and intervention needs of newborns and children with hearing loss. Indeed, when this program began, there were pilot programs in the country, probably back about 12 or 13 years ago, 3 percent of the children born in the United States were tested. Today, it's well over 95 percent of the entire universe of newborns born in the United States today are being tested.

As we all know, the first 3 years of life are the most important period for language and speech development. It is essential that hearing impaired infants and young children be identified and an intervention begun in order to take full advantage of the developing sensory systems. If unidentified, these children will lose out on the crucial period of speech and language learning.

Auditory impairment can impact social, emotional, cognitive, and academic development leading to personal, vocational, and economical defects. Delayed identification in management of severe to profound hearing loss can impede a child's ability to adopt to life in a hearing or deaf community.

The early hearing, detection, and intervention programs include screening, audiological evaluation, and early intervention to enhance communication, thinking, and behavioral skills needed to achieve academic and social success. The EHDI programs are serving a critical need in a successful manner.

Today, I call upon Congress to continue the success that has been experienced since the year 2000 and enact legislation to reauthorize EHDI programs. H.R. 1198 builds upon the EHDI authorization from the year 2000 to address areas of continuing challenge.

First, it would provide authority to address those children who are falling through cracks and not receiving necessary care after a screening that shows they have potential hearing loss.

Second, it is clear that family-to-family support is critical in the first months after a child is identified with hearing loss. Excellent family-to-family support programs developed by state EHDI programs and other organizations are not yet wildly implemented. This legislation would provide the agency authority to support and disseminate such programs that are working for parents and their children.

Third, it is clear that more research and study is needed in the area of hearing detection and intervention.

The SPEAKER pro tempore. The time of the gentleman has expired.

Mr. DEAL of Georgia. I yield the gentleman an additional minute.

Mr. WALSH of New York. I thank the gentleman.

H.R. 1198 would enable NIH to establish a post-doctoral research fellowship program to effectively recruit researchers to become involved in early hearing detection and intervention.

Finally, H.R. 1198 provides the agency the authority to address the shortage of trained health professionals and other personnel necessary to make certain that every child who is screened with a hearing problem gets access to appropriate interventions needed to succeed.

I urge my colleagues to support this important legislation. Again, I thank my cochairs on the caucus.

Mrs. CAPPS. Madam Speaker, I continue to reserve.

Mr. DEAL of Georgia. I would urge the adoption of the resolution, and I yield back the balance of my time.

Mrs. CAPPS. Madam Speaker, I am prepared to close, and as I do, I would like to remind us all that since the authorization of the Early Hearing Detection Intervention Act in 2000, we've seen a tremendous increase in the numbers of newborns who are being screened for hearing loss; and with this passage of this reauthorization, we can continue to build upon the success of the past 8 years and make sure that every child has access to diagnosis and treatment of hearing loss.

Mr. VAN HOLLEN. Madam Speaker, I rise in strong support of the Early Hearing Detection and Intervention Act.

Sadly, thousands of infants are born with a hearing loss each year. Fortunately, thanks to the Early Hearing Detection and Intervention (EHDI) program that was established in 2000, today approximately 93 percent of all newborns are screened. Many infants with hearing loss and their families have benefited from early identification of hearing loss. The EHDI program allows babies with hearing loss to develop normally and lead productive lives by ensuring that they will be ready to learn when they enter school.

However, many infants who are identified as having a hearing disability due to the screening tests do not receive timely follow-up care because of shortages in trained professionals needed for infant hearing screening programs. We must do better in ensuring that infants and their families have access to comprehensive hearing loss care. The bill seeks to accomplish this by presiding comprehensive information about family support, training, and information services to the family of children identified with hearing loss and ensure that they are given the opportunity to consider all the options of early intervention services, educational and program placements.

This legislation will improve on the successful Early Hearing Detection and Intervention program. I urge my colleagues to vote for this much needed bill.

Mrs. CAPPS. Madam Speaker, I yield back the balance of my time.

The SPEAKER pro tempore. The question is on the motion offered by the gentlewoman from California (Mrs. CAPPS) that the House suspend the rules and pass the bill, H.R. 1198, as amended.

The question was taken; and (two-thirds being in the affirmative) the rules were suspended and the bill, as amended, was passed.

A motion to reconsider was laid on the table.

