NEAL R. GROSS & CO., INC.

RPTS WALTER

HIF137140

EXAMINING INITIATIVES TO ADVANCE PUBLIC HEALTH

WEDNESDAY, MAY 17, 2017

House of Representatives

Subcommittee on Health

Committee on Energy and Commerce

Washington, D.C.

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

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

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

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

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

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

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

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

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

[The Bill H.R. 931 follows:]

**********INSERT 1**********

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

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

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

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

[The Bill H.R. 1876 follows:]

**********INSERT 2**********

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

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

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

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

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

[The Bill H.R. 767 follows:]

**********INSERT 3**********

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

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

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

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

**********INSERT 4**********

Mr. Burgess. Welcome to you.

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

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

[The statement of Mr. Burgess follows:]

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

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

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

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

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

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

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

The chair recognizes the subcommittee ranking member, Mr.

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

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

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

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

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

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

Several studies have identified that firefighters are at

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

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

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

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

I have long-supported encouraging volunteerism through

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

[The statement of Chairman Walden follows:]

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

And I thank you very much. I yield back.

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

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

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

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

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

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

STATEMENT OF KEVIN O'CONNOR

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

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

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

Firefighters respond to every conceivable disaster,

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**********INSERT 5**********

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

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

STATEMENT OF CHERYL D. WATSON-LOWRY

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Thank you.

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

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

Mr. Burgess. Thank you and thank you for your testimony.

Dr. Levine, you are recognized for 5 minutes for a summarization of your opening statement, please.

STATEMENT OF MARTIN LEVINE

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Thank you.

[The statement of Dr. Levine follows:]

**********INSERT 7**********

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

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

STATEMENT OF JORDAN GREENBAUM

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

827 Thank you very much for allowing me to testify in front of
828 you today.
829 [The statement of Dr. Greenbaum follows:]
830
831 **********INSERT 8**********

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Mr. Burgess. I see.

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

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

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

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

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

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

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

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

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

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

Mr. Green. Thank you, Mr. Chairman.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

And I yield back.

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

Mr. Green. Well, I had 5 seconds.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Mr. Griffith. This bill will cover everything.

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

And Mr. Chairman, I yield back.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Dr. Watson-Lowry. Huge. Huge.

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

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

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

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

Dr. Watson-Lowry. Thank you.

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

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

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

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

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

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

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

Mr. Guthrie. Okay, thanks.

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

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

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

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

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

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

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

Dr. Watson-Lowry. Exactly.

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

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

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

Mr. Guthrie. Perfect. Perfect.

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

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

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

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

Mr. Guthrie. Right.

Dr. Levine. That is the difficulty.

Mr. Guthrie. Okay, thanks for that.

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

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

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

My time has expired and I yield back.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Mr. Sarbanes. Thank you. I yield back.

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

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

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

Mr. Burgess. Without objection, so ordered.

[The information follows:]

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

Mr. Collins. Thank you.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

So, would you comment on that please?

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

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

That is critical for children to receive care. When

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

Ms. Eshoo. There are repercussions.

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

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

Ms. Eshoo. There is.

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

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

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

Ms. Eshoo. Thank you very, very much.

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

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

Dr. Levine. Thank you for the question.

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

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

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

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

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

And with that, I want to thank you again for what you do.

I yield back.

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

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

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

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

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

Mr. Lance. Yes.

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

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

Mr. O'Connor. Absolutely.

Mr. Lance. Yes.

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

Mr. Lance. I see.

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

Mr. Lance. I see.

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

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

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

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

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

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

Mr. O'Connor. Correct.

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

Should any study include the effect on volunteer firefighters?

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

Mr. Lance. Yes.

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

legislation for that reason.

Mr. Lance. Thank you.

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

Dr. Levine. That is correct, sir.

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

Dr. Levine. I live in your district.

Mr. Lance. Where do you live?

Dr. Levine. Short Hills.

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

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

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

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

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

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

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

Mr. Lance. Yes, of course.

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

Mr. Lance. Yes.

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

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

Mr. Lance. Yes.

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

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

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

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

Thank you, Mr. Chairman.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Mr. Carter. Exactly. Exactly.

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

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

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

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

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

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

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

And Mr. Chairman, I yield back.

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

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

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

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

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

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

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

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

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

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

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

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

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

get more information to you in writing from the ADA.

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

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

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

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

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

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

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

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

Mr. Green. Okay, thank you.

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

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

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

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

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

Mr. Green. To get through that ice.

Thank you, Mr. Chairman.

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

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

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

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

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

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

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

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

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

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

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

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

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

we get it but we have got to be prepared.

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

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

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

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

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

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

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

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

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

Mr. Bilirakis. Thank you very much.

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

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

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

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

provide cost savings?

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

Mr. Bilirakis. Sure.

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

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

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

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

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

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

What do you think?

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

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

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

Mr. Bilirakis. I want my bills passed.

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

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

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

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

Without objection, so ordered.

[The information follows:]

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

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

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

Without objection, the subcommittee stands adjourned.

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