with 110 of those occurring in Tennessee. Those are just the cases that were reported. Human trafficking remains a hidden crime, and victims rarely seek help because of cultural barriers or due to fear of their traffickers, law enforcement, or of being deported, because many are imported into our country to engage in sex crimes.

In April 2016, I joined with the Department of Homeland Security in hosting our conference in Memphis, and from there came our legislation. The SOAR Act directs the Secretary of Health and Human Services to establish a program to provide training to healthcare providers at all levels on human trafficking.

Trafficking victims often end up in healthcare settings, and because traffickers want to maximize profits, victims will not have health insurance and will not often follow up on treatment. And pimps and johns will beat up the women, and they will end up in a public healthcare facility because they don't have insurance.

Mr. Speaker, 57 percent of trafficking victims report physical injuries, and nearly all report having faced either sexual abuse or physical violence. These injuries caused a reported 63 percent of trafficking victims to go to the emergency room when they are being exploited. Many victims also end up with sexually transmitted infections, including HIV, and are at high risk of pregnancy. As a result, nearly 88 percent of trafficked victims are seen by a healthcare provider at some point and, more likely than not, it is in an emergency room. So these are the people we seek out most to train and see the signs of trafficking to be able to report it to law enforcement and help these ladies out of the situation they are in.

Despite this, out of more than 5,600 hospitals in the country, only a handful have a plan for treating patients who are victims of trafficking, and over 95 percent of emergency room personnel are not trained to identify trafficking victims. As a result, it is estimated that only 1 percent of human trafficking victims are identified when they seek emergency care.

We must encourage healthcare professionals to be alert to possible instances of human trafficking when victims appear in clinics or doctors' offices for needed care, and we must provide them the additional training and resources to accomplish this goal.

I am proud to work on the SOAR to Health and Wellness Act and I urge my colleagues to help pass it today. I thank my cosponsors and the Republican leadership for scheduling this bill.

Mr. GENE GREEN of Texas. Mr. Speaker, I know how important trafficking is for the Chair in his history, and I think the Speaker of the House has an interest in this bill, too.

Mr. Speaker, I yield back the balance of my time.

Mr. BURGESS. Mr. Speaker, I yield 5 minutes to the gentleman from Illinois (Mr. KINZINGER), a valuable member of the Committee on Energy and Commerce and, in fact, the vice chairman of the Subcommittee on Oversight and Investigations.

Mr. KINZINGER. Mr. Speaker, I rise in strong support of H.R. 767, the Stop, Observe, Ask, and Respond to Health and Wellness Act. I am a proud colead of this important bill with Mr. COHEN from Tennessee, and I thank him for his work.

Mr. Speaker, when someone says ''human trafficking,'' oftentimes we view it as a problem far away from our shores that affects people who are not us. It is hard to imagine that this modern-day slavery is happening over here, hurting the people within our community every day. In my home State of Illinois, we have the fifth highest number of trafficking cases in this country; and the city of Rockford, in my district, is ranked second behind Chicago in human trafficking cases.

The most important thing we can do to combat this heinous crime is to raise awareness. That is what the SOAR to Health and Wellness Act is designed to do. This important legislation would expand on a pilot program with the Department of Health and Human Services by supporting the training of healthcare workers to identify victims and best care for them through established protocols and procedures.

Many times, when trafficking victims come to emergency rooms, healthcare professionals may not always spot the signs that their patient was a victim of human trafficking. Education is critical in combating human trafficking, and our awareness could, in fact, save a life.

Mr. Speaker, I strongly encourage my colleagues to support H.R. 767. I believe it can have an impact towards identifying cases of human trafficking and helping the most vulnerable and at-risk individuals of this evil crime.

Mr. BURGESS. Mr. Speaker, this is a worthwhile bill. I urge my colleagues to support it.

Mr. Speaker, I yield back the balance of my time.

The SPEAKER pro tempore. The question is on the motion offered by the gentleman from Texas (Mr. BURGESS) that the House suspend the rules and pass the bill, H.R. 767, 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.

MILITARY INJURY SURGICAL SYSTEMS INTEGRATED OPERATIONALLY NATIONWIDE TO ACHIEVE ZERO PREVENTABLE DEATHS ACT

Mr. BURGESS. Mr. Speaker, I move to suspend the rules and pass the bill (H.R. 880) to amend the Public Health Service Act to facilitate assignment of military trauma care providers to civilian trauma centers in order to maintain military trauma readiness and to support such centers, and for other purposes, as amended.

