S. HRG. 111–604

Senate Hearings

Before the Committee on Appropriations

Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriations

Fiscal Year 2011

111*th* CONGRESS, SECOND SESSION

S. 3686

DEPARTMENT OF EDUCATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES
DEPARTMENT OF LABOR
NONDEPARTMENTAL WITNESSES

Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriations, 2011 (S. 3686)

S. HRG. 111–604

DEPARTMENTS OF LABOR, HEALTH AND HUMAN SERVICES, AND EDUCATION, AND RELATED AGENCIES APPROPRIATIONS FOR FISCAL YEAR 2011

HEARINGS

BEFORE A

SUBCOMMITTEE OF THE

COMMITTEE ON APPROPRIATIONS

UNITED STATES SENATE

ONE HUNDRED ELEVENTH CONGRESS

SECOND SESSION

ON

S. 3686

AN ACT MAKING APPROPRIATIONS FOR THE DEPARTMENTS OF LABOR, HEALTH AND HUMAN SERVICES, AND EDUCATION, AND RELATED AGENCIES FOR THE FISCAL YEAR ENDING SEPTEMBER 30, 2011, AND FOR OTHER PURPOSES

Department of Education
Department of Health and Human Services
Department of Labor
Nondepartmental Witnesses

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DEPARTMENTS OF LABOR, HEALTH, AND HUMAN SERVICES, AND EDUCATION, AND RELATED AGENCIES FOR FISCAL YEAR 2011

WEDNESDAY, MARCH 10, 2010

U.S. SENATE,
SUBCOMMITTEE OF THE COMMITTEE ON APPROPRIATIONS,
Washington, DC.

The subcommittee met at 3:05 p.m., in room SD–124, Dirksen Senate Office Building, Hon. Tom Harkin (chairman) presiding.

Present: Senators Harkin, Reed, Pryor, and Cochran.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE OF THE SECRETARY

STATEMENT OF HON. KATHLEEN SEBELIUS, SECRETARY

OPENING STATEMENT OF SENATOR TOM HARKIN

Senator HARKIN. The Subcommittee on Labor, Health, Human Services, Education and Related Agencies will come to order.

Well, Madam Secretary, welcome back to the subcommittee. I first want to start by commending you for the outstanding work you're doing to help enact healthcare reform. We can see the finish line at last. And your leadership is one of the reasons that we can see that finish line.

I know it will be tempting for Senators on both sides of the dais to want to debate the pros and cons of health reform with you today. But I would urge the subcommittee members to keep their focus on the subject of our hearing. And that is the President's proposed fiscal year 2011 budget for the Department of Health and Human Services (HHS).

On the whole, there's much to like in the HHS budget. As we all know the President's budget holds the line on nonsecurity-related spending overall in fiscal year 2011. But the President promised to use a scalpel, not an ax, to achieve that freeze. And HHS is one of the Federal agencies that would get an increase, 2.5 percent more than in fiscal year 2010.

I was particularly pleased that the President included a major boost for efforts to root out fraud in Medicare and Medicaid. Reducing healthcare fraud and abuse has been a priority of mine for many years. And it will play a key role in bringing our long-term deficits under control. Significant increases were also proposed for the National Institutes of Health (NIH), for Head Start, childcare

and a new caregiver's initiative that will help families take care of their elderly relatives.

Other provisions in the budget raise cause for concern, however. For example, the President's budget would cut funding for the Centers for Disease Control and Prevention (CDC). The budget also includes a $1.8 billion cut to discretionary funding under the LIHEAP program. But overall, I think the President's budget is a good start. I look forward to discussing it in more detail with you during this hearing.

I also want to add, Madam Secretary, how lucky you are to have an Assistant Secretary like Ellen Murray to advise you on all these issues. At last year's budget hearing she was sitting next to me on the dais. Today she is advising you. I can tell you from experience you're in very good hands. And I read it just as she wrote that for me right there.

Senator HARKIN. Now I turn to Senator Cochran.

STATEMENT OF SENATOR THAD COCHRAN

Senator COCHRAN. Mr. Chairman, thank you very much for convening the hearing.

Madam Secretary, we appreciate your being here to talk about the budget request. And we look forward to hearing your testimony.

PREPARED STATEMENT

I ask unanimous consent that the balance of my remarks be placed in the record. I will also include a statement from the Chairman, Senator Inouye. He regrets that he could not be present.

Senator HARKIN. Thank you very much, Senator Cochran.

[The statement follows:]

PREPARED STATEMENT OF SENATOR THAD COCHRAN

Mr. Chairman, thank you for chairing this hearing to review the budget for fiscal year 2011 for the Department of Health and Human Services. We are pleased to welcome the Secretary of Health and Human Services, Kathleen Sebelius to her second appearance before our subcommittee, and we look forward to working with her to support our Nation's investment in healthcare, social services programs, medical research, and disease prevention.

I am pleased that your budget includes a $1 billion increase for the National Institutes of Health. These additional dollars are essential if we are to continue to make scientific discoveries in cancer, autism, heart disease, and the many other maladies that plague so many Americans.

I was also pleased to see your announcement last week regarding the $10 million in funds from the America Recovery and Reinvestment Act to help communities find ways to curb smoking and combat obesity, improve access to healthy foods, and increase physical activity.

This subcommittee will be challenged to balance the competing needs of the programs contained in your $74 billion budget. We look forward to working with you to maintain our commitment to fiscal restraint while providing much needed increases for high-priority programs.

PREPARED STATEMENT OF SENATOR DANIEL K. INOUYE

Secretary Sebelius, last October Dr. Mary Wakefield, the Administrator of the Health Resources and Services Administration, visited Hawaii and I would like to thank you for your support of her trip. She visited a number of Community Health Centers and toured several hospitals and educational facilities on the neighboring islands. The people of Hawaii were very grateful to host her visit and thankful for

the opportunity to discuss critical healthcare concerns of the State. In addition she met with representatives from the National Kidney Foundation of Hawaii to talk about the increasing incidence of kidney disease among the Filipino population.

Thank you again, and I will provide questions for the record to the subcommittee later.

Senator HARKIN. Again, Madam Secretary, welcome back to the subcommittee. And again, thank you for your leadership. And just by way of introduction, Kathleen Sebelius became the 21st Secretary of the Department of Health and Human Services on April 29, 2009.

In 2003, she was elected Governor of Kansas and served in that capacity until her appointment as Secretary. Prior to her election as governor she served as a Kansas State Insurance Commissioner. She is a graduate of Trinity Washington University and the University of Kansas.

Madam Secretary, welcome. Your statement will be made a part of the record in its entirety. And please proceed as you so desire.

SUMMARY STATEMENT OF HON. KATHLEEN SEBELIUS

Secretary SEBELIUS. Well, thank you very much, Chairman Harkin and Senator Cochran and members of the subcommittee. I am glad to be back to discuss the 2011 budget for HHS. I think the budget builds on many of the themes that President Obama laid out in his State of the Union Address this year, strengthening our healthcare system, laying the foundation for future growth, and rooting out waste and fraud to make programs even more effective.

Under this budget we plan to make prudent investments in our Nation's health and long-term prosperity that members of this subcommittee and you, Mr. Chairman, have pushed for years in prevention, in wellness, in attacking healthcare fraud and supporting our children during those formative, early years and in biomedical research that leads to life saving cures to name just a few areas. So today I'd like to briefly highlight a few of these priorities. And then I look forward to our discussion about the issues in this budget.

Mr. Chairman, as you pointed out many times, what we have today in America is a sick/cure system, not a healthcare system. And last February, under your leadership, we took a huge step in the direction to change the focus of that system. With the investments in the Recovery Act we made the single largest investment in prevention and wellness in American history including the almost $373 million in grants for promising local programs that we look forward to releasing in the next couple of weeks. Our budget for 2011 builds on this investment with new efforts to reduce the harmful effects and tremendous costs of chronic disease in the urban populations to create a new health prevention corps and prevent unintended pregnancies, among other programs that we intend to focus on.

Senator Cochran, I know that the First Lady recently traveled to your home State of Mississippi as part of her initiative in the Let's Move campaign to end childhood obesity in a generation and highlighted some of Mississippi's very successful efforts in this area. And these are exactly the kind of promising approaches and strategies that we'd like to make sure and place around the country.

Our budget makes a historic investment in fighting healthcare fraud. Again, Mr. Chairman, your subcommittee started us on this path 2 years ago with the first discretionary funding. We've built on that.

When American families are struggling to make every dollar count we need to be just as vigilant in how we spend their money. The new fraud fighting funds will help us expand proven strategies like putting Medicare fraud strike forces in cities that are hubs for fraudulent activity. And they allow us to invest in promising new approaches like systems that will help us analyze claims data and suspicious activities in real time.

When the budget takes effect it's going to be a lot harder for criminals to get rich stealing from our healthcare system and our seniors. And before you ask, Mr. Chairman, our budget does continue the Senior Medicare Control Program which you helped to start many years ago and is a great reserve of eyes and ears on the ground.

A third area of focus that I want to highlight for the subcommittee is our Early Childhood programs. Again, building on the Recovery Act, our budget includes an increase of $1 billion for Head Start, an extra $1.6 billion for childcare, creating room in childcare programs for 235,000 additional children. And with these increases we're putting a new focus on quality. The years 0 to 5 are at least as important as the years that children spend in kindergarten through the 12th grade, maybe more important according to the scientists. And there's no reason we shouldn't insist on the same high standards and the same rigorous focus on results.

And finally the budget includes a very critical increase of nearly $1 billion for the NIH. And I want to thank Chairman Harkin and Senator Cochran, Senator Specter and others on this subcommittee for their steadfast support for NIH and its critical work discovering the building blocks of disease and developing the cures of the future. The budget is going to help these cures get to American families faster.

So these are just a few areas in which our budget will employ new resources and new approaches to improve the lives of American families. I look forward to discussing some of the other priorities with you in a few minutes. But first I want to just clarify one point.

PREPARED STATEMENT

The budget is intended to be a complement, not a substitute, for health insurance reform. The only way to increase health security and stability, bring down healthcare costs and give Americans better insurance choices is to pass comprehensive health insurance reform. Combined with a reform effort, the budget is a major step toward building a stronger, healthier America. But even then, we'll need your help improving the health, safety, and well being of the American people. It's a goal we can only achieve by working together. And no one has a more important role than Congress.

So I appreciate the opportunity to be with you today and look forward to the discussion.

[The statement follows:]

PREPARED STATEMENT OF HON. KATHLEEN SEBELIUS

Chairman Harkin, Senator Cochran, and members of the subcommittee, thank you for the invitation to discuss the President's fiscal year 2011 budget for the Department of Health and Human Services (HHS).

In his State of the Union Address, President Obama laid out an aggressive agenda to create jobs, strengthen opportunity for working families, and lay a foundation for long-term growth. His fiscal year 2011 budget is the blueprint for putting that vision into action.

At HHS, we are supporting that agenda by working to keep Americans healthy, ensuring they get the healthcare they need, and providing essential human services for children, families, and seniors.

Our budget will make sure that the critical health and human services our Department offers to the American people are of the highest quality and are directly helping families stay healthy, safe, and secure—especially as we continue to climb out of a recession.

It promotes projects that will rebuild our economy by investing in next-generation research and the advanced development of technology that will help us find cures for diseases, innovative new treatments, and new ways to keep Americans safe, whether we are facing a pandemic or a potential terrorist attack.

But this budget isn't just about new programs or new priorities or new research. It is also about a new way of doing business with the taxpayers' money. Where there is waste and fraud, we must root it out. Where there are loopholes, we must close them. And where we have opportunities to increase transparency, accountability, and program integrity, we must take them. These are top priorities of the President. They are top priorities of mine. And our budget reflects that they are top priorities for my Department.

The President's fiscal year 2011 budget for HHS totals $911 billion in outlays. The budget proposes $81 billion in discretionary budget authority for fiscal year 2011, of which $74 billion is within the jurisdiction of the Labor, Health and Human Services, Education, and Related Agencies Subcommittee.

This budget is a major step toward a healthier, stronger America. But it is a complement, not a substitute for health insurance reform.

This administration strongly believes that the only sure way to increase health security and stability, bring down healthcare costs, and give Americans better insurance choices is to pass comprehensive health insurance reform. To that end, the President has put forth a proposal that bridges the House and Senate bills and incorporates the best ideas of Republicans and Democrats.

His proposal—which he has called on Congress to swiftly pass—will give American families and small business owners more control over their healthcare by holding insurance companies accountable. It will give Americans protection from insurance company abuses, create a new consumer-friendly health insurance marketplace, and begin to bring down costs for families, businesses, and Government. Reform is projected to reduce the deficit by about $100 billion in the first decade, and roughly $1 trillion in the second decade, and, by controlling healthcare costs, put the Federal Government on a path to fiscal responsibility.

After meeting last week with the CEOs of America's largest insurance companies, who acknowledged that the current health insurance system fails to provide transparency and affordable coverage to all Americans, I am more convinced than ever that the only way to fix our broken health insurance system is to enact these common-sense reforms. And after more than 1 year of conversation, Americans deserve an up or down vote.

My hope is that Congress will follow through on the hard work they have done over the last 12 months and send a bill to the President soon. But for now, I'd like to begin with a broad overview of my Department's 2011 budget priorities, many of which are aimed toward the same goals. Then I'll look forward to taking some of your questions.

Investing in Prevention

Reducing the burden of chronic disease, collecting and using health data to inform decisionmaking and research, and building an interdisciplinary public health workforce are critical components to successful prevention efforts. The budget includes $20 million for the Centers for Disease Control and Prevention (CDC) Big Cities Initiative to reduce the rates of morbidity and disability due to chronic disease in up to 10 of the largest U.S. cities. These cities will be able to incorporate the lessons learned from implementing evidence-based prevention and wellness strategies of the American Recovery and Reinvestment Act of 2009 (Recovery Act) Communities Putting Prevention to Work Initiative. This Recovery Act initiative is key to promoting

wellness and preventing chronic disease, and we appreciate the support of Congress, and particularly Chairman Harkin, in making these funds available. In March, HHS will award $373 million for the cornerstone of this initiative, funding communities to implement evidence-based strategies to address obesity, increase physical activity, improve nutrition, and decrease smoking. The Big Cities Initiative requested in fiscal year 2011 will allow us to build on the success of the Recovery Act.

The budget also includes $10 million at CDC for a new Health Prevention Corps, which will recruit, train, and assign a cadre of public health professionals in State and local health departments. This program will target disciplines with known shortages, such as epidemiology, environmental health, and laboratory science.

To support teen and unintended pregnancy prevention and care activities in the Office of Public Health and Science and CDC, the budget provides $222 million in funds. Of this, $125 million will be used for replicating programs that have proven effective through rigorous evaluation to reduce teenage pregnancy; research and demonstration grants to develop, replicate, refine, and test additional models and innovative strategies; and training, technical assistance and outreach. Also, provided in the request is $4 million to carry out longitudinal evaluations of teenage pregnancy prevention approaches, and another $4 million in Public Health Service evaluation funds for this activity. This also includes $22 million for CDC to reduce the number of unintended pregnancies through science-based prevention approaches. In addition, the fiscal year 2011 Adolescent Family Life (AFL) budget includes $17 million to provide support for AFL Care demonstration grants and research programs. In an effort to ameliorate the negative effects of childbearing on teen parents, their infants and their families, care grant community-based projects develop, test, and evaluate interventions with pregnant and parenting teens, and focus on ways to build and strengthen families.

Behavioral health is essential to the well-being of all Americans. The budget includes an additional $135 million in the Substance Abuse and Mental Health Services Administration and Health Resources and Services Administration (HRSA) for innovative approaches to prevent and treat substance abuse and mental illness. These efforts include increases of $35 million for community-based prevention, $25 million to expand behavioral health services at health centers, and $17 million associated with homelessness prevention. An increase of $13 million will expand the treatment capacity of drug courts, and $33 million will strengthen our capacity to deter new drug threats and assess our progress in reducing substance abuse.

Reducing Healthcare Fraud

When American families are struggling to make every dollar count, we need to be just as vigilant about how their money is spent. That's why the Obama administration is cracking down on criminals who steal from taxpayers, endanger patients, and jeopardize the future of our health insurance programs.

Last May, President Obama instructed Attorney General Holder and I to create a new Health Care Fraud Prevention and Enforcement Action Team, which we call "HEAT" for short. HEAT is an unprecedented partnership that brings together high-level leaders from both departments so that we can share information, spot trends, coordinate strategy, and develop new fraud prevention tools.

As part of this new partnership, we are developing tools that will allow us to identify criminal activity by analyzing suspicious patterns in claims data. Medicare claims data used to be scattered among several databases. If we wanted to find out how many claims had been made for a certain kind of wheelchair, we had to go look in several different places. This single, searchable database means that for the first time ever, we'll have a complete picture of what kinds of claims are being filed across the country.

Our fiscal year 2011 budget includes $1.7 billion in funding to fight fraud, including $561 million in discretionary funds to strengthen Medicare and Medicaid program integrity activities, with a particular emphasis on fighting healthcare fraud in the field, increasing Medicare and Medicaid audits, and strengthening program oversight while reducing costs. We appreciate the subcommittee's support of past requests for fraud prevention; and building on the successes we have been able to achieve with those funds, we are now seeking an additional $250 million over the fiscal year 2010 level that we hope you can support.

This investment will better equip the Federal Government to minimize inappropriate payments, pinpoint potential weaknesses in program integrity oversight, target emerging fraud schemes by provider and type of service, and establish safeguards to correct programmatic vulnerabilities. This multi-year discretionary investment will save $9.9 billion over 10 years.

The budget also includes a set of new administrative and legislative program integrity proposals that will give HHS the necessary tools to fight fraud by enhancing

provider enrollment scrutiny, increasing claims oversight, and improving Medicare's data analysis capabilities, which will save approximately $14.7 billion over 10 years. Along with the $9.9 billion in savings from the discretionary investments, these new program authorities will save a total of $25 billion in Medicare and Medicaid expenditures over 10 years.

Improving Quality of and Access to Healthcare

At HHS, we continue to find ways to better serve the American public, especially those citizens least able to help themselves. We are working to improve the quality of and access to healthcare for all Americans by supporting programs intended to enhance the healthcare workforce and the quality of healthcare information and treatments through the advancement of health information technology (IT) and the modernization of the healthcare system.

As Congress continues its work to provide security and stability for Americans with health insurance and expand coverage to those Americans who do not have insurance, HHS maintains its efforts toward achieving those goals through activities with the Children's Health Insurance Program (CHIP), health IT, patient-centered health research, prevention and wellness, community health centers, and the health workforce.

The budget includes $3.6 billion for Centers for Medicare & Medicaid Services' (CMS) Program Management. To strengthen the ability of CMS to meet current administrative workload demands resulting from recent legislative requirements and continued growth of the beneficiary population, the funding provides targeted investments to revamp IT systems and optimize staffing levels so that CMS can meet the future challenges of Medicare, Medicaid, and CHIP while being an active purchaser of high-quality and efficient care.

For example, $110 million will support the first year of a comprehensive Health Care Data Improvement Initiative (HCDII) to transform CMS's data environment from one focused primarily on claims processing to one also focused on state-of-the art data analysis and information sharing. Without this funding CMS would not be able to transform Medicare and Medicaid into leaders in value-based purchasing and in data sources for privacy-protected patient-centered health research. This funding is imperative for CMS to meet the needs of future growth, financial accountability, and data content and availability. The HCDII is the cornerstone of a business strategy that will optimize the delivery of efficient, high-quality healthcare services. CMS needs this funding to strengthen disaster recovery and security operations to protect against loss of data or services; to enable timely data sharing and analysis to fight fraud, waste, and abuse; and to transform payment processes to support quality outcomes.

To strengthen and support our Nation's healthcare workforce, the budget includes $1.1 billion within the HRSA for a wide range of programs. This funding will enhance the capacity of nursing schools, increase access to oral healthcare through dental workforce development grants, target students from disadvantaged backgrounds, and place an increased emphasis on ensuring that America's senior population gets the care and treatment it needs.

The budget includes an increase of $290 million to ensure better access to health centers through further expansions of health center services and integration of behavioral health into health centers' primary care system. This funding builds on investments made under the Recovery Act and will enable health centers to serve more than 20 million patients in fiscal year 2011, which is 3 million more patients than were served in fiscal year 2008.

The budget advances the President's health IT initiative by accelerating health IT adoption and electronic health records (EHR) utilization—essential tools for modernizing the healthcare system. The budget includes $78 million, an increase of $17 million, for the Office of the National Coordinator for Health Information Technology to continue its current efforts as the Federal health IT leader and coordinator. During fiscal year 2011, HHS will also begin providing an estimated $25 billion over 10 years of Recovery Act Medicare and Medicaid incentive payments primarily to physicians and hospitals who demonstrate meaningful use of certified EHRs, which will improve the reporting of clinical quality measures and promote healthcare quality, efficiency, and patient safety.

The budget supports HHS-wide patient-centered health research, including an additional $261 million within the Agency for Healthcare Research and Quality over fiscal year 2010. HHS also continues to invest the $1.1 billion provided by the Recovery Act to improve healthcare quality by providing patients and physicians with state-of-the-art, evidence-based information to enhance medical decision-making.

Promoting Public Health

Whether responding to pandemic flu or researching major diseases, HHS will continue its unwavering commitment to keeping Americans healthy and safe.

The budget includes more than $3 billion, an increase of $70 million, for CDC and HRSA to enhance HIV/AIDS prevention, care, and treatment. This increase includes $31 million for CDC to integrate surveillance and monitoring systems, address high-risk populations, and support HIV/AIDS coordination and service integration with other infectious diseases. The increase also includes $40 million for HRSA's Ryan White program to expand access to care for underserved populations, provide life-saving drugs, and improve the quality of life for people living with HIV/AIDS.

To improve CDC's ability to collect data on the health of the Nation for use by policy makers and Federal, State, and local leaders, the budget provides $162 million for health statistics, an increase of $23 million above fiscal year 2010. This increase will ensure data availability on key national health indicators by supporting electronic birth and death records in States and enhancing national surveys.

The budget includes $222 million, an increase of $16 million, to address Autism Spectrum Disorders (ASD). Research at the National Institutes of Health (NIH) will pursue comprehensive and innovative approaches to defining the genetic and environmental factors that contribute to ASD, investigate epigenetic changes in the brain, and accelerate clinical trials of novel pharmacological and behavioral interventions, CDC will expand autism monitoring and surveillance and support an autism awareness campaign, and HRSA will increase resources to support children and families affected by ASD through screening programs and evidence-based interventions.

The budget includes $352 million, an increase of $16 million, for CDC Global Health Programs to build global public health capacity by strengthening the global public health workforce; integrating maternal, newborn, and child health programs; and improving global access to clean water, sanitation, and hygiene. Specifically, CDC will expand existing programs and develop programs in new countries to provide workforce training in areas such as epidemiology and outbreak investigation, and to implement programs that distribute water quality interventions to create safe drinking water. In addition, CDC will integrate interventions, such as malaria control measures, expanded immunizations, and safe water treatment, to reduce newborn, infant, and child mortality. Additionally, the budget includes $6 million in the Office of Global Health Affairs to support global health policy leadership and coordination.

Protecting Americans From Public Health Threats and Terrorism

Continued investments in countermeasure development and pandemic preparedness will help ensure that HHS is ready to protect the American people in either natural or manmade public health emergencies. The budget includes $476 million, an increase of $136 million, for the Biomedical Advanced Research and Development Authority to sustain the support of next-generation countermeasure development in high-priority areas by allowing the BioShield Special Reserve Fund to support both procurement activities and advanced research and development.

Reassortment of avian, swine, and human influenza viruses has led to the emergence of a new strain of H1N1 influenza A virus, 2009 H1N1 flu, that is transmissible among humans. On June 24, 2009, Congress appropriated $7.65 billion to HHS for pandemic influenza preparedness and response to 2009 H1N1 flu. HHS has used these resources to support States and hospitals, to invest in the H1N1 vaccine production, and to conduct domestic and international response activities. The budget includes $302 million for ongoing pandemic influenza preparedness activities at CDC, NIH, Food and Drug Administration, and the Office of the Secretary for international activities, virus detection, communications, and research. In addition, the use of balances from the June 2009 funds, will enable HHS to continue advanced development of cell-based and recombinant vaccines, antivirals, respirators, and other activities that will help ensure the Nation's preparedness for future pandemics. Previous appropriations for H5N1 allowed us to be better prepared for H1N1 than we ever would have been otherwise, and only by continued work on better vaccines, antivirals, and preparedness will we be ready for the next virus—which could well be a greater challenge than H1N1 has been.

Improving the Well-being of Children, Seniors, and Households

In addition to supporting efforts to increase our security in case of an emergency, the HHS budget also seeks to increase economic security for families and open up doors of opportunity to those Americans who need it most.

The budget provides critical support of the President's Zero to Five Plan to enhance the quality of early care and education for our Nation's children. The budget

lays the groundwork for a reauthorization of the Child Care and Development Block Grant and entitlement funding for childcare, including a total of $6.6 billion for the Child Care and Development Fund, an increase of $800 million in the Child Care and Development Block Grant and $800 million in the Child Care Entitlement. These resources will enable 1.6 million children to receive child care assistance in fiscal year 2011, approximately 235,000 more than could be served in the absence of these additional funds.

The administration's principles for reform of the Child Care and Development Fund include establishing a high standard of quality across childcare settings, expanding professional development opportunities for the childcare workforce, and promoting coordination across the spectrum of early childhood education programs. The administration looks forward to working with Congress to begin crafting a reauthorization proposal that will make needed reforms to ensure that children receive high-quality care that meets the diverse needs of families and fosters healthy child development.

To enable families to better care for their aging relatives and support seniors trying to remain independent in their communities, the budget provides $102.5 million for a new Caregiver Initiative at the Administration on Aging. This funding includes $50 million for caregiver services, such as counseling, training, and respite care for the families of elderly individuals; $50 million for supportive services, such as transportation, homemaker assistance, adult daycare, and personal care assistance for elderly individuals and their families; and $2.5 million for respite care for family members of people of all ages with special needs. This funding will support 755,000 caregivers with 12 million hours of respite care and more than 186,000 caregivers with counseling, peer support groups, and training.

Funding for the Head Start program, run by the Administration for Children and Families (ACF), will increase by $989 million to sustain and build on the historic expansion made possible by the Recovery Act. In fiscal year 2011, Head Start will serve an estimated 971,000 children, an increase of approximately 66,500 children over fiscal year 2008. Early Head Start will serve approximately 116,000 infants and toddlers, nearly twice as many as were served in fiscal year 2008. The increase also includes $118 million to improve program quality, and the Administration plans to implement key provisions of the 2007 Head Start Act reauthorization related to grantee recompetition, program performance standards, and technical assistance that will improve the quality of services provided to Head Start children and families.

The budget proposes a new way to fund the Low Income Home Energy Assistance Program to help low-income households heat and cool their homes. The request provides $3.3 billion in discretionary funding. The proposed new trigger would provide, under current estimates, $2 billion in mandatory funding. Energy prices are volatile, making it difficult to match funding to the needs of low-income families, so under this proposal, mandatory funds will be automatically released in response to quarterly spikes in energy prices or annual changes in the number of people living in poverty.

Investing in Scientific Research and Development

The investments that HHS is proposing in our human services budget will expand economic opportunity, but another critical way to grow and transform our economy is through a healthy investment in research that will not only save lives but also create jobs.

The budget includes a program level of $32.2 billion for NIH, an increase of nearly $1 billion, to support innovative projects ranging from basic to clinical research, as well as including health services research. This effort will be guided by NIH's five areas of exceptional research opportunities: supporting genomics and other high-throughput technologies; translating basic science into new and better treatments; reinvigorating the biomedical research community; using science to enable healthcare reform; and focusing on global health. The administration's interest in the high-priority areas of cancer and autism fits well into these five NIH theme areas. In fiscal year 2011, NIH estimates it will support a total of 37,001 research project grants, including 9,052 new and competing awards.

Recovery Act

Since the Recovery Act was passed in February 2009, HHS has made great strides in improving access to health and social services, stimulating job creation, and investing in the future of healthcare reform through advances in health IT, prevention, and scientific research. HHS Recovery Act funds have had an immediate impact on the lives of individuals and communities across the country affected by the economic crisis and the loss of jobs.

As of September 30, 2009, the $31.5 billion in Federal payments to States helped maintain State Medicaid services to a growing number of beneficiaries and provided fiscal relief to States. NIH awarded $5 billion for biomedical research in more than 12,000 grants. Area agencies on aging provided more than 350,000 seniors with more than 6 million meals delivered at home and in community settings. Health Centers provided primary healthcare services to more than 1 million new patients.

These programs and activities will continue in fiscal year 2010, as more come on line. For example, 64,000 additional children and their families will participate in a Head Start or Early Head Start experience. HHS will be assisting States and communities to develop capacity, technical assistance and a trained workforce to support the rapid adoption of health IT by hospitals and clinicians. The CDC will support community efforts to reduce the incidence of obesity and tobacco use. New research grants will be awarded to improve health outcomes by developing and disseminating evidence-based information to patients, clinicians, and other decisionmakers about what interventions are most effective for patients under specific circumstances.

The Recovery Act provides HHS programs an estimated $141 billion for fiscal years 2009–2019. While most provisions in HHS programs involve rapid investments, the Recovery Act also includes longer-term investments in health IT (primarily through Medicare and Medicaid). As a result, HHS plans to have outlays totaling $86 billion through fiscal year 2010.

Conclusion

This testimony reflects just some of the ways that HHS programs improve the everyday lives of Americans. Under this budget, we will provide greater security for working families as we continue to recover from the worst recession in our generation. We will invest in research on breakthrough solutions for healthcare that will save money, improve the quality of care, and energize our economy. And we will push forward our goal of making Government more open and accountable.

My Department cannot accomplish any of these goals alone. It will require all of us to work together. And I am eager to work with you to advance the health, safety, and well-being of the American people. Thank you for this opportunity to speak with you today. I look forward to answering your questions.

Senator HARKIN. Thank you very much, Madam Secretary. And we'll start 5-minute rounds, whoever is keeping this clock going here. Who keeps the clock going? There we go.

WASTE, FRAUD, AND ABUSE

Madam Secretary again, I applaud you for your continued efforts in the waste, fraud, and abuse areas. We have figures that show how much money we save when we invest in that.

I think for every $1 we spend we save $6 and that's real money. And the largest portion, the Medicare Integrity Program, we get $14 for every $1 we spend. So from the standpoint of just economics it's important, but also to provide more integrity of the programs. So I applaud you for that.

H1N1 EMERGENCY SUPPLEMENTAL

Another thing I wanted to cover with you was the emergency supplemental funding we appropriated last year. We appropriated $7.65 billion to address the critical needs relating to the emerging H1N1 influenza virus. But in the 2011 budget request I've noticed you're using $555 million from this emergency supplemental for things that we usually fund in our annual appropriations bill. These are the annual costs for flu preparedness activities at CDC and in the Office of the Secretary.

I understand it also includes staff salaries. These costs can hardly be called an emergency. Can you just tell me how you justify these emergency supplemental fundings for these types of ongoing costs?

Secretary SEBELIUS. Mr. Chairman, it was our goal in seeking 2011 funding to be mindful of the budget situation and the President's desire not to increase discretionary funding for 3 years starting this year. And recognizing that, first of all the appropriations made by this subcommittee over time and certainly the supplemental funding helped us be very well prepared to face the pandemic that arrived here in April with a new vaccine, with a very robust outreach effort. But as you know when we requested supplemental funding it was still anticipated that we might need two doses per person. We were not at all certain how lethal the disease would be.

We were building a contingency plan based on the best possible preparedness activities. What we found ourselves, as the second wave of the flu has dramatically decreased, that we are still working with State and local efforts to have people vaccinated. But we have additional funding and we thought rather than seeking new funds from the subcommittee process that we'd be more appropriate to use for ongoing flu efforts. The efforts they're being used for are pandemic efforts that, as you know, are underway year in and year out whether we're in the midst of a pandemic or not.

So the CDC activities will continue on. Our work with State and local partners will continue on. The kind of staff support that you mentioned is part of the preparedness efforts that are underway year in and year out. But we just decided not to bank that money and then seek additional funds from the subcommittee, but use the funds that were available in an effort to be as prudent as possible.

EARLY CHILDHOOD PROGRAMS

Senator HARKIN. Very good. I appreciate that.

As a matter of fact, one other area that I've been a long-time supporter of is early childhood programs. On the education side I've talked a great deal with your counterpart, Secretary Duncan. As we both know many States have shown that children who receive high-quality, early childhood services are less likely to commit crimes, more likely to graduate from high school, more likely to hold a job and everything. But the key seems to be whether the services are indeed high quality.

The National Head Start Impact Study released last month shows that most of the gains that children show after participating in these programs tend to wear off after first grade. And this is troubling. So we have to make sure that the quality of early childhood programs is consistently high.

And could you just talk for a minute about how you plan to address the quality issue in the 2011 budget request?

Secretary SEBELIUS. Absolutely. Mr. Chairman, I share your concern that it's always a key issue for parents to have their children in safe childcare situations. But I think more importantly or as important is to make sure that they are actually developing the skills that they're ready to learn once they hit kindergarten. And too often that doesn't happen in many of the childcare settings.

So the study that you mention is a snapshot of some years ago of what the results were of Head Start programs. And I can assure you that there have been a number of investments in quality since

that snapshot was taken. But even more importantly this year we share the notion that we have to greatly enhance quality.

And too often there are somewhat erratic standards at the State level. Some States have set very high-quality standards. Others have not.

So we are actually applying some of the funding this year for the additional Head Start money to quality standards that would be developed and implemented across the country to make sure that whether you're in Arkansas or Rhode Island or Iowa or Mississippi in a Head Start program that you would anticipate the same high-quality standards and that that would be part of the funding going forward.

Senator HARKIN. Is that $118 million?

Secretary SEBELIUS. Yes, sir. I'm sorry. Yes, we didn't apply all of the funding to slots. We think quality enhancements nationwide are a critical part of this effort.

Senator HARKIN. Thank you, Madam Secretary. Senator Cochran.

LET'S MOVE CAMPAIGN

Senator COCHRAN. Madam Secretary, thank you very much for being here to discuss the budget request before the subcommittee. We appreciate some of the highlights you outlined and of your intentions as Secretary to solve some of the problems that face many of us back in our States. And I noticed right away you're putting an emphasis on obesity and you have called attention to the fact that the First Lady came to Mississippi to talk about the Let's Move campaign, more activity, more healthy eating practices. And we surely need that in our State.

And so I was pleased to see that the emphasis is being placed by your Department and also at the White House on doing something about this really big problem. In Mississippi we win the prize. We're number one in childhood and adult obesity.

So we welcome these efforts. And we hope that we can work with the Department to put the money where the problem is and let you show us what can be done. And we need leadership. And we welcome that.

Do you have any specific things to tell us about what the elements of this program might be?

Secretary SEBELIUS. Well, Senator Cochran, in the Let's Move campaign the First Lady has really outlined four principal goals. And HHS will be involved in a number of them. More tools and information for parents to make good choices and that's everything from our Food and Drug Administration (FDA) looking at new, easier to read, easier to find food labeling to the CDC updating and clarifying nutrition standards.

So parents who want to shop smarter, buy healthier food will be able to find it on a grocery shelf and not have to read some dense barcode on the back of a package. Pediatricians have stepped up saying that they are in agreement that every child who gets a checkup should have a body mass index. But more than just having the body mass index on a regular basis, pediatricians need to have a conversation with the parents about what it means. And literally

write prescriptions for more exercise and/or healthier eating habits. Helping parents, again, to make some choices that matter.

A second pillar is focused on schools where kids spend a lot of their time. The Department of Agriculture is working to upgrade what's fed to children in school breakfast and school lunch programs. And make it healthier and more nutritious working again with the CDC on nutrition guidelines.

The physical education component of schools has kind of fallen off the radar screen in too many cases. And what we know from the Secretary of Education studies is that not only are children healthier, but they actually are better learners if they actually move around some during the course of the school day.

So reinstituting physical education will be part of school. Working with soft drink manufacturers on marketing sugary beverages inside schools and a lot of activity has been done so far in terms of voluntarily removing high-sugar content drinks from schools and substituting water and juices. So that's kind of component number two.

Number three is we've got 23 million Americans who live in so-called food deserts where they don't have access to fresh fruits and vegetables. So they may want to eat in a healthier manner, but they literally don't have any place within 2 miles of their home to go buy a piece of fruit or a fresh vegetable.

So again the Department of Agriculture is not only doing mapping of those so-called food deserts. But looking at initiatives with local farmers, local grocers, to try and establish a different protocol. We have some dollars available in our budget for helping to subsidize some of those healthier choices and figure out if it's a price strategy or an access strategy.

And the fourth component of Let's Move is let's see, I'm blanking on it for a moment. Parents and kids and—I'll get back to you on this and submit the information at a later date.

[The information follows:]

Physical Activity.—The fourth component of the Let's Move campaign is increasing physical activity. The administration will encourage children to be more physically active each day rather than spending more time watching TV and playing video games.

Senator COCHRAN. Health centers. One thing to do is to use the health centers as a place—

Secretary SEBELIUS. That—

Senator COCHRAN. For the children that go to Head Start programs there, the parents can come in and visit with healthcare professionals who are there at those centers.

Secretary SEBELIUS. Ok.

Senator COCHRAN. We found in our State that bringing all these programs together in one location certainly helps a lot, particular to the very young, those who haven't started elementary school. And you can't start too early.

Secretary SEBELIUS. Absolutely.

Senator COCHRAN. I think a lot of these habits are formed very early. And I'm sure you are aware of that. One area of our State, the Mississippi Delta, has had great success in developing a Delta Health Alliance.

And I hope that we can see funding directed to programs like that so that we can continue to see progress that can be made. Local medical centers using Mississippi Valley State University, Delta State University, University of Mississippi, and Mississippi State University, all have roles to play in our State in that effort. So thank you for getting off to such a good start in mapping out a plan of action.

Secretary SEBELIUS. Well and Senator, I look forward to learning the lessons that are already being enacted in Mississippi. I know your governor and the First Lady of Mississippi have taken a real interest and effort in this area. And I absolutely agree that community health centers can play an enormously important role.

Senator COCHRAN. Thank you.

Secretary SEBELIUS. Thank you.

Senator HARKIN. Senator Reed.

LOW INCOME HOME ASSISTANCE PROGRAM (LIHEAP)

Senator REED. Thank you, Mr. Chairman.

Madam Secretary, thank you very much.

The chairman already alluded to the issue of LIHEAP funding which is critical not only to my State but to practically every State in both the cold winter States and the very, very hot summer States. The chairman over the last few years, ensured that we've had very robust funding. This $2 billion reduction to the LIHEAP Block Grant will translate into a $13.6 million cut for Rhode Island, which is a sizable number for us.

And also it undercuts the certainty of planning in terms of what monies they might have. I know you're creating a mandatory stream of funding with a trigger that will kick in when prices rise or when economic conditions worsen, but all of that I think will be discounted because it will be so difficult to anticipate these conditions. And essentially States will be planning for and allocating and getting a waiting list on the basis of a lower block grant.

The other issue too, is that this trigger is going, I think, to be difficult to sort of estimate when it precisely kicks in. And also it's unclear to me what the formula for distribution is if the trigger kicks in. And by way of that, this January there was contingency money released to the States. Rhode Island actually got $4 million less than the previous year at a time when our employment sadly, is second or third in the Nation. So the subjectivity of distribution of this funding is going to, I think, contribute to significant concerns.

My question, I think, is can we do better?

One, in terms of the baseline number?

Two, how do you specifically propose to resolve the trigger and the distribution formula?

Secretary SEBELIUS. Well Senator, let me just start by saying I, first of all, not only appreciate the interest and leadership in the LIHEAP program in the past, but also recognize as a governor who distributed LIHEAP funds how essential it is to people who cannot pay their bills in the winter and some in the summer. So I know what a critical safety net that is.

In terms of the distribution methodology this year which I know again, was a subject of some concern, particularly in the Northeast.

We looked at two factors for the money that was distributed in January.

One was the cost of heating oil, which had come down to some degree over where we had been in the previous year, but in addition to that, the number of States who were actually experiencing unusually cold winters. And there were States that were far more scattered than some patterns we had seen in the past. And added to that the unemployment index as an indicator of States in real economic hardship.

And as you know 14 States were deemed to be, not by our count, but by the weather assessments, 5 percent colder during those winter months than had been experienced in the past. And we then distributed the money, some additional money to those 14 States as well as a formula grant to the others based on what we were seeing. There still is a pot of money for the LIHEAP funding this year that is still being held anticipating either further distributions this winter or in the summer months having some real spikes in temperature that require additional distributions.

In terms of the proposition for 2011 and the trigger proposal, there is a $3.3 billion discretionary fund, but then a $2 billion mandatory fund that would activate with a trigger, which would result actually in an increase in the overall LIHEAP funding for 2011, not a decrease in funding. And the combination trigger would be based on the analysis of the cost of energy plus an assessment of the poverty population in a State based on who is eligible for the Supplemental Nutrition Assistance Program. So it would be again, not our subjective look at it. But it would look at eligibility for the food and nutrition program combined with the heating oil prices for the winter.

We anticipate that if energy prices are high and people are having a struggle paying their bills the trigger would be met. And again, having the poverty sensitivity would help enhance that ability and the formula would be divided according to the population. So I know that there was some discussion last year on our budget about a formula that just looked at the price of winter fuel.

And we thought the addition of a recognition that this is an economic downturn and this is about people paying their bills. So, to look at who is in economic difficulty along with the price made a lot more sense and made the trigger a lot more sensitive.

Senator REED. Just two points because my time expired.

One is let us go over so the numbers because I have an indication that if you look at the formula money plus the trigger money it won't be as much as previous years. But that might be my miscalculation.

Secretary SEBELIUS. We would love to get the—yes. We'd love to get that.

Senator REED. The second point is even in the best of times when the economy is doing very well and the temperature is relatively mild, there are long, long waiting lists in my State and other States. So this notion of needing a trigger because, the demand only comes up during economic crises is not substantiated by the facts. But I thank the chairman for his indulgence.

Thank you, Madam Secretary.

Secretary SEBELIUS. Well then Senator I would volunteer that we would love to work with you on this.

Senator REED. Well, thank you.

Secretary SEBELIUS. First, getting you the numbers and making sure we're on the same page and then talking to you about—because I think we share the same goal that we don't want people struggling to pay their heating bills or having to turn off the heat when they can't pay them. So we want to work with you.

[The information follows:]

LIHEAP FUNDING

[In millions of dollars]

	Fiscal year 2010 appropriation	Fiscal year 2011 President's budget	Increase/ decrease
Discretionary	5,100	3,300	−1,800
Mandatory trigger [1]		2,000	+2,000
Total	5,100	5,300	+200

[1] For scoring purposes, $2 billion is assumed for fiscal year 2011.

Senator REED. Thank you, Madam Secretary. Thank you.

Senator HARKIN. Thank you very much. And I just personally want to thank you, Senator Reed, for your leadership in this area. You've been stalwart on that. And I look forward to making sure you get this all worked out for us.

Senator Pryor.

Senator PRYOR. Thank you, Mr. Chairman. Madam Secretary, welcome once again to the subcommittee. It's always good to see you. I believe the administration has made a commendable effort to reduce waste, fraud, and abuse in healthcare programs both in its budget request and in its healthcare reform proposal.

What support do you need from this subcommittee in the appropriations process as it moves forward to ensure that we're taking the necessary steps to end, as much as humanly possibly, waste, fraud, and abuse in our public health programs?

Secretary SEBELIUS. Well, Senator, I'm glad you asked that question.

First of all, let me just reiterate that I think the President takes this effort very, very seriously. It's one of the reasons he asked the Attorney General and me to, as Cabinet officers, convene a joint effort. And we are working very well with the Justice Department, and the strike forces now that are in seven cities are really paying off, big results.

So the budget has a couple of requests.

One is an additional $250 million in discretionary funding, which would allow us to expand the footprint of those strike forces. And as you heard Chairman Harkin say, we know that every dollar invested returns multiple dollars. And that's just dollars we get back in the door for prosecutions and can return to the fund and make the Medicare fund more solvent. I think there's an additional impact that is impossible to measure, which is that we discourage people from committing crimes in the first place by making it very clear that we intend to prosecute vigorously and come after them. So that's one piece of the puzzle.

Another big piece of the puzzle is a data system request that is in for the CMS budget, about $110 million to begin a multiyear process to upgrade our system. What we miss right now is the ability to look at data sets in one system. Medicare is the biggest health insurance program, I think, in the world. We pay out—we pay more than $1 billion in claims to providers over the course of the year; more than $500 billion worth of benefits every year.

We still have those data sets in multiple places. So it's impossible to check errant behavior unless you check six or seven systems. We have a plan that has been developed that by the end of 2011 we would be at a real time, one data set, flexible ability to share that data with law enforcement officers.

To do the same thing that frankly major credit card companies can do, which is watch what's happening.

Senator PRYOR. Right.

Secretary SEBELIUS. And immediately go after folks. And we need more boots on the ground.

Senator PRYOR. Yes. I think it's great that you say that. I'm glad to know that you're on top of that because when I was the State's attorney general we did the Medicaid fraud piece of enforcement.

Secretary SEBELIUS. Yes.

Senator PRYOR. And on all those cases, you know, we would do these extensive investigations and all this but it was always after the fact.

Secretary SEBELIUS. Pay and chase.

Senator PRYOR. Oftentimes it was 1 or 2 years later and some of these people you can never find again.

Secretary SEBELIUS. Right.

Senator PRYOR. Or they've been doing this for so long you're never going to get the money back from them or whatever the case may be. I support the idea of trying to get to a point where we can go to real time. You mentioned credit card companies. But also other health insurance companies do that where they're able to look at claims in real time.

I mean literally when someone is at the register they will get a prompt. I don't know how it works. But under what they're doing, the insurance company will be able to say, "No, we need to check on this right now."

So it's out there. We can do this. We can do this a lot smarter. And I think we can save tens of billions of dollars every year by doing that.

GEOGRAPHIC VARIANCE IN MEDICARE REIMBURSEMENT

We have a concern in Arkansas on what we call geographic variance in Medicare reimbursement. You know that issue very well. And I'm sure in your home State you may have some of this as well.

But if healthcare reform is enacted and I know that's not a certainty as we speak. But if it is, will you work to ensure that any geographic variations in reimbursement are fairly calculated and do not discriminate against rural America?

Secretary SEBELIUS. Well, Senator, as you said, I'm very familiar with the difficulty often of providing quality health services in more rural areas. And the cost estimations have to be calculated

about what it requires to do that. So I would love to work with you and other members. As you know, Senator, I like to refer to your State as "Our Kansas."

So I think we are sister States and we——

Senator PRYOR. We have—and that's exactly right.

Secretary SEBELIUS. But yes, I would very much like to work with you on that issue.

Senator PRYOR. Great.

PANDEMIC PREPAREDNESS

The last question I have for this round is I know we've been through the H1N1 flu pandemic and I'm sure different people would agree or disagree about how well that was managed by the Federal Government. But what does the administration's budget doing to put us in an even better position this coming flu season and the years to come to handle either H1N1 or some other pandemic?

Secretary SEBELIUS. Well, Senator, the ongoing efforts of pandemic planning continue. And the budget, I think, through the CDC, through our hospital preparedness grants, through our partnership efforts with State and local governments continues to ramp that up. I don't think there's any question of that—and this subcommittee was really instrumental in helping those years of preparation so that this year when something hit we were really far more prepared than we would have been if we were facing it for the first time.

We are in the process and I look forward, Mr. Chairman, to coming back to this subcommittee and others in an entire systemwide review. Not just H1N1, but really our whole countermeasures effort. We think it's appropriate to use this most recent situation as a way to say how prepared are we for whatever comes at us next, whether it's a pandemic that we get some warning for and know something about and know what kind of vaccine or a dirty bomb on a subway.

What did we learn?

Where are the gaps in the system?

Where are the efforts that we need to move forward?

We know we need more manufacturing capacity for vaccine. That was very clear.

We know we need different technology for vaccine production. You know, the time table of growing virus in eggs is slow. And that needs to ramp up.

But we need to look at the whole system. And that's underway. And we anticipate when you return from the break in a couple of weeks we will have an ability to report back on a whole range of lessons learned from H1N1.

Senator PRYOR. Great. Thank you, Mr. Chairman.

Senator HARKIN. Thank you, Senator Pryor.

VACCINE PRODUCTION AND DISTRIBUTION INFRASTRUCTURE

Just to follow up, if the pandemic did not happen, I am concerned that we then start to think, "Welll, that was just a scare anyway. It really wasn't going to happen."

Now we fall into lethargic mode by thinking that we can delay implementation of preventative measures. You put your finger on it. We have to build the structures.

Secretary SEBELIUS. You bet.

Senator HARKIN. That can respond more rapidly, cell-based systems so we can grow the viruses or RNA-based systems that, can even be more rapidly utilized. But as I understand it we only put one new one online. Is that right?

Secretary SEBELIUS. We cut the ribbon in a plant in North Carolina just this year.

Senator HARKIN. Yes, that's right.

Secretary SEBELIUS. And there is planning underway for the second plant.

Senator HARKIN. And that's going to be on track, on time? We have the funds for that?

Secretary SEBELIUS. I think you have the funds for one additional plant the way the funding looks now instead of I think it was anticipated 5 or 6 years ago that the funds were being set aside for four plants.

Senator HARKIN. Well.

Secretary SEBELIUS. And the cost of the North Carolina plant turns out that it exceeded what was estimated to be a number of years ago.

Senator HARKIN. Well, Madam Secretary, again, one of the problems for having these kinds of plants is the question, what do they do every year? I mean, if you don't have something that's confronting you, how do they keep viable? That's been the big problem with vaccine production.

That's why I suggested, modestly, a year or two ago that perhaps what we ought to do on the Federal level is provide a free flu shot to every person in the country every year. Oh, I forget what the cost came in on that. And there was a cost to it.

But then you balance it against how many people get sick just from annual flu, and are hospitalized, and the people that die from the flu—and you add that cost. Then we could see if you can really do great outreach programs with a free flu shot.

First of all you keep these plants going because they have to meet the demand every year and if we have a pandemic that has a different strain, they can shift to that immediately.

Second, you build up the infrastructure. If you do have a pandemic that is hitting us, one of the big problems is just getting it out through shopping centers and churches and schools and wherever, drug stores and every other place. And if you do that on an annual basis then you build up a really good infrastructure that's ongoing. And I think you also will build up more of a public support for these vaccinations.

A lot of people don't get flu shots because, well, why? I don't know. They don't think they work or they've heard they shouldn't get them. They're afraid of getting them, that type of thing. And there are a lot of people in this country who are allergic to eggs who cannot get these shots because of the egg-based production.

Secretary SEBELIUS. Right.

Senator HARKIN. I haven't revisited that for some time, but again thinking about having a couple of plants that are cell based. How

do we keep them energized? How do we keep—and we can't just leave them set there waiting for the next pandemic to come.

So I would be interested in discussing that with you later on.

Secretary SEBELIUS. Well I think that would be very helpful.

Dr. Nikki Lurie, who is the Assistant Secretary for Preparedness and Response, has been charged with this whole countermeasures review. And certainly one of the issues is how we prepare for things we don't even know are coming. What sort of stockpile do we need against anthrax or unknown viruses that may head our way? What's the market for that? So we would love to continue that conversation with you.

I think one of the lessons learned is the kind of distribution system that you just mentioned. This year, as you know, the H1N1 virus had a much younger target population. So we were trying to encourage vaccination of people who typically do not get a seasonal flu shot. They're too young or they typically don't get the flu.

We've had an estimated 72 to 81 million people vaccinated, using an estimated 81 to 91 million doses, and people are still being vaccinated. And we used a lot of nontraditional sources, school-based clinics which hadn't been used for years and turned out to be very successful with kids. A lot of outreach with faith based groups. We went from a 40,000 site distribution system for the children's vaccines to 150,000 sites for H1N1 vaccine

And so we have a more robust distribution system, a more robust outreach system than has been in place, I would suggest, in a very long time in America. And that's, I think, very good news for whatever comes at us next.

Senator HARKIN. Well, I think we have to keep that——

Secretary SEBELIUS. Right.

Senator HARKIN. Activated, some way.

Secretary SEBELIUS. Yes.

Senator HARKIN. And that is what I'm concerned about. We've done that. But now it's faded out. And we may not do it next year. Then a couple years go by. And we may have to really gen it up again. That's why I focus on the annual flu.

Secretary SEBELIUS. Well with 36,000 people a year dying from flu and 200,000 hospitalized—that's our annual flu data—and that's pretty serious.

COMMUNITIES PUTTING PREVENTION TO WORK

Senator HARKIN. That's pretty serious. And it costs a lot of money.

But I did have one more question. And not to make too far a leap from vaccinations to prevention, but this subcommittee put $1 billion in the stimulus bill for prevention activities at HHS.

As you mentioned in your statement the cornerstone of that is a $373 million grant system to communities which I assume will be awarded sometime soon. I don't know when you might inform me of that. I understand that States and communities that are awarded this ARRA funding will be asked to implement their choice of a list of evidence based programs that your Department determined are the most likely to be effective.

I asked my staff. I have not seen that list. If you have that could you share that with us? And where did you go to come up with this list of evidence-based programs that could be effective?

Secretary SEBELIUS. Ah, Mr. Chairman, first of all, we'd be glad to share those data with you.

[The information follows:]

MAPPS INTERVENTIONS

Attached is the list of evidence-based MAPPS interventions (Media, Access, Point of decision information, Price and, Social support services) from which States and communities awarded ARRA funding for the "Communities Putting Prevention to Work" initiative will choose to implement. This list can be found at http://www.cdc.gov/chronicdisease/recovery/PDF/MAPPS__Intervention__Table.pdf

MAPPS INTERVENTIONS FOR COMMUNITIES PUTTING PREVENTION TO WORK

Five evidence-based MAPPS strategies, when combined, can have a profound influence on improving health behaviors by changing community environments: Media, Access, Point of decision information, Price, and Social support/services. The evidence-based interventions below are drawn from the peer-reviewed literature as well as expert syntheses from the community guide and other peer-reviewed sources, cited below. Communities and states have found these interventions to be successful in practice. Awardees are expected to use this list of evidence-based strategies to design a comprehensive and robust set of strategies to produce the desired outcomes for the initiative.

	Tobacco	Nutrition	Physical activity
Media	Media and advertising restrictions consistent with Federal law [11]. Hard hitting counteradvertising [12 13 14 15]. Ban brand-name sponsorship [15] .. Ban branded promotional items and prizes [16].	Media and advertising restrictions consistent with Federal law [53 54 55 56 57 58 59]. Promote healthy food/drink choices [57 58 60]. Counteradvertising for unhealthy choices [61].	Promote increased physical activity [98 99 103 106 126 127] Promote use of public transit [98 99 103 106 126 127] Promote active transportation (bicycling and walking for commuting and leisure activities) [98 99 103 106 126 127] Counteradvertising for screen time [98 99 103 106 126 127]

	Tobacco	Nutrition	Physical activity
Access	Usage bans (i.e., 100 percent smoke-free policies or 100 percent tobacco-free policies) [6 7 102]. Usage bans (i.e., 100 percent smoke-free policies or 100 percent tobacco-free school campuses [5 6 7 8 9 10]. Zoning restrictions [5 6 7] ..... Restrict sales (e.g., Internet, sales to minors, stores/events without tobacco, etc.) [5 6 7]. Ban self-service displays and vending [5 6 7].	Healthy food/drink availability (e.g., incentives to food retailers to locate/offer healthier choices in underserved areas, healthier choices in child care, schools, worksites) [24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 78 79 80 81 82 83 91 92 93 94 95 96 97]. Limit unhealthy food/drink availability (whole milk, sugar sweetened beverages, high-fat snacks) [34 39 40 41 42 84 85 86 87 88]. Reduce density of fast food establishments [32 43]. Eliminate transfat through purchasing actions, labeling initiatives, restaurant standards [44 45 46]. Reduce sodium through purchasing actions, labeling initiatives, restaurant standards [47 48 49]. Procurement policies and practices [25 26 30 31 50 51]. Farm to institution, including schools, worksites, hospitals, and other community institutions [50 51 52].	Safe, attractive accessible places for activity (i.e., access to outdoor recreation facilities, enhance bicycling and walking infrastructure, place schools within residential areas, increase access to and coverage area of public transportation, mixed-use development, reduce community design that lends to increased injuries) [136 137 138] City planning, zoning, and transportation (e.g., planning to include the provision of sidewalks, parks, mixed-use development, reduce community design that lends to increased injuries) [99 100 101 102 105 106] Require daily quality physical education in schools [113 114 115 116 117 118 119 120] Require daily physical activity in afterschool/child care settings Restrict screen time (afterschool, daycare) [107 108 109 110 111]
Point of purchase/promotion.	Restrict point of purchase advertising as allowable under Federal law [17]. Product placement [17]	Signage for healthy vs. less healthy items [25 26 62 63 89 90]. Product placement and attractiveness [25 26 62 63 89 90]. Menu labeling [65 66 67 68]	Signage for neighborhood destinations in walkable/mixed-use areas (library, park, shops, etc.) [99 100 101 106 140] Signage for public transportation, bike lanes/boulevards [99 100 101 106 140]
Price	Use evidence-based pricing strategies to discourage tobacco use [1 2 3]. Ban free samples and price discounts [4].	Changing relative prices of healthy vs. unhealthy items (e.g., through bulk purchase/procurement/competitive pricing) [22 23 24 25 26 75 76 77].	Reduced price for park/facility use [133 134 135] Incentives for active transit [134 135] Subsidized memberships to recreational facilities [99 100 110 111]
Social support and services.	Quitline and other cessation services [18 19 20].	Support breastfeeding through policy change and maternity care [69 70 71 72 73 74].	Safe routes to school [104 112 128 129 130 131 132] Workplace, faith, park, neighborhood activity groups (e.g., walking, hiking, biking, etc.) [99 100 105 106]

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Secretary SEBELIUS. And the community grants I think are about to go out the door in the next, I think somewhere in the next 2-week period of time the awards will be made. And the focus looking at not only the—we had a multidiscipline team, scientists from NIH, the surveillance folks from and public health folks from CDC, our Office of Public Health and Science, all looking at not only what the most serious cost drivers were for underlying disease conditions, but also what were effective strategies that had been measured and looked at.

And the two focus areas for the community grants were determined to be smoking cessation efforts and efforts aimed at obesity as the two drivers for a large number of the chronic conditions that

cause healthcare spending to rise and cause quality of life to go down. So the so-called list looked at measures that had existed across States and communities that were effective strategies, had been measured, had been proven effective. And we would be delighted to share those with you.

But the community grants were available to either look at smoking cessation and/or obesity or both, one or the other or both. But those were the two kinds of targets. As opposed to spreading them out across the horizon that the focus on those two areas.

And then the hope is, as you know, with the ARRA funding is to have kind of measurable results. So at the end of 2 years the goal is to have some strategies which really do either encourage young people from not smoking in the first place, decrease smoking dramatically and/or make a real dent in obesity. And then be able to come back and hopefully work with members of Congress to take some of those programs to scale.

If we can find effective ways, effective strategies to deal with those two underlying conditions, we can dramatically change health outcomes and dramatically lower health costs.

Senator HARKIN. Very good. Thank you, Madam Secretary.

Senator COCHRAN. Mr. Chairman.

I think the Secretary has done a great job in presenting the budget request and answering our questions. It's a pleasure working with you in helping make sure that what we decide to appropriate is in the national interest and serves the public interest.

Senator HARKIN. Thank you.

WASTE, FRAUD, AND ABUSE

I just had one other thing that I would bring up and that is this waste, fraud and abuse that, you mentioned. I have a partial list in front of me. I have an entire list that adds up to literally billions of dollars of fines and settlements paid by pharmaceutical companies.

Secretary SEBELIUS. You bet.

Senator HARKIN. That have been ripping off Medicare and Medicaid.

Secretary SEBELIUS. Yes, sir.

Senator HARKIN. So a lot of times we think about Medicare fraud and abuse, waste, you know you think well, there's somebody out there, some person out there that's putting in for something that they shouldn't get. Well, what about Pfizer? Pfizer just paid $2.3 billion, the largest——

Secretary SEBELIUS. The largest——

Senator HARKIN [continuing]. Settlement in United States history.

Secretary SEBELIUS. Yes.

Senator HARKIN. Now attorneys know that when you settle, you settle because you're afraid of what may happen if you actually go to court. That's why you settle. They settled $2.3 billion, $668 million to Medicare, $331 million to Medicaid. That was just this year.

Four other pharmaceutical companies, Mylan Pharmaceuticals, AstraZeneca, UDL and Ortho-McNeil, just paid $124 million to Medicaid this year. And Ethex was fined $23.4 million. Now all of

these were done by the Attorney General's Office. And that's just this year.

I can go back 6, 7, 8 years. Attorneys General in the Bush administration and others that went after these companies and got all these fines and settlements, hundreds of millions of big, big dollars. Well, that's good. I applaud the Attorneys General for doing that, both the present Attorney General and his predecessors.

But what can we put in place so they don't do that in the first place? And I hope that your Department will look at that. How was it that these pharmaceutical companies got by with this? And some of them got by with it—this didn't just happen over a couple of months. I mean they've been doing it for years.

Then all of a sudden someone catches them. The Department of Justice asks for them. That takes a long time, couple years. And then they finally build a case. They get the evidence. And then they either get fined or they get settled.

So I hope and this is just—I don't know if you want to respond to this or not, but I would really be looking forward to working with you on how you can build systems up that just don't allow these kinds of big bucks to be taken out of the system over long periods of time.

Secretary SEBELIUS. Well, I couldn't agree with you more, Mr. Chairman. I think that in the case of the Pfizer settlement, it was a situation where they were improperly marketing and prescribing a drug specifically in violation of the authority that they had been given by the FDA. And it not only was a case of, you know, driving profits for their company, but also putting patients in jeopardy. I don't think there's any question that patients were being inappropriately prescribed a drug that they knew was not going to work for the situation that they had.

So it's kind of a double concern. It not only involved dollars, but it involved patient safety. And I can guarantee that the new FDA leadership takes that very seriously, and has enhanced the efforts to make sure that off market products are not allowed and that we follow up much more vigorously. But also I think, again, having a settlement like this puts a number of manufacturers on notice that we are taking this very seriously. And intend to make sure that they are appropriately using the authority that they've been given.

Senator HARKIN. Is there a good working relationship between you and FDA on issues like this?

Secretary SEBELIUS. Oh, absolutely, absolutely. And the drug safety and the drug protocol is something I think they take very seriously. And we're very involved in this effort as is our Inspector General. I mean, this was again, a collaborative effort.

You're right. It took a number of years. The good news is that money went right back in to both the Medicare Trust Fund and the Medicaid funds for States. States got a share of those returns. And I think it helps make those more solvent for the future.

Senator HARKIN. Madam Secretary, thank you very much. That's very reassuring.

Senator COCHRAN. Thank you, Mr. Chairman. I join you in thanking the Secretary for your cooperation with our subcommittee. We look forward to working with you as we go through this fiscal year. Thank you very much.

Secretary SEBELIUS. Thank you, Senator.

ADDITIONAL COMMITTEE QUESTIONS

Senator HARKIN. Thank you, Senator Cochran.

Thank you, Madam Secretary.

If there is nothing else that you would like us to consider——

Secretary SEBELIUS. Mr. Chairman, we look forward to working with you. Thank you very much.

[The following questions were not asked at the hearing, but were submitted to the Department for response subsequent to the hearing:]

QUESTIONS SUBMITTED BY SENATOR TOM HARKIN

PROJECT BIOSHIELD

Question. Madam Secretary, I would like to commend your the Department of Health and Human Services (HHS) for including in its most recent broad agency announcement for medical countermeasure development a clear articulation of the Department's scenario-based medical countermeasure requirements for anthrax and smallpox. For several years, industry has been concerned regarding the lack of clearly articulated evidence-based requirements. This public articulation of the requirements is very welcome; however, it raises important concerns about the resources that remain in the Project BioShield Special Reserve Fund (SRF). Are the remaining SRF funds sufficient to procure technologically appropriate countermeasures for the identified requirements?

Answer. The Assistant Secretary for Preparedness and Response (ASPR) has plans for the $2.4 billion remaining in the SRF, including anticipated procurements of countermeasures for the threat areas of anthrax, botulism, smallpox, and acute radiation syndrome illnesses. Under Biomedical Advanced Development Authority (BARDA) advanced research and development program there are numerous medical countermeasures under development. Some of these programs may mature enough before the end of fiscal year 2013 to become eligible for late-stage development and procurement under Project BioShield. These medical countermeasures address threat areas such as anthrax, smallpox, botulism, acute radiation syndrome, and chemical agent nerve analysis.

Question. How does HHS anticipate balancing the needs to continue funding advanced development activities with the need to continue stockpiling products to meet these stated requirements?

Answer. In early December, I directed my Department to conduct a full review of the public health emergency medical countermeasure enterprise, which is the program that ultimately translates the ideas from the research bench into approved products that the United States can depend upon in the event of naturally occurring emerging diseases, pandemic diseases, or threats from chemical, biological, radiological, and nuclear (CBRN) agents. The MCM enterprise review is examining how policies affect every step of the medical countermeasure development, manufacturing, and stockpiling process, finding ways to improve and implement necessary changes. The goals of the review are to enhance the medical countermeasure development and production process, increase the number of promising discoveries going into advanced development, and provide more robust and rapid product manufacturing. HHS senior leadership with those of other Departments like the Department of Defense (DOD) meets regularly to discuss the medical countermeasure portfolios for CBRN and flu programs across the Federal Government and HHS toward understanding and achieving strategic goals and meeting product requirements.

Question. Does HHS have a long-term strategy for how it plans to replenish the SRF or otherwise devote funding to the procurement of countermeasures for these identified requirements?

Answer. HHS has initiated a long-term strategy for development and procurement of CBRN medical countermeasures that coordinates with DOD quadrennial strategy and planning for medical countermeasures. This strategy will be informed by the findings and recommendations of the medical countermeasure review that is nearing completion. Initiatives resulting from the medical countermeasure review will inform the budget process and assist in the balancing of resources for medical countermeasures with those of other high-priority initiatives at HHS.

MEDICAL COUNTERMEASURES

Question. Last summer, in the face of the H1N1 pandemic, HHS moved with remarkable speed to approve new influenza vaccines and approve emergency-use authorization for medical products critical to protecting Americans. The entire Department responded to this threat as if it were a matter of national security. While the process was not without its problems in general it was fast, efficient and remarkably transparent. I am concerned that this same sense of urgency is not being applied to medical countermeasures being developed to prevent or mitigate the threats that have been identified as critical national security priorities but have not yet materialized. The intentional release of CBRN agents or the detonation of a nuclear device will come with little or no warning, we as a Nation must have already developed and stockpiled safe and effective countermeasures if we are to respond to these types of threats. What measures has HHS taken to ensure the efficient and timely review of medical countermeasures for CBRN threats?

Answer. In early December, I directed my Department to conduct a full review of the medical countermeasure process from the research bench into approved products that the United States can depend upon in the event of naturally occurring emerging diseases, pandemic diseases, or threats from CBRN agents. This review was initiated, based in part by observations of our national response capability at that time for the 2009 H1N1 influenza pandemic, and by procurement actions to develop an approved next-generation anthrax vaccine under the BioShield authorities. The executive leaders within HHS, including those from the ASPR, Centers for Disease Control and Prevention (CDC), Food and Drug Administration (FDA), and the National Institute of Allergy and Infectious Diseases, have worked diligently toward completing a comprehensive review of the medical countermeasure enterprise, which will be provided to me soon.

Question. Does BARDA or the NIH provide funding resources to the FDA to help offset the cost associated with pre-biologics license application (pre-BLA) or pre-new drug application (pre-NDA) regulatory activities? Could additional funds improve the ability of FDA to providing timely review and responses to companies that are under contract with the Federal Government to develop products that the national security apparatus of the U.S. Government has identified as critical unmet needs?

Answer. BARDA and the National Institutes of Health (NIH) do not provide funding to FDA to help offset the cost associated with pre-BLA or pre-NDA regulatory activities. Currently, the administration is conducting a comprehensive review of the Public Health Emergency Medical Countermeasure Enterprise, including medical countermeasure development priorities and resources, which includes FDA's resources to robustly engage with partners throughout a product's developmental lifecycle. FDA places a top priority on regulatory inquiries and submissions from sponsors and U.S. Government partners that are engaged in developing products that have been identified as meeting a critical need.

Question. How extensively has the leadership of the FDA and the staff responsible for reviewing medical countermeasures been briefed on the national security threat assessments for CBRN agents? How many FDA employees that are involved in the review of medical countermeasures being developed under contract with BARDA and NIH have the appropriate security clearances necessary to allow them to receive classified briefings?

Answer. FDA leadership has been briefed and is very aware of the national security threat assessments for CBRN agents. FDA leadership is briefed by the HHS Office of Security and Strategic Information, and FDA has an employee assigned to that Office. In addition, FDA's Office of Criminal Investigations, within the Office of Regulatory Affairs, works with the intelligence community to obtain information and briefs FDA's leadership as needed. Across FDA's three Centers that review medical countermeasure products, 106 employees that have been or in the future may be involved in medical countermeasure-related reviews have received special clearances to review classified documents related to product review submissions.

EARLY CHILDHOOD EDUCATION

Question. Madam Secretary, you and Secretary Duncan have been working very closely in the area of early childhood education. How do you see the collaboration continuing? What lessons has HHS learned about approaches to supporting at-risk children and their families that can be carried over into K–3 education?

Answer. Because quality early childhood education spans the ages of birth to age 8 and involves the transition of children from early childhood programs into our Nation's schools, continued collaboration between the two Departments is essential. Secretary Duncan and I have been working very closely, and we have a number of joint efforts currently underway. We have formed working groups consisting of the

best minds in both Departments to address the most pressing issues in the early childhood field, including creating a more educated, better-trained early childhood workforce; better connecting the early education and health systems; and improving the way data are collected and used to improve early childhood systems at the State level; and coordinating Federal research and evaluation efforts in the area of early childhood. The two Departments are currently co-hosting listening sessions across the country to hear from the foremost experts and early childhood practitioners concerning these issues. The Departments consult regularly on the early childhood initiatives underway in each Department and will continue to collaborate on future initiatives and legislation that are vital to the development and education of our Nation's youngest children.

Historically, HHS's approach to supporting the early education of at-risk children has been to foster growth in all developmental domains. In addition to emphasizing early education domains, such as literacy and early math, a strong focus on health, nutrition, and social-emotional development, for example, is essential in efforts to prepare children for school. This is a vital lesson that can be carried over into K–3 education. Children who miss school for health-related reasons or cannot attend to what is being taught cannot be successful in school. In addition, HHS has been very successful in promoting family involvement and support as two essential elements of high-quality early education for at-risk families. Parents whose children attend the Head Start program, for example, not only receive services and parenting support as part of their child's participation in the program, but also are active partners in the child's education, weighing in on the curriculum selection and staffing decisions. The support that families receive, and the sense of empowerment they feel, play a role in positively affecting children's school readiness outcomes.

Question. How many States have applied for State Advisory Council funding to date and how do you plan to encourage States to implement that requirement of the Head Start Act?

Answer. We have received six applications for State Advisory Council funding. One of these six States has received its funding and a second State is about to receive its funding.

We have been in communication with all 50 States, the 5 territories, and the District of Columbia and all but a few have indicated that they are actively working on completing their application. Several intend to submit their applications in May, but the majority of States have indicated target submission dates in June and July—knowing they have until August 1, 2010 to submit.

We are mailing a communication to the Governors during the week of May 3 asking them to indicate their intent to apply and the target date for submittal of their application. We hope to get all responses by the end of May and have asked Governor's to fax back their responses by May 25 allowing us sufficient time to request States to submit an addendum to their initial application if they are interested in an additional supplemental award subject to the availability of funds.

Question. I understand that HHS is in the process of writing regulations to implement the 2007 amendments to the Head Start Act. Where is HHS in this process? When do you expect the new performance standards to be released for comment?

Answer. HHS is in the process of revising the performance standards to ensure that they reflect the most recent evidence on the components of a high-quality early childhood program. During the revision process, the Office of Head Start conducted listening sessions with each of the 12 regions, including American Indian/Alaska Native and Migrant and Seasonal Head Start, as well as a parent focus group and a national stakeholder group in order to incorporate input from grantees. HHS expects to publish a Notice of Proposed Rulemaking (NPRM) for public comment before the end of the year.

HHS also is drafting a regulation that establishes a designation renewal system to determine if a Head Start agency is delivering a high-quality and comprehensive Head Start program. HHS expects to publish an NPRM by this fall.

BREAST CANCER SCREENING

Question. Secretary Sebelius, the President's budget would cut $4 million from the National Breast and Cervical Cancer Early Detection Program (NBCCEDP). If I'm doing the figures correctly, that funding level would result in 7,000 fewer cancer screenings next year. Is that true? How do you expect to transition this program as new legislation is enacted to extend insurance and preventive screenings in particular?

Answer. The fiscal year 2011 President's budget requests $211 million for the NBCCEDP, which is $4 million below fiscal year 2010. This reduction is part of a CDC-wide effort to achieve efficiencies in travel and contracting and to maintain the

program's impact with the goal of funding the same the number of cancer screenings. Thus, the proposed travel and contract reductions will not have any programmatic impact on the NBCCEDP activities. Regarding the provisions in the Affordable Care Act that extends coverage for recommended cancer screening services, CDC is actively exploring innovative ways to increase and improve cancer screenings. These approaches include using policy and systems change strategies; improving case management and care coordination, tailoring outreach to underserved communities; improving quality assurance of screening services; enhancing surveillance to monitor screening use and quality; and increasing education and awareness for the public and providers. CDC is also working to identify what the remaining uninsured population may be beyond 2014 and looking to define potential roles that State and local health departments could play in quality assurance and delivery of preventive services.

BLOOD DISORDERS

Question. The President's budget proposes consolidating a number of programs in the CDC. In particular, I'm concerned about the plan for funding around blood disorders? Can you give me some details on CDC's plans for the blood disorders programs in fiscal year 2011? What activities will be supported and at what funding level?

Answer. The fiscal year 2011 President's budget requests $20 million for a program that realigns CDC's Blood Disorders Program to address the public health challenges associated with blood disorders and related secondary conditions. Rather than fund a disease-specific program for specific categories of blood disorders, the new program uses a comprehensive and coordinated agenda to prioritize population-based programs targeting the most prevalent blood disorders. This public health approach will impact as many as 4 million people suffering with a blood disorder in the United States versus approximately 20,000 under the current programmatic model. This approach builds upon the successful collaboration CDC has with the national network of hemophilia treatment centers as well as the thrombosis and thalassemia centers. In fiscal year 2011, CDC plans to focus on the following three areas of greatest burden and unmet need: deep vein thrombosis and pulmonary embolism, hemoglobinopathies (such as sickle cell disease and thalassemia), and bleeding disorders. By using this broader approach, CDC anticipates increased program efficiencies by merging and re-designing data collection systems from those that focus on single disorders to a single system that collects data needed for monitoring health outcomes for multiple disease and disorders.

TOBACCO LAB

Question. Madam Secretary, as you know, last year the Family Smoking Prevention and Tobacco Control Act became law. That bill gave authority to the HHS to regulate tobacco for the first time, however, that bill would not have been possible without the detailed information gathered by the smoking lab at the CDC. I understand the FDA is working on developing their own laboratory to test tobacco products. What functions do you foresee FDA taking over and what functions will CDC retain? How are the CDC and the FDA coordinating the transition?

Answer. FDA is responsible for the regulation of tobacco products and the administration of the Family Smoking Prevention and Tobacco Control Act, among other statutes. FDA executes its regulatory and public health responsibilities in four areas: protecting the public health, scientific standard-setting and product review, compliance and regulation, and public education and outreach. Comparatively, CDC performs research and surveillance to further the scientific understanding of how chemical composition and product design influence the health consequences of tobacco products, to provide a scientific basis for evaluating risk, and to aid public health officials in evaluating the effectiveness of tobacco control measures. As we move forward, CDC will continue to perform these functions. As FDA implements this historic piece of legislation, CDC and FDA are coordinating efforts, which include developing new methods for evaluating the constituents and ingredients in tobacco products; evaluating the impact of regulatory actions; and testing tobacco products and constituents.

QUESTIONS SUBMITTED BY SENATOR DANIEL K. INOUYE

COMMUNITY HEALTH CENTERS (CHC)

Question. Senator Burdick and I were instrumental in the establishment of the National Institute for Nursing Research (NINR) and for 25 years the Institute has

been dedicated to improving the health and healthcare of Americans through the funding of nursing research and research training. Since it was established, the Institute has focused on promoting and improving the health of individuals, families, communities, and populations. How does the (National Institutes of Health) NIH plan to further expand this critical arm of research?

Answer. The fiscal year 2011 budget request includes $150.2 million, and increase of $4.6 million above the fiscal year 2010 appropriation, for the National Institute of Nursing Research (NINR). NINR continues to support and advance innovative research studies in self-management, symptom management, caregiving; health promotion and disease prevention; research capacity development; technology integration; and end-of-life research. NINR has begun to develop their next strategic plan which is scheduled for release early in fiscal year 2012. Stakeholder input, a priority setting process, and public health concerns will shape the direction of NINR.

Question. At my request, the University of Hawaii at Hilo established the College of Pharmacy. The College of Pharmacy's inaugural class of 90 students began in August 2007, will graduate in 2011, and will hopefully stay in Hawaii to meet the growing demand for pharmacists. Historically, Hawaii's youth interested in becoming pharmacists would travel to the mainland for school, and not return. It is my vision that the people of Hawaii will have educational opportunities in the health professions that will in turn increase access to care to residents in rural and underserved communities. Has there been any discussion on establishing schools of allied health in remote communities to meet the growing needs for healthcare and improve access to care in rural America?

Answer. HRSA programs work to increase access to healthcare in rural America through the training of allied health professionals. For example, the Area Health Education Centers (AHEC) Program encourages the establishment and maintenance of community-based training programs in off-campus rural and underserved areas in an overall effort to attract students into health careers with an emphasis on careers in the delivery of primary care to underserved populations. The program works to train culturally competent health professionals who will return to their home communities and provide healthcare to the underserved. In fiscal year 2008, the AHEC Program provided education and training to approximately 4,000 allied health students in community-based rural training sites.

Question. America faces a shortage of nurse faculty, further complicating the problems of the nursing shortage. According to a study conducted by the American Association of Colleges of Nursing in 2008, schools of nursing turned away 49,948 qualified applicants to baccalaureate and graduate nursing programs. The top reason cited for not accepting these potential students was a lack of qualified nurse faculty. This element of the shortage has created a negative chain reaction—without more nurse faculty, additional nurses cannot be educated; and without more nurses, the shortage will continue. What efforts has the Department of Health and Human Services (HHS) made to address the shortage of qualified nurse faculty?

Answer. HRSA's principal tools for addressing the nurse faculty shortage are the Nurse Faculty Loan Program (NFLP) and the Advanced Education Nursing (AEN) Program. The NFLP makes grants to schools that provide low-interest loans to nurse faculty students and then cancel a portion of the loans when the individual completes a service commitment. The AEN program provides grants to nursing schools to develop and operate advanced practice nursing training programs, as well as to provide traineeship support to students. During the latest reporting period covering academic year 2008–2009, fiscal year 2008, 133 schools participated in the NFLP facilitating the graduation of 223 students qualified to fill nurse faculty positions. During the same period, 194 NFLP graduates reported employment as nurse faculty. In fiscal year 2009, 149 schools participated with an estimated 1,100 students receiving loans to support their education to become faculty. Grantees report that the NFLP has facilitated the graduation of 764 students qualified to fill nurse faculty positions.

The NFLP also received funding under the American Recovery and Reinvestment Act (ARRA). In fiscal year 2009, these funds were used to provide additional support to 65 (included in the 149) schools of nursing to support an estimated 500 additional students for a total of 1,600 students receiving funding from regular appropriations and ARRA. In fiscal year 2010, the remaining ARRA funds will be used to make an estimated 700 additional loans.

In fiscal year 2009, 160 AEN Program grants were awarded to schools of nursing. Twenty-one of the projects focused specifically on innovative teaching and learning content to prepare nurse educators. We estimate that 160 grants will be awarded in fiscal year 2010.

Question. Using Hawaii as an example, what happens when a State is unable to pay health plans contracted to provide access to care for Medicaid beneficiaries? In

this particular case, the Governor has apparently refused to release funds necessary to draw down Federal matching funds designated for the State's Medicaid Program. Does the department have any remedies in place to mandate that the States make funds available to ensure access to care for Medicaid beneficiaries?

Answer. Our goal is to address payment issues before they impact Medicaid beneficiaries' access to care. In any case where Centers for Medicare & Medicaid Services (CMS) hears a State is contemplating a payment delay, our regional office staff work with the States to understand the impact of any delays on plans and beneficiaries and, where appropriate, to identify alternative approaches. We are aware that Hawaii is planning to delay its contractual payments to Medicaid managed care organizations (MCOs) in order to postpone payments to the next State fiscal year. The CMS is working aggressively with the State to share our concerns and ensure that the delayed payments to the MCOs do not result in the MCOs' inability to pay their network providers or otherwise impact beneficiary access.

Question. With your increased focus on prevention, it seems as though a natural partnership would be with the community health centers whose focus is on public health and prevention. Has the department explored any collaborative partnership ideas with the Centers for Disease Control and Prevention (CDC) and the CHCs?

Answer. HRSA convened a 3-day meeting with CDC in November of 2009 to explore opportunities for continued collaboration. HRSA has been working closely with CDC on the HHS Healthy Weight Initiative as well as the Tobacco Prevention and Control Initiative. Additionally, HRSA is partnering with CDC on improving HIV screening and testing within health centers.

Question. In regards to partnerships, rural areas in States like Hawaii and Alaska may have community health centers and/or an Indian Health Service (in Alaska) or Tribal Health facility. What, if any, type of collaboration has taken place in ensuring rural residents receive healthcare closest to home?

Answer. HHS works with each health center organization to identify the need for primary care services for the underserved and vulnerable populations in their respective service areas. HHS encourages health centers to identify additional existing primary care providers in the area, and to collaborate with them so that the target populations receive appropriate levels of care for their needs. Nationally, there are 7 jointly funded CHC and Urban Indian Health Clinics. In addition, 19 tribal entities currently receive section 330 health center funding to provide care within their communities.

Question. On November 21, 1989, section 218 of Public Law 101–166 stated that the NIH building No. 36 is hereby named the Lowell P. Weicker Building and on May 30, 1991, the NIH dedicated building 36 to Governor Weicker. During NIH campus renovations, the Weicker building was destroyed to make room for a Neuroscience Research Center. Has the NIH given any consideration to preserving the honorable recognition of Governor Lowell P. Weicker?

Answer. NIH is currently reviewing the status of existing facilities on our campus, including the naming of buildings. However, naming another building for Senator Weicker, or any individual, requires congressional action.

QUESTIONS SUBMITTED BY SENATOR PATTY MURRAY

WORKFORCE/SUSTAINABLE GROWTH RATE (SGR)

Question. I was glad to hear you talk about the need to support and strengthen our healthcare workforce. I know how important it is to ensure that our workforce needs are met. As we work to ensure quality, affordable healthcare coverage for all Americans, we must make sure there are enough qualified professionals to provide that care. This is why I led the charge to write a strong workforce title in the HELP healthcare reform bill. I was also glad to hear in your testimony particular focus on ensuring that America's senior population gets the care and treatment it needs. And one of the greatest barriers to that is the unfair and inequitable way that Medicare reimburses doctors and providers using the deeply flawed SGR formula. I have heard from so many doctors across my home State of Washington who have had to re-evaluate their ability to treat Medicare patients. Some have decided to turn away new Medicare patients, while others have been forced to drop them all together. We need to do something about this. The President's budget includes $371 billion over 10 years to address physician payments. The budget seems to assume that Congress will pass a serious of short-term patches rather than a single permanent fix, and it reflects zero growth in the fee schedule. But short-term solutions aren't enough. Without a more equitable and accurate system of reimbursement, doctors will continue to worry about being paid for doing their job, and seniors will find it harder

and harder to access the care they need. This is especially true in areas like my home State of Washington where doctors and hospitals are penalized for treating patients efficiently and well. So my questions are: What is the administration's policy on a long-term fix to the SGR?

Answer. The administration supports comprehensive, but fiscally responsible reforms to the physician payment formula. We also believe that Medicare and the country need to move toward a system in which doctors face incentives for providing high-quality care rather than simply "more" care—a principle reflected in the Affordable Care Act's (ACA) payment and delivery reforms.

I look forward to working with you and your colleagues in Congress to reform Medicare's payment methodology for physicians' services to address these concerns in a sustainable and responsible manner.

Question. Why was a long-term solution for this problem not addressed in the President's fiscal year 2011 budget?

Answer. The President's fiscal year 2011 budget request reflected the likely cost of providing zero percent annual payment updates for physicians—an honest budgeting approach to reflect the expected cost of truly addressing this policy. To that end, the fiscal year 2011 budget includes an adjustment totaling $371 billion over 10 years (fiscal year 2011–fiscal year 2020) to reflect the administration's best estimate of future congressional action, based on Congress' repeated interventions on scheduled physician payment reductions in recent years. However, this adjustment does not signal a specific administration policy. Rather, the administration intends to continue to work with Congress to jointly develop a long-term solution to the physician reimbursement formula.

TITLE X

Question. I was pleased to hear you mention in your testimony the investment the President's budget makes in science-based teen-pregnancy prevention initiatives. Another proven program that helps prevent unintended pregnancies is the title X program, which is the only Federal program exclusively dedicated to family planning and reproductive-health services. Publicly funded family-planning services have helped reduce the rates of unintended pregnancy and abortion in the United States, and in fact, the Centers for Disease Control and Prevention (CDC) has included family planning on its list of the top 10 most valuable public-health achievements of the 20th century. I was pleased to see that the President's budget again calls for an increase in title X funding. Do you agree that, in order to reduce the need for abortion, we must invest in valuable family planning services?

Answer. Yes, publicly funded family planning services provided under the title X program play an important role in preventing teen and unintended pregnancy. During 2008, family planning services were provided through title X-funded clinics to more than 5 million individuals, 24 percent of whom were under the age of 20. It is estimated that the contraceptive services provided through the title X family planning program helped to prevent almost 1 million unintended pregnancies during 2008.

TEEN-PREGNANCY PREVENTION INITIATIVES

Question. Last year's fiscal year 2010 omnibus eliminated funding for rigid abstinence-only-until-marriage programs, which by law were required to have nonmarital abstinence promotion as their "exclusive purpose" and were prohibited from discussing the benefits of contraception. In sharp contrast, the new approach—championed by this subcommittee—will focus on programs that have demonstrated their effectiveness, and all funded programs will be required to be age appropriate and medically accurate. The next step is for administration officials to draft the more detailed rules and regulations to determine which specific programs get funded. When is the Office of Adolescent Health (OAH) expected to release its request for proposals and how will it determine which programs are eligible for funding under this new initiative? How do you anticipate distributing the funds?

Answer. OAH has released three Funding Opportunity Announcements (FOA). The "Tier 1" FOA for replicating programs that have proven effective through rigorous evaluation was released on April 2, 2010. Applicants may apply in 1 of 4 funding ranges:

—*Range A.*—$400,000 to $600,000 per year
—*Range B.*—$600,000 to $1,000,000 per year
—*Range C.*—$1,000,000 to $1,500,000 per year
—*Range D.*—$1,500,000 to $4,000,000 per year

The "Tier 2" FOA for innovative approaches to teen pregnancy prevention was released on April 9, 2010, in conjunction with the Administration for Children and

Families (ACF) Personal Responsibility Education Program funds reserved for innovative youth pregnancy prevention strategies. Applicants may apply in 1 of 2 funding ranges:

—*Range A.*—$400,000 to $600,000 per year

—*Range B.*—$600,000 to $1,000,000 per year

A third FOA, which will also use Tier 2 funds in collaboration with CDC, provides funds for demonstrating the effectiveness of multi-component, community-wide approaches to teenage pregnancy prevention; was released on May 4, 2010. Applicants may apply in 1 of 2 funding ranges:

—*Range A.*—$750,000 to $1,500,000 per year

—*Range B.*—$300,000 to $700,000 per year

All three FOA's will be subject to a competitive peer-review process.

Under a contract with the Department of Health and Human Services (HHS), Mathematical Policy Research (MPR) conducted an independent, systematic review of the evidence base. This review defined the criteria for the quality of an evaluation study and the strength of evidence for a particular intervention. Based on these criteria, HHS has defined a set of rigorous standards an evaluation must meet for a program to be considered effective and therefore eligible for funding under this announcement.

Applicants were requested to review the list of evidence-based curriculum and youth development programs which HHS identified as having met these standards. A summary listing of these interventions was published in appendix A of the FOA. Program models listed in appendix A are eligible for replication under this funding announcement. Applicants that wish to replicate a program that is not on the list in Appendix A, may apply to do so, but a set of stringent criteria, described below, must be met.

More detailed information about the review process and the programs eligible for replication is available at: http://www.hhs.gov/ophs/oah.

If an applicant wants to apply to replicate a program model that is not on the list in appendix A, all of the following criteria must be met to qualify for funding under this FOA:

—The research or evaluation of the program model that the applicant seeks to replicate was not previously reviewed.

—There is research on or evaluations of the program model that meet the screening and evidence criteria used for the review of the other program models.

—The application must include all relevant research and evaluation information.

—The application must be submitted by May 17, 2010 to provide for the time that will be needed to review the evidence submitted.

Tier 1 final award decisions will be made by the Director of the OAH. Tier 2 final award decisions will be made collaboratively by the Director of OAH and the Commissioner of ACYF. In making decisions, the Director and the Commissioner will take into account the score and rank order given by the Objective Review Committee, and other considerations as follows:

The availability of funds.

—Representation of evidence-based teenage pregnancy prevention programs across communities, including varied types of interventions and evidence-based strategies.

—Geographic distribution nationwide.

—Inclusion of communities of varying sizes, including rural, suburban, and urban communities.

—Feasibility of evaluation plan (for applications in Tier 1 Ranges C and D and Tier 2).

—Inclusion of a range of populations disproportionately affected by teenage pregnancy.

Question. In determining which programs or group of programs are (or are not) effective, both the quality of a study and the magnitude of a program's impact are crucial. A large body of evidence shows that more comprehensive approaches—those that encourage abstinence, but also contraceptive use for young people who are having sex—can be effective. But rigid, moralistic, abstinence-only-until-marriage programs of the type promoted under previous Federal policy have been found in study after study not to be effective. How will the administration define a program as effective or promising?

Answer. Under a contract with HHS, MPR conducted an independent systematic review of the evidence base for programs to prevent teen pregnancy. This review defined the criteria for the quality of an evaluation study and the strength of evidence for a particular intervention. Based on these criteria, HHS has defined a set of rigorous standards an evaluation must meet in order for a program to be considered effective and therefore eligible for funding as an evidence-based program under Tier

1 of the new teenage pregnancy prevention program. The MPR review had four steps:

—*Find Potentially Relevant Studies*.—Studies were identified by a review of reference lists from earlier research syntheses, a public call for studies to solicit new and unpublished research, a search of relevant research and policy organizations' Web sites, and keyword searches of electronic databases. Nearly 1,000 potentially relevant studies were identified.

—*Screen Studies To Review*.—To be eligible for review, a study had to examine the effects of an intervention using quantitative data and statistical analysis. It had to estimate program impacts on a relevant outcome-sexual activity (for example, delayed sexual initiation), contraceptive use, sexually transmitted infections (STIs), pregnancy, or births. The study had to focus on United States youth ages 19 or younger and have been conducted or published since 1989. A total of 199 studies met these screening criteria.

—*Assess Quality of Studies*.—Impact studies that met the screening criteria were reviewed by trained MPR staff and assigned a rating of high, moderate, or low based on the rigorous and thorough execution of their research designs. The high rating was reserved for random assignment studies with low attrition of sample members and no sample reassignment. The moderate rating was given to quasi-experimental designs with well-matched comparison groups at baseline, and to certain random assignment studies that did not meet all the criteria for the high rating.

—*Assess Evidence of Effectiveness*.—A framework was developed for grouping programs into different evidence categories, based on the impact findings of studies meeting the criteria for a high or moderate rating. HHS then defined which of these categories would be eligible for funding. To qualify for funding, a program had to be supported by at least one high- or moderate-rated impact study showing a positive, statistically significant impact on at least one priority outcome (sexual activity, contraceptive use, STIs, pregnancy, or births), for either the full study sample or key subgroup (defined by gender or baseline sexual experience).

In total, 28 programs met the funding criteria, reflecting a range of program models and target populations. Of those programs, 20 had evidence of impacts on sexual activity (for example, sexual initiation, number of partners, or frequency of sexual activity), 9 on contraceptive use, 4 on STIs, and 5 on pregnancy or births.

Question. As the President's principal advisor on health-related matters, how do you plan to work with the President to promote responsible sex education for young people?

Answer. I have made reducing teen and unintended pregnancies one of my areas for key interagency collaborations at HHS. I have identified the several strategies to reduce teen and unintended pregnancy that are comprehensive in nature, cross organizational boundaries, and focus on the evidence of what works both in the public health and social services arenas.

In addressing these strategies, HHS will draw upon the expertise of the public health and human services parts of HHS, including the ACF, the Office of the Assistant Secretary for Planning and Evaluation (ASPE), the CDC, the Health Resources and Services Administration (HRSA), the National Institutes of Health (NIH), the newly created OAH and the Office of Population Affairs (OPA) within the Office of Public Health and Science. Key among the strategies are:

—*Invest in Evidence-based Teen Pregnancy Reduction Strategies and Continue To Develop the Evidence-based Practice*.—HHS will employ a comprehensive, evidence-based approach to reducing teen pregnancy. Under the newly funded Teen Pregnancy Prevention Program, HHS will fund the replication of models that have been rigorously evaluated and shown to be effective at reducing teen pregnancy or other behavioral risk factors as well as research and demonstration projects designed to test innovative strategies to prevent teen pregnancy. By conducting high-quality evaluations of both types of approaches—those replicating evidence-based models and innovative strategies—this initiative will expand the evidence base and uncover new ways to address this issue. Additional funding made available under the ACA will provide formula grants to States to fund evidence based models and test new strategies as well. ACF, ASPE, CDC, OAH, and OPA will each play a critical role in these efforts.

—*Target Populations at Highest Risk for Teen Pregnancy*.—HHS efforts will focus on demographic groups that have the highest teen pregnancy rates, including Hispanic, African-American, and American Indian youth, and target services to high-risk, vulnerable and culturally under-represented youth populations, including youth in foster care, runaway and homeless youth, youth with HIV/AIDS, youth living in areas with high teen birth rates, delinquent youth, and youth who are disconnected from usual service delivery systems.

SEXUALLY TRANSMITTED DISEASES (STDS) PREVENTION IN TEENS

Question. Unintended teen pregnancy is not the only negative sexual health outcome facing America's young people. One young person every hour is infected with HIV and young people ages 15–25 contract about one-half of the 19 million STDs annually, even though they make up only one-quarter of the sexually active population. By focusing the funding only on teen pregnancy prevention, and not including the equally important health issues of STDs and HIV, it seems that an opportunity has been missed to provide true, comprehensive sex education that promotes healthy behaviors and relationships for all young people, including lesbian, gay, bisexual, and transgender youth. So many negative health outcomes are inter-related and educators on the ground know that they best serve young people when they address the inter-related health needs of young people. What is the administration's position on making this a comprehensive prevention initiative that addresses the inter-related health needs of adolescents, including unintended pregnancy, STD, and HIV prevention?

Answer. As the review of the evidence revealed, 28 programs met the funding criteria, reflecting a range of program models and target populations. And these results also support the inter-relatedness of health needs of adolescents. Of those 28 programs, 20 had evidence of impacts on sexual activity (for example, sexual initiation, number of partners, or frequency of sexual activity), 9 on contraceptive use, 4 on STIs, and 5 on pregnancy or births.

Addressing the health needs of adolescents is very important to me. Specifically, I have made reducing teen and unintended pregnancy and supporting the National HIV/AIDS strategy two of my key areas for interagency collaborations at HHS. (As well as a strategic initiative to prevent and reduce tobacco use that includes national campaigns to prevent and reduce youth tobacco use.) I have identified the following set of strategies to reduce teen and unintended pregnancy.

In addressing these strategies, HHS will draw upon the expertise of the public health and human services parts of the Department, including the ACF, ASPE, CDC, HRSA, NIH, the newly created OAH, and OPA within the Office of Public Health and Science.

—*Invest in Evidence-based Teen Pregnancy Reduction Strategies and Continue To Develop the Evidence-based Practice*.—HHS will employ a comprehensive, evidence-based approach to reducing teen pregnancy. Under the newly funded Teen Pregnancy Prevention Program, HHS will fund the replication of models that have been rigorously evaluated and shown to be effective at reducing teen pregnancy or other behavioral risk factors as well as research and demonstration projects designed to test innovative strategies to prevent teen pregnancy. By conducting high-quality evaluations of both types of approaches—those replicating evidence-based models and innovative strategies—this initiative will expand the evidence base and uncover new ways to address this issue. Additional funding made available under the ACA will provide formula grants to States to fund evidence based models and test new strategies as well. ACF, ASPE, CDC, OAH, and OPA will each play a critical role in these efforts.

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—*Increase Access to Clinical Services*—HHS will ensure access to a broad range of family planning and related preventive health services, including patient education and counseling; STI and HIV prevention education, testing, and referral. Services can be provided through community health centers, title X family planning clinics, and public programs. HHS-funded health services under the title X family planning program will encourage family participation in the decision of minors to seek family planning services and provide counseling to minors on ways to resist attempts to coerce them into engaging in sexual activity.

ANTIMICROBIAL RESISTANCE

Question. The World Health Organization (WHO) has identified antimicrobial resistance as one of the three greatest threats to human health. Two recent reports demonstrate that there are few candidate drugs in the pipeline to treat infections due to highly drug-resistant bacteria. One of these reports, for example, found only 15 antibacterial drugs in the development pipeline, with only 5 having progressed to clinical trials to confirm clinical efficacy (phase III or later). Are there any plans

to create a seamless approach to the research and development of new antibacterial drugs, particularly those designed to combat gram-negative infections, to ease the transition across the spectrum of enterprise from basic research to product development and procurement? What other actions can NIH/National Institute of Allergy and Infectious Diseases (NIAID) take to ensure that these needed new antibacterial drugs become available as soon as possible?

Answer. The NIAID conducts and supports basic research to identify new antimicrobial targets and translational research to apply this information to the development of therapeutics; to advance the development of new and improved diagnostic tools for infections; and to create safe and effective vaccines to control infectious diseases and thereby limit the need for antimicrobial drugs.

NIAID provides a broad array of pre-clinical and clinical research resources and services to researchers in academia and industry designed to facilitate the movement of a product from bench to bedside. By providing these critical services to the research community, NIAID can help to bridge gaps in the product development pipeline and lower the financial risks incurred by industry to develop novel antimicrobials. NIAID is attuned to the need for antimicrobials for Gram-negative bacteria and is working with several biotechnology companies and pharmaceutical companies to develop novel agents. NIAID also is conducting studies to inform the rational use of existing antimicrobial drugs or alternative therapies to help limit the development of antimicrobial resistance.

In addition, development of broad spectrum antibiotics is a key program in the portfolio of medical countermeasures that HHS' Biomedical Advanced Development Authority (BARDA) uses to address the medical consequences of biothreats like anthrax, plague, tularemia, or enhanced bacterial threats that are antibiotic resistance. BARDA's efforts focus on development of these products toward licensure and stockpiling after NIAID and industry have shown proof of principle for the antibiotic candidates. BARDA supports industry in the advanced development of new antibiotics through cost-reimbursement contracts. BARDA continues to look for new and improved ways to support development of new antibiotics to treat newly emerging bacterial pathogens with antibiotic resistance.

VACCINE-PREVENTABLE DEATHS

Question. We have been extremely successful in reducing the number of vaccine-preventable deaths in children. Unfortunately, we still have around 45,000 such deaths each year in adults. Millions of American adults go without routine and recommended vaccinations because our medical system is not set up to ensure adults receive regular preventive healthcare, which costs us about $10 billion annually in direct healthcare costs. What plans does CDC have for programs to increase the numbers of adults who receive vaccinations each year?

Answer. One area of focus of CDC's adult immunization efforts is to increase influenza vaccination rates among healthcare workers. CDC is collaborating with the Centers for Medicare and Medicaid Services to explore public reporting of influenza vaccination rates among this high risk population as a quality performance measure for healthcare institutions. CDC is also working with State immunization programs to maintain the number of providers and partnerships that were developed out of the H1N1 response, including obstetricians and gynecologists, internists, pharmacists, and school-located vaccination clinics.

QUESTIONS SUBMITTED BY SENATOR MARY L. LANDRIEU

FOSTERING CONNECTIONS TO SUCCESS AND INCREASING ADOPTIONS ACT

Question. Last year, Congress passed the Fostering Connections to Success and Increasing Adoptions Act with the intention of reforming the foster care and child welfare system. Many States have reported difficulties in implementing the provisions outlined in the bill and are looking for additional guidance from the Department of Health and Human Services (HHS). What is HHS doing to help States implement these reforms? How can we continue to provide reforms to transform the child welfare system so that it is efficient and promotes permanent placement of children in families rather than long-term foster or institutional care?

Answer. HHS is committed to ensuring the safety, permanency, and well-being of children, particularly those who are at risk of entering or are already in the child welfare system. To that end, we are working hard to implement the many reforms made through the Fostering Connections to Success and Increasing Adoptions Act.

We have issued a number of policy guidance documents and program instructions on Fostering Connections and continue to address additional questions from States

and tribes. For example, we have issued detailed guidance on how a State or tribe can take up the option of the new Title IV–E Guardianship Assistance Program and submit claims for Federal reimbursement.

HHS is also focused specifically on implementing a number of initiatives to achieve permanency in a timely manner for children so that they do not end up in long-term foster or institutional care. For example, the President's new fiscal year 2010 long-term foster care initiative is a $20 million, 5-year demonstration grant program engaging States, localities, tribes, and private organizations in implementing innovative intervention strategies aimed at reducing the number of children who stay in foster care for extended periods of time. In addition to funding services, the initiative awards grantees bonus funding for demonstrating improvement in the outcomes for children who have been in foster care for an extended period of time or who are at risk of remaining in foster care for long periods. We will conduct a rigorous national cross-site evaluation of the demonstration to determine whether this approach is successful and can be replicated. HHS also continues to work in collaboration with States to engage in program improvement efforts that reduce barriers to permanency as identified through the Child and Family Service Reviews. Further, HHS is actively engaged in raising the profile of the needs of children in need of permanency through our support for the AdoptUsKids initiative. This initiative focuses on the adoption of older youth and other children who remain in foster care for the longest periods. As of March 2010, more than 12,000 foster children previously featured on the initiative's Web site found permanent, adoptive homes.

Finally, we are providing assistance to States and tribes on Fostering Connections and permanency initiatives through a comprehensive network of training and technical assistance partners. This network includes National Resource Centers and regional Implementation Centers that focus on in-depth and long-term consultation and support to States and tribes to execute strategies to achieve sustainable, systemic change for greater safety, permanency, and well-being for families.

We look forward to working with the subcommittee on additional reforms that may achieve permanency for our Nation's most vulnerable children.

MENTAL HEALTH SERVICES

Question. Providing mental health services in the wake of a disaster and during the recovery is critical to the community, however, the system seems to be fragmented. How can we coordinate the work so that children especially can get the support that they need?

Answer. Emergency Support Function (ESF) #8 of the National Response Framework, the Federal Government's guiding principles for a unified national response to disasters and emergencies, lays out the principles for providing public health and medical services during disasters and emergencies. These services explicitly include mental and behavioral health. The Office of the Assistant Secretary for Preparedness and Response (ASPR) in its coordination role for ESF #8 actively works with ESF #8 partners to identify and address mental health needs, including those of children that are appropriate for Federal assistance. During a response, the Emergency Management Group (EMG) utilizes behavioral health subject matter experts within the ASPR Division of At-risk, Behavioral Health, and Community Resilience to provide guidance, assist with triage of State requests for assistance, and support coordination efforts as needed between the EMG, HHS Operating Divisions like the Substance Abuse and Mental Health Services Administration (SAMHSA), ESF #8 partners like the American Red Cross, and affected States' Disaster Behavioral Health Coordinators.

Additionally, in order to provide the needed mental health services and supports following a disaster and into the recovery period, the Federal Emergency Management Administration (FEMA) and SAMHSA coordinate to support State and local mental health networks through financial support, training, and technical assistance.

FEMA funds several grants targeted to areas with Presidentially declared disasters for which SAMHSA—through its Emergency Mental Health Management and Traumatic Stress Services Branch at the Center for Mental Health Services—provides technical assistance, program guidance, and oversight. Among these funding opportunities are Crisis Counseling Assistance and Training Program (CCP) grants to increase local mental health staff and provide outreach and education for States which have identified a gap in mental health resources following a disaster. CCP Immediate Services Program grants to State mental health authorities to provide up to 60 days of funding for services immediately following the declaration of a disaster, and CCP Regular Services Program grants can provide an additional 9

months of support following a disaster. Supplementary funding is also available for special circumstances.

In ongoing efforts, SAMHSA collaborates with FEMA to provide training—including annual trainings—to State mental health staff to develop crisis counseling training and preparedness plans and to encourage State-to-State information exchange. SAMHSA also maintains the Disaster Technical Assistance Center and the Disaster Behavioral Health Information Series to provide toolkits and a readily available source of information—including information specifically focused on children and adolescent mental health—to assist States, territories, and local entities in delivering effective mental healthcare during disasters.

Additionally, the National Commission on Children and Disasters (NCDD) was established to carryout a comprehensive study to examine and assess the needs of children as they relate to preparation for, response to, and recovery from disasters. Through its interim report released last October, NCDD identified gaps and shortcomings in the provision of mental health services to children in disasters and made recommendations that will be used to inform legislative and executive branch policies and programs.

In order to address the concerns of NCDD, HHS' ASPR has established a monthly meeting with the Commissioners to discuss HHS's progress. Additionally, this month, the ASPR and the Assistant Secretary for Children and Families will begin convening an HHS Working Group on Children and Disasters to facilitate communication and collaboration across the Department to improve the coordination of services for children—including mental and behavior health services—before, during, and after disasters and emergencies.

COMMUNITY HEALTH CENTERS

Question. The primary care community health centers created to fill the need after Hurricane Katrina have proved to be an extremely successful model to keep the uninsured and under-insured out of the emergency room. How can we provide ongoing support for successful programs like this?

Answer. The fiscal year 2011 President's budget request includes an increase of $290 million for the Health Center program to continue the American Recovery and Reinvestment Act investment in 127 Health Center New Access Points as well as the services initiated under the Increased Demand for Services grants to health centers nationwide. This funding level will also support the development of approximately 25 new access points, increasing access to comprehensive primary healthcare services to an estimated 150,000 additional health center patients. Additionally, this level will support an estimated 125 service expansion grants to expand the integration of behavioral health into existing primary healthcare systems, enhancing the availability and quality of addiction care at existing health centers.

HEALTHCARE REFORM

Question. What is your perspective on healthcare reform, its impact on State budgets, and the cost of healthcare for those who currently have insurance?

Answer. Health insurance reform ensures a strong Federal-State partnership and does not strain State budgets. Specifically, health insurance reform: provides new, additional funding to States to support coverage expansions; strengthens States' roles in insurance oversight, delivery system reform, and prevention; reduces Medicaid and Medicare costs; reduces State uncompensated care; ends the "hidden tax" to finance care for the uninsured; eliminates the need for most State-funded coverage programs; creates jobs, spurs the local economy and generates tax revenues; and invests in community health centers.

In terms of healthcare costs for families: In its analysis, the nonpartisan Congressional Budget Office confirmed that lower administrative costs, increased competition, and better pooling for risk will mean lower average premiums for American families:

—Americans buying comparable health plans to what they have today in the individual market would see premiums fall by 14 to 20 percent.

—Most Americans buying coverage on their own would qualify for tax credits that would reduce their premiums by an average of nearly 60 percent—even as they get better coverage than what they have today.

—Those who get coverage through their employer today will likely see a decrease in premiums as well.

—And Americans who currently struggle to find coverage today would see lower premiums because more people will be covered.

QUESTIONS SUBMITTED BY SENATOR RICHARD J. DURBIN

MEDICAID COVERAGE

Question. An article in the New York Times on March 15, 2010, entitled, "As Medicaid Payments Shrink, Patients Are Abandoned," highlighted what I have been hearing from Illinois providers for some time now. In this difficult economy, States are squeezing payments to providers in Medicaid at the same time the economy is fueling continuous growth in enrollment. As a result, patients are finding it increasingly difficult to locate doctors and dentists who will accept their Medicaid coverage. Many of the providers in Illinois tell us they cannot afford to take Medicaid patients. As a result, many delay care or forego it altogether, or end up going to hospital emergency rooms. Can you speak to the importance of provider payments in Medicaid, the impact on patient care, and any consideration the Department of Health and Human Services (HHS) has given to providing additional incentives to States to increase their payment rates?

Answer. The administration recognizes the importance of adequate Medicaid provider payment rates and is pleased that the Health Care and Education Reconciliation Act of 2010 increases Medicaid payments to primary care physicians for calendars years 2013 and 2014. As a former Governor, I understand the tough choices States have to make when facing a difficult economy. However, I also recognize that Medicaid provider payment rates can affect access to care, and therefore is an area ripe for examination. I expect the newly formed Medicaid and CHIP Payment Advisory Commission will provide helpful guidance to enable us to undertake more robust consideration of Medicaid rates so that we can ensure all Medicaid beneficiaries have access to the healthcare providers they need.

CRITICAL ACCESS HOSPITALS (CAH)

Question. CAHs are, by definition, critically important to rural communities throughout Illinois. Within CAHs, there is a heavy reliance on anesthesia services provided by certified registered nurse anesthetists (CRNA). CRNAs are the sole anesthesia providers in the vast majority of rural hospitals. Without CRNA services, many U.S. rural and CAHs would not be able to offer care. Recent rulings by the Centers for Medicare and Medicaid Services (CMS) have denied rural hospitals' claims for tens of thousands of dollars each in annual Medicare funding that they had come to rely upon to serve their communities. In addition, due to recent reclassifications of certain CAHs from rural to urban and as being located in a "Lugar" county, CMS has denied "pass-through" payment to these facilities for CRNA services. Can you advise the subcommittee on the potential for revisiting the CMS policy of denying reimbursement for on-call costs of CRNA services in the Rural Pass-through Program and the policy of denying payments to CAHs that have recently been reclassified as urban and in Lugar counties?

Answer. With respect to on-call costs of CRNA services in CAHs, section 1834(g)(5) of the Social Security Act (SSA) states that in determining the reasonable costs of outpatient CAH services, the Secretary recognizes as allowable costs amounts for "physicians, physician assistants, nurse practitioners, and clinical nurse specialists who are on-call (as defined by the Secretary) to provide emergency services but who are not present on the premises of the critical access hospital involved." The statute is explicit in allowing Medicare payment for on-call costs only of these designated practitioners and only for emergency services in CAHs. Accordingly, CMS does not have the authority to pay for on-call costs of CRNA services.

With respect to pass-through payments for CRNAs, in the fiscal year 2011 hospital inpatient prospective payment system (IPPS) proposed rule published on May 4, we are proposing to permit urban hospitals that have been classified as rural under section 1886(d)(8)(E) of the SSA to be paid on the basis of reasonable costs for anesthesia services and related care furnished by a qualified nonphysician anesthetist. We are not proposing to change our policy that would permit Lugar hospitals to be paid reasonable costs for such services. As stated in the proposed rule, Lugar facilities are considered urban under section 1886(d) of the SSA, and therefore, we do not believe it would be consistent with the statute to permit these facilities, which are not considered rural, to be paid on the basis of reasonable costs for CRNA services.

HEALTH PROFESSIONS PROGRAMS

Question. The University of Illinois at Chicago (UIC) is the largest medical school in the United States, and it houses the largest component of minority students in the country, including the largest single training center for Latino medical students and third largest for African-American students. In fact, 70 percent of the minority

physicians in Chicago and 60 percent of those in the State were trained at UIC. I commend the administration's investment in the Minority Centers of Excellence program and the Health Career Opportunity Program, increasing funding for these two programs for the first time in years. What other plans does HHS have to ensure a diverse healthcare workforce and for a robust health professions pipeline programs at Health Resources and Services Administration (HRSA) in fiscal year 2011?

Answer. The administration prioritizes increasing the diversity of the health professions workforce and views it as a key strategy for increasing access to healthcare and reducing health disparities. In fact, HHS invested $50 million of the $200 million in American Recovery and Reinvestment Act (ARRA) funds designated for workforce programs in programs that specifically focus on increasing the diversity of the workforce. More than 50 percent of students in HRSA's Bureau of Health Professions-funded training programs are from minority and/or disadvantaged backgrounds. This year HRSA engaged its stakeholders to discuss strategies for increasing the diversity of the health professions workforce and for measuring the effectiveness of these strategies. In fiscal year 2011, HRSA will continue to implement program improvements that can result in a more diverse workforce.

Question. I have noted that health professionals graduating from the minority health professions schools have a propensity to practice in medically underserved areas, many times community health centers. However, the existing Graduate Medical Education Program does little, if anything, to promote the practice of residents in underserved areas or in settings outside of the traditional hospital. What can we do to highlight this relationship and strengthen the pipeline from the minority health institutions to the community health centers with financial resources already allocated?

Answer. With a looming shortage of primary care professionals and increased attention on preventive medicine, we acknowledge the value of training more residents in nonhospital sites and it is our intent to make sure Medicare medical education rules encourage and facilitate this kind of activity.

Medicare permits hospitals to receive indirect medical education and other medical education payments for those residents training in nonhospital sites if the hospital incurs "all or substantially all the costs" of the training at those sites. The Affordable Care Act (ACA) clarifies this standard by requiring hospitals to pay stipends and benefits for trainees in nontraditional settings. The ACA also provides other avenues to encourage training in nonhospital settings, including financial support for teaching health centers, increased funding for primary care, and a 5-year, $230 million program to support the expansion of primary care residency programs in community-based teaching health centers.

Question. The workforce shortages in State and local health departments have been well-documented. The President's budget for fiscal year 2011 includes a new proposal for a Health Prevention Corps (HPC). Can you elaborate about how this proposal will help address workforce shortages in State and local health departments, and how the Centers for Disease Control and Prevention (CDC) plans to recruit a diverse work force into this field?

Answer. The fiscal year 2011 President's budget requests $10 million for the HPC, which will recruit, train, and place participants in State and local health departments to fill positions in disciplines with documented workforce shortages. While HPC participants are learning on the job, they will also provide direct service to their health department and the State or local jurisdiction, such as by participating in public health surveillance activities, supporting outbreak investigations or environmental health assessments, or identifying important biologic specimens. CDC plans to ensure diversity among the HPC participants by recruiting strategically through social networking, student associations (including minority student associations), college career counselors, student and school listservs, alumni associations, and university/college organizations.

CHILDHOOD OBESITY PREVENTION

Question. I'm very pleased to see that childhood obesity prevention has been an important priority for this administration and particularly the First Lady. CDC has invested in research and strategic partnerships to develop best practices in nutrition and physical activity. How has the CDC partnered with school systems to put this information into practice, and what additional steps could be taken in the future to ensure that this information is disseminated effectively?

Answer. CDC supports a variety of programs and activities that address childhood overweightness and obesity in school and community settings. For instance, CDC's Division of Adolescent and School Health provides funding and technical support to 22 State departments of education and one tribe to address critical health issues,

including obesity. CDC also supports school-based activities that contribute to obesity prevention and control efforts, such as promoting a systematic, data-driven approach to implementing evidence-based school health policies and programs, and developing and disseminating tools to help schools implement these practices.

In addition, communities funded through the Healthy Communities Program and the Recovery Act Communities Putting Prevention to Work Program are partnering with school district leaders and staff to address childhood obesity through nutrition and physical activity strategies. These programs aim to promote wellness and to provide positive, sustainable health change by advancing policy, systems, and environmental change approaches, with a strategic focus on obesity prevention.

COMMUNITY HEALTH CENTERS

Question. As you know, through the ARRA, we made a historic investment in our Nation's community health centers. While this investment is reaping benefits in communities across the Nation—including more than 35 health centers in Illinois, we know that there is still tremendous unmet need in health centers across the country. One demonstration of this need was in the competition for Facility Investment Program (FIP) funding available to health centers for large-scale construction projects through ARRA. Although more than 600 applications were submitted, only 85 could be approved. Those applications are still valid, and I am interested in the potential for funding these high-scoring, but unfunded applications. In addition, can you project how many jobs could be created if Congress were to provide additional funds for health center FIP funding in the range of $2 billion.

Answer. As you note, significant interest has been expressed in the Health Center Facility Investment Program that was funded through the ARRA. The ACA includes an additional $1.5 billion (for fiscal year 2011 through fiscal year 2015) for investments in health center facilities. We envision health centers that applied for ARRA funding being eligible for receipt of this funding. At this point, it is difficult to project how many jobs will be created through the expenditure of this funding.

MEDICARE SECONDARY PAYER (MSP)

Question. Recently, I have heard concerns regarding the MSP system and a beneficiary's privacy. It seems that the current system is making it very difficult for many beneficiaries to settle cases and receive their settlement funds in the same timeframe as non-Medicare beneficiaries. The MSP reporting requirements in section 111 of the Medicare and Medicaid Extension Act of 2007 gave the Secretary discretion to establish the rules governing this new reporting process. I understand that those rules require beneficiaries to provide their social security number (SSN) or Medicare health information claim numbers (HICN) number to third parties as part of this reporting process. In light of our concerns of identity theft and the fact that HHS advises beneficiaries to keep these numbers private, what can be done so that beneficiaries do not have to disclose this information?

Answer. HHS and CMS are committed to protecting the identity of Medicare beneficiaries and ensuring that they are able to access their healthcare benefits in a secure way. The HICN, also known as the Medicare number, serves as a beneficiary's identification number for Medicare entitlement. An individual may become entitled to Medicare through Social Security based on his or her own earnings or that of a spouse, parent, or child. HICNs reflect the social security number (SSN) of the individual who is entitled to Medicare, preceded or followed by a suffix that pertains to the specific beneficiary. Therefore, while in many cases a beneficiary's HICN includes their personal SSN, it is not always the case.

Since the MSP process requires CMS to re-examine all billing and payments made by Medicare on behalf of a beneficiary, it would be impossible to perform this search without using a beneficiary's Medicare number, or the HICN. However, I want to assure you that we have strong guidelines and procedures in place to ensure that beneficiaries are protected from unauthorized disclosure of their personal information.

QUESTIONS SUBMITTED BY SENATOR JACK REED

LOW INCOME HOME ASSISTANCE PROGRAM (LIHEAP)

Question. I am deeply concerned about the proposed $2 billion cut in the LIHEAP block grant, which represents a $13.6 million reduction in funding for the State of Rhode Island. While the budget proposal calls for the creation of a so-called mandatory "trigger" fund to make up the difference, there is no certainty that the gap in

the block grant will be filled for each State. Is it a certainty that the mandatory fund will be triggered in fiscal year 2011?

Answer. Under current economic estimates, substantial mandatory funding will be triggered in fiscal year 2011 under the administration's legislative proposal. We estimate that $2 billion will be released, bringing total LIHEAP funding to $5.3 billion, an increase of $200 million above fiscal year 2010.

Question. If the mandatory fund is triggered, how can States be assured that they will not see a cut from the level of funding they received in fiscal year 2010 in the absence of any kind of funding formula?

Answer. Under our legislative proposal, the administration would determine a State allocation of triggered mandatory funds. A funding formula was not proposed because we believe having discretion over State allocations provides flexibility necessary to respond to the unique aspects of each heating or cooling season. Since we expect substantial funds to be triggered by an overall increase in the percentage of households receiving Supplemental Nutrition Assistance (SNAP) we would expect that States where SNAP usage has increased the most would see increased funding compared to fiscal year 2010. The discretion provided by the proposal would allow us to address unique circumstances. For example, if two States had the same increase in SNAP usage, the one experiencing severe weather could receive additional funds.

Question. How are States supposed to plan their programs without a clear sense of how much funding they will receive? Why is it not simpler and more predictable to fully fund the block grant?

Answer. Since LIHEAP funding is currently subject to an annual appropriation, States must currently plan their programs without knowing how much discretionary funding they will receive. LIHEAP appropriations are frequently not enacted until mid-winter, several months after States begin their heating programs. Under our legislative proposal, however, most mandatory funding would be allocated to the States at the beginning of the Federal fiscal year, as they start their heating programs.

Question. In the out-years, the budget shows a significant decline in funding that will be released under the trigger. Given the administration's commitment to capping nonsecurity discretionary spending and the reduced baseline established for the block grant in this budget (again, $2 billion less than fiscal year 2009 and 2010), it will be difficult to make up for the shortfall that will occur on the mandatory side. Indeed, it appears that this proposal would lock-in a cut to overall LIHEAP funding in future years. How does the administration plan to ensure that the program does not experience such a cut? Will you propose increased funding for the block grant in future years?

Answer. The administration believes that the $5.3 billion requested for LIHEAP is appropriate given the circumstances predicted for fiscal year 2011. These circumstances include a significant increase in energy prices and a 48 percent increase in the proportion of U.S. households receiving SNAP. After fiscal year 2011, current predictions show more stable energy prices and significant decreases in the proportion of households receiving SNAP. Based on these predictions, the amount of mandatory funding that we would project to be released by the trigger proposal also declines significantly. Should energy prices increase rapidly, and/or SNAP participation remain high, the trigger would automatically provide a higher level of mandatory funds. While current economic estimates show declining mandatory funding after fiscal year 2011, the trigger proposal ensures that the amount of mandatory LIHEAP funding will be higher automatically if there is an increase in need

VACCINATIONS—SECTION 317 IMMUNIZATION PROGRAM

Question. In 2009, the Centers for Disease Control and Prevention (CDC) submitted a report to Congress which illustrated that the section 317 immunization program requires additional funding to carry out its essential public health mission of protecting Americans from preventable diseases. I am pleased that the American recovery and Reinvestment Act (ARRA) began to address this funding need. For the first time, entire families in some States received the Tetanus-Diphtheria-Pertussis vaccine. In other States, children were able to receive their annual influenza vaccine in their school, which helped keep children in the classroom, not sick at home. With the success that we have seen over the past year, how did you reach the decision to not maintain this enhanced funding level in the proposed fiscal year 2011 budget?

Answer. The support that the ARRA provided to CDC's section 317 Immunization Program was one-time funding. The fiscal year 2011 President's budget requests $579 million, which is +$17 million above fiscal year 2010. CDC will continue support for the purchase of vaccine and for State immunization infrastructure and oper-

ations so that public health departments can provide vaccine underinsured and uninsured children and adults. With these efforts, CDC plans to keep childhood immunization rates at record high levels in the United States.

HEALTHCARE WORKER VACCINATION

Question. Healthcare workers are in direct contact with individuals who are often highly susceptible to contracting other diseases and conditions. As such, ensuring that health workers, not just patients, receive vaccinations are not just a matter of wellness, but also patient safety. Unfortunately, we know from a recent reports that only 40 percent of health workers nationwide, for example, receive annual flu vaccinations. Recognizing that this was a problem, hospitals in my State of Rhode Island are required to report flu vaccination rates of health workers to the Department of Health. Individual health workers actually accept or decline (for a specified reason) their vaccine at their place of employment, which has increased the rate of vaccination in just the past few years. What could be done at the national level to increase vaccination rates among healthcare workers?

Answer. Mandatory healthcare personnel influenza vaccination requirements and public reporting of healthcare personnel influenza vaccination status has been used to increase coverage rates at the healthcare institution and State-levels. CDC is currently working with Centers for Medicare and Medicaid Services (CMS) to assess the effectiveness and feasibility of establishing a mechanism for public reporting of influenza vaccination coverage among healthcare personnel by making this a national quality performance measure for healthcare institutions.

TITLE VII HEALTH PROFESSIONS FUNDING

Question. We know that a strong healthcare workforce will help to meet the healthcare needs of patients around the country. And, as we work to pass health reform legislation, we know that the number of new individuals who will, for the first time, have access to primary care doctors will create even greater strain on the system. For this reason, I was pleased that the ARRA provided an additional $200 million to train a new generation of healthcare workers. This investment will also make a significant economic impact. In 2008, medical schools and teaching hospitals had a combined $512 billion impact on the national economy. And each trained and practicing primary care doctor, for example, has a $1.5 million impact on the economy. How will you work to prioritize funding increases that directly impact job creation and economic recovery?

Answer. Health Resources and Services Administration (HRSA) is coordinating with the Department of Labor (DOL) to ensure investments in health workforce are complimentary, reduce shortages in health professions, and provide economic opportunities. HRSA and DOL will soon submit to the Congress a joint strategic plan for how they will invest their resources in fiscal year 2010 and beyond. One key area of emphasis is building career ladders in the healthcare sector. Career ladder programs allow individuals to expand their skills and increase their income. In fiscal year 2010, Congress appropriated funds for HRSA to implement an initiative to improve training for nursing aides and home health aides. This initiative will generate more economic opportunities for individuals who pursue these careers. According to Bureau of Labor statistics, these two occupations are among the fastest growing.

THE HEMOPHILIA PROGRAM (CDC)

Question. The President's budget for fiscal year 2011 proposes to eliminate CDC's Blood Disorders Division and establishes a new program described as "a public health approach to blood disorders." The explanation provides few details on what existing activities will be maintained or changed and what new activities will be initiated. Can you provide a detailed explanation of CDC's new approach, with a particular emphasis on how it will impact the cost-effective research, treatment, and surveillance conducted under the Hemophilia Program, as well as a description of how the $20.4 million will be spent?

Answer. The fiscal year 2011 President's budget requests $20 million for a program that realigns CDC's Blood Disorders Division to address the public health challenges associated with blood disorders and related secondary conditions. Rather than fund a disease-specific program for specific categories of blood disorders, the new program uses a comprehensive and coordinated agenda to prioritize population-based programs targeting the most prevalent blood disorders. This public health approach will impact as many as 4 million people suffering with a blood disorder in the United States versus approximately 20,000 under the current programmatic model. In fiscal year 2011, CDC plans to focus on the following three areas of greatest burden and unmet need: deep vein thrombosis and pulmonary embolism,

hemoglobinopathies (such as sickle cell disease and thalassemia), and bleeding disorders. CDC has a long and robust history of partnership with a national network of 135 hemophilia treatment centers that has a documented history of improved health outcomes for hemophilia patients. CDC plans to continue this national network for the hemophilia population as well as those suffering from the most prevalent blood disorders.

OCEAN STATE CROHN'S AND COLITIS AREA REGISTRY

Question. The President's budget eliminates a very successful program at the CDC focused on Crohn's disease and ulcerative colitis—painful and debilitating diseases. The CDC program supports much-needed epidemiology research on these disorders which has been conducted exclusively in Rhode Island through the Crohn's and Colitis Foundation of America (CCFA). A substantial Federal investment has already been made in connecting more than 22 physicians groups and hospitals in Rhode Island that are engaged in the research. And CDC Director and Administrator Dr. Frieden wrote in a recent letter that, "[w]e have been pleased with the success of our collaboration with CCFA" and "the registry is meeting its aim to gain insight into the etiology of IBD, to learn why the course of illness varies among individuals, and determine what factors may improve outcomes." If these statements are accurate, what is the rationale for eliminating this successful program and how can we work together to ensure that existing efforts are maintained with adequate Federal funding?

Answer. For fiscal year 2011, the President's budget does not continue the specific $686,000 provided in fiscal year 2010 for Inflammatory Bowel Disease (IBD) as the request seeks to eliminate duplicative programs that take narrow, disease-specific approaches rather than a broader public health approach. CDC will continue to provide technical assistance to partners who are researching the natural history of IBD and factors that predict the course of the disease. This research includes studies examining provider variation in the treatment of Crohn's disease, disparities in mortality for IBD patients, disparities in surveillance for colorectal cancer associated with this disease, and variation in outcomes in relation to race.

QUESTION SUBMITTED BY SENATOR MARK PRYOR

ABSTINENCE

Question. The Consolidated Appropriations Act, 2010, established a funding stream for a new Teen Pregnancy Prevention Program. The Conference Report included language providing $110,000,000 for a new teenage pregnancy prevention initiative. The Conference Report underscored the value of abstinence: "The conferees intend that programs funded under this initiative will stress the value of abstinence and provide age-appropriate information to youth that is scientifically and medically accurate." It is my understanding that Arkansas and other States' programs dedicated to abstinence education would likely be able to apply for funds from a $25 million pool of research and development grant program funding, but no guarantee exists that these programs would receive continued funding and they could be eliminated.

Answer. Twenty-eight different programs met the funding criteria, reflecting a range of program models and target populations, some included abstinence components. States such as Arkansas may select one of these models and apply under tier 1 or may apply under the tier 2 innovative approaches pool from either the Teen Pregnancy Prevention funds in OS or the Personal Responsibility Education Program (PREP) innovative strategies funds in ACF. Additionally, the department of Health and Human Services is still determining the funding process for the PREP evidence-based replication programs which totals approximately $55 million and is designed to educate adolescents on a number of personal responsibility areas including abstinence. In addition, the Patient Protection and Affordable Care Act includes $50 million in annual mandatory funding for States to provide abstinence education, which may be a source of support for these programs.

QUESTIONS SUBMITTED BY SENATOR ARLEN SPECTER

AMERICAN RECOVERY AND REINVESTMENT ACT (ARRA)

Question. Madam Secretary, the Department Health and Human Services (HHS) fiscal year 2011 budget presented provides an increase of $1 billion. While this would appear to be a satisfactory amount, when taking into account the stimulus

funding provided for the National Institutes of Health (NIH) which will be coming to an end this year, the reduction is catastrophic. The stimulus funds have brought a resurgence of scientists to labs to find cures to the greatest maladies of our times. Given the need to continue this funding please explain HHS's thinking behind this $1 billion increase.

Answer. The fiscal year 2011 budget request does not fully continue the one-time ARRA funding expected to be obligated in fiscal year 2010. NIH planned for most of the research supported by the ARRA to be completed in 1 or 2 years, or to supplement and accelerate ongoing research. However, NIH does plan to use part of its $1 billion budgeted increase in fiscal year 2011 to continue specific initiatives begun or expanded with ARRA funds. Examples of such projects being continued with fiscal year 2011 funds include using The Cancer Genome Atlas to catalog all of the reasons why normal cells become malignant; shortening the time it takes to develop and test new cancer treatments through the Accelerating Clinical Trials of Novel Oncologic Pathways Program; sequencing candidate genes to identify genetic contributors to autism spectrum disorder; and strengthening the NIH Basic Behavioral and Social Sciences Opportunity Network initiative.

Question. Last year, President Obama signed an executive order to expand the number of embryonic stem cell lines that are eligible for Federal funding. Last year $143 million (including ARRA funds) was spent on human embryonic research by the NIH. Do you believe that funding level was sufficient and what we can expect for fiscal year 2011?

Answer. Funding levels have not been the limiting factor in the support of human embryonic research. The major limitations have been the restrictions on the number of stem cell lines available for research and the quantity of applications submitted. President Obama's Executive Order 13505 of March 9, 2009, removing previous Federal restrictions, and NIH's new stem cell research guidelines of July 7, 2009, implementing the Executive Order has gone a long way in addressing these past limitations. Currently, NIH has formally approved 64 human embryonic stem cell lines to be eligible for Federal research support. NIH estimates it will spend at least $126 million in fiscal year 2011 on human embryonic stem cell research, an increase of $38 million, or 43 percent, more than fiscal year 2008 levels.

I would also mention that on February 26, 2010, NIH announced a new initiative to use its Common Fund resources beginning in fiscal year 2010 to establish an intramural Induced Pluripotent Stem Cell Center to drive the translation of scientific knowledge about stem cell biology into new cell-based treatments. The capability of transforming human skin fibroblasts and other cells into induced pluripotent stem cells could lead to major advances in therapeutic replacement of damaged or abnormal tissue without risk of transplant rejection.

With this opening up of Federal support for human embryonic stem cells, and with the development of induced pluripotent stem cells, researchers will have an unprecedented opportunity in fiscal years 2010 and 2011 to understand the earliest stages of human development, and to explore powerful new therapeutic approaches to Parkinson's disease, type 1 diabetes, spinal cord injury, and a long list of rare genetic diseases.

MEDICARE PART D

Question. Prior to Medicare Part D, when Medicaid was the primary payer of medications in long-term care, pharmacies were required to provide a credit for unused medication in most States. As a result, pharmacies looked for ways to reduce or reuse the medications, which helped curb the amount of waste. However, since the inception of Medicare Part D, which has no mechanism to provide a credit for unused medication, waste has grown significantly, costing taxpayers billions and contaminating our water supplies. Because of the current reimbursement system in Part D, long-term care pharmacies have no incentive to reduce medication waste. Is medication waste in long-term care something the agency is paying attention to and what steps can the agency take to eliminate this waste? Are you considering any incentives, such as higher dispensing fees for long-term care pharmacies and/or technology and research grants?

Answer. Thank you for the question Senator Specter. Centers for Medicare and Medicaid Services (CMS) shares your concern regarding the wasteful dispensing of prescription drugs in long-term care settings. We have been addressing medication waste concerns as we work toward implementing the provision in the Affordable Care Act (ACA) which we worked on with Congress to ensure that prescription drugs are dispensed with a higher degree of efficiency. The ACA requires part D plans to implement waste reduction techniques beginning with the 2012 plan year. We are in the process of consulting with key stakeholders such as pharmacists,

nursing homes, and plans as we develop utilization management techniques that will reduce the waste associated with the dispensing of 30-day refills in long-term care settings.

BIOPRODUCTION FACILITY

Question. On May 20, 2009, we met to discuss the establishment of a facility to develop and manufacture biologics. Since that time we have seen the production of H1N1 vaccine fall woefully short, missing the delivery date for vaccines by months. A public/private manufacturing and development facility would help ensure access to vaccines and other medical countermeasures for Americans. I have worked with Biomedical Advanced Research and Development Authority (BARDA) to move this project forward and they have indicated their support. Could you explain why funding for this important project was not included in your budget?

Answer. HHS is currently conducting a review of medical countermeasure (MCM) development, which will examine domestic manufacturing capacity for pandemic influenza vaccines and other MCMs. HHS is also working with the Department of Defense in order to coordinate countermeasure facility needs.

The fiscal year 2010 budget for BARDA includes $5 million to support the initial planning phase of core services (formerly called bioproduction facilities). HHS plans to solicit proposals and award contracts to support architectural and mechanical engineering concept design for potential facilities. The goal will be to evaluate the potential of strategic partnerships between the Federal Government, major biopharmaceutical companies, and smaller biotech companies to create domestic-based, flexible, multi-product manufacturing facilities focused on providing countermeasure services. Priority services would include the advanced development and manufacturing of biological medical countermeasures with limited or no commercial markets.

ANTHRAX VACCINE

Question. It is my understanding that the Department has a requirement and need to contract for additional doses of the Food and Drug Administration (FDA) licensed anthrax vaccine because the number of the doses in the Strategic National Stockpile currently are well below the total needed to meet HHS's 75 million anthrax vaccine dose requirement and the shelf-life dates for using the earlier stockpiled anthrax vaccine doses have expired and others will continue to expire. It is also my understanding that with the termination of an earlier contract and delays in the development of new experimental anthrax vaccines, HHS now estimates that it will take at least 8 years before potential development and FDA licensure of new anthrax vaccines. Given that many Government and other experts are saying that the number one WMD threat is anthrax and there is a continuing need for protecting first responders and citizens from another potential anthrax attack with both vaccines and drugs, what are your plans and timing for contracting for additional doses of the current FDA licensed vaccine to replenish the stockpile and move toward meeting the 75 million dose stockpile requirement?

Answer. The medical countermeasure review will propose enhancements to the countermeasure production process, addressing promising discoveries, advanced development, robust manufacturing, including for MCMs for anthrax threats.

The Centers for Disease Control and Prevention (CDC) currently has a contract in place with Emergent for procurement of additional 14.5 million doses of FDA-licensed anthrax vaccine in order to move toward meeting the 75 million dose stockpile requirement, and is receiving the full production capacity of this vaccine.

BARDA terminated on December 7, 2009 a solicitation under Project BioShield RFP for rPA anthrax vaccine after multiple technical evaluation panels determined that none of the proposal from Offerors were able to meet the maximum statutory requirement of reaching FDA licensure within 8 years. On the same day, BARDA issued special instructions under their broad agency announcement to support advanced development of next generation anthrax vaccines including rPA vaccine candidates. Proposals were received, reviewed, and are currently under contract negotiations with an expectation to issue contract awards in fiscal year 2010.

Question. Given the delays and uncertainties with the development, procurement, manufacture, and availability associated with vaccines in general and most recently for the pandemic vaccine, would it not be prudent now for HHS to enter into negotiations as early as possible for procurement of a multi-year supply of the anthrax vaccine for the stockpile to assure that we are better prepared to respond to an anthrax attack or multiple attacks?

Answer. CDC currently has a contract, with a multi-year contracting mechanism to ensure preparedness, in place with Emergent for procurement of additional 14.5

million doses of FDA-licensed anthrax vaccine in order to move toward meeting the 75 million dose stockpile requirement, and is receiving the full production capacity of this vaccine.

SUBCOMMITTEE RECESS

Senator HARKIN. Same here. The subcommittee will stand recessed. Thank you, Madam.

[Whereupon, at 3:58 p.m., Wednesday, March 10, the subcommittee was recessed, to reconvene subject to the call of the Chair.]

DEPARTMENTS OF LABOR, HEALTH AND HUMAN SERVICES, AND EDUCATION, AND RELATED AGENCIES APPROPRIATIONS FOR FISCAL YEAR 2011

TUESDAY, MARCH 23, 2010

U.S. SENATE,
SUBCOMMITTEE OF THE COMMITTEE ON APPROPRIATIONS,
Washington, DC.

The subcommittee met at 9 a.m., in room SD–138, Dirksen Senate Office Building, Hon. Tom Harkin (chairman) presiding.

Present: Senators Harkin, Reed, Specter, and Cochran.

DEPARTMENT OF LABOR

OFFICE OF THE SECRETARY

STATEMENT OF HON. HILDA L. SOLIS, SECRETARY

OPENING STATEMENT OF SENATOR TOM HARKIN

Senator HARKIN. The Subcommittee on Labor, Health, Human Services, Education, and Related Agencies will come to order.

Welcome back to the subcommittee, Madam Secretary. I thank you for adjusting your time to come a little early.

We are boarding the bus at 10:15 a.m. to go to the White House, and I don't want to miss this historic occasion, to be there for signing of the healthcare reform bill. I might point out I have my Franklin Roosevelt tie on today, as a reminder of what we are about to witness, and the momentous occasion that's going to take place this morning with President Obama signing the healthcare bill into law. So, thank you for coming up early.

Well, Madam Secretary, just a few comments, here. First of all, thanks to President Obama and to the team he has around him, including you, and thanks to actions taken by Congress in the recovery bill, it seems that the economy is stabilizing. But, still far too many people do not have a job. The national unemployment rate officially stands at 9.7 percent; that's about 14.9 million Americans out of work. But we know there's another 8 to 9 million people out there that want to work full time, can work full time, but the jobs just aren't available.

Now, we know the situation could have been worse. The Congressional Budget Office recently estimated that roughly 2 million workers had jobs last quarter because of the Recovery Act. Two million. Today, more than 200 construction workers are helping build a new Job Corps Center at the Ottumwa Campus of the In-

dian Hills Community College in my State of Iowa. Madam Secretary, you were there for me last year when we broke ground for this center. These construction jobs were made possible by $23 million in Recovery Act funds.

And I just noticed that Dr. Lindenmayer, who is the president of Indian Hills Community College, is here today with some students from the Denison Job Corps Center. And I want to welcome them here today. Again, this is why we're doing this, to focus on the job force, our Nation's workforce of the future.

FISCAL YEAR 2011 BUDGET

Madam Secretary, your fiscal year 2011 budget builds on the foundations set by the Recovery Act and the 2010 appropriations bill. You have proposed key investments in workforce innovation, green job training, and I compliment you for that. Your budget would also continue the Disability Employment Initiative that we started last year in the 2010 appropriations bill. Again, more than 20 million disabled Americans are not participating in our workforce. That's a missed opportunity. We must do better. And I thank you for continuing this program in your budget.

The downturn in the economy also means that workers' rights are more vulnerable to employer abuse or misunderstanding. Your budget proposes important investments that will help address worker misclassification, workplace safety, health activities, and, of course, international labor rights. I'm particularly pleased to see a proposed increase for Bureau of International Labor Affairs (ILAB), which leads our fight against the worst forms of child labor around the world. Thank you for that.

Lastly, this budget does not simply propose to spend more money, it proposes to ensure the money is spent wisely. Your budget requests $40 million for 5 rigorous evaluations of DOL activities. These evaluations will help us learn how to best structure our DOL programs so they can operate more efficiently and effectively.

PROPOSED FREEZE ON DISCRETIONARY SPENDING

Madam Secretary, as you know the President has proposed a freeze on all nondefense discretionary spending for this year, so the choices we have as appropriators this year in writing our bill will not be easy ones. So, your testimony and your continued working with us will help keep us informed us as we try to shoehorn in all that we want to do within the President's proposal and to not have any increases.

So, now I turn it over to Secretary Hilda Solis, sworn in as the 25th Secretary of Labor on February 24, 2009. I was privileged to be there to watch this very historic occasion. Prior to her confirmation, she served as a representative of the 32nd Congressional District in California. Secretary Solis is a noted leader on the issue of clean energy jobs, as well as training for veterans, displaced workers, at-risk youth, and improving the overall lives of disadvantaged and everyday working families. A graduate of California State Polytechnic University, got her master of public administration from the University of Southern California. As a former Federal employee, she worked in the Carter White House Office of Hispanic

Affairs and as a management analyst with Office of Management and Budget in the in the Civil Rights Division.

So, we were all very delighted when the President asked you to be his Secretary of Labor not only because of your knowledge of how we work up here, but because of your background as well. You brought a wealth of experience to this, and I think the last year has shown that. Thank you very much for your great leadership, and the floor is yours.

SUMMARY STATEMENT OF HON. HILDA L. SOLIS

Secretary SOLIS. Thank you very much, Mr. Chairman.

And, to the Vice Chairman, who isn't with us, and to the other subcommittee members, I want to thank you for inviting me here today to discuss our fiscal year 2011 budget and our request.

I'd like to review selected highlights of my testimony with you.

RECOVERY ACT RESOURCES

First, I want to begin by saying that it's not possible to discuss next year's budget without acknowledging the immediate need to put people back to work. And you said it very pointedly. I'm proud of the work that we have done with the Recovery Act resources, including the assistance that was provided through the unemployment program, the Unemployment Insurance (UI) and COBRA benefits programs; the creation of nearly, 318,000 summer jobs for our youth; and the training opportunities that we created, particularly in health careers; and for jobs in the new green economy.

UNEMPLOYMENT RATE

While these efforts are helping, they are clearly not sufficient and not enough. At the 9.7 percent unemployment rate, which remains persistently and unacceptably high, I know that you have been working hard with your colleagues to reach consensus on measures that will allow us to continue to help all Americans until the labor market fully recovers.

There have been, clearly, some setbacks. But, as my testimony indicates, I hope that we can commit $1.2 billion to ensure a robust summer jobs program this year. And I want to thank, in particular, Senator Murray and yourself, Chairman Harkin, for your work on this particular issue, and pledge to work with you to see that we get this done. I would also like to see a jumpstart in our employment through a $500 million investment on the job training programs and add funding to further support our oversubscribed training programs.

WORKFORCE INVESTMENT PROGRAMS

We then need to sustain these investments through programs that give workers the tools they need to succeed in the 21st century economy. And I want to highlight some of the measures in our budget request that will accomplish this goal.

For the first time in more than a decade, the budget proposes a significant increase in funding for the Workforce Investment (WIA), programs. As you know, my team has been pleased to work closely with you and your staff on the process of WIA reauthorization. Fol-

lowing our approach in that process, the additional resources we're requesting for WIA are inextricably linked to reform through the establishment of two new WIA innovation funds.

GREEN JOBS INNOVATION FUND

The budget also requests an increase of $45 million for Green Jobs Innovation Fund. And I can tell you from our experience with the Recovery Act, these competitions were very, very demanding. We had an enormous number of applicants that applied for this funding. So, the need is very great. We know that there are some wonderful partnerships that are out there, but our resources were limited and we couldn't fund all of them. Additional resources would allow us to meet this demand, connecting trainees with jobs by requiring that grantees work with employers to ensure that participants gain the necessary skills and industry-recognized credentials that will help them move into better and higher-paying jobs.

DISABILITY EMPLOYMENT INITIATIVE

Mr. Chairman, based on the approach that you championed this year, two Department of Labor (DOL) agencies—Employment and Training Administration (ETA) and the Office of Disability Employment (ODEP)—will continue to receive $12 million each to continue their joint disability employment initiative to increase the capacity of the one-stop system to provide accessible services to individuals with disabilities.

WORKER PROTECTION PROGRAMS

I know you understand it can be too easy to exploit workers when jobs are scarce. And we need to remain vigilant in protecting the rights and safety of our workers. In fiscal year 2011, our budget continues that vigilance by hiring additional enforcement personnel. We build upon the resources you provided us with last year, to return our worker protection programs to fiscal year 2001 levels or greater, after years—many years of decline. To do so, the request includes $1.7 billion, equivalent to 10,957 full-time employees, for worker protection. This funding level is $67 million, or 4 percent, more than last year's level and the agency-by-agency details are in my prepared testimony.

To reinvigorate our regulatory agenda—the request for worker protection includes increases to supplement the development of regulations in areas such as pensions, worker health, and safety.

EMPLOYEE MISCLASSIFICATION

The budget also contains an important interagency effort to address employee misclassification. Workers wrongly classified as independent contractors are denied critical benefits and protections to which they may be entitled to as employees, including overtime, health coverage, workers' compensation, family medical leave, and unemployment insurance. In addition, misclassification results in billions of dollars of loss to the Government through unpaid taxes. Our budget includes $25 million to hire additional enforcement personnel targeted at misclassification and to fund competitive grants to help States to address this growing problem.

Restoring our economy requires ensuring the world economy is sound and balanced. I firmly believe that our responsibility to promote acceptable conditions of work abroad is very, very much linked to our worker protection agenda here at home. It is with this goal in mind that we're requesting an additional $22 million for ILAB to increase the monitoring of labor provisions of trade agreements, including provisions related to child labor, and to support programs to improve labor rights for workers with our trading-partner countries.

PREPARED STATEMENT

Before I conclude, I want to say a few words about our commitment to ensuring accountability for the resources that you entrust us with. This is why my testimony links investments to performance outcomes and why we have a new commitment to program evaluation. Members of the subcommittee, we all know that too many Americans are ready and willing to work, but can't find a job. The budget before you will help spur new and better job opportunities while fostering safe workplaces and respect and dignity for workers' rights. This is what my goal of "Good Jobs for Everyone" is. And I look forward to working with you, Mr. Chairman, to see that vision is fulfilled.

I'm happy to respond to any questions that you may have.

[The statement follows:]

PREPARED STATEMENT OF HILDA L. SOLIS

Chairman Harkin, Vice Chairman Cochran, and members of the subcommittee, thank you for the invitation to testify today. I appreciate the opportunity to discuss the fiscal year 2011 budget request for the Department of Labor (DOL).

The total request for DOL in fiscal year 2011 is $116.5 billion and 17,800 full-time equivalent employees (FTE), of which $17.1 billion is before the subcommittee. Of that amount, $14 billion is requested for discretionary budget authority. Our budget request will build on the $4.8 billion in discretionary as well as the mandatory resources included for the Department in the American Recovery and Reinvestment Act (ARRA).

