EMS for a lot of the small businesses that have these. Which EMS do they notify? Our area has -- it is all generally referred to where I live as the Roanoke Valley -- but you have city of Salem, the city of Roanoke, and Roanoke County, all of which are completely

separate and have separate fire, police, and rescue squad folks. Some are paid. Some are volunteer. And so it might be difficult. I think we do need to look at that policy.

But that being said, one of your examples kind of struck something that my friends who are trial lawyers have raised an issue, and that is, it appears that when you look at the actual lawsuits, there are more lawsuits for not having the AED on premises than there are for having it but using it improperly. In fact, they can't find a whole lot of cases where that has been the case based on the existing law. And I was concerned because one of your examples was Walmart sells them, but they may not have them. And I actually think that is a bigger liability issue for whatever retail establishment, whether it be Walmart, Kmart, whomever, if they are selling the device but they don't have one charged up ready to go, that is probably a bigger liability issue than having one prepared and then having somebody who is doing the best they can not use it properly. What do you have to say to that? Because I am trying to decide what to do on this bill, and I think both sides have some merit to their arguments.

Dr. Reiner. So it is important to know that the bill leaves State laws alone. So any provision in a State law that the folks in that State feel is important as it pertains to training or registration or supervision, any of those provisions remains in force. All that this bill says is that if you have a working defibrillator, you are protected. So that entities like Walmart or Target can know that,

look, they are going to do the best they can to get all these local ordinances right. But it is important for them to protect their community and their employees. And they are going to do the best they can. But they need to know that if their defibrillator is in working order, they are protected.

So it doesn't create new law. It doesn't cost industry a cent. It doesn't cost the government a penny. But there are a lot of people who die from this. I see folks who come to my hospital in two conditions: One person has had an out-of-hospital cardiac arrest, and they have been in close proximity to a defibrillator, and if they have been shocked pretty quickly, that person goes home to their family. The second patient has been someplace; it has taken a while for paramedics to get there. And they come to my place in a different circumstance, and they go to the morgue.

Mr. Griffith. And I appreciate that. I think we want to get that policy right. I apologize for cutting you off. But my time is up, and I have to yield back.

Thank you, sir. I appreciate your testimony today.

Mr. Pitts. The chair thanks the gentleman.

I now recognize the gentlelady from Florida, Ms. Castor, 5 minutes for questions.

Ms. Castor. Good morning. Thank you, Mr. Chairman, for calling this hearing. And thanks to all the witnesses for being here today, especially for including H.R. 4153, the Educating to Prevent Eating

Disorders bill, and H.R. 2713, the Title VIII Nursing Workforce Reauthorization Act. And I want to thank my colleague, Representative Lois Capps, for introducing the Title VIII Nursing Workforce Reauthorization Act. I am a proud cosponsor of this bill, which would reauthorization critical nursing workforce initiatives that are so desperately needed.

And I hear from Dianne Morrison-Beedy, the dean of the College of Nursing at the University of South Florida in Tampa, and her excellent team there, some of the most passionate advocates for a strong nursing workforce. That is one reason why USF's College of Nursing was ranked as one of the top, the best graduate schools this year on the national ranking. I am very proud of them. Ensuring that we have qualified registered nurses and advanced practice nurses is critical to meeting our Nation's healthcare needs.

I would also like to thank my colleagues and friends, Representative Renee Ellmers and Yvette Clarke, for introducing H.R. 4153, Educating to Prevent Eating Disorders. We filed this bill last week. It is an important bill that is aimed at reducing eating disorders with early intervention. Specifically, our bill would create a 3-year pilot initiative which would provide grants to schools, serving middle-school-aged children to test the impact of providing students with interventions to prevent, identify, intervene, and manage eating disorders. We will help the pilot schools hire a healthcare provider who will administer the initiative. The schools

participating in the pilot will submit a report detailing the process they used and the outcomes that they achieved. And it will be posted on the Agency for Healthcare Research and Quality Web site. There is a huge desire for accurate, up-to-date information on these challenges. And we have got to do more to prevent young people from suffering from an eating disorder. I am a mother of two teenage girls. And we know some of their friends who have struggled with these issues. And, oftentimes, families just don't know where to turn. There are not resources out there to help them deal with this. And as Representative Ellmers knows and has championed, you have got to intervene early. So I am grateful to all of you.

I want to thank Dr. Bermudez for being here. And I would like to ask you, could you briefly discuss the different types of eating disorders and the serious health consequences they cause and whether or not we have seen a rise in the number of individuals impacted by an eating disorder?

Dr. Bermudez. Sure. Glad to. Thank you.