The Clerk read the title of the bill.

The text of the bill is as follows:

H.R. 880

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 ''Military Injury Surgical Systems Integrated Operationally Nationwide to Achieve ZERO Preventable Deaths Act'' or the ''MISSION ZERO Act''.

SEC. 2. MILITARY AND CIVILIAN PARTNERSHIP FOR TRAUMA READINESS GRANT PROGRAM.

Title XII of the Public Health Service Act (42 U.S.C. 300d et seq.) is amended by adding at the end the following new part:

''PART I—MILITARY AND CIVILIAN PARTNERSHIP FOR TRAUMA READINESS GRANT PROGRAM

''SEC. 1291. MILITARY AND CIVILIAN PARTNERSHIP FOR TRAUMA READINESS GRANT PROGRAM.

''(a) MILITARY TRAUMA TEAM PLACEMENT PROGRAM.—

''(1) IN GENERAL.—The Secretary shall award grants to not more than 20 eligible high-acuity trauma centers to enable military trauma teams to provide, on a full-time basis, trauma care and related acute care at such trauma centers.

''(2) LIMITATIONS.—In the case of a grant awarded under paragraph (1) to an eligible high-acuity trauma center, such grant—

''(A) shall be for a period of at least 3 years and not more than 5 years (and may be renewed at the end of such period); and

''(B) shall be in an amount that does not exceed $1,000,000 per year.

''(3) AVAILABILITY OF FUNDS AFTER PERFORMANCE PERIOD.—Notwithstanding section 1552 of title 31, United States Code, or any other provision of law, funds available to the Secretary for obligation for a grant under this subsection shall remain available for expenditure for 100 days after the last day of the performance period of such grant.

''(b) MILITARY TRAUMA CARE PROVIDER PLACEMENT PROGRAM.—

''(1) IN GENERAL.—The Secretary shall award grants to eligible trauma centers to enable military trauma care providers to provide trauma care and related acute care at such trauma centers.

''(2) LIMITATIONS.—In the case of a grant awarded under paragraph (1) to an eligible trauma center, such grant—

''(A) shall be for a period of at least 1 year and not more than 3 years (and may be renewed at the end of such period); and

''(B) shall be in an amount that does not exceed, in a year—

''(i) $100,000 for each military trauma care provider that is a physician at such eligible trauma center; and

''(ii) $50,000 for each other military trauma care provider at such eligible trauma center.

''(c) GRANT REQUIREMENTS.—

''(1) DEPLOYMENT.—As a condition of receipt of a grant under this section, a grant recipient shall agree to allow military trauma care providers providing care pursuant to such grant to be deployed by the Secretary of Defense for military operations, for training, or for response to a mass casualty incident.

''(2) USE OF FUNDS.—Grants awarded under this section to an eligible trauma center may be used to train and incorporate military trauma care providers into such trauma

center, including expenditures for malpractice insurance, office space, information technology, specialty education and supervision, trauma programs, research, and State license fees for such military trauma care providers.

''(d) RULE OF CONSTRUCTION.—Nothing in this section shall be construed to affect the extent to which State licensing requirements for health care professionals are preempted by other Federal law from applying to military trauma care providers.

''(e) REPORTING REQUIREMENTS.—

''(1) REPORT TO THE SECRETARY AND THE SECRETARY OF DEFENSE.—Each eligible trauma center or eligible high-acuity trauma center awarded a grant under subsection (a) or (b) for a year shall submit to the Secretary and the Secretary of Defense a report for such year that includes information on—

''(A) the number and types of trauma cases managed by military trauma teams or military trauma care providers pursuant to such grant during such year;

''(B) the financial impact of such grant on the trauma center;

''(C) the educational impact on resident trainees in centers where military trauma teams are assigned;

''(D) any research conducted during such year supported by such grant; and

''(E) any other information required by the Secretaries for the purpose of evaluating the effect of such grant.

''(2) REPORT TO CONGRESS.—Not less than once every 2 years, the Secretary, in consultation with the Secretary of Defense, shall submit a report to Congress that includes information on the effect of placing military trauma care providers in trauma centers awarded grants under this section on—

''(A) maintaining readiness of military trauma care providers for battlefield injuries;

''(B) providing health care to civilian trauma patients in both urban and rural settings;

''(C) the capability to respond to surges in trauma cases, including as a result of a large scale event; and

''(D) the financial State of the trauma centers.