PUTTING PEOPLE BACK TO WORK

Workers and their families are hurting in these tough economic times. We know that job opportunities and economic security are of utmost importance to Americans. During my travels throughout the country, I have met many people who expected to be in their peak earning years, and yet were struggling to find employment and maintain retirement savings. At DOL, we are putting people back to work and assisting unemployed workers who need our help. Through ARRA investments funded by the Congress, we have:

—Funded more than $49 billion in benefits to unemployed workers;
—Created nearly 318,000 summer youth job opportunities;
—Invested $500 million in training and research for emerging "green jobs" and another $220 million to help workers pursue careers in health care and other high-growth industry sectors;
—Created more than 18,000 new community service employment opportunities for seniors;
—Provided job-related services to more than 3.2 million unemployment insurance claimants;
—Provided direct assistance to more than 190,000 unemployed workers and their families seeking affordable health coverage and the COBRA subsidy.

While these efforts are helping Americans during these difficult times, they are clearly not enough. The unemployment rate remains persistently and unacceptably high. This administration wants to ensure that investments in job creation will continue until the labor market fully recovers from the economic downturn. The president has proposed a robust package to spur job creation, including new investments

in small business, infrastructure, and clean energy. In addressing the need for additional jobs legislation, the administration supports additional job-creating investments in key DOL initiatives:

First, last summer the ARRA created more than 300,000 summer jobs for at-risk youth in 2009, addressing an alarmingly high youth unemployment rate. Based on that experience, we believe that local areas can expand the program to create up to 350,000 jobs this summer, providing work experience to help young people build their futures and income their families can use in a weak economy. We can accomplish this with an additional $1.2 billion investment in summer and youth employment. In keeping with our approach to WIA reauthorization, this amount should include $150 million for competitive grants to support innovative programs and build knowledge of what strategies, including paid work experience, produce the best educational and employment outcomes for disconnected youth.

Second, training programs that bring workers into contact with employers form key partnerships that will result in people getting jobs. We support an additional $500 million to expand on-the-job training, refresh the skills of the long-term unemployed, and link them to real employment opportunities as the economy rebounds.

Third, through grant programs we will be prioritizing training in emerging industries where we know there are jobs, such as clean energy, an area where we see a lot of potential for additional training efforts. The administration supports an additional $300 million to continue two ARRA programs—Pathways Out of Poverty Grants ($225 million) and Energy Training Partnerships ($75 million). For both of these programs, we received many more quality applications than we were able to fund. As a result, additional resources would allow us to quickly fund these high-quality programs.

We also applaud the action that has been taken to extend unemployment benefits and health insurance. These programs ensure a continued safety net for individuals who cannot find jobs, and the benefits help stimulate the economy by putting money back in workers' pockets who then spend it in their local communities. These programs are vital, and we look forward to working with Congress to extend the duration of these programs.

We must work together to respond to the plea from millions of Americans for job opportunities and assistance. That means that we need to create new and better jobs for the 21st century economy. And because it is too easy to exploit workers when jobs are scarce, we need to be vigilant in protecting the rights and safety of workers. At DOL, my strategic vision is to provide good jobs for everyone. Here are some of the ways that we define a good job:

—A good job can support a family by increasing incomes, narrowing the wage gap and allowing workplace flexibility.
—A good job is safe and secure and gives people a voice in the workplace.
—A good job is sustainable and innovative, for example a green job.
—A good job will help rebuild a strong middle class.
—A good job provides access to a secure retirement and to adequate and affordable health coverage.

The resources requested in our fiscal year 2011 budget will help to make the vision of good jobs for everyone a reality. They will build on and leverage the job creation efforts begun with ARRA and continued with the fiscal year 2010 appropriation. I am committed to doing my best to see that the new jobs created with the economic recovery are good jobs that are open to the diverse group that represents the workers of the future.

PREPARING FOR JOBS OF THE FUTURE

DOL is looking to prepare workers with the tools they need to succeed in the 21st century economy, and for innovative ways to promote economic recovery. The fiscal year 2011 budget request for the Department's Employment and Training Administration (ETA) is $10.9 billion in discretionary funds and 1,080 FTE, not including the 148 FTE associated with the proposed legislation for foreign labor certification application fees. Through innovative program strategies, the budget request for ETA will allow DOL to increase the skills of the American workforce, while addressing all segments of the population.

Innovation Funds

Reflecting the urgent need to prepare workers for 21st century jobs, for the first time in more than a decade, the fiscal year 2011 budget proposes a significant increase in funding for the Workforce Investment Act (WIA) grant programs for adults, dislocated workers, and youth. The budget requests $3.4 billion for these programs, an increase of $209 million above the fiscal year 2010 level. However, the additional resources are inextricably linked to reform.

In keeping with the administration's WIA reauthorization plan, a percentage of the funds appropriated for adults, dislocated workers and youth will be reserved for the budget's proposed new Partnership for Workforce Innovation, which encompasses $321 million of funding in the Departments of Labor and Education. At DOL, two new innovation funds would provide competitive grants to State and local entities that can demonstrate new and promising ways of preparing individuals for jobs of the future. There are funds for adults and youth. For adults, the $108 million Workforce Innovation Fund would be funded through a 5 percent reserve from the WIA Adult and Dislocated Worker Programs. Innovation funding will be used, in part, to support and test "learn and earn" strategies like on-the-job training and apprenticeships. For youth, the $154 million Youth Innovation Fund will be funded by a 15 percent reserve of the funds appropriated for Youth; the funds will support summer and year-round employment opportunities and "work experience plus" programs for out-of-school youth. We are confident that the partnership for workforce innovation will create strong incentives for change that will improve the effectiveness of the WIA programs, and provide incentives for States and localities to break down program silos and improve service delivery.

Green Jobs

The demand for green job training opportunities is enormous—and DOL has been unable to keep pace with the record number of applications for grants. We believe that this unprecedented level of interest represents the need for resources that focus on green jobs training, which complements job creation efforts. We also believe this demonstrates the need to assist people who are already working, but who may be underemployed, to gain skills—and portable credentials—that will help them move into better, higher-paying jobs in emerging sectors.

The budget requests $85 million for the Green Jobs Innovation Fund, an increase of $45 million (89 percent) from the fiscal year 2010 appropriation. The request will provide training opportunities for some 14,110 workers. These funds will support DOL's efforts to achieve its high-priority performance goal in the employment and training arena, which is aimed at increasing opportunities for America's workers to acquire the skills and knowledge to succeed in a knowledge-based economy (and includes training more than 120,000 Americans for green jobs by June 2012). The budget will also complement the competitive grant awards made through the $500 million appropriation included for high-growth and emerging industry sectors under ARRA, and the $40 million provided in the fiscal year 2010 appropriation.

YouthBuild

The fiscal year 2011 budget includes $120 million, an increase of $17.5 million (17 percent) for YouthBuild to provide an estimated 230 competitive grants to local organizations for the education and training of approximately 7,450 disadvantaged youth age 16–24. Under these grants, youth will participate in classroom training and learn construction skills by helping to build affordable housing. In fiscal year 2011, DOL will continue the "green" transition of YouthBuild by encouraging connections with other Federal agencies involved in creating green jobs—such as the Departments of Energy and Housing and Urban Development—in order to leverage resources and new "green" opportunities for YouthBuild participants.

Transitional Jobs

The fiscal year 2011 budget proposes that $40 million for second-year funding to demonstrate and evaluate transitional job program models, which combine short-term subsidized or supported employment with case management services to help individuals with significant employment barriers obtain the skills needed to secure unsubsidized jobs. The initiative, which is a critical part of our jobs agenda, will target noncustodial parents to strengthen their workforce skills and experience, and help the children who rely on them for support. DOL is carrying out this demonstration collaboratively with other Federal agencies, such as the Departments of Health and Human Services and Justice. In partnership with these agencies, we are working to develop and implement a rigorous evaluation strategy for this demonstration.

Strengthening Unemployment Insurance Integrity and Promoting Re-employment

The severity of the recession has placed great stress on the Unemployment Insurance (UI) system, which has paid out unprecedented amounts of unemployment compensation. This administration is committed to protecting the financial integrity of the UI system, and helping unemployed workers return to work as swiftly as possible. In addition to providing the funding that States rely on to administer this important safety net program, our approach includes:

—A package of legislative changes that would prevent, identify, and collect UI overpayments and delinquent employer taxes. We estimate that these legisla-

tive proposals would reduce overpayments by $2.632 billion and employer tax evasion by $282 million over 10 years (net of the income tax offset).

—A request of $55 million (an increase of $5 million over the fiscal year 2010 level) in discretionary funding to support Reemployment and Eligibility Assessments, which include in-person interviews at One-Stop Career Centers with UI beneficiaries to discuss their need for re-employment services and their continuing eligibility for benefits. In fiscal year 2011, this investment, combined with the $10 million request included in State administration, will help 710,000 UI beneficiaries find jobs faster. It is expected to save $2.3 billion over a 10-year period.

We urge the Congress to act on these important proposals to strengthen the financial integrity of the UI system and help unemployed workers return to work.

Senior Community Service Employment Program (SCSEP)

The fiscal year 2011 budget proposes $600.5 million for the SCSEP, which will support some 61,900 slots for low-income seniors in part-time, minimum wage community service jobs. The request continues funding at the base amount of the fiscal year 2010 appropriation. As you know, in fiscal year 2010 the Congress provided a special multi-year appropriation of $225 million to help low-income seniors facing special economic challenges, asking that we allocate those funds within 45 days of enactment. In January 2010, DOL moved quickly to award these funds to offer immediate employment opportunities.

Job Corps

The budget includes $1.7 billion to operate a nationwide network of 124 Job Corps centers in fiscal year 2011. Job Corps provides training to address the individual needs of at-risk youth and equip them with the skills they need to enter the world of work. The fiscal year 2011 budget sets forth an ambitious agenda to reform and improve the Job Corps program's performance. We have begun this agenda in fiscal year 2010, which includes:

—Fully integrating Job Corps with DOL's other employment and training programs, with the return of the program to the ETA.

—A rigorous and comprehensive review of Job Corps center operations and management to identify areas most in need of reform.

—Remediation of program performance shortfalls at the lowest performing centers.

—Analysis of contracting practices and procedures to identify potential savings and strategies to improve cost effectiveness.

We are optimistic that our reform agenda will identify ways to produce better outcomes at a lower cost. To the extent that our efforts produce long-run cost avoidance, rather than near-term savings, the budget includes appropriations language that would allow the transfer of up to 15 percent of the $105 million appropriation for construction to meet center operational needs. This authority was first provided by Congress in ARRA. Job Corps received $250 million from ARRA, which it is using to fund shovel-ready construction projects that stimulate job growth in center communities. In addition, ARRA funds are promoting environmental stewardship in Job Corps by supporting development of green-collar job training, technology enhancements, and fleet efficiency.

Veterans' Employment and Training Service (VETS)

We know returning veterans can contribute greatly to our economy. For DOL's VETS, the fiscal year 2011 budget request is $262 million and 234 FTE. The fiscal year 2011 budget includes $41 million for the Homeless Veterans Reintegration Program, an increase of $5 million (14 percent) more than fiscal year 2010. The request will allow the program to provide employment and training assistance to more than 25,000 homeless veterans, and increase our reach to homeless women veterans. In addition, the budget requests $8 million for the Transition Assistance Program (TAP) for spouses and family members (including those with limited English proficiency), an increase of $1 million (14 percent) from fiscal year 2010. TAP Workshops will enroll roughly an additional 15,000 participants worldwide in fiscal year 2011, and play a key role in reducing jobless spells and helping service members transition successfully to civilian employment.

State Paid Leave

Workforce and workplace changes have made it increasingly difficult for working families to meet their work and family responsibilities. The vast majority of American workers have family care-giving responsibilities outside of work and no full-time caregiver at home. Nearly half of private-sector workers do not have paid sick leave to care for themselves, and even fewer have leave available to care for another

family member when they are ill. Millions of workers risk losing pay—and even their jobs—when they are sick or their children are sick. No worker should be placed in that position. Similarly, most workers do not have paid family leave—for example, to care for a newborn or newly adopted or fostered child.

State programs that provide for paid leave offer a solution for working families who cannot afford to take unpaid leave but need to take time off work to care for a newborn, bond with a new child or care for themselves and their families. The fiscal year 2011 budget requests $50 million for a State Paid Leave Fund to provide grants to help States establish paid leave programs.

PROTECTING WORKERS' RIGHTS AND SAFETY

In the jobs of the future as well as in jobs of the present, workers should be safe and their rights should be protected. To achieve our goal of rebuilding the middle class, we need to level the playing field and restore fair play for all working people. The fiscal year 2011 budget continues our commitment to protect the rights and safety of workers by hiring additional enforcement personnel and strengthening our regulatory efforts. The request includes $1.7 billion in discretionary funds and 10,957 FTE for our worker protection activities. This funding level is $67 million (4 percent) and 177 FTE above the fiscal year 2010 appropriation. The budget returns the worker protection programs to the fiscal year 2001 staffing levels or greater, and builds on the progress begun in fiscal year 2010 to restore capacity in our worker protection programs.

Employee Misclassification Initiative

Employers who misclassify their employees as independent contractors often avoid paying the minimum wage and overtime. They evade payroll taxes, and often do not pay for workers' compensation or other employment benefits. As a result, employees are denied the protections and benefits of this Nation's most important employment laws, and their employers gain an unfair advantage in the market place. Employees are particularly vulnerable to misclassification in these difficult economic times. The fiscal year 2011 budget requests $25 million for a multi-agency initiative to strengthen and coordinate Federal and State efforts to enforce statutory prohibitions, and identify and deter employee misclassification as independent contractors.

For the Wage and Hour Division (WHD), the fiscal year 2011 budget requests an additional $12 million and 90 new investigators to expand its efforts to ensure that workers are employed in compliance with the laws we enforce. The funds will support targeted investigations that focus on industries where misclassification is most likely to lead to violations of the law, and training for investigators in the detection of workers who have been misclassified.

The Misclassification Initiative also will support new, targeted ETA efforts to recoup unpaid payroll taxes due to misclassification and promote the innovative work of States on this problem. This initiative includes State audits of problem industries supported by Federal audits, and $10.9 million for a pilot program to reward the States that are the most successful (or most improved) at detecting and prosecuting employers that fail to pay their fair share of taxes due to misclassification and other illegal tax schemes that deny the Federal and State UI Trust Funds hundreds of millions of dollars annually.

In addition, the Misclassification Initiative includes:

—For the Office of the Solicitor, $1.6 million and 10 FTE to support enforcement strategies, with a focus on coordination with the States on litigation involving the largest multi-State employers that routinely abuse independent contractor status.

—For the Occupational Safety and Health Administration (OSHA), $150,000 to train inspectors on worker misclassification issues.

—Legislative changes that will require employers to properly classify their workers, provide penalties when they do not, and restore protections for employees who have been classified improperly.

With these efforts, we intend to reduce the prevalence of misclassification and secure the protections and benefits of the laws we enforce. This effort strikes at the core of DOL's mission—and the hard working people of this country deserve no less.

Wage and Hour Division

I take the failure to pay workers the wages that they have earned very seriously, and I am committed to enforcing all employment laws—particularly those related to payment of the minimum wage and overtime. Workers deserve this money, and it will bring new resources to low-income households where most of it will be spent and help reinvigorate local communities. As I noted earlier, we have already increased wage hour enforcement staffing. At 1,672 FTE, the staffing level for the

WHD requested in fiscal year 2011 is 29 percent higher than the fiscal year 2009 level. As new investigators grow into their jobs, they will be an even stronger force for securing compliance with basic labor standards protections. The fiscal year 2011 budget request of $244.2 million for WHD will support targeted investigations, meaningful compliance assistance, and—in support of DOL's high-priority performance goals—reduce repeat violations of minimum wage, overtime, and workplace safety laws.

Office of Federal Contract Compliance Programs

I am also committed to vigorously enforcing the laws that combat discrimination, for our goal is to protect workers who—ultimately—are America's most important asset. The fiscal year 2011 request for the Office of Federal Contract Compliance Programs (OFCCP) is $113.4 million and 788 FTE, an increase of $8 million from the fiscal year 2010 level. The 2010 appropriation has allowed OFCCP to return to 2001 staffing levels, and the 2011 request will make it possible to maintain that level.

The fiscal year 2011 budget will allow OFCCP to broaden its enforcement efforts and focus on identifying and resolving both individual and systemic discrimination. OFCCP will focus its attention on a broad range of issues that arise in individual cases, including harassment, retaliation, termination, and failure to promote. Since Federal contractors are obligated to self-audit and correct identified problems, OFCCP will step up monitoring of this element of contractor compliance. As part of OFCCP's enforcement of Executive Order 11246, Equal Employment Opportunity, a renewed emphasis on conducting construction reviews is planned.

Office of Workers' Compensation Programs

The fiscal year 2011 discretionary budget request for administration of the Office of Workers' Compensation Programs (OWCP) totals $127.3 million and 921 FTE to support the Federal Employees' Compensation Act (FECA) ($103.5 million), the longshore and harbor workers' compensation program ($17.2 million) and $6.6 million for the Division of Information Technology Management and Services (DITMS). DITMS provides information technology general services support for the programs that were previously within the Employment Standards Administration (ESA) and was previously funded in ESA's program direction and support activity. DITMS was transferred to OWCP with the understanding that it would provide the same level of IT support. The request includes an additional $3.2 million and 9 FTE to address the burgeoning workload under the Defense Base Act arising from claims associated with injuries to war-zone contract workers in Afghanistan and Iraq.

A high-priority performance goal for fiscal year 2011 will be a new, jointly sponsored OWCP and OSHA initiative entitled "Protecting Our Workforce and Ensuring Reemployment" (POWER). The new program is designed to bring a greater focus on the Federal Government as a model employer of workers injured on the job and returning to the workplace, or for employing workers with disabilities.

The OWCP budget also includes mandatory funding totaling $53.8 million and 295 FTE to administer part B of the Energy Employees Occupational Illness Compensation Program Act (EEOICPA), and $72.8 million and 265 FTE for Part E of the Act. EEOICPA provides compensation and medical benefits to employees or survivors of employees of the Department of Energy and certain of its contractors and subcontractors, who suffer from a radiation-related cancer, beryllium-related disease, chronic silicosis or other covered illness as a result of work at covered Department of Energy contractor facilities.

Lastly, OWCP's fiscal year 2011 budget includes $38.3 million in mandatory funding and 198 FTE for its administration of parts B and C of the Black Lung Benefits Act, and $58.4 million and 127 FTE in FECA Fair Share administrative funding.

Office of Labor-Management Standards

The fiscal year 2011 budget request for the Office of Labor-Management Standards (OLMS) totals $45.2 million and 269 FTE. This is an increase of $4 million from the fiscal year 2010 level. OLMS administers the Labor-Management Reporting and Disclosure Act (LMRDA), which establishes safeguards for union democracy and union financial integrity and requires public disclosure reporting by unions, union officers, employees of unions, labor relations consultants, employers, and surety companies. OLMS also administers DOL's responsibilities under Federal transit law by ensuring that fair and equitable arrangements protecting mass transit employees are in place before the release of Federal transit grant funds. The fiscal year 2011 budget includes an additional $2.5 million to allow OLMS to modernize an aging, mission-critical information technology system. This project will increase transparency to the public, reduce reporting burden and administrative costs, and improve program efficiency.

Employee Benefits Security Administration

DOL's Employee Benefits Security Administration (EBSA) protects the integrity of pensions, health plans, and other employee benefits for more than 150 million people. The fiscal year 2011 budget request for EBSA is $162 million and 941 FTE, an increase of $7.1 million (5 percent) and 31 FTE compared to the fiscal year 2010 level. The additional resources will support a significantly greater demand for regulatory guidance, research, outreach, education, and assistance. The budget will improve EBSA's ability to ensure America's workers, retirees and their families have access to a secure retirement and affordable health insurance. I am very proud of the work this agency has done under ARRA, implementing a new appeal program related to an individual's appeal of the denial of his or her COBRA premium assistance, and responding to more than 190,000 inquiries and complaints from unemployed workers and their families seeking affordable health coverage and the COBRA subsidy; hosting more than 2.5 million visitors to our dedicated COBRA Web site; and conducting 826 outreach events related to the new program, including compliance assistance Web casts and seminars and on-site visits with workers facing layoff at their place of employment.

OSHA

I am proud that OSHA is restoring its capacity to strongly enforce statutory protections, provide technical support to small businesses, promulgate safety and health standards, strengthen the accuracy of safety and health statistics, and ensure that workers know about the hazards they face and their rights under the law. The fiscal year 2011 budget request for OSHA is $573.1 million and 2,360 FTE, an increase of $14.5 million and 25 FTE more than the fiscal year 2010 level. The budget redirects 35 FTE from compliance assistance to enforcement and supports DOL's high-priority performance goal to reduce workplace injuries by targeting establishments and industries with the highest injury, illness, and fatality rates—with the goal of reducing by 2 percent per year the number of fatalities associated with the four leading causes of workplace death in OSHA's jurisdiction: falls; electrocution; caught in or between; and struck by. The request also includes an additional $4 million to expand OSHA's regulatory program, $1 million for consultation programs focused on small businesses, and $1.5 million for State plans. These additional resources will support a vigorous enforcement presence in the Nation's workplaces and ensure that hard-to-reach workers know about their rights and the hazards they face.

Mine Safety and Health Administration (MSHA)

MSHA is celebrating 40 years of legislation aimed at improving working conditions for America's workers, and last year, MSHA recorded the safest year in mining in U.S. history. The fiscal year 2011 budget requests $360.8 million and 2,430 FTE and supports MSHA's comprehensive strategy to curb debilitating and potential fatal diseases caused by coal mine dust. The budget includes an increase of $2.3 million and 21 FTE for the metal and nonmetal mine safety and health budget activity to bolster enforcement and conferencing. The budget will ensure a 100 percent completion rate for all mandatory safety and health inspections; support MSHA's enhanced enforcement initiatives, which target patterns of violation, flagrant violators, and scofflaws; and allow MSHA to promulgate new standards related to reducing health hazards associated with exposure to coal mine dust and crystalline silica. The request also allows MSHA to continue its work to enhance mine rescue and emergency operations and will support DOL's high-priority performance goal—which targets the most common causes of fatal accidents and is aimed at reducing workplace fatalities at mining sites by 5 percent per year based upon a rolling 5-year average.

Office of the Solicitor

The Office of the Solicitor (SOL) provides the legal services that support DOL, including DOL's enforcement programs. The fiscal year 2011 budget includes $130.4 million and 658 FTE for SOL, an increase of $5.2 million and 22 FTE from fiscal year 2010. This amount includes $122.5 million in discretionary resources and $7.9 million in mandatory funding. The budget includes an increase of $2 million to support an additional 12 FTE to handle increased Mine Safety and Health enforcement litigation resulting from the substantial increase in the number of cases at the Federal Mine Safety and Health Review Commission. The fiscal year 2011 budget will support SOL's enforcement litigation, issuance of timely legal opinions, legal support for rulemaking, and increased efficiency through its acquisition of legal technology.

Pension Benefit Guaranty Corporation

For administrative expenses of the Pension Benefit Guaranty Corporation (PBGC), the fiscal year 2011 budget requests $466.3 million and 942 FTE. The

budget includes an increase of $14.7 million for the PBGC's benefit determination process to cover the projected long-term costs of absorbing participants of several very large pension plans that terminated in late fiscal year 2009. In addition, $200,000 and 1 FTE are requested to increase the capacity of the Office of Inspector General to support its audit, investigation, and training activities.

ENSURING ACCOUNTABILITY AND TRANSPARENCY

Spending tax dollars wisely helps DOL achieve our mission on behalf of America's workers, and builds trust among our stakeholders. We are committed to ensuring a sense of responsibility, accountability, and transparency at DOL. Our fiscal year 2011 budget supports those goals.

Built around my vision of good jobs for everyone, DOL is currently updating its strategic plan, which will be published by September 30, 2010 and cover fiscal years 2010–2016—a span during which the Department will mark its 100th anniversary of service to America's workers.

Over the next several months, we will be reaching out to a broad range of stakeholders—including Congress—to solicit their input and perspective on a new strategic goal framework that will govern all aspects of work in DOL.

Our strategic planning efforts dovetail nicely with President Obama's commitment to improve the performance of the Federal Government through three complementary performance management strategies. They are:

—Use performance information to lead, learn, and improve outcomes;
—Communicate performance coherently and concisely for better results and transparency; and
—Strengthen problem-solving networks.

As part of this process, DOL's fiscal year 2011 budget articulates five ambitious—but realistic—high-priority performance goals that we will strive to achieve in the next 18 to 24 months. These goals—which I've touched on above—offer an opportunity for DOL to achieve remarkable and lasting benefits for the American people. Our high-priority performance goals will focus the agencies on the most critical needs affecting the safety, health, and economic security of workers. We are working with our colleagues in the Office of Management and Budget to establish an action plan for implementation of the Department's high-priority performance goals—including quarterly milestones that we will use to gauge the progress and success of our implementation strategy.

A Strengthened Commitment to Program Evaluation

In the 2011 budget, the administration encouraged Departments to volunteer for a new program evaluation initiative designed to strengthen rigorous, objective assessments of existing Federal programs to help improve results and better inform funding decisions. DOL is proud to be one of a limited number of agencies selected to pilot this new approach in the fiscal year 2011 budget. The budget includes $40.3 million to fund 5 rigorous evaluations and demonstrations of workplace safety enforcement and workforce development services. Most are demonstrations that would provide program services, coupled with rigorous evaluations of the strategies. While the evaluations are still in the design phase, we expect a substantial portion of this funding will go to States, workforce agencies, or for participant services. The five evaluations, which will be shaped and guided by DOL, working closely with the Office of Management and Budget and Council of Economic Advisors, will cover the following:

—WIA performance measures;
—Effects of job counseling;
—Using linked administrative data to evaluate workforce programs;
—Incentives for dislocated workers; and
—Effects of OSHA inspection strategies.

In addition, the budget includes $10 million in the departmental management account and $11.6 million in the training and employment services account to continue to pursue a robust, DOL-wide evaluation agenda. To effectively manage the new evaluation resources, DOL is establishing a Chief Evaluation Office in fiscal year 2010 to directly manage the Department-wide evaluation resources, and work with the other components of the Department to ensure a high level of rigor and quality in the evaluations they support.

Workforce Data Quality Initiative

The fiscal year 2011 budget requests $13.8 million for second-year funding for the DOL's Workforce Data Quality Initiative, which we are carrying out in partnership with the Department of Education. The initiative provides competitive grants to develop longitudinal data systems that have the capability to link workforce and edu-

cation data collected as individuals progress through the education system and into the workforce. These data systems can provide valuable information to consumers, practitioners, policymakers, and researchers about the performance of education and workforce development programs. In fiscal year 2010, up to 12 States will receive grants to implement longitudinal databases over a 3-year period. The fiscal year 2011 request will support participation of up to 12 additional States in the initiative.

OTHER PROGRAMS

Bureau of Labor Statistics

Through its 21 economic programs, the Bureau of Labor Statistics (BLS) produces some of the Nation's most sensitive and important economic data. The fiscal year 2011 budget proposes $645.4 million and 2,465 FTE for BLS, an increase of $34 million (6 percent) from the fiscal year 2010 level. The budget proposes several initiatives to modernize and improve the accuracy of BLS survey data. For example:

—An increase of $27.3 million is requested to improve the data quality of the Consumer Price Index (CPI) and Consumer Expenditure (CE) Survey, including work to support the Census Bureau in its development of a supplemental poverty measure.

—An increase of $4.9 million is included to expand the Occupational Employment Statistics (OES) program to annual data reporting from a subset of establishments, making possible year-to-year comparisons.

In addition, the fiscal year 2011 budget proposes new, cost-effective data collection strategies that would not diminish the quality of the data that BLS publishes. For example:

—A restructuring of the way in which the current employment statistics produces State and metropolitan area data estimates would save $5 million annually.

—An alternative, model-based methodology will allow BLS to produce locality pay data at a lower cost. The new approach will eliminate the Locality Pay Surveys, ensure no reduction in the data quality, and save $10 million annually.

Finally, the fiscal year 2011 budget proposes to eliminate the international labor comparisons program. The savings from this elimination and the two-cost effective data collection strategies mentioned above will be used to partially finance the OES, CPI, and CE enhancements.

We look forward to working with Congress to implement the fiscal year 2011 budget strategies to improve and modernize the critically important economic data produced by BLS.

Office of Disability Employment Policy (ODEP)

Even though the majority of workers with disabilities are prepared, willing, and able to work, they remain a largely untapped labor pool. We know that people with disabilities are out of the labor force at a much higher rate than their counterparts without disabilities, and we are launching innovative partnerships to increase their employment opportunities. For example, along with the Office of Personnel Management (OPM), in April DOL is hosting a national hiring event for people with disabilities with participation by numerous Federal agencies and human resources professionals. Also, along with the Departments of Defense and Veterans Affairs, we have relaunched an improved national resource directory Web site for America's wounded warriors, their caregivers, other members of the veterans community, and employers. By visiting www.nationalresourcedirectory.gov, customers can now access thousands of services and resources at the national, State, and local levels to support recovery, rehabilitation, and community reintegration for veterans.

The fiscal year 2011 budget requests $39 million and 52 FTE for ODEP to combat the problem by developing policy and policy strategies that, when implemented by ODEP's Federal, State, and local partners that include public and private-sector employers, will:

—Increase physical and programmatic access for individuals with disabilities in WIA partner programs and at One-Stop Career Centers, through a partnership between ETA and the Department of Education.

—Increase the employment of people with disabilities within the Federal Government, in partnership with OPM.

—Make workplaces more inclusive and welcoming to both transitioning youth and adults with disabilities.

—Expand access to employment supports—like technology and transportation. These services are crucial to the success of all workers in the job market, especially those with disabilities. ODEP will utilize ongoing partnerships with the Departments of Commerce, Transportation, and Education; the General Serv-

ices Administration; the National Science Foundation; businesses; technology designers, developers and manufacturers; and the disability community to ensure that emerging workplace information and communication technology is universally available.

—Spur new strategies for integrated employment opportunities for workers with disabilities within minority, women, and veteran-owned businesses. For example, ODEP's "Add Us In" initiative will fund a competitive grant to encourage small businesses, particularly minority-owned businesses, to increase the number of people with disabilities hired by such employers.

The request includes $12 million for ODEP to continue its partnership with ETA on the Disability Employment Initiative, which strives to increase the capacity and accountability of the One-Stop Career system to provide accessible programs and services to individuals with disabilities. A companion request of $12 million is contained within the ETA budget. Our goal is to ensure that good jobs for everyone includes workers with disabilities.

Bureau of International Labor Affairs (ILAB)

One of my goals as Secretary of Labor is to help American workers build the foundation for a sustained recovery of the global economy, while contributing to a more balanced pattern of global trade in the future and respect for workers' rights around the world. The fiscal year 2011 budget requests $115 million for the ILAB, an increase of $22 million and 10 FTE from the fiscal year 2010 level. The additional resources will allow ILAB to significantly expand support for innovative, successful programs that address root causes of violations of workers' rights in developing country trading partners. Of the increased resources, $20 million will be added to the $6.5 million in funding that has been provided by Congress since fiscal year 2008 for such workers rights initiatives. Given the challenges of the global economic crisis, we believe that these programs are more necessary than ever to prevent and address incidents of labor exploitation abroad.

The additional $2 million increase in resources will be used to increase oversight, monitoring and reporting on labor rights in countries that have free trade agreements and trade preference programs with the United States and on reporting and analysis of progress countries are making to eliminate the worst forms of child labor. We anticipate adding 10 new FTE for these purposes.

The fiscal year 2011 budget will support DOL's high-priority performance goal to make measurable improvements in worker rights and livelihoods and progress against the worst forms of child labor in at least eight countries by the end of fiscal year 2011. The budget will also continue the Bureau's longstanding commitment to building international relationships that improve global working conditions and strengthen labor standards around the world.

Women's Bureau

This year, the Women's Bureau will mark 90 years of work formulating standards and policies that promote the welfare of wage-earning women and advance their opportunity for fair and profitable employment. The Bureau's efforts to provide women in the workplace with the information and tools needed to obtain good jobs and economic security for themselves and their families is invaluable in this time of economic recovery.

The Bureau's fiscal year 2011 budget includes $12.3 million and 58 FTE, which is $700,000 above the fiscal year 2010 enacted level. This budget will allow the Women's Bureau to continue and increase its role of conducting research, outreach, and evaluations of programs and policies affecting working women. The budget will also allow the Bureau to work with the Bureau of Labor Statistics to improve data collection on work-family responsibilities, and support my vision of good jobs for everyone.

CONCLUSION

Too many Americans are ready, willing, and able to work—but cannot find a job. The fiscal year 2011 budget for DOL will help spur new and better job opportunities, foster safe workplaces that respect workers' rights, and ensure American workers are ready for 21st century jobs. I am committed to achieving the goal of Good Jobs for Everyone, and I look forward to working with the members of this subcommittee to make that vision a reality.

Mr. Chairman, this is an overview of the programs proposed at DOL for fiscal year 2011.

I am happy to respond to any questions that you may have.

Senator HARKIN. Thank you very much, Madam Secretary.

I meant to say, before you started, and I will say it now, that the record will remain open, prior to your statement, for an opening statement by Senator Cochran or any other Senators who wish to submit such a statement.

WORKER PROTECTION

Madam Secretary, thank you again for your great leadership. And let me just go over a couple things.

The worker protection measures that you have talked about are heartwarming. It's about time that we recognize what has happened in the past. The Wage and Hour Division, which enforces minimum wage and overtime pay protections, lost 30 percent of its staff between fiscal year 2000 and fiscal year 2008. That loss of inspectors led to a drop of 36 percent in the number of inspections conducted by the Wage and Hour Division.

In the last 8 years, 2000 to 2008, the Occupational Safety and Health Administration (OSHA) issued only 3 significant safety and health regulations, two of which were issued as a result of court orders. The previous administration killed the ergonomics regulation, which we debated here for a long time, and then a plan was presented to lead to reduced ergonomic injuries. Well, that was fine. The problem is the plan was never implemented. So, your budget, the 2011 budget request, will provide OSHA the resources it needs to address these regulatory issues that have been so neglected in the past.

Also, your emphasis on green jobs—let's face it, that is the future. And young people have to be trained for those green jobs.

DISABILITY EMPLOYMENT INITIATIVE

One thing I wanted to cover with you is the Disability Employment Initiative that we started last year, the $24 million. And you—you're continuing that this year. I appreciate that. ETA and ODEP submitted a report last month on how they will implement this initiative. And I want to compliment your staff on developing a thoughtful plan that I believe will lead to improved services and outcomes for people with disabilities.

Just as a background—in February 2010, the labor force participation rate of individuals with disabilities was 21.9 percent. Think about that. People with disabilities who want to work, who can work, had a—well that's 78 percent, I guess, unemployment rate. That's just unconscionable. Right now there are navigators—disability program navigators for more than 40 States.

In the March 10 report by your inspector general which was titled "Information on DOL's Efforts to Access for Persons with Disabilities to the One-Stop Career System," a couple of points really stand out. When One-Stop Centers connected individuals with disabilities with jobs, employers were just as likely to keep them as a nondisabled worker. However, individuals with disabilities were less likely to be connected with jobs in the first place. So, what this tells me is, we've got to do a better job of making these connections. Once they were connected with employers, the data shows that they stayed on the job and were kept on the job just as much as nondisabled people.

DISABILITY PROGRAM NAVIGATORS

Now, the other thing is that the report suggests that the navigators, the disability program navigators, are really part of the answer. One-Stop Centers that had access to disability program navigators did a better job, according to this study, of connecting individuals with disabilities with jobs than those without navigators. So, again, that argues to make sure that we get more navigators out there.

Lastly, the report noted that DOL does not have quantifiable goals or measures that assess DOL's progress in ensuring comprehensive access in One-Stops for individuals with disabilities. My staff tells me that DOL now is considering some options on this issue, so I encourage you to—hopefully, to get those done. And, just consider the Inspector General's report in asking your staff to again focus on these One-Stops with the navigators. How do we get more people with disabilities in, to connect them, and use the navigators a little more than what we were doing in the past to get people with disabilities jobs? So, I ask you to, look at that. I don't need a response on that.

Secretary SOLIS. Yes, Mr. Chairman, I know that with the amount of money that you have provided us with, for both the ODEP and with ETA, we are going to focus in on this initiative. And we do realize that it is something that should be more comprehensive in nature. And so, we will be testing this and working in certain regional areas to make sure that we're doing the right thing, that we have the right tools available so we can make this happen, and then, hopefully, come back and expand the program.

So, I agree with you, we should be doing more. And the success is really going to mean whether the quality of service that the navigators provide is made available to these clients, and, hopefully, that will result in job placement.

I do want to tell you about an initiative that we're planning with OPM, with Director Berry. We have a big event planned with him in April for people with disabilities, to get them in Federal employment. And it's going to be carried out through our Assistant Secretary, Kathy Martinez, who I hope you've had an opportunity to meet with. A very dynamic individual. If you haven't met her, I hope we can arrange for that. But, our goal there is to make sure that the Federal Government lead by example, and that we do as much as we can to begin to employ individuals with disabilities even in our own agencies.

Senator HARKIN. Very good. I appreciate that. Look forward to continuing to work with you. And I look forward to meeting Ms. Martinez and talking with her about this.

JOB CORPS

Let me just shift to Job Corps. Again, I thank you for coming out to Iowa—it was a beautiful day. And I have a great picture of us throwing shovels of dirt in the air at the Job Corps Center. Because of the Recovery Act, we have somewhere between 200 and 250 workers there, building these new buildings.

Now, there's one thing I did want to cover with you. Your budget suggests that you're expecting the Center to be occupied in mid-

program year 2011. Well, that says to me around December. My staff has been checking with the people in Ottumwa and the construction people, and they say that the Center will be ready to serve students many months earlier, perhaps around May of next year. So, again, I'm wondering about that 6-month gap, and I'd ask you to look at that and see if we can't give some assurances that, as soon as that new Center's completed, assuming that it's done by May, that we can get students in there right away, rather than leaving it set until December. Can you inform me about that?

Secretary SOLIS. Yes. Mr. Chairman, I know that this is of great importance to you, and was happy to be out there with you, with that groundbreaking ceremony that I attended.

I wanted to just mention that we have had some changes in our program. We finally have a new director in the Job Corps program, who I hope that you'll also get a chance to meet. Her name is Edna Primrose, and she is also a former employee of the Job Corps program. This will help us by having leadership there that can help us with the changes and reforms we need to help expedite a lot of these projects. And yours is one, of course, of particular concern to us.

I will work with you and your staff in any way that I can to see how we can try to expedite this as much as possible. I know that the project is currently about 43 percent complete. And I, like you, would like to see that we are fully operational by the year 2012, if not sooner, and that we have available at least 300 slots for students, there.

So, I want to work with you, and obviously with Jane Oates, our Assistant Secretary, who you know, is also very much on top of—she's not—I don't think she's here with us——

Senator HARKIN. She's not here.

Secretary SOLIS [continuing]. Today. But she, believe me, has been just unstoppable——

Senator HARKIN. Right. Right.

Secretary SOLIS [continuing]. In helping us get these programs moving. And Job Corps is a very, very important program. That's one of the programs that I oversee that I have had the pleasure of visiting throughout the country. That's one of the programs that I personally make an effort to go visit. So, it is, I think, one of the premier programs. It's been around for so many years, and really doesn't get enough credit by the public because they do some very incredible things.

DENISON JOB CORPS

And I want to welcome the students and the participants in your area that are here with us today.

Senator HARKIN. Right. I mentioned Kevin Fineran is also here, he's the guy that runs the Denison Job Corps Center; and Judi Giersdorf, from MDC, who runs these Job Corps Centers overseas. So, welcome here, and also to the students that are here.

Excuse me just a minute.

I was supposed to meet with you later, but I have to rush out of here. I have to go to the White House for the signing of the healthcare bill. So, I apologize for not being able to meet with you later. Now, back to the witness.

Madam Secretary, I just want to say that, on this issue, assuming that we can get this up and ready to go by next May, if we need to make some adjustments here to ensure that we have the money available, I want to know that. I don't want to see the building sitting empty for 6 months or more if we're ready to go. So, if we need to make some adjustments. Please advise me, yes?

Secretary SOLIS. I will be pleased to follow up with you Senator——

Senator HARKIN. Okay.

Secretary SOLIS [continuing]. Mr. Chairman.

Senator HARKIN. I appreciate that very, very much.

ILAB

Oh, just one last thing before I turn it over to Senator Cochran: ILAB. You mentioned this is a very high priority for me. It's something that I've been looking after for a long, long time, going back to the Clinton administration. And again, your increase is more than welcome, because we didn't have those requests in the past, and we always had to add money here. But, I think, it's just one of the good things that our Nation does, is to forcefully go out and work with International Labor Organization and the International Program for the Elimination of Child Labor (IPEC).

Believe me, I've been in a lot of these countries, I've looked at this—what they are doing, and I can't think of anything that gives a better face for America and what we're about in the world than trying to ensure that children are protected, that they aren't abused; that they aren't put in these unsafe work conditions. Everyplace I've been, the people of those countries, and their—to some extent, their governments—sometime we have a little problems with governments—but, believe me, it's just one of the really great things that we do. And so, I'm just glad that you're still focusing on that.

I know there's always a tussle between what you might call "workers' rights" and—for the general workforce—and perhaps IPEC, in terms of focusing on child labor. I understand that. I guess I would lean more toward looking at child labor, because they have no one to stick up for them. No one. And sometimes to the extent that adult workers may have certain organizations, certain way—certain other things that they can go to, but these kids don't. So, I tend to say, "Let's look at that first," but you can't forget about the other stuff, but I tend to lean more toward making sure that we put a focus on our anti-child-labor activities.

Secretary SOLIS. Thank you, Mr. Chairman. I know that you have been one of our champions on this issue, in helping to protect children from the worst forms of child labor. And thank you for helping to champion some of the efforts, so that we can provide assistance and support through microloan programs to help make sure that families don't have to send their children into the workforce under, in some, despicable conditions. I know that this is something you care very deeply about. And we do not want to minimize or take away from our efforts in enforcement of child labor laws that are being broken or that we feel are egregious. So, we want to do everything we can to highlight both of those issue areas.

And I am very delighted with the new Assistant Secretary we have there, Sandra Polaski, who is really helping to set a name for ILAB, and returning it, I think, to where it should have been some 10 years ago. She is also very deeply involved in working with other countries to help foster and expand programs that you helped to initiate. The Cambodia experience is the one that I refer to, where we get a certain sector of the garment industry, all the players there, to understand that we should all be abiding by certain standards. And once that happened, then markets open up, because there is a level of trust that helps both partners. And I think it's something that we were—we stepped away from in the last few years, and now, with our ability to do this because of additional funding, we're going to be able to expand that and, hopefully, share with other parts of the world what we can do.

I know that Sandra Polaski has been visiting in Central America, and trying to see how we can gain more of our foot in the door in countries like El Salvador and Nicaragua and even going back to Jordan. So, there's some very exciting things happening. And I'd love to be able to sit down and talk to you more about it.

G20 LABOR MINISTER'S MEETING

And, as you know, we are also sponsoring an upcoming G20 Labor Minister's Meeting that'll be held here in Washington for the first time. There's a great deal of interest to see other countries sharing with us, and we sharing with them our practices, what we've learned, what works, but also, more importantly, preparing our President and other dignitaries from across the G20 countries to put forward a platform that will look at worker protection, safety, and job creation. So, there's a host of good things that are coming out of ILAB, even as small as it is. I'm very proud of the work that they're doing.

Senator HARKIN. Well, I'm proud of their work, too. And thank you for your leadership on ILAB.

Secretary SOLIS. Thank you, Mr. Chairman.

Senator HARKIN. Senator Cochran.

Senator COCHRAN. Mr. Chairman, thank you.

Welcome, Madam Secretary. We appreciate your service in this important undertaking.

HURRICANE KATRINA

When the gulf coast of Mississippi was devastated by Hurricane Katrina, the Job Corps Center there was destroyed. And it's been 2 years plus since that event, and we still don't have a new facility in place. But—there had been a temporary facility planned, but a lot of delays have caused it to lag, and we had heard it's now scheduled for opening in April. We're pleased with that. There is a permanent dormitory in the design phase, we're told, but it'll be 2 more years before that's finished.

I would just bring this to your attention, in hopes that somebody can get involved and help expedite the repairs, the opening of a temporary facility, and, finally, the construction of the buildings that were destroyed by the hurricane. Do you have any information you could share with us about that?

Secretary SOLIS. Yes. Thank you, Senator Cochran. I know that this is of a great deal of concern for many people, especially because of the area. Hurricane Katrina was so devastating that we're still trying to build up other facilities there, as well, that the Federal Government is targeting. But, this is something that—I know is very important. We do have some temporary facilities there available. We believe that, by June 20 of this year, we'll be able to include another, larger number of students that we can service. Right now what we're doing is bringing in, every 2 weeks, about 20 additional students. So, by the time we hit June, we'll have about 168. They will be in that temporary facility, but we are working quickly to see that we can—as fast as possible, of course with your help, we'll work with you to see if we can get the necessary tools available to make this happen a lot sooner.

I know that our goal is to get at least 300 students there. And I do want to inform you that we just hired a new director for Job Corps—Mrs. Primrose—who is a former student of our program—not student, but someone who actually worked in the program and understands the needs and how—and the attention that the Job Corps program really deserves.

So, I feel very confident that we're going to be able to work with you and with our Assistant Secretary for ETA, Jane Oates, to make this possible. And I look forward to working with you. I, too, am very anxious to see this program in its more permanent facility.

Senator COCHRAN. Well, thank you very much. I'm encouraged by what you're saying. I'm glad to know that it has your personal attention. We appreciate your leadership in moving the construction forward.

OFFICE OF LABOR MANAGEMENT STANDARDS (OLMS)

One other thing that has been brought to my attention, in preparation for the hearing, and that is that the enforcement of labor standards is in the hands of the OLMS. And there's some question about whether or not funds have been requested in an amount that will permit this office to carry out its responsibilities. I understand that financial disclosure forms are filed by unions, with this office. And is there any effort to cut down on the oversight, or any of the enforcement activities, of OLMS, as reflected in these low levels of funding requests?

Secretary SOLIS. Senator Cochran, I'm glad you asked me that question. I know the last time that I was here before the subcommittee, I stressed that we would do everything in our power to make sure that we level the playing field, that we work to be more accountable and transparent with union members, and also making sure that we could disclose information. And I'm actually happy to say that, with our commitment in the fiscal year 2011 budget, we're actually increasing the amount of money—$3.8 million—for OLMS. Much of that will go into technology so that we can make it easier for reporting to be disclosed on forms that will be accessible through electronic means. And that's something that hasn't been done as extensively as we would like. So, we'll actually be able to increase, from 3 to 12, the number of public forms that will be electronically submitted. So, there will be more disclosure.

What we're trying to also do is really focus in on those egregious cases that come about. I want to report that criminal investigations are up for 2009. In 2008, it was 393; 2009, it was 404. Convictions, 103 for 2008; for 2009, 120. So, I can tell you that we are working very hard to make sure that we investigate those places and—necessary reporting requirements have to be adhered to, and we're trying to make it easier for in OLMS to make sure that we get the right information, that we don't overburden the system with unnecessary information, but that it is clear, transparent, and available for union members to see, as well.

PREPARED STATEMENT

Senator COCHRAN. Thank you very much. And, we may have some other questions that we may submit for the record, Mr. Chairman.

Senator HARKIN. Absolutely.

Senator COCHRAN. Thank you.

[The statement follows:]

PREPARED STATEMENT OF SENATOR THAD COCHRAN

Mr. Chairman, thank you for calling this hearing to discuss the fiscal year 2011 budget for the Department of Labor.

I want to welcome Secretary Solis to her second appearance before this subcommittee and look forward to her testimony.

Madam Secretary, I want to commend you for your continued support of the Youthbuild Program. With funding from your department, the Corporation for National and Community Service and private foundations, amazing work has been done in the Gulf Coast region. Young people from the Youthbuild Americorps Gulf Coast Program have rebuilt more than 150 homes damaged by Hurricane Katrina. This program has given out-of-school, out-of-work youth the opportunity to obtain their general education diploma, gain vocational training, and get paid while learning. We look forward to working with you to continue this important program.

Once again, I thank you Mr. Chairman for calling this important hearing.

Secretary SOLIS. Thank you, Senator.

Senator COCHRAN. Thank you, Madam Secretary.

Senator HARKIN. Senator Specter.

STATEMENT OF SENATOR ARLEN SPECTER

Senator SPECTER. Thank you, Mr. Chairman.

Madam Secretary, thank you for taking on this important job. With all of the excitement in the House of Representatives in the last few days, do you ever miss it?

Secretary SOLIS. I feel even more connected today.

Senator SPECTER. Well, you left your key position in the House; and with all of the excitement and activity, I thought you might have some thought about that line, especially a couple of days after the big event.

DECREASE IN FUNDING

Madam Secretary, I note that there has been a decrease in funding for the DOL, some $300 million from the 2010 level. And with the enormous responsibilities you have for occupational safety, health, and mine safety, and Job Corps, seems to be hard for you to stretch the dollars.

VETERANS EMPLOYMENT AND TRAINING SERVICE (VETS)

There are a couple of specific items I would like your comment about. And one relates to the VETS. The funding there, as I see the briefing notes, will allow for employment and training assistance to some 25,000 homeless veterans. And that seems to me to be a relatively small number of the veterans who are returning from very difficult duty in Iraq, Afghanistan, and other places. And how many—if you know, or provide it later—of the veterans who could qualify for that kind of employment and training service are there, beyond the 25,000?

Secretary SOLIS. Senator Specter, we're looking at the issue of employment placement through VETS, something that I think has been put aside in the past few years.

We have a very dynamic Assistant Secretary there. Ray Jefferson, who you may know, is a West Point graduate, also served in, I believe, Afghanistan, and brings to the Department a real enthusiasm, as well as strategic direction of where we need to go with helping our veterans that are coming home. This is a very serious problem and concern for all of us. I know that what we have done is try to increase the budget so we not only look at employment opportunities, but that we engage with private partners, such as the Chamber of Commerce, for creating these partnerships so that we can easily place some of our returning veterans in business and job opportunities throughout the country.

This is something that I believe has to happen now, because there's a high rate of unemployment amongst our returning young veterans, in particular—the rate is very, very high. I realize that our budget is somewhat limited, but we're testing some new theories, so to speak. One of them is the TAP program, which will help those veterans that are coming home be able to reintegrate and understand what services are immediately available. We're working in partnership with the Department of Defense on this, but it's something that I don't think has really been fully developed. And so, we're taking a shot at it, because I think it's something that's very important to help provide even further assistance so that veterans and their family members, their spouses, also have the ability to draw down information and services that they're eligible for.

You wouldn't believe how many people I've come across, as a former member in my district, visiting some of these locations where veterans are returning, and they're kind of rushed through in a—maybe a 1-day event where they're given information, that may not really be digested well that one day, because they're coming home, they're thinking about other things. We believe that services have to be—have to be carried out in a manner that's actually going to be effective. So, we want to be able to monitor what we're doing; we want to be accountable; we want to make sure that the right services are happening for our veterans, and especially homeless veterans, as well as female veterans. And that's why we're making available an amount of $5 million to start working with female veterans who are coming back and really struggling, many who have experienced sexual assault and may become homeless, as well.

I hope we can work with you on——

Senator SPECTER. Madam Secretary, I'd appreciate it if you'd take a look at the total number of veterans in that category who need that service. Perhaps this is something where there could be some assistance from the Veterans Administration. I serve on the Veterans Committee, used to chair it. And they have a—an extensive budget. And perhaps we could have some coordination there, if, in fact, there is a large number, beyond what you can accommodate within your budget.

Secretary SOLIS. Senator, I'd be happy to work with you on that. Obviously, the Veterans Administration has a much larger budget, as you state, than we do. And I would definitely like to work with Cabinet member Shinseki. We've had discussions about this, and it would—I would very much like to work with you, and, of course, the Chairman, on this.

[The information follows:]

The veterans' courts got their start at homeless veterans stand-down events when organizers decided to provide homeless veterans with an opportunity to address legal barriers such as DUIs, misdemeanors, child support and other legal-related issues which precluded many homeless veterans from seeking reintegration into the mainstream. This concept has been expanded by the Department of Veterans Affairs (VA) to include issues related to mental health and drug courts.

Veterans' Employment and Training Service (VETS) has supported homeless veterans stand-down events through not-for-profits who serve homeless veterans. This support includes local veterans employment representatives and/or Disabled Veterans Outreach Program specialists being available to address employment and training needs of homeless veterans.

Our recent Solicitation for Grant Application (SGA) focusing on incarcerated veterans has a component to address issues that impact on the re-entry of veterans from Federal, State, and local correctional facilities. In an effort to ensure that veterans being served by these grants receive access to a wide-range of services, the SGA contains language which requires partnership with the VA including collaboration with medical centers and especially the VA re-entry specialists and justice outreach coordinators.

VETS' staff recently attended a national VA conference to assist in the training of justice outreach coordinators to ensure that a linkage with local workforce staff occurs to provide employment and training opportunities for veterans who are coming out of incarceration and/or jail.

VETS' staff also attended a defendant/offender workforce development conference to discuss interaction with the criminal justice system in partnership with the VA with correctional institutes and parole and probation officers.

We announced on April 26, 2010, a grant competition under 38 U.S.C. 2021, which provides employment assistance to Veterans who are homeless and this year we have targeted homeless female veterans and veterans with families. Additional information may be found on our Web site at http://www.dol.gov/vets

Lastly, VETS is planning a postaward conference for all of their Homeless Veterans Reintegration Program and Incarcerated Veterans' Transition Program service providers and will devote time to discuss the role of the Department of Labor in assisting veterans who are leaving a Federal, State, or local jail as well as working with the VA's justice outreach coordinators to provide a plan for those veterans interacting with the veterans' courts.

MINE SAFETY

Senator SPECTER. The issue of mine safety is a gigantic one. We tend to downplay it until there is a tragedy, and then we're all up in arms about it. In the MINER Act of 2006, there was a requirement for communications gear. An interesting article in the Charleston Gazette reported on a lack of wireless communications in some—only 34 of the Nation's 415 active underground mines possessed fully functional wireless underground communications capabilities. Would you take a look at that issue and let us know

if that figure is accurate, and, if so, what the plans are to cover the balance of those facilities?

Secretary SOLIS. Yes, Senator Specter. I am intrigued by the kind of work that is done by our Mine Safety and Health Administration (MSHA) programs now, and had the opportunity last year to go down and actually visit one of our mines in Virginia, and saw the equipment—some of the more premier equipment that's available for communication. It was explained to me how that works, if there are disasters that occur, what backup plans are necessary. And they're very costly, on both sides—for us to do the inspection, in terms of our staff, but also for the employer. So, there is a need for us to focus more on what mines are not doing, because of their inability or not knowing that these safety precautions need to be put in place. I would certainly want to work with you. I know this is something that our new Assistant Secretary, Joe Main, takes seriously about ways to improve our work in MSHA— and is somebody who has a great deal of respect, I think, from both sides—management and labor.

[The information follows:]

UNDERGROUND COMMUNICATIONS AND TRACKING EQUIPMENT

As of April 2, 2010, there were 414 active underground coal mines and 75 active nonproducing mines required to have electrical communications and tracking (C&T) systems within an approved emergency response plan (ERP). Of those 489 mines, 441, or 90 percent, had an approved ERP that included provisions for a C&T system.

As of March 31, 2010, 58 mines had C&T equipment completely installed and operational in both the outby and inby section loading points. An additional 154 mines were in process of installing C&T systems.

The remaining 229 mines with an approved ERP [441 − (58 + 154)] were awaiting delivery of system components from manufacturers or suppliers. Mine Safety and Health Administration (MSHA) supplemental questions and answers on Program Policy Letter No. P09–V01 states that mine operators must provide to MSHA, within 15 days of plan approval, a purchase order for the communication and tracking systems that will be installed in accordance with an approved ERP. Absent factors beyond the operator's control, the system(s) must be installed within 3 months of the delivery date specified in the bona fide purchase order. As of April 2, 2010, operators with approved plans had purchase orders with delivery dates as late as 2011.

MSHA's districts continue their work with the remaining 48 mines that do not yet have an approved ERP to develop an acceptable plan. In instances where MSHA and the operator cannot come to agreement on an approved plan, MSHA is working with the Office of the Solicitor to take legal action to bring the operator into compliance with the act.

Senator SPECTER. One final comment. You and I have talked about the possibility of your coming to Pennsylvania. It's not as a far as Iowa or Mississippi or Rhode Island. The work that you're doing has tremendous impact, generally, but especially on the big cities, on the Job Corps, so many unemployed minorities with so many difficulties. So, we'll pursue that, on the staff level.

Thank you very much, Madam Secretary.

Secretary SOLIS. I look forward to that visit. Thank you——

Senator SPECTER. Thank you.

Secretary SOLIS [continuing]. Senator. Thank you.

Senator HARKIN. Senator Reed.

STATEMENT OF SENATOR JACK REED

Senator REED. Thank you very much, Mr. Chairman.

And thank you, Madam Secretary, for your work and for joining us today.

One of the consequences of this severe financial crisis is more than 30 States have borrowed up to $35 billion from the Federal Government to continue paying their regular unemployment compensation benefits. And as some States look for ways to pay back their loans and balance their budgets, they're at least contemplating raising taxes on employers, which would be, essentially, counterproductive, in the sense that we are doing all we can to encourage hiring by lowering the cost of employees. The States in this situation would be pushing against us. So, it leads to the obvious question of what we can do to help these States.

In the 1980s, there was some—both permanent and some temporary assistance offered to States who were in danger of credit reduction when they don't repay their loans. I'm wondering what you and the Department are thinking about in this context, and what, together, we can do to provide some assistance.

Secretary SOLIS. Thank you, Senator Reed. And I also want to thank you for the opportunity to visit your State and your Job Corps last year.

Senator REED. Thank you.

Secretary SOLIS. I will say that this is a very serious recession that I still think we are in. And I know that many of our States, including the one that I'm from, California, have seen just unprecedented levels of use of the UI Trust Fund. And yes, we do have to do something. And I'd be happy to work with you to figure out how we can try to fix this, because many—too many people are suffering. And it isn't enough just to think about this in terms of this short-term crisis, but to think, long-term, how we can remedy this.

So, I'm looking and anxious to hear what options you might have, so that I can work with you and take back to—take back to our administration—how we can shorten the time that people get benefits and help the systems work better. There are major problems with the infrastructure, the delivery system itself, the fact that many—even State employees are being furloughed in this area, and that aren't even able to expedite and process some of these applications. And then, to further add to it, the fact that many of our States aren't creating or generating any revenue to pay in, so our businesses aren't able to participate as they, maybe, would have. These are not normal times, and it requires some new thinking. And I look forward to working with you. I hope that's sufficient.

EXTENDING TEMPORARY WAIVER OF INTEREST PAYMENTS

Senator REED. Well, thank you very much, Madam Secretary. I think we understand the problem, and now we have to really roll up our sleeves and see what we can do, specifically. And not only in terms of the efficiencies you outlined, but avoiding the contradiction of Federal policy lowering the cost of employment and State policy raising the cost of employment.

There's another aspect of this issue, and that is: In the Recovery Act, there was a temporary waiver of interest payments and accrual of interest on Federal advances to the unemployment funds through the end of this year. What are your thoughts about extending those provisions for the following year?

Secretary SOLIS. I would want to work with you closely on that to see what we can come up with. I know that the administration is looking at different packages right now. And I know you've been very helpful, with some of your ideas. So, I look forward to working with you. I think you have a great deal of experience in this area that can help us. So, I'm willing to work with you on that.

Senator REED. Well, thank you. I think we all recognize that your advocacy within the Cabinet for this—these programs and these policies is absolutely critical. So, if you work inside, we'll try to work outside, I guess. And we'll work together.

NEW WORKFORCE INNOVATION FUND

One of the aspects of the President's budget is the $108 million for the new Workforce Innovation Fund, including expanding "learn and earn" strategies, like apprentice programs. And it raises a question, in terms of accelerating apprentice programs that are incorporating these programs in Federal construction contracts. To be specific, we've been working with the Navy, in Newport, and trying to have them recognize this one factor award in their contract award, those companies who participate in apprentice programs, as a way to incentivize them to develop apprentices. And I wonder, generally, across the board, what would be your attitude toward a—including this factor—apprenticeship programs—in the award of Federal contracts.

Secretary SOLIS. Well, Senator, as you know, we have—through the ETA program, we run our own apprenticeship program, as well—a registered program there. And I know that, in the course of this recession, we've really found that some of the best programs are run through these various apprenticeship programs, where you have private industry as well as labor working together, on-the-job training. And the masterful skill and training and certification that's gained by it, I think, makes these individuals much more marketable than if they would've gone through another program. It is—they're more costly, they're limited in reach, in terms of how many people can be a part of this. And I'm looking at ways of how we can expand it. So, I'm actually very favorably looking at how we can do that. So, that's another area that I would like to work with you on.

Through our WIA programs, if I can just mention, we have made it a point to also provide assistance to pre-apprenticeship programs, because there's a lot of folks that want to get into apprenticeship programs, but aren't prepped up enough to understand the requirements and the rigors, because these programs are very highly technical in skill and skill development and the skill sets that must be acquired. And I can see where, if we're going to try to push a new—a whole new generation of people to get into these jobs, we're going to need to have an expansive way of allowing for access to reach more people. So, that's something that we're also exploring, but I definitely want to see more opportunity available so that we can have apprenticeship programs in some of our major Federal projects that we undertake.

So, I very much agree with your statement.

Senator REED. Thank you, Madam Secretary.

Thank you, Mr. Chairman.

Senator HARKIN. Thank you all very much.

SUMMER YOUTH EMPLOYMENT

I just had one follow-up question, Madam Secretary, and it had to do with summer youth employment. The Recovery Act provided $1.2 billion, we had 300,000 young Americans. I met a lot of them last summer, in my own home State, and we had a meeting March 9, Senator Murray had an amendment that would have provided $1.5 billion in supplemental funding for DOL's youth for the summer employment program, but it failed, on a budget point of order, even though we had 55 votes in favor of it. But, I'm just wondering how you're viewing the summer coming up. And what can we do with whatever funds you might have? And we're going to have a lot of kids out there that could be working this summer, so how do you see that unfolding? I mean, we're now in March already, almost April.

Secretary SOLIS. Mr. Chairman, I know that this is an issue that both Senator Murray and yourself have been championing for some time. I, too, was disappointed that the proposed amendment was not passed. I'm ready to work with you and other Members of the Senate to see how we can get additional funds. I know the President is committed to seeing this program funded in a way that we can, hopefully, bring in another 350,000 students to participate. Last year, we were at 318,000. We doubled the number of young people that we thought could be involved in the program.

We know it works. It is something very important. I know the House has, I believe, a measure that they're proposing that doesn't go quite as far. I understand that under a Federal Emergency Management Agency supplemental, there will be some amount of money—$600 million, I believe—which, again, isn't quite the amount that Senator Murray and you were pushing. So, I would want to work with you to see how quickly we can get this done, because people have to plan now, at the local level, to start hiring up and get this program in place. We were very fortunate that, after 10 years, we were able to get this program somewhat up on its feet. But, we want to expand it and make sure that it is available for all those that need this program. And I agree, when you see these students in these programs, some of them are just amazing—the work that they gain, the experience they gain, but also the work ethic that inspires them to want to continue to go to school, but also hold down a job.

Senator HARKIN. I can't tell you how many I talked to last summer that—you know, were thrilled with what they were doing. And many of them are just saving their money to go to college. I mean, this is some of the money that helps them get through school; plus giving them, as you said, job training and work experience, that type of thing; plus helping our economy.

SUPPLEMENTAL APPROPRIATION FOR SUMMER YOUTH EMPLOYMENT

So, I'm hopeful that sometime soon the Congress will be able to appropriate some money for summer youth employment. You just don't have it in your budget. I mean, there's no way we can hire 300,000 young people this summer with what you have. It has to be a supplemental appropriation. And, as you point out, we're now

coming to April—we've got a couple weeks off for Easter break—we come back, so if we're going to do it, we have to do it pretty soon, in order to get the money out, make sure the youth get employed this summer.

I can't think of a more important thing to do in the immediate timeframe than that.

Secretary SOLIS. Senator, thank you. I know this is one of those programs where the money goes out quickly, and it is either spent or it's saved. But, in most cases, some of the students that I met with were actually helping to supplement their income. I met with some students in Puerto Rico that were working on conservation projects along the beach. And you know how tourism is very important to that part of the country. That money, some of the students were telling me, was used to help their families pay rent, because the unemployment rate there is even double. So, it's amazing what young people will do when there is an opportunity made available through these programs.

Senator HARKIN. Sure.

Well, Madam Secretary, thank you again, very much for coming up early.

Secretary SOLIS. Thank you.

ADDITIONAL COMMITTEE QUESTIONS

Senator HARKIN. The subcommittee will have a number of questions for the record. And the record will be open for 10 days for Members to submit additional questions.

Thank you very much.

[The following questions were not asked at the hearing, but were submitted to the Department for response subsequent to the hearing:]

QUESTIONS SUBMITTED BY SENATOR TOM HARKIN

EMPLOYMENT AND TRAINING ADMINISTRATION (ETA)

Question. ETA has proposed $107,651,000 and appropriations language to establish a new Workforce Innovation Fund (WIF). ETA is planning to use not more than 5 percent of an allocation under the proposed adult and dislocated worker WIF for rigorous evaluation of all project funded under the demonstration phase of the program.

How many demonstration grants would ETA award under the program? What would the evidentiary standard be for replication projects using "promising or proven" projects, and how many replication grants would be funded at the requested amount?

Answer. The Innovation Fund will test and replicate innovative strategies for training and re-employment services that respond to the current and future needs of workers and the economy. The mix of demonstration and replication grants, as well as standards for replicating promising or proven program practices, will be developed as part of the Solicitation for Grant Applications (SGA). The number of grants will depend on the size, scope, and design of the grants awarded, and will be influenced by the innovative concepts and promising practices proposed by applicants to address issue areas such as "learn and earn" models, linkages with economic development, supporting regional and sectoral collaboration, reaching underserved populations, working across programs to provide comprehensive services, and enhancing technology to increase the quality or expand the scope of services provided.

WIF also will allow applicants to propose promising practices or approaches they wish to replicate and build evidence that the approach is effective or can be taken to a larger scale. The SGA will include response criteria for applicants to address when proposing to replicate "promising or proven" approaches, which will include

evidence that the approach produces positive performance outcomes or has significant impacts, and other evidence supporting the rationale for replication.

I look forward to working with the subcommittee on this important endeavor and providing further information about our progress and activities.

Both the American Recovery and Reinvestment Act (ARRA) and the fiscal year 2010 Department of Labor Appropriations Act provided local Workforce Investment Boards (WIB) with the authority to contract with institutions of higher education or other eligible training providers if it would facilitate the training of multiple individuals in high-demand occupations and not limit customer choice. The fiscal year 2011 budget continues this authority.

Question. How has the Department of Labor (DOL) monitored and evaluated the use of this authority? Is it a cost-effective mechanism for providing support for training at the local level?

Answer. DOL monitors the use of the authority to contract with institutions of higher education or other eligible training providers under ARRA through our standard desk and on-site grant reviews and other oversight activities. ETA does not collect such information through its approved data collection systems. This authority was also included as part of DOL's fiscal year 2010 appropriation for use during the program year starting July 1, 2010. Use of the authority varies by State, depending on need and program design. However, many local WIBs are using this authority to add flexibility to their program design. In a recession, it is common that the number of students attending training greatly increases and creates a shortage in available training for in-demand occupations. In such cases, contracted training can be useful in expanding opportunities and consumer choice.

The use of contracts to provide training capacity for One-Stop Career Center customers gives local areas flexibility beyond Individual Training Accounts (ITAs) to meet customer needs. Contracting authority allows local areas to cover a larger range of costs than ITAs, allowing local areas to develop new curricula and expand training offerings to meet the skill needs of growing industry sectors. Local areas indicate that contracted training that expands existing program capacity by funding seats during off-hours or at alternate sites can be less expensive than the cost of the class in the traditional setting. In cases where contracted training is more expensive on a per-student basis than an ITA slot, local areas report that the costs of forgoing or delaying training of WIA participants due to limited capacity exceed the additional monetary cost of offering these courses via contract. Increasing training capacity can help low-income adults and dislocated workers enter the workforce more quickly. Therefore, we believe that this authority can offer a cost-effective, customer-driven alternative for providing support for training at the local level.

The fiscal year 2011 request for youth activities includes $153,750,000 and appropriations language creating a Youth Innovation Fund (YIF). The fund would support grants for summer and year-round employment opportunities, and Work Experience Plus grants.

Question. How many of each type of grant will be awarded at the budget request amount? What would the evidentiary standard be for projects seeking to replicate program practices that are proven successful?

Answer. At the budget request amount, ETA anticipates awarding 30 to 50 grants to support summer and year-round employment opportunities and between 18 and 25 Work Experience Plus grants. Similar to the WIF, the mix of demonstration and replication grants, as well as standards for replicating promising or proven program practices, will be developed for the YIF as part of the SGA. The number of grants will depend on the size, scope, and design of specific projects awarded funding, and will be influenced by the innovative concepts and promising practices proposed by applicants, including strategies to create new partnerships with the private sector, organized labor, public sector, and community organizations, and to test new approaches to delivering work and learning experiences and related services to improve outcomes for underserved populations, such as out-of-school youth, youth with disabilities, or homeless youth. The SGA will include response criteria asking applicants to provide evidence that the proposed approach produces or has the potential to produce positive impacts on educational and employment outcomes.

The fiscal year 2011 congressional budget justification indicates that ETA will continue its focus on developing collaborative systems at the Federal, State, and local level for serving the youth most in need. ETA recently issued guidance on innovative contracting strategies to better serve youth most in need.

Question. Have you seen any changes made in State and local practices related to the strategies outlined in this contracting guidance? Have your efforts on coordination identified other barriers to using resources effectively to serve youth most in need? If so, what are they and what actions are planned by DOL and Federal partners to address them?

Answer. The contracting guidance was released in February 2010 and it is too early to see any changes made in State and local practices related to structuring contracts to better serve the youth most in need. In order to encourage collaboration across systems to more effectively serve the youth most in need, ETA and the Administration for Children and Families in the Department of Health and Human Services issued a joint letter in January 2010 encouraging the workforce system to partner with Temporary Assistance for Needy Families (TANF) agencies to create subsidized employment opportunities, including summer jobs, using ARRA TANF emergency funding. ETA also issued Training and Employment Notice 24–09 to highlight this partnership. Since January, a number of States have started to develop the type of partnerships outlined in the joint letter.

ETA was planning to complete 50–75 on-site monitoring reviews of One-Stop Centers in program year 2010.

Question. What has this monitoring found on the issues of access and services for individuals with disabilities, including specifically physical and programmatic barriers? How do these findings compare to such reviews in program year 2009? How many reviews are planned for program year 2011?

Answer. ETA is currently in the last quarter of program year 2009, and entering program year 2010 on July 1, 2010. Program year 2011 will begin July 1, 2011.

In early program year 2009, in preparation for the addition of ARRA funding, ETA visited all 53 States and territories and 156 local areas for a total of 209 visits to determine their readiness for ARRA activities. These were not monitoring reviews, but integration of programs and accessibility of program services were examined.

In regular program compliance monitoring visits, ETA has monitored 53 States and territories and at least 114 One-Stop Career Centers in program year 2009. The small number of compliance issues identified included the weight of a One-Stop entrance door in Delaware and a Washington, DC youth classroom on the second floor without elevator access. Both areas resolved the problem. Most regions report no issues, and state that centers have been successful in building up the training and resources for staff, as well as additional resources and relationships with employers for individuals with disabilities. In region 6 for example, California, Arizona, Idaho, and Hawaii have been pursuing the purchase of additional assistive technology and upgrades to existing assistive technology for their comprehensive One-Stop Career Centers. The States of California and Arizona have also increased sponsorship and coordination efforts to promote the availability of accessible programs and services for people with disabilities, and have utilized a portion of their Wagner-Peyser ARRA funds to increase awareness of service accessibility for people with disabilities. Whenever issues of compliance arise the regional office issues corrective action plans and provides technical assistance, and ETA advises States to closely monitor implementation of the corrective action plans.

In addition, Office of Disability Employment and ETA will conduct a separate independent survey of the physical, programmatic, and communications accessibility of the One-Stop Career Center system in the fall of 2011. DOL anticipates that a number of large, medium, and small comprehensive One-Stop Career Centers will be selected across several States. A full survey of accessibility will be conducted in the fall of 2011 that includes review of WIB policies and procedures relative to the availability of intensive and training services for individuals with disabilities.

Work plans for monitoring have not yet been formulated for program year 2011, which begins July 1, 2011. However, we anticipate a similar number of local reviews in program year 2010 and 2011 as were conducted in 2009.

The 2011 request for Job Corps operations is $1,572,253,000, a decrease of $1,762,000 below the 2010 level. The budget indicates that "The budget requires that efficiencies within Job Corps operations are pursued."

Question. Please describe the efficiencies that Job Corps has achieved in recent years and what may be pursued in 2011 that will not compromise the outcome goals of the program.

Answer. The Office of Job Corps routinely seeks program efficiencies that produce a cost savings without compromising the effectiveness of service to its students. As part of the 2011 budget, the program is pursuing a reform agenda to identify additional operational efficiencies and improve student outcomes.

One of the operational efficiencies Job Corps is pursuing is to reduce ever-increasing utility and fuel costs. The activities Job Corps plans to conduct include: reducing the program's General Services Administration vehicle fleet; replacing traditional vehicles with alternative energy-efficient electric vehicles; and ARRA-funded energy efficient upgrades that will reduce utilities costs at Job Corps center facilities. To complement these efforts, we have implemented a nationwide energy conservation campaign, funded by ARRA, which promotes the adoption of "green" practices by

students and staff. Further, our new Job Corps centers are being built to meet Leadership in Energy and Environmental Design specifications and will be state-of-the-art, energy-efficient facilities.

Job Corps also is working to maximize centers' slot capacity utilization, which includes increasing student retention. The program anticipates an increase in students' average length of stay as a result of our rigorous career technical training system that includes industry-focused foundations courses for new students and the incorporation of industry-recognized certifications. Under this system, students need to remain in the program longer to complete program requirements and this increased retention will reduce costly student turnover.

Finally, Job Corps is exploring ways to decrease the cost of large-scale, on-center services, such as basic medical care and prescription drugs, without compromising the quality or provision of these services to students. The program also will evaluate its discretionary national office support contracts for possible reduction or conversion to Federal staff.

Question. What connections have been made across systems to provide support to Job Corps students eligible for services through systems, such as Medicaid?

Answer. As part of the admissions process, and upon conditional enrollment, students are asked to provide verification of any private insurance or Medicaid coverage. If the applicant has no coverage, center staff assists the applicant in applying for either State medical coverage and/or Medicaid.

The Job Corps program also encourages all centers to establish working relationships with their local health departments and community health organizations. This allows the program to augment its available resources to deliver a wider array of services.

Job Corps Health and Wellness Desk Reference Guides developed for center health and wellness managers, center mental health consultants, disability coordinators, and center physicians provide suggestions and examples for cost-saving strategies by developing relationships with community resources (e.g., check for agencies that may be receiving grant money to provide a range of services—from mental health to family planning to nutrition planning; contact local health department and review what services are available at no cost to Job Corps students; review with local hospital and associated clinics their policies on providing free/low-cost services to economically disadvantaged patients).

Technical Assistance Guides (TAGs) provide guidance regarding community connections (e.g., TEAP TAG encourages centers to establish community connections that support relapse prevention efforts and provides examples (e.g., self-help groups). The Family Planning TAG encourages centers to supplement program components not available on center with free or low-cost community resources and provides examples. The Immunization TAG encourages centers to contact their State/local health departments to determine vaccine availability under the Vaccines for Children (VFC) program which provides free vaccines to children who are on Medicaid, are without insurance or underinsured, or are Indian/Alaskan Natives).

Regional office staff monitors the health and wellness programs as part of their regular monitoring of the centers.

The Advisory Committee on Job Corps made a number of recommendations about improving services to students with disabilities through Job Corps centers.

Question. What actions is ETA taking or planning to take to help improve such services? How does the 2011 budget support such these actions?

Answer. The Job Corps Advisory Committee made a number of recommendations to improve Job Corps' handling of students with disabilities. We have already pursued several recommendations, and seek to continue their implementation as part of our 2011 budget request.

One recommendation was to improve center staffs education about disabilities. The program responded by dramatically increasing its training opportunities for center staff through platform trainings, webinars, the provision of on-site technical assistance, and the deployment of information toolkits through the Job Corps Disability Web site.

The Advisory Committee also suggested that centers hire special education teachers to assist students with disabilities. Job Corps centers are encouraged to employ these teachers, whenever possible. The Office of Job Corps will continue to work to increase the number of special education teachers at our centers.

In keeping with the Advisory Committee's recommendation, Regional Disability Specialists have been employed by Job Corps and support centers in their respective regions. These specialists serve as technical experts and provide center staff with assistance in the area of disability accommodations and education.

Another committee recommendation was to improve employer outreach for the hiring of students with disabilities. Job Corps is conducting webinars for placement

staff on communicating with employers about the benefits of hiring students with disabilities.

We also created tools and identified resources that would improve students' self-advocacy skills, enabling them to become knowledgeable of and confident in their rights. Additionally, Job Corps has expanded its strategic alliances with other groups to better leverage and augment the disability-related services it can provide.

The budget request indicates that funds have been requested for a "compensation adjustment" for professional Job Corps staff and further indicates that staff compensation is a part of "program reform."

Question. Can you describe what "program reform" means and how the 2011 budget will be used to support to support this effort?

Answer. The Office of Job Corps' agenda for program reform will include identification of program inefficiencies that can be resolved to produce savings, such as reducing fuel and utility costs, maximizing centers' slot capacity and improving student retention, and taking advantage of economies of scale for targeted on center services.

Job Corps is also planning to conduct an assessment of its operational structure, with a particular focus on center performance. The review will examine variations in the way the program model is being implemented across centers and identify best practices at high-performing centers that can and should be replicated across the Job Corps system. In response to the findings, Job Corps will develop aggressive improvement plans to assist lower performing centers. The administration has begun the process of procuring an outside evaluator to conduct this review.

To maintain high-quality instruction, one specific challenge that Job Corps faces as part of reform is staff compensation levels for our academic and career technical training instructors. Job Corps analyzed a sample of academic and career technical instructor salaries in April 2009. The sample was representative of instructor salaries at approximately 30 percent of centers operated by private or nonprofit contractors. Selected centers were located across all six regions and included large and small centers in urban and rural locations. The results of the sample showed that Job Corps instructor salaries averaged $19.89 per hour ($41,371 annually) contrasted with a Bureau of Labor Statistics (BLS) national instructor average of $34.62 per hour ($71,999 annually). Individual analysis by center indicated some variations based on geographical location.

As part of the 2011 budget, DOL proposes adjusting compensation levels to place our instructors on equal footing with their counterparts in the public school system. Over the past several years, the program has had difficulty in attracting and retaining qualified instructors, due to the disparity in income of these two groups.

Misclassification of employees as independent contractors is a significant issue that denies employees benefits to which they are entitled and results in revenue losses for the Unemployment Insurance Trust Fund and other accounts.

Question. Please describe how ETA will structure each of the grant competitions for the $10,950,000 in State Unemployment Insurance and Employment Service Operations (SUIESO) funds requested for the misclassification initiative.

Answer. ETA is currently working to develop an implementation plan for these grants. We anticipate the grants that will enable States to build their capacity to identify worker misclassification in the context of the Unemployment Insurance (UI) program will focus in two key areas: technology infrastructure to engage in cross-agency information sharing and capacity to do more targeted employer audits. These grants will be awarded competitively. State workforce agencies responsible for administering the UI program will be the eligible grantees.

The second type of grant will focus on States that have been aggressive and innovative in developing processes to identify and correct worker misclassification in the context of the UI program. These grants will be competitive and will require States to have demonstrated results as a criterion for receiving an award. States will also be required to identify how they will use the grant funds to further their ability to be successful in identifying worker misclassification.

Question. Would DOL's misclassification initiative be assisted by changes in the Fair Labor Standards Act (FLSA) expanding employer record keeping, requiring notices to newly hired workers explaining their classification and their rights, increasing penalties against employers who misclassify their workers, and protecting workers from retaliation for challenging their employment status?

Answer. Cross-agency collaboration has already begun, under the leadership of the Vice President's office, to improve identification of worker misclassification across programs. DOL is exploring all possible options for addressing misclassification, including ways to provide better guidance to both workers and employers, and to increase information sharing between DOL agencies and the States that are also working on this issue. DOL's Wage and Hour Division (WHD), which

is responsible for enforcement of the FLSA, is planning to update the FLSA record-keeping regulations. As part of this rulemaking, WHD is considering requiring employers to notify workers of their rights under the FLSA and their status under FLSA as an employee or independent contractor. Your suggestion will be provided to the working group which is exploring ways to reduce worker misclassification.

SUIESO

Question. The 2011 budget request includes $18.52 million for administration of the Work Opportunity Tax Credit (WOTC). It also indicates that application backlogs may exceed 1 million by the end of fiscal year 2011. The congressional budget justification indicates that "ETA proposes to conduct an intensive strategic management analysis to identify the administrative tools, process improvements, and IT investments that could support States in their efforts to reduce pending applications."

ETA already has undertaken a "comprehensive program review" of the WOTC program. What were the findings of this review, and related planned and implemented actions? What is the timeline for completing the intensive strategic management analysis?

Answer. In the 2009 comprehensive review of WOTC, ETA used State performance reports and information from State and regional WOTC coordinators to identify the States that had the largest backlogs. ETA then followed up with individual calls to the 10 States with the largest backlogs to discuss the reasons for the backlogs and to ask them to develop corrective action plans when necessary. Additionally, as part of its comprehensive technical assistance strategy, ETA has worked with all States to identify the causes of backlogs and successful ways to remediate backlogs based on anecdotal information. This information is disseminated to States through ETA's regional offices. The information obtained from the 2009 review did not yield adequate promising practices that could be implemented to reduce backlogs, and ETA now believes a comprehensive strategic management analysis of the WOTC certification process is necessary.

This comprehensive strategic management analysis will be used to assess application processing system protocols, recommend action to improve processing and reduce the current backlog of WOTC applications, and recommend information technology (IT) solutions, especially for States with little or no automation. The analysis will be based on a selected sample of State Workforce Agencies (SWA), and will employ various data collection methods such as review of operational material, and site visits. Based upon the findings, a report will include recommended actions for ETA to provide SWAs with promising tools and practices to reduce application backlogs, to improve the application process, and to suggest IT solutions reduce application backlogs. Once a contract is awarded, ETA anticipates the review to be conducted over 3 to 4 months, with expected completion by the end of August 2010

In an era when a growing majority of families are headed by two working parents or a single wage-earner, paid leave programs are one cornerstone of a vital support system for working families that also includes paid sick days for short-term illnesses, increasing the availability of flexible work arrangements, and other family-friendly initiatives.

Question. How would funds requested for the new State paid leave fund be allocated to States and for what purposes may the funds be used?

Answer. DOL is currently developing a more detailed implementation plan for the State paid leave funds requested in the fiscal year 2011 budget. While DOL anticipates that the bulk of the funds will be given to States for implementation grants, because States are in varying degrees of readiness for implementation, the Department may offer smaller planning or expansion grants. Implementation grants will be targeted to those States demonstrating a readiness to implement a State paid leave program, and funds may be used for the administrative costs associated with ramping up the program such as putting technology infrastructure in place and implementing an outreach effort to educate workers on their eligibility for benefits. All States will be eligible to apply for these grants.

Question. What further steps does DOL plan to take to promote policies that help workers balance their work and family obligations, under ETA, the Women's Bureau (WB), and other DOL agencies?

Answer. In fiscal year 2011 the WB will build on the lessons learned from its successful flex-options project. Workplace flexibility solutions, such as flexible work schedules, family-friendly leave policies, and telework, help employees navigate their work, family, and personal responsibilities, while simultaneously helping employers meet their recruitment/retention needs and helping communities ease traffic congestion 1and reduce their carbon footprints. Utilizing proposed funding provided in the fiscal year 2011 submission, WB will work with BLS to initiate the collection

of data on parental leave, child care responsibilities, family leave insurance programs usage, and other data related to the intersection of work and family responsibilities. WB will work with other DOL and Federal agencies, employers, women's organizations, and other stakeholders to use data and expand flexible workplace practices, and to promote laws and policies to help workers achieve work-life balance.

Question. What legislative changes are necessary to assist the administration in achieving its goals?

Answer. Apart from the Department of Labor's fiscal year 2011 Appropriations Act, no additional Federal legislation is necessary to implement the State paid leave grants. Should the need for legislative changes be identified in our ongoing work in this area, we will be happy to work with the Congress to develop legislative proposals.

INJURY AND ILLNESS RECORDKEEPING

Question. This subcommittee has raised concerns over the past several years about the underreporting of workplace injuries and illnesses, and directed OSHA to enhance its oversight and enforcement of employer injury and illnesses recordkeeping. As a result, OSHA has initiated a national emphasis program (NEP) designed to address this issue.

Why did OSHA complete almost one-third fewer recordkeeping inspections than targeted for fiscal year 2009? How will OSHA ensure that NEP recordkeeping inspections stay on track in 2010? What has OSHA found through its NEP, particularly its programmed inspections in fiscal year 2009 and fiscal year 2010? How does the 2011 budget request build on these findings? How much funding is included in the request to continue the program?

Answer. OSHA's NEP on recordkeeping was originally scheduled to be implemented on August 1, 2009. After undergoing extensive revisions during summer 2009 to ensure that the NEP would lead to the detection of the underreporting of injuries and illnesses, the NEP was implemented on September 30, 2009. Due to the extensive work on preparing the content and administration of the NEP, the recordkeeping inspection total for fiscal year 2009 dropped, and was not part of the NEP.

The recordkeeping NEP is designed to be maximally sensitive to under-recorded and mis-recorded injuries and illnesses in selected establishments, and to enforce the agency's recordkeeping requirements. Inspections under the NEP assess the accuracy of the information employers are required to record on the OSHA 300 log. The agency issues citations and penalties, as appropriate, for recordkeeping violations. The NEP targets establishments operating in historically high-rate industries that have reported low rates of injuries and illnesses. The program also includes establishments in the construction and poultry-processing industries, due to the inherently high-hazard nature of the work in those industries, and to questions that have been raised regarding recording practices in those industries.

Assessments of the accuracy of establishment-specific recordkeeping data are made by conducting interviews with employers, employees, company recordkeepers, first-aid providers, and healthcare providers. The assessments include a review of relevant records and documentation, such as medical records, workers' compensation records, and first-aid records. The NEP complements other efforts to evaluate and verify the accuracy of injury and illness rates, including OSHA's data initiative audit, and the BLS' efforts.

In fiscal year 2010, OSHA intensified training of its Compliance Safety and Health Officers (CSHOs) on identifying potential problems in recordkeeping data and systems. The agency's Training Institute staff revised the core curriculum for CSHOs to include a week-long mandatory training course on recordkeeping. OSHA plans to continue its recordkeeping NEP through fiscal year 2010, at which time the program will be assessed and recommendations will be made on whether or not to continue it in its present form. Assuming the assessment at the end of this fiscal year leads to the recordkeeping NEP continuing in its present form, the fiscal year 2011 budget request makes $1 million available for the recordkeeping enforcement initiative to maintain the number of recordkeeping inspections planned for fiscal year 2010.

Following are the results of Federal and State inspections conducted under the recordkeeping NEP during fiscal year 2010.

Recordkeeping NEP Inspections as of 4/19/10

OSHA has initiated 104 Federal inspections under the recordkeeping NEP through April 19, 2010. Of the 104 inspections, 11 have involved the issuance of citations for 45 violations of the recordkeeping regulation (part 1904), resulting in

$25,450 of penalties. It should also be noted that the vast majority of the 104 inspections are still open and subject to the citation of additional violations.

State Plan Inspections

Total inspection = 33 (31 are from the State of Oregon)
NIC inspections = 15

HIRING PLAN FOR ENFORCEMENT STAFF

Question. The budget request includes $227.149 million for Federal enforcement, which is an increase of $29.203 million and 160 full-time equivalents (FTE) more than the 2009 level.

What is DOL's plan (timeline and associated activities) for hiring these additional staff?

Answer. OSHA is committed to a hiring plan that emphasizes increasing its enforcement staff. Since February 2009, the agency's regional offices have hired 185 staff, of whom more than 150 are CSHOs and 13 are whistleblower investigators. The agency has a target of filling 270 positions during fiscal year 2010, and estimates that 150 possible hires are currently in the selection process, 100 of which are CSHOs. The number of hires since February 2009 and the target for hiring in fiscal year 2010 both account for historical attrition rates, therefore leading to goals that are greater than the requested FTE increases in fiscal year 2010 and fiscal year 2011.

OSHA maintains relationships with a wide variety of academic institutions and professional and trade groups to promote career opportunities within the agency. A Federal Career Intern Program has been implemented to add another facet to the agency's recruitment strategies for attracting highly qualified CSHOs, including future whistleblower investigators, to help the agency meet its hiring goals.

ERGONOMICS ENFORCEMENT

Question. Last year, the subcommittee encouraged OSHA to consider collecting information on musculoskeletal disorders in a separate column on the agency's recordkeeping form. OSHA plans to issue a final rule that will allow for the collection of this information.

How will this request enable OSHA to move forward on ergonomics-related enforcement activities?

Answer. A final rule will be issued in 2010 to revise the Occupational Safety and Health Administration's (OSHA) recordkeeping form to restore a separate column on musculoskeletal disorders (MSD) that was removed from the form in the last administration. Restoring this column will improve the workplace injury and illness data collected by OSHA and BLS. Having more complete and accurate data will further our understanding of work-related MSDs, which is certainly beneficial to any ergonomics research, and also better inform employers about ergonomic hazards in their workplaces.

OSHA has also launched a recordkeeping NEP, which will help ensure that musculoskeletal injuries are being recorded accurately by employers filling out the OSHA recordkeeping logs.

OSHA plans to continue to use the general duty clause, when appropriate, for enforcement when inspections find unaddressed hazards causing or likely to cause musculoskeletal injuries.

EVALUATIONS OF STATE PLANS

Question. The subcommittee provided additional funding under the OSHA State Plan program to help State Plan States rebuild capacity that has been lost in recent years. OSHA has also announced plans to conduct baseline special evaluations of each State plan during fiscal year 2010. These evaluations seek to better assess the current performance of each State plan and identify issues of concern.

What is the timeline for assessing these plans? How will OSHA help State Plans address deficiencies identified during these evaluations? How will the 2011 budget request help meet the requirement that State plans be at least as effective as Federal programs?

Answer. Since December 2009, OSHA regional offices have been conducting enhanced evaluations of State plan performance during fiscal year 2009. These reviews, which emphasize enforcement, are in the process of being completed, and we plan to issue the special baseline evaluation reports by early this summer. Upon completion of the reports, the States will be expected to develop corrective action plans with timetables to address any deficiencies identified. We do not expect to find significant deficiencies in all State plans, but will continue to address problems that

we do find and ensure that the State plans fulfill their commitments for effective programs. OSHA offers formal training to State plans and will provide informal training and technical assistance at the regional level upon request in areas such as accident investigations and enforcement of specific standards. In addition, OSHA will continue to communicate with States and monitor their progress in meeting their commitments as part of the national OSHA program.

The additional $1.5 million in grant funding requested for the States in fiscal year 2011 is intended to provide additional funding for increased personnel, staff training and equipment, and specific enforcement initiatives, which should enable the State programs to better keep pace with Federal developments and remain at least as effective as the Federal program. This funding should also allow all States to fill vacant positions and prevent them from reducing their programs due to budget shortfalls. As the economy improves, States are expected to use the additional funds for program enhancements.

TIMELINES FOR RULEMAKINGS

Question. Please identify the timelines for completion of the safety and health standards work with respect to notices of proposed rulemaking (four expected in each of fiscal years 2010 and 2011) and final rules (five expected in fiscal year 2010 and four expected in fiscal year 2011).

Answer. OSHA is revising its regulatory agenda to reflect the administration's priorities and new initiatives. The regulatory program is being expanded with the additional personnel authorized in the fiscal year 2010 budget, and the expansion will continue if the additional resources requested in fiscal year 2011 are provided. Five proposed rules are planned during fiscal year 2010. On January 29, 2010, OSHA published a proposal for a musculoskeletal column on the OSHA 300 injury and illness log, and received comments until March 30, 2010. The agency is reviewing the comments, and anticipates publishing a final rule in July 2010. Additionally, a proposal for walking and working surfaces will be published this spring. Proposals for standards improvement and consultation agreements are in the final stages of review, and will also be published soon. Finally, a proposal and direct final rule to implement a court remand for the hexavalent chromium rule were published on March 16, 2010, and the direct final rule is anticipated to become effective during fiscal year 2010.

In addition to the hexavalent chromium and musculoskeletal disorders column rulemakings, OSHA is on target to publish five other final rules during fiscal year 2010. Three of these, including two whistleblower standards and the final rule for construction cranes and derricks, are considered to be high-priority rulemakings. The cranes and derricks rule was submitted to the Office of Management and Budget (OMB) for Executive Order review on April 7. The other two rules are currently in internal review, pending submission to OMB. OSHA has also completed final actions for the abbreviated Portacount respirator fit-testing method rulemaking and the acetylene consensus standards update.

OSHA projects that the agency will publish four proposals in fiscal year 2011. Two new, high-priority items were added to the spring regulatory agenda, a rulemaking on injury and illness prevention programs and one to modernize OSHA's injury and illness recordkeeping regulations. The next step for the injury and illness prevention programs rulemaking is to hold stakeholder meetings in anticipation of publishing a proposal during fiscal year 2011. Additionally, during fiscal year 2011, the agency plans to publish proposed rules for beryllium, silica, and an update of the injury and illness recordkeeping industry exemptions to be consistent with newer industry classification systems.

OSHA plans to publish five final rules during fiscal year 2011. The final rules for nationally recognized testing laboratories, consultation agreements, and shipyard general working conditions are anticipated to be completed at the beginning of fiscal year 2011. The final rule for electric power and generation is also on track for publication in fiscal year 2011. Finally, the hearings to update the hazard communication rule have been completed, and the posthearing comment period will close on May 31, 2010. After OSHA reviews the comments received, the agency will begin work on the final rule—preamble, regulatory text, and economic analyses—which is projected to be published in fiscal year 2011.

QUESTIONS SUBMITTED BY SENATOR DANIEL K. INOUYE

SENIOR COMMUNITY SERVICE EMPLOYMENT PROGRAM (SCSEP)

Question. In 2010, funds appropriated for the SCSEP were increased to provide more opportunities in paid community service training and service for unemployed, low-income older persons.

What plans do you have for future support of this dramatic increase in funding for a program of considerable importance to low-income seniors and community service agencies throughout the country?

Answer. The fiscal year 2011 budget requests a total of $600,425,000 for the SCSEP. This amount equals the base amount of the fiscal year 2010 appropriation and is a $28.5 million increase more than fiscal year 2009. The fiscal year 2010 appropriation of $825,425,000 included a one-time special infusion of $225 million into SCSEP to quickly serve additional unemployed, low-income seniors in the current difficult economic times. However, as the economy continues to improve, we believe that the fiscal year 2011 budget request of $600,425,000 is appropriate and will provide part-time employment opportunities in community service for low-income older workers.

In part, due to the recession, many seniors have expressed a need for skill training funds specifically appropriated for low income older workers in the Workforce Investment Act (WIA) funded one-stop centers.

Question. How is the Department of Labor (DOL) planning to address the needs of a growing older population of job seekers in the workforce development system in the near to intermediate term?

Answer. Older workers will account for an increasingly large portion of America's workforce in the decades ahead. The public workforce system under the WIA has served an increasing number of older workers over the past few years and currently provides job training and employment services to older workers at a rate roughly equal to their share of the total unemployed workforce.

DOL plans to address the needs of this growing older population of job seekers in several ways. We will continue to help employers recognize the value of older workers as talented and productive employees and as mentors to younger workers. Last summer, we invested $10 million in 10 demonstration grants under the Aging Worker Initiative (AWI). These grants are designed to expand the public workforce investment system's understanding of how to best serve older workers, and develop models to share with all local workforce investment areas. AWI focuses on providing training and related services to individuals 55 and older that result in employment and advancement opportunities in high-growth sectors. Its ultimate goal is to provide better, more expansive services to older Americans for many years to come. In fiscal year 2011, DOL will utilize the results of the AWI demonstration grants to build the capacity of the public workforce system to better serve additional older workers who need and want good jobs. DOL will build on lessons learned and its experience under the "regular" SCSEP and additional American Recovery and Reinvestment Act (ARRA) investments to encourage and expand "green" jobs opportunities for older, low-income workers. In addition, DOL will continue to encourage the One-Stop Career Center system to increase its role in assisting older workers who want to update their skills, helping job-ready older workers obtain employment, and breaking down the barriers to fair and diverse work places for older workers.

The national sponsor for the SCSEP serving American Indians often operates in areas with unemployment rates considerably higher than the average for the United States. This makes placement into unsubsidized employment extremely difficult and reflects poorly on the sponsor's evaluation.

Question. Does DOL have plans for recognizing local unemployment conditions when evaluating placement rates for national sponsors serving seniors in such areas?

Answer. DOL currently takes into account local economic conditions during the annual performance goal negotiation process with each grantee, including two grantees that serve primarily the American Indian community—the National Indian Council on Aging and the Institute for Indian Development. The past performance of each SCSEP grantee (which reflects conditions faced at the local level) is also a key factor in determining performance goals. During the annual negotiation process with DOL, each grantee is urged to present information about unemployment and other economic factors which create additional barriers to meeting performance goals. In addition, any grantee may present new information during the program year regarding local or regional economic or environmental emergencies that could justify an adjustment of goals. Mid-year goal adjustments can also be made based on national economic conditions.

The national sponsor serving Asian and Pacific Island aging communities through SCSEP has articulated high barriers to providing service: 85–95 percent of enrollees have limited or non-English speaking proficiency (depending on the project site), some have literacy issues, and many are new immigrants with limited U.S. work history and access to social security or pensions. In short, this sponsor reaches out to the most difficult to serve and vulnerable of our seniors. These characteristics make it unrealistic to continuously meet performance requirements. A distinct challenge, for example, is the average earnings performance measure which requires that enrollee who exit the program for unsubsidized employment earn an average $13,000 per year. The sponsor considers it a success when enrollees move on to unsubsidized employment, particularly with benefits. However, evaluating program performance based on earnings level penalizes an otherwise successful performance.

Question. What is DOL doing to address these special situations with SCSEP so as to minimize the negative aspects of a "one size fits all" approach to performance evaluation?

Answer. DOL does not use a "one size fits all" approach to performance evaluation; rather it takes into account labor market and economic conditions. For example, the National Asian Pacific Center on Aging (NAPCA) serves a large number of participants with language barriers—89 percent in the four quarters ending December 31, 2009—and its overall performance is good. While NAPCA has not yet met its negotiated entered employment rate goal of 39.9 percent for the 6-month period between July 1 and December 31, 2009, it has exceeded its average earnings goal of $6,490 for SCSEP participants placed in unsubsidized full- or part-time employment. In addition, its employment retention goal for participants who obtained employment is only 0.1 percent below the performance goal of 67.6 percent for that time period.

The Employment and Training Administration (ETA) is currently in the process of implementing a regression-based model for the major programs in the workforce system. This regression-based model addresses the negative aspects of a "one size fits all" approach to performance management because it applies economic conditions, such as the unemployment rate, and program participant characteristics to adjust program goals and targets. ETA is currently applying this model to the SCSEP national performance goals and plans to extend the model to State and local areas over the next 2 years.

National sponsors of the SCSEP serving American Indians and Asian Pacific Islander Americans are often limited to serving only those enrollees in the counties assigned by DOL. This leaves large segments of the American Indian and Asian Pacific Islander American seniors inaccessible to these national sponsors best-equipped to serve these elders in terms of language and cultural sensitivities.

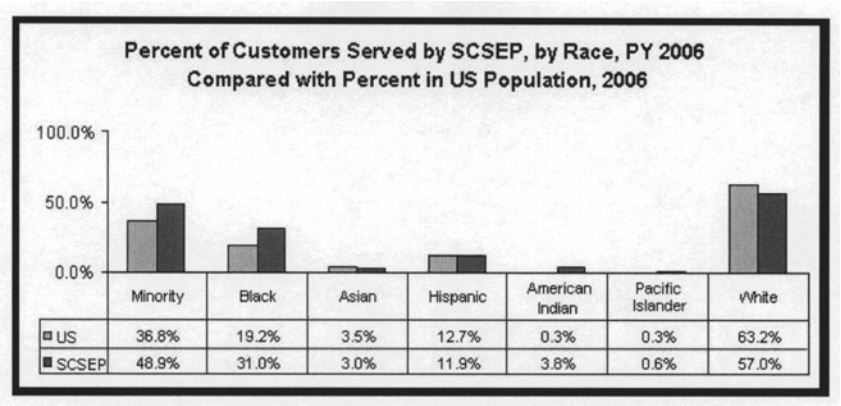
Question. What can DOL do to better align these national sponsors with the seniors they are equipped to and charged with serving?

Answer. Current legislation directs DOL to allocate authorized positions on a county level. Because the American Indian and Asian Pacific Islander populations are widely dispersed, DOL requires each SCSEP grantee to serve the minority individuals residing in the county(s) where they provide service. Nationally, SCSEP serves a substantially higher proportion of minorities than their incidence in the population. For example, 48.9 percent of SCSEP participants are minority compared with 36.8 percent in the U.S. population. SCSEP also serves slightly higher proportions of three specific minority groups—Blacks, American Indians, and Pacific Islanders—than their incidence in the population. The following table shows the distribution of minority participants served by the SCSEP grantees as a whole and by each of the three current minority grantees during calendar year 2009.

SCSEP minority participants	Total number served by all SCSEP grantees	Number served by the National Asian Pacific Center on Aging	Number served by the National Indian Council on Aging	Number served by the Institute for Indian Development	Total for minority grantees
Hispanic, Latino, or Spanish origin	9,660	21	57	1	79
American Indian or Alaska Native	2,160	1	438	24	463
Asian	2,696	736	7	.....	743
Black or African American	27,135	44	71	98	213
Native Hawaiian or Pacific Islander	598	13	1	.....	14

We are working to complete a report on service to minorities and will have more recent data in a few weeks. In the interim, the following table demonstrates the percentage of minority groups served by the SCSEP in comparison to the percentage

of minority groups in the U.S. population aged 55 and older as of 2006. Data from the past 2 years show no disparities in service that impact minorities overall and few for individual minority groups.



	Minority	Black	Asian	Hispanic	American Indian	Pacific Islander	White
US	36.8%	19.2%	3.5%	12.7%	0.3%	0.3%	63.2%
SCSEP	48.9%	31.0%	3.0%	11.9%	3.8%	0.6%	57.0%

As the economy slows, global competition intensifies, and energy costs rise, many industries such as agriculture are releasing workers. Nowhere is this more evident than in Hawaii with the termination of all dairy operations on the island of Oahu and the rapid collapse of century-old sugarcane and pineapple plantations throughout the State. These dramatic changes are occurring at a time of increased awareness of Hawaii's fragile food security and increased need for food safety at all levels of the food production chain.

Question. What steps are you taking to harness the potential of dislocated agricultural workers to address the unique food security and food safety issues found in Hawaii?

Answer. The WIA of 1998 established a decentralized public workforce system where information about and access to a wide array of job training and employment services are available through local One-Stop Career Centers. DOL allocates WIA funds to States using statutory formulas, and States such as Hawaii, in turn, use similar formulas to allocate funds to local workforce areas to be administered by local workforce investment boards that plan and oversee the local system.

Workers that lose their jobs can access three levels of service through local One-Stop Career Centers: (a) "core" services including outreach, job search and placement assistance, and labor market information; (b) "intensive" services including comprehensive assessments, development of individual employment plans, career planning and counseling, and supportive services such as child care and transportation; and (c) "training" services, including occupational classroom or on the job training that can be combined with basic skills training, and entrepreneurial training. Eligible farmworkers in Hawaii also can access a range of services through the National Farmworker Jobs Program grantee Maui Economic Opportunity, Inc. located in Wailuku. Thus, Hawaii is well-positioned to address the needs of the local economy and to help workers affected by the termination of food production operations transition to good jobs. As the State of Hawaii develops policies and strategies to address food security and food safety issues, the public workforce system will be available to support its workforce development needs.

Question. Can you share your DOL's vision of what a robust, highly effective summer jobs program looks like, how we get there, and how we make it as inclusive and responsive to the needs of all eligible youth?

Answer. A robust, highly effective summer jobs program would include a broad outreach and recruitment strategy focusing on both in-school youth and disconnected, out-of-school youth; broad employer outreach in both the public and private sector to ensure a broad range of summer job options for youth including opportunities in high-growth or high-demand industries such as healthcare and green jobs; and, an assessment of each youth's skill level, interests, and needs in order to match them to the summer job that would provide the, greatest benefit for them and their employers. In addition, such a summer jobs program would offer a thorough orientation for both youth and employers; work readiness training for youth to prepare them for their summer job; a monitoring strategy for both youth and worksites to ensure quality work experiences and to provide support to both youth and employers if any issues with the youth's employment arise; and transition services following

summer employment to ensure youth successfully transition into education or to unsubsidized employment. Through the implementation of summer employment opportunities under ARRA, local programs are on their way to achieving this vision, and through DOL's fiscal year 2011 budget request for a Youth Innovation Fund, DOL will fund innovative summer employment models to continue these efforts and learn which particular approaches produce the best employment and educational outcomes for youth. The strategies identified above will assist in making summer employment programs inclusive, responsive to the needs of all eligible youth, and benefit local communities.

APPRENTICESHIPS

Question. Madam Secretary, I believe we have an underappreciated and underutilized jewel in our Nation's apprenticeship system. As you know, exceptional apprenticeship programs combine rigorous academic and technical instruction with authentic, on-the-job training and learning. As a result, these programs are highly valued by employers, unions, and students.

How we can continue to grow our apprenticeship programs, and rebuild our Nation's ability to fill middle and high-skills occupations and grow key industries, such as those in the emerging green economy?

Answer. ETA continues to focus on expanding registered apprenticeship opportunities for America's workers, enabling them to "learn while earning" along career paths to middle- and high-skilled occupations, particularly those in high-growth industries and the emerging green economy. DOL's efforts have centered on: (a) expanding resources available to the National Apprenticeship System; (b) increasing the budget for the Office of Apprenticeship to plan, encourage, and register apprenticeship programs; and (c) promoting partnerships between the broader workforce system and registered apprenticeship programs.

For example, a significant number of DOL's recently awarded ARRA competitive grants included registered apprenticeship as a critical partner in training and employing thousands of workers in green industries and occupations. In addition, DOL recently awarded $6.5 million in grant funds to 11 national organizations to expand and advance apprenticeship programs, with many upgrading their training efforts to meet the needs of the emerging green economy. Finally, DOL's fiscal year 2011 budget request includes a proposal for an employer-paid fee on H–2B visas that would support a new grant initiative to expand registered apprenticeship at the national, State, and local levels.

DOL's fiscal year 2011 budget would increase the budget for the Office of Apprenticeship by approximately 35 percent from the fiscal year 2009 budget of about $21 million. This increase will ensure that the Office of Apprenticeship will meet its core responsibilities for the promotion of registered apprenticeship, partnering with State agencies, protecting the welfare of America's apprentices, ensuring equal opportunity, and fulfilling new responsibilities resulting from recent regulations that strengthen performance accountability for the National Apprenticeship System.

DOL also encourages State and local workforce agencies and boards to expand registered apprenticeship programs that can prepare workers for careers in the renewable energy sectors and for other "green jobs". We have developed, offered, and plan to expand a series of regional "Collaborate for Success: Partnering with Registered Apprenticeship Action Clinics" where State-based teams learn how to incorporate registered apprenticeship into their workforce development strategies and learn how to improve partnerships with community colleges, community-based organizations, healthcare providers, "green" employers, and economic development entities.

QUESTIONS SUBMITTED BY SENATOR PATTY MURRAY

STATE PROGRAMS

Question. Along with 26 other States, my home State of Washington, under an agreement with Occupational Safety and Health Administration (OSHA), operates an occupational safety and health program in accordance with section 18 of the Occupational Safety and Health Act of 1970. Washington State's OSHA plan is administered by the Washington State Department of Labor and Industries. The departments' primary focus is on protecting the safety and welfare of Washington's 3 million plus workers with on-the-job safety and health through inspections and enforcement programs through voluntary consultations and training. They also help protect consumers from unsound building practices, combat illegal employment practices, and help develop the State's skilled workforce through apprenticeship programs. In

years past the successes of our State programs has been jeopardized by the lack of funding from the Federal level to maintain current programs let alone to expand and implement new safety standards for new equipment and or technologies.

Does the Department of Labor (DOL) have any ideas on how the State and Federal level can worker closer together to further implement workplace safety standards?

Answer. OSHA and the States that operate approved State plans, including Washington State, maintain an ongoing partnership to ensure protection for all the Nation's workers. OSHA meets three times a year with the full membership of the Occupational Safety and Health State Plan Association (OSHSPA), which represents all 27 States operating State plans, and an additional three times a year with the OSHSPA Board of Directors. At these meetings, the attendees discuss Federal and State initiatives, and share information to enhance both Federal and State programs. OSHA's Regional Administrators and their staffs work with the State plans on a daily basis to coordinate efforts, provide technical assistance, and monitor their performance. State plan representatives serve on task forces with OSHA to address issues such as newly identified hazards and compliance initiatives. While States may focus their enforcement and outreach activities on State-specific industries and hazards, States also participate in OSHA National Emphasis Programs to address selected hazards on a nationwide basis.

OSHA is also working with the States to broaden their participation in more of these national programs in the interest of greater nationwide consistency. The State plans all participate in OSHA's management information system; information on State inspections is available on OSHA's Web site and in its database in exactly the same manner and detail as OSHA's Federal inspections.

Finally, in an effort to ensure that State plans are at least as effective as the Federal plan, we are currently conducting special reviews of all of the State plans, which will include recommendations on improvements they can make in their operations.

Question. Can I have a commitment from you that we will continue to keep State OSHA plans fully funded and functional so as not to increase the heavy burden of inspections and cases handled on the Federal level?

Answer. OSHA's State plan funding levels are set by Congress as part of the agency's annual appropriation, and OSHA will continue to distribute all available funds appropriated by Congress in accordance with the Act. No State plan is required by law to contribute more than a 50 percent match of the available Federal funds for the total costs to the State of their safety and health program. However, many States have chosen to contribute significant additional funding. Currently, 19 of the 27 approved State plans, including Washington, contribute additional State funds over and above the amount that OSHA allocates to them from amounts made available for State plans in the agency's annual appropriation. The other eight States provide the 50 percent share, the same as the Federal funds made available to them.

The fiscal year 2010 appropriation included an $11.8 million increase for State plans, the first significant funding increase in many years. The funds were distributed to States in accordance with a funding formula that takes into account a State's worker population and the extent to which its industries are hazardous. The eight States which were unable to match all or part of the increase for this fiscal year will be given until fiscal year 2012 to obtain matching funds. The fiscal year 2011 budget requests $105.9 million for State plan programs, an increase of $1.5 million from the fiscal year 2010 level.

REGULATIONS

Question. On OSHA's rule on cranes and derricks—this rule to protect construction workers has been in the works for years and repeatedly delayed. The latest regulatory agenda says the final rule will be issued in July 2010.

Is this rule on track to be issued by this date?

Answer. Yes. The final rule for cranes and derricks has been submitted to the Office and Management and Budget in anticipation of a July 2010 publication date.

After a number of years of inaction under the last administration, we appreciate that OSHA is now moving forward to develop and issue needed regulations. There are many serious hazards that need to be addressed. I would like to ask you about a few specific rules and when we might expect movement.

Question. OSHA's rule on silica has also been repeatedly delayed. Will a proposed silica rule be issued in July as listed in the regulation agenda?

Answer. Newly appointed Assistant Secretary David Michaels is providing strong leadership and is committed to moving forward with the silica rulemaking. OSHA

recently completed a peer review of the health effects and risk assessment sections needed to develop the proposed rule. The agency is continuing to refine the scientific risk assessment and develop the robust economic analysis required to support a proposed rule; consequently, the proposal will not be issued in July as had been projected in last fall's regulatory agenda. Please be assured that the rulemaking for silica remains a high priority for the agency. OSHA is working to complete these analyses and the proposed rule is scheduled to be published in February 2011.

Question. In 2007, 14 workers were killed at the Imperial sugar refinery in Georgia when sugar dust caused a deadly explosion. The Chemical Safety Board recommended that OSHA needs a regulation to prevent these kinds of explosions in the future.

What are OSHA's plans for issuing a proposed rule and a final rule on combustible dust?

Answer. On October 19, 2009, OSHA published an Advanced Notice of Proposed Rulemaking (ANPR) for combustible dust. The comment period officially closed in January 2010. More than 110 comments have been submitted, which are currently under review by OSHA personnel. On December 14, 2009, OSHA hosted two stakeholder meetings in Washington, DC. Two additional meetings were held in Atlanta, Georgia, on February 17, 2010. Nearly 100 stakeholders have expressed their views to OSHA so far. Two more meetings are scheduled for Chicago on April 21, 2010.

OSHA's economists are analyzing the responses to the ANPR and reviewing other sources of information to help analyze the economic impacts of a proposed rule. A Small Business Regulatory Fairness Act Panel is being planned for the spring of 2011 to solicit input on the potential economic impacts on small businesses. OSHA is drafting a proposed rule as it continues to conduct research, solicit and analyze input from stakeholders, and review responses to the ANPR. OSHA anticipates that a proposed rule for combustible dust will be published in 2012.

MISCLASSIFICATION

Question. As you know, we've been advocating, and the subcommittee has been focused on the problem of employee misclassification as independent contractors for some time now. Those efforts have resulted in the President's active support new budget proposals and a new joint Labor-Treasury initiative to "strengthen and coordinate Federal and State efforts to enforce statutory prohibitions, identify, and deter misclassification of employees." The budget includes $25 million to support four program components.

Misclassification not only deprives workers of numerous rights and benefits (e.g., overtime pay, the employer's share of Social Security and Medicare contributions, rights to a safe workplace, civil rights protections, etc.), but it also gives tax cheats an unfair advantage in competing for business over responsible employers who follow the law. And, at a time of significant budget deficits, it is a major source of revenue losses for the Federal and State governments.

I was excited to see that this administration is being proactive about the problem of misclassification abuses.

How soon will you be able to get this initiative up and running?

Answer. Should the Congress provide the requested funds, the different elements that are a part of the initiative will be implemented at various points over the next year. The DOL's budget request for fiscal year 2011 includes $25 million for DOL, including $12 million for increased enforcement of wage and overtime laws in cases where employees have been misclassified; these funds will allow us to hire more investigators and provide better training on how to determine who is an employee and who is an independent contractor. Even though these funds will not be available until fiscal year 2011, we are already planning how best to target enforcement to identify and remedy widespread misclassification and we are emphasizing this issue in our current, fiscal year 2010 enforcement strategy.

Question. The proposal indicates this is a "joint Treasury-Labor initiative" to detect and deter misclassification.

What exactly will be the Department of the Treasury's role in this joint effort?

Answer. DOL has established a working group, headed by the Wage and Hour Division (WHD) Deputy Administrator, which includes members from a number of DOL agencies, including OSHA and ETA. This working group is also working with the Vice President's Middle Class Task Force and the Department of the Treasury on a Government-wide effort to develop strategies to address misclassification.

The Department of the Treasury is seeking legislation to allow it to better define and clarify worker classification standards—which benefits workers and firms by reducing uncertainty—and to prospectively reclassify misclassified workers. The Presi-

dent's budget estimates that this would increase Treasury receipts by more than $7 billion over 10 years, much of it consisting of unpaid taxes.

Question. I am glad to see that the portion of the initiative that will be implemented by the WHD is appropriately targeted to industries and employers that have been identified as having a record of significant misclassification violations.

Can you elaborate on other aspects of the initiative that are designed to maximize your investigative resources, for instance coordination with State efforts?

Answer. The DOL's working group is exploring ways for all DOL agencies to provide better guidance to both workers and employers and increase information sharing between DOL agencies. Over the next few months, the working group plans to bring in a diverse array of stakeholders, including unions, worker advocates, and employer groups, to get their input on misclassification and what steps we should take. We are also planning to meet with representatives from State misclassification task forces to learn from their experiences.

—I think it is especially important that you have proposed a pilot program of competitive grants to reward and help States that have stepped up efforts to detect and prosecute misclassification violations. These programs, usually undertaken by State Unemployment Insurance Administrators, are severely understaffed and underfunded.

Question. What does the DOL hope to achieve with the grants program?

Answer. An additional $10,950,000 is requested for the ETA for two initiatives focused on increasing the capacity to address misclassification within the Federal/State administered Unemployment Insurance program. The first initiative provides states the opportunity to compete for grants to increase their capacity to participate in data sharing activities with the IRS and other Federal and State agencies; to implement targeted audit strategies; establish a cross-State agency task force to target egregious employer schemes to avoid taxation through misclassification, and to develop education and outreach programs. The second initiative would pilot a high-performance award program designed to encourage States to improve misclassification efforts. States that are most successful (or most improved) at detecting and prosecuting employers that fail to pay their fair share of taxes due to misclassification and other illegal tax schemes will be rewarded.

BUREAU OF LABOR STATISTICS (BLS)

Question. Madam Secretary, the President's budget for the BLS includes a new initiative designed to restructure the Current Employment Statistics (CES) Program. This CES initiative proposes reducing funding to the State labor market information (LMI) agencies by $12 million (a 50+ percent reduction in BLS funding to the States for CES) while re-programming $7 million to fund BLS staff to make improvements in data collection and survey response rates. As proposed, the net savings to the CES program would be $5 million. BLS indicates that this change will have no net impact on data quality and variance at the national level. While this savings goal is laudable in this period of significant budget concerns, I have some concerns about the negative impact that this move could have on State LMI agencies in maintaining their capacity to generate, analyze, and disseminate data to State and local policymakers—especially when data is so critical to guiding people toward employment opportunities during this recovery.

BLS indicates that this proposal will improve data quality overall and provides evidence that the proposed change to the CES program would have little impact on national employment estimates. However, a number of State LMI agencies have expressed concern that this move will reduce BLS' ability to access local knowledge in making estimates (given the reduction in State staff). The State LMI agencies also contend that the change will increase the variance for employment estimates reported in about one-third of the States (according to BLS's technical explanation). This greater variance in State or regional estimates will be much more difficult to explain to State or local policymakers using the data. The LMI agencies are responsible for explaining State estimates from this program to budget and tax revenue forecasters, economic developers, workforce developers, and other policy makers that rely on the CES to inform their decisionmaking. As proposed, this change would substantially reduce the State knowledge base in supporting user questions about this important program since fewer staff will be familiar with how the estimates are being generated and the rationale behind some variance.

Furthermore, there is some concern that this "centralization" could have significant long-term implications for the Federal-State statistical system, first established during the Great Depression. Certainly, enormous advances in information technology have occurred since the program was put into place, providing opportunities for increased efficiencies and shifting responsibilities. This may be an appropriate

time to conduct a thoughtful, thorough review of the current state of the Federal-State cooperative effort, not just for the Current Employment Statistics program, but also for other BLS data programs such as Local Area Unemployment Statistics, Occupational Employment Statistics, the Quarterly Census of Employment and Wages, and Mass Layoffs Statistics. Such a review would provide the basis for implementing a more considered, effective approach to a 21st system cooperative system, one that takes full advantage of the complementary strengths of BLS and the LMI agencies.

Question. I'd like to ask DOL to provide a long-term vision for how the Federal-State statistical system is to be strengthened, improved and expanded. And I'd like to ask the department to consider undertaking a deliberative review of this Federal-State cooperative.

Answer. The DOL thanks the Senator for sharing her concerns about the BLS proposal to restructure the CES program. While the proposal does reduce the number of State-funded positions, it reduces the workload on States commensurately. Moreover, the proposal allows for States to retain about 100 positions for collecting and providing BLS with local knowledge for making estimates, and for conducting analysis and dissemination of the estimates to State and local users.

Regarding State concerns about the quality of the estimates, BLS research comparing State-made to BLS-made estimates indicates that about one-third of the former showed smaller errors (when benchmarked to the annual comprehensive employment count from the unemployment insurance system). However, BLS-made estimates were comparable in accuracy for one-third of States, and more accurate for another third of States. For this research, BLS made its estimates in a completely automated fashion with no analyst review or intervention in the estimation process. After the implementation of this proposal, estimation will be conducted by a staff of about 30 BLS analysts and the quality of BLS-made estimates for publication will be higher than the quality of the estimates generated for research purposes. In addition, the BLS-made estimates will reflect a consistent, objective, and transparent methodology across all States.

Upon implementation, this proposal will reinvest a portion of the savings from restructuring to improve survey response rates and accelerate the rate at which the sample of businesses is refreshed. Both of these enhancements will contribute to reducing statistical error in the national, State, and area estimates. BLS staff would welcome the opportunity to meet to address any other questions on the CES restructuring proposal.

The DOL continues to value Federal-State cooperation in the accomplishment of BLS statistical programs. Working through BLS, the DOL consults regularly with the State LMI agencies on strategies for strengthening and improving the statistical system. The fiscal year 2011 budget request for BLS includes approximately $80 million in support of State operations on the five cooperative statistical programs. This amount also includes a request for additional resources for one of these programs—Occupational Employment Statistics (OES)—to improve the usefulness of OES data for identifying trends in occupational employment and wages. In particular, this initiative will improve the quality of OES data for State and local decisionmaking on investments in education and training programs. Lastly, the Department will take the suggestion to review the Federal-State cooperative programs into consideration.

QUESTIONS SUBMITTED BY SENATOR MARY L. LANDRIEU

VOLUNTARY PROTECTION PROGRAMS

Question. Currently, there are more than 100 sites in the Voluntary Protection Programs (VPP) in and actively pursuing VPP status in the State of Louisiana. Collectively, these sites employ approximately 24,656 workers.

How will the proposed shift in the Department of Labor's (DOL) Occupational Safety and Health Administration (OSHA) resources from compliance assistance to enforcement impact these VPP sites in terms of their ability to either obtain or retain VPP their ability to participate in the VPP in 2011?

Answer. OSHA is not eliminating the VPP. However, OSHA is looking for other nongovernmental-funded ways to continue the program. Given the budgetary issues facing the Nation, the agency is making hard choices to use our limited resources where they are most needed.

As a result, OSHA is reducing Federal resources spent on companies that fully understand and exercise their responsibility to protect their workers' health and safety to invest resources in companies that are not doing a good job protecting their

employees. The agency recognizes the importance of the, VPP, and participating companies that have made a valuable contribution to workplace safety by going above and beyond OSHA's requirements and serving as models for others.

According to Government Accountability Office (GAO) report on the VPP published in May 2009, approximately 80 percent of VPP worksites have fewer than 500 employees.

Question. Has OSHA studied and concluded separately on the impact on small businesses of the fiscal year 2011 DOL budget proposal to shift OSHA resources from compliance assistance to enforcement? What are OSHA's plans to review the impact on small businesses that participate in the VPP of implementing a user fee system to fund VPP?

Answer. Currently, 99 of 1,644 Federal VPP sites—or 6 percent of the total—meet the small business definition (i.e., 250 or fewer employees and not part of a corporation/organization with 500 or more employees.) Only 30 percent of all workers are employed in establishments larger than 250 employees. In other words, 94 percent of VPP sites are part of large companies where only 30 percent of Americans work.

In addition, OSHA's fiscal year 2011 budget includes a $1 million increase for the State Consultation Program, which provides free on-site consultative services for small businesses that request assistance in achieving voluntary employee protection. The Consultation Program is particularly useful to small businesses, and the additional funding requested in fiscal year 2011 will help meet the demand from small employers seeking assistance to come into compliance with OSHA requirements

The May 2009 GAO report found merit in the VPP programs overall, but that OSHA had not developed goals or measures to assess the performance of the VPP, and the agency's efforts to evaluate the program's effectiveness had not been adequate. OSHA generally agreed with the GAO report's recommendations to develop procedures and measures to assess the performance of the VPP.

Question. What is the current status of implementing the recommendations from the GAO report for assessing the performance of the VPP?

Answer. OSHA is currently reassessing all aspects of the VPP due in part to the GAO report of May 2009. At the same time, OSHA is an active participant in the Department-wide 2010–2016 strategic planning process and is formulating new performance measures for all of its programs.

QUESTIONS SUBMITTED BY SENATOR JACK REED

Question. There are more than 16,000 public libraries in the United States, most of which provide job/career information and resources, such as access to computers so that patrons can search for jobs and file for government services such as unemployment benefits. In the economic downturn, libraries are a community resource increasingly in demand, especially by those who are unemployed.

How will the Department of Labor (DOL) work to better integrate libraries into our workforce system so that they receive the support they need to continue providing these services to the public?

Answer. DOL, Employment and Training Administration (ETA) has entered into a partnership with the Institute for Museum and Library Services (IMLS) in recognition of the critical role that both the public workforce system and the Nation's public libraries play in responding to jobseekers' needs. The goal of the partnership is to encourage libraries and the workforce system to collaborate at the State and local levels, resulting in increased employment and training services to job seekers that lead to good jobs, including career pathways and sustainable wages.

ETA and IMLS are engaged in a number of activities to support libraries in meeting the growing employment needs of their patrons. For example, ETA has already incorporated libraries and existing co-locations between libraries and One-Stop Career Centers into America's Service Locator (www.servicelocator.org), an online search tool for local service providers. This allows a library patron or job seeker to locate the nearest One-Stop Career Center and library within their community so that they can access the employment and training services they need. ETA is preparing to announce the ETA/IMLS partnership to the workforce system, including the announcement of successful collaborations between libraries and the public workforce system, and to encourage development of such partnerships at the State and local levels.

In addition, ETA has shared information about the employment and training resources available through the public workforce system with IMLS and its strategic partners. For example, ETA has begun to disseminate information about its national electronic tools, including CareerOneStop (www.careeronestop.org) and the occupational database O*NET (www.onlineonetcenter.org), that provide important ca-

reer information and resources to individual libraries and library systems. ETA also plans to conduct a webinar to orient and train librarians and other staff to the electronic tools, which are accessible to library patrons and other job seekers anytime at any physical location via the Internet. Lastly, ETA staff is using library newsletters and other dissemination channels to inform the library community about events and developments that are relevant to workforce development and this partnership.

In comparison to the more than 16,000 public libraries, there are roughly 1,800 federally funded "One-Stop" Career Centers under the Workforce Investment Act. There is some evidence that the unemployed are opting to use their local library for the services that the One-Stops are designed to provide due to location or other reasons. It has also been reported that some of these centers refer users to their local libraries for additional job search assistance. At the same time, there are some examples of libraries and local workforce development organizations working together to provide help to job seekers, such as in North Carolina.

Question. What are your thoughts on ways we can support and expand these collaborations to best serve job seekers?

Answer. Partnerships between the Nation's public workforce system and the library system increases the access points by which job seekers can receive critical career information and job assistance. ETA plans to announce the existing partnership between ETA and the IMLS at the Federal level and encourage partnerships at the State and local levels. This will be followed by an ETA-sponsored webinar for the public workforce system this summer that showcases promising examples of collaboration. Examples of partnership activities to be highlighted include:

—co-locating One-Stop Career Centers and libraries;
—collaborating to train library staff about employment and training resources available through the public workforce system;
—using library space to provide services to library patrons, (e.g., familiarizing them with career resources offered through the public workforce system and available electronically) or to host career events (e.g., career fairs); and
—sharing workforce and labor market information, including data on high-growth industries and occupations, from the public workforce system to libraries.

Both ETA and IMLS are engaging their respective systems' intergovernmental and other stakeholder organizations to identify examples of existing partnership activities that can be widely shared with leaders from the workforce and library systems. For example, during a National Governors Association event, ETA, IMLS, and workforce system and library leaders from the State of North Carolina discussed State level partnerships. In addition, ETA is also collaborating with the National Association of State Workforce Agencies and the National Association of Workforce Boards to identify promising collaborations at the State and local levels. Collaborative efforts will include the utilization of the Reemployment Works! Community of Practice—a virtual community for workforce professionals dedicated to exchanging promising practices, tools, and resources for connecting unemployed individuals with careers—to disseminate information and strategies about how partnerships between the public workforce and library systems can help jobseekers find new jobs and enter career pathways.

QUESTIONS SUBMITTED BY SENATOR THAD COCHRAN

WORKFORCE INVESTMENT ACT (WIA) WORKFORCE INNOVATION FUND (WIF)

Question. WIA provides job training and related services to unemployed and underemployed individuals including programs for adults, youth, dislocated workers, and others. As part of the partnership for WIF with the Department of Education, the budget proposes to reserve 5 percent of the appropriation for adult and dislocated worker programs to form a new WIF and 15 percent of the appropriation for youth services to create a Youth Innovation Fund. Innovation funding would provide grants to test new practices of expanding and improving services and outcomes in the workforce development system and to replicate promising or proven workforce strategies, such as apprenticeships and on-the-job-training.

NOTE: According to the Bureau of Labor Statistics, the seasonally adjusted unemployment rate for youth (16–24) nationwide is 18.5 percent for February 2010. In Mississippi, the overall unemployment rate is 10.9 percent (no State data is available specifically for Mississippi youth)

Given the high levels of youth unemployment, why is the Employment and Training Administration (ETA) proposing a cut (fiscal year 2011 compared to fiscal year 2010) in State formula grants for youth activities?

Answer. In fiscal year 2011, the Department of Labor (DOL) is requesting $1,025,000,000 to support WIA youth formula activities, an increase of $100,931,000 more than the fiscal year 2010 level. The fiscal year 2011 target for participants is 306,998, which includes 266,274 Formula Grant participants and 40,724 Youth Innovation Fund participants. This is an increase of 24,572 participants more than the fiscal year 2010 target. Fifteen percent ($153.75 million) of the request would be dedicated to testing and validating strategies for improving service delivery and outcomes for at-risk youth through the Youth Innovation Fund. The funds allotted to local workforce areas to provide services are not reduced; the 2011 request reduces the State reserve from 15 to 10 percent, so the share for local services is unaffected.

The Youth Innovation Fund will fund and rigorously evaluate innovative approaches to providing education and employment services to at-risk youth, particularly out-of-school youth. It will have two components: Summer and Year-Round Employment grants and Work Experience Plus grants. The Summer and Year-Round Employment grants will support paid work experiences for both in-school and out-of-school youth. The Work Experience Plus grants will allow local workforce investment boards, working in partnership with youth service providers, Governors and State workforce boards, to test innovative approaches for serving out-of-school youth in a comprehensive manner, combining work experience, education, and support services. Work Experience Plus programs will seek to help youth disconnected from education and from work move into postsecondary education leading to industry-based credentials, degrees, and employment. DOL expects that the Youth Innovation Fund ultimately will provide for more effective use of WIA formula funds through innovation and learning about what works for at-risk youth.

Question. Are the proposed innovation grants multi-year grants and would they require funding in subsequent years?

Answer. In fiscal year 2011, DOL envisions the Innovation Fund grants would be competitively awarded as multi-year grants. DOL believes multi-year grants are needed to allow adequate time to test and evaluate the innovative models and approaches that the Innovation Funds are designed to encourage. The Innovation Funds are proposed as a means of driving reform and continuous improvement, encouraging cooperation across programs and regions, and allowing the identification and replication of evidence-based approaches. DOL looks forward to working with Congress to support the Innovation Funds in WIA reauthorization and in subsequent years.

Question. If these proposed innovation grants are intended as multi-year grants, what are the proposed periods (e.g., 3 years, 5 years)?

Answer. DOL anticipates that the Innovation Fund grants will be multi-year grants, generally of up to 3 years. A multi-year approach offers grantees sufficient time to test their approaches, allow for flexibility where needed, and provide DOL with sufficient time to carry out a review or evaluation of the grant and other administrative responsibilities, such as grant close-out activities.

JOB CORPS

Question.

In prior years, DOL indicated that the appropriations for construction would be used to improve the condition of facilities at Job Corps centers. Specifically, DOL would place emphasis on the backlog of repairs on existing buildings and disposal of "surplus, nonmission-dependent properties."

What are the specific program efficiencies DOL is seeking to improve?

Answer. The Office of Job Corps expects to improve efficiencies in several areas. For example, we will use a multi-pronged approach to reduce increasing utility and fuel costs. The program is reducing its General Services Administration vehicle fleet, and replacing traditional vehicles with alternative energy-efficient electric vehicles for use on centers. Construction projects funded under the American Recovery and Reinvestment Act (ARRA) have included energy efficient upgrades that will reduce utilities costs at Job Corps center facilities. To complement these efforts, we have implemented a nationwide energy conservation campaign, funded by ARRA, which promotes the adoption of green practices by students and staff. Further, our new Job Corps centers are being built to Leadership in Energy and Environmental Design specifications and will be state-of-the-art, energy-efficient facilities.

Job Corps also is working to maximize centers' slot capacity utilization. The program anticipates an increase in students' average length of stay as a result of our rigorous career technical training system that includes industry-focused foundation courses for new students and the incorporation of industry-recognized certifications. Students must remain in the program longer to complete these program requirements. This increased retention will reduce costly student turnover.

Finally, Job Corps is exploring ways to decrease the cost of large scale on-center services, such as basic medical care and prescription drugs, without compromising the quality or provision of these services to students. The program also will evaluate its discretionary national office support contracts for possible reduction or conversion to Federal staff.

Question. How will DOL determine whether the benefits gained from transferring funds to operations will be greater than the benefits lost from less construction and renovation?

Answer. With the majority of shovel-ready projects already funded by the Recovery Act, the program anticipates no material loss to construction and renovation. In fact, over the coming months, Job Corps will be undergoing a large design phase to prepare construction projects for launch. Any decision to transfer funding would be preceded by a thorough review of the relative costs and benefits.

FOREIGN LABOR CERTIFICATION

Question. What specific steps is DOL taking to detect and deter fraud in the foreign labor certification process?

Answer. Within the ETA, the Office of Foreign Labor Certification (OFLC) undertakes a number of steps to both detect and deter fraud in the programs for which it has responsibility. These actions vary by visa program depending upon specific authorities, e.g. statutory and regulatory authorizations available to the OFLC. Many "triggers" or "flags" are built into application processing systems, both electronically and manually, in order to detect and prevent fraud from occurring.

Examples of specific actions include: (1) validating that the application OFLC receives was submitted by that employer and not someone fraudulently filing in their name; (2) verifying employer Federal Employer Identification Numbers; and (3) checking debarment tables, and other internal measures. In addition, OFLC extensively uses its audit authority and a request for information process when questions and/or concerns arise about an application, an employer, or its representative. Frequently applications are placed into audit when there are concerns about the availability of U.S. workers for the requested position, employer responses which trigger an audit, e.g., recruitment period not consistent with program requirements, etc. When and wherever appropriate, OFLC utilizes its debarment and revocation authority as additional means of insuring program integrity. OFLC also participates in the ongoing investigation and where necessary, prosecution of individuals involved in suspected instances of fraud. OFLC, along with DOL 's Wage and Hour Division, participates in Office of Inspector General investigations, provides expert testimony at grand jury trials, as well as contribute to other Federal agency investigations.

Question. Employers wishing to hire foreign workers often express frustration with the labor condition application (LCA) process and describe it as unresponsive to their need to hire people expeditiously.

What are the current backlogs, if any, by visa type, and what is the average "turn-around" time to process LCAs?

Answer. ETA's OFLC administers four major foreign labor certification programs:
—Permanent Labor Certification Program (PERM or the Green Card)
—H–1B Specialty Occupations Program (LCAs)
—H–2A Temporary Agricultural Program
—H–2B Temporary Non-Agricultural Program

The table below displays the application process and current case processing times for each of these programs. The Immigration and Nationality Act specifically requires the Secretary of Labor, prior to granting a labor certification, to insure that the employment of the foreign worker will not adversely impact the wages and working conditions of similarly employed U.S. workers. The OFLC also must determine there are no available U.S. workers for the requested position. These statutory obligations mean that to provide America's workers with opportunities to access jobs there is greater scrutiny of occupations and employers with pending applications in labor markets impacted by the layoffs.

In November 2009, ETA initiated an intensive effort designed to reduce PERM's backlog of cases. Its goal for fiscal year 2010 is to reduce the backlog by 50 percent to approximately 35,000 cases. We are on schedule, and we will continue this effort as part of our larger DOL commitment to customer service.

TABLE 1A.—ETA OFLC VISA CASE PROCESSING REPORT, FISCAL YEAR 2010 (THROUGH MARCH 31, 2010)

Visa category	Total applications processed				Active workload		
	Totals	Certified	Denied	Withdrawn	Pending cases	Backlog	Average "turn around" time
PERM	40,299	35,051	3,809	1,439	48,306	Yes	11 months
H–1B	152,630	127,201	20,834	4,595	7,031	No	4–5 days
H–2B	3,199	2,738	461	.....	120	No	16 days
H–2A	3,415	2,961	76	78	334	No	22 days
Fiscal year 2010 grand total	199,243	167,951	25,180	6,112	55,791		

Source: Administrative records extracted from the ETA–OFLC Case Management Systems.

Question. The U.S. economy entered into a recession in December 2007. Although some economic indicators suggest that growth has resumed, unemployment remains high and is projected to remain so for some time. Since 2008, how many LCAs has DOL approved annually?

Answer. The following table displays case processing information for fiscal year 2008, fiscal year 2009, and 50 percent of the year for fiscal year 2010. With the exception of the H–1B Program (excluded by statute), all of the programs have required "testing" of the local labor market prior to the approval and granting of labor certification to insure domestic workers are fully considered for the job opportunity.

TABLE 1B.—ETA OFLC SUMMARY REPORT, FISCAL YEAR 2008–2010 (THROUGH MARCH 31, 2010)

Visa category	2008	2009	2010 [1]
PERM:			
Cases processed	61,997	38,247	40,299
Cases certified	49,205	29,502	35,051
Workers requested	([2])	([2])	([2])
Workers certified	([2])	([2])	([2])
H–1B:			
Cases processed	369,381	263,243	152,630
Cases certified	368,958	266,230	127,201
Workers requested	654,871	438,273	360,104
Workers certified	651,762	483,203	225,146
H–2B:			
Cases processed	11,177	7,090	3,199
Cases certified	10,257	5,871	2,738
Workers requested	292,645	218,274	79,091
Workers certified	250,343	154,489	61,192
H–2A:			
Cases processed	8,096	8,150	3,115
Cases certified	7,944	7,665	2,961
Workers requested	86,113	103,955	65,753
Workers certified	82,078	86,014	53,349

Source: Administrative records extracted from the ETA–OFLC Case Management Systems.

[1] Includes cases processed from October 1, 2009 through March 31, 2010.
[2] Not applicable. A permanent ''green card'' application only contains one named beneficiary.

Question. For the PERM Program, the decrease in case certifications from fiscal year 2008 to fiscal year 2009 is attributable, in large measure to the following reasons:

—Inadequate number of Federal staff to perform final case adjudications.
—Increased integrity measures implemented, e.g., the number of cases placed in audit, supervised recruitment. The declining state of the economy especially U.S. worker availability in conjunction with employer layoff data prompted increased scrutiny of applications especially those filed by employers who were experiencing layoffs.
—The state of the economy did affect the nature and number of H–2B filings. Further, changes in the regulations implementing both the H–2A and H–2B influenced filing patterns.

Question. Would you please provide these statistics by occupation, trade group and visa category?

Answer. The table below entitled "Top 10 PERM Occupations, fiscal year 2008–2010" illustrates the top 10 occupations for which employers requested workers by type of visa for each of the 3 fiscal years (thru March 31, 2010). OFLC does not collect data by trade group, so that is not included. Because nearly all positions certified under the H–2A visa program involve the planting, cultivating, and harvesting of fruits and vegetables, more than 98 percent of workers are employed in the occupation of "Farmworker Laborer, Fruits and Vegetables."

TABLE 1D.—ETA OFLC TOP 10 H–1B OCCUPATIONS, FISCAL YEAR 2008–2010 (THROUGH MARCH 31, 2010)

Top occupation	Applications processed	Applications certified	Workers requested	Workers certified
FISCAL YEAR 2008				
Computer systems analysis and programming	183,162	183,462	380,299	379,864

TABLE 1D.—ETA OFLC TOP 10 H–1B OCCUPATIONS, FISCAL YEAR 2008–2010 (THROUGH MARCH 31, 2010)—Continued

Top occupation	Applications processed	Applications certified	Workers requested	Workers certified
Architectural occupations	4,251	4,360	27,234	26,436
College and university occupations	23,159	23,192	24,843	24,810
Other computer related occupations	19,361	19,405	23,326	23,278
Accountant, auditors, and related occupations	14,515	14,550	23,063	22,990
Budget and management occupations	7,776	7,797	21,333	21,367
Electrical engineering occupations	13,531	13,583	16,979	16,853
Physicians and surgeons	9,359	9,400	13,693	13,598
Data communications and network occupations	4,741	4,756	12,630	12,613
Secondary school education occupations	4,007	4,028	9,286	9,167
FISCAL YEAR 2009				
Computer systems analysis and programming	107,858	108,349	233,742	238,039
Budget and management occupations	5,569	5,620	38,348	38,721
Other computer related occupations	12,470	12,551	18,617	18,510
Architectural occupations	2,140	2,172	17,316	16,301
College and university occupations	16,076	16,132	16,655	16,597
Accountant, auditors, and related occupations	10,542	10,667	16,482	16,357
Electrical engineering occupations	8,926	8,987	11,104	10,980
Physicians and surgeons	7,740	7,804	10,600	10,500
Miscellaneous managers and officials	5,403	5,451	6,932	6,884
Miscellaneous professional, technical, and managerial occupations	5,014	5,062	6,466	6,418
FISCAL YEAR 2010 [1]				
Computer software engineers, applications	14,396	12,675	75,773	20,547
Computer programmers	17,740	15,936	54,693	52,354
Software quality assurance engineers and testers	1,059	940	53,601	1,470
Computer systems analysts	16,451	14,835	45,599	43,275
Computer software engineers, systems software	7,216	6,629	10,180	9,445
Physicians and surgeons, all other	2,589	2,196	4,785	3,398
Financial analysts	3,813	3,097	4,572	3,791
Market research analysts	3,804	2,654	3,934	2,771
Management analysts	2,934	2,348	3,932	3,287
Physical therapists	2,241	1,924	3,808	3,352

Source: Administrative records extracted from the ETA–OFLC Case Management Systems.

[1] Includes cases processed from October 1, 2009 through March 31, 2010.

TABLE 1E.—ETA OFLC TOP 10 H–2B OCCUPATIONS, FISCAL YEAR 2008–2010 (THROUGH MARCH 31, 2010)

Top occupation	Applications processed	Applications certified	Workers requested	Workers certified
FISCAL YEAR 2008				
Landscape laborer	3,458	3,375	79,223	76,383
Housekeeping, cleaner	724	689	23,984	22,442
Construction worker I	610	572	16,591	14,618
Forest worker	121	114	12,983	12,416
Amusement park worker	152	150	7,322	7,262
Welder fitter	57	30	6,785	2,466
Housekeeper	203	192	6,537	5,829
Waiter/waitress	166	158	5,030	3,961
Dining room attendant	213	208	4,451	4,325
Tree planter	49	46	4,371	4,187
FISCAL YEAR 2009				
Landscape laborer	2,030	1,793	55,840	48,315
Forest worker	128	113	13,606	11,375
Welder fitter	78	1	11,916	30
Housekeeping, cleaner	325	277	10,381	8,256
Construction worker I	341	273	9,170	6,185

TABLE 1E.—ETA OFLC TOP 10 H–2B OCCUPATIONS, FISCAL YEAR 2008–2010 (THROUGH MARCH 31, 2010)—Continued

Top occupation	Applications processed	Applications certified	Workers requested	Workers certified
Housekeeper	279	240	9,097	6,392
Amusement park worker	132	129	7,571	6,783
Industrial commercial groundskeeper	224	208	5,363	4,840
Horse stable attendant	320	265	4,095	3510
Welder, combination	30	.....	3,378	.....
FISCAL YEAR 2010 [1]				
Landscape laborer	1,041	986	25,337	22,184
Industrial commercial groundskeeper	207	189	5,624	4,598
Amusement park worker	108	104	4,928	4,754
Housekeeper	196	173	4,821	3,590
Housekeeping, cleaner	134	103	3,614	2,121
Construction worker I	111	87	3,417	2,056
Forest worker	54	37	3,313	1,725
Landscape specialist	49	48	1,511	1,332
Horse stable attendant	66	59	1,365	1,004
Waiter/waitress	69	64	1,125	1,027

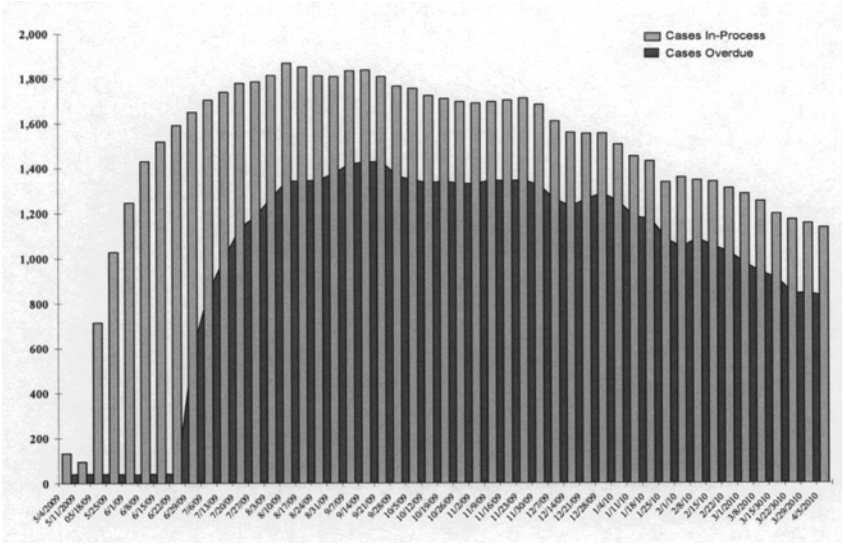
Source: Administrative records extracted from the ETA–OFLC Case Management Systems.

[1] Includes cases processed from October 1, 2009 through March 31, 2010.

FEDERAL UNEMPLOYMENT BENEFITS AND ALLOWANCES

Question. What is the current backlog of determination decisions? How long does it currently take to reach determinations on trade adjustment assistance (TAA) petitions?

Answer. In the first 90 days under the Trade and Globalization Adjustment Assistance Act of 2009 (TGAAA), TAA received more than 2,300 petitions for assistance. The initial petition filings created the backlog that TAA has systemically reduced on a weekly basis.



There are currently 835 cases that have been under investigation for more than 40 days; the average backlogged case is 133 days overdue. The time taken to reach a decision is steadily decreasing as DOL works through the remainder of the petition backlog.

Question. How did DOL prepare for the sharp increase in petitions? Has DOL hired additional investigators?

Answer. DOL began preparing for the anticipated increase in program petitions immediately after the President signed the ARRA containing the TGAAA. At that time, DOL had about 20 Federal staff and 14 contract staff working in the TAA program. Those staff included staff focused on petition investigations, program policy, funding, data collection and management, and office support.

The TGAAA significantly expanded the TAA program which resulted in an increase in petition filings of 104 percent from fiscal year 2008 to fiscal year 2009. While the ARRA reauthorized and expanded the program, it did not contain any funding specifically for the Federal administration of TAA. DOL used departmental management funds included in the ARRA to fund staffing and other TGAAA implementation costs.

Using these ARRA funds and other existing DOL resources, the DOL's ETA began a major hiring effort. As of March 2010, ETA had 28 permanent Federal staff and 20 ARRA-funded temporary Federal staff working on the TAA program. Of the 48 current program staff, 42 currently focus on petition investigations and the associated data management and notification process, while 6 focus on delivery of services, program policy, funding, correspondence and data collection, and management. Additionally, ETA has nine contract staff providing support to the TAA office.