You know, the main eating disorders that we are really talking about -- anorexia nervosa, bulimia nervosa, and binge eating disorder -- now, an important characteristic here to distinguish is that these are not fads. These are serious mental illnesses. You can't tell somebody who has an eating disorder by looking at them. And this is no longer an illness of Caucasian, privileged young women. This is an illness that affects all genders, all races, all ethnicities,

all social economic statuses. And that is important to come at it from.

Anorexia nervosa really constitutes a caloric restriction with loss of weight. These are people that when the disease is advanced, you can see them and you can recognize them as people who are alarmingly underweight.

In the case of bulimia, these people often binge eat, which means that they consume a very large amount of calories in a short period of time and then feel very guilty and tend to induce some form of purging, most of the time by vomiting, inducing vomiting, or abusing laxatives. But there are other forms as well.

And binge eating disorders are people who will binge recurrently and not engage in the compensatory mechanisms that include the purging behavior.

So that is really what we are talking about, the opportunity for early identification and appropriate early intervention I think would save many, many, many, lives.

Ms. Castor. Does the data show that the number of cases is increasing? Has it stayed level?

Dr. Bermudez. So the data shows that the number of cases, number one, is increasing. But also that the presentation, the clinical presentations of the cases are also increasing. So we are seeing some what is called demographic drifts. We are seeing younger and younger children involved in eating disorders, as young as 7 and 8 years of age. That was unheard of a few years ago. More mature people in

midlife, more women than men but men also in midlife, people from different races, and different ethnicities. So the protective factors that certain groups, like African Americans on Asian Americans or Hispanic Americans, had, those protective factors have eroded. And we are seeing more men represented across the spectrum of eating disorders, from anorexia to bulimia to binge eating disorder.

Ms. Castor. Thank you very much.

I yield back my time.

Mr. Pitts. The chair thanks the gentlelady.

I now recognize the gentleman from Indiana, Dr. Bucshon, for 5 minutes for questions.

Mr. Bucshon. Thank you, Mr. Chairman.

I was a cardiovascular and thoracic surgeon for 15 years prior to coming to Congress. So I want to comment primarily on the defibrillator issue.

I recently helped distribute defibrillators to a couple of the counties for law enforcement and other businesses based on grants through the Lugar Center, former Senator Lugar, and our State has a grant program that helps with these type of things. And H.R. 4152 is a necessary step in furthering the dissemination of AEDs.

Let me give you some personal experience. You commented, Dr. Reiner, about the two situations, that you see patients. And I have seen some also that have survived but have not survived in a state which is consistent with their pre-arrest state. I have specifically two

patients that I ended up doing surgery on that have long-term brain injury that changed their lives dramatically and the lives of their family. And I have also been consulted on many patients who are in the ICU who were found to have coronary disease. But I ultimately ended up not treating that patient with surgery because of a very severe brain injury for which they never woke up essentially and did not recover.

My two patients that had brain injuries had cardiac arrest at work. They had colleagues who were trained in BLS, basic life support, almost immediate CPR, no defibrillator available, 5 to 10 minutes' time before a defibrillator became available. They survived but had injury. So this is really important.

The other thing is -- and I am going to ask you to comment on this -- education of the public in the use and importance of these is critical. Employees and businesses, school children, as is pointed out by your study, it is very important. And I think for the future we probably need to start training school children, I would think, in their health class or something just about this because one of the biggest barriers to use, even if they are available, is fear. And I had a colleague of mine in an airport traveling to Washington who saw a person that had an arrest. There were people standing around. And he was a physician. And he said: Is there a defibrillator available?

Of course, there was. And they used it. And that patient survived and, subsequently, had heart surgery and is normal. But had he not been there as someone who was available to overcome his fear

because of his training, that may not have happened. So there are some barriers.

So, in combination with availability, can you comment on what your thoughts are also on the importance of education and helping people overcome their fear?

Dr. Reiner. I think that is a wonderful point, Congressman. The biggest issue is that people don't know that they can do this. We took a defibrillator out to the Verizon Center a couple years ago and filmed people as they walked down the street. We said: Hey, do you want to try and use a defibrillator? These were folks who had never used it. And they all could do it. They could do it very quickly. And the universal response: Oh, now I won't hesitate to use it if I ever have to.

But this kind of uncertainty is not just for the general public, but it exists for corporations. They are afraid of being sued if they get it wrong. All this bill says is if you have a defibrillator that works, you are protected from liability. It is a simple bill. But once national organizations start educating people about the bill, then I agree; we need to educate everyone how to use these devices. Imagine having a fire extinguisher in the corner that had labels on it that said "for use by trained rescuers only."

Mr. Bucshon. Right. Right.

Dr. Reiner. This is a fire extinguisher that talks to you.