''(f) DEFINITIONS.—For purposes of this part:

''(1) ELIGIBLE TRAUMA CENTER.—The term 'eligible trauma center' means a Level I, II, or III trauma center that satisfies each of the following:

''(A) Such trauma center has an agreement with the Secretary of Defense to enable military trauma care providers to provide trauma care and related acute care at such trauma center.

''(B) Such trauma center utilizes a risk-adjusted benchmarking system to measure performance and outcomes, such as the Trauma Quality Improvement Program of the American College of Surgeons.

''(C) Such trauma center demonstrates a need for integrated military trauma care providers to maintain or improve the trauma clinical capability of such trauma center.

''(2) ELIGIBLE HIGH-ACUITY TRAUMA CENTER.—The term 'eligible high-acuity trauma center' means a Level I trauma center that satisfies each of the following:

''(A) Such trauma center has an agreement with the Secretary of Defense to enable military trauma teams to provide trauma care and related acute care at such trauma center.

''(B) At least 20 percent of patients of such trauma center in the most recent 3-month period for which data is available are treated for a major trauma at such trauma center.

''(C) Such trauma center utilizes a risk-adjusted benchmarking system to measure performance and outcomes, such as the Trauma Quality Improvement Program of the American College of Surgeons.

''(D) Such trauma center is an academic training center—

''(i) affiliated with a medical school;

''(ii) that maintains residency programs and fellowships in critical trauma specialties and subspecialties, and provides education and supervision of military trauma team members according to those specialties and subspecialties; and

''(iii) that undertakes research in the prevention and treatment of traumatic injury.

''(E) Such trauma center serves as a disaster response leader for its community, such as by participating in a partnership for State and regional hospital preparedness established under section 319C–2.

''(3) MAJOR TRAUMA.—The term 'major trauma' means an injury that is greater than or equal to 15 on the injury severity score.

''(4) MILITARY TRAUMA TEAM.—The term 'military trauma team' means a complete military trauma team consisting of military trauma care providers.

''(5) MILITARY TRAUMA CARE PROVIDER.—The term 'military trauma care provider' means a member of the Armed Forces who furnishes emergency, critical care, and other trauma acute care, including a physician, military surgeon, physician assistant, nurse, respiratory therapist, flight paramedic, combat medic, or enlisted medical technician.

''(g) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section—

''(1) $7,000,000 for fiscal year 2018, of which—

''(A) $4,500,000 shall be for carrying out subsection (a); and

''(B) $2,500,000 shall be for carrying out subsection (b);

''(2) $12,000,000 for fiscal year 2019, of which—

''(A) $8,000,000 shall be for carrying out subsection (a); and

''(B) $4,000,000 shall be for carrying out subsection (b); and

''(3) $15,000,000 for each of fiscal years 2020 through 2022, of which—

''(A) $10,000,000 shall be for carrying out subsection (a); and

''(B) $5,000,000 shall be for carrying out subsection (b).''.

SEC. 3. CUT-GO COMPLIANCE.

Subsection (f) of section 319D of the Public Health Service Act (42 U.S.C. 247d–4) is amended by striking ''through 2018'' and inserting ''through 2017, and $75,300,000 for fiscal year 2018''.

The SPEAKER pro tempore. Pursuant to the rule, the gentleman from Texas (Mr. BURGESS) and the gentleman from Texas (Mr. GENE GREEN) each will control 20 minutes.

The Chair recognizes the gentleman from Texas (Mr. BURGESS).

GENERAL LEAVE

Mr. BURGESS. Mr. Speaker, I ask unanimous consent that all Members may have 5 legislative days to revise and extend their remarks and insert extraneous material into the RECORD on the bill.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from Texas?

There was no objection.

Mr. BURGESS. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, 40 years ago I was an intern and resident at Parkland Hospital in Dallas. Any intern or resident will tell you the month of July is significant in the life of an intern or resident. You were last week's medical student, and you are this week's intern managing the emergency room; or you were last year's intern, and you are this week's house officer managing perhaps a busy practice, perhaps a busy emergency room. As such, every intern and resident remembers the end of that first week of their internship or residency. It is just something that you do. You got through the first week of what was a very trying time. So I remember well July 7 of my internship, July 7 of my residency.