Question. What are DOL's plans to reduce the backlog of petitions?

Answer. In addition to the intensive hiring effort undertaken by ETA, DOL has implemented an office realignment strategy to more effectively and efficiently address the TAA petition backlog. This strategy includes better TAA petition management; more equally balanced team and management structures; and incorporated a specialized team of investigators tasked with quickly resolving the most difficult cases. DOL also secured the assistance of a TAA investigation expert to help examine different and effective strategies within the current investigative process. Through this study, DOL identified areas to improve the petition investigation process and has implemented changes that are leading to more efficient case investigations. As a result, DOL has reduced the backlog by 37 percent since the beginning of January 2010. DOL continues to explore hiring options to ensure efficient staff planning and preparation for attrition of staff as a result of the expiration of ARRA-funded positions on September 30, 2010. As part of its planning for the loss of staff, DOL has requested an increase of 16 full-time equivalents for the TAA program in fiscal year 2011.

Question. How many petitions has DOL certified from firms that would not have been eligible for TAA benefits prior to the expansion of the program? How many workers have been certified in the period since the expansion compared to the same time period prior to the expansion?

Answer. Under the TGAAA, TAA has certified more than 2,300 petitions and certified an estimated 255,000 workers from May 18, 2009 to April 12, 2010. The same time-period in the previous year, TAA certified 1,561 petitions and 153,463 estimated workers.

TAA CERTIFICATIONS UNDER THE 2009 AMENDMENTS (MAY 18, 2009–APRIL 12, 2010)

	Number of certifications	Percentage of certifications	Estimated number of workers
PRIMARY CERTIFICATION			
Company imports of articles	185	7.94	24,017
Company imports of services	37	1.59	2,540
Customer imports of articles	315	13.53	40,363
Customer imports of services	22	.94	4,565
Imports of finished articles containing like or directly competitive components	7	.3	591
Imports of finished articles containing foreign components	3	.13	124
Imports of articles produced using worker services	4	.17	345
Increased aggregate imports	69	2.96	9,243
Shift in production	730	31.34	96,100
Acquisition of articles from a foreign country	89	3.82	7,674
Shift in services	357	15.33	17,515
Acquisition of services from a foreign country	106	4.55	6,916
Public agency	.....	.....	.....
ITC determination	20	.86	5,813

TAA CERTIFICATIONS UNDER THE 2009 AMENDMENTS (MAY 18, 2009–APRIL 12, 2010)—Continued

	Number of certifications	Percentage of certifications	Estimated number of workers
SECONDARY CERTIFICATION			
Secondary component supplier	283	12.15	33,554
Secondary service supplier	74	3.18	3,098
Downstream producer	28	1.2	2,980
Totals	2,329	100	255,438

The certification rate under the TGAAA is about 82 percent compared to 70 percent prior to the TGAAA. While DOL cannot quantify the number of workers that would have been denied prior to the expansion, the increase in the certification rate is attributable to the expansions in the service sector in the TGAAA. Prior to the TGAAA workers who performed services could be certified, but only when associated with the production of an article; the TGAAA allows for stand-alone service sector certifications and includes other smaller expansions. In fiscal year 2008, workers not producing an article caused the greatest numbers of TAA denials.

Question. What is the administration's position on reauthorizing the TAA program when it expires on December 31, 2010?

Answer. The administration supports the reauthorization of the TAA program, including continuing the expansions to the program contained in the TGAAA, and included reauthorization in the 2011 President's budget.

OFFICE OF LABOR-MANAGEMENT STANDARDS (OLMS)

Question. OLMS administers and enforces provisions of the Labor-Management Reporting and Disclosure Act. This Act requires that labor unions, which represent private sector employees, file financial disclosure reports with OLMS and make those reports available to union members. The Act also established minimum standards for elections to choose union officers.

In fiscal year 2010, the administration requested, and Congress approved, an 8 percent reduction in the budget for OLMS. For fiscal year 2011, the administration requests a $3.8 million increase but the majority is for computer modernization. The fiscal year 2011 request would keep the number of employees at 269—the same level as the current fiscal year. This is well below the 298 employed at the agency in fiscal year 2009.

How has the reduction in staffing since fiscal year 2009 affected the enforcement of union reporting requirements?

Answer. OLMS is fully funded and is well-positioned to maintain and improve upon its historically strong enforcement record. OLMS continues to improve targeting of audits and ensuring increased internal process efficiency in order to bring the best cases to protect union members' rights. In fact, OLMS' fiscal year 2009 enforcement numbers clearly demonstrate an increase in the number of criminal investigations, conviction levels, and delinquent report investigations, as compared to fiscal year 2008.

Enforcement activity	Fiscal year 2008	Fiscal year 2009
Election complaint investigations	130	129
Supervised re-run elections	35	32
Election complaints resolved (figure represents both agreements and lawsuits)	35	32
Criminal investigations	393	404
Indictments	131	122
Convictions	103	120
Compliance audits	798	754
Delinquent report investigations	2,019	2,596
Deficient investigations	799	749

Enforcement activity	Fiscal year 2008, first half	Fiscal year 2009, first half	Fiscal year 2010, first half
Election complaint investigations	50	60	72
Supervised re-run elections	16	19	10

Enforcement activity	Fiscal year 2008, first half	Fiscal year 2009, first half	Fiscal year 2010, first half
Election complaints resolved (figure represents both agreements and lawsuits)	10	15	17
Criminal investigations	181	184	154
Indictments	70	52	59
Convictions	53	55	56
Compliance audits	353	360	246
Delinquent report investigations	721	845	968
Deficient report investigations	375	343	255

At the midpoint of fiscal year 2008 and fiscal year 2009, delinquent and deficient report investigations were roughly comparable to the midyear fiscal year 2010 figure, shown above in the far right column. Specifically, as of March 31, 2009, OLMS recorded 845 delinquent report investigations and 343 deficient report investigations. As of March 31, 2008, the figures were 721 and 375, respectively.

Question. For the last fiscal year, how many unions have not filed their financial disclosure forms?

Answer. OLMS estimates that 25,378 Labor Organization Annual Financial Reports were due in fiscal year 2009. Not all unions use the same fiscal year beginning and ending dates; slightly less than two-thirds use a January 1–December 31 fiscal year. To conform the different fiscal year beginning and ending dates with the Federal fiscal year dates, we here include unions whose fiscal year ended on or after 10/1/2008 but on or before 9/30/2009. Because the reports are not actually due until 90 days following the close of the union's fiscal year, the 25,378 total reflects all unions who would owe OLMS a report sometime during fiscal year 2009. As of April 19, 2010, approximately 860 labor unions had not filed the fiscal year 2009 report.

Question. How will DOL ensure that OLMS remains independent now that the office reports directly to the Secretary?

Answer. Effective November 8, 2009, the umbrella organization known as the Employment Standards Administration (ESA) ceased to exist. DOL had decided to abolish ESA while maintaining the four component programs (the Wage and Hour Division, OLMS, the Office of Federal Contract Compliance Programs, and the Office of Workers' Compensation Programs) as stand-alone organizations, reporting directly to the Secretary of Labor. This move greatly improved the visibility and access of the four agencies to the Secretary, facilitating improved communication and more efficient operations. OLMS, as the previous statistics clearly demonstrate, remains committed to a robust enforcement program.

BUDGET DEFICIT

Question. In fiscal year 2009, the Federal budget deficit was $1.4 trillion. The administration is projecting a deficit of $1.6 trillion for fiscal year 2010. The administration has requested a 3 percent increase in discretionary funding for DOL for fiscal year 2011 (up from $13.5 billion to $14 billion). While the administration proposes some program eliminations and program reductions, they do not offset the proposed increases in the budget.

What are the DOL's long-term plans to slow or reduce the increase in discretionary spending?

Answer. DOL is working within the administration's direction to freeze discretionary nonsecurity spending for 3 years. As such, we continue to examine how to focus limited resources on achieving results for DOL. We are currently developing a new strategic plan for DOL that implements my strategic vision of "Good Jobs for Everyone". We have established outcome goals that support this vision and are currently developing performance goals. As we determine our resource needs, having these goals will help us develop responsible budget requests within the President's direction. We are also looking at what programs are not working or do not clearly support my vision. Consistent with applicable law, resources will be shifted from these ineffective programs to those that are proven to work.

Ultimately, DOL's plan is to invest in improving jobs for America's workforce. As unemployment decreases, so does the administrative costs of the unemployment insurance program. As worker pay increases, so rises the resources to reduce our reliance on borrowing to balance the Federal budget. In short, our focus on "Good Jobs for Everyone" is an investment that will help reduce discretionary spending as well as speed the Nation's economic recovery.

Question. What are DOL's plans to improve the efficiency and effectiveness of programs administered by DOL?

Answer. DOL is requesting $14 billion in discretionary funding for fiscal year 2011, a reduction of $299 million (3 percent) below the fiscal year 2010 discretionary budget of $14.3 billion. In fiscal year 2011, DOL will implement a new evaluation program that will rebuild DOL's evaluation capacity and support a rigorous evaluation agenda that measures the efficiency and effectiveness of programs and interventions and informs policy, management, and resource allocation decisions.

The new evaluation program will be headed by a Chief Evaluation Officer (CEO) who will be responsible for developing a comprehensive DOL evaluation program that ensures that research and evaluation are aligned with DOL's performance goals and strategic vision. The CEO will assist agencies in preparing their annual research and evaluation plans and provide technical assistance in project design and analysis.

In fiscal year 2010, resources are being allocated to evaluations that improve the effectiveness of Government through evidenced-based research. The highest priority has been given to impact evaluations, or evaluations aimed at determining the causal effects of programs.

In fiscal year 2011, DOL received $40.3 million to fund five rigorous evaluations and demonstration of workplace safety enforcement and workforce development services. Many of these evaluations will employ random assignment methods and others will use the most rigorous empirical methods available.

In keeping with the President's vision of a transparent and accountable Government, DOL will publish all final reports from program evaluations in a timely manner.

QUESTION SUBMITTED BY SENATOR MITCH MCCONNELL

Question. Given the high rate of unemployment within the veteran's population, what is the Department of Labor (DOL) doing to help ensure that these brave service members are able to find jobs when they return to civilian life?

Answer. The Veterans' Employment and Training Service (VETS) is playing a leadership role within the DOL to assist returning service members in their transition back to civilian life. To leverage the broader range of resources available across DOL, VETS is undertaking new initiatives in partnership with other Federal and DOL agencies. They include:

—*Applying Priority of Service to Leverage Enhanced Resources*.—In partnership with the Employment and Training Administration (ETA), VETS is emphasizing that the recently published Final Rule on Priority of Service for veterans and eligible spouses is to be applied to the enhanced services delivered by ETA under the funding provided through the American Recovery and Reinvestment Act (ARRA).

—*Initiating a Redesign of Transition Assistance Program (TAP) Employment Workshops*.—VETS, in partnership with the Department of Defense and the Department of Veterans Affairs, has exercised lead responsibility over the past 25 years for the employment workshops offered under TAP. VETS recently undertook an internal review of the employment workshop component of TAP and concluded that this set of services will benefit from an external review, with an eye to redesigning the curriculum. A contract for the external review and redesign is expected to be awarded during this fiscal year.

—*Partnering With Job Corps for Younger Veterans*.—In partnership with the ETA's Office of Job Corps, VETS is taking new initiatives to offer younger veterans at risk of unemployment the opportunity for referral to Job Corps Centers. This initiative will take advantage of VETS' access to separating service members at TAP employment workshops.

—*Stimulating Employment Opportunities for Veterans*.—VETS is undertaking a major outreach initiative to employers. The Assistant Secretary for Veterans' Employment and Training has convened an employer summit, established a relationship with the U.S. Chamber of Commerce, and has assigned VETS' field staff to conduct outreach activities with employers operating at the State and local levels.

—*Improving Customer Service to Returning Veterans Facing Issues With Employers*.—To improve customer service to veterans who file complaints under the Uniformed Services Employment and Reemployment Rights Act (USERRA), VETS developed a Web-based tutorial for nationwide dissemination and streamlined some burdensome, paper-oriented aspects of this program. The tutorial is an interactive instruction with video clips to increase service member's and employer awareness with respect to service member's rights under the USERRA.

—*Refocusing the Jobs for Veterans State Grants*.—With participation by ETA, VETS is emphasizing increased delivery of intensive services by Disabled Veterans' Outreach Program specialists and increased conduct of employer outreach and job development activities by Local Veterans' Employment Representative (LVER) staff.

—*Capitalizing on New Work Opportunity Tax Credit Incentives*.—In the reauthorization of the Work Opportunity Tax Credit (WOTC) and in the recent authorization of ARRA, Congress enhanced the opportunities for veterans to benefit from the incentives available to employers under WOTC. In partnership with ETA, VETS is developing strategies to empower LVER staff to assist veterans in gaining pre-certification for WOTC.

—*Enhancing and Expanding Outreach Through Electronic Media*.—VETS has reengineered the Agency's Web site, has conducted a Web-based outreach session with key stakeholders and has applied social networking for enhanced outreach to veterans.

—*Bridging the Gap With Rural Communities*.—VETS has taken steps to leverage existing rural outreach networks in an effort to overcome the geographic and cultural barriers separating veterans in remote locations from mainstream work opportunities.

—*Strengthening Veteran Opportunities Among Federal Contractors*.—VETS is supporting the efforts of the Office of Federal Contract Compliance Programs to revise the regulations governing affirmative action by Federal contractors in the hiring of targeted veteran groups, so that the Federal contractors' responsibilities are more clearly specified.

SUBCOMMITTEE RECESS

Senator HARKIN. The subcommittee will stand recessed.

[Whereupon, at 9:52 a.m., Tuesday, March 23, the hearing was adjourned and the subcommittee was recessed, to reconvene subject to the call of the Chair.]

DEPARTMENTS OF LABOR, HEALTH AND HUMAN SERVICES, AND EDUCATION, AND RELATED AGENCIES APPROPIATIONS FOR FISCAL YEAR 2011

WEDNESDAY, APRIL 14, 2010

U.S. SENATE,
SUBCOMMITTEE OF THE COMMITTEE ON APPROPRIATIONS,
Washington, DC.

The subcommittee met at 9:34 a.m., in room SD–138, Dirksen Senate Office Building, Hon. Tom Harkin (chairman) presiding.

Present: Senators Harkin, Landrieu, Reed, Pryor, Cochran, Shelby, and Alexander.

DEPARTMENT OF EDUCATION

OFFICE OF THE SECRETARY

STATEMENT OF HON. ARNE DUNCAN, SECRETARY

OPENING STATEMENT OF SENATOR TOM HARKIN

Senator HARKIN. Good morning. The Senate Appropriations Subcommittee on Labor, Health and Human Services, Education, and Related Agencies will now come to order.

Secretary Duncan, welcome back to the subcommittee. You and I have had many occasions to talk recently, both here and in my home State, about the reauthorization of the Elementary and Secondary Education Act (ESEA).

As you know, we are in the process of holding several reauthorization hearings in the Health, Education, Labor and Pensions (HELP) Committee—not in this subcommittee, in the HELP Committee—and I share your commitment to completing that work this year.

But today, we are here to talk specifically about funding. This is the Appropriations Committee. When it comes to resources, it is a time of both great promise and great peril. While the books on fiscal year 2010 won't be closed for another 6 months, we can already safely predict that the Federal Government will spend far more money on education this year than in any other year in history.

Between the regular 2010 appropriations bill and last year's American Recovery and Reinvestment Act (ARRA), the Education Department will provide more than $100 billion to States, districts, and higher education programs across the country this year. The State Fiscal Stabilization Fund (SFSF) in particular has been one of the great success stories of the ARRA. That funding is currently

supporting more than 300,000 education jobs across the country and certainly helped to mitigate the effects of the recession.

STUDENT AID AND FISCAL RESPONSIBILITY ACT

Last month, we also celebrated the passage of the Student Aid and Fiscal Responsibility Act. This landmark legislation eliminated wasteful corporate subsidies in the Federal student loan program and strengthened the Pell Grant program.

FISCAL YEAR 2011 BUDGET REQUEST INCREASE OVER 2010

The President's proposed education budget for fiscal year 2011 also holds promise. As we all know, the President's budget holds the line on nonsecurity-related spending overall in fiscal year 2011, but the President pledged to use a scalpel and not an ax to achieve the freeze, and the Department of Education is one of the Federal agencies that would receive an increase of 7.5 percent more than in fiscal year 2010.

EDUCATION LAYOFFS

Despite these positive developments for Federal funding of education, there are many danger signs. That is because the bottom has fallen out for State and local funding in many communities across the country, just as the funding for the SFSF begins to wind down in September of this year. Every day brings more reports about a massive wave of layoffs that could soon strike school districts and institutions of higher education.

Based on estimates we are seeing so far, the number of pink slips for educators could easily top 100,000 this fall. Job cuts of this magnitude would, of course, have a devastating impact on families across the country and could stall the Nation's economic recovery. But they would also take a terrible toll on our education system.

Large numbers of layoffs mean bigger class sizes, fewer program offerings, less time for students to learn in school. It is hard to see how you can get this kind of education reform that you, Mr. Secretary, and Senators on this subcommittee want to achieve if schools are cutting their instructional time.

KEEP OUR EDUCATORS WORKING BILL

That is why later today I will introduce a bill—the Keep Our Educators Working Act. This bill will create a $23 billion education jobs fund that will provide money to every State for the specific purpose of hiring or retaining school employees next year—teachers, principals, librarians, counselors, custodians, and so on.

And we must act soon. We must act soon. As I said, the money that we had in the ARRA, that was for 2 years, expires September 30 of this year. We know that there are pink slips already going out, maybe as many as 100,000 or more.

But right now, we have to act because State departments of education and local school boards are already making their decisions. They are making their decisions this month in April and in May about what they have to do next year. This is not something that we can fix in August. We have to fix it now. And that is why I will

do everything I can to bring up on the floor of the Senate as soon as possible this $23 billion funding bill.

Now, why is it $23 billion? Well, it is about 50 percent of what was in the ARRA. The ARRA provided for 2 years. We are just looking at this as a 1-year shot for next year, and so it is about 50 percent of what we had in the ARRA.

So I just say to you, Mr. Secretary, we are going to do everything we can, and I am going to ask for your help and the President's help in getting this done. As I said, time is of the essence here.

PELL GRANT SHORTFALL

Now, another danger on the horizon is the Pell shortfall. Again, during tough economic times, more students and more financially needy students seek a higher education. That can lead to a temporary funding shortfall in the Pell program. And one of the relatively unheralded accomplishments of the student reconciliation bill was the inclusion of significant funding to address that shortfall.

I want to personally thank you publicly, Mr. Secretary, for working so hard with us to provide those funds. But we are still about $5.7 billion short in the Pell Grant program. If we don't find a way to make up the difference, every program in our appropriations bill and even programs in other agencies could suffer.

So I am hoping we can continue to work with the administration to fight for the rest of the Pell funding in the upcoming spending bill that we will be reporting out of this subcommittee. And so, we will talk more about those issues soon, but I first want to turn to Senator Cochran for any opening remarks that he would like to offer.

STATEMENT OF SENATOR THAD COCHRAN

Senator COCHRAN. Mr. Chairman, thank you very much for convening this hearing when we review the observations and statement of the distinguished Secretary of Education.

The President has submitted a budget request to the Congress, and it is our obligation to review the request and consider the opinions of those who are involved in education and who have responsibilities for administering the Federal programs supporting education in our country. So it is a very important responsibility, and this subcommittee is going to work hard to try to make sure that we provide the funding that is needed to help ensure that our students throughout the country have opportunities to learn and prosper.

And that is the purpose of our hearing today, to get an overview of the budget and to make sure that we are going to do the right thing in supporting these activities administered by Secretary Duncan and his able staff members.

But you know we really owe a great deal of thanks to the teachers and the administrators throughout the country who really are at the point where the action occurs and where the responsibilities are discharged that make a big difference in the lives of our students. So, with that in mind, we are happy to have you before the subcommittee, Mr. Secretary, and we invite you to proceed to make

whatever comments you think will be helpful to our understanding of the budget request.

Senator HARKIN. Thank you. Thank you very much, Senator Cochran.

Arne Duncan became the ninth Secretary of the U.S. Department of Education on January 20, 2009. Before his appointment, Secretary Duncan served as the chief executive officer of the Chicago Public Schools. Before serving in Chicago, he ran the Ariel Education Initiative, which covered college costs for a group of inner-city youth, and was instrumental in starting a new public elementary school which ranks among the top schools in Chicago.

Secretary Duncan, a graduate of Harvard University, welcome again to the subcommittee. And Mr. Secretary, your statement will be made a part of the record in its entirety, and please proceed as you so desire.

SUMMARY STATEMENT OF HON. ARNE DUNCAN

Secretary DUNCAN. Thank you, Mr. Chairman, Vice Chairman Cochran, members of the subcommittee.

STATE AND LOCAL LEVEL EDUCATION CUTBACKS AND LAYOFFS

I plan to begin today by talking about education reform because there is a lot of good news to report, but before I do, I want to talk about education jobs. We are gravely concerned that the kind of State and local budget threats our schools face today will put our hard-earned reforms at risk.

Every day, every single day brings media reports of layoffs, program cuts, class time reductions, and class size increases. None of this is good for children. Here is just a sample in some of your States.

Mr. Chairman, you and I recently visited schools in Iowa, which just announced 1,500 layoffs, half of them teachers. In Ames, they are reducing full-day kindergarten to half day and delaying textbook purchases.

In my home State of Illinois, they are looking at cutting 20,000 teaching jobs. In California and New York, they have also announced more than 20,000 job cuts each. I think the superintendent of Los Angeles is testifying before this committee later today.

Schools in Jackson, Mississippi, are increasing class size, while public colleges in neighboring Louisiana are canceling summer classes in the face of $300 million in budget cuts over the next 2 years.

I recently read there are some schools in Kansas that have gone to a 4-day school week, and Hawaii began Friday furloughs earlier this year. New Jersey surveyed more than 300 school districts, and two-thirds are cutting sports, bands, and clubs. Many are also dropping after-school summer programs.

Charlotte, North Carolina, will cut 600 teachers next year. Appleton, Wisconsin, is losing 50 positions, mostly teachers, while one district in Washington State is cutting 10 percent of its teaching workforce.

In a survey of school administrators, one-third of them say they may have to cut summer school despite compelling research show-

ing that summer learning loss amongst low-income students is a significant contributor to the achievement gap.

IMPACT OF LAYOFFS AND CUTBACKS ON OVERALL ECONOMY

While there is no hard number yet for the entire country, we think the State budget cuts could imperil anywhere from 100,000 to 300,000 education jobs. That not only creates hardships for hard-working educators who lose their jobs and the children they teach, but the damage ripples through the economy as a whole.

The layoffs would create a new drag on the economy when, despite the recent encouraging jobs reports, we still have a long way to go. Literally, tens of millions of students will experience these budget cuts in one way or another. Moreover, schools, districts, and States that are working so hard to improve will see their reforms undermined by these budget problems.

COMMITMENT TO IMPROVING EDUCATION

The financial crisis facing public education is coming at an especially crucial moment for America. We are more focused than ever before on the importance of education to our economy and more committed than ever before to challenging ourselves to get better.

There is a broad consensus that we must invest at every level—from early childhood through college—to help the next generation succeed and compete in our global economy. There is a deep commitment from stakeholders across the spectrum that education is one issue that absolutely can bring us together. And at every level of our education system, there is groundbreaking work underway to improve the way we teach and learn.

STATE EDUCATIONAL STANDARDS

Forty-eight States are working together to raise education standards across the country because they understand we must better prepare our children for college and careers. No more dumbing down standards due to political pressure. No more lying to children.

Let me be clear. This is a State-led movement. These are not Federal standards.

RACE TO THE TOP COMPETITION

States are also preparing for phase two of the Race to the Top competition. This $4 billion program, which represents less than 1 percent of K–12 education funding nationally, has prompted States and stakeholders to sit down together and have the kind of difficult, but necessary conversations that have never happened before.

The results, in a word, are stunning, even before money has gone out the door. Legal barriers to reform have been eliminated, progressive labor agreements have been forged, and new partnerships have emerged around bold and far-reaching plans. By one count, 26 States have passed laws to strengthen their education reform agendas. No one is defending the status quo.

And there is enormous demand for the program. Forty States and the District of Columbia applied in phase one, requesting, col-

lectively, $13 billion. We expect at least the same amount, if not more applications in phase two. And this is just one of our competitive programs.

STATE IMPROVEMENT GRANTS AND INVESTING IN INNOVATION

Thanks to School Improvement Grants provided by Congress in the last two budgets and the ARRA, educators across America are also confronting the toughest challenge in education, which is fixing their lowest-performing schools. Thanks to the Investing in Innovation program (i3), that was also created by Congress through the ARRA, school districts, foundations, and community partners are developing innovative new learning models to take into our classrooms and our schools.

We expect as many as 2,500 applications, and we know that we will have at least 2 applications from every State. The entire country is looking to drive innovation at the local level, where we must take to scale what is working.

TRAINING, RETAINING, AND RECRUITING TEACHERS

Today, our colleges of education are rethinking how they train teachers for the classrooms of tomorrow. States, districts, and schools are rethinking how they recruit, support, and evaluate teachers in order to strengthen their profession. Teachers deserve better mentoring and professional development than they receive today.

ACCESS TO HIGHER EDUCATION

And today, millions more young people are getting grants to attend college, thanks to the leadership of the President and Congress and the historic decision to shift billions of dollars from bank subsidies for student loans to help low-income students pay for college.

Mr. Chairman, this would never have happened without your leadership. And I want you to know how much that means to me personally.

ESEA REAUTHORIZATION AND FISCAL YEAR 2011 BUDGET REQUEST

All of this work has been accelerated by your leadership and your collective commitment to children and education. And with your leadership, we want to do much more to support this work at the local level. Our proposed ESEA blueprint is defined by three words—fair, flexible, and focused.

We want to create a fair system of accountability that instead of stigmatizing schools and educators rewards them for excellence. We want to focus on growth and gain rather than absolute test scores. Rather than dictating one-size-fits-all solutions, we want to give States and districts more flexibility to improve the vast majority of schools that may have challenges, but by no measure are failing.

And third, we want to focus resources and support on students most at risk in chronically low-performing schools and schools with ongoing large achievement gaps.

GOALS OF REFORM STRATEGIES

Our 2011 budget request supports continuing formula funding for low-income and special education students and teachers and principals, as well as students learning English and other diverse populations of children from rural to migrant to homeless. But we also know that too many children at risk today are not well served by the status quo, which is why I want to continue driving reform with competitive programs.

All of our reform strategies have two goals—to raise the bar for all students and to close the achievement gap. We have to create better opportunities for students who need them the most. So with our budget request, we hope to continue Race to the Top, the Investing in Innovation Fund, and programs to get great teachers and principals into schools and classrooms where they are needed the most. To close the achievement gap, we must get serious about closing the opportunity gap.

EARLY LEARNING CHALLENGE FUND

Mr. Chairman, I know that you and others worked tirelessly to include the Early Learning Challenge Fund in the student lending bill, and I thank you for that. Given that it ultimately was not included, we want to work with you to bring it back because we must do more to help students start school ready to succeed. That investment in early childhood education may be the best long-term investment we as a Nation can make.

STUDENT AID FUNDING

Two other unmet needs are the remaining shortfall in the Pell Grant program and the increased administrative costs associated with the shift to 100 percent direct lending.

I greatly appreciate the Senate leadership in helping cover the Pell shortfall in the reconciliation bill. Now I want to work with Congress to address the remainder of the shortfall through a supplemental appropriation or other appropriate measure to avoid putting pressure on other critical education programs.

ADMINISTRATIVE COST OF 100 PERCENT DIRECT LENDING

Last, given that we are now assuming 100 percent of the student loan portfolio, we must strengthen our student lending operation to ensure that the student aid program is efficient and our private contracts are well-managed. Most of the additional money we are requesting will support private loan servicing contracts.

I want to salute Congress on both sides of the aisle for embracing our responsibility to our children and investing in education. Thanks to all of you, we have entered an exciting new era of educational reform, progress, and opportunity.

ARRA

I also ask you to consider the looming budget threat that could put all of this at risk. The ARRA dollars given to the Department of Education helped save an estimated 400,000 jobs at the State and local level, mostly in education, but also in public safety and other areas of critical need. It was the right thing to do, and it

proved that fiscal relief is an effective way to create economic activity and jobs.

NEED FOR ADDITIONAL EMERGENCY EDUCATION FUNDS

The final round of funding is now making its way to State capitals and school districts and to college students through Pell Grants, but it is not nearly enough to avert the catastrophe unfolding across the country. And so, today, on behalf of Governors, mayors, educators, students, parents, business leaders, community leaders, and everyone who shares the view that education is the key to our economic strength and civic vitality, I urge Congress to consider another round of emergency support for America's schools.

If we do not help avert this State and local budget crisis, we could impede reform and fail another generation of children. The fact is that gaps for special education, low-income, and minority students remain stubbornly wide. All of you know the reality of the challenges that our students and, therefore, our Nation face today. We must confront this reality with honesty, courage, and a commitment to challenge the status quo.

COLLEGE AND CAREER READINESS

One in four, 1 in 4 of our high school students today fails to graduate. Forty percent of students who go on to college need remedial education. They are not actually ready. And huge numbers of young people determined to go to college and pursue a career drop out because of financial or academic challenges.

If we want reform to move forward, we need an education jobs program. Jobs and reform go hand in hand. It is difficult to improve the quality of education while losing teachers, raising class size, eliminating days of instruction, eliminating after-school and summer-school programs. Our children, particularly disadvantaged children, desperately need more time, not less.

PREPARED STATEMENT

Teachers work very hard, and the vast majority of them give their heart and soul to their profession. They are heroes in every sense of the word, and we need to support them, especially because we are asking more of them. The status quo in education is not good enough. We must all get better. Our children need it, and our future demands it.

Thank you so much. I am now happy to take any questions you might have.

[The statement follows:]

PREPARED STATEMENT OF ARNE DUNCAN

Mr. Chairman and members of the subcommittee: Thank you for this opportunity to testify on behalf of the President's 2011 budget request for education. I want to begin by thanking all of you for your commitment to our children's education. This subcommittee has played a critical role in helping the Department to accomplish an extraordinary amount of work over the past year, both to help America's education system weather the economic recession and to launch key initiatives to improve the quality of that system.

It was just more than a year ago that Congress and President Obama worked together to complete the American Recovery and Reinvestment Act of 2009 (Recovery Act). This legislation is delivering nearly $100 billion in education funding to Recovery Act recipients, including States and school districts, to help address budget

shortfalls in the midst of the most severe financial crisis and economic recession since the Great Depression. To date, the Department has awarded more than $69 billion. For the quarter ending December 31, 2009, recipients reported that assistance from the Department of Education funded approximately 400,000 jobs overall, including more than 300,000 education jobs, such as principals, teachers, librarians, and counselors. These numbers are consistent with the data submitted in October, during the first round of reporting, and this consistency reflects the steady and significant impact of the Recovery Act. Although State and local education budgets remain strained, schools systems throughout the country would be facing much more severe situations were it not for the Recovery Act. The Recovery Act also increased Federal postsecondary student aid to help students and families pay for college.

I believe that the Recovery Act did much more than just provide short-term financial assistance to States and school districts. Indeed, I think the Recovery Act will be seen as a watershed for American education because it also laid the groundwork for needed reforms that will help improve our education system and ensure America's prosperity for decades to come. Thanks to the Recovery Act, all States now are working to strengthen their standards and assessments, improve teacher and leader effectiveness, improve data systems and increase the use of data to improve instruction, and turn around low-performing schools.

In addition, the Recovery Act helped to jumpstart a new era of innovation and reform, particularly through the $4 billion Race to the Top Program and the $650 million Investing in Innovation Fund. Many States already have demonstrated their interest in Race to the Top by making essential changes, such as allowing data systems to link the achievement of individual students to their teachers and enabling the growth or expansion of high-quality charter schools, and on March 29 we were pleased to announce the first two Race to the Top awards to Delaware and Tennessee. Both of these States submitted applications demonstrating a successful track record, bold reforms, broad buy-in, and statewide impact. Tennessee capitalized on its value-added assessment system as the foundation for future reforms, while Delaware is building on its Vision 2015 blueprint. Both States also secured broad support through a combination of changing their State laws and coalition-building among school districts, unions, businesses, advocacy groups, and local philanthropies. I am confident that other States will draw on these lessons to submit even stronger applications during the second phase of the Race to the Top competition this summer.

States also are demonstrating the progress they have made toward implementing the reforms called for in the State Fiscal Stabilization Fund in their applications for phase II of that funding. We must continue to invest in innovation and scale up what works to make dramatic improvements in education. The President's fiscal year 2011 budget requests $1.35 billion for Race to the Top awards, both for States and for a new school district-level competition, as well as $500 million in additional funding for the Investing in Innovation (i3) Program.

Most recently, I want to thank all of the members of the subcommittee who supported the Health Care and Education Reconciliation Act, which President Obama signed into law on March 30, 2010. This legislation will allow the Department to make much-needed reforms to Federal postsecondary student loan programs that will save an estimated $68 billion over the next 11 years. These savings will be redirected toward a more generous and fiscally stable Pell Grant program, lowering the cost of student loans, improving our community college system, and increasing support for Historically Black Colleges and Universities and other minority-serving institutions.

PRESIDENT OBAMA'S 2011 BUDGET REQUEST

The centerpiece of the 2011 budget request for the Department of Education is the pending reauthorization of the Elementary and Secondary Education Act (ESEA). The President is asking for a discretionary increase of $3.5 billion for fiscal year 2011, of which $3 billion is dedicated to ESEA, the largest-ever requested increase for ESEA. Moreover, if Congress completes an ESEA reauthorization that is consistent with the President's plan, the administration will submit a budget amendment for up to an additional $1 billion for ESEA programs. We would greatly appreciate your support for this historic budget.

The Department's budget and performance plan for 2011 also includes a limited number of high-priority performance goals that will be a particular focus over the next 2 years. These goals, which will help measure the success of the Department's cradle-to-career education strategy, reflect the importance of teaching and learning at all levels of our education system. The Department's goals include turning around struggling schools, improvements in the quality of teaching and learning, implemen-

tation of comprehensive statewide data systems, and simplifying student aid. These goals and other performance information are included in the President's fiscal year 2011 budget materials and are on www.ed.gov.

FISCAL YEAR 2011 BUDGET REQUEST AND ESEA REAUTHORIZATION

Our 2011 budget request incorporates an outline of our key principles and proposals for ESEA reauthorization. These proposals are explained in more detail in our "Blueprint for Reform," which was released on March 13, 2010 and which also is available at www.ed.gov. We have thought a great deal about the appropriate Federal role in elementary and secondary education, and want to move from a simple focus on rules, compliance, and labeling of insufficient achievement, toward a focus on flexibility for States and local educational agencies (LEAs) that demonstrate how they will use program funds to achieve results, and on positive incentives and rewards for success. That is why, for example, our 2011 budget request includes $1.85 billion in new funding for the Race to the Top and i3 Programs. In addition, our reauthorization proposal for title I, part A of ESEA would reward schools or LEAs that are making significant progress in improving student outcomes and closing achievement gaps. Our budget and reauthorization proposals also would increase the role of competition in awarding ESEA funds to support a greater emphasis on programs that are achieving successful results.

We believe that our goals of providing greater incentives and rewards for success, increasing the role of competition in Federal education programs, supporting college- and career-readiness, turning around low-performing schools, and putting effective teachers in every classroom and effective leaders in every school require a restructuring of ESEA program authorities. For this reason, our budget and reauthorization proposals would consolidate 38 existing authorities into 11 new programs that give States, LEAs, and communities more choices in carrying out activities that focus on local needs, support promising practices, and improve outcomes for students, while maintaining Federal support for the most disadvantaged students, including dedicated formula grant programs for students who face unique challenges, such as English learners, homeless children, migrant students, and neglected and delinquent students.

COLLEGE AND CAREER READINESS

Another key priority is building on the Recovery Act's emphasis on stronger standards and high-quality assessments aligned with those standards. We believe that a reauthorized title I program, which our budget request would fund at $14.5 billion, should focus on graduating every student college- and career-ready. States would adopt standards that build toward college- and career-readiness, and implement high-quality assessments that are aligned with and capable of measuring individual student growth toward these standards. To support States in this effort, our request would provide $450 million, an increase of 10 percent, for a reauthorized Assessing Achievement program (currently State assessments).

States would measure school and LEA performance on the basis of progress in getting all students, including groups of students who are members of minority groups, from low-income families, English learners, and students with disabilities, on track to college- and career-readiness, as well as in closing achievement gaps and improving graduation rates for high schools. States would use this information to differentiate schools and LEAs and provide appropriate rewards and supports, including recognition and rewards for those showing progress and required interventions in the lowest-performing schools and LEAs. To help turn around the Nation's lowest-performing schools, our budget would build on the $3 billion in school improvement grants provided in the Recovery Act by including $900 million for a School Turnaround Grants Program (currently School Improvement Grants). This and other parts of our budget demonstrate the principle that it is not enough to identify which schools need help—we must encourage and support State and local efforts to provide that help.

EFFECTIVE TEACHERS AND SCHOOL LEADERS

We also believe that if we want to improve student outcomes, especially in high-poverty schools, nothing is more important than ensuring that there are effective teachers in every classroom and effective leaders in every school. Longstanding achievement gaps closely track the inequities in classrooms and schools attended by poor and minority students, and fragmented ESEA programs have failed to make significant progress to close this gap. Our reauthorization proposal will ask States and LEAs to set clear standards for effective teaching and to design evaluation systems that fairly and rigorously differentiate between teachers on the basis of effec-

tiveness and that provide them with targeted supports to enable them to improve. We also will propose to restructure the many teacher and teacher-related authorities in the current ESEA to more effectively recruit, prepare, support, reward, and retain effective teachers and school leaders. Key budget proposals in this area include $950 million for a Teacher and Leader Innovation Fund, which would support bold incentives and compensation plans designed to get our best teachers and leaders into our most challenging schools, and $405 million for a Teacher and Leader Pathways Program that would encourage and help to strengthen a variety of pathways, including alternative routes, to teaching and school leadership careers.

We also are asking for $1 billion for an Effective Teaching and Learning for a Complete Education authority that would make competitive awards focused on high-need districts to improve instruction in the areas of literacy, science, technology, engineering, mathematics, the arts, foreign languages, civics and government, history, geography, economics and financial literacy, and other subjects. Our request also includes $2.5 billion for an Effective Teachers and Leaders formula grant program to help States and LEAs improve teaching and enhance the teaching profession.

In addition, throughout our budget, we have included incentives for States and LEAs to use technology to improve effectiveness, efficiency, access, supports, and engagement across the curriculum. In combination with the other reforms supported by the budget, these efforts will pave the way to the future of teaching and learning.

IMPROVING STEM OUTCOMES

One area that receives special attention in both our 2011 budget request and our reauthorization plan is improving instruction and student outcomes in science, technology, engineering, and mathematics (STEM). The world our youth will inherit will increasingly be influenced by science and technology, and it is our obligation to prepare them for that world.

The 2011 request includes several activities that support this agenda and connect with President Obama's "Educate to Innovate" campaign, which is aimed at fostering public-private partnerships in support of STEM. Our goal is to move American students from the middle of the pack to the top of the world in STEM achievement over the next decade, by focusing on (1) enhancing the ability of teachers to deliver rigorous STEM content and providing the supports they need to deliver that instruction; (2) increasing STEM literacy so that all students can master challenging content and think critically in STEM fields; and (3) expanding STEM education and career opportunities for underrepresented groups, including women and girls and individuals with disabilities.

Specifically, we are asking for $300 million to improve the teaching and learning of STEM subjects through the Effective Teaching and Learning: STEM Program; $150 million for STEM projects under the $500 million request for the i3 Program; and $25 million for a STEM initiative in the Fund for the Improvement of Postsecondary Education to identify and validate more effective approaches for attracting, retaining, engaging, and effectively teaching undergraduates in STEM fields. In addition, I have directed the Department to work closely with other Federal agencies, including the National Science Foundation, the Department of Defense, the National Aeronautics and Space Administration, and the National Institutes of Health to align our efforts toward our common goal of supporting students in STEM fields.

COMPREHENSIVE SOLUTIONS

We also recognize that schools, parents, and students will benefit from investments in other areas that can help to improve student outcomes. Toward that end, we are proposing to expand the new Promise Neighborhoods Program by including $210 million in our budget to fund school reform and comprehensive social services for children in distressed communities from birth through college and career. A restructured Successful, Safe, and Healthy Students Program would provide $410 million to—for the first time—systematically measure school climates, which we know can affect student learning. This will help direct funding to schools that show the greatest need for resources to increase students' safety and well-being by reducing violence, harassment and bullying; promote student physical and mental health; and prevent student drug, alcohol, and tobacco use.

COLLEGE ACCESS AND COMPLETION

The administration has made college- and career-readiness for all students the goal of its ESEA reauthorization proposal, because most students will need at least some postsecondary education to compete for jobs in the 21st century global economy. For this reason, we are proposing a College Pathways and Accelerated Learning Program that would increase high school graduation rates and preparation for

college by providing students in high-poverty schools with opportunities to take advanced coursework that puts them on a path toward college. This new program would help expand access to accelerated learning opportunities such as Advanced Placement and International Baccalaureate courses, dual-enrollment programs that allow students to take college-level courses and earn college credit while in high school, and "early college high schools" that allow students to earn a high school degree and an associate's degree or 2 years of college credit simultaneously.

Just as essential to preparing students for college is ensuring that students and families have the financial support they need to pay for college. We took a giant step toward this goal with the passage of the Health Care and Education Reconciliation Act, which will make key changes in student financial aid and higher education programs that are consistent with President Obama's goal of restoring America's status as first in the world in the percentage of college graduates by 2020. In combination with the Reconciliation Act, the 2011 request would make available more than $156 billion in new grants, loans, and work-study assistance—an increase of $58 billion, or 60 percent, more than the amount available in 2008—to help almost 15 million students and their families pay for college. And another achievement of the Recovery Act, the new American Opportunity Tax Credit, will provide an estimated $12 billion in tax relief for 2009 filers. The budget proposes to make this refundable tax credit permanent, which will give families up to $10,000 to help pay for 4 years of college.

The Reconciliation Act also will invest more than $40 billion in Pell Grants to ensure that all eligible students receive an award and that these awards are increased in future years to help keep pace with rising college costs. Beginning in 2013, the act will provide annual increases based on the change in the Consumer Price Index that are expected to raise the maximum Pell award from $5,550 in 2013 to $5,975 in 2017. In addition, by the 2020–2021 academic year, the number of Pell Grant recipients is expected to grow by more than 820,000.

Finally, the Reconciliation Act will allow postsecondary students enrolling in 2014 or later, and who obtain a Federal student loan, to limit their monthly loan payments to 10 percent of their discretionary income, down from the previous requirement of 15 percent of income. More than 1 million borrowers will be eligible to reduce their monthly payments, and to obtain forgiveness of all remaining student loan debt after 20 years of payments, or just 10 years for public service workers such as teachers or nurses or those in military service.

IMPROVING OUTCOMES FOR ADULT LEARNERS

The 2011 budget request includes funding for a variety of programs that support adult learners, including career and technical education, and adult basic and literacy education. These programs provide essential support for State and local activities that help millions of Americans develop the knowledge and skills they need to reach their potential in the global economy. For example, our request would provide $1.3 billion for Career and Technical Education State Grants to support continued improvement and to increase the capacity of programs to prepare high school students to meet State college and career-ready standards. One of our greatest challenges is to help the 90 million adults for whom increasing basic literacy skills is a key to enhancing their career prospects. For this reason, we are asking for $612.3 million for Adult Basic and Literacy Education State Grants, an increase of $30 million more than the comparable 2010 level, to help adults without a high school diploma or the equivalent to obtain the knowledge and skills necessary for postsecondary education, employment, and self-sufficiency.

IMPROVING OUTCOMES FOR PERSONS WITH DISABILITIES

The budget also includes several requests and new initiatives to enhance opportunities for students and other persons with disabilities. For example, we are proposing a $250 million increase for Grants to States under the Individuals with Disabilities Education Act to help ensure that students with disabilities receive the education and related services they need to prepare them to lead productive, independent lives. The $3.6 billion request for Rehabilitation Services and Disability Research would consolidate nine Rehabilitation Act programs into three to reduce duplication and improve the provision of rehabilitation and independent living services for individuals with disabilities. The request includes a $6 million increase more than the 2010 level for a new Grants for Independent Living Program (which consolidates Independent Living State Grants and Centers for Independent Living) and would provide additional funding for States with significant unmet needs. It also includes $25 million for a new program that would expand supported employment opportunities for youth with significant disabilities as they transition from school to

the workforce, through competitive grants to States to develop innovative methods of providing extended services.

The budget provides $112 million for the National Institute on Disability and Rehabilitation Research to support a broad portfolio of research and development, capacity-building, and knowledge translation activities. And the request includes $60 million—$30 million under Adult Education and $30 million under Vocational Rehabilitation—for the Workforce Innovation Fund, a new initiative in partnership with the Department of Labor. The proposed Partnership for Workforce Innovation, which encompasses $321 million of funding in the Departments of Education and Labor, would award competitive grants to encourage innovation and identify effective strategies for improving the delivery of services and outcomes for beneficiaries under programs authorized by the Workforce Investment Act. This investment will create strong incentives for change that, if scaled-up, could improve cross-program delivery of services and outcomes for beneficiaries of programs under the Workforce Investment Act.

CONCLUSION

In conclusion, we have made extraordinary progress in meeting the needs of our schools and communities in the midst of financial crisis and recession, making long-needed reforms in our Federal postsecondary student aid programs, and reawakening the spirit of innovation in our education system from early learning through college. The next step to cement and build on this progress is to complete a fundamental restructuring of ESEA, and we believe strongly that our 2011 budget request is essential to that effort. I look forward to working with the subcommittee toward that goal and have every confidence that with your continuing leadership and strong support from President Obama and the American people, we will accomplish this important task.

Thank you. I would be happy to answer any questions you may have.

EDUCATION JOBS BILL

Senator HARKIN. Mr. Secretary, thank you for a very eloquent statement.

I can't agree with you more. The status quo is not acceptable, and it is not acceptable during economic downturns to say that we are just going to take a lot of this out of the hide of education. You only get one chance at that, and if we fail our kids, that means we fail our future.

So I am encouraged by your, I think, statement of support for a jobs, an education jobs bill. I mentioned the one that I am putting in today. I hope that we can count on your active support and the support of the administration in getting this emergency funding through because it is an emergency. And so, again, I hope we can count on your support for that. You mentioned that, and I appreciate it.

Secretary DUNCAN. Yes, I appreciate your leadership so much. We absolutely need a jobs bill, and I look forward to working with you to work on the details of it.

This is the right thing for the country. It is the right thing for the economy. It is the right thing for our children.

DEFINING AND FUNDING EARLY LEARNING EDUCATION

Senator HARKIN. Absolutely. And we will consult with you on how best to get that done and structure it.

You also mentioned something else, the early learning part of the bill that we didn't get in reconciliation because of a budget problem that we had, but something that you know I care very deeply about. It is one I talk about all the time, that we are always playing catch-up ball. And one of the reasons we play so much catch-

up is that we don't put a lot of emphasis on the time when kids' brains are developing the most, and that is from birth to 5.

As you heard me say before, I said it yesterday at a hearing at the HELP Committee, that perhaps we ought to rethink that elementary education starts at birth. It doesn't start when you get to kindergarten. Maybe it starts when you are born.

That is not my statement. That was a statement made by the Committee on Education Development in 1991 that was set up by President Reagan to look at what we needed in education. It was a committee of business people. I guess President Reagan wanted the business community to tell us what we needed in education.

Well, the committee met during the ensuing years after that. And finally, in 1991, they came out with a report. I was chairman of this subcommittee at that time. And James Renier, the head of Honeywell, presented that report to us. And mind you, here are some of the biggest business leaders in America, heads of big corporations, taking a look at education and what was needed. And their executive summary was very simple. It said we must remember that education begins at birth and that preparation for education begins before birth.

The whole report was focused on early childhood learning. This is 1990, 1991. Twenty-one years later, we are still trying to figure out what to do on education. We have got to put more into early learning.

FUNDING FOR EARLY CHILDHOOD EDUCATION IN 2010

So, again, we are going to do everything we can in this budget cycle. I know it is not in your budget because you were probably counting on the money being in the reconciliation bill, which got knocked out. So, Mr. Secretary, I hope that we can count on working with you to find ways of getting that money back in our budget cycle for even as early as next year and working with us on that.

Secretary DUNCAN. We have to. And that is exactly right. We didn't include it in our budget because we thought it was coming in through the other source.

But let me tell you, Mr. Chairman, I would like to work with you to adjust our proposed budget. And we think we cannot walk away from this. This is the most important thing we can do, and so we want to figure out some ways with you to adjust our proposed fiscal year 2011 budget so that we can invest in early childhood education. We can't afford not to do that.

Senator HARKIN. Well, I can tell you I have had conversations with my counterpart on the House side concerning this issue and with you, and I look forward to working with you to see how we can shoehorn this in some way.

Secretary DUNCAN. Our staff is working on a couple different options, and we should come back to you shortly with a proposal or two.

Senator HARKIN. I appreciate that very much.

RACE TO THE TOP COMPETITION

Mr. Secretary, one thing I would just like to cover before I move on, and that is the whole Race to the Top issue. There has been a lot of debate, on, yes, Race to the Top. You have got a lot of

money focused on grants to specific States when even as you pointed out in your comments, that whole structure is in danger right now.

And so, the question has been raised to me as should we focus that kind of money on a few specific States that may win a competition, or do we need to focus this more on the broader structural basis of education?

I think you partially answered that when you said that this is about 1 percent, if I am not mistaken. I think you said about 1 percent of the total education funding. So when put in that context, it gives more credence to this Race to the Top.

Can you just tell us more of your thoughts on that and how we respond to the idea that, because of the structural problems, how can we focus on the Race to the Top?

Secretary DUNCAN. It is a great question. I just think, frankly, we have to walk and chew gum at the same time. So we need to save jobs, absolutely. But we need reform as well. And these two things go hand in hand. They reinforce each other.

If we are simply trying to preserve the status quo, we need to do that, but that is not going to get us where we need to go. We have a dropout rate that is unacceptable. We have far too many students who do graduate who aren't actually prepared for college or careers. And so, we need to make sure we don't go south and get worse, and that is what we are concerned about with the huge budget cuts that States and districts are looking at.

DROPOUT RATE

At the same time, we have to be pushing very hard to get better, and we have to get that dropout rate down to zero absolutely as fast as we can. There are no good jobs out there today in the legal economy for a high school dropout. There are almost no good jobs out there if you just have a high school diploma. You have to have some form of training beyond that—4-year universities, 2-year community colleges, trade, technical, vocational training.

RACE TO THE TOP FUNDING

And so, we have to get better. We invest as a country each year approximately $650 billion in K to 12 education, $650 billion. Race to the Top, at $4 billion, is less than 1 percent of national spending on education, and I think I can make a pretty good case to you that the amount of change we have seen around the country due to that less than 1 percent investment has been extraordinary.

And we look forward in this next round to seeing more States win and benefit. We think States that go through the process are getting better and stronger, and they are having those conversations that haven't happened historically. And so, we hope we have a much larger set of winners in the second round. And as you know, we are coming back in the fiscal year 2011 budget, we want to do a third round of Race to the Top and get to that next set of States. And so, this is an ongoing evolutionary process.

But to see the amount of change that has happened with a very small amount of money I think is simply extraordinary. We had high hopes going in, and it has far exceeded our wildest expecta-

tions. And so, these are not—these ideas are not in conflict. These are false dichotomies. We have to do both.

We have to make sure we don't go south. We have to make sure we are not seeing hundreds of thousands of people laid off. But we need to push for real, dramatic, transformational change at the same time.

Senator HARKIN. Mr. Secretary, I appreciate that answer. You are right. We have got to do both, and we can't let up on one or the other.

Senator Cochran.

RURAL AND LOW-INCOME SCHOOL DISTRICT FUNDING

Senator COCHRAN. Mr. Chairman.

Mr. Secretary, I noticed, looking through the summary of the request from the administration, that we are not seeing the increases requested for some of the programs that are targeted to low-income and poverty families whose students live in the rural areas of the country, the small towns. And I am disappointed in that.

For example, my State has the highest percentage of students who qualify for the benefits of the title I program. Only the District of Columbia has a higher percentage than the students in our State. And I am worried that the budget request submitted by the administration sort of freezes that in place and doesn't provide for increases in formula grants under the title I program, for instance.

And so, the schools and the communities with the highest numbers of poor students are going to continue to be held back and suffer in comparison with the resources that are being made available to students in the wealthier and larger cities of the country. Does this call for another look at the budget and with some emphasis being placed on improving and enlarging the amount of money going to these poor school districts, or are they going to be locked into last place forever?

SCHOOL IMPROVEMENT GRANT FUNDING

Secretary DUNCAN. That is the last thing we would want, Senator. And you may know through the School Improvement Grants Program, which is going to the lowest-performing schools—I just checked the numbers—Mississippi is going to get an additional $46 million to help those children in poor communities—rural, urban, whatever it might be—who have been in historically very low-performing schools to try and transform the opportunities for them.

So, it is a huge influx of resources coming to Mississippi and coming to every State around the country. And what I think we have done, quite frankly, is we have labeled lots of schools failures, but not much has changed in most places. In most places we really haven't seen the kind of transformational change to help those poor students break out of poverty and build successful lives.

We are putting out an unprecedented amount of money—it is interesting that Race to the Top has gotten all the press and publicity. That is for 100 percent of the Race to the Top schools. That is $4 billion. But, there is $3.5 billion in school improvement grant funds just for the bottom 5 percent.

And so, almost $46 million comes to Mississippi. The State is going to figure out what is the best way to turn around those low-

performing schools. We have a couple of models out there. But we want to make sure those children who historically have been underserved have a chance with a real sense of urgency to get a much better education.

RURAL EDUCATION ACHIEVEMENT PROGRAM (REAP)

Senator COCHRAN. Well, one thing that bothers me, too, is the fact that we have level funding proposed by the administration for the REAP. The budget request freezes that program at a level of $174.9 million. It was designed to help rural districts overcome the additional costs associated with geographic isolation, distances that have to be traveled during the day in school buses from rural areas to the places where the schools are located.

Transportation costs are up. Employee benefit costs are down. And there is an increase in poverty in most of these areas that qualify for the REAP, but it is level funding. That is an example of something that disturbs me, and I hope the administration will look carefully at the decisions that are made by the congressional committees in the House and the Senate.

I would not be surprised at all, and as a matter of fact, I am hopeful that we will increase these funds that are available for competitive grants for some States and districts. But formula grants provide a reliable stream of funding to States and local districts that just don't have the teachers or the administrators with the educational backgrounds that are required to help move these districts forward.

MIGRANT EDUCATION PROGRAM

So I know that money is tight. The Migrant Education Program is another one. Mississippi's funds for that program are going to be reduced from $1.076 million to $640,000. And these things just keep cropping up in this budget request page after page after page.

CONSOLIDATIONS

Consolidating programs, as the administration proposes in the Even Start Family Literacy program, is going to cost Mississippi an estimated $830,000 in Even Start funding for fiscal year 2010. So I hope the administration will take another look at the budget request and work with the Congress to try to identify a fairer and more acceptable program for rural schools and small States.

INVESTING IN INNOVATION FUND

Secretary DUNCAN. I absolutely look forward to working with you, Senator. And just to reiterate, the things we are doing, like the Investing in Innovation Fund, that $650 million fund, have actually included a competitive advantage for rural communities and rural districts. So we are really trying to make sure we are touching those communities.

PROGRAM CONSOLIDATIONS

Where we consolidated programs, in every area, we actually increased funding. So there is a chance, whether it is around teachers and leaders, whether it is around a well-rounded education,

student supports, diverse learners, because in every area we consolidated, we are actually increasing the amount of funds, which doesn't usually happen with consolidation. So there is a real chance for States and districts to put their best foot forward and get more resources in those areas. But we are trying to do fewer things, but do those things, those fewer things, do them in a world-class manner.

Senator HARKIN. Thank you, Senator Cochran.

Senator Landrieu.

RACE TO THE TOP—FIRST ROUND COMPETITION

Senator LANDRIEU. Thank you.

Thank you, Mr. Secretary. And I appreciate your enthusiasm and your focus on improving our schools because it is quite a challenge.

I wanted to ask you, if I could, just about the Race to the Top program. Let me just get to my question here. We were one of the States that applied, as you know, and have been very encouraged by words that you and your administration have spoken about the good work that is happening in Louisiana that has been going on, as you know, for some time.

The administration requested $1.4 billion to extend Race to the Top. Now the first competition has come to a close. We were not one of the States chosen, but I believe Delaware and, what was the other one, were.

After evaluating some of the scores, however, of the States that did apply, it was interesting that if you decided to grade them somewhat differently by throwing out the high and the low, which is done in the Olympics and is done in many competitions, to get a better, clear average, the top two States would have remained the same. But in Louisiana's case, we would have moved up considerably.

RACE TO THE TOP—APPLICATION SCORING

So that is just one question I pose to you. When you do the second round, are you thinking about the opportunity of a more fair scoring, number one? And number two, it was also interesting that a high weight was given to what seemed to be an application that had all parishes or counties onboard, all teacher unions onboard, all school boards onboard, which, in an ideal world, you know, would be what we were hoping for.

But as you know, as a reformer in the trenches, it is sometimes difficult to deliver all the teacher unions, all the counties, all the parishes. And for applications like ours that represented a very strong and risk associated application for about half, to not be designated, I have to say, was just a real disappointment.

So my questions are, one, is there going to be any new approach to scoring that might result in a more fair reflection of the actual quality of the application? And number two, why are we going to insist that if you can't get every school board and every county stepped up, your State can't try with the counties that are ready to go and willing to take the risk?

Secretary DUNCAN. Really good questions, and obviously, Louisiana has done an extraordinary job in very, very difficult circumstances of driving reform and has made huge progress, and I

know there is real disappointment that the State didn't win in the first round. I would absolutely urge the State to come back and come back stronger the second round. As you know, there is a huge amount of money that is going to go out, between $3.4 billion and $3.5 billion in the second go-around.

To answer those two questions, I will answer the second question first that bold reform and broad stakeholder support is a winning combination. But watered down reform and broad stakeholder support is not. Bold reform matters, and I——

Senator LANDRIEU. But let me just interrupt because this is very important. Nothing in our application was watered down.

Secretary DUNCAN. Right.

Senator LANDRIEU. The problem is if you push to get everyone there, you will give us no choice but to water down. In other words, half of something strong is better than 100 percent of something weak and watered down. And that is what I am very concerned about, and I think there are many members that are driving this reform effort that are absolutely taken aback at the posture of this department.

Secretary DUNCAN. Well, again, if you look at the results, the two winners were able to do both. But if you look at folks that came in with high scores right behind that, they had very broad reforms. And if we are going to fund 10 to 15 States, whatever the magic number will be in the second round, I think there is a huge opportunity there. So I——

Senator LANDRIEU. So it is a real opportunity, I want to just say, for some unions. And some unions have been supportive, and some teacher unions have been supportive. But it is a real opportunity for those that don't want to be supportive, and there are obviously many entrenched interests, not just some unions, but school board members and others. I mean, this is a fight in every State, as anybody that is in this battle knows. This is a battle. It is not a waltz.

And so, what you are saying is if you can't get everyone in your State to step up, we can't help you to start because it is so counter to the way that I have been leading this reform movement in Louisiana. So I just want to, Mr. Chairman, say how strongly I feel about the way this administration—and I am one of their biggest supporters. But this is going to have to be changed, in my view. Not watering down, but strengthening and rewarding those that will take the risk of reform, whether everybody is there or not.

In any efforts I have led for reform, you don't get 100 percent participation at the front end. You might get 10 people that show up at the line and say we are willing to go. Ninety people are back here. Then next year, 20 percent show up at the line, and you leave 80 percent behind. And soon, it is reform. So I am completely confused.

TEACH FOR AMERICA (TFA)

And my second question is this, and I will add, Mr. Chairman, I know. But TFA, and the members of this subcommittee understand how strong TFA has been. I want to just read for the record, Mr. Chairman, it is harder today to get into Harvard Law School—I mean, it is harder today to get into TFA than it is to get into Harvard Law School. What a phenomenal success TFA has been.

Think about that. Not even a Government-run program, not even a Government-started program. But a nonprofit, entrepreneurial, innovative program that has accomplished more than all of us, in my view, together, getting qualified teachers in the classroom, and we haven't fully funded their effort. I am going to submit a full funding to this chairman for his request.

And when any Federal program can say that they are putting more qualified teachers in the classroom than are going to Harvard Law School, then we might take the funding and shift it over there.

Thank you.

Senator HARKIN. Thank you, Senator.

Senator Alexander.

FUNDING EXCELLENCE IN EDUCATION

Senator ALEXANDER. Thank you, Mr. Chairman.

Mr. Secretary, thank you for being here.

I very much appreciate your leadership, the way you go about your job, the bipartisan way you do it. I am glad to be a part of a bipartisan working group to try to fix No Child Left Behind. I appreciate the struggle of trying to emphasize excellence at the same time you are trying to support schools, both.

I remember as a Governor when I tried to encourage master teachers and centers of excellence and chairs of excellence. People would say, well, why would you do that when we need money for what we are already doing? And the answer really was, I don't think taxpayers really want to support much more funding for more of the same, but they will support a lot more funding for excellence. And there are many different ways to do it, but I am going to support your request for funding for excellence wherever I have the opportunity to do it.

RACE TO THE TOP—FIRST ROUND COMPETITION

And I have a question along a couple of lines about three specific programs, but I wanted, in senatorial custom, to make a couple of preliminary observations first. One is Tennessee was glad—and I can say this because I had nothing to do with it. The Governor, the legislature, the educators did it—to be one of the two winners of Race to the Top.

And as terrific as that is going to be for the State, the Federal Government is really giving with one hand and taking away with another because the new healthcare bill, between 2014 and 2019, is going to add between $1.1 billion and $1.5 billion of costs, most of which will have to come out of education, while the Race to the Top brings half a billion dollars of costs.

ARRA FUNDING

Second, our Governor, a Democratic Governor, said at the time of the stimulus funding 2 years ago that these are one-time funds, don't spend it on continuing operations. So as the chairman talks about $23 billion more, I wonder from whose schoolchildren we are going to borrow this money? Because we have a looming debt crisis in our country, and we will need to debate this. We all want to help our children, help our schools. But that is a deep concern.

FEDERAL DIRECT STUDENT LOANS PROGRAM

As far as student loans, we didn't have much of a chance to debate that here. You know my views, and they are different than yours. But I think it is important to say that what we are really doing with this Federal takeover of the student loan program is borrowing money from 19 million students. We are borrowing the money—the Federal Government is—at 2.8 percent and loaning it to them at 6.8 percent and taking the savings and using it to pay for Pell Grants and some for healthcare.

And I think it would be better if we are going to take it over and create so-called "savings" if we give the students the savings. We could lower the interest rate from 6.8 percent to 5.3 percent on the student loans and let that $61 billion or so be in the pockets of the 19 million students who are borrowing money to go to school.

HISTORY AND CIVICS EDUCATION

Now on my questions, and then I will leave the rest of my time to you, there are three programs that I am especially interested in. One is the proposal Senator Byrd, the late Senator Kennedy, and I introduced to try to take the Federal programs on history and civics and consolidate them and make them an appropriate part of what the Federal Government does to help children learn—to support State and local efforts to help children learn what it means to be an American and finding a dedicated stream of funding for that.

TEACHER INCENTIVE FUND (TIF)

Two is the TIF, which has been the most useful tool, I think, to you in Chicago, when you were superintendent, to many school districts around the country to help find effective ways, fair ways to pay teachers more for teaching well. And I wonder under your blueprint plans whether you are not running the risk of de-emphasizing that program?

TFA

And finally, along with Senator Landrieu, I strongly support TFA. It is an authorized program in the law, not an earmark, just as the history program is. And I am wondering if your blueprint that you are working with us on fixing No Child Left Behind doesn't de-emphasize it as well?

So history and civics, the TIF for effective teaching and school leadership, and TFA, your comments on the priority those will have as you look forward the next few years?

Secretary DUNCAN. Yes. I will try and take them in reverse order. On TFA, and I appreciate your passion and leadership on that, and Senator Landrieu, your passion and leadership. And let me be very clear, I am a huge fan of TFA, and I have seen the benefits around the country. I actually helped bring them to Chicago before I was the CEO of Chicago Public Schools. And that influx of talent, commitment, and passion has been extraordinary around the country.

Senator Landrieu, as you know so well, talent matters tremendously. It is a phenomenal pool of hard-working, committed folks

going to tough communities—inner-city, urban, rural, whatever it might be—who want to make a difference in students' lives. And so, I just want to be very, very clear where I stand on that.

And the funding, we have, as you know, dramatically increased that pool of funding for teacher programs, and there is a real chance for TFA to put their best foot forward and through a competitive process bring in not just what they currently get but, frankly, significantly more resources. And that potential is there for them, as there are for other great programs that are bringing talent into education.

And I don't think there is anything more important we can do as the baby boomer generation moves toward retirement than to bring in great new talent.

Following the submission of their application for funding, the Department will likely award a grant to TFA in June 2010. Grant funds are typically available for 12 months, which would be until June 2011. And so, there should be funding there, and there will also be an opportunity going forward for them to compete for, frankly, significantly larger pools of money.

TIF INVESTMENT

On the TIF, I have appreciated your leadership and vision on this for a long time. And it is one of the most important things we think we can do. As you know, we want to significantly increase that investment, going from $400 million in fiscal year 2010 to a proposed $950 million in 2011.

And please, don't have any concerns about watering that down. We will absolutely—let me be clear. We will absolutely require grantees to create systems for identifying and rewarding outstanding teachers, as well as principals. And so, that commitment is unwavering, and I can't be more clear on that.

On the first one, teaching American history, again, that is an area where we are actually increasing the investment, $265 million for the history, arts, financial literacy, foreign languages, a 17 percent increase. We are doing it, as you know, on a competitive basis. But that pool of money, again, did not shrink, it is up 17 percent, and great programs have a chance, again, not just to maintain funding, but to, frankly, increase their funding.

Senator ALEXANDER. Thank you, Mr. Chairman.

Senator HARKIN. Thank you, Senator Alexander.

Senator Pryor.

COMPETITIVE ABILITY OF RURAL AND SMALL DISTRICTS

Senator PRYOR. Thank you, Mr. Chairman.

And Mr. Secretary, thank you for being here today, and I do have a few questions for you. And first, let me say that I like competition. I think that is good that we introduce more competition into some of this. But I do have a concern about a rural State or a rural setting, smaller school districts that maybe don't have the resources and maybe don't have the grant writing background.

And how do you factor that in considering that some districts in some States—some of the areas that need it the most—may be the least capable of going through the process? How do you address that?

Secretary DUNCAN. That is a great question. We spent a lot of time thinking about that. And let me be really clear. We are not looking for great grant writers or fancy PowerPoint presentations. That is not our interest.

We want to go where the need is. And there is tremendous unmet need in rural communities. And what we want people to do is just to simply show us their vision, show us where they want to go, show us their commitment to raising the bar for all students and closing the achievement gap, and that is where we want to invest.

And so, whether it is the TIF grants, whether it is Investing in Innovation, where we made actually a competitive advantage for rural communities, we want the funds to go where the need is. And so, hold us accountable for that, but this is not going to be judged by the prettiest pie chart or the prettiest PowerPoint presentation. We want to go where there is real commitment, where there is real courage, where folks want to get better and demonstrate that commitment. And we want to partner with you to take to scale what works.

NUMBER OF URBAN VS. RURAL SCHOOL DISTRICTS

If we are serious about scaling-up best practices, the majority of our students are not in urban school districts. That is the reality. It is 2,000 districts out of 15,000. We have to play on a nationwide basis, and we are absolutely committed to doing that.

COMPARABILITY OF EDUCATIONAL SERVICES

Senator PRYOR. Great. Let me ask you another question about comparability. About 57 percent of all students in Arkansas are economically disadvantaged, and more than 1,700 students in my State take advantage of supplemental services. In terms of comparability, your blueprint aims to "encourage increased resource equity at every level of the system" and to "over time require districts to ensure that their high-poverty schools receive State and local funding levels comparable to those received by their low-poverty schools."

Can you clarify that and explain how that works and what you mean by that?

ADDRESSING THE ACHIEVEMENT AND OPPORTUNITY GAPS

Secretary DUNCAN. Yes. Let me just, you know, explain the big picture. We as a Nation are rightfully focused on the achievement gap. I think we have had lots of talk about that. We have had very few places fundamentally breaking through on closing that achievement gap. And what I keep saying is that if we are serious about closing the achievement gap, we have to close what I call the opportunity gap.

And to do that, we have to make sure that communities that have been historically underserved, be they rural, inner-city, urban, are finding ways to attract and retain the best teachers and the best principals. Talent matters tremendously in education.

And I think in far too many places, there are very few incentives and, frankly, lots of disincentives for the best talent to go to the

communities and the children who need the most help. And so, what we would really be doing is challenging everyone to think about what we are doing systemically to get students in the communities who often, frankly, for decades have been poorly served, how are we going to change that? How are we going to challenge the status quo?

And this is one of many attempts to really start to address that question in a much more meaningful way than what I have seen historically.

APPROACH TO ESEA REAUTHORIZATION

Senator PRYOR. Good. You know, when I think about your background being from the Chicago area, and I know you have done a lot of work with inner-city work there, that is great. And then when I look at some of our districts in Arkansas that are rural and have all kinds of challenges, and a lot of our students there do—and I think if you look at a test score, they might score the same in some ways, but there may be a lot of factors that go into that score that cause them, for different reasons, to score that way. And I was glad to hear you say earlier that your three Fs are fair, flexible, and focused because I do think you have to be fair, but also you have to be flexible. You have to recognize the differences and the different factors that go into getting the results we want to get. And I remember back when I was the attorney general of my State, we had a big lawsuit over school funding. And some of that is very difficult to determine in terms of how you get from point A to point B and what you can do as a State or a district or certainly the Department of Education—what you can do to try to get us the results we need.

So I just encourage you to be fair, flexible, and focused, but also keep in mind that second F, that flexibility, because one size is not going to fit all.

RECOGNIZING ACHIEVEMENT

Secretary DUNCAN. No, I really appreciate that. And again, we just want to look for places that have that commitment to closing the gap and continue to support them.

I just checked Arkansas's money for school turnarounds, again that bottom 5 percent in every State, you define who those bottom 5 percent are. You figure out how we get better—$34 million. We are trying to put a huge amount of resources for, again, those children who haven't had the opportunities they need to fundamentally break through, whether it is more time, whether it is different leadership. Whatever it might be, we have to do better with a real sense of urgency.

And we are trying to put our money where our mouth is. We are trying to put our resources there and say let us have some courage and let us do some things in a different manner.

The final thing I will say is that so much of what bothered me about the previous law, well—let me just give you a quick example. Let us say you were a sixth grade teacher, and I came to you as a student three grade levels behind, reading at a third grade level. If I left your classroom one grade level behind, you were labeled a failure. Your school was labeled a failure.

I think not only are you not a failure, I don't just think you are a good teacher, I think you are a great teacher. I gained 2 years of growth for a year's instruction. That teacher is a phenomenal teacher. We should be learning from them. We shouldn't be stigmatizing them. We should be replicating that. We should be rewarding that.

We should figure out why I came to your class three grade levels behind and figure out what is going on downstream.

Senator PRYOR. Right.

Secretary DUNCAN. But we want to really look at growth and gain and how much we are improving. If a dropout rate is going from 50 percent to 45 to 40 to 35, it's still too high, but it's going the right way. If it is at 50, 50, 50, 52, 55, well, that is a real problem. That is a place that is stagnating, not getting any better.

PROMISE NEIGHBORHOODS INITIATIVE

So really looking at improvement, and it takes lots of things. It takes a community. It takes parental engagement. It takes challenging students. We have this Promise Neighborhoods Initiative, which we haven't talked about, where we want to create communities around schools that make sure students are safe and make sure the entire neighborhood is working behind students so they can be successful academically.

So we want to come at this from a lot of different approaches, but ultimately, we want to look at who is serious about seeing students improve dramatically.

Senator PRYOR. Yes. I think my State has a good story to tell there. The numbers in my State are going in the right direction, but it has taken a lot of hard work at the local and State level.

Thank you, Mr. Chairman.

Senator HARKIN. Thank you, Senator.

Senator Shelby.

IMPACT OF WEAK ECONOMY ON EDUCATION

Senator SHELBY. Thank you, Mr. Chairman.

Welcome, Mr. Secretary. I want to get into an area that Senator Pryor did. My State of Alabama, the unemployment rate in Alabama, February 2007, was 3.4 percent. We had some good years, a lot of good years.

The unemployment rate jumped to 4.2 percent February 2008. February 2009, it had gone up to 8.7 percent. February 2010, it is 11.1 percent, it was. So this wreaks havoc on everything—the economy, the collection of taxes, the schools.

I think we have been making a lot of progress in my State of Alabama with our schools, but the economy is weakened, as I have pointed out. We have lost more than 2,000 teachers. Think about it. Two thousand teachers in the past 4 years, and our jobless rate, as I pointed out, has tripled. There is a correlation between all this.

It has been proposed that we might lose another 1,500 teachers in the coming years. How will schools, not just my State, but around the country, but particularly Alabama right now, if we continue to carry out reforms, can we do this as we lose all these teachers, Mr. Secretary?

EMERGENCY JOBS BILL FOR EDUCATION

Secretary DUNCAN. It is a great question. Before you got here, the Chairman spoke eloquently, and I supported him. I think we need—I don't know if you would agree or disagree. I think we need an emergency jobs bill. I don't have my numbers in front of me for Alabama. But we saved, conservatively, 300,000 educator jobs around the country last year.

Alabama got absolutely its fair share, but we are very, very concerned. So I am strongly supporting emergency action by Congress. What is happening in Alabama, we are seeing very, very similar, if not worse numbers in the majority of States around the country. It is a devastating time.

Senator SHELBY. It is not just my State, but we have problems in my State. We have a lot of promise, but we have some problems, as you know. But it is the Nation——

Secretary DUNCAN. It is the entire country. No one is untouched by this. And when you see tens of thousands, hundreds of thousands of educators being laid off, that has a huge impact on the entire economy. It has an impact on students' futures, and I think this would be the right investment to make. It is the right thing to do at the right time for the right reasons.

So that is something that Senator Harkin is actually proposing today, an emergency jobs bill, and we want to work with him on the details. But, if it is something interesting, I would love to continue that conversation.

RURAL DISTRICTS ABILITY TO COMPETE FOR GRANTS

Senator SHELBY. But the grants, Senator Pryor brought this up, does the grant program do detriment to a lot of the rural counties, smaller counties all over America, as opposed to some of the more urbane, urban counties?

Secretary DUNCAN. Not at all. And again, I want you to really hold us accountable. What we want is to invest—the Investing in Innovation Fund or the Promise Neighborhoods initiative, we want to work throughout the country. And there is tremendous unmet need in rural communities and rural States.

I was fortunate to be in your State a couple of weeks back and have an absolutely memorable visit, and the challenges that I saw were staggering. And we want to invest in those places that want to get better and where there is tremendous need, and that includes rural communities.

Senator SHELBY. Just a few minutes ago, I believe, you stated, and I will quote you, "We want to go where the need is."

Secretary DUNCAN. Yes, sir.

HIGH SCHOOL GRADUATION RATE

Senator SHELBY. Just a few minutes ago. Well, obviously, we have some needs. We are not by ourselves. Alabama has, it is my information, had a high school graduation rate of 67 percent, compared to the national rate of 74 percent. And this is—although we have improved, we have got a long way to go.

But if we lose money or we lose out on the funding program, I think we will not be by ourselves, would we?

Secretary DUNCAN. No, I agree. And so, again, I think if we can get a jobs bill passed, that would be a huge benefit. Alabama has made real progress. I am a big fan of your State superintendent. I think he is doing——

Senator SHELBY. He is going to testify in a few minutes.

Secretary DUNCAN. Is he? Well, he is a fantastic—I am glad I said the right thing then.

But in all seriousness, I am a big fan of his. He is working extraordinarily hard. To see his level of commitment and the community support of his efforts was remarkable, and I think with the jobs—he will talk about the problems, but with a jobs bill we have a chance to make sure we don't get worse and, at the same time, try and push for the kind of real transformational change we need.

Senator SHELBY. Well, in a nutshell, how will the grant program work as compared to the status quo?

Secretary DUNCAN. Well, we are talking about a couple of different things. If we have a jobs program, that would help to preserve somewhere between 100,000 and 300,000 jobs, education jobs around the country. And there is desperate need out there. At the same time we are doing that, we don't just want to preserve the status quo. We have to continue to get better.

And so, Race to the Top, the Investing in Innovation Fund, School Improvement Grants, TIF, Promise Neighborhoods, all those are attempts to really have the kind of breakthrough changes that we need. So we need to do both at the same time. These ideas are not in conflict. We have got to do both.

Senator SHELBY. But if you go where the need is, you are going to go to a lot of the rural areas, too, are you not?

Secretary DUNCAN. Yes, sir.

Senator SHELBY. Okay. Thank you, Mr. Chairman.

CLOSING REMARKS TO THE SECRETARY OF EDUCATION

Senator HARKIN. Secretary Duncan, thank you very much for your testimony and for answering questions. We may hold the record open for a while here to have some written questions from Senators who were not able to be here because of schedule conflicts.

So, with that, Mr. Secretary, thank you very much. Look forward to working with you.

Secretary DUNCAN. Thanks for all your leadership.

Senator HARKIN. Thank you, Mr. Secretary.

INTRODUCTION OF EDUCATION JOBS PANEL

The Secretary will be excused. We have a second panel that will be coming up, a panel to talk about education jobs, which we heard about here with Secretary Duncan and others on this panel.

Senator HARKIN. All right. If we could get our panel seated? Mr. Ramon C. Cortines is the superintendent of the Los Angeles Unified School District. Mr. Cortines began his teaching career in Aptos, California, in 1956. From 1995 to 1997, he served as special adviser to U.S. Secretary of Education Richard Riley.

We have Chris Bern, president of the Iowa State Education Association and a math teacher at Knoxville High School, graduate of Buena Vista College in Storm Lake with a degree in mathematics.

And I will skip over the next because I will leave that to Senator Shelby. Then we have Mr. Marc S. Herzog, currently chancellor of Connecticut Community Colleges, a position he has held since 1999. Mr. Herzog holds a master's of science degree in guidance and counseling from Central Connecticut State University and a bachelor of arts degree in education from Yankton College in South Dakota.

And with that, I will yield to my friend from Alabama for purposes of an introduction.

Senator SHELBY. Thank you. Thank you, Chairman Harkin.

I will be brief, but I don't get this chance every day. We have a distinguished superintendent of education from Alabama. He is sitting here, Dr. Joe Morton, and I am pleased to welcome him here, and I hope to engage him in a few minutes in some questions.

Dr. Morton's impressive background includes, among other things, the creation and implementation of the Alabama Reading Initiative; the Alabama Math, Science, and Technology Initiative; and the First Choice plan, a new graduation plan for Alabama students. We are proud of his tenure. Under his tenure, we have shown significant academic gains in reading and math assessment scores, and he has been judged a national leader in training future teachers and principals.

We are pleased to have you here today, Dr. Morton.

Senator HARKIN. Thank you very much, Senator Shelby.

Dr. Morton, we welcome you here also.

We will start here from just as I introduced, Dr. Cortines over. And I looked over your testimonies last evening. They will all be made a part of the record in their entirety, and I would ask if you could kind of sum it up in, oh, 5 to 7 minutes, and then we can get into some questions and answers.

I have asked this panel to be here to mostly focus on the issue of jobs and what is happening. You heard us talk here before with the Secretary. Senator Shelby talked about it also. What are we seeing out there? What is happening so that we are not caught unawares here? What are we looking at next year in your States, in your districts, things like that, that we should be taking some action on very soon.

If you have other things you want to talk about, that is fine, too. But I would like to focus a little bit on this jobs issue.

Mr. Cortines, welcome again. Here we just had someone from Los Angeles at a hearing yesterday, Green Dot.

Mr. CORTINES. Marco Petruzzi.

Senator HARKIN. Exactly, right. He was on another Committee I chaired yesterday.

Mr. Cortines, welcome, and please proceed.

STATEMENT OF RAMON C. CORTINES, SUPERINTENDENT, LOS ANGELES UNIFIED SCHOOL DISTRICT

Mr. CORTINES. Thank you.

Chairman Harkin and subcommittee members, thank you for this invitation. I head the second-largest district in the Nation. Our enrollment is 618,000 students, and as you know, it is larger than the total number of students who attend public schools in 25 States.

First, let me thank and congratulate Senator Harkin for introducing the Keep Our Educators Working, which would create a $23 billion education jobs fund modeled after the SFSF that was established in the ARRA. I support this bill and ask all to support for the teachers, the principals, the counselors, school nurses, and other essential public school employees that are losing their jobs.

Today, I ask you to help us to stop the hemorrhaging of teachers and other essential public school employees in Los Angeles and across the Nation in other big cities, in small towns, and in rural areas. Two thousand teachers gone from our district, and more are on the chopping block right now as State funding continues to shrink.

I don't know every name of those 2,000 teachers, but our students do. Who is the first person you see at a school? Office workers, who are disappearing. Our schools would neither be healthy or beautiful without custodians, whose numbers continue to dwindle.

You name it—teachers, principals, counselors, school nurses, cafeteria workers, support personnel—are a part of an unchecked exodus forced by California's financial realities.

Unfortunately, it is not over. The district was forced last month to send out nearly 5,200 reduction in force notices to principals, teachers, and other school-based staff. Some, though certainly not all, will keep their jobs because the unions representing these individuals have agreed last week to shorten the school year by 5 days this June and next year, too, to save $175 million.

As a result, our students' teachers are losing instructional time and taking a pay cut. Their sacrifices are generally appreciated, but much more is needed to close a $640 million budget gap. Because of the State budget problems, thousands of noninstructional employees will soon lose their jobs. Many of those lucky enough to keep their positions are subject to unpaid furlough days, a steep reduction of work time, and significant pay cuts during the next school year.

Furlough days are one way to save jobs. I have worked with the unions representing school police, office workers, bus drivers, and others who are willing to work fewer days and earn less so more employees can keep their jobs. That is why I am asking to save our employees and protect the futures of our students.

I am asking to support the $23 billion in education aid that Members of the House included through the SFSF in the Jobs for Main Street Act. If Congress provides this money, the Los Angeles District could receive approximately $250 million and save as many as 3,000 jobs.

What more can Washington do? Provide more funding for the disadvantaged students. And it has been said this morning, whether they are in urban districts or mid-sized districts or rural America, President Obama's budget for the fiscal year 2010–2011 freezes title I spending, and that will have a very negative consequence for our district. Devastating to the district's 631 title I schools, it will specifically hurt at least 78 percent of our students based on eligibility for free and reduced lunch periods and hamper our efforts to close the achievement gap.

We appreciate the additional title I dollars received last year. Neither I nor headquarters dictated how that money would be

spent. It was pushed out to the schools, and school teachers, parents, administrators, and the community, they made the decisions on how we would spend that money. For example, many schools chose to hire additional teachers to preserve smaller class size at the primary grades.

Washington can also help keep a promise made long ago to provide 40 percent of the cost of special education. The fiscal year 2010–2011 budget would limit funding to 17 percent, resulting in a shortage of $172 million for the district. And despite the shortfall, the Federal Government requires special education to get the services, and they deserve to support them in every way.

Paying for these requirements diverts local contributions from the instruction of more than 500,000 students who do not have disabilities.

Senator HARKIN. Mr. Cortines, could I ask you to summarize, please?

PREPARED STATEMENT

Mr. CORTINES. Okay. As I conclude, I want you to know that one of our outstanding seniors, Tyki, read—if you read his bio, you may dismiss him as an unfortunate statistic. Born crack addicted, father passed away, mother incarcerated, bounced from home to home.

Today, Tyki is a straight-A student at Washington Prep High School in south Los Angeles. He is excelling in advanced placement calculus, biology, chemistry, and physics. And when he graduates, he is headed to the U.S. Military Academy. There are countless stories like Tyki in the L.A. student body.

Thank you for your consideration, support, and help.

[The statement follows:]

PREPARED STATEMENT OF RAMON C. CORTINES

Chairman Harkin and subcommittee members, thank you for this invitation to testify on behalf of the Los Angeles Unified School District (LAUSD), the Nation's second largest. I am Superintendent Ramon C. Cortines. Our enrollment of 618,000 students is larger than the total number of students who attend public school in 25 States. I also would like to take this opportunity to thank Chairman Harkin for his strong leadership and advocacy for education issues in the Congress. We stand together in the march toward an educated America, where all students are prepared and encouraged to read, write, think, and speak as 21st century learners who will become the next generation of leaders, teachers, doctors, engineers, writers, electricians, contractors, and business owners. That will not happen if our district and school districts across the Nation in big cities, small towns and rural areas continue to hemorrhage teachers and other essential employees.

CALIFORNIA'S BAD NEWS BUDGET

In California, public education is suffering one of the greatest threats in decades as funding from the State shrinks. Also threatened is an opportunity for great, systemic and long-lasting reform, always a challenge but even more so when the unpredictable budget cuts keep coming, month after month.

The numerous and unyielding reductions in State funding have translated into the LAUSD's current deficit of $640 million and a projected deficit of $263 million in 2011–2012. And, the news never improves. State Controller John Chiang recently announced that the upcoming fiscal years will be particularly difficult for our State because the temporary tax hikes approved by the legislature last year will expire; Federal stimulus funds will be gone; and funds that the State borrowed from local governments will become due. Furthermore, the State's Legislative Analyst Office has projected that California will have a $20 billion deficit every year for the next 5 years.

It is not hyperbole to State that the LAUSD is again facing a budget crisis of the most unprecedented proportion. We have cut $1.5 billion from our budgets over the past 2 years. That's a lot of jobs.

Two thousand teachers gone last year and more are on the chopping block right now. Office workers, the first person you see at a school, disappearing. Our schools would be neither healthy nor beautiful without custodians whose numbers continue to dwindle. You name it. Teachers, administrators, counselors, school nurses, cafeteria workers, support personnel are part of an exodus forced by financial realities.

LAUSD was forced last month to send out nearly 5,200 reduction-in-force notices to teachers, principals, and other school-based staff. Some, though certainly not all, will keep their jobs because the unions representing our teachers and administrators just agreed last week to shorten the school year by 5 days this June and next in order to save about $157 million and preserve class sizes that are already too high. Teachers are losing instructional time and taking a pay cut. Their sacrifices are certainly appreciated, but alone do not close the budget gap.

Unfortunately, many more LAUSD employees will soon lose their jobs including thousands of noninstructional staff. Many of the lucky ones who keep their jobs must take more than 40 unpaid furlough days, a pay cut of more than 20 percent as the workload increases. I have worked with unions representing school police, office workers, bus drivers and others who are willing to work fewer days, and earn less so more can keep their jobs.

WHAT WASHINGTON CAN DO—JOBS, JOBS, JOBS

LAUSD is not the only district in California facing layoffs. Statewide, nearly 22,000 teachers have received notices of potential layoffs. According to the California Department of Education, more than 16,000 teachers lost their jobs last year, and roughly 10,000 classified or noninstructional school employees have met the same fate over the last couple of budget cycles. As you can see, public schools urgently need additional money now for the 2010–11 school year.

I applaud members of the House of Representatives for including an additional $23 billion in education aid through the State Fiscal Stabilization Fund (SFSF) in the Jobs for Main Street Act, which passed in December. I urge the Senate to support similar education jobs relief to save teachers and protect the futures of students. If Congress provides this $23 billion, it is estimated that LAUSD could receive approximately $250 million and save as many as 3,000 jobs.

WHAT MORE CAN WASHINGTON DO—MORE MONEY FOR DISADVANTAGED STUDENTS

In addition to an immediate infusion of fiscal relief to save jobs, Washington should provide additional investments in such critical education programs as title I and special education. While the fiscal year 2011 budget proposed by President Obama gives education an overall increase of $3.5 billion, including a $3 billion (12 percent) increase for the Elementary Secondary Education Act (ESEA), it freezes title I, which will have serious negative consequences for the LAUSD. It will hurt at least 78 percent of our students, and more as the numbers who qualify for free and reduced-price lunch are increasing. It will be devastating to LAUSD's 631 title I schools.

FULLY FUND SPECIAL EDUCATION

The fiscal year 2011 budget also fails to increase the Federal share of funding for special education, limiting it to only 17 percent of the costs. Congress must make good on the original promise to provide 40 percent. LAUSD currently receives $135 million in Federal funds for special education, which—if fully funded—should amount to $307 million, a shortage of $172 million. During the current school year, LAUSD serves 82,751 special education students. The Individuals with Disabilities Education Act (IDEA) mandates that each special education student receives an individualized education plan, which determines required supports and services regardless of costs that continue to rise. Add to that financial burden, the number of special education students continues to rise. This unfunded Federal requirement forces the diversion of locally contributed general fund dollars from the instruction of the more than 500,000 LAUSD students who do not have disabilities.

STOP THE STATE FROM HIJACKING FUNDS WASHINGTON INTENDS FOR PUBLIC EDUCATION

We appreciate the assistance our schools have already received from Washington. The American Recovery and Reinvestment Act (ARRA) provided critical help during the current school year in the form of additional aid for title I of the ESEA, IDEA,

and through SFSF. The funds LAUSD received allowed us to save approximately 7,000 jobs of teachers and other employees.

With the help of $359 million from the SFSF, LAUSD was able to save more than 4,600 jobs last year. The ARRA title I and IDEA money helped us save another 2,143 jobs. In the case of the title I dollars, neither I nor anyone else at headquarters dictated how they would be spent. That money was pushed out to schools to decide how the money could be best spent on that individual campus.

Even more jobs could have been saved, but unfortunately, in order to shore up the State's depleting resources, the California Department of Finance kept millions in SFSF that LAUSD had counted on to use this coming year to help fill our $640 million budget gap. That is certainly not what Washington intended. Given the State's penchant for hijacking dollars earmarked for public education to address its own budget shortfalls, those funds should flow directly to local school districts to protect our students, schools and jobs.

THE UNIQUENESS OF THE LOS ANGELES UNIFIED SCHOOL DISTRICT

As head of LAUSD, I lead the Nation's second largest district. At least 78 percent of our students qualify for either free or reduced-priced lunches. More than 74 percent of our students are Latino, and almost 11 percent are African American. More than 40 percent are English language learners, a reflection of the close to 100 languages and dialects spoken in their homes. LAUSD is the second largest employer in Los Angeles County, with 72,000 employees who serve more than 891 K–12 schools. Our students come from a 710-square mile area that, in addition to Los Angeles, includes dozens of cities and unincorporated neighborhoods located in the surrounding Los Angeles County. In short— our size, our diversity, our mission, and our challenges are great.

INNOVATION

In September, 37 schools—including some brand-new campuses and some of our existing lowest-performing schools—will be operated by nonprofit groups, collaborative teams of teachers and administrators, and charter schools under the new and competitive Public School Choice Initiative. Speaking of charters schools, no district in this Nation has more than LAUSD. Add to these multiple routes to success for our students, partnership and pilot schools. If outsiders can do a better job of educating any of our students, we welcome their help, and we want to learn from their successes. If insiders can do a better job, including teams from the teachers' union and the bargaining unit representing principals and administrators, they are also welcome to help improve our schools.

We also welcome the involvement of more parents. An annual school report card intended for parents and guardians chronicles strengths and weaknesses of each campus ranging from academic achievement to attendance, while also tracking failures and soaring improvement in categories such as parental involvement per school.

NOT SATISFIED WITH CHRONIC FAILURE

To address the specific needs of a low-performing school, I ordered the turnaround of one high school under the No Child Left Behind Act. A new principal is already on-board and teachers, including veterans and newcomers, are applying for the opportunity to boost student achievement. That is just the beginning.

At Belmont High School, teachers, students, and the community overcame decades of struggle and overcrowded classrooms to raise its State standardized Academic Performance Index (API) score by 78 points last year. Belmont High is part of the Belmont Zone of Choice where all area students select between the historic campus and three newly built high schools where students are educated through small learning communities and pilot schools focused on various careers and themes.

PROGRESS

LAUSD employs more than 30,000 teachers ranging from miracle workers and outstanding instructors to some who are not making the grade. Help is provided through professional development and peer assistance review a collaborative program with the teachers union. In addition, I have toughened a flawed evaluation process that too often allowed all but the weakest teachers to pass probation and get tenure, which translates into a job for life. Principals are being held accountable for weeding out nonpermanent teachers who are neither a benefit to students nor schools. Probationary teachers who received "needs improvement" in one or more

categories in their last evaluation are being scrutinized as are 175 permanent teachers who received an overall "below standard" evaluation. Teachers who have received sub par evaluations for the past 2 school years, will not get a third chance. As a result, in June, more ineffective permanent and probationary teachers will be ushered out of this District—so better teachers will not be laid off.

CONCLUSION

Clearly the LAUSD needs your help. Please make public education your highest priority and fund this historic opportunity for reform. Teacher and other school-related jobs should be viewed as an investment in America's present and future. Every job lost adds to the unemployment rate and the housing foreclosure crisis—but in this case, it also hinders the education of hundreds of thousands of students in the Los Angeles area and across the Nation. Education-related jobs directly impact our students' futures in ways that can only be partially quantified at this time. The loss of instructional days, class offerings, enrichment courses, Arts programming, and other vital services may negatively affect our students for generations.

Again, I would like to thank Senator Harkin for the opportunity to testify today, and for his strong and continuing leadership for education.

Senator HARKIN. Thank you very much, Mr. Cortines.

Mr. Bern, welcome.

STATEMENT OF CHRIS BERN, PRESIDENT, IOWA STATE EDUCATION ASSOCIATION

Mr. BERN. Thank you, Chairman Harkin, Ranking Member Cochran, and members of the subcommittee.

My name is Chris Bern, and I have been a public school teacher in Iowa for more than 30 years. Two years ago, I was elected to serve as president of the Iowa State Education Association, representing 34,000 dedicated educators in more than 350 school districts across Iowa.

We are fortunate in Iowa to have some of the best public schools in the country. Yet today, in Iowa and across the country, scores of talented, experienced teachers and education support professionals are at risk of losing their jobs due to historic State and local budget deficits.

I am very worried about what this means for our economy, as investments in education are inextricably linked to economic strength. But more importantly, I am worried about what it means for our students.

A school district facing massive job losses will face larger class sizes and/or elimination of programs, both of which are detrimental to students. Not one fewer student is coming through our doors because of the economic crisis. They still need us to help them, inspire them, and educate them every single day.

The education jobs crisis is not only about adults. It is about children, who get only one shot at an education and didn't ask to go to school during this crisis. Although our State revenue picture improved slightly this spring, we still anticipate as many as 1,500 teachers and support workers will receive pink slips. That's almost 4 percent of Iowa's education workforce. And that doesn't count the other positions not being filled due to retirements and attrition.

The education investment in the ARRA was critically important. It funded 6,715 education jobs in Iowa—teachers, librarians, nurses, and support workers. Close to 5,000 of those jobs resulted directly from the aid in the SFSF. We desperately need this aid extended now.

Let me tell you about one of my colleagues whose job was saved because of ARRA, an Iowa City special education teacher who was pink-slipped last year. She split her time in two schools working with students needing individual assistance. Without her, these students most certainly would fail. ARRA saved her job. She is now employed full time at Penn Elementary and continues her work with special needs students.

What would the classroom be like without her and others like her? If she had lost her job, she says that she may have left the profession. We cannot afford that collateral damage either.

The Senate needs to act quickly on an education jobs package. The House has already passed $23 billion for an education jobs fund. That bill will help save or fund as many as 4,900 Iowa education jobs.

I want to thank you, Senator Harkin, for your leadership in introducing a similar bill in the Senate this week, the Keep Our Educators Working Act. I hope your colleagues will support it and approve it quickly.

My colleagues back home asked me to deliver a strong message—please act now to help avert the looming layoffs that will reach into almost every Iowa community, threatening our economic recovery and our students' education.

I also ask the Senate to look closely at the administration's proposal to increase the use of competitive education grants. Formula grants provide a solid foundation of resources needed to ensure a quality education. This has never been more important than in today's economy. Many rural districts would simply be unable to compete, as they do not have staff to write grant proposals. Instead of winners and losers, all districts should receive the resources they need to succeed.

PREPARED STATEMENT

My bottom line today is that Iowans expect our schools and our teachers to receive the support they deserve. Please give us those resources, and I promise that we will attract and keep the brightest educators, and we will continue to educate the future of this great Nation.

Thank you.

[The statement follows:]

PREPARED STATEMENT OF CHRIS BERN

Thank you, Chairman Harkin, Ranking Member Cochran, and the members of the subcommittee for allowing me this opportunity to speak before you today. I applaud you, Chairman Harkin, and your subcommittee for holding this hearing today to discuss the urgent need for continued investment in education jobs. This hearing couldn't be timelier, as immediate action is needed to jumpstart local economies, and keep our schools fully staffed at a time when many students and families are experiencing great stress.

My name is Chris Bern and I have been a public school teacher in Iowa for more than 30 years. I began my career teaching middle school math in Woodbine and moved to Knoxville, where I taught math at the high school, alternative high school, and middle school level over the years. Two years ago I was elected to serve as President of the Iowa State Education Association. I am proud to represent 34,000 dedicated educators in more than 350 school districts across Iowa.

We are fortunate in Iowa to have some of the best public schools in the country. We have a long history of attracting the best and the brightest to teach in our schools and we have the graduation rates to prove that we are doing our jobs well.

If educators are given the proper resources and supports, the sky is the limit on learning for our students. Study after study proves that the most important factors in a student's ability to learn are the skills and knowledge of teachers and education support professionals.

Yet today, in Iowa and across our country, scores of talented, experienced teachers and education support professionals are at risk of losing their jobs due to historic State and local budget deficits. In fact, this spring, Iowa's teachers were faced with the threat of massive "pink slips" as the State's proposed budget dipped well below what schools' needs were. School superintendents throughout the State threatened massive layoffs as American Recovery and Reinvestment Act (ARRA) money was used up and State money did not fill in the gaps.

I am very worried about what this means for our economy, as scores of research and common sense tell us that investments in education are inextricably linked to economic strength. More importantly, however, I am worried about what it means for our students.

In our experience there are only two outcomes for a school district facing massive job losses: larger class sizes or the elimination of programs, both of which are detrimental to students. In Iowa and across the country, school boards and superintendents have released proposals to increase class sizes, and reduce program offerings. In Iowa, music, arts, and physical education programs were all on the chopping block. Class sizes ballooned and "excess" positions were proposed for elimination. Not surprisingly, parents and other concerned Iowans have been in an uproar, because they realize that Iowa's children will suffer. Iowans have gotten a glimpse of what these job losses might mean for their kids and they don't like what they see.

Not one fewer student is coming through our doors because of the economic crisis. They still need us to be there helping them, inspiring them, and educating them every single day. The education jobs crisis is not only about adults, it is about our children, who get only one shot at an education and didn't ask to go to school during this time of economic crisis. Little Johnny still deserves the same quality education his sister got when she walked through our doors during better times.

We got a small break this spring as our State revenue picture improved slightly. In the end though, the layoffs and the other cuts are expected to be as drastic as predicted. The picture will be clearer by the end of this month when our State requires layoff notices to be sent. But we know it will not be a pretty picture. We anticipate the number of teachers and education support professionals who will receive pink slips to be as high as 1,500. That's almost 4 percent of our education professional workforce in Iowa. That number doesn't even take into account the number of positions which will be lost due to retirements and attrition.

The education investment in the ARRA was critically important to us in Iowa. It funded 6,715 education jobs in Iowa—teachers, librarians, nurses, support workers, as the most recent Department of Education report shows. Close to 5,000 of those jobs came as a direct result of the aid in the State Fiscal Stabilization Fund (SFSF). We desperately need this aid extended before the next school year.

I want to tell you about one of my colleagues whose job was saved because of ARRA.

Recently, we spoke to a special education teacher in Iowa City who was pink slipped last year. She split her time in two schools working with students needing individual educational assistance. Without her position, these students wouldn't get the one-on-one assistance and would most certainly fail. ARRA saved her job. She is now employed full time at Penn Elementary and continues her work with special needs students. What would the classroom be like without her and others like her? Who would help these students?

We asked if she had lost her job last spring, would she have left the profession. She didn't know. We cannot afford that collateral damage either.

So, how can the Senate help?

First, the Senate needs to act quickly on an education jobs package. As you know, last December, the House of Representatives passed a jobs bill that included $23 billion for an Education Jobs Fund—essentially an extension of the SFSF in the ARRA. We project that bill would provide Iowa with enough emergency aid to help save or fund as many as 4,900 education jobs. Needless to say, this could go a very long way in helping to avert the crisis that is right in front of us.

My colleagues back home asked me to come here to deliver a strong message—please act now to approve additional Federal aid targeted to help avert the looming layoffs that will reach into almost every Iowa community, threatening our economic recovery and our students' education.

Leaving States to cut education more deeply—and we already are cut to the bone—without additional Federal aid is short-sighted. Lessening the quality of education a student receives today as a result may prove irreversible. Long-term pro-

ductivity growth and a higher standard of living are dependent on an educated workforce.

Second, I want to ask the Senate to look very closely at the administration's proposal to use competitive education grants to allocate Federal money. Formula grants provide a solid foundation for the resources needed to ensure a quality education. While that foundation has always been important, it has never been more so than in today's difficult economic climate. Our schools need a level of certainty and stability in funding that they can count on, without having to divert scarce time and resources to grant applications. Many of our rural districts would simply be unable to compete, as they do not have the staff to write grant proposals. We believe a competitive system serves only to create funding winners and losers, rather than providing all districts the resources they need to succeed.

Chairman Harkin, Ranking Member Cochran, and the members of the subcommittee, my bottom line today is that Iowans expect our schools—and our teachers—to receive the support they deserve from the Federal and State governments.

A lot of very smart people in Washington often talk about the next best thing to solve our Nation's education crisis. But, the answer isn't the next "silver bullet" to raise all test scores. It isn't the next greatest strategy to raise kids' reading skills. And, it isn't some magical test that will suddenly unlock every student's learning potential and every teacher's worth. I want to make one thing crystal clear: Teachers are not the problem here. We are the solution. We have been in the classroom each and every day teaching students. We just need the resources to do our work.

So, please give us those resources to help ensure the fiscal stability of our educational system, and ensure that our schools stay fully staffed and I promise that we will attract and keep the best and brightest educators and we will continue to educate the future of this great Nation.

The road to economic stability and prosperity for Iowa and our Nation runs through our public schools, and each and every student deserves the best we can offer.

Thank you for the opportunity to provide this testimony.

Senator HARKIN. Thank you very much, Chris.

And now we will turn to Dr. Joe Morton.

STATEMENT OF JOSEPH B. MORTON, Ph.D., STATE SUPERINTENDENT OF EDUCATION, ALABAMA STATE DEPARTMENT OF EDUCATION

Dr. MORTON. Thank you, Chairman Harkin.

My own Senator, Mr. Shelby, thank you.

Thank you for inviting me to testify before the subcommittee today on the current fiscal crisis facing the States and its impact on education-related jobs across the country.

I am Joseph B. Morton and have been introduced as State superintendent of education, and I am here representing Alabama. But also I represent the Council of Chief State School Officers, which is an organization that represents 50 State superintendents of education, the District of Columbia, the Department of Defense Education Activity, and 5 U.S. extra-State jurisdictions.

And I am here to offer full support for a $23 billion jobs bill for education on behalf of my organization and my State. We need this money to keep our educators working.

Unfortunately, as we all realize, State budgets lag behind a national recovery. In fact, in the Rockefeller Institute of Government report recently released, tax collections have declined for four consecutive quarters across the United States in State budgeting.

States are now in the process of developing and finalizing fiscal year 2011 budgets. And without some kind of quick and near-term action, this continuing fiscal crisis will result in additional job cuts at a time when the Nation and Congress are centrally focused on the need for job creation and retention.

I call your attention to my home State, as my own Senator Shelby has so eloquently already described, a State that is depend-

ent on and very aware of the sensitivity to the economy because our educational activities in Alabama are funded on a statewide 4-cent sales tax and individual and corporate income taxes. So as the economy moves, so moves educational funding in Alabama.

And as Senator Shelby outlined, we thought we were in good times in 2008 because in the spring of 2007, as we developed that 2008 budget, we had a record education budget of $6.7 billion. We had 3.4 percent unemployment, which is still 73,000 people. But it was low, and we thought things were good, and then the bottom fell out.

And here we are today, $1.2 billion less in State funding. One point two billion dollars out of a $6.7 billion budget has gone away in State funding.

Our schools and our State's schoolchildren and their families are hurting, and Alabama is not alone. Our unemployment rate today of 11.1 percent is 227,000 people that cannot find work. That impacts the education funding for our State.

As of Monday of this week, I completed a survey of all 132 school districts in my State, and based on the budget that was adopted last week by the Alabama Legislature, I asked local superintendents of education to tell me how many jobs would be cut based on that budget. My response came back, regrettably, that as our student population is increasing, we will lose 1,599 teachers and administrators, and 1,228 support workers. A total of 2,827 fewer jobs in August of this year, as opposed to today.

We know the California situation. We know that in Illinois, it is just as bad. Ten thousand layoffs already in Illinois, and another 10,000 predicted. We know that layoffs are all relative to the size of the district. I can tell you in our State of Alabama, there are counties that if they lay off 12 people, that is equal to 1,200 in some districts. It is relative to the situation, and we have virtually every district in our State laying off people.

Education, as we know, is a long-term investment. It strengthens the Nation's economy and, over time, provides a strong return on investment. We know that we need a jobs bill. We know that the ARRA, especially the SFSF, worked in our State, and it worked across this Nation.

The University of Washington found that 342,000 jobs were funded by that ARRA. And we know in Washington State, 2,700 jobs; South Carolina, 5,000; and in Alabama, we know that we can save with the continuation of that act 2,772 jobs.

We have elected in our State to split the current ARRA SFSF over 2 fiscal years so we would avoid the worst of the funding cliff, and it still was not enough. Even with that, even with our budget of 2011 including one half of our SFSF, we still will lose 2,700 jobs.

So, with that, may I conclude by saying that my association, the Council of Chief State School Officers, also supports in principle the blueprint for reform, but we have some questions. We have some interest in the detail of that, and at the expressed desire of the chair, I won't go into that at this time since this is more focused on a jobs bill.

PREPARED STATEMENT

But let me conclude by saying that not only is it my strong personal—I offer my strong personal support, but I offer the support of 50 State superintendents of education for a jobs bill in our Nation and soon.

[The statement follows:]

PREPARED STATEMENT OF JOE MORTON

Chairman Harkin, Ranking Member Cochran, Senator Shelby, and members of the subcommittee, thank you for inviting me to testify before the subcommittee today on the current fiscal crisis facing the States and its impact on education-related jobs across the country. My name is Joe Morton and I am here today in my capacity as State Superintendent of Education for the great State of Alabama and as a member of the Council of Chief State School Officers, a national organization representing the State superintendents in all 50 States, the District of Columbia, the Department of Defense Education Activity, and 5 U.S. extra-State jurisdictions.

As my time is limited, I will get right to the point, State governments continue to struggle with the budgetary challenges associated with the severe economic downturn this Nation has been facing since 2007. I'm here today in strong support of the House-passed Jobs for Main Street Act and its $23 billion extension of the State Fiscal Stabilization Fund. Schools need additional funding now or school boards will be forced to cut teaching and other key positions in our public schools. Fewer teachers in the classroom will only frustrate needed reforms in the Nation's persistently lowest-performing schools and the improvements that schools must make to ensure that all students leave high school ready for college and careers.

Unfortunately, State budgets lag behind any national recovery by a year or more, so even as we are beginning to see economic growth at the national level, much State fiscal turnaround may still be some time away. In point of fact, the Rockefeller Institute of Government reported that State tax collections have declined for four consecutive quarters. Due to these revenue declines, 36 States were forced to cut more than $55 billion for fiscal year 2010 and 30 of those States cut both K–12 and higher education. Since the start of this recession, States have reported total estimated budget gaps of almost $430 billion, and the Center for Budget and Policy Priorities reports remaining budgetary gaps of more than $140 billion just for the upcoming fiscal year.

States are in the process now of finalizing their budgets for fiscal year 2011. Without near-term action, this continuing fiscal crisis will result in additional jobs cuts at a time when the Nation and Congress are centrally focused on the need for job creation and retention.

I call your attention to my home State as a prime example of what is so prevalent in many States. Alabama is unique in many ways, but one is that it has two budgets to operate all State- supported agencies, programs, and institutions. The General Fund Budget funds all State agencies such as transportation, prisons, Medicaid, public safety, etc. The education budget funds all State-supported education endeavors from Pre-K to medical schools. Both funds have dedicated State taxes to support annual appropriations from the Alabama Legislature.

In looking at education funding and personnel issues, one only has to look at the last four education budgets approved by the Legislature and to correspondingly look at State-unemployment figures for the same fiscal years. Realizing that the two largest education revenue sources used for funding the education budget are a statewide 4 cent sales tax and personal and corporate income taxes, it is readily apparent that the State education funding is directly tied to current economic conditions. Accordingly, if State revenues are lagging then correspondingly one would assume local school system revenues are lagging also. Of the 132 school systems in Alabama, 60 have established lines of credit from local banking institutions and either currently use this financial tool or will use it this fiscal year in order to meet payrolls and keep current on their monthly expenses.

Funding for the past 4 fiscal years and the unemployment rates for those years shown on the following chart give a very clear and vivid indication as to why State education funding is in crisis in Alabama and why a jobs bill approved by Congress would be vitally important to educational progress in Alabama and across the Nation:

ALABAMA EDUCATION BUDGETS AND UNEMPLOYMENT RATES—FISCAL YEAR 2008–2011

Fiscal year 2008 Education budget (Adopted Spring 2007) $6,729,089,656	Unemployment rate in Alabama (February 2007) 3.4 percent—73,551 people
Fiscal year 2009 Education budget (Adopted Spring 2008) $5,693,326,351 (Includes a mid-year 11 percent reduction of funds)	Unemployment rate in Alabama (February 2008) 4.1 percent—88,972 people
Fiscal year 2010 Education budget (Adopted Spring 2009) $5,322,329,577 (Includes a mid-year 7.5 percent reduction of funds)	Unemployment rate in Alabama (February 2009) 8.7 percent—187,149 people
Fiscal year 2011 Education budget (Adopted Spring 2010) $5,495,772,478	Unemployment rate in Alabama (February 2010) 11.1 percent—227,717 people

A State survey conducted by my office of all 132 school systems, which concluded on April 12, 2010, indicates that even with a State-adopted education budget for fiscal year 2011, which includes the use of State Fiscal Stabilization Funds, there will be 2,827 fewer jobs in Alabama's K–12 public schools in August 2010 than exists today, even as the student enrollment increases. This is why Alabama educators support a jobs bill.

Sadly, Alabama is not unique in this alarming regard. As has widely been reported, California sent 23,000 pink slip notifications out just last month. Illinois has already announced close to 10,000 teacher layoffs with an additional 10,000 predicted. Just 4 school districts in Mississippi combined to lose 160 teachers and a single school district in Wisconsin is planning to cut 50 jobs.

In addition to the near-term impact these cuts will have on individual students, the reductions will also harm the Nation's productivity. Education is a long-term investment that strengthens the Nation's economy over time and provides a strong return on investment. For example, a recent study by the Alliance for Excellent Education found that cutting the dropout rate in the Nation's 50 largest cities in half would lead to $536 million in increased tax revenue, an additional $2.8 billion in spending and more than $4 billion in increased earnings per year. Given these profound figures, education must be among the highest-priority investments for the country even during challenging budgetary times.

There is no doubt in my mind that the current crisis would have been far worse if not for the significant education funding provided by Congress for the American Recovery and Reinvestment Act and the State Fiscal Stabilization Fund (SFSF) more specifically. What we know is that SFSF worked. A recent study by the Center on Reinventing Public Education at the University of Washington found that more than 342,000 jobs are funded by the Recovery Act. SFSF funds paid for 2,700 education jobs in Washington State alone and almost 5,000 in South Carolina.

Since we know that the SFSF worked, an extension is not only logical but urgently needed to help sustain our commitment to education reform and improvement. Estimates of the proposed SFSF extension would provide an additional $345 million for the State of Alabama, funding an estimated 4,150 education jobs. New Hampshire would see an additional $95 million and save 2,000 jobs, and Tennessee would see almost $450 million for an estimated 1,700 education jobs. In total, the House-proposed extension would fund 250,000 education-related jobs across the country.

In spite of the current economic crisis and the challenges facing State governments, American education is experiencing a period of significant transformation and reform. States are focused like never before on strengthening standards and assessments, improving systems of educator development, and developing comprehensive data systems and the next generation systems of learning. As you know, CCSSO, in collaboration with the National Governor's Center for Best Practices, is close to finalizing the common core standards for college and career readiness in Mathematics and English Language Arts. This historic step is but one of many groundbreaking reforms that States are undertaking to develop coherent birth-to–20 high-performing systems of comprehensive reform that promote continuous improvement at all levels of the education spectrum.

To make these efforts fully come to fruition though, we need a stable funding stream and a new State-Federal partnership—through the reauthorized ESEA—to help ensure Federal investments keep pace with the changing landscape and the increased role of the State as leading comprehensive reform. The President's proposed budget is a strong starting point, but State chiefs would like to highlight several areas in need of greater investment.

First, current funds for student assessments are woefully inadequate to develop high-quality summative assessments, let alone to develop the next generation of formative and interim assessments. The $350 million Race to the Top Assessment set-aside is appreciated, but long-term funding is needed within ESEA to implement and sustain any product of this new competition.

Second, States recognize the need for focus and attention on the persistently lowest-performing schools through concerted school improvement interventions. But as SEAs now play the central role in providing technical assistance and other supports to their struggling districts and in many cases directly intervene in schools that are chronically underperforming, States are very hopeful that Congress will provide additional resources. Building State-level capacity is an essential component to statewide school turnaround.

Third, State chiefs understand and appreciate the value of new competitive grant programs as a catalyst for driving reform, but we implore the Congress to view those increases as above and beyond core funding for key formula programs like title I, IDEA, and State Longitudinal Data Systems. These investments are needed to ensure that all students, regardless of income, race, special needs, or other characteristics, are receiving a high-quality education.

Lastly, let me say that State chiefs strongly support the Department's proposed consolidation of programs into 11 more coherent funding streams. Such an approach will provide States with increased flexibility to target resources toward the greatest areas of need. This change will certainly enable States to better allocate Federal resources and will also eliminate redundant reporting.

In closing, let me again issue my strong personal support and that of the other chief State school officers around the country for an education jobs fund. It is needed and it will pay dividends.

Thank you again for inviting me to testify before the subcommittee today. I look forward to answering your questions.

Senator HARKIN. Thank you very much, Dr. Morton.

Dr. MORTON. Thank you.

Senator HARKIN. Very eloquent statement. And now we turn to summarize things up here, Mr. Herzog. Welcome.

STATEMENT OF MARC S. HERZOG, CHANCELLOR, CONNECTICUT COMMUNITY COLLEGES

Mr. HERZOG. Thank you, Chairman Harkin, Ranking Member Cochran, and distinguished members of the subcommittee, we thank you for this opportunity to appear before you today.

My name is Marc S. Herzog, and I am the chancellor of the Connecticut Community Colleges. I am also here today on behalf of the American Association of Community Colleges, which represents the Nation's approximately 1,200 community colleges, which are currently enrolling almost 8 million students.

The Connecticut community college system is a State system of publicly supported 2-year colleges. This is a precarious time for community colleges. Our ability to sustain the current level of education services and to respond to the enormous demands being placed on us carries with it a profound long-term economic implication.

Community colleges play a significant role in the education and skill building of the American workforce. And certainly, that has been recognized by President Obama, who has challenged community colleges to graduate 5 million more students by the year 2020.

Enrollments in the Nation's community colleges have surged dramatically during this recession. Credit enrollments have risen in

the last 2 years by 16.9 percent. That is 1.2 million students. These dramatic enrollment increases have caused our colleges to literally scramble to expand our course offerings and student support services while undergoing cuts in public funding, which have been averaging 4 percent per year in each of the last 2 years.

Despite every budgetary strategy imaginable, doing more with less, we believe that hundreds of thousands of individuals have effectively been denied access to community colleges over the last 2 years because of the lack of availability of program offerings. This is really a national tragedy because community colleges serve students who frequently have no other option to attend college but a community college.

Let me turn to the situation in Connecticut, since it reflects what is actually occurring nationally. Let me also add that there are many 4-year public institutions in higher education that face a similar situation.

Connecticut's community colleges are serving more than one-third more students today than we did a decade ago. We have an increase of more than 58 percent in full-time equivalent enrollment. That is actually the measure of the amount of teaching that is going on in our classrooms today of a count of credit hours.

We serve 50 percent of the undergraduates in public higher education, and we serve two-thirds of the minority students attending public higher education. Last fall, our enrollments grew by 10 percent at a time when our system budget declined by more than 10 percent.

Our State general fund support for public higher education is funded at maintenance of effort level in compliance with the ARRA SFSF. The Federal ARRA SFSF in Connecticut was used to preserve educational services in the K–12 sector. But despite the stimulus funding, the State of Connecticut today, this fiscal year, is still facing a $500 million deficit with a $700 million adjustment still necessary for the next fiscal year, fiscal year 2011. And the State is expected to face a $4 billion shortfall in the next biennium.

Given this and similar situations across the country, we need to help avoid I believe what you termed earlier, Senator Harkin, the cliff. We support and urge the enactment of a Keep Our Educators Working Act, which dedicates $23 billion to retaining, hiring, and training educational personnel. At almost 70 percent of the total budget for community colleges are devoted to labor costs, this legislation becomes critical for our institutions.

Mr. Chairman, we thank you for your leadership on this issue and for recognizing the importance of supporting public K–12 and higher education in our hour of extreme need. We believe that without substantial Federal investment in education jobs, that faculty, academic, and institutional support staff and administrators will be laid off in many States. But more importantly, thousands of students of all ages will lose opportunities to gain education and skills needed to turn around our economy and to contribute to America's future prosperity.

We understand the tremendous constraints that Congress is operating under, but we see no alternative to some form of Federal assistance.

Finally, in addition to the Keeping Our Educators Working Act, there are numerous Federal education and workforce programs that are essential to community colleges. Let me just comment very briefly on three.

The Pell Grant program, which we are thankful to this subcommittee for your support. Pell Grants provide the opportunity to attend higher education for a significant portion of our population. One-third of the population today receiving Pell Grants attend an American community college.

The strengthening institutions program included in the title III act of the Higher Education Act, this program will clearly provide a great force for institutional improvement.

And last, the Career Pathways Innovation Fund, which the Obama administration has proposed eliminating, this program, under its previous name, the Community Job-Based Training Grants Program, has had a very positive impact on community colleges and our local economies, and it would be very shortsighted to terminate it.

PREPARED STATEMENT

Mr. Chairman, I thank you for this opportunity to appear before you today, and I certainly would be happy to respond to any questions you might have.

Thank you.

[The statement follows:]

PREPARED STATEMENT OF MARC S. HERZOG

Chairman Harkin, Ranking Member Cochran, and distinguished members of the subcommittee, thank you for the opportunity to appear before you today. My name is Marc S. Herzog and I am the chancellor of the Connecticut Community Colleges.

The Connecticut community college system includes 12, 2-year public colleges with a shared mission to make educational excellence and the opportunity for lifelong learning affordable and accessible to all Connecticut citizens. The colleges provide general education programs for career enhancement; transfer programs to expand access to 4-year degrees; developmental education programs to reduce academic barriers; student services to enhance student success; community service programs; and career education for jobs in such areas as nursing and allied health, information technology, emergency services, and early childhood education. Together these colleges provide the State of Connecticut with a solid, statewide foundation for higher education and workforce development.

I am here today on behalf of the Connecticut Community Colleges and the American Association of Community Colleges (AACC), which represents the Nation's 1,177 community colleges. Rising enrollments, declining State and local funding, and the economic freefall have presented a veritable crisis for our colleges. Without substantial financial investments in education jobs, not only will faculty and administrators be laid off in many States, but thousands of students of all ages will lose opportunities to gain the education and skills needed to turn around our economy and contribute to America's future prosperity.

ENROLLMENT SURGE

Typically, enrollments in postsecondary education increase during difficult economic times. Enrollments at the Nation's community colleges have surged dramatically, with credit enrollments rising 16.9 percent over the last 2 years, to approximately 8 million credit students, just under half of the Nation's undergraduates. Full-time enrollments (FTEs) increased by 24 percent over the same period. These unprecedented enrollment increases have been fueled both by new high school graduates and adult learners returning in droves to community college classrooms.

For younger students and their families, lower tuitions at community colleges make them an affordable option; the average tuition for a full-year, full-time student is just $2,544, which enables most community college students to avoid debt en-

tirely. For older students, unemployment and threats of job loss reinforce the importance of college degrees and new skills training to secure employment in today's highly competitive market. Both new graduates and adult learners benefit from the partnerships community colleges continue to forge with business and industry.

These dramatic enrollment increases have presented many challenges. Colleges have been scrambling to expand their course offerings despite serious budget constraints, and students have learned that they must apply early for financial aid and register in advance for classes. Nevertheless, we believe that hundreds of thousands of individuals have effectively been denied access to community college over the last 2 years due to the unavailability of program offerings. This is a national tragedy. While very few community colleges cap enrollments or admissions outright, this is done in the de facto policy when students cannot access the programs they need.

These access issues carry with them profound long-term economic implications for the country. On average, community college graduates earn 23 percent more annually than those who only hold a high school diploma.

In Connecticut, community colleges are serving more than one-third more students than they were a decade ago, with double digit increases in enrollments system wide this academic year. Community colleges serve as the point of entry into higher education for more than 50 percent of Connecticut's undergraduates in public higher education, including two-thirds of the State's minority undergraduates. Last fall, a record-breaking 55,112 headcount students registered for credit courses at the Connecticut Community Colleges. Another 35,000+ students will enroll in noncredit programs throughout the year with approximately 50 percent of these students focusing on acquiring the skills required by the State's employers and the workforce of the 21st century.

STATE BUDGET CRISIS AND STIMULUS FUNDING

The economy in Connecticut, the State budget and the budget for higher education, continue to face enormous challenges, particularly within the community college sector where enrollment growth has consistently exceeded that of other public and private colleges. In Connecticut, our college funding comes from tuition and fees, Federal, State, and private grants, and the State's general fund. Last fall enrollments grew by approximately 10 percent at a time when the college system's budget had declined through reductions and rescission by more than 10 percent.

The Connecticut community college system budget for the current year is just below the fiscal year 2008 funding level. State general fund support for public higher education is funded at maintenance of effort levels in compliance with the American Recovery and Reinvestment Act (ARRA) State Fiscal Stabilization Funding (SFSF) requirement. Federal ARRA State fiscal stabilization funding was used to preserve the State's educational services in the K–12 sector. Despite the influx of Federal stimulus funding, the State is facing a $500 million deficit in the current fiscal year with a shortfall of $700 million projected for the fiscal year 2011. In the 2012–2013 biennium, with stimulus funding exhausted, the State will face a $4 billion deficit.

The Connecticut community colleges have exerted extraordinary efforts to absorb and serve the expanding enrollments and growing educational needs of the students who have turned to them in the last 2 years—16.8 percent more FTE students since 2008, with a budget below the fiscal year 2008 level. While additional students bring added tuition revenues, they also bring increased demands that must be met with reduced resources. Colleges raise tuition modestly each year in an effort to balance student access and affordability with unavoidable cost increases.

The capacity of our colleges is stretched to the breaking point and the continued growth that we anticipate in the next 2 years and beyond cannot be met without adequate funding support. Yet higher education is frequently looked to as the "balance wheel," according to a report from the American Council on Education, in the State budget process, particularly when budgets are in decline and demand for services are growing. Unfortunately, the burdens of the current economy and the heavy weight of economic forecasts are pushing any attempt at balance beyond the tipping point.

In virtually every State, community colleges as well as the 4-year public colleges and universities face State funding reductions. Despite rising enrollments, these State budget cuts have led to layoffs, furloughs, reduction in hours for adjunct faculty, and hiring freezes. Colleges are stretching services to the limit, and, in many places, turning students away.

The ARRA SFSF has helped to blunt what would have been even deeper State budget cuts to education. According to a recently released report by the State Higher Education Executive Officers, 15 States used ARRA funds in fiscal year 2009 "to

cover operational shortfalls, accounting for 3 percent of total State and local support for higher education." In fiscal year 2010, SFSF funding comprised 10 percent of all higher education funding in 9 States. Community college leaders in several States report that ARRA funds have helped them avoid significant layoffs, temper tuition increases and serve more students. But, these same officials are deeply concerned that public higher education is facing a budget cliff with the expiration of ARRA funding. A few examples:

—Community colleges in Iowa received $23.1 million from the SFSF and $2.5 million from the government services funds (total of $25.6 million) in fiscal year 2010. There were no funds in fiscal year 2009 and there are no funds for fiscal year 2011. These funds were used to avoid layoffs and reduce tuition increases in fiscal year 2010. As an example, for the July 1, 2009–March 31, 2010 time period, a total of 257 full-time equivalent employees were retained as a result of this funding (401,106 hours worked). Even with this ARRA support, State appropriations for community colleges will have decreased by 13 percent between fiscal year 2009 and fiscal year 2011.

—In Colorado, ARRA funds were used to revert a 49.5 percent cut in State appropriations to community colleges in fiscal year 2009–2010. ARRA funds and the ARRA maintenance-of-effort (MOE) requirements will help to blunt cuts to the colleges in fiscal year 2010–2011, though they still face a cut of 7.2 percent that would have been 17.8 percent without ARRA funds. Looking ahead to fiscal year 2011–2012, without the same MOE requirements in place and having already expended its ARRA funds, the Colorado community colleges fear deep cuts are in store for them without another direct infusion of Federal funds.

—The Alabama Community College System received approximately $35 million in ARRA funds, split evenly between fiscal year 2010 and 2011. These funds have helped to mitigate (but not eliminate) the need to raise tuition and fees and have saved 341 jobs. The ARRA funds have also allowed the Alabama system to serve more students and avoid enrollment caps.

—In Washington, $8.5 million in ARRA funds helped to restore a 9 percent cut to community colleges in fiscal year 2009–2010, allowing them to serve 1,500 FTE students. ARRA funds and the MOE requirements have also muted potential budget cuts for fiscal year 2010–2011, but the colleges are still expecting a 4–5 percent cut. Here, too, college officials are very concerned about profound budget cuts once the ARRA funds are expended.

EDUCATION JOBS BILL

Given that State tax revenues are not likely to recover in time, community colleges and other public higher education institutions desperately need additional Federal resources to avoid this anticipated "cliff" effect in many States. For this reason, AACC urges enactment of legislation containing an "Education Jobs Fund," as in the legislation introduced today by Senator Harkin and the original House-passed "Jobs for Main Street Act." Action of this nature is needed in order to avert major cuts on many of our campuses, which in turn will lead to a further denial of access to our programs. Approximately 70 percent of the total budgets of community colleges are devoted to labor costs. Without enactment of the "Keep Our Educators Working Act" or similar legislation, it is unclear how many community colleges will manage.

The proposed legislation would create a $23 billion "Education Jobs Fund," like that in the SFSF to help States and localities retain teachers and faculty. We appreciate the recognition of the importance of both K–12 and higher education funding in this legislation. Further, with the inclusion of MOE language, the legislation should ensure that the Federal investment in public education will achieve its full and intended impact.

FISCAL YEAR 2011 FUNDING

Numerous Federal education and workforce training programs are essential to community colleges and the students they serve, providing critical student financial aid, institutional support, and resources to train workers for highly competitive jobs. Many of these initiatives also help community colleges hire and retain faculty for specific programs. The recently enacted budget reconciliation legislation provides significant investments in Federal student aid and institutional assistance, as well as funding for the Community College and Career Training Grant program, a new Trade Adjustment Assistance program that was created (but not funded) by ARRA.

The following represents some of the funding priorities for community colleges for fiscal year 2011.

THE FEDERAL PELL GRANT PROGRAM

A record number of students are relying on Federal Pell Grants. Nearly 9 million college students, approximately one-third of them attending community colleges, will receive Pell Grants in fiscal year 2011. For community college students, the Pell Grant program remains by far the most important student aid program.

Community colleges are grateful for the significant investments made in the Federal Pell Grant program under provisions contained in the recently enacted budget reconciliation legislation. These increases will enhance access and help students steer clear of debt. The Connecticut Community Colleges have disbursed $59.1 million in Federal Pell Grants this academic year, an increase of 59 percent in 1 year, to more than 21,000 students, an increase of 34 percent. More than 5,000 of these Pell recipients were unemployed or had a spouse who was unemployed; and 13 percent of the dependent student recipients reported at least one parent was unemployed.

FEDERAL STUDENT SUPPORT SERVICES AND INSTITUTIONAL AID

In addition to the Federal student aid and student support services (such as TRIO and GEAR UP), community colleges strongly support funding for institutional aid under titles III and V of the Higher Education Act (HEA). Two point fifty-five billion dollars of additional funding is provided for minority-serving institutions (MSIs) over the next decade in the recent budget reconciliation legislation. AACC continues to support funding for the MSIs and advocates for additional resources for the strengthening institutions program. Strengthening institutions, contained in title III–A of the HEA, tends to be overshadowed by other institutional aid programs, but is an extremely effective program that benefits from healthy competition each year.

PERKINS CAREER AND TECHNICAL EDUCATION PROGRAMS

Perkins Career and Technical Education (CTE) programs are the largest Federal source of institutional support for community colleges, helping them to improve all aspects of cutting-edge career and technical education programs. In his fiscal year 2011 budget, President Obama proposed the consolidation of the tech prep program into the basic state grants and level funding of Perkins CTE. AACC supports the preservation of the tech prep program and increasing total funding to $1.4 billion for the Perkins CTE programs.

CAREER PATHWAYS INNOVATION FUND

AACC urges the subcommittee to continue to fund the Career Pathways Innovation Fund. This program, formerly the Community-Based Job Training Grants (CBJTG), serves a vital need by expanding the capacity of community colleges to train workers for jobs in high-demand, high-growth industries. Since its inception in fiscal year 2005, this program has brought together community colleges, local businesses, and Federal workforce investment boards to prepare workers for employment in industries such as healthcare, advanced manufacturing, and technology. While the administration's budget proposed eliminating the program because it duplicated the proposed American Graduation Initiative (AGI), AGI was not enacted and the resources provided by this program, which provides both immediate training and some funding for longer-term program development, are sorely needed. AACC strongly supports the continuation of this program with at least $125 million in fiscal year 2011.

Connecticut is the only State in the Nation to receive awards in all four rounds of the CBJTG program. Credit certificate programs combine academic and technical skills with occupational specialty courses developed with input from each industry to ensure relevance to employer needs. The most recent grant focuses on energy efficiency and conservation to advance Connecticut's Energy Vision, which mandates that, by 2020, at least 20 percent of Connecticut's power will be supplied by renewable sources.

Grant funded initiatives have increased the number of students succeeding at the college level and entering growing fields of employment in the State. Connecticut Department of Labor data indicate that earnings for students in targeted degree programs served by two of the grants (nursing, respiratory care, physical therapy assistant, radiologic technician, and medical assistant) increased from $23,626 in 2005 to $57,740 in 2008—a 144 percent increase.

CONCLUSION

Numerous studies show that there is a strong positive correlation between educational attainment and income. The average community college graduate earns about $7,000 more each year than someone who has only a high school education. The "middle skills" jobs for which community colleges provide preparation are expected to grow robustly over the next decade.

Investments in education jobs provide both short-term and long-term benefits by preserving faculty jobs, expanding education and training opportunities at the postsecondary level, and helping Americans attain the postsecondary degrees and credentials that will drive our future economy.

Thank you, Mr. Chairman and members of the subcommittee, for this opportunity to speak with you today.

Senator HARKIN. Thank you, Mr. Herzog. Thank you all very much for your eloquent statements.

I think it is worth noting that we just heard from a teacher from Iowa; a superintendent from the second-largest school district in the United States, Los Angeles; a State school chief from Alabama; and a community college chancellor from Connecticut. You basically all said the same thing.

The jobs crisis in education is real. This is not something "maybe if." It is happening right now, and it is real. And it is not just a problem in one State or one area. It is a problem nationally.

Now, let me get to one point rapidly that came up earlier, and it will come up again. The bill that I am putting in today is deemed an emergency bill, which means it is not offset by spending cuts someplace else. We are in an economic mess right now.

Some people have said, wait a minute, you are going to borrow from our kids and our grandkids to pay for this now? That shouldn't be. We are borrowing too much from our kids and grandkids.

Well, quite frankly, I agree we are borrowing too much from our kids and grandkids. We have a terrible deficit problem, debt problem—debt and deficit problem. But it seems to me this is targeted only for education. How can you argue on the one hand that it is okay for a kid to borrow to go to college, but it is not all right to borrow to make sure that there is a college for the kid to go to? That there are teachers in our high schools and in our grade schools to prepare these kids for the future?

It seems to me if there is one legitimate area where we can borrow from the future, it is in education. Because what kind of jobs will my grandkids and great-grandkids have if we don't have a well-educated group of young people today who will be providing the leadership and the technology and the innovations and the job creations and the business leadership that will provide those jobs in the future?

So you can argue about borrowing from the future for this or that. There are a lot of legitimate arguments on that. Some of it I don't care much about either. But in this one area, it seems to me this is legitimate. To ask our unborn in the future to help pay for the education of their—of what will be their grandparents and great-grandparents today so that they will have a better future then.

So I wanted to get to that because if we are going to get bogged down in taking money from here and there, and we are all in this mess right now, an economic mess. We will be here for the next 2 years, 5 years debating that.

We have a real cliff problem right now. And as I said, it is happening. You testified it is happening. Pink slips are going out now. It is April, May. That is when the decisions are being made. We don't have the luxury of waiting—well, maybe this fall we will get to it. That is too late. Or next winter. That is too late.

This is a real crisis that we have, and that is why I appreciate your sort of bringing this to a head from all different sectors—large, small, community colleges, chief State school officers all over this country—because it is a national problem.

And I must as, as the chairman of this subcommittee and the chairman of the education authorizing committee, there is not enough being said about this nationally. It is sort of like it is there. We know it is going to happen and it is happening, but there is not much focus on that in the national press.

I will tell you when the focus will happen. If we don't do anything and we wind up next fall, and all of a sudden classes are cut, school years are being decimated, and teachers are sent home when we don't have enough bus drivers to get our kids in rural Iowa to the schools because they had to lay off the bus drivers. When we have had to cut back maybe on school lunch programs because we can't hire the cafeteria workers.

Oh, yes. You will get a lot of publicity then, folks. There will be a lot in the press, a lot on TV. And where was Congress? Where were we? Asleep at the switch?

Well, we can't just respond to something simply because it is popular in the press right now. I think one of our obligations as elected officials is to anticipate, think about what we have to do now to keep from having these bad things happen down the road.

Well, I have got 38 seconds left to ask a question. I guess, if anything, I would again ask you all just any general comments you have on who is going to be laid off and what you see out there if we don't act now? If you just have any response to that at all? You have kind of covered it, but if you have any specific things that you didn't mention in your testimony.

Mr. Cortines.

Mr. CORTINES. No, I think we do have to look at all, and you have covered that. And even though I represent a very large, urban system, when you say "all," that means rural America also. That means the mid-size also.

And it does mean not just teachers and administrators, it means custodians and cafeteria workers and secretaries. It takes all of those wraparound services to make for a good comprehensive educational environment.

Senator HARKIN. Mr. Bern.

Mr. BERN. And I would just add it is happening all over the State. I mean, we have teachers living in fear, not knowing whether they are going to have a job—not just teachers, support workers, bus drivers, cooks, secretaries, and everyone is living in fear right now because they don't know.

Our legislature did pass a budget just recently, but before that, we had superintendents planning for the worst-case scenarios. And in Des Moines, they were talking about 300 job cuts. Thankfully, our legislature found some money, and so things aren't going to be quite as bad. But the Des Moines school system just passed a budg-

et last night, and they are going to be cutting 171 positions. So help is desperately needed.

Senator HARKIN. When you said for our entire State, you mentioned 1,500?

Mr. BERN. That is our estimate right now, 1,500 positions.

Senator HARKIN. Dr. Morton.

Dr. MORTON. I would just point out one thing. And I look at a jobs bill as an investment, and I know people worry about their 401(k)'s and their retirement. I think people in this Nation ought to worry about the dropout rate and who is going to work and are they going to be able to work?

And with this jobs bill, we will have teachers that could stay on the job and work with young people to keep them in school. And if you look at the Alliance for Excellent Education, they have a model for every State, and what would be saved and what would be added back to the economy of that State if we could reduce our dropout rate and increase our high school graduation rate so they could go on to a community college or a 4-year college and get a job and be a productive citizen.

And we know just from their information that if we could reduce the dropout rate by half in the 50 largest cities in America, it would increase the increased earnings per year by $4 billion, and that is just in 50 cities. So think of the Nation and what could happen with this investment, and that is the way I look at it, as an investment.

Senator HARKIN. Very good.

Mr. HERZOG. Senator, in our system, we have already lost 177 people this year. The kinds of services that you lose are hours of access to a college library, laboratories, all of those academic instructional support services that students need.

At the same time, where access to community colleges has never been greater, our goal is to have success at our colleges. And the very people that we need to support students are the very people that will go.

Senator HARKIN. Thank you all very much.

I will go to my good friend, Senator Shelby.

Senator SHELBY. Thank you, Mr. Chairman.

I think it is very important, and you have done this, you have focused, among other things, on the loss of teachers and support and so forth. That is important. But we should never, never lose focus on the student. Of course, it is related to that, and nobody knows that better than the four of you.

But because what do we care about? We care about everybody, but we care about that student getting a quality education to be ready for the workforce. And they are not going to get there on their own, and I think you are pointing that out.

Dr. Morton, one of your initiatives, and I mentioned it earlier, and you got a lot of credit, and rightfully so, for it is the Alabama Math, Science, and Technology Initiative. And in light of our Nation, not just our State, but the whole Nation's need to stay competitive with other countries and try to be a world leader in math, science, and high biotech-related industries and research, what was your reaction to the Race to the Top application from the Depart-

ment of Education and, my understanding, allocation of 15 out of 500 points to that topic?

That seems to be low and is troubling to me, 15 out of 500 points——

Dr. MORTON. Senator Shelby——

Senator SHELBY [continuing]. Which will drive the industry and the Nation and the world in the future.

Dr. MORTON. Our whole initiative was built on the fact that we think that America and Alabama students, their future is in math and science and technology.

Senator SHELBY. Absolutely.

Dr. MORTON. We know that President Obama campaigned on it. And I, quite frankly, was stunned when I opened the criteria for Race to the Top and had been—we had invested a lot of money and effort, and we are not going to back away from that investment. I think it is the right investment.

Senator SHELBY. You can't.

Dr. MORTON. We got Huntsville, and we got UAB in Birmingham and Mobile, and we are going to stay behind that investment. But I was stunned and disappointed to find that out of 500 possible points for Race to the Top, only 15 points, 3 percent of the whole application dealt with science, technology, engineering, and mathematics, the STEM.

I don't get—there is a disconnect there I don't——

Senator SHELBY. Absolutely. And it seems like it is upside down. This needs to be changed.

Dr. MORTON. It did not open the door for America to walk through and not be 20th or 25th in the world in 14-year-old math and science scores. If we are going to be number one, we have got to invest in engineering, mathematics, technology, biotech.

And Race to the Top, $4.3 billion, allotted 3 percent, 15 out of 500 points to that topic. I was very disappointed.

Senator SHELBY. I think it was a flawed program. You do, too, that it was?

Thank you. Thank you, Mr. Chairman.

Senator HARKIN. Very interesting.

Dr. MORTON. Yes, sir. I would——

Senator HARKIN. You learn something new every day around here.

Dr. MORTON. I think our Nation would be honored if someone would kind of look into that.

Senator HARKIN. Well, I think we will look into that.

Dr. MORTON. Thank you.

Senator HARKIN. Okay. Let me get that. Five hundred points, and only 15——

Dr. MORTON. Three percent are on STEM—science, technology, engineering, and mathematics education.

Senator HARKIN. Hmmm.

Senator SHELBY. Mr. Chairman, I wish you, as chairman of this subcommittee, would look into this, and I think you will have a lot of support on both sides of the aisle, Democrats and Republicans.

Senator HARKIN. Well, Dick, let us work together. Let us find out. That doesn't sound—this shouldn't be. It should be higher.

Senator SHELBY. That is the way it is set out, isn't it?

Dr. MORTON. Yes, sir. That is the way the criteria break out.
Senator SHELBY. Thank you.

ADDITIONAL COMMITTEE QUESTIONS

Senator HARKIN. Well, thank you. Thank the panel. Thank you all very much, and we will do everything possible and ask for your continued involvement and help in this effort.

[The following questions were not asked at the hearing, but were submitted to the Department for response subsequent to the hearing:]

QUESTIONS SUBMITTED TO HON. ARNE DUNCAN

QUESTIONS SUBMITTED BY SENATOR MARY L. LANDRIEU

RACE TO THE TOP

Question. The administration has requested $1.35 billion to extend the Race to the Top competition. In the first round of this year's competition, you selected only the States that demonstrated exceptionally high levels of statewide support from superintendents, school board presidents, teachers' unions, and charter schools. As you are well aware, real reform too often encounters resistance from some teachers' associations and school boards. Proven results are often the only meaningful way to convince the doubters. Therefore, I believe that supporting real reformers is a smarter strategy, whether or not the reform plan has near unanimous stakeholder buy-in.

Also, there has been some discussion about the Race to the Top scoring process. For example, six first-round finalist applications—including the application from my home State of Louisiana—saw a particularly wide gap between their highest and lowest scores. According to a recent report by The New Teacher Project, throwing out the highest and lowest scores of each State application would have dramatically changed the rankings for applications from finalist States like Louisiana and Georgia. Some have suggested that a broader range of reviewers could help to dampen the impact that only one negative review would have. Others have suggested clarifying whether the criteria are objective or comparative.

As you approach Round Two of the Race to the Top and as we consider funding an additional $1.35 billion for next year, how might you change the evaluation criteria to support bold reform and ensure a fair scoring process?

Answer. While I understand your concern about the potential for tradeoffs between, on the one hand, proposing serious reforms and, on the other, gaining stakeholder support, we believe that States should make every effort to both craft ambitious reforms and engage affected stakeholders and leaders in making the reforms a reality. We do not believe that ambitious reform and stakeholder support are mutually exclusive. It is important to note that, while the two phase 1 winners, Delaware and Tennessee, did have high levels of stakeholder support, this buy-in did not soften their reform efforts. It is also worth noting that a number of highly rated phase 1 States that fell just short of winning phase 1 awards had strong conditions and plans for reform with lower levels of stakeholder support. The message, I hope, is that we are not in favor of weakening reforms in order to strengthen stakeholder support; however, we do acknowledge that on-the-ground reforms in education, to be successful, require the active participation of school leaders, teachers, and other stakeholders. The Race to the Top criteria and scoring system are designed to incent and reward programs that are ambitious yet achievable.

Regarding your concern about a single reviewer on a panel affecting the competition's outcome, I would observe that any diversity of opinions among reviewers was the product of a rigorous review process:

—Each of the 58 reviewers was carefully chosen for his or her expertise from a pool of approximately 1,500 applicants.

—For tier 1, each reviewer spent roughly 30 hours reading each application, and then discussed each application in detail with his or her panel. To facilitate these discussions, we provided each panel with a measure of the variation between individual reviewers' scores for each criterion on that application. This allowed reviewers to quickly identify and focus their discussions on differences in scores, and to ensure that those differences were based not on misunderstandings of the criteria, but on legitimate disagreements as to the quality of the State's responses.

—For finalist States, reviewers had three additional opportunities to discuss the applications: (1) the panels met to discuss the questions they would ask of States during the Q&A session; (2) reviewers asked questions of the State to clarify or validate their scores and comments; and (3) following the State's presentation and Q&A session, the panels met a final time.

We believe that if, after going through such a rigorous process, one of these carefully selected experts believed that an application deserved a relatively higher or lower score than other reviewers on the panel believed it deserved, that professional opinion should not be ignored by the Department. Discounting the diversity in reviewer opinions or scores could exclude meaningful information that was the product of a thorough review process. To ignore or eliminate such information would be counterproductive to our goal of funding the highest-quality applications. Please also understand that, even if we had thrown out the highest and lowest scores in the phase 1 competition, Delaware and Tennessee would have still been the two top-scoring applications. Thus, taking that step would likely not have affected the outcome of the competition.

Having said that, I agree that we might increase inter-reviewer reliability by improving our peer reviewer training. In phase 1 of the competition, we had no exemplar applications because the competition was brand new—thus, we could not "anchor" reviewers' understandings in any common activities. Using the information we gained during phase 1, we plan to expand our reviewer training for phase 2 to include workshops in which reviewers read and discuss sample responses, practice the "panel review" process, and develop a deeper understanding of the criteria and scoring rubric. We expect these actions to improve the overall quality of both scoring and commenting.

Finally, we are in the early stages of thinking about the criteria for a phase 3 of Race to the Top. We will work hard to ensure that all aspects of a phase 3, from the criteria to the reviewer training, are deeply informed by what is working, and what is not working as well, in Race to the Top and other Department programs.

TEACHER AND LEADER PATHWAYS PROGRAM

Question. In the budget, you have proposed to consolidate a number of existing education funding streams into a few competitive programs. One program affected by this consolidation of funding streams is Teach for America, the national program that recruits outstanding college graduates to teach for 2 years in underserved schools. This program has been incredibly successful all over the country, particularly in my home State of Louisiana where we now have 608 corps members in 148 schools reaching 38,500 low-income students.

Right now, because of the enormous increase in applications that Teach for America is experiencing, it has the opportunity to double in size, but doing so will require a reliable funding stream. The timing of the proposed grant competition would not allow Teach for America to grow in 2011 or 2012—and they would be forced to reduce the size of the incoming corps.

How do you propose to bridge this funding gap so that Teach for America can continue to grow and place effective teachers in the schools where they are needed the most during this upcoming school year?

Answer. I share your admiration for the important role that Teach for America plays—as well as other alternative pathways to teaching programs—in helping high-need districts recruit candidates to teach in high-need schools. During the 2008–2009 school year, the last year of my tenure in Chicago, 248 Teach for America corps members were teaching in the Chicago Public School System and helping to raise the achievement and improve the lives of more than 25,000 students. The 2010 appropriation of $18 million for Teach for America represents an increase of more than 20 percent above the funding it received in 2009 under the Fund for the Improvement of Education. The Department expects to receive an application for these funds from Teach for America shortly and anticipates that it will be able to award the grant 4 to 6 weeks later.

For 2011, the administration has requested $405 million for a new Teacher and Leader Pathways program that would allow States and districts to create or expand teacher and leader preparation programs, including alternative routes to teaching like Teach for America. This creates an opportunity for Teach for America and other organizations committed to recruiting and supporting exceptional teachers to partner with States and districts to compete for significantly more funding than is currently available to them under the current system of smaller, often narrowly targeted programs. We recognize that a significant change like this creates uncertainty, but the Administration is committed to working with the Congress, States, districts, and other stakeholders, including Teach for America, to ensure that the implemen-

tation of this new program supports and enhances their efforts to improve education.

Investing in Innovation Program and Support for Teach for America

Organizations like Teach for America are also eligible to compete for funding under the Investing in Innovation program, which supports the development and expansion of innovative practices to improve student achievement and close achievement gaps. Applications for the 2010 competition were due on May 12, 2010. The administration has also requested $500 million for this program in 2011 to support another round of awards for exceptional, innovative programs. In addition, States may use funds received under the Race to the Top and under the proposed Effective Teachers and Leaders State grants program to support Teach for America projects.