Mr. Bucshon. I agree with that. And that is why I have a real

issue when trial lawyers, for example, have questions about people using things in good faith that save people's lives. And as a physician, my personal view is it is really sad that they would consider the financial benefits of suing people doing things in good faith. I really take offense to that, honestly.

Dr. Gregg, you commented on your screening test. Are they better than an amniocentesis?

Dr. Gregg. That is the point. An amniocentesis is the diagnostic test. That is the point.

Mr. Bucshon. I guess the reason I am asking is because at some point, when did the screening test supplant a more invasive study and become the standard?

Dr. Gregg. Screening tests have been in place for more than 30 years. The initial screening test was age alone. You will remember that age 35 was what rattled people's cage a little bit. Today, we recognize that the detection rate of age alone is not better than about 30 percent, just using age as a marker to go to the amniocentesis, as you are implying.

So we put in place multiple other -- over the last decades -- multiple other screening paradigms have been put into place. Today, with noninvasive prenatal screening, we are at a 98-percent detection rate from that 30 percent for advanced maternal age. The followup test is the amniocentesis or the chorionic villus sampling.

Mr. Bucshon. I guess my point is, at some point, a screening test

becomes a standard of care for the test, and it supplants a more invasive test. My time is up.

Dr. Gregg. An EKG doesn't replace what you do.

Mr. Bucshon. Understood. Fair point.

I yield back.

Mr. Pitts. The chair thanks the gentleman.

I now recognize the gentleman from California, Mr. Cardenas, 5 minutes for questions.

Mr. Cardenas. Thank you very much, Mr. Chairman.

Thank you Doctor, Doctor, Doctor, Doctor, Doctor, Doctor, and all of the people here who are on the panel giving us their expertise and also my colleagues who have practiced as well. Thank you so much for shedding light on many of these issues.

I am not a doctor, nor do I play one on TV. But I do care about the state of health care for our country and certainly now that a new chapter in my family's life has begun, as our daughter and her husband announced to us very nonchalantly that they are pregnant and our first grandchild is on the way. And that being the case, it leads to my first question having to do with prenatal screenings.

An article late last year in Disability Scoop discussed some limitations of cell-free DNA prenatal screenings and suggested that the need for quality control needs to be improved. So my first question is to Dr. Gregg. Are you aware of any noninvasive prenatal tests that are regulated by the FDA?

Dr. Gregg. No.

Mr. Cardenas. No? Okay. Some companies that make these tests have made claims about the high accuracy of their results or have made claims of very few false positives. Do any Federal agencies, such as the FDA, evaluate the claims that these companies are making to ensure that they are valid and supported by clinical data?

Dr. Gregg. Currently, the FDA does not regulate this particular LDT.

Mr. Cardenas. So those claims, where and how are they validated by third parties today?

Dr. Gregg. By third parties?

Mr. Cardenas. Yes.

Dr. Gregg. I am not aware that they have been validated by third parties.

There have been a significant number of peer-reviewed publications, large international trials, that validate the test metrics of these particular tests.

Mr. Cardenas. Is that, do you feel that that suffices to ensure the public that that accuracy is in line with what the claims are? Or could we possibly enlist some kind of agency to go ahead and help us understand that accuracy and have more, at least more appreciation for that accuracy?

Dr. Gregg. I am satisfied with the claims. I would say that an involvement of a Federal agency has value. We think there should be

some oversight of these laboratories. CLIA and CAP currently provide this oversight. To me and to ACMG, one of the principal values of FDA oversight would involve labeling and marketing aspects. Clinical validity has been established for other types of prenatal screening for aneuploidy. These out-of-the-box kits are probably regulated already but not molecular-based testing in this way.

Mr. Cardenas. Uh-huh. What can Congress possibly do to assure the quality of these tests and that the tests are providing accurate and reliable information to providers and specifically pregnant women?

Dr. Gregg. Well, the tests already provide accurate information. The laboratories themselves do currently have CLIA and CAP oversight. So that is already in place.

Mr. Cardenas. So, right now, as you see it, Dr. Gregg, the environment is at least satisfactory for those assurances and understanding by not only the practitioners but also the patients?

Dr. Gregg. No, I don't think it is satisfactory as far as it relates to practitioners or patients. And that is what H.R. 3441 proposes to do, is put in place the educational initiatives so that they are detailed, indepth, and provide for a balanced and accurate information as the technology evolves.

Currently, the technology has expanded beyond simple aneuploidies or common aneuploidies. As I said earlier, there are genomic changes that the technology is now being used to report screening results to. There is a need for more studies. And what we

haven't talked about here is the underlying bioinformatics that follows what happens in the laboratory. The bioinformatics is a big piece. It is proprietary. And at some level, there probably needs to be some digging into that black box to make sure that we can validate the bioinformatic pieces. The companies sure can play a better role in disclosing the data that they have access to. I think they probably with a nudge would be willing to do that. But that is the type of oversight I think that needs to be in place on the laboratory side.