Mr. Speaker, in 2016, July 7 also took on additional significance in Dallas, Texas. Five police officers were killed and 9 more were injured during a shooting in downtown Dallas. In the immediate aftermath of the attack, area hospitals sprang into action and activated their disaster plans. I am proud to say that the staff at Parkland Hospital, the staff at Baylor University Hospital, and other medical professionals provided excellent emergency care to the victims of the attack.

Mr. Speaker, it is critical that we have people who are able to respond when called. Now, additionally, I have long believed that the American military is the arsenal of democracy and that it is critical for upholding freedom in the world. Each member of the United States Armed Forces has an important role in a collective team effort. This is especially true in a combat zone, where trauma surgeons are some of the most crucial members of the Armed Forces. These medical professionals are trained to save the lives of soldiers who sustain traumatic injuries on the battlefield, and they are some of the best in the business.

However, as wars wind down and our soldiers come home, the experience that military trauma surgeons have gained overseas may be diminished or lost unless these surgeons continue to train and to prepare for their next possible deployment. To let this expertise and skill drift away would be a significant loss to trauma patients, both at home and abroad. Trauma, Mr. Speaker, is not limited to the battlefields and active conflicts. Unfortunately, no community is immune from the threat of traumatic injury, and community doctors must be prepared to give lifesaving care to trauma victims.

However, there is a way that we can ensure trained combat surgeons' skills are utilized to help American patients here in the homeland who need it. The MISSION ZERO Act seeks to connect American patients with battle-tested trauma care through the craft of military trauma care providers. The bill provides grants to allow military trauma care providers and teams to offer care in our Nation's leading trauma centers and systems.

Here is the bottom line: the MISSION ZERO Act is a win for both civilian patients and military trauma doctors.

Mr. Speaker, I am grateful that this bipartisan legislation has finally come

to the floor. Along with my fellow Texan, Mr. GENE GREEN, I introduced this bill in 2016 following that particularly traumatic incident that struck so close to home.

Texas is not unique in its need for this expertise. Over the last few months alone, our Nation has witnessed a need for trauma care hospitals across the country. One such incident was the Amtrak derailment near Dupont, Washington, on December 18, 2017. That incident resulted in 3 passenger fatalities and 70 injuries over a busy freeway.

As we have seen, having access to experienced trauma care can become the difference between life and death for a critically injured patient. There is no doubt that integrating military physicians into the trauma and disaster system is beneficial not only for American patients, but also for American soldiers.

I am encouraged by the bipartisan effort to support both our servicemen and our Nation's trauma system, and I thank the cosponsors from both sides of the aisle for their support of this important legislation.

Quite simply, the MISSION ZERO Act is common sense, and I urge Members to join me in supporting this lifesaving legislation.

Mr. Speaker, I reserve the balance of my time.

□ 1715

Mr. GENE GREEN of Texas. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, I rise in strong support of H.R. 880, the Military Injury Surgical Systems Integrated Operationally Nationwide to Achieve ZERO Preventable Deaths Act, or MISSION ZERO Act.

I am proud to have worked closely with Energy and Commerce Subcommittee on Health Chairman BURGESS and my colleagues from Florida and North Carolina, Representative CASTOR and Representative HUDSON, on this legislation.

The MISSION ZERO Act will help us move towards a trauma system that achieves the goal of zero preventable traumatic deaths.

Whether in response to a gruesome sports injury, a car accident on the highway, or, unfortunately, a tragic event like the recent school shooting in Parkland, Florida, Americans of all ages and backgrounds depend on our trauma care system to respond with skilled experts to provide the services necessary to save lives and prevent disability.

The MISSION ZERO Act will help us ensure access to quality trauma care based on the best available evidence by establishing a grant program to assist civilian trauma centers to partner with military trauma professionals. This partnership will benefit our civilian trauma centers by increasing the availability of trauma professionals to serve in trauma centers across the United States.

This partnership will benefit our military trauma system by allowing trauma professionals to maintain their trauma care capabilities during times of peace and help ensure they are prepared to meet the needs of our heroes on the battlefield.

I urge my colleagues to support this legislation and help ensure that Americans in need of trauma services, whether civilian or in the Armed Forces, receive the highest quality of care possible.