TEACHER AND LEADER INNOVATION FUND

Question. The administration's request includes $950 million for the new Teacher and Leader Innovation Fund. How does the administration plan to encourage these States and LEAs to develop and use innovative teacher compensation systems under the proposed Elementary and Secondary Act (ESEA) reauthorization?

Answer. The Teacher and Leader Innovation Fund would provide support for State and LEA efforts to develop and implement innovative approaches to human capital systems. It would support compensation reforms and complementary reforms of teacher and principal development and evaluation, teacher placement, and other practices. Grantees, selected competitively, would use program funds to reform teacher and school leader compensation and career advancement systems, improve the use of evaluation results for retention and compensation decisions, and implement other innovations to strengthen the workforce.

TEACHER INCENTIVE FUND

Question. How will the Teacher and Leader Innovation Fund work should it not be reauthorized?

Answer. If authorized, the Teacher and Leader Innovation Fund would build on the strengths of the Teacher Incentive Fund (TIF). If Congress does not reauthorize the ESEA in time to govern the fiscal year 2011 appropriation, the administration believes its requested increase for ESEA programs should be devoted to existing programs best positioned to reform K–12 education, such as the TIF, and would seek funding of $800 million for this program, $400 million more than the fiscal year 2010 appropriation, for continuation grant costs and approximately 100 new awards.

CHARTER SCHOOLS—EXPANDING EDUCATIONAL OPTIONS PROGRAM

Question. I was pleased to see that your budget request follows on President Obama's promise to increase support for charter schools. Your request includes a $54 million increase for Charter Schools Grants, even if ESEA is not reauthorized this year. Could you talk about how the administration plans to address the challenges charter schools face in securing facilities funding?

Answer. The administration is proposing a new program that would replace current ESEA programs that support choice-based models of school reform as well as family outreach. The Expanding Educational Options program would include two separate grant competitions: (1) Supporting Effective Charter Schools Grants; and (2) Promoting Public School Choice Grants. Under the Supporting Effective Charter Schools Grants competition, State educational agencies, charter school authorizers, charter support organizations, charter management organizations, and other nonprofit organizations in partnership with LEAs would be eligible to apply for competitive grants to start or expand effective public charter schools and other effective autonomous public schools. The Department would work to ensure the creation of quality schools by selecting applicants based on their record of success in supporting, overseeing, or operating (depending on the type of grantee) effective charter and other autonomous schools, including their record of closing ineffective charter and other autonomous schools, as appropriate, and their commitment to starting schools that would expand options for students attending low-performing schools. In addition, the Department would give priority to applicants proposing to create or expand effective public charter schools.

As part of this strategy, we believe it is crucial to continue to support State and local efforts to ensure that charter schools have adequate facilities. We are proposing in reauthorization that, rather than renew various separate programs for charter facilities, Congress allows a portion of funds (no more than 10 percent) from the Supporting Effective Charter Schools Grants program to be used to award

grants to those programs that most effectively leverage Federal dollars to support charter school facilities. This could result in new funding for credit enhancement programs as well as other programs that support charter school facilities.

Charter Schools Facilities Programs

The fiscal year 2010 appropriations act permitted the Department to use a total of $23,082,000 (from the appropriation for the Charter Schools Program) to continue the State Charter Schools Facilities Incentive program and the Credit Enhancement for Charter School Facilities program. From that amount, the Department intends to use $14,782,000 to make second-year continuation grants under the State Charter School Facilities Incentive program and $8,300,000 for Credit Enhancement for Charter Facilities program. The Department's proposed reauthorization also includes language that would ensure the continued funding of Facilities Incentive Grants to States made in fiscal year 2009 for the remainder of their award period.

Under the administration's fiscal year 2011 request for the Expanding Educational Options program, approximately $298,000,000 would be available for new charter schools awards and approximately $102,000,000 would be available for the continuation of multi-year charter schools awards made before reauthorization. At least $14,782,000 of that amount would be available for State Charter School Facilities grants and up to $40,000,000 in new awards could be available for programs that also support charter school facilities.

QUESTIONS SUBMITTED BY SENATOR JACK REED

LEVERAGING EDUCATIONAL ASSISTANCE PARTNERSHIP (LEAP) PROGRAM

Question. I have long worked to improve and fund the LEAP program. As such, I was disappointed that the President's fiscal year 2011 budget eliminated funding for LEAP.

Particularly during this economic downturn, why would the administration propose to eliminate critical need-based aid for low-income students—a program that leverages millions of dollars in need-based grant aid on the State level, and indeed the only program that serves to maintain a State role in providing such need-based grant aid?

While we both are pleased that significant increases to Pell Grants were included in the recent student loan reform law, we still have a ways to go in meeting the financial need of students. Do you agree that we must leverage the ability of States, institutions, businesses, and philanthropic organizations to partner together and provide necessary aid and support for students and that the Federal Government cannot be the only player at the table when it comes to student aid and support?

Answer. While providing critical need-based aid remains a priority to the administration, LEAP funding was not requested for fiscal year 2011 because it was clear States have committed to sustaining their financial support for students. Since its authorization, LEAP has helped to increase State participation, both in terms of the number of States providing this aid and in the amounts they provide students. For example, in academic year 2006–2007, estimated State matching funds totaled nearly $1 billion. This is more than $950 million more than the level generated by LEAP's dollar-for-dollar match, and far more than would be required even under the 2-for-1 match under Special LEAP. This suggests a considerable level of State commitment, regardless of Federal expenditures, which is not expected to diminish absent LEAP program funding. In place of directing funds to LEAP, the administration believes in investing these limited resources in other need-based aid programs, including increasing the maximum Pell Grant award and providing $750 million to encourage greater college access through State and community innovation in the College Access Challenge Grants program.

COLLEGE ACCESS CHALLENGE GRANTS (CACG)

Question. While you may offer CACG as an alternative source (to LEAP), how do you reconcile the fact that providing need-based grant aid is just one of many optional activities for State nonprofits in CACG and, as such, the Department's report from last year shows that only 9 of 50 States used CACG funding for need-based grant aid?

Answer. While LEAP has been able to supply need-based grant aid specifically, CACGs provide more opportunity for participation by charitable and philanthropic organizations, as well as State and local governments to aid in the CACG work done by a State, including through providing financial resources to students. The program includes a match requirement of one-third of the cost of the activities which

may come from philanthropic or other sources, incentivizing increased investment and collaboration. The recently passed Student Aid and Fiscal Responsibility Act (SAFRA) authorizes additional funds for the CACGs program, totaling $150 million per year through fiscal year 2014, providing a huge opportunity to develop promising new practices and create a data-driven approach for delivering on a college access strategy. The legislation also provides for an increased minimum award, such that nearly 20 States will see a quadrupling of their grant awards. This will allow for both increased State as well as nonprofit participation, and gives States more opportunity to be sources of need-based grant aid for students.

SCHOOL LIBRARIES

Question. As you know, the Department's own evaluation of the Improving Literacy Through School Libraries program, released last year, found that it has been successful. For instance, the evaluation, which includes a discussion of the research showing the impact of improving school libraries on student achievement, found among other things that the program has improved the quality of the disadvantaged school libraries receiving the grants, as well as increased collaboration and coordination among teachers and school librarians on curriculum and related matters. Do you think the Federal Government should support initiatives that research has shown to be effective? And, if so, why does your budget seek to consolidate funding for a number of programs shown to be effective by the Department of Education's own evaluations, such as the Improving Literacy Through School Libraries program?

Answer. The Department takes the findings of each evaluation seriously and believes that we should learn from promising practices and try to build on them. However, the evaluation report you mention also stated that some or all of the score increase may be associated with other school reform efforts. Consequently, the report concluded that no definitive statement could be made about the effect of participation in the program on reading assessment scores.

The administration is proposing to consolidate the Improving Literacy through School Libraries program in order to make more effective use of the funding for literacy. Federal literacy programs have historically taken a fragmented approach. The administration believes State and local efforts to improve literacy will be more coherent and more likely to drive dramatic improvements in student achievement if they have a comprehensive pre-K–12 focus. States and districts could use funds from this larger, comprehensive program to expand school or classroom library services. This could include increasing library collections, opening library facilities for longer hours, or providing professional development to school librarians.

GUIDANCE ON USE OF FEDERAL FUNDS TO SUPPORT LIBRARIES

Question. You have on occasion, including in a letter to me, expressed the importance of well-resourced school libraries. Indeed, such well-resourced and well-staffed school libraries play an essential and vibrant role in amplifying the learning that goes on in classrooms and providing students with the critical thinking skills to evaluate and use information and ultimately gain knowledge. As such, did you provide any specific guidance to schools regarding using ARRA or ESEA funding to support school libraries and school librarians?

Answer. In September 2009, the Department issued guidance entitled using title I, part A ARRA Funds for Grants to Local Educational Agencies to Strengthen Education, Drive Reform, and Improve Results for Students, which included information on how title I ARRA funds could be used to strengthen school libraries. This guidance specifies that "In a Title I school operating a school wide program, Title I, Part A ARRA funds may be used to purchase library books if using the funds for that purpose is consistent with needs identified in the comprehensive needs assessment and articulated in the school wide plan." It goes on to provide clarification about how local educational agencies (LEAs) should first leverage State and local resources and about schools operating a targeted assistance program. This guidance document also states that expanding title I reading and mathematics resources and libraries may be an activity that LEAs can carry out in meeting the requirement to provide equitable services to private school students.

EFFECTIVE TEACHING AND LEARNING: LITERACY PROGRAM

Question. How do you propose ensuring that investments in school libraries are made when evidence suggests that (1) libraries are among the first items cut from cash-strapped school budgets and (2) in the absence of a specific Federal investment, school libraries have languished, such as what occurred when the school library pro-

gram included in the original ESEA was eliminated during the Reagan administration?

Answer. The Effective Teaching and Learning: Literacy program would provide competitive State literacy grants to State educational agencies (SEAs), or SEAs in partnership with appropriate outside entities, in order to support State and local efforts aimed at implementing and supporting a comprehensive literacy strategy that provides high-quality literacy instruction and support to students. Local educational agencies could use their grant funds to expand their library collections, open their school libraries for longer hours, or provide professional development to school librarians. We believe that this would be the best approach to ensuring that school libraries and library services are supported as part of a comprehensive approach to improving student literacy.

TEACHER QUALITY PARTNERSHIP GRANTS

Question. Last Congress, I helped author provisions in title II of the Higher Education Opportunity Act—the Teacher Quality Partnership Grants (TQP) program—to reform college teacher preparation programs, where more than 85 percent of new teachers are prepared each year. The final bill that included these provisions had overwhelming support—it passed the Senate 83–8 and the House 380–49. Congress spent more than 5 years deliberatively crafting this program on a bipartisan and bicameral basis leading up to the reauthorization in 2008. The majority of the first grants through this program were just awarded earlier this month.

Yet the administration has proposed to eliminate this program even though there has been no opportunity to prove its effectiveness. We have heard for many years that college teacher preparation programs need to be reformed. However, by consolidating TQP with a number of non-college-based teacher certification programs, there will be no guarantee that college teacher preparation programs receive funding to actually undertake the reform we both acknowledge needs to occur.

How will eliminating the one guaranteed Federal source of funding for college teacher preparation programs help reform them in any systematic way?

Answer. I see the administration's proposal to consolidate smaller, narrowly targeted programs into a Teacher and Leader Pathways program in which institutions of higher education would partner with States and districts to compete for funding as a natural extension of the teacher preparation reforms enacted in the Higher Education Opportunity Act. Under the Teacher Quality Partnership Grant program, institutions of higher education, in partnership with high-need districts and schools, compete for grants to support model teacher preparation programs that are accountable for recruiting highly qualified candidates, including minorities and individuals from other occupations, and training them to be highly qualified teachers who are prepared to meet the needs of high-need schools and districts. In 2009, we awarded $43 million in 28 grants to support pre-baccalaureate and/or teacher residency programs, with $100 million in ARRA funds awarded in 2010 to support 12 additional grants. The 2011 request for the Teacher and Leader Pathways program would provide $405 million to significantly expand the amount of funding available to States and districts to enable them to partner with college-based teacher preparation programs and other organizations to compete for funding to develop or expand efforts to recruit, train, and support teachers to teach in high-need schools or high-need subjects.

STRENGTHENING TEACHER PREPARATION PROGRAMS

Question. Doesn't the need for reform bolster the case instead for dedicated resources to strengthen these programs, from which 85–90 percent of teachers enter the field?

Answer. In speeches at the Curry School of Education at the University of Virginia and Teachers College at Columbia University, I have stressed the important role that colleges of education play in preparing the vast majority of individuals who become teachers and challenged them to reform their programs to make them accountable for producing teachers across subject areas who are prepared to help all students, regardless of race, national origin, disability, or ZIP code to reach their full potential. As teachers in the baby boom generation begin to retire, districts will need even more highly effective teachers from both traditional colleges of education and alternative routes to teaching. Any qualified organization or institution that is willing to partner with States and districts and be held accountable for preparing teachers who are able to increase student achievement and close achievement gaps should be able to compete for scarce Federal resources. Our proposed Teacher and Leader Pathways program is flexible about the path through which teachers are

prepared but firm about the results which grantees will be held accountable for producing.

TEACHER AND LEADER PATHWAYS PROGRAM

Question. Why propose to eliminate a program before its effectiveness has even been tested?

Answer. The administration's 2011 request for the Teacher and Leader Pathways program included $57 million to continue support for the 28 grants that were awarded in 2009. As I mentioned in response to an earlier question, the administration's budget request would not eliminate funding for partnerships between institutions of higher education and districts to improve the quality of teacher preparation programs. Instead, it would consolidate these and other program authorities to create a larger pool of funds for which States and districts could compete for resources to support a broad range of activities and approaches tailored to the needs of their communities.

EVALUATION OF TEACHER QUALITY PARTNERSHIP GRANTS

The Department is committed to investing in rigorous research and evaluation on the effectiveness of various approaches to improving teacher quality. In 2010, the Institute of Education Sciences awarded a contract for an evaluation of the effectiveness of the teacher residency projects supported through the Teacher Quality Partnership Grant program, including 12 grants awarded in 2009 and 7 grants awarded in 2010 with funds appropriated under the ARRA. The results of this evaluation will help States and districts make informed decisions, while also providing valuable information to institutions of higher education and other teacher residency programs to help them refine and enhance their programs.

TEACHER PREPARATION

Question. Do you agree that teacher preparation programs should have rigorous clinical experiences, comprehensive induction and mentoring, and be closely partnered and aligned with local school districts?

Answer. Recent research suggests that pathways into teaching are more effective when they focus on the classroom and provide opportunities for teachers to study what they will be doing as first-year teachers. For example, teachers who came from programs in which they engaged in actual teaching practices, or engaged in a "capstone project"—often resulting in a portfolio of work produced in K–12 classrooms during the pre-service education component—were more likely to produce positive student achievement gains during their first year of teaching than were teachers who did not engage in these learning experiences. Under the administration's reauthorization proposal, individuals participating in the proposed Teacher Pathway program would receive intensive clinical experience and induction support, including high-quality mentoring. In addition, the Teacher Pathways program would support teacher preparation activities that are aligned with the needs of local communities.

QUESTIONS SUBMITTED BY SENATOR MARK PRYOR

SCHOOL TURNAROUND GRANTS

Question. The Department's fiscal year 2011 budget request proposes $900 million for a reauthorized School Turnaround Grants program intended to help States and local education agencies "turn around" the country's 5,000 lowest performing schools over the next 5 years. The Department's Blueprint for Elementary and Secondary Education Act reauthorization outlines four models including a school closure model, a restart model, a turnaround model, and a "transformation model" in which the principal is replaced, staff are strengthened, and extended learning time is provided, among other reforms. For rural areas, these models pose a challenge. I'm concerned that some of the proposed reforms may not be optimal for Arkansas—especially with respect to laying off one-half of the school staff or shutting down the school and reopening it.

Mr. Secretary, how will you ensure rural districts have flexibility in school improvement through the proposed four models under the school turnaround grants program you have proposed?

Answer. We recognize that rural school districts face unique challenges and require flexibility to develop and implement effective plans for turning around their persistently lowest-achieving schools. In particular, some rural schools may have difficulty providing access to a well-rounded education, recruiting and retaining ef-

fective teachers, and serving high concentrations of poor students. At the same time, we know that all children can learn with the appropriate support, and the School Turnaround Grant program was designed to help all districts and schools, including those in rural areas, provide that support. The transformation model, in particular, was developed with input from stakeholders from rural communities, to make sure that these communities have the ability to turn around their struggling schools. This model gives rural districts an option that can work for them and that can deliver dramatic change students need.

PROGRAM CONSOLIDATIONS

Question. In the Department's budget proposal, many K–12 programs are consolidated into fewer, broader programs aimed at meeting targeted goals. Arkansans have benefited from several worthy programs, such as Teach for America, Javits, and Literacy Through School Libraries, that have been consolidated.

How will these larger programs meet the needs many of the smaller programs targeted?

Answer. In most cases, the larger, consolidated programs we are proposing through reauthorization are flexible enough to continue supporting high-quality projects that carry out activities in the specific areas you mention. Our goal in consolidating multiple current authorities is not to eliminate support for worthy reforms and activities, but to focus effort in a few critical areas, build an evidence base of what works through rigorous program evaluations, and help us lead the field by directing funding and attention to scaling up the best ideas.

Question. How do you envision funding should be structured to meet the overall goals of these consolidated programs?

Answer. The President's budget includes a proposed structure for funding activities within broader, more comprehensive authorities contained in our reauthorization plan. We believe these broader authorities will provide States and districts the flexibility to focus on their specific needs, enable the Department to build an evidence base of what works through rigorous program evaluations, and help us lead the field by directing funding and attention to scaling up the best ideas.

QUESTIONS SUBMITTED BY SENATOR THAD COCHRAN

PROGRAM CONSOLIDATION PROPOSAL AND PROSPECTIVE APPLICANTS

Question. The Department of Education's fiscal year 2011 budget proposes authorizing legislation which would consolidate a number of existing programs, including the National Writing Project, into 11 new programs. Under your consolidation proposal, could you identify the types of organizations that you anticipate will compete for grants, including organizations that receive grants under the existing programs?

Answer. The eligible entities will vary by program and it is difficult to speculate which organizations might choose to apply for competitions that have not yet been announced. An organization such as the National Writing Project would be encouraged to partner with States or districts in order to further the implementation of comprehensive literacy plans under the Effective Teaching and Learning: Literacy program.

NATIONAL WRITING PROJECT

Question. As the Department of Education's budget appears to direct funding to States and localities, how would national nonprofit organizations, such as the National Writing Project, be able to compete for funding?

Answer. Eligible entities vary by program. National nonprofit organizations would still be eligible for funding in programs such as Investing in Innovation and national activities competitions within Effective Teaching and Learning for a Complete Education. The National Writing Project could participate in these competitions or partner with States and districts in order to further the implementation of comprehensive literacy plans.

GEOGRAPHIC EDUCATION

Question. As geographic literacy will be critical for our Nation's students to compete in a global economy, does the Department of Education's fiscal year 2011 budget proposal to create a new Effective Teaching and Learning for a Well-Rounded Education program do enough to ensure that funding is committed to geographic education activities?

Answer. The administration agrees that geography is an important subject that our students should study as part of a complete education. Our proposal for Effective Teaching and Learning for a Well-Rounded Education would provide support for geography, as well as other subjects, through the identification, development, implementation, and replication of evidence-based programs, strategies, and practices. Under the current ESEA, geography is listed as one of the core academic subjects but ESEA funding has not been used to strengthen geography education unless States or districts have elected to use some of their formula funds for that purpose. By making geography one of the subjects that could be supported directly with grants from the Effective Teaching for a Well-Rounded Education program, we believe that our proposal would make geography a more prominent focus in the reauthorized law and make it more likely that projects supporting geography education will be funded.

Question. What assurances can the Department of Education make to ensure that under this new program funding would be directed to geographic literacy activities?

Answer. Under our reauthorization proposal, the Department could designate specific subjects to be supported in a particular year, or could hold a broad competition through which eligible entities could apply to carry out projects in any of the subjects covered by the program (the arts, foreign languages, civics and government, geography, environmental education, and economics and financial literacy). The Department could also support interdisciplinary projects cutting across a number of those projects. The amount of funding used to support geography would depend on the amount of the annual appropriation, the requirements and priorities announced by the Department, and the quality of applications received.

CAREER AND TECHNICAL EDUCATION

Question. The Carl D. Perkins Career and Technical Education Act is the primary program in the Department of Education that supports preparing students for their future careers, a key element of the new focus on college and career readiness. What role do you see career and technical education playing in helping students become career and college ready?

Answer. Career and Technical Education (CTE) programs represent one of the many pathways available to students to help them become college and career ready. These programs provide instruction that integrates both academic rigor and career and technical skills. In addition, the statutory requirement that States offer "programs of study" should enhance the capacity of CTE programs to prepare students for career and college. Programs of study are coherent sequences of nonduplicative CTE courses that progress from the secondary to the postsecondary level, include rigorous and challenging academic content along with career and technical content, and lead to an industry-recognized credential or certificate at the postsecondary level or to an associate or baccalaureate degree. They may also incorporate a dual-enrollment component, where a student takes postsecondary coursework while still in high school and accrues postsecondary credits while doing so. High school students who have completed programs of study are not only likely to graduate college and career ready, but they also have already taken foundational courses in a specific career area and are ready for more advanced coursework at the postsecondary level in the same career area.

REACH OF CTE PROGRAMS AND STEPS TO IMPROVE CTE PROGRAMS

Question. How can programs continue to expand and improve to serve more students under the Department of Education's fiscal year 2011 budget proposal?

Answer. Career and technical education programs already serve most high school students in this country. According to an April 2009 National Center for Education Statistics report, 97 percent of all 2005 public high school graduates had earned CTE credits. In terms of improving programs, the requirement that States offer programs of study as part of their CTE programs holds great promise. State and local recipients of Perkins funds must create at least one program of study for their students. A program of study must be specific to a career field and integrate academic and technical content in a coherent manner. It must also clearly specify the progression of coursework a student should follow at the secondary level and the coursework a student would pursue at the postsecondary level to eventually attain a credential or degree in that career area. In addition, the courses must not be duplicative. Thus, this approach should not only ensure that CTE students are attaining both academic and technical content, but that they do not need to repeat coursework during their postsecondary studies. In addition, it lets students know exactly what they need to do attain a credential, certificate, or degree in a specific

area. The Department has provided guidance and technical assistance to States in order to help them develop rigorous high-quality programs of study.

21ST CENTURY COMMUNITY LEARNING CENTERS

Question. How would the process of awarding grants occur under the Department of Education's fiscal year 2011 budget proposal to make 21st Century Community Learning Centers (21stCCLC) grants competitive?

Answer. As for any other competitive grant competition, the Department would set evaluation criteria and prepare application requirements and criteria to which eligible entities would have to respond to be considered for a grant. Assuming that the fiscal year 2011 appropriation for the 21st CCLC program adopts the administration's proposal and continues to be multiyear funds, the 21st CCLC grants would be competitively awarded to States during fiscal year 2012.

Question. How many States do you anticipate would receive 21stCCLC awards in fiscal year 2011?

Answer. The Department has not established an estimated number of awards. We would fund as many high-quality applications as possible with the amount Congress appropriates for the program.

Question. As under the current 21stCCLC formula grant structure where all States are guaranteed to receive a share of funding, will small States, such as Mississippi, be able to effectively compete against large States for these awards?

Answer. Our experience indicates that small States can be as competitive as the larger States. For instance, most recently in the Race to the Top Phase 1 competition, one very small State (Delaware) and one medium-size State (Tennessee) were the two winners.

Question. How would States that do not receive a competitive award under this restructured program make up for the loss in Federal funding for the 21stCCLC?

Answer. States that do not receive 21stCCLC could consider ways that State funds and other Federal funding streams, such as title I or the Child Care Development Block Grant, can be used for activities that were supported by the 21st CCLC program. We would also strongly encourage States take steps to enable them to submit a high-quality application for a grant in future years.

PUBLIC TELEVISION CHILDREN'S PROGRAMMING

Question. The Department of Education's fiscal year 2011 budget proposes to consolidate funding for Ready To Learn (RTL), a program with a nearly 20-year proven record of using the power and reach of public television's children's programming to better prepare young children for success in school. This new "Effective Teachers and Learning: Literacy program," would appear to make direct RTL funding unavailable to public broadcasting and would negatively impact national distribution. At the same time, the Department has put out a Request for Proposals (RFP) for the program's fiscal year 2010 funding that calls for "transmedia storytelling" projects, rather than television-focused projects. What assurances can you give that the Department will continue its nearly 20-year partnership with public television?

Answer. From the amount requested for the Effective Teaching and Learning for a Complete Education programs, the administration would reserve funds to support a range of national activities. Public telecommunications entities—such as the Public Broadcasting Service (PBS) and the Corporation for Public Broadcasting (CPB)—would be encouraged to compete for such national activities funding to create high-quality, educational content for children. It is important to recognize that even if neither PBS nor CPB were to submit a winning application in response to the 2010 competition, the Department's partnership with public television would still remain healthy because the majority of funds available to support this activity would very likely end up going to support applications from one or more of the many PBS-affiliate stations, which currently develop and produce much of the original children's educational programming content that is distributed over public television.

READY TO LEARN

Question. Will Ready to Learn have the same impact, reach and success if carriage on television is phased-out or minimized?

Answer. The Department envisions that the impact, reach, and success of Ready to Learn could be augmented by taking steps to ensure that high-quality, educational programming content not only reaches and benefits the widest audience possible, but also to ensure that such materials are coordinated across a variety of media distribution platforms, including television. The Department does not envision that "carriage" or distribution of children's educational programming content using television will be phased-out or minimized. Instead, in the Request for Pro-

posals published in March 22, 2010, the Department "encourages applicants to deliver early learning content through the well-planned and coordinated use of multiple media platforms." This well-planned and coordinated use of platforms necessarily includes television—but we believe that the potential educational benefits of children's programming content can be greatly enhanced if television is not relied on as the sole distribution mechanism.

EARLY LEARNING CHALLENGE FUND

Question. The Department of Education's fiscal year 2011 budget proposal does not request funds for a new Early Learning Challenge Fund since it was assumed that funding would be enacted and funded as part of the budget reconciliation act. Since funding did not come to bear in reconciliation, what are your plans for funding the Early Learning Challenge Fund?

Answer. Early learning remains a priority for the administration and we are considering ways that we can work with Congress to provide funds for the Early Learning Challenge Fund.

INCORPORATING EARLY LEARNING INTO FEDERAL EDUCATION PROGRAMS

Question. How do you intend to incorporate early learning into existing program authorities?

Answer. Early learning is a high priority for the Department. We are encouraging States and LEAs to use ESEA title I, part A funds to support high-quality early learning programs, and are continuing to support early learning services for students with disabilities through the IDEA parts B and C. We also will be working with States to implement the Striving Readers program; at least $32 million of the $250 million fiscal year 2010 appropriation for that program will be used to serve children from birth through age 5. In addition, $10 million will be used to provide formula grants to States for the establishment or support of a State Literacy Team with expertise in literacy development and education for children from birth through grade 12.

It is also important to note that we are incorporating early learning into our reauthorization proposal for the ESEA. For example, the proposed Academic Excellence in Core Subjects programs would support State and local efforts to implement high-quality instruction in literacy, science, technology, engineering, and mathematics, and other subjects that are part of a well-rounded education. The Excellent Instructional Teams programs would also improve early learning programs by allowing the use of program funds to support teachers and leaders who serve children before kindergarten entry.

EDUCATIONAL TECHNOLOGY

Question. The Department of Education's fiscal year 2011 budget proposal would eliminate the Enhancing Education Through Technology Program. While the budget proposal states that technology will be infused throughout programs, a State grant program that specifically provides funds for helping schools upgrade their technology needs and to integrate technology into instruction would not receive funding. How would the Department of Education's fiscal year 2011 budget proposal ensure that funding is provided for these activities?

Answer. The administration proposes to support the integrated use of technology through the Effective Teaching and Learning for a Complete Education programs. The proposed new programs will include (1) Effective Teaching and Learning: Literacy; (2) Effective Teaching and Learning: Science, Technology, Engineering, and Mathematics (STEM); and (3) Effective Teaching and Learning for a Well-Rounded Education. For these three new programs, applicants that propose to use technology to address student learning challenges will be given priority.

The Department's fiscal year 2011 budget request includes $300 million for STEM education grants to be awarded on a competitive basis. Grantees will be required to use its funds to carry out activities to improve teaching and learning in mathematics or science and may also carry out activities to improve teaching and learning in technology or engineering.

In addition, the Department plans to emphasize using technology to drive improvements in educational quality through the reauthorized Investing in Innovation program. Under that proposal, the Secretary would be authorized to designate support for the effective use of education technology to improve teaching and learning as one of the priorities that applicants may address in their applications for competitive awards.

REPLICATING PROMISING PRACTICES AND STRATEGIES

Question. The Department of Education's fiscal year 2011 budget proposal places a strong emphasis on identifying promising practices and strategies that can be replicated in classrooms, schools, and districts. What will the Department of Education do to capture and disseminate this knowledge so educators and administrators across the country can use promising practices to improve classroom instruction, school leadership, academic performance for all students, and close historic achievement gaps?

Answer. The Department employs a wide range of grant and contract vehicles to ensure that classroom educators, school leaders, and State and district policymakers have the information they need to select promising practices and strategies that meet the needs of their students. Through the What Works Clearinghouse and the Education Resources Information Center, the Institute of Education Sciences makes research and evaluation studies available to both the research and practitioner communities in clear, concise formats that provide methodological and technical information on the strength of the evidence to support claims of effectiveness. The Department's technical assistance providers, including the Regional Educational Laboratories, the Comprehensive Centers, the Parental Information and Resource Centers, the Equity Assistance Centers, and Parent Information Centers, work with States, districts, schools, and parents to translate research and evaluation findings into practical strategies to improve student achievement. In addition, through the Technical Assistance and Dissemination program, the Office of Special Education Programs supports a network of grants providing technical assistance, dissemination, and model demonstration activities on a range of issues related to improving the education of students with disabilities. The Department is working to develop a comprehensive strategy that will leverage technical assistance and dissemination resources across programs and offices to coordinate the provision of services and foster the sharing of best practices and research information across programs and topic areas.

SUBCOMMITTEE RECESS

Senator HARKIN. Thank you very, very much. Thank you all.

[Whereupon, at 11:17 a.m., Wednesday, April 14, the subcommittee was recessed, to reconvene subject to the call of the Chair.]

DEPARTMENTS OF LABOR, HEALTH AND HUMAN SERVICES, AND EDUCATION, AND RELATED AGENCIES APPROPRIATIONS FOR FISCAL YEAR 2011

WEDNESDAY, MAY 5, 2010

U.S. SENATE,
SUBCOMMITTEE OF THE COMMITTEE ON APPROPRIATIONS,
Washington, DC.

The subcommittee met at 9:35 a.m., in room SD–124, Dirksen Senate Office Building, Hon. Tom Harkin (chairman) presiding.

Present: Senators Harkin, Pryor, Specter, and Cochran.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

NATIONAL INSTITUTES OF HEALTH

STATEMENT OF FRANCIS S. COLLINS, M.D., Ph.D., DIRECTOR, NATIONAL INSTITUTES OF HEALTH

OPENING STATEMENT OF SENATOR TOM HARKIN

Senator HARKIN. The Senate Subcommittee on Labor, Health, Human Services, and Education, and Related Agencies appropriations will come to order.

I want to start, first, by welcoming Dr. Francis S. Collins, who, of course, has appeared before this subcommittee many times over the past 20 years. Until now, he always testified as the Director of the National Human Genome Research Institute (NHGRI), today, wearing a much different and bigger hat, as Director of the entire National Institutes of Health (NIH).

The fiscal year 2010 budget for the NHGRI is $516 million. The budget for NIH as a whole is $31 billion. Well, at least that's where it is right now, anyway; we're looking at that. And, of course, the portfolio as NIH Director is much larger than the one that Dr. Collins had at the NHGRI.

But, having known Dr. Collins for all these years, I can't tell you how proud I am, and honored, that he is, now, the Director of the NIH.

I can remember when you first took over at the Genome Project—I think it was called a "project" at that time—1992? 1993? I knew I was close, Dr. Collins. I was close. And to take the project to the complete mapping and sequencing of the human genome was a singular accomplishment. And as I said, watching you during that whole time, and watching you shepherd that thing through,

I'm telling you, you're in the right place at the right time, right now, as Director of NIH.

One of the things that—when you think about the issues that confront NIH today—what role does biomedical research play in healthcare reform? How can we capitalize on the Human Genome Project that we completed? How can we do a better job of translating basic research in the field? How can we encourage some of our brightest young minds to enter this field when we've got tight budgets? So, we need someone who thinks big to head up NIH, and that's why we have Dr. Collins here, because he does think big, and he accomplishes big things.

So, the President's budget for the NIH for 2011 calls for a $1 billion increase more than the 2010 level, a total of $32 billion; it's about a 3.2 percent increase, which I am told is the same as the biomedical inflation rate.

But, fiscal year 2011 will bring with it a very special set of challenges; namely, how to achieve the softest possible landing for NIH after the $10.4 billion that was appropriated in the American Recovery and Reinvestment Act (ARRA). That is one area that I hope to explore with Dr. Collins in our question-and-answer period.

I also want to spend some time discussing one of the questions I raised earlier, how we can more effectively translate basic science into treatments and practices that actually improve people's health.

I know you've heard me say this many times before, Dr. Collins, that there's a reason it's called the National Institutes of Health, not the National Institutes of Basic Research.

But, before we hear from Dr. Collins, I would yield to Senator Cochran for his opening statement.

STATEMENT OF SENATOR THAD COCHRAN

Senator COCHRAN. Mr. Chairman, thank you very much for conducting this hearing, looking at the budget requests for the next fiscal year for the Department; that is, the NIH; specifically, under the generalship of Dr. Collins.

We appreciate very much your fine leadership and good work not only as a researcher, but also to manage and help identify priorities that help this subcommittee decide how much funding we need to place in the different accounts in this bill. It's a very large bill. We wish it could be larger, but the budget constrains us. But, within that budget framework, we have to identify the highest priorities, and your testimony will help us do a better job of that. And so, we appreciate your assistance to the subcommittee and your leadership in your role.

Thank you.

Senator HARKIN. Thank you, Senator Cochran.

I didn't read that before I sat down, I just thought "turning discovery into health." That's one of the things I wanted to talk about.

[The information follows:]

www.nih.gov/about/discovery

Senator HARKIN. Well, Francis S. Collins, M.D., Ph.D., was sworn in as the 16th Director of the NIH in August 2009, after being unanimously confirmed by the Senate. A physician-geneticist noted for his discoveries of diseased genes, his leadership of the

Human Genome Project. Prior to becoming NIH Director, he served as the Director of the NHGRI at NIH. He received his B.S. from the University of Virginia, Ph.D. from Yale, and an M.D. from the University of North Carolina at Chapel Hill.

Well, Dr. Collins, welcome. You're no stranger to this subcommittee. Your statement will be made a part of this record in its entirety, and you can please proceed as you so desire.

SUMMARY STATEMENT OF FRANCIS S. COLLINS

Dr. COLLINS. Well, thank you, Senator. And it is a great pleasure to be here. Good morning to all of you. It's an honor to appear to present the NIH's budget request for fiscal 2010 and to discuss my vision for the future of biomedical research.

I'd like for my written testimony to be included in the record, and I'm going to deviate from it quite a bit this morning in this opening set of remarks.

First of all, I'd certainly like to thank all of you for your steadfast support of NIH's mission: to discover fundamental knowledge about the nature and behavior of living systems, but then to apply that knowledge to fight illness and to reduce the burdens of disability. And this is—of course, we are the National Institutes of Health—I think I've quoted you on that, actually, Senator Harkin—not the National Institute of Basic Science. We are passionate about taking the discoveries that are pouring out of research laboratories, and moving them quickly toward clinical benefits.

Over the course of 15 years as Director of the NHGRI, I must say I was grateful for this subcommittee's strong support. Even at a time, early on, when the scientific community was somewhat divided about whether the Genome Project was worth investing in, this subcommittee was a strong supporter. And you, particularly, Mr. Chairman, were a vocal and articulate visionary for what this project might do. And your vision has been coming true ever since. And I—I'm personally grateful to you for that leadership.

So, I want to introduce you today, instead of going through some specific scientific advances, to some people.

Let's begin with Kate Robbins. Eight years ago, at the age of 44, this nonsmoking mother of two, was diagnosed with lung cancer; specifically, non-small-cell lung cancer. It had already metastasized to her brain. Normally this would be a death sentence. Despite surgery, radiation, chemotherapy, the cancer continued its deadly march, moving into her liver, into her pancreas. Still, she kept on fighting. And in early 2003, she enrolled in a trial of a drug called gefitinib, which is trade name Iressa, which is a new genome-based drug for cancer, based on a molecular understanding of what has gone wrong in certain cases of lung cancer.

Now, after she started the drug, most of her metastases vanished. Look at these CT-scans. This was her original one. In 2002, all of those dark areas are cancer in her liver. Just 6 months later, all but one is gone. And today there is no evidence of cancer in her liver, at all.

Now, why doesn't this work in all cases? In her case, a miraculous recovery. She's 7½ years out, with no sign of cancer in her liver or her lungs or her pancreas.

The disappointing news is that this drug only works in about one-fifth of lung cancer patients. But, we now know why. If your tumor has a specific mutation in a gene called EGFR, this drug is for you. If your tumor does not have that mutation, this drug probably will not work. So, this demonstrates the potential of personalized medicine, which is a major frontier right now for cancer, for heart disease, for virtually all conditions; that we can individualize treatment instead of doing the one-size-fits-all approach.

Well, next I'd like you to meet 9-year-old Corey Haas. This is Corey and his mom and dad. Corey was affected by a disease that was robbing him of his vision, a disease called Leber's congenital amaurosis, which is quite a mouthful, but it leads to progressive vision loss. And by age 7, Corey was legally blind. But, he underwent, in an experimental procedure supported by NIH at the University of Pennsylvania, a gene-therapy approach. Basically, the idea here was to take a normal copy of RPE65 and inject it, in a viral vector, into the back of his eye. And let me show you what happened, in the videos that you can see.

One eye was treated, and then, by patching one eye and looking to see how he would do in being able to follow some arrows on the floor, you can see what the effects were.

So, let's start here. Now, at this point, his treated eye has been blocked, so you're seeing what he's able to see without treatment, trying to follow these little arrows on the floor. And he's basically being asked to follow them, he's saying, "I can't see them." He's frustrated; he's standing there, he really can't see where anything is. They're asking, "Do you want a clue?" He finally says, "I can't see anything."

Now, same day, they now patch the untreated eye so he can see with the eye that's received the gene therapy. And watch what happens. "Okay, follow those arrows, Corey." No mistakes. He even had to climb over an obstacle, there, and go all the way around. And he decided he was doing so well, he wouldn't even stop, he'd just walk outside the door.

And if we had the audio, you would have heard wild applause from the researchers, at that point.

So, isn't that dramatic? And this has been, in Corey, sustained for more than a year, and now the consideration is to treat the other eye.

A third story. This is one that features prevention-oriented research. Now this is about Leslie Cook. She smoked for 25 years, half of her life, a habit that put her at increased risk for heart attack, cancer, and many other diseases. She's a high-powered real estate lawyer; she tried to kick the habit many times. She tried the gum, the patch, you name it; nothing worked for her.

And then she enrolled in a phase II trial of a vaccine against nicotine, called NicVAX. The vaccine spurs the immune system to generate antibodies against nicotine. Those bind to it, preventing it from entering the brain, and therefore no pleasure response occurs after smoking. NicVAX did the trick for Leslie; she has not smoked in 3½ years.

And there is now a phase III trial underway here, supported by the ARRA, to test this in 1,000 smokers at 20 centers. It's the first-ever phase III trial of a smoking cessation vaccine.

So, thanks to the discoveries you have funded——

Senator HARKIN. Working on a broad basis? Now, this is not personalized, it doesn't depend on a certain gene, or——

Dr. COLLINS. No. In this case, the vaccine is actually raised against the nicotine itself, so the antibodies are against the material in the cigarette smoke that gives people a high, and it blocks that effect, and so there's no point in smoking and they have an easier time quitting. It's pretty dramatic. That has not, I think, previously been tried for this purpose.

So, we're mixing immunology and drug addiction in interesting ways. There are efforts underway to do this, also, for other drugs of addiction.

Well, let me quickly conclude, here, by just quickly pointing out to you that these represent just a few of the exciting areas of opportunity. When I first came to this job—and it is an incredible responsibility, of leading the NIH—I scanned the landscape a bit, of biomedical research, to identify areas that seemed ripe for major advances and, in the process of doing so, identified five themes that I thought were particularly ripe for investment. And you have in front of you this publication from Science, published in January, that goes through a description of those five themes, and I think that's been reasonably well received by the scientific community.

One of them is to use the high-throughput technologies that have been invented in the last few years—genomics, nanotechnology, imaging, computational biology—to really tackle questions in a comprehensive way; questions like the causes of cancer or autism or what role microbes play in disease when we can't actually culture them in the laboratory but we can detect their presence by DNA analysis.

A second opportunity, and one that you've mentioned already, Mr. Chairman, the importance of translating the basic science discoveries into new and better treatments, of building a bridge, as you see done here for San Francisco, but a bridge between basic research and drugs and empowering academic investigators to play a larger role in that. And the Cures Acceleration Network (CAN), which is part of the healthcare reform bill, is an important aspect of this that we're very excited about.

I should also say, stem cells fit into here, and I'm happy to tell you there are now 64 human embryonic stem cell lines that are on the NIH registry and approved for Federal funding, followed up on Obama's Executive order from a year ago.

A third area, represented by these banners here, is to reach out with NIH research results and actually have an effect on our healthcare system. And that means personalized medicine research, health disparities research, comparative effectiveness research, behavioral research, and even healthcare economics. We're having a major meeting on that next week.

A fourth area is to recognize that we have both opportunities and perhaps responsibilities to apply our medical research efforts to those in less fortunate parts of the world, and that means a focus on AIDS, tuberculosis, and malaria, but, going beyond that, to neglected tropical diseases and noncommunicable disorders, which are the most rapidly growing cause of morbidity and mortality in the developing world.

And finally, the reinvigoration and empowerment of the research community, which is a challenge, especially at times of stressed budgets, to be sure that we're encouraging young investigators, that we're encouraging innovation, that we're training the next generation, using the Ruth Kirschstein awards. And I should, for a moment here, just say how much we miss Dr. Kirschstein, such a remarkable leader of NIH. We're having a special symposium in her honor, later this month, bringing back many of the people who were supported by those Kirschstein awards, in recognition of the role she's played in so much of what we've done in training.

Also in front of you is this pamphlet. And let me just conclude by saying, if our Nation can be bold enough to act upon these many unprecedented opportunities, we'll be amazed at what tomorrow will bring, and how swiftly we can turn discovery into health, as this title says. The one-size-fits-all approach to medicine will be a thing of the past; we will be using genetic information to personalize our healthcare.

But, if you'll allow me, I see a future in which we will use stem cells to repair spinal cord injuries. We'll bioengineer bones and cartilage to replace wornout joints. We'll use nanotechnology to deliver therapies with exquisite precision. We'll pre-empt heart disease with minimally invasive image-guided procedures, and use an artificial pancreas or other new technologies to manage diabetes better.

I look forward to a universal vaccine for influenza, so that you don't have to get a shot every year for the new strain. I look forward to the possibility, more possible now than ever, of an AIDS vaccine and a malaria vaccine. And I dream of a day when we'll be able to prevent Alzheimer's disease, Parkinson's disease, and many others that rob us, too soon, of family and friends.

PREPARED STATEMENT

As you've heard, the fiscal year 2011 request from this subcommittee is $32.157 billion, an increase of $1 billion. These funds will enable the biomedical research community to pursue a number of substantial opportunities in these major scientific and health opportunity areas.

So, I'm really grateful for the chance to be here this morning. I'm pleased to respond to any questions that you might have.

Thank you very much.

[The statement follows:]

PREPARED STATEMENT OF FRANCIS S. COLLINS

Good morning, Mr. Chairman and distinguished members of the subcommittee: It is a great honor to appear before you today to present the fiscal year 2011 budget request for the National Institutes of Health (NIH), and to discuss my vision for the future of biomedical research.

First, I'd like to thank each of you for your steadfast support of NIH's mission: discovering fundamental knowledge about living systems and then applying that knowledge to fight illness, reduce disability, and extend healthy life. In particular, I want to thank the subcommittee for the fiscal year 2010 budget level of $31 billion, and the $10.4 billion provided to NIH through the American Recovery and Reinvestment Act. I was very grateful for the subcommittee's interest and support over the course of my 15 years as Director of the National Human Genome Research Institute, most notably during our successful effort to sequence the human genome. Now, as steward of NIH's entire research portfolio, I truly believe that the opportunities for us to work together to improve America's health have never been greater.

One of my first actions upon being named NIH Director was to scan the vast landscape of biomedical research for areas ripe for major advances that could yield substantial benefits downstream. I found many of the most exciting opportunities could be grouped under five main themes: taking greater advantage of high-throughput technologies; accelerating translational science, that is, turning discovery into health; helping to reinvent healthcare; focusing more on global health; and reinvigorating the biomedical research community.

The administration's request of $32.1 billion for NIH's biomedical research efforts in fiscal year 2011 would help more researchers take greater advantage of these unprecedented opportunities, all with the aim of helping people live longer, healthier, more rewarding lives. We at NIH are fortunate to have a very solid foundation upon which to build, established by such extraordinary leaders as James Shannon, Nobel laureate Harold Varmus, Elias Zerhouni, and the late and much missed Ruth Kirschstein.

THE RESEARCH MARATHON

In his fiscal year 2009 budget remarks, Dr. Zerhouni warned that our Nation's biomedical research effort is in a race that we cannot afford to lose. I wholeheartedly agree, and want to provide a few more insights about what that race involves.

Science is not a 100-yard dash. It is a marathon—a marathon run by a relay team that includes researchers, patients, industry experts, lawmakers, and the public.

Thanks to discoveries funded through NIH appropriations, we have covered a lot of ground in this marathon. Let us take a moment to look back at a few of the advances made possible by NIH-supported research, and then look ahead to some of our Nation's biggest health challenges and how NIH intends to meet them.

HOW FAR WE'VE COME

U.S. life expectancy has increased dramatically over the past century and still continues to improve, gaining about 1 year of longevity every 6 years since 1990. A baby born today can look forward to an average life span of 77.7 years, almost three decades longer than a baby born in 1900.

Not only are people living longer, they are staying active longer. From 1982 through 2005, the proportion of older people with chronic disabilities dropped by almost one-third, from 27 percent to 19 percent.

Some of the most impressive gains have been made in the area of cardiovascular disease. In the mid-20th century, cardiovascular disease caused half of U.S. deaths, claiming the lives of many people still in their 50s or 60s. Today, the death rate for coronary heart disease is more than 60 percent lower—and the death rate for stroke, 70 percent lower—than in the World War II era.

What fueled these improvements? One major contributor has been the insights from the NIH-funded Framingham Heart Study, which began in the late 1940s and is still going strong. This population-based study, which changed the course of public health by defining the concept of disease risk factors, continues to break new ground with its recent move to add a genetic component to its analyses.

Other factors include NIH-supported research that led to minimally invasive techniques to prevent heart attacks and to highly effective drugs to lower cholesterol, control high blood pressure, and break up artery-clogging blood clots. Science also played a crucial role in formulating approaches to help people make lifestyle changes that promote cardiovascular health, such as eating less fat, exercising more, and quitting smoking.

Many chronic conditions have their roots in the aging process. One such disease, osteoporosis, can lead to life-threatening bone fractures among older people. NIH-funded research has led to new medications and management strategies for osteoporosis that have reduced the hospitalization rate for hip fractures by 16 percent since 1993. Science has also transformed the outlook for people with age-related macular degeneration, a major cause of vision loss among the elderly. Twenty years ago, little could be done to prevent or treat this disorder. Today, because of new treatments and procedures based on NIH research, 750,000 people who would have gone blind over the next 5 years will continue to have useful vision.

Biomedical research also has benefited those at the other end of the age spectrum. NIH-funded research has given hearing to thousands of children who were born profoundly deaf. This hearing is made possible through a cochlear implant, an electronic device that mimics the function of cells in the inner ear. Since the Food and Drug Administration (FDA) approved cochlear implants for pediatric use in 2000, more than 25,000 children have received the devices, enabling many to develop normal language skills and succeed in mainstream classrooms.

Then, there are the infectious diseases—diseases that often know no boundaries when it comes to age, sex, or physical fitness. One of NIH's greatest achievements over the past 30 years has been to lead the global research effort against the human immunodeficiency virus (HIV)/acquired immunodeficiency syndrome (AIDS) pandemic. With discovery building upon discovery, researchers first gained fundamental insights about how HIV works, and then went on to develop rapid HIV tests, identify a new class of HIV-fighting drugs, and, finally, figure out how to combine those drugs in life-saving ways in the clinic. As a result, HIV infection has changed from a virtual death sentence into a manageable, chronic disease. Today, HIV-infected people in their 20s who receive combination therapy may expect to live to age 70 or beyond.

HOW FAR WE HAVE TO GO

Although we have accomplished much, and as tempting as it may be for NIH to rest upon its laurels, we all know that biomedical research still has an enormous amount of ground to cover before discovery is turned into health for all Americans.

Consider the challenge posed by cancer. This disease still claims the lives of more than 500,000 Americans annually—about one every minute. But in 2007, for the first time in our Nation's history, the absolute number of cancer deaths in the United States went down. And, over the past 15 years, cancer death rates have dropped 11.4 percent among women and 19.2 percent among men, which translates into some 650,000 lives saved—more than the population of Washington, DC. These are very encouraging milestones, but they are not nearly enough.

NIH-funded research has revolutionized how we think about cancer. A decade or two ago, cancer treatment was mostly reactive, diagnosis was based on the organ involved and treatment depended on broadly aimed therapies that often greatly diminished a patient's quality of life. Today, basic research in cancer biology is moving treatment toward more effective and less toxic therapies tailored to the genetic profile of each patient's cancer.

Among the early success stories in this area is the drug trastuzumab (Herceptin) for breast cancer. An NIH-sponsored clinical trial found that when breast cancer patients whose tumors were genetically matched to trastuzumab received the drug, along with standard chemotherapy, their risk of cancer recurrence fell 40 percent. That improvement is the best ever reported in postsurgical treatment of breast cancer. Studies also have found that the chemotherapy drugs gefitinib (Iressa) and erlotinib (Tarceva) work much better in the subset of lung cancer patients whose tumors have a certain genetic change.

To accelerate the development of more individualized strategies for more types of cancer, NIH has tapped into the promise of high-throughput technologies to launch The Cancer Genome Atlas (TCGA). Over the next few years, TCGA's research team will build comprehensive maps of the key genomic changes in 20 major types and subtypes of cancer. This information, which is being made rapidly available to the worldwide scientific community, will provide a powerful new tool for all those striving to develop better ways to diagnose, treat, and prevent cancer.

Already, TCGA has produced a comprehensive molecular classification system for ovarian cancer and glioblastoma, the most common form of brain cancer. The survey of glioblastoma recently revealed five new molecular subtypes of the disease. In addition, researchers found that responses to aggressive therapies for glioblastoma varied by subtype. The findings hold promise for matching the most appropriate therapies with brain cancer patients and may also lead to therapies directed at the molecular changes underlying each subtype, as has already happened for some types of breast cancer.

Diabetes is another disease that is inflicting much damage on U.S. health. More than 23 million Americans currently have diabetes—nearly 8 percent of the population. Another 57 million have blood sugar levels that indicate they are at serious risk of developing the disease, which is a major cause of kidney failure, stroke, heart disease, lower-limb amputations, and blindness.

For type 2 diabetes, prevention appears to be the name of the game. This form of the disease, which accounts for more than 90 percent of diabetes among adults, often can be averted or delayed by lifestyle factors. The NIH-funded Diabetes Prevention Program (DPP) trial showed that one the most effective ways to lower the risk of type 2 diabetes is through regular exercise and modest weight loss. There is good reason to believe that such efforts may lead to a lifetime of health benefits. A recent follow-up study of DPP participants found the protective effects of weight loss and exercise persist for at least a decade. The United Health Group has recently announced a partnership with Walgreen's and the YMCA to implement the results of this groundbreaking NIH-funded research on a broad scale.

More than one-third of adults in the United States are obese, according to the latest data from the National Health and Nutrition Examination Survey which is conducted by the Centers for Disease Control and Prevention (CDC). And there are signs that the next generation may face an even greater struggle. Over the past 30 years, obesity has more than doubled among U.S. children ages 2 through 5 and nearly tripled among young people over the age of 6. Those statistics translate into tens of millions of Americans who face an increased risk of type 2 diabetes, as well as cardiovascular disease, high blood pressure, certain cancers, osteoarthritis, and other serious health problems associated with excess body fat.

To address America's growing problem with obesity, NIH has launched a variety of initiatives aimed at developing innovative approaches for weight control. One such effort, called the National Collaborative on Childhood Obesity Research, has pulled together experts from four NIH Institutes, the CDC, and the Robert Wood Johnson Foundation. One example of their work is the Trial of Activity for Adolescent Girls, a national study to develop and test school- and community-based interventions to get girls more involved in gym class, organized sports, or recreational activities. Another NIH program, called We Can!, provides families with practical tools for weight control at more than 1,000 community sites nationwide. How to get more people to lose weight is also among the questions being explored by OppNet, a new trans-NIH initiative for basic behavioral and social sciences research.

Meanwhile, other NIH-funded researchers are busy uncovering information about genes and environment that may pave the way for more personalized, targeted strategies for controlling weight and preventing diabetes. For example, in just the past few years, we have identified more than 30 genetic risk factors for type 2 diabetes.

A better understanding of genetic and environmental factors may also help solve a longstanding medical puzzle: the causes of autism. Children with autism spectrum disorders experience a range of problems with language and social interactions, sometimes accompanied by repetitive behaviors or narrow, obsessive interests. Recent studies funded by NIH have associated autism risk with several genes involved in the formation and maintenance of brain cells, but much more work is needed to follow up on these clues.

In fiscal year 2011, NIH will support comprehensive and innovative approaches to piece together the complex factors that contribute to autism spectrum disorders. One ambitious effort will involve sequencing the complete genomes of 300 people with autism and their parents. Other researchers will examine a mother's exposure during pregnancy to identify possible environmental contributions. NIH hopes to use these insights to develop new molecular and behavioral therapies for such disorders, as well as to identify possible strategies for prevention.

Another brain disorder, depression, presents a different set of challenges. Although researchers have made significant progress in understanding the biology of depression, improving treatment, and lessening the social stigma associated with mental illnesses, suicide still claims the lives of twice as many Americans as homicide. And it does not end there—untreated depression also increases the risk of heart disease and substance abuse.

How can medical research reduce depression's tragic toll? One way may be getting people into treatment more quickly. Researchers today are using functional magnetic resonance imaging and other innovative technologies to see how the brains of people with depression differ from those without the disorder. Rapid diagnosis is just part of the equation. Finding the right antidepressant drug for any particular patient currently is a lengthy, trial-and-error process that can take weeks before symptoms are relieved. NIH supports laboratory research aimed at developing quicker-acting antidepressants, as well as genetic studies that will help to match individuals with the drugs most likely to work for them.

In 2008, 143 soldiers died by suicide—the highest rate since the Army began keeping records three decades ago. To address this problem, NIH and the U.S. Army recently partnered to launch the largest study ever of suicide and mental health among military personnel. The Army Study to Assess Risk and Resilience in Service Members will identify risk factors that may inform efforts to develop more effective approaches to suicide prevention.

TRANSFORMING DISCOVERY INTO HEALTH

Whatever the disease, be it depression, diabetes, or something much rarer, NIH's emphasis in fiscal year 2011 and beyond will be on translating basic discoveries into new diagnostic and treatment advances in the clinic.

In the past, some have complained that NIH has been too slow to convert fundamental observations into better ways to diagnose, treat, and prevent disease. Al-

though some of that criticism may have been deserved, most of the delay has stemmed from the lack of good ideas about how to traverse the long and winding road from molecular insight to therapeutic benefit.

That is now changing. For many disorders, there are new opportunities for NIH to shorten and straighten the pathway from discovery to health. This expectation is grounded in several recent developments: the dramatic acceleration of our basic understanding of hundreds of diseases; the establishment of NIH-supported centers that enable academic researchers to use such understanding to screen thousands of chemicals for potential drug candidates; and the emergence of public-private partnerships to aid the movement of drug candidates identified by academic researchers into the commercial development pipeline.

Let me give you one example of how NIH plans to implement this strategy: the Therapeutics for Rare and Neglected Diseases (TRND) program. This effort will bridge the wide gap in time and resources that often exists between basic research discoveries and the human testing of new drugs.

A rare disease is one that affects fewer than 200,000 Americans. However, if all 6,800 rare diseases are considered together, they afflict more than 25 million Americans. Private companies seldom pursue new therapies for these types of diseases because of the high cost of research and low likelihood of recovering their investments. Effective drugs exist for only about 200, or less than 3 percent, of rare diseases. Unlike rare diseases, neglected diseases may be quite common in some parts of the world, especially in developing countries. However, there also is a dire shortage of effective, affordable treatments for many of these major causes of death and disability.

Working in an open environment in which all of the world's top experts on a disease can be involved, TRND will enable certain promising compounds to be taken through the preclinical development phase—a time-consuming, high-risk phase often referred to as "the valley of death" by pharmaceutical firms focused on the bottom line. Besides speeding development of drugs for rare and neglected diseases, TRND will serve as a model for therapeutic development for common diseases, many of which are being resolved into smaller, molecularly distinct subtypes.

NIH will also take other steps to build a more integrated pipeline that connects all of the steps between identification of a potential therapeutic target by a basic researcher and the point when the FDA approves a therapeutic for clinical use. Among the tools at our disposal is the NIH Clinical and Translational Sciences Award program, which currently funds 46 centers and has awardees in 26 States and plans to add even more in fiscal year 2011. This national network is pulling together interdisciplinary clinical research teams to work in unprecedented ways to develop and deliver tangible health benefits. We also need to take advantage of the Nation's largest research hospital, the Mark O. Hatfield Clinical Research Center, located on the NIH campus in Bethesda, Maryland. Just as they blazed a trail for safe and effective human gene therapy, NIH clinical researchers may be well-positioned to move the ball forward for other pioneering approaches, such as those using human embryonic stem cells or induced pluripotent stem cells derived from skin cells.

To make the most of these new opportunities, the NIH and FDA recently forged a landmark partnership with the formation of a Joint Leadership Council. Members of this Leadership Council will work together to ensure that regulatory considerations form an integral component of biomedical research planning, and that the latest science is integrated into the regulatory review process. Such collaboration will advance the development of products to treat, diagnose and prevent disease, as well as enhance the safety, quality, and efficiency of clinical research and medical product approval.

BIOMEDICAL RESEARCH PROPELS U.S. ECONOMY

It is crucial to keep in mind that investing in NIH not only improves America's health and strengthens our Nation's biomedical research potential, it empowers the entire U.S. economy. Consider the following statistics:

—A report issued by Families USA calculated that in 2007, every $1 in NIH funding resulted in an additional $2.11 in economic output in the United States.

—In fiscal year 2007, a typical NIH grant supported the salaries of about 7 high-tech jobs in full or in part.

—The 351,000 jobs resulting from NIH awards paid an average annual wage of more than $52,000 per annum and account for more than $18 billion in wages for fiscal year 2007.

—Long-term, NIH-funded R&D sparks U.S. economic innovation in the high-technology and high value-added pharmaceutical and biotechnology industries. For

example, between 1982 and 2006, one-third of all drugs and nearly 60 percent of promising new molecular entities approved by the FDA cited either an NIH-funded publication or an NIH patent.

—Gains in average U.S. life expectancy from 1970–2000 were worth an estimated $95 trillion.

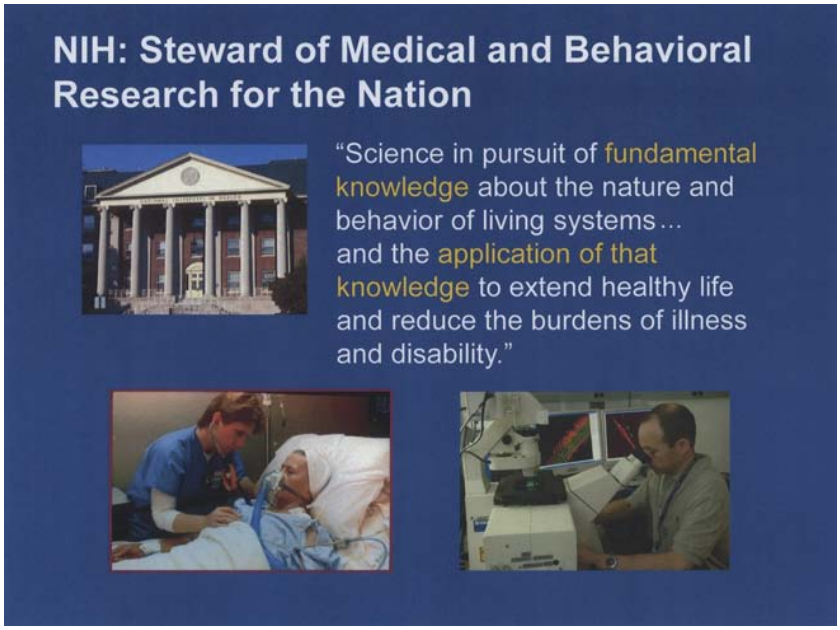
IMAGINE THE FUTURE

If our Nation is bold enough to act today upon the many unprecedented opportunities now offered by biomedical research, we may be amazed at what tomorrow will bring.

In the world I envision just a few decades from now, we will use stem cells to repair spinal cord injuries; bioengineered tissues to replace worn-out joints; genetic information to tailor health outcomes with individualized prescriptions; and nanotechnology to deliver therapies with exquisite precision. I also dream of a day when, in ways yet to be discovered, we will be able to prevent Alzheimer's, Parkinson's, and other diseases that rob us much too soon of family and friends.

Just imagine what such a future would mean for our Nation and all humankind. This is what keeps NIH in the research marathon, and why we ask you to go the distance with us.

Thank you Mr. Chairman.



Kate's Story

- Diagnosed at age 44 with metastatic lung cancer
- Cancer spread after surgery, radiation, and chemotherapy
- Participated in a clinical trial testing Iressa™ (gefitinib), a new genome-based drug for cancer

The NEW ENGLAND JOURNAL of MEDICINE

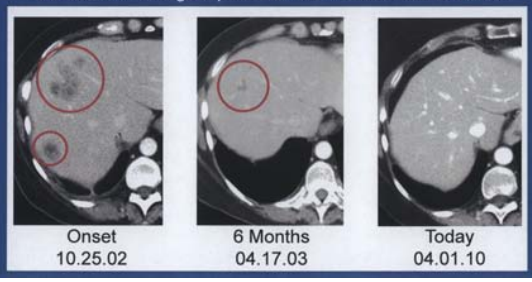
MAY 20, 2004

Activating Mutations in the Epidermal Growth Factor Receptor Underlying Responsiveness of Non–Small-Cell Lung Cancer to Gefitinib

Personalized Cancer Treatments

- Kate's metastases shrank; now undetectable in lungs, liver, pancreas
- Why doesn't Iressa work in all cases?
  - Response depends on specific mutation in *EGFR* gene
- Demonstrates the potential of personalized medicine

CT scans showing response of liver metastases to Iressa



Onset 10.25.02 | 6 Months 04.17.03 | Today 04.01.10

Corey's Story

- Leber's congenital amaurosis is caused by a mutation in the *RPE65* gene
- Corey was legally blind by age 7
- Gene therapy procedure was performed in one eye
- Corey's eyesight is returning

Using the untreated eye

Using the treated eye

Leslie's Story

- Tried to stop smoking a number of times
- Four years ago, she enrolled in a NicVAX Phase 2 clinical trial …
  - Stimulates production of antibodies to nicotine
  - Bound nicotine cannot enter brain, subverting rewarding effects
- Leslie's results: "To this day, I haven't smoked a cigarette since. I don't want one."

NicVAX Phase III Trial

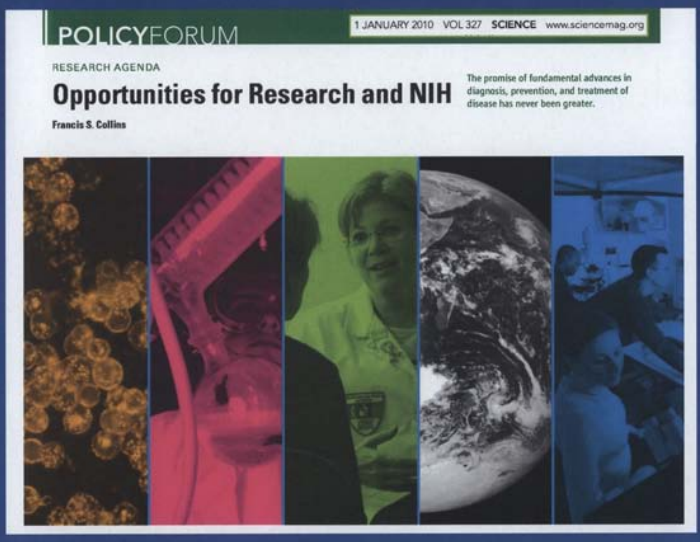
- Involves 1,000 smokers at 20 centers around the U.S.
- NIH Recovery Act funds ($10 million) are helping pay for the trial
  - Vaccine rooted in NIH-funded basic research
  - First-ever phase III trial of a smoking cessation vaccine

CLINICAL TRIALS

CLINICAL PHARMACOLOGY & THERAPEUTICS
2005;78(5):456-67

Safety and immunogenicity of a nicotine conjugate vaccine in current smokers

Dorothy K. Hatsukami, PhD, Stephen Rennard, MD, Douglas Jorenby, PhD, Michael Fiore, MD, MPH, Joseph Koopmeiners, Arjen de Vos, MD, PhD, Gary Horwith, MD, and Paul R. Pentel, MD *Minneapolis, Minn, Omaha, Neb, Madison, Wis, and Rockville, Md*



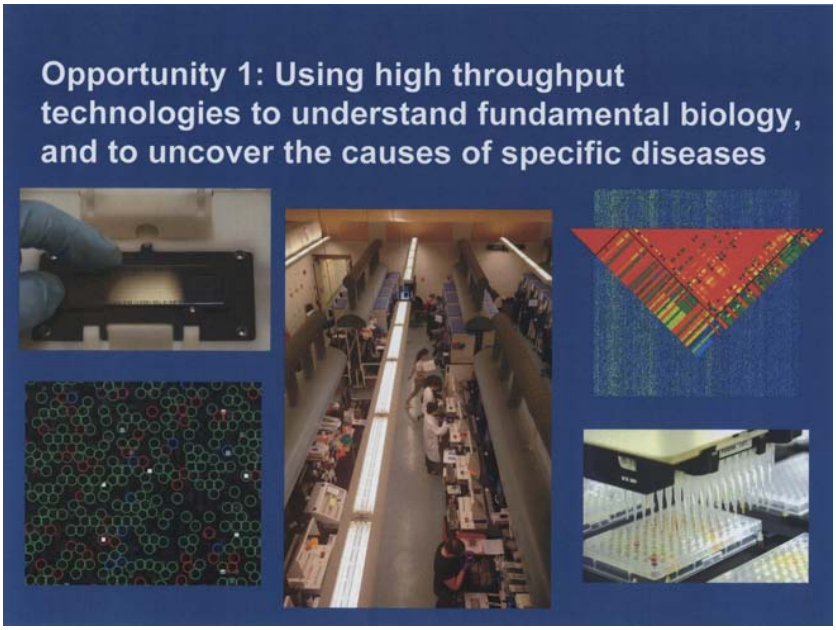
POLICYFORUM
1 JANUARY 2010 VOL 327 SCIENCE www.sciencemag.org

RESEARCH AGENDA

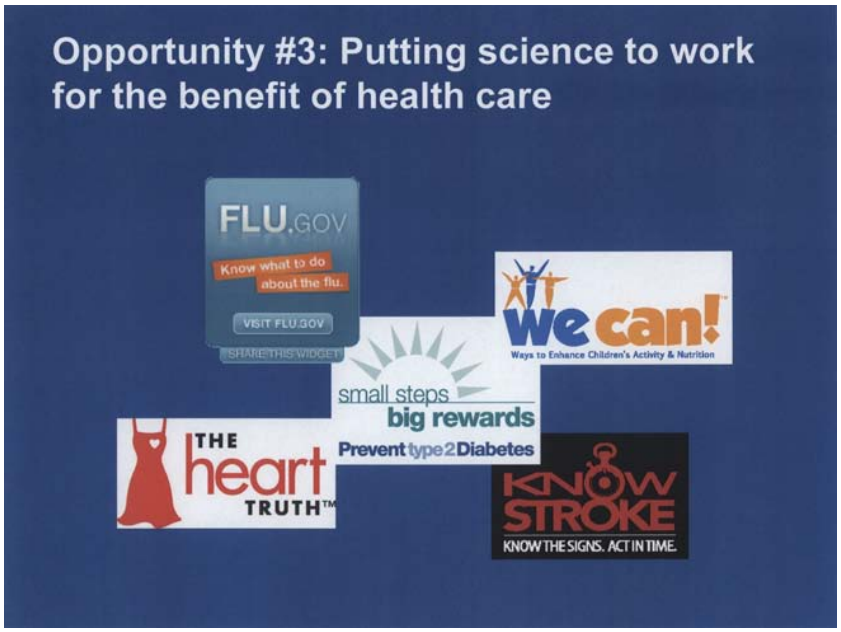
Opportunities for Research and NIH

The promise of fundamental advances in diagnosis, prevention, and treatment of disease has never been greater.

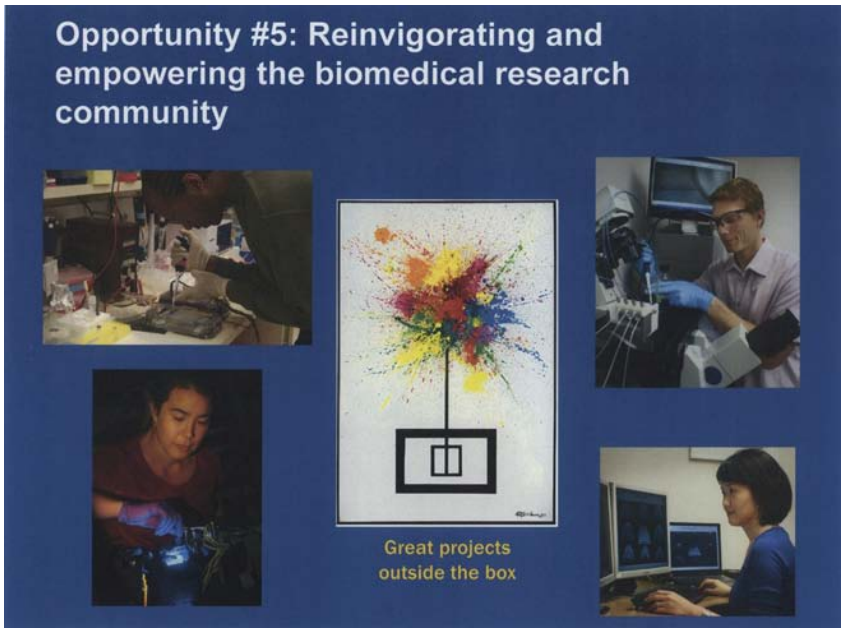
Francis S. Collins


Opportunity 1: Using high throughput technologies to understand fundamental biology, and to uncover the causes of specific diseases


Opportunity #2: Translating basic science discoveries into new and better treatments
Basic Research
Drugs
Drugs
Basic
Research


Opportunity #3: Putting science to work for the benefit of health care
FLU.GOV
Know what to do about the flu.
VISIT FLU.GOV
SHARE THIS WIDGET
we can!
Ways to Enhance Children's Activity & Nutrition
small steps
big rewards
Prevent type 2 Diabetes
THE heart TRUTH™
KNOW STROKE
KNOW THE SIGNS. ACT IN TIME.


Opportunity #4: Encouraging a greater focus on global health
DISEASE CONTROL PRIORITIES PROJECT
HOME | PUBLICATIONS | CUSTOM BOOKS AND SLIDES | NEWS AND EVENTS | TOOLS AND RESOURCES
Tropical Diseases Lacking Adequate Control Measures: Dengue, Leishmaniasis, and African Trypanosomiasis
Depression
Leading cause of disability worldwide...
World Health Organization
nature
MALARIA PARASITES



NICVAX SMOKING VACCINE

Senator HARKIN. Well, Dr. Collins, thank you very much.

I asked my staff to get me some more information on that smoking vaccine. It's just something I had not heard about. That could be phenomenal.

[The information follows:]

SMOKING VACCINE

Tobacco remains the leading cause of preventable death in the United States, linked to more than 400,000 deaths each year. That is why the National Institutes of Health is accelerating research to eradicate tobacco addiction, including working with a private partner, Nabi Biopharmaceuticals, via a $10 million grant from the National Institute on Drug Abuse, to achieve that goal.

American Recovery and Reinvestment Act (ARRA) funding released in September will help pay for the first phase III trial of NicVAX, a smoking cessation vaccine designed to help people quit and remain abstinent. It was given fast track designation by the Food and Drug Administration and has already successfully completed a proof-of-concept trial; successful completion of the phase III study will bring the vaccine closer to final approval.

As a result of ARRA funding, Nabi entered an agreement with GlaxoSmithKline to receive an additional $40 million to exclusively in-license NicVAX on a worldwide basis and develop follow-on, next-generation nicotine vaccines, with the possibility of additional $500 million depending on the outcome of the trial. This work is an excellent example of leveraging Government resources to further develop and market a medication for tobacco addiction.

Similar to vaccines for infectious diseases, NicVAX works by stimulating the immune system to produce antibodies; in this case, however, to the drug nicotine. Nicotine (a small molecule) normally travels quickly through the lungs into the bloodstream and then to the brain. However, when nicotine molecules are bound to antibodies, they become too large to enter the brain, thus subverting the behavioral effects of the drug. Results to date show that smokers who achieved high antibody levels had higher rates of quitting and longer stretches of abstinence than those given placebo (18 percent vs. 6 percent complete abstinence after 52 weeks). The vaccine was also well tolerated, with few side effects.

NicVAX's unique immunological mechanism of action elicits anti-nicotine antibodies lasting for several months—a potential benefit over current therapies. Early results showed that it reduced craving and withdrawal symptoms, which often prompt relapse. This should improve smokers chances to end the addiction/relapse cycle that plagues the great majority of those trying to quit.

A successful phase II proof-of-concept trial was completed in late 2007, in which NicVAX showed significant improvement in smoking cessation rates and continuous long-term smoking abstinence compared to placebo, in those who achieved high antibody levels. For the phase III trial, modifications were made to the original protocol to improve the likelihood of success. An additional vaccination was added and the timing of the quit attempt was modified to coincide with the optimal level of antibody response. Twenty-two investigative sites have been selected, and include highly experienced academic-based smoking cessation centers and experienced nonacademic sites. The study will enroll 1,000 subjects who want to quit smoking. They will be randomized to 1 of 2 treatment groups: (1) placebo control or (2) active vaccine treatment.

Participants will be followed for 1 year from the start of immunization. The study's main goal is to determine the percentage of those who are abstinent during the final 16 weeks of the study (weeks 37–52). Other endpoints include safety, withdrawal symptoms, craving, cigarette consumption, evaluation of the smoking experience, short-term cessation rates after each injection, and assessment of abstinence.

Recruitment for the phase III trial is on target and the study is going well. Final data are expected within 2 years of study start, which was in November 2009.

Dr. COLLINS. Yes, indeed.

Senator HARKIN. I mean, from prevention we know what smoking leads to, and all the diseases it leads to, and the cost to society. And most people I meet that have been on smoking want to stop, but they just have a tough time.

Dr. COLLINS. They do, indeed.

Senator HARKIN. So, this could be remarkable. Do you know when—how—that trial is ongoing right now?

Dr. COLLINS. It's ongoing, reasonably recently started. I can find out for you the expected end date of the trial, but they're certainly pushing this forward with all due speed.

[The information follows:]

To find the recent clinical trials go to: http://www.cancer.gov/clinicaltrials/lung-cancer-updates.

Senator HARKIN. Now, let me ask you this, Doctor——

Well, let's start a 6-minute round? Is that what we have, here? Who's operating my clock? There we go. Okay, fine.

Dr. Collins, I noticed, on the funding, here, for next year, how some Institutes go up by 3.2 percent, some by 2.5 percent, some by 2.8 percent, some by—and they're all over the place. I assume they are some of these differences accounted for by focusing on those thematic areas that you just mentioned, those five theme areas? Is that what is driving that now?

Dr. COLLINS. That's exactly right.

Senator HARKIN. What——

Dr. COLLINS. Those five themes seem to be areas of exceptional opportunity. When we looked at the investments of the various Institutes in those areas a couple of years ago—which is not a perfect, but a somewhat good predictor of what might be possible in fiscal year 2011—it was clear that those opportunities are not entirely evenly distributed. And so, recognizing that that $1 billion, although it's only going to keep up with inflation, still ought to be invested in innovative ways, we attempted to do some arranging of the budget to reflect that, and that's what you see in those differences between Institutes. They're modest, but they are impor-

tant, I think, to point out, that we're not just doing everything in lockstep.

Senator HARKIN. Well, one has to always be careful when you're dealing in percentages.

Dr. COLLINS. Yes.

Senator HARKIN. As I've often pointed out, zero-to-one is an infinite increase. So, sometimes those that get very little funding, to get them up a little bit, looks like it's a huge percentage increase. So, I always want to be careful and look at the percentage increases there.

Dr. COLLINS. Point taken.

Senator HARKIN. Well, for instance, the Library of Medicine has 4 percent. Well, but it's so small, line of increase amounts for that. So, I always like to look at that very carefully.

Dr. COLLINS. You're quite right, Senator.

FISCAL YEAR 2010 AND POST-ARRA

Senator HARKIN. The other one I wanted to get into, here, with you is on the funding cliff. So, we put the money in the ARRA. At the time, it was decided that we'd put that in, it was a 2-year slug of money for at least the following reasons: one, because we didn't want researchers being laid off; we wanted to keep people employed. A lot of researchers were in the middle of projects and studies that we did not want to interrupt. But, we knew that we were probably going to face this, 2 years from now. So, I guess my question is, What kind of challenges are you facing? How do you provide for this soft landing? Are we facing any interruptions at all—in terms of some science that's being done right now because of this cliff?

Dr. COLLINS. So, Senator, this is the question that keeps me up at night. On the screen there, you'll see what the total funding for NIH has been over the last 10 years, and those red bars there are the dollars that came from the ARRA, which we are deeply grateful for, and which provided a real shot in the arm for some exciting, innovative research that, otherwise, would have had to wait a long time to get started; things like the Cancer Genome Atlas, for instance, which really was able to move forward at an unprecedented pace because of the availability of those funds.

But, as you can see, the difference between fiscal year 2010, total, when you include the $5.2 billion of ARRA dollars, compared to the President's budget for fiscal year 2011 is certainly a drop, and that's the cliff that everybody talks about, right there, about $4 billion.

Senator HARKIN. Right.

Dr. COLLINS. We have done what we can, in anticipation that this might be a really challenging year, to try to be sure that the ARRA dollars were invested, as much as possible, in short-term needs. So, for example, $1 billion of this has gone to construction in the extramural community. Additional dollars have gone to equipment needs, things that were one-time requirements. And some dollars have gone to projects that we thought we could get done in 2 years, although that's a very short cycle time for a scientific project.

But, we also felt that this was an opportunity to stimulate some real innovations and to get people to put forward some out-of-the-box ideas; and they did, in huge numbers. The Challenge Grants, for example, we thought we might get 4,000 applications; we got 20,000. There was a great pent-up need here for support for new ideas. And many of those are, in fact, funded and will have, now, the question in their minds, "What do we do after the 2 years is expended?"

One thing we are doing is to encourage those who believe that they can't quite finish their project and they haven't quite spent all the money in 2 years, to ask for a no-cost extension, and we will consider those quite seriously. And if it seems reasonable, and they're making reasonable progress, we will grant that, so at least to stretch out this cliff a little bit.

But, there's no question that the consequences of this situation are going to be significant. We currently estimate success rates for NIH grantees—which have been in the 25 to 35 percent level for most of the last 30 years, and are now at 21 percent, are going to drop further in fiscal year 2011, at this budget level, probably to about 15 percent. That's one chance out of seven that a given grant would get supported. And there's no question that is going to be stressful for all of us.

Senator HARKIN. That's not good.

Well, we've been wrestling with this, ourselves. I am of the opinion that we need to do more at NIH. The question is, Where do we get the funding and—with all of the other things that the Appropriations Committee has to do, and with budget constraints? But, we'll see what we can do.

I want to get one question—well, I'm down to zero. I'll ask the question after Senator Cochran gets through with his.

Senator Cochran.

DISCOVERIES ON THE HORIZON

Senator COCHRAN. Mr. Chairman, thank you very much.

Dr. Collins, thank you again for being here and helping us review the budget request and pointing out your views of how we should identify the priorities and the most important ways we can use the funds available to this subcommittee.

We know that you're a research scientist, and you've been rewarded with a lot of recognition, medals, and honors, because of the outstanding research you have done, and it reminds me of Dr. Arthur Guyton's success as a researcher at the University of Mississippi Medical Center. The University continues to perform research there. And although he's no longer with us, he had a fascinating and very influential impact on heart disease and its understanding and therapies to help people live longer and have better lives.

Is there anything going on in the research field right now that rivals the work you, personally, did and were praised so highly for, and Dr. Arthur Guyton, as well? Do we have any, really, blockbuster researchers out there that you've identified in helping us provide funding for?

Dr. COLLINS. Well, yes, I'm happy to tell you, there is an amazing cadre of creative, innovative, productive scientists now involved

in biomedical research. I certainly agree that Dr. Guyton was a legendary character. I studied his book when I was in medical school; that's how I learned a lot about physiology and about the heart.

And when you look around today—well, you could count Nobel Prizes, I suppose. NIH has been the source of support for no less than 131 Nobel Prizes over the last few decades. And, in fact, this past fall, when the Nobel Prizes were given out, both for medicine and for chemistry, of the six awardees, five of them were our grantees. Remarkable people, people like Liz Blackburn and Carol Greider, who were awarded the prize for discovering telomeres and the enzyme that maintains those ends of the chromosomes, so they don't get ratty, like your shoelaces, if you didn't have some way to protect those ends. Remarkable stories, all of those.

Many of them coming from a direction you couldn't have predicted, but one of the wonders of the way NIH has been able to support research is that we base our decisions, many of them, on what comes across to us by investigators with ideas that go through the most rigorous peer-review system in the world, and then are given the funds to chase after those ideas.

A new program that we're investing in, called the Pioneer Awards, is particularly trying to identify those very creative individuals who we could unleash to follow their ideas, and not have them quite so constrained by the systems that sometimes are in place, that—we need to track research, but there are times where you want to let somebody just go for it. And we're determined to use those kinds of mechanisms and things like New Innovators to make that happen.

In that—particular areas that NIH is supporting, I will mention cancer, because I think we are, actually, at a remarkable moment, in terms of being able to understand, at that most detailed DNA level, what goes wrong in a cancer cell; not just some of the things, but all of the things that go wrong in a cancer cell. Why does a good cell go bad? And what could we use as—with that information, to develop therapies that are targeted—like Kate Robbins, the case I told you about—specifically toward their tumor? That was a pipedream 5 or 6 years ago. Now it is absolutely transforming people's ideas of how to go forward. And the researchers working on that—many of them 20-somethings, many of them with computational backgrounds, because a lot of the challenge now is to figure out how to analyze the mountains of data that can be produced. They are remarkable to hang out with.

So, I'm actually quite inspired by our cohort of researchers. My concern is, we need to be sure we're giving them the confidence that that support is going to be there, so that they stick it out and are willing to take risks and not just do the obvious next steps.

JACKSON HEART STUDY

Senator COCHRAN. One of the undertakings in our State is the Jackson Heart Study, which has been a comprehensive review of the individual medical histories of people who have heart problems, and seeing if we can identify factors that can be changed or corrected to help us do a better job of providing opportunities for healthy lives, rather than a destiny that is more likely to involve heart problems. What is the status of that study? And are you re-

questing funding, in this budget request, to continue or go forward from that study to something else?

Dr. COLLINS. We are very enthusiastic about that study, Senator, and delighted by your strong support of this from the beginning. So, this is carried out in Mississippi, in Jackson, with the University of Mississippi and Tougaloo College participating. NIH has a big role in this, supported by the National Heart, Lung, and Blood Institute (NHLBI). And already, a lot of very important observations have come forward studying, particularly, cardiovascular disease in African Americans, about which we didn't know enough, and now we're starting to learn.

So, for instance, we're learning that hypertension and obesity and diabetes, the three of those together, the so-called "metabolic syndrome," occurs at phenomenally high rates in this group. We're also learning that even individuals of normal body weight have a higher incidence of hypertension and diabetes in this group, and that's a puzzle, and a question is trying to be answered now: Is that diet? Is that environment? Is that genetics? We have to figure out what are those causes, because obviously these are diseases that have a great deal of consequence, in terms of heart disease and strokes.

We are learning that this kind of gathering together is also a great way to get community involvement. And the ways in which the Jackson Heart Study has embraced the community, and been embraced by the community, is a wonderful model for doing research on health disparities.

The funding for 2011 for the Heart Study is very much a part of this budget, and the NHLBI intends to continue that at least through 2013. At that point, they will be evaluating what progress has been obtained. But, everything I have heard from the leadership is, they're—they expect to continue this for a long time.

Senator COCHRAN. Well, thank you very much.

Thank you, Mr. Chairman.

INSTITUTE OF MEDICINE (IOM) REPORT ON CLINICAL TRIALS

Senator HARKIN. Thank you, Senator Cochran.

I've got two or three things I'd like to follow up on, here.

Dr. Collins, last year President Obama vowed to find, quote, "a cure for cancer in our time." But, I remember when President Nixon declared a war on cancer. They've been fighting that thing ever since. So, while I appreciate the President's vow, I just wonder if we're going in the right direction.

Now, you've come up with some things here that give us a lot of hope, but, just recently, the IOM issued a report that was very critical of the National Cancer Institute's (NCI) Clinical Trial Network (CTN). According to the IOM, the CTN is underfunded, and is approaching, "a state of crisis." Most disturbing of all, about 40 percent of its cancer trials are never completed, which might suggest that we're wasting valuable time and money.

So, again, I want to give you the opportunity to respond to that. The IOM report found that the CTN is too bureaucratic, its research is poorly coordinated. Due to cumbersome review procedures, the average time between developing an idea for a trial and getting it started is about 2 years. Another problem they pointed

out was the distressingly low participation rate of adults in clinical trials. So, I wanted to kind of go over that with you and how are you responding to this IOM study.

Dr. COLLINS. Senator, I think all of us are quite concerned about this situation. Certainly, I've studied that IOM report carefully and talked to the leadership at the NCI about this. The cooperative groups, 10 of them, that have been conducting clinical trials on cancer for as long as 50 years, have certainly produced wonderful data over the course of time. But, there's no question that the current system is not functioning as well as it should. And that's what this report pointed out.

I should mention that it was Dr. Niederhuber and the leadership of the NCI that asked for the IOM to look at this, so they were fully aware of the need for some changes, and asking IOM to help out with this, and are now, I think, embracing that report and already moving forward to try to make such changes.

Clearly, there are a number of serious issues here. One is the very long time, as you've mentioned, between the time when a protocol is conceived and when the first patient is enrolled. And that had stretched out to 2½ years. Well, here we have a field that's moving so quickly, by the time you get to the point of enrolling a patient, sometimes the protocol didn't seem like one that you would really want to support at that point. So, that timetable has to be shortened. NCI has moved forward, now, to make changes that will limit that to 1 year, and no more.

And obviously, part of this is our own system of trying to run multicenter trials, which has gotten really quite convoluted and complicated, in the sense that, particularly, for human-subjects approval, every center has its own IRB, and the IRB has to review the consent form. And if you're trying to run a trial that involves dozens of centers, and every IRB wants to tweak things a little bit, you can see how time passes and you don't end up with things getting underway very quickly.

Senator HARKIN. Why can't——

Dr. COLLINS. Furthermore, there may be——

Senator HARKIN. Why don't we consolidate that?

Dr. COLLINS. Well, exactly. We need central IRBs, and there is a major move underway to implement that. It has been, I think, delayed by the fact that many legal minds have been involved, saying that institutions shouldn't really deem anyone other than their own IRB as capable of reviewing——

Senator HARKIN. Do we have to do anything legislatively, Dr. Collins?

Dr. COLLINS. I think this actually can be handled without legislation. I will tell you, there's a great groundswell now, not just from cancer, but from many other areas of clinical research, to do something to streamline our human-subjects effort, that we are not really, in every instance, using this in a way to protect participants in research, but we've gotten all tangled up in the bureaucracy. And sometimes we are mixing up the things that are really high risk with things that are very low risk. And we need a revamping there. And I think this is something that's going to get attention quite soon.

Other areas—there's a problem, in some instances, where protocols may be run in too many centers, and each center is only enrolling a very small number of patients. And so, it's not an efficient way to do things.

There may not be a sufficient evaluation of whether a protocol is actually the best use of the money for that disease at that point. There needs to be more of a scientific rigor in the process.

All of those are accepted, now, I think, by the NCI.

There will be new leadership of the NCI; an announcement of that sort is imminent. And I am sure the new NCI Director will take this on as a very high priority, to try to understand how best to re-engineer this CTN, because this is critical for our future. We're going to have a much higher throughput of new molecular entities coming forward from this molecular understanding of cancer, and we have to have an engine in place to test them and see what works and what doesn't. So, this could not be more important, and I appreciate your raising the issue.

ALZHEIMER'S DISEASE

Senator HARKIN. Well, thank you. I have a couple more. I had a question that has to do with Alzheimer's, but maybe a little bit broader than that.

A panel, convened by NIH, issued a finding, last month, that left a lot of people confused, I think, about Alzheimer's. According to this panel, there is no evidence that any of the strategies that people have been told to use to prevent Alzheimer's actually makes any difference. That includes getting exercise, taking supplements, keeping your mind active, doing crossword puzzles, and so forth. According to this panel, there's no evidence that any of these measures prevent you from getting this disease.

So, one question on that would be how we interpret a finding like that. The other question about Alzheimer's has to do with a broader level of funding, and how we think about funding for different diseases.

But, let's focus on this one, first, about the finding. What do we tell people? How do we interpret this finding?

Dr. COLLINS. Well, I think there have been a lot of messages out there that people were confused by—what works, what doesn't work. The whole point of the NIH panel was to actually look at the evidence and try to see, What do we objectively know about measures that could be used to delay or prevent this disease? Because this is a disease that affects, obviously, very large numbers of people, and we're all concerned about it. I just turned 60; I'm thinking about this more than I used to.

And, basically, all of the things that were put forward as potentially being beneficial in reducing the risk haven't held up very well to rigorous scientific evaluation. It looks as if doing crossword puzzles or doing Sudoku, it makes you better at doing crossword puzzles and doing Sudoku.

It isn't clear that there's evidence it has a more global effect, in terms of protecting your mental capacities as you're getting older.

The one exception that they thought perhaps there was some evidence for is diet, and particularly Omega-3 fatty acids, which are something that you find in fish. And there is some data supporting

that as a possible preventive measure, and that one deserves more study. But, it was one bright light.

And then, of course, there are well-documented environmental influences that we know about. Smoking, for instance, is clearly a risk factor for Alzheimer's, as well as a long list of other things. And certainly, obesity seems to have a connection, as well.

But, in terms of the specific mental exercises, which I think was one of the disappointments for a lot of people who hoped that that would be a way that you could take control of the situation and help yourself, there didn't seem to be evidence to support that.

Senator HARKIN. Thank you.

Senator Cochran.

INSTITUTIONAL DEVELOPMENT

Senator COCHRAN. Mr. Chairman, thank you.

We were talking, in my first round of questions, about the University of Mississippi and the legacy of Dr. Arthur Guyton. One thing that this subcommittee decided to do a few years ago was to earmark—oh, heaven forbid—some money, in this particular bill, and target the funding for grants and research to institutions in States that were getting less money and less attention to their work and applications than many other States had—which had long records of success and notoriety in certain areas.

Now, the University of Mississippi Medical Center, it was benefited greatly from one person's influence—Dr. Arthur Guyton. We talked about that. But, there are other institutions—within small States, in particular—who just come out on the short end of the stick when they apply for grants and try to get Federal support for work they're doing. Some of the ideas may be good, but the money is just never—never finds its way to those institutions.

So, we set aside, in fiscal year 2009, $224 million in a program designated for Institutional Development Awards. The purpose of that is to spread the money out in areas that would not, probably, be seriously considered for grants, finding and looking for the activities and the research that's being done, and having national impact and importance.

I guess my question is—Mississippi received $5 million—a little over—of the amount appropriated. That's only 2.4 percent of the total, so it's not like we out-maneuvered everybody; we didn't. But—and I guess that's the reason for my question. Some States do better than others in this, and I was just wondering, Is there any way for—a more careful review can be made to be sure that the intent of the set-aside is carried forward and that some States are not treated too much better than everybody else, so—the consequences of being left out?

Mississippi shares 2.4 percent, for example. That doesn't sound like much to me. What are your thoughts about how we could better define what this money is for to make sure it carries out the intent of the Congress?

Dr. COLLINS. Well, thank you, Senator.

So, yeah, the Institutional Development Awards (IDEA), have been strongly supported by NIH. They're administered by the National Center for Research Resources. And, yes, the budget for fiscal year 2010 was—went up $229 million. These are competitive,

they are available to the States who are identified as IDEA States, one of which is Mississippi, but there are a number of others that are traditionally underfunded by NIH, oftentimes because they have a lower proportion of institutions that are heavy in research efforts. But, we felt that we needed to be sure—we were finding opportunities in those States, and that those States had opportunities for NIH funding.

There are a couple of specific programs: The Centers of Biomedical Research Excellence, COBRE, or "Cobra," is one. There's an IDEA Network of Biomedical Research Excellence, INBRE. And, in fact, most of the States in the IDEA Network have been applying for those, and many of them with considerable success. But, it is a competitive program, where the peer-review system kicks in. And so, because of our interest in making sure that, with the funds available, we support what seems to the experts, who are not biased toward any particular State, but are trying to identify the best use of the money—we have to see where those outcomes fall.

Another program, though, that is, I think, relevant, here, is actually the ability, through the ARRA, to support construction efforts that have been asked for in the IDEA States. And Mississippi recently received such a construction grant; Arkansas did. In fact, a number of the IDEA States, for this $1 billion of construction money, that were part of the ARRA, have been quite successful. And we're delighted to see that, because that may be a way, then, to build that capacity, so that, in the coming years, they'll be in an even better position to be highly competitive for these funds.

Senator COCHRAN. Thank you very much.

Senator HARKIN. Senator Specter.

STATEMENT OF SENATOR ARLEN SPECTER

Senator SPECTER. Thank you, Mr. Chairman.

Dr. Collins, I join my colleagues in welcoming you here. Thank you for taking on this important job.

My view, as expressed repeatedly, is that the National Institutes of Health are the crown jewels of the Federal Government—perhaps the only jewels. And in an era where we are searching for ways to prolong lives, save lives, and save money, it seems to me that we ought to be funding NIH a lot more aggressively than we are.

Senator Harkin and I led the way, with Senator Cochran's concurrence, and others, to raise NIH funding from $12 to $30 billion, $10 billion more than the stimulus. And the stimulus, I have heard, has created a whole wave across America of a—may the record show the witness is nodding in the affirmative——

Dr. COLLINS. Yes, he is.

CAN

Senator SPECTER [continuing]. Great surge of enthusiasm and rekindled a lot of interest in young people, who had been very much concerned because the funding had tapered off. There had been a loss of real dollars—in excess of $5 million—when we had to—accommodated for cost of living adjustments and also some across-the-board cuts.

And last year's funding was disgraceful, at $772 million. And this year's funding is also disgraceful, in my opinion, at $1 billion, with the comment made, "Well, you got $10 billion before," but it wasn't meant to lessen the annual funding. So, I'm going to repeat a message to you, which I have made frequently; that is that the scientific is going to have to become a lot more politically active blowing your horn. The statistics are very impressive as to what the increased funding did for NIH on mortality rates, on strokes, and much progress on many strains of cancer, and heart disease, and right down the line. And I think what you have to do, for the Congress and for the administration, is show how many dollars it saves.

Senator Harkin has been a real leader here on what he has done on wellness, the new concept, the Harkin Wellness Doctrine, a little exercise and annual exams and catching off ailments before they become chronic and debilitating and expensive. A lot of money to be saved by research; tremendous amounts of money to be raised by research.

And your medical communities have gotten a lot of money. University of Pittsburgh has gotten $4 billion in the last decade. And it's so across the country. You got a lot of prominent people on those boards, politically influential people. And appropriations run on politics, on the pressure. You've got a great case, but it hasn't been expressed very well. And I don't fault Dr. Zerhouni or the prior—he was a great director——

Dr. COLLINS. I agree.

Senator SPECTER [continuing]. And staffed by great people.

Now, I understand that you convened a meeting of your 27 Institutes to talk about CAN, which is new. And it has been put forward to bridge the gap, so-called valley of death, as I've heard it expressed in the scientific community, between the bench and bedside, between research and practical application. It has an authorization of $500 million, not a whole lot of money for that kind of a project, but what is—first of all, can you confirm the meeting that the 27 Institutes got together on CAN and what was the thrust of the conversation?

Dr. COLLINS. Well, thank you, Senator. And let me, first, say how appreciative your leadership has been over these years in supporting the cause of biomedical research, and particularly the critical role you've played for NIH support, including the ARRA funding, which, as you've alluded to, provided a remarkable shot in the arm for the research community and is being spent, I think, in truly exciting ways.

With regard to the CAN, this part of the healthcare reform legislation, as you know, puts forward a proposal of having the NIH take on, in new and flexible ways, the acceleration of the process of going from a basic science discovery to a clinical advance; a drug therapy, most likely, but this would also apply to other kinds of clinical advances. We did discuss this last Thursday, all of the Institutes' directors together for a full-day retreat.

Senator SPECTER. I heard there was a lot of enthusiasm for it.

Dr. COLLINS. There was a lot of enthusiasm. People were delighted about the potential, here, because the science has reached the point of making this a real possibility. Not that NIH would be-

come a drug development company, but the partnerships that we could now establish between NIH and the private sector through this kind of legislation are really exciting and unprecedented and are being very well received, both by the academics and people in companies.

Senator SPECTER. What is your professional judgment as to the kind of priority attention that the CAN ought to receive?

Dr. COLLINS. From my perspective, this is one of the five themes that I published in Science magazine as being most worthy of high-priority attention. The CAN fits very nicely into that, but provides some additional flexibility. So, this is a very high priority for us, and obviously we are mindful of the fact that, at the moment, this is authorized, but not appropriated. And we are also mindful of the fact that this may be a difficult year, in fiscal year 2011, with the ending of the ARRA dollars. But, certainly, from my perspective, as the NIH Director, and speaking for all those other Institute directors, this is something people are very anxious to get started on, and they have great hopes for, recognizing this is high-risk research, that many drug development programs fail, that if we're going to undertake this, we have to be prepared for that. But, I think we could learn a lot by doing this in a new way.

Senator SPECTER. Many programs fail and many programs succeed.

Dr. COLLINS. Indeed.

Senator SPECTER. And the successes have been monumental in what you have done for prolonging and saving lives. What could you do with the $500 million, Dr. Collins? Tell this subcommittee how much you could accomplish with it.

Dr. COLLINS. So, to undertake a project where you go from a basic science discovery to a Food and Drug Administration (FDA) approval of a drug is several years and expensive effort. With $500 million, we could probably proceed with about 20 projects, simultaneously, that went all the way from soup to nuts in that pipeline, and probably another 20 where we identify compounds, that are already in freezers of companies, that have been abandoned for various reasons, because they didn't work out for one application, but they might work out for a different one, so-called "repurposing," which would allow you to skip over many expensive steps. That would be quite a bold effort, indeed, to take on roughly, then, 40 projects on 40 different targets.

Senator SPECTER. One final comment, with the red light on. I would like you to go back to your office and review what could be accomplished with the $500 million, in as specific terms as you could, what you project you could do with that. And I know it is very hard to talk about saving lives, but you have some experience in what has gone on in other lines, statistically; and to the extent you could quantify it on saving lives, prolonging lives, or saving money, I think it would be very helpful, when the Chairman and the rest of us sit down to allocate the funds, here.

This is a very difficult subcommittee, having the Labor and Health and Human Services, and Education Departments. The competition for the money is absolutely fierce. So, the more specific you can be, the stronger the case can carry.

Thank you, Dr. Collins.

Thank you, Mr. Chairman.

Senator HARKIN. I just want to, first of all, say that this whole CAN that we put into the healthcare reform bill was a singular effort by Senator Specter.

[The information follows:]

CURES ACCELERATION NETWORK (CAN)

As you know Senator Specter, the Cures Acceleration Network (CAN), authorized in the Patient Protection and Affordable Care Act of 2010, would provide the National Institutes of Health (NIH) with new authorities to advance the development of "high need cures" by smoothing the pathway for developing new drugs, biologics, and devices, particularly through the so-called "valley of death" phase of the therapeutic pipeline. CAN would provide NIH with new authorities and flexible funding mechanisms, including the ability to leverage the Government's investment through matching funds. In addition to supporting the development of novel compounds and the repurposing abandoned products, it would provide NIH with an opportunity to carry out systematic process engineering that would result in a more efficient and effective therapeutic development pipeline. The program would operate in close coordination with the Food and Drug Administration and private sector stakeholders. CAN's authorities would allow us to use three novel funding mechanisms—Cures Acceleration Grant Awards, which could allow up to $15 million per award and additional funds in subsequent years; Cures Acceleration Partnership Awards, which could allow us to leverage additional funds so that a total of $20 million could be put toward every $15 million award; and, Cures Acceleration Flexible Research Awards, which could allow discretionary use of other funding mechanisms for up to 20 percent of the appropriation.

Methicillin-resistant Staphylococcus aureus (MRSA) provides an example of how CAN could contribute to improving health, saving lives, and lowering healthcare costs. MRSA is a major and growing clinical and public health challenge, and there is a need to develop antibiotics that are effective in treating this potentially life-threatening infection. MRSA occurs in hospitals and other settings where people are in close contact with one another, including nursing homes, dormitories, military barracks, athletic centers, and prisons. All sectors of the population are vulnerable, and certain groups are at higher risk, including children, the elderly, and people with concurrent health conditions. In 2005, MRSA caused approximately 94,000 invasive infections and 19,000 deaths. Total hospital costs for patients with MRSA infections were more than twice as high as those for patients with methicillin-treatable Staph infections ($34,657 compared to $15,923).

Industry interest in developing new antibiotics for drug-resistant infectious diseases like MRSA has declined considerably in recent years. Since 1999, 10 of the 15 largest companies have fully abandoned, or cut down significantly, discovery efforts in this field.[1] CAN could help address the deficits in the antibiotic drug development pipeline for treatments for MRSA and other drug resistant pathogens by leveraging established research resources, bringing together the pharmaceutical industry, regulatory and the financial communities, and applying necessary incentives to identify compounds for later phase development of new antibiotics. CAN's approach could make important contributions to this area.

The de novo development and characterization of each new drug ready for clinical testing would require approximately $20 million. The repurposing of a drug, which has already undergone considerable chemical and biologic characterization, would require approximately $5 million. An appropriation of $500 million would therefore allow us to support approximately 20 novel drug development projects and another 20 projects using compounds that have been abandoned for lack of capital, market demand, or regulatory and developmental hurdles. We anticipate that the program would eventually make major contributions to improving health, saving lives, and lowering healthcare costs associated with many serious human disorders and conditions that currently lack effective therapies and pose major burdens for individuals, their families, and society.

Senator SPECTER. Thank you, Mr. Chairman.

Senator HARKIN. He really dogged that one. And since I wear the other hat, as chairman of that other committee, too—this is one

[1] Kresse, H et al. The antibacterial drugs market. Nature Reviews Drug Discovery, January 2007.

that Senator Specter championed and got in there and was on us all the time to make sure that it was not dropped. And so, it was held in there, and I thank him for that.

I agree that this is something that really needs to be done, and we've talked about it personally many times in the past. And, Senator Specter, I think, has really been the great leader on this one.

Again, of course, Arlen also put his finger on it—we have a lot of competition for a lot of money here, and we have constrained budgets. So, I'm going to play a little bit of the devil's advocate here.

What would funding the CAN up to that $500 million, or however close—what would that allow NIH to do, that it can't do now?

Dr. COLLINS. No, it's appropriate to——

THERAPEUTICS FOR RARE AND NEGLECTED DISEASES PROGRAM

Senator HARKIN. Why can't you do it now?

Dr. COLLINS. It's appropriate to ask those questions. So we are, in fact, pushing this translational agenda in innovative ways. There's a program that this Congress has funded, the Therapeutics for Rare and Neglected Diseases, the TRND program, which aims to try to fill in some of the missing pieces in the "valley of death" that's necessary to cross if you're going to go from a promising compound to an FDA application for a clinical trial. And we're pursuing that quite vigorously.

And, Senator, I do understand the pressures on the budget system are severe. And I should have said earlier that, in that condition, the fact that the President's budget was able to come up with a $1 billion increase for NIH is something that—we should all, sort of, credit the administration with their vision for science. And I, personally, am delighted to see that this is an administration that has put science at such a high priority, even with frozen discretionary budgets.

What we could do that the CAN legislation provides is not just about money, though, it's also about flexibilities. So, what that legislation allows is that some proportion of that money can be used in a Defense Advanced Research Projects Agency (DARPA) like model, where you have flexible research authority to go beyond traditional grants, contracts, and cooperative agreements, to manage projects in very forward-looking ways. And that, for this kind of science, where you need to make decisions quickly, where you need to bring in other partners in a quick turnaround when you see you need to fill a void in what the science is showing you needs to be done, can be quite valuable. And we do not, at the present time, have that kind of flexibility for this sort of project. And we could benefit from that.

FLEXIBLE RESEARCH AUTHORITY

Senator HARKIN. But, Dr. Collins, you have the flexibility, now that it's authorized. I know, you have that—what you're saying is, you don't have the money.

Dr. COLLINS. Well actually, the way the bill was written, it says that the flexibilities of this bill may not be utilized unless the appropriation is put forward. Some appropriation is required before this is activated. So, unless, in the appropriations process that you

all are thoughtfully leading, there is a green light offered to this project by providing some kind of funding, I am not permitted to take advantage of the authorized flexibilities. That's the way the legislation was put together.

Senator HARKIN. Even if we just appropriate a dollar?

Dr. COLLINS. A dollar would, I suppose, do it, although it. It might be a little hard to do a DARPA program with $1. I don't know.

Senator HARKIN. I mean, I'm just talking about the trigger mechanism that allows this—you just told me something I didn't know. I didn't know that. So, this is very interesting.

Dr. COLLINS. And, of course, Senator, the other question is, in trying to figure out all of the priorities that I now struggle with, How does this fit? And obviously, you might say, "Well, why don't you just do this with the budget you've got?" Well, that would mean I would have to do less of something else. And already, with our 15 percent success rates looming, you can imagine how much of a stress and strain that is.

Senator HARKIN. Dr. Collins, I feel your pain.

Dr. COLLINS. I'm sure you do.

Senator HARKIN. That same thing is hitting us here—not just here, but in health, education—we're going to have some real problems in education, meeting our needs in higher education. So, we've just got a lot of things that are pulling at us, and we just are not going to have the funds to do it. So, we've got to make some pretty tough decisions, too. And some of our friends are not going to be very happy with some of the decisions that we make, but we're all going to have to sharpen our pencils and just try to prioritize things. And what I'm hearing about the CAN is—it's a very high priority.

Dr. COLLINS. That's correct.

Senator HARKIN. The translational research. And so, I'm going to take a look at what you just told me about—that there's a trigger mechanism in the legislation.

I think, Senator Specter, that's something we're going to have to take a look at here.

And I accept your word on that. We'll just have to see how much we need to put in there that would trigger that.

Now, I know Senator Specter would like the full $500 million. Yes.

Senator HARKIN. Actually, so would I.

Senator SPECTER. We could——

Senator HARKIN. I don't have any problem with the $500 million, but I——

Senator SPECTER. We could do more than that. That was the appropriation for fiscal year 2010.

Senator HARKIN. Oh——

Senator SPECTER. And now it's a set sum, so we could do $1 billion.

Senator HARKIN. It was $500 million for 2010, such sums after that.

Senator SPECTER. So, we're now at a set sum, so it could be $1 billion or $2 billion.

Senator HARKIN. You tell me where to get the money, and——

Senator SPECTER. I will.

Senator HARKIN. Okay. And we'll just put it out there, who we're going to take it away from to get that money. Like I said, we just have a lot of different demands on our money.

I had one follow up——

Senator SPECTER. Mr. Chairman, you and I have found as much as $3.77 billion, in the past. And it was just exactly what you mentioned, it was the sharp pencil.

Senator HARKIN. Well, in the past——

Senator SPECTER. And there are other accounts which do not rate with curing cancer or Parkinson's or Alzheimer's. And you and I did it before, and we can do it again.

Senator HARKIN. Yeah, we did it before, when we had some budget flexibility. I don't see much of that there right now. I just don't. Unless you've got some way of getting it.

Anyway, I ran up my time. I'm yielding to Senator Specter for another round. Do we have another round?

Senator SPECTER. No, that's it, Mr. Chairman. That really is.

Well, I have one other item that I would like to take up, and that is the funding on minority health.

NATIONAL CENTER ON MINORITY HEALTH AND HEALTH DISPARITIES (NCMHD)

Senator SPECTER. I note that it is in the budget for $219 million. The health reform bill elevated the NCMHD at NIH to an Institute. And the administration requested a budget of $219 million, which, by comparison, seems low. What do you recommend on that, Dr. Collins?

Dr. COLLINS. Well, actually, the NCMHD, is a major coordinator of minority health and health disparity research at NIH, but certainly all of the Institutes are invested in this area. If you look at the graph, here on the screen, the total investments estimated for 2011, with this budget, would be more like $2.7 billion, so more than 10 times what the funding is, specifically for that Institute.

Because we actually think that minority health and health disparities ought to be a priority for all of the Institutes. Whether it's the NCI or the NHLBI, or the Diabetes Institute, these are all areas where health disparities are a critical matter.

Senator SPECTER. Well, then why was a new Institute established for minority health, if it's accommodated at other places?

Dr. COLLINS. I think there was a desire to have it more visible, to have a coordinating function, which that——

Senator SPECTER. $219 million doesn't give you a whole lot of visibility.

Dr. COLLINS. It has provided an opportunity to give endowments, for instance, to some of the traditionally minority-serving institutions. That's a major part of what that Center, and now Institute, has done, when that flexibility didn't exist before. And certainly this Institute, every 4 years, puts forward a strategic plan, which they coordinate, on health disparities. And that didn't really have a home before, in terms of doing that kind of strategic plan coordination; and now it does.

Senator SPECTER. Thank you.

Thank you, Mr. Chairman.

BURDEN OF DISEASE

Senator HARKIN. Thanks, Senator Specter.

Let me follow up on the Alzheimer's thing that I started off with on. The first part just had to do with that finding of that panel. But, here's the whole issue of how NIH decides how much to spend on individual diseases. It's something that keeps coming up; year after year, I hear about it.

First of all, Congress does not earmark funding levels by disease. And I hope we never do. As long as I'm chairman, we never will.

I'm often asked, by patients and advocates, for example, how to explain the NIH funding level for a disease like Alzheimer's.

As we know, Alzheimer's is an enormous burden on our society, not just in human terms, but in terms of our overall economy. There's an estimate out there that, from 2010 to 2050, the Medicare and Medicaid costs of Alzheimer's will total—ready for this one?—about $20 trillion. That's just for the care of Alzheimer's. Now, I don't know if that's high or low; I'm just tossing this estimate out there. Even if it was half that, it would be staggering.

And yet, if you look at the NIH budget, funding for Alzheimer's makes up a much smaller share than one might expect; about 1.5 percent.

Another example: pancreatic cancer is the fourth leading cause of cancer-related death, but less than 2 percent of the NCI's budget is devoted to this disease.

So, my question, basically, is this, Dr. Collins. What role does the burden of a disease—the burden on society—play in where NIH allocates its money?

Dr. COLLINS. Senator, it's a great question, and it's a question that all of the people who have sat in this chair in prior years have also wrestled with. From the very beginning of NIH and its system of trying to define how to set priorities, there have always been debates about what are the right weighting factors to apply to particular diseases. And I would say that it's a complicated enough calculus that it'll take a minute to explain.

So, first of all, some of what NIH does needs not to be focused on a specific disease; otherwise, we will not have the foundational discoveries that result in Nobel Prizes and transformative understandings about neuroscience and immunology and cell biology and all of those things that are the really important foundation upon which everything rests. So, we would not want to have our entire budget specifically focused on disease research, or we would probably be mortgaging our future.

When it comes to those things that are clearly in need of attention, how do we decide? So, this—certainly, the burden of disease has to be a big factor, and the cost of that disease has to be a big factor. And you've quoted numbers for Alzheimer's that are staggering in that regard. And diabetes could also be cited in that way—and cancer and heart disease.

But, if we based our decisions solely on those issues, then rare diseases would tend to get ignored, or funded in only the very smallest amounts. If a rare disease happens to strike your own family, it's hard to say it doesn't matter. For that person, the bur-

den of disease is very high. So, we clearly have a responsibility there, as well.

And oftentimes, studying rare diseases gives us insights into common diseases. We study progeria, that affects maybe 30 kids in this country, and we learned something about aging that we never knew before, which affects all of us. Those kinds of connections keep popping up over and over again. We wouldn't have statins if we hadn't started out by studying a rare cause of very high cholesterol levels. All of those, I think, are reasons not to focus solely on burden of disease.

And then, there's scientific opportunity, which has got to be a big part of this. To say, "We have a disease problem, and we're going to throw money at it," if nobody has an idea about what to do, is unlikely to be productive.

And to take another area, which maybe is not quite as much of a burden, or quite as much of an expense, but where you can see the scientific field is just poised for a breakthrough, you don't want to miss that opportunity.

So, the job of those 27 Institute Directors, and my job, is to try to survey the landscape, sort of, weekly, and figure out how to do that steering of the ship to try to be sure we are investing most wisely. Do we always get it completely right? I wouldn't say we could claim that, but I think we do pretty well. And we are supported, of course, by this remarkable peer-review system. There's two levels which both looks at the scientific rigor of a grant proposal and then, at the second level, tries to figure out where are the highest program priorities, factoring in things like burden of disease. And when you look at the landscape of what we do across diseases, it doesn't match up precisely with what you might have guessed, just based on epidemiology, but I think it's fair to say there's a pretty strong connection.

Alzheimer's—you know, we are working hard on that. There are 30 new drugs that are in various stages of being developed for this approach, using things that we've learned about the amyloid deposits in the brain, and the enzymes that are involved in breaking that down, and how to encourage them to do a better job.

Vaccination—we talked about vaccination against nicotine; maybe a vaccination against amyloid, for Alzheimer's, which, unfortunately, in the early trials, a few years ago, ran into some unfortunate side effects. But, people are developing new ideas about how to get around that.

I couldn't agree more that, if there's an area that desperately needs a breakthrough, it's Alzheimer's disease. A lot of people trying.

PANCREATIC CANCER

Senator HARKIN. Again, that gets me to another question about causes and the rapid growth of certain diseases. It just seems like Alzheimer's is exploding.

Pancreatic cancer—the huge increase in pancreatic cancer in just the last few years. And different medical personnel I've talked to about this says that there's something going on out there; something is causing this huge increase in pancreatic cancer, but no one can quite figure out what it is.

And so, that's why I say, you need to look at this—I mean, it—I'd like to have some sort of satisfaction, or some feeling, positive feeling, that NIH is pivoting a little bit on this and saying, "What is causing this? Why?" and guiding some more research into pancreatic cancer and what's happening there.

We always knew that it was one of those secret kinds of cancers; in other words, you didn't know about it until it was too late——

Dr. COLLINS. Yeah.

Senator HARKIN [continuing]. Because there was no markers for it or anything. But, it's not only that now, but it's just the huge increase. I forget the figure, but it's just up tremendously, the number of people being diagnosed with pancreatic cancer.

Do you think NCI is pivoting and looking at this and putting more emphasis on it?

Dr. COLLINS. I think pancreatic cancer is a cause of major concern at NCI, and is for me, personally, when you see the number of individuals being diagnosed with this disease, which, as you say, often comes to light after it's already too late, because it doesn't reveal itself until it's already, oftentimes, spread. It is, all too often, a disease that we don't do much for, at the present time, except chemotherapy, which may gain a few months. And, of course, some notable figures—Patrick Swayze, diagnosed with this disease, and the way in which that created a new personal face, has brought even more attention to this, as well it should.

So, pancreatic cancer is one of the cancers being pursued by the Cancer Genome Atlas. This comprehensive effort to try to identify what exactly goes wrong in a pancreatic cell to cause it to grow out of control this way, and not just look under the lampposts, where we've been looking all along for clues, but actually using the tools of genomics to get all the answers that—all of the ways that a cell in the pancreas can start to go bad. And that will, I am confident, Senator, give us a comprehensive ability, both to do a better job of early diagnosis, but, most importantly, to identify new therapeutic magic bullets that will go to the heart of that cancer, like Gleevec does for leukemia; except we need a Gleevec for pancreatic cancer, don't we? And the problem right now is, we don't know what the target is that we're shooting at. The Cancer Genome Atlas will reveal the complete list of targets.

Of course, that doesn't happen overnight. That's a process. And again, the CAN, we talked about a minute ago, may assist, once the target's identified, in speeding up the process of getting something ready for a clinical trial. All of those steps have to be integrated together.

Again, I think having new leadership, imminently, for the NCI, is going to be quite timely in this regard. I am impatient, just as you are—frustrated, as you are—about this terrible disease of pancreatic cancer, and how many people we lose to it, and how impotent we seem to be, so often, in being able to stop the course of the disease.

Senator HARKIN. Yes.

Dr. COLLINS. And I would not want to have a day go by where we were passing up on the opportunity of new ideas to do something about this.

Senator HARKIN. Yes, because like B-cell lymphoma and things like that, and what NCI has done has been miraculous.

Dr. COLLINS. Yes.

Senator HARKIN. The cure rate there is just phenomenal.

Dr. COLLINS. Yes.

Senator HARKIN. It's very, very good.

Dr. COLLINS. Well, that's a good point, because there you have targets, and——

Senator HARKIN. Yes.

Dr. COLLINS [continuing]. There, the drugs have developed against those targets. And, boy, they work.

FDA AND THE NIH

Senator HARKIN. Yes, they sure do. Okay, we'll follow up on that.

You recently joined Secretary Sebelius and FDA Commissioner Hamburg in announcing a new partnership between NIH and FDA that, again, is intended to speed up the process of turning basic scientific discoveries into treatments. Well, what is this effort? How does this correlate with CAN? What are the goals? Is this different than what we've been talking about?

Dr. COLLINS. It's a part of the whole system that needs to be coordinated, integrated, optimized. I think it's clear that relationships between NIH and FDA have to be really well orchestrated in order for all of those complicated steps, in going from an idea to having a successful clinical trial, to go forward without missteps that cost time and cost money.

The FDA has enormous challenges in front of them, in terms of the way in which the development of therapeutics is evolving. The idea that you might, for instance, for cancer, need to get to a place where most patients are not being given one compound, but maybe two or three, that's targeted specifically to their tumor. Because you're going to know, in their tumor, exactly what's gone wrong. So, you look at your list of drugs, and you pick the combination that you know is zeroed in on their problem. Well, how does FDA evaluate a clinical trial of thousands of patients, where they aren't all taking the same thing? So, they need scientific research efforts to prepare them for that.

The regulatory science that Peggy Hamburg has been talking about is exactly what's needed. We, at NIH, agree. Fact, we have funded, with FDA, for the first time, a research program on regulatory science. We just announced that. We got 59 letters of intent. There are really interesting things being put forward, that the scientific community thinks they could offer to help FDA with the things that are coming down the pike, as far as regulatory challenges.

And many academic investigators, if they're getting more involved in the development of therapeutics—and the CAN will make that happen—they're not familiar with exactly how to do this, and there's a risk that they might sort of get very close to an FDA application, and then find out they've left out something really important, and have to backtrack, and waste time and money. So, we have to tighten up those relationships.

So, Peggy Hamburg and I have been meeting—and since last summer—to talk about how to do that. This new leadership coun-

cil, which she and I will cochair, will involve senior leadership of both agencies, and will involve many people at middle level, so that we could prepare for the opportunities that are coming, and not end up in some sort of bureaucratic mixup, which would be really heartbreaking to see.

I think the atmosphere is just right for this.

PATIENT ADVOCATES

Senator HARKIN. Tell me about the role of what I would call "patient advocacy groups." When you're going out to conduct human trials and, as you say, there's always risks when you conduct human trials—I think it's important to inform patients, from the beginning, help them understand what you're going through, in terms of the regulatory end of it. So, I'm just wondering when you're setting up this regime of involving these patient advocacy groups so that they can be supportive because they want to get the human trials out there. I think it might be wise to have them involved so that they understand what you're doing and that they can be a proponent of it, that they can be out in the public, advocating for this and sort of acting as a shield for you out there, perhaps, because a lot of people don't understand what you might be doing, and these groups could help you. So, I hope you'll look at involving them in this process.

Dr. COLLINS. Senator, I completely agree with you. I think there are many heroes, and "sheroes," out there in the advocacy organizations——

Senator HARKIN. Yes.

Dr. COLLINS [continuing]. Who have remarkable insight into what we could do to improve the success of our whole enterprise. And we listen to them, with great attentiveness. And certainly, with regard to this relationship, we have already had some of those informal consultations. And on June 2, we're holding a public, sort of, town meeting about this new NIH–FDA Leadership Council, and asking advocates and other members of the public to come forward and tell us what they think are the highest-priority matters for this council to address.

Senator HARKIN. So, it's an online town meeting?

Dr. COLLINS. I think we're web casting it, and it's also, certainly, encouraging people to come live and come to the microphone.

Senator HARKIN. Ah. Is that going to be out at the campus?

Dr. COLLINS. It is.

STEM CELLS

Senator HARKIN. Very good. That's on June 2. Well, I appreciate that. I think that would be important.

Is there anything—oh, yeah, of course. How could I leave you without asking about stem cells?

I wouldn't let this go.

You recently announced that—as you did, also, in your opening statement—that some additional human embryonic stem cell lines have been approved for NIH funding, and including the line that's been studied more than any other. Again, what's the significance of this? How many lines are we up to now? And give me some crystal-ball-gazing. Where are we headed?

Dr. COLLINS. Thanks for the question, because this is a very exciting area of biomedical research.

There are now 64 human——

Senator HARKIN. Sixty-four?

Dr. COLLINS [continuing]. Embryonic stem cell lines that have been approved by this NIH process that was stimulated by Obama's Executive order and that are up on the NIH registry and may now be used by researchers using Federal funds. And that is a number that is going to continue to grow. We have more than 100 additional lines that are in the process of being reviewed.

The goal, of course, of the review is to be sure that the consent process that was utilized for the embryo donors was above reproach. We want to be sure that these lines were obtained in a way that is entirely open to ethical scrutiny. And that is why the NIH has been conducting the reviews of those documents before certifying such a line.

We were very happy to be able to get the materials, just about a month ago, on a few of the lines that had been particularly heavily used since 2001, when, as you recall, President Bush's decision was that lines could not be used that were derived after that. But, there were 21 lines that were allowed, at that point.

Senator HARKIN. Right.

Dr. COLLINS. And there were a couple of them that were used particularly heavily. One, called H1, we were able to approve right away, because we had the documentation. The one that was causing a lot of anxiety in the community is a line called H9, and it just took a while for the deriver of that line—derivers, because it involved both Israel and the United States—to locate all the documents and to get them to us. Once we had them, we did a rigorous review, in a very short turnaround. We're happy to see that everything was totally in order and approved that line. And I think that settled down some of the concerns that people had about whether that line was still going to be available to them, or not. We had allowed researchers to continue to work with it, with an existing grant; but, if somebody came back for a competing renewal, we wanted them to start working with approved lines. They can now use H9 as long as they want; it's fine. And there will be hundreds more coming through.

On top of that, of course, there's great excitement about this additional way of making a pluripotent stem cell by taking a skin cell and, with just four genes, carefully chosen—and this is the remarkable work of Shinya Yamanaka, who I'm sure someday ought to win the Nobel Prize—you can take that skin cell and turn that into a pluripotent cell that basically can make any cell type that you would want it to, if you stimulate it with the right cocktail of cytokines and so on. Just phenomenal, Senator, that there's this much plasticity in the system, and that a cell that's been sitting in your skin all those years that—since you were originally born—is capable of having that ability. But, I guess it sort of makes sense, from a genome perspective; after all, that skin cell has the whole genome.

Senator HARKIN. Yes, right.

Dr. COLLINS. It just needs to be woken up again and encouraged to think that it's young and has all those potentials to do everything you could imagine.

That is an area that is just bursting with potential. We are actually starting, on the NIH campus, a special center for the so-called induced pluripotent stem cells (iPS)——

Senator HARKIN. Oh.

Dr. COLLINS [continuing]. And the specific goal there is to push the agenda toward actual clinical applications.

Senator HARKIN. Great.

Dr. COLLINS. The beauty of these, if it turns out to be as successful as we all hope, is that these are your cells; and so, if you were to need them for Parkinson's disease, because you develop that, or for a liver problem, you should be able to receive that kind of autotransplant, without the rejection problems that would otherwise apply if the cells came from somebody else. So, that is a big positive about this.

The questions are safety, particularly, because a pluripotent cell sometimes grows when it isn't supposed to. And one of the ways we actually characterize pluripotent stem cells, like iPS cells or embryonic stem cells, is by whether they can make tumors if you put them into——

Senator HARKIN. Oh.

Dr. COLLINS [continuing]. A particular mouse model. And obviously, we have to be very sure, before we try this in human applications, that we're not creating more trouble.

There is, as you may know, a single FDA-approved trial for clinical use of human embryonic stem cells. It's for spinal cord injury. It's by a company called Geron. They have not yet enrolled their first patient, but expect to later this year. Obviously, everyone is watching that, although I think, realistically, one should not assume that the very first trial of any brand new therapy is going to tell the whole tale about its promise.

But, of all the areas that are going forward right now in biomedical research, that I think have been breathtaking in their potential, this is right near the top of the list. And I think NIH, as you can maybe tell from my remarks, is pretty excited about pushing this forward with as much energy and as many resources as we're able to.

Senator HARKIN. I'd just ask my staff to get me all the information on this spinal cord. I had read about it, know a little bit, but I don't have—but, if you can get me some information on that, I'd appreciate it.

Dr. COLLINS. Happy to do that.

[Information follows:]

STEM CELLS FOR SPINAL CORD INJURIES

Geron Corporation is a biotechnology company based in California. Its lead human embryonic stem cell (hESC)-based therapeutic candidate, GRNOPC1, contains human embryonic stem cell hESC-derived neural support cells developed for the treatment of acute spinal cord injury. In pre-clinical studies, GRNOPC1 has been demonstrated to repair myelin, a protective nerve coating, and to stimulate nerve growth leading to the restoration of function in animal models of acute spinal cord injury. The initial proof-of-principle animal studies were conducted by Dr. Hans Keirstead, an investigator at the University of California, Irvine with funding from the National Institute of Neurological Disorders and Stroke.

In January 2009, Geron's Investigational New Drug application for GRNOPC1, which application the company had submitted to the U.S. Food and Drug Administration (FDA), went into effect. In May 2009, FDA placed a hold on the start of the phase 1 clinical trial and requested that Geron conduct additional pre-clinical studies to provide further assurance of GRNOPC1's safety. Geron has recently reported that additional data have been submitted to FDA, and its Web site now indicates that phase 1 clinical trials are expected to proceed in the third quarter of 2010.

If Geron's clinical trial is allowed to proceed and GRNOPC1, as the subject of a biologics license application, is shown to be safe and effective, the therapy may provide a treatment option for thousands of patients who suffer severe spinal cord injuries each year.

http://www.gemcris.od.nih.gov

Senator HARKIN. And the last issue—the last issue of Scientific American, which I always call the "layman's magazine of an NIH report"—something I can understand; it's my must-reading every month, the Scientific American—but, the last cover—get a copy of—it was all on the iPS, on the adult stem cells, as they say. And it was a fascinating article about turning the clock back. And Dr.—I forget his name.

Dr. COLLINS. Yamanaka.

SICKLE CELL DISEASE

Senator HARKIN.—Yamanaka, yes—is featured in that, and the way it was written is—just makes you think that this could be the—the way to go. I don't know. That's why I've always been in favor of all stem cell research, whether—whatever it is, whatever pathway it leads us down, within the ethical guidelines that we've established.

Dr. COLLINS. Well, think about sickle cell disease as a possible application for iPS. This has already been done in a mouse model, which is one of the reasons I think I'm——

Senator HARKIN. Yes.

Dr. COLLINS [continuing]. Particularly excited about its potential for humans. If you could take somebody with sickle cell disease, this terrible disorder, where a hemoglobin mutation causes the red cells to clog up in the vessels and cause all manner of organ damage and much pain. Take a skin cell, make it into an iPS cell, grow up a bunch of those, and then, using well-established experimental protocols, convert those iPS cells into bone marrow stem cells, and infuse them back in, after you've fixed the sickle mutation, which you can do while the—you're still working with a iPS cell in a culture dish. So, you can kind of do the whole cycle.

That has been done by Rudy Jaenisch, at MIT, in a mouse model, and cured sickle cell disease in the mouse. Now, everybody will say, "We've cured a lot of diseases in mice," and we have. But, by this protocol, it's pretty radical and pretty exciting, and certainly—one of the diseases that I hope will be high on the list for first human applications will be sickle cell. It's a 100 years since that disease was first described. This year, 100 years.

AUTOLOGOUS STEM CELLS

Senator HARKIN. Amazing. Yes.

Let me ask you about autologous stem cells. I've been meeting somewhat with FDA on this, in terms of a change in their approval process that took place in the—in about 2005, if I'm not mistaken. And—but, that's another—that's the regulatory end. I'm just more

interested in the scientific end, because I've had people in my office who have had autologous stem cell treatment. And—interesting group of people. One was a pilot who had been in an airplane crash and was, basically, paralyzed from his waist down. And through a process of autologous stem cells—I mean, he's not walking like you and I, but with canes and crutches. I mean, he's actually walking. But, you know, not fully recovered.

Another person that had some heart problems brought in his different PET scans and different things like that, and, through autologous stem cells, has never had to have heart surgery.

And there were a few others that I met. But, this is all through autologous stem—and some of that's being done in our country right now. Some of that's being done.

Can you enlighten me as to what this involves? And what is NIH doing in autologous stem cells?

Dr. COLLINS. So, this is an interesting area, and a rather controversial one——

Senator HARKIN. Yes, I know.

Dr. COLLINS [continuing]. In terms of, what capability these autologous stem cells have to home in on the site where they're needed and how they actually turn into the kind of cells that are needed there in order to compensate for what's happened, whether it's a spinal cord injury, whether it's a heart attack and you're trying to provide an opportunity to repair itself?

Frankly, the NIH-supported studies on this have not been as encouraging as many people had hoped. Take the approach to heart attack. Ten years ago, there was a lot of suggestion—enthusiasm, here—that bone marrow stem cells might, if given directly into the heart muscle after a heart attack, allow repair of that area that had suffered damage. And there were experiments done in animals that looked encouraging; and human trials that were done, in many centers, that had somewhat mixed results.

And I think, now, looking back on that, the evidence that that has actually been beneficial is not nearly as convincing as one would like.

That has not stopped, of course, the research from going forward. And it shouldn't. And I can't tell you, but I could for the record, exactly what the total is—now is, of NIH-supported autologous stem cell trials.

I will say that I've heard some heartbreaking stories of people who have gone outside of the United States to undergo these kinds of trials, in the hands of people who really are not scientifically very rigorous, and bad things have happened, in terms of the consequences—infections, stem cells that got in the wrong place, people basically spending large sums of money for the kinds of therapies that really had no scientific basis, in hopes that it would help them.

So, anybody contemplating that ought to be sort of eyes wide open, as far as what the evidence is.

And we will continue to push this approach. We spend more money on adult stem cells than we do on embryonic stem cells, because of the potential opportunities there. And obviously, there are great successes, particularly bone marrow transplant, that we can all point to, that has saved many, many lives. But, the broader ap-

plications for curing problems that involve solid organs, I think, are much more challenging.

There's a protocol just getting started, not with autologous cells, but with fetal cells, to try to treat Lou Gehrig's disease, ALS, which is obviously a disease of great frustration and great tragedy when it strikes.

So, these kinds of approaches deserve every bit of attention, as long as they're done rigorously and as long as we find out, at the end of the study, "Did it work, or did it not?" so that we can guide people who are interested in that outcome.

Senator HARKIN. I'd like to know more about autologous stem cells. Get me some information. I'd just like to know, you know, what's being done at NIH in research on autologous stem cells.

Dr. COLLINS. We're happy to provide a summary of that——

Senator HARKIN. Oh, good.

Dr. COLLINS [continuing]. For you, Senator.

[The information follows:]

AUTOLOGOUS STEM CELLS

Autologous stem cell transplantation (ASCT) is the use of an individual's own stem cells for the treatment of disease. The best known application of this technique is commonly referred to as "bone marrow transplantation," where an individual's hematopoietic (blood) stem cells are harvested and then reintroduced to reconstitute the blood and immune system. This form of ASCT has been in use for many years, and has demonstrated clinical effectiveness for the treatment of several diseases.

However, the concept of ASCT can be expanded to include stem cells harvested from one organ system to treat another organ system. Proof of principle animal studies revealed that stem cells harvested from organs such as bone marrow, skin, gut or endometrium, may be able to treat diseases in or ameliorate damage to solid organs such as the heart, brain, or spinal cord. These findings have raised hopes that these treatments could be transferred to the clinic and have led to the development of a growing cellular therapy industry within the United States and abroad. The application of ASCT across organ systems in humans is still in early experimental phases, and, unfortunately, the controlled studies conducted thus far have demonstrated mixed results, with some even having severe negative consequences.

The National Institutes of Health (NIH) continues to support research into the development of safe and effective treatments for diseases and disorders using ASCT. I am providing you with a summary of NIH-supported clinical trials using autologous stem cells. This summary is a broad overview of the many research projects being conducted.

National Cancer Institute (NCI)

ASCT is an important treatment option for several hematologic cancers as well as other types of cancer and other diseases. In this case, a patient's own bone marrow is used as a source of stem cells to reconstitute his/her blood cell producing capability following high-dose curativeintent chemotherapy. However, ASCT is not curative for all patients and NCI continues to support research to refine and improve outcomes using ASCT in both intramural and extramural research settings. Strategies under investigation include adding novel agents and agent combinations following transplant and adding immunotherapeutic drugs in conjunction with transplant. These strategies are a therapeutic tool in treatment of the following disease states (among others): multiple myeloma and other plasma cell disorders such as amyloidosis and Waldenstrom's macroglobulinemia; Hodgkin's disease and non-Hodgkin's lymphoma; acute myelogenous leukemia and acute lymphoblastic leukemia; neuroblastoma; inflammatory breast cancer; systemic lupus erythematosus; and leukocyte adhesion deficiency.

National Heart, Lung, and Blood Institute (NHLBI)

ASCT holds great potential for treating cardiovascular, lung, and blood diseases and the development of clinically feasible applications is an important part of NHLBI's strategic plan.

In the cardiovascular area, ASCT is being investigated in phase I/II trials for the treatment of damaged or malfunctioning heart muscle, and in an upcoming phase

I trial for treatment of peripheral artery disease. Bone marrow mononuclear cells and mesenchymal cells are being tested for treatment of acute myocardial infarction (heart attack) and heart failure by injecting stem cells directly into the heart. In another study, cardiac-derived progenitor cells, obtained via cardiac biopsy, are being tested for treatment of individuals with ischemic left ventricular dysfunction. Finally, parent-banked umbilical cord blood-derived stem cells will be tested for treatment of limb muscle damage by injection into the affected muscle.

In the hematology area, ASCT has been performed for more than five decades. In 2001, NHLBI initiated a network specifically to conduct multi-center trials to improve outcomes in blood and marrow transplantation, including eight clinical trials involving ASCT. Examples include a comparison of cell sources (autologous vs. allogeneic), a comparison of conditioning regimens used prior to ASCT, and the possible benefit of combining intensive chemotherapy with an autologous stem cell transplant. Investigator-initiated studies have also been implemented including a long-running program project grant on stem cell transplantation.

National Institute of Allergy and Infectious Diseases (NIAID)

NIAID researchers are investigating potential opportunities for improving immune function in patients with certain rare genetic disorders, including X-linked Chronic Granulomatous Disease, X-linked severe combined immune deficiency, and WHIMS (warts, hypogammaglobulinemia, infection, and myelokathexis syndrome) through gene therapy and other treatments targeting human hematopoietic stem cells. NIAID also is supporting two trials to assess autologous hematopoietic stem cell transplantation "to reset" the human immune system in patients who suffer from the autoimmune diseases multiple sclerosis and systemic sclerosis.

National Human Genome Research Institute (NHGRI)

NHGRI is supporting a gene therapy trial for a rare form of inherited immunodeficiency called adenosine deaminase (ADA) deficient severe combined immunodeficiency (SCID). Eligible children with ADA–SCID are admitted to the Clinical Center where their autologous bone marrow stem cells are collected and subjected to retroviral-mediated gene transfer to correct the genetic defect before being reinfused. Results from treated ADA–SCID patients indicate that this approach can regenerate immune responses in these severely immune-compromised subjects.

National Center for Research Resources (NCRR)

NCRR supports ASCT through its General Clinical Research Centers. Researchers are investigating the use of ASCT in patients with relapsed Hodgkin's or non-Hodgkin's lymphoma. Other scientists are transfusing autologous umbilical cord blood to regenerate pancreatic islet insulin-producing beta cells and improve blood glucose control is being tested. Finally, other researchers are comparing disease-free survival between two different clinical protocols for ASCT.

National Institute of Dental and Craniofacial Research (NIDCR)

Bone marrow contains a population of stromal stem cells capable of regenerating bone and supporting the formation of marrow. NIDCR-supported scientists are planning a study that would involve harvesting bone marrow from the hip of patients with cranial (skull) defects that have failed standard treatments (metal plates, plastic overlays). The stromal cells in the marrow will be expanded and then attached to ceramic particles and placed into the cranial defects. Patients will be monitored to determine if new bone is formed.

National Institute on Neurological Disorders and Stroke (NINDS)

NINDS is supporting a clinical protocol that receives biospecimens from patients with multiple sclerosis who have received autologous hematopoietic stem cells. The NINDS intramural researchers perform immunological analysis on the specimens to elucidate mechanisms of treatment action.

Senator HARKIN. That'd be good. I'd appreciate that.

Well, that's good. I enjoyed this session very much.

As you know, Dr. Collins, I have always, in the past, tried to have sessions with each of the Directors of the Institutes. However, because of some added responsibilities I have this year, now, I—my time is being crunched a lot, and I can't do that right now. I am hopeful, though—and I say this for the record—that sometime during this year, when I find some space opened up a little bit, that I might ask Mr. Fatemi and Ms. Taylor to also see if we can

pull this together again, where I can set up a few days and have three or four down at a time, and sit down, because it's very enlightening. It's better than reading Scientific American, so, I just want you to know that I'm contemplating that. I hope I can do that, at some point yet during this calendar year.

Dr. COLLINS. All of us at NIH would love that opportunity, Senator, and we do appreciate the many heavy loads that you're carrying this year, and your strong support of medical research.

ADDITIONAL COMMITTEE QUESTIONS

Senator HARKIN. Thank you.

And congratulations, again, on taking over the reins, and we're looking forward to working with you on this terrible budget crunch that we have.

Thanks, Dr. Collins.

Dr. COLLINS. Thank you, Senator.

[The following questions were not asked at the hearing, but were submitted to the Department for response subsequent to the hearing:]

QUESTIONS SUBMITTED BY SENATOR TOM HARKIN

MEDLINE PLUS

Question. Dr. Collins, I am pleased at the importance you have placed on communicating to the American public about the valuable work done at NIH. As you may know, it was this subcommittee that first called on the National Institutes of Health (NIH) several years ago to start a magazine that would go directly to consumers to help people take charge of their health and provide reliable up-to-date information directly from the experts at NIH. What can be done to make sure that this NIH MedlinePlus magazine and its bilingual counterpart, NIH MedlinePlus Salud, gets out to every doctor's office and federally funded health center? Do you have the resources to do this?

Answer. The NIH MedlinePlus magazine is the gold standard of reliable, up-to-date health information in plain language and in a reader-friendly format. I share your enthusiasm for it and its bilingual edition, the NIH MedlinePlus Salud, which is in both Spanish and English. As you know, the magazine contains no advertising and is produced through a partnership between NIH, particularly National Library of Medicine (NLM), and the Friends of the National Library of Medicine. The magazine is distributed through community health centers, hospital emergency rooms, physicians' offices, libraries, and other locations where the public receives health services and health information. Specific issues or sections of issues are also used for targeted health education and disease prevention campaigns. At its current budget level, NLM is able to support printing and distribution of an average of 260,000 copies of each issue of the English version. To date, private sector support has allowed printing and distribution of about 100,000 copies of the Spanish version. Both versions are now available online at: http://www.nlm.nih.gov/medlineplus/magazine/.

To increase distribution of the magazines, we are working to extend our partnership to include other Government agencies and private organizations that have an interest in supporting the distribution of health information from NIH to their respective constituencies and audiences. For example, the Peripheral Arterial Disease Coalition and the American Diabetes Association supported the distribution of additional copies of two 2009 issues. The National Alliance for Hispanic Health supported the production and distribution of the first two issues of NIH MedlinePlus Salud. The NIH and the NLM will continue to encourage partnerships with other public and private organizations in an effort to ensure that this publication reaches the widest possible audience, every doctor's office, and every federally funded health center in America.

AMERICAN RECOVERY AND REINVESTMENT ACT (ARRA)

Question. NIH received $10.4 billion in ARRA—roughly $5 billion a year in fiscal years 2009 and 2010. That money is about to run out. How do you achieve the soft-

est possible landing in fiscal year 2011? What are some of the challenges you will face?

Answer. The $10.4 billion in ARRA for NIH has resulted in more than 15,000 grants and contracts to date, with more expected by September 30, 2010. These funds have served as a catalyst for inspiring innovative biomedical research in many areas of science relevant to health and disease.

With regard to ensuring the softest possible landing beyond fiscal year 2011, NIH has taken steps to limit reliance on ARRA funding. From the outset, we decided to use these funds primarily for one-time expenditures, special equipment, construction, innovative grants, and special projects, which could either be advanced or completed within 2 years. NIH also anticipated that some of the ARRA grantees who were awarded 2-year grants in fiscal year 2009 would seek continued funding in fiscal year 2011. These applications will be among those considered in the regular NIH competitive grant review process.

The nature and pace of science is often unique to each research question. We expect a staggered increase in applications over the next few years resulting from the completion of the ARRA awards. Success rates of applicants may potentially be affected by gradual increases in application submission rates. NIH will continue to support applications that are rated by peer-reviewers to be meritorious and which address the programmatic priorities of the NIH Institutes and Centers.

GRANT RESTRICTIONS

Question. Dr. Collins, in a January 2010 interview in The Chronicle of Higher Education, you suggested that universities are "becoming too reliant on NIH money, allowing faculty members to obtain all their income from Federal research grants." You said that when faculty members run multiple research projects at the same time, "that turns that investigator into a grant-writing machine perhaps more than a doing-of-science machine." You added that any new restrictions on NIH grants "would have to be phased in over a fairly long period of time because many universities and faculty members would find that quite disruptive." What sorts of changes to the NIH grant system are you envisioning for the future? Would you favor limits on the number of grants scientists could receive simultaneously from NIH? If faculty members should not expect to obtain all their income from Federal research grants, what other sources could supply the funds?

Answer. Over the past several years, the NIH has supported an increasing number of extramural research projects; ARRA provided additional support to expand and accelerate these efforts. In the upcoming and future years, we expect to see a higher number of applications for extramural awards, which could increase competition for the limited resources available. Given this, it simply may not be sustainable to have a large number of investigators deriving all or most of their salary from NIH grants. But before making any changes to our grants policy, we need to carefully explore alternatives and seek input from the relevant stakeholder groups and from the subcommittee. Any recommended changes would then have to be phased in over a period of time, as universities and researchers would find rapid change disruptive to the health of the American biomedical research community.

QUESTIONS SUBMITTED BY SENATOR DANIEL K. INOUYE

LOWELL P. WEICKER CONFERENCE ROOM

Question. I understand that you are considering dedicating a conference room in the National Institutes of Health (NIH) Neuroscience Research Center to Lowell P. Weicker. I greatly appreciate your commitment to preserving the honorable recognition of Governor Weicker and respectfully request an update on the status of the dedication of the conference room?

Answer. NIH intends to dedicate a conference room to honor Senator Weicker's legacy of contributions to the advancement of human health through research. We anticipate the dedication to take place soon after the Porter Neuroscience Research Center phase II project is completed. The Porter Center, which is being built on the western portion of NIH's Bethesda campus with funding from the American Recovery and Reinvestment Act (ARRA), is scheduled to be completed in 2013. We will keep the Senate apprised of the specific plans for the dedication as the building's completion date approaches.

NURSING RESEARCH

Question. Senator Burdick and I were instrumental in the establishment of the National Institute for Nursing Research (NINR) and for 25 years NINR has been

dedicated to improving the health and healthcare of Americans through the funding of nursing research and research training Since it was established, NINR has focused on promoting and improving the health of individuals, families, communities, and populations. How does the NIH plan to further expand this critical arm of research?

Answer. NINR supports clinical and basic research that develops knowledge to: build the scientific foundation for clinical practice; prevent disease and disability; manage and eliminate the symptoms caused by illness; enhance end-of-life and palliative care; and train the next generation of nurse scientists. In order to expand these vital areas of research at NIH, the President's fiscal year 2011 budget requests $150,198,000 for NINR, a 3.2 percent increase more than fiscal year 2010.

In fiscal year 2011, NINR will build upon the important scientific research advances the Institute has supported more than its 25-year history. For example, NINR research in health promotion and disease prevention will explore strategies to understand and promote behavioral changes in individuals; evaluate health risks within communities; and explore biological factors that underlie susceptibility and mediate disease risk. To improve quality of life for those with chronic illness, NINR will continue to support symptom management research to illuminate the biological and behavioral aspects of symptoms such as pain, insomnia, and fatigue, and to enhance the ability of patients to manage their own conditions. NINR's end-of-life and palliative care program supports science to improve the understanding of the needs of dying persons, their families, and caregivers by examining such topics as the alleviation of symptoms; psychological care; advance directives; spirituality; and family decisionmaking. NINR training programs will ensure ongoing advancements in science and improvements in health through the support and development of an innovative, multidisciplinary, and diverse scientific workforce. In addition, across all of its research programs, NINR will continue its commitment to promoting health equity and eliminating health disparities in at-risk and underserved populations through the development of culturally appropriate, evidence-based interventions.

Finally, NINR will continue to support basic and clinical research to develop the scientific basis for clinical practice. These efforts will promote the translation of research into practice; assess cost-effectiveness of clinical interventions; improve the delivery, quality, and safety of clinical care; and establish the foundation of evidence-based practice. Evidence-based practice is essential to ensuring that all Americans receive the highest-quality, most-efficient healthcare. It is NINR's emphasis on clinical research that places NINR in a position to make major contributions to the NIH Director's goals for translating basic research to clinical practice, supporting science to enable better healthcare, and reinvigorating the biomedical workforce.