Mr. Cardenas. One last point, if you will allow me, Mr. Chairman, I think that, unfortunately, proprietary information should not preclude us from making sure that what is going on out there is safe. And I think the government can play a protective role in protecting that proprietary information and bringing a better semblance of the environment for what is going on. Thank you so much.

Thank you, Mr. Chair.

Mr. Pitts. The chair thanks the gentleman.

I now recognize the gentleman from Florida, Mr. Bilirakis, 5 minutes for questions.

Mr. Bilirakis. Thank you, Mr. Chairman. I appreciate it so very much.

And I want to thank all of the sponsors of these really good bills.

And thanks for agenda-ing the bill today, Mr. Chairman, having the hearing.

Dr. Bermudez, the subject of eating disorders has been of great

importance to several of my constituents. They have come to my office, both in D.C. but also locally. In October, I met with a group of advocates and heard their personal stories about how they or their loved ones were affected by these debilitating mental illnesses. What are some of the biggest challenges to identifying the early signs of an eating disorder?

RPTR GENEUS

EDTR SECKMAN

[11:58 a.m.]

Dr. Bermudez. So eating-related pathology has an interesting characteristic, which is that people tend to not want to be discovered, right. So people in other areas of medicine want to seek the help and want others to know because that is the path to accessing help. In eating disorders, that is not the case. There is a lot of secretiveness in the clinical presentations of an eating disorder. So imagine, you know, a 14-year-old, who, you know, learns about some of this on the Internet or may have some friends that have been affected. They talk about it, and she sort of begins to change her behavior through restriction and dieting and exercise. Well, she doesn't want anybody to know. That is one of the biggest challenges. This is not a child who is going to come to the parents and say: Mom, Dad, I am struggling; I have a problem. This is a child that is going to work hard not to be discovered. Hence, the importance of educating those in the front lines, those individuals that really, day to day, are interacting with children.

Mr. Bilirakis. So which are they -- I know you brought it up. I hate to interrupt. What should we look for, our loved ones look for, a parent look for? How can we detect this?

Dr. Bermudez. We should look for change. We should look for

signs that are telling us that something is really changing in the way this individual views themselves and is trying to project themselves and fit into the world around them. So when a young person starts to make self-deprecating statements about their size, their weight, their appearance, their desirability; when a young person starts to, you know, make excuses to not eat; when a young person is losing weight and stops participating in the normal activities that they had interest in and love, especially social aspects of them, then I think families need to sort of pick that up and become concerned and seek appropriate assessment.

Mr. Bilirakis. Thank you. What are the most effective early intervention treatments?

Dr. Bermudez. So the diagnosis -- formalizing the diagnosis becomes very important. So after a screening test that raises a level of suspicion or parental familial concern, a thorough assessment becomes really important. And that assessment includes looking for medical complications of the eating disorder behaviors and psychiatric complications of the eating disorder behaviors. Once that diagnosis is made, then you can sort of assess the level of severity: Where is the illness at, you know, in the spectrum of severity of the illness? Because that may determine where we start the treatment process. And so the different levels of care, including medical stabilization, psychiatric stabilization, outpatient services that are age-appropriate, disease appropriate, inpatient -- intensive

outpatient programs, partial hospitalization, residential treatment, and inpatient eating disorder specialized efforts are all in the armamentarium, and so that assessment helps guide the family in making the decision as to where is the appropriate place to start.

Mr. Bilirakis. How many millions of people are affected by this disorder?

Dr. Bermudez. About 30 million people, so about 20 million women and 10 million men at some point in their lives will be affected by an eating disorder in the United States.

Mr. Bilirakis. Not just teenagers? All ages?

Dr. Bermudez. All ages.

Mr. Bilirakis. Okay. Thank you.

Thank you, very much, doctor.

Dr. Asplund, thank you for your testimony, again, today. As an avid sports fan and an attorney, the issue of athletes being able to receive medical attention from their team physician while across State lines has been of interest to me for a very long time, even when I was in the legislature in Florida.

You mentioned that merely exempting team physicians from the State's licensure requirements would not be sufficient because there is still a risk of a lawsuit. Can you explain how this complicates or hinders your ability to provide the best possible care for athletes?

Dr. Asplund. Thank you for your question. I am not sure that the language of the bill or the law hinders an ability to provide health

care. What it does, though, is it takes away protection for the athletic trainer or the physician after they have provided that health care in case something were to go wrong.