Mr. Speaker, I yield such time as she may consume to the gentlewoman from Florida (Ms. CASTOR), the cosponsor of the bill, and I thank the cosponsors of this bill for serving on the Energy and Commerce Committee.

Ms. CASTOR of Florida. Mr. Speaker, I rise in strong support of the MISSION ZERO Act, H.R. 880, and I would like to thank Chairman BURGESS, Ranking Member GENE GREEN from Texas, and Mr. HUDSON from North Carolina for sponsoring this legislation with me.

The MISSION ZERO Act will assist the Department of Defense in assigning trauma surgeons to our civilian trauma centers. It will help fill the gap that we currently have in care recently examined by the National Academies of Sciences, Engineering, and Medicine.

The MISSION ZERO Act will establish grant initiatives for eligible trauma systems to incorporate full military trauma teams or individual military trauma providers into our hospitals—the ones that have busy emergency rooms.

This mutually beneficial partnership will allow civilian doctors and nurses and care providers the chance to learn more about military best practices and will give our military trauma care providers the opportunity to utilize their cutting-edge expertise without leaving the military.

I have seen this initiative in action already back home in Tampa at Tampa General Hospital, located just a few miles down the road from MacDill Air Force Base, which is home to U.S. Central Command, U.S. Special Operations Command, and the 6th Air Mobility Wing, which is also home to the 6th Air Medical Group.

Since about 2011, they have had an ongoing partnership to do just what this bill provides: create a lot of energy and shared expertise in the civilian trauma center at Tampa General Hospital and bring in the military specialists so they can continue to hone their caregiving and craft. They use nurses, surgeons, and all sorts of specialists.

The initiative allows military and civilian medical teams to work in the most intense trauma environments—that is, our level one trauma center—and take very good care of folks all across central Florida. These partnerships are vital for continued training for our community and our military.

I think Dr. BURGESS and Mr. GENE GREEN from Texas are doing a great service by replicating this in other trauma centers across the United States.

The MISSION ZERO Act is endorsed by the American Congress of Neurological Surgeons, American College of Emergency Physicians, American College of Surgeons, and the Trauma Care Association of America.

Again, I thank Dr. BURGESS, Ranking Member GENE GREEN from Texas, Mr. HUDSON, and all my Energy and Commerce colleagues, and I urge everyone here in the House to support this important bill.

Mr. GENE GREEN of Texas. Mr. Speaker, I yield back the balance of my time.

Mr. BURGESS. Mr. Speaker, this is an important bill. I urge my colleagues to support it, and I yield back the balance of my time.

The SPEAKER pro tempore. The question is on the motion offered by the gentleman from Texas (Mr. BURGESS) that the House suspend the rules and pass the bill, H.R. 880, 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.

CONGENITAL HEART FUTURES REAUTHORIZATION ACT OF 2017

Mr. BURGESS. Mr. Speaker, I move to suspend the rules and pass the bill (H.R. 1222) to amend the Public Health Service Act to coordinate Federal congenital heart disease research efforts and to improve public education and awareness of congenital heart disease, and for other purposes, as amended.

The Clerk read the title of the bill.

The text of the bill is as follows:

H.R. 1222

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 ''Congenital Heart Futures Reauthorization Act of 2017''.

SEC. 2. NATIONAL CONGENITAL HEART DISEASE SURVEILLANCE SYSTEM.

Section 399V–2 of the Public Health Service Act (42 U.S.C. 280g–13) is amended to read as follows:

''SEC. 399V–2. NATIONAL CONGENITAL HEART DISEASE RESEARCH, SURVEILLANCE, AND AWARENESS.

''(a) IN GENERAL.—The Secretary shall—

''(1) enhance and expand research and surveillance infrastructure to study and track the epidemiology of congenital heart disease (in this section referred to as 'CHD'); and

''(2) award grants to eligible entities to undertake the activities described in this section.

''(b) NATIONAL CONGENITAL HEART DISEASE STUDY.—

''(1) IN GENERAL.—The Secretary shall plan, develop, implement, and submit one or more reports to the Congress on a study to improve understanding of the epidemiology of CHD across the lifespan, from birth to adulthood, with particular interest in the following:

''(A) Health care utilization of those affected by CHD.

''(B) Demographic factors associated with CHD, such as age, race, ethnicity, gender, and family history of individuals who are diagnosed with the disease.

''(C) Outcome measures, such that analysis of the outcome measures will allow derivation of