□ 1515

WAKEFIELD ACT

Mrs. CAPPS. Madam Speaker, I move to suspend the rules and pass the bill (H.R. 2464) to amend the Public Health Service Act to provide a means for continued improvement in Emergency Medical Services for Children, as amended.

The Clerk read the title of the bill.

The text of the bill is as follows:

H.R. 2464

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Wakefield Act''.

SEC. 2. FINDINGS AND PURPOSE.

(a) FINDINGS.—Congress makes the following findings:

(1) There are 31,000,000 child and adolescent visits to the Nation's emergency departments every year.

(2) Over 90 percent of children requiring emergency care are seen in general hospitals, not in free-standing children's hospitals, with one-quarter to one-third of the patients being children in the typical general hospital emergency department.

(3) Severe asthma and respiratory distress are the most common emergencies for pediatric patients, representing nearly one-third of all hospitalizations among children under the age of 15 years, while seizures, shock, and airway obstruction are other common pediatric emergencies, followed by cardiac arrest and severe trauma.

(4) Up to 20 percent of children needing emergency care have underlying medical conditions such as asthma, diabetes, sickle-cell disease, low birth weight, and bronchopulmonary dysplasia.

(5) Significant gaps remain in emergency medical care delivered to children. Only about 6 percent of hospitals have available all the pediatric supplies deemed essential by the American Academy of Pediatrics and the American College of Emergency Physicians for managing pediatric emergencies, while about half of hospitals have at least 85 percent of those supplies.

(6) Providers must be educated and trained to manage children's unique physical and psychological needs in emergency situations, and emergency systems must be equipped with the resources needed to care for this especially vulnerable population.

(7) Systems of care must be continually maintained, updated, and improved to ensure that research is translated into practice, best practices are adopted, training is current, and standards and protocols are appropriate.

(8) The Emergency Medical Services for Children (EMSC) Program under section 1910 of the Public Health Service Act (42 U.S.C. 300w–9) is the only Federal program that focuses specifically on improving the pediatric components of emergency medical care.

(9) The EMSC Program promotes the nationwide exchange of pediatric emergency medical care knowledge and collaboration by those with an interest in such care and is depended upon by Federal agencies and national organizations to ensure that this exchange of knowledge and collaboration takes place.

(10) The EMSC Program also supports a multi-institutional network for research in pediatric emergency medicine, thus allowing providers to rely on evidence rather than anecdotal experience when treating ill or injured children.

(11) The Institute of Medicine stated in its 2006 report, ''Emergency Care for Children: Growing Pains'', that the EMSC Program ''boasts many accomplishments . . . and the work of the program continues to be relevant and vital''.

(12) The EMSC Program has proven effective over two decades in driving key improvements in emergency medical services to children, and should continue its mission to reduce child and youth morbidity and mortality by supporting improvements in the quality of all emergency

medical and emergency surgical care children receive.

(b) PURPOSE.—It is the purpose of this Act to reduce child and youth morbidity and mortality by supporting improvements in the quality of all emergency medical care children receive.

SEC. 3. REAUTHORIZATION OF EMERGENCY MEDICAL SERVICES FOR CHILDREN PROGRAM.

Section 1910 of the Public Health Service Act (42 U.S.C. 300w–9) is amended—

(1) in subsection (a), by striking ''3-year period (with an optional 4th year'' and inserting ''4-year period (with an optional 5th year'';

(2) in subsection (d)—

(A) by striking ''and such sums'' and inserting ''such sums''; and

(B) by inserting before the period the following: '', $25,000,000 for fiscal year 2009, $26,250,000 for fiscal year 2010, $27,562,500 for fiscal year 2011, $28,940,625 for fiscal year 2012, and $30,387,656 for fiscal year 2013'';

(3) by redesignating subsections (b) through (d) as subsections (c) through (e), respectively; and

(4) by inserting after subsection (a) the following:

''(b)(1) The purpose of the program established under this section is to reduce child and youth morbidity and mortality by supporting improvements in the quality of all emergency medical care children receive, through the promotion of projects focused on the expansion and improvement of such services, including those in rural areas and those for children with special healthcare needs. In carrying out this purpose, the Secretary shall support emergency medical services for children by supporting projects that—

''(A) develop and present scientific evidence;

''(B) promote existing and innovative technologies appropriate for the care of children; or

''(C) provide information on health outcomes and effectiveness and cost-effectiveness.