ALLIED HEALTH SCHOOLS IN REMOTE COMMUNITIES

Question. At my request, the University of Hawaii at Hilo established the College of Pharmacy. The College of Pharmacy's inaugural class of 90 students began in August 2007, will graduate in 2011, and will hopefully stay in Hawaii to meet the growing demand for pharmacists. Historically, Hawaii's youth interested in becoming Pharmacists would travel to the mainland for school, and not return. It is my vision that the people of Hawaii will have educational opportunities in the health professions that will in turn increase access to care to residents in rural and underserved communities. Has there been any consideration of focusing research efforts on the benefit of establishing schools of allied health in remote communities to meet the growing needs for healthcare and improve access to care in rural America?

Answer. Allied health education is an important part of the U.S. rural healthcare infrastructure. Allied health professionals form a vital part of the healthcare infrastructure necessary to support ambulatory, pharmacy and institutional primary and preventive care, yet the complement of allied health training and subsequent rural practice choices are limited. Several studies have highlighted the gross deficiencies in the health status of those living in rural areas, as well as the disparities in the distribution of health resources. Allied health education is offered in approximately 2,000 widely dispersed rural locations. Of significance, from a health policy perspective is the realization that primary healthcare profession shortage designation areas significantly lack allied health training education and resources. These concerns have served as a catalyst for the National Center on Minority Health and Health Disparities (NCMHD) and other Federal partners such as Health Resources and Services Administration to develop new directions for rural health research and workforce studies.

Research indicates that targeted expansion of allied health training resources in rural underserved areas might improve the healthcare infrastructure, enhance ac-

cess to care, and provide career opportunities for residents of rural areas. NCMHD will continue to support a rural health research agenda as part of its activities. This includes collaborative efforts to address the distribution of allied health professions training and workforce distribution, providing research infrastructure and capacity for rural-based institutions to support allied health education training and meet NIH's goal of developing scientific resources for disease prevention. Future research will be able to identify the optimal mix of allied health professionals necessary to support healthier rural communities.

CHRONIC KIDNEY DISEASE

Question. Hawaii experiences a higher than average rate of Chronic Kidney Disease (CKD) with 1 person in 7, compared to a national average of 1 person in 9, afflicted with this disease. Among the Asian/Pacific Islander (API) population groups, Filipinos have one of the highest rates of incidence per capita. National Kidney Foundation of Hawaii in 2007 it is estimated that of the 156,000 residents with CKD, approximately 32 percent are Filipino. Has there been any consideration to focusing research efforts on preventing chronic kidney disease among the API population groups?

Answer. The National Kidney Disease Education Program (NKDEP) is an initiative of the National Institutes of Health that is designed to reduce the morbidity and mortality caused by chronic kidney disease (CKD) and its complications. NKDEP works to reduce the burden of CKD and focuses its efforts on those communities most affected by the disease including African Americans, American Indians, and APIs.

In 2008, the NKDEP initiated the Community Health Center (CHC)–CKD Pilot to identify effective strategies or improving detection and treatment of chronic kidney disease in community health centers—critical primary care settings for many people at increased risk for CKD. The pilot involves a small group of centers in the Northeast that work together to design, implement, and monitor performance improvements related to CKD. NKDEP is currently developing plans to broaden the pilot project nationally and will use data from the pilot phase pilot and lessons learned to inform this expansion. CHCs in Hawaii would be appropriate participants in this effort. Representatives from NKDEP have been in contact with Hawaii State Representatives and the Hawaii National Kidney Foundation since March 2008 and have provided technical assistance on how NIH resources could potentially be utilized to reduce the burden of chronic kidney disease among Hawaiians.

HEPATITIS B

Question. Hepatitis B and liver cancer, as caused by the hepatitis B virus (HBV), are the single greatest health disparities affecting the API populations in the United States. While up to 14 percent of the API population is infected with HBV, only 0.4 percent of the Caucasian-American population is infected. Asian Americans, native Hawaiians, and APIs comprise more than half of the 2 million estimated HBV carriers in the United States and consequently have the highest rate of liver cancer among all ethnic groups. Has there been any consideration of focusing research efforts on preventing HBV in APIs and other groups disproportionately affected by HBV?

Answer. The NIH supports research and education activities focusing on groups that are disproportionately affected by HBV. For example, the multi-center Hepatitis B Research Network, established in 2008, aims to advance understanding of disease processes and natural history, as well as to develop effective approaches to treating and controlling HBV. The network includes 21 clinical sites across the United States, including Hawaii, and a central data coordinating center. The network's centers are in the final stages of planning several clinical trials in both adults and children. Recognizing the health disparities affecting the API populations, the network plans to conduct trials testing antiviral therapy in these particularly at-risk groups. In another at-risk population, the NIH is conducting studies on the use of antiviral therapy during pregnancy to prevent the spread of HBV from a chronically infected mother to her newborn. The network will enroll pregnant women with HBV into clinical studies to assess risk factors associated with reduction in maternal-infant transmission.

Research to develop new classes of drugs that are safe and effective in treating HBV infections is essential to effectively addressing HBV disparities. It is also critical to study how HBV develops resistance to new classes of drugs. For example, in studies conducted in nonhuman primates, NIH scientists and their colleagues determined that the replication rate for HBV is higher than previously thought. A higher replication rate increases the frequency of HBV genetic mutations, including

those mutations that cause the virus to become resistant to drugs. This finding may help enhance the ability to predict when HBV virus will develop drug resistance which, in turn, will inform the use of existing antiviral therapies, including the use of a single antiviral drug versus combination therapies. NIH-funded researchers also discovered that selective combinations of existing drugs (nucleotides and nucleosides) may work better together not only to inhibit the emergence of mutated strains, but also to do a better job of reducing circulating virus.

A workshop, arranged by NIH together with the U.S.-Japan Cooperative Medical Sciences Program and the Asia Pacific Association for the Study of Liver, was held in Hong Kong in February 2009. Its purpose was to understand the issues related to antiviral drug resistance encountered in the treatment of HBV infected patients in the countries of the Asia-Pacific region. Issues discussed included determining the extent and burden of resistance in Southeast Asia, which has the highest prevalence and incidence of HBV infection worldwide. Other issues discussed were the need for databases to catalogue and track virus mutations associated with resistance; to track patient management; and to study correlations between treatment and clinical outcome.

Other NIH-supported basic and clinical research holds promise for populations disproportionately affected by HBV. For example, currently licensed antiviral drugs for HBV target a single step in the viral replication cycle. As resistance with this class of drugs seems inevitable, NIH-supported investigators, through partnership initiatives and investigator-initiated proposals, are redirecting their research to novel targets in the replication cycle and are pursuing the development of different classes of drugs. Other studies are ongoing to explore host responses to HBV infection, how the virus spreads in the liver, the influence of viral inoculum on outcome, and the cascade of host responses leading to chronicity or resolution.

There are ongoing efforts to promote coordination and planning of all HBV research within NIH and across the Department of Health and Human Services. Strategic plans, such as the trans-NIH Action Plan for Liver Disease Research (http://liverplan.niddk.nih.gov) and the plan produced by the National Commission on Digestive Diseases (http://NCDD.niddk.nih.gov), were developed with trans-NIH and trans-DHHS input, and highlight important research goals relevant to controlling HBV. In 2008, NIH convened a Consensus Development Conference on the Management of Hepatitis B. The conclusions of this conference can be found at the following Web site: (http://consensus.nih.gov/2008/hepbstatement.htm). The NIH is also providing expert input on the HHS Viral Hepatitis Interagency Working Group to coordinate the responses to the challenges described in the recent Institute of Medicine report on HBV and liver cancer.

In addition to research activities, the National Digestive Diseases Information Clearinghouse provides educational materials for the public on HBV to improve knowledge and awareness (available at: http://digestive.niddk.nih.gov/diseases/pubs/hepatitis/index.htm). Materials on HBV are available in several languages, which include Chinese, Korean, Vietnamese, and Tagalog. There is a new series of fact sheets focusing on hepatitis B-related issues affecting API.

DIABETES

Question. One of the gravest threats to the healthcare system is the chronic disease of diabetes with its impact on both the economy and on the quality of life for nearly 24 million Americans. In Hawaii, Native Hawaiians have more than twice the rate of diabetes as Whites and are more than 5.7 times as likely as Whites living in Hawaii to die from diabetes. Education and prevention are essential to controlling this serious, costly, and deadly disease. What innovative research efforts have been considered to improve diabetes outcomes and prevent diabetes?

Answer. NIH research has helped to significantly increase the life expectancy of people with diabetes and led to the development of a proven method to help prevent or delay the most common form of the disease, type 2 diabetes. For example, the landmark Diabetes Prevention Program (DPP) clinical trial demonstrated that a lifestyle intervention aimed at modest weight loss achieved a 58 percent reduction in diabetes rates among people at risk in a 3-year trial. The intervention was effective in both men and women and in all ethnic groups tested and was especially effective in older participants. Results published since the original findings have shown that the intervention remains effective for at least 10 years. In addition to reducing rates of diabetes, the intervention also led to improved blood pressure and lipid levels with less use of medications. The study included a site in Hawaii.

To develop lower cost methods to deliver the DPP intervention to the 57 million Americans with pre-diabetes who could benefit, the NIH has vigorously pursued DPP translational research. One innovative NIH sponsored study tested a group

lifestyle intervention, modeled after the DPP's, that is delivered at YMCAs. This approach yields a sharp reduction of cost per patient, and appears to be achieving excellent interim results. Importantly, YMCAs are located throughout the United States, including in many communities at high risk of type 2 diabetes. For example, the State of Hawaii is home to 17 YMCA branches. A fully national implementation of these methods would have the potential to affect diabetes treatment for Native Hawaiians in significant ways. Because of the excellent results achieved in this program to date, the Centers for Disease Control and Prevention (CDC) is planning to expand it to 10 more YMCA locations around the country. Similarly, the United Health Group, a private insurer, has announced plans to pay for its subscribers in six cities who are at risk of diabetes to receive at no charge a YMCA-based diabetes prevention intervention modeled on the program. These are outstanding examples of the adoption of evidence-based prevention methods to alleviate a serious national healthcare problem.

The National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK) is also sponsoring a major multi-center trial to study the effects of lifestyle change and weight loss on the course of type 2 diabetes. Exciting preliminary results at 4 years have shown improved diabetes control and reductions in cardiovascular disease risk factors despite less use of medication. As with the DPP, the study includes a substantial representation of minority groups disproportionately affected by type 2 diabetes. To build on the findings from major NIH-supported trials that have transformed diabetes care by establishing therapies that reduce diabetes complications and premature mortality, ongoing studies are examining translation of these approaches into communities at risk. One such research effort is employing community health workers in American Samoa, where diabetes rates are 3-fold higher than in the U.S. mainland, to test methods for delivering care there, as informed by results from previous NIH studies.

It is particularly important to understand how diabetes is affecting children in America. The SEARCH for Diabetes in Youth study, a joint program of the CDC and the NIH, is collecting data on the incidence and prevalence of type 1 and type 2 diabetes in young people of diverse ethnicity, and thus is providing information to better understand the diabetes disparity among young APIs as well as other groups. One SEARCH center, located at the Kuakini Medical Center in Honolulu, will help provide the most accurate statistics to date on childhood diabetes in Hawaii. The National Diabetes Education Program (www.ndep.nih.gov), another joint effort of NIH and CDC, distributes educational materials conveying the vital health messages that have come from the major NIH-sponsored diabetes studies. Many of these materials have been translated into a wide array of languages, including the Pacific Island languages of Chamorro, Tagalog, Tongan, Chuukese, and Samoan, as well as Japanese, Indonesian, and other languages of the Pacific Rim. These programs are helping to extend the benefit of NIH diabetes research to people of diverse ethnicity in the United States and throughout the world.

COLLABORATIVE CANCER RESEARCH

Question. What is the status of the administrations' efforts to continue collaborative cancer research and program efforts focused on reducing cancer health disparities in native Hawaiians?

Answer. The administration's efforts to continue collaborative cancer research and program efforts focused on reducing cancer health disparities in Native Hawaiians are exemplified in a number of community-based participatory research programs supported by the Center to Reduce Cancer Health Disparities of the National Cancer Institute (NCl/CRCHD). These include:

Community Networks Program (CNP)

This program was recently renewed and the new CNP centers initiative (RFA–CA–09–032) extends the previous efforts of NCI to support community-based participatory research (CBPR) in racial and ethnic minorities and other underserved populations. The goals of the CNP Centers are (1) to develop and perform evidence-based intervention research to increase use of beneficial biomedical and behavioral procedures for cancer prevention, detection and treatment, which may include related co-morbid conditions; and (2) to train and promote the development of a critical mass of competitive new researchers using CBPR to reduce health disparities. This program and its predecessors have promoted and continue to promote CBPR-based cancer health disparities research. As part of the current NCl/CRCHD CNP, NCI supports two projects aimed at reducing cancer health disparities in native Hawaiian populations.

The 'Imi Hale Native Hawaiian Cancer Network is aimed at reducing cancer incidence and mortality among native Hawaiians by maintaining and expanding an in-

frastructure that: (1) promotes cancer awareness within native Hawaiian communities; (2) provides education and training to develop native Hawaiian researchers; and (3) facilitates research that aims to reduce cancer health disparities experienced by native Hawaiians. 'Imi Hale is housed at Papa Ola Lkahi, a nonprofit native Hawaiian community-based agency in Honolulu, is dedicated to improving native Hawaiian health and well being. They collaborate with key partners at the community, State, and national levels. Examples of clinical partners are the five Native

Hawaiian Health Care Systems (NHHCS, providing access and prevention services to Native Hawaiians on the State's seven inhabited islands), the Queen's Medical Center, and Breast and Cervical Cancer Control Program. Examples of program partners include CIS, ACS, and Hawaii Primary Care Association. Examples of educational and research partners include the University of Hawaii, Oregon Health and Sciences University, and the NHHCS IRB.

Weaving an Islander Network for Cancer Awareness, Research, and Training (WINCART) is a community-academic consortium employing CBPR to reduce preventable cancer incidence and mortality among five API communities in southern California. The specific aims of WINCART are to: (1) identify individual, community, and health service barriers to cancer control among APIs; (2) improve access to and utilization of existing cancer prevention and control services; (3) facilitate the development, implementation, and evaluation of community-based participatory research studies; (4) create opportunities to increase the number of well-trained API researchers through training, mentorship, and participatory research projects; (5) sustain community-based education, training, and research activities by increasing partnerships with governmental and community agencies, funders, and policy makers; and (6) disseminate research findings to aid in the reduction of cancer health disparities for APIs. Project methods include implementation and evaluation of community awareness activities in each API population; conducting cancer prevention and control research; and recruitment/training/mentorship of API researchers.

Basic Research in Cancer Health Disparities (R21/U01)

Two new NCI-supported funding opportunities, PAR09–160 and PAR09–161, have been developed to encourage basic research studies to determine whether there are biological causes and mechanisms of cancer health disparities and support the development of a nationwide cohort of scientists with a high level of basic research expertise in cancer health disparities research. PAR09–160 will focus on the development of resources and tools, such as racial/ethnic specific biospecimens, cell lines and methods that are necessary to conduct basic research in cancer health disparities. PAR09–161 will provide an avenue for entry into cancer disparities research through collaboration and association with researchers with specific expertise in emerging technologies in cancer research.

Minority Institution/Cancer Center Partnership (MI/CCP)

The MI/CCP program supports a partnership program that promotes research in cancer health disparities. The University of Guam (UOG), and the Cancer Research Center of Hawaii (CRCH), an NCI-designated cancer center at the University of Hawaii at Manoa, have been engaged in a unique and successful partnership over the past 6 years to establish a Cancer Research Center of Guam on the campus of UOG, to increase number of faculty and students engaged in cancer research at UOG, and to increase the number of faculty from CRCH addressing issues of particular relevance for cancer health disparities in the Hawaii/Pacific region.

CANCER PREVENTION

Question. How will the NIH continue to support an infrastructure that has identified and mentored more native Hawaiian researchers in cancer prevention and control than any other institution has done in the past 20 years?

Answer. NIH is committed to enhancing workforce diversity within the research enterprise, and as part of that effort, seeks to support infrastructures that recruit and retain a strong cadre of competitive researchers from diverse backgrounds working in cancer prevention and control. Within NCI, there are a number of current activities that will continue to support an infrastructure to train and mentor native Hawaiian and other Pacific island cancer researchers. Examples of programs within NCI's CRCHD that support training infrastructure for native Hawaiians include:

MI/CCP

The NCl/CRCHD supports a partnership program between minority serving institution partners and a NCI-designated cancer center to foster training and research activities. For example, the newly awarded 5-year U54 University of Guam and the

University of Hawaii at Manoa MI/CCP partnership has a well-established infrastructure for mentoring of Hawaiian and Guamanian researchers in cancer research as part of their diversity training program.

CNP

The goal of the NCl/CNP program is to develop and increase capacity building in support of community-based participatory education, research and training to reduce cancer health disparities. The program has increased the development of a cadre of new investigators, including among native Hawaiian researchers, in the field of cancer health disparities research. To date, a total of 34 native Hawaiians have been trained, representing 7 percent of the total CNP trainees. The CNP native Hawaiian trainees have submitted 40 grant applications and a total of 12 were funded for a 30 percent success rate. Building on the success of the CNP program, the new 5-year CNP centers program has been established, and will continue to support infrastructure for diversity training.

Promote Workforce Diversity (PAR–09–162)

The Exploratory Grant Award to Promote Workforce Diversity in Basic Cancer Research (PAR–09–162) supports under-represented minorities, such as native Hawaiians, in basic cancer research. Through this funding opportunity, NCI encourages institutions to diversify their faculty populations, and increase the participation of individuals currently under-represented in basic cancer research, such as individuals from under-represented racial and ethnic groups, individuals with disabilities, and individuals from socially, culturally, economically, or educationally disadvantaged backgrounds that have inhibited their ability to pursue a career in health-related research.

Continuing Umbrella of Research Experiences (CURE)

The ongoing CURE program offers unique training and career development opportunities to enhance diversity in cancer and cancer health disparities research. With a focus on broadening the cadre of under-represented investigators engaging in cancer research, the ongoing CURE program identifies promising candidates from high school through junior investigator levels and provides them with a continuum of competitive funding opportunities. Today, there are 30 CURE supported trainees and 14 high school and undergraduate students who are native Hawaiians.

Diversity Supplements

These diversity supplements are designed to foster diversity in the research workforce. These supplements support and recruit students, postdoctoral, and eligible investigators from groups shown to be under-represented in biomedical research. Currently, two native Hawaiian junior investigators are supported by diversity supplements.

NCI Community Center Centers Program (NCCCP)

The NCCCP is designed to create a community-based cancer center network to support basic, clinical, and population-based research initiatives, addressing the full cancer care continuum—from prevention, screening, diagnosis, treatment, and survivorship through end-of-life care. The NCCCP pilot has added the Queen's Medical Center, Honolulu, Hawaii (The Queen's Cancer Center) to its 30-hospital network.

Cancer Health Disparities Geographic Management Program (GMaP)

GMaP, a new initiative, is developing transdisciplinary regional networks dedicated to the coordination and support of cancer health disparities research training and outreach using regional management approach. Creating sustainable partnerships among institutions and agencies involved in cancer health disparities research and cancer care, this initiative seeks to advance cancer health disparities, diversity training and ultimately, contribute to disparities reduction. A companion program, the Biospecimen/biobanking Management Program, will support research and training infrastructure specific to biospecimen collections among under-represented populations across the country.

CANCER RESEARCH

Question. How will NCI support entities like 'Imi Hale, who engage Hawaiian communities in identifying and addressing cancer health disparities and invest in building community capacity to mobilize local resources and train local staff? The mission of the NCI CRCHD is to reduce the unequal burden of cancer in our society and train the next generation of competitive researchers in cancer and cancer health disparities research.

Answer. The NCI's CRCHD coordinates multiple programs that focus on community based participatory cancer disparities research and multi-institution collaborations to reduce the unequal burden of cancer and train the next generation of competitive cancer researchers. These programs include CNP, Patient Navigation Research Program (PNRP), MI/CCP, and CURE. All of the following programs are either in Hawaii or extend to native Hawaiians and address cancer health disparities and community building among Hawaiian communities.

CNP

The NCl/CRCHD CNP builds capacity in community-based participatory research, educational outreach, and professional training through partnerships with community organizations and institutions working with multiple racial/ethnic and underserved populations, including Hawaiian populations. The goal of the program is to improve access to beneficial cancer interventions and treatment in communities experiencing significant cancer health disparities. Currently, the NCI is supporting 25 CNP projects developing programs to increase the use of cancer interventions in underserved communities. Interventions include proven approaches including smoking cessation, increasing healthy eating and physical activity, and early detection and treatment of breast, cervical, and colorectal cancers.

Each CNP has put together an advisory group that serves as the "voice of the community." These advisory groups work with local community members to gather information and then deliver back results. A steering committee of community-based leaders, researchers, clinicians and public health professionals provides additional support.

To sustain successful efforts in their communities, CNP grantees work closely with policymakers and nongovernmental funding sources. Together, CNP grantees and NCI train investigators, identify potential research opportunities, and work to ensure that best practice models are widely disseminated.

MI/CCP

MI/CCP is designed to: (1) increase Minority Serving Institutions participation in cancer research and research training and (2) increase the involvement and effectiveness of NCI-designated Cancer Centers in developing effective research, education, and outreach programs to encourage diversity among competitive researchers and reduce cancer health disparities. These partnerships foster and support intensive collaborations to develop stronger cancer programs aimed at understanding the reasons behind significant cancer health disparities among racial and ethnic minority and socioeconomically disadvantaged populations. NCI supports grants under this program that establish such a partnership program in Hawaii.

The NCl/CRCHD supports a partnership program with UOG and CRCH, an NCI-designated cancer center at the University of Hawaii at Manoa. Engaged in a unique and successful partnership over the past 6 years, this program has established a Cancer Research Center of Guam on the campus of UOG to (1) increase the number of faculty and students engaged in cancer research at UOG; (2) increase the number of minority scientists of API ancestry engaged in cancer research, and providing pertinent undergraduate, graduate, and postgraduate education and training opportunities for API students; (3) further strengthen the research focus at CRCH on cancer health disparities with particular emphasis on aspects of particular relevance for the people of Hawaii and the Pacific; and (4) enhance the awareness of cancer and cancer prevention and, ultimately, to reduce the impact of cancer on the population in the Territory of Guam, the other U.S.-associated Pacific island territories, and Hawaii.

CURE

The CURE program is a strategic approach for training a diverse generation of competitive cancer researchers. The CURE provides educational support to students and junior investigators from high school through postdoctoral studies and mentors them in the early phases of their careers in cancer research. This approach builds on the success of the research supplements to promote diversity and strategically addresses each level of the biomedical research and education pipeline to increase the pool of researchers from underserved populations. There are currently 14 high school and undergraduate students being supported by a CURE supplement in Hawaii.

Diversity Supplements

These research supplements are designed to foster diversity in the research workforce. They support and recruit students, postdoctoral, and eligible investigators from groups shown to be under-represented in biomedical research. There are currently two junior investigators being supported by diversity supplements in Hawaii.

NCCCP

Another program within NCI addressing health disparities is the NCCCP program. The NCCCP is designed to create a community-based cancer center network to support basic, clinical and population-based research initiatives, addressing the full cancer care continuum—from prevention, screening, diagnosis, treatment, and survivorship through end-of-life care. The NCCCP has seven major focus areas to: (1) improve access to cancer screening, treatment, and research; (2) improve quality of care at community hospitals; (3) increase participation in clinical trials; (4) enhance cancer survivorship and palliative care services; (5) participate in biospecimen research initiatives to support personalized medicine; (6) expand use of electronic health records and connect to cancer research data network; and (7) enhance cancer advocacy.

Reducing and eliminating cancer disparities continues to be a major commitment for NCI, the research community, healthcare providers and policymakers. In recent years, the cancer research community has also begun to focus on understanding why members of some population groups experience higher cancer incidence and mortality rates than others.

CANCER RESEARCH

Question. Hawaiian researchers have been very effective in addressing the unequal burden of cancer among native Hawaiians; however Hawaiian researchers are not equally represented in the researcher pool. How will the administration demonstrate its long-term commitment to programs like 'Imi Hale that address disparities at all levels and identify, mentor, and provide research training, fellowships and grant opportunities to native Hawaiians interested in cancer research?

Answer. The NIH continues to promote its diversity programs to under-represented individuals at the college, graduate school, postdoctoral, and faculty stages of a scientist's career. Native Hawaiians are a key target group within these programs. Examining NIH's efforts in its formal research training programs at the pre- and postdoctoral levels, the most recent data from 2007 are encouraging regarding native Hawaiians and APIs. They show that 4 percent of NIH trainees self-identified as native Hawaiian and APIs, which is higher than the proportion of this group in the total U.S. population.

The challenge is to retain and sustain these individuals as they transition into their independent research careers. NIH has several key programs in place that are aimed at addressing this challenge. Specifically, CNP (http://grants.nih.gov/grants/guide/rfa-files/rfa-ca-09-032.html) is designed to support community-based participatory research in underserved populations and provide a training venue for preparing a new cadre of scientists to address health disparities research. Second, new initiatives in research in cancer health disparities (http://grants.nih.gov/grants/guide/pafiles/PAR-09-160.html and http://grants.nih.gov/grants/guide/pa-files/PAR-09-161.html) are also designed to provide a venue for young scientists to prepare for careers in health disparities research. MI/CCP between the University of Hawaii and UOG, and community-based programs, including the 'Imi Hale Native Hawaiian Cancer Network supported by the NCI, are dedicated to health disparities research in the Hawaii and Pacific region.

Finally, native Hawaiians and APIs are encouraged to apply for the Diversity Supplement to Research Grants Program (http://grants.nih.gov/grants/guide/pa-files/PA0908190.html) both on the Mainland and in Hawaii. This program has supported more than 500 APIs at stages of their careers ranging from college education to faculty research scientists. NIH intends to continue its support for all of these programs.

TUBERCULOSIS

Question. Dr. Collins, thank you for your continuing leadership on biomedical research issues. I would like to turn for a moment to tuberculosis (TB), one of the oldest diseases known to mankind. As you know, TB continues to impact millions of people around the world, including in my home State of Hawaii, which has the highest rates of TB in the Nation: 128 cases in 2008 or a rate of 9.6 per 100,000 Hawaiians. Further, complicating this already serious situation is the 20 percent increase Hawaii has experienced in the more difficult and expensive to treat multidrug resistant forms of TB, in part because of the decades that have passed since new treatments have been developed. Could you give me an overview of the research initiatives NIH is currently undertaking to address the drug resistant forms of TB.

Answer. TB research at NIH is primarily conducted and supported by the National Institute of Allergy and Infectious Diseases (NIAID). Through grants and

other mechanisms and through its intramural research program, NIAID supports a globally relevant TB research agenda. NIAID TB research is focused on all aspects of TB, including drug-susceptible and drug-resistant TB, as well as TB in HIV co-infected persons. NIAID-sponsored basic TB research includes studies to better understand the biology of TB and the host-pathogen interaction, including latent TB infection in human hosts and in animal models of infection and disease. NIAID-supported translational and clinical research is focused on the identification and development of new diagnostics, drugs, and vaccines. To better understand TB in special populations, NIAID's research agenda includes studies of TB in children and immune suppressed persons as well as studies to clarify the interaction of HIV and TB to improve TB prevention and treatment. To date, NIAID's investment in basic, translational, and clinical science has led to the development of several new candidate TB drugs, diagnostics, and vaccines. In addition, the NIAID developed a research agenda in fiscal year 2008, the NIAID Research Agenda for Multidrug-Resistant and Extensively Drug-Resistant Tuberculosis (MDR/XDR–TB), to complement and leverage ongoing efforts and focus on specific research gaps for MDR/XDRTB.

Specific NIAID research activities include the following:

Research on the pharmacological basis of drug resistance in infectious diseases.

—Studies to characterize drug-resistant TB strains, their epidemiology and their impact on disease progression, host immune response, and response to therapy.

—An initiative in fiscal year 2010 to support targeted clinical trials to evaluate and improve the optimal use of currently existing therapies for TB and support for phase I clinical studies of new TB drug candidates.

—Intramural and extramural studies of a multitude of international basic science, translational, diagnostic, and clinical research activities to better characterize drug-resistant TB and gain insight into what specific healthcare interventions need to be developed to combat and prevent drug-resistant TB.

—Collaborations with the HIV/AIDS clinical trials networks to expand studies of drug- sensitive and drug-resistant TB as a co-infection in patients with HIV/AIDS, enhance the capacity for international clinical trials on TB, and increase efforts to combat the co-epidemics of TB and HIV.

—An intramural research program project at the South Korean Masan National Tuberculosis Hospital, which cares for the largest population of MDR–TB inpatients in the world, to study the natural history of MDR–TB and the occurrence of extensively drug-resistant TB (XDR–TB) in patients who have completely failed chemotherapy.

—Coordination of drug-sensitive and drug-resistant TB research activities with other Federal agencies through the U.S. TB Task Force, as well as with other Government and nongovernmental organizations such as the WHO/Stop TB Partnership, programs funded by the Bill & Melinda Gates Foundation, and not-for-profit product development partnerships.

UNDER-REPRESENTED BIOMEDICAL RESEARCHERS

Question. For the past 19 years, the Distance Learning Center has been pioneering a new training paradigm, the STEMPREP Project, to create the next generation of researchers from native Hawaiian and other under-represented minority students. The project provides an earlier start in the training pipeline (7th grade) to a national pool of minority child prodigies who desire a career in STEM and medicine. As we continue our efforts to reduce and ultimately eliminate the racial and ethnic health disparities that plague our healthcare system, we must support a generation of physician scientists and researchers who have the skills to develop sound public health solutions and advance public health through scientific discovery. How will the administration demonstrate its commitment to programs like the Physician Scientist Training Program that has called for an increase in the supply of biomedical researchers from under-represented racial and ethnic minority populations?

Answer. The NIH has a history of creating and supporting policies and programs with the goal of promoting and providing a diverse workforce in the biomedical, behavioral, clinical, and social sciences. NIH programs are designed to recruit, train, retain, and develop the careers of under-represented individuals, and every NIH research training, fellowship, career development, and research education project award Funding Opportunity Announcement explicitly States this policy. A number of programs target talented science undergraduates by providing funds for their college tuition and a stipend for living expenses to promote their pursuit of a career in biomedicine. At the doctoral level of education, the NIH awards fellowships, traineeships, and research grant supplements to individuals in support of their studies toward the research doctorate degree. At the postdoctoral level, NIH offers

fellowships, career development, and research grant supplements to promote the transition of young scientists to independent investigators.

In terms of a commitment to providing a diverse workforce in the future, the NIH continues to evaluate and explore new and creative programs to promote a diverse workforce. Most recently, the NIH has committed ARRA funds to support the NIH Director's Pathfinder Award to Promote Diversity in the Scientific Workforce (DP4) which was announced on March 5, 2010. This new research grant program encourages exceptionally creative individual scientists to develop highly innovative approaches for promoting diversity within the biomedical research workforce. The proposed research must reflect ideas substantially different from those already being pursued or apply existing research designs in new and innovative ways to unambiguously identify factors that will improve the retention of students, postdocs and faculty from diverse backgrounds in the workforce (http://grants.nih.gov/grants/guide/rfa-files/RFA-OD-10-013.html).

New studies and grant programs are also underway to identify barriers to underrepresented individuals being incorporated into the biomedical workforce and to more effectively address those barriers. The National Institute of General Medical Sciences has launched two new research grant programs to explore the development of new interventions to improve diversity (http://grants.nih.gov/grants/guide/rfa-files/RFA-GM-10-008.html and http://grants.nih.gov/grants/guide/rfa-files/RFA-GM-09-011.html).

In addition, the Office of the Director is undertaking studies to more explicitly identify attrition points along the pathway between high school and achieving independence as a biomedical scientist. Relating this information to variables such as race, ethnicity and gender should enable NIH to target interventions more selectively and improve our ability to recruit and retain a diverse population of researchers.

QUESTIONS SUBMITTED BY SENATOR ARLEN SPECTER

CURES ACCELERATION NETWORK

Question. Moving the new authorized Cures Acceleration Network (CAN) forward is of critical importance. What would the timeline be for getting the program started if funding is provided?

Answer. If funding is provided, the first step would be to appoint CAN's advisory board and identify priority areas. After this, the National Institutes of Health (NIH) would prepare grant and contract solicitation announcements within approximately 2 months of the first board meeting. Applicants would be given 60 days to prepare applications in response to the solicitation(s). The application reviews would occur within several weeks following receipt, and awards made rapidly thereafter. Under this timetable, we would expect to disburse awards within the first year.

CLINICAL CENTER

Question. What is the current number of patients being treated at the Mark O. Hatfield Clinical Research Center in Bethesda? As the largest clinical research hospital in the world, what capacity is it? If it is not at full capacity when do you anticipate that it will be?

Answer. As of May 26, 2010, the Mark O. Hatfield Clinical Research Center has seen 17,450 patients in the inpatient and outpatient settings; approximately 38,000 inpatient days and 61,000 outpatient visits this fiscal year. The current inpatient capacity at the Mark O. Hatfield Clinical Research Center is 234 beds. A new 6-bed high containment unit that will allow us to study patients with infectious diseases is scheduled to open shortly and will increase the Center's total capacity to 240 beds.

In fiscal year 2010, the Mark O. Hatfield Clinical Research Center has been operating at an average daily census of 166 inpatients per day which represents an occupancy level of approximately 70 percent. Based on plans that the Institutes are making fiscal year 2011, we anticipate an increase in inpatient activity of approximately 2 percent more than fiscal year 2010. In addition, NIH leaders are exploring the feasibility of opening the Mark O. Hatfield Clinical Research Center to the outside research community, and discussions are underway with the NIH Scientific Management Review Board. Such a change could lead to increased utilization.

PANCREATIC CANCER

Question. Pancreatic cancer research accounts for only about 2 percent of NIH's budget, even though it is the forth leading cancer killer and has one of the lowest survival rates. What can be done to increase funding?

Answer. Since the publication of Pancreatic Cancer: An Agenda for Action in 2001, the National Cancer Institute (NCI) has expanded its portfolio of pancreatic cancer research from $21.8 million in fiscal year 2001 to $89.7 million in fiscal year 2009, an increase of more than 300 percent. During this period, the total NCI budget increased by about 30 percent; thus, the growth in the pancreatic cancer portfolio has been approximately tenfold larger than the growth in the total NCI budget. As documented in Pancreatic Cancer: Six Years of Progress in 2007, the NCI pancreatic cancer research portfolio has grown within each of the six major research priority areas identified in 2001.

In addition to an increase in funding, there have also been increases in the number of projects funded (up more than 275 percent since fiscal year 2000), unique RO1 Grant Principal Investigators funded (up more than 200 percent since fiscal year 2000), and training/career development awards (up more than 65 percent since fiscal year 2005). Part of the growth came about through planned actions and funding opportunities specific to pancreatic cancer, and part grew out of an increasingly larger pool of pancreatic cancer researchers successfully competing for general funding opportunities and unsolicited research grants.

In addition, pancreatic cancer projects were also funded through the American Recovery and Reinvestment Act of 2009 (ARRA). In fiscal year 2009, 79 pancreatic cancer-related projects received ARRA funding totaling $10.7 million. These projects include some focused on training/career development that are relevant to growing the critical mass of pancreatic cancer investigators, a group of traditional RO1 research grants, a Challenge Grant, and a Grand Opportunity or "GO" grant. The NCI Community Cancer Centers Program, a group already working on pancreatic cancer, has been further developed with ARRA funds. The ACTNOW initiative, which supports high-priority, early-phase clinical trials of new cancer treatments on an accelerated timeline includes a clinical trial addressing pancreatic cancer. Finally, The Cancer Genome Atlas project (TCGA) is using ARRA funds to rapidly increase the number of cancers covered by the project, including pancreatic cancer. ARRA has provided a unique opportunity to accelerate progress in pancreatic cancer research.

NCI has focused considerable expertise on assessing the state of the science in pancreatic cancer and developing a targeted network of pancreatic cancer experts for consultation with NCI program staff In 2006, NCI created a Gastrointestinal Cancer Steering Committee (GISC) with seven specific disease-site task forces, including one focused on pancreatic cancer. GISC members include all Cooperative Group gastrointestinal disease committee chairs, representatives from the Specialized Programs of Research Excellence (SPOREs), Cancer Center and R01/P01 investigators, along with community oncologists, biostatisticians, patient advocates and NCI staff. Through GISC, NCI convened a Pancreas State of-the-Clinical Science meeting in 2007 to discuss the integration of basic and clinical knowledge into the design of clinical trials for pancreatic cancer and to define the direction for clinical trials investigation for pancreatic cancer over the next 3 to 5 years. A Consensus Report from the meeting, published in the Journal of Clinical Oncology in November 2009, emphasized the importance of enhanced molecular targets and targeted drugs for pancreatic cancer, better preclinical models, and improved phase II studies. The GISC is an active part of NCI's programmatic development for pancreatic and other gastrointestinal cancers. The GISC' s pancreatic cancer task force provides important leadership, meeting on a monthly basis to coordinate strategy between the cooperative groups, identifying new leads to explore, and monitoring ongoing trials. Within the pancreatic cancer task force, a working group has been created to focus on development of trials for locally advanced disease. In addition, as part of the operational efficiency working group guidelines for the development of clinical trials, the pancreatic cancer task force is now operating under an accelerated timeline for the development of phase II and III clinical trials.

Finally, in response to earlier congressional language, NCI will be holding an internal meeting this summer to discuss research and training initiatives relevant to pancreatic cancer.

Question. In 2001, NCI developed a set of 39 recommendations for increasing pancreatic cancer research, including attracting more scientists to this field of study. Nine years later, only five of its own recommendations have been implemented. Over the same time period the NCI's budget has grown by more than $1 billion, so it's not a question of funds being available. Given the fact that pancreatic cancer

deaths are increasing, what concrete steps will you take to make this field of study a higher priority?

Answer. Since the publication of Pancreatic Cancer: An Agenda for Action in 2001, the NCI has expanded its portfolio of pancreatic cancer research from $21.8 million in fiscal year 2001 to $89.7 million in fiscal year 2009, an increase of more than 300 percent. During this period, the total NCI budget increased by about 30 percent; thus, the growth in the pancreatic cancer portfolio has been approximately tenfold larger than the growth in the total NCI budget. As documented in Pancreatic Cancer: Six Years of Progress in 2007, the NCI pancreatic cancer research portfolio has grown within each of the six major research priority areas identified in 2001.

A genome-wide association study to uncover the causes of pancreatic cancer, known as PanScan, has identified five important genetic regions that greatly influence the risk of developing pancreatic cancer. NCI is now focused in detail on each of these genetic risk regions. NCI is active in the Pancreatic Cancer Genetic Epidemiology Consortium, founded to examine susceptibility genes in familial pancreatic cancer.

Other initiatives include the Pancreatic Cancer Cohort Consortium, and pancreatic and GI SPOREs. In November 2009, NCI launched one of the largest phase III trials ever undertaken in pancreatic cancer (RTOG 0848), intended to enroll 900 patients to evaluate both Erlotinib and chemoradiation as adjuvant treatment.

Pancreatic cancer studies have been funded within the Cancer Nanotechnology Platform Partnerships, the Early Detection Research Network, and the Tumor Glycome Laboratories of the NIH Alliance of Glycobiologists for Detection of Cancer and Cancer Risk. NCI is collaborating with the Pancreatic Cancer Action Network (PanCAN) and the Lustgarten Foundation for Pancreatic Cancer research on the Pancreatic Cancer Research Map. This project facilitates collaborations among pancreatic cancer researchers to speed the development of national strategies, and leverage resources for pancreatic cancer research. The map provides a unified collection of pancreatic cancer research projects, funding opportunities, and investigators.

QUESTIONS SUBMITTED BY SENATOR THAD COCHRAN

SPINAL MUSCULAR ATROPHY (SMA)

Question. What role can the National Institutes of Health (NIH) play in laying the groundwork for SMA and to develop new therapies and work with the Food and Drug Administration (FDA) to support new therapies? Please update the subcommittee on what are the next steps that NIH is planning to take to prepare for, support and sustain the efforts that will be necessary up to and through clinical trials for SMA?

Answer. Due to NIH's continued investment in SMA research, including studies on disease mechanisms and preclinical/translational therapy development, the first treatments for SMA are now advancing through the therapeutic development pipeline. The NIH has taken a number of steps to continue to support development of potential treatments up to and through clinical trials.

NIH supports a variety of projects for translating basic research findings into therapies that can be tested in a clinical setting. The SMA Project, funded by the NIH and guided by experts from industry, academia, NIH, and the FDA, is an innovative, contract-based, "virtual-pharma" program to develop drugs and test them in the laboratory. The project holds two patents on two sets of compounds that show significant promise and, assuming successful preclinical testing, a phase I clinical trial to assess safety should begin in 2011. The project is also continuing to pursue other leads.

To complement the SMA project, the NIH also funds investigator-initiated therapy development projects. This year, National Institute of Neurological Disorders and Stroke (NINDS) began funding a major milestone-driven collaboration between an academic lab and a biotech company to develop a lead compound into a drug that is ready for clinical testing in SMA patients. An investigator-initiated grant funded by the National Institute of Child Health and Human Development is designed to assess the natural history of the disease and perform pilot studies to evaluate potential interventions in a broad cohort of SMA patients. Additionally, NIH has used American Recovery and Reinvestment Act (ARRA) funds to make investments in rapidly developing opportunities, including a Grand Opportunity grant on delivery of therapeutic genes for motor neuron diseases. Stem cell research relevant to SMA has also been funded, including studies of induced pluripotent stem cells derived from SMA patients.

NIH has also made a commitment to support high-quality clinical trials for SMA and other pediatric disorders. In February, the NINDS Council approved NINDS–NET, a multi-site clinical research network to expedite early phase clinical trials of therapies from academic research, foundations, or biotech companies. Because all network participants are required to have expertise in clinical trials for pediatric neurological disorders as well as adult diseases, this clinical research network provides the framework for high-quality trials for SMA and other rare disorders.

The NIH, working with SMA volunteer organizations, has organized a workshop for later this year that will focus on therapies that are approaching readiness for clinical testing, what hurdles remain, and what is needed for effective SMA clinical trials. A second workshop, organized by both the NIH and FDA, will address specifically the use of anti-sense oligonucleotides in treating neuromuscular disorders including SMA, and will provide FDA input into clinical and preclinical studies. Both of these workshops will not only facilitate communication among SMA researchers, NIH, and the FDA, but will also help the research community plan for moving therapies into clinical trials.

CROHN'S DISEASE

Question. Dr. Collins, I want to thank you and the leadership of the National Institute of Diabetes and Digestive and Kidney Diseases for advancing research on Crohn's disease and ulcerative colitis. As you know, these are extremely painful and debilitating disorders that are increasing in prevalence. Can you tell us what needs to be done to translate the remarkable genetic discoveries of recent years into better treatments for patients?

Answer. The NIH support for research on the genetics of Crohn's disease and ulcerative colitis—the two major forms of inflammatory bowel diseases (IBD)—is providing the foundation for the development of unique and effective therapies for patients who suffer from these diseases. Following the discovery of the first IBD-associated gene, the NIH established a major program in 2002—the IBD Genetics Consortium—to accelerate the discovery of genetic variants that are associated with the disease. To date, this very successful program has uncovered nearly 50 genetic variants that are associated with both major forms of IBD. Progress in this area was bolstered by recent investments from ARRA, which provided additional support for the consortium to enhance its ability to expand and develop resources. In addition, ARRA supported innovative projects to identify genetic variations that are less common amongst people with Crohn's disease and extend the success of genome wide association studies to identify genetic variations that predispose individuals from different ethnic groups to developing IBD. As researchers continue to discover additional genetic variants associated with IBD, it will be important for these advances to be translated into better treatments for patients. Through ARRA and regular appropriations, the NIH is supporting research to define the biological processes that are perturbed by genetic variants associated with IBD. In some cases, genetic variants that have limited direct associations with IBD may have significant biological consequences, and it will be important to consider these factors when developing models of disease risk. By further understanding the genetic variants associated with disease and their molecular consequences, researchers will be able to develop and validate biomarkers as indicators of disease risk, disease prognosis, and patient responses to therapies. In addition, as the biological pathways underlying IBD are better defined, researchers will identify targets for developing new therapeutics to help treat these painful and debilitating disorders.

MINORITY HEALTH

Question. How will the new data collection requirements on race and ethnicity, primary language, geographic location, and disability status affect research at NIH? How will this information be used? Are you collaborating with the existing Department of Health and Human Services, Office of Minority Health (OMH) in order to coordinate and establish an effective Government effort to address minority health issues?

Answer. The new data collection requirements will advance NIH's research-based efforts for improving the health of the Nation. The limited specificity, uniformity and quality of data collection and reporting procedures has been a significant restraint in identifying and monitoring efforts to reduce health disparities. According to a recent report by the Institute of Medicine (IOM) "Race, Ethnicity, and Language Data: Standardization for Health Care Quality Improvement, "from the Subcommittee on Standardized Collection of Race/Ethnicity Data for Healthcare Quality Improvement," consistent methods for collecting and reporting healthcare data on

racial and ethnic minorities are essential to informing evidence-based disparity reduction initiatives.

In addition, as the demographics of the United States continue to shift, it is essential to understand the diversity of the Nation based on race, ethnicity, primary language, and disability status. Collecting information on the geographic distributions of racial and ethnic populations will aid researchers in understanding how geographic location and environmental factors for example, contribute to the existence and persistence of health disparities. During the past 10 years there has been a growing appreciation of the role these factors play in health disparities. Collecting this data will assist researchers in understanding how these factors, working independently and dependently, contribute to the excess burden of disease, morbidity, and mortality experienced by racial and ethnic minorities relative to majority populations.

This enhanced data collection will be useful in clinical research, especially in Comparative Effectiveness Research, where there will be the need to collect information on these racial and ethnic subgroups to produce statistically reliable evidence-based results. Statistical oversampling of certain subpopulations in clinical comparative effectiveness research will be done as needed. In addition to improving data collection across Federal categories of race and ethnicity, information is needed on racial and ethnic subgroups. This new data collection will be critical to monitoring the health status and needs of immigrant and language minority populations. This calculates to approximately 100 different ethnic groups with populations more than 100,000 living in the United States.

Health disparities are persistent and eliminating them requires an in-depth understanding of how multiple factors—social and biological—act independently and dependently. Collecting information on race, ethnicity, primary language, disability status, and geographic location will allow researchers to better understand these factors and their interactions. Scientists will use it to design interventions tailored to meet the needs of racial and ethnic populations as a function of primary language or geographic location, or other factors.

The NIH, through the National Center on Minority Health and Health Disparities (NCMHD), has had a long-standing tradition of collaboration and coordination of minority health and health disparities activities with the HHS OMH. Over the years the NCMHD and OMH have worked collaboratively to address a number of minority health issues both domestically and internationally, as well as support several minority health initiatives with funding from some of the Institutes and Centers. Most recently, the NIH has participated in:

—The development of the HHS National Partnership Action Plan led by OMH;
—NIH is represented on the HHS Health Disparities Council which deals with minority health and health disparities issues across the HHS and for some time has been led by the OMH;
—NCMHD and OMH are collaborating on an ARRA initiative to develop Centers of Excellence for Comparative Effectiveness Research through the NCMHD Centers of Excellence; and
—NCMHD and OMH serve as two of three Federal Government co-leads for the Federal Collaboration on Health Disparities Research (FCHDR) which is aimed at enhancing wide Federal Government coordination around minority health and health disparities.

INSTITUTIONAL DEVELOPMENT AWARD (IDEA)

Question. Does the list of eligible States ever change to reflect their greater or lesser success over time in attracting competitive NIH research funding?

Answer. When Congress authorized the Institutional Development Award (IDeA) program in 1993, its intent was to promote geographic distribution of NIH funding across the United States. in order to increase the research capacity in eligible States. The eligibility to participate in the IDeA program has been evaluated on a yearly basis and the list of eligible States has not changed over the years with the exception of Alabama, which was once an IDeA eligible State that became ineligible based on its success in obtaining NIH funding. The current list of IDeA eligible States can be found on the National Center for Research Resources' (NCRR) Web site at http://www.ncrr.nih.gov/research__infrastructure/institutional__development__award/.

The current IDeA eligibility criteria are based on two components: (1) a success rate for competing research projects and centers of less than 20 percent for obtaining NIH grant awards during 2001–2005; or (2) less than $120 million average NIH funding during 2001–2005 (regardless of success rate), excluding IDeA awards and R&D contracts.

NCRR is currently evaluating whether the IDeA eligibility criteria are still appropriate to accomplish the legislative intent. As it does so, the eligibility criteria and the IDeA-eligible States will remain the same.

QUESTIONS SUBMITTED BY SENATOR RICHARD C. SHELBY

BIODEFENSE

Question. In National Institute of Allergy and Infectious Diseases (NIAID)'s Strategic Plan for Biodefense Research 2007 Update, NIAID outlined three "broad spectrum" strategies as a way to maximize biodefense capabilities. One of these strategies was the exploration of broad spectrum platforms, which NIAID describes as standardized methods that can be used to significantly reduce the time and cost required to bring medical countermeasures to market. Please explain how much funding has been spent in this area and what milestones have been reached.

Answer. NIAID's product development strategy has broadened from a "one bug-one drug" approach toward a more flexible, broad-spectrum approach. This process involves developing medical countermeasures that are effective against a variety of pathogens and toxins, developing technologies that can be widely applied to improve classes of products, and establishing platforms that can reduce the time and cost of creating new products. The broad-spectrum strategy recognizes both the expanding range of biological threats and the limited resources available to address each individual threat. NIAID provided $653 million in fiscal year 2009 to a number of initiatives that have the potential to lead to the development of broad spectrum platforms. Examples of milestones in the development of broad-spectrum strategies that have been facilitated by NIAID funding include:

—The preclinical development of Advax™, a vaccine adjuvant platform technology. Advax™ has been approved for human use in Australia for at least five different candidate vaccines and currently is being tested in seasonal and pandemic influenza vaccines and hepatitis B vaccines that are ready to enter phase III clinical trials.

—The development of LJ001, a broad-spectrum antiviral that has shown activity against multiple viruses, including influenza, Ebola, Marburg, hepatitis C, and West Nile.

—Syntiron's broad-spectrum vaccine technology that is currently used for candidate vaccines for Staphylococcus, Salmonella, plague, and anthrax.

BIODEFENSE

Question. Specifically, equine source plasma has been successfully used in the development of passive antibody therapy for postexposure treatment of agents such as botulinum toxin. I understand this same technique can be used for treatment of a number of the Category A biological threat agents such as Bacillus anthracis, hemorrhagic fevers (i.e., Ebola and Marburg), and Yersinia pestis. Is NIAID familiar with this platform of therapeutics and its successes? Has NIAID applied funding either from within its directly appropriated funds or from BARDA transferred funds to the development of passive antibody therapeutics? If so how much and on what projects?

Answer. NIAID is significantly involved in the development and use of passive antibody therapy for postexposure treatment of agents such as botulinum toxin and has provided more than $92 million in funding over the past 3 years for the development of passive antibody therapy for Category A agents. Among other efforts, NIAID supported the development of the botulinum toxoid antibody from horses for a product that is now included in the Strategic National Stockpile; coordinated with the Biomedical Advanced Research and Development Authority (BARDA) for development of animal models in support of licensure of botulinum anti-toxins; and supported initial work to develop ricin polyclonal antibodies from equine antisera.

CONCLUSION OF HEARINGS

Senator HARKIN. The subcommittee will stand recessed.

[Whereupon, at 11:05 a.m., Wednesday, May 5, the hearings were concluded, and the subcommittee was recessed, to reconvene subject to the call of the Chair.]

DEPARTMENTS OF LABOR, HEALTH AND HUMAN SERVICES, AND EDUCATION, AND RELATED AGENCIES APPROPRIATIONS FOR FISCAL YEAR 2011

U.S. SENATE,
SUBCOMMITTEE OF THE COMMITTEE ON APPROPRIATIONS,
Washington, DC.

NONDEPARTMENTAL WITNESSES

[CLERK'S NOTE.—The subcommittee was unable to hold hearings on nondepartmental witnesses. The statements and letters of those submitting written testimony are as follows:]

PREPARED STATEMENT OF THE ASSOCIATION OF AMERICAN CANCER INSTITUTES

The Association of American Cancer Institutes (AACI), representing 95 of the Nation's premier academic and free-standing cancer centers, appreciates the opportunity to submit this statement for consideration by the United States Senate's Subcommittee on Labor, Health and Human Services, and Education, and Related Agencies.

AACI applauds recent budgetary commitments—notably, increased funding for the National Institutes of Health (NIH) and support from the Obama administration through the American Recovery and Reinvestment Act of 2009 (ARRA)—that have created a more encouraging landscape for cancer research compared to recent years. We hope that this support will continue in the years ahead, to ensure that this recognition of the importance of biomedical research is sustained.

AACI congratulates the administration and Congress on their commitment to ensuring quality care for cancer patients, as well as for providing researchers with the tools that they need to develop better cancer treatments and, ultimately, to cure this disease.

President Obama has released his fiscal year 2011 budget which includes a $1 billion increase to NIH budget for an expansion of support for biomedical research. This funding boost would make the NIH budget $32.1 billion, representing a 3.2 percent increase. The National Cancer Institute (NCI) would receive an additional $161 million, or 3.16 percent more, for a total of $5.26 billion.

AACI has joined its colleagues in the biomedical research community in supporting the proposed increase for NIH and in calling on Congress to further strengthen the impact of the President's request by increasing funding to $35 billion.

With the extra NIH and NCI funding, the cancer community will be better equipped to leverage ARRA financial support. ARRA dollars have helped to sustain the momentum achieved in reducing death rates from cancer, and they are proving to be an effective means of stimulating local economies and creating or maintaining jobs throughout the country.

For example, The Ohio State University Comprehensive Cancer Center and the Winthrop P. Rockefeller Cancer Institute at the University of Arkansas for Medical Sciences are moving forward with major construction projects supported by ARRA funding. Another AACI member, the University of New Mexico Cancer Center, is buying equipment and hiring more staff with ARRA money, while a researcher at Tennessee's Vanderbilt-Ingram Cancer Center is studying imaging techniques in colorectal cancer with help from ARRA grants (Association of American Cancer Institutes, AACI Update, February 2010).

Maintaining the flow of sufficient, dependable funding streams for NCI will help to continue the work that started under the stimulus plan. It will also serve as recognition that $70 million worth of great ideas—the approximate amount of ARRA funding for NCI to date—might not have been explored if it were not for the administration's unprecedented infusion of funds for cancer research. And much untapped scientific potential remains.

Cancer Research: Benefiting all Americans

Cancer's financial and personal impact on America is substantial and growing—1 in 2 men and 1 in 3 women will face cancer in their lifetimes, and cancer cost our Nation more than $228 billion in 2008 (Centers for Disease Control and Preventions, Addressing The Cancer Burden: At A Glance 2010). This year, cancer will become the world's number one killer. Investing in cancer research is a prudent step—both for the health of our Nation and for our Nation's economic well-being.

Cancer research, conducted in academic laboratories across the country, saves money by reducing healthcare costs associated with the disease, enhances the United States' global competitiveness, and has a positive economic impact on localities that house a major research center. While these aspects of cancer research are important, what cannot be overstated is the impact cancer research has had on individuals' lives—lives that have been lengthened and even saved by virtue of discoveries made in cancer research laboratories at cancer centers across the United States.

Biomedical research has provided Americans with better cancer treatments, as well as enhanced cancer screening and prevention efforts. Some of the most exciting breakthroughs in current cancer research are those in the field of personalized medicine. In personalized medicine for cancer, not only is the disease itself considered when determining treatments, but so is the individual's unique genetic code. This combination allows physicians to better identify those at risk for cancer, detect the disease, and treat the cancer in a targeted fashion that minimizes side effects and refines treatment in a way to provide the maximum benefit to the patient.

In the laboratory setting, multi-disciplinary teams of scientists are working together to understand the significance of the human genome in cancer. For instance, the Cancer Genetic Markers of Susceptibility initiative is comparing the DNA of men and women with breast or prostate cancer with that of men and women without the diseases to better understand the diseases. The Cancer Genome Atlas is in development as a comprehensive catalog of genetic changes that occur in cancer.

These projects—along with the work being performed by dedicated physicians and researchers at cancer centers across the United States every day—have the potential to radically change the way cancer, as a collection of diseases, affects the people who live with it every day. Every discovery contributes to a future without cancer as we know it today.

Clinical Trials

Clinical trials are the cornerstone of cancer research, and it is commonly held that "yesterday's clinical trials are today's standard therapies". Without clinical trials we cannot discover new cancer drugs and better treatments, and without volunteers we cannot conduct trials.

With no more than 5 percent of adult cancer patients participating in clinical trials, attracting volunteers to trials has been a long-standing struggle for cancer researchers. And yet, thanks in large part to advances realized through clinical trials, two-thirds of cancer patients now survive at least 5 years after diagnosis, compared with only half a generation ago.

Unfortunately, running a clinical trial from start to finish can be prohibitively complicated and expensive. While the Nation's cancer centers represented by AACI work to untangle red tape and other factors that can derail trials, a serious obstacle stands largely beyond their control—the cost to patients of participating in trials.

Section 2709 of the Patient Protection and Affordable Care Act of 2010 requires health insurance plans, including those offered through the Federal Employee Health Benefit Program, to provide coverage for routine costs associated with participation in clinical trials.

Commercial health insurers often refuse to pay for routine care costs associated with a clinical trial, arguing that the trial is "investigational" and thus optional or unnecessary. Consequently, patients experience financial difficulties that limit their participation in trials. That, in turn, has a negative impact on research and patients' ability to receive promising treatments that are available through trials. It slows the development of new cancer therapies.

Routine costs associated with clinical trials include physician visits, blood work, hospital stays and x-rays. These costs would usually be reimbursed by the insurer

if the patient was not participating in a clinical trial. The investigational portion of the trial (usually a new drug or device) is not charged to the patient or the insurer.

Since 1994, 27 States and the District of Columbia have passed laws requiring insurance coverage for routine patient care costs when patients participate in clinical trials, and another 5 States have established cooperative agreements with insurers to do so. However, beyond the patchwork nature of such coverage, some of these laws do not necessarily require insurers to cover all cancer patients, such as those in phase I or II clinical trials, or those with employer self-insured plans, in which a large company self-insures its employees. With the new Federal policy, all cancer patients can now afford to enroll in a potentially life-saving clinical trial.

The Nation's Cancer Centers

The nexus of cancer research in the United States is the Nation's network of cancer centers represented by AACI. These cancer centers conduct the highest-quality cancer research anywhere in the world and provide exceptional patient care. The Nation's research institutions, which house AACI's member cancer centers, receive an estimated $3.15 billion from NCI to conduct cancer research; this represents 65 percent of NCI's total budget (U.S. Department of Health and Human Services, National Institutes of Health, National Cancer Institute 2008 Fact Book). In fact, 84 percent of NCI's budget supports research at nearly 650 universities, hospitals, cancer centers, and other institutions in all 50 States. Because these centers are networked nationally, opportunities for collaborations are many—assuring wise and nonduplicative investment of scarce Federal dollars.

Collaboration between the cancer centers' and NCI is also essential, and extramural input in shaping NCI's programmatic priorities is vital for effecting cancer research breakthroughs. Furthermore, AACI endorses the call for greater collaboration expressed in recent testimony by Robert S. DiPaola, MD, Director of the Cancer Institute of New Jersey, delivered before the Health Subcommittee of the House Energy and Commerce Committee. The association is in strong agreement with Dr. DiPaola that "culture of collaboration" needs to be nurtured among NCI-designated cancer centers, as well as between such centers and the pharmaceutical and biotechnology companies that develop drug treatment for cancer and related illnesses.

In addition to conducting basic, clinical, and population research, the cancer centers are largely responsible for training the cancer workforce that will practice in the United States in the years to come. Much of this training depends on Federal dollars, via training grants and other funding from NCI. Sustained Federal support will significantly enhance the centers' ability to continue to train the next generation of cancer specialists—both researchers and providers of cancer care.

By providing access to a wide array of expertise and programs specializing in prevention, diagnosis, and treatment of cancer, cancer centers play an important role in reducing the burden of cancer in their communities. The majority of the clinical trials of new interventions for cancer are carried out at the Nation's network of cancer centers.

Ensuring the Future of Cancer Care and Research

Because of an aging population, an increasing number of cancer survivors require ongoing monitoring and care from oncologists, and new therapies that tend to be complex and often extend life.

Demand for oncology services is projected to increase 48 percent by 2020. However, the supply of oncologists expected to increase by only 20 percent and 54 percent of currently practicing oncologists will be of retirement age within that timeframe. Also, alarmingly, there has been essentially no growth over the past decade in the number of medical residents electing to train on a path toward oncology as a specialty (American Society of Clinical Oncology, Forecasting the Supply of and Demand for Oncologists: A Report to the American Society of Clinical Oncology (ASCO) from the AAMC Center for Workforce Studies, 2007).

Without immediate action, these predicted shortages will prove disastrous for the state of cancer care in the United States. The discrepancy between supply and demand for oncologists will amount to a shortage of 9.4 to 15.1 million visits, or a shortage of 2,550 to 4,080 oncologists. (American Cancer Society, Cancer Facts and Figures 2008).

Cancer physicians—while essential—are only one part of the oncology workforce that is in danger of being stretched to the breaking point. For example, the Health Resources and Services Administration has predicted that by 2020, more than 1 million nursing positions will go unfilled. The Department of Health and Human Services projects that today's 10 percent vacancy rate in registered nursing positions will grow to 36 percent, representing more than 1 million unfilled jobs by 2020.

Greater Federal support for training oncology physicians, nurses, and other professionals who treat cancer must be enacted to prevent a disaster where demand for oncology services far outstrips the system's ability to provide adequate care for all.

Conclusion

These are exciting times in science and, particularly, in cancer research. The AACI cancer center network is unrivaled in its pursuit of excellence, and places the highest priority on affording all Americans access to superior cancer care, including novel treatments and clinical trials. It is through the power of collaborative innovation that we will accelerate progress toward a future without cancer, and research funding through the NIH and NCI is essential to achieving our goals.

PREPARED STATEMENT OF THE AMERICAN ASSOCIATION OF COLLEGES OF NURSING

The American Association of Colleges of Nursing (AACN) respectfully submits this testimony highlighting funding priorities for nursing education and research programs in fiscal year 2011. AACN represents nearly 650 schools of nursing at public and private institutions with baccalaureate and graduate nursing programs that include more than 270,000 students and 13,000 faculty members. These institutions educate almost half of our Nation's Registered Nurses (RNs) and all of the Advanced Practice Registered Nurses (APRNs), nurse faculty, and researchers.

The Nationwide Nursing Shortage

The United States is in the midst of a nursing shortage that has impacted the quality care in our Nation's healthcare system for 12 years. The current economic downturn has led to a false impression that the nursing shortage is "easing" in some parts of the country because hospitals are enacting hiring freezes and nurses are choosing to delay retirement. However, this trend is only temporary. More positions continue to open for RNs across the country due to factors such as an aging population, increased complexity of care, and a significant population with chronic diseases. Moreover, the new healthcare reform law will increase access to care, which will require a surge in the number healthcare providers. RNs and APRNs will be in high demand. This comes at a time when the U.S. Bureau of Labor Statistics (BLS), currently reports that nursing is the Nation's top profession in terms of projected job growth with more than 581,000 new positions being created through 2018 (a 22 percent increase in the workforce). Unless we act now, this shortage will further jeopardize patient access to quality care.

Nursing and economic research clearly indicate that today's shortage is far worse than those of the past. The current supply and demand for nurses demonstrates two distinct challenges. First, due to the present and looming demand for healthcare by American consumers, the supply is not growing at a pace that will adequately meet long-term needs, including the demand for primary care, which is often provided by APRNs. This is further compounded by the number of nurses who will retire or leave the profession in the near future, ultimately reducing the nursing workforce. Second, the supply of nurses nationwide is stressed due to capacity barriers in schools of nursing. According to AACN, 54,991 qualified applicants were turned away from baccalaureate and graduate nursing programs in 2009 primarily due to insufficient number of faculty, clinical sites, classroom space, clinical preceptors, and budget constraints. Federal support for nursing education is critical at this juncture in American history. National reform goals cannot be met without an adequate number of nurses to provide the cost-effective and quality care associated with the nursing discipline.

Nursing Workforce Development Programs: A Proven Solution

For nearly five decades, the title VIII Nursing Workforce Development Programs (42 U.S.C. 296 et seq.) have supported hundreds of thousands of nurses and nursing students. The title VIII programs award grants to nursing education programs, as well as provide direct support to nurses and nursing students through loans, scholarships, traineeships, and programmatic grants.

The Nursing Workforce Development Programs are effective and meet their authorized mission. AACN's 2009–2010 title VIII Student Recipient Survey included responses from 1,420 students who noted that these programs played a critical role in funding their nursing education, which will ultimately help them to achieve future career goals. The students responding to the title VIII survey have career aspirations that meet the direct needs of the healthcare system and the profession. A high percentage of the students surveyed (48.9 percent) reported that their career goal is to become a nurse practitioner. Given the demand for primary care providers,

the title VIII funds are helping to support the next generation of these essential practitioners. Moreover, the nurse faculty shortage continues to inhibit the ability of nursing schools to increase student capacity and address the shortage. Of the students who responded to the survey, 40.6 percent stated their ultimate career goal was to become nurse faculty. Providing support for title VIII is the key to help schools expand student capacity, fill vacant nursing positions, and, in turn, improve healthcare quality.

While millions of Americans are struggling during this economic downturn and thousands of students need to obtain student loans for their education, Federal support is greatly appreciated. The student recipients reported that more funding was needed for these programs to help offset the considerable cost of nursing education. Fifty-two percent of the students responded that the title VIII funding paid for 25 percent or less of their total student loans. Of those students, 26 percent stated that the funding paid for less than 5 percent of their total nursing student loans.

Over the last 45 years, Congress has used the title VIII authorities as a mechanism to address past nursing shortages. When the need for nurses was great, higher funding levels were appropriated. For example, during the nursing shortage in the 1970s, Congress provided $160.61 million to the title VIII programs in 1973. Adjusting for inflation to address the 37-year difference, $160.61 million (fiscal year 1973 funding level) in 2010 dollars would be approximately $784 million. At a time when nursing economists project the current shortage to be twice as large as any nursing shortage experienced in this country since the mid-1960s, more must be invested in title VIII to decrease the magnitude of the RN demand.

AACN respectfully requests $267.3 million (a 10 percent increase) for the Nursing Workforce Development programs authorized under title VIII of the Public Health Service in fiscal year 2011. Last year, your subcommittee provided a significant funding boost for title VIII that helped support the Loan Repayment and Scholarship program and Nurse Faculty Loan program. These increases will help bolster the pipeline of nurses and nurse faculty, which are so critical to reversing the nursing shortage. It is extremely important to maintain last year's funding level for these crucial programs in fiscal year 2011. AACN believes the 10 percent requested increase should be directed to the four title VIII programs that have not kept pace with inflation since fiscal year 2005. These programs include the Advanced Education Nursing, Nursing Workforce Diversity, Nurse Education, Practice, and Retention, and Comprehensive Geriatric Education programs, which help expand nursing school capacity and increase patient access to care. The 10 percent increase awarded to these programs in proportion to their fiscal year 2010 funding level would be a wise investment of Federal resources.

Nursing Research: Supporting Health Promotion and Disease Prevention

The National Institute of Nursing Research (NINR) is 1 of the 27 Institutes and Centers at the National Institutes of Health (NIH). As the nucleus for nursing science, NINR funds research that establishes the scientific basis for health promotion, disease prevention, and high-quality nursing care services to individuals, families, and populations. Often working collaboratively with physicians and other researchers, nurse scientists are vital in setting the national research agenda. While medical research focuses on curing diseases, nursing research is conducted to prevent disease. The four strategic areas of emphasis for research at NINR are:

—*Promoting Health and Preventing Disease*.—Presently, more than 1.7 million Americans die each year from chronic diseases. Nurse researchers focus on investigating wellness strategies to prevent these chronic diseases. A healthcare system that promotes prevention is a major focus of the new health reform law, and NINR is a leader in funding scientific research to discover optimal prevention methods.

—*Eliminating Health Disparities*.—Race, gender, socioeconomic status, ethnic origin, geography, and culture impact the healthcare of individuals and communities. NINR is committed to funding research that investigates culturally appropriate interventions and care strategies focused on at-risk populations.

—*Improving Quality of Life*.—Disease prevention is a critical goal of clinical research. NINR is committed to funding research that assists individuals with managing their own health conditions, decreases adverse symptoms, and reduces the burden on caregivers.

—*Setting Directions for End-of-Life Research*.—Palliative care and respect for those at the end of their life is a critical part of treatment for serious and life-threatening illness. This care is provided alongside disease treatment to ease suffering and improve the quality-of-life for the patient. NINR seeks, through scientific research, to improve the understanding of the processes underlying

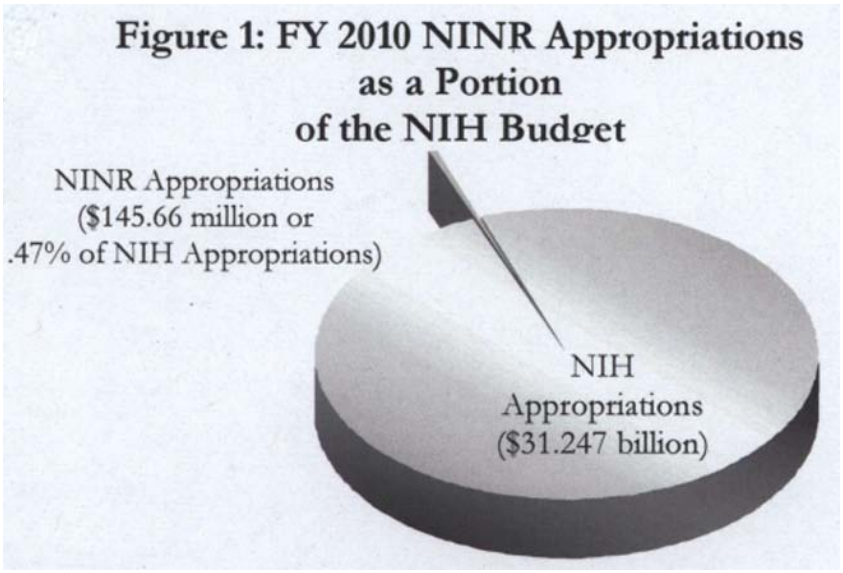
palliative care efforts and develop effective strategies to optimize care across all patient populations.

Research conducted at NINR improves quality of care to benefit health both globally and nationally. With increased appropriations for NINR, more comprehensive, complex, and longitudinal studies could be funded in the areas provided below as well as meet the current goals, projects, and priorities of the Institute.

—Expand the scope of science in symptom management;
—Global health;
—Increase funding for scientist-initiated research applications;
—Expand the translation, dissemination, and outreach of NINR generated research to bridge the gap between scientific evidence and clinical practice;
—Evaluate the impact of nursing science on the health of the Nation; and
—Support future nurse researchers.

Considering that NINR presently allocates 7 percent of its budget to training that helps develop the pool of nurse researchers, additional funding would support NINR's efforts to prepare faculty researchers needed to educate new nurses.

NINR's fiscal year 2010 funding level of $145.66 million is approximately 0.47 percent of the overall $31.247 billion NIH budget (see Figure 1). Spending for nursing research is a modest amount relative to the allocations for other health science institutes and for major disease category funding. For NINR to adequately continue and further its mission, NINR must receive additional funding. Cuts in funding have impeded NINR from supporting larger comprehensive studies needed to advance nursing science and improve the quality of patient care.



Therefore, AACN respectfully requests $160 million for the National Institute of Nursing Research, an additional $14.34 million over the fiscal year 2010 level.

The Capacity for Nursing Students and Faculty Program, Section 804 of the Higher Education Opportunity Act of 2008 (Public Law 110–315)

According to AACN (2010), the major barriers to increasing student capacity in nursing schools are insufficient numbers of faculty, admission seats, clinical sites, classroom space, clinical preceptors, and budget constraints. The Capacity for Nursing Students and Faculty Program, a section of the Higher Education Opportunity Act of 2008, offers capitation grants (formula grants based on the number of students enrolled/or matriculated) to nursing schools allowing them to increase the number of students. AACN respectfully requests $50 million for this program in fiscal year 2011.

Conclusion

AACN acknowledges the fiscal challenges within which the Subcommittee and the entire Congress must work. However, the Title VIII authorities provide a dedicated,

long-term vision for educating the new nursing workforce and the next cadre of nurse faculty. The National Institute of Nursing Research invests in developing the scientific basis for quality nursing care. The Capacity for Nursing Students and Faculty Program will allow schools to increase student capacity. To be effective these programs must receive additional funding. AACN respectfully requests $267.3 million for title VIII programs, $160 million for NINR, and $50 million for the Capacity for Nursing Students and Faculty Program in fiscal year 2011. Additional funding for these programs will assist schools of nursing to expand their educational and research programs, educate more nurse faculty, increase the number of practicing RNs, and ultimately improve the patient care provided in our healthcare system.

PREPARED STATEMENT OF THE AMERICAN ASSOCIATION OF COLLEGES OF OSTEOPATHIC MEDICINE

On behalf of the American Association of Colleges of Osteopathic Medicine (AACOM), I am pleased to submit this testimony in support of increased funding in fiscal year 2011 for programs at the Health Resources Services Administration (HRSA), the National Institutes of Health (NIH), and the Agency for Healthcare Research and Quality (AHRQ). AACOM represents the administrations, faculty, and students of the Nation's 26 colleges of osteopathic medicine and three branch campuses that offer the doctor of osteopathic medicine degree. Today, more than 18,000 students are enrolled in osteopathic medical schools. Nearly 1 in 5 U.S. medical students is training to be an osteopathic physician, a ratio that is expected to grow to 1 in 4 by 2019.

Title VII

The health professions education programs, authorized under title VII of the Public Health Service Act and administered through the HRSA, support the training and education of health practitioners to enhance the supply, diversity, and distribution of the healthcare workforce, acting as an essential part of the healthcare safety net and filling the gaps in the supply of health professionals not met by traditional market forces. Title VII and title VIII nurse education programs are the only Federal programs designed to train clinicians in interdisciplinary settings to meet the needs of special and underserved populations, as well as increase minority representation in the healthcare workforce.

According to HRSA, an additional 30,000 health practitioners are needed to alleviate existing health professional shortages. Combined with faculty shortages across health professions disciplines, racial and ethnic disparities in healthcare, and a growing, aging population, the anticipated demand for access to care once 32 million more Americans have health insurance as a result of healthcare reform will strain an already fragile healthcare system. While AACOM appreciates the investments that this subcommittee has made in these programs, it recommends increasing funding to $330 million in fiscal year 2011 for the title VII programs. Investment in these programs, including the Training in Primary Care Medicine Program, the Health Careers Opportunity Program, and the Centers of Excellence, is necessary to address the primary care workforce shortage. Strengthening the workforce has been recognized as a national priority, and the investment in these programs recommended by AACOM will help sustain the health workforce expansion supported by the American Recovery and Reinvestment Act (ARRA) and necessitated by the demand for a well trained, diverse workforce that this country will experience as a result of healthcare reform.

National Health Service Corps (NHSC)

AACOM applauds Congress for increasing the authorization to $414 million in fiscal year 2011 for the NHSC through direct appropriations and including the authorized Community Health Center Fund (CHC Fund), which also covers the NHSC, in the Patient Protection and Affordable Care Act. Approximately 50 million Americans live in communities with a shortage of health professionals, lacking adequate access to primary care. Through scholarships and loan repayment, NHSC supports the recruitment and retention of primary care clinicians to practice in underserved communities. At a field strength of 4,760 in fiscal year 2009, the NHSC still fell more than 24,000 practitioners short of fulfilling the need for primary care, dental, and mental health practitioners in federally designated Health Professions Shortage Areas (HPSAs), as estimated by HRSA. Growth in HRSA's Community Health Center Program must be complemented with increases in the recruitment and retention of primary care clinicians to ensure adequate staffing, which the NHSC provides. ARRA funding for the NHSC has been vital in this regard, and additional investment will be necessary to sustain the progress as the ARRA funding period ends.

AACOM supports the President's budget request of $169 million for the NHSC program in fiscal year 2011, which would be sufficient to trigger the release of dollars from the CHC Fund. AACOM further recommends that the subcommittee include report language directing the Secretary to provide enhanced funding for the NHSC, as required under the Patient Protection and Affordable Care Act.

Medical School Development

The President's fiscal year 2011 budget request included $100 million for the development of new medical schools in HPSAs. The grant program would be administered by HRSA. The budget projected that these funds would support approximately 20 grants for new academic health centers to provide training and research in community-oriented settings. The goal is to increase clinical training in HPSAs as well as to increase the number of new providers who go on to practice in these underserved areas. AACOM supports the appropriation of these funds at a time when it is critical to support the training of new medical students in order to ensure that Americans have access to care.

NIH

Research funded by the NIH leads to important medical discoveries regarding the causes, treatments, and cures for common and rare diseases as well as disease prevention. These efforts improve our Nation's health and save lives. To maintain a robust research agenda, further investment will be needed. AACOM recommends $35 billion in fiscal year 2011 for the NIH.

In today's increasingly demanding and evolving medical curriculum, there is a critical need for more research geared toward evidence-based osteopathic medicine. AACOM believes that it is vitally important to maintain and increase funding for biomedical and clinical research in a variety of areas related to osteopathic principles and practice, including osteopathic manipulative medicine and comparative effectiveness. In this regard, AACOM encourages support for the NIH's National Center for Complementary and Alternative Medicine to continue fulfilling this essential research role.

AHRQ

The AHRQ supports research to improve healthcare quality, reduce costs, advance patient safety, decrease medical errors, and broaden access to essential services. AHRQ plays an important role in producing the evidence base needed to improve our Nation's health and healthcare. The incremental increases for AHRQ's Patient Centered Health Research Program in recent years, as well as the funding provided to AHRQ in the ARRA, will help AHRQ generate more of this research and expand the infrastructure needed to increase capacity to produce this evidence. More investment is needed, however, to fulfill AHRQ's mission and broader research agenda, especially research in patient safety and prevention and care management research. AACOM recommends $611 million in fiscal year 2011 for AHRQ, as requested by the President. This investment will preserve AHRQ's current programs while helping to restore its critical healthcare safety, quality, and efficiency initiatives.

AACOM greatly appreciates the support of the subcommittee for these funding priorities in an ever-increasing competitive environment and is grateful for the opportunity to submit its views. AACOM looks forward to continuing to work with the subcommittee on these important matters.

PREPARED STATEMENT OF THE AMERICAN ASSOCIATION OF COLLEGES OF PHARMACY

AACP and its member colleges and schools of pharmacy appreciate the continued support of the U.S. Senate Appropriations Subcommittee on Labor, Health and Human Services, and Education, and Related Agencies. Our Nation's 116 accredited colleges and schools of pharmacy are engaged in a wide-range of programs supported by grants and funding administered through the U.S. Department of Education and agencies of the Department of Health and Human Services (HHS). We also understand the difficult task you face annually in your deliberations to do the most good for the nation and remain fiscally responsible to the same. AACP respectfully offers the following recommendations for your consideration as you undertake your deliberations.

U.S. DEPARTMENT OF EDUCATION SUPPORTED PROGRAMS AT COLLEGES AND SCHOOLS OF PHARMACY

AACP supports the recommendation of the Student Aid Alliance that the:

—Perkins Loan Program Federal Capital Contribution should be increased to the newly reauthorized level of $300 million and loan cancellations should be increased to $125 million.
—Pell Grant maximum be increased to $5,710.
—Gaining Early Awareness and Readiness for Undergraduate Programs (GEAR UP) should be increased to the authorized level of $400 million.
—Graduate level programs should be increased to $126 million.

AACP recommends a funding level of $160 million for the Fund for the Improvement of Post Secondary Education (FIPSE).

The Department of Education supports the education of healthcare professionals by:

—assuring access to education through student financial aid programs;
—supporting educational research allows faculty to determine improvements in educational approaches; and
—maintaining the quality of higher education through the approval of accrediting agencies.

AACP actively supports increased funding for undergraduate student financial assistance programs. Admission to into the pharmacy professional degree program requires at least 2 years of undergraduate preparation. Student financial assistance programs are essential to assuring colleges and schools of pharmacy are accessible to qualified students. Likewise, financial assistance programs that support graduate education are an important component of creating the next generation of scientists and educators that both our nation and higher education depend on.

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES SUPPORTED PROGRAMS AT COLLEGES AND SCHOOLS OF PHARMACY

Agency for Healthcare Research and Quality (AHRQ)

AACP supports the Friends of AHRQ recommendation of $611 million for AHRQ programs in fiscal year 2011.

Pharmacy facultyare strong partners with the Agency for Healthcare Research and Quality (AHRQ). Academic pharmacy researchers are working to develop a sustainable health services research effort among faculty with AHRQ grant support. As partners in the AHRQ Effective Healthcare programs (CERTs, DeCIDE), pharmacy faculty researchers improve the effectiveness of healthcare services. Some of this research will take place through the development of practice-based research networks focused on improving the medication use process.

Researchers, including faculty at the University of Illinois, Chicago School of Pharmacy, supported through an AHRQ DEcIDE Network contract determined that a specific drug triad regularly prescribed to patients suffering from chronic obstructive pulmonary disease reduced the risk of death. Researchers determined that other drug combinations increased the risk of death. This research was published in the Archives of Internal Medicine allowing for ready translation of this life-saving knowledge into practice. AHRQ Contract Number 290–05–0038

Pharmacy faculty researchers at the University of Iowa, supported by AHRQ grant HS018353–01, will seek to improve the quality of medication therapy management programs (MTM) which is a mandated service of the Medicare Part D benefit. This research will provide additional guidance to CMS, PDPs, and other payers and organizations interested in improving the quality of care provided to patients in regard to their medications.

Centers for Disease Control and Prevention (CDC)

AACP supports the CDC Coalition recommendation of $8.8 billion for CDC core programs in fiscal year 2011.

The educational outcomes of a pharmacist's education include those related to public health. When in community-based positions, pharmacists are frequently providers of first contact. The opportunity to identify potential public health threats through regular interaction with patients provides public health agencies such as the CDC with on-the-ground epidemiologists. Pharmacists support the public health system through the risk identification of patients seeking medications associated with preventing and treating travel-related illnesses. Pharmacy faculty are engaged in CDC-supported research in areas such as immunization delivery, integration of pharmacogenetics in the pharmacy curriculum and inclusion of pharmacists in emergency preparedness. Information from the National Center for Health Statistics (NCHS) is essential for faculty engaged in health services research and for the professional education of the pharmacist.

Researchers at the University of Mississippi School of Pharmacy will be supported in their work to develop and test new malaria drugs by CDC grant 3U01CI000211–05S1.

Health Resources and Services Administration (HRSA)

AACP supports the Friends of HRSA recommendation of $8.5 billion for fiscal year 2011.

HRSA is a Federal agency with a wide-range of policy and service components. Faculty at colleges and schools of pharmacy are integral to the success of many of these. Colleges and schools of pharmacy are the administrative units for interprofessional and community-based linkages programs including geriatric education centers and area health education centers. Pharmacy faculty are supported in their research efforts regarding rural health issues through the Office of Rural Health Policy. Pharmacy students benefit from diversity program funding including Scholarships for Disadvantaged Students.

Office of Pharmacy Affairs

AACP recommends a program funding of $5 million for fiscal year 2011 for the Office of Pharmacy Affairs.

AACP member institutions are actively engaged in Office of Pharmacy Affairs (OPA) efforts to improve the quality of care for patients in federally qualified health centers and entities eligible to participate in the 340B drug discount program. The success of the HRSA Patient Safety and Clinical Pharmacy Collaborative is a direct result of past OPA actions linking colleges and schools of pharmacy with federally qualified health centers. www.hrsa.gov/patientsafety. The result of these links has been the establishment of medical homes that improve health outcomes for underserved and disadvantaged patients through the integration of clinical pharmacy services. The Office of Pharmacy Affairs would benefit from a direct line-item appropriation so that public-private partnerships aimed at improving the quality of care provided at federal qualified health centers can be sustained and expanded.

Poison Control Centers

Colleges and schools of pharmacy are supported by HRSA grant funding for the operation of 9 of the 42 poison control centers administered by HRSA.

Jill E. Michels, faculty member from the University of South Carolina—South Carolina College of Pharmacy (USC), and the Palmetto Poison Center (PPC) were awarded a $310,000 grant from HRSA. The PPC is housed at the College of Pharmacy and serves all 46 counties in South Carolina receiving more than 37,000 calls per year for information and advice. The PPC provides services free-of-charge to the public and health professionals 24 hours-a-day, 365 days-a-year. A recent USC study found that for every $1 spent on the Palmetto Poison Center, more than $7 were saved in unnecessary healthcare costs, including emergency room and physician visits, ambulance services, and unnecessary medical treatments. http://poison.sc.edu/about.html

Bureau of Health Professions (BHPr)

AACP supports the Health Professions and Nursing Education Coalition (HPNEC) recommendation of $600 million for title VII and VIII programs in fiscal year 2011.

AACP member institutions are active participants in BHPr programs. Two colleges of pharmacy are current grantees in the Centers of Excellence program (Xavier University—Louisiana, University of Montana). This program focuses on increasing the number of underserved individuals attending health professions institutions. Colleges and schools of pharmacy are also part of title VII interprofessional and community-based linkages programs including Geriatric Education Centers and Area Health Education Centers. These programs are essential for creating the educational approaches necessary for the Institute of Medicine's recommendations of improving quality through team-based, patient-centered care.

PREPARED STATEMENT OF THE AMERICAN ASSOCIATION FOR CANCER RESEARCH

The American Association for Cancer Research (AACR) recognizes and expresses its thanks to the United States Congress for its longstanding support and commitment to funding cancer research. The continuing investment in research through the American Recovery and Reinvestment Act of 2009 (ARRA) and the fiscal year 2010 budget will support current projects and provide for new efforts in the fight against cancer. These new efforts are now underway and promise to yield innovative and potentially breakthrough approaches to understanding, preventing, treating, and ultimately curing cancer. The full potential, however, will not be fully realized in a

short 1- or 2-year period. Sustained, stable funding through regular appropriations will be necessary to allow researchers to uncover the discoveries today that will lead to more lives saved tomorrow.

Unquestionably, the Nation's investment in cancer research is having a remarkable impact. Cancer deaths in the United States have declined in recent years. This progress is occurring in spite of an aging population and the fact that more than three-quarters of all cancers are diagnosed in individuals aged 55 and older. Yet this good news will not continue without stable and sustained Federal funding for critical cancer research priorities.

AACR urges the United States House of Representatives to strongly support biomedical research funding at the National Institutes of Health (NIH), including carrying out President Obama's vision for doubling cancer research funding in order to find a cure for cancer in our time. Therefore, the AACR supports the biomedical community's recommendation of sustaining the current funding for NIH, which would amount to $35.2 billion in fiscal year 2011.

AACR: Fostering a Century of Research Progress

AACR has been moving cancer research forward since its founding in 1907. Celebrating its 101st annual meeting in Washington, DC, this April, the AACR and its more than 30,000 members worldwide strive tirelessly to carry out its important mission to prevent and cure cancer through research, education, and communication. It does so by:

—fostering research in cancer and related biomedical science;
—accelerating the dissemination of new research findings among scientists and others dedicated to the conquest of cancer;
—promoting science education and training; and
—advancing the understanding of cancer etiology, prevention, diagnosis, and treatment throughout the world.

Facing an Impending Cancer "Tsunami"

Over the last century, enormous progress has been made toward the conquest of the Nation's second most lethal disease (after heart disease). Thanks to discoveries and developments in prevention, early detection, and more effective treatments, many of the more than 200 diseases called cancer have been cured or converted into manageable chronic conditions while preserving quality of life. The 5-year survival rate for all cancers has improved over the past 30 years to more than 65 percent. The completion of the doubling of the NIH budget in 2003 is bearing fruit as many new and promising discoveries are unearthed and their potential realized. However, there is much left to be done, especially for the most lethal and rare forms of the disease.

We recognize that the underlying causes of the disease and its incidence have not been significantly altered. The fact remains that men have a 1 in 2 lifetime risk of developing cancer, while women have a 1 in 3 lifetime risk. The leading cancer sites in men are the prostate, lung and bronchus, and colon and rectum. For women, the leading cancer sites are breast, lung and bronchus, and colon and rectum. And cancer still accounts for 1 in 4 deaths, with more than half a million people expected to die from their cancer in 2010. Age is a major risk factor this Nation faces a virtual "cancer tsunami" as the baby boomer generation reaches age 65 in 2011. A renewed commitment to progress in cancer research through leadership and resources is essential to avoid this cancer crisis.

Blueprint for Progress: National Cancer Institute (NCI) Strategic Objectives

Basic, translational, and clinical cancer research in this country are conducted primarily through three venues—government, academia, and the nonprofit sector—and the pharmaceutical/biotechnology industry. The Congress provides the appropriations for the NCI, through which most of the Government's research on cancer is conducted. The NCI has developed documents and processes that describe and guide its priorities established with extensive community input for the use of these finite resources. "The NCI Strategic Plan for Leading the Nation" and "The Nation's Investment in Cancer Research: An Annual Plan and Budget Proposal Fiscal Year 2011" are the recognized professional blueprints for what needs to be done to accelerate progress against cancer.

AACR and many in the cancer research community concur that if the NCI receives the increased investment of $1.2 billion as proposed for fiscal year 2011, the NCI will have the capability to rebuild America's research infrastructure capacity and accelerate research progress in critical priority areas:

—understanding the causes and mechanisms of cancer;
—accelerating progress in cancer prevention;
—improving early detection and diagnosis;

—developing effective and efficient treatments;
—understanding the factors that influence cancer outcomes;
—improving the quality of cancer care;
—improving the quality of life for cancer patients, survivors, and their families; and overcoming cancer health disparities.

Federal Investment for Local Benefit

More than half of the NCI budget is allocated to research project grants that are awarded to outside scientists who work at local hospitals and universities throughout the country. More than 6,500 research grants are funded at more than 150 cancer centers and specialized research facilities located in 49 States. In more than half the States, grants and contracts to institutions exceed $15 million. This Federal investment also provides needed economic stimulus to local economies. For example, on average, each $1 of NIH funding generated more than twice as much in State economic output in fiscal year 2007. Many AACR member scientists across the Nation are engaged in this rewarding work, and many have had their long-term research jeopardized by grant reductions caused by the flat and declining overall funding for the NCI since 2003. The recent increase in fiscal year 2010 appropriations and the ARRA funding will help to revitalize America's research infrastructure; however, sustained and stable funding is critical to reap the benefits of this investment. Thus, the AACR supports sustaining the current investment in the NCI with a budget of $5.8 billion.

Understanding the Causes and Mechanisms of Cancer

Basic research into the causes and mechanisms of cancer is at the heart of what the NCI and many of AACR's member scientists do. The focus of this research includes: investigating the underlying basis of the full spectrum of genetic susceptibility to cancer; identifying the influence of the macroenvironment (tumor level) and microenvironment (tissue level) on cancer initiation and progression; understanding the behavioral, environmental, genetic, and epigenetic causes of cancer and their interactions; developing and applying emerging technologies to expand our knowledge of risk factors and biologic mechanisms of cancer; and elucidating the relationship between cancer and other human diseases.

Basic research is the engine that drives scientific progress. The outcomes from this fundamental basic research including laboratory and animal research, in addition to population studies and the deployment of state-of-the-art technologies will inform and drive the cancer research enterprise in ways and directions that will lead to unparalleled progress in the search for cures.

Accelerating Progress in Cancer Prevention

Preventing cancer is far more cost-effective and desirable than treating it. NCI's strategic plan supports research in: understanding and modifying behaviors that increase risk; reducing the influence of genetic and environmental risk factors; and interrupting the initiation of cancer through early medical intervention. A critical component of this multifaceted approach is ensuring that evidence-based advances that have been shown to inform and motivate people toward healthy behaviors are widely disseminated and accessible.

The NCI uses multidisciplinary teams and a systems biology approach to identify early events and determine how to modify them. More than half of all cancers are related to modifiable behavioral factors, including tobacco use, diet, physical inactivity, sun exposure, and failure to get cancer screenings. The NCI supports research to understand how people perceive risk, make health-related decisions, and maintain healthy behavior. Prevention is the keystone to success in the battle against cancer.

Developing Effective and Efficient Treatments

The future of cancer care is all about developing individualized therapies tailored to the specific characteristics of a patient's cancer. The NCI's research in this area concentrates on: identifying the determinants of metastatic behavior; validating cancer biomarkers for prognosis, metastasis, treatment response, and progression; accelerating the identification and validation of potential cancer molecular targets; minimizing the toxicities of cancer therapy; and integrating the clinical trial infrastructure for speed and efficiency. The completion of the Human Genome Project and breakthroughs resulting from The Cancer Genome Atlas project are leading the way toward an era of personalized medicine.

Overcoming Cancer Health Disparities

Some minority and underserved population groups suffer disproportionately from cancer. Solving this issue will contribute significantly to reducing the cancer burden.

The NCI's investments in this area include: studying the factors that cause cancer health disparities; working with underserved communities to develop targeted interventions; developing the knowledge base for integrating cancer services to the underserved; collaborating to implement culturally appropriate information dissemination approaches to underserved populations; and examining the role of health policy in eliminating cancer health disparities. One size does not fit all in cancer research special populations require special treatment to achieve success.

Training and Career Development for the Next Generation of Researchers

Of critical importance to the viability of the long-term cancer research enterprise is supporting, fostering, and mentoring the next generation of investigators. The NCI historically devotes approximately 4 percent of its budget to support training and career development, including sponsored traineeships, a Medical Scientist Training Program, special set-aside grant programs, and bridge grants for early career cancer investigators. Increased funding for these foundational opportunities is essential to retain the scientific workforce that is needed to continue the fight against cancer.

AACR's Initiatives Augment Support for the NCI

The NCI is not working alone or in isolation in any of these key areas. NCI research scientists reach out to other organizations to further their work. The AACR is engaged in scores of initiatives that strengthen, support, and facilitate the work of the NCI. Just a few of AACR's contributions include:

—sponsoring the largest meeting of cancer researchers in the world, with more than 14,000 scientists, where 6,000 scientific abstracts featuring the latest basic, translational, and clinical scientific advances are presented;
—publishing more than 3,400 original research articles each year in six prestigious peer-reviewed scientific journals, including Cancer Research, the most frequently cited cancer journal;
—sponsoring the annual International Conference on Frontiers of Cancer Prevention Research, the largest such prevention meeting of its kind in the world;
—supporting the work of the AACR Chemistry in Cancer Research Working Group;
—convening and supporting the AACR–FDA–NCI Cancer Biomarkers Collaborative;
—hosting, with NCI, the Molecular Targets and Cancer Therapeutics Conference;
—sponsoring and supporting a Minorities in Cancer Research Council and a Women in Cancer Research Council;
—conducting the scientific review and grants administration for the more than $100 million donated to Stand Up To Cancer; and
—raising and distributing more than $5 million in awards and research grants.

Stable, Sustained Increases in Research Funding

Remarkable progress is being made in cancer research, but much more remains to be done. Cancer costs the Nation more than $228 billion in direct medical costs and lost productivity due to illness and premature death. Respected University of Chicago economists Kevin Murphy and Robert Topel have estimated that even a modest 1 percent reduction in mortality from cancer would be worth nearly $500 billion in social value. In addition, investments in cancer research stimulate the local economy today and promise huge potential returns in the future. Thanks to successful past investments, promising research opportunities abound and must not be lost. To maintain our research momentum, AACR urges the United States House of Representatives to support a budget of $35.2 billion for the NIH, including $5.8 billion for NCI.

Prepared Statement of the American Association for Dental Research

Introduction

Mr. Chairman and members of the subcommittee, I am David Wong, Director of the Dental Research Institute at the University of California, Los Angeles (UCLA) School of Dentistry. My testimony is on behalf of the American Association for Dental Research (AADR).

I thank the subcommittee for this opportunity to testify about the exciting advances in oral health science. Research funded by the National Institutes of Health (NIH) has returned significant dividends in terms of recent advances in healthcare, including dental care and oral health research thanks to the efforts of the National Institute of Dental and Craniofacial Research (NIDCR). Since 1948, NIDCR has conducted research, trained researchers, and disseminated health information in order

to improve the health of Americans and make it possible for them to live longer and healthier lives.

What Is the American Association for Dental Research?

The AADR, headquartered in Alexandria, Virginia, is a nonprofit organization with more than 4,000 individual members and 100 institutional members within the United States. Its mission is: (1) to advance research and increase knowledge for the improvement of oral health; (2) to support and represent the oral health research community; and (3) to facilitate the communication and application of research findings. AADR is the largest Division of the International Association for Dental Research.

Why Oral Health Is Important

Oral health is an essential component of health throughout life. Poor oral health and untreated oral diseases and conditions can have a significant impact on quality of life. They can affect the most significant human needs including the ability to eat and drink, swallow, maintain proper nutrition, smile, and communicate.

Over the past 50 years, there has been a dramatic improvement in oral health. Still, oral diseases remain a major concern. Oral health and general health are inseparable. Diseases and conditions of the mouth have a direct impact on the health of the entire body.

Good oral health can help improve birth outcomes, keep children from developing painful cavities and prevent seniors, and those with chronic health conditions, from developing life-threatening complications. In recent years, new scientific reports have linked poor oral health to poor general health. Dental decay (cavities) is one of the most common chronic illnesses among children. Although most dental diseases are preventable, many children unnecessarily suffer from dental disease because of inadequate home care and lack of access to dental services. An estimated 51 million school hours per year are lost in the United States because of dental-related illness. Poor oral health has been related to decreased school performance, poor social relationships, and less success later in life.

Employed adults in the United States lose more than 164 million hours of work each year as a result of oral health problems or dental visits. About 30 percent of adults 65 years old and older have lost all of their natural teeth. Older Americans with the poorest oral health are those who are economically disadvantaged, lack insurance, and are members of racial and ethnic minorities.

As the Nation ages, oral health issues related to gum disease and the impact of medical treatments and medicines will increase. Maintaining good oral health throughout a person's life is important.

Research Accomplishments

Oral and Systemic Health.—The oral cavity plays an important role in the overall health of the body. Some say the mouth is the body's mirror. And while associations between oral and systemic health can be made, specific cause-and-effect relationships remain elusive. It has been reported that 3 out of every 4 Americans have signs of mild periodontal disease. Almost 30 percent show signs of the more severe disease, chronic periodontitis. We now have reason to believe that the health of your teeth and gums may have a significant effect on the overall health of your body. Recent scientific literature suggests a strong relationship between oral disease and other systemic diseases and medical conditions.

According to numerous studies, there are three ways oral disease may affect your overall health. First, bacteria from your gums enter the saliva. From the saliva it may adhere to water droplets within the air you inhale each time you breathe. These bacteria laden water droplets may be aspirated into the lungs, potentially causing pulmonary infection and pneumonia. This can be a serious problem for the elderly or those who may suffer from generalized weakened immunity, associated with chronic obstructive pulmonary disease (COPD). Inflammatory mediators found in inflamed gums called "cytokines" can also enter your saliva.

Secondly, bacteria associated with periodontal disease can enter the body's circulatory system through the gums (periodontium) around teeth and travel to all parts of the body. As the oral bacteria travels, it may cause secondary infections or it may contribute to the disease process in other tissues and organ systems.

Finally, inflammation associated with periodontal disease may stimulate a second systemic inflammatory response within the body and contribute to or complicate other disease entities that may have an inflammatory origin such as, cardiovascular disease, diabetes, and kidney disease.

The goal of many studies being conducted at dental schools and research centers throughout the world is to understand just how oral bacteria affect overall health. As these studies are published, healthcare professionals will begin to better under-

stand the underlying biological mechanisms that are responsible for this oral systemic connection.

Health Disparities.—Despite remarkable improvements in the oral health of many, not everyone in the nation has benefited equally. Oral, dental, and craniofacial conditions remain among the most common health problems for low-income, racial/ethnic minority, disadvantaged, disabled, and institutionalized individuals across the life span. Dental caries, periodontal diseases, and oral and pharyngeal cancer are of particular concern.

The NIDCR Health Disparities Research Program supports studies that:

—Provide a better understanding of the basis of health disparities and inequalities;

—Develop and test interventions tailored and targeted to underserved populations; and

—Explore approaches to the dissemination and implementation of effective findings to assure rapid translation into practice, policy and action in communities.

The NIDCR supports:

—Research that seeks to understand a broadened array of determinants of disparities/inequalities in oral health status and care at multiple levels;

—Interventional research designed to have a meaningful impact on oral health status and quality of life that will influence action in healthcare, public policy, or diseases/disability prevention in communities;

—Cost analyses of interventions as well as comparative effectiveness studies;

—Behavioral and social science intervention research that is grounded in theory and considers mechanisms of action;

—Research that utilizes new technologies and approaches that are practical, culturally appropriate and sustainable for individuals, caregivers, and workers.

—Novel interventions as well as those that have previously been untested with vulnerable populations.

Researchers from many backgrounds and disciplines contribute to health disparities/inequalities research. Some of the disciplines of researchers on health disparities/inequalities research teams are genetics, dentistry and dental hygiene, and medicine and nursing. Teams that conceptualize, plan and conduct this type of research include community members of the disadvantaged and vulnerable population subgroups as partners in the research enterprise.

Salivary Diagnostics.—Oral and systemic diseases can be difficult to diagnose, involving complex clinical evaluation and/or blood and urine tests that are labor intensive, expensive, and invasive. Now, after years of research, saliva is poised to be used as a noninvasive diagnostic fluid for a number of oral and systemic conditions. Salivary diagnostics has come of age. In just a little more than 6 years, research supported by the NIDCR has sprung to the forefront of basic, translational, and clinical research.

Saliva not only combats bacteria and viruses that enter the mouth, but it also serves as a first line of defense in oral and systemic diseases. It contains many compounds indicating a person's overall health and disease status and, like blood or urine, its composition may be altered in the presence of a disease. Saliva is very easy to collect, providing a major advantage over the use of blood or urine for diagnostic tests. Saliva has the same biomarkers found in blood and urine.

Oral cancer affects 38,000 Americans each year. The death rate associated with this cancer is especially high due to delayed diagnosis. Saliva is not only more accurate than blood for oral cancer detection, but saliva diagnostics will likely outperform other biomedia for other disease diagnostics as well. The risk of oral cancer, prostate cancer, breast cancer, and a host of other health conditions can be determined and often prevented when acting on information provided from a saliva hormonal assay. Saliva tests could prove to be a potentially life-saving alternative to detect diseases where early diagnosis is critical, such as certain cancers. For most cancers, successful treatment depends on early detection and successful prevention depends on the accurate evaluation of risk. Early detection of oral cancer will increase survival rate, improve the quality of life of cancer patients, and will result in a significant reduction in healthcare costs.

Conclusion

As you can see, Mr. Chairman, there are many research opportunities with an immediate impact on patient care that need to be pursued. A consistent and reliable funding stream for NIH overall, and NIDCR in particular, is essential for continued improvement in the oral health of Americans.

In order to sustain momentum in the field of oral and systemic health, health disparities, and salivary diagnostics, it is requested that NIH receive a fiscal year 2011

appropriation of $35 billion, of which NIDCR should receive an fiscal year 2011 appropriation of $481 million.

Thank you for the opportunity to testify.

PREPARED STATEMENT OF THE AMERICAN ACADEMY OF FAMILY PHYSICIANS

As one of the largest national medical organizations, representing 94,700 family physicians, residents, and medical students, the AAFP recommends that the Senate Appropriations Subcommittee on Labor, Health and Human Services, and Education, and Related Agencies continue its commitment to title VII in fiscal year 2011 and increase funding for other key Health Resources and Services Administration programs to allow health reform to succeed. We also recommend increased funding for the Agency for Healthcare Research and Quality to provide better healthcare all.

HEALTH RESOURSES AND SERVICES ADMINISTRATION

The Patient Protection and Affordable Care Act (Public Law 111–148) holds the promise of health security for Americans and moves us toward genuine health system reform, but it will require the support of this subcommittee to invest in the necessary primary care physician workforce. Primary care physicians will serve as a strong foundation for a more efficient and effective healthcare system. We are pleased that the health reform law reauthorizes the title VII health professions programs including the grants for the education and training of primary care physicians under title VII, section 747.

Workforce Shortages

Successful implementation of health reform requires an investment to strengthen our Nation's primary care workforce. The current national primary care physician workforce of just more than 200,000 is estimated to be 8,000–10,000 lower than projected demand based on adjusted average population utilization patterns, according to the Robert Graham Center for Policy Studies in Family Medicine and Primary Care. However, distribution is not equitable leaving many areas with physician shortages, especially in rural and underserved communities with measurable social deprivation.

In the coming years, medical services utilization is likely to rise given the increasing and aging population as well as the insured status of more of the populace. Those demographic trends will cause primary care physician shortages to worsen. By 2025, the current downturn in primary care physician production is expected to yield a workforce 28.5 percent below need based on current practice models or 50 percent below the level needed to provide all Americans with a patient-centered medical home.

The recently enacted health reform legislation includes a number of provisions to increase the primary care workforce. It amends and expands many of the existing health workforce programs authorized under title VII (health professions) and makes a number of changes to Medicare graduate medical education (GME) payments to teaching hospitals, in part to encourage the training of more primary care physicians. The new law also establishes a national commission to study projected health workforce needs and make appropriate recommendations. Increasing the level of Federal funding for primary care training would reinvigorate medical education, residency programs, as well as academic and faculty development in primary care to prepare physicians to support the patient centered medical home.

This subcommittee has demonstrated its commitment to a strong primary care workforce by doubling the appropriation for training under title VII section 747 of the Public Health Services Act in the American Recovery and Reinvestment Act of 2009 (Public Law 111–5).

The AAFP urges the subcommittee to provide a fiscal year 2011 appropriation of $170 million for the title VII section 747 Primary Care Training and Enhancement and the Integrative Academic Administrative Units programs as authorized by the Patient Protection and Affordable Care Act. We also recommend an appropriation of at least $600 million for all of the Health Professions Training Programs authorized under title VII of the Public Health Services Act.

Rural Health Needs

Physician shortages are harder for Americans in rural areas who face more barriers to care than those in urban and suburban areas. Rural residents also struggle with the higher rates of illness associated with lower socioeconomic status.

We were pleased that title VII, section 749B, the "Rural Physician Training Grants" program, was enacted to help medical schools to recruit students most like-

ly to practice medicine in underserved rural communities, provide rural-focused training and experience, and increase the number of recent medical school graduates who practice in underserved rural communities.

Family physicians provide the majority of care for America's underserved and rural populations.[1] Despite efforts to meet scarcities in rural areas, the shortage of primary care physicians continues. Studies, whether they be based on the demand to hire physicians by hospitals and physician groups or based on the number of individuals per physician in a rural area, all indicate a need for additional physicians in rural areas.

HRSA's Office of Rural Health administers a number of programs to improve healthcare services to the quarter of our population residing in rural communities.

The AAFP requests that the Committee provide $4 million in fiscal year 2011 for title VII section 749B Rural Physician Training Grants. The AAFP also encourages the subcommittee to provide $176 million for the programs administered by HRSA's Office of Rural Health to address the many unique health service needs of rural communities.

Teaching Health Centers

The AAFP supported the authorization in the health reform legislation of the innovative Teaching Health Centers program under title VII section 749A to increase primary care physician training capacity. Federal financing of graduate medical education has led to training which occurs mainly in hospital inpatient settings in spite of the fact that most patient care is delivered outside of hospitals in ambulatory settings across the Nation. As a result, we have been training physicians using experiences which poorly prepare them to practice primary care in the community outside the hospital.

The Teaching Health Center program will train primary care residents in nonhospital settings where most primary care is delivered. A Teaching Health Center can be any community based ambulatory care setting that operates a primary care residency program including Federally Qualified Health Centers or Federally Qualified Health Centers Look Alikes, Rural Health Clinics, Community Mental Health Centers, a Health Center operated by the Indian Health Service, or a center receiving title X grants.

We were pleased that the Patient Protection and Affordable Care Act authorized a mandatory appropriations trust fund of $230 million over 5 years to fund the operations of Teaching Health Centers. However, if this program is to be effective, there must be funds for the planning grants to establish newly accredited or expanded primary care residency programs.

The AAFP recommends that the subcommittee appropriate the full authorized amount for the new title VII Teaching Health Centers development grants of $50 million for fiscal year 2011.

National Health Service Corps

The National Health Services Corps (NHSC) has long served to provide access to healthcare to underserved Americans and offer incentives for practitioners to enter primary care. NHSC also provides important student debt relief for new physicians.

Student debt was found to be a significant barrier to the production of primary care physicians by a report published in March 2009, by the Graham Center with the support of the Macy Foundation.[2] The AAFP supports the work of the NHSC toward the goal of full funding for the training of the health workforce and zero disparities in healthcare. We recognize that this subcommittee provided an increase for the NHSC in the American Recovery and Reinvestment Act, and we commend Congress for increasing the authorization level for the NHSC in the new health reform law.

The AAFP recommends that the National Health Service Corps receive $414.1 million in fiscal year 2011 as authorized in the Patient Protection and Affordable Care Act which makes $290 million of that amount available from a fund created in section 10503.

Workforce Commission

The AAFP has called for a commission on national health workforce issues which represents the multiple stakeholders and reports to Congress and the Executive Branch as appropriate. We were pleased that the health reform bill established a

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[1] Hing E, Burt CW. Characteristics of office-based physicians and their practices: United States, 2003–04. Series 13, No. 164. Hyattsville, MD: National Center for Health Statistics. 2007.

[2] The Robert Graham Center. Specialty and Geographic Distribution of the Physician Workforce: What Influences Medical Student & Resident Choices? March 2, 2009.

National Health Care Workforce Commission to provide "analysis of, and recommendations for, eliminating the barriers to entering and staying in primary care, including provider compensation." We also recognize the importance of the National Center for Health Care Workforce Analysis as well as State and Regional Centers for such analysis. The legislation authorized such sums as necessary to establish the Commission as well as $8 million in planning grants and $150 million for implementation grants. The National Center was authorized at $7.5 million annually and the State and Regional Centers were authorized at $4.5 million annually.

The AAFP recommends that the subcommittee fully fund the National Health Care Workforce Commission, the National and State and Regional Centers for Health Care Workforce Analysis in fiscal year 2011.

AGENCY FOR HEATLHCARE RESEARCH AND QUALITY

To assure the success of health reform, we must also focus on paying for quality rather than quantity. The mission of the Agency for Healthcare Research and Quality (AHRQ)—to improve the quality, safety, efficiency, and effectiveness of healthcare for all Americans—closely mirrors the AAFP's own mission. AHRQ is a small agency with a huge responsibility for research to support clinical decision-making, reduce costs, advance patient safety, decrease medical errors and improve healthcare quality and access. Family physicians recognize that AHRQ has a critical role to play in patient-centered, comparative effectiveness research.

Primary Care Extension Program

The AAFP commends the Congress for authorizing in the Patient Protection and Affordable Care Act a Primary Care Extension Program to be administered by AHRQ to provide support and assistance to primary care providers about evidence-based therapies and techniques so that providers can incorporate them into their practice. Family physicians Kevin Grumbach, MD and James W. Mold, MD, MPH recognized that small primary care practices need a similar kind of support offered by the Federal Government to farms by the Cooperative Extension Service to implement innovation and best practices.[3]

The AAFP requests that the subcommittee provide $731 million for AHRQ in fiscal year 2011 to provide for the funding requested by the President's budget request of $611 million as well as the important new Primary Care Extension program authorized by the health reform law at $120 million.

PREPARED STATEMENT OF THE AMERICAN ASSOCIATION FOR GERIATRIC PSYCHIATRY

The American Association for Geriatric Psychiatry (AAGP) appreciates this opportunity to comment on issues related to fiscal year 2011 appropriations for mental health research and services. AAGP is a professional membership organization dedicated to promoting the mental health and well being of older Americans and improving the care of those with late-life mental disorders. AAGP's membership consists of approximately 2,000 geriatric psychiatrists as well as other health professionals who focus on the mental health problems faced by aging adults. Although we generally agree with others in the mental health community about the importance of sustained and adequate Federal funding for mental health research and treatment, AAGP brings a unique perspective to these issues because of the elderly patient population served by our members.

A National Health Crisis: Demographic Projections and the Mental Disorders of Aging

The aging of the baby boomer generation will result in an increase in the proportion of persons older than 65 from 12.7 percent currently to 20 percent in 2030, with the fastest growing segment of the population consisting of age 85 and older. During the same period, the number of older adults with major psychiatric illnesses will more than double, from an estimated 7 million to 15 million individuals, meeting or exceeding the number of consumers in discrete, younger age groups.

The cost of treating mental disorders can be staggering. For example, it is estimated that total costs associated with the care of patients with Alzheimer's disease is more than $100 billion per year in the United States. Psychiatric symptoms (including depression, agitation, and psychotic symptoms) affect 30 to 40 percent of people with Alzheimer's and are associated with increased hospitalization, nursing home placement, and crippling family burden. These psychiatric symptoms can in-

[3] Grumbach K, Mold JW. A Health Care Cooperative Extension Services: Transforming Primary Care and Community Health. JAMA, June 24, 2009—Vol. 301, No. 24.

crease the cost of treating these patients by more than 20 percent. However, these costs pale when compared to the costs of not treating mental disorders including lost work time, co-morbid illness, and increased nursing home utilization. It is also important to note the added burden, financial and emotional, on family caregivers, as the Nation's informal caregiving system is already under tremendous strain and will require more support in the years to come.

Preparing a Workforce To Meet the Mental Health Needs of the Aging Population

In 2008, the Institute of Medicine (IOM) released a study of the readiness of the Nation's healthcare workforce to meet the needs of its aging population. The Re-tooling for an Aging America: Building the Health Care Workforce called for immediate investments in preparing our healthcare system to care for older Americans and their families. AAGP is deeply grateful to this subcommittee and its House counterpart for providing, in the appropriations bill for fiscal year 2010, funding for a follow-up study of the current and projected mental and behavioral healthcare needs of the American people, particularly for aging and growing ethnic populations. This study, first proposed by Senator Kohl in the Retooling the Health Care Workforce for an Aging America Act (S. 245), will complement the 2008 IOM study in providing in-depth consideration of the mental health needs of geriatric and ethnic minority populations that were precluded by the broad scope of the earlier one.

Virtually all healthcare providers need to be fully prepared to manage the common medical and mental health problems of old age. In addition, the number of geriatric health specialists, including mental health providers, needs to be increased both to provide care for those older adults with the most complex issues and to train the rest of the workforce in the common medical and mental health problems of old age. The small numbers of specialists in geriatric mental health, combined with increases in life expectancy and the growing population of the Nation's elderly, foretells a crisis in healthcare that will impact older adults and their families nationwide.

Already, there are programs administered by the Bureau of Health Professions in the HHS Health Resources and Services Administration administers that are aimed to help to assure adequate numbers of healthcare practitioners for the Nation's geriatric population, especially in underserved areas. The breadth of these programs has been strengthened by provisions from S. 245 included in the recently enacted Patient Protection and Affordable Care Act (PPACA).

The geriatric health professions program supports these important initiatives:

—The Geriatric Education Center (GEC) program provides interdisciplinary training for healthcare professionals in assessment, chronic disease syndromes, care planning, emergency preparedness, and cultural competence unique to older Americans. PPACA authorizes $10.8 million in supplemental grants for the GEC Program to support training in geriatrics, chronic care management, and long-term care for faculty in a broad array of health professions schools, as well as direct care workers and family caregivers. GECs receiving these grants are required to develop and include material on depression and other mental disorders common among older adults, medication safety issues for older adults, and management of the psychological and behavioral aspects of dementia in all appropriate training courses.

—The Geriatric Training for Physicians, Dentists, and Behavioral and Mental Health Professionals provides fellows with exposure to older adult patients in various levels of wellness and functioning and from a range of socioeconomic and racial/ethnic backgrounds.

—The Geriatric Academic Career Awards (GACA) support the academic career development of geriatric specialists in junior faculty positions who are committed to teaching geriatrics in professional schools. PPACA expands the disciplines eligible for the awards. GACA recipients are required to provide training in clinical geriatrics, including the training of interdisciplinary teams of healthcare professionals.

—PPACA authorized a new Geriatric Career Incentive Awards Program in title VIII of the Public Health Service Act for grants to foster great interest among a variety of health professionals in entering the field of geriatrics, long-term care, and chronic care management. This program was authorized for $10 million over 3 years.

—A new program, authorized by PPACA at $10 million for 3 years, will provide advanced training opportunities for direct care workers in the field of geriatrics, long-term care or chronic care management.

AAGP strongly supports increased funding for the existing programs, particularly as the disciplines included have been expanded, and funding to fully authorized levels for the new programs.

National Institutes of Health (NIH) and National Institute of Mental Health (NIMH)

With the graying of the population, mental disorders of aging represent a growing crisis that will require a greater investment in research to understand age-related brain disorders and to develop new approaches to prevention and treatment. Even in the years in which funding was increased for NIH and the NIMH, these increases did not always translate into comparable increases in funding that specifically address problems of older adults. For instance, according to figures provided by NIMH, NIMH total aging research amounts decreased from $106,090,000 in 2002 to $85,164,000 in 2006 (dollars in thousands: $106,090 in 2002, $100,055 in 2003, $97,418 in 2004, $91,686 in 2005, $85,164 in 2006).

The critical disparity between federally funded research on mental health and aging and the projected mental health needs of older adults is continuing. If the mental health research budget for older adults is not substantially increased immediately, progress to reduce mental illness among the growing elderly population will be severely compromised. While many different types of mental and behavioral disorders occur in late life, they are not an inevitable part of the aging process, and continued and expanded research holds the promise of improving the mental health and quality of life for older Americans. This trend must be immediately reversed to ensure that our next generation of elders is able to access effective treatment for mental illness. Federal funding of research must be broad-based and should include basic, translational, clinical, and health services research on mental disorders in late life.

AAGP believes that it is critical that NIH begin to invest increased funding in future evidence-based treatments for our Nation's elders. Annual increases of funds targeted for geriatric mental health research at NIH should be used to: (1) identify the causes of age-related brain and mental disorders to prevent mental disorders before they devastate lives; (2) speed the search for effective treatments and efficient methods of treatment delivery; and (3) improve the quality of life for older adults with mental disorders.

Participation of Older Adults in Clinical Trials

Federal approval for most new drugs is based on research demonstrating safety and efficacy in young and middle-aged adults. These studies typically exclude people who are old, who have more than one health problem, or who take multiple medications. As the population ages, that is the very profile of many people who seek treatment. Thus, there is little available scientific information on the safety of drugs approved by the Food and Drug Administration (FDA) in substantial numbers of older adults who are likely to take those drugs. Pivotal regulatory trials never address the special efficacy and safety concerns that arise specifically in the care of the Nation's mentally ill elderly. This is a critical public health obligation of the Nation's health agencies. Just as the FDA has begun to require inclusion of children in appropriate studies, the agency should work closely with the geriatric research community, healthcare consumers, pharmaceutical manufacturers, and other stakeholders to develop innovative, fair mechanisms to encourage the inclusion of older adults in clinical trials. Clinical research must also include elders from diverse ethnic and cultural groups. In addition, AAGP urges that Federal funds be made available each year for support of clinical trials involving older adults.

Study on NIH Funding for Mental Disorders among Older Adults

As little emphasis has been placed on the development of new treatments for geriatric mental disorders, AAGP encourages NIH to promote the development of new medications specifically targeted at brain-based mental disorders of the elderly. AAGP urges this subcommittee to request a Government Accountablity Office (GAO) study on spending by NIH on conditions and illnesses related to the mental health of older individuals. NIH has already undertaken, in its Blueprint for Neuroscience Research, an endeavor to enhance cooperative activities among NIH Institutes and Centers that support research on the nervous system. A GAO study of the work being done by these 16 Institutes in areas that predominately involve older adults could provide crucial insights into possible new areas of cooperative research, which in turn will lead to advances in prevention and treatment for these devastating illnesses.

Center for Mental Health Services

It is critical that there be adequate funding for the mental health initiatives under the jurisdiction of the Center for Mental Health Services (CMHS) within the Substance Abuse and Mental Health Services Administration (SAMHSA). While research is of critical importance to a better future, today's patients must also receive appropriate treatment for their mental health problems.

Evidence-based Mental Health Outreach and Treatment for the Elderly

For the last 8 years $5 million has been allocated for evidence-based mental health outreach and treatment to the elderly. AAGP urges an increase in funding from $5 million to $10 million for this essential program to disseminate and implement evidence-based practices in routine clinical settings across the States.

Centers of Excellence for Depressive and Bipolar Disorders

PPACA also included authorization for a new national network of centers of excellence for depressive and bipolar disorders, which will enhance the coordination and integration of physical, mental and social care that are critical to the identification and treatment of depression and other mental disorders across the lifespan. The work of these centers will help to disseminate and implement evidence-based practices in clinical settings throughout the country. AAGP strongly supports funding for the centers authorized by this legislation.

Conclusion

AAGP recommends:

—Increased funding for the geriatric health professions education programs under title VII of the Public Health Service Act and full funding for new programs authorized by the PPACA;
—Funding to support clinical trials involving older adults;
—A GAO study on spending by NIH on conditions and illnesses related to the mental health of older individuals;
—Increased funding for evidence-based geriatric mental health outreach and treatment programs at CMHS;
—Funding for Centers of Excellence for Depressive and Bipolar Disorders.

PREPARED STATEMENT OF THE AMERICAN ASSOCIATION OF IMMUNOLOGISTS

The American Association of Immunologists (AAI), a not-for-profit professional association representing more than 6,500 of the world's leading experts on the immune system, appreciates having this opportunity to submit testimony regarding fiscal year 2011 appropriations for the National Institutes of Health (NIH). The vast majority of AAI members—research scientists and physicians who work in academia, Government, and industry—depend on NIH funding to advance their work.[1] With more than 80 percent of the $30.5 billion budget awarded to scientists in communities throughout the United States and around the world, NIH funding advances not only immunological and biomedical research, but also regional and national economies by creating and supporting skilled jobs that are focused on improving human health.[2]

The Immune System's Wide Reach

Influenza, HIV/AIDS, malaria, tuberculosis, salmonella, the common cold, and more—all are infectious diseases that challenge and sometimes overcome the defenses mounted by the immune system. Chronic diseases like cancer, diabetes, multiple sclerosis, rheumatoid arthritis, asthma, inflammatory bowel disease, and lupus, are either caused by—or due in large part to—an overactive or underactive immune response.[3] Scientists' discovery of ways to prevent, diagnose, and treat these diseases depends on increased knowledge in the field of immunology.[4] Important new challenges require understanding the immune response to: (1) pathogens

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[1] AAI members receive grants from the National Institute of Allergy and Infectious Diseases (NIAID), the National Cancer Institute; the National Institute on Aging, and the National Institute of Arthritis and Musculoskeletal and Skin Diseases, but may also receive grants from other NIH Institutes and Centers.

[2] NIH funding supports "almost 50,000 competitive grants to more than 325,000 researchers at over 3,000 universities, medical schools, and other research institutions in every State and around the world." See http://www.nih.gov/about/budget.htm (2/8/10).

[3] The immune system works by recognizing and attacking bacteria and viruses inside the body and by controlling the growth of tumor cells. A healthy immune system can protect its human or animal host from illness or disease either entirely—by destroying the virus, bacterium, or tumor cell—or partially, resulting in a less serious illness. It is also responsible for the rejection response following transplantation of organs or bone marrow. The immune system can also malfunction, causing the body to attack itself, resulting in an "autoimmune" disease, such as Type 1 diabetes, multiple sclerosis, lupus or rheumatoid arthritis.

[4] Although the first vaccine (against smallpox) was developed in 1798, most of our basic understanding of the immune system has developed in the last 30–40 years, making immunology ripe for new discoveries.

that threaten to become the next pandemic,[5] (2) man-made and natural infectious organisms that are potential agents of bioterrorism (including plague, smallpox, and anthrax),[6] and (3) environmental threats. The immune system, therefore, plays a crucial role in preserving human and animal health[7] and increasingly—in our fast-paced, interconnected world—ensuring both community and global health.

Recent Advances in Immunological Research

Knowledge of the intricacies of the immune system has led to unprecedented medical advances such as successful organ transplantation, new vaccines, and better treatments. Recent immunological advances may further yield profound improvements for people afflicted with debilitating diseases. One such advance involves lupus, a serious chronic autoimmune disease affecting some 1.5 million Americans.[8] Exciting recent results from the largest clinical trials yet performed have opened the door for the first new drug for effective lupus treatment in 50 years. These trials show that a new type of therapeutic that inactivates the natural molecule "BLyS" results in substantial disease reduction in lupus patients. Both the discovery of BLyS and the development of novel effective treatments are a product of decades of basic immunology research by scientists supported by NIH and other nonprofit organizations.

An advance with international importance was the successful response of the biomedical research community to the 2009 swine flu/H1N1 influenza outbreak. Researchers working against time were able to develop an effective vaccine within 4 months after the first U.S. case was diagnosed on April 13, 2009[9]. This success depended on years of comprehensive basic research on the immune and viral systems, including the ability to identify the molecular DNA sequence of the virus necessary to produce a vaccine. This provided an excellent "test run" for a future pandemic of even more significant public health concern,[10] and demonstrated a successful collaboration among basic and translational scientists, clinical practitioners, and pharmacological companies against an infectious disease pandemic.

Another advance involves the successful use of new and improved technologies to identify all the human genes stimulated by a vaccine, in this case, the Yellow Fever vaccine.[11] This was the first time scientists could determine how different individuals immunized with the same vaccine responded on a molecular level; this approach will significantly enhance our ability to determine how effective vaccines stimulate protective responses and may lead the way to customize vaccines to be more effective for the individual.

The NIH Budget: Building on a Strong Start

AAI greatly appreciates the strong support of this subcommittee for medical research, from doubling the NIH budget (fiscal year 1999 to fiscal year 2003), to passing the fiscal year 2009 and 2010 Appropriations Acts, to including in the "American Recovery and Reinvestment Act of 2009" (ARRA) a $10.4 billion supplemental ap-

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[5] While researchers and public health professionals must respond to emergent threats, AAI believes that the best preparation for a pandemic is to focus on basic research to combat seasonal flu, including building capacity, pursuing new production methods, and seeking optimized flu vaccines and delivery methods.

[6] To best protect against bioterrorism, scientists should focus on basic research, including working to understand the immune response, identifying new and potentially modified pathogens, and developing tools (including new and more potent vaccines) to protect against these pathogens.

[7] Research on the immune system leads to new vaccines/treatments for pets and livestock, and improves our understanding of animal to human transmission [as, for example, with H1N1 influenza ("swine flu")].

[8] See http://www.lupusresearch.org/about/press-room/press-releases/new-study-findings-represent.html.

[9] See http://www3.niaid.nih.gov/about/directors/pdf/110409NIAIDStatementLHHSH1N1.pdf. On 7/22/09, NIAID reported the launch of clinical trials on two candidate H1N1 vaccines in adults (see http://www.nih.gov/news/health/jul2009/niaid-22.htm). On 8/18, NIAID announced it would begin trials in children (see http://www3.niaid.nih.gov/news/newsreleases/2009/H1N1pedvax.htm). The Food and Drug Administration approved a vaccine on 9/15; it was made publicly available on 10/5 (see http://www3.niaid.nih.gov/about/directors/pdf/110409NIAIDStatementLHHSH1N1.pdf).

[10] A pandemic can be mild or serious. Seasonal influenza, which may or may not lead to a pandemic, results in ~200,000 hospitalizations and ~36,000 deaths nationwide in an average year. A serious influenza pandemic could result in the hospitalization of nearly 10 million Americans and the death of almost 2 million, at a projected cost of over $680 billion. (See "Pandemic Influenza: Warning, Children At-Risk," Trust for America's Health, 10/07, at http://healthyamericans.org/reports/fluchildren/KidsPandemicFlu.pdf).

[11] Published in *Nature Immunology*, Jan. 10, 2009, pp. 116–25, from the laboratory of B. Pulendran.

propriation for NIH. ARRA underscored both the President's and Congress's realization that investing in biomedical research would not only improve individual and global health, but also stimulate economic activity and job creation: NIH has estimated that each NIH grant supports, on average, "6 to 7 in-part or full scientific jobs,"[12] while Families USA, a nonprofit consumer organization, has found that, on average, each $1 of NIH funding going into a State generates more than twice as much in State economic output.[13]

As a result of this generous infusion of funds, NIH has also been able to fund many excellent, innovative projects with great promise for advancing human health, and to invest in modernizing the Nation's research infrastructure. And while AAI—and the biomedical research community—are deeply grateful for these funds, AAI is concerned that imminent advances may not come to fruition if the fiscal year 2011 appropriations level fails to acknowledge the crucial role that ARRA funding now plays within the NIH budget. The AAI funding recommendation for fiscal year 2011 is premised on that concern and designed to address that future.

AAI Recommendation for NIH Funding for Fiscal Year 2011: Achieving the President's Vision

Although President Obama's proposed fiscal year 2011 budget of $32.2 billion, a 3.2 percent increase over the regular fiscal year 2010 appropriations level, is a good next step toward achieving the President's vision that "investments in research will improve and save countless lives for generations to come . . .,"[14] it will not ensure that important ongoing research currently funded by combined regular and supplemental (ARRA) appropriations is not interrupted, suspended or delayed. AAI urges the subcommittee to provide NIH with a fiscal year 2011 budget of $37 billion to preserve ongoing research and to enable NIH to grow modestly from its 2009 and 2010 program levels of ~$35 billion.[15] Such a budget would also provide NIH with predictable, sustained funding that stabilizes ongoing research projects and the overall research enterprise, inspiring many of our brightest young students to pursue careers in biomedical research.[16]

NIH Research Priorities for Fiscal Year 2011

AAI is concerned that the President's proposed budget focuses primarily on large-scale, trans-NIH initiatives, at the expense of investigator-initiated research, a proven route to medical advancement. In fact, the fiscal year 2011 budget decreases the number of competing Research Project Grants by 199. AAI urges that the budget support the NIH Director's stated commitment to individual investigator-initiated research. In addition, AAI supports the proposed 6 percent increase for the Ruth Kirschstein National Research Service Awards, a long-needed training stipend increase for the young scientists who are the next generation of research leaders. AAI also supports the President's request for $300 million for the Global Fund to Fight AIDS, Tuberculosis, and Malaria—infectious diseases which devastate people and communities worldwide.

Preserving High-quality Peer Review

Peer review is at the heart of the many decades of successful biomedical research in the United States; the NIH peer review system is internationally respected and highly successful. NIH is currently implementing dramatic changes intended to improve its system. Although AAI supports NIH's effort to address legitimate problems, AAI is concerned that some of the changes have harmed the peer review system, its reviewers, and its applicants, and believes that independent oversight and evaluation is urgently needed.

The NIH Common Fund

AAI is concerned that the proposed increase of $17.5 million for the NIH Common Fund (CF), which supports trans-NIH initiatives, may over-emphasize large-scale,

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[12] Testimony of Raynard S. Kington, M.D, Ph.D., Acting Director, National Institutes of Health, Witness appearing before the House Subcommittee on Labor-HHS-Education Appropriations, March 26, 2009.

[13] "In Your Own Backyard: How NIH Funding Helps Your State's Economy," Families USA (June 2008).

[14] See http://www.whitehouse.gov/blog/09/09/30/An__Historic__Commitment__to__Research.

[15] After adding an increase for the projected rate of biomedical research inflation (3.2 percent), and (2) a modest increase for growth (2.5 percent), the total increase requested above the fiscal year 2010 program level is 5.71 percent.

[16] Presidential candidate Barack Obama acknowledged that "Sustained and predictable increases in research funding will allow the United States to . . . provide greater support for . . . young scientists at the beginning of their careers." (See http://www.sciencedebate2008.com/www/index.php?id=42) (8/30/08).

multi-disciplinary initiatives, as compared with entrepreneurial investigator-initiated approaches. Although AAI recognizes the value of interdisciplinary research, the CF should not permit the funding less well regarded research. Instead, all CF applications should be subject to a transparent and rigorous peer review process like all other funded research grant applications. In addition, AAI recommends that the CF not grow faster than the overall NIH budget so that individual researchers, who drive American scientific advancement, are not marginalized.

NIH Operations and Oversight

AAI strongly supports the President's request for $1.525 billion for the NIH Research, Management, and Services account, which supports the management, monitoring, and oversight of all research activities. NIH must have adequate resources to supervise and oversee its increasingly large and complex portfolio.

The NIH Public Access Policy

AAI requests that the subcommittee require NIH to publicly report on the cost of the NIH Public Access Policy (Policy), including the cost of implementing the voluntary Policy (May 2, 2005-January 11, 2008); the mandatory Policy (fiscal year 2009 and fiscal year 2010); and the Policy in fiscal year 2011 (projected cost). AAI believes that the Policy duplicates publications and services which are already provided cost-effectively and well by the private sector. The private sector, including not-for-profit scientific societies, already publishes—and makes publicly available—thousands of scientific journals (and millions of articles) that report cutting-edge research funded by NIH and other entities. AAI urges that, rather than supporting a Government bureaucracy that competes with private publishers, NIH should partner with publishers to enhance public access while addressing publishers' key concerns, including respecting copyright law and ensuring journals' continued ability to provide quality, independent peer review of NIH-funded research.

Conclusion

AAI thanks the subcommittee for its strong support for biomedical research, the NIH, and the biomedical researchers who devote their lives to scientific discovery and the prevention, treatment, and cure of disease.

PREPARED STATEMENT OF THE ASSOCIATION OF AMERICAN MEDICAL COLLEGES

The Association of American Medical Colleges (AAMC) is a not-for-profit association representing all 131 accredited U.S. medical schools; nearly 400 major teaching hospitals and health systems; and nearly 90 academic and scientific societies. Through these institutions and organizations, the AAMC represents 128,000 faculty members, 75,000 medical students, and 110,000 resident physicians. The association appreciates the opportunity to address four programs that play critical roles in assisting medical schools and teaching hospitals to fulfill their missions of education, research, and patient care: the National Institutes of Health (NIH); the Agency for Healthcare Research and Quality (AHRQ); health professions education funding through the Health Resources and Services Administration (HRSA)'s Bureau of Health Professions; and the National Health Service Corps (NHSC). The AAMC thanks the Subcommittee for its steadfast support of these programs.

National Institutes of Health (NIH).—The AAMC believes that the NIH is one of the Nation's greatest achievements. The Federal Government's unwavering support for medical research through the NIH has created a scientific enterprise that is the envy of the world and has contributed greatly to improving the health and well-being of all Americans—indeed of all humankind.

The AAMC supports the Obama administration's proposal to increase funding for NIH to $32 billion in fiscal year 2011. Boosting NIH's funding to a level that keeps pace with biomedical inflation recognizes the need for continued, predictable growth in the Nation's medical research effort. At a time when the Nation faces extraordinary fiscal challenges, the President's commitment to medical research is a wise investment that will yield long-term benefits for our Nation's health. The partnership between NIH and America's medical schools and teaching hospitals continues to serve as the engine for this Nation's search for an ever-greater understanding of the mechanisms underlying human health and disease. The foundation of scientific knowledge that continues to be built through NIH-funded research drives medical innovation that improves health and quality of life through new and better diagnostics, improved prevention strategies, and more effective treatments.

For example, a new ability to comprehend the genetic mechanisms responsible for disease is already providing insights into diagnostics and identifying a new array of drug targets. We are entering an era of personalized medicine, where prevention,

diagnosis, and treatment of disease can be individualized, instead of using the standardized approach that all too often wastes healthcare resources and potentially subjects patients to unnecessary and ineffective medical treatments and diagnostic procedures.

Peer-reviewed, investigator-initiated basic research is the heart of NIH research. These inquiries into the fundamental cellular, molecular, and genetic events of life are essential if we are to make real progress toward understanding and conquering disease. Additional funding is needed to sustain and enhance basic research activities, including increasing support for current researchers and promoting opportunities for new investigators and in those areas of biomedical science that have historically been underfunded.

The application of the results of basic research to the detection, diagnosis, treatment, and prevention of disease is the ultimate goal of medical research. Clinical research not only is the pathway for applying basic research findings, but it often provides important insights and leads to further basic research opportunities. The AAMC supports additional funding for the continued expansion of clinical research and clinical research training opportunities, including rigorous, targeted postdoctoral training; developmental support for new and junior investigators; and career support for established clinical investigators, especially to enable them to mentor new investigators.

Anecdotal evidence suggests that changes in healthcare delivery systems and other financial factors pose a serious threat to the research infrastructure of America's medical schools and teaching hospitals, particularly for clinical research. The AAMC supports efforts to enhance the research infrastructure, including resources for clinical and translational research; instrumentation and emerging technologies; and animal and other research models.

The AAMC supports efforts to reinvigorate research training, including developing expanded medical research opportunities for minority and disadvantaged students. For example, the volume of data being generated by genomics research, as well as the increasing power and sophistication of computing assets on the researcher's lab bench, have created an urgent need, both in academic and industrial settings, for talented individuals well-trained in biology, computational technologies, bioinformatics, and mathematics to realize the promise offered by modern interdisciplinary research.

The AAMC is heartened by the administration's proposals to provide a 6 percent stipend increase for predoctoral and postdoctoral research trainees supported by NIH's Ruth L. Kirschstein National Research Service Awards program. These stipend increases are necessary if medical research is to remain an attractive career option for the brightest U.S. students. Attracting the most talented students and postdoctoral fellows is essential if the United States is to retain its position of world leadership in biomedical and behavioral research.

As President Obama noted in his State of the Union address, "We need to encourage American innovation." Research conducted and supported by NIH has played a major role in the development of the biotechnology, pharmaceutical, and medical device industries and continues to provide the basis for their continued success. Sustaining this Nation's investment in medical research will continue to strengthen our Nation's economic health by creating skilled and high-paying jobs, new products and industries, and improved technologies.

Agency for Healthcare Research and Quality.—Complementing the medical research supported by NIH, AHRQ sponsors health services research designed to improve the quality of healthcare, decrease healthcare costs, and provide access to essential healthcare services by translating research into measurable improvements in the healthcare system. The AAMC firmly believes in the value of health services research as the Nation continues to strive to provide high-quality, efficient, and cost-effective healthcare to all of its citizens. The AAMC supports the President's request for AHRQ, which calls for $611 million for the agency in fiscal year 2011.

As the lead Federal agency to improve healthcare quality, AHRQ's overall mission is to support research and disseminate information that improves the delivery of healthcare by identifying evidence-based medical practices and procedures. The funding increase proposed in the President's budget will allow AHRQ to continue to support patient-centered health research and other valuable research initiatives, including strategies for translating the knowledge gained from patient-centered research into clinical practice, healthcare delivery, and provider and patient behaviors. These research findings will better guide and enhance consumer and clinical decisionmaking, provide improved healthcare services, and promote efficiency in the organization of public and private systems of healthcare delivery.

While we support a strong investment in patient-centered health research, we also encourage the subcommittee to maintain balance across AHRQ's portfolio to

allow the agency to support the full spectrum of activities aligned with its mission. For example, the President's budget does not continue funding for the Centers for Education and Research in Therapeutics (CERTs) grants, and instead, funds six new CERTs in the Patient-Centered Health Research portfolio and one new pediatric patient safety CERT. The AAMC believes AHRQ is perfectly positioned to take the lead on improving the quality of healthcare through the reduction of medical errors, and strongly supports the CERTs program; we encourage the subcommittee not to limit or narrow its scope. The request also decreases other initiatives within the agency's "Crosscutting Activities" portfolio, including a proposed decrease for investigator-initiated research that would preclude AHRQ from offering any new grants in this area.

Additionally, in recent years, much of the funding for AHRQ has been derived from interagency transfers, rather than direct appropriations. The AAMC urges the subcommittee to provide the majority of the agency's funding through direct appropriations.

Health Professions Funding.—The AAMC thanks the Subcommittee for the increased support in recent years for the health professions and nursing education programs under titles VII and VIII of the Public Health Service Act. These programs work to improve the diversity, distribution, and supply of the health professions workforce, with an emphasis on primary care and interdisciplinary training.

The AAMC is pleased that the Patient Protection and Affordable Care Act (Public Law 111–148) updated and restructured the existing title VII and VIII programs to improve their efficiency, effectiveness, and accountability, and reauthorized them at funding levels that reflect the health workforce needs of the Nation. To enable the programs to perform most optimally and help achieve the goals of the legislation, the AAMC joins the Health Professions and Nursing Education Coalition (HPNEC) in support of an fiscal year 2011 appropriation of at least $600 million for the existing title VII and title VIII programs. This funding level will allow the programs to continue educating and training health professionals that are prepared to respond to the increased demand for healthcare services, improving access and quality of care across the country.

In addition to the existing health professions programs, the legislation authorizes several new programs and initiatives under titles VII and VIII designed to mitigate health workforce challenges and expand the scope of the programs to additional fields. These new programs recognize the breadth of shortages across healthcare disciplines and aim to alleviate these existing and looming workforce shortages. The AAMC encourages the subcommittee to support these new programs with an investment that supplements the support for the core of title VII and VIII programs that have demonstrated their effectiveness.

During their 40-year existence, the title VII and VIII programs have created a network of initiatives across the country that supports the training of many disciplines of health providers. These are the only Federal programs designed to create infrastructures at health professions schools and in their communities that facilitate customized training designed to bring the latest emerging national priorities to the populations at large and meet the healthcare needs of special, underserved populations. The AAMC urges the subcommittee to continue its commitment to the title VII and VIII health professions programs.

National Health Service Corps.—The AAMC lauds the ambition of the Patient Protection and Affordable Care Act to provide up to $414 million for the NHSC in fiscal year 2011 through discretionary appropriations and the HHS Secretary's new Community Health Center (CHC) Fund.

The NHSC is widely recognized—both in Washington and in the underserved areas it helps—as a success on many fronts. It improves access to healthcare for the growing numbers of underserved Americans, provides incentives for practitioners to enter primary care, reduces the financial burden that the cost of health professions education places on new practitioners, and helps ensure access to health professions education for students from all backgrounds. Over its 39-year history, the NHSC has offered recruitment incentives, in the form of scholarship and loan repayment support, to more than 29,000 health professionals committed to serving the underserved.

In spite of the NHSC's success, demand for health professionals across the country remains high. At a field strength of 4,760 in fiscal year 2009, the NHSC fell more than 24,000 practitioners short of fulfilling the need for primary care, dental, and mental health practitioners in Health Professions Shortage Areas (HPSAs), as estimated by HRSA. While the "American Recovery and Reinvestment Act of 2009" (Public Law 111–5) provided a temporary boost in annual awards, this increase must be sustained to help address the health professionals workforce shortage and growing maldistribution.

The AAMC supports the President's fiscal year 2011 budget request ($169 million), which will ensure that the NHSC has access to additional dedicated funding through the HHS Secretary's CHC Fund. The AAMC further recommends that the subcommittee include report language directing the Secretary to provide enhanced funding for the NHSC over the fiscal year 2008 level, as directed under healthcare reform.

PREPARED STATEMENT OF THE AMERICAN ASSOCIATION OF NURSE ANESTHETISTS

FISCAL YEAR 2011 APPROPRIATIONS REQUEST SUMMARY

	Fiscal year 2010 actual	Fiscal year 2011 budget	AANA fiscal year 2011 request
HHS/HRSA/BHPr Title VIII Advanced Education Nursing, Nurse Anesthetist Education Reserve.	Awaiting grant allocations—in fiscal year 2009 awards amounted to approximately $3.5 million.	Grant allocations not specified.	$4 million for nurse anesthesia education
Total for Advanced Education Nursing, from Title VIII.	$64.44 million for Advanced Education Nursing.	$64.44 million for Advanced Education Nursing.	$76.514 million for Advanced Education Nursing
Title VIII HRSA BHPr Nursing Education Programs	$243,872,000	$243,872,000	$267,300,000
CDC/Division of Healthcare Quality and Promotion.			$26 million
HHS/Office of the Secretary			$1 million

The American Association of Nurse Anesthetists (AANA) is the professional association for the 44,000 Certified Registered Nurse Anesthetists (CRNAs) and student nurse anesthetists practicing today, representing over 90 percent of the nurse anesthetists in the United States. Today, CRNAs deliver approximately 32 million anesthetics to patients each year in the U.S. CRNA services include administering the anesthetic, monitoring the patient's vital signs, staying with the patient throughout the surgery, and providing acute and chronic pain management services. CRNAs provide anesthesia for a wide variety of surgical cases and in some states are the sole anesthesia providers in almost 100 percent of rural hospitals, affording these medical facilities obstetrical, surgical, and trauma stabilization, and pain management capabilities. CRNAs work in every setting in which anesthesia is delivered, including hospital surgical suites and obstetrical delivery rooms, ambulatory surgical centers (ASCs), pain management units and the offices of dentists, podiatrists and plastic surgeons. Nurse anesthetists are experienced and highly trained anesthesia professionals whose record of patient safety in the field of anesthesia was bolstered by the Institute of Medicine report in 2000, which found that anesthesia is 50 times safer than in the 1980s. (Kohn L, Corrigan J, Donaldson M, ed. To Err is Human. Institute of Medicine, National Academy Press, Washington DC, 2000.) Nurse anesthetists continue to set for themselves the most rigorous continuing education and re-certification requirements in the field of anesthesia. Relative anesthesia patient safety outcomes are comparable among nurse anesthetists and anesthesiologists, with Pine having concluded, "the type of anesthesia provider does not affect inpatient surgical mortality." (Pine, Michael MD et al. "Surgical mortality and type of anesthesia provider." Journal of American Association of Nurse Anesthetists. Vol. 71, No. 2, p. 109—116. April 2003.)

Even more recently, a study published in Nursing Research indicates that obstetrical anesthesia, whether provided by CRNAs or anesthesiologists, is extremely safe, and there is no difference in safety between hospitals that use only CRNAs compared with those that use only anesthesiologists. (Simonson, Daniel C et al. "Anesthesia Staffing and Anesthetic Complications During Cesarean Delivery: A Retrospective Analysis." Nursing Research, Vol. 56, No. 1, pp. 9–17. January/February 2007). In addition, a recent AANA workforce study showed that CRNAs and anesthesiologists are substitutes in the production of surgeries. Through continual improvements in research, education, and practice, nurse anesthetists are vigilant in our efforts to ensure patient safety.

CRNAs provide the lion's share of anesthesia care required by our U.S. Armed Forces through active duty and the reserves. For decades, CRNAs have staffed ships, remote U.S. military bases, and forward surgical teams without physician an-

esthesiologist support. In addition, CRNAs predominate in rural and medically underserved areas, and where more Medicare patients live.

IMPORTANCE OF TITLE VIII NURSE ANESTHESIA EDUCATION FUNDING

The nurse anesthesia profession's chief request of the subcommittee is for $4 million to be reserved for nurse anesthesia education and $76.514 million for advanced education nursing from the title VIII program. We feel that this funding request is well justified, as we are seeing a vacancy rate of nurse anesthetists in the United States that is impacting the public's access to healthcare. The title VIII program, which has been strongly supported by members of this subcommittee in the past, is an effective means to help address the nurse anesthesia workforce demand.

Increasing funding for advanced education nursing from $64.44 million to $76.514 million is necessary to meet the continuing demand for nursing faculty and other advanced education nursing services throughout the United States. The program provides for competitive grants that help enhance advanced nursing education and practice and traineeships for individuals in advanced nursing education programs. This funding is critical to meet the nursing workforce needs of Americans who require healthcare, particularly as we see more patients enter the system with the successful passage of health reform. More APRNs will be needed to fill the gap to ensure access to care. In addition, this funding provides a two-fold benefit for the nurse workforce. It not only seeks to increase the number of providers in rural and underserved America but also prepares providers at the master's and doctoral levels, increasing the number of clinicians who are eligible to serve as faculty.