As I testified earlier, many medical malpractice carriers tie that malpractice coverage to that licensure link. And so of the major malpractice carriers that we surveyed, almost 30 percent said they wouldn't cover someone out of State regardless of licensure if they were out of State; 50 percent said they would cover them out of State only if they had a license in that second State; and there was 25 or so percent that wouldn't cover them at all -- I am sorry -- there is 25 percent that wouldn't cover them regardless of what State they were in. So having the licensure piece overlooked or not married up will put physicians and athletic trainers and other providers that provide that care at potential great malpractice risk.

Mr. Bilirakis. Teams are having trouble hiring physicians for these positions because of the risk of lawsuits?

Dr. Asplund. I am not aware of any difficulty in hiring providers. It is nearly the provision of care and then the risk that that may involve.

Mr. Bilirakis. Very good. Thank you so much.

Dr. Asplund. Thank you.

Mr. Bilirakis. I appreciate it.

And I yield back, Mr. Chairman.

Mr. Pitts. The chair thanks the gentleman.

I now recognize the gentleman from New York, Mr. Engel, 5 minutes for questions.

Mr. Engel. Thank you very much, Mr. Chairman.

Dr. Breedlove, before I came, Mr. Pallone asked you a question about the rate of maternal mortality. I am wondering if we could come back to that because I wasn't quite sure -- we were listening on the TV. I wasn't quite sure what the answers are.

The statistics I have is that it increased from 7.2 deaths per 100,000 births just in 1987, and it is more than double today, 17.8 deaths per 100,000 births in 2011. And I just -- what is the reason for that? That is really alarming, or it seems alarming. What is the reason for that, and are other developed countries experiencing the same thing in mortality rates?

Ms. Breedlove. I think from the data that is being collected by the CDC and the collaborative work groups related to maternal mortality in our country, we are finding that some of it does have to do with access to prenatal care and early assessment, the risk criteria during pregnancy, but some of it also has to do with care provision in the hospital systems themselves, whether that is the level of care provided, that the appropriate providers are in the right place for crisis management, or that those who are in hospital facilities have adequate training and resources to provide the provisions they need for critical high-risk patients.

So, unfortunately, you know, there are many variables, including

the rising rate of cesarean section and the complications that come with that. So the effort that is occurring by many collaboratives, including ACOG, Society for Maternal-Fetal Medicine, AWHONN, the nursing organization, is to begin to implement care bundles that are hospital-based but also to define levels of maternal care which will have the right providers at the right facility for the need of the patient.

Mr. Engel. Is part of it that older women are having more babies than they were 30 years ago, or does that have nothing to do with it?

Ms. Breedlove. I am not sure I could answer that question.

Perhaps my colleague, Dr. Gregg could, in terms of advanced maternal age and increased risk. Certainly, the increase in multiples can play a part in that, but I would defer to Dr. Gregg.

Mr. Engel. Okay.

Dr. Gregg.

Dr. Gregg. Thank you for --

Mr. Engel. You are happy to --

Dr. Gregg. I actually chair the -- co-chair the Florida maternal mortality committee, which is recognized as one of the most thorough maternal mortality committees in the country. We review every maternal death in the State that has specific criteria.

Let me just say that a couple of things have happened. The way data on maternal mortality is ascertained has changed. So I heard somebody say there was a drop and somebody else say it is increasing.

So all of that relates to who is obtaining the data. There were two entities within CDC both obtaining data, and now it is obtained across more States than ever before. So we are seeing -- what appear to be an increase in numbers are due to better ascertainment. And when that is compared worldwide, it looks like the U.S. does poorly. We have to remember that, worldwide, many countries don't collect any data or have very spotty data-collection capabilities. So I just want to put that out there.

There are increasingly -- women of advanced maternal age are getting -- not 35; to me, it is much higher than that -- are getting pregnant. They have other associated medical conditions that go along with advanced age.

We have more women getting pregnant that in times past couldn't get pregnant because they had underlying medical conditions that did not support pregnancy well. We have interventions to help them get pregnant. So now we are seeing sicker patients enter pregnancy, and we are having to manage sick patients in a pregnancy that challenges their physiology, so --

Mr. Engel. Thank you. It makes sense. Since I have you, let me ask you another question not related to this, but I understand that, as drafted, the patient and provider education campaigns, including in H.R. 3441, would need to be funded using existing resources. So has any analysis been done to determine what the cost of these campaigns might be or where the funding might be pulled from to finance them?

Dr. Gregg. I am not aware of a financial analysis or financial analysis report and don't have the data on that. I apologize.

Mr. Engel. Okay. Thank you.