''(2) The program established under this section shall—

''(A) strive to enhance the pediatric capability of emergency medical service systems originally designed primarily for adults; and

''(B) in order to avoid duplication and ensure that Federal resources are used efficiently and effectively, be coordinated with all research, evaluations, and awards related to emergency medical services for children undertaken and supported by the Federal Government.''.

The SPEAKER pro tempore. Pursuant to the rule, the gentlewoman from California (Mrs. CAPPS) and the gentleman from Georgia (Mr. DEAL) each will control 20 minutes.

The Chair recognizes the gentlewoman from California.

GENERAL LEAVE

Mrs. CAPPS. I ask unanimous consent that all Members may have 5 legislative days to revise and extend their remarks and include extraneous materials on the bill under consideration.

The SPEAKER pro tempore. Is there objection to the request of the gentlewoman from California?

There was no objection.

Mrs. CAPPS. Madam Speaker, I yield myself such time as I may consume.

Madam Speaker, I rise in strong support of H.R. 2464, the Wakefield Act. This legislation reauthorizes the Emergency Medical Services for Children ''EMSC'' program. The EMSC program ensures state-of-the-art emergency medical care for ill or injured children and adolescents.

Since its establishment more than 20 years ago, the EMSC program has driven major improvements in emergency care for children. In fact, injury-related deaths among children have dropped by 40 percent over that time period. Enormous strides have been made in areas such as ensuring that all ambulances carry appropriate pediatric supplies and equipment, and in collecting data on pediatric emergency care to inform future quality improvement efforts. Although much progress has been achieved, more remains to be done.

H.R. 2464 is an important piece of legislation that will work toward ensuring the best emergency medical care for children.

I would like to congratulate my colleague on the Energy and Commerce Committee, JIM MATHESON, and commend him for his hard work and dedication to this important piece of legislation.

I encourage all of my colleagues to join me in support of H.R. 2464.

Madam Speaker, I reserve the balance of my time.

Mr. DEAL of Georgia. Madam Speaker, I yield myself such time as I may consume.

Madam Speaker, I, too, rise in support of H.R. 2464, which reauthorizes the Emergency Medical Services for Children program. It is, indeed, the only Federal program dedicated to improving emergency care for children. Since its inception in 1984, death rates due to pediatric injury have dropped some 40 percent.

The program provides grants to States to improve existing medical emergency services systems, and to evaluate pediatric emergency care data to improve future treatment efforts. Many emergency centers do not have all of the necessary supplies to treat pediatric emergencies, despite the fact that 18 percent of emergency department patients are children.

The legislation also increases the authorization for this program by 5 percent annually for the next 5 years starting at $25 million in FY 2009. The bill also extends by 1 year the period that the Secretary of the Department of Health and Human Services may award grants under the program. The bill had broad bipartisan support in the committee, and I would urge its passage.

Madam Speaker, I reserve the balance of my time.

Mrs. CAPPS. Madam Speaker, I am very pleased to yield 5 minutes to the gentleman from Utah (Mr. MATHESON).

Mr. MATHESON. Madam Speaker, I rise today to speak in support of H.R. 2464, the Wakefield Act. I am the lead sponsor of this legislation, along with Representative PETER T. KING on the other side of the aisle.

Today, the hospital emergency department is such a fundamental part of our health system that it's easy to forget that emergency medicine is a relatively new specialty. Emergency rooms were first established in the 1970s as medical personnel returned from the Vietnam War. The skills developed to save soldiers' lives on the battlefield were being put to use saving victims of car crashes and other traumas.

However, the bodies of adult soldiers are very different from those of kids. By the early 1980s, doctors were seeing marked disparities in survival rates among adults and children with similar injuries. In fact, kids had twice the death rate in emergencies as adults.

In 1984, the Emergency Medical Services for Children program was first created. This unique act has driven fundamental changes in America's emergency medical system. Since it was established, child injury death rates have dropped 40 percent. The research that resulted from this legislation helped establish pediatric emergency medicine as its own specialty.

Program grants have provided seed money to every State and territory to help first responders and hospitals improve children's emergency care. In the mid-1980s, emergency personnel received little training in caring for children. Now, thanks to this program, paramedics can be exclusively trained, and their ambulances are stocked with the equipment and supplies needed by seriously injured kids.