There continues to be high demand for CRNA workforce in clinical and educational settings. In 2007, an AANA nurse anesthesia workforce study found a 12.6 percent vacancy rate in hospitals for CRNAs, and a 12.5 percent faculty vacancy rate. The supply of clinical providers has increased in recent years, stimulated by increases in the number of CRNAs trained. Between 2000–2009, the number of nurse anesthesia educational program graduates doubled, with the Council on Certification of Nurse Anesthetists (CCNA) reporting 1,075 graduates in 2000 and 2,239 graduates in 2009. This growth is leveling off somewhat, but is expected to continue. However, even though the number of graduates has doubled in 8 years, the nurse anesthetist vacancy rate remained steady at around 12 percent, which is likely due to increased demand for anesthesia services as the population ages, growth in the number of clinical sites requiring anesthesia services, and CRNA retirements.

The problem is not that our 108 accredited programs of nurse anesthesia are failing to attract qualified applicants. It is that they have to turn them away by the hundreds. The capacity of nurse anesthesia educational programs to educate qualified applicants is limited by the number of faculty, the number and characteristics of clinical practice educational sites, and other factors. A qualified applicant to a CRNA program is a bachelor's educated registered nurse who has spent at least 1 year serving in an acute care healthcare practice environment. Nurse anesthesia educational programs are located all across the country, including Alabama, Arkansas, Iowa, Illinois, Louisiana, Pennsylvania, Rhode Island, Tennessee, Texas, Washington, and Wisconsin.

Recognizing the important role nurse anesthetists play in providing quality healthcare, the AANA has been working with the 108 accredited nurse anesthesia educational programs to increase the number of qualified graduates. In addition, the AANA has worked with nursing and allied health deans to develop new CRNA programs. To truly meet the nurse anesthesia workforce challenge, the capacity and number of CRNA schools must continue to grow. With the help of competitively awarded grants supported by Title VIII funding, the nurse anesthesia profession is making significant progress, expanding both the number of clinical practice sites and the number of graduates.

The AANA is pleased to report that this progress is extremely cost-effective from the standpoint of Federal funding. Anesthesia can be provided by nurse anesthetists, physician anesthesiologists, or by CRNAs and anesthesiologists working together. As mentioned earlier, the study by Pine et al confirms, "the type of anesthesia provider does not affect inpatient surgical mortality." Yet, for what it costs to educate one anesthesiologist, several CRNAs may be educated to provide the same service with the same optimum level of safety. Nurse anesthesia education represents a significant educational cost-benefit for supporting CRNA educational programs with Federal dollars vs. supporting other, more costly, models of anesthesia education.

To further demonstrate the effectiveness of the title VIII investment in nurse anesthesia education, the AANA surveyed its CRNA program directors to gauge the impact of the title VIII funding. Of the 11 schools that had reported receiving com-

petitive title VIII Nurse Education and Practice Grants funding from 1998 to 2003, the programs indicated an average increase of at least 15 CRNAs graduated per year. They also reported on average more than doubling their number of graduates. Moreover, they reported producing additional CRNAs that went to serve in rural or medically underserved areas.

We believe it is important for the subcommittee to allocate $4 million for nurse anesthesia education for several reasons. First, as this testimony has documented, the funding is cost-effective and needed. Second, this particular funding is important because nurse anesthesia for rural and medically underserved America is not affected by increases in the budget for the National Health Service Corps and community health centers, since those initiatives are for delivering primary and not surgical healthcare. Third, this funding meets an overall objective to increase access to quality healthcare in medically underserved America.

TITLE VIII FUNDING FOR STRENGTHENING THE NURSING WORKFORCE

The AANA joins The Nursing Community and the Americans for Nursing Shortage Relief (ANSR) Alliance in support of the Subcommittee providing a total of $267.3 million in fiscal year 2011 for nursing shortage relief through title VIII. This amount is a modest 10 percent increase over fiscal year 2010 levels and necessary in a time of expanded access through health reform. As more patients enter the system, it's imperative there are enough nurses to care for them. AANA asks that of the $267.3 million, $76.514 million go to Advanced Education Nursing to help increase clinicians in underserved communities and those eligible to serve as faculty. The AANA appreciates the support for nurse education funding in fiscal year 2010 and past fiscal years from this subcommittee and from the Congress.

In the interest of patients past and present, particularly those in rural and medically underserved parts of this country, we ask Congress to invest in CRNA and nursing educational funding programs and to provide these programs the sustained increases required to help ensure Americans get the healthcare that they need and deserve. Quality anesthesia care provided by CRNAs saves lives, promotes quality of life, and makes fiscal sense. This Federal support for title VIII and advanced education nurses will improve patient access to quality services and strengthen the Nation's healthcare delivery system.

SAFE INJECTION PRACTICES

As a leader in patient safety, the AANA has been playing a vigorous role in the development and projects of the Safe Injection Practices Coalition, intended to reduce and eventually eliminate the incidence of healthcare facility acquired infections. In the interest of promoting safe injection practice, and reducing the incidence of healthcare facility acquired infections, we recommend the subcommittee provide the following appropriations for fiscal year 2011:

—$26 million for the Centers for Disease Control and Prevention's (CDC) Division of Healthcare Quality and Promotion to address outbreaks and promote innovative ways to adhere to injection safety and infection control guidelines. $5 million would be used to support the CDC's efforts around provider education and patient awareness activities; and

—$1 million for the Department of Health and Human Services (HHS) to expand its current focus for reducing healthcare acquired infections (HAIs) from hospitals to outpatient settings with the development of an action plan to reduce HAIs in outpatient settings with a specific focus on injection safety.

PREPARED STATEMENT OF THE AMERICAN ACADEMY OF NURSE PRACTITIONERS

The American Academy of Nurse Practitioners is the full service organization representing more than 135,000 nurse practitioners throughout the United States. This testimony speaks to the need for continued and increased Federal funding for nurse practitioner educational programs and traineeships for the coming fiscal year.

As the subcommittee knows, nurse practitioners are highly qualified healthcare providers who have demonstrated their ability and interest in providing primary care to individuals and families in both rural and urban settings, regardless of age, occupation or income. The quality of their care has been well documented over the years. With their advanced preparation, they are able to manage the medical and health problems seen in the primary care and acute care settings in which they work.

Nurse practitioners constitute an effective body of primary care providers that may be utilized at a cost savings in both fee for service and managed care arenas

in this country. Savings to the Federal government of greater than $100,000,000 per year in the Medicare program alone are estimated when full utilization of nurse practitioners is implemented. Likewise, managed care data has demonstrated cost savings among patients seen by nurse practitioners when compared to similar patients being cared for by physicians.

Other cost savings that can be realized by the Government when nurse practitioners are appropriately utilized, include savings due to reductions in emergency room visits and hospitalizations and savings associated with the treatment of illness in its early stages. Studies in both fee for service and managed care have been conducted that demonstrate cost savings in diagnostic testing, prescribing, and hospitalizations and emergency room use when these two groups of providers are utilized to provide primary care to populations of all ages.

Nurse practitioner specialties include family, adult, pediatric, women's health, and gerontology. Their services include obtaining medical histories, performing physical examinations, ordering, performing, supervising and interpreting diagnostic tests, diagnosing and treating acute episodic and chronic illnesses including the prescription of medications and other nonpharmacologic treatments, and appropriate referral to other sources of care. In addition, they are skilled in the areas of health promotion and disease prevention which include health education, screening, and counseling for patients of all ages.

Nurse practitioners provide care in both rural and urban settings, in community health centers, public health clinics, hospitals and hospital outpatient clinics, Indian Health Service and National Health Service Corps sites as well as other freestanding primary care settings. According to data collected by the American Academy of Nurse Practitioners, more than 70 percent of nurse practitioners provide primary care and more than 50 percent of their patients have family incomes in the poverty range.

In order to guarantee the proper preparation of nurse practitioners, assistance in the development of high-quality programs continues to be needed across the country. The funding for such programs has always been limited, and should always be more. The value and worth of such funding continues to be undisputable.

The sums of money described here are but a drop in the bucket compared to investments made by the Federal Government to underwrite the cost of preparing other medical professionals. Yet in the face of significant nursing shortages, the existence of more than 40,000,000 people with no health insurance and the continued lack of primary care providers in this country increases in this funding are obviously needed. Without these increases, additional barriers to the effective utilization of the most cost-effective primary care providers in our healthcare system are created.

Likewise, traineeship monies are being utilized by students in all 50 States and the District of Columbia. These monies are of particular importance in the recruitment of nurse practitioners. Current funds fall far short of the mark for assisting in the preparation of these important, cost-effective healthcare providers in the system. These appropriations help to reduce barriers for many students desiring to become nurse practitioners. Surveys of nurse practitioners have shown this investment to be a good one in terms of assisting students who otherwise might not be able to return to school, and in terms of adding providers who care for the rural and urban underserved in this country.

The recommended increase of 10 percent to the current funding levels in the advanced practice line of title VIII will only begin to make a dent in meeting the unmet healthcare needs of today's populations. In light of the current and future needs for primary care providers, it is obvious that increasing appropriations for nurse practitioner education, traineeships and program exploration will be a wise investment.

We thank the members of the Appropriations Committee for their efforts in behalf of nurse practitioners and the patients they serve. We know you recognize the value of our services and the need for utilizing us in the provisions of quality, cost-effective healthcare. It is obvious that we can be part of the solution to the current shortage of healthcare providers in this country and we are asking for your help to facilitate the process. If there is anything we can do to provide further information or assistance regarding this issue, please feel free to call on us.

PREPARED STATEMENT OF THE AMERICAN ACADEMY OF OPHTHALMOLOGY

EXECUTIVE SUMMARY

The American Academy of Ophthalmology requests fiscal year 2011 NIH funding at $35 billion, which reflects a $3 billion increase more than President Obama's pro-

posed funding level of $32 billion. Funding at $35 billion, which reflects NIH's net funding levels in both fiscal year 2009 and fiscal year 2010, ensures it can maintain the number of multi-year investigator-initiated research grants, the cornerstone of our Nation's biomedical research enterprise.

The vision community commends Congress for $10.4 billion in NIH funding in the American Recovery and Reinvestment Act (ARRA), as well as fiscal year 2009 and fiscal year 2010 funding increases that enabled NIH to keep pace with biomedical inflation after 6 previous years of flat funding that resulted in a 14 percent loss of purchasing power. Fiscal year 2011 NIH funding at $35 billion enables it to meet the expanded capacity for research—as demonstrated by the significant number of high-quality grant applications submitted in response to ARRA opportunities—and to adequately address unmet need, especially for programs of special promise that could reap substantial downstream benefits, as identified by NIH Director Francis Collins, M.D., Ph.D. in his top five priorities. As President Obama has stated repeatedly, including at a visit to the NIH in September 2009, biomedical research has the potential to reduce healthcare costs, increase productivity, and ensure the global competitiveness of the United States.

The Academy requests that Congress improve upon the President's proposed 2.5 percent NEI increase—the second smallest increase of all Institutes and Centers—especially if it does not increase overall NIH funding above the President's request.

In 2009, Congress spoke volumes in passing S. Res. 209 and H. Res. 366, which acknowledged NEI's 40th anniversary and designated 2010–2020 as The Decade of Vision, in which the majority of 78 million baby boomers will turn 65 years of age and face greatest risk of aging eye disease. This is not the time for a less-than-inflationary increase that nets a loss in NEI's purchasing power, which eroded by 18 percent in the fiscal year 2003–2008 timeframe. NEI-funded research is resulting in treatments that save vision and restore sight, which can reduce healthcare costs, maintain productivity, ensure independence, and enhance quality of life.

Fiscal year 2011 NIH funding at $35 billion enables the NEI to build upon the impressive record of basic and clinical collaborative research that meets NIH's top five priorities and was funded through fiscal year 2009–2010 ARRA and increased "regular" appropriations.

NEI's research addresses the pre-emption, prediction, and prevention of eye disease through basic, translational, epidemiological and comparative effectiveness research which also address the top five NIH priorities, as identified by Dr. Collins: genomics, translational research, comparative effectiveness, global health, and empowering the biomedical enterprise. NEI continues to be a leader within the NIH in elucidating the genetic basis of ocular disease—NEI Director Paul Sieving, M.D., Ph.D., has reported that one-quarter of all genes identified to date through collaborative efforts with the National Human Genome Research Institute (NHGRI) are associated with eye disease or visual impairment.

NEI received $175 million of the $10.4 billion in NIH ARRA funding. As a result, NEI's total funding levels in the fiscal year 2009–2010 timeframe were $776 million and $794.5 million, respectively. In fiscal year 2009, NEI made 333 ARRA-related awards, the majority of which reflect investigator-initiated research that funds new science or accelerates ongoing research, including 10 Challenge Grants. Several examples of research and the reasons why it is important, include:

—*Biomarker for Neovascular Age-related Macular Degeneration (AMD)*.—Researchers will use a recently discovered biomarker for choroidal neovascularization (CNV)—the growth of abnormal blood vessels into the retina and responsible for 90 percent of vision loss associated with AMD—to develop an early detection method to minimize vision loss. Why is this important? AMD is the leading cause of vision loss in the United States, especially in the elderly.

—*Cellular Approach to Treating Diabetic Retinopathy (DR)*.—Researchers propose to develop a clinical treatment for diabetic retinopathy—in which diabetes damages small blood vessels in the retina, causing them to leak—that uses stem cells from the patient's own blood that have been activated outside of the body and then returned to repair damaged vessels in the eye. Why is this important? DR is the leading cause of vision loss in younger Americans and its incidence is disproportionately higher in African Americans, Latinos, and Native Americans.

—*Small Heat Shock Proteins as Therapeutic Agents in the Eye*.—Researchers propose to develop new drugs to prevent or reverse blinding eye diseases, such as cataract (clouding of the lens), that are associated with the aggregation of proteins. Research will focus on the use of small "heat shock" proteins that facilitate the slow release and prolonged delivery of targeted macromolecules to degenerating cells of the eye. Why is this important? Delivering effective, long-

lasting therapies through a minimally invasive route into the eye is a major challenge.

—*Identification of Genes and Proteins That Control Myopia Development*.—Researchers propose to identify targets that will facilitate development of interventions to slow or prevent myopia (nearsightedness) development in children. Identifying an appropriate myopia prevention target can reduce the risk of blindness and reduce annual life-long eye care costs. Why is this important? More than 25 percent of the U.S. population has myopia, costing $14 billion annually, from adolescence to adulthood.

—*Comparison of Interventions for Retinopathy of Prematurity (ROP)*.—In animal studies, researchers will simulate Retinopathy of Prematurity—a blinding eye disease that affects premature infants—and study novel treatments that involve modulating the metabolism of the retina's rod photoreceptors. Why is this important? ROP affects 15,000 children a year, about 400–600 of whom progress to blindness, at an estimated lifetime cost for support and unpaid taxes of $1 million each.

—*The NEI Glaucoma Human Genetics CollaBORation, NEIGHBOR*.—This research network, in which seven U.S. teams will lead genetic studies of glaucoma, may lead to more effective diagnosis and treatment. Researchers were primarily funded through ARRA supplements. Why is this important: Glaucoma, a complex neurodegenerative disease that is the second leading cause of preventable blindness in the United States, often has no symptoms until vision is lost.

—*Comparative Effectiveness of Interventions for Primary Open Angle Glaucoma (POAG)*.—Researchers will evaluate existing data on the effectiveness of various treatment options for primary open angle glaucoma—many emerging from past NEI research. Why is this important? POAG is the most common form of the disease, which disproportionately affects African Americans and Latinos.

In addition to ARRA funding, the "regular" appropriations increases in fiscal year 2009–2010 enabled NEI to continue to fund key research networks, such as:

—The African Descent and Glaucoma Evaluation Study (ADAGES), is designed to identify factors accounting for differences in glaucoma onset and the rate of progression between individuals of African and European descent.

—The Diabetic Research Clinical Research Network's (DRCR) initiation of new trials comparing the safety and efficacy of drug therapies as an alternative to laser treatment for diabetic macular edema and proliferative diabetic retinopathy.

—The Neuro-Ophthalmology Research Disease Investigator Consortium (NORDIC), which will lead multi-site observational and treatment trials involving nearly 200 community and academic practitioners, to address the risks, diagnosis and treatment of visual dysfunction due to increased intracranial pressure and thyroid eye disease.

The unprecedented level of fiscal year 2009–2010 vision research funding is moving our Nation that much closer to the prevention of blindness and restoration of vision. With an overall NIH funding level of $35 billion, which translates to an NEI funding level of $794.5 million, the vision community can accelerate these efforts, thereby reducing healthcare costs, maintaining productivity, ensuring independence and enhancing quality of life.

If Congress does not increase fiscal year 2011 NIH funding above the President's request, it is even more vital to improve upon the proposed 2.5 percent increase for NEI.

The NIH budget proposed by the administration and developed by Congress during the very first year of the Congressionally-designated Decade of Vision should not contain a less-than-inflationary increase for NEI due to the enormous challenges it faces in terms of the aging population, the disproportionate incidence of eye disease in fast-growing minority populations and the visual impact of chronic disease (e.g., diabetes). If Congress is unable to fund NIH at $35 billion in fiscal year 2011 (NEI level of $794.5 million) and adopts the President's proposal, the 2.5 percent increase in funding must be increased to at least an inflationary level of 3.2 percent to prevent any further erosion in NEI's purchasing power. NEI funding is an especially vital investment in the overall health, as well as the vision health, of our Nation. It can ultimately delay, save and prevent health expenditures, especially those associated with the Medicare and Medicaid programs, and is therefore a cost-effective investment.

Vision loss is a major public health problem: increasing healthcare costs, reducing productivity, diminishing life quality.

NEI estimates that more than 38 million Americans age 40 and older experience blindness, low vision, or an age-related eye disease such as AMD, glaucoma, diabetic

retinopathy or cataracts. This is expected to grow to more than 50 million Americans by year 2020. The economic and societal impact of eye disease is increasing not only due to the aging population, but due to its disproportionate incidence in minority populations and as a co-morbid condition of chronic disease such as diabetes.

Although NEI estimates that the current annual cost of vision impairment and eye disease to the United States is $68 billion, this number does not fully quantify the combined impacts of direct healthcare costs, lost productivity, reduced independence, diminished quality of life, increased depression and accelerated mortality. The continuum of vision loss presents a major public health problem and financial challenge to the public and private sectors.

ABOUT THE AMERICAN ACADEMY OF OPHTHALMOLOGY

The American Academy of Ophthalmology is a 501c(6) educational membership association. The Academy is the largest national membership association of eye M.D.s with more than 27,000 members, over 17,000 of which are in active practice in the United States. Eye M.D.s are ophthalmologists, medical and osteopathic doctors who provide comprehensive eye care, including medical, surgical and optical care. More than 90 percent of practicing U.S. eye M.D.s are Academy members.

PREPARED STATEMENT OF THE AMERICAN ACADEMY OF PHYSICIAN ASSISTANTS

On behalf of the nearly 80,000 clinically practicing physician assistants in the United States, the American Academy of Physician Assistants is pleased to submit comments on fiscal year 2011 appropriations for Physician Assistant (PA) educational programs that are authorized through title VII of the Public Health Service Act.

A member of the Health Professions and Nursing Education Coalition (HPNEC), the Academy supports the HPNEC recommendation to provide at least $330 million for title VII programs in fiscal year 2011, including a minimum of $7 million to support PA educational programs. This would fund the programs at the 2005 funding level, not accounting for inflation.

AAPA recommends that Congress provide additional support to grow the PA primary care workforce through healthcare reform initiatives. A reformed healthcare system will require a much-expanded primary healthcare workforce, both in the private and public healthcare markets. For example, the National Association of Community Health Centers' March 2009 report, Primary Care Access: An Essential Building Block of Health Reform, predicts that in order to reach 30 million patients by 2015, health centers will need at least an additional 15,585 primary care providers, just over one-third of whom are nonphysician primary care professionals.

The Academy believes that the recommended restoration in funding for title VII health professions programs is well justified.

A review of PA graduates from 1990–2009 demonstrates that PAs who have graduated from PA educational programs supported by title VII are 67 percent more likely to be from underrepresented minority populations and 47 percent more likely to work in a rural health clinic than graduates of programs that were not supported by title VII.

A study by the UCSF Center for California Health Workforce Studies found a strong association between physician assistants exposed to title VII during their PA educational preparation and those who ever reported working in a federally qualified health center or other community health center.

Title VII safety net programs are essential to the development and training of primary healthcare professionals and, in turn, provide increased access to care by promoting healthcare delivery in medically underserved communities. Title VII funding is especially important for PA programs as it is the only Federal funding available on a competitive application basis to these programs.

The AAPA is very appreciative of the recent funding increases, for the Title VII Health Professions Programs, in the fiscal year 2009 Omnibus appropriations bill (Public Law 111–8), which appropriated $221.7 million, a 14.3 percent increase, more than fiscal year 2008 and the American Recovery and Reinvestment Act (Public Law 111–5), which invested $200 million in expanding Title VII Health Professions Programs. However, the AAPA believes that these recent investments only begin to rectify the chronic underfunding of these programs and address existing and looming shortages of health professionals, especially physician assistants. According to HRSA, an additional 30,000 health practitioners are needed to alleviate existing health professional shortages.

We wish to thank the members of this subcommittee for your historical role in supporting funding for the health professions programs, and we hope that we can count on your support to restore funding to these important programs in fiscal year 2010 to the fiscal year 2005 funding level.

Overview of Physician Assistant Education

Physician assistant programs train students to practice medicine with physician supervision. PA programs are located within schools of medicine or health sciences, universities, teaching hospitals, and the Armed Services. All PA educational programs are accredited by the Accreditation Review Commission on Education for the Physician Assistant.

The typical PA program consists of 26 months of instruction, and the typical student has a bachelor's degree and about 4 years of prior healthcare experience. The first phase of the program consists of intensive classroom and laboratory study. More than 400 hours in classroom and laboratory instruction are devoted to the basic sciences, with more than 75 hours in pharmacology, approximately 175 hours in behavioral sciences, and almost 580 hours of clinical medicine.

The second year of PA education consists of clinical rotations. On average, students devote more than 2,000 hours, or 50–55 weeks, to clinical education, divided between primary care medicine—family medicine, internal medicine, pediatrics, and obstetrics and gynecology—and various specialties, including surgery and surgical specialties, internal medicine subspecialties, emergency medicine, and psychiatry. During clinical rotations, PA students work directly under the supervision of physician preceptors, participating in the full range of patient care activities, including patient assessment and diagnosis, development of treatment plans, patient education, and counseling.

After graduation from an accredited PA program, physician assistants must pass a national certifying examination developed by the National Commission on Certification of Physician Assistants. To maintain certification, PAs must log 100 continuing medical education hours every 2 years, and they must take a recertification exam every 6 years.

Physician Assistant Practice

Physician assistants are licensed healthcare professionals educated to practice medicine as delegated by and with the supervision of a physician. In all States, physicians may delegate to PAs those medical duties that are allowed by law and are within the physician's scope of practice and the PA's training and experience. All States, the District of Columbia, and Guam authorize physicians to delegate prescriptive privileges to the PAs they supervise. Nineteen percent of all PAs practice in nonmetropolitan areas where they may be the only full-time providers of care (State laws stipulate the conditions for remote supervision by a physician). Approximately 41 percent of PAs work in urban and inner city areas. Approximately 40 percent of PAs are in primary care. Roughly 80 percent of PAs practice in outpatient settings AAPA estimates that in 2008, more than 257 million patient visits were made to PAs and approximately 332 million medications were written by PAs.

Critical Role of Title VII Public Health Service Act Programs

Title VII programs promote access to healthcare in rural and urban underserved communities by supporting educational programs that train health professionals in fields experiencing shortages, improve the geographic distribution of health professionals, increase access to care in underserved communities, and increase minority representation in the healthcare workforce.

Title VII programs are the only Federal educational programs that are designed to address the supply and distribution imbalances in the health professions. Since the establishment of Medicare, the costs of physician residencies, nurse training, and some allied health professions training have been paid through Graduate Medical Education (GME) funding. However, GME has never been available to support PA education. More importantly, GME was not intended to generate a supply of providers who are willing to work in the Nation's medically underserved communities—the purpose of title VII.

Furthermore, title VII programs seek to recruit students who are from underserved minority and disadvantaged populations, which is a critical step towards reducing persistent health disparities among certain racial and ethnic U.S. populations. Studies have found that health professionals from disadvantaged regions of the country are 3 to 5 times more likely to return to underserved areas to provide care.

It is also important to note that a December 2008 Institute of Medicine report characterized HRSA's health professions programs as "an undervalued asset."

Title VII Support of PA Educational Programs

Targeted Federal support for PA educational programs is authorized through section 747 of the Public Health Service Act. The program was reauthorized in the 105th Congress through the Health Professions Education Partnerships Act of 1998, Public Law 105–392, which streamlined and consolidated the Federal health professions education programs. Support for PA education is now considered within the broader context of training in primary care medicine and dentistry.

Public Law 105–392 reauthorized awards and grants to schools of medicine and osteopathic medicine, as well as colleges and universities, to plan, develop, and operate accredited programs for the education of physician assistants, with priority given to training individuals from disadvantaged communities. The funds ensure that PA students from all backgrounds have continued access to an affordable education and encourage PAs, upon graduation, to practice in underserved communities. These goals are accomplished by funding PA educational programs that have a demonstrated track record of: (1) placing PA students in health professional shortage areas; (2) exposing PA students to medically underserved communities during the clinical rotation portion of their training; and (3) recruiting and retaining students who are indigenous to communities with unmet healthcare needs.

The PA programs' success in recruiting and retaining underrepresented minority and disadvantaged students is linked to their ability to creatively use title VII funds to enhance existing educational programs. For example, PA programs in Texas use title VII funds to create new clinical rotation sites in rural and underserved areas, including new sites in border communities, and to establish nonclinical rural rotations to help students understand the challenges faced by rural communities. One Texas program uses title VII funds for the development of Web based and distant learning technology and methodologies so students can remain at clinical practice sites. In New York, a PA program with a 90 percent ethnic minority student population uses title VII funding to focus on primary care training for underserved urban populations by linking with community health centers, which expands the pool of qualified minority role models that engage in clinical teaching, mentoring, and preceptorship for PA students. Several other PA programs have been able to use title VII grants to leverage additional resources to assist students with the added costs of housing and travel that occur during relocation to rural areas for clinical training.

Without title VII funding, many of these special PA training initiatives would not be possible. Institutional budgets and student tuition fees simply do not provide sufficient funding to meet the needs of medically underserved areas or disadvantaged students. The need is very real, and title VII is critical in meeting that need.

Need for Increased Title VII Support for PA Educational Programs

Increased title VII support for educating PAs to practice in underserved communities is particularly important given the market demand for physician assistants. Without title VII funding to expose students to underserved sites during their training, PA students are far more likely to practice in the communities where they were raised or attended school. Title VII funding is a critical link in addressing the natural geographic maldistribution of healthcare providers by exposing students to underserved sites during their training, where they frequently choose to practice following graduation. Currently, 36 percent of PAs met their first clinical employer through their clinical rotations.

Changes in the healthcare marketplace reflect a growing reliance on PAs as part of the healthcare team. Currently, the supply of physician assistants is inadequate to meet the needs of society, and the demand for PAs is expected to increase. A 2006 article in the Journal of the American Medical Association (JAMA) concluded that the Federal Government should augment the use of physician assistants as physician substitutes, particularly in urban CHCs where the proportional use of physicians is higher. The article suggested that this could be accomplished by adequately funding title VII programs. Additionally, the Bureau of Labor Statistics projects that the number of available PA jobs will increase 39 percent between 2008 and 2018. Title VII funding has provided a crucial pipeline of trained PAs to underserved areas. One way to assure an adequate supply of physician assistants practicing in underserved areas is to continue offering financial incentives to PA programs that emphasize recruitment and placement of PAs interested in primary care in medically underserved communities.

Despite the increased demand for PAs, funding has not proportionately increased for title VII programs that educate and place physician assistants in underserved communities. Nor has title VII support for PA education kept pace with increases in the cost of educating PAs. A review of PA program budgets from 1984 through 2004 indicates an average annual increase of 7 percent, a total increase of 256 percent over the past 20 years, as Federal support has decreased.

Recommendations on Fiscal Year 2011 Funding

The American Academy of Physician Assistants urges members of the Appropriations Committee to consider the inter-dependency of all public health agencies and programs when determining funding for fiscal year 2010. For instance, while it is critical, now more than ever, to fund clinical research at the National Institutes of Health (NIH) and to have an infrastructure at the Centers for Disease Control and Prevention (CDC) that ensures a prompt response to an infectious disease outbreak or bioterrorist attack, the good work of both of these agencies will go unrealized if the Health Resources and Services Administration is inadequately funded. HRSA administers the "people" programs, such as title VII, that bring the results of cutting edge research at NIH to patients through providers such as PAs who have been educated in title VII-funded programs. Likewise, CDC is heavily dependent upon an adequate supply of healthcare providers to be sure that disease outbreaks are reported, tracked, and contained.

The Academy respectfully requests that title VII health professions programs receive $330 million in funding for fiscal year 2011, including a minimum of $7 million to support PA educational programs. Thank you for the opportunity to present the American Academy of Physician Assistants' views on fiscal year 2011 appropriations.

PREPARED STATEMENT OF THE ALLIANCE FOR AGING RESEARCH

Chairman Harkin and members of the subcommittee, for more than two decades the not-for-profit Alliance for Aging Research has advocated for research to improve the experience of aging for all Americans. Our efforts have included supporting Federal funding of aging research by the National Institutes of Health (NIH), through the National Institute on Aging (NIA) and other institutes and centers that work with the NIA on cross-cutting initiatives. To this end, the Alliance appreciates the opportunity to submit testimony highlighting the important role that the NIH plays in facilitating aging research activities and the ever more urgent need for increased appropriations to advance scientific discoveries to keep individuals healthier longer.

The Alliance for Aging Research supports the continuation and expansion of NIH research activities which affect tens of millions of older Americans. The NIA leads national research efforts within the NIH to better understand the aging process and ways to better maintain the health and independence of Americans as they age. Research on healthy aging has never been more critical for so many Americans as the first of the baby boomers will turn 65 in 2011. Presently, there are about 36 million Americans age 65 and older and this group is expected to double in size within the next 25 years. By 2050, an estimated 19.4 million Americans will be over the age of 85. Healthcare spending in the United States is growing, and by 2018 national healthcare spending is projected to be about $4.4 trillion and account for 20.3 percent of GDP, according to Centers for Medicare and Medicaid Services.

Many diseases of aging are expected to become more widespread as the number of older Americans increases. The number of Americans age 65 and older with Alzheimer's disease is projected to more than double by 2030. A recent report in the Journal of Clinical Oncology projected cancer incidence will increase by about 45 percent from 2010–2030, accounted for largely by cancer diagnoses in older Americans and minorities, and by 2030, people aged 65 and older will represent 70 percent of all cancer diagnoses in the United States. Currently, the average 75-year old has three chronic health conditions and takes five prescription medications. Six diseases—heart disease, stroke, cancer, diabetes, Alzheimer's and Parkinson's diseases—cost the United States more than $1 trillion each year. The rising tide of chronic diseases of aging threatens to deluge the U.S. healthcare system in the coming years.

Late-in-life diseases such as type 2 diabetes, cancer, neurological diseases, heart disease, and osteoporosis are increasingly driving the need for healthcare services in this country. If rapid discoveries are not made now to reduce the prevalence of age-related diseases and conditions like these, the costs associated with caring for the oldest and sickest Americans will place an unmanageable burden on patients, their families, and our healthcare system. According to a 2005 AHRQ report, up to $2.5 billion per year could be saved by preventing diabetes-related hospitalizations with appropriate primary care, and much of the savings would come from Medicare and Medicaid. Osteoporosis is estimated to cost the United States $25.3 billion per year by 2025 unless discoveries are made to better treat and prevent the disease. According to an Alzheimer's Association report from 2004, research breakthroughs that slow the onset and progression of Alzheimer's disease could yield annual Medicare savings of $51 billion by 2015 and $126 billion by 2025. Research which leads

to a better understanding of the aging process and human vulnerability to age-related diseases could help Americans live longer, more productive lives, and help reduce the need for care to manage costly chronic diseases.

In fiscal year 2009, the NIA, which supports a range of genetic, biological, clinical, social and economic research related to aging and the diseases of the elderly, oversaw approximately 1,900 research projects. Through the Division of Aging Biology (DAB), the NIA funds research focused on understanding and exploiting the mechanisms underlying the aging process. Research supported by the DAB program is critically important in that much of it is centered around how changes in function considered to be "normal aging" become risk factors for many age-associated infirmities. Some studies supported by the DAB assess the beneficial effects of reducing caloric intake in animals. Intramural and extramural research is ongoing to test compounds that mimic this process in subjects with the potential to extend the years of disease-free life. Both approaches have produced promising results that may lead to insights into human applications. By capitalizing on these and other successful studies to identify genes that influence longevity, investigators hope to delay the onset of disease and disability associated with human aging in the future.

The NIA has supported grants in recent years to examine public health concerns caused by the rising obesity epidemic. In particular, NIA's Division of Behavioral and Social Science Research funded projects to investigate the role social networks play in influencing an individual's food choices, acceptability of being overweight, and how those networks might be modifiable to slow the spread of obesity; as well as those to explore how the rapid increase in obesity will negatively affect U.S. gains in life expectancy. Investigators supported by the Division of Geriatrics and Clinical Gerontology have focused heavily on the central role exercise plays in improving the health of older adults, reducing health risks associated with diabetes and cardiovascular disease, and lowering the risk of death by increasing a individual's fitness level. Results from studies such as these will not only yield important information for use in the care of the elderly, but also for promoting healthier behavior by the larger U.S. population.

The NIA also participates in collaborations on disease-specific research aimed at preventing, diagnosing, and more effectively treating age-related illnesses. The Alzheimer's Disease Neuroimaging Initiative (ADNI) is a major public-private partnership led by the NIA to evaluate imaging technologies, biological markers, and other tests to improve knowledge surrounding the progression of Alzheimer's disease. ADNI has produced a wealth of data that is accessible to researchers worldwide. It is believed that ADNI findings could lead to shorter and less costly clinical trials for Alzheimer's therapies. Streamlined clinical trials could accelerate the development and approval of more effective AD treatments to the benefit of those who are yet to be diagnosed.

The Diabetes Prevention Program (DPP), a large nationwide clinical study of adults at high risk for diabetes, funded in part by the NIA, showed that lifestyle intervention (intensive training on diet, physical activity and behavior changes with the goal of weight loss) reduced the development of diabetes by 58 percent over several years. The risk reduction was even greater, 71 percent, among adults aged 60 years or older. Taking an oral diabetes drug reduced the development of diabetes among participants by 31 percent, but was less effective in adults older than age 45 compared to younger adults. This landmark research study identified effective interventions for adults with pre-diabetes and showed the development of diabetes was not necessarily inevitable but could be slowed or prevented in this group by losing a modest amount of weight through diet and exercise. More recent studies, both completed and ongoing, have further examined DPP data and continue to build on the findings from the diverse group of study participants. The Diabetes Prevention Program Outcomes Study is examining the long term risk reduction effects of the DPP intervention and the clinical course of new-onset diabetes and complications in participants, with attention to differences among minority populations and gender groups. Shedding light on differences between these groups could have wide-reaching implications for millions of Americans at risk for diabetes and may assist in the creation of more effective interventions.

Eighty percent of all the nonprofit medical research in the United States is funded by the NIH. However, the unfortunate reality is that shrinking budgets have impeded progress. Aging is a field of research whose progress has been hampered by stagnant funding. In part the scarcity of resources has resulted in a decline of the overall success rate for NIH research grant applications. The effect of this has been reluctance on behalf of new investigators to submit truly ground-breaking research proposals for consideration. To operate in this environment the NIA and other Institutes involved in aging-related research have not been able to fund increasing numbers of high-quality research grants each year. At its lowest point only one in four

research proposals could be funded by the NIH. In recognition of this downward trend, last February President Obama signed into law the American Recovery and Reinvestment Act of 2009 (ARRA), which appropriated $10.4 billion in funding to the NIH to be used expeditiously in fiscal year 2009 and fiscal year 2010. That March, the NIH budget for fiscal year 2009 was increased 3.2 percent more than fiscal year 2008 to $30.3 billion. This was a much needed boost across the NIH Institutes for critical medical research to benefit Americans, including just more than 170 research grants funded by the NIA in ARRA's first year.

Promising areas of research targeted by the NIA to receive ARRA funds include those to identify additional risk factor genes associated with Alzheimer's disease, discovering improved diagnostic tools, possible biomarkers, and therapies. ADNI will receive the most significant amount of stimulus funding to further groundbreaking research that will enable experts to track changes in living brains as older adults as they transition from normal cognitive aging to the early stages of Alzheimer's disease. The overall impact of this investment will be to increase knowledge of the sequence and timing of events leading up to disease onset and to develop better methods of early detection and monitoring of the disease. Another grant awarded funding through ARRA will develop new technologies, called biosensors, to follow protein folding in cells. Proper protein folding (proteostasis) is important to health. Researchers believe that protein folding is affected by age. If proteins are formed incorrectly, or they misfold normal cell function is disrupted. These problems are thought to cause disease. The biosensors created with ARRA funds will help monitor aging and age-related disease by focusing on patterns of protein folding. ARRA funds have also been awarded to investigators who will study the effects of rapamaycin, a compound that mimics caloric restriction, on models of human diseases in mice. Models of Alzheimer's disease, atherosclerosis, cardiovascular disease, Parkinson's disease, kidney disease and cancer will be utilized in this project. The investigators will ultimately seek to determine if the quality of life for the mice has improved and if the age-related diseases have been slowed or reduced over a 2-year period.

The ARRA funding begins to make up for flat budgets and unfunded research proposals that have occurred in recent years. However, research at the NIH cannot be sustained and will not flourish in the long term without a steady increase in appropriations which, at minimum, keeps pace with inflation. A slowdown in NIH funding will have a devastating impact on the rate of basic discovery, innovation and the development of interventions which could have major health benefits for the burgeoning population of older Americans. The Alliance for Aging Research supports funding the NIH at $35 billion in fiscal year 2011 with a minimum of $1.14 billion in funding for the NIA specifically. This level of support would allow the NIH and the NIA to adequately fund new and existing research projects, accelerating progress toward findings which could prevent, treat, slow the progression or even possibly cure conditions related to aging. With the silver tsunami on the near horizon, an increased investment in NIA's research activities has never been more necessary or had such potential to impact so many Americans.

Mr. Chairman, the Alliance for Aging Research thanks you for the opportunity to outline the challenges posed by the aging population that lie ahead as you consider the fiscal year 2011 appropriations for the NIH and we would be happy to furnish additional information upon request.

PREPARED STATEMENT OF THE AMERICAN BRAIN COALITION

Introduction

The National Institutes of Health (NIH) is the world's leader in medical discoveries that improve people's health and save lives. NIH-funded scientists at universities and research centers throughout the Nation investigate ways to prevent, treat, and even cure the complex diseases of the brain. Because there is much work still to be done, the American Brain Coalition (ABC) writes to ask for the Senate Appropriations Committee's continued support for increased biomedical research funding at NIH.

ABC

ABC is a nonprofit organization that seeks to reduce the burden of brain disorders and advance the understanding of the functions of the brain. The ABC, made up of more than 50 member organizations, brings together afflicted patients, the families of those that suffer, the caregivers, and the professionals that research and treat diseases of the brain.

The brain is the center of human existence, and the most complex living structure known. As such, there are thousands of brain diseases from Rett Syndrome and au-

tism to mental illness and Parkinson's disease. ABC, unlike any other organization, brings together people affected by all diseases of the brain.

The ABC is working to raise public awareness and support for diseases of the brain. Fifty million Americans—our relatives, friends, neighbors, and your constituents—are affected by diseases of the brain. This number does not include the millions more family members whose lives are affected as they care for those who suffer. Our goal is to be a united voice for these patients, and to work with Congress and the administration to alleviate the burden of brain disease. A large part of that goal involves support for NIH research.

Thank You for Your Support

ABC would like to thank the members of this subcommittee and the Senate for its support for the $10 billion provided to NIH in the 2009 economic stimulus package. This funding provided the opportunity for a substantial number of 2-year research grants and infrastructure projects in every State of the Nation to move forward and enhance our understanding of an array of physical and mental health concerns.

Progress in the fields of addiction, alcoholism, Parkinson's disease, and stroke has already been made by scientists funded through ARRA funding. One such investigator is studying how to improve motor function following stroke. Another investigator is using specially designed video games to understand the cognitive effects of autism, in order to develop behavioral or drug treatments. Please visit http://bit.ly/a0g8aA to learn more about the progress made.

More than 1,900 new investigators received ARRA grant funding. Scientists were inspired to do more research and patients suffering from debilitating neurological and psychiatric disorders were given hope, thanks to your generous support of ARRA.

Congressional Support Accelerates Discovery

In the late 1990s, Congress made a commitment to double the budget of the NIH over the course of 5 years. The primary goal for the added funds was to discover better treatments and cures for human disease. Congress delivered on its promise, and scientists have amassed a wealth of medical knowledge. Today, researchers have a greater understanding of how the brain and nervous system function due to NIH-funded research.

Many recent scientific discoveries, including those in neurology, psychiatry, and behavioral research have begun to show their potential. Insights into the biology of schizophrenia, epilepsy, Alzheimer's, and other disorders have led to the development of enhanced diagnostic techniques, better prevention methods, and more effective treatments. Simply put: the result of congressional support for research leads to improved patient care.

Today's Research: Hope for the Future

Today's research is the foundation for future breakthroughs. The Federal Government's investment in research must be sustained in order to translate today's scientific findings into further bedside treatments, and the ABC supports NIH in its entirety. Recent discoveries, such as those listed below, are a direct result of robust funding for the NIH.

—The development of drugs that reduce the severity of symptoms for those suffering with multiple sclerosis and Parkinson's disease.
—The identification of stroke treatment and prevention methods.
—The discovery of a new class of anti-depressants that produce fewer side effects than their predecessors.
—The creation of new drugs to help prevent epileptic seizures.
—The expansion of treatments for the psychotic symptoms of schizophrenia.

My own field of research concerns schizophrenia, a devastating brain disorder that affects 1 percent of the population but is the seventh most costly medical illness to our society because of its life-long disability. Basic brain research funded by the National Institute of Mental Health has transformed our understanding of the disorder and illuminated new targets for therapeutic intervention that affect symptoms untouched by existing drugs.

Research Improves Health and Fuels the Economy

Diseases of the nervous system pose a significant public health and economic challenge, affecting nearly 1 in 3 Americans at some point in life. Improved health outcomes and positive economic data support the assertion that biomedical research is needed to improve public health today and save money tomorrow.

Not only does research save lives and fuel today's economy, it is also a wise investment in the future. For example, 5 million Americans suffer from Alzheimer's

disease today, and the cost of caring for these people is staggering. Medicare expenditures are $91 billion each year, and the cost to American businesses exceeds $60 billion annually, including lost productivity of employees who are caregivers. As the baby boom generation ages and the cost of medical services increases, these figures will only grow. Treatments that could delay the onset and progression of the disease by even 5 years could save $50 billion in healthcare costs each year. Research funded by the NIH is critical for the development of such treatments. The cost of investing in NIH today is minor compared to both current and future healthcare costs.

Additionally, it is estimated that each billion of dollars of NIH funding generates 15,000 to 20,000 well-paying jobs that can't be sent offshore. Science funding also generates more than twice as much in State and local economic output. A strong Federal investment in research can assist your State in maintaining a biomedical research foundation that attracts companies and investors. For instance, in fiscal year 2007, NIH dollars generated more than $50 billion in new State business.

Strong science funding can bolster the economy today and improve our Nation's long term health and competitiveness tomorrow. Robust research and development investment remains the key to America's long-term global competitiveness. NIH funding serves as the basis for future innovation and industries such as pharmaceutical, medical device, and biotechnology.

Fiscal Year 2011 Recommendation

ABC supports $35 billion for the National Institutes of Health in fiscal year 2011. This represents the new functional capacity funded by the annual appropriations process and the American Recovery and Reinvestment Act. In addition, it will help the NIH to achieve its broad research goals and provide hope for the millions of Americans affected with neurological and psychiatric disorders, while strengthening the economy and creating jobs throughout the country.

There is still much work to be done to uncover the mysteries of the brain. Fiscal year 2011 provides Congress with the opportunity to renew its past commitment to health funding as a national priority.

PREPARED STATEMENT OF THE AMERICAN COLLEGE OF CARDIOLOGY

The American College of Cardiology (ACC) appreciates the opportunity to provide the subcommittee with recommendations for fiscal year 2011 funding for cardiovascular research and prevention. The ACC is a more than 38,000 member, nonprofit professional medical society and teaching institution whose mission is to advocate for quality cardiovascular care—through education, research promotion, development and application of standards and guidelines—and to influence healthcare policy.

Heart disease is America's number one killer and a major cause of permanent disability. Nearly 1 in 3 adults in the United States suffers from heart disease. Heart disease and stroke will cost the United States an estimated $503.2 billion in 2010, including healthcare costs and lost productivity.

The death rates attributable to cardiovascular disease actually have declined due to advances in science through diagnostic tests, drug and device therapies, surgical innovations, enhanced emphasis on prevention, and innovative public education programs. Federal research provided for many of these advances that improve understanding of the prevention and treatment of cardiovascular disease, leading to better outcomes and increased quality of life for patients.

ACC FUNDING RECOMMENDATIONS FOR FISCAL YEAR 2011

As the subcommittee considers its appropriations for programs within the Department of Health and Human Services, the ACC urges support of the following recommendations.

National Institutes of Health (NIH)

The ACC supports an appropriation of $35.2 billion for the National Institutes of Health (NIH). This funding level will allow the NIH to build on momentum achieved from investments from the American Recovery and Reinvestment Act (ARRA). The NIH currently invests only 4 percent of its budget on heart research; the ACC urges NIH to invest a higher percentage of its budget to heart research.

National Heart, Lung, and Blood Institute (NHLBI)

The ACC supports an appropriation of $3.514 billion for the National Heart, Lung, and Blood Institute (NHLBI). The NHLBI does critical research into the causes, diagnosis, and treatment of heart disease.

Agency for Healthcare Research and Quality (AHRQ)

The ACC supports the President's budget request of $611 million for the Agency for Healthcare Research and Quality (AHRQ). The ACC supports the recent increases in funding for AHRQ's comparative effectiveness research program, and also believes AHRQ's health services research related to healthcare costs, quality, and access are critically important.

CDC Heart Disease and Stroke Prevention

The ACC supports an appropriation of $76.221 million for the Centers for Disease Control and Prevention (CDC) Division for Heart Disease and Stroke Prevention. These public education efforts are helping to reduce blood pressure and cholesterol, educate about heart disease and stroke signs and symptoms, enhance emergency response and quality care, and end treatment disparities.

The ACC also supports an appropriation of $37.087 million for CDC's WISEWOMAN program. This program screens uninsured and under-insured low-income women ages 40 to 64 for heart disease and stroke risk and those with abnormal results receive counseling, education, referral and follow up.

HRSA Rural and Community AED Program

The ACC supports an appropriation of $8.927 million for the Health Resources and Services Administration (HRSA) Rural and Community Access to Emergency Devices Program, which would restore it to its fiscal year 2005 level when 47 States received resources from the initiative. This program provides competitively awarded grants to States to purchase automated external defibrillators (AEDs), train lay rescuers and first responders in their use, and place them in public areas where sudden cardiac arrests are likely to occur. In 2009 only ten states received funding for this initiative.

NHLBI and CDC: Congenital Heart Disease Research and Surveillance

The ACC is pleased that the recently enacted "Patient Protection and Affordable Care Act" includes provisions to enhance and expand the infrastructure to track the epidemiology of congenital heart disease (CHD) and to conduct and support research on it. The ACC as well as the Adult Congenital Heart Association, Mended Little Hearts and Children's Heart Foundation, stand ready to work with the subcommittee to advance these policies.

Congenital heart defects are the most common birth defect in the United States and are a leading cause of child mortality. The success of childhood cardiac intervention has created a new chronic disease—CHD. Those who receive successful intervention will need life-long special cardiac care and face high rates of heart failure, rhythm disorders, stroke and sudden cardiac death. Thanks to the increase in survival, the CHD population is rising by 5 percent a year; there are about 800,000 children and 1 million adults in the United States now living with CHD.

Despite the prevalence and seriousness of the disease, data collection and research are limited. Federal funding support for CHD surveillance through CDC and research through NHLBI is necessary to help prevent premature death and disability in this rapidly growing and severely underserved population.

CARDIOVASCULAR DISEASE RESEARCH GAPS

As the healthcare system evolves towards better integration of health information technology (HIT), clinical decision support tools, and performance measurement, the need for meaningful clinical practice guidelines is essential. The American College of Cardiology Foundation (ACCF) and the American Heart Association (AHA) have a long history in the development of clinical practice guidelines, and have close to 20 guidelines on a range of cardiovascular topics. The guidelines are developed through a rigorous, evidence-based methodology, including multiple layers of review and expert interpretation of the evidence on an ongoing, regular basis.

Many clinical research questions remain unanswered or understudied, however. The ACC has identified knowledge gaps for cardiovascular disease that if addressed, have potential to positively impact patient outcomes, costs, and the efficiency of care delivery. A Federal investment through the NHLBI and AHRQ to answer the following questions will help to better narrow the target population who can benefit from treatment and therefore increase the efficacy and efficiency of patient-centered care delivery.

—What is the effect of common cardiovascular therapies on elderly populations whose metabolism and kidney function are lower and may not respond to medications in the same way as the younger patients typically included in clinical trials?

—What is the effect of common cardiovascular therapies on patients with multiple other diseases/conditions?
—What is the effect of common cardiovascular therapies on women? What are signs and risk factors for cardiovascular disease in women?
—What are the best approaches to increasing patient compliance with existing therapies?
—What screening and risk models (existing or new) could further define who will benefit from various therapies?
—What are the optimal management strategies for anticoagulation and antiplatelet agents in heart attack patients, patients with stents, and atrial fibrillation patients to maximize benefit and reduce bleeding risks?
—What are the best approaches to managing complex but understudied cardiovascular topics such as congenital heart disease, valvular heart disease, and hypertrophic cardiomyopathy? These topics have become areas of higher research interest as techniques have developed to extend the lives of patients with these disorders.
—What are the risks and benefits of common off-label uses of widely used therapies and procedures?
—What are the risks and benefits of various cardiovascular screening protocols, such as those for imaging methods used to correctly identify patients who will benefit from surgical, endovascular, and/or medical interventions?
—What are the best catheter-based techniques to increase treatment success and reduce complications for both coronary and cardiac rhythm procedures?
—What are the effects of nutrition, environment and genetics on the occurrence of congenital heart defects?

The above list of topics is not exhaustive but gives an overview of some of the themes of the evidence gaps that exist across the ACCF/AHA guidelines. In addition to specific clinical research topics, the ACCF recommends funding to help address structural issues that could help identify, prioritize, and interpret research findings over the long term.

—The NIH and or AHRQ should fund more trials of direct comparison of clinical effectiveness between pharmacological and other therapies. Without these important trials, the current emphasis on promoting comparative effectiveness will be founded upon efficacy trials and not effectiveness.
—The NHLBI should work with the clinical cardiology community to proactively design clinical trials to address unanswered clinical questions and identify methods that allow for greater comparability among studies. NHLBI should work with ACCF and the AHA to develop an evidence model that would drive future research initiatives based on current evidence gaps in the guidelines; and
—NIH should fund the development of a robust informatics infrastructure across Institutes to process research evidence. Studies should be designed such that their results could be "fed" into a computer model that would provide additional insights for developers of clinical recommendations.
—NIH and or AHRQ should fund studies of patient preference and values.

ARRA IN ACTION: COLLABORATING TO IMPROVE CARDIOVASCULAR CARE

In September 2009, the ACC was pleased to be awarded two Federal grants under ARRA. The ACC has applied for three others, in addition to serving as a subcontractor on several other grant applications.

Grand Opportunity Grants

Comparative Effectiveness of PCI versus CABG Grant

The NHLBI awarded a Grand Opportunity grant to the ACC in partnership with the Society of Thoracic Surgeons (STS) to study the comparative effectiveness of the two forms of coronary revascularization; percutaneous coronary intervention (PCI) and coronary artery bypass graft (CABG) surgery (Award Number 1RC2HL10148). Now entering the second half of this 2 year award period, the study is comparing these two cardiac procedures using existing databases from the ACC and STS, as well as the Centers for Medicare and Medicaid Services 100 percent denominator file data. By linking these three databases, the study will help physicians make better decisions and improve healthcare for patients with coronary artery disease.

National Cardiovascular Research Infrastructure (NCRI) Grant

The NHLBI also awarded a Grand Opportunity grant (Award Number 1RC2HL101512–01) to Duke Clinical Research Institute (DCRI), with the ACC serving as a subcontractor, to develop a clinical investigator network based upon the data collection activities of ACC's National Cardiovascular Data Registries (NCDRr).

These registries have previously been used to quantify outcomes and identify gaps in the delivery of quality cardiovascular patient care in the United States. The current grant will extend these existing systems by establishing a National Cardiovascular Research Infrastructure (NCRI) that will unify sites with a centralized clinical research network. NCRI will facilitate interoperable clinical research by enhancing site recruitment, training, performance, and accountability and will create a sustained improvement in the efficiency and quality of the interaction between the clinical research subject, the clinician investigator, the expert guidelines committee, and policymakers.

Prospect Grants #RFA–HS–10–005: Building New Clinical Information for Comparative Effectiveness Research

Valvular Heart Disease Registry Grant Application

In February 2010, ACC and STS again joined forces to submit a grant application entitled "ACCF–STS Database Development and Collaboration on the Comparative Effectiveness of Valvular Heart Disease." This application was in response to the above announcement from AHRQ. The DCRI Data Coordinating and Analysis Center collaborated on the development of this grant and, if awarded, would provide the clinical outcomes and analysis for the project. The purpose of this grant would be for ACCF and STS to take advantage of their existing registries to create and maintain a sustainable disease-based, multi-center registry for valvular heart disease (VHD), a robust, efficient system of longitudinal follow-up for registry patients, and to perform a direct comparison of initial clinical outcomes following different management strategies of patients with severe aortic stenosis.

Infrastructure Development for the Comparative Effectiveness of Atrial Fibrillation

In partnership with the Heart Rhythm Society (HRS), ACC submitted a grant to AHRQ proposing to develop the electronic database infrastructure necessary to collect prospective data of patients with atrial fibrillation through use of ACC's NCDR. Once developed, new evidence comparing various interventions will be available by using this new NCDR registry database to better understand the procedures and improve healthcare for patients with atrial fibrillation, one of the most common arrhythmias in clinical practice. Such data will contain process, risk-adjusted outcomes, utilization, provider characteristics, and cost data spanning several years that has a potentially great benefit to society. Specifically, this study will permit comparative effectiveness research of the management of patients with atrial fibrillation, including comparisons across race, gender, and age. These comparisons will be more comprehensive than any currently available, and will be of inestimable benefit in provider decisionmaking and patient care in a variety of clinical situations.

Enhanced Registries for Quality Improvement and Comparative Effectiveness (AHRQ #RFA–HS–10–020)

Integrating Local EHR Data into the ACC NCDR Registry to Improve Care (LEAN) Grant Application

The aim of this grant application is to develop an informatics solution that captures and delivers real-time clinical patient information to multiple care settings. ACC is collaborating with Yale University School of Medicine, Christiana Care Center for Outcomes Research, Sisters of Mercy Health System, Saint Luke's Hospital of Kansas City-Mid America Heart Institute, and Duke University Medical Center on this important endeavor. The formation of the proposed infrastructure will not only drive quality improvement, but also facilitate comparative effectiveness research. This project aligns particularly well with the goals and purposes expressed nearly 2 years ago by the ACCF and the NCDR with the launch of the IC^3 Registry (renamed the PINNACLE Registry™ in the fall of 2009). PINNACLE was designed to improve the quality of outpatient cardiovascular care by reducing inappropriate variations in care, by eliminating gaps in care, and by improving care coordination for patients with cardiovascular disease. Realization of these objectives will rely on the existence of a strong, unified data collection infrastructure that will allow for retrieval across both inpatient and outpatient care settings, as well as provide quality improvement feedback.

PREPARED STATEMENT OF THE ADULT CONGENIAL HEART ASSOCIATION

The Adult Congenial Heart Association (ACHA) is pleased that the recently enacted "Patient Protection and Affordable Care Act" includes provisions to enhance and expand the infrastructure to track the epidemiology of congenital heart disease

(CHD) and to conduct and support research on causation, including genetic causes; long-term outcomes in individuals with congenital heart disease; diagnosis, treatment, and prevention; studies using longitudinal data and retrospective analysis to identify effective treatments and outcomes; and identifying barriers to life-long care for individuals with congenital heart disease. The Adult Congenital Heart Association, along with coalition partners Mended Little Hearts and Children's Heart Foundation, stand ready to work with the subcommittee and Members of Congress to advance these policies.

CHD are the most common birth defect in the United States and are a leading cause of child mortality. The success of childhood cardiac intervention has created a new chronic disease—CHD. Those who receive successful intervention will need life-long special cardiac care and face high rates of heart failure, rhythm disorders, stroke, and sudden cardiac death. Thanks to the increase in survival, the CHD population is rising by 5 percent a year. There are about 800,000 children and 1 million adults in the United States now living with CHD.

Despite the prevalence and seriousness of the disease, data collection and research are limited. In 2004, the National Heart, Lung and Blood Institute (NHLBI) convened a working group on congenital heart disease, which recommended developing a research network to conduct clinical research and establishing a national database of patients.

Federal funding support for CHD surveillance through CDC and research through NHLBI will help prevent premature death and disability in this rapidly growing and severely underserved population.

PREPARED STATEMENT OF THE AMERICAN CONGRESS OF OBSTETRICIANS AND GYNECOLOGISTS

The American Congress of Obstetricians and Gynecologists, representing 53,000 physicians and partners in women's healthcare, is pleased to offer this statement to the Senate Committee on Appropriations, Subcommittee on Labor, Health and Human Services, and Education, and Related Agencies. We thank Chairman Harkin, and the entire subcommittee for their leadership to continually address women's health research at the Department of Health and Human Services. Today, the United States lags behind other nations in healthy births, yet remains high in birth costs. ACOG's Making Obstetrics and Maternity Safer (MOMS) Initiative seeks to improve maternal outcomes through more research and better data, and we urge you to make this a top priority in fiscal year 2011.

Research is critically needed to understand why our maternal and infant mortality rate remains comparatively high. Having better data collection methods and comprehensive maternal mortality reviews has shown maternal mortality rates in some States, such as California, to be higher than previously thought. States without these resources are likely underreporting maternal and infant deaths and complications from childbirth. Without accurate data, the full range of causes of these deaths remains unknown. Effective research based on comprehensive data is a key MOMS element to developing and implementing evidence-based interventions.

Unfortunately, the MOMS Initiative is threatened by the sizeable cliff in research funding that will be created in fiscal year 2011 once the stimulus package ends this year. Building funding levels from the stimulus into the base for fiscal year 2011 appropriations will ensure the continuation of current research important to the MOMS Initiative, and ensure that future research necessary to improving maternal outcomes does not go unfunded.

The President's budget for fiscal year 2011 takes a positive first step towards this goal, including a $1 billion increase for NIH, and ACOG requests the subcommittee build on these increases to maintain the momentum created by the stimulus. The NIH and many other HHS agencies are vital to carrying out the goals of the MOMS Initiative. Therefore, ACOG asks for a 13.5 percent increase for NIH to $35.2 billion, a 22.3 percent increase for HRSA to $9.15 billion, a 35.9 percent increase for CDC to $8.8 billion, and a 53.9 percent increase for AHRQ to $611 million.

Research and programs in the following areas are vital to the MOMS Initiative:

Maternal/Child Health Research at the NIH

The Eunice Kennedy Shriver National Institute of Child Health and Human Development (NICHD) conducts the majority of women's health research. Despite the NIH's critical advancements, reduced funding levels have made it difficult for research to continue.

ACOG supports a 12.5 percent increase in funds over fiscal year 2010 to $1.495 billion for the NICHD. These funds will assist the following research areas critical to the MOMS Initiative:

Reducing the Prevalence of Premature Births

There is a known link between pre-term birth and infant mortality, and women of color are at increased risk for delivering pre-term. NICHD is helping our Nation understand how adverse conditions and health disparities increase the risks of premature birth in high-risk racial groups, and how to reduce these risks. Prematurity rates have increased almost 35 percent since 1981, accounting for 12.5 percent of all births, yet the causes are unknown in 25 percent of cases. Preterm births cost the Nation $26 billion annually, $51,600 for every infant born prematurely. Direct healthcare costs to employers for a premature baby average $41,610, 15 times higher than the $2,830 for a healthy, full-term delivery.

ACOG supports the Surgeon General's effort to make the prevention of pre-term birth a national public health priority, and urges Congress to allocate $1 million to NICHD to create a Trans-disciplinary Research Center on Prematurity to help streamline efforts to reduce pre-term births.

Obesity Research, Treatment, and Prevention

Obese pregnant women are at higher risk for poor maternal and neonatal outcomes. Additional research and interventions are needed to address the increased risk for poor outcomes in obese women receiving infertility treatment, the increased incidence of birth defects and stillbirths in obese pregnant women, ways to optimize outcomes in obese women who become pregnant after bariatric surgery, and the increased future risk of childhood obesity in their offspring.

ACOG is grateful to the NIH for making obesity a priority and initiating transdisciplinary approaches to combat obesity. We also applaud First Lady Michelle Obama for naming childhood obesity a top priority. ACOG urges the NIH and the NICHD to make obesity in pregnant women a high priority, to improve the health of mother and child.

Maternal/Child Health Programs at CDC

CDC funds programs that are critical to providing resources to mothers and children in need. Where NIH conducts research to identify causes of pre-term birth, CDC funds programs that provide resources to mothers to help prevent pre-term birth, and help identify factors contributing to pre-term birth and poor maternal outcomes.

ACOG supports a 35.9 percent increase in funds over fiscal year 2010 to $8.8 billion to increase CDC's ability to bring prevention, treatment and interventions to more women and children in need, and to help enact some of the important provisions within healthcare reform. This funding will help the following programs important to the MOMS Initiative:

Maternal Mortality Reviews, Division of Reproductive Health

National data on maternal mortality is inconsistent and incomplete due to the lack of standardized reporting definitions and mechanisms. To capture the accurate number of maternal deaths and plan effective interventions, maternal mortality should be addressed through multiple, complementary strategies. ACOG recommends that CDC fund States in implementing maternal mortality reviews that would allow them to conduct regular reviews of all deaths within the State to identify causes, factors in the communities, and strategies to address the issues. Combined with adoption of the recommended birth and death certificates in all States and territories, CDC could then collect uniform data to calculate an accurate national maternal mortality rate. Results of maternal mortality reviews will inform research needed to identify evidence based interventions addressing causes and factors of maternal mortality and morbidity.

ACOG urges Congress to provide $2.375 million to the Division of Reproductive Health to assist States in setting up maternal mortality reviews.

Electronic Birth Records and Death Records, National Center for Health Statistics (NCHS), National Vital Statistics System (NVSS)

NCHS is the Nation's principal health statistics agency; it collects, analyzes and reports on data critical to all aspects of our healthcare system. NCHS collects State data needed to monitor maternal and infant health, such as use of prenatal care, and smoking during pregnancy. This data allows investigators to monitor maternal and child health objectives, and develop efficient prevention and treatment strategies.

Uniform consistent data from birth and death records is critical to conducting research and directing public programs to combat maternal and infant death. Only 75 percent of States and territories use the 2003 recommended birth certificates and 65 percent have adopted the 2003 recommended death certificate. Within the increased funding provided to NCHS in the President's budget, $8 million was included specifically for the National Vital Statistics System (NVSS) to support States and territories in implementing the 2003 birth certificate and modernizing their infrastructure to collect these data electronically to expand the scope and quality of data collected on a national basis. The President's budget provides NVSS $3 million to phase in the 2003 death certificate and electronic death records in States and territories.

ACOG urges Congress to allocate $11 million for States to modernize their birth and death records systems to the 2003 recommended guidelines, consistent with the President's budget.

Safe Motherhood/Infant Health

Two to three women a day die from delivery complications. The Safe Motherhood Program supports CDC's work with State health departments and other groups to identify and gather information on pregnancy-related deaths; collect and provide information about women's health and health behaviors before, during, and immediately after pregnancy; and expand the acceptance and use of findings and guidelines on preconception care into everyday practice and healthcare policy.

Safe Motherhood also tracks infant morbidity and mortality associated with preterm birth. ACOG is concerned with recent trends particularly among rates of late pre-term births. Increased funding is needed for CDC to improve national data systems to track pre-term birth rates and expand epidemiological research that focuses especially on the causes and prevention of preterm birth and births at 37–38 weeks gestation.

ACOG urges Congress to include a 23.7 percent increase in funds to $55.4 million for Safe Motherhood, consistent with the President's budget.

Maternal/Child Health Programs at HRSA

HRSA delivers critical resources to communities to improve the health of mothers and children. ACOG urges a 22.3 percent increase in funds over fiscal year 2010 to $611 million to increase the scope of HRSA programs, ultimately bringing more resources to more mothers and children. This funding will help expand the following programs important to the MOMS Initiative:

Fetal Infant Mortality Reviews, Healthy Start Program

After decades of decline, the U.S. infant mortality rate is again on the rise and is particularly severe among minority and low-income women. The infant mortality rate among African American women has been increasing since 2001 and reached 14.2 deaths per 1,000 births in 2004. There also has been a startling rise in infant mortality in the South. Mississippi, for example, had an infant mortality rate of 11.4 in 2005 compared to 9.6 the previous year.

The Healthy Start Program through HRSA promotes community-based programs that focus on infant mortality and racial disparities in perinatal outcomes. These programs are encouraged to use the Fetal and Infant Mortality Review (FIMR) which brings together ob-gyn experts and local health departments to help solve problems related to infant mortality. Today more than 220 local programs in 42 States find FIMR a powerful tool to help solve infant mortality.

ACOG urges Congress to include $.5 million for Healthy Start Programs to include FIMR.

Maternal Child Health Block Grant (MCH)

The MCH is the only Federal program that exclusively focuses on improving the health of mothers and children. State and territorial health agencies and their partners use MCH Block Grant funds to reduce infant mortality, deliver services to children and youth with special healthcare needs, support comprehensive prenatal and postnatal care, screen newborns for genetic and hereditary health conditions, deliver childhood immunizations, and prevent childhood injuries.

ACOG urges Congress to increase funding for MCH $730 million, a 10.3 percent increase over fiscal year 2010.

Comparative Effectiveness Research on Maternal Disparities at AHRQ

There are glaring disparities in maternal outcomes among different ethnic and racial groups, particularly related to pre-term birth and maternal and infant mortality rates among African American women. For that reason, disparities research is a major tenant of ACOG's MOMS Initiative. Comparative effectiveness research has

the capacity to greatly improve pre-term birth rates and maternal and infant mortality rates by testing the efficacy of prevention and treatment interventions on different populations. As more comparative effectiveness research gets funded from the stimulus and healthcare reform bills, ACOG urges Congress to make disparities research into maternal outcomes a top priority.

ACOG supports a 53.9 percent increase in funds for AHRQ to $611 million, consistent with the President's budget.

Again, we would like to thank the subcommittee for its continued support of programs to improve women's health, and we urge you to consider our MOMS Initiative in fiscal year 2011.

PREPARED STATEMENT OF THE AMERICAN COLLEGE OF PHYSICIANS

Chairman Harkin and Ranking Member Cochran, thank you for allowing me to share the American College of Physicians' (ACP) views on the Department of Health and Human Services (HHS) budget for fiscal year 2011.

I am Joseph W. Stubbs, MD, FACP, President of the ACP. I have also had the privilege of serving adult patients for the past 27 years as a full-time internist and geriatrician in a nine-person primary care group practice in Albany, Georgia. Every day, I see where the rubber of health policy meets the road of real patient lives. In my practice, we have more than 50 employees, and I have seen the ratio of physician to staff grow from 1:3 to 1:6 in the last 10 years. Healthcare in the United States is facing an unprecedented challenge of affordability and sustainability. I am pleased to be able to represent ACP.

ACP represents 129,000 internal medicine physicians, residents, and medical students. ACP is also the Nation's largest medical specialty society and its second largest physician membership organization.

ACP is pleased to urge full funding for the following proven programs that currently receive appropriations from the subcommittee:

—Title VII, section 747, Primary Care Training and Enhancement, at no less than $125 million;

—National Health Service Corps, $414,095,394, in addition to the $290 million in enhanced funding through the Community Health Fund; and

—Agency for Healthcare Research and Quality, $611 million.

In addition to fully funding the existing programs noted above, ACP is pleased to support the following new programs, as created in the Patient Protection and Affordable Care Act (PPACA), with the stipulation that they should be fully funded:

—Title VII, section 747A, Teaching Health Centers, $50 million;

—Primary Care Training Extension Program, $120 million;

—National Health Care Workforce Commission;

—State healthcare workforce development grants; and

—State demonstration programs to evaluate alternatives to current medical tort litigation, $50 million.

We are experiencing a primary care shortage in this country, the likes of which we have not seen. The expected demand for primary care in the United States continues to grow exponentially while the Nation's supply of primary care physicians dwindles and interest by U.S. medical graduates in adult primary care specialties steadily declines. With passage of the PPACA, we expect the demand for primary care services to increase with the addition of 32 million Americans receiving access to health insurance, once the law is fully implemented.

A strong primary care infrastructure is an essential part of any high-functioning healthcare system. In this country, primary care physicians provide 52 percent of all ambulatory care visits, 80 percent of patient visits for hypertension, and 69 percent of visits for both chronic obstructive pulmonary disease and diabetes, yet they comprise only one-third of the U.S. physician workforce. Those numbers are compelling, considering that more than 100 studies show primary care is associated with better outcomes and lower costs of care (http://www.acponline.org/advocacy/where__we__stand/policy/primary__shortage.pdf).

Many regions of the country are currently experiencing shortages in primary care physicians. The Institute of Medicine reports that it would take 16,261 additional primary care physicians to meet the need in currently underserved areas alone. A 2008 study published in Health Affairs projects a shortage of 35,000 to 40,000 or more primary care physicians for adults by 2025 (Colwill JM, Cultice JM, Kruse RL. Will generalist physician supply meet demands of an increasing and aging population? Health Affairs (Millwood). 2008 May–Jun;27(3):w232–41. Epub 2008 Apr 29). With an aging and growing population, family physicians' and general internists' workloads are expected to increase by 29 percent between 2005 and 2025. To help

alleviate the shortage of primary care physicians, we believe sufficient funding should be provided for title VII programs and the National Health Service Corps.

The health professions education programs, authorized under title VII of the Public Health Service Act and administered through the Health Resources and Services Administration (HRSA), support the training and education of healthcare providers to enhance the supply, diversity, and distribution of the healthcare workforce, filling the gaps in the supply of health professionals not met by traditional market forces, and are critical to help institutions and programs respond to the current and emerging challenges of ensuring all Americans have access to appropriate and timely health services.

Within the title VII program, while we applaud the President's request for $54 million for the section 747, Training in Primary Care Medicine and Dentistry, with passage of the PPACA and the reauthorization of the section 747, Primary Care Training and Enhancement, we urge the subcommittee to fund the program at $177.6 million, which is double the amount of funding the program received in fiscal year 2005, the high watermark for this program. We urge the subcommittee to not designate a percentage of the funding to a specific primary care disciple, as has been done in previous years. The reauthorization of the section 747 program calls for capacity building in the fields of general internal medicine, general pediatrics, and family medicine, as well as eliminates the rateable reduction language which has diverted over two-thirds of the funding in this program to one primary care discipline. The section 747 program is the only source of Federal training dollars available for general internal medicine, general pediatrics, and family medicine. For example, general internists, who have long been at the frontline of patient care, have benefited from title VII training models that promoted interdisciplinary training that helped prepare them to work with other health professionals, such as physician assistants, patient educators and psychologists.

ACP strongly supports the creation of the title VII, section 749A, Teaching Health Centers Development Grants, as established in the PPACA, which would provide grants and Graduate Medical Education funding for Teaching Health Centers to train primary care physicians in community based settings. Developing residency programs within community-based ambulatory primary care settings, with the appropriate infrastructure investment, will help strengthen the primary care workforce. Residents in primary care training programs need increased exposure to the ambulatory care setting, a practice environment that demonstrates that satisfaction can be gained from providing ongoing, continuous care to patients. The evidence suggests that residents who spend increased time in outpatient settings opposed to the hospital deliver a higher quality of care and maintained a higher degree of satisfaction from their work. ACP strongly urges the subcommittee to fully fund this program at its fiscal year 2011 authorized level of $50 million.

ACP recommends an appropriation of $414,095,394 for the National Health Service Corps (NHSC), the amount authorized for fiscal year 2011 under the PPACA. This is in addition to the $290 million in enhanced funding the HHS Secretary has been given the authority to provide to the NHSC through the Community Health Care Fund in fiscal year 2011, as authorized under the PPACA. The increase in funds must be sustained to help address the health professionals' workforce shortage and growing maldistribution.

The NHSC scholarship and loan repayment programs provide payment toward tuition/fees or student loans in exchange for service in an underserved area. The programs are available for primary medical, oral, dental, and mental and behavioral professionals. Participation in the NHSC for 4 years or more greatly increases the likelihood that a physician will continue to work in an underserved area after leaving the program. In 2000, the NHSC conducted a large study of NHSC clinicians who had completed their service obligation up to 15 years before and found that 52 percent of those clinicians continued to serve the underserved in their practice.

At a field strength of 4,760 in fiscal year 2009, the NHSC fell more than 24,000 practitioners short of fulfilling the need for primary care, dental, and mental health practitioners in Health Professions Shortage Areas (HPSA), as estimated by HRSA. The NHSC estimates that nearly 50 million Americans currently live in a HPSA and that 27,000 primary care professionals are needed to adequately serve the people living in a HPSA. The National Advisory Council on the NHSC has recommended that Congress double the appropriations for the NHSC to more than double its field strength to 10,000 primary care clinicians in underserved areas. The programs under NHSC have proven to make an impact in meeting the healthcare needs of the underserved, and with more appropriations, they can do more.

The Primary Care Extension Program, a new program created by the PPACA under title III of the Public Health Service Act, would help to educate and provide technical assistance to primary care providers including general internists currently

in practice, about evidence-based therapies, preventive medicine, health promotion, chronic disease management, and mental health. This much-needed assistance will strengthen primary care practices caring for newly insured individuals and an aging population with multiple chronic conditions. ACP encourages the subcommittee to fund this program at its fiscal year 2011 authorized level of $120 million.

We encourage the subcommittee to fully fund the necessary amounts for the National Health Care Workforce Commission, as created by the passage of the PPACA. The Commission is authorized to review current and projected healthcare workforce supply and demand and make recommendations to Congress and the administration regarding national healthcare workforce priorities, goals, and polices. ACP believes the Nation needs sound research methodologies embedded in its workforce policy to determine the Nation's current and future needs for the appropriate number of physicians by specialty and geographic areas; the work of the Commission is imperative to ensure Congress is creating the best policies for our Nation's needs.

The PPACA also establishes a competitive healthcare workforce development grant program for the purpose of enabling State partnerships to complete comprehensive planning and to carry out activities leading to coherent and comprehensive healthcare workforce development strategies at the State and local levels. We urge the subcommittee to fully fund the necessary amounts as needed, for both planning and implementation grants, given that our States are an essential link in sustaining our Nation's health.

The Agency for Healthcare Research and Quality (AHRQ) is the leading public health service agency focused on healthcare quality. AHRQ's research provides the evidence-based information needed by consumers, providers, health plans, purchasers, and policymakers to make informed healthcare decisions. ACP is dedicated to ensuring AHRQ's vital role in improving the quality of our Nation's health and endorses the President's fiscal year 2011 budget request of $611 million. This amount will allow AHRQ to continue its critical healthcare safety, quality, and efficiency initiatives; strengthen the infrastructure of the research field; re-ignite innovation and discovery; develop the next generation of scientific pioneers; and ultimately, help transform health and healthcare.

ACP is supportive of ARHQ's investigator-initiated research program, a critically important element of our Nation's healthcare research effort. The funding stream provides for many clinical innovations, innovations that improve patient outcomes, facilitates the translation of research into clinical practice and disease management strategies, and addresses the healthcare needs of vulnerable populations. Investment in AHRQ's investigator-initiated research is an investment in America's health. Additionally, investment in investigator-initiated research represents a cost-effective and efficient use of our Federal health research dollars. The relatively modest investment provided to clinical investigators in the form of grants often result in advancements with positive economic implications far outweighing the original investment.

The PPACA allows the HHS Secretary to establish State demonstration programs to evaluate alternatives to current medical tort litigation, such as certificate of merit programs, which require a finding that a suit has merit before it can proceed to trial, and health courts, which would have cases heard by a panel of medical experts rather than a lay jury. ACP believes that reform of medical liability system is essential, and this program is a step in that direction. ACP strongly urges the subcommittee to fully fund the program at its authorized level of $50 million immediately, allowing States the opportunity to build upon the work already being done under the October 2009 Funding Opportunity Announcement released by AHRQ, entitled "Medical Liability Reform and Patient Safety Planning Grants."

CONCLUSION

Mr. Chairman and Ranking Member Cochran, I appreciate the opportunity to offer testimony on the importance of HHS budget for fiscal year 2011.

ACP is keenly aware of the fiscal pressures facing the subcommittee today, but strongly believes the United States must invest in these programs in order to achieve a high performance healthcare system and build capacity in our public health system. ACP greatly appreciates the support of the subcommittee on these issues and looks forward to working with Congress as you begin to work on the fiscal year 2011 appropriations process.

PREPARED STATEMENT OF THE AMERICAN COLLEGE OF PREVENTIVE MEDICINE

Recommendation

The American College of Preventive Medicine (ACPM) urges the Labor, Health and Human Services, Education, and Related Agencies Appropriations Subcommittee to reaffirm its support for training preventive medicine physicians and other public health professionals by providing $5 million in fiscal year 2011 for preventive medicine residency training under the public health, dentistry, and preventive medicine line item in title VII of the Public Health Service Act. ACPM also supports the recommendation of the Health Professions and Nursing Education Coalition that $600 million be appropriated in fiscal year 2011 to support all health professions and nursing education and training programs authorized under titles VII and VIII of the Public Health Service Act.

The Need for Preventive Medicine is Growing

In today's healthcare environment, the tools and expertise provided by preventive medicine physicians are integral to the effective functioning of our Nation's public health system. These tools and skills include the ability to deliver evidence-based clinical preventive services, expertise in population-based health sciences, and knowledge of the social and behavioral aspects of health and disease. These are the tools employed by preventive medicine physicians who practice in public health agencies and in other healthcare settings where improving the health of populations, enhancing access to quality care, and reducing the costs of medical care are paramount. As the body of evidence supporting the effectiveness of clinical and population-based interventions continues to expand, so does the need for specialists trained in preventive medicine.[1] [2] [3]

Organizations across the spectrum have recognized the growing demand for public health and preventive medicine professionals. The Institute of Medicine released a report in 2007 calling for an expansion of preventive medicine training programs by an "additional 400 residents per year". The Health Resources and Services Administration's (HRSA) Bureau of Health Professions, using data extracted from the Department of Labor, reports that the demand for public health professionals will grow at twice the rate of all occupations between 2000 and 2010.[4] The Council on Graduate Medical Education recommends increased funding for training physicians in preventive medicine.[5] In addition, the Nation's medical schools are devoting more time and effort to population health topics.[6] These are just a few of the examples demonstrating the growing demand for preventive medicine professionals.

In fact, preventive medicine is the only 1 of the 24 medical specialties recognized by the American Board of Medical Specialties that requires and provides training in both clinical medicine and public health. Preventive medicine physicians possess critical knowledge in population and community health issues, disease and injury prevention, disease surveillance and outbreak investigation, and public health research. Preventive medicine physicians are employed in hospitals, State and local health departments, Health Maintenance Organizations (HMOs), community and migrant health centers, industrial sites, occupational health centers, academic centers, private practice, the military, and Federal Government agencies.

The recent focus on emergency preparedness is also driving the demand for these skills. Unfortunately, many experts have expressed concerns about the preparedness level of our public heath workforce and its ability to respond to emergencies. The nonpartisan, not-for-profit Trust for America's Health has published annual reports assessing America's public health emergency response capabilities. The most recent report, released in December 2008, found that neither State nor Federal Governments are adequately prepared to manage a public health emergency. One reason

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[1] Berrino F Role of Prevention: Cost Effectiveness of Prevention. *Annals of Oncology* 2004; 15:iv245–iv248.

[2] Eikjemans G, Takala J. Moving Knowledge of Global burden into Preventive Action. *American Journal of Industrial Medicine* 2005; 48:395–399.

[3] Ortegon M, Redekop W, Niesen L. Cost-Effectiveness of Prevention and Treatment of the Diabetic Foot. *Diabetes Care* 2004; 27:901–907.

[4] Biviano M. Public Health and Preventive Medicine: What the Data Shows. Presented at the 9th Annual Preventive Medicine Residency Program Directors Workshop, San Antonio, Texas. HRSA. 2002.

[5] Glass JK. Physicians in the Public Health Workforce. In Update on the Physician Workforce. Council on Graduate Medical Education. 2000.

[6] Sabharwal R. Trends in Medical School Graduates' Perceptions of Instruction in Population-Based Medicine. In Analysis in Brief. American Association of Medical Colleges. Vol. 2, No. 1. January 2002.

for this is a significant shortfall in funding needed to improve the Nation's public health systems.[7]

Furthermore, the Centers for Disease Control and Prevention recently affirmed that there are significant holes in U.S. hospital emergency planning efforts for bioterrorism and mass casualty management.[8] These include varying levels of training among hospital staff for treating exposures to chemical, biological or radiological agents; lack of memoranda of understanding with supporting local healthcare facilities; and lack of preparedness training for explosive incidents. Yet, the skills needed to effectively prepare for and respond to bioterrorism and other public health threats—epidemiologic surveillance, disease prevention and containment, understanding and management of the health systems—are at the heart of preventive medicine training and public health practice. Preventive medicine training produces the public health leaders needed to effectively respond to today's threats to the public's health. A recent article on public health leadership trends showed that health department directors who were not physicians had difficulty handling serious outbreaks and other medical emergencies.[9]

The Supply of Preventive Medicine Specialists is Shrinking

According to HRSA and health workforce experts, there are personnel shortages in many public health occupations, including among others, preventive medicine physicians, epidemiologists, biostatisticians, and environmental health workers.[10]

Exacerbating these shortages is a shrinking supply of physicians trained in preventive medicine:

—In 2002, only 6,893 physicians self-designated as specialists in preventive medicine in the United States, down from 7,734 in 1970. The percentage of total U.S. physicians self-designating as preventive medicine physicians decreased from 2.3 percent to 0.8 percent over that time period.[11]

—Between 1999 and 2006, the number of residents enrolled in preventive medicine training programs declined nearly 20 percent.[12]

—The number of preventive medicine residency programs decreased from 90 in 1999 to 71 in 2008–2009.[12]

ACPM is deeply concerned about the shortage of preventive medicine-trained physicians and the ominous trend of even fewer training opportunities. The decline in numbers is dramatic considering the existing critical shortage of physicians trained to carry out core public health activities. This deficiency will lead to major gaps in the expertise needed to deliver clinical prevention and community public health. The impact on the health of those populations served by HRSA may be profound.

Funding for Residency Training is Eroding

Physicians training in the specialty of Preventive Medicine, despite being recognized as an underdeveloped national resource and in shortage for many years, are the only medical residents whose graduate medical education (GME) costs are not supported by Medicare, Medicaid or other third-party insurers. Training occurs outside hospital-based settings and therefore is not financed by GME payments to hospitals. Both training programs and residency graduates are rapidly declining at a time of unprecedented national, State, and community need for properly trained physicians in public health and disaster preparedness, prevention-oriented practices, quality improvement and patient safety. Both the Council on Graduate Medical Education and Institute of Medicine have called for enhanced training support.

Currently, residency programs scramble to patch together funding packages for their residents. Limited stipend support has made it difficult for programs to attract and retain high-quality applicants; faculty and tuition support has been almost non-

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[7] Hearne S, Chrissie J, Segal L, Stephens T, Earls M. Ready or Not? Protecting the Public's Health from Diseases, Disasters, and Bioterrorism 2008; Trust for America's Health. www.healthyamericans.org.

[8] Niska R, Burt C. Bioterrorism and mass casualty preparedness in hospitals: United States, 2003. Advance data from vital and health statistics; no 364. Hyattsville, MD: National Center for Health Statistics. 2005.

[9] Kahn, LH. A Prescription for Change: The Need for Qualified Physician Leadership in Public Health. Health Affairs 2003; 22:241–8.

[10] Health Professions and Nursing Education Coalition. Recommendation for Fiscal Year 2007. March 2006.

[11] American Medical Association (AMA). Physician Characteristics and Distribution in the U.S. 2004, Table 5.2, p. 323.

[12] AMA. Graduate Medical Education Database. Copyright 1994–2005, Chicago, IL.

existent.[13] Directors of residency programs note that they receive many inquiries about and applications for training in preventive medicine; however, training slots often are not available for those highly qualified physicians who are not directly sponsored by an outside agency or who do not have specific interests in areas for which limited stipends are available (such as research in cancer prevention).

The Health Resources and Services Administration (HRSA)—as authorized in title VII of the Public Health Service Act—is a critical funding source for several preventive medicine residency programs, as it represents the largest Federal funding source for these programs. HRSA funding ($2.3 million in 2010) currently supports only physicians in preventive medicine training programs. An increase of $2.7 million will allow HRSA to support up to 25 new preventive medicine residents.

These programs directly support the mission of the HRSA health professions programs by facilitating practice in underserved communities and promoting training opportunities for underrepresented minorities:

—Forty percent of HRSA-supported preventive medicine graduates practice in medically underserved communities, a rate four times the average for all health professionals.[4] These physicians are meeting a critical need in these underserved communities.

—One-third of preventive medicine residents funded through HRSA programs are under-represented minorities, which is three times the average of minority representation among all health professionals.[4] Increased representation of minorities is critical because (1) under-represented minorities tend to practice in medically underserved areas at a higher rate than nonminority physicians, and (2) a higher proportion of minorities contributes to high-quality, culturally competent care.

—Fourteen percent of all preventive medicine residents are under-represented minorities, the largest proportion of any medical specialty.

The Bottom Line: A Strong, Prepared, Public Health System Requires a Strong Preventive Medicine Workforce

The growing threats of a flu pandemic, disasters, and terrorism has thrust public health into the forefront of the Nation's consciousness. ACPM applauds recent investments in disaster planning, information technology, laboratory capacity, and drug and vaccine stockpiles. However, any efforts to strengthen the public health infrastructure and disaster response capability must include measures to strengthen the existing training programs that help produce public health leaders.

Many of the public health leaders who guided the Nation's public health response in the aftermath of the September 11 attacks and the recent hurricane disasters were physicians trained in preventive medicine. According to William L. Roper, MD, MPH, Dean of the School of Public Health, The University of North Carolina at Chapel Hill, "Investing in public health preparedness and response without supporting public health and preventive medicine training programs is like building a sophisticated fleet of fighter jets without training the pilots to fly them."

PREPARED STATEMENT OF THE ASSOCIATION FOR CLINICAL RESEARCH TRAINING (ACRT)

The Association for Clinical Research Training (ACRT), the Association for Patient-Oriented Research (APOR), the Clinical Research Forum (CR Forum), and the Society for Clinical and Translational Science (SCTS) represent a coalition of professional organizations dedicated to improving the health of the public through increased clinical and translational research, and clinical research training. United by the shared priorities of the clinical and translational research community, ACRT, APOR, CR Forum, and SCTS advocate for increased clinical and translational research at the National Institutes of Health (NIH), the Agency for Healthcare Research and Quality (AHRQ), and other Federal science agencies.

On behalf of ACRT, APOR, CR Forum, and SCTS, I would like to thank the Subcommittee for their continued support of clinical and translational research, and clinical research training. The creation of the Patient-Centered Outcomes Research Institute in recent healthcare reform legislation will provide a much-needed and greatly appreciated boost to comparative effectiveness research (CER) at the Federal level. As outlined by NIH Director Dr. Francis Collins in his five priorities for NIH, the translation of basic science to clinical treatment is an integral component of

[13] Magee JH. Analysis of Program Data for Preventive Medicine Residencies in the United States: Report to the Bureau of Health Resources & Services Administration. Washington, DC: American College of Preventive Medicine, 1997.

modern biomedical research, and a necessity to developing the treatments and cures of tomorrow.

Today, I would like to address a number of issues that cut to the heart of the clinical and translational research community's priorities, including the Clinical and Translational Science Awards program (CTSA) at NIH, career development for clinical researchers, and support for CER at the Federal level.

As our Nation's investment in biomedical research expands to provide more accurate and efficient treatments for patients, we must continue to focus on the translation of basic science to clinical research. The CTSA program at NIH is quickly becoming an invaluable resource in this area, but full funding is needed if we are to truly take advantage of the CTSA infrastructure.

Fully Funding and Support for the CTSA Program at NIH

With its establishment in 2006, the CTSA program at NIH began to address the need for increased focus on translational research, or research that bridges the gap between basic science discoveries and the bedside. Originally envisioned as a consortium of 60 academic institutions, the CTSA program currently funds 46 academic medical research institutions nationwide, and is set to expand to the full 60 by 2012. The CTSAs have an explicit goal of improving healthcare in the United States by transforming the biomedical research enterprise to become more effectively translational. Specifically, the CTSA program hopes to (1) improve the way biomedical research is conducted across the country; (2) reduce the time it takes for laboratory discoveries to become treatments for patients; (3) engage communities in clinical research efforts; (4) increase training and development in the next generation of clinical and translational researchers; and (5) accelerate T1 translational science.

Although the promise of the CTSA program is recognized both nationally and internationally, it has suffered from a lack of proper funding along with NIH, and the National Center for Research Resources (NCRR). In 2006, 16 initial CTSAs were funded, followed by an additional 12 in 2007 and 14 in 2008. Level-funding at NIH curtailed the growth of the CTSAs, preventing recipient institutions from fully implementing their programs and causing them to drastically alter their budgets after research had already begun. If budgets continue to decline, the CTSAs risk jeopardizing not only new research but also the research begun by first, second, and third generation CTSAs. Professional judgment determined full funding to be at a level of $700 million.

We recognize the difficult economic situation our country is currently experiencing, and greatly appreciate the commitment to healthcare Congress has demonstrated through stimulus funding, the fiscal year 2010 appropriations process, and most recently through healthcare reform. The CTSAs are currently funding 46 academic research institutions nationwide at a level of $474 million, with the goal of full implementation by 2012. In order to reach full implementation of 60 CTSAs by 2012, and to realize the promise of the CTSAs in transforming biomedical research to improve its impact on health, it is imperative that the CTSA program receive funding at the level of $700 million in fiscal year 2011. Without full funding, more CTSAs will be expected to operate with fewer resources, curtailing their transformative promise.

A major part of the CTSA program's promise lies in its synergy with all of NIH's Institutes and Centers (ICs), and the acceleration and facilitation of the ICs' impact. The translation of laboratory research to clinical treatment directly benefits patients suffering from complex diseases and all fields of medicine. The CTSA program has created improved translational research capacity and processes from which all NIH's ICs stand to benefit. The development of a formal NIH-wide plan to link all ICs to the CTSA program would efficiently capitalize on NIH and NCRR's investment in clinical and translational science.

It is our recommendation that the subcommittee support full implementation of the CTSA program by providing $700 million in fiscal year 2011, and we ask that the subcommittee support the development of a formal NIH-wide plan to integrate the CTSAs to all of NIH's Institutes and Centers.

Continuing Support for Research Training and Career Development Programs Through the K Awards

The future of our Nation's biomedical research enterprise relies heavily on the maintenance and continued recruitment of promising young investigators. Clinical investigators have long been referred to as an "endangered species", as financial barriers push medical students away from research. This trend must be arrested if we are to continue our pursuits of better treatments and cures for patients.

The K Awards at NIH and AHRQ provide much-needed support for the career development of young investigators. As clinical and translational medicine takes on increasing importance, there is a great need to grow these programs, not reduce them. Career development grants are crucial to the recruitment of promising young investigators, as well as to the continuing education of established investigators. Reduced commitment to the K–12, K–23, K–24, and K–30 awards would have a devastating impact on our pool of highly trained clinical researchers. Even with the full implementation of the CTSA program, it will be critical for institutions without CTSAs to retain their K–30 Clinical Research Curriculum Awards, as the K–30s remain a highly cost-effective method of ensuring quality clinical research training. ACRT, APOR, CRF, and SCTS strongly support the ongoing commitment to clinical research training through K Awards at NIH and AHRQ.

We ask the subcommittee to continue their support for clinical research training and career development through the K Awards at NIH and AHRQ, in order to promote and encourage investigators working to transform biomedical science.

Continuing Support for CER

Comparative effectiveness research or "CER" emerged at the forefront of the healthcare reform debate, capturing the interest of lawmakers and the American people. CER is the evaluation of the impact of different options that are available for treating a given medical condition for a particular set of patients. This broad definition can include medications, behavioral therapies, and medical devices among other interventions, and is an important facet of evidence-based medicine. On behalf of ACRT, APOR, CR Forum, and SCTS, I would like to thank the Senate for the creation of the Patient-Centered Outcomes Research Institute in the Patient Protection and Affordable Care Act, as well as the $1.1 billion included for CER at NIH and AHRQ in the American Recovery and Reinvestment Act (ARRA). Both AHRQ and NIH have long histories of supporting CER, and the standards for research instituted by agencies like NIH and AHRQ serve as models for best practices worldwide. Not only are these agencies experienced in CER, they are universally recognized as impartial and honest brokers of information.

We are pleased that Congress recognizes the importance of these activities and believe that the peer review processes and infrastructure in place at NIH and AHRQ ensure the highest quality CER. We believe that collaboration between the Patient-Centered Outcomes Research Institute, NIH, and AHRQ will motivate all Federal CER efforts. In addition to support for the CTSA program at NIH, we encourage the Subcommittee to provide continued support for Patient-Centered Health Research at AHRQ.

Thank you for the opportunity to present the views and recommendations of the clinical research training community. On behalf of ACRT, APOR, CR Forum, and SCTS, I would be happy to be of assistance as the appropriations process moves forward.

PREPARED STATEMENT OF THE AMERICAN COLLEGE OF SPORTS MEDICINE

On behalf of the American College of Sports Medicine (ACSM), I am pleased to offer this written testimony to the Senate Appropriations Subcommittee on Labor, Health and Human Services, Education, and Related Agencies for inclusion in the official Committee record. I will focus my comments on the importance of programs within the Department of Health and Human Services (HHS), the Department of Education, and programs recently authorized in the Patient Protection and Affordable Care Act (Public Law 111–148) that serve as a means to educate about or provide services that enhance healthy lifestyles for all Americans. Within these programs, ACSM is strongly supportive of the inclusion of provisions that enhance access to information about physical activity and exercise as a mechanism for improving health and reducing chronic diseases or health disparities.

ACSM is a 35,000-member organization that applies knowledge, training, and dedication in sports medicine and exercise science to promote healthier lifestyles for people around the globe. ACSM members are dedicated to improving public health through a spectrum that ranges from basic research to translating that research into effective practice. ACSM members include leading scientists, physicians, educators, public health experts, clinical exercise physiologists, health and fitness professionals, physical therapists, and more.

The Nation's focus on physical activity and exercise as a means to improve health and prevent disease has recently been garnering increased attention. However, expanded and sustained Federal support is necessary to fully leverage the health benefits that have been shown to result from physical activity and exercise. Additional

funding is needed to expand basic and translational research to ensure that the most up-to-date and effective guidance is disseminated and that programs are developed with the goals of keeping Americans strong and healthy and reducing the levels of chronic diseases such as heart disease, diabetes, obesity, stroke, osteoporosis, and depression.

In particular, scientific and medical research conducted at the National Institutes of Health (NIH) will be instrumental in building on current efforts to improve the Nation's health and reduce diseases and health disparities. ACSM appreciates the subcommittee's past support for NIH and encourages the subcommittee to maintain its commitment by allocating a total discretionary budget of $32.239 billion, which is equal to the President's fiscal year 2011 budget request for NIH. ACSM also encourages the subcommittee to direct a portion of this increased funding toward institutes and programs that focus on prevention and wellness. The combination would allow NIH to fund a record number of research grants, including those that will help us to understand what is needed to ensure Americans live healthier lifestyles.

In addition, summarized below are recommendations for fiscal year 2011 funding for programs within HHS, the Department of Education, and new programs recently authorized through the Patient Protection and Affordable Care Act (Public Law 111–148) to help ensure that the necessary mechanisms are provided to improve health, eliminate disparities, and reduce diseases among all Americans.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

The agencies within HHS include programs that support ACSM's goals. ACSM urges the subcommittee's support for the following HHS programs:

Community Health Centers.—ACSM appreciates the subcommittee's support for the Health Centers program within the Health Resources and Services Administration (HRSA). The Health Centers program provides access to comprehensive primary healthcare, including supportive services such as transportation and education for individuals and families in high-need communities. ACSM urges the Committee to appropriate at least the President's fiscal year 2011 request of $2.5 billion for the program, an increase of $290 million above the fiscal year 2010 enacted level and to direct a portion of this funding to allow new and existing centers to expand to include services and information that highlight the health benefits of physical activity and exercise.

Centers for Disease Control and Prevention.—ACSM supports the increases proposed in the President's fiscal year 2011 budget request for programs within the Centers for Disease Control and Prevention (CDC), including: Chronic Disease Prevention, Health Promotion and Genomics, a total of $937 million; Public Health Research, a total of $31 million; and Preventive Health and Health Services Block Grant, a total of $102 million. ACSM urges the Committee to direct a portion of the funding within these programs to physical activity and exercise programs and research.

PATIENT PROTECTION AND AFFORDABLE CARE ACT

ACSM urges the subcommittee to fund the following programs authorized in the Patient Protection and Affordable Care Act (Public Law 111–148), which deal with prevention of chronic disease and improving public health:

Prevention and Public Health Fund.—This fund would be administered by the Secretary of HHS and would increase funding for programs authorized by the Public Health Service Act for prevention, wellness, and public health activities. ACSM urges the Committee to use its authority to transfer money from the fund to existing or new programs authorized by the Public Health Service Act that have a particular focus on physical activity and exercise, including the Community Transformation grant program.

U.S. Preventive Services Task Force/Community Preventive Services Task Force.—These task forces will coordinate with the Advisory Committee on Immunization Practices, and will comprise experts to review scientific evidence related to effectiveness, appropriateness, and cost-effectiveness of clinical preventive services for the purpose of developing recommendations to be widely distributed to and utilized by the public. ACSM urges the Committee to appropriate the necessary funding to establish these task forces, in order to help ensure that the best practices in health and wellness, including physical activity and exercise guidelines and recommendations, are being promoted.

Education and Outreach Campaign.—This campaign would be developed by a public-private partnership with the aim of raising public awareness of health improvement across the life span. ACSM urges the Committee to appropriate funding to allow for successful development and implementation of the campaign.

DEPARTMENT OF EDUCATION

ACSM urges the subcommittee to support the following program at the Department of Education:

Carol M. White Physical Education Program/Successful, Safe, and Healthy Students.—ACSM supports programming within the Department of Education that focuses on developing healthy lifestyles for students and the Nation's youth population. In the President's fiscal year 2011 budget request, the Carol M. White Physical Education Program was proposed for consolidation into an overarching Successful, Safe, and Healthy Students program, of which one goal is improving students' physical health and well-being through the use of, or access to, comprehensive services that improve student physical activity and fitness. ACSM urges the Committee to provide increased funding for the Carole M. White Physical Education Program or direct a significant portion of the funding provided to the Successful, Safe, and Healthy Students program to focus on physical activity, exercise, and the development of healthy lifestyles for youth.

I appreciated the opportunity to submit these recommendations and hope the Committee will consider them while developing appropriations for fiscal year 2011.

PREPARED STATEMENT OF THE AMERICAN DIABETES ASSOCIATION

Thank you for the opportunity to provide this testimony to the Senate Labor, Health and Human Services, and Education, and Related Agencies Subcommittee. I am pleased to have the opportunity to submit testimony on behalf of the American Diabetes Association. As someone who has lived with diabetes for more than 30 years, I am proud to be a representative of the 81 million American adults and children living with diabetes or pre-diabetes.

Every minute, three more people are diagnosed with the disease. While nearly 24 million Americans have diabetes today, that number is expected to grow to 44 million in the next 25 years if present trends continue. Every 24 hours, 230 people with diabetes will undergo an amputation, 120 people will enter end-stage kidney disease programs, and 55 people will go blind from diabetes. Each and every day diabetes will cost our country over a half a billion dollars, yet, it is but a fraction of the costs that lie ahead unless we take action immediately to stop the march of this epidemic.

Thanks to you and your colleagues, Congress has consistently funded vital Department of Health and Human Services programs to help reduce the overwhelming costs of diabetes. However, if we are to cure and prevent diabetes, there is much more to accomplish. Therefore, the Association urges the Senate Labor, Health and Human Services, and Education, and Related Agencies Subcommittee to invest in research and prevention proportionate to the magnitude of the burden diabetes has on our country and, by doing so, to change the future of diabetes in America.

As the Nation's leading nonprofit health organization providing diabetes research, information and advocacy, the Association believes Federal funding for diabetes prevention and research is critical, not only for the 24 million American adults and children (nearly 8 percent of the population) who currently have diabetes, but for the 57 million more with pre-diabetes. Of the 24 million, 6 million are unaware they have diabetes. Together, this means 25 percent of the U.S. population either has, or is at risk for developing, this serious disease. Federal funding for diabetes prevention and research efforts is critical to reversing this epidemic.

Diabetes is a chronic condition that impairs the body's ability to use food for energy. The hormone insulin, which is made in the pancreas, helps the body change food into energy. In people with diabetes, either the pancreas does not create insulin, which is type 1 diabetes, or the body does not create enough insulin and/or cells are resistant to insulin, which is type 2 diabetes. If left untreated, diabetes results in too much glucose in the blood stream. The majority of diabetes cases, 90 to 95 percent, are type 2, while type 1 diabetes accounts for 5 to 10 percent of diagnosed cases. The complications of diabetes are widespread and serious. In those with pre-diabetes, blood glucose levels are higher than normal and taking action to reduce their risk of developing diabetes is essential.

The Centers for Disease Control and Prevention (CDC) has identified diabetes as a disabling, deadly epidemic that is on the rise. Between 1990 and 2001, the prevalence of diabetes increased by 60 percent. According to the CDC, 1 in 3 children born in the year 2000 is likely to develop the disease in their lifetime if current trends continue. This number is even greater among minority populations, where nearly 1 in 2 children will develop diabetes.

Additionally, type 2 diabetes, traditionally seen in older patients, is beginning to reach a younger population, due in part to the surge in childhood obesity. Approximately 1 in every 500 children and adolescents has Type 1 diabetes, and an alarm-

ing 2 million adolescents (or 1 in 6 overweight adolescents) aged 12–19 have prediabetes. The impact diabetes has on individuals and the healthcare system is enormous and continues to grow at a shocking rate. Diabetes is a leading cause of kidney disease, adult-onset blindness and lower limb amputations as well as a significant cause of heart disease and stroke. Since 1987, the death rate due to diabetes has increased by 45 percent. In that same period, death rates for heart disease, stroke, and cancer have dropped.

In addition to the physical toll, diabetes also attacks our pocketbooks. A recent study by the Lewin Group found when factoring in the additional costs of undiagnosed diabetes, pre-diabetes, and gestational diabetes, the total cost of diabetes and related conditions in the United States in 2007 was $218 billion ($18 billion for undiagnosed diabetes; $25 billion for pre-diabetes; $623 million for gestational diabetes). That year, medical expenditures due to diabetes totaled $116 billion, including $27 billion for diabetes care, $58 billion for chronic diabetes-related complications, and $31 billion for excess general medical costs. Indirect costs resulting from increased absenteeism, reduced productivity, disease-related unemployment disability and loss of productive capacity due to early mortality totaled $58 billion. This is an increase of 32 percent since 2002. Thus, in just 5 years, the cost of diabetes increased by $42 billion, or $8 billion per year. In fact, approximately 1 out of every 5 healthcare dollars is spent caring for someone with diagnosed diabetes, while 1 in 10 healthcare dollars is attributed to diabetes. Additionally, one-third of Medicare expenses are associated with treating diabetes and its complications.

Despite these numbers, there is hope. A greater Federal investment in diabetes research at the National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK) at the National Institutes of Health (NIH), and prevention, surveillance, control, and research work currently being done at the Division of Diabetes Translation (DDT) at the CDC is crucial for finding a cure and improving the lives of those living with, or at risk for, diabetes. Additionally, the National Diabetes Prevention Program (NDPP), a new program authorized through the Patient Protection and Affordable Care Act (Public Law 111–148, section 399V–3), is poised to cut dramatically the number of new diabetes cases in high-risk individuals. In this vein, for fiscal year 2011, the American Diabetes Association is requesting:

—$2.209 billion for the NIDDK, an increase of $252 million over the fiscal year 2010 level. This additional funding will act to offset years of flat funding and inflation that caused cutbacks to promising research. It will also demonstrate Congress's commitment to science and research.

—$86 million for the CDC's DDT, which represents a total increase of $20 million for the DDT's critical prevention, surveillance and control programs. Expanded investment in the DDT will produce much larger savings in reduced acute, chronic, and emergency care spending.

Additionally, we are also requesting your support of $80 million for the implementation of the NDPP through the Prevention and Public Health Fund created in Public Law 111–148.

NIH's National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK)

One of the 27 Institutes housed at the NIH, NIDDK is poised to make major discoveries that could prevent diabetes, better treat its complications, and—ultimately—find a cure. Researchers at the NIH are working on a variety of projects that represent hope for the millions of individuals with both type 1 and type 2 diabetes. The list of advances in treatment and prevention is long, but it is important to understand much more can be achieved for people with diabetes with an increased investment in scientific research at the NIDDK.

Researchers have already learned a great deal about the biology of diabetes, and they now understand much more about the loss of islet cell function, which can affect the body's ability to regulate blood glucose levels. These discoveries have led directly to islet cell transplants and ongoing work to extend the life of transplanted cells. Thanks to research at the NIDDK, people with diabetes now manage their disease with a variety of insulin formulations and regimens far superior to those used in decades past. The result is the ability to live healthier lives with diabetes. Because of these advances, my hemoglobin A1C, which provides a snapshot of an individual's blood glucose, went from 12.9 percent to 5.9 percent. This is a dramatic development for me and proof of the importance of NIDDK's work.

Recent discoveries at the NIDDK include the ability to predict type 1 diabetes risk, new drug therapies for type 2 diabetes, and the discovery of genetic markers that explain the increased burden of kidney disease among African Americans. The NIDDK funded the Diabetes Prevention Program, a multicenter clinical research trial that found modest weight loss through dietary changes and increased physical activity could prevent or delay the onset of type 2 diabetes by 58 percent.

While great strides have been made in diabetes research, there are many unanswered questions about the disease that merit further study. Towards that end, the NIDDK, in its role as the convener of the Diabetes Mellitus Coordinating Committee, a panel of key HHS agencies, including the Food and Drug Administration and the CDC, and other Federal partners such as the Department of Veterans Affairs, has developed a Diabetes Research Strategic Plan, to be finalized later this year, which outlines diabetes research needs.

The plan identifies a number of areas for additional research. These include study into the intersection of genetic and environmental risk factors for diabetes in people of color in order to reduce the prevalence of the disease and its complications; identification of the key genetic factors that predispose or protect individuals against diabetes complications; and, study of the natural history of type 1 diabetes in order to foster the design of preventive therapy. Additional fiscal year 2011 funding would allow the NIDDK to support additional research in order to build upon past successes, improve prevention and treatment, and close in on a cure.

CDC's Division of Diabetes Translation (DDT)

The CDC's DDT works to eliminate the preventable burden of diabetes through proven educational programs, best practice guidelines and applied research. Funds appropriated to the DDT focus on developing and maintaining State-based Diabetes Prevention and Control Programs (DPCPs); supporting the National Diabetes Education Program (NDEP); defining the diabetes burden through the use of public health surveillance; and translating research findings into clinical and public health practice. Our request of an additional $20 million will allow these critical programs at the DDT to reach more at risk Americans and help to prevent or delay this destructive disease.

The DDT's most important efforts are based within the DPCPs in all 50 States, the District of Columbia, and 8 other territories and are cornerstones of the Division's work. DPCPs work to not only reduce the incredible burden of diabetes, but to make certain the people they serve are fully aware of the disease and those with or at risk of developing diabetes are receiving the highest quality of care possible. Because they are community based, DPCPs are highly adaptable and capable of reaching those at greatest risk in a given area. DPCPs provide a vital infrastructure to coordinate diabetes prevention and control efforts, however, a severe lack of funding leaves DPCPs unable to reach all of those who could benefit from their work.

The Division also recognizes the role that education and awareness plays in the fight against diabetes. With this in mind, the DDT implements the NDEP in coordination with the NIDDK. The NDEP develops and disseminates information on the prevention and control of diabetes that serve as the guiding principles to improve the treatment and outcomes for people with diabetes and to prevent or delay the onset of diabetes. Another vital component of the DDT's efforts is the National Diabetes Surveillance System, which provides comprehensive diabetes data at the national, State, and local levels so analysts may better track the epidemic, and ensure the most effective use of taxpayer dollars.

The DDT also identifies important research findings, including the results of clinical trials and scientific studies, in order to pinpoint the public health implications of the research. These findings are applied in healthcare systems and within local communities. Areas of translational research include access to quality care for diabetes; cost-effectiveness of diabetes prevention and control activities; effectiveness of health practices to address risk factors for diabetes; and demonstration of primary prevention of type 2 diabetes. One example of a highly successful translational effort by the DDT is the Diabetes Prevention Program Initiative (DPPI), a structured lifestyle intervention modeled after the NIDDK's Diabetes Prevention Program (DPP) clinical research study. The DPPI is proving group lifestyle intervention can lower diabetes risk while being delivered in a cost effective way in a community setting, thus increasing the likelihood of improved outcomes for individuals at risk of developing the disease.

While the DDT has played an invaluable and instrumental role in fighting the diabetes epidemic, the reach of the Division could be significantly broader with additional fiscal year 2011 funding. With an additional $20 million, the DDT will be able to expand the reach of DPCPs in every State and territory. Given the dramatic decreases in funding for State and local health departments, supporting the work of the DPCPs to provide prevention and control guidelines and technical assistance to health officials in local communities is more critical than ever to ensure access to affordable and high-quality diabetes care and services.

Increased funding for the DDT will also allow the Division to build upon its work in reducing health disparities through vital programs such as the Native Diabetes Wellness Program, furthering the development of effective health promotion activi-

ties and messages tailored to American Indian/Native Alaskan communities. Additional resources will enable the DDT to expand its translational research studies that will lead to improved public health interventions. An excellent example of this work is the Search for Diabetes in Youth study; a collaboration between the DDT and the NIDDK designed to further clarify the impact of type 2 diabetes in youth so prevention activities aimed at young people can be improved.

The National Diabetes Prevention Program (NDPP)

Further studies of the DPP have shown this groundbreaking intervention can be replicated in community settings for a cost of less than $300 per participant. With this in mind, the NDPP was authorized by the Patient Protection and Affordable Care Act of 2010 (Public Law 111–148). This new program will provide funding to the CDC to expand such evidence-based programs across the country. The Association acknowledges your leadership in the implementation of Public Law 111–148, specifically the Prevention and Public Health Fund (section 4002), which provided $15 billion in mandatory funding over the next 10 years for public health, wellness and prevention programs. We respectfully ask the subcommittee to support $80 million from the Fund for the NDPP.

The NDPP meets the goals of the Fund, which seeks to make a national investment in prevention and public health programs, both to improve the health of Americans and to rein in healthcare costs. The Urban Institute reported our country could save as much as $190 billion over 10 years by bringing the NDPP to scale. Implementation of the NDPP would allow the CDC to expand the reach of evidence-based community programs to identify, refer and provide those at high risk for diabetes with cost-effective interventions.

CONCLUSION

As you consider the fiscal year 2011 appropriation for the NIDDK and the DDT, we ask that you consider diabetes is an epidemic growing at an astonishing rate. If left unaddressed diabetes will overwhelm the healthcare system with tragic consequences. To change this future we need to increase our commitment to research and prevention in a way that reflects the burden diabetes poses both for us and for our children.

Increasing NIDDK funding to $2.209 billion for next year opens the door to research opportunities that will both improve patient outcomes and reduce the economic cost of diabetes. Through the CDC's important programs at the DDT, we have the chance to drastically reduce the number of people with diabetes. Given the astounding costs of diabetes, the request of $86 million for DDT is a modest investment in our future. Further, $80 million from the Prevention and Public Health Fund for the implementation of the NDPP will not only improve the health of millions of Americans who are at high risk for diabetes, but it will also save healthcare costs in the long term.

Our fight against diabetes must be significantly expanded. Your continued leadership in combating this growing epidemic is essential in stemming the epidemic. Thank you for your commitment to the diabetes community and for the opportunity to submit this testimony. The Association is prepared to answer any questions you might have on these important issues.

PREPARED STATEMENT OF THE AMERICAN DENTAL EDUCATION ASSOCIATION

The American Dental Education Association (ADEA) is pleased to offer its recommendations for fiscal year 2011 appropriations for dental education and research.

The ADEA represents all 60 dental schools in the United States, in addition to more than 700 dental residency training programs and nearly 600 allied dental programs, as well as more than 12,000 faculty who educate and train the nearly 50,000 students and residents attending these institutions. It is at these academic dental institutions that future practitioners and researchers gain their knowledge, where the majority of dental research is conducted, and where significant dental care is provided. ADEA member institutions serve as dental homes for a broad array of racially and ethnically diverse patients, many who are uninsured, underinsured, or reliant on public programs such as Medicaid and the Children's Health Insurance Program for their healthcare.

ADEA's requests build upon funding from the American Economic Recovery and Reinvestment Act (ARRA) and the Labor, Health and Human Services, and Education, and Related Agencies fiscal year 2010 appropriations. The Department of Health and Human Services has several oral health programs that address the various aspects needed to improve oral healthcare in America. These programs build

and sustain State oral health departments, fund proven public health programs to prevent oral disease, target research to eradicate dental disease, and work to develop an adequate workforce of dentists with advanced training to serve children, the aged and those suffering from specific diseases like AIDS.

Our budget recommendations include the following:

—*Dental Education*.—The Title VII Health Professions Education and Training Programs and Diversity and Student Aid Programs, administered by the Health Resources and Services Administration (HRSA);

—*Oral Health Research*.—The National Institutes of Health (NIH) and the National Institute of Dental and Craniofacial Research (NIDCR); and

—*Access to Care*.—The Ryan White CARE Act HIV/AIDS Dental Reimbursement Program and the Community-Based Dental Partnerships Program; the Dental Health Improvement Act; the Oral Health Program at the Centers for Disease Control and Prevention (CDC); and the National Health Service Corps (NHSC).

Specifically, the ADEA respectfully urges the subcommittee to provide $30 million for section 5303 of (Public Law 111–148) for the continuation and enhancement of dental training programs. The following programs help to address the Nation's oral healthcare needs:

DENTAL EDUCATION

$16 Million for General Dentistry and Pediatric Dentistry Residency Training in the Title VII Health Professions Programs

The Title VII General and Pediatric Dentistry Programs are critical to building the primary care dental workforce. Support for these programs is essential to expanding existing or establishing new general dentistry and pediatric dentistry residency programs, which have shown to be effective in increasing access to dental care for vulnerable populations, including patients with developmental disabilities, children, and geriatric patients. These primary care dental residency programs generally include outpatient and inpatient care and afford residents an excellent opportunity to learn and practice in all phases of primary care dentistry, including trauma and emergency care, and comprehensive ambulatory dental care for adults and children.

$118 Million for Diversity and Student Aid

$33 Million for Centers of Excellence

$49 Million for Scholarships for Disadvantaged Students

$35 Million for Health Careers Opportunity Program

$1.3 Million for Faculty Loan Repayment Program

The Title VII Diversity and Student Aid programs play a critical role in helping to diversify the health profession's student body and thereby the healthcare workforce. Blacks, Hispanics, and American Indians currently represent more than 25 percent of the U.S. population. By the year 2050, nearly 1 in 5 Americans (19 percent) will be an immigrant, compared with 1 in 8 (12 percent) in 2005. Despite these population trends, minorities are underrepresented in the U.S. healthcare workforce. This is no less true of dentistry, where they comprise less than 5 percent of dentists and about 9 percent of dental faculty. For the last several years, these programs have not enjoyed an adequate level of funding to sustain the progress that is necessary to meet the challenges of an increasingly diverse U.S. population.

ORAL HEALTH RESEARCH

$35 Billion for the NIH, Including $463 Million for the NIDCR

Discoveries stemming from dental research have reduced the burden of oral diseases, led to better oral health for tens of millions of Americans, and uncovered important associations between oral and systemic health. Dental researchers are poised to make new breakthroughs that can result in dramatic progress in medicine and health, such as repairing natural form and function to faces destroyed by disease, accident, or war injuries; diagnosing systemic disease from saliva instead of blood samples; and deciphering the complex interactions and causes of oral health disparities involving social, economic, cultural, environmental, racial, ethnic, and biological factors. Dental research is the underpinning of the profession of dentistry. With grants from NIDCR, dental researchers in academic dental institutions have built a base of scientific and clinical knowledge that has been used to enhance the quality of the Nation's oral health and overall health.

Dental scientists also are putting science to work for the benefit of the healthcare system through translational research, comparative effectiveness research, health

information technology, health research economics, and further research on health disparities. NIDCR continues to make disparities a priority by renewing five disparities centers for 2008–2015: Boston University Henry M. Goldman School of Dental Medicine, the University of California San Francisco School of Dentistry, the University of Colorado Denver School of Dental Medicine, the University of Florida College of Dentistry, and the University of Washington School of Dentistry.

The latest NHANES data that provided a full dental examination, 1999–2004, show that dental caries in young children has actually increased, particularly in those populations covered by SCHIP and Medicaid. The June 2009 IOM Study on Comparative Effectiveness Research (CER) included two oral health topics in the top 100 national priorities for CER.

NIDCR funded four ARRA Challenge Grants on CER. Investments in dental research will produce inventions that make corporations more competitive in the global economy and benefit everyone with new businesses and jobs. Investments in dental research will produce inventions that make corporations more competitive in the global economy and benefit everyone with new businesses and jobs. It is important to note that NIH disproportionately creates higher-paying employment opportunities that require a higher level of technical sophistication in construction, staffing, and supporting laboratories. The average wage associated with jobs created through NIH grants and contracts was $52,000 in 2007.

ACCESS TO DENTAL CARE

$19 Million for the Dental Reimbursement Program and the Community-Based Dental Partnerships Program, part F of the Ryan White HIV/AIDS Treatment and Modernization Act

Patients with compromised immune systems are more prone to oral infections like periodontal disease and tooth decay. By providing reimbursement to dental schools and schools of dental hygiene, the Dental Reimbursement Program provides access to quality dental care for people living with HIV/AIDS while simultaneously providing educational and training opportunities to dental residents, dental students, and dental hygiene students who deliver the care. The Dental Reimbursement Program is a cost-effective Federal/institutional partnership that provides partial reimbursement to academic dental institutions for costs incurred in providing dental care to people living with HIV/AIDS. Particularly important to this program is the fact that Congress designated dental care as a "core medical service" when it reauthorized the Ryan White program in 2006.

The Community-Based Dental Partnership Program fosters partnerships between dental schools and communities lacking academic dental institutions to ensure access to dental care for HIV/AIDS patients living in those areas.

$20 Million for the Dental Health Improvement Act (DHIA)

This program supports the development of innovative dental workforce programs specific to States' dental workforce needs and increases access to dental care for underserved populations. In fiscal year 2006, Congress provided first-time DHIA funding of $2 million to assist States in developing innovative dental workforce programs. The inaugural grant cycle, held in fiscal year 2006, yielded 36 applications from States. Eighteen States were awarded grants ranging from $67,865 to $124,080. Grants are being used to support a variety of initiatives including, but not limited to, loan repayment programs to recruit culturally and linguistically competent dentists to work in underserved areas with underserved populations including the developmentally disabled; rotating residents and students in rural areas; recruiting dental school faculty; training pediatricians and family medicine physicians to provide oral health services (screening exams, risk assessments, fluoride varnish application, parental counseling, and referral of high-risk patients to dentists); and supporting teledentistry.

$33 Million for the Oral Health Programs at the Centers for Disease Control and Prevention (CDC)

The CDC Oral Health Program expands the coverage of effective prevention programs. The program increases the basic capacity of State oral health programs to accurately assess the needs of the State, organize and evaluate prevention programs, develop coalitions, address oral health in State health plans, and effectively allocate resources to the programs. CDC's funding and technical assistance to States is essential to help oral health programs build capacity. Increasing the funding will help to ensure that all States that apply may be awarded an oral health grant.

$414 Million for the NHSC

The NHSC scholarship and loan repayment program provides awards to healthcare professionals, including dentists and dental hygienists who agree to work in underserved communities for a minimum of 2 years. Participants must work in a Health Professional Shortage Area (HPSA), and dentists and dental hygienists work in Dental Health Professional Shortage Areas (Dental HPSAs). According to the HRSA there are 4,230 Dental HPSAs with 49 million people living in them. It would take 9,642 practitioners to meet their need for dental providers (a population to practitioner ratio of 3,000:1). The dedicated clinicians of the NHSC provide quality care to millions of people who would otherwise lack adequate access to health services.

The ADEA is grateful to the subcommittee for considering our fiscal year 2011 budget requests for Federal agencies and programs that sustain and enhance dental education, oral health research, and access to care. A continuing Federal commitment is needed to help meet the challenges oral diseases pose to the Nation's most vulnerable citizens, including children. Also critical is the development of a partnership between the Federal Government and dental education programs to implement a national oral health plan that guarantees access to dental care for everyone, ensures continued dental health research, and eliminates disparities and workforce shortages.

PREPARED STATEMENT OF THE ARTHRITIS FOUNDATION

The Arthritis Foundation greatly appreciates the opportunity to submit testimony in support of increased funding for arthritis prevention at the Centers for Disease Control and Prevention (CDC); additional investment in arthritis research at the National Institutes of Health (NIH); and funding for the Health Resources and Services Administration (HRSA) to commence a loan repayment program for pediatric specialists.

Arthritis is a term used to describe more than 100 different conditions that affect joints as well as other parts of the body. Arthritis is one of the most prevalent chronic health problems and the most common cause of disability in the United States. Forty-six million people (1 in 5 adults) and almost 300,000 children live with the pain of arthritis every day. The medical and societal impact of arthritis in the United States is staggering at $128 billion, including $81 billion in direct costs for physician visits and surgical interventions and $47 billion in indirect costs for missed work days. Counter to public perception, two-thirds of the people with doctor-diagnosed arthritis are under the age of 65.

By the year 2030, an estimated 67 million or 25 percent of the projected adult population will have arthritis. Furthermore, arthritis limits the ability of people to effectively manage other chronic diseases. More than 57 percent of adults with heart disease and more than 52 percent of adults with diabetes also have arthritis. The Arthritis Foundation strongly believes that in order to prevent or delay arthritis from disabling people and diminishing their quality of life that a significant investment in prevention and intervention strategies is essential. Research shows that the pain and disability of arthritis can be decreased through early diagnosis and appropriate management, including evidence based self-management activities such as weight control and physical activity. The Arthritis Foundation's Self-Help Program, a group education program, has been proven to reduce arthritis pain by 20 percent and physician visits by 40 percent. These interventions are recognized by the CDC to reduce the pain of arthritis and importantly reduce healthcare expenditures through a reduction in physician visits.

CDC

During the past year, the CDC has partnered with the Arthritis Foundation and more than 50 organizations to create a National Public Health Agenda for Osteoarthritis. The Agenda states the need to increase availability of evidence-based intervention strategies; increase public health attention for prevention and disease management; and increase research to better understand disease risk factors and other effective disease management strategies.

With CDC funding, 12 State health departments in partnership with other State organizations have successfully increased public awareness of the burden of arthritis and increased the availability of four main interventions. First, self-management education (as described above) is proven to improve the quality of life and healthcare for people with arthritis and should be expanded to people with symptomatic arthritis. Second, physical activity is the best medicine to fight arthritis pain. The promotion of low-impact aerobic physical activity and muscle strengthening ex-

ercises for weight loss and to provide joint support is key. Losing just 1 pound of weight reduces 4 pounds of pressure off each knee. Third, preventing joint injuries through existing policies and interventions which have been shown to reduce arthritis-related joint injuries. Finally, promoting weight management and healthy nutrition will facilitate the prevention and treatment of arthritis. Now, is the time to make a significant investment to sustain and improve the reach of these proven interventions.

Currently, the CDC's arthritis program receives $13 million in annual funding and about half of that amount is distributed via competitive grant to 12 States. An additional investment of $10 million would fund 12–14 new States and enable evidence-based prevention programs to reach many more Americans through innovative delivery approaches. The Arthritis Foundation strongly recommends that Congress invest an additional $10 million (total of $23 million) in the CDC's arthritis program in fiscal year 2011 to expand proven prevention and treatment strategies and fund up to 14 new States.

NIH/National Institute of Arthritis and Musculoskeletal and Skin Diseases (NIAMS)

While new treatment options are available which greatly improve the quality of life for people living with arthritis, the ultimate goal is to find a cure. The Arthritis Foundation firmly believes research holds the key to tomorrow's advances and provides hope for a future free from arthritis pain. As the largest nonprofit contributor to arthritis research, the Arthritis Foundation fills a vital role in the big picture of arthritis research. Our research program complements Government and industry-based arthritis research by focusing on training new investigators and pursuing innovative strategies for preventing, controlling, and curing arthritis. By supporting researchers in the early stages of their careers, the Arthritis Foundation makes important initial discoveries possible that lead to ultimate breakthrough results.

The mission of NIAMS is to support research into the causes, treatment, and prevention of arthritis and musculoskeletal and skin diseases, the training of basic and clinical scientists to carry out this research, and the dissemination of information on research progress in these diseases. Research opportunities at NIAMS are being curtailed due to the stagnating and in some cases declining numbers of new grants being awarded for specific diseases. The training of new investigators has unnecessarily slowed down and contributed to a crisis in the research community where new investigators have begun to leave biomedical research careers in pursuit of other more successful endeavors.

The Arthritis Foundation is dedicated to finding a cure for arthritis. However, the investment in NIH research is absolutely crucial to realize this dream. With continued and increased investment in research, the Arthritis Foundation believes a cure is on the horizon. To support research that will lead to improved treatments and a potential cure for arthritis, the Arthritis Foundation urges Congress to provide $603.8 million, a 12 percent increase, for the NIH/NIAMS.

HRSA

Juvenile arthritis is the leading cause of acquired disability in children and is the sixth most common childhood disease. Sustaining the field of pediatric rheumatology is essential to the care of the almost 300,000 children under the age of 18 living with a form of juvenile arthritis. Children who are diagnosed with juvenile arthritis will live with this chronic and potentially disabling disease for their entire life. Therefore, it is imperative that children are diagnosed quickly and start treatment before significant irreversible joint damage is done. However, it is a challenge to first find a pediatric rheumatologist, as nine States do not have a single one, and then to have a timely appointment as many States have only one or two to see thousands of patients. Pediatric rheumatology is one of the smallest pediatric subspecialties with less than 200 pediatric rheumatologists actively practicing in the United States. A report to Congress in 2007 stated there was a 75 percent shortage of pediatric rheumatologists and recommended loan repayment program to help address the workforce issue.

The recent passage of the Patient Protection and Affordable Care Act authorizes HRSA to commence a loan repayment program for pediatric specialists and authorizes Congress to appropriate $30 million for this program. A percentage of this funding should be allocated for pediatric rheumatology. The Arthritis Foundation strongly recommends funding this program immediately at the $30 million level to help increase the pediatric rheumatology workforce.

The Arthritis Foundation appreciates the opportunity to submit our recommendations to Congress on behalf of the 46 million people with arthritis. The mission of the Arthritis Foundation is the prevention, control, and cure of arthritis. The Arthritis Foundation urges Congress to focus Federal investment through a $23 million

appropriation for arthritis prevention at CDC; a $30 million appropriation to help control juvenile arthritis; and a 12 percent increase toward a cure in arthritis research at the NIH. Each part of the equation-prevention, control, and cure-are an essential part to a future world free of arthritis pain and disability.

PREPARED STATEMENT OF THE AMERICAN HEART ASSOCIATION

Over the past 50 years, significant progress has been made in the battle against cardiovascular disease (CVD) and stroke. The improved diagnosis and treatment has been remarkable—as has the survival rate. According to the National Institutes of Health (NIH), 1.6 million lives have been saved since the 1960s that otherwise would have been lost to CVD. Americans can expect to live on average 4 years longer due to the reduction in heart-related deaths.

However, one startling fact remains. Heart disease and stroke are still respectively the No. 1 and No. 3 killers of men and women in the United States. Nearly 2,300 Americans die of CVD each day—one death every 38 seconds. CVD is a leading cause of disability and will cost our Nation an estimated $503 billion in medical expenses and lost productivity this year.

An estimated 81 million American adults now suffer from heart disease, stroke, and other forms of CVD. Risk factors such as obesity and diabetes are increasing. At the age of 40, lifetime risk for CVD is 2 in 3 for men and more than 1 in 2 for women.

In the face of these staggering statistics, heart disease and stroke research, treatment and prevention programs remain woefully underfunded and overall funding for the NIH is too volatile to have the continuity of effort needed for the major breakthroughs that will redefine diseases, spur prevention and promote best care.

CVD is the No. 1 killer in each State and many preventable and treatable risk factors continue to rise. Yet, the Centers for Disease Control and Prevention (CDC) invests on average only 16 cents per-person a year on heart disease and stroke prevention. Specifically, CDC still provides basic implementation awards to only 14 States for its Heart Disease and Stroke Prevention Program and only 20 States are funded for WISEWOMAN—a heart disease and stroke screening and prevention program proven to be effective in reaching uninsured and under-insured low-income women ages 40 to 64 with a high prevalence of risk factors for these diseases.

Where you live could also affect if you survive a very deadly form of heart disease—sudden cardiac arrest (SCA). Only 10 States received funding in fiscal year 2009 for Health Resources and Services Administration's (HRSA) Rural and Community Access to Emergency Devices Program designed to save lives from sudden cardiac death.

The American Heart Association applauds the Administration and Congress for providing hope to the 1 in 3 adults in the United States who live with the consequences of CVD through the enactment of the American Recovery and Reinvestment Act (ARRA).

The $10 billion in funding for NIH and the $650 million for Communities Putting Prevention to Work Program are wise and prudent investments that have provided a much needed boost to improve our Nation's physical and fiscal health. Yet, these funds denote a one-time infusion of resources. Stable and sustained funding is imperative in fiscal year 2011 to advance heart disease and stroke research, prevention and treatment.

FUNDING RECOMMENDATIONS: INVESTING IN THE HEALTH OF OUR NATION

Heart disease and stroke risk factors continue to rise, yet promising research opportunities to stem this tide go unfunded. Americans still die from CVD, while proven prevention programs and techniques beg for implementation. Clearly, now is the time to capitalize on the momentum achieved under ARRA to enhance research, prevention and treatment of America's No. 1 and most costly killer. If Congress fails to build on this progress, Americans will pay more in the future in lives lost and higher healthcare costs. Our recommendations below address these issues in a comprehensive and fiscally responsible manner.

Capitalize on ARRA Investment for the National Institutes of Health (NIH)

NIH research has revolutionized patient care and holds the key to finding new ways to prevent, treat and even cure CVD, resulting in longer, healthier lives and reduced healthcare costs. NIH invests resources in every State and in 90 percent of congressional districts. Each NIH grant generates on average 7 jobs.

The American Heart Association Advocates.—We advocate for a fiscal year 2011 appropriation of $35.2 billion for NIH—a $4.2 billion increase more than fiscal year

2010, to capitalize on the momentum achieved under the ARRA investment to save lives, advance better health, spur our economy and spark innovation. NIH-supported research prevents and cures disease, generates economic growth and preserves the U.S. role as the world leader in pharmaceuticals and biotechnology.

Enhance Funding for NIH Heart and Stroke Research: A Proven and Wise Investment

Death rates for coronary heart disease fell 36 percent and nearly 34 percent for stroke from 1996–2006. These declines are directly related to NIH heart and stroke research, with scientists on the verge of exciting discoveries that could lead to new treatments and even cures. Landmark NIH research has shown that surgery and stenting are both safe and effective in preventing stroke. It has demonstrated that over-zealous blood pressure lowering and combination lipid drugs do not cut cardiovascular disease in adult diabetics more so than standard evidence-based care; nor does postmenopausal hormone therapy avert heart disease or stroke. And it has defined the genetic basis of risky responses to vital blood-thinners.

In addition to saving lives, NIH-funded research can cut healthcare costs. For example, the original NIH tPA drug trial resulted in a 10-year net $6.47 billion reduction in stroke healthcare costs. The Stroke Prevention in Atrial Fibrillation Trial 1 produced a 10-year net savings of $1.27 billion. But, in the face of such solid returns on investments and other successes, NIH still invests a meager 4 percent of its budget on heart research, and a mere 1 percent on stroke research.

Cardiovascular Disease Research: National Heart, Lung, and Blood Institute (NHLBI)

Despite progress and promising research opportunities, there is no cure yet for CVD. As our population ages, the demand will increase for more and better ways to allow Americans to live healthy and productive lives despite CVD. Stable and sustained funding is needed to allow NHLBI to build on ARRA investments that provided grants to use genetics to identify and treat those at greatest risk from heart disease; hasten drug development to treat high cholesterol and high blood pressure; and create tailored strategies to treat, slow or prevent heart failure. Other important studies include an analysis of whether maintaining a lower blood pressure than currently recommended further reduces risk of heart disease, stroke, and cognitive decline. This information is critically important to ideally manage the burden of heart disease and stroke. Continued needed funding will allow for aggressive implementation of other initiatives in both the NHLBI general and cardiovascular strategic plans.

Stroke Research: National Institute of Neurological Disorders and Stroke (NINDS)

An estimated 795,000 Americans will suffer a stroke this year, and more than 137,000 will die. Many of the 6.4 million survivors face severe physical and mental disabilities, emotional distress and huge costs—a projected $74 billion in medical expenses and lost productivity in 2010.

Stable and sustained funding is required for NINDS to capitalize on ARRA investments to prevent stroke, protect the brain from damage and enhance rehabilitation. This includes: (1) initiatives to determine whether MRI brain imaging can assist in selecting stroke victims who could benefit from the clot busting drug tPA beyond the 3-hour treatment window; (2) assessing chemical compounds that might shield brain cells during a stroke; and (3) advance stroke rehabilitation by studying whether the brain can be helped to "rewire" itself.

Continued needed funding will also allow for assertive implementation of the NINDS Stroke Progress Review Group Report—a long-term, stroke research strategic plan. A variety of research initiatives have been undertaken, but more resources are needed to fully implement the plan. The fiscal year 2010 estimate for NINDS stroke research is less than half of the expected need.

The American Heart Association Advocates: AHA supports an fiscal year 2011 appropriation of $3.514 billion for the NHLBI; and $1.857 billion for the NINDS. These funding levels represent comparable increases to the Association's overall recommended percentage increase for the NIH.

Increase Funding for the Centers for Disease Control and Prevention (CDC)

Prevention is the best way to protect the health of all Americans and reduce the economic burden of heart disease and stroke. However, effective prevention strategies and programs are not being implemented due to insufficient Federal resources. Currently, CDC invests on average only 16 cents per-person each year on heart disease and stroke prevention.

For example, despite the fact that cardiovascular disease remains the No. 1 killer in every State, CDC's Division for Heart Disease and Stroke Prevention still funds

only 14 States to implement programs in healthcare, worksite and community settings to: (1) reduce high blood pressure and elevated cholesterol; (2) improve emergency response and quality care; and (3) end treatment disparities. Another 27 States receive funds for capacity building (planning). However, there are no funds for actual implementation and many of these States have been stalled in the planning phase for years—some for a decade. Nine States receive no prevention resources at all.

This CDC division also administers the WISEWOMAN program that screens uninsured and under-insured low-income women ages 40 to 64 in 20 States for heart disease and stroke risk. They receive counseling, education, referral and follow-up as needed. From 2000 to mid-2008, WISEWOMAN reached more than 84,000 low-income women, provided more than 210,000 lifestyle interventions, and identified 7,647 new cases of high blood pressure, 7,928 new cases of high cholesterol, and 1,140 new cases of diabetes. Among those participants who were re-screened 1 year later, average blood pressure and cholesterol levels had decreased considerably.

The American Heart Association Advocates: AHA joins with the CDC Coalition in support of an appropriation of $8.8 billion for CDC core programs, including increases for the Heart Disease and Stroke Prevention Program and WISEWOMAN. Within the total for CDC, AHA recommends $76.221 million for the Heart Disease and Stroke Prevention Program, allowing CDC to: (1) add the nine unfunded States; (2) elevate more States to basic program implementation; (3) continue to support the remaining funded States; (4) maintain the Paul Coverdell National Acute Stroke Registry; (5) increase the capacity for National, State and local heart disease and stroke surveillance; and (6) provide additional assistance for prevention research and program evaluation. AHA also advocates $37 million to expand WISEWOMAN to additional States and screen more eligible women in funded States. And, we join the Friends of the NCHS in recommending $162 million for the National Center for Health Statistics.

Restore Funding for Rural and Community Access to Emergency Devices (AED) Program

About 92 percent of SCA victims die outside of a hospital. However, prompt CPR and defibrillation, with an automated external defibrillator (AED), can more than double their chances of survival. Communities with comprehensive AED programs have achieved survival rates of about 40 percent. HRSA's Rural and Community AED Program provides grants to States to buy AEDs, train lay rescuers and first responders in their use and place AEDs where SCA is likely to occur. During year one, 6,400 AEDs were bought, and placed and 38,800 people were trained. Due to budget cuts, only 10 States received funds for this life-saving program in fiscal year 2009.

The American Heart Association Advocates: For fiscal year 2011, AHA advocates restoring HRSA's Rural and Community AED Program to its fiscal year 2005 level of $8.927 million.

Increase Funding for the Agency for Healthcare Research and Quality (AHRQ)

AHRQ develops scientific evidence to improve health and healthcare. Through its Effective Health Care Program, AHRQ supports research on outcomes, comparative effectiveness and appropriateness of pharmaceuticals, devices and healthcare services for diseases, such as heart disease, stroke, and high blood pressure. Also, AHRQ's health information technology (HIT) plan is helping bring healthcare into the 21st century through more than $300 million invested in over 200 projects and demonstrations since 2004. AHRQ and its partners identify challenges to HIT adoption and use; develop solutions and best practices; and produce tools that help hospitals and clinicians successfully integrate HIT. This work is a key component to healthcare reform.

The American Heart Association Advocates.—AHA joins Friends of AHRQ in advocating for $611 million for AHRQ to preserve its vital initiatives, boost the research infrastructure, reignite innovation, nurture the next generation of scientists and help reinvent health and healthcare.

Cardiovascular disease continues to inflict a deadly, disabling and costly toll on Americans. But, our recommended funding increases for NIH, CDC, and HRSA outlined above will save lives and cut rising healthcare costs. The American Heart Association urges Congress to seriously consider our recommendations during the fiscal year 2011 appropriations process. They represent a wise investment for our Nation and the health and well-being of this and future generations.

PREPARED STATEMENT OF THE AMERICAN INDIAN HIGHER EDUCATION CONSORTIUM

DEPARTMENT OF EDUCATION PROGRAMS

Higher Education Act Programs

Strengthening Developing Institutions.—Section 316 of Higher Education Act (HEA) title III–A, specifically supports TCUs through two separate grant programs: (a) formula funded development grants, and (b) competitive facilities/construction grants designed to address the critical facilities needs at TCUs. The TCUs request that the subcommittee appropriate $36 million to support these two vital programs.

TRIO Programs.—Retention and support services are vital to achieving the administration's goal of having the highest percentage of college graduates globally by 2020. The President's fiscal year 2011 budget request includes level funding for TRIO programs, which if ultimately enacted, will result in a decrease in the current level of program services. In addition to increasing Pell Grants, it is imperative that Congress bolster TRIO programs such as Student Support Services and Upward Bound so that low-income students are given the support necessary to persist in and, ultimately, complete their postsecondary courses of study. The TCUs support an increase in fiscal year 2011 TRIO programs and technical assistance funding.

Pell Grants.—TCUs urge the subcommittee to fund the Pell Grant program at the highest possible level.

Perkins Career and Technical Education Programs

Section 117 of the Carl D. Perkins Vocational and Technical Education Act provides funding for the operating budgets for the Nation's two tribally controlled vocational institutions: United Tribes Technical College in Bismarck, North Dakota, and Navajo Technical College in Crownpoint, New Mexico. AIHEC requests $10 million for the two tribal colleges that are funded under this section. Additionally, TCUs strongly support the Native American Career and Technical Education Program (NACTEP) authorized under section 116 of the act.

Relevant Title IX Elementary and Secondary Education Act (ESEA) Programs

Adult and Basic Education.—Although Federal funding for tribal adult education was eliminated in fiscal year 1996, TCUs continue to offer much needed adult education, GED, remediation and literacy services for American Indians, yet their efforts cannot meet the demand. The TCUs request that the subcommittee direct $5 million of the Adult Education State Grants appropriated funding to make awards to TCUs to support their ongoing and essential adult and basic education programs.

American Indian Teacher and Administrator Corps.—The American Indian Teacher Corps and the American Indian Administrator Corps offer professional development grants designed to increase the number of American Indian teachers and administrators serving their reservation communities. The TCUs request that the subcommittee support these programs at $10 million and $5 million, respectively.

DEPARTMENT OF HEALTH AND HUMAN SERVICES PROGRAM

Tribal Colleges and Universities Head Start Partnership Program (DHHS–ACF)

TCUs are ideal partners to help achieve the goals of Head Start in Indian country. The TCUs are working to meet the mandate that Head Start teachers earn degrees in Early Childhood Development or a related discipline. The TCUs request that a minimum of $5 million be designated for the TCU-Head Start Partnership program, to ensure the continuation of current programs and the resources needed to expand participation to include additional TCU-Head Start Partnership programs.

BACKGROUND ON TCUS

TCUs are accredited by independent, regional accreditation agencies and like all institutions of higher education, must undergo stringent performance reviews on a periodic basis to retain their accreditation status. In addition to college level programming, TCUs provide essential high school completion (GED), basic remediation, job training, college preparatory courses, and adult education programs. TCUs fulfill additional roles within their respective reservation communities functioning as community centers, libraries, tribal archives, career and business centers, economic development centers, public meeting places, and child and elder care centers. Each TCU is committed to improving the lives of its students through higher education and to moving American Indians toward self-sufficiency.

TCUs, chartered by their respective tribal governments, were established in response to the recognition by tribal leaders that local, culturally based institutions are best suited to help American Indians succeed in higher education. TCUs effec-

tively blend traditional teachings with conventional postsecondary curricula. They have developed innovative ways to address the needs of tribal populations and are overcoming long-standing barriers to success in higher education for American Indians. Since the first TCU was established on the Navajo Nation more than 40 years ago, these vital institutions have come to represent the most significant development in the history of American Indian higher education, providing access to, and promoting achievement among, students who may otherwise never have known postsecondary education success.

JUSTIFICATIONS FOR FISCAL YEAR 2011 APPROPRIATIONS REQUESTS FOR TCUS

Higher Education Act

The Higher Education Act Amendments of 1998 created a separate section (§ 316) within title III–A specifically for the Nation's TCUs. Programs under titles III and V of the act support institutions that enroll large proportions of financially disadvantaged students and that have low per-student expenditures. Tribal colleges, which are truly developing institutions, are providing access to quality higher education opportunities to some of the most rural, impoverished, and historically underserved areas of the country. A clear goal of the HEA title III programs is "to improve the academic quality, institutional management and fiscal stability of eligible institutions, in order to increase their self-sufficiency and strengthen their capacity to make a substantial contribution to the higher education resources of the Nation." The TCU title III program is specifically designed to address the critical, unmet needs of their American Indian students and communities, in order to effectively prepare them to succeed in a global, competitive workforce. The TCUs urge the subcommittee to appropriate $36 million in fiscal year 2011 for HEA title III–A section 316, an increase of $5.8 million more than fiscal year 2010, and to direct the Department to reserve a portion of the funds, as authorized, to award several competitive construction grants. These funds will afford these developing institutions the resources necessary to continue their ongoing grant programs, and address the needs of their historically underserved students and communities, as well as their substandard facilities and infrastructure issues.

Retention and support services are vital to achieving the administration's goal of having the highest percentage of college graduates globally by 2020. The TRIO-Student Support Services program was created out of recognition that college access was not enough to ensure advancement and that multiple factors worked to prevent the successful completion of higher education for many low-income and first-generation students and students with disabilities. Therefore, in addition to increasing Pell Grants, it is critical that Congress also bolster student assistance programs such as Student Support Services so that low-income students have the support necessary to allow them to persist in and, ultimately, complete their postsecondary courses of study.

The importance of Pell Grants to TCU students cannot be overstated. Department of Education figures show that the majority of TCU students receive Pell Grants, primarily because student income levels are so low and our students have far less access to other sources of financial aid than students at State-funded and other mainstream institutions. Within the TCU system, Pell Grants are doing exactly what they were intended to do—they are serving the needs of the lowest-income students by helping them gain access to quality higher education, an essential step toward becoming active, productive members of the workforce. TCUs urge the subcommittee to fund this critical program at the highest possible level.

Carl D. Perkins Career and Technical Education Act

Tribally Controlled Postsecondary Career and Technical Institutions.—Section 117 of the Perkins Act provides operating funds for two of our member institutions: United Tribes Technical College in Bismarck, North Dakota, and Navajo Technical College in Crownpoint, New Mexico. The TCUs urge the subcommittee to appropriate $10 million for section 117 of the act.

Native American Career and Technical Education Program.—The Native American Career and Technical Education Program (NACTEP) under section 116 of the act reserves 1.25 percent of appropriated funding to support Indian vocational programs. The TCUs strongly urge the subcommittee to continue to support NACTEP, which is vital to the continuation of much needed career and technical education programs being offered at TCUs.

Greater Support of Indian Education Programs

American Indian Adult and Basic Education (Office of Vocational and Adult Education).—This program supports adult basic education programs for American Indians offered by State and local education agencies, Indian tribes, agencies, and

TCUs. Despite a lack of funding, TCUs must find a way to continue to provide basic adult education classes for those American Indians that the present K–12 Indian education system has failed. Before many individuals can even begin the course work needed to learn a productive skill, they first must earn a GED or, in some cases, even learn to read. The number of students in need of remedial education before embarking on their degree programs is considerable at TCUs. There is a broad need for basic adult educational programs and TCUs need adequate funding to support these essential activities. TCUs respectfully request that the subcommittee direct $5 million of the funds appropriated for the Adult Education State Grants to make awards to TCUs to help meet the ever increasing demand for basic adult education and remediation program services that exists on their respective reservations.

American Indian Teacher/Administrator Corps (Special Programs for Indian Children).—American Indians are severely underrepresented in the teaching and school administrator ranks nationally. These competitive programs are designed to produce new American Indian teachers and school administrators for schools serving American Indian students. These grants support recruitment, training, and in-service professional development programs for Indians to become effective teachers and school administrators and in doing so become excellent role models for Indian children. We believe that the TCUs are ideal catalysts for these two initiatives because of their current work in this area and the existing articulation agreements they hold with 4-year degree awarding institutions. The TCUs request that the subcommittee support these two programs at $10 million and $5 million, respectively, to increase the number of qualified American Indian teachers and school administrators in Indian country.