Let me ask Dr. Reiner. In your testimony, you discuss the patchwork of laws that exist across 50 States with respect to liability for those who own or deploy automatic external defibrillators. And I would be interested to know what kinds of laws exist with regard to training and storage for these defibrillators. And the reason I am asking this is, while I take your points concerning liability, it occurs to me that we really should also be considering how we can enhance awareness and skill around these defibrillators. Obviously, they save lives. The usage rates might improve if defibrillators had to be stored, say, in permanent locations, and I know State laws vary. So if you could perhaps shed some light on how they vary in this respect. If you can --

Dr. Reiner. Thank you for the question, Mr. Engle. I completely agree. Defibrillators are -- work best when they are located in places where people congregate. And in a building like this, they are easy to find. But in other parts of busy cities, they are not. So part of the solution is education to the business community, community at large, educating people that these are easy to use, teaching kids -- I love the idea to teach kids how to use these while they are in middle school and high school. But the other piece of this is removing the concern for liability, what I think is the

unnecessary concern for liability that business owners do have for acquiring this technology. An AED cost about the same as a MacBook. It is cheap. This is decades-proven technology, but businesses are afraid of it.

Mr. Engel. Thank you. I want to just say in concluding that I always like when there are a bunch of doctors in the room, so I feel if anything happens to me, we can get good care.

Thank you all for testifying today. We really appreciate it.

Mr. Pitts. The chair thanks the gentleman.

I now recognize the vice chairman of the subcommittee, Mr. Guthrie, 5 minutes for questions.

Mr. Guthrie. Thank you very much. I appreciate all of you being here, but I want to focus on the Sports Medicine Licensure Clarity Act. That is the one that I am the sponsor of. I have a friend who is an emergency room physician, but he also is -- I don't know if he is a team doctor or designated doctor. He is one of the doctors who travel with Auburn University. So I remember when I first came across this issue and got interested in it because of his experience, I said: Do you realize when you were at the BCS game in California and the Rose Bowl, as much fun as you were having, enjoying it, you were probably there with -- you are unclear what your liability coverage would be if you are there?

And I know one of my colleagues was -- I don't where they were going with it -- but talked about being a lawyer. This isn't

preventing opportunities for people to bring malpractice suits. It just makes sure you are covered, your insurance is covered, so it is not taking away anybody's ability to move forward. It is just making sure that doctors have the surety that they are being covered.

And, also, I would just like to compliment Georgia Southern. I got to see you guys play a couple of years ago at Georgia Tech. I was there for a game. My son is there. And it was a closer game than some thought, and I think there was a controversial overturn that changed the game for Georgia Tech's behalf, and so a lot of fans get upset. But I remember walking out and going: Wow, Georgia Southern handled everything with class and a lot of -- great program, a lot to be proud in that program. And I know you are going to Mobile, so you are going to have to go to Alabama without a license, right, practicing license.

So that is the thing that we are trying to fix is that, you know, you have got Western Kentucky University. You are playing Bowling Green. We are from Bowling Green. A lot of people think we are playing you guys, but we are Western Kentucky University, and we are going to Miami. And so I remember, last year, we actually went to the Bahamas Bowl, and it is amazing how many 18- to 22-year-old young men do not have passports. So my office actually spent about a month trying to get everybody cleared to go. So when these games happen and it is a single game somewhere, you just can't do paperwork for every scenario that you are moving forward.

So we just want to fix it. I think it just makes it smarter. I

think everybody agrees that the team physician should be able to travel with the team -- who knows the young men and women, and knows there may be a previous injury, what they are favoring. So instead of bringing a local physician there who doesn't know the history of each kid, it is important to do so.

So I just want to ask you about the licensing process for sportsmen and professionals at the State level, and I know it would be very expensive and cumbersome and maybe even impossible, from the time you get a full bid until you are ready to play a ball game, to get licensed as a sports professional in a State. So what is kind of the process currently to be licensed as a sports professional in Georgia or any other State you are familiar with?

Dr. Asplund. Mr. Guthrie, thank you for the question, and thank you for the support of our bill.

You are correct. All 50 States and territories have differing requirements or processes to get a medical license. They generally look at your educational background, your malpractice claims, your continuing medical education, and then they issue a license. And while each State has sort of an underlying -- they are all similar, but yet they are different. And so we have been to Alabama three times this year to play -- or been there twice, and we are going to go back a third time. And had I known with enough time to get a temporary 14-day license -- which, according to the State of Alabama, would cost $500 and would only last for 14 days. So on our initial trip to south

Alabama, I could have paid $500, gotten 14 days of coverage. Two months later, when we went to Troy, I would have to pay another $500 to get 14 days of coverage and, now that we are returning to Mobile, another $500 for this 14 days of coverage. So the temporary medical licensing may work on occasion when you know that you have -- when you know where you are going.

Mr. Guthrie. But even if you are licensed there, there is no guarantee that your malpractice insurance recognizes that, right? That is what we are trying to clarify as well.

Dr. Asplund. That is correct. And in a study that we talked about, malpractice carriers sometimes tie their coverage to your State of license. So each State is different. The process is costly, anywhere from $150 to $900 per State, and the timeframe on that is anywhere from 2 to 6 months until that paperwork can process.

Mr. Guthrie. I want to get to a couple of other questions. So the bill doesn't restrict what you can do. You couldn't have gone to Troy hospital -- or if you went to Montgomery or wherever you went or Birmingham -- and perform an orthopedic surgery on a player that was hurt?

Dr. Asplund. Correct.

Mr. Guthrie. And it does restrict what you can do. So pretty much what we understand is on-the-field coverage?

Dr. Asplund. Yes. It restricts it to on-the-field or in-the-training-room type coverage. Any coverage that would occur in

a medical facility, like a hospital or a clinic, would not be covered by this bill. It is typical stuff that you would do on the sidelines, in the training room, underneath the stadium.

Mr. Guthrie. And why is that important? I have got just a couple of seconds, so I want to make sure. Why is it important? Because I know my friend was telling me that, you know, this person has a sore ankle; this person has done it before; if he hurts it again in the game, I know where to go. Why is it better to have -- I guess I am answering it -- but why is it better to have you with your team than just hire a local doctor to come cover the game?

Dr. Asplund. Well, you highlight some of the concerns with the orthopedic issues, but we are seeing more and more young people with complex medical issues that are playing sports at the highest level. We have several asthmatics, several diabetics. We have two athletes who have no colon at all. And so there are complex medical issues that also come into play. The example I highlighted in my testimony of a spinal cord care, that process is practiced and rehearsed weekly with our team, and so if a new doctor were just to fall in on our team, there may be some miscommunication and a potential catastrophic injury if the neck was turned too soon or the back was turned too soon, rendering an athlete paralyzed.

Mr. Guthrie. Are you employed by the school, or are you a private physician who travels with the team?

Dr. Asplund. In this particular job, I am employed by the school

and, hence, the State, and so would be covered -- likely covered by the Georgia Tort Act for performing my job, but when I was at Ohio State, I was a private practice contract.

Mr. Guthrie. That is what my friend is. So you would be in the same situation, so not everybody is covered.

I am running over time.

Dr. Asplund. Correct.

Mr. Guthrie. So it is important that we do this. And I appreciate being involved in it.

Dr. Asplund. Thank you very much.

Mr. Guthrie. Thank you.

Mr. Pitts. The chair thanks the gentleman.

I now recognize the gentlelady from North Carolina, Mrs. Ellmers, 5 minutes for questions.

Mrs. Ellmers. Thank you, Mr. Chairman.

Again, thank you to our panel. This has been a very good subcommittee hearing, and the testimony has been wonderful.

Dr. Bermudez, my questioning is primarily for you on our bill, on our eating disorders bill. And I would just like to ask you, you mentioned some of the myths that are associated with eating disorders. Can you just expand a little bit on what some of those myths are?

Dr. Bermudez. Absolutely, and thank you. The reality is that eating disorders affect everybody. Everybody is at risk. So if -- you know --

Mrs. Ellmers. It is not just young females.

Dr. Bermudez. Yes. If you have sons and daughters and if you have nieces and nephews and if you have grandchildren, they are all at risk in a societal context like ours. So the key is not to -- is to take it away from the concept of choice, such as people sort of choose to do this and this is about lookism, and take it into the context of this is a brain-based mental illness that profoundly affects the lives of not only the person who is identified with the illness but all of those affected and surrounding them as well. So that is one important shift.

The other important shift is it is everybody's disease, every gender, every race, every ethnicity, every socioeconomic status, and so that no one is exempt because of who they are or what they look like. Those are, I think, the two important distinctions in dispelling the myths.

Mrs. Ellmers. Now, as far as the most common eating disorders, I know we talked a little about anorexia. We talked about binge eating, which certainly, we know that that is part of the bulimia nervosa. Do you also consider, kind of along the line of the binge eating, those who are overweight and eating disorders associated with, you know, maybe not the binge side of it but the eating -- you know, we know that we have kind of an epidemic in this country of obesity. Would you consider that part of this too or no?

Dr. Bermudez. So I think we need to make some distinctions and

highlight some similarities. I think the main distinction that is really important, I think, for the public to understand is that obesity is a real problem in our country, but obesity, in and of itself, is not a mental health illness.

Mrs. Ellmers. Correct. And that would be one of the clarifications that would be made in the process of treatment?

Dr. Bermudez. Absolutely.