Nowhere has this been more critical than in rural areas where the closest emergency room is often many miles from the scene of an accident. Getting it right for these small patients in the first critical minutes often means the difference between life and death.

Data collection and training seminars offered under this program, including from the Emergency Medical Services for Children Data Analysis Resource Center based in my district at the University of Utah, help ensure that best practices are developed and disseminated across the country.

The Emergency Medical Services for Children program's authorization expired in September 2005. In the summer of 2006, the Institutes of Medicine released a report which documented the value of this program. It noted the gaps that still remain in providing quality emergency care for children. And there is still a serious gap between the percentage of kids who end up in the emergency room and the percentage of emergency rooms staffed, trained and equipped to respond appropriately. The report said this program is ''well positioned to assume a leadership role'' in closing this gap.

I am pleased that H.R. 2464, the Wakefield Act, has bipartisan and bicameral support, including support from 75 of my colleagues in the House of Representatives. The bill is endorsed by over 50 organizations, including the American Academy of Pediatrics, the American College of Emergency Physicians, the American Medical Association, the Emergency Nurses Association, and many more.

Madam Speaker, this legislation enhances the program by authorizing the appropriate funding needed to ensure

the program can drive improvements in emergency and disaster care for children.

Madam Speaker, I want to acknowledge the bipartisan nature in which this bill moved through our committee, working on both sides of the aisle within the Energy and Commerce Committee. We worked together to make this bill as good as it can be.

Madam Speaker, nobody likes to see a child get hurt. Together, we can assure that when that happens, children have the best possible chance for recovery and a good outcome. I strongly urge the adoption of this legislation.

Mr. DEAL of Georgia. Madam Speaker, I urge the adoption of this resolution.

I yield back the balance of my time.

Mrs. CAPPS. Madam Speaker, I am pleased to yield 3 minutes to the gentleman from North Dakota (Mr. POMEROY).

Mr. POMEROY. I thank the gentlelady for yielding, and I am also very pleased to speak in favor of H.R. 2464, the Wakefield Act.

I wanted to bring you just a little bit of perspective in terms of the difference this act has made in one young man's life, and I think it's reflective of a number of children who have been saved by having medical appropriate services for traumatic and life-threatening injuries of kids.

The Wakefield Act is called the Wakefield Act in recognition of a living memory of a family, the family of Tom Wakefield, who was involved in a horrible head-on traffic accident as they drove to the airport for a winter's vacation. A vehicle crossed the median and struck this vehicle head on, killing Tom and two of his children, one age three and one age seven. Twelve-year-old Lucas lost his arm in the accident and was almost lost as well.

Emergency responders on the scene and thereafter saved his life and the life of his mother, Loy. I know this family, and I know their survivors, and I care deeply about them. They have certainly impressed upon me, as they would impress upon any of you, just how vitally important it is that we equip our emergency response to deal with any who may be hurt. And the 40 percent improvement in saving lives of children since the act was initially passed in 1984 shows just how critically important this reauthorization is. I'm very pleased that the Commerce Committee has done the work to bring it to the floor today, and I am grateful for the chance to speak on the bill.

I was at an event just this weekend where Lucas, now fully recovering, adapted to his new circumstance. This is a young man that makes me very, very proud. And I believe the Wakefield Act, named in honor of his family, is a very appropriate commendation of the ongoing efforts to keep all our children safe.

Mrs. CAPPS. Madam Speaker, I have no further requests for time. And following that eloquent testimony to the value of this legislation, we can all recognize that H.R. 2464 is an important measure that will work toward ensuring the best emergency medical care for all children.

I again want to congratulate my colleague on the Energy and Commerce Committee, JIM MATHESON, and all of those who have spoken today, including the ranking member of the subcommittee, for all the hard work and dedication to this important piece of legislation. I urge all of my colleagues to join in support of H.R. 2464.

Mr. KING of New York. Madam Speaker, today I rise as a strong supporter of H.R. 2464, the Wakefield Act, which will reauthorize the Emergency Medical Services for Children program for an additional 4 years.

Since the program began in 1984, EMSC grants have helped all 50 States to better prepare their health systems to treat children in an emergency. The EMSC program has improved the availability of child-appropriate equipment in ambulances and emergency departments, supported hundreds of programs to prevent injuries, and provided thousands of hours of training to EMTs, paramedics, and other emergency medical care providers.