DEPARTMENT OF HEALTH AND HUMAN SERVICES/ADMINISTRATION FOR CHILDREN AND FAMILIES/HEAD START

Tribal Colleges and Universities (TCU) Head Start Partnership Program.—The TCU-Head Start Partnership has made a lasting investment in our Indian communities by creating and enhancing associate degree programs in Early Childhood Development and related fields. Graduates of these programs help meet the degree mandate for all Head Start program teachers. More importantly, this program has afforded American Indian children Head Start programs of the highest quality. A clear impediment to the ongoing success of this partnership program is the erratic availability of discretionary funds made available for the TCU-Head Start Partnership. In fiscal year 1999, the first year of the program, some colleges were awarded 3-year grants, others 5-year grants. In fiscal year 2002, no new grants were awarded. In fiscal year 2003, funding for eight new TCU grants was made available, but in fiscal year 2004, only two new awards could be made because of the lack of adequate funds. The TCUs request that the subcommittee direct the Head Start Bureau to designate a minimum of $5 million, of the more than $8.2 billion included in the President's fiscal year 2011 budget request for programs under the Head Start Act, for the TCU-Head Start Partnership program, to ensure that this critical program can be expanded so that all TCUs have the opportunity to participate in the TCU-Head Start Partnership program to benefit their respective tribal communities.

CONCLUSION

TCUs are providing access to higher education opportunities to many thousands of American Indians and essential community services and programs to many more. The modest Federal investment in TCUs has already paid great dividends in terms of employment, education, and economic development, and continuation of this investment makes sound moral and fiscal sense. TCUs need your help if they are to sustain and grow their programs and achieve their missions to serve their students and communities.

Thank you again for this opportunity to present our funding recommendations. We respectfully ask the members of the subcommittee for their continued support of the Nation's TCUs and full consideration of our fiscal year 2011 appropriations needs and recommendations.

PREPARED STATEMENT OF THE AMERICAN INSTITUTE FOR MEDICAL AND BIOLOGICAL ENGINEERING

Mr. Chairman and members of the subcommittee: The American Institute for Medical and Biological Engineering (AIMBE) appreciates the opportunity to submit testimony to advocate for funding for research within the National Institutes of Health (NIH) broadly, and specifically research funding within the National Insti-

tute for Biomedical Imaging and Bioengineering (NIBIB). NIH and NIBIB provide avenues for research funding that are vital to the Nation's efforts to support medical and biological engineering (MBE) innovation. AIMBE represents 50,000 individuals and organizations throughout the United States, including major healthcare companies, academic research institutions and the top 2 percent of engineers, scientists and clinicians whose discoveries and innovations have touched the health of many Americans. While today's testimony focuses on the impact MBE has on improving the health and well being of Americans, it is important to note that MBE can also have a positive impact on many of the other important issues facing us today; ranging from improvements to the environment by finding green-energy solutions, to solving problems relating to hunger, disease prevention, diagnosis and treatment of disease; to economic growth spurred by the innovation of new health products.

AIM BE was founded in 1991 to establish a clear and comprehensive identity for the field of medical and biological engineering—which applies principles of engineering science and practice to imagine, create, and perfect the medical and biological technologies that are used to improve the health and quality of life of Americans and people across the world. AIMBE's vision is to ensure MBE innovations continue to develop for the benefit of humanity.

AIMBE applauds the past support of this subcommittee to provide funding to NIH, and is particularly pleased to see the strong investment in NIH provided by the American Recovery and Reinvestment Act. However, we believe more stable, adequate and reliable funding is necessary to ultimately ensure America remains competitive and continues to develop innovations that improve human health. We therefore support NIBIB at the level of $332.4 million for fiscal year 2011. This increase in funding will support important work which is highly translatable or applicable research into products that are life-saving, and life enhancing. NIBIB is the only Institute at the NIH with the specific purpose of supporting and conducting biomedical engineering research, which impacts all sectors of health across many disease states. Research conducted within NIBIB is on the cutting edge of biomedical engineering research and has the potential to save lives and reduce healthcare costs.

While each Institute within the NIH plays a vital role researching and identifying disease prevention and treatment positively impacting patient outcomes; the NIBIB plays a unique role and has not benefited from large-scale NIH funding increases, such as the doubling of the budget in 2004. First appropriated with its own funding in 2004 (fiscal year 2003 and fiscal year 2004 were funded through transfers from other Institutes within NIH), the mission of NIBIB is to improve health by leading the development and accelerating the application of biomedical technologies. The NIBIB is committed to integrating the physical and engineering sciences with the life sciences to advance basic research and medical care. This is achieved through research and development of new biomedical imaging and bioengineering techniques and devices to fundamentally improve the detection, treatment, and prevention of disease; enhancing existing imaging and bioengineering modalities; supporting related research in the physical and mathematical sciences; encouraging research and development in multidisciplinary areas; supporting studies to assess the effectiveness and outcomes of new biologics, materials, processes, devices, and procedures; developing nonimaging technologies for early disease detection and assessment of health status; and developing advanced imaging and engineering techniques for conducting biomedical research at multiple scales through modeling and simulation. Finally, the NIBIB plays an important role in providing engineering research resources to the entirety of the NIH. As the only engineering research arm within the NIH, NIBIB is often relied upon to partner with other institutes at the NIH to provide engineering expertise. The Laboratory of Molecular Imaging and Nanomedicine, and Laboratory of Bioengineering and Physical Science are two examples of NIBIB's role as a partner for researchers working at other Institutes at the NIH.

We strongly recommend that early-stage, proof-of-concept projects for translational research be funded at an enhanced level, ideally 0.5 percent of all external research budgets, at all Institutes. This is critical to maintaining the U.S. lead in innovation by moving new discoveries and novel systems to the stage where third-party private funding can take them through development to the marketplace where they help patients and health of Americans. Publicly held companies cannot invest in this stage of work due to stockholder pressures, so that the Federal Government is critical to ensuring the viability of this innovation pipeline.

NIBIB as a Stimulus for Innovation/Cost Effectiveness

The fiscal year 2010 NIBIB Budget submission is $316.6 million, a 2.7 percent increase from the fiscal year 2009 appropriation, and is 37 percent lower than the original 5-year congressional authorization for NIBIB funding of $504 million. As

the economy worsens, private industry and private investors are less likely to invest in high-risk research, potentially slowing the pace of innovation. By funding bioengineering research, NIBIB fills a void by providing funding for high-risk, high-reward research that leads to the development of new technologies. Often times, private investors in biomedical innovation are unwilling to invest in this type of research, because of the risks involved. However, NIBIB can be a mechanism to bring new technologies to market and fills the void left by a lack of private capital.

The NIBIB's Quantum Grants program, for example, challenges the research community to propose projects that have a highly focused, collaborative, and interdisciplinary approach to solve a major medical problem or to resolve a highly prevalent technology-based medical challenge. The program consists of a 3-year exploratory phase to assess feasibility and identify best approaches, followed by a second phase of 5 to 7 years. Major advances in medicine leading to quantifiable improvements in public health require the kind of funding commitment and intellectual focus found in the Quantum Grants program at NIBIB, because early stage investors are reluctant to invest in high-risk research. That said, the Quantum Grants offer a place for Government to invest in translational research, potentially solving huge medical problems facing Americans today.

The five currently funded Quantum Grants focus on: stem cell therapies for patients suffering from the effects of diabetes and stroke; the utilization of nanoparticles to help visualize brain tumors so that surgeons can easily see and remove the cancerous mass in the patient's brain; the development of an implantable artificial kidney offering an improved quality of life for patients currently undergoing dialysis treatment; and a microchip to capture circulating tumor cells for clinicians to diagnose cancer earlier than ever before, giving patients a greater hope for recovery thanks to earlier detection and treatment. All these projects, in their early stages of funding, have demonstrated promise for improving patient outcomes in the laboratory setting.

An increase of funding to NIBIB and the Quantum Grants program may offer opportunities to expedite research beyond laboratory study and move to clinical trial. For example, if this research is developed and put on the market, the cost reduction to a person with kidney disease would radically decrease because it would eliminate the need for dialysis, which is a costly and resource heavy procedure typically done in an out-patient hospital setting.

The Fundamental Role of Engineering Research

Advances in the process of engineering research, in a variety of fields, are a part of technological innovation. Medical and biological engineering draws from research specialties across disciplines (including mechanical, electrical, material, medical and biological engineering, and clinicians), bringing together teams to create unique solutions to the most pressing health problems. Engineering is the practical application of science and math to solve problems. For example, the insulin pump, which is the primary device used by patients with diabetes who requires continuous insulin infusion therapy, is the result of multi-disciplinary effort by engineers to develop a more efficient way to manage diabetes. The science to develop and perfect an insulin pump existed well before the creation of the medical device; however it took biomedical engineers to apply the basic science toward product development.

The first insulin pump to be manufactured was released in the late 1970s. It was known as the "big blue brick" because of its size and appearance. It sparked interest among healthcare professionals who saw it as a device that would render syringes obsolete for people who have daily insulin injection needs. While the technology was promising, the first commercial pump lacked the controls and interface to make it a safe alternative to manual injections. Dosage was inaccurate thus making the device more of a danger than a solution.

It was only in the beginning of the 1990's that biomedical engineers began to develop more user-friendly models that could be used by diabetics. Advances in biomedical engineering research focused on reducing device size, increasing energy efficiency (and thus improving battery life), and improving reliability were of great benefit to insulin pump manufacturers who were able to make their models smaller, more affordable, and easier for patients to use. Insulin pumps enable many diabetic patients to live productive lives due to fewer absences from work and reduced hospitalizations.

A similar advancement in the treatment of atherolosclerosis through MBE is the use of angioplasty with an arterial stent which releases drugs directly to the coronary artery (referred to as a drug eluting stent). This advancement has replaced more then 500,000 bypass surgeries a year, at an annual cost savings of $4 billion, and an immeasurable improvement in the quality of life of patients receiving this treatment.

Engineering research in human physiology, specifically in range of motion and function, has increased the function for artificial limbs. The decreasing mortality and increasing number of disabled war veterans highlights the need for more highly functional prosthetics. Engineering research and development processes have taken the strapped wooden leg to a realistic synergic leg and foot transtibial prosthetic that employs advanced biomechanics and microelectronic controls to allow a fuller range of motion, including running. Basic engineering research in polymers and materials science has changed the look and feel of prosthetic limbs so they are no longer easily discernable, reducing the stigma, and making them more durable, lessening the cost of maintenance and replacement. Researchers in Baltimore, Cleveland and Chicago are developing the next generation of prosthetic limbs, utilizing cutting edge biomedical engineering research to develop prosthesis that are more sensitive, more responsive, and more lifelike then anything developed in the past. These new "bionic limbs" are giving patients pieces of their body back, pieces taken from them through traumatic injury or disease. Increases in funding to NIBIB, who uniquely partners with other Federal agencies such as the Department of Veterans Affairs and Department of Defense, may lead to biomedical engineering innovations to improve the quality of life of warfighters injured on the battlefield as well as civilians.

The engineering research process has played a large part in extending and deploying innovative imaging technologies such as magnetic resonance imaging (MRI) and ultra-fast computerized tomography (CT scan). These technologies facilitate early detection of disease and dysfunction, allowing for earlier treatment and slowing the progression of disease. When prescribed correctly these technologies can reduce the costs of healthcare by diagnosing diseases earlier, allowing for earlier clinical intervention and reduced hospitalizations with faster recovery times.

The Nation deserves to obtain a strong return on its investment in the basic medical research funded by NIH. Additional engineering research, including translation of basic research into new devices and more efficient medical procedures, is a critical part of ensuring that return. This combination of basic scientific studies and engineering research, will in turn, lead to many technological innovations which will improve the quality of life and well being of Americans. Industry will supply developmental engineering research; however, they usually do not support the fundamental level of engineering research done at NIH and NIBIB due to the high risks to their returning investments. The government needs to continue to fund the vital research at NIH and NIBIB to continue to be a leader in healthcare innovation, and for the creation of jobs in the healthcare segment of our national economy.

AIMBE looks forward to the opportunity to continue this dialogue with all of you individually. Thank you again for your time, and consideration on this important matter.

PREPARED STATEMENT OF THE ASSOCIATION OF INDEPENDENT RESEARCH INSTITUTES

The Association of Independent Research Institutes (AIRI) respectfully submits this written testimony for the record to the Senate Appropriations Subcommittee on Labor, Health and Human Services, and Education, and Related Agencies. AIRI appreciates the commitment that the members of this subcommittee have made to biomedical research through your strong support for the National Institutes of Health (NIH), and recommends that you maintain this support for NIH in fiscal year 2011 by providing the agency with a total discretionary budget of at least $32.239 billion as requested by President Obama. This would be a 3.2 percent increase more than the fiscal year 2010 enacted level.

AIRI is a national organization of 91 independent, nonprofit research institutes that perform basic and clinical research in the biological and behavioral sciences. AIRI institutes vary in size, with budgets ranging from a few million to hundreds of millions of dollars. In addition, each AIRI member institution is governed by its own independent Board of Directors, which allows our members to focus on discovery based research while remaining structurally nimble and capable of adjusting their research programs to emerging areas of inquiry. Researchers at independent research institutes consistently exceed the success rates of the overall NIH grantee pool, and receive about 10 percent of NIH's peer reviewed, competitively awarded extramural grants. On average, AIRI member institutes receive a total of $1.6 billion in extramural grants from NIH in any given year.

Through passage of the American Recovery and Reinvestment Act (ARRA) and recent year appropriations bills, Congress has taken important steps to jump start the Nation's economy through investments in science. Simultaneously, Congress is advancing and accelerating the biomedical research agenda in this country by focusing

on scientific opportunities to address public health challenges. NIH now has the ability to fund a record number of research grants, with special emphasis on groundbreaking projects in areas that show the greatest potential for improving health, including genetic medicine, clinical research, and health disparities. In addition, NIH is also funding construction projects and providing support for equipment and instrumentation, which is critically needed to update aging research facilities. We urge NIH to continue its commitment to facility, equipment, and infrastructure support. The infrastructure that we are creating needs to be maintained. Large fluctuations in funding will be disruptive to training, to careers, to long range projects and ultimately to progress. The research engine needs a predictable, sustained investment in science to maximize our return.

NIH is responding to its charge of stimulating the economy through job creation by supporting new scientists. ARRA investments allowed us to see firsthand how research is impacting the economy. We cannot stop the momentum created by these historic investments. We need to be able to continue to advance the new directions charted with the ARRA support in 2011 and beyond.

Keeping up with the rising cost of medical research in the fiscal year 2011 appropriations will help NIH begin to prepare for the "post-stimulus" era. In 2011 and beyond we need to make sure that the total funding available to NIH does not decline and that we can resume a steady, sustainable growth that will enable us to complete the President's vision of doubling our investment in basic research, which is why we are respectfully urging this subcommittee to increase funding for NIH in fiscal year 2011 by at least 3.2 percent.

AIRI'S COMMITMENT

Pursuing New Knowledge.—The United States model for conducting biomedical research, which involves supporting scientists at universities, medical centers, and independent research institutes, provides an effective approach to making fundamental discoveries in the laboratory and translating them into medical advances that save lives. AIRI member institutes are private, stand-alone research centers that set their sights on the vast frontiers of medical science, specifically focused on pursuing knowledge about the biology and behavior of living systems and to apply that knowledge to extend healthy life and reduce the burdens of illness and disability.

—*High Throughput Technologies*.—AIRI Institutes have embraced technologies and research centers to collaborate on biological research for all diseases. Using advanced technology platforms or "cores," AIRI institutes use genomics, imaging, and other broad-based technologies for drug discovery.

—*Translational Research*.—Translational sciences bridges the divide between basic biomedical research and implementation in a clinical setting. Currently, more than 15 AIRI member institutes are affiliated with and collaborate with the Clinical and Translational Science Awards (CTSA) Program. Many AIRI institutes also support research on human embryonic stem cells (hESC) with the hope of discovering new and innovative disease interventions.

—*Using Science to Enable Health Care Reform*.—As basic biomedical research institutes, AIRI members collaborate with other research partners on patient-centered outcomes research. AIRI members act as the basic research arm for disease treatment (for example, by supporting genetic testing), while other project collaborators study other aspects of disease intervention in an effort to learn the best practices for preventing and treating disease.

—*Global Health*.—AIRI member institutes focus on a wide range of diseases, many of which have a global affect on human health. Besides supporting research for the treatments, vaccines, and cures of the world's deadliest diseases, a number of AIRI institutes partner with research institutions in the developing world to support international disease research, such as collaborations on HIV/AIDS, Tuberculosis, and Malaria.

—*Reinvigorating the Biomedical Research Community*.—AIRI supports policies that promote the United States' ability to maintain a competitive edge in biomedical science. The biomedical research community is dependent upon a knowledgeable, skilled, and diverse workforce to address current and future critical health research questions. The cultivation and preservation of this workforce is dependent upon the ability to recruit scientists and students globally as well as training programs in basic and clinical biomedical research. Initiatives focusing on career development and recruiting a diverse scientific workforce are important to innovation in biomedical research for the benefit of public health.

Providing Efficiency and Flexibility.—AIRI member institutes' small size and valuable flexibility provide an environment that is particularly conducive to creativity and innovation. In addition, independent research institutes possess a unique versatility/culture that encourages them to share expertise, information, and equipment across their institutes and elsewhere, which helps to minimize bureaucracy and increase efficiency when compared to larger degree granting academic universities.

Supporting Young Researchers.—While the primary function of AIRI institutes is research, most are strongly involved in training the next generation of biomedical researchers and ensuring that a pipeline of promising researchers are prepared to make significant and potentially transformative discoveries in a variety of areas.

AIRI would like to thank the subcommittee for its important work to ensure the health of the Nation, and we appreciate this opportunity to present funding recommendations concerning NIH in the fiscal year 2011 appropriations bill. AIRI looks forward to working with Congress to carry out the research that will lead to improving the health and quality of life for all Americans.

PREPARED STATEMENT OF THE AMERICAN LUNG ASSOCIATION

SUMMARY OF PROGRAMS

Centers for Disease Control and Prevention (CDC)

Increased overall CDC funding—$8.8 billion
—Funding CDC COPD Program—$3 million
—Funding Healthy Communities—$52.8 million
—Office on Smoking and Health—$280 million
—Asthma programs—$70 million
—Environment and Health Outcome Tracking—$50 million
—Tuberculosis programs—$220.5 million
—CDC Influenza preparedness—$159.1 million
—NIOSH—$364.3 million

National Institutes of Health (NIH)

Increased overall NIH funding—$35 billion
—National Heart, Lung and Blood Institute—$3.514 billion
—National Cancer Institute—$5.725 billion
—National Institute of Allergy and Infectious Diseases—$5.395 billion
—National Institute of Environmental Health Sciences—$779.4 million
—National Institute of Nursing Research—$163 million
—National Center on Minority Health & Health Disparities—$236.9 million
—Fogarty International Center—$78.4 million

The American Lung Association is pleased to present our recommendations to the Labor, Health and Human Services, and Education, and Related Agencies Appropriations Subcommittee. The public health and research programs funded by this subcommittee will prevent lung disease and improve and extend the lives of millions of Americans who suffer from lung disease.

The American Lung Association is the oldest voluntary health organization in the United States, with national offices and local associations around the country. Founded in 1904 to fight tuberculosis, the American Lung Association today fights lung disease in all its forms through research, advocacy and education.

A SUSTAINED AND SUSTAINABLE INVESTMENT

We thank the chairman and the subcommittee for your leadership in healthcare reform and the priority paid to prevention and wellness. The investments this committee makes can and will pay near-term and long-term dividends for the health of the American people.

Specifically, we want to highlight the need for the American Recovery and Reinvestment (ARRA) funds to be incorporated into base funding levels in order to sustain these critical investments, particularly for the Center for Disease Control and Prevention's public health programs. These investments in prevention and wellness are crucial to ensuring a healthier population and a reduction in healthcare costs. Chronic disease is a huge driver of cost and human suffering and incorporating the ARRA funds into the baseline will allow sustained investments in proven interventions like smoking cessation.

The United States must also maintain its renewed commitment to medical research. While our focus is on lung disease research, we strongly support increasing the investment in research across the entire National Institutes of Health.

LUNG DISEASE

Each year, almost 400,000 Americans die of lung disease. It is responsible for 1 in every 6 deaths. More than 35 million Americans suffer from a chronic lung disease. Each year lung disease costs the economy an estimated $173 billion. Lung diseases include: lung cancer, asthma, chronic obstructive pulmonary disease (COPD), tuberculosis, pneumonia, influenza, sleep disordered breathing, pediatric lung disorders, occupational lung disease and sarcoidosis.

IMPROVING PUBLIC HEALTH

The American Lung Association strongly supports investments in the public health infrastructure. In order for the CDC to carry out its prevention mission, and to assure an adequate translation of new research into effective State and local programs to improve the health of all Americans, we strongly support increasing the overall CDC funding to $8.8 billion.

We strongly encourage improved disease surveillance and health tracking to better understand diseases like asthma. We support an appropriations level of $50 million for the Environment and Health Outcome Tracking Network to allow Federal, State, and local agencies to track potential relationships between hazards in the environment and chronic disease rates.

We strongly support investments in communities to bring together key stakeholders to identify and improve policies and environmental factors influencing health in order to reduce the burden of chronic diseases. These programs lead to a wide range of improved health outcomes including reduced tobacco use. We strongly recommend at least $52.8 million in funding for the Healthy Communities program to expand its reach to more communities.

CHRONIC OBSTRUCTIVE PULMONARY DISEASE

Chronic Obstructive Pulmonary Disease, or COPD, is the fourth leading cause of death both in the United States and worldwide. Yet, it remains relatively unknown to most Americans. COPD refers to a group of largely preventable diseases, including emphysema and chronic bronchitis that gradually limit the flow of air in the body. It has been estimated that 12.1 million patients have been diagnosed with some form of COPD and as many as 24 million adults may suffer from its consequences. In 2006, 120,970 people in the United States died of COPD. The annual cost to the nation for COPD in 2010 is projected to be $49.9 billion. Medicare expenses for COPD beneficiaries were nearly 2.5 times that of the expenditures for all other patients.

Despite the enormity of this problem, COPD receives far too little attention at CDC or in health departments across the Nation. The American Lung Association strongly supports the establishment of a national COPD program within CDC's National Center for Chronic Disease Prevention and Health Promotion with a specific line item of $3 million for fiscal year 2011 to create a comprehensive national action plan for combating COPD. Creating this plan will address the public health role in prevention, treatment and management of this disease.

Today, COPD is treatable but not curable. Despite promising research leads, the American Lung Association believes that research resources committed to COPD are not commensurate with the impact COPD has on the United States and the world. The American Lung Association strongly recommends that the NIH and other Federal research programs commit additional resources to COPD research programs. We strongly support funding the National Heart, Lung and Blood Institute and its lifesaving lung disease research program at $3.514 billion.

TOBACCO USE

Tobacco use is the leading preventable cause of death in the United States, killing more than 443,000 people every year. Smoking is responsible for 1 in 5 U.S. deaths. The direct healthcare and lost productivity costs of tobacco-caused disease and disability are also staggering, an estimated $193 billion each year.

Given the magnitude of the tobacco-caused disease burden and how much of it can be prevented; the CDC Office on Smoking and Health should be much larger and better funded. This neglect cannot continue if the nation wants to prevent disease and promote wellness. Public health interventions have been scientifically proven to reduce tobacco use.

In light of new funds available from the Patient Protection and Affordable Care Act and the subcommittee's fiscal year 2010 request to OSH for a 5-year plan to significantly reduce tobacco use in the United States, the American Lung Associa-

tion urges that a minimum of $280 million be appropriated to CDC's Office on Smoking and Health for fiscal year 2011.

LUNG CANCER

An estimated 364,996 Americans are living with lung cancer. During 2009, an estimated 219,440 new cases of lung cancer were diagnosed, and 158,664 Americans died from lung cancer in 2006. Survival rates for lung cancer tend to be much lower than those of most other cancers and significant health disparities exist in the incidence and treatment of this disease.

Lung cancer receives far too little attention and focus. Given the magnitude of lung cancer and the enormity of the death toll, the American Lung Association strongly recommends that the NIH and other Federal research programs commit additional resources to lung cancer. We support a funding level of $5.725 billion for National Cancer Institute and urge more attention and focus on lung cancer.

ASTHMA

Asthma is a chronic lung disease in which the bronchial tubes become swollen and narrowed, preventing air from getting into or out of the lung. Approximately 23.3 million Americans currently have asthma, of which 12.7 million had an asthma attack in 2008. Asthma is expensive and incurs an estimated annual economic cost of $20.7 billion to our Nation. Asthma is the third leading cause of hospitalization among children under the age of 15. It is also one of the leading causes of school absences. The Federal response to asthma has three components: research, programs and planning.

We recommend that the National Heart, Lung and Blood Institute receive $3.514 billion and the National Institute of Allergy and Infectious Diseases be appropriated $5.395 billion, and that both agencies continue their investments in asthma research in pursuit of treatments and cures.

The American Lung Association also recommends that CDC be provided $70 million in fiscal year 2011 to expand its asthma programs.

INFLUENZA

Influenza is a highly contagious viral infection and one of the most severe illnesses of the winter season. It is responsible for an average of 226,000 hospitalizations and 36,000 deaths each year. Further, the emerging threat of a pandemic influenza is looming as the recently emerging strain of H1N1 reminded us. The American Lung Association supports funding the Federal CDC Influenza efforts at $156 million. We also support investments in influenza totaling $45 million for the Food and Drug Administration (FDA), $35 billion for the National Institutes of Health (NIH), and $66 million for the Office of the Secretary, as proposed in the President's budget.

TUBERCULOSIS

Tuberculosis primarily affects the lungs but can also affect other parts of the body. There are an estimated 10 million to 15 million Americans who carry latent TB infection. Each has the potential to develop active TB in the future. In 2008, there were 12,904 cases of active TB reported in the United States. While declining overall TB rates are good news, the emergence and spread of multi-drug resistant TB pose a significant threat to the public health of our Nation. Continued support is needed if the United States. is going to continue progress toward the elimination of TB. We request that Congress increase funding for tuberculosis programs at CDC to $220.5 million.

CONCLUSION

Mr. Chairman, lung disease is a continuing, growing problem in the United States. It is America's number three killer, responsible for 1 in 6 deaths. Progress against lung disease is not keeping pace with other major causes of death and more must be done. The level of support this subcommittee approves for lung disease programs should reflect the urgency illustrated by these numbers.

PREPARED STATEMENT OF THE AMERICAN LIVER FOUNDATION

Mr. Chairman and members of the subcommittee, thank you for giving the American Liver Foundation the opportunity to provide testimony as the subcommittee begins to consider funding priorities for fiscal year 2011. My name is Dr. Allan Wolkoff

and I am the Chairman of the Board of Directors of the American Liver Foundation (ALF), a national voluntary health organization dedicated to the prevention, treatment and cure of hepatitis and other liver diseases through research, education and advocacy. I am also a Professor of Medicine and Chief of the Division of Hepatology at the Albert Einstein College of Medicine.

ALF has a nationwide network of divisions and provides information to 300,000 patients and families. More than 70,000 physicians, including primary care practitioners and liver specialists and scientists also receive information from ALF. The ALF Board of Directors is composed of scientists, clinicians, patients and others who are directly affected by liver diseases. Every year ALF handles more than 100,000 requests for information, helping patients and their families understand their illnesses, informing them about available services, and showing them that there are knowledgeable and concerned individuals to assist them in every possible way.

Mr. Chairman, ALF joins the Ad Hoc Group for Medical Research Funding, a coalition of some 300 patient and voluntary health groups, medical and scientific societies, academic research organizations and industry, in recommending $35 billion in funding for the National Institutes of Health in fiscal year 2011. While the ALF recognizes the demands on our Nation's resources, we believe the ever-increasing health threats and expanding scientific opportunities continue to justify increased funding levels for the National Institutes of Health (NIH). To ensure that NIH's momentum is not further eroded, and to ensure the fight against diseases and disabilities that affect millions of Americans can continue, ALF supports $35 billion for the NIH in fiscal year 2011 and a minimum increase of 12 percent ($235 million) for the National Institute for Diabetes and Digestive and Kidney Diseases and for liver disease research across all NIH Institutes.

In addition to the NIH, there are a number of programs within the jurisdiction of the subcommittee that are important to ALF including the Centers for Disease Control's Division of Viral Hepatitis and the Health Resources Services Administration. Mr. Chairman, our specific recommendations for these and other areas of interest are summarized in a table at the end of this statement.

RECOGNIZING THE LEADERSHIP OF THE SUBCOMMITTEE

Mr. Chairman, ALF appreciates your leadership and the leadership of this Subcommittee in supporting NIH in a time of fiscal austerity. Your leadership in supporting CDC and HRSA are also greatly recognized and appreciated. These programs are important to our shared goals of improving the public health response to the threats of hepatitis and liver disease and to increasing the rate of organ donation. We applaud the subcommittee's leadership in making progress in these important areas and to allocating increased funding to these programs during periods of fiscal austerity.

A NATIONAL STRATEGY FOR PREVENTION AND CONTROL OF HEPATITIS B AND C.

The ALF is very pleased that the Office of the Secretary has convened and established an inter-departmental task-force to address the public health challenge of viral hepatitis. This is an important step for the Department to take to develop a comprehensive response to the challenge of hepatitis. In January 2010, the Institute of Medicine released a groundbreaking report titled "Hepatitis and Liver Cancer: A National Strategy for Prevention and Control of Hepatitis B and C" documenting the problem and highlighting a course of action to address it. ALF urges its review and consideration by the Task Force. ALF also urges the Committee to request an update from the Task Force of their recommendations and actions and further urges the Committee to review and address the chronic underfunding of viral hepatitis prevention programs within the Department, including the National Institutes of Health and the CDC's Division of Viral Hepatitis.

THE NATIONAL INSTITUTES OF HEALTH AND THE LIVER DISEASE RESEARCH ACTION PLAN

We depend upon the NIH to fund research that will lead to new and more effective interventions to treat people with liver diseases. The American Liver Foundation joins with the Ad Hoc Group for Biomedical Research and requests a funding level of $35 billion for the NIH in fiscal year 2011.

We thank the subcommittee for their continued investment in NIH in fiscal year 2010. Sustaining progress in medical research is essential to the twin national priorities of smarter healthcare and economic revitalization. With additional investment, the nation can seize the unique opportunity to build on the tremendous momentum emerging from the strategic investment in NIH made through the 2009 American Recovery and Reinvestment Act (ARRA). NIH invested those funds in a range of po-

tentially revolutionary new avenues of research that will lead to new early screenings and new treatments for disease.

In fiscal year 2009, NIH spent approximately $651 million on liver disease research overall (ARRA and non-ARRA funds), and estimates that in fiscal year 2010 $635 million will be spent. This includes research for viral hepatitis, liver cancer, and a host of other liver diseases. An additional $235 million (12 percent increase) for the National Institute of Diabetes and Digestive and Kidney Diseases, the Institute with lead on liver disease research, could make transformational advances in research leading to better treatments for people with liver disease. The ALF recommends that in fiscal year 2011 the National Institute of Diabetes and Digestive and Kidney Diseases be funded at $2,192,247,000 and that overall NIH funding total $35 billion.

Mr. Chairman, in December of 2004, the NIDDK released the Liver Disease Research Action Plan outlining major research goals for the various aspects of liver disease. Working with the leading scientific experts in the field, the plan is organized into 16 chapters and identifies numerous areas of research important to virtually every aspect of liver disease, including: improving the success rate of therapy of hepatitis C; developing noninvasive ways to measure liver fibrosis; developing sensitive and specific means of screening individuals at high risk for early hepatocellular carcinoma; developing standardized and objective diagnostic criteria for major liver diseases and their grading and staging; and decreasing the mortality rate from liver disease. Each year, the plan is reviewed and updated. The ALF urges the Committee to provide adequate funding and policy guidance to NIH to urge continued implementation of the plan.

CDC'S DIVISION OF VIRAL HEPATITIS

The Division of Viral Hepatitis (DVH) is included in the National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention at the CDC, and is responsible for the prevention and control of viral hepatitis, a disease which impacts more than 6 million Americans and often leads to liver cancer and liver failure. The DVH provides the scientific and programmatic foundation for the prevention, control and elimination of hepatitis virus infections in the United States and also assists the international public health community in these activities. DVH works with State and local health departments to provide the guidance and technical expertise needed to integrate hepatitis prevention services such as hepatitis A and B vaccine, hepatitis B and C counseling, and testing and referral to existing public health programs serving individuals at high risk.

DVH is currently funded at $19.3 million, $6 million less than its funding level in fiscal year 2003, which does not allow for the provision of core prevention services. The ALF joins the hepatitis community and urges a fiscal year 2011 funding level for the Division of Viral Hepatitis of $50 million.

INCREASING THE SUPPLY OF ORGANS FOR DONATION

As the subcommittee knows, even with advances in the use of living liver donors, the increase in the demand for livers needed for transplantation will continue to exceed the number available. The need to increase the rate of organ donation is critical. On April 9, 2010 there were 106,917 men, women and children on the national transplantation waiting list. Last year an average of 80 patients were transplanted each day; however a daily average of 18 patients died because the organ they needed did not become available in time to save them. The shortage of organs for donation can be positively impacted by healthcare professionals, particularly physicians, nurse, and physician assistants that are frequently the first to identify and refer a potential donor. These professionals also have an established relationship with the family members that weigh the option to donate their loved one's organs. In order to improve the knowledge and skills of the several key health professions, ALF requests funding to develop curriculum and continuing medical education programs for targeted health professions. To launch a new five year effort to improve the competency of health professionals to help meet the goal of increasing the number or organs available for transplantation $450,000 is requested for the United Network for Organ Sharing (UNOS) to be made available from within the Division of Health Professions set aside authority for technical assistance.

SUMMARY AND CONCLUSION

Mr. Chairman, again we wish to thank the subcommittee for its past leadership. Significant progress has been made in developing better treatments and cures for the diseases that affects mankind due to your leadership and the leadership of your colleagues on this subcommittee. Significant progress has also similarly been made

in the fight against liver disease. For fiscal year 2011 we recommend a 12 percent, increase for NIH above the level of the fiscal year 2010 funding levels, with the level of liver disease research also increased by at least 12 percent. We also urge a $50 million for the CDC's Division of Viral Hepatitis to strengthen the public health response to hepatitis and liver disease and a $2 million increase to HRSA's Division of Transplantation, as well as $450,000 for the Division of Health Professions to increase the rate of organ donation. Mr. Chairman, if this country is to maintain its leadership role in health maintenance, disease prevention, and the curing of diseases, adequate funding for NIH, CDC and HRSA is paramount. The ALF appreciates the opportunity to provide testimony to you on behalf of our constituents and yours.

ALF RECOMMENDATIONS FOR FISCAL YEAR 2010 FUNDING

NIH and the Liver Disease Research Action Plan: $35 billion for NIH overall and 12 percent increase for the National Institute of Diabetes and Digestive and Kidney Diseases; and +$25 million to implement the Liver Research Action Plan.

CDC: National Hepatitis C Prevention Strategy, Public Health Information, HAV & HBV Vaccinations: Fund the CDC's Division of Viral Hepatitis at $50 million to strengthen the public health response to chronic viral hepatitis.

HRSA: Expanding the supply or organs: +$450,000 for an organ donation curriculum development initiative at HRSA's Division of Health Professions.

LETTER FROM THE AMERICAN MOSQUITO CONTROL ASSOCIATION

APRIL 12, 2010.

Hon. TOM HARKIN,
Chairman, Labor, Health and Human Services, Education, and Related Agencies Subcommittee, Washington, DC.

DEAR CHAIRMAN HARKIN: On behalf of the American Mosquito Control Association, I am writing to ask your assistance in maintaining $26.7 million in funding for controlling vector-borne diseases including West Nile Virus (WNV) under the fiscal year 2011 Labor, Health and Human Services, and Education, and Related Agencies appropriations bill.

The American Mosquito Control Association represents an international association of individuals and organizations interested in mosquito and other vector control. Our mission is to provide leadership, information, and education leading to the enhancement of public health and quality of life through the suppression of mosquitoes and other vectors.

Since 1999, there have been more than 29,000 documented cases of WNV in the United States.

Almost 12,000 of those cases have involved West Nile Neuroinvasive Disease, the most severe form. It is estimated that 1.65 million people in the United States have been infected with and 1,122 people have died from WNV since 1999. It is believed that WNV will continue to intermittently produce local or regional epidemics resulting in thousands of human cases.

Since 2000, appropriated funds have been provided to the Centers for Disease Control and Prevention for distribution to States to assist them in developing and sustaining public health infrastructure to reduce risk of WNV. These funds are used for surveillance and monitoring of mosquito populations and the presence of WNV, for virus testing, and for applied research. Many State public health agencies and State, county, or municipal mosquito control programs depend upon these funds to contend with WNV, and have also utilized this support to develop capacity to deal with exotic diseases transmitted by insects that may be introduced into the country.

However, the President's budget recommendation for fiscal year 2011 eliminates all of the current $26.7 million of this funding. Given the virulence of WNV, coupled with the fiscal strain already put on States due to various economic factors, we respectfully request that the Labor, Health and Human Services, and Education, and Related Agencies Appropriations Subcommittee resist elimination of any of this funding for fiscal year 2011. Any savings provided by eliminating this essential funding will be insignificant compared to the losses suffered if the mosquito vector populations that spread WNV are not adequately suppressed.

Thank you for your consideration of this urgent public health matter.

Sincerely,

DAVID BROWN,
Chairman.

PREPARED STATEMENT OF THE ASSOCIATION OF MATERNAL AND CHILD HEALTH PROGRAMS

Chairman Harkin and distinguished subcommittee members: I am grateful for this opportunity to submit written testimony on behalf of the Association of Maternal and Child Health Programs (AMCHP), our members, and the millions of women and children that are served by the Title V Maternal and Child Health Services Block Grant. My name is Dr. Phyllis Sloyer and I am the current President of AMCHP, as well a Division Director at the Florida Department of Health. I am asking the subcommittee to support an increase in funding for the Title V Maternal and Child Health Services Block Grant to $730 million for Federal fiscal year 2011.

To help illustrate the importance of Title V MCH Block Grant funding, I want to begin by sharing the story of a girl from Iowa who was helped by title V-supported services:

—Cora is a girl who was born 34 weeks prematurely. She was first seen at a Child Health Specialty Clinic when she was only 3 weeks of age. While at the clinic, she was diagnosed with plagiocephaly—sometimes referred to a "flat head syndrome." This problem occurs when a portion of an infant's skull becomes flattened due to pressure from outside forces and is not uncommon in premature infants. Workers at the clinic provided the new family with vital information on the disorder and what to expect. Cora was able to be seen by a pediatrician via telemedicine and was able to obtain a referral to see specialists in the treatment of plagiocephal. Cora is now 20 months old and likes to go to the local park and ride the merry-go-round. This same clinic that helped Cora and her family is supported by the Title V MCH Block Grant and would not be able to remain open without the funds and support that title V funds offer. It is a great thing that families can come to a clinic close to their home, or be seen using health technology and be provided a complete physical, neurological, developmental evaluation for their kids.

This is just one example of the literally thousands of children, children with special healthcare needs and pregnant women that are served by Title V MCH Block Grant programs in Chairman Harkin's State alone. The Title V MCH Block Grant supports a similar network in my home State of Florida, and none of this could happen without Title V MCH Block Grant funding.

Health reform was a great step forward in advancing the health of women and children but America still faces huge challenges in improving maternal and child health outcomes and addressing the needs of very vulnerable children.

Reductions in maternal and infant mortality have stalled in recent years and rates of preterm and low birth weight births have increased over the last decade. Today the United States ranks 30th in infant mortality rates and 41st in maternal mortality when compared to other nations. Every 18 minutes a baby in America dies before his or her first birthday. Each day in America we lose 12 babies due to a Sudden Unexpected Infant Death. There are places in this country where the African-American infant mortality rate is double, and in some places even triple, the rate for whites. Preventable injuries remain the leading cause of death for all children, the United States still fails to adequately screen all young children for developmental concerns and childhood obesity has reached epidemic proportions, threatening to reverse a century of progress in extending life expectancy.

Health reform will increase coverage and work to improve access to healthcare and services for millions of Americans and Title V MCH Block Grant programs have the expertise to assure that women's and children's specific needs are addressed as programs are implemented. MCH is uniquely positioned to support and strengthen health reform by:

—Ensuring that improvements in health, not just healthcare, are realized through health reform. Coverage and access to medical care have only a limited impact on overall population health. Within the maternal and child health community, many States are seeing that early access to quality prenatal care services is no longer adequate to assure healthy birth outcomes for high-risk women. Despite expanded access to healthcare for pregnant women, the infant mortality rate in America has not improved significantly in the past decade. Programs funded by the Title V MCH Block Grant can help assure statewide implementation of primary prevention strategies including public information and education efforts targeted to populations at risk. Title V MCH Block Grant can help guide implementation of systems of comprehensive secondary prevention services (including newborn screening and counseling; regionalized systems of perinatal and neonatal high-risk services; high-risk tracking and follow-up services; early intervention services; and infectious disease control).

—Offering leadership and support for outreach, enrollment, and access to family-centered care. All children will now have health insurance coverage and Title V MCH Block Grant programs can help reach out to those children and their families to help them access the healthcare system. Since the 1990's Title V MCH leaders have been instrumental in supporting the Bright Futures initiative that sets a standard of care for kids and children with special healthcare needs. In health reform, co-pays for these preventive care and screening guidelines were eliminated, showing that Congress recognizes the importance of this national health promotion and Maternal and child health programs at the State level will support and promote The Bright Futures guidelines by offering training to children's health professionals. Many already insured individuals report they do not have a usual source of care. Only 50 percent of Children with Special Health Care Needs report that they receive comprehensive care within the context of a medical home and less than 20 percent of youth with special needs are able to find an adult healthcare provider who can appropriately care for them. Those with special needs often need additional services and care coordination not typically covered by health insurance.

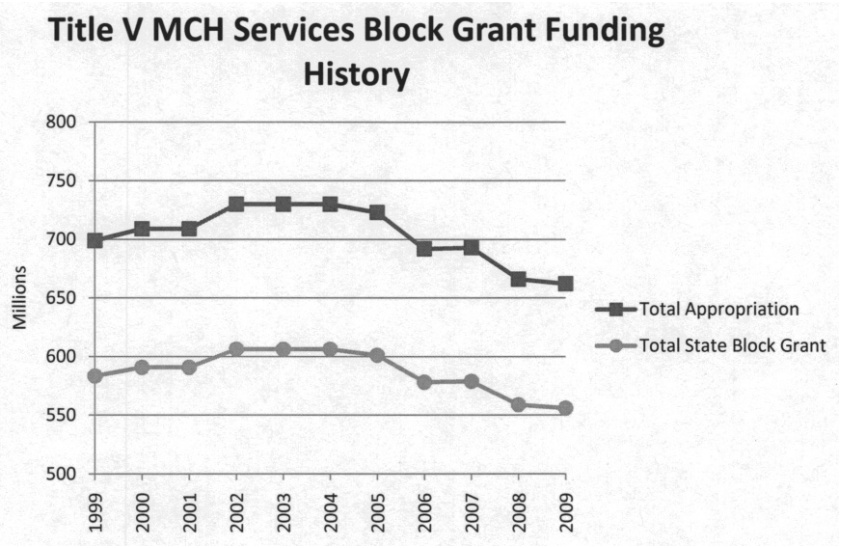
—Assessing the health status of women and children by conducting data collection, surveillance, and monitoring activities related to MCH population health measurement and outcomes. Title V MCH Block Grant programs regularly collect and report on public health measures, vital statistics, and personal health services data and use this information to inform state and local program planning.

Without increased funding, Title V MCH Block Grant Programs will be overwhelmed by this work if they are not provided the resources they need. AMCHP asks for your leadership in providing States the funding they need by increasing the Title V MCH Block Grant to $730 million for fiscal year 2011. We have a track record of demonstrating that we make a positive difference and are fully accountable for the funds that we receive. Increasing the funding to the Title V MCH Block Grant is an effective and efficient way to invest in our Nation's women, children, and families.

The Office of Management and Budget found that Title V MCH Block Grant-funded programs deliver results and decrease the infant mortality rate, prevent disabling conditions, increase the number of children immunized, increase access to care for uninsured children, and improve the overall health of mothers and children. Close coordination with other health programs assures that funding is maximized and services are not duplicated.

Our results are available to the public through a national website known as the Title V Information System. Such a system is remarkably rare for a Federal program and we are proud of the progress we have made.

However, despite the increasing demand for maternal and child health services, reductions to the Title V MCH Block Grant threaten the ability of programs to carry out their vital work. As States continue to face increasing economic hardship, more women and children will seek services through Title V MCH Block Grant funded programs. Due to years of reduced investment, the Title V MCH Block Grant is at its lowest funding level since 1993, $662 million, meaning States again are being asked to continue to serve additional people with less.



Crucial MCH activities are also supported by title V under the Special Projects of Regional and National Significance (SPRANS) program, including MCH research, training, hemophilia diagnostic and treatment centers, and MCH improvement projects that develop and support a broad range of strategies. The SPRANS investment drives innovation for MCH programs and is an important part of the Title V MCH Block Grant.

Mr. Chairman and distinguished members, in closing I ask you to imagine with me an America in which every child in the United States has the opportunity to live until his or her first birthday; a Nation where our Federal and State partnership has effectively moved the needle on our most pressing maternal and child health issues. Imagine a day when we are celebrating significant reductions or even the total elimination of health disparities by creatively solving our most urgent maternal and child health challenges. The Title V MCH Block Grant aims to do just that—using resources effectively to improve the health of all of America's women and children. Investing in the Title V MCH Block Grant is a cost-effective investment in our Nation's future, and we again appreciate your leadership to fund it at to $730 million for Federal fiscal year 2011. Thank you.

PREPARED STATEMENT OF THE ASSOCIATION OF MINORITY HEALTH PROFESSIONS SCHOOLS

Mr. Chairman and members of the subcommittee, thank you for the opportunity to present my views before you today. I am Dr. Leo Rouse, Chairman of the Association of Minority Health Professions Schools (AMHPS) and the dean of the college of dentistry at Howard University. AMHPS, established in 1976, is a consortium of our Nation's 12 historically black medical, dental, pharmacy, and veterinary schools. The members are two dental schools at Howard University and Meharry Medical College; four schools of medicine at The Charles Drew University, Howard University, Meharry Medical College, and Morehouse School of Medicine; five schools of pharmacy at Florida A&M University, Hampton University, Howard University, Texas Southern University, and Xavier University; and one school of veterinary medicine at Tuskegee University. In all of these roles, I have seen firsthand the importance of minority health professions institutions and the Title VII Health Professions Training programs.

Mr. Chairman, time and time again, you have encouraged your colleagues and the rest of us to take a look at our Nation and evaluate our needs over the next 10 years. I want to say that minority health professional institutions and the Title VII Health Professionals Training programs address a critical national need. Persistent and severe staffing shortages exist in a number of the health professions, and chronic shortages exist for all of the health professions in our Nation's most medically

underserved communities. Furthermore, even after the landmark passage of health reform, it is important to note that our Nation's health professions workforce does not accurately reflect the racial composition of our population. For example while blacks represent approximately 15 percent of the U.S. population, only 2–3 percent of the Nation's health professions workforce is black. Mr. Chairman, I would like to share with you how your subcommittee can help AMHPS continue our efforts to help provide quality health professionals and close our Nation's health disparity gap.

There is a well-established link between health disparities and a lack of access to competent healthcare in medically underserved areas. As a result, it is imperative that the Federal Government continue its commitment to minority health profession institutions and minority health professional training programs to continue to produce healthcare professionals committed to addressing this unmet need.

An October 2006 study by the Health Resources and Services Administration (HRSA), entitled "The Rationale for Diversity in the Health Professions: A Review of the Evidence" found that minority health professionals serve minority and other medically underserved populations at higher rates than nonminority professionals. The report also showed that; minority populations tend to receive better care from practitioners who represent their own race or ethnicity, and non-English speaking patients experience better care, greater comprehension, and greater likelihood of keeping follow-up appointments when they see a practitioner who speaks their language. Studies have also demonstrated that when minorities are trained in minority health profession institutions, they are significantly more likely to: (1) serve in rural and urban medically underserved areas; (2) provide care for minorities; and (3) treat low-income patients.

As you are aware, Title VII Health Professions Training programs are focused on improving the quality, geographic distribution and diversity of the healthcare workforce in order to continue eliminating disparities in our Nation's healthcare system. These programs provide training for students to practice in underserved areas, cultivate interactions with faculty role models who serve in underserved areas, and provide placement and recruitment services to encourage students to work in these areas. Health professionals who spend part of their training providing care for the underserved are up to 10 times more likely to practice in underserved areas after graduation or program completion.

In fiscal year 2011, funding for the Title VII Health Professions Training programs must be restored to the fiscal year 2005 level of at least $300 million, with two programs—the Minority Centers of Excellence (COEs) and Health Careers Opportunity Program (HCOPs)—in particular need of further funding restoration. In addition, the National Institutes of Health (NIH)'s National Institute on Minority Health and Health Disparities (NIMHD), as well as the Department of Health and Human Services (HHS)'s Office of Minority Health (OMH), are both in need of a funding increase.

Minority Centers of Excellence (COE).—COEs focus on improving student recruitment and performance, improving curricula in cultural competence, facilitating research on minority health issues and training students to provide health services to minority individuals. COEs were first established in recognition of the contribution made by four historically black health professions institutions to the training of minorities in the health professions. Congress later went on to authorize the establishment of "Hispanic", "Native American" and "Other" Historically black COEs. For fiscal year 2011, I recommend a funding level of $33.6 million for COEs.

Health Careers Opportunity Program (HCOP).—HCOPs provide grants for minority and nonminority health profession institutions to support pipeline, preparatory, and recruiting activities that encourage minority and economically disadvantaged students to pursue careers in the health professions. Many HCOPs partner with colleges, high schools, and even elementary schools in order to identify and nurture promising students who demonstrate that they have the talent and potential to become a health professional. For fiscal year 2011, I recommend a funding level of $35.6 million for HCOPs.

National Institutes of Health (NIH): Extramural Facilities Construction

Mr. Chairman, if we are to take full advantage of the recent funding increases for biomedical research that Congress has provided to NIH over the past decade, it is critical that our Nation's research infrastructure remain strong. The current authorization level for the Extramural Facility Construction program at the National Center for Research Resources is $250 million. The law also includes a 25 percent set-aside for "Institutions of Emerging Excellence" (many of which are minority institutions) for funding up to $50 million. Finally, the law allows the NCRR Director to waive the matching requirement for institutions participating in the pro-

gram. We strongly support all of these provisions of the authorizing legislation because they are necessary for our minority health professions training schools. In fiscal year 2011, please provide a funding appropriation of $50 million for extramural facilities.

Research Centers in Minority Institutions.—The Research Centers at Minority Institutions program (RCMI) at the National Center for Research Resources has a long and distinguished record of helping our institutions develop the research infrastructure necessary to be leaders in the area of health disparities research. Although NIH has received unprecedented budget increases in recent years, funding for the RCMI program has not increased by the same rate. Therefore, the funding for this important program grow at the same rate as NIH overall in fiscal year 2011.

Strengthening Historically Black Graduate Institutions—Department of Education.—The Department of Education's Strengthening Historically Black Graduate Institutions program (title III, part B, section 326) is extremely important to AMHPS. The funding from this program is used to enhance educational capabilities, establish and strengthen program development offices, initiate endowment campaigns, and support numerous other institutional development activities. In fiscal year 2011, an appropriation of $75 million is suggested to continue the vital support that this program provides to historically black graduate institutions.

National Center on Minority Health and Health Disparities (NCMHD).—NCMHD is charged with addressing the longstanding health status gap between minority and nonminority populations. The NCMHD helps health professional institutions to narrow the health status gap by improving research capabilities through the continued development of faculty, labs, and other learning resources. The NCMHD also supports biomedical research focused on eliminating health disparities and develops a comprehensive plan for research on minority health at the NIH. Furthermore, the NCMHD provides financial support to health professions institutions that have a history and mission of serving minority and medically underserved communities through the Minority Centers of Excellence program. For fiscal year 2011, I recommend a funding level of $500 million for the NCMHD.

Department of Health and Human Services' Office of Minority Health (OMH).—Specific programs at OMH include: assisting medically underserved communities with the greatest need in solving health disparities and attracting and retaining health professionals; assisting minority institutions in acquiring real property to expand their campuses and increase their capacity to train minorities for medical careers; supporting conferences for high school and undergraduate students to interest them in health careers, and supporting cooperative agreements with minority institutions for the purpose of strengthening their capacity to train more minorities in the health professions.

The OMH has the potential to play a critical role in addressing health disparities. For fiscal year 2011, I recommend a funding level of $75 million for the OMH.

Mr. Chairman, please allow me to express my appreciation to you and the members of this subcommittee. With your continued help and support, AMHPS's member institutions and the Title VII Health Professions Training programs can help this country to overcome health disparities. Congress must be careful not to eliminate, paralyze or stifle the institutions and programs that have been proven to work. The Association seeks to close the ever widening health disparity gap. If this subcommittee will give us the tools, we will continue to work towards the goal of eliminating that disparity everyday.

Thank you, Mr. Chairman, and I welcome every opportunity to answer questions for your records.

PREPARED STATEMENT OF THE AMERICAN NURSES ASSOCIATION

The American Nurses Association (ANA) appreciates this opportunity to comment on fiscal year 2011 appropriations for nursing education, workforce development, and research programs. Founded in 1896, ANA is the only full-service professional association representing the interests of the Nation's 3.1 million registered nurses (RNs) through its constituent member nurses associations, its organizational affiliates, and its workforce advocacy affiliate, the Center for American Nurses. The ANA advances the nursing profession by fostering high standards of nursing practice, promoting the rights of nurses in the workplace, projecting a positive and realistic view of nursing, and by lobbying the Congress and regulatory agencies on healthcare issues affecting nurses and the public.

The ANA gratefully acknowledges this subcommittee's history of support for nursing education and research. We also appreciate your continued recognition of the important role nurses play in the delivery of quality healthcare services. This testi-

mony will provide an update on the status of the nursing shortage, its impact on the Nation, and the outlook for the future.

The Nursing Shortage Today

The nursing shortage is far from solved. Here are a few quick facts:

—The Bureau of Labor Statistics reports that registered nursing will have remarkable job growth in the time period spanning 2006–2016. During this time decade, the healthcare system will require more than 1 million new nurses.

—The Health Resources and Services Administration (HRSA) projects that the supply of nurses in America will fall 26 percent (more than 1 million nurses) below requirements by the year 2020. In year 2020, Wisconsin's demand for full-time RNs will outstrip the supply by 20 percent (a shortage of 10,200 RNs). New York's shortage will reach 39 percent (54,200 RNs) and Ohio will have a 30 percent shortage (34,000 RNs). California's demand will outstrip its supply by 45 percent (116,600 RNs).

This growing nursing shortage is having a detrimental impact on the entire healthcare system. Numerous studies have shown that nursing shortages contribute to medical errors, poor patient outcomes, and increased mortality rates. A study published in the January/February 2006 issue of Health Affairs showed that hospitals could avoid 6,700 deaths per year by increasing the amount of RN care provided to their patients. This study, "Nurse Staffing in Hospitals: Is There a Business Case for Quality?" by Jack Needleman, Peter Buerhaus, et al. also revealed that hospitals are currently providing 4 million days worth of inpatient care annually to treat avoidable patient complications associated with a shortage of RN care.

Research published in the October 23, 2002 Journal of the American Medical Association also demonstrated that more nurses at the bedside could save thousands of patient lives each year. In reviewing more than 232,000 surgical patients at 168 hospitals, researchers from the University of Pennsylvania concluded that a patient's overall risk of death rose roughly 7 percent for each additional patient above four added to a nurse's workload.

Nursing Workforce Development Programs

Federal support for the Nursing Workforce Development Programs contained in title VIII of the Public Health Service Act is unduplicated and essential. The 107th Congress recognized the detrimental impact of the developing nursing shortage and passed the Nurse Reinvestment Act (Public Law 107–205). This law improved the title VIII Nursing Workforce Development programs to meet the unique characteristics of today's shortage. This achievement holds the promise of recruiting new nurses into the profession, promoting career advancement within nursing, and improving patient care delivery. However, this promise cannot be met without a significant investment. ANA strongly urges Congress to increase funding for title VIII programs by at least $23 million (10 percent increase) to a total of $267.3 million in fiscal year 2011.

Current funding levels are clearly failing to meet the need. In fiscal year 2008 (most recent year statistics are available), HRSA was forced to turn away 92.8 percent of the eligible applicants for the Nurse Education Loan Repayment Program (NELRP), and 53 percent of the eligible applicants for the Nursing Scholarship Program (NSP) due to a lack of adequate funding. These programs are used to direct RNs into areas with the greatest need—including departments of public health, community health centers, and disproportionate share hospitals.

In 1973, Congress appropriated $160.61 million to title VIII programs. Inflated to today's dollars, this appropriation would equal $763.52 million, more than three times the fiscal year 2010 appropriation. Certainly, today's shortage is more dire and systemic than that of the 1970's; it deserves an equivalent response.

Title VIII includes the following program areas:

NELRP and Scholarships.—This line item is comprised of the NELRP and the NSP. In fiscal year 2010, the NELRP s received $93.8 million.

The NELRP repays up to 85 percent of a RN's student loans in return for full-time practice in a facility with a critical nursing shortage. The NELRP nurse is required to work for at least 2 years in a designated facility, during which time the NELRP repays 60 percent of the RN's student loan balance. If the nurse applies and is accepted for an optional third year, an additional 25 percent of the loan is repaid.

The NELRP boasts a proven track record of delivering nurses to facilities hardest hit by the nursing shortage. HRSA has given NELRP funding preference to RNs who work in departments of public health, disproportionate share hospitals, skilled nursing facilities, and federally designated health centers. However, lack of funding has hindered the full implementation of this program. In fiscal year 2008, 92.8 per-

cent of applicants willing to immediately begin practicing in facilities hardest hit by the shortage were turned away from this program due to lack of funding.

The NSP offers funds to nursing students who, upon graduation, agree to work for at least 2 years in a healthcare facility with a critical shortage of nurses. Preference is given to students with the greatest financial need. Like the NELRP, the NSP has been stunted by a lack of funding. In fiscal year 2008, HRSA received 3,039 applications for the NSP. Due to lack of funding, a mere 177 scholarships were awarded. Therefore, 2,862 nursing students (94 percent) willing to work in facilities with a critical shortage were denied access to this program.

Nurse Faculty Loan Program.—This program establishes a loan repayment fund within schools of nursing to increase the number of qualified nurse faculty. Nurses may use these funds to pursue a master's or doctoral degree. They must agree to teach at a school of nursing in exchange for cancellation of up to 85 percent of their educational loans, plus interest, over a 4-year period. In fiscal year 2010, this program received $25 million.

This program is vital given the critical shortage of nursing faculty. America's schools of nursing cannot increase their capacity without an influx of new teaching staff. Last year, schools of nursing were forced to turn away tens of thousands of qualified applicants due largely to the lack of faculty. In fiscal year 2008, HRSA funded 95 faculty loans.

Nurse Education, Practice, and Retention Grants.—This section is comprised of many programs designed to support entry-level nursing education and to enhance nursing practice. The education grants are designed to expand enrollments in baccalaureate nursing programs; develop internship and residency programs to enhance mentoring and specialty training; and provide new technologies in education including distance learning. All together, the Nurse Education, Practice, and Retention Grants supported 42,761 nurses and nursing students in fiscal year 2008. The program received $39.8 million in fiscal year 2010.

Retention grant areas include career ladders and improved patient care delivery systems. The career ladders program supports education programs that assist individuals in obtaining the educational foundation required to enter the profession, and to promote career advancement within nursing. Enhancing patient care delivery system grants are designed to improve the nursing work environment. These grants help facilities to enhance collaboration and communication among nurses and other healthcare professionals, and to promote nurse involvement in the organizational and clinical decisionmaking processes of a healthcare facility. These best practices for nurse administration have been identified by the American Nurse Credentialing Center's Magnet Recognition Program. These practices have been shown to double nurse retention rates, increase nurse satisfaction, and improve patient care.

Nursing Workforce Diversity.—This program provides funds to enhance diversity in nursing education and practice. It supports projects to increase nursing education opportunities for individuals from disadvantaged backgrounds—including racial and ethnic minorities, as well as individuals who are economically disadvantaged. In fiscal year 2008, 85 applications were received for workforce diversity grants, 51 were funded. In fiscal year 2010, these programs received $16 million.

Advanced Nurse Education.—Advanced practice registered nurses (APRNs) are nurses who have attained advanced expertise in the clinical management of health conditions. Typically, an APRN holds a master's degree with advanced didactic and clinical preparation beyond that of the RN. Most have practice experience as RNs prior to entering graduate school. Practice areas include, but are not limited to: anesthesiology, family medicine, gerontology, pediatrics, psychiatry, midwifery, neonatology, and women's and adult health. Title VIII grants have supported the development of virtually all initial State and regional outreach models using distance learning methodologies to provide advanced study opportunities for nurses in rural and remote areas. In fiscal year 2008, 5,649 advanced education nurses were supported through these programs. In fiscal year 2010, these programs received $64.4 million.

These grants also provide traineeships for master's and doctoral students. Title VIII funds more than 60 percent of U.S. nurse practitioner education programs and assists 83 percent of nurse midwifery programs. More than 45 percent of the nurse anesthesia graduates supported by this program go on to practice in medically underserved communities. A study published last year in the Journal of Rural Health showed that 80 percent of the nurse practitioners who attended a program supported by title VIII chose to work in a medically underserved or health profession shortage area after graduation.

Comprehensive Geriatric Education Grants.—This authority awards grants to train and educate nurses in providing healthcare to the elderly. Funds are used to train individuals who provide direct care for the elderly, to develop and disseminate

geriatric nursing curriculum, to train faculty members in geriatrics, and to provide continuing education to nurses who provide geriatric care. In fiscal year 2008, 6,514 nurses and nursing students were supported through these programs. In fiscal year 2010, these grants received $4.5 million.

The growing number of elderly Americans and the impending healthcare needs of the baby boom generation make this program critically important.

Conclusion

While ANA appreciates the continued support of this subcommittee, we are concerned that title VIII funding levels have not been sufficient to address the growing nursing shortage. In preparation for the implementation of healthcare reform initiatives, which ANA supported, we believe there will be an even greater need for nurses and adequate funding for these programs is even more essential. ANA asks you to meet today's shortage with a relatively modest investment of $267.3 million in title VIII programs. Thank you.

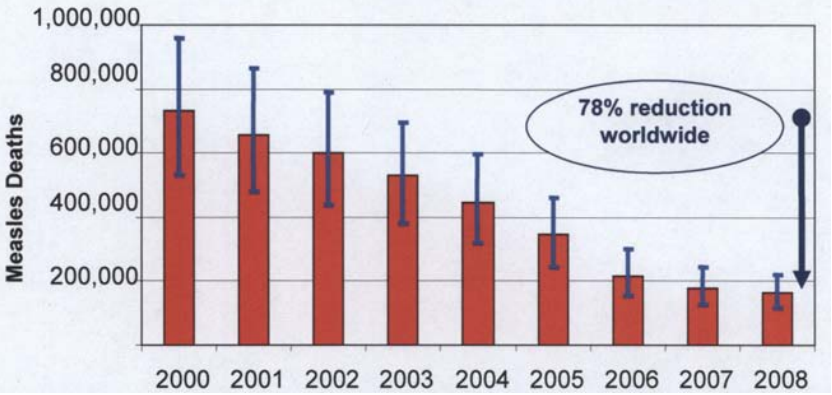
PREPARED STATEMENT OF THE AMERICAN NATIONAL RED CROSS

Chairman Tom Harkin, Ranking Member Thad Cochran, and members of the subcommittee, the American Red Cross and the United Nations Foundation appreciate the opportunity to submit testimony in support of measles control activities of the U.S. Centers for Disease Control and Prevention (CDC). The American Red Cross and the United Nations Foundation recognize the leadership that Congress has shown in funding CDC for these essential activities. We sincerely hope that Congress will continue to support the CDC during this critical period in measles control.

In 2001, CDC—along with the American Red Cross, the United Nations Foundation, the World Health Organization, and UNICEF—founded the Measles Initiative, a partnership committed to reducing measles deaths globally. The current U.N. goal is to reduce measles deaths by 90 percent by 2010 compared to 2000 estimates. The Measles Initiative is committed to reaching this goal by proving technical and financial support to governments and communities worldwide.

The Measles Initiative has achieved "spectacular"[1] results by supporting the vaccination of more than 700 million children. Largely due to the Measles Initiative, global measles mortality dropped 78 percent, from an estimated 733,000 deaths in 2000 to 164,000 in 2008. During this same period, measles deaths in Africa fell by 92 percent, from 371,000 to 28,000.

Figure1: **Estimated Number of Global Measles Deaths, 2000-2008**



Working closely with host governments, the Measles Initiative has been the main international supporter of mass measles immunization campaigns since 2001. The Initiative mobilized more than $720 million and provided technical support in more than 60 developing countries on vaccination campaigns, surveillance and improving routine immunization services. From 2000 to 2008, an estimated 4.3 million measles deaths were averted as a result of these accelerated measles control activities at a

[1] The Lancet, Volume 8, page 13 (January 2008).

donor cost of $184/death averted, making measles mortality reduction one of the most cost-effective public health interventions.

Nearly all the measles vaccination campaigns have been able to reach more than 90 percent of their target populations. Countries recognize the opportunity that measles vaccination campaigns provide in accessing mothers and young children, and "integrating" the campaigns with other life-saving health interventions has become the norm. In addition to measles vaccine, Vitamin A (crucial for preventing blindness in under nourished children), de-worming medicine (reduces malnutrition), and insecticide-treated bed nets (ITNs) for malaria prevention are distributed during vaccination campaigns. The scale of these distributions is immense. For example, more than 40 million ITNs were distributed in vaccination campaigns in the last few years. The delivery of multiple child health interventions during a single campaign is far less expensive than delivering the interventions separately, and this strategy increases the potential positive impact on children's health from a single campaign.

By the end of 2008 all WHO regions, with the exception of one (South East Asia), achieved the 2010 goal 2 years ahead of target. The extraordinary reduction in global measles deaths contributed an estimated 25 percent of the progress to date toward Millennium Development Goal #4 (reducing under 5 child mortality). However, at the height of global achievements in measles control, a sharp decline in commitments threatens to erase the gains of the last decade and a global measles resurgence is likely. If mass immunization campaigns are not continued, an estimated 1.7 million measles-related deaths could occur between 2010–13, with more than half a million deaths in 2013 alone.

To achieve the 2010 goal and avoid a resurgence of measles the following actions are required:

—Accelerating activities, both campaigns and further efforts to improve routine measles coverage, in India since it is the greatest contributor to the global burden of measles.

—Sustaining the gains in reduced measles deaths, especially in Africa, by strengthening immunization programs to ensure that more than 90 percent of infants are vaccinated against measles through routine health services before their first birthday as well as conducting timely, high-quality mass immunization campaigns.

—Securing sufficient funding for measles-control activities both globally and nationally. The Measles Initiative faces a funding shortfall of an estimated $47 million for 2011. Implementation of timely measles campaigns is increasingly dependent upon countries funding these activities locally. The decrease in donor funds available at global level to support measles elimination activities makes increased political commitment and country ownership of the activities critical for achieving and sustaining the goal of reducing measles mortality by 90 percent.

If these challenges are not addressed, the remarkable gains made since 2000 will be lost and a major resurgence in measles deaths will occur.

By controlling measles cases in other countries, U.S. children are also being protected from the disease. Measles can cause severe complications and death. A resurgence of measles occurred in the United States between 1989 and 1991, with more than 55,000 cases reported. This resurgence was particularly severe, accounting for more than 11,000 hospitalizations and 123 deaths. Since then, measles control measures in the United States have been strengthened and endemic transmission of measles cases have been eliminated here since 2000. However, importations of measles cases into this country continue to occur each year. In 2008, several measles outbreaks in the United States, all linked to importation of the virus from overseas, led to the largest number of U.S. measles cases since 1996. These cases resulted in dozens of hospitalizations and the costs of response to the outbreaks were substantial, both in terms of the costs to public health departments and in terms of productivity losses among people with measles, parents of sick children, and people exposed to measles cases.

The Role of CDC in Global Measles Mortality Reduction

Since fiscal year 2001, Congress has provided approximately $43.6 million annually in funding to CDC for global measles control activities. These funds were used toward the purchase of approximately 415 million doses of measles vaccine for use in large-scale measles vaccination campaigns in more than 60 countries in Africa and Asia, and for the provision of technical support to Ministries of Health in those countries. Specifically, this technical support includes:

—Planning, monitoring, and evaluating large-scale measles vaccination campaigns;

—Conducting epidemiological investigations and laboratory surveillance of measles outbreaks; and
—Conducting operations research to guide cost-effective and high-quality measles control programs.

In addition, CDC epidemiologists and public health specialists have worked closely with WHO, UNICEF, the United Nations Foundation, and the American Red Cross to strengthen measles control programs at global and regional levels. While it is not possible to precisely quantify the impact of CDC's financial and technical support to the Measles Initiative, there is no doubt that CDC's support—made possible by the funding appropriated by Congress—was essential in helping achieve the sharp reduction in measles deaths in just 8 years.

The American Red Cross and the United Nations Foundation would like to acknowledge the leadership and work provided by CDC and recognize that CDC brings much more to the table than just financial resources. The Measles Initiative is fortunate in having a partner that provides critical personnel and technical support for vaccination campaigns and in response to disease outbreaks. CDC personnel have routinely demonstrated their ability to work well with other organizations and provide solutions to complex problems that help critical work get done faster and more efficiently.

In fiscal year 2010, Congress has appropriated approximately $51.9 million to fund CDC for global measles control activities. The American Red Cross and the United Nations Foundation thank Congress for the increase in financial support from past years. We respectfully request level funding for fiscal year 2011 for CDC's measles control activities to prevent a global resurgence of measles and a loss of progress toward Millennium Development Goal #4.

Your commitment has brought us unprecedented victories in reducing measles mortality around the world. In addition, your continued support for this initiative helps prevent children from suffering from this preventable disease both abroad and in the United States.

Thank you for the opportunity to submit testimony.

PREPARED STATEMENT OF AMERICANS FOR NURSING SHORTAGE RELIEF

The undersigned organizations of the ANSR Alliance greatly appreciate the opportunity to submit written testimony regarding fiscal year 2011 appropriations for Title VIII—Nursing Workforce Development Programs. We represent a diverse cross-section of healthcare and other related organizations, healthcare providers, and supporters of nursing issues that have united to address the national nursing shortage. ANSR stands ready to work with the Congress to advance programs and policy that will ensure that our Nation has a sufficient and adequately prepared nursing workforce to provide quality care to all well into the 21st century. The Alliance, therefore, urges Congress to:

—Appropriate $267.3 million in funding in fiscal year 2011 for the Nursing Workforce Development Programs under title VIII of the Public Health Service Act at the Health Resources and Services Administration (HRSA).
—Direct the requested increase at the title VIII programs that have not kept pace with inflation since fiscal year 2005: Advanced Education Nursing, Nursing Workforce Diversity, Nurse Education, Practice and Retention, and Comprehensive Geriatric Education. These programs, which help expand nursing school capacity and increase patient access to care, would greatly benefit from the 10 percent increase awarded in proportion to their fiscal year 2010 funding levels.

The Extent of the Nursing Shortage

Nursing is the largest healthcare profession in the United States. According to the National Council of State Boards of Nursing, there were nearly 3.733 million licensed RNs in 2008.[1] Nurses and advanced practice nurses (nurse practitioners, nurse midwives, clinical nurse specialists, and certified registered nurse anesthetists) work in a variety of settings, including primary care, public health, long-term care, surgical care facilities, and hospitals. In 2008, 60 percent of RN jobs were in hospitals.[2] About 8 percent of RN jobs were in physician offices, 5 percent in

[1] National Council of State Boards of Nursing, (2010). *2008 Nurse Licensee Volume and NCLEX® Examination Statistics. (Research Brief Vol. 42)*. On the Internet at: https://www.ncsbn.org/10_2008NCLEXExamStats_Vol42_web_links.pdf (Accessed March 15, 2010).
[2] Bureau of Labor Statistics, U.S. Department of Labor. *Occupational Outlook Handbook, 2010–11 Edition*, Registered Nurses. On the Internet at: http://www.bls.gov/oco/ocos083.htm (Accessed February 26, 2010).

home healthcare services, 5 percent in nursing care facilities, and 3 percent in employment services. The remainder worked mostly in government agencies, social assistance agencies, and education services. A Federal report published in 2004 estimates that by 2020 the national nurse shortage will increase to more than one million full-time nurse positions. According to these projections, which are based on the current rate of nurses entering the profession, only 64 percent of projected demand will be met.[3] A study, published in March 2008, uses different assumptions to calculate an adjusted projected demand of 500,000 full-time equivalent registered nurses by 2025.[4] According to the U.S. Bureau of Labor Statistics, employment of registered nurses is expected to grow by 22 percent from 2008 to 2018, much faster than the average for all occupations and, because the occupation is very large, 581,500 new jobs will result. Based on these scenarios, the shortage presents an extremely serious challenge in the delivery of high-quality, cost-effective services, as the Nation looks to reform the current healthcare system. Even considering only the smaller projection of vacancies, this shortage still results in a critical gap in nursing service, essentially three times the 2001 nursing shortage.

Building the Capacity of Nursing Education Programs

Nursing vacancies exist throughout the entire healthcare system, including long-term care, home care and public health. Even the Department of Veterans Affairs, the largest sole employer of RNs in the United States, has a nursing vacancy rate of 10 percent. In 2006, the American Hospital Association reported that hospitals needed 116,000 more RNs to fill immediate vacancies, and that this 8.1 percent vacancy rate affects hospitals' ability to provide patient/client care.[5] Government estimates indicate that this situation only promises to worsen due to an insufficient supply of individuals matriculating in nursing schools, an aging existing workforce, and the inadequate availability of nursing faculty to educate and train the next generation of nurses. At the exact same time that the nursing shortage is expected to worsen, the baby boom generation is aging and the number of individuals with serious, life-threatening, and chronic conditions requiring nursing care will increase. Consequently, more must be done now by the government to help ensure an adequate nursing workforce for the patients/clients of today and tomorrow.

A particular focus on securing and retaining adequate numbers of faculty is essential to ensure that all individuals interested in—and qualified for—nursing school can matriculate in the year they are accepted. The National League for Nursing found that in the 2007–2008 academic year, 119,000 qualified applications—or 39 percent of all qualified applications submitted to nursing education programs—were denied due to lack of capacity. Baccalaureate degree programs turned away 24 percent of its applications, while associate degree programs turned away 42 percent.[6] Aside from having a limited number of faculty, nursing programs struggle to provide space for clinical laboratories and to secure a sufficient number of clinical training sites at healthcare facilities.

The Alliance supports the need for sustained attention on the efficacy and performance of existing and proposed programs to improve nursing practices and strengthen the nursing workforce. The support of research and evaluation studies that test models of nursing practice and workforce development is integral to advancing healthcare for all in America. Investments in research and evaluation studies have a direct effect on the caliber of nursing care. Our collective goal of improving the quality of patient/client care, reducing costs, and efficiently delivering appropriate healthcare to those in need is served best by aggressive nursing research and performance and impact evaluation at the program level.

The Impact on the Nation's Public Health Infrastructure

The National Center for Health Workforce Analysis reports that the nursing shortage challenges the healthcare sector to meet current service needs. Nurses make a difference in the lives of patients/clients from disease prevention and management to education to responding to emergencies. Chronic diseases, such as heart

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[3] Health Resources and Services Administration, (2004). *What is Behind HRSA's Projected Supply, Demand, and Shortage of Registered Nurses?* On the Internet at: http://bhpr.hrsa.gov/healthworkforce/reports/behindrnprojections/4.htm. (Accessed February 26, 2010).

[4] Buerhaus, P., Staiger, D., Auerbach, D. (2008). *The Future of the Nursing Workforce in the United States: Data, Trends, and Implications*. Boston, MA: Jones & Bartlett.

[5] American Hospital Association, (2007). *The State of America's Hospitals: Taking the Pulse, Findings from the 2007 AHA Survey of Hospital Leader*. On the Internet at: http://www.aha.org/aha/content/2007/PowerPoint/StateofHospitalsChartPack2007.ppt. (Accessed December 3, 2008).

[6] National League for Nursing, (2010). *Nursing Data Review 2007–2008: Baccalaureate, Associate Degree, and Diploma Programs*. On the Internet at: http://www.nln.org/research/slides/index.htm. (Accessed February 26, 2010).

disease, stroke, cancer, and diabetes, are the most preventable of all health problems as well as the most costly. Nearly half of Americans suffer from one or more chronic conditions and chronic disease accounts for 70 percent of all deaths. In addition, increased rates of obesity and chronic disease are the primary cause of disability and diminished quality of life.

Even though America spends more than $2 trillion annually on healthcare—more than any other nation in the world—tens of millions of Americans suffer every day from preventable diseases such as type 2 diabetes, heart disease, and some forms of cancer that rob them of their health and quality of life.[7] In addition, major vulnerabilities remain in our emergency preparedness to respond to natural, technological and manmade hazards. An October 2008 report issued by Trust for America's Health entitled "Blueprint for a Healthier America" found that the health and safety of Americans depends on the next generation of professionals in public health.[8] Further, existing efforts to recruit and retain the public health workforce are insufficient. New policies and incentives must be created to make public service careers in public health an attractive professional path, especially for the emerging workforce and those changing careers.

An Institute of Medicine report notes that nursing shortages in U.S. hospitals continue to disrupt hospitals operations and are detrimental to patient/client care and safety.[9] Hospitals and other healthcare facilities across the country are vulnerable to mass casualty incidents themselves and/or in emergency and disaster preparedness situations. As in the public health sector, a mass casualty incident occurs because of an event where sudden and high patient/client volume exceeds the facilities/sites resources. Such events may include the more commonly realized multi-car pile-ups, train crashes, hazardous material exposure in a building or within a community, high occupancy catastrophic fires, or the extraordinary events such as pandemics, weather-related disasters, and intentional catastrophic acts of violence. Since 80 percent of disaster victims present at the emergency department, nurses as first receivers are an important aspect of the public health system as well as the healthcare system in general. The nursing shortage has a significant adverse impact on the ability of communities to respond to health emergencies, including natural, technological and manmade hazards.

Summary

The link between healthcare and our Nation's economic security and global competitiveness is undeniable. Having a sufficient nursing workforce to meet the demands of a highly diverse and aging population is an essential component to reforming the healthcare system as well as improving the health status of the nation and reducing healthcare costs. To mitigate the immediate effect of the nursing shortage and to address all of these policy areas, ANSR requests $267.3 million in funding for the Nursing Workforce Development Programs under Title VIII of the Public Health Service Act at HRSA in fiscal year 2011. The requested increase should be directed at the Title VIII programs that have not kept pace with inflation since fiscal year 2005: Advanced Education Nursing, Nursing Workforce Diversity, Nurse Education, Practice and Retention, and Comprehensive Geriatric Education. These programs, which help expand nursing school capacity and increase patient access to care, would greatly benefit from the 10 percent increase awarded in proportion to their fiscal year 2010 funding levels.

UNDERSIGNED ORGANIZATIONS

Academy of Medical-Surgical Nurses
American Academy of Ambulatory Care Nursing
American Academy of Nurse Practitioners
American Academy of Nursing
American Association of Critical-Care Nurses
American Association of Nurse Anesthetists
American Association of Nurse Assessment Coordinators
American Association of Nurse Executives

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[7] KaiserEDU.org. "U.S. Health Care Costs: Background Brief." Kaiser Family Foundation. On the Internet at: <http://www.kaiseredu.org/topics_im.asp?imID=1&parentID=61&id=358> (Accessed November 24, 2008).

[8] Trust for America's Health. (2008). *Blueprint for a Healthier America: Modernizing the Federal Public Health System to Focus on Prevention and Preparedness*. On the Internet at: http://healthyamericans.org/report/55/blueprint-for-healthier-america (Accessed December 3, 2008).

[9] Institute of Medicine. Committee on the Future of Emergency Care in the United States Health System. (2007) *Hospital-Based Emergency Care: At the Breaking Point*. On the Internet at: http://www.iom.edu/?id=48896. (Accessed December 3, 2008).

American Association of Occupational Health Nurses
American College of Nurse Practitioners
American Organization of Nurse Executives
American Psychiatric Nurses Association
American Society for Pain Management Nursing
American Society of PeriAnesthesia Nurses
American Society of Plastic Surgical Nurses
Association for Radiologic & Imaging Nursing
Association of Pediatric Hematology/Oncology Nurses
Association of periOperative Registered Nurses
Association of Rehabilitation Nurses
Association of State and Territorial Directors of Nursing
Association of Women's Health, Obstetric & Neonatal Nurses
Citizen Advocacy Center
Developmental Disabilities Nurses Association
Emergency Nurses Association
Gerontological Advanced Practice Nurses Association
Infusion Nurses Society
International Society of Nurses in Genetics, Inc.
Legislative Coalition of Virginia Nurses
National Association of Clinical Nurse Specialists
National Association of Hispanic Nurses
National Association of Neonatal Nurses
National Association of Neonatal Nurse Practitioners
National Association of Nurse Massage Therapists
National Association of Nurse Practitioners in Women's Health
National Association of Orthopaedic Nurses
National Association of Pediatric Nurse Practitioners
National Association of Registered Nurse First Assistants
National Black Nurses Association
National Council of State Boards of Nursing
National Council of Women's Organizations
National Gerontological Nursing Association
National League for Nursing
National Nursing Centers Consortium
National Nursing Staff Development Organization
National Organization for Associate Degree Nursing
National Organization of Nurse Practitioner Faculties
National Student Nurses' Association, Inc.
Nurses Organization of Veterans Affairs
Pediatric Endocrinology Nursing Society
RN First Assistants Policy & Advocacy Coalition
Society of Gastroenterology Nurses and Associates, Inc.
Society of Pediatric Nurses
Society of Trauma Nurses
Women's Research & Education Institute
Wound, Ostomy and Continence Nurses Society

PREPARED STATEMENT OF THE ASSOCIATION OF ORGAN PROCUREMENT ORGANIZATIONS

The Association of Organ Procurement Organizations (AOPO) supports additional funding for the Division of Transplantation. AOPO is the nonprofit, national organization that represents the Nation's 58 federally designated organ donation agencies through advocacy, support, and program development that will maximize the availability of organs and tissues. AOPO seeks to enhance the quality, effectiveness, and integrity of the donation process. The Division of Transplantation's mission is to provide oversight and guidance to the donation and transplantation regulations and processes in the United States, and, in that role, it enhances the efforts of AOPO and other organizations working to increase the number of lives saved through transplantation, research, education, and therapy.

The timeliness of this funding request is particularly urgent. Organ donation saves lives. Since transplantation is standard therapy for end-stage organ failure, donation is a vital component of end-of-life care in the United States. There are almost 107,000 people waiting for a transplant in the United States, 18 of whom will die today while waiting for the gift of life. That equates to approximately one person dying every 90 minutes, an entirely preventable public health crisis.

In 2005, the Office of Management and Budget (OMB) set a Federal goal to increase the number of organs donated annually by deceased individuals in the United States to 35,000 by 2012. In 2009, more than 24,000 organs were donated. As one of the catalysts in the donation process, organ procurement organizations (OPOs) must coordinate with all stakeholders to reach this Federal goal. OPOs provide community education and programs to medical professionals to help them participate and support the donation process in every hospital in the United States. The hospital turns to the OPO for support and expertise when a donation situation presents itself. By law, OPOs must meet strict Federal performance standards and operate within a regulated system under the Department of Health and Human Services.

Increasing organ availability in the United States can be achieved through several simultaneous strategies: enrolling all willing donors in donor registries; improving how donation from deceased donors is handled in U.S. hospitals; and by encouraging and protecting those who wish to donate organs while they are still alive.

Organ donation from deceased donors remains the most important source of increasing organ availability. Today, donation occurs in approximately 68 percent of eligible cases. This is up from 50 percent in 2003. OPOs now recover more than 3 organs per deceased individual. More increases can be achieved if the government and organ donation and transplantation professionals act on the changing nature of the organ donor pool. The increases in the incidence of obesity, diabetes and hypertension that affect the general public affect organ donors as well. It takes more resources to evaluate medically complex donation cases and it takes longer for recipients to recover from transplantation when these organs are received. Outdated Federal regulations fail to account for this new donation and transplantation reality, and do not go far enough to safeguard the potential supply of organs and tissues from possible unintended consequences. Performance outcome measures for transplant hospitals and OPOs must be risk-adjusted to account for the use of these donors with potentially compromising medical conditions. OPOs are already reimbursed on a cost-basis. Any reduction in payment would cause recovery costs to fall below the actual costs of procuring organs. Increased funding is critical to ensure that organ and tissue recovery does not decrease as a result of inadvertent consequences. New healthcare reform measures should not affect reimbursement policies by penalizing hospitals for potentially longer inpatient stays to manage transplant recipients with challenged donor organs because transplanting these organs is the optimal outcome for these patients.

Current OPO success measures are based on organs transplanted per donor and categorized by the type of donor. Preliminary work shows promise with a more objective and replicable evaluation system for OPOs. With additional funding, new tools can be developed that strengthen performance-based metrics and expand organ donation potential. To accomplish these goals, it is necessary for HHS officials and representatives of HRSA and CMS to partner with the donation and transplantation community to create a regulatory and reimbursement environment that fosters achievement of national performance goals.

The President's fiscal year 2011 budget allocates $4 million for Breakthrough Collaboratives on Organ Donation and Transplantation, initiatives that encourage teams of organ procurement, transplantation and critical care professionals to improve the organ donation and transplantation process in their local areas. OPOs must have the ability to identify, recruit, train, and financially support the involvement of critical care professionals (e.g., physicians, nurses, respiratory therapists) in local, regional, and national efforts to optimize donor organ function prior to donation. Best practices are shared for replication on a local level. More funding can and should be provided to ensure that healthcare professionals are properly trained to partner with OPO professionals to lead the donation process in their hospitals. We recommend that funding for the Collaboratives be increased from $4 million to $6 million to strengthen this national learning program.

The extra $2 million appropriated to the Division of Transplantation in fiscal year 2010 was allocated to the OPTN (Organ Procurement and Transplantation Network) to develop strategies to increase living donation and establish a greater number of paired kidney programs. Although living donation is one way to increase the supply of scarce resources, and the $2 million will make a positive impact, our country currently lacks the infrastructure to take full advantage of this donation option. Barriers to living donation remain. For example, there is no national living donor registry. Even more concerning, insurance companies can include living donation as a pre-existing condition. Legislation to include prohibiting living organ donation as a pre-existing condition for health insurance exclusions was introduced more than a year ago in both the House (H.R. 1558) and Senate (S. 623). Last June, a bill was introduced that would amend the Family and Medical Leave Act of 1993 to allow non-Federal employees up to 12 weeks of unpaid, job-protected leave in a 12-month

period to provide living donation. Other methods to encourage living donation, such as the Living Organ Donor Tax Credit Act of 2009 (H.R. 218), have been proposed to allow incentives to encourage organ donation. Though this bill is stalled, it would allow a nonrefundable tax credit of up to $5,000 for unreimbursed costs and lost wages related to living donation. No action has been taken on any of these bills. Until this is done, it could be unwise to encourage more organ donation from living individuals.

OPOs and other agencies, such as Donate Life America, have tried to counterbalance the rising waiting list numbers by increasing the number of Americans who are registered organ and tissue donors. At the end of 2009, donor registrants in state registries topped 86.3 million. Donate Life America has just released a survey in early 2010 showing that 57 percent of U.S. adults support organ donation, a 7 percent increase from a 2009 survey. While 57 percent of Americans would sign up, only 37.1 percent have actually done so, indicating many do not know how to do so.

Representative Clay from Missouri proposed a bill (H.R. 3071) which authorized successful grants for the development, enhancement, expansion, and evaluation of State organ and tissue donor registries to aid in this effort to expand the donor pool. In addition, AOPO has worked with States to strengthen donor designation laws through efforts such as a nationwide effort to pass the revised Uniform Anatomical Gift Act (UAGA) in every State, and through a proposed resolution to the National Association of Attorneys General (NAAG). Donor registries have proven successful, but to close this gap, funding for public and professional education programs focused on increasing donor registrations should be extended from $3.749 million to $6.2 million.

Almost 107,000 people in the United States are waiting for lifesaving organ transplants, and every 11 minutes another name is added to the transplant waiting list. A million more suffer from conditions that could be successfully treated with donated corneas or tissue. The current system is not keeping pace with the critical shortage of vital organs in this country. Through additional funding for research, training and outreach, many more lives will be saved and improved.

The Division of Transplantation represents less than 0.35 percent of HRSA's discretionary budget authority, but adequate funding to help reach the HRSA national performance goals could amount to millions of dollars in savings to the Medicare program as a result of patients being freed from the requirement of long-term dialysis. These are the additional increases to the fiscal year 2011 budget supported by AOPO:

—Additional funding for the Division of Transplantation should be granted. In order to reach Federal goals, the pool of potential donors must be widened. OPOs are looking at numerous ways to increase organ donation. Some programs are taking advantage of extended criteria donors, while others are mastering other donation options such as donation after cardiac determination of death. In order to fully and safely explore these and other avenues to increase donation, funding for these and other programs must be specified. OPOs operate under strict governmental guidelines, which limit the amount of research and development OPOs can perform.

—Studies about the effect of potential healthcare reform measures should be conducted to guarantee organ recovery is not negatively impacted. We recommend that the $500,000 to conduct a study to define organ donor potential in the United States be increased to $2 million.

—HRSA has not altered the types of organ donation grants in several years. We recommend that funding for new grant projects to increase organ donation be given $10.2 million, up from $7.2 million requested.

PREPARED STATEMENT OF THE AMERICAN PSYCHOLOGICAL ASSOCIATION

The American Psychological Association (APA), in Washington, DC, is the largest scientific and professional organization representing psychology in the United States, including more than 150,000 researchers, educators, clinicians, consultants, and students. APA works to advance psychology as a science, as a profession and as a means of promoting health, education and human welfare. Below are APA's recommendations for the funding of programs in the Departments of Health and Human Services, and Education for fiscal year 2011.

APA supports the recommendations of the Ad Hoc Group for Medical Research Funding of $35 billion for the National Institutes of Health, and of the Coalition for Health Funding which supports an increase of $9.3 billion for all the agencies of the U.S. Public Health Service. The public health system requires additional sup-

port after years of underinvestment. We are concerned that our already fragile public health infrastructure lacks the capacity to support mounting health needs under the weight of an ongoing recession, an aging population, a health workforce shortage, and persisting declines in health status.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Bureau of Health Professions, Graduate Psychology Education Program.—The APA requests that the Subcommittee include $7 million for the Graduate Psychology Education Program (GPE) within the Health Resources & Services Administration. This nationally competitive grant program provides integrated healthcare services to underserved rural and urban communities and individuals most in need of mental and behavioral health support with the least access to these services (e.g., children, older adults, chronically ill persons, victims of abuse or trauma, including veterans). To date there have been 70 grants in 30 States to universities and hospitals throughout the Nation. All psychology graduate students who benefited from GPE funds are expected to work with underserved populations and 34–100 percent will work in underserved areas immediately after completing the training.

Currently it is authorized under the Public Health Service Act (Public Law 105–392 section 755(b)(1)(J)) and funded under the "Allied Health and Other Disciplines" account in the Labor, Health and Human Services, and Education, and Related Agencies appropriations bill. Explicit authorizing legislation was introduced in the First Session of the 111th Congress in the U.S. Senate (S. 811), as well as in the U.S. House of Representatives (H.R. 2066). The GPE Program has been included in the President's Budget for the past 2 years.

Established in 2002, GPE grants have supported the interdisciplinary training of more than 2,500 graduate students of psychology and other health professions to provide integrated healthcare services to underserved populations. The fiscal year 2011 GPE funding request will focus especially on providing services to older adults, returning veterans, and the unemployed. The GPE funding request will also be used to create training opportunities at our Nation's Federal Qualified Health Centers, which play a critical role in meeting the health and mental/behavioral healthcare needs of underserved communities all across the country.

The GPE Program specifically seeks to address the needs of older adults. Approximately 20 percent of older adults have a mental health condition, such as depression, anxiety, alcohol, or substance abuse. In addition, studies show that substance abuse combined with depression makes older adults especially vulnerable to suicide (Retooling for an Aging America, IOM, 2008). Moreover, older adults with chronic illnesses such as heart disease have higher rates of depression than those who are physically healthy (APA, 2008). Rural areas have a greater percentage of older adults than urban areas, and older adults in rural communities have a higher incidence of chronic illnesses such as heart disease, diabetes, high blood pressure, and obesity than those in urban communities (Alliance for Health Reform, RWJ Foundation, January 2010).

Because of their extensive education and training, psychologists are uniquely qualified to address the needs of unemployed persons (e.g., assessing skills and interests for retraining; determining the emotional status of the individual; treating mental and behavioral health issues; and providing guidance for job searches, interviewing strategies and techniques). The issue of joblessness and unemployment is a serious problem for many families, including those of returning veterans. Job loss due to multiple deployments has become a serious issue for this population, especially in the current economy.

Center for Mental Health Services, Minority Fellowship Program.—MFP's mission is to increase the number of minority mental health professionals and by training mental health professionals to become culturally competent. APA urges Congress to fund Minority Fellowship Program at $7.5 million for fiscal year 2011. APA does not recommend that SAMHSA include additional organizations in the program if it would mean reductions in funding for current grantees.

Center for Substance Abuse Prevention, Substance Use and Mental Disorders of Persons with HIV.—HIV-positive individuals who have co-occurring mental health and substance use disorders rarely receive "integrated" care with a treatment plan for all three disorders. APA recommends that Congress urge HRSA and SAMHSA to collaborate to expand the availability of the integrated care model. An integrated approach to HIV/AIDS care, mental health support and substance abuse treatment can improve patient adherence and lead to more favorable health outcomes for people living with HIV/AIDS.

Emergency Mental Health and Traumatic Stress Services Branch, Child Trauma.—APA urges full funding for the National Child Traumatic Stress Initiative at

the authorized level of $50 million for fiscal year 2011. Also, APA recommends the Committee to encourage SAMHSA to expand the duration of NCTSI grant awards from 3 years to 6 years.

Centers for Disease Control and Prevention, National Center for Health Statistics, Sexual and Gender Identity Inclusion in Health Data Collection.—APA recommends the allocation of an additional $2 million in funding for NHIS in the NCHS budget, to cover the cost of adding a sexual orientation/gender identity question to the survey. This would enable government agencies to better understand and plan for the unique health needs of lesbian, gay, bisexual, and transgender individuals.

CDC, National Center for Injury Prevention and Control, Youth Violence Prevention.—APA supports CDC's efforts to foster innovation in evidence-based youth violence prevention strategies through its Striving to Reduce Youth Violence Everywhere program. Recent, high-profile incidents have highlighted youth violence as a significant public health concern and homicide as the second leading cause of death among individuals age 10–24.

Community Health Centers (CHCs), Child Maltreatment Prevention.—APA recommends the implementation of at least 10 demonstration projects of evidence-based preventative parenting programs through CHCs. Technical assistance to demonstration sites should be provided by organizations with expertise in parent-child relationships, parenting programs, prevention of child maltreatment, and the integration of behavioral health in primary and community health center settings. APA recommends evaluating the demonstration projects' implementation and outcomes. APA also supports education, recruitment, and training of mental health and primary care providers to implement culturally informed preventative programs that enhance parenting practices and screenings at the centers.

Administration for Children and Families, Healthy Media for Youth.—Research links sexualization with three of the most common mental health problems of female children, adolescents, and adults: eating disorders, depression or depressed mood, and low self-esteem. APA encourages HHS to fund media literacy and youth empowerment programs to prevent and counter the effects of the sexualization of female children, adolescents, and adults.

Strengthening Families.—APA encourages ACF to continue its support of research programs that aim to strengthen families with economic hardship using empirically supported skills-based approaches. These projects aim to teach proven family strengthening skills and principles such as relationship education, stress management, and child-centered parenting to promote healthy inter-parental relationships that lead to healthy, well-functioning children.

National Institutes of Health (NIH), behavioral research.—Understanding the complex influences of behavior on health is a critical part of NIH's mission. There is strong evidence that half of all deaths in the United States can be attributed to behavioral factors such as smoking, poor diet, substance abuse, and physical inactivity. In addition, behavioral and social factors contribute to the staggering costs of preventable morbidity and mortality. NIH-supported behavioral and social sciences research ranges from basic research on memory, learning and perception, to prevention research, to clinical trials and comparative effectiveness research.

NIH, Office of Behavioral and Social Sciences Research.—OBSSR was authorized by Congress in the NIH Revitalization Act of 1993 and established in 1995. For fiscal year 2011, APA supports a budget of $41.32 million for OBSSR to fulfill its coordinating role, commensurate with the administration's request of $38.2 million for the Office and the scientific community's request for the NIH as a whole.

NIH, Office of Behavioral and Social Sciences Research, Basic Behavioral and Social Sciences Research.—APA is pleased that NIH has established a initiative to increase and coordinate trans-NIH support for basic behavioral and social sciences research. Coordinated by OBSSR with leadership and contributions from multiple NIH institutes, the Opportunity Network for Basic Behavioral and Social Sciences Research (OppNet), will fund basic research to help fill gaps in knowledge about fundamental mechanisms and patterns of behavioral and social functioning, relevant to health and well-being, as they interact with each other, with biology and the environment.

NIH, National Institute on Minority Health and Health Disparities, Health Disparities.—The recent healthcare reform legislation elevated the National Center on Minority Health and Health Disparities within NIH, giving it greater authority to address the health disparities that exist in minority communities. APA recommends that Congress provide sufficient funding for NIMHD to carry out its mandated functions, and urges Congress to support NIMHD in its enhanced role to address priority health conditions of minority populations.

NIH, Behavioral Research Highlights.—The following areas of NIH-supported research are good examples of the breadth and vitality of the behavioral research portfolio at NIH:

NIH Roadmap, Science of Behavior Change.—By focusing basic research on the initiation, personalization, and maintenance of behavior change, and by integrating work across disciplines, this Roadmap effort and subsequent trans-NIH activity could lead to an improved understanding of the underlying principles of behavior change, and drive a transformative increase in the efficacy, effectiveness, and (cost) efficiency of many behavioral interventions.

NIMH, Children's Mental Health.—Early diagnosis, prevention and treatment is critical for the millions of families affected by autism, attention deficit hyperactivity disorder, anxiety disorders, depression, bipolar disorder, and eating disorders. NIMH is supporting important clinical trials to demonstrate the evidence base for effective pharmacological and behavioral interventions treatments for child and adolescent populations with these disorders.

NIDA, Tobacco Addiction.—While significant declines in smoking have been achieved in recent decades, too many Americans, particularly youth, remain addicted to tobacco products. NIDA-supported researchers are identifying genetic and environmental factors that contribute to nicotine dependence and affect the efficacy of smoking cessation treatments.

DEPARTMENT OF EDUCATION

National Institute on Disability and Rehabilitation Research: Disability Research.—APA recommends that NIDRR pursue mental health-related research proposals through its investigator-initiated and other grants programs, including sponsoring studies that will demonstrate the impact of socio-emotional, behavioral and attitudinal aspects of disability. APA encourages initiatives that support a broad field of NIDRR research, including Health and Functioning, Community Integration and Employment which will address societal barriers, such as stigmatization and discrimination, and their impact on people with physical, mental and neurological disabilities.

PREPARED STATEMENT OF THE ASSOCIATION FOR PROFESSIONALS IN INFECTION CONTROL AND EPIDEMIOLOGY

The Association for Professionals in Infection Control and Epidemiology (APIC) thanks you for this opportunity to submit testimony and greatly appreciates this subcommittee's leadership in providing the necessary funding for the Federal Government to have a leadership role in the effort to eliminate healthcare-associated infections (HAIs).

APIC's mission is to improve health and patient safety by reducing the risk of healthcare-associated infections and related adverse outcomes. The organization's more than 13,000 members, known as infection preventionists, direct infection prevention programs that save lives and improve the bottom line for hospitals and other healthcare facilities throughout the United States and around the globe. Our association strives to promote a culture within healthcare institutions where all members of the healthcare team fully embrace the elimination of HAIs. We advance these efforts through education, research, collaboration, practice guidance, public policy, and credentialing.

HAIs are among the leading causes of preventable death in the United States, accounting for an estimated 1.7 million infections and 99,000 associated deaths in 2002. In addition to the substantial human suffering caused by HAIs, these infections contribute $28 billion to $33 billion in excess healthcare costs each year.

We are greatly appreciative of funding provided in the fiscal year 2010 Consolidated Appropriations Act to resource HAI reduction efforts. In particular, we support the $5 million appropriation for the HHS Office of the Secretary to coordinate and integrate HAI-related activities across the Department, $136 million for the Centers for Disease Control and Prevention's (CDC) emerging infectious diseases portfolio for expanded surveillance, public health research and prevention activities, $15 million to expand the CDC National Healthcare Safety Network (NHSN) and finally, $34 million for the Agency for Healthcare Research and Quality's (AHRQ) MRSA Collaborative Research Initiative and for implementing evidence-based HAI prevention training nationwide.

In fiscal year 2011, we ask that you support the CDC Coalition's $8.8 billion for CDC's "core programs." CDC serves as the command center for our Nation's public health defense system against emerging and re-emerging infectious diseases. From pandemic flu preparedness and prevention activities to West Nile virus to smallpox

to SARS, the Centers for Disease Control and Prevention is the Nation's—and the world's—expert resource and response center, coordinating communications and action and serving as the laboratory reference center. APIC members rely on CDC for accurate information and direction in a crisis or outbreak. We ask that you provide $2.3 billion for the CDC's Infectious Diseases programs.

Because our members are on the front line in healthcare facilities, bringing their expertise in infection prevention to the patient's bedside, there are so many areas within the CDC budget that we could highlight. Allow us to outline some of the areas of greatest concern to our membership. We support the administration's fiscal year 2011 request for $27 million to expand NHSN to approximately 2,500 new hospitals. Currently, 21 States require hospitals to report HAIs using NHSN. However, CDC supports more than 2,300 participating hospitals in NHSN in all 50 States. This surveillance system plays an important role in improving patient safety at the local and Federal levels. NHSN's data analysis function helps our members analyze facility-specific data and compare rates to national aggregate metrics. It also allows CDC to estimate and characterize the current burden of HAIs in the United States. Every step taken to create interoperable data systems in which our members can input HAI data and have it go directly to NHSN is a step toward freeing our members to do more hands-on infection prevention activities.

We also appreciate the administration's proposal of $155.9 million for emerging infectious diseases in fiscal year 2011 and ask that you increase funding for this purpose to $200 million to allow CDC to work with partners at the State and local level to detect and respond to this important public health threat.

In addition, we support the $10 million budget request for the new Health Prevention Corps. We appreciate the importance of targeting disciplines with existing shortages with a workforce program designed to recruit talented new individuals for State and local health departments.

APIC is concerned, that the administration's proposed budget would cut the Antimicrobial Resistance budget by $8.6 million, just more than 50 percent. We agree with the agency's congressional justification that this is "one of the world's most pressing public health problems" and ask that you increase funding for CDC antimicrobial resistance activities in fiscal year 2011 to $40 million.

In addition, we support the $34 million in the administration's fiscal year 2011 budget to build upon AHRQ efforts—now in all 50 States, the District of Columbia and Puerto Rico—to reduce bloodstream infections in intensive care units (ICUs) through implementation of a safety compliance checklist and providing staff with evidence-based practices. We support these efforts and AHRQ's plans to reach out to the CDC to identify and design projects to reduce the incidence of HAIs in other infection sites using evidence-based practices.

Further, APIC supports the administration's request to build upon American Recovery and Reinvestment Act (ARRA) efforts by supporting use of the HAI survey tool developed jointly by CDC and the Centers for Medicare and Medicaid Services (CMS) with ARRA funds. The administration's fiscal year 2011 request under Survey and Certification would increase survey frequencies at ambulatory surgery centers (ASCs) to every 4 years. Due to the increasing number of surgeries performed in outpatient settings, and the need to ensure that basic infection prevention practices are followed, APIC supports efforts to increase the use of this survey tool.

Finally, we support the administration's $5 million request for HAI activities to support continued efforts of the HHS Action Plan to Prevent Healthcare-Associated Infections (HAI Action Plan). This funding will allow HHS to continue current efforts and expand upon a national media campaign, utilize social media tools, develop a single comprehensive Web site for HAI information, and evaluate the media campaign and original Action Plan and assess whether it is achieving its intended goals.

We believe the development of the HAI Action Plan and the funding to support these activities has been an essential tool in the effort to build support for a coordinated Federal message on preventing infections. Additionally, we feel very strongly that the CDC has the necessary expertise to define appropriate metrics through which the HAI Action Plan can best measure its efforts.

APIC strongly believes that to move toward our goal of HAI elimination, there needs to be a concerted effort to fund research into the knowledge gaps outlined in the HAI Action Plan, with an eye toward the science of implementation.

This subcommittee has taken essential steps in using stimulus funds to build the necessary infrastructure within States to address HAI reduction. Your leadership has also put resources into improving surveillance efforts and scaling-up proven HAI prevention approaches. However, while resources have encouraged States to plan for HAI prevention efforts, APIC's 2009 Economic Survey of our membership

indicates that infection prevention budgets within healthcare facilities have been hard hit, particularly in the area of education.

Three-quarters of our members who reported that their budgets were cut in our recent survey have experienced decreases for the education that trains healthcare workers in preventing HAI transmission. Half saw reductions in overall budgets for infection prevention, including money for technology, staff, education, products equipment and updated resources. Nearly 40 percent had layoffs or reduced hours. While we fully support your effort to put infrastructure in place in States to promote HAI reduction efforts and believe that was a very wise use of one-time stimulus funding, we need to make clear that our membership would be hard-pressed to scale up HAI reduction efforts while their budgets are facing these kinds of decreases.

We thank you for the opportunity to submit testimony and greatly appreciate this subcommittee's leadership in providing the necessary funding for the Federal government to have a leadership role in the effort to eliminate HAIs.

PREPARED STATEMENT OF THE AMERICAN PUBLIC POWER ASSOCIATION

The American Public Power Association (APPA) is the national service organization representing the interests of more than 2,000 municipal and other State and locally owned utilities throughout the United States (all but Hawaii). Collectively, public power utilities deliver electricity to 1 of every 7 electricity consumers (approximately 45 million people), serving some of the Nation's largest cities. However, the vast majority of APPA's members serve communities with populations of 10,000 people or less.

We appreciate the opportunity to submit this statement supporting funding for the Low-Income Home Energy Production Assistance Program (LIHEAP) for fiscal year 2011.

APPA has consistently supported an increase in the authorization level for LIHEAP. The administration's fiscal year 2011 budget requests $3.3 billion for LIHEAP. APPA supports a level of $5.1 billion for the program.

APPA is proud of the commitment that its members have made to their low-income customers. Many public power systems have low-income energy assistance programs based on community resources and needs. Our members realize the importance of having in place a well-designed low-income customer assistance program combined with energy efficiency and weatherization programs in order to help consumers minimize their energy bills and lower their requirements for assistance. While highly successful, these local initiatives must be coupled with a strong LIHEAP program to meet the growing needs of low-income customers. In the last several years, volatile home-heating oil and natural gas prices, severe winters, high utility bills as a result of dysfunctional wholesale electricity markets and the effects of the economic downturn have all contributed to an increased reliance on LIHEAP funds.

Also when considering LIHEAP appropriations this year, we encourage the subcommittee to provide advanced funding for the program so that shortfalls do not occur in the winter months during the transition from one fiscal year to another. LIHEAP is one of the outstanding examples of a State-operated program with minimal requirements imposed by the Federal Government. Advanced funding for LIHEAP is critical to enabling States to optimally administer the program.

Thank you again for this opportunity to relay our support for increased LIHEAP funding for fiscal year 2011.

PREPARED STATEMENT OF THE AMERICAN PHYSIOLOGICAL SOCIETY

The American Physiological Society (APS) thanks the Chairman and all the members of this subcommittee for their support for the National Institutes of Health (NIH). Research carried out by the NIH contributes to our understanding of health and disease, which allows all Americans to look forward to a healthier future. In this testimony, APS recommends that the NIH be funded at $37 billion in fiscal year 2011.

APS is a professional society dedicated to fostering research and education as well as the dissemination of scientific knowledge concerning how the organs and systems of the body work. APS was founded in 1887 and now has nearly 10,000 member physiologists. APS members conduct NIH-supported research at colleges, universities, medical schools, and other public and private research institutions across the United States.

Momentum From the American Recovery and Reinvestment Act (ARRA) Should be Maintained at NIH

The inclusion of $10.4 billion for biomedical research in ARRA has provided the NIH with an unprecedented opportunity to move science forward. To date, the ARRA investment has funded more than 14,000 scientific projects in all 50 States.[1]

Last year the NIH moved quickly to take advantage of the opportunities provided by ARRA to address important areas of scientific need. ARRA funds are already being used to support new science in high-priority areas such as biomarker discovery, regenerative medicine, stem cell research and translational science through the Challenge Grant program. ARRA funds are also being used to support highly meritorious research proposals that had gone unfunded due to years of slow growth in the NIH budget. In recent years, only 1 out of every 5 proposals submitted to the NIH received funding, leaving many important research questions unexplored. The ARRA funds have allowed NIH to direct funds to some of the most interesting and important projects that were unfunded for budgetary reasons. ARRA funds will also reach the next generation of scientists through hands-on summer research experiences for approximately 5,000 undergraduates and science educators.

As a result of the ARRA investment, the NIH estimates that 50,000 jobs nationwide will be created or retained.[2] The widespread distribution of NIH ARRA funds has already had a direct economic impact on the research community by funding labs and projects that would otherwise have gone unfunded. However, State and local economies also stand to benefit substantially from the stimulus funds being spent by NIH researchers. A report by Families USA showed that on average in the year 2007, every $1 of NIH funding generated twice as much in State economic output.[3]

In order to capitalize and build on the functional capacity created through the ARRA investment, we urge Congress to make every effort to fund the NIH at a level of $37 billion in fiscal year 2011. Funding at this level takes into account the additional ARRA funds that have been added to the NIH budget, and allows for growth at the rate of the biomedical research and development price index (BRDPI). This will maintain the momentum created by ARRA and start the NIH on a new path of consistent and sustainable growth in future budget cycles.

NIH Funds Outstanding Science

As a result of improved healthcare, Americans are living longer and healthier lives in the 21st century than ever before. However, diseases such as heart failure, diabetes, cancer, and emerging infectious diseases continue to inflict a heavy burden on our population. The NIH invests heavily in basic research to explore the mechanisms and processes of disease. This investment results in new tools and knowledge that can be used to design novel treatments and prevention strategies. A key example comes from the recent outbreak of H1N1 flu. From the time that the first cases of the disease emerged, it took approximately 6 months to develop a vaccine, identify those most at risk and begin to understand how and why the H1N1 flu strain differs from those seen in an average year. The ability to rapidly respond to this and other threats to human health is directly dependent upon maintaining a robust scientific enterprise.

Last year the Nobel Prize in Physiology or Medicine was awarded to three longtime NIH grantees. Drs. Jack Szostak, Elizabeth Blackburn and Carol Greider shared the 2009 prize for their discovery of how the tips of chromosomes are protected from degradation during cell division. Since the discovery of this fundamental cellular mechanism, researchers have been able to apply this knowledge to better understand how cells age and why they sometimes become cancerous. Collectively NIH has supported their research for more than 30 years.[4] Three other NIH grantees won the Nobel Prize in Chemistry in 2009. Drs. Venkatraman Ramakrishnan, Thomas A. Steitz and Ada E. Yonath identified the structure of the ribosome, the molecular machinery that makes proteins in cells. NIH has supported these researchers in their work for nearly four decades.[5]

NIH Nurtures the Biomedical Research Enterprise

In addition to supporting research, the NIH must also address workforce issues to ensure that our Nation's researchers are ready to meet the challenges they will face in the future. The administration's fiscal year 2011 budget proposal includes

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[1] http://report.nih.gov/recovery/arragrants.cfm
[2] http://report.nih.gov/PDF/Preliminary_NIH_ARRA_FY2009_Funding.pdf
[3] http://www.familiesusa.org/assets/pdfs/global-health/in-your-own-backyard.pdf
[4] http://www.nigms.nih.gov/News/Results/nobel20091005.htm
[5] http://www.nigms.nih.gov/News/Results/nobel_20091007a.htm

funding for a 6 percent increase in stipend levels for National Research Service Awards. The APS applauds this proposed increase and calls on Congress to make every effort to fully fund the request.

New investigators entering the scientific workforce have frequently encountered long training periods before gaining independence and funding for their own research labs. In fiscal year 2007, the average age of new investigators receiving their first awards from NIH rose to 42 years. To address this problem and foster the next generation of scientists, the NIH has committed to funding new investigators at approximately the same rate as established investigators.[6] This will allow investigators to become independent and able to explore innovative ideas at an earlier stage of their careers. However, efforts will be successful only if funds are available to continue to support the careers of new and young investigators beyond the period of their first grant.

The NIH is also home to the Institutional Development Award (IDeA) Program. Established in 1993, the goal of the IDeA program is to broaden the geographic distribution of NIH funds by serving researchers and institutions in areas that have not historically received significant NIH funding. IDeA builds research capacity and improves competitiveness in those States through the development of shared resources, infrastructure and expertise. IDeA currently serves institutions and investigators in 23 States and Puerto Rico.

The APS joins the Federation of American Societies for Experimental Biology in urging that NIH be provided with $37 billion in fiscal year 2011 so that researchers can build on the momentum and capacity created through the ARRA investment.

PREPARED STATEMENT OF THE ASSOCIATION FOR PSYCHOLOGICAL SCIENCE

SUMMARY OF RECOMMENDATIONS

As a member of the Ad Hoc Group for Medical Research Funding, Association for Psychological Science (APS) recommends $35 billion for the National Institutes of Health (NIH) in fiscal year 2011.

APS requests subcommittee support for behavioral and social science research and training as a core priority at NIH in order to: better meet the Nation's health needs, many of which are behavioral in nature; realize the exciting scientific opportunities in behavioral and social science research; and accommodate the changing nature of science, in which new fields and new frontiers of inquiry are rapidly emerging.

Given the critical role of basic behavioral science research and training in addressing many of the Nation's most pressing public health needs, we ask the subcommittee to ensure that NIH leadership sustains its cross-NIH basic behavioral research funding initiative, the Basic Behavioral and Social Science Opportunity Network (OppNet), and coordinates with all Institutes and Centers to provide support for basic behavioral science research.

APS encourages the subcommittee to support behavioral science priorities at individual institutes. Examples are provided in this testimony to illustrate the exciting and important behavioral and social science work being supported at NIH.

Mr. Chairman, members of the subcommittee: My name is Dr. Amy Pollick, and I am speaking on behalf of the APS. Thank you for the opportunity to provide this statement on the fiscal year 2011 appropriations for NIH. As our organization's name indicates, APS is dedicated to all areas of scientific psychology, in research, application, teaching, and the improvement of human welfare. Our 22,000 members are scientists and educators at the Nation's universities and colleges, conducting NIH-supported basic and applied, theoretical, and clinical research. They look at such things as: the connections between emotion, stress, and biology and the impact of stress on health; they use brain imaging to explore thinking and memory and other aspects of cognition; they develop ways to manage debilitating chronic conditions such as diabetes and arthritis as well as depression and other mental disorders; they look at how genes and the environment influence behavioral traits such as aggression and anxiety; and they address the behavioral aspects of smoking and drug and alcohol abuse.

As a member of the Ad Hoc Group for Medical Research Funding, APS recommends $35 billion for NIH in fiscal year 2011, an increase of 12.6 percent more than the fiscal year 2010 appropriations level. This increase would halt the erosion of the Nation's public health research enterprise, and help restore momentum to our efforts to improve the health and quality of life of all Americans.

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[6] http://grants.nih.gov/grants/new__investigators/index.htm

Within the NIH budget, APS is particularly focused on behavioral and social science research and the central role of behavior in health. The remainder of my testimony concerns the status of those areas of research at NIH.

HEALTH AND BEHAVIOR: THE CRITICAL ROLE OF BASIC AND APPLIED PSYCHOLOGICAL RESEARCH

Behavior is a central part of health. Many leading health conditions—such as heart disease; stroke; lung disease and certain cancers; obesity; AIDS; suicide; teen pregnancy; drug abuse and addiction; depression and other mental illnesses; neurological disorders; alcoholism; violence; injuries and accidents—originate in behavior and can be prevented or controlled through behavior.

As just one example: stress is something we all feel in our daily lives, and we now have a growing body of research that illustrates the direct link between stress and health problems:

—chronic stress accelerates not only the size but also the strength of cancer tumors;
—chronic stressors weaken the immune system to the point where the heart is damaged, paving the way for cardiac disease;
—children who are genetically vulnerable to anxiety and who are raised by stressed parents are more likely to experience greater levels of anxiety and stress later in life;
—animal research has shown that stress interferes with working memory; and
—stressful interactions may contribute to systemic inflammation in older adults, which in turn extends negative emotion and pain over time.

None of the conditions or diseases described above can be fully understood without an awareness of the behavioral and psychological factors involved in causing, treating, and preventing them. Just as there exists a layered understanding, from basic to applied, of how molecules affect brain cancer, there is a similar spectrum for behavioral research. For example, before you address how to change attitudes and behaviors around AIDS, you need to know how attitudes develop and change in the first place. Or, to design targeted therapies for bipolar disorder, you need to know how to understand how circadian rhythms work as disruptions in sleeping patterns have been shown to worsen symptoms in bipolar patients.

NIH's New Commitment to Basic Behavioral Science Research Should Be Made Permanent

Broadly defined, behavioral research explores and explains the psychological, physiological, and environmental mechanisms involved in functions such as memory, learning, emotion, language, perception, personality, motivation, social attachments, and attitudes. Within this, basic behavioral research aims to understand the fundamental nature of these processes in their own right, which provides the foundation for applied behavioral research that connects this knowledge to real-world concerns such as disease, health, and life stages. Thanks in large part to the leadership of this Committee and your counterparts in the House, NIH has launched a new initiative that supports and expands new basic behavioral research throughout NIH. In November 2009, NIH leadership launched the Basic Behavioral and Social Science Opportunity Network (OppNet), and has already released several funding opportunities. OppNet is currently organizing its strategic plan to prioritize research areas it will fund over the next 4 years. This plan should include, at the very least, the following areas of research that will be critical to its success and more importantly, critical for the NIH to best take advantage of what this field has to offer:

—identifying the dimensions of the environment that create, moderate, and reverse risks for mental and physical health disorders;
—a rigorous understanding of emotions, their regulation, and functions;
—development of multiple methods of behavioral measurement;
—the role of emotions and environmental factors in behavior change;
—animal models of behavior that enrich our understanding of human processes;
—interpersonal interactions across the lifespan and across social, economic, and cultural contexts; and
—individual processes underlying personality, self, and identity.

While we are greatly encouraged by the launch of OppNet, it is slated to end in 2014. That, combined with the lack of a permanent organizational structure for basic behavioral research at NIH, creates enormous uncertainty for an enterprise that by nature inherently requires a longer-term, stable commitment.

APS respectfully asks the subcommittee to:

—ensure that NIH adequately supports and sustains a strong, permanent program of basic behavioral science research and training as a critical element in improving the health and welfare of all Americans; and

—ensure that behavioral research is a priority at NIH both by providing maximum funding for those institutes where behavioral science is a core activity and encouraging NIH to advance a model of health that includes behavior in its scientific priorities.

Psychological Clinical Science Training and Public Health

One in 4 adults and 1 in 5 children in the United States have a diagnosable mental disorder that impairs normal functioning, and mental illness accounts for more than 15 percent of the burden of disease in major nations; the economic burden associated with mental illness exceeds that of all forms of cancer combined. The costs associated with mental illness are staggering; $69 billion was spent on mental health services in the United States alone in 1996. This is more than 7 percent of our total health spending. For these reasons, it is critical that our understanding of, diagnosis, treatment, and prevention of mental illness reflects the very best and most modern science possible.

Unfortunately, the vast majority of clinical psychologists are currently being trained outside of the major research universities and hospitals. Even in the best of these training programs, students receive little or no direct contact with cutting-edge research. In many of these programs there is even an anti-science bias; students in these programs are being trained to diagnose and treat mental illness using methods that have no scientific support or, even worse, that have been shown to be of little or no value. To combat this problem, a group of the top 50 clinical psychology programs in the United States formed the Academy for Psychological Clinical Science, an organization committed to reaffirming the critical importance of science in clinical psychology training. The Academy recently established an independent accreditation system to insure that clinical psychology training programs meet the highest scientific standards, which will be critical for re-establishing the scientific foundation of clinical psychology.

Individuals with mental illness and their families will know that practitioners who graduate from these programs will be delivering treatments that incorporate state-of-the-art scientific advances and that have passed the most critical scientific tests of their efficacy. Those communities and organizations wishing to provide state-of-the-art, scientifically based mental health services will know where to seek consultation and find the very best personnel. And finally, this new accreditation system will increase the supply of highly skilled scientists who will continue to fight the good fight again the ravages of mental illness.

The National Institute of Mental Health's (NIMH) mission includes the assurance that that the science-based interventions its researchers generate can be used by patients, families, healthcare providers, and the wider community involved in mental healthcare. Most of the institutions that will be accredited under the new system (called the Psychological Clinical Science Accreditation System) include NIMH-funded researchers, and NIMH has already begun to support the new system in the spirit of advancing scientifically-sound treatments that its research helped develop. APS asks the Committee to support the new accreditation system for psychological clinical science training programs in order to reduce the burden of mental illness on individuals, families, communities, and society, through the use of empirically validated treatments by qualified practitioners.

BEHAVIORAL SCIENCE AT KEY INSTITUTES

In the remainder of my testimony, I would like to highlight examples of cutting-edge behavioral science research being supported by individual institutes.

National Cancer Institute (NCI).—NCI is at the forefront of supporting behavioral science in the spirit of advancing the Nation's effort to prevent cancer. The Behavioral Research Program continues to invest in research on the development and dissemination of interventions in areas such as tobacco use, dietary behavior, sun protection, and decisionmaking. For example, knowledge about basic psychological mechanisms can be brought to bear on warnings about risky behavior, with a particular focus on tobacco use. The recently enacted FDA regulation of tobacco products is a landmark opportunity for tobacco control, and it presents a complimentary invitation for psychological science to revolutionize the study of warning labels and risky behavior. Specifically, recent research on graphic warning labels for cigarettes indicates that specific types of images can improve understanding of the consequences of smoking, and encourage motivations to quit smoking. APS asks the subcommittee to support NCI's behavioral science research and training initiatives and to encourage other Institutes to use them as models.

National Institute on Aging (NIA).—NIA's Division of Behavioral and Social Research has one of the strongest psychological science portfolios in all of NIH, and is supporting wide-ranging and innovative work. For example, older individuals face

important and often complex decisions about retirement and other financial matters, and the normal aging process alters many of the psychological capacities and neural systems that come into play when making these decisions. Researchers are now looking at how healthy aging influences the psychological and neural bases of economic choice, and hope to speed along the development of interventions that remediate problems with decisionmaking in the elderly, resulting in public health benefits. NIA's commitment to cutting-edge behavioral science is further illustrated by the Institute's leadership role in NIH's new Common Fund initiative on the Science of Behavior Change. APS asks the subcommittee to support NIA's behavioral science research efforts and to increase NIA's budget in proportion to the overall increase at NIH in order to continue its high-quality research to improve the health and well-being of Americans across the lifespan.

Eunice Kennedy Shriver National Institute for Child Health and Human Development (NICHD).—NICHD is to be commended for supporting a broad spectrum of behavioral research, particularly as it relates to real-world problems. Let me give you one example, centering on the effects of socioeconomic adversity on children's brain development. Researchers are beginning to clarify the relationship among socioeconomic status (SES), early life experience, and learning in adolescents. We know that learning ability is positively correlated with SES, and recent research suggests that the effects of childhood experience on the development of certain parts of the brain may partially explain this. Researchers at the University of Pennsylvania are now learning about the nature and causes of the SES disparity in learning ability by examining its scope across different types of learning and different neural systems, and assessing its relation to early experience, including stress and parental nurturing. Thus, we are closer to understanding the crucial role played by learning in the academic, occupational, and personal lives of all Americans, and the prospect of preserving and fostering the learning ability in at-risk youth though the application of insights from the cognitive neuroscience of memory, stress, and early experience. APS asks the subcommittee to support NICHD's sustained behavioral science research portfolio and to encourage other Institutes to partner with NICHD to maximize the development of interventions in early stages of life that have invaluable benefits in adulthood.

National Institute on Deafness and Other Communication Disorders (NIDCD).—NIDCD supports a vibrant and important portfolio of behavioral science research on voice, speech, and language. This research expands our understanding of the role of each hemisphere of the brain in communication and language, of early specialization of the brain, and of the recovery process following brain damage. Scientists are now exploring the genetic bases of child language disorders, as well as characterizing the linguistic and cognitive deficits in children and adults with language disorders. This and similar research programs are important because they offer valuable insight into the basis of the disorder and the associated academic problems encountered by many children with SLI. They are also likely to improve the classification, diagnosis, and treatment of other language, reading, and speech disorders. APS asks the subcommittee to support NIDCD's behavioral science research program and to increase NIDCD's budget in proportion to the overall increase at NIH in order to continue making significant advances in our understanding of and treatments for communication disorders in Americans of all ages.

It's not possible to highlight all of the worthy behavioral science research programs at NIH. In addition to those reviewed in this statement, many other Institutes play a key role in the NIH behavioral science research enterprise. These include the National Institute of Mental Health, the National Institute on Alcohol Abuse and Alcoholism, and the National Institute on Drug Abuse. Behavioral science is a central part of the mission of these Institutes, and their behavioral science programs deserve the subcommittee's strongest possible support.

This concludes my testimony. Again, thank you for the opportunity to discuss NIH appropriations for fiscal year 2011 and specifically, the importance of behavioral science research in addressing the Nation's public health concerns. I would be pleased to answer any questions or provide additional information.

PREPARED STATEMENT OF THE AMERICAN PHYSICAL THERAPY ASSOCIATION

Chairman Harkin and Members of the Senate Subcommittee on Labor, Health and Human Services, and Education, and Related Agencies: On behalf of more than 74,000 physical therapists, physical therapist assistants, and students of physical therapy, the American Physical Therapy Association (APTA) thanks you for the opportunity to submit official testimony regarding recommendations for the fiscal year 2011 appropriations. APTA's mission is to improve the health and quality of life of

individuals in society by advancing physical therapist practice, education, and research. Physical therapists across the country utilize a wide variety of Federally funded resources to work collaboratively toward the advancement of these goals. APTA's recommendations for Federal funding as outlined in this document reflect the commitment toward these priorities for the good of society and the rehabilitation community.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

National Institutes of Health (NIH)

Rehabilitation research was funded at $404 million within NIH's approximately $30.5 billion budget in fiscal year 2009. This represents roughly 1 percent of NIH funds for an area of biomedical research that impacts a growing percentage of our Nation's seniors, persons with disabilities, young persons with chronic disease or traumatic injuries, and children with development disabilities. The Institute of Medicine estimates that 1 in 7 individuals have an impairment or limitation that significantly limits their ability to perform activities of daily living. Investment in and recognition of rehabilitation within NIH is a necessary step toward continuing to meet the needs of these individuals in our population. Through the American Recovery and Reinvestment Act (ARRA), rehabilitation research has been able to take advantage of an extra infusion of approximately $75 million in fiscal year 2009. However, APTA believes that rehabilitation research at NIH has been underfunded for many years. The funds currently utilized are well-invested for the impact that rehabilitation interventions will have on the quality of lives of individuals. Continued investment and greater recognition and coordination of rehabilitation research among Institutes and across Federal Departments will enhance the returns the Federal Government receives when investing in this area. Taking this into consideration, APTA advocates for $35.2 billion (a $4.2 billion increase more than fiscal year 2010) for NIH to capitalize on the momentum achieved under the ARRA investment to improve health, spur economic growth and innovation, and advance science.

Specifically, the physical therapy and rehabilitation science community recommends that Congress allocate crucial funding enhancements in the following Institutes:

—$1.5 billion (a 12.5 percent increase more than fiscal year 2010) for the Eunice Kennedy Shriver National Institute of Child Health and Human Development which houses the National Center for Medical Rehabilitation Research (NCMRR), the only entity within NIH explicitly focused on the advancement of rehabilitation science. NCMRR fosters the development of scientific knowledge needed to enhance the health, productivity, independence, and quality-of-life of people with disabilities. A primary goal of the Center-supported research is to bring the health-related problems of people with disabilities to the attention of the best scientists in order to capitalize upon the myriad advances occurring in the biological, behavioral, and engineering sciences.

—$1.857 billion ($221 million increase more than fiscal year 2010) for the National Institute of Neurological Disorders and Stroke. This funding level is required to enhance existing initiatives and invest in new and promising research to prevent stroke and advance rehabilitation in stroke treatment. Despite being a major cause of disability and the number three cause of death in the United States, NIH invests only 1 percent of its budget on stroke research. However, APTA recognizes the advancements that NIH-funded research has achieved in the specific area of stroke rehabilitation. APTA commends this area of leadership at NIH and encourages a continued focus on rehabilitation interventions and physical therapy to maximize an individual's function and quality of life after a stroke.

—$500 million in arthritis and musculoskeletal research within the National Institute of Arthritis and Musculoskeletal and Skin Diseases

Centers for Disease Control and Prevention (CDC)

APTA was disappointed to see the cuts that have been proposed for CDC through the administration's fiscal year 2011 budget proposal. The potential contributions of CDC to the lives of countless individuals are limited only by the resources available for carrying out its vital mission. Our Nation and the world will continue to benefit from further improvement in public health and investment in scientific advancement and prevention. APTA recommends Congress provide at least $8.8 billion for CDC's fiscal year 2010 "core programs" in the fiscal year 2011 Labor, Health and Human Services, and Education, and Related Agencies appropriations bill. This request reflects the support CDC will need to fulfill its core missions for fiscal year

2011. APTA strongly believes that the activities and programs supported by CDC are essential in protecting the health of the American people.

Physical therapists play an integral role in the prevention, education, and assessment of the risk for falls. The CDC is currently only allocating $2 million per year to address the increasing prevalence of falls, a problem costing more than $19.2 billion a year. Among older adults, falls are the leading cause of injury deaths. This is why APTA respectfully requests that $20.7 million be provided in funding for the "Unintentional Injury Prevention" account to allow CDC's National Center for Injury Prevention and Control to comprehensively address the large-scale growth of older adult falls.

Currently, CDC's program on arthritis receives $13 million in annual funding, and about half of which is distributed via competitive grants to 12 States to deliver and promote proven arthritis intervention strategies. Physical therapy interventions are designed to restore, maintain, and promote maximal physical function for people with arthritis. An additional investment of $10 million, beginning in fiscal year 2011, would fund up to 14 new States and bring evidence-based prevention programs to many more Americans through innovative delivery approaches.

Traumatic Brain Injury (TBI) is a leading cause of death and disability among young Americans and continues to be the signature injury of the conflicts in Iraq and Afghanistan. CDC estimates that at least 5.3 million Americans, approximately 2 percent of the U.S. population, currently require lifelong assistance to perform activities of daily living as a result of TBI. High-quality, evidence-based rehabilitation for TBI is typically a long and intensive process. From the battlefield to the football field, American adults and youth continue to sustain TBIs at an alarming rate and funding is desperately needed for better diagnostics and evaluation, treatment guidelines, improved quality of care, education and awareness, referral services, State program services, and protection and advocacy for those less able to advocate for themselves. APTA recommends at least $10 million in fiscal year 2011 for CDC's TBI Registries and Surveillance, Brain Injury Acute Care Guidelines, Prevention, and National Public Education/Awareness programs.

APTA would like to see $76 million ($20 million increase more than fiscal year 2010) for CDC's Heart Disease and Stroke Prevention Program in fiscal year 2011. CDC spends on average only 16 cents a person each year on heart disease and stroke prevention, despite the fact that heart disease, stroke, and other forms of cardiovascular disease remain our Nation's number one and most costly killer. A $20 million increase in funding will allow CDC to support the 9 States that receive no funding for the competitively awarded Heart Disease and Stroke Prevention Program, elevate more States to basic program implementation, and support the other funded States.

CDC's Well-Integrated Screening and Evaluation for Women Across the Nation (WISEWOMAN) programs screens uninsured and under-insured low-income women ages 40 to 64 for heart disease and stroke risk and those with abnormal results receive counseling, education, referral and follow up. WISEWOMAN reached more than 84,000 women and provided more than 210,000 lifestyle intervention sessions from 2000 to mid-2008, while also identifying 7,647 new cases of high blood pressure, 7,928 new cases of high cholesterol, and 1,140 new cases of diabetes. Among those WISEWOMAN participants who were re-screened 1 year later, average blood pressure and cholesterol levels had decreased considerably. APTA recommends $37 million ($16.3 million increase more than fiscal year 2010) for CDC's WISEWOMAN Program in fiscal year 2011.

Health Resources and Services Administration (HRSA)

Through the successful passage of healthcare reform legislation, it becomes more important now than ever that America is able to supply an adequate and well-trained healthcare workforce to meet the demands of an expanded market of U.S. citizens that have health insurance coverage. APTA urges you to provide at least $9.15 billion for HRSA in fiscal year 2011. This amount reflects the minimum amount necessary for the agency to adequately meet the needs of the populations they serve. The relatively level funding HRSA has received over the past several years has undermined the ability of its successful programs to grow and be expanded to represent professions that shape the entire healthcare team, such as physical therapy. Any shortage areas of physical therapists and rehabilitation professionals may become more accentuated as the percentage of the U.S. population that has health coverage increases and demand rises. It is beneficial to undertake efforts to strengthen the healthcare workforce and delivery across the whole spectrum of an individual's care—from onset through rehabilitation. More resources are needed for HRSA to achieve its ultimate mission of ensuring access to culturally

competent, quality health services; eliminating health disparities; and rebuilding the public health and healthcare infrastructure.

In conjunction with the importance of funding TBI efforts within CDC, APTA also recommends $8 million for the HRSA Federal TBI State Grant Program and $4 million for the HRSA Federal TBI Protection & Advocacy (P&A) Systems Grant Program

DEPARTMENT OF EDUCATION

In 2008, as part of the reauthorization of the Higher Education Act (Public Law 110–315), the Loan Forgiveness for Service in Areas of National Need (LFSANN) program was created. This program would provide a modest amount of loan forgiveness for a variety of education and healthcare professional groups, including physical therapists, upon a commitment to serve in targeted populations that were identified as areas of crucial importance and national need. However, the program has not been implemented because it has not received any funding. APTA commends the recent efforts of Congress to reform the higher education loan industry. The lowering of the limit on the income-based repayment plan for consolidated Federal Direct Loans will assist the burdensome payments for all higher education loan borrowers. However, this program still fails to meet the most important impact of LFSANN—channeling providers and professionals into areas where there are demonstrated shortages and high need, such as physical therapy care for veterans and children and adolescents. APTA strongly urges Congress to take action and provide $10 million in initial funding for this vital LFSANN program that will impact the healthcare and education services of those most in need.

National Institute for Disability and Rehabilitation Research (NIDRR)

NIDRR has been one of the longest standing agencies to focus on federally funded medical rehabilitation research. Rehabilitation research makes a difference in the lives of individuals with impairments, functional limitations, and disability. Advancements in rehabilitation research have led to greater quality of life for individuals who have spinal cord injuries, loss of limb, stroke and other orthopedic, neurological, and cardiopulmonary disorders. Investment in NIDRR is a necessary step toward continuing to meet the needs of individuals in our population who have chronic disease, developmental disabilities or traumatic injuries. Therefore, APTA recommends at least $20 million per year for NIDRR to support research and development, capacity building, and knowledge translation in health, rehabilitation, and function.

APTA also requests $11 million for NIDRR's TBI Model Systems administered by the Department of Education. The TBI Model Systems of Care program represents an already existing vital national network of expertise and research in the field of TBI, and weakening this program would have resounding effects on both military and civilian populations. The TBI Model Systems are the only source of nonproprietary longitudinal data on what happens to people with brain injury. They are a key source of evidence-based medicine and rehabilitation care for this crucial and growing population.

Interagency Committee on Disability Research (ICDR)

APTA would like to see $1.5 million appropriated for the ICDR to support a research agenda-setting summit. The disability and rehabilitation research community feels that such a meeting would ultimately be beneficial to work cooperatively on strategies to leverage the Federal investments in disability and rehabilitation research across all respective agencies and facilitate the conducting of meaningful collaborative projects and initiatives, including capacity building and knowledge translation.

CONCLUSION

APTA looks forward to working with the subcommittee and the various agencies outlined above to advance the resources available for the rehabilitation needs of society.

PREPARED STATEMENT OF THE ASSOCIATION OF PUBLIC TELEVISION STATIONS AND PUBLIC BROADCASTING SERVICE

On behalf of America's 361 public television stations, we appreciate the opportunity to submit testimony for the record on the importance of Federal funding for local public television stations.

Corporation for Public Broadcasting—Fiscal Year 2013 Request: $604 Million, Advance Funded

More than 40 years after the inception of public television, local stations continue to serve as the treasured cultural institutions envisioned by their founders, reaching America's local communities with unsurpassed programming and services. Furthermore, the power of digital technology has enabled stations to greatly expand their delivery platforms to reach Americans where they are increasingly consuming media—online and on-demand—in addition to on-air.

However, at the same time that stations are expanding their services and the impact they have in their communities, stations are also facing unprecedented revenue declines—presenting them with the greatest financial challenge in their 40-year history. Every revenue source upon which our operations depend is under siege. State funding support is in a wholesale free-fall. Financial contributions from foundations and underwriters, at the local and national levels, have declined. Individual contributions, the bed-rock of every public station's annual operating budget, are dropping, reflecting the effects of rising unemployment and declining personal discretionary income. As such, increased Federal support for public broadcasting is perhaps more important now than ever before.

Funds appropriated to CPB reach local stations in the form of Community Service Grants (CSGs). CSGs, while accounting for approximately 15 percent of the average station's overall budget, serve as the backbone of support for stations. Stations are also able to leverage those CSGs to raise additional funds from State legislatures, private foundations and their viewers.

Funding through CPB is absolutely essential to public television stations. A 2007 GAO report concluded that Federal funding, such as CSGs, is an irreplaceable source of revenue, and that "substantial growth of non-Federal funding appears unlikely." It also found that "cuts in Federal funding could lead to a reduction in staff, local programming or services."

Federal support for CPB and local public television stations has resulted in a nationwide system of locally owned and controlled, trusted, community-driven and community responsive media entities. For the seventh consecutive year, a 2010 Roper poll rated public television the most trusted institution among nationally known organizations. And in a recent report, the American Academy of Pediatrics recommended that Congress increase funding for public television, characterizing it as "the sole source for high quality, educational, noncommercial programming for children."

In addition, the advent of digital technology has created enormous potential for stations, allowing them to bring content to Americans in new, innovative ways while retaining our public service mission. Public television stations are now utilizing a wide array of digital tools to expand their current roles as educators, local conveners and vital sources of trusted information at a time when their communities need them most.

For example, in an effort to address the decline of local journalism, CPB has just announced a significant investment in partnership with 28 local public television and radio stations to form seven regional journalism centers. The Centers will form teams of multimedia journalists, who will focus on issues of particular relevance to each region; their in-depth reports will be presented regionally and nationally via digital platforms, community engagement programs and radio and television broadcasts. For example, in the Plains, the project will focus on agribusiness including farming practices, food and fuel production. In the Upper-Midwest, the collaboration will focus on the changing economy of the region. In the Southwest, a bilingual reporting team will focus on cultural shifts that are transforming the southwest, including Latino, Native American, and border issues.

In order for our stations to continue playing this vital role in their communities, APTS and PBS respectfully request $604 million for CPB, advance funded for fiscal year 2013. Advance funding is essential to the mission of public broadcasting. The longstanding practice ensures that stations are able to insulate programming decisions from political influence, leverage the promise of Federal dollars to raise State, local and private funds, and have the critical lead-in time needed to plan and produce programs.

Digital Funding—Fiscal Year 2010 Request: $59.5 million

Public television stations have been at the forefront of the digital transition, embracing the technology early and recognizing its benefits to their viewers. Fortunately, Congress wisely recognized that the Federal mandated transition to digital broadcast would place a hardship on public television's limited resources. Since 2001, Congress has provided public television stations with funds to ensure that they have the ability to continue to meet their public service mission and deliver

the highest-quality educational, cultural and public affairs programming post-transition.

Although the Federal mandated portion of the transition is complete, what remains to be finished is the ability of stations to fully replicate in digital their analog services. As stations have completed the transition of their main transmitters, they will continue to convert their master controls, digital storage equipment and other necessary studio equipment—necessary to produce and distribute local educational programming. This program is also critical to providing funds that can be invested in interactive public media that maximizes investments in digital infrastructure—including such content investments as the American Archive.

Unlike most commercial broadcasters, public television has used this new public digital spectrum to maximize programming choices by offering an array of new channel options, including the national offerings of V-me (the first 24-hour, Spanish-language, educational channel), World, and Create.

More importantly, stations have also used these multicast capabilities to expand their local offerings with digital channels dedicated to community or State-focused programming. Some stations have even utilized this technology to provide gavel-to-gavel coverage of their state legislatures. In addition, digital broadcasting has enabled stations to double the amount of noncommercial, children's educational programming offered to the American public.

APTS and PBS respectfully request $59.5 million in CPB Digital funding for fiscal year 2011 to enable stations to fully leverage this groundbreaking technology.

Ready To Learn and Ready to Teach (U.S. Department of Education)

The President's budget proposed for the consolidation of both the Ready To Learn and Ready To Teach programs into larger grant programs. APTS and PBS are concerned that the consolidation of these programs could lead to, at worst, the elimination of these critical programs that Congress has seen fit to invest more than $216 million since fiscal year 2005. At best, under the proposed budget, these programs would cease to exist in their current structure, removing the mechanisms that have provided for the tremendous efficient and effective nature in which these programs successfully operate.

Consolidation or elimination of these programs would severely affect the ability of local stations to respond to their communities' educational needs, removing the needed resources provided by these programs for children, parents and teachers. For example, our stations that participate in Ready To Learn or Ready To Teach activities in places such as Iowa (Iowa Public Television), Wisconsin (Wisconsin ECB), Washington (KCTS 9), Louisiana (Louisiana Public Broadcasting), Illinois (WSIU, WEIU), Arkansas (AETN), Pennsylvania (WPSU, WQLN, WITF, WVIA), Mississippi (Mississippi Public Broadcasting), New Hampshire (New Hampshire Public Television), Texas (KLRN, KLRU, KAVC, KAMU, KEDT, KMBH, KUHT, KNCT, KTXT, KOCV, KWBU), Alabama (Alabama Public Television) and Tennessee (WLJT, WNPT) would be severely impacted by the proposed consolidation.

We urge that the subcommittee maintain the Ready To Learn and Ready To Teach programs as stable line-items in the fiscal year 2011 budget and resist the calls for consolidation. Additionally, we encourage the subcommittee to express their support for Ready To Learn and Ready To Teach as stable, Federal funded programs as Congress considers the reauthorization of the Elementary and Secondary Education Act which contains the authorizing language for both of these programs.

Ready To Learn—Fiscal Year 2011 Request: $32 million

With a specific target of at-risk children, Ready To Learn is improving the reading skills of all of America's children through fully researched, engaging educational television and on-line content, with a particular focus on more than 150,000 low-income households in 23 States and the District of Columbia. Ready To Learn content, based on the findings of the National Reading Panel of 2000, is on-air-reaching 99 percent of the country's television households through Public Television stations—as well as on-line, and on the ground in classrooms and communities.

In addition to successful on the ground partnerships with local stations, national nonprofit organizations and State education leaders, including the Council of Chief State School Officers, Ready To Learn's signature component is its research-based and teacher-tested television programs that teach key reading skills, including: "SUPER WHY!", "WordWorld", "Martha Speaks", "Sesame Street", "Between The Lions", and "The Electric Company" produced by the best educational children's content producers.

Recent evaluations of one such program, "SUPER WHY!", tell a story of enormous success.

The evaluation found that preschool children who watched the program performed significantly better on most of the standardized measures of early reading achievement when compared with those preschool children who watched an alternate program. In fact, pre-test to post-test gains averaged 28.7 percent for "SUPER WHY!" viewers compared with an average gain of 13.2 percent for alternate program viewers. Specifically, preschool children demonstrated significant growth in targeted early literacy skills featured in "SUPER WHY!", including alphabet knowledge, phonological and phonemic awareness, symbolic and linguistic awareness, and comprehension.

In addition, "SUPER WHY!'s" 2008 5-day Summer Reading Camps—33 camps in 19 communities with 454 low-income Pre-K children—produced measurable results in raising children's reading skills through their interaction with strategically executed instructional materials designed to boost letter knowledge, decoding, encoding, and reading ability. During these camps, preschoolers showed an 84 percent gain in phonics skills and a 139 percent gain in word recognition skills.

A separate study conducted by the University of Michigan, found that low income children who were exposed to Ready to Learn content used in formal curriculum preformed at nearly the same level as their higher income peers—effectively erasing the achievement gap.

With additional funding, Ready To Learn can continue to meet the needs of those most lacking reading skills by extending the program's community engagement and partnership-driven work to additional high-need communities nationwide and by increasing capacity and reach through the innovative use of digital media.

APTS and PBS respectfully request $32 million for Ready To Learn in fiscal year 2011.

Ready To Teach—Fiscal Year 2011 Request: $17 million

Ready To Teach was first introduced in Congress in 1994 as a demonstration project to show how distance learning technology coupled with public broadcasting's rich educational content could help teachers enhance their proficiency in specific curriculum areas.

Later authorized under the No Child Left Behind Act, Ready To Teach currently funds the development of digital educational services aimed at enhancing teacher performance. Through four Ready To Teach services—PBS TeacherLine, e-Learning for Educators, VITAL and HELP—PBS, Alabama Public Television, Thirteen/WNET and Rocky Mountain PBS (RMPBS), have provided online professional development targeted toward Pre-K–12 educators, video clips aligned to math and reading State standards, and an English-Language Learner program for math instruction.

Together, Ready To Teach programs have served nearly 500,000 educators since 2001, and represent an enormously successful utilization of innovative, digital technology for the benefit of teachers and their students in the 21st century classroom.

APTS and PBS respectfully request $17 million in fiscal year 2011 in order to build the library of professional development courses, resources and support materials for teachers through the public broadcasting infrastructure, and increase the number of local stations able to participate in Ready To Teach, thereby increasing the efforts to prepare highly qualified teachers.

PREPARED STATEMENT OF THE ASSOCIATION OF REHABILITATION NURSES

Introduction

On behalf of the Association of Rehabilitation Nurses (ARN), I appreciate having the opportunity to submit written testimony to the Senate Labor, Health and Human Services, and Education, and Related Agencies Appropriations Subcommittee regarding funding for nursing- and rehabilitation-related programs in fiscal year 2011. ARN represents 5,700 Registered Nurses (RNs) with 10,000 nurses certified in the specialty who work to enhance the quality of life for those affected by physical disability and/or chronic illness. ARN understands that Congress has many concerns and limited resources, but believes that chronic illnesses and physical disabilities are heavy burdens on our society that must be addressed.

Rehabilitation Nurses and Rehabilitation Nursing

Rehabilitation nurses help individuals affected by chronic illness and/or physical disability adapt to their condition, achieve their greatest potential, and work toward productive, independent lives. They take a holistic approach to meeting patients' nursing and medical, vocational, educational, environmental, and spiritual needs. Rehabilitation nurses begin to work with individuals and their families soon after the onset of a disabling injury or chronic illness. They continue to provide support

and care, including patient and family education, and empower these individuals when they return home, or to work, or school. The rehabilitation nurse often teaches patients and their caregivers how to access systems and resources.