And so the other distinction that, to me, is really important, though, is that there are similarities. There are potential advantages here. There is potential value to better understand and address some of the issues with obesity because at the end of the day, in a stressful living situation, in a complex society likes ours, which really means that kids grow up with significant perceived stress, we tend to either eat too little or eat too much. The reality is that the relationship between our developmental stance, our constant concept of self or self-view, and our relationship with food are integrally tied. So as we learn about prevention, as we better understand how to do early intervention and teach the front line, parents, teachers, about what to recognize and the steps to take to secure more adequate next-step assessments, not only would we be protecting the most vulnerable, but we will learn a whole lot about the resiliency factors that keep those that stay well. So we may very well learn how to keep them well. And along those lines, we may very well learn what happens when the eating goes not just toward bingeing

or purging or anorexia but simply eating too much and ending on the side of obesity.

Mrs. Ellmers. Which leads to its own set of --

Dr. Bermudez. Right.

Mrs. Ellmers. You did mention that we have seen this in children as young as 7 or 8. So I have a very basic question. We are looking at middle school as the -- starting the pilot program. Do you think maybe we should rethink that and maybe start it earlier?

Dr. Bermudez. I think, based on the information we know, the demographics of eating-related pathology that we know today, middle school is a critical place to start.

Mrs. Ellmers. Okay.

Dr. Bermudez. It is a vulnerable time of life. It is a time when, in the normal process of separation, individuation, kids are beginning to sort of find their own path. Peer influence and cultural influences sort of are highlighted. So it is really a vulnerable time of life. Statistically speaking, I think this is really where the payoff is.

Mrs. Ellmers. The best --

Dr. Bermudez. But we should not ignore the fact that younger children may also be affected.

Mrs. Ellmers. Very good.

And I have one last question with 30 seconds left. I want to target where we were going with the eating disorder and, you know, early

intervention and possibly not being able to make the goals that we want and leading to some of the physical illnesses that end up happening. And I know, in your testimony, you basically said eating disorders are serious, potentially life-threatening conditions that affect a person's emotional and physical health. And it goes on to say that, you know, it could affect your organs going on to heart, brain, other vital organs, retarded growth, osteoporosis, kidney problems, gastrointestinal dysfunction, and even heart failure.

With that in mind -- and one of our biggest challenges here in Washington is being able to put forward legislation with funding, moving forward so that we can actually show that there is going to be progress made into the future, which will eventually lead to fiscal savings when we are talking about things like Medicaid, Medicare coverage. Now, I know you are in eating disorders, and that is your specialty. But in your medical background, would you not say that if we could prevent this and keep this person healthier as a result of intervention, that this will help to save that person from having lifelong or end-of-life issues that would affect them and the cost of health care?

Dr. Bermudez. Representative Ellmers, I think that is a key point of H.R. 4153. We are talking about not just saving lives and saving people from suffering, but this is an area in which, you know, an ounce of prevention is worth many, many, many pounds of cure. So these are expensive illnesses to treat. These take a significant toll

on a very important sector of our society, which is our, you know, bright, otherwise healthy young people. And my sense is that what we will learn from this pilot program is that this is really where the future is to say: Let's get ahead of the curve here and not just continue to sort of do the remedial care that we have been focused on.

Mrs. Ellmers. Yes. Focus on prevention.

Well, thank you, again, so much.

And, again, thank you to our panel. This has been a very, very good subcommittee, but I have learned a lot as well. So thank you.

Mr. Pitts. The chair thanks the gentlelady.

We have a UC request?

Mr. Guthrie. Thank you, Mr. Chairman.

I do have a unanimous consent to add into the record or put into the record several letters, one from an association -- a coalition of healthcare providers supporting the bill, a letter of support from the American Association of Orthopaedic Surgeons, a letter of support from the American Medical Association, also from the American Osteopathic Association, from the National Athletic Trainers' Association.

And I know we were discussing how this affects college football more than anything because of your role, but this is also one from Major League Baseball, the NBA, the NCAA, NHL, NFL, and the Olympic and Paralympic Committees. And I will ask unanimous consent they be put into the record.

Mr. Pitts. Without objection, so ordered.

[The information follows:]

******** COMMITTEE INSERT ********

Mr. Pitts. That concludes our time of questioning.

I will have some followups, so I will send those to you in writing. We ask that you, please, respond promptly.

I remind members that they have 10 business days to submit questions for the record. Members should submit their questions by the close of business on Wednesday, December 23.

Really a very, very excellent hearing, very informative, very high-quality testimony. Thank you very much for coming and speaking to the subcommittee today.

Without objection, the subcommittee stands adjourned.

[Whereupon, at 12:26 p.m., the subcommittee was adjourned.]