In my home State of New York, EMSC funds are going toward the development of a statewide, standardized system that recognizes hospitals capable of managing pediatric emergencies, both trauma and medical. This will enhance the State's ability to transfer injured children to the hospital best suited to their treatment. New York is also utilizing EMSC funds to ensure that all ambulances have the essential pediatric equipment and supplies for prehospital pediatric emergency care.

Across the country, EMSC is enabling State and local emergency care providers to better treat children. The projects funded under EMSC are vital for the safety and well-being of America's children and have saved countless lives throughout the program's existence. During a time when a terrorist attack or natural disaster may occur at any moment, it is essential that we ensure that we are adequately prepared to care for every infant, toddler, and child in an emergency situation.

I would like to thank Representative MATHESON for his hard work and continued leadership on this issue, and I urge you to support the Wakefield Act.

Mrs. CAPPS. Madam Speaker, I yield back the balance of my time.

The SPEAKER pro tempore. The question is on the motion offered by the gentlewoman from California (Mrs. CAPPS) that the House suspend the rules and pass the bill, H.R. 2464, as amended.

The question was taken.

The SPEAKER pro tempore. In the opinion of the Chair, two-thirds being in the affirmative, the ayes have it.

Mr. MATHESON. Madam Speaker, on that I demand the yeas and nays.

The yeas and nays were ordered.

The SPEAKER pro tempore. Pursuant to clause 8 of rule XX and the Chair's prior announcement, further proceedings on this motion will be postponed.

CYTOLOGY PROFICIENCY IMPROVEMENT ACT OF 2008

Mrs. CAPPS. Madam Speaker, I move that the House suspend the rules and pass the bill (H.R. 1237) to amend the Public Health Service Act to provide revised standards for quality assurance in screening and evaluation of gynecologic cytology preparations, and for other purposes, as amended.

The Clerk read the title of the bill.

The text of the bill is as follows:

H.R. 1237

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Cytology Proficiency Improvement Act of 2008''.

SEC. 2. REVISED STANDARDS FOR QUALITY ASSURANCE IN SCREENING AND EVALUATION OF GYNECOLOGIC CYTOLOGY PREPARATIONS.

(a) IN GENERAL.—Section 353(f)(4)(B)(iv) of the Public Health Service Act (42 U.S.C. 263a(f)(4)(B)(iv)) is amended to read as follows:

''(iv) requirements that each clinical laboratory—

''(I) ensure that all individuals involved in screening and interpreting cytological preparations at the laboratory participate annually in a continuing medical education program in gynecologic cytology that—

''(aa) is approved by the Accrediting Council for Continuing Medical Education or the American Academy of Continuing Medical Education; and

''(bb) provides each individual participating in the program with gynecologic cytological preparations (in the form of referenced glass slides or equivalent technologies) designed to improve the locator, recognition, and interpretive skills of the individual;

''(II) maintain a record of the cytology continuing medical education program results for each individual involved in screening and interpreting cytological preparations at the laboratory;

''(III) provide that the laboratory director shall take into account such results and other performance metrics in reviewing the performance of individuals involved in screening and interpreting cytological preparations at the laboratory and, when necessary, identify needs for remedial training or a corrective action plan to improve skills; and

''(IV) submit the continuing education program results for each individual and, if appropriate, plans for corrective action or remedial training in a timely manner to the laboratory's accrediting organization for purposes of review and on-going monitoring by the accrediting organization, including reviews of the continuing medical education program results during on-site inspections of the laboratory.''.

(b) EFFECTIVE DATE AND IMPLEMENTATION; TERMINATION OF CURRENT PROGRAM OF INDIVIDUAL PROFICIENCY TESTING.—

(1) EFFECTIVE DATE AND IMPLEMENTATION.—Except as provided in paragraph (2), the amendment made by subsection (a) applies to gynecologic cytology services provided on or after the first day of the first calendar year beginning 1 year or more after the date of the enactment of this Act, and the Secretary of Health and Human Services (hereafter in this subsection referred to as the ''Secretary'') shall issue final regulations implementing such amendment not later than 270 days after such date of enactment.

(2) TERMINATION OF CURRENT INDIVIDUAL TESTING PROGRAM.—The Secretary of Health and Human Services shall terminate the individual proficiency testing program established pursuant to section 353(f)(4)(B)(iv) of the Public