Rehabilitation nursing is a philosophy of care, not a work setting or a phase of treatment. Rehabilitation nurses base their practice on rehabilitative and restorative principles by: (1) managing complex medical issues; (2) collaborating with other specialists; (3) providing ongoing patient/caregiver education; (4) setting goals for maximum independence; and (5) establishing plans of care to maintain optimal wellness. Rehabilitation nurses practice in all settings, including freestanding rehabilitation facilities, hospitals, long-term subacute care facilities/skilled nursing facilities, long-term acute care facilities, comprehensive outpatient rehabilitation facilities, and private practices, just to name a few.

To ensure that patients receive the best quality care possible, ARN supports Federal programs and research institutions that address the national nursing shortage and conduct research focused on nursing and medical rehabilitation, e.g., traumatic brain injury. Therefore, ARN respectfully requests that the subcommittee provide increased funding for the following programs:

Nursing Workforce and Development Programs at the Health Resources and Services Administration (HRSA)

ARN supports efforts to resolve the national nursing shortage, including appropriate funding to address the shortage of qualified nursing faculty. Rehabilitation nursing requires a high-level of education and technical expertise, and ARN is committed to assuring and protecting access to professional nursing care delivered by highly educated, well-trained, and experienced Registered Nurses (RNs) for individuals affected by chronic illness and/or physical disability.

According to the Department of Health and Human Services, an estimated 36,750 nurses need to be recruited, educated, and retained through the Federal Nursing Workforce Development program at HRSA to meet the current demands of the healthcare system. Efforts to recruit and educate individuals interested in nursing have been thwarted by the shortage of nursing faculty. In July 2008, the American Health Care Association reported that more than 19,400 RN vacancies exist in long-term care settings. These vacancies, coupled with an additional 116,000 open positions in hospitals reported by the American Hospital Association in July 2007, bring the total RN vacancies in the United States to more than 135,000. The demand for nurses will continue to grow as the baby-boomer population ages, nurses retire, and the need for healthcare intensifies. According to the U.S. Bureau of Labor Statistics (BLS), nursing is the Nation's top profession in terms of projected job growth, with more than 587,000 new nursing positions being created through 2016. Furthermore, BLS analysts project that more than 1 million new and replacement nurses will be needed by 2016.

ARN strongly supports the national nursing community's request of $267.3 million in fiscal year 2011 funding for Federal Nursing Workforce Development programs at HRSA.

National Institute on Disability and Rehabilitation Research (NIDRR)

The National Institute on Disability and Rehabilitation Research (NIDRR) provides leadership and support for a comprehensive program of research related to the rehabilitation of individuals with disabilities. As one of the components of the Office of Special Education and Rehabilitative Services at the U.S. Department of Education, NIDRR operates along with the Rehabilitation Services Administration and the Office of Special Education Programs.

The mission of NIDRR is to generate new knowledge and promote its effective use to improve the abilities of people with disabilities to perform activities of their choice in the community, and also to expand society's capacity to provide full opportunities and accommodations for its citizens with disabilities. NIDRR conducts comprehensive and coordinated programs of research and related activities to maximize the full inclusion, social integration, employment and independent living of individuals of all ages with disabilities. NIDRR's focus includes research in areas such as: employment, health and function, technology for access and function, independent living and community integration, and other associated disability research areas.

ARN strongly supports the work of NIDRR and encourages Congress to provide the maximum possible fiscal year 2011 funding level.

National Institute of Nursing Research (NINR)

ARN understands that research is essential for the advancement of nursing science, and believes new concepts must be developed and tested to sustain the continued growth and maturation of the rehabilitation nursing specialty. The National Institute of Nursing Research (NINR) works to create cost-effective and high-quality

healthcare by testing new nursing science concepts and investigating how to best integrate them into daily practice. NINR has a broad mandate that includes seeking to prevent and delay disease and to ease the symptoms associated with both chronic and acute illnesses. NINR's recent areas of research focus include the following:

—End of life and palliative care in rural areas;
—Research in multi-cultural societies;
—Bio-behavioral methods to improve outcomes research; and
—Increasing health promotion through comprehensive studies.

ARN respectfully requests $160 million in fiscal year 2011 funding for NINR to continue its efforts to address issues related to chronic and acute illnesses.

Traumatic Brian Injury (TBI)

Approximately 1.5 million American children and adults are living with long-term, severe disability, as a result of TBI. Moreover, this figure does not include the 150,000 cases of TBI suffered by soldiers returning from wars in Iraq and Afghanistan.

The annual national cost of providing treatment and services for these patients is estimated to be nearly $60 million in direct care and lost workplace productivity. Continued fiscal support of the Traumatic Brain Injury Act will provide critical funding needed to further develop research and improve the lives of individuals who suffer from traumatic brain injury.

Continued funding of the TBI Act will promote sound public health policy in brain injury prevention, research, education, treatment, and community-based services, while informing the public of needed support for individuals living with TBI and their families.

ARN strongly supports the current work being done by the Centers for Disease Control and Prevention (CDC) and HRSA on TBI programs. These programs contribute to the overall body of knowledge in rehabilitation medicine.

ARN urges Congress to support the following fiscal year 2011 funding requests for programs within the TBI Act: $10 million for CDC's TBI registries and surveillance, prevention and national public education and awareness efforts; $8 million for the HRSA Federal TBI State Grant Program; and $4 million for the HRSA Federal TBI Protection and Advocacy Systems Grant Program.

Conclusion

ARN appreciates the opportunity to share our priorities for fiscal year 2011 funding levels for nursing and rehabilitation programs. ARN maintains a strong commitment to working with Members of Congress, other nursing and rehabilitation organizations, and other stakeholders to ensure that the rehabilitation nurses of today continue to practice tomorrow. By providing the fiscal year 2011 funding levels detailed above, we believe the subcommittee will be taking the steps necessary to ensure that our Nation has a sufficient nursing workforce to care for patients requiring rehabilitation from chronic illness and/or physical disability.

PREPARED STATEMENT OF THE ASSOCIATION FOR RESEARCH IN VISION & OPHTHALMOLOGY

The Association for Research in Vision & Ophthalmology (ARVO) has two major requests:

—For Congress to fund the National Institutes of Health (NIH) in fiscal year 2011 at $35 billion; and
—For Congress to make vision health a priority in the total funding of NIH by increasing National Eye Institute (NEI) funding more than the President's proposed 2.5 percent increase for NEI.

The requested increase in the total NIH budget is a $3 billion increase more than President Obama's proposed funding level of $32 billion. We are also concerned that NEI funding has been less than the increase for NIH funding for all funding cycles since 2001. NEI has lost 20.1 percent loss in purchasing power[1] over the last 10 years, while NIH has lost 17.2 percent loss in purchasing power[1] over the last 10 years.

ARVO commends Congress for actions taken in fiscal year 2009 and fiscal year 2010 to fund NIH. This includes the $10.4 billion for NIH funding in the American Recovery and Reinvestment Act (ARRA). We also applaud the fact that the 2011 NIH budget draft, requesting a 3.2 percent increase for NIH, keeps pace with inflation for the first time in 10 years. However, ARVO still has concerns about long-

[1] Calculations were based solely upon annual biomedical research and development price index and annual appropriated amounts.

term, sustained and predictable funding for vision research at the NEI, which has lost approximately 3 percent more purchasing power [1] than NIH in the past decade, which is not in proportion to the fact that vision disorders are the fourth most prevalent disability in the United States and the most frequent cause of disability in children.[2–5]

ARVO also commends Congress for passing S. Res. 209 and H. Res. 366, which acknowledged NEI's 40th anniversary as a free-standing institute and designated 2010–2020 as the Decade of Vision, in which the majority of 78 million baby boomers will turn age 65 and face great risk of developing aging eye diseases. In a 2007 report, age-related eye diseases were estimated to cost $51.4 million.[6] Costs to healthcare also add up when more individuals with vision impairment live in nursing homes than would be the case if they had normal vision.[7] NEI-funded research results in treatments and therapies that save vision, restore sight, reduce healthcare costs, maintain productivity, ensure financial independence, and enhance quality of life.

ARVO requests $35 billion in NIH funding for fiscal year 2011, especially to ensure that NEI can build upon the impressive record of basic and clinical collaborative research that meets NIH's top five priorities and has been funded through fiscal year 2009–2010 ARRA and regular appropriations.

NEI research addresses the top five NIH priorities, as identified by Dr. Collins: genomics, translational research, comparative effectiveness, global health, and empowering the biomedical enterprise.[8] Such research also addresses the pre-emption, prediction, personalization (ex. gene therapy), and prevention of eye disease through basic, translational, epidemiological, and comparative effectiveness research. NEI continues to be a leader within NIH for elucidating the genetic basis of eye disease. NEI Director, Paul Sieving, MD, Ph.D. has reported that one-quarter of all genes identified to date through collaborative efforts with the National Human Genome Research Institute (NHGRI) are associated with eye disease/visual impairment.

NEI received $175 million of the $10.4 billion in NIH ARRA funding. As a result, NEI's total funding levels in the fiscal year 2009–2010 timeframe were $776 million and $794.5 million, respectively. In fiscal year 2009, NEI made 333 ARRA-related awards, the majority of which reflect investigator-initiated research that funds new science or accelerates ongoing research, including ten Challenge Grants. Several examples of research, and the reasons why it is important, include:

—*Biomarker for Neovascular Age-related Macular Degeneration (AMD)*.—Researchers are utilizing a recently discovered biomarker to develop an early detection method to minimize vision loss. This marker identifies a risk factor (for abnormal growth of blood vessels into the retina), which causes 90 percent of the vision loss associated with AMD. *Importance:* 1.75 million people were living with AMD in 2000, and the number is estimated to reach 3 million by 2020.[9] Without accounting for healthcare inflation, the most recent estimated of cost for AMD [10] treatment times 3 million is ($2.5–4.8 billion) over 5 years.

—*Cellular Approach to Treating Diabetic Retinopathy (DR)*.—Researchers are developing a clinical treatment for diabetic retinopathy by using specially treated stem cells from the patient's own blood to repair damaged vessels in the eye. *Importance:* DR is increasing in younger Americans and the aging population. In a 2004 paper, the reported prevalence was 4.1 million Americans.[11]

—*Small Heat Shock Proteins as Therapeutic Agents in the Eye*.—Researchers propose to develop new drugs to prevent or reverse blinding eye diseases, such as cataract (clouding of the lens), that are associated with the aggregation of proteins. Research will focus on the use of small "heat shock" proteins that facilitate the slow release and prolonged delivery of targeted macromolecules to degenerating cells of the eye. *Importance:* Delivering effective, long-lasting therapies through a minimally invasive route into the eye may help to reduce cataracts, the leading cause of low vision among all Americans.[12]

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[2] Federal Interagency Forum on Aging-Related Statistics. Older Americans 2000: key indicators of well-being. Washington, DC: U.S. Government Printing Office; 2000 Aug. 114.
[3] http://www.ncbi.nlm.nih.gov/pubmed/15078664
[4] http://www.healthypeople.gov/data/2010prog/focus28/2004fa28.htm
[5] http://www.preventblindness.org/vpus/
[6] http://www.preventblindness.org/research/Impact__of__Vision__Problems.pdf
[7] Archives of Ophthalmology. Vol. 124, No. 12:1754.
[8] Science. Vol. 327:36.
[9] Archives of Ophthalmology. Vol. 122, No. 4:564.
[10] Ophthalmology. Vol. 115, No. 1:18.
[11] Archives of Ophthalmology. Vol. 122, No. 4:552.
[12] http://www.nei.nih.gov/news/pressreleases/041204.asp

—*Identification of Genes and Proteins that Control Myopia Development*.—Researchers propose to identify targets that will facilitate development of interventions to slow or prevent myopia (nearsightedness) development in children. Identifying an appropriate myopia prevention target can reduce the risk of blindness and reduce annual life-long eye care costs. *Importance:* More than 25 percent of the U.S. population has myopia, costing $14 billion annually, from adolescence to adulthood (data from NEI-supported study on myopia).[14]

—*Comparison of Interventions for Retinopathy of Prematurity (ROP)*.—In animal studies, researchers will simulate Retinopathy of Prematurity—a blinding eye disease that affects premature infants—and then study novel treatments that involve modulating the metabolism of the retina's rod photoreceptors. *Importance:* ROP affects 15,000 children a year, about 400–600 of whom progress to blindness, at an estimated lifetime cost for support and unpaid taxes of $1 million each.[15–16]

—*The NEI Glaucoma Human genetics collaBORation, NEIGHBOR*.—This research network, in which seven U.S. teams will lead genetic studies of the disease, may lead to more effective diagnosis and treatment. Researchers were primarily funded through ARRA supplements. *Importance:* Glaucoma, a complex neurodegenerative disease that is the second leading cause of preventable blindness in the United States, often has no symptoms until vision is lost.[17]

—*Comparative Effectiveness of Interventions for Primary Open Angle Glaucoma (POAG)*.—Researchers will evaluate existing data on the effectiveness of various treatment options for primary open angle glaucoma—many emerging from past NEI research. *Importance:* POAG is the most common form of the disease, which disproportionately affects African Americans and Latinos. It is estimated that 3.36 million individuals will have glaucoma by 2020.[18] This number times the average cost of treatment,[19] not accounting for inflation, is ($2.1–8.4 billion/year).

In addition to ARRA funding, the "regular" appropriations increases in fiscal year 2009–2010 enabled the NEI to continue to fund key research networks, such as the following:

—The African Descent and Glaucoma Evaluation Study (ADAGES), which is designed to identify factors accounting for differences in glaucoma onset and rate of progression between individuals of African and European descent. Importance: African Americans are more than three times as likely to develop visual impairment from glaucoma, compared to other ethnic groups.[20]

—The Diabetic Research Clinical Research Network's (DRCR) initiation of new trials comparing the safety and efficacy of drug therapies as an alternative to laser treatment for diabetic macular edema and proliferative diabetic retinopathy. *Importance:* In 2007, an estimated 23.6 million Americans were living with diabetes, and almost 1.6 million new cases were diagnosed per year. One out of 12 individuals with diabetes has diabetic retinopathy.[21]

—The Neuro-Ophthalmology Research Disease Investigator Consortium (NORDIC), which will lead multi-site observational and treatment trials, involving nearly 200 community and academic practitioners, to address the risks, diagnosis, and treatment of visual dysfunction due to increased intracranial pressure and thyroid eye disease.

—*Importance:* A broad spectrum of neuro-ophthalmic disorders collectively affects millions of people. Many are associated with other neurological disease processes and have not been adequately investigated because they are rare. NORDIC will address unanswered questions about risks, diagnosis, and treatment that could not be studied without a clinical research organization.[22]

The unprecedented level of fiscal year 2009–2010 vision research funding is moving our Nation that much closer to the prevention of blindness and restoration of vision. With an overall NIH funding level of $35 billion, which translates to an NEI funding level of $794.5 million, the vision community can accelerate these efforts, thereby reducing healthcare costs, maintaining productivity, ensuring independence, and enhancing quality of life.

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[14] Archives of Ophthalmology. Vol. 101:405–407
[15] http://www.nei.nih.gov/news/pressreleases/041210b.asp
[16] http://www.actionfund.org/actionfund/Blindness__in__America.asp?SnID=2
[17] http://www.glaucoma.org/learn/glaucoma__awaren.php
[18] Archives of Ophthalmology. Vol. 122, No. 4:532.
[19] Archives of Ophthalmology. Vol. 124, No. 1:12.
[20] http://www.nei.nih.gov/nehep/programs/glaucoma/goals.asp#data
[21] http://www.nei.nih.gov/strategicplanning/disparities__strategic__plan.asp#retinopathy
[22] http://www.nyee.edu/pdf/m__kupersmith.pdf

Summary

ARVO urges fiscal year 2011 NIH and NEI funding at $35 billion and $794.5 million, respectively.

PREPARED STATEMENT OF THE AMERICAN SOCIETY OF CLINICAL ONCOLOGY

The American Society of Clinical Oncology (ASCO), the world's leading professional organization representing more than 28,000 physicians and other professionals who treat people with cancer, appreciates this opportunity to express our views on funding for the National Institutes of Health (NIH) for fiscal year 2011. ASCO's members set the standard for cancer patient care worldwide and lead the way in carrying out clinical research aimed at improving the screening, prevention, diagnosis, and treatment of cancer. ASCO's efforts are also directed toward advocating for policies that provide access to high-quality care for all patients with cancer and supporting the clinical and translational research in the area of oncology that is critical to improving the lives of our citizens.

ASCO thanks the subcommittee for its continued investment in cancer research through the annual appropriations process, as well as through the American Recovery and Reinvestment Act (ARRA). The years of investment in cancer research are paying off in the most important ways—deaths rates are decreasing, survival rates are increasing, and treatments have fewer side-effects. Researchers are discovering that not only is cancer made up of hundreds of diseases, but these diseases have numerous subtypes that can be treated with targeted therapies. This translates to progress in treatments, as well as the need for exponentially more research.

Without sustained and predictable increases in funding for NIH and the National Cancer Institute (NCI), the progress that has been made will be significantly delayed. On behalf of the cancer community, we wish to highlight that we are very grateful for the support of the administration and Congress, which resulted in NIH receiving an inflationary increase in fiscal year 2010. However, between 2004 and 2008, NIH actually lost more than 13 percent of the purchasing power it had in 2003, the final year of the NIH budget doubling period.

In addition to providing important economic stimulus to local communities throughout the United States provided through funding for research, the ARRA funding for research helped restore this significant decline in NIH purchasing power. With the ARRA funding, Congress temporarily reinstated the impact and spirit of doubling the NIH budget. Progress in fighting cancer would be faster, more efficient, and more sustainable if funding were equally steady and sustainable.

APPROPRIATIONS FOR FISCAL YEAR 2011 FOR NIH

ASCO is joining with the biomedical research community in respectfully requesting the subcommittee appropriate $35 billion to NIH for fiscal year 2011. This request would maintain the total funding levels from fiscal year 2010 (including an annualized portion of the ARRA funds for research, which is 50 percent of the total ARRA funds for research), and allow us to sustain the pace of research made possible with ARRA. By adding an annualized portion of the research dollars provided by ARRA to the base budget of NIH, important advancements will continue to be made.

Research is a long-term process and allowing the important work begun with ARRA funds will ensure faster progress in cancer research. Progress that has meaning and important positive impacts in patients' lives will continue to be made—it is a question of how quickly progress will be made going forward and whether researchers in the United States will continue to play a leadership role in pursuing these advancements.

ASCO is also respectfully requesting that the subcommittee dedicate itself to a sustained, multi-year commitment to research funding. Meaningful progress cannot be made if NIH funding does not keep pace with the annual increase in the cost of conducting biomedical research. Unpredictable increases and decreases in NIH funding not only make it difficult for NIH to make commitments to multi-year projects, but also serve to discourage the best and brightest researchers to pursue careers in medical research. Sustained and predictable funding is key to a prosperous and vigorous biomedical research enterprise.

BENEFITS OF ARRA

ARRA has given biomedical research a much needed boost in funding, but those funds are set to expire on September 30, 2010. ARRA has made it possible to enhance important research projects at NIH and the NCI, such as accelerating the

identification of genomic alterations in tumor types in The Cancer Genome Atlas. This project is mapping cancer genes and will lead to increased understanding of how to target new treatments to halt the development and spread of cancer. Other uses of ARRA funds at NCI include the Accelerating Clinical Trials of Novel Oncologic PathWays (ACTNOW), the Cancer Human Biobank, and grants to Cancer Centers all across the country to promote personalized cancer care and drug development. These efforts are the beginning of a long-term process to translate discoveries into new treatments for cancer patients. Preservation of ARRA funds in the base NIH budget is necessary to translate these important discoveries into meaningful improvements in care for cancer patients.

Funding cancer research also benefits local communities. According to a Families USA report, for every $1 in grants given by NIH, the economic benefit to the local community is, on average nationally, $2.21 in economic stimulus by way of new business activity, jobs and wages.

CLINICAL TRIALS AND TRANSLATIONAL RESEARCH

In the area of oncology, clinical trials play a significant role in the day-to-day treatment options that should be available to patients, in large part because clinical trials often provide the best hope for successful treatment for cancer patients. NIH and NCI are leading the way by funding some very important data-driven translational research and clinical trials, bringing new, innovative therapies from research laboratories into clinics and hospitals to offer our patients targeted, personalized care. Clinical trials are absolutely critical to identify better, more cost effective care and longer lives for cancer patients. Translational research and clinical trials have changed the standard of care in many cancers.

Clinical trials funded by NIH and NCI examine important questions that are not being investigated elsewhere, generate practice-changing science, and often recruit difficult to reach subpopulations. Unfortunately, these trials are at risk, due to concerns about inadequate funding, the pace of the trials and accrual rates. Clinical trials are increasingly being conducted overseas, due to the costs and regulatory complexities of conducting trials in the United States. This denies your constituents the opportunity to participate, either as a physician conducting research or as a patient enrolling, in a clinical trial. Congress must demonstrate a continued commitment to ensure biomedical research is federally funded. NIH research advances have transformed the way cancer is prevented, detected and treated, and cancer has become a much more survivable disease as a result.

Federal funding has led to advances in screening that significantly contributed to the decline in cancer death rates. Federally funded clinical trials have also contributed directly to most patients having meaningful access to recommended chemotherapy regimens within their communities, often with far fewer side effects than in the past. Today, as a direct result of the investment in biomedical research (i.e., clinical trials and translational research), we are implementing changes that are improving cancer care for our patients.

Because of these advances and the incredible scientific opportunities facing us, ASCO urges the NIH and NCI to focus more of its resources in the area of clinical trials and translational research. Specifically, ASCO would also like to see an increase in the NCI per-case reimbursement for physicians who enroll patients on federally funded clinical trials. Studies conducted by ASCO and C-Change indicate that the current payment rate accounts for only half of the actual extra costs imposed on healthcare providers to enroll and participate within NCI-funded clinical trials. An ASCO survey of clinical trial sites in August 2009 revealed that a significant portion of sites are considering limits to their participation in federally funded research—in large part due to the inadequate funding provided. The funding NCI provides to sites that participate in their trials should be increased to account for actual research costs and keep pace with the growing costs of collecting and maintaining data and hiring skilled staff to oversee the research.

ASCO again thanks the subcommittee for its continued dedication to Americans facing cancer through support of the important work accomplished under the guidance of NIH and NCI. We look forward to working with all members of the subcommittee to advance cancer research.

PREPARED STATEMENT OF THE AMERICAN SOCIETY FOR MICROBIOLOGY

The American Society for Microbiology (ASM) is pleased to submit the following testimony on the fiscal year 2011 appropriation for the National Institutes of Health (NIH). The ASM is the largest single life science organization in the world with more than 40,000 members.

The ASM is grateful for the support of Congress for the NIH, which is the single largest source of funding for biomedical research, with an annual budget of more than $31 billion. NIH supports extraordinary biomedical research successes, which are also critical to national security and a catalyst for the Nation's industrial, business, and education enterprises. To ensure continued biomedical research progress and to keep pace with the cost of conducting research, we recommend that Congress provide at least an 8 percent increase for NIH, and a higher level of funding, if possible.

NIH Funding: The Need for Increased Funding for Biomedical Research

In 2009, healthcare costs in the United States reached $2.5 trillion, nearly 17 percent of the gross national product and more than any other nation, yet key health outcomes need improvement. Biomedical research offers innovative individual and population based medical interventions that will improve health and productivity. In fiscal year 2011 the NIH will support emerging technology dependent areas like computational biology and DNA sequencing, as well as basic research and trans-NIH, multidisciplinary programs, including: (1) genomics and other high-throughput technologies; (2) translational medicine to expedite the path from basic research to clinical treatments and preventives; (3) greater focus on global health; (4) use of science in support of healthcare reform; and (5) revitalization of medical research, including training new scientists.

In fiscal year 2011, NIH will support research by its own 6,000 scientists and by nearly 325,000 other researchers at more than 3,100 institutions, including medical schools, universities, and hospitals. About 83 percent of the fiscal year 2011 appropriation will fund extramural research, stimulating medical innovations, local economies, and the technical workforce needed to sustain the Nation's high-tech competitiveness. The Department of Health and Human Services funds 85 percent of the country's life sciences research, primarily through the 37,000 research project grants NIH will award in fiscal year 2011.

Each dollar of NIH funding results in another $2 in business activity and other financial benefits. Last year, analysts found that 20 percent of every NIH stimulus dollar spent under the 2009 American Recovery and Reinvestment Act (ARRA) purchased commercial products like software, instruments, and reagents, boosting technology-based industries and services. ARRA has enabled NIH to invest $10.4 billion over 2 years in NIH programs, distributed to researchers across the Nation through roughly 14,000 grants to date. ARRA stimulus funds to NIH ultimately will create or retain 50,000 jobs. ARRA funding clearly has stimulated NIH research, which until recently suffered years of stagnant or declining resources.

With stimulus funds, NIH was able to support about 20 percent of grant applicants; but in fiscal year 2011, that figure likely will drop by half, to an historically low funding rate that will impinge medical innovation in the United States. NIH received more than 20,000 proposals last year for new Challenge grants, which specifically support high-risk, high-return projects, but only 229 could be funded. Increased funding for NIH in fiscal year 2011 is essential to ensure that scientists can pursue research opportunities that will lessen the human burdens of disease and disability.

NIH Funding: Foundation for Advances in Medicine

Last September, NIH and the U.S. Army concluded their joint clinical trial in Thailand of a new AIDS vaccine, the first vaccine candidate to elicit a protective effect in humans against HIV infection. In 2009, NIH achieved advances in the global offensive against H1N1 influenza, most notably rapid development and implementation of clinical trials for various H1N1 vaccines. The three winners of the 2009 Nobel Prize in physiology or medicine had received more than $31 million in NIH research grants, while the three Nobel winners in chemistry received more than $17 million. Their respective studies on cellular aging and on the structure and function of ribosomes have transformed medical science and will continue to do so into the future.

Worldwide, communicable diseases are responsible for 51 percent of the calculated "years of life lost" each year, according to the World Health Organization (WHO). Even in wealthy nations like the United States, preventable infectious diseases persist as leading causes of morbidity and mortality. The National Institute of Allergy and Infectious Diseases (NIAID) sponsors a range of research activity from diseases like malaria and HIV/AIDS, to immune system disorders, biodefense, and the antibiotic resistance among pathogenic microbes to drug treatments. NIAID focuses on nearly 300 pathogens that include bacteria, viruses, parasites, fungi and prions. New therapies, vaccines, diagnostics, and other products nurtured by NIAID have benefited every American and contributed in some way to global health.

Influenza.—Approximately 86 million Americans have received 97 million doses of 2009 H1N1 influenza vaccine largely developed and tested with the support of NIAID. Although the H1N1 pandemic has fortunately proved to be more moderate than originally feared, it still has produced an estimated 59 million U.S. cases since April 2009; 265,000 hospitalizations; and 12,000 deaths. Stopping H1N1 requires thorough understanding of the viral pathogen's unique features. Ninety percent of seasonal flu deaths occur in those older 65, whereas 87 percent of reported H1N1 deaths were patients under 65. In the past year, NIAID funded numerous H1N1 studies, including microscopic exams of respiratory tissue from fatal cases; lab experiments suggesting that H1N1 may outcompete seasonal flu virus strains and may be more communicable; a series of vaccine trials in different human subpopulations; and alternative vaccine production strategies, including tissue culture based vaccines and an early clinical trial of a candidate DNA vaccine, an experimental class of vaccine where a pathogen's genetic material is injected directly into the body.

HIV/AIDS.—In fiscal year 2011, The NIH will spend nearly $3.2 billion for research on HIV/AIDS, which remains one of the most intractable health challenges faced by the world. An estimated 33 million people are living with HIV worldwide, and another 2 million have died. Each year, there are 56,300 new HIV infections in the United States; of the estimated 1.1 million Americans living with HIV, 21 percent are unaware of their infection. The NIAID's Vaccine Research Center investigates multiple approaches to new vaccine development, like how neutralizing antibodies develop during natural HIV infection, which could point to an effective vaccine. NIAID also supports other prevention strategies, such as using antiretroviral drugs to stop mother to child HIV transmission (an estimated 430,000 children became infected in 2008, mostly through birth or breastfeeding from an HIV infected mother). In 2009, NIAID outlined its "test and treat" prevention agenda, based on a WHO mathematical model predicting that universal, voluntary, annual HIV testing and immediate treatment for those who test positive could radically reduce HIV incidence within a decade, and potentially end the pandemic within 50 years.

Global Health Infectious.—Diseases can quickly spread through the world's populations and across national borders. Global health research at NIAID informs science based public health policies worldwide, and the institute participates in several global partnerships with entities like WHO and UNICEF. It also has interagency agreements with USAID, CDC, NASA, and the State Department to combat diseases that migrate from country to country. With its scientific expertise in major global diseases, NIAID will be a vital contributor to the Administration's new Global Health Initiative (GHI) designed to reform and coordinate U.S. support for international health. NIAID has established programs tied to four of the six GHI focus areas, that is, HIV/AIDS, tuberculosis, malaria, and neglected tropical diseases (also, health systems and health workforce; maternal, newborn, and child health).

Malaria.—This disease threatens an estimated 3.3 billion people, nearly half of the world's population. Each year, this age-old disease causes about 250 million clinical cases and nearly 1 million deaths, most of those deaths in and children under 5 years and pregnant women. At least four species of the causative Plasmodium protozoa are transmitted through bites from dozens of Anopheles mosquito species, all of which can develop resistance to known pesticides and antimalarial drugs and a fifth human malaria parasite was recently discovered in Asia. The complex parasite vector human host cycle ranks malaria among medicine's grand challenges. NIAID funds basic and applied research to develop tools and strategies for the treatment, prevention, and control of this disease.

One-third of the world's population is infected with the pathogen Mycobacterium tuberculosis. There are 9.4 million new tuberculosis cases annually and 1.8 million deaths, making TB the leading cause of global mortality after HIV/AIDS. Public health efforts against TB are often outmoded, the mostly commonly used diagnostics were developed a century ago, there have been no new drugs introduced for decades, and the last new vaccine was produced 40 years ago. Therapy is difficult at best, and the emergence of drug-resistant strains has greatly complicated treatment. TB cases classified as "extensively drug resistant" (XDR) now occur in nearly 60 nations, with mortality rates exceeding 95 percent in some areas. NIAID funding supports research to discover updated diagnostics, therapeutics, and vaccines.

The so called "neglected tropical diseases" (NTDs) like leishmaniasis, sleeping sickness, and Chagas disease cumulatively infect more than 1 billion people and kill 534,000 per year. WHO categorizes 14 diseases as NTDs important to global health, serious illnesses that most often affect impoverished countries. Many are often fatal, usually ignored by control and treatment programs, and associated with poor surveillance tools and systems. NIAID conducts research on selected NTDs.

NIH Funding: Defense Against Emerging Infectious Diseases

The proposed fiscal year 2011 budget increases funding for NIAID's activities emerging infectious diseases. These diseases might migrate or evolve naturally, perhaps developing resistance to standard drug treatments, or their pathogens might be deliberately dispersed as agents of bioterrorism. NIAID funding has created countermeasures against anthrax, botulinum toxin, and smallpox.

In recent years, alarmed public health officials have devoted increasing resources toward mitigating the social and economic impacts of antimicrobial resistance. NIAID supports multiple projects devoted to the biological aspects of this problematic phenomenon. Drug resistant pathogens of greatest concern include methicillin resistant Staphylococcus aureus (MRSA), vancomycin-resistant enterococci (VRE), and the microbial causes of malaria, HIV/AIDS, influenza, tuberculosis, streptococcal pneumonia, and various foodborne illnesses. Many resistant infections develop in healthcare settings. Each year, about 2 million people develop infections in U.S. hospitals, with 90,000 deaths. About 70 percent of those infections are linked to pathogens resistant to at least one drug. Data now indicate that the problem outside healthcare settings is greater than originally believed. In fiscal year 2011, NIAID will fund a new initiative, Development of Therapeutic Products for Biodefense, with particular emphasis on broad spectrum products or those addressing the growing dilemma of antimicrobial resistance.

NIH Funding: Moving Forward in Biomedical Research

Discoveries through NIAID and NIGMS programs have fostered breakthrough tools and methods vital to sectors of the US medical enterprise, like biotechnology. Research strategies at NIH must take advantage of cutting edge technologies and modern scientific disciplines like genomics and bioinformatics. NIAID research partnerships will develop next-generation biodefense diagnostics, like those using nanotechnology-based microfluidic platforms, in vivo imaging methods, or other emerging technologies.

By supporting high-risk, high-return projects, NIGMS lays the foundation for future advances in disease diagnosis, treatment, and prevention. It promotes large-scale initiatives to solve complex problems through collaborative research. An example is the NIGMS pharmacogenetics research program, which integrates laboratory science and databases linking genes, medicines, and diseases. In December, NIGMS announced five new projects in its pharmacogenomics collaboration with Japan's Center of Genomic Medicine; one will examine why antiretrovirals used to treat HIV are not effective in some people.

NIH funding also invests in the future by building the workforce needed to sustain innovation. Each year, NIH also provides grants for STEM education across the United States, and supports pre- and postdoctoral scientists at the NIH campus or with fellowships elsewhere. NIGMS alone supports approximately 50 percent of Ph.D. training positions at NIH.

NIH plays a key role in accelerating transformation of basic science into clinical tools that save lives. The ASM recommends that Congress approve at least an 8 percent increase for the National Institutes of Health.

PREPARED STATEMENT OF THE AMERICAN SOCIETY FOR MICROBIOLOGY

The American Society for Microbiology (ASM) is pleased to submit the following testimony on the fiscal year 2011 appropriation for the Centers for Disease Control and Prevention (CDC). The ASM is the largest single life science organization in the world with more than 40,000 members.

The ASM is very concerned that the proposed CDC budget of $6.6 billion for fiscal year 2011 is 2 percent below the fiscal year 2010 appropriation. The administration's proposed budget is inconsistent with the need to adequately fund the agency acknowledged to be the principal Federal driver in meeting our Nation's goals for enhanced prevention and wellness. Focusing only on the infectious disease component of the CDC budget, the ASM notes that the administration has proposed a $19.6 million increase in this area. However, such a modest increase does not adequately address the growing complexity and challenges of emerging infectious diseases. These challenges have been abundantly evident over the past year with the H1N1 influenza pandemic. Furthermore, the proposed budget substantially decreases two priority program areas: the CDC's vector-borne diseases program (by $26.7 million, which will essentially eliminate the program), and the CDC's antimicrobial resistance program (by $6.8 million). In the fiscal year 2011 budget, both programs are to be supported out of emerging infectious disease funds. Therefore, the proposed increase of $19.6 million for emerging infectious diseases is insufficient

to offset the $34 million in proposed reductions for vector-borne diseases and antimicrobial resistance, resulting in a net decrease of $15 million for emerging infectious diseases.

Eliminating funding for the vector-borne diseases program will impair CDC's collaborations with State and local partners consisting of vector-borne disease surveillance, outbreak response, the development of new diagnostics, diagnostic training and proficiency testing, as well as applied research and prevention efforts to address arboviral diseases. In the proposed budget, it is unclear what, if any, support will be available in fiscal year 2011 for prevention and control of vector-borne pathogens. This funding reduction will essentially destroy the infrastructure developed in the past decade in response to the importation of West Nile virus in 1999 and its subsequent spread across the United States, and will leave the country vulnerable to similar importation of other vector-borne diseases. In view of the net reduction for infectious diseases of approximately $15 million, the ASM recommends that Congress increase the budget for emerging infectious diseases and for CDC by at least 8 to 10 percent, to restore and strengthen funding for infectious disease prevention and control and other priority public health programs.

Vector-borne Diseases.—The administration's proposed elimination of funding (−$26.7 million) for vector-borne diseases, including West Nile Virus, in its fiscal year 2011 budget will have serious repercussions. Many emerging or re-emerging infectious diseases are tied to pathogens transmitted from animals to humans, often through insect vectors. CDC programs protect public health through "one health" strategies, based on the understanding that human health is intertwined with the health of animals and the environment. The vector-borne program not only supports the West Nile virus activities, but also supports work on agents like plague, tularemia, Lyme disease, dengue fever, and Japanese encephalitis. Lyme disease is by far the most common tickborne infection in the United States and exacts an enormous toll in healthcare costs and lost productivity. The U.S. mainland is constantly threatened by the potential for establishment of dengue virus, as occurred last year in the Florida Keys. Emerging public health risks like chikungunya virus in South Asia and the Indian Ocean are an ongoing concern similar to West Nile. To appropriately address vector-borne infections requires a vibrant infrastructure for detection, diagnosis, response and prevention at the national, State, and local level. The proposed budget cuts will substantially dismantle the system developed in response to West Nile virus, causing much of the $200 million investment over the last decade to disappear. ASM urges the Administration to restore the vector borne disease funding.

Antimicrobial Resistant Infections.—The administration's proposed budget reduces the antimicrobial resistance program by $6.8 million. The ASM disagrees with the proposed fiscal year 2011 decreases for crucial CDC efforts at a time when drug-resistant pathogens continue to emerge in both the community and healthcare setting. The decrease will, among other negative outcomes, substantially cut funding to States for surveillance and control programs. As a partner in the Federal Interagency Action Plan to Combat Antimicrobial Resistance, CDC has been instrumental in tracking the grim increase in microbial pathogens resistant to antimicrobial drugs, like methicillin-resistant Staphylococcus aureus (MRSA). Invasive MRSA infections attack about 94,000 Americans annually, contributing to 19,000 deaths. MRSA is an increasing problem in community settings where different control strategies are necessary than in the hospital environment. A similar trend is being seen with Clostridium difficile, an organism once largely confined to hospital and nursing home settings but now associated with increasing severity in the community. Microbial drug resistance is driven by various factors, from pathogens' natural evolution to the growing use of antimicrobials in human and animal healthcare. One estimate suggests that between 5 and 10 percent of all hospitalized U.S. patients acquire a drug-resistant infection, adding $5 billion in annual healthcare costs. CDC either leads or collaborates in multiple projects against antimicrobial resistance, like the World Health Organization (WHO) effort to reduce the global spread of cephalosporin-resistant gonorrhea. Reduced funding would seriously impact the ability to mount and sustain programs to confront the problem of antimicrobial resistant pathogens.

CDC Funding: The Need for Increased Resources

While life expectancy has steadily increased, influenza, pneumonia, and septicemia caused by microbial pathogens remain among the top 10 causes of death. The sudden emergence of pandemic H1N1 in the spring of 2009 in Mexico, California, and Texas highlights the profound impact infectious diseases can have on our well being and economy. In addition to such emergent threats, other infectious diseases are on the rise. Reported cases of sexually transmitted Chlamydia infections have

more than tripled since 1990, making it the most commonly reported infectious disease in the United States. Each year, children are absent 38 million school days due to influenza. About 43,000 Americans still develop acute hepatitis B annually, despite effective vaccines. The estimated annual cost to U.S. hospitals of treating healthcare associated infections ranges from $28.4 billion to $45 billion. Foodborne illnesses continue to produce tens of millions of infections annually. And each year, Americans visit physician offices, hospital outpatient units or emergency rooms for infectious and parasitic diseases an estimated 30 million times.

The CDC Office of Infectious Diseases (OID) has three programs to prevent numerous microbial diseases: the National Center for Immunization and Respiratory Diseases, the National Center for Emerging and Zoonotic Infectious Diseases and the National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention. The CDC's Center for Global Health and other agency offices add expertise to the fight against disease pathogens here and abroad. In the past year, CDC personnel have contributed to the fight against H1N1 influenza and identified or confirmed the causes of disease outbreaks nationwide. They monitor drug-resistant tuberculosis and other communicable diseases at U.S. ports of entry, and collaborate with local, State, Federal, and international partners to protect and promote good health in countries such as Haiti in response to the recent catastrophic earthquake.

Monitoring Disease, Protecting Public Health

HIV/AIDS.—CDC estimates that about 1.1 million persons in the United States are living with HIV or AIDS; an estimated 21 percent do not know that they are infected. With life saving antiretroviral treatments now available, earlier diagnosis is the goal of recent CDC guidances on opt-out testing in correctional institutions and other settings and for routine screening in all healthcare settings for those aged 13–64 years and pregnant women, and retesting at least annually for all at high risk. In November, CDC reported that HIV incidence among intravenous drug users had declined by nearly 80 percent since the late 1980s, a positive public health outcome, yet late diagnosis of new infections persists. The fiscal year 2011 budget increases funds for a National HIV/AIDS Strategy under development, to include renewed efforts toward HIV risk reduction.

Hepatitis.—Two percent of the U.S. population or an estimated 5.3 million are living with chronic hepatitis B (HBV) or hepatitis C (HCV), most unaware of their infection unless they later develop liver disease or cancer. Last year, a CDC study concluded that in the previous decade, failures by healthcare workers to follow basic infection control practices had placed more than 60,000 U.S. patients at risk for HBV or HCV infection. In January, the Institute of Medicine called for a new, improved national strategy to prevent and control these infections. Each year an estimated 25,000 persons become infected with hepatitis A (HAV), even though rates of acute symptomatic cases have declined by 92 percent since a vaccine first became available in 1995. CDC now recommends HAV vaccine for all children at age one, since children are a major source of infection for adults who can develop more serious symptoms. CDC reported last year that vaccination among U.S. children increased from about 26 percent in 2006 to more than 47 percent in 2007, but this means that still over half of our children are needlessly at risk of a fully preventable disease like hepatitis A. They also serve as a source of infection to vulnerable adults.

Tuberculosis.—In a new CDC report, preliminary statistics from the agency's National TB Surveillance System reveals that 2009 saw the largest single year decrease in U.S. cases since data collection began in 1953. The 11,540 cases reported last year were roughly 11 percent fewer than the previous year, with declines in both U.S.- and foreign-born persons, although the TB rate among foreign born was still nearly 11 times higher. Possible explanations for the unprecedented drop, which CDC is investigating, include failure to recognize, diagnose, or report the disease due to weakening infrastructure or diversion of public health resources to the H1N1 response. This would represent a serious setback to TB disease control and elimination efforts in the United States. The emergence of tuberculosis bacteria resistant to available antimicrobial drugs has alarmed health organizations worldwide. CDC scientists identified genetic mutations associated with drug resistance in tuberculosis bacteria, which are now included in CDC laboratory testing available to State public health laboratories.

Foodborne/Waterborne Illness.—A recent study estimates that the total economic impact of foodborne illness in the United States reaches $152 billion annually. Last April, CDC reported that progress in foodborne illness prevention had reached a plateau, with the incidence of the most common foodborne illnesses stagnating over the previous 3 years after several years of decline in the late 1990s and early 2000s. Of particular concern is the incidence of Salmonella infections, which persists at 14–

16 cases per 100,000 Americans and periodically causes disease outbreaks. CDC reports the following foodborne illnesses: (1) of the 1,270 outbreaks in 2006, 621 had a confirmed single cause, most often norovirus (54 percent), followed by Salmonella (18 percent); and (2) foods tied to the largest number of outbreak cases were poultry (21 percent), leafy vegetables (17 percent) and fruits-nuts (16 percent). The ASM commends the appreciable increases in fiscal year 2011 funding for food safety activities that will boost CDC capabilities, such as expanded outbreak surveillance and standardized investigations at the State and local level. The proposed fiscal year 2011 budget specifically supports CDC water quality programs, including expansion of its Safe Water System and Water Safety Plan to additional countries to reduce waterborne diseases like cholera, giardiasis and cryptosporidioisis.

Preventing Disease, Protecting Public Health

Over the past year, considerable CDC resources focused on preventing H1N1 influenza. Americans have received 97 million doses of H1N1 vaccine via CDC distribution systems. Although the pandemic has been less severe than originally feared, it has still resulted in an estimated 55 million U.S. cases since April 2009, 246,000 hospitalizations and 11,000 deaths, many in infants, children, and young adults. CDC testing determined that many Americans who died from H1N1 had coinfections with the common pneumonia bacterium, Streptococcus pneumoniae, which likely contributed to their death. Unfortunately, vaccine preventable pneumococcal infections still kill an estimated 40,000 Americans each year. CDC officials are currently assessing the lessons learned during the 2009–2010 influenza season.

In February, CDC recommended universal use in children of an updated pneumococcal vaccine just approved by the Food and Drug Administration, which should greatly reduce S. pneumoniae infections and stop a leading cause of bacteremia, meningitis and pneumonia. Pneumonia kills nearly 2 million children each year, most in impoverished nations.

Improving Preparedness and Response

Being prepared for the unexpected is one of CDC's primary responsibilities in protecting our health and well-being. During an emergency, CDC can quickly convene expert teams and deploy both personnel and medical supplies anywhere in the world. CDC leads Federal efforts to detect and contain biothreats and to ensure availability of medical countermeasures. It operates the Strategic National Stockpile, a repository of countermeasures for rapid deployment, as well as its quarantine stations at the Nation's borders. It distributes grants to State and local health departments to build capacity against public health emergencies and acts of terrorism. The ASM supports the proposed additional fiscal year 2011 funds to improve CDC's overall preparedness and response efforts, including the Laboratory Response Network and Select Agent Program.

In light of the significant role played by the CDC as the Nation's first line of defense against a host of infectious disease threats and its leadership in national efforts to promote wellness and prevention, these efforts should not be handicapped by a funding reduction as proposed in the 2011 budget. The ASM supports an 8 to 10 percent increase in infectious disease activities to assure critical programs are not reduced or eliminated and that opportunities to prevent and control infectious diseases are not curtailed. ASM appreciates the opportunity to comment on the fiscal year 2011 budget for the CDC.

PREPARED STATEMENT OF THE AMERICAN SOCIETY OF MECHANICAL ENGINEERS

The NIH Task Force ("Task Force") of the Inter Sector Committee on Federal Research and Development (ISCFRD) of ASME is pleased to provide comments on the bioengineering-related programs contained within the National Institutes of Health (NIH) fiscal year 2011 budget request. The Task Force is focused on the application of mechanical engineering knowledge, skills, and principles for the conception, design, development, analysis, and operation of biomechanical systems.

The Importance of Bioengineering

Bioengineering is an interdisciplinary field that applies physical, chemical, and mathematical sciences, and engineering principles to the study of biology, medicine, behavior, and health. It advances knowledge from the molecular to the organ levels, and develops new and novel biologics, materials processes, implants, devices, and informatics approaches for the prevention, diagnosis, and treatment of disease, for patient rehabilitation, and for improving health. Bioengineers have employed mechanical engineering principles in the development of many life-saving and life-im-

proving technologies, such as the artificial heart, prosthetic joints, diagnostics, and numerous rehabilitation technologies.

Background

The NIH is the world's largest organization dedicated to improving health through medical science. During the last 50 years, NIH has played a leading role in the major breakthroughs that have increased average life expectancy by 15 to 20 years.

The NIH is comprised of different Institutes and Centers that support a wide spectrum of research activities including basic research, disease and treatment-related studies, and epidemiological analyses. The mission of individual Institutes and Centers varies from either study of a particular organ (e.g., heart, kidney, eye), a given disease (e.g., cancer, infectious diseases, mental illness), a stage of life (e.g., childhood, old age), or finally it may encompass crosscutting needs (e.g., sequencing of the human genome and the National Institute of Biomedical Imaging and Bioengineering (NIBIB).

The total fiscal year 2011 NIH budget request is $32.2 billion, or 3.2 percent above the $31.2 billion fiscal year 2010 appropriated amount. The Task Force recognizes that this proposed increase is significant given the administration's commitment to reducing the Federal deficit. However, the Task Force notes that the administration's 3.2 percent increase to the overall NIH budget is less than the up to 3.8 percent projected increase in research costs due to inflation—as predicted by the Biomedical Research and Development Price Index (BRDPI)—and as a consequence actually results in an effective decrease in funding for the NIH compared to fiscal year 2010. The Task Force therefore recommends out-year budget increases well beyond BRDPI inflation rates to compensate for this flat level of funding.

The Task Force further notes that NIH received $10.4 billion as part of the American Recovery and Reinvestment Act (ARRA) of 2009 (Public Law 111–5), an important influx for several key divisions of NIH over the fiscal year 2009 and fiscal year 2010 funding cycles, particularly the NIBIB, which received $78 million—less than 1 percent of the $10.4 billion ARRA budget assigned to the NIH for the fiscal year 2009 and fiscal year 2010 funding cycles. NIBIB has already exhausted approximately 95 percent of this budget, leaving little ARRA funding to leverage through the fiscal year 2010 budget cycle and underscore the need for more robust investment in bioengineering at NIBIB. While this one-time influx of funding for health research and infrastructure was justified, the Task Force notes that the unstable nature of such funding inhibits the potential impact on the economy and should not be viewed as a viable substitute for steady and consistent support from Congress for these critical national research priorities.

Overall research and development activities are expected to account for 97.4 percent of the total fiscal year 2011 NIH budget, or $31.4 billion. With this, the administration estimates 9,052 research project grants (RPGs) will be supported, 199 less than fiscal year 2010, essentially flat year-on-year. Of the administration's priority programs this year, the Task Force commends the recommended $382 million in support for the National Nanotechnology Initiative, a 6 percent or $22 million increase over fiscal year 2010.

NIBIB Research Funding

The administration's fiscal year 2011 budget requests $325.93 million for the NIBIB, an increase of $9.47 million or 3 percent from the fiscal year 2010 appropriated amount. This increase is less than the 3.8 percent projected increase in research costs due to inflation (predicted by the BRDPI index) and, as a consequence, actually results in an effective decrease in funding for NIBIB compared to fiscal year 2010. The mission of the NIBIB is to seek to improve human health by leading the development and application of emerging and breakthrough technologies based on a merging of the biological, physical, and engineering sciences.

The budget for NIBIB Research Grants would increase by $6.1 million to $268.8 million, a 2.4 percent increase from fiscal year 2010. Funding for intramural research would increase 3.6 percent to $11.5 million from $11 million in fiscal year 2010. NIBIB's Research Management and Support request is $17.7 million, a 5.4 percent increase or $0.84 million over fiscal year 2010.

NIBIB funds the Applied Science and Technology (AST) program, which supports the development and application of innovative technologies, methods, products, and devices for research and clinical application that transform the practice of medicine. The fiscal year 2011 request for AST is $176.8 million, a $5.2 million increase or 3 percent from fiscal year 2010.

Additionally, NIBIB funds the Discover Science and Technology (DST) program, which is focused on the discovery of innovative biomedical engineering and imaging

principles for the benefit of public health. The fiscal year 2011 request for DST is $95.1 million, a $2.2 million or 2.4 percent increase from fiscal year 2010.

The Technological Competitiveness-Bridging the Sciences program, which funds interdisciplinary approaches to research, would receive $24.9 million in fiscal year 2011, a $0.9 million increase or 3.6 percent over the fiscal year 2010 enacted level.

Task Force Recommendations

The Task Force is concerned that the United States faces rapidly growing challenges from our counterparts in the European Union and Asia with regards to bioengineering advancements. While total health-related U.S. research and development investments have expanded significantly over the last decade, investment in bioengineering at NIBIB have remained relatively flat over the last several years. In fact, the fiscal year 2011 budget actually represents a small reduction in funding when the fiscal year 2003 NIBIB appropriation of $280 million is adjusted for inflation ($329 million in 2010 dollars).

The Task Force wishes to emphasize that, in many instances, bioengineering-based solutions to healthcare problems can result in improved health outcomes and reductions in healthcare costs—a fundamental tenet of the President's National Innovation Strategy. For example, coronary stent implantation procedures cost approximately $20,000, compared to bypass graft surgery at double the cost. Stenting involves materials science (metals and polymers), mechanical design, computational mechanical modeling, imaging technologies, etc. that bioengineers work to develop. Not only is the procedure less costly, but the patient can return to normal function within a few days rather than months to recover from bypass surgery, greatly reducing other costs to the economy. Therefore, we strongly urge Congress to consider increased funding for bioengineering within the NIBIB and across NIH, and work to strengthen these investments in the long run to reduce U.S. healthcare costs and support continued U.S. leadership in bioengineering.

The NIBIB must obtain sustained funding increases, both to accelerate medical advancements as our Nation's population ages, and to mirror the growth taking place in the bioengineering field. The Task Force believes that the administration's budget request for fiscal year 2010 is not aligned with the challenges posed by this objective; a 3 percent budget increase will not keep up with current inflationary increases for biomedical research, eroding the United States' ability to lay the groundwork for the medical advancements of tomorrow.

While the Task Force supports Federal proposals that seek to double Federal research and development in the physical sciences over the next decade, we believe that strong Federal support for bioengineering and the life sciences is especially essential to the health and competitiveness of the United States. The supplemental funding that NIH received as part of ARRA and the budget request by the administration does not completely erase the past several years of disappointing budgets. Congress and the administration should work to develop a specific plan, beyond President Obama's call for "innovations in healthcare technology" in his "Strategy for American Innovation", to focus on specific and attainable medical and biomedical research priorities which will reduce the costs of healthcare and improve healthcare outcomes. Further, Congress and the administration should include in this strategy new mechanisms for partnerships between NSF and the NIH to promote bioengineering research and education. The Task Force feels these initiatives are necessary to build capacity in the U.S. bioengineering workforce and improve the competitiveness of the U.S. bioengineering research community.

PREPARED STATEMENT OF THE AMERICAN SOCIETY FOR NUTRITION

The American Society for Nutrition (ASN) appreciates this opportunity to submit testimony regarding fiscal year 2011 appropriations for the National Institutes of Health (NIH) and the National Center for Health Statistics (NCHS). ASN is the professional scientific society dedicated to bringing together the world's top researchers, clinical nutritionists, and industry to advance our knowledge and application of nutrition to promote human and animal health. Our focus ranges from the most critical details of research to very broad societal applications. ASN respectfully requests $37 billion for NIH, and we request $162 million for NCHS in fiscal year 2011.

Basic and applied research on nutrition, nutrient composition, the relationship between nutrition and chronic disease and nutrition monitoring are critical to the health of all Americans and the U.S. economy. Awareness of the growing epidemic of obesity and the contribution of chronic illness to burgeoning healthcare costs has highlighted the need for improved information on dietary components, dietary intake, strategies for dietary change and nutritional therapies. Preventable chronic

diseases related to diet and physical activity cost the economy more than $117 billion annually, and this cost is predicted to rise to $1.7 trillion in the next 10 years. It is for this reason that we urge you to consider these recommended funding levels for two agencies under the Department of Health and Human Services that have profound effects on nutrition research, nutrition monitoring, and the health of all Americans—the NIH and the NCHS .

NIH

NIH is the Nation's premier sponsor of biomedical research and is the agency responsible for conducting and supporting 90 percent (more than $1.4 billion) of federally funded basic and clinical nutrition research. Nutrition research, which makes up about 4 percent of the NIH budget, is truly a trans-NIH endeavor, being conducted and funded across multiple Institutes and Centers. Some of the most promising nutrition-related research discoveries have been made possible by NIH support.

In order to fulfill the extraordinary promise of biomedical research, including nutrition research, ASN recommends an fiscal year 2011 funding level of $37 billion for the agency.

Over the past 50 years, NIH and its grantees have played a major role in the explosion of knowledge that has transformed our understanding of human health, and how to prevent and treat human disease. Because of the unprecedented number of breakthroughs and discoveries made possible by NIH funding, scientists are helping Americans to live longer, healthier, and more productive lives. Many of these discoveries are nutrition-related and have impacted the way clinicians prevent and treat heart disease, cancer, diabetes, and age-related macular degeneration.

During the next 25 years, the number of Americans with chronic disease is expected to reach 46 million, and the number of Americans older than age 65 is expected to be the largest in our Nation's history. Sustained support for basic and clinical research is required if we are to confront successfully the healthcare challenges associated with an older, and potentially sicker, population.

For several years in a row the NIH budget failed to keep up with inflation and subsequently, the percentage of dollars funding nutrition-focused projects declined. Thanks to Congress' inclusion of nearly $10 billion for NIH in H.R. 1, the American Recovery and Reinvestment Act, the scientific enterprise has been revitalized and additional biomedical research projects have been supported. ASN was pleased to see that more than 2 years. These projects also are, in addition to generating new findings to improve human health and nutrition, providing jobs and generating commercial activity throughout the broader community. It is imperative that we continue our commitment to biomedical research and to fulfill the hope of the American people by making the NIH a national priority. Otherwise, we risk losing our Nation's dominance in biomedical research.

The research engine needs predictable, sustained investment in science to maximize our return on investment. Recent experience has demonstrated how cyclical periods of rapid funding growth followed by periods of stagnation is disruptive to the discovery process, can lead to fewer students choosing careers in research, impedes long-range projects and ultimately slows progress. NIH needs sustainable and predictable budget growth to achieve the full promise of medical research to improve the health and longevity of all Americans.

CDC National Center for Health Statistics

The National Center for Health Statistics (NCHS), housed within the Centers for Disease Control and Prevention (CDC), is the Nation's principal health statistics agency. The NCHS provides critical data on all aspects of our healthcare system, and it is responsible for monitoring the Nation's health and nutrition status. Nutrition and health data, largely collected through the National Health and Nutrition Examination Survey (NHANES), is essential for tracking the health and well being of the American population, and it is especially important for observing health trends in our Nation's children. Knowing both what Americans eat and how their diets directly affect their health provides valuable information to guide policies on food safety, food labeling, food assistance, military rations and dietary guidance. Not surprisingly, NHANES serves as a gold standard for nutrition and health data collection around the world.

For several years, flat and decreased funding levels threatened the collection of this important information, most notably vital statistics from the NHANES. Beginning in fiscal year 2009, Congress made a renewed commitment to this agency by appropriating an additional $11 million to the agency—for nearly $125 million total—in fiscal year 2009 and a $14 million boost in fiscal year 2010. Actions in fiscal year 2009 halted what would have been the beginning of drastic cuts to the

agency's premier health surveys—NHANES and the National Health Information Survey—that were slated to occur should the agency not receive additional funds. Last year's continued support enabled the agency to rebuild after years of underinvestment. ASN appreciates very much the leadership this subcommittee has shown in securing steady and sustained funding increases for NCHS over the past 3 fiscal years.

To continue support for the agency and its important mission, ASN supports the President's fiscal year 2011 budget request of $162 million for the agency.

The obesity epidemic is a case in point that demonstrates the value of the work done by NCHS. It is because of NHANES that our nation became aware of this growing public health problem, and as obesity rates have increased to 31 percent of American adults (which we know because of continued monitoring), so too have rates of heart disease, diabetes and certain cancers. It is only through continued support of this program that the public health community will be able to stem the tide against obesity. Continuous collection of this data will allow us to determine not only if we have made progress against this public health threat, but also if public health dollars have been targeted appropriately. A recent report from the Institute of Medicine recognized the importance of NHANES and called for the enhancement of current surveillance systems to monitor relevant outcomes and trends with respect to childhood obesity.[1]

Now that healthcare reform has been signed into law, collecting health statistics is of even greater importance. Providing an additional $23 million in fiscal year 2011 continues the progress on a path that can mitigate previous years of flat-funding and ensure we have a 21st century health statistics system in the United States.

ASN thanks your subcommittee for its support of the NIH and NCHS in previous years.

PREPARED STATEMENT OF THE AMERICAN SOCIETY OF PLANT BIOLOGISTS

On behalf of the American Society of Plant Biologists (ASPB) we would like to thank the subcommittee for its extraordinary support of the National Institutes of Health (NIH) and ask that the subcommittee members encourage increased funding for plant biology research, which has contributed in innumerable ways to improving the lives of people throughout the world.

ASPB is an organization of more than 5,000 professional plant biologists, educators, graduate students, and postdoctoral scientists. A strong voice for the global plant science community, our mission—which is achieved through engagement in the research, education, and public policy realms—is to promote the growth and development of plant biology and plant biologists and to foster and communicate research in plant biology. The Society publishes the highly cited and respected journals Plant Physiology and The Plant Cell, and it has produced and supported a range of materials intended to demonstrate fundamental biological principles that can be easily and inexpensively taught in school and university classrooms by using plants.

Plant Biology Research and America's Future

Plants are vital to our very existence. They harvest sunlight, converting it to chemical energy for food and feed; they take up carbon dioxide and produce oxygen; and they are almost always the primary producers in the Earth's ecosystems. Plants and plant-based products directly or indirectly provide our food, our shelter, and our clothing.

Plant biology research is making many fundamental contributions in vital areas including health and nutrition, energy, and climate change. For example, because plants are the ultimate source of both human nutrition and nutrition for domestic animals, plant biology has the potential to contribute greatly to reducing healthcare costs as well as playing an integral role in discovery of new drugs and therapies. Although NIH does offer some funding support to plant biology research, with increased funding plant biologists can offer much more to advance the missions of NIH. In the next section, we highlight the particular relevance of plant biology research to human health.

Plant Biology and NIH

The mission of the NIH is to pursue "fundamental knowledge about the nature and behavior of living systems and the application of that knowledge to extend

[1] Institute of Medicine. Progress in Preventing Childhood Obesity Washington, DC: National Academies Press, 2006.

healthy life and reduce the burdens of illness and disability." Plant biology research is highly relevant to this mission.

Plants are often the ideal model systems to advance our "fundamental knowledge about the nature and behavior of living systems," as they provide the context of multi-cellularity while affording ease of genetic manipulation, a lesser regulatory burden, and inexpensive maintenance requirements. Many basic biological components and mechanisms are shared by both plants and animals. For example, a molecule named cryptochrome that senses light was identified first in plants and subsequently found to also function in humans, where it plays a central role in regulating our biological clock. Jet lag provides one familiar example of what happens to us when our biological clock is disrupted, but there are also human genetic disorders that have been linked to malfunctioning of the clock. As another example, some fungal pathogens can infect both humans and plants, and the molecular mechanisms employed by both the pathogen and its targeted host can be very similar.

Health and Nutrition

Plant biology research is also central to the application of basic knowledge to "extend healthy life and reduce the burdens of illness and disability." This connection is most obvious in the inter-related areas of nutrition and clinical medicine. Without good nutrition, there cannot be good health. Indeed, one World Health Organization study on childhood nutrition in developing countries concluded that more than 50 percent of the deaths of children less than 5 years of age could be attributed to malnutrition's effects in exacerbating common illnesses such as respiratory infections and diarrhea. Strikingly, most of these deaths were not linked to severe malnutrition but only to mild or moderate nutritional deficiencies. Plant biology researchers are working today to improve the nutritional content of crop plants by, for example, increasing the availability of nutrients and vitamins such as iron, vitamin E and vitamin A. (Up to 500,000 children in the developing world go blind every year as a result of vitamin A deficiency).

By contrast, obesity, cardiac disease, and cancer take a striking toll in the developed world. Among many plant biology initiatives relevant to these concerns are research to improve the lipid composition of plant fats and efforts to optimize concentrations of plant compounds that are known to have anti-carcinogenic properties, such as the glucosinolates found in broccoli and cabbage, and the lycopenes found in tomato. Ongoing development of crop varieties with tailored nutraceutical content is an important contribution that plant biologists are making toward realizing the goal of personalized medicine, especially personalized preventative medicine.

Drug Discovery

Plants are also fundamentally important as sources of both extant drugs and drug discovery leads. In fact, more than 10 percent of the drugs considered by the World Health Organization to be "basic and essential" are still exclusively obtained from flowering plants. Some historical examples are quinine, which is derived from the bark of the cinchona tree and was the first highly effective anti-malarial drug; and the plant alkaloid morphine, which revolutionized the treatment of pain.

These pharmaceuticals are still in use today. A more recent example of the importance of plant-based pharmaceuticals is the anti-cancer drug taxol. The discovery of taxol came about through collaborative work involving scientists at the National Cancer Institute within NIH and plant biologists at the U.S. Department of Agriculture. The plant biologists collected a wide diversity of plant materials, which were then evaluated for anti-carcinogenic properties. It was found that the bark of the Pacific yew tree yielded one such compound, which was isolated and named taxol after the tree's Latin name, Taxus brevifolia. Originally, taxol could only be obtained from the tree bark itself, but additional research led to the elucidation of its molecular structure and eventually to its chemical synthesis in the laboratory.

On the basis of a growing understanding of metabolic networks, plants will continue to be sources for the development of new medicines to help treat cancer and other ailments. Taxol is just one example of a plant secondary compound. Since plants produce an estimated 200,000 such compounds, they will continue to provide a fruitful source of new drug leads, particularly if collaborations such as the one described above can be fostered and funded. With additional research support, plant biologists can lead the way to developing new medicines and biomedical applications to enhance the treatment of devastating diseases.

Conclusion

Despite the fact that plant biology research underlies so many vital practical considerations for our country, the amount invested in understanding the basic function and mechanisms of plants is small when compared with the impacts of this informa-

tion on multibillion dollar sectors of the economy such as health, energy, and agriculture.

Clearly, the NIH does recognize that plants are a vital component of its mission. However, because the boundaries of plant biology research are permeable and because information about plants integrates with many different disciplines that are highly relevant to NIH, ASPB hopes that the subcommittee will provide additional resources through increased funding to NIH for plant biology in order to help pioneer new discoveries and new methods in biomedical research.

PREPARED STATEMENT OF THE AMERICAN SOCIETY OF TROPICAL MEDICINE AND HYGIENE

The American Society of Tropical Medicine and Hygiene (ASTMH)—the principal professional membership organization representing, educating, and supporting scientists, physicians, clinicians, researchers, epidemiologists, and other health professionals dedicated to the prevention and control of tropical diseases—appreciates the opportunity to submit written testimony to the Senate Labor, Health and Human Services, and Education, and Related Agencies Appropriations Subcommittee. We respectfully request that the subcommittee provide the following allocations in the fiscal year 2011 Labor, Health and Human Services, and Education, and Related Agencies appropriations bill to support a comprehensive effort to promote malaria, neglected tropical disease (NTD), and diarrheal disease control programming globally:

—$35 billion to the National Institutes of Health (NIH);
—$5.04 billion to the National Institute of Allergy and Infectious Diseases (NIAID);
—$78.5 million to the Fogarty International Center (FIC);
—$18 million to the Centers for Disease Control and Prevention (CDC) for malaria research, control, and program evaluation efforts with a $6 million set-aside for program monitoring and evaluation; and
—Direct funding to the CDC for ongoing efforts on NTDs and diarrheal disease.

ASTMH Background

The 3,700 members of ASTMH work in a myriad of public, private, and nonprofit environments. The largest proportion of our membership (34 percent) work in academia at the Nation's leading research universities. Fifteen percent of ASTMH members are employed by the U.S. military, and 11 percent are employed in public institutions and Federal agencies. Nine percent of ASTMH members are in private practice, with another 4 percent working in industry (e.g., pharmaceutical companies). The balance of the ASTMH membership works in numerous other capacities and for various other entities seeking to reduce and prevent tropical disease.

Tropical Medicine and Tropical Diseases

The term "tropical medicine" refers to the wide-ranging clinical, research, and educational efforts of physicians, scientists, and public health officials with a focus on the diagnosis, mitigation, prevention, and treatment of vector borne diseases prevalent in the areas of the world with a tropical climate. Most tropical diseases are located in either sub-Saharan Africa, parts of Asia (including the Indian subcontinent), or Central and South America. Many of the world's developing nations are located in these areas; thus tropical medicine tends to focus on diseases that impact the world's most impoverished individuals.

ASTMH aims to advance policies and programs that prevent and control those tropical diseases which particularly impact the global poor. The United States has a long history of leading the fight against tropical diseases which cause human suffering and pose a great financial burden that can negatively impact a country's economic and political stability. The benefits of U.S. investment in tropical diseases are not only humanitarian, they are diplomatic as well. ASTMH members and others work to reduce the impact of tropical diseases and to directly and positively impact populations that are otherwise generally ignored, but on whom many countries' futures depend. Tropical diseases, many of them neglected for decades, impact U.S. citizens working or traveling overseas as well as our military personnel. Furthermore, some of the agents responsible for these diseases can be introduced and become established in the United States (as was the case with West Nile virus), or might even be weaponized.

Malaria

Malaria remains a global emergency affecting mostly poor women and children; it is an acute, sometimes fatal disease caused by the single-celled Plasmodium para-

site transmitted to humans by Anopheles mosquitoes. Malaria can cause anemia, jaundice, kidney failure, and death. Despite being treatable and preventable, malaria is one of the leading causes of death and disease worldwide. Approximately every 30 seconds, a child dies of malaria—a total of about 800,000 under the age of 5 every year. (During the time it took to read this message, 10 children have died.)

The World Health Organization (WHO) estimates that one-half of the world's people are at risk for malaria and that there are 108 malaria-endemic countries. Malaria-related illness and mortality not only take a human toll, they severely impact economic productivity and growth. The WHO has estimated that malaria reduces sub-Saharan Africa's economic growth by up to 1.3 percent per year.

Fortunately, malaria can be both prevented and treated using four types of relatively low-cost interventions: (1) the indoor residual spraying (IRS) of insecticide on the walls of homes; (2) long-lasting insecticide-treated nets (LLIN); (3) Artemisinin-based combination therapies (ACTs); and (4) intermittent preventive therapy (IPT) for pregnant women in areas with high transmission. However, limited resources preclude the provision of these interventions and treatments to all individuals and communities in need. Thus, ASTMH calls upon Congress to fund a comprehensive approach to malaria control, including public health infrastructure improvements, mosquito abatement initiatives, and increased availability of existing anti-malarial drugs, development of new anti-malarial drugs and better diagnostics, and research to identify an effective malaria vaccine.

Neglected Tropical Diseases, Diarrheal Disease and Arboviruses

According to WHO, more than 1 billion people—one-sixth of the world's population—suffer from one or more NTDs, including arboviruses such as yellow fever and Dengue fever. The pediatric death toll due to diarrheal illnesses exceeds that of AIDS, tuberculosis, and malaria combined. In poor countries, diarrheal disease is second only to pneumonia in causing the deaths of children under 5 years old. Every week, 31,000 children in low-income countries die from diarrheal diseases. Diarrheal and NTDs, including arboviruses, are a symptom of poverty and disadvantage. Most of those affected are the poor populations in rural areas, urban slums or conflict zones. Traditionally, these diseases have been neglected by the world.

Requested Activities and Funding Levels

NIAID.—Malaria continues to be among the most daunting global public health challenges we face and one-sixth of the world's population suffers from one or more NTDs. A long-term investment is needed to achieve the drugs, diagnostics and research capacity needed to control malaria and neglected tropical disease. NIAID, the lead institute for malaria research, plays an important role in developing the drugs and vaccines needed to fight malaria.

Malaria.—NIH estimates spending approximately $152 million overall with for malaria research and $36 million for research related specifically to creating a malaria vaccine in fiscal year 2011. NIAID, the lead Institute for this research, has developed an Implementation Plan for Global Research on Malaria, which is focused on five research areas: vaccine development, drug development, diagnostics, vector control, and infrastructure and research capability strengthening.

NTDs.—The NIH, through NIAID conducts research to better understand NTDs, which includes conducting its own basic and clinical studies as well as extramural research. These efforts include:

—Research at the NIAID Laboratory of Parasitic Diseases to uncover how NTD-causing pathogens interact with humans, animals, and the organisms that spread them from host to host. The lab conducts patient-centered research at the NIH Clinical Center in Bethesda, MD, as well as field studies in India, Latin America, and Africa.

—Actively supporting the discovery and development of drugs for NTDs including a low-cost treatment for visceral leishmaniasis and identifying new drugs for sleeping sickness and Chagas disease.

—The Vector Biology Research Program at NIAID supports research on several vectors that transmit agents of NTDs. Many of these projects have field components in disease-endemic areas of the world.

—NIAID also has research repositories that provide researchers with parasite species, standard study protocols, and training.

ASTMH encourages NIH to continue and expand its investment in malaria, NTD, diarrheal disease, and arbovirus research and to coordinate that work with other Government agencies to maximize resources and ensure development of basic discoveries into useable solutions. NIAID is at the forefront of these efforts and contin-

ued funding is crucial to developing the next generation of drugs, vaccines, and other interventions.

FIC.—Although biomedical research has provided major advances in the treatment and prevention of malaria, neglected tropical diseases and other infectious diseases, these benefits are often slow to reach the people who need them most. Highly effective anti-malarial drugs exist; when patients receive these drugs promptly, their lives can be saved. FIC plays a critical role in strengthening science and public health research institutions in low-income countries. For example, for nearly a decade FIC has funded a program that has produced a substantial number of researchers with the expertise to address the research and clinical challenges associated with diarrheal diseases in Latin America. This strong international collaboration is fostering new discoveries on the long-term effects of and treatments for diarrheal diseases. By promoting applied health research in developing countries, the FIC can speed the implementation of new health interventions for malaria and NTDs.

FIC works to strengthen research capacity in countries where populations are particularly vulnerable to threats posed by malaria and neglected tropical diseases. FIC efforts that strengthen the research workforce in-country—including collaborations with U.S.-supported global health programs—help to ensure the continuous improvement of programs, adapting them to local conditions. This maximizes the impact of U.S. investments and is critical to fighting malaria and other tropical diseases.

FIC addresses global health challenges and supports the NIH mission through many activities, including:

—collaborative research and capacity building projects relevant to low- and middle-income nations;

—institutional training grants designed to enhance research capacity in the developing world, with an emphasis on institutional partnerships and networking;

—the Forum for International Health, through which NIH staff share ideas and information on relevant programs and develop input from an international perspective on cross-cutting NIH initiatives;

—the Multilateral Initiative on Malaria, which fosters international collaboration and co-operation in scientific research against malaria; and

—the Disease Control Priorities Project, a partnership supported by FIC, the Bill & Melinda Gates Foundation, the WHO, and the World Bank to develop recommendations on effective healthcare interventions for resource-poor settings.

ASTMH urges the subcommittee to allocate additional resources to the FIC in fiscal year 2011 to increase these efforts, particularly as they address the control and treatment of malaria, NTDs, and diarrheal disease.

CDC Malaria Efforts.—ASTMH calls upon Congress to fund a comprehensive approach to malaria control, including adequately funding the important contributions of CDC. CDC originally grew out of the WWII "Malaria Control in War Areas" program. Since its founding, the Atlanta-based agency has maintained a strong role in efforts to research and mitigate malaria. Although malaria has been eliminated as an endemic threat in the United States for more than 50 years, CDC remains on the cutting edge of global efforts to reduce the toll of this deadly disease.

The CDC is crucial partner in the President's Malaria Initiative (PMI), a $6.2 billion, 9-year effort led by the U.S. Agency for International Development (USAID) in conjunction with CDC and other Government agencies to lower the incidence of malaria in 15 targeted countries in sub-Saharan Africa by 50 percent.

CDC efforts on malaria fall into three broad areas—prevention, treatment, and monitoring/evaluation. The agency performs a wide range of basic research within these categories, such as:

—Providing technical assistance to malaria-endemic, non-PMI countries;

—Conducting research on LLINs, IRS, malaria in pregnancy, and case management including diagnosis, treatment and antimalarial drug resistance to inform new strategies and prevention approaches;

—Assessing new monitoring, evaluation and surveillance strategies;

—Conducting additional research on malaria vaccines, including field evaluations; and

—Developing novel public health strategies for improving access to antimalarial treatment and delaying the appearance of antimalarial drug resistance.

CDC NTD Programs.—CDC has had a long history of working on NTDs and has provided much of the science that underlies those global policies and programs in existence today. ASTMH encourages the Subcommittee to provide direct funding to the CDC to continue its work on NTDs, diarrheal diseases, and arboviruses, such as Japanese encephalitis and Dengue. This work is important to any global health initiative as individuals are often infected with multiple NTDs simultaneously. It is essential that CDC be encouraged to continue its monitoring, evaluation and tech-

nical assistance in these areas as an underpinning of efforts to control and eliminate these diseases. Currently the CDC receives zero dollars directly for NTD work; however this should be changed to allow for more comprehensive work to be done on NTDs directly at the CDC.

Conclusion

Thank you for your attention to these important global health matters. We know you face many challenges in choosing funding priorities, and we hope you will provide the requested fiscal year 2011 resources to those programs identified above. ASTMH appreciates the opportunity to share its views, and we thank you for your consideration of our requests.

PREPARED STATEMENT OF THE AMERICAN THORACIC SOCIETY

SUMMARY: FUNDING RECOMMENDATIONS

[In millions of dollars]

	Amount
National Institutes of Health	35,000
National Heart, Lung & Blood Institute	3,514
National Institute of Allergy and Infectious Disease	5,395
National Institute of Environmental Health Sciences	779.4
Fogarty International Center	78.4
National Institute of Nursing Research	163
Centers for Disease Control and Prevention	8,800
National Institute for Occupational Safety and Health	364.3
Asthma Programs	70
Division of Tuberculosis Elimination	220.5
Chronic Disease Prevention and Health Promotion: COPD	3
Office on Smoking and Health	280
National Sleep Awareness Roundtable	1

The American Thoracic Society (ATS) is pleased to submit our recommendations for programs in the Labor, Health and Human Services, and Education, and Related Agencies Appropriations Subcommittee purview. Founded in 1905, the ATS is an international education and scientific society that focuses on respiratory and critical care medicine. The ATS's 18,000 members help prevent and fight respiratory disease through research, education, patient care, and advocacy.

LUNG DISEASE IN AMERICA

Diseases of breathing constitute the third-leading cause of death in the United States, responsible for 1 of every 7 deaths. Diseases affecting the respiratory (breathing) system include chronic obstructive pulmonary disease (COPD), lung cancer, tuberculosis (TB), influenza, sleep-disordered breathing, pediatric lung disorders, occupational lung disease, sarcoidosis, asthma, and critical illness. The death rate due to COPD has doubled within the last 30 years and is still increasing, while the rates for the other three top causes of death (heart disease, cancer and stroke) have decreased by more than 50 percent. The number of people with asthma in the United States has surged more than 150 percent since 1980 and the root causes of the disease are still not fully known.

In recognition of the rising global burden of lung disease and the need for increased awareness and action to promote lung health, the ATS, in conjunction with the Federation of International Respiratory Societies, has declared 2010 to be the Year of the Lung. Throughout 2010, the ATS will be sponsoring a series of congressional briefings and other events to raise lung disease awareness.

National Institutes of Health (NIH)

The ATS deeply appreciates the $10 billion in supplemental funding provided for the NIH in the American Recovery and Reinvestment Act. This funding has sustained NIH support for groundbreaking research into diseases like COPD and asthma that affect millions of Americans. It is critical that this reinvestment in biomedical research is reinforced through annual budget increases that permit the NIH to respond to public health needs. We ask the subcommittee to provide $35 billion in funding for the NIH in fiscal year 2011.

Despite the rising lung disease burden, lung disease research is underfunded. In fiscal year 2009, lung disease research represented just 20.4 percent of the National

Heart Lung and Blood Institute's (NHLBI) budget. Although COPD is the fourth-leading cause of death in the United States, research funding for the disease is a small fraction of the money invested for the other three leading causes of death. In order to stem the devastating effects of lung disease, research funding must continue to grow.

Centers for Disease Control and Prevention (CDC)

In order to ensure that health promotion and chronic disease prevention are given top priority in Federal funding, the ATS supports a funding level for the CDC that enables it to carry out its prevention mission, and ensure an adequate translation of new research into effective State and local public health programs. We ask that the CDC budget be adjusted to reflect increased needs in chronic disease prevention, infectious disease control, including TB control to prevent the spread of drug-resistant TB, and occupational safety and health research and training. The ATS recommends a funding level of $8.8 billion for the CDC in fiscal year 2011.

COPD

COPD is the fourth-leading cause of death in the United States and the third-leading cause of death worldwide, yet the disease remains relatively unknown to most Americans. COPD is the term used to describe the limitation in breathing due mainly to emphysema and chronic bronchitis. CDC estimates that 12 million patients have COPD; an additional 12 million Americans are unaware that they have this life threatening disease.

The ATS feels that resources committed to COPD for research and education are not commensurate with the impact the disease has on Americans. According to the NHLBI, COPD costs the U.S. economy an estimated $37 billion per year. We recommend that the subcommittee encourage NHLBI and other NIH Institutes to devote additional resources to finding improved treatments and a cure for COPD. The ATS commends the NHLBI for its leadership on educating the public about COPD through the COPD Education and Prevention Program.

CDC also has a role to play in this work. To address the increasing public health burden of COPD, we encourage the creation of a CDC COPD program at the Center for Chronic Disease Prevention and Health Promotion, and request an appropriation of $3 million in fiscal year 2011 for this program. We are hopeful that the program will include development of a national COPD response plan, expansion of data collection efforts and creation of other public health interventions for COPD, and that the CDC be encouraged to add COPD-based questions to future CDC health surveys, including the National Health and Nutrition Evaluation Survey, the National Health Information Survey, and the Behavioral Risk Factor Surveillance Survey.

TOBACCO CONTROL

Cigarette smoking is the leading preventable cause of death in the United States, responsible for 1 in 5 deaths annually. The ATS congratulates the President and the Congress for enactment of the Family Smoking and Tobacco Prevention Act. The CDC's Office of Smoking and Health coordinates public health efforts to reduce tobacco use. In order to significantly reduce tobacco use within 5 years, as recommended by the subcommittee in fiscal year 2010, the ATS recommends $280 million in funding for the Office of Smoking and Health in fiscal year 2011.

PEDIATRIC LUNG DISEASE

Lung disease affects people of all ages. The ATS is pleased to report that infant death rates for various lung diseases have declined for the past 10 years. In 2006, about 1 in 5 deaths in children under 1 year of age was due to a lung disease. It is also widely believed that many of the precursors of adult respiratory disease start in childhood. The ATS encourages the NHLBI to continue with its research efforts to study lung development and pediatric lung diseases.

ASTHMA

The ATS believes that the NIH and the CDC must play a leadership role in assisting individuals with asthma. National statistical estimates show that asthma is a growing problem in the United States. Approximately 22.2 million Americans currently have asthma, including 7 million children. African Americans have the highest asthma prevalence of any racial/ethnic group. The age-adjusted death rate for asthma in the African-American population is three times the rate in whites. The ATS recommends an fiscal year 2011 funding level of $70 million for the CDC's asthma program.

SLEEP

Sleep is an essential element of life, but we are only now beginning to understand its impact on human health. Several research studies demonstrate that sleep-disordered breathing and sleep-related illnesses affect an estimated 50–70 million Americans. The public health impact of sleep illnesses and sleep disordered breathing is still being determined, but is known to include increased mortality, traffic accidents, lost work and school productivity, cardiovascular disease, obesity, mental health disorders, and other sleep-related comorbidities. Despite the increased need for study in this area, research on sleep and sleep-related disorders has been underfunded. The ATS recommends a funding level of $1 million in fiscal year 2011 to support activities related to sleep and sleep disorders at the CDC, including for the National Sleep Awareness Roundtable, surveillance activities, and public educational activities. The ATS also recommends an increase of funding for research on sleep disorders at the Nation Center for Sleep Disordered Research at the NHLBI.

TUBERCULOSIS (TB)

TB is the second-leading global infectious disease killer, claiming 1.8 million lives each year. It is estimated that 9–14 million Americans have latent TB. Drug-resistant TB poses a particular challenge to domestic TB control owing to the high costs of treatment and intensive healthcare resources required. Treatment costs for multidrug-resistant TB range from $100,000 to $300,000. The global TB pandemic and spread of drug resistant TB present a persistent public health threat to the United States.

Despite declining rates, persistent challenges to TB control in the United States remain. Specifically: (1) racial and ethnic minorities continue to suffer from TB more than majority populations; (2) foreign-born persons are adversely impacted; (3) sporadic outbreaks occur, outstripping local capacity; (4) continued emergence of drug resistance; and (5) there are critical needs for new diagnostics, treatment, and prevention tools.

In 2008, Congress passed the Comprehensive Tuberculosis Elimination Act (CTEA, Public Law 110–392). This historic legislation revitalized programs at CDC and the NIH with the goal of putting the United States back on the path to eliminating TB. The new law also authorizes an urgently needed reinvestment into new TB diagnostic, treatment and prevention tools. The ATS, recommends a funding level of $220.5 million in fiscal year 2011 for CDC's Division of TB Elimination, as authorized under the CTEA, and encourages the NIH to expand efforts, as requested under the CTEA, to develop new tools to reduce the rising global TB burden.

CRITICAL CARE

The burden associated with provision of care to critically ill patients is enormous, and is anticipated to increase significantly as the population ages. Investigation into diagnosis, treatment, and outcomes in critically ill patients should be a high priority, and the NIH should be encouraged and funded to coordinate investigation related to critical illness in order to meet this growing national imperative.

FOGARTY INTERNATIONAL CENTER

The Fogarty International Center (FIC) at NIH provides training grants to U.S. universities to teach AIDS treatment and research techniques to international physicians and researchers. Because of the link between AIDS and TB infection, FIC has created supplemental TB training grants for these institutions to train international health professionals in TB treatment and research. These training grants should be expanded and offered to all institutions. The ATS recommends Congress provide $78.4 million for FIC in fiscal year 2011, to allow expansion of the TB training grant program from a supplemental grant to an open competition grant.

RESEARCHING AND PREVENTING OCCUPATIONAL LUNG DISEASE

The National Institute of Occupational Safety and Health (NIOSH) is the sole Federal agency responsible for conducting research and making recommendations for the prevention of work-related diseases and injury. The ATS recommends that Congress provide $364.3 million in fiscal year 2011 for NIOSH to expand or establish the following activities: the National Occupational Research Agenda; tracking systems for identifying and responding to hazardous exposures and risks in the workplace; emergency preparedness and response activities; and training medical professionals in the diagnosis and treatment of occupational illness and injury.

CONCLUSION

Lung disease is a growing problem in the United States. The level of support this subcommittee approves for lung disease programs should reflect the urgency illustrated by these numbers. The ATS appreciates the opportunity to submit this statement to the subcommittee.

PREPARED STATEMENT OF THE ANIMAL WELFARE INSTITUTE

As part of the fiscal year 2010 appropriations bill for the National Institutes of Health (NIH), both the Senate and the House of Representatives included language in their reports directing NIH to take steps to end the use of Class B dealers by its grant recipients. Grantees affected by this language are small in number. According to USDA, for the period November 2007-November 2008, 2,863 dogs and 276 cats came from Class B dealers. This constitutes just 3 percent of the almost 95,000 total dogs and cats used in fiscal year 2007 for all research purposes, which include not only NIH-sponsored research, but also non-NIH-related research, testing and teaching.

Both chambers were responding to a report from the National Academy of Sciences (NAS) ("Scientific and Humane Issues in the Use of Random Source Dogs and Cats in Research"), undertaken at the request of Congress, that "critically examine[d] the general desirability and necessity of using random source dogs and cats in NIH-funded research, and the specific necessity of using Class B dealers as a source of such animals for NIH-funded research." (p. 2) While the Committee "concluded that under some circumstances, dogs and cats with qualities of random source animals may be desirable and necessary for NIH-funded research," it also "determined Class B dealers are not necessary as providers of random source animals for NIH-related research" (p. 5) and that adequate numbers of such animals are available from other sources. Acknowledging this finding, the Senate Appropriations Committee said, in part, that it "expects the NIH to phase out, as quickly as possible, the use of any of its funds for the purchase of, or research on, dogs or cats obtained from those USDA-licensed Class B dealers who acquire dogs or cats from third parties . . . and resell them. Specifically, the NIH should not award any new grants or contracts that involve such animals and should immediately begin supporting alternative sources of random source animals from non-class B dealers."

NIH has been dragging its feet in addressing the problem of Class B dealers for a decade, since Congress first expressed its concern over the matter. Based on statements NIH representatives have made with respect to the NAS report and the appropriations report language, we expect them to continue dragging their feet. We respectfully request that the subcommittee follow up the strong, sound position it laid out in the report language with statutory language prohibiting NIH from awarding or renewing any grants or contracts that involve the use of dogs or cats acquired from class B dealers, and that, moreover, NIH immediately begin supporting alternative sources of random-source dogs and cats from non-Class B dealers.

It should be clarified that the NAS report addressed extramural research funded by NIH, not NIH's internal research endeavors. The irony is, NIH ceased using Class B dealers in its own intramural research over 20 years ago, recognizing the problems—both ethical and scientific—caused by acquiring dogs from sources that treat the animals inhumanely; fail to provide proper veterinary care and the basic necessities such as clean water, food, and shelter; acquire animals through fraud and deception; and are constantly under investigation for violations of the Animal Welfare Act (AWA). In fact, in a recent article in Science (David Grimm, "Dog Dealers' Days May Be Numbered," Vol. 327, 26 February 2010, p. 1076–1077), Dr. Robert Whitney, former director of NIH's National Center for Research Resources (1972–1992) and Deputy Surgeon General of the U.S. Public Health Service (1992), is quoted as saying, "By using these animals, we risk losing our credibility with the public. It's an Achilles' heel for research." Even so, NIH steadfastly refuses to hold its extramural grant recipients to the same high standard it requires of its intramural researchers.

Of the 10 remaining licensed Class B dealers who sell live random source dogs and cats for experimentation, one is presently under a 5-year license suspension, and 6 are under investigation for AWA violations. And welfare problems with licensed Class B dealers are myriad. Needed veterinary care is lacking for many random source animals. Heartworm is a widespread problem, particularly in the South. Hookworm and mange are as well. Inspectors have observed animals at dealer premises with mange, "loose stool with some blood," "ring-worm like lesions," infected eyes, bite wounds, lameness, tumors, chronic cough, and animals who are se-

verely underweight and others with a "purulent discharge from the nose." In most cases, there is no record of any veterinary care.

Research institutions may reject animals delivered by a dealer because of the poor condition of the dogs and cats, leaving them to be hauled from location to location to see if there will be a taker. If not, the animal may be taken back and left to die or simply shot. Some at research institutions have let USDA know of their concerns. One such email identified a cat "in very poor condition: cache[c]tic, severely matted hair coat and a severe case of ear mites." It went on to note "many of the cats that we receive are wild or are almost wild. I do not understand where these cats come from and how they are examined for health certificates. I thought the animals had to come from someone who had raised and bred the animals on their property or from a specific shelter."

The conditions for housing, feeding, and care can be problematic as well. An Ohio dealer was cited for "contaminated straw, wet with urine and excessive feces. Excessive flies. Water receptacles contaminated with black and green algae—a thick layer." A dealer in Indiana had dogs unable to avoid contact with excreta. Another dealer's inspection report notes, "Some 70–75 percent dogs have water and bread and little bits of dog food floating in water. There were some dogs that had only bread and water. Some had dog food floating in water. Most of dogs had not eaten the watery food blend . . . About 70 percent of the total dogs had non-potable water. Water was mixed with bread and dog food and sitting in the direct sun."

The NAS report took note of these failures to provide for the animals' basic welfare: "In addition, the Committee determined that the husbandry standards and humane treatment of animals was unacceptably variable among existing Class B dealers, and not commensurate with NIH standards of research animal care and quality." (p. 86; emphasis added.) The report also observed that "random source dogs and cats used for research probably endure greater degrees of stress and distress compared to purpose-bred animals. This conclusion has implications not only for the welfare of random source animals but also for their overall reliability as research models." (p. 59)

USDA is also pursuing separate investigations regarding apparent supply violations identified during tracebacks conducted of dealer records necessitated by ongoing questions about the illegality of the sources of animals. Unlike any other licensees covered under the AWA, this one group—Class B dealers selling dogs and cats for research—has a long-standing problem maintaining complete and accurate records. An insurmountable hurdle for USDA is that the AWA allows anyone who claims to have bred and raised an animal to profit by selling the animal to a random source dealer-and how can USDA be expected to disprove it?

Complicating matters further is the fact that dealers commonly network with each other; that is, animals are sold from buncher (an unlicensed dealer who literally bunches together animals from various sources) to dealer to another dealer, often across multiple State lines, before being sold for research. With animals changing hands and being shipped across the country, how is USDA supposed to keep up with the movement of animals and verify their source?

Another shell game dealers like to play is passing the business on to other members of the family after showing them the ropes. Sometimes a former employee of a dealer, who has also learned how to work the system, may go off on his own and get licensed as well. Brothers Danny and Johnny Schachtele of Missouri ran their licensed Class B dealer operation as a team beginning in 1987. Later Johnny left the business and Danny's wife, Mildred, replaced him. Over the ensuing years, the husband-wife team were cited by USDA for a host of violations of the AWA, and they were charged with a laundry list of violations, including failure to maintain records that fully and correctly disclose the identities and other required information of the persons from whom dogs were acquired on 51 separate occasions, including one incident that pertained to 43 dogs. Further, they were charged with failing to provide complete certifications on seven separate occasions, including one that pertained to 195 dogs. The husband died before the case was resolved and though the wife was fined $107,250, the judge suspended $100,000 of it. But the story doesn't end here.

The couple's son and daughter-in-law, after helping mom close down her business, set up their own Class B dealer operation. Becky and Tony Schachtele have been cited repeatedly by USDA for apparent violations including inadequate veterinary care, faulty recordkeeping, inadequate cleaning and sanitization and problems with housing and primary enclosures. Among multiple dogs in need of veterinary care, the USDA inspector noted one dog "standing with its head down and rocking in an abnormal manner from front to back and side to side . . . dull eyes . . . never lifted its head . . . was very thin with very prominent, easily visible bony structures . . . the dogs abdomen was extremely tucked and its hair coat was dull."

At one inspection alone, 48 records had incomplete addresses for the persons who sold the animals; 31 animal certification forms were incomplete; and 44 forms had inconsistent and therefore inaccurate information regarding the animals and when they were acquired and sold. Though under investigation, the Schachteles are still selling dogs and cats for research.

During a House Agriculture Subcommittee hearing held back in 1996, then-Assistant Secretary of Agriculture Michael Dunn described his frustration with random source dealers: "Every time we develop a new way to look for something, they develop a new way to hide it." To address these numerous and ongoing violations, USDA has to inspect random source dealers four times a year instead of once a year as is done with all other licensees and registrants under the AWA. It spends approximately $300,000 per year trying to regulate this small number of dealers, and even with that, the department acknowledged in its NAS testimony that it cannot guarantee that stolen pets are not being sold into research.

The effect on the animals of such inhumane treatment, and the costs of enforcement, are not included in the calculation when NIH cites the cheaper cost of random source dogs and cats acquired from Class B dealers. But the NAS report does take this into account: ". . . [O]ftentimes dogs and cats from Class B dealers are not free from disease. In addition to being a potential threat to other animals and people in the research facility, they may need to undergo prolonged quarantine, socialization, treatment, or be removed from the study all together [sic]. These hidden costs may substantially increase the actual final cost by hundreds of dollars per animals. Additionally, the price of USDA/APHIS oversight of Class B dealers . . . represents a substantial cost to the U.S. government and ultimately the American public that is not incurred by NIH, the research institution, nor the research investigator." (p.75)

The AWA was passed in 1966 to address the illegal supply of dogs and cats to laboratories, and now, over four decades later, these problems are still widespread. What has changed significantly over this lengthy period of time is the availability of animals from suppliers other than random source dealers. Given the problems inherent in the use of licensed Class B dealers, researchers have increasingly and successfully shifted to acquiring most of their dogs and cats from licensed Class A breeders—and by using these dealers instead, the researchers will receive animals who have been raised under controlled conditions, with the health and vaccination status and the genetic background on each individual animal known. In addition, some dogs and cats are being bred for experimentation at registered research facilities, and in some cases, inexpensive random type animals are purchased directly from animal pounds.

NIH has told this Subcommittee that it is "committed to ensuring the appropriate care and use of animals in research." However, NIH has left the decision of whether or not to buy dogs and cats from random source dealers "to the local level on the basis of scientific need." NIH defends the use of Class B dealers arguing that these dealers are needed to obtain "animals that may not be available from other sources, such as genetically diverse, older, or larger animals." The National Academies report clearly states that "it is not necessary to acquire them [random source dogs and cats] through Class B dealers," ("Report In Brief"), and that adequate numbers are available through alternative sources.

All animals used in research should be obtained from lawful sources. Taxpayer dollars, in the form of NIH extramural grants, must not continue to fund research using dogs and cats from dealers whose modus operandi involves illegal acquisition of animals, fraudulent or incomplete records and other illicit activities, and failure to abide by the minimum care requirements of the AWA.

Thank you very much for your consideration of our request for statutory language to address this issue and put an end to wasting taxpayer money on propping up this corrupt system.

PREPARED STATEMENT OF THE BUILDING AND CONSTRUCTION TRADES DEPARTMENT AFL–CIO

My name is Erich (Pete) Stafford and I am the Director of Safety and Health for the Building and Construction Trades Dept (BCTD) AFL–CIO. The BCTD is composed of 13 international unions representing some 3 million members employed in the building and construction industry.

The purpose of this testimony is to request your support for increased funding for the National Institute for Occupational Safety and Health (NIOSH), and its construction research program.

Despite improvements in workplace safety and health, nearly 15 American workers die each day from injuries sustained at work, and 134 die from work-related diseases. Of those killed every day, nearly 4 work in the construction industry.

Indeed, construction has the dubious distinction of being the single most hazardous industry in the United States accounting for some 1,200 construction workers killed on the job each year. (see attached chart). Another 150,000 suffer serious injuries requiring time off from work. Moreover, due to exposures to an array of toxic and hazardous substances, construction workers have unacceptably high levels of occupational disease including cancers, silicosis, asbestosis, and other heart, lung and neurological diseases.

While construction workers make up only 8 percent of the U.S. workforce, they account for more than 22 percent of all work-related deaths. The number of construction workers killed on the job is 10 times the number of firefighters and law enforcement officers killed in the line of duty each year, and 20 times the number of job-related deaths to miners.

In addition to the human tragedy, the economic costs are staggering. The total cost of fatal and nonfatal injuries and disease in the construction industry has been estimated at nearly $13 billion annually. And, that does not count the costs of workers' compensation, which, at $30 billion a year, are twice that of manufacturing and three times that for all industries.

NIOSH, is the only Federal agency responsible for conducting research and making recommendations for the prevention of work-related injury and illness. Yet it is one of the most under funded health research agencies in the Federal Government, and is hamstrung by being buried in the bowels of the Centers for Disease Control and Prevention bureaucracy where it remains an orphan.

Except for a special $80 million increase for the World Trade Center (WTC) health program and some $7 million for nanotechnology research, the President's fiscal year 2011 NIOSH budget request remains at last year's level. While we support both the WTC and nanotechnology programs, we think it's high time for the Congress to review the entire NIOSH program with an eye towards dramatically improving both its structural place within the Department of HHS and its funding.

With respect to funding, especially funding for the NIOSH National Occupational Research Agenda (NORA) program, we recommend a $25 million increase more than the President's static $124.5 million NORA request. This would permit a modest expansion of NIOSH/NORA research activities beyond nanotechnology.

We are particularly concerned with NORA funding for the "construction initiative" that seeks to (1) identify safety and health problem areas and obstacles to prevention and (2) translate that research into practice via partnerships and field studies across a variety of construction trades.

A recent National Academy of Sciences' Institute of Medicine review of the NIOSH construction program, recommended:

—Increased funding for the program.

—Strengthening NIOSH's internal management of the program.

—Retaining "The National Construction Center" as the main focus for "research to practice" (R2P) activities.

According to the National Academy: "Total annual funding for the Construction Research Program between fiscal year 1997 and fiscal year 2007 has averaged about $17.8 million, ranging from a high of $20.3 million in fiscal year 1997 to a low of $13.8 million in fiscal year 2007. . . . When adjusted for inflation and changes in technologies, the funding level for the program has declined in terms of real purchasing power . . ."

Moreover, the study committee concluded ". . . that in spite of budget constraints, the Construction Research Program has made an impact on one of the most dangerous and largest of U.S. industries. The committee finds the funding level inadequate and recommends that high-level attention be given to determining how to provide program resources that are commensurate with a more robust pursuit of the program's goals . . ."

Given the research agenda outlined and recommended by the NAS Review Committee, we believe that the construction program should be placed on a sounder financial footing and recommend that it receive additional funds from the $25 million NIOSH/NORA budget increase we have requested.

To address the many construction safety and problems in our industry, the BCTD research arm—The Center for Construction Research and Training (CPWR)—has, for many years, been working with NIOSH through the NORA construction research initiative. The CPWR was recently awarded another 5-year extension of its NIOSH contract to serve as the "National Construction Center" to coordinate the "Research to Practice" program. Unfortunately, funding for the "National Construction Center" has remained flat for the past 15 years at about $5 million annually.

We strongly believe that the best way to address what has become a safety and health crisis in our industry is through targeted and applied research to better understand the causes of construction-related incidents and illness and find ways implement solutions on U.S. construction sites. While there is certainly an additional need for better standards and enforcement by the Department of Labor, NIOSH construction research is the critical first step towards a safer and healthier construction workforce.

In addition to fostering more investigator-initiated extramural research into risks from emerging technologies such as nano-particles and strengthening NIOSH administration, a modest increase in funding would expand the transfer of research-to-practice functions of the National Construction Center with special emphasis on:

—Social marketing outreach to small-to-medium sized (less than 50 employees) workplaces

—Special worker populations including immigrant, minority, young and older workers.

—Opportunities to combine safety and health with more energy-efficient construction practices and investigate emerging hazards in green construction.

As you consider the fiscal year 2011 Labor, Health and Human Services, and Education, and Related Agencies appropriation bill, we urge you to take some time to consider the safety and health of our building and construction workforce. The current situation is simply unacceptable and, in light of demands for increased public spending for construction projects to stimulate the economy, the safety and health pressures on our workers will only become more intense.

Thank you.

FACILITIES IN THE U.S. CONSTRUCTION INDUSTRY

	2003	2004	2005	2006	2007
Construction	1,171	1,278	1,243	1,297	1,239
Transportation	>800	>800 +	>800	<900	<900
Manufacturing	>400	>400	<400	>400	400
Agriculture	>700	>600	>700	>600	600
Mining	>100 +	>100	>100	200	<200

Source: Center for Construction Research and Training.

SAFETY AND HEALTH FACTS [1]

The construction industry employs only 8 percent of the workforce but it suffers 22 percent of all work-related deaths.

Low-skilled, low-paid laborers suffer the most fatalities.

Construction establishments with less than 20 workers account for 55 percent of all fatalities.

Lung cancer deaths are 50 percent higher among construction workers than the U.S. population, adjusted for smoking.

Construction workers are twice as likely to have chronic obstructive lung diseases.

Construction workers are five times as likely to have a cancer of the lung lining, mesothelioma, and 33 times as likely to have asbestosis, an incurable and fatal lung disease.

30–40 percent of construction workers suffer musculoskeletal disorders and chronic pain.

50 percent of construction workers have noise-induced hearing loss.

Construction workers account for 17 percent of workers with elevated blood lead levels.

Welding fumes account for 75 percent of boilermakers, 15 percent of ironworkers and 7 percent of pipefitters exceed the accepted 8-hour level for manganese exposure; a known neurotoxin.

[1] Source: Center for Construction Research and Training.

LETTER FROM THE BRAIN INJURY ASSOCIATION OF AMERICA

APRIL 7, 2010.

Hon. TOM HARKIN,
Chairman, Senate Appropriations Subcommittee on Labor, Health and Human Services, and Education and Related Agencies, Washington, DC.

Hon. THAD COCHRAN,
Ranking Member, Senate Appropriations Subcommittee on Labor, Health and Human Services, and Education and Related Agencies, Washington, DC.

DEAR CHAIRMAN HARKIN AND RANKING MEMBER COCHRAN: Thank you for the opportunity to submit this written testimony with regard to the fiscal year 2011 Labor, Health and Human Services, and Education, and Related Agencies appropriations bill. My testimony is on behalf of the Brain Injury Association of America (BIAA), our national network of State affiliates, and hundreds of local chapters and support groups from across the country.

A traumatic brain injury (TBI) is a blow or a jolt to the head that temporarily or permanently disrupts brain function—i.e., who we are and how we think, act, and feel. In the civilian population alone every year, more than 1.5 million people sustain brain injuries from falls, car crashes, assaults and contact sports. Males are more likely than females to sustain brain injuries. Children, teens, and seniors are at greatest risk.

Recently, we are seeing an increasing number of service members returning from the conflicts in Iraq and Afghanistan with TBI, which has been termed one of the signature injuries of the War. A recent study conducted by the RAND Corporation found that 320,000 troops, or 19 percent of all service members, returning from Operations Enduring Freedom and Iraqi Freedom may have experienced a traumatic brain injury during deployment. Many of these returning service members are undiagnosed or misdiagnosed and subsequently they and their families will look to community and local resources for information to better understand TBI and to obtain vital support services to facilitate successful reintegration into the community.

For the past 13 years Congress has provided minimal funding through the Health Resources and Services Administration (HRSA) Federal TBI Program to assist States in developing services and systems to help individuals with a range of service and family support needs following their loved one's brain injury. Similarly, the grants to State Protection and Advocacy Systems to assist individuals with traumatic brain injuries in accessing services through education, legal and advocacy remedies are woefully underfunded. Rehabilitation, community support, and long-term care systems are still developing in many States, while stretched to capacity in others. Additional numbers of individuals with TBI as the result of war-related injuries only adds more stress to these inadequately funded systems.

BIAA respectfully urges you to provide States with the resources they need to address both the civilian and military populations who look to them for much needed support in order to live and work in their communities.

With broader regard to all of the programs authorized through the TBI Act, BIAA specifically requests:

—$10 million (+$4 million) for the Centers for Disease Control and Prevention TBI Registries and Surveillance, Brain Injury Acute Care Guidelines, Prevention and National Public Education/Awareness

—$8 million (+$1 million) for the Health Resources and Services Administration (HRSA) Federal TBI State Grant Program

—$4 million (+$1 million) for the HRSA Federal TBI Protection & Advocacy (P&A) Systems Grant Program

CDC—National Injury Center.—The Centers for Disease Control and Prevention's National Injury Center is responsible for assessing the incidence and prevalence of TBI in the United States. The CDC estimates that 1.4 million TBIs occur each year and 3.4 million Americans live with a life-long disability as a result of TBI. In addition, the TBI Act as amended in 2008 requires the CDC to coordinate with the Departments of Defense and Veterans Affairs to include the number of TBIs occurring in the military. This coordination will likely increase CDC's estimate of the number of Americans sustaining TBI and living with the consequences.

CDC also funds States for TBI registries, creates and disseminates public and professional educational materials, for families, caregivers and medical personnel, and has recently collaborated with the National Football League and National Hockey League to improve awareness of the incidence of concussion in sports. CDC plays a leading role in helping standardize evidence based guidelines for the management of TBI and $3 million of this request would go to fund CDC's work in this area as

well as support a pilot project to improve hospital compliance with existing guidelines.

HRSA TBI State Grant Program.—The TBI Act authorizes the HHS, Health Resources and Service Administration (HRSA) to award grants to (1) States, American Indian Consortia and territories to improve access to service delivery and to (2) State Protection and Advocacy (P&A) Systems to expand advocacy services to include individuals with traumatic brain injury. For the past 13 years the HRSA Federal TBI State Grant Program has supported State efforts to address the needs of persons with brain injury and their families and to expand and improve services to underserved and unserved populations including children and youth; veterans and returning troops; and individuals with co-occurring conditions.

In fiscal year 2009, HRSA reduced the number of State grant awards to 15, in order to increase each monetary award from $118,000 to $250,000. This means that many States that had participated in the program in past years have now been forced to close down their operations, leaving many unable to access brain injury care.

Increasing the program to $8 million will provide funding necessary to sustain the grants for the 15 States currently receiving funding along with the three additional States added this year and to ensure funding for four additional States. Steady increases over 5 years for this program will provide for each State including the District of Columbia and the American Indian Consortium and territories to sustain and expand State service delivery; and to expand the use of the grant funds to pay for such services as Information & Referral (I&R), service coordination and other necessary services and supports identified by the State.

HRSA TBI P&A Program.—Similarly, the HRSA TBI P&A Program currently provides funding to all State P&A systems for purposes of protecting the legal and human rights of individuals with TBI. State P&As provide a wide range of activities including training in self-advocacy, outreach, information, and referral and legal assistance to people residing in nursing homes, to returning military seeking veterans benefits, and students who need educational services.

Effective Protection and Advocacy services for people with traumatic brain injury is needed to help reduce government expenditures and increase productivity, independence and community integration. However, advocates must possess specialized skills, and their work is often time-intensive. A $4 million appropriation would ensure that each P&A can move towards providing a significant PATBI program with appropriate staff time and expertise.

National Institute on Disability and Rehabilitation Research (NIDRR) TBI Model Systems of Care.—Funding for the TBI Model Systems in the Department of Education is urgently needed to ensure that the Nation's valuable TBI research capacity is not diminished, and to maintain and build upon the 16 TBI Model Systems research centers around the country.

The TBI Model Systems of Care program represents an already existing vital national network of expertise and research in the field of TBI, and weakening this program would have resounding effects on both military and civilian populations. The TBI Model Systems are the only source of nonproprietary longitudinal data on what happens to people with brain injury. They are a key source of evidence-based medicine, and serve as a "proving ground" for future researchers.

In order to make this program more comprehensive, Congress should provide $11 million (+$1.5 million) in fiscal year 2011 for NIDRR's TBI Model Systems of Care program, in order to add one new Collaborative Research Project. In addition, given the national importance of this research program, the TBI Model Systems of Care should receive "line-item" status within the broader NIDRR budget.

We ask that you consider favorably these requests for the CDC, the HRSA Federal TBI Program, and the NIDRR TBI Model Systems Program to further data collection, increase public awareness, improve medical care, assist States in coordinating services, protect the rights of persons with TBI, and bolster vital research.

Sincerely,

SUSAN H. CONNORS,
President/CEO,
Brain Injury Association of America.

PREPARED STATEMENT OF THE CAEAR COALITION

On behalf of the tens of thousands of individuals living with HIV/AIDS to whom the members of the Communities Advocating Emergency AIDS Relief (CAEAR) Coalition provide care, I want to thank Chairman Tom Harkin and Ranking Member Thad Cochran for affording CAEAR Coalition the opportunity to submit this written

testimony for the record regarding increased funding for the Ryan White HIV/AIDS Program.

CAEAR Coalition is a national membership organization which advocates for Federal appropriations, legislation, policy and regulations to meet the care, treatment, support service, and prevention needs of people living with HIV/AIDS and the organizations that serve them. CAEAR Coalition's proactive national leadership is focused on the Ryan White Program as a central part of the Nation's response to HIV/AIDS. CAEAR Coalition's members include Ryan White Program part A, part B, and part C consumers, grantees, and providers.

A Wise Investment in a Program That Works

The Ryan White Program works. Those on the epidemic's frontlines know this to be true, and that faith received a ringing endorsement from the White House Office of Management and Budget (OMB). In its 2007 Program Assessment Rating Tool (PART), OMB gave the Ryan White Program its highest possible rating of "effective"—a distinction shared by only 18 percent of all programs rated. According to OMB, effective programs "set ambitious goals, achieve results, are well-managed and improve efficiency." Even more impressively, OMB's assessment of the Ryan White Program found it to be in the top 1 percent of all Federal programs in the area of "Program Results and Accountability." Out of the 1,016 Federal programs rated—98 percent of all Federal programs—the Ryan White Program was one of seven that received a score of 100 percent in "Program Results and Accountability."

The reauthorization of the Ryan White Program signed in October 2009 was a tremendous victory for people living with HIV/AIDS and those who care for them. We are grateful for congressional efforts to ensure that this vital program continued uninterrupted when it expired in September. As you are aware, the Ryan White Program serves as the indispensable safety net for thousands of low-income, uninsured, or underinsured people living with HIV/AIDS.

—Part A provides much-needed funding to the 56 major metropolitan areas hardest hit by the HIV/AIDS epidemic with severe needs for additional resources to serve those living in their communities.

—Part B assists States and territories in improving the quality, availability, and organization of healthcare and support services for individuals and families with HIV disease.

—The AIDS Drug Assistance Program (ADAP) in part B provides urgently needed medications to people living with HIV/AIDS in all 50 States and the territories.

—Part C provides grants to 357 faith- and community-based primary care health clinics and public health providers in 49 States, Puerto Rico and the District of Columbia. These clinics play a central role in the delivery of HIV-related medical services to underserved communities, people of color, and rural areas.

—Part F AETC supports training for healthcare providers to identify, counsel, diagnose, treat, and manage individuals with HIV infection and to help prevent high-risk behaviors that lead to infection. It has 130 program sites in all 50 States.

We thank you in advance for your consideration of our comments and our request for:

—$905 million for part A to support grants to the cities hardest hit by HIV/AIDS so they can provide quality care to people with HIV/AIDS (an increase of $225.9 million);

—$474.7 million for part B base to provide additional needed resources to the States in their efforts to address the HIV/AIDS epidemic (an increase of $55.9 million).

—$1,205.1 million in funding for the ADAP line item in part B so uninsured and underinsured people with HIV/AIDS can access the prescribed medications they need to survive (an increase of $307.1 million).

—$337.8 million for part C to support grants to community-based organizations, agencies, and clinics that provide quality care to people living with HIV/AIDS (an increase of $131 million).

—$50 million to fund the 11 regional centers funded under by part F AETC to offer specialized clinical education and consultation on HIV/AIDS transmission, treatment, and prevention to frontline healthcare providers (an increase of $15.9 million).

The increases CAEAR Coalition seeks in the current funding for part A, part B base and ADAP, part C, and part F AETC reflect the reality that the HIV/AIDS epidemic and the healthcare and social service needs of people with HIV/AIDS require significantly more Federal resources than those provided in recent years. There continues to be an ever-growing gap between the number of people living with AIDS in the United States in need of care and the resources available to serve them.

For example, between 2001 and 2007 the number of people living with AIDS grew 33 percent and yet funding for medical care and support services in the Nation's hardest hit communities grew less than 12 percent between 2001 and 2010. Similarly, funding for part C-funded, community-based primary care clinics, which provided medical care for people living with HIV/AIDS in rural and urban communities nationwide, grew by only 11 percent between 2001 and 2010 as the number of people they care for grew by 52 percent.

Growing Needs, Diminishing Resources

In 2008, CDC yet again revised upward its estimate of persons living with HIV/AIDS in the United States to 1,106,400 (as of 2006). Approximately one-half of those people have yet to access HIV-related medical care and there is a projected influx of newly diagnosed individuals into care as a result of CDC initiatives to promote routine HIV testing. CDC also estimates that in 2006, more than 56,000 people were newly infected with HIV. Ryan White Program part A, part B base and ADAP, part C, and part F AETCs must receive adequate increases to meet the healthcare and supportive services needs of individuals already in care and those newly identified HIV patients entering care-many of whom will require comprehensive medical treatment and supportive services at the time of diagnosis.

Additional increases are desperately needed to address the growing demand for services, offset the rising cost of care, and help the many jurisdictions forced year after year to make service reductions and eliminations to rebuild their programs.

State budget cuts have created an immediate ADAP funding crisis. Many State ADAPs are on the brink of the worst funding shortfall in many years and there is a record number of people in need of ADAP services due to the economic downturn. As of March 2010, there are 662 people on ADAP waiting lists in 10 States. Additionally, ADAP waiting lists and other cost-containment measures, including limited formularies, reducing eligibility, or removing already enrolled people from the program, are clear evidence that the need for HIV-related medications continues to outstrip availability. ADAPs are forced to make difficult trade-offs between serving a greater number of people living with HIV/AIDS with fewer services or serving fewer people with more services. Additional resources are needed to reduce and prevent further use of cost-containment measures to limit access to ADAPs and to allow all State ADAPs to provide a full range of HIV antiretrovirals and treatment for opportunistic infections.

The number of clients entering the 357 part C community health centers and outpatient clinics has consistently increased over the last 5 years. More than 248,000 persons living with HIV and AIDS receive medical care in part C-funded community health centers and clinics each year. These community- and faith-based HIV/AIDS providers are staggering under the burden of treatment and care after years of funding cuts prior to the modest increase in recent years. The CDC has implemented a number of initiatives designed to promote routine HIV testing to identify people living with HIV. Their success continues to generate new clients seeking care at part C-funded health centers and clinics with no commensurate increase in the funds necessary to provide access to comprehensive, compassionate treatment and care.

Increasing Testing Requires Increasing Access to Care

The fiscal year 2011 appropriation presents a crucial initial opportunity to restore the Ryan White Program to the levels of funding demanded by the epidemic as the Centers for Disease Control and Prevention (CDC) continue their increased efforts to expand HIV testing to help people living with HIV learn their status. With the continued influx of newly diagnosed individuals into care and the additional 56,000 estimated new cases of HIV every year, the Ryan White program must receive adequate increases to meet the healthcare and supportive services needs of individuals already in care and those newly identified HIV patients.

CAEAR Coalition supports efforts to help identify those individuals infected with HIV but unaware of their status. However, CAEAR Coalition is concerned that without the simultaneous allocation of additional resources for treatment, these CDC initiatives have resulted in a significant increase in the demand for HIV/AIDS services without the capacity in place to provide that care.

Increased demand for services has placed a severe strain on the HIV/AIDS safety net and forced community-based providers to stretch already scarce resources even further to address growing needs. This additional pressure on an already overburdened system will leave many of the 200,000+ HIV-infected individuals who do not know their HIV status without access to the care they need. CAEAR Coalition urges Congress and the administration to provide a commensurate increase for treatment programs to meet the demand that has resulted from the CDC testing initiative.

Sufficient Funding for Ryan White Programs Saves Money and Saves Lives

Increased funding for Ryan White Programs will reap a significant health return for minimal investment. Data show that part A and part C programs have reduced HIV-related hospital admissions by 30 percent nationally and by up to 75 percent in some locations. The programs supported by the Ryan White HIV/AIDS Program also have been critical in reducing AIDS mortality by 70 percent. Taken together, the Ryan White Program works—resulting in both economic and social savings by helping keep people healthy and productive.

CAEAR Coalition is eager to work with Congress to meet the challenges posed by the HIV/AIDS epidemic. Congress and the Administration must do more to address the grim reality that the domestic epidemic is not static; it is continuing to grow at a significant rate and more Federal resources are needed to prevent it from becoming a public health catastrophe similar to what we are witnessing in the developing world. Already, some communities in the United States have infection and death rates similar to those in Africa. We must make a commensurate domestic investment to care for people in our own communities. CAEAR Coalition looks forward to working with the subcommittee and the Congress to help meet the needs of Americans living with HIV/AIDS as the appropriations process moves forward.

Given the Ryan White Program's stellar history of accomplishments, the vast need for more resources to address unmet need, and such strong praise from the Federal Government's most stringent and assiduous assessors, we hope the subcommittee will act to provide these relatively modest funding increases.

PREPARED STATEMENT OF THE COUNCIL OF ACADEMIC FAMILY MEDICINE

On behalf of the Council of Academic Family Medicine (CAFM), we are pleased to submit testimony on behalf of several programs under the jurisdiction of the Health Resources and Services Administration (HRSA) and the Agency for Healthcare Research and Quality (AHRQ).

We are very pleased to have supported the Patient Protection and Affordable Care Act (PPACA) and to see it enacted into law. We appreciate Congress's efforts to extend healthcare coverage to all and are pleased that the law contains significant efforts to support and sustain programs that will help produce a workforce needed to take care of the Nation. As the law acknowledges, there is much that must be done to support primary care production and nourish the development of a high-quality, highly effective primary care workforce to serve as a foundation for our healthcare system.

Health Care Reform Requires a Robust Primary Care Workforce

The PPACA contains many measures to address the need for more primary care physicians. As you know, increased access for patients in terms of insurance coverage is critical, but not sufficient to resolve the growing shortage of primary care physicians. In fact, increased coverage, without increased numbers of primary care physicians, is a recipe for disaster. The implementation of the 2006 Massachusetts healthcare reform law demonstrated that universal coverage will overwhelm a healthcare system with too few primary care physicians, especially, family physicians. Addressing the shortage of primary care physicians requires a long-term commitment to train an appropriate number of these essential healthcare providers. We must increase our investment in effective programs that encourage medical students to enter primary care specialties.

Toward that end, there are several programs and agencies whose domain is critically important to producing more primary care physicians and providing them with the tools to support high quality care. It is those programs and agencies that come under this subcommittee's jurisdiction and that this testimony addresses.

Primary Care Training and Enhancement

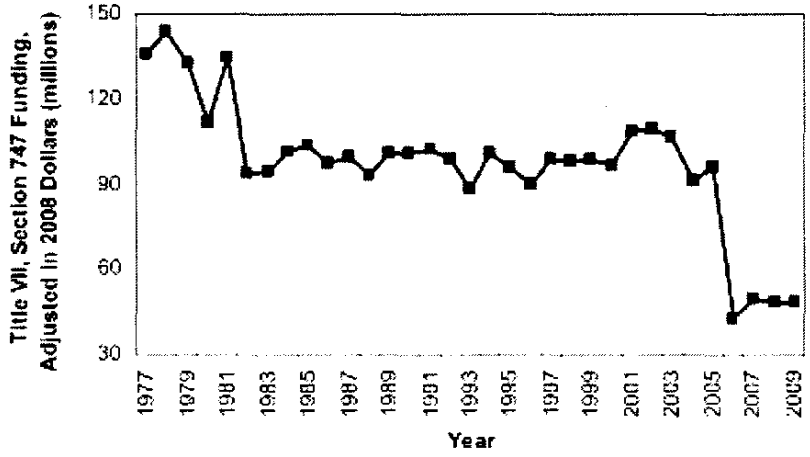
Section 747 of the Public Health Service Act has a long history of providing necessary funding for the training of primary care physicians. In each reauthorization Congress has modified the program to obtain certain key goals. The current authorization gives direction to HRSA to recognize and prioritize training that will support development of expertise in new competencies, including those relevant to providing care through patient-centered medical homes, development of infrastructure within primary care departments for the improvement of clinical care and research critical to primary care delivery, as well as innovations in team management of chronic disease, integrated models of care, and transitioning between healthcare settings. One new area of endeavor is the integration of academic administrative units within a

school of medicine to promote team based care and true primary care production. This provision has a separate, additional authorization of $750,000.

The Advisory Committee on Training in Primary Care Medicine and Dentistry recommends $235 million for these programs (including dentistry which has subsequently been dropped from this cluster). Other key advisory bodies such as the Institute of Medicine (IOM) and the Congressional Research Service (CRS) call for increased funding. The IOM (December 2008) pointed to the drastic decline in title VII funding and described these health professions workforce training programs as "an undervalued asset." The Congressional Research Service found that reduced funding to the primary care cluster has had a negative impact on the effectiveness of the programs during a time when more primary care is needed (February 2008).

According to the Robert Graham Center, (Title VII's decline: Shrinking investment in the primary care training pipeline, October 2009), "the number of graduating U.S. allopathic medical students choosing primary care declined steadily over the past decade, and the proportion of minorities within this workforce remains low." Unfortunately, this decline coincides with a decline in funding of primary care training funding—funding that we know is associated with increased primary care physician production and practice in underserved areas.

Figure. Title VII, Section 747 Funding Over Time



The report goes on to say that "the nation needs renewed or enhanced investment in programs like Title VII that support the production of primary care physicians and their placement in underserved areas." This situation is only exacerbated by the wonderful explosion of people who will gain insurance coverage under the new healthcare reform law. Given the tremendous need, we urge the Committee to provide a fiscal year 2011 appropriation of $170 million for the title VII, section 747 Primary Care Training and Enhancement, including the Integrative Academic Administrative Units program, as authorized by the Patient Protection and Affordable Care Act. We also recommend an appropriation of at least $600 million for all of the Health Professions Training Programs authorized under title VII of the Public Health Services Act.

Rural Physician Training Grants

We were pleased that the PPACA included a new program as part of title VII of the Public Health Service Act, section 749B, entitled the "Rural Physician Training Grants" program. It is intended to increase the supply of rural physicians by authorizing grants to medical schools which establish or expand rural training. The program would provide grants to produce rural physicians of all specialties. It would help medical schools recruit students most likely to practice medicine in underserved rural communities, provide rural-focused training and experience, and increase the number of medical graduates who practice in underserved rural communities.

According to a July 2007 report of the Robert Graham Center (Medical school expansion: An immediate opportunity to meet rural healthcare needs), data show that although 21 percent of the U.S. population lives in rural areas, only 10 percent of

physicians practice there. The Graham Center study describes the educational pipeline to rural medical practice as "long and complex." There are multiple tactics needed to reverse this situation, and this grant program includes several of them. Strategies to increase the number of physicians practicing in rural areas include "increasing the number of rural-background students in medical school, selecting the "right" students and giving them the "right" content and experiences to train them for rural practice." This is exactly what this grant program is designed to do.

We request the subcommittee provide the fully authorized amount of $4 million in fiscal year 2011 for title VII, section 749B Rural Physician Training Grants.

Teaching Health Centers Development Grants

One of the more creative programs to come out of the healthcare reform bill as it relates to workforce is the establishment of Teaching Health Centers (THCs). These are community health centers or other similar venues that sponsor residency programs and provide residents with their ambulatory training experiences in the health center. This training in the community, rather than solely at the hospital bedside is one of the hallmarks of family medicine training. In fact, numerous family medicine residency programs currently align with health centers to provide residents with their ambulatory continuity training in these settings. However, payment issues have always caused a tension and struggle between the hospital, which currently receives reimbursement for residents it sponsors when they train in the hospital, and programs that require training in nonhospital settings. This program is designed to provide residency programs and community health centers grant funding to plan for a transition in sponsorship, or the establishment of new programs.

It allows the Secretary to award grants to THCs (community based ambulatory patient care centers that operate a primary care residency program; listed as FQHC, rural health clinic, community mental health center, health center operated by Indian Health Service, or a center receiving title X grants) to establish new accredited or expanded primary care residency programs. We were pleased that the Patient Protection and Affordable Care Act authorized a mandatory appropriations trust fund of $230 million over 5 years to fund the operations of Teaching Health Centers. However, if this program is to be effective, there must be funds for the planning grants to establish newly accredited or expanded primary care residency programs.

We recommend the subcommittee appropriate the full authorized amount for the new title VII Teaching Health Centers development grants of $50 million for fiscal year 2011.

AHRQ

Research related to the most common acute, chronic, and comorbid conditions that primary care clinicians care for on a daily basis is currently lacking. Primary care physicians are in the best position to design and implement research of the common clinical questions confronted in practice. AHRQ supports research to improve healthcare quality, reduce costs, advance patient safety, decrease medical errors, and broaden access to essential services. While targeted funding increases in recent years have moved AHRQ in the right direction, more core funding is needed to help AHRQ fulfill its mission.

The Institute of Medicine's report, Crossing the Quality Chasm: A New Health System for the 21st Century (2001) recommended a much larger investment in AHRQ. It recommended $1 billion a year for AHRQ to "develop strategies, goals, and action plans for achieving substantial improvements in quality in the next 5 years . . " AHRQ is critical to retooling the American healthcare system.

We support the President's budget request for AHRQ in fiscal year 2011 of $611 million. With the inclusion of new programs authorized under the PPACA, we support a total appropriations level of $731 million for the Agency.

Primary Care Extension Program

One of the most exciting new programs to be included in the new healthcare reform law is one that utilizes the experience of the United States Agriculture Extension Service as its model. This new program, under title III of the Public Health Service Act, is designed to support and assist primary care providers with the adoption and incorporation of techniques to improve community health. As the authors of an article describing this new concept (JAMA, June 24, 2009) have stated, "To successfully redesign practices requires knowledge transfer, performance feedback, facilitation, and HIT support provided by individuals with whom practices have established relationships over time. The farming community learned these principles a century ago. Primary care practices are like small farms of that era, which were geographically dispersed, poorly resourced for change, and inefficient in adopting new techniques or technology but vital to the Nation's well-being."

Congress agreed with the authors that "practicing physicians need something similar to the agricultural extension agent who was so transformative for farming," and authorized this program at $120 million for fiscal year 2011 and 2012.

We support the President's budget request for AHRQ in fiscal year 2011 of $611 million. In addition, since the $611 million does not include this newly passed provision, we request the subcommittee provide AHRQ with an additional $120 million for the Primary Care Extension program authorized by the health reform law, bringing the total request to $731 million.

Workforce Commission

We have recognized the need, and called for a national commission on health workforce issues for many years. We are pleased that the PPACA established a National Health Care Workforce Commission to provide "analysis of, and recommendations for, eliminating the barriers to entering and staying in primary care, including provider compensation." We also recognize the importance of the National Center for Health Care Workforce Analysis as well as State and Regional Centers for such analysis. PPACA authorizes such sums as necessary to establish the Commission as well as $8 million in planning grants and $150 million for implementation grants. The National Center was authorized at $7.5 million annually and the State and Regional Centers were authorized at $4.5 million annually.

We recommend the Committee fully fund the National Health Care Workforce Commission, the National and State and Regional Centers for Health Care Workforce Analysis in fiscal year 2011.

We appreciate the work of the Committee in making difficult choices when funding many critical programs. We caution the committee not to ruin the positive impact of healthcare reform by not supporting the complementary programs that are so necessary to its success.

PREPARED STATEMENT OF THE COALITION FOR THE ADVANCEMENT OF HEALTH THROUGH BEHAVIORAL AND SOCIAL SCIENCE RESEARCH

Mr. Chairman and members of the subcommittee, the Coalition for the Advancement of Health Through Behavioral and Social Science Research (CAHT–BSSR) appreciates and welcomes the opportunity to comment on the fiscal year 2011 appropriations for the National Institutes of Health (NIH). CAHT–BSSR includes 13 professional organizations, scientific societies, coalitions, and research institutions concerned with the promotion of and funding for research in the social and behavioral sciences. Collectively, we represent more than 120 professional associations, scientific societies, universities, and research institutions.

CAHT–BSSR would like to thank the subcommittee and the Congress for its continued support of the NIH. Strong sustained funding is essential to national priorities of better health and economic revitalization. Providing adequate resources in fiscal year 2011 that allows the NIH to keep up with the rising costs of biomedical, behavioral, and social sciences research will help NIH begin to prepare for the era beyond recovery. It is essential that funding in fiscal year 2011 and beyond allow the agency to resume steady, sustainable growth and allow for fulfilling the President's vision of doubling our investment in basic research. Accordingly, CAHT–BSSR joins the Ad Hoc Group for Medical Research in its request for $35 billion in funding for NIH in fiscal year 2011. This level of funding will sustain America's enhanced medical research capacity. It also represents the new functional capacity funded by annual appropriations and the historic American Recovery and Reinvestment Act (ARRA).

NIH Behavioral and Social Sciences Research.—NIH supports behavioral and social science research throughout most of its 27 institutes and centers. The behavioral and social sciences regularly make important contributions to the well-being of this Nation. Due in large part to the behavioral and social science research sponsored by the NIH, we are now aware of the enormous contribution behavior makes to our health. At a time when genetic control over diseases is tantalizingly close but not yet possible, knowledge of the behavioral influences on health is a crucial component in the Nation's battles against the leading causes of morbidity and mortality: obesity, heart disease, cancer, AIDS, diabetes, age-related illnesses, accidents, substance use and abuse, and mental illness.

As a result of the strong congressional commitment to the NIH in years past, our knowledge of the social and behavioral factors surrounding chronic disease health outcomes is steadily increasing. The NIH's behavioral and social science portfolio has emphasized the development of effective and sustainable interventions and pre-

vention programs targeting those very illnesses that are the greatest threats to our health, but the work is just beginning.

The grandest challenge we face is understanding the brain, behavior, and society—from global warming to responding to short term pleasures; from self destructive behavior, such as addiction, to life style factors that determine the quality of life, infant mortality rate and longevity. Nearly 125 million Americans are living with one or more chronic conditions, like heart disease, cancer, diabetes, kidney disease, arthritis, asthma, mental illness and Alzheimer's disease. Significant factors driving the increase in healthcare spending in the United States are the aging of the U.S. population, and the rapid rise in chronic diseases, many caused or exacerbated by behavioral factors: for example, obesity, caused by sedentary behavior and poor diet; addictions and resulting health problems caused by tobacco and other drug use. Behavioral and social sciences research supported by NIH is increasing our knowledge about the factors that underlie positive and harmful behaviors, and the context in which those behaviors occur.

CAHT–BSSR applauds the NIH's recognition that the "scientific challenges in developing an integrated science of behavior change are daunting." We especially commend the new basic behavioral and social science research trans-NIH initiative, Opportunity Network for Basic Behavioral and Social Sciences Research (OppNet), being undertaken by the NIH to examine the important scientific opportunities that cut across the structure of NIH and designed to look for strategic opportunities to build areas of research where there are gaps and that have the potential to affect the missions of multiple institutes and centers. Research results could lead to new approaches for reducing risky behaviors and improving health.

Likewise, we commend the designation of the "Science of Behavior Change" Roadmap Initiative included in the third cohort of research areas for the Common Fund. We agree with the goals of this Roadmap Pilot to "establish the groundwork for a unified science of behavior change that capitalizes on both the emerging basic science and the progress already made in the design of behavioral interventions in specific disease areas. By focusing basic research on the initiation, personalization, and maintenance of behavior change, and by integrating work across disciplines, this Roadmap effort and subsequent trans-NIH activity could lead to an improved understanding of the underlying principles of behavior change. This should drive a transformative increase in the efficacy, effectiveness, and (cost) efficiency of many behavioral interventions."

With the recent passage of healthcare reform legislation, there has been the accompanying and appropriate attention to the issue of personalized healthcare. CAHT–BSSR believes that personalization needs to reflect genes, behaviors, and environments. And as the agency has acknowledged with its recent support of the Science of Behavior Change initiative, assessing behavior is critical to helping individuals see how they can improve their health. It is also critical to helping healthcare systems see where it needs to put resources for behavior change. Fortunately, the NIH acknowledges the need to focus less on finding the "magic answer" and, at the same time, recognizes that healthcare is different from region to region across the country. Full personalization needs to consider the environmental, community, and neighborhood circumstances that govern how individuals' genes and behavior will influence their health. For personalized healthcare to be realized, we need a sophisticated understanding of the interplay between genetics and the environment, broadly defined.

CAHT–BSSR applauds the NIH's recognition of a unique and compelling need to promote diversity in health-related research. The agency expects these efforts to lead to: the recruitment of the most talented researchers from all groups; an improvement in the quality of the educational and training environment; a balanced perspective in the determination of research priorities; an improved ability to recruit subjects from diverse backgrounds into clinical research; and an improved capacity to address and eliminate health disparities. Numerous studies provide evidence that the biomedical and educational enterprise will directly benefit from broader inclusion.

NIH recognizes that developing a more diverse and academically prepared workforce of individuals in S.T.E.M. disciplines will benefit all aspects of scientific and medical research and care. CAHT–BSSR applauds the agency its recognition that to remain competitive in the 21st century global economy, the Nation must foster new opportunities, approaches, and technologies in math and science education. This recognition extends to the need for a coordinated effort to bolster science, technology, engineering, and math (S.T.E.M.) education nationwide, starting at the earliest stages in education. We applaud the agency for its use of ARRA funds to support research designed to strengthen and enhance efforts to attract young people to

biomedical and behavioral science careers and to improve science literacy in adults and children.

CAHT–BSSR also commends the NIH for commissioning the Institute of Medicine (IOM) study of LGBT (lesbian, gay, bisexual, and transgender) health issues, research gaps and opportunities. LGBT populations are among those for whom little or no national-level health data exist resulting in significant gaps in knowledge and research on LGBT health. At the same time, multidisciplinary research has begun to identify important sexual orientation and gender identity-related health concerns and disparities. The IOM study is a step in the right direction to begin to address many of the research challenges this issue presents, including methodological limitations. The study could examine the best methodological practices for investigating health concerns in LGBT communities. It also provides the opportunity for the development of a strategic plan for the NIH to investigate and address the health concerns of LGBT people. At the very least, the IOM study could examine the current state of knowledge on LGBT health, including general health concerns and health disparities.

NIH OFFICE OF BEHAVIORAL AND SOCIAL SCIENCES RESEARCH

The NIH Office of Behavioral and Social Sciences Research (OBSSR), authorized by Congress in the NIH Revitalization Act of 1993 and established in 1995, serves as a convening and coordinating role among the institutes and centers at NIH. In this capacity, OBSSR develops, coordinates, and facilitates social and behavioral science research agenda at NIH; advises the NIH director and directors of the 27 Institutes and Centers; informs NIH and the scientific and lay publics of social and behavioral science research findings and methods; and trains scientists in the social and behavioral sciences. For fiscal year 2011, CAHT–BSSR supports a budget of $41.32 million for OBSSR commensurate with the administration's request of $38.2 million for the Office and the scientific community's request for the NIH as a whole.

To achieve its vision of bringing together the biomedical, behavioral, and social sciences research communities to work towards solving the most pressing health challenges faced by society, OBSSR is expanding its efforts to promote and support social and behavioral science research in four areas: (1) problem-based research; (2) basic science; (3) systems-thinking approaches to population health; and (4) interdisciplinary team science. Given the NIH's focus on gene and environment interaction, new leading edge research examining how social and behavioral factors change or alter the actions of genes to influence health and disease is needed.

OBSSR focuses on cross-cutting behavioral and social research issues (e.g., "Long-term Maintenance of Behavior Change") using its modest budget to seed cross-institute research initiatives. OBSSR has spurred cutting edge research in areas such as measures of community health, including new community-based participatory programs supporting intervention research methods to disease prevention and health promotion in medically underserved areas; socioeconomic status; health literacy; and new methodology development.

In fiscal year 2011, OBSSR, in addition to continuing to support cross-cutting behavioral and social science research issues intends to address the issue of health literacy. Low health literacy is a wide spread problem, affecting more than 90 million adults in the United States, where 43 percent of adults demonstrate only the most basic or below-basic levels of prose literacy. Low health literacy results in patients' inadequate engagement in decisions regarding their healthcare and can hinder their ability to realize the benefits of healthcare advances. Research has linked low or limited health literacy with such adverse outcomes as poorer self-management of chronic diseases, fewer healthy behaviors, higher rates of hospitalizations, and overall poorer health outcomes. These situations hamper the effectiveness of health professionals' efforts to prevent, diagnose and treat medical conditions, and limit many healthcare consumers' abilities to make important healthcare decisions.

CAHT–BSSR would be pleased to provide any additional information on these issues. Below is a list of coalition member societies. Again, we thank the subcommittee for its generous support of the National Institutes of Health and for the opportunity to present our views.

CAHT–BSSR
American Educational Research Association
American Psychological Association
American Sociological Association
Association of Population Centers
Center for the Advancement of Health
Consortium of Social Science Associations
Council on Social Work Education

Federation of Associations in Behavioral & Brain Sciences
National Association of Social Workers
Population Association of America
Society for Behavioral Medicine
Society for Research in Child Development
The Alan Guttmacher Institute (AGI)

PREPARED STATEMENT OF THE CENTER FOR AMERICAN PROGRESS ACTION FUND

The Center for American Progress Action Fund commends the Senate Appropriations Committee and the House Labor, Health and Human Services, Education Appropriations Subcommittee for reporting out strong fiscal year 2011 Labor, Health and Human Services, Education Appropriations bills. Both pieces of legislation make investments in the innovative education reform programs needed to make our schools better.

These education reform programs, proposed by the Obama administration and funded through the two Labor-HHS bills, constitute the right mix of formula-based funding and innovation promotion necessary to improve our schools. Some may question the soundness of investing in innovative reforms at a period when our country is still working to recover from the recession. The reality, however, is that the need for innovation has never been greater. School achievement has remained essentially flat for more than 30 years, and without significant changes in the way we fund and operate schools we will almost certainly not see any significant gains in the future.

We wanted to share our recommendations for the educational priorities outlined below as the House and Senate prepare to reconcile the two bills before final passage in either a standalone bill or within an omnibus spending bill.

Race to the Top

Race to the Top, a competitive grant program, has been a part of the Federal education agenda for only a short period. But it has already yielded some of the most significant reforms ever seen in education by tying Federal dollars to systemic education reform. Twenty-eight States changed their policies in 2009 and 2010 to improve their chances of winning a piece of the pie. We urge you to include the House funding level of $800 million, which will allow us to continue building on these early successes.

Race to the Top was originally enacted through the American Recovery and Reinvestment Act, or ARRA, and has not been authorized. CAP Action urges the committee to use its authority to fund this promising program.

Investing in Innovation Fund

The House bill includes $400 million for the Investing in Innovation, or i3 fund, which is nearly the full amount of the President's request. This program was also enacted through ARRA and has not been authorized. But we again urge you to use your authority to include this funding level in the final bill. The i3 fund awards grants to districts as well as nonprofit organizations partnering with schools and districts to scale up evidence-based practices and programs.

There already has been promising growth in nonprofit educational entrepreneurs such as the New Teacher Project and College Summit, but these have been established in the absence of significant Federal investment. They rely instead on philanthropy, the private sector, and local school district contracts. While their achievements have been dramatic, limited funding and other policy barriers challenge efforts to take their practices to scale.

Teacher Incentive Fund

The Teacher Incentive Fund is a 4-year-old appropriations line item that supports competitive grants to States and school districts to implement pay-for-performance programs in high-needs schools. TIF funds may also support pay for teaching in subject shortage areas such as mathematics and science as well as career ladders for teachers that offer them additional pay for increased responsibilities.

Critics argue that "merit pay" is a failed policy that has been around since the early 1900s. But the truth is that past merit pay programs were destined to fail. They were based on subjective measures of teacher performance and weren't part of a comprehensive plan to improve teachers' instructional practice. The kinds of programs TIF now supports are generally comprehensive programs that include professional development, high-quality evaluation, and performance-based compensation. And the Department of Education's new guidance for TIF has an even greater focus on comprehensive approaches.

Title I School Improvement Grants

Our education system desperately needs resources to turn around the Nation's lowest-performing schools. School improvement grants support targeted reforms at the lowest-achieving 5 percent of Title I schools in each State. The SIG program also funds efforts to decrease the number of "drop-out" factories, or high schools that continually graduate 60 percent or less of students.

Through the use of SIG funds we are finally seeing the type of dramatic interventions needed to end the cycle of underperformance at these schools. We are also encouraged by the recommendation made by the Senate Appropriations Committee Report (111–243) that SIG funds be used to support strategies meeting more rigorous evidentiary standards (see discussion below).

Unfortunately, too few dollars reach the schools with the greatest need, particularly high schools. While the funding level in the House bill remains embargoed, CAP Action urges the committee to move forward with the Senate funding level of $625 million in school improvement grants and help ensure that a more significant proportion of these dollars reach middle and high schools.

21st Century Learning Centers Program

The Senate Labor-HHS bill includes $1.266 billion—a $100 million increase—in funding for the 21st Century Community Learning Centers program, or CCLC, which has traditionally funded afterschool programs, to support expanded learning time and community schools. CAP Action urges you to include this level of funding in the final legislation as well as the report language that provides new flexibility to use funds to expand school time.

Expanded learning time schools formally incorporate traditional out-of-school activities-including enrichment activities such as the arts and service opportunities-into the official school calendar so that all students have access, including those living in high poverty. Expanded learning time can close not only academic achievement gaps but enrichment gaps as well.

Community schools are fully equipped to tackle "out-of-school" barriers by opening up social and health resources to students and their families. Community schools that seamlessly integrate academic and nonacademic services help educators navigate the effects of poverty, ill health, and language barriers so students are ready to learn every day.

CCLC dollars are currently limited to activities during nonschool hours, which prohibits the expansion of expanded learning time and community schools. CAP Action thus calls on the committee to lift this prohibition and provide States, districts, and schools with the flexibility to choose to dedicate these dollars to the models that best suit their students' needs.

Charter Schools Program

The Charter Schools Program provides grants to States to support the planning and development of new charter schools. This funding is critical because charter schools usually receive less public funding than traditional public schools. In fact, a recent study finds that charter schools receive 19.2 percent less funding per pupil on average.

The existence of charter schools has spurred the development of some of the most promising school models for educating disadvantaged students. School models like KIPP, Yes Prep, and Achievement First have achieved unprecedented outcomes for students in poverty and have even outperformed schools with higher-income students. A recent Mathematica study of KIPP middle schools found that the schools had a positive impact on students' math and reading achievement 4 years after students entered the schools.

High-achieving charter schools like these would not exist without adequate financial support. We understand that the House bill includes $266 million in funding for the Charter School Program, and we urge you to include this in the final legislation.

Promise Neighborhoods

Promise Neighborhoods are focused on improving educational outcomes for children living in our most distressed communities and represent an unprecedented shift in how localities address child poverty and academic opportunity. Each Promise Neighborhood will provide "cradle-to-career" services to support students who attend schools in a designated geographic area. Schools, city governments, colleges and universities, nonprofits, health providers, and other organizations in each Promise Neighborhood will collaborate to finally break down the silos that may have prevented past efforts to help low-income students achieve.

The Department of Education recently awarded 21 planning grants to communities across the country to create Promise Neighborhoods. The important work funded by these planning grants will be wasted without sufficient funding in the fiscal year 2011 budget to scale up these initiatives. We hope you will provide at least $60 million for Promise Neighborhoods—as was included in the House bill—and encourage you to provide more if possible to bring the funding level closer to the Administration's original request of $210 million.

Evidence-based intervention

The Senate Appropriations Committee Report (111–243) calls for a refinement of the criteria relating to interventions appropriate for persistently failing schools. We strongly support this language, which encourages the Department of Education to urge States and districts to use their Title I School Improvement Grants only for interventions that meet two standards of evidence specified by the Investing in Innovation (i3) grant program. Specifically, Congress should stipulate that the Department of Education foster the use of intervention strategies meeting the evidence standards required of "validation" grants or "scale-up" grants under i3.

This approach honors the idea that educators should strive generally to expose children to research-based practices. And it creates a logical connection between the department's support for research and development on the one hand and its support for sound practice on the other.

A challenging economy requires responsible Federal spending. CAP Action believes the fiscal year 2011 education appropriations budget should target investment to support the necessary innovative reforms to strengthen our schools for the 21st century. The House LHHS subcommittee and the Senate Appropriations Committee both produced strong bills. Together they will help to provide all of America's young people with a high-quality education that prepares them for college and a career. Thank you for your consideration.

PREPARED STATEMENT OF THE CENTER FOR CIVIC EDUCATION

I appreciate the opportunity to present this testimony requesting continued support of $35 million (the same amount as fiscal year 2010) for the civic education program (Elementary and Secondary Education Act, Sections 2341–2346) that the U.S. Department of Education (ED) cut from its fiscal year 2011 budget request to Congress. I am Charles N. Quigley, executive director of the Center for Civic Education (Center), the principal organization supported under the Education for Democracy Act.

Other worthy organizations supported under the Act include the Center on Congress at Indiana University (COC), the National Conference of State Legislatures (NCSL), the Council for Economic Education, and a domestic network of public- and private-sector organizations in every State and Congressional District in the Nation. Together with the Center, these organizations provide effective programs in civic and economic education to millions of students annually at precollegiate levels in the United States and in more than 80 emerging and advanced democracies throughout the world.

The justification for the elimination of funding for the civic education program, namely, that such activities would be continued through a consolidated competitive program of relatively small grants, is not supported by the facts. Furthermore, it overlooks the valuable national infrastructure of programming—supported by Congress through many years of directed funding—that would be lost without this sustained investment. The national program funded under the Education for Democracy Act is implemented with the assistance of an extensive network of State and congressional district coordinators that provides equal support to schools in every congressional district in the form of free curricular materials, assistance in professional development, and other technical assistance. This equal support for schools in each congressional district would not be available under the proposed consolidation plan.

THE EDUCATION FOR DEMOCRACY ACT

The Education for Democracy Act (EDA) supports highly successful national and international projects authorized and approved by the U.S. Congress and funded by the U.S. Department of Education. Since 1987, directed funding from the EDA has ensured that more than 30 million students across the Nation have been taught the principles of American constitutional democracy through the We the People: The Citizen and the Constitution program and related programs. In addition, millions of students in emerging democracies throughout the world have benefited from the

civic and economic education exchange programs supported by the EDA. The proposed elimination of this directed funding in favor of competitive grants to numerous smaller initiatives would ensure the destruction of this proven, exemplary domestic civic education program representing 22 years of federally funded investment.

Congress has long recognized that directed funding is essential for certain large-scale projects of national significance. The improvement of civic education in the United States and the establishment of effective civic and economic education programs in emerging democracies require a large-scale, long-term program involving the establishment of extensive national implementation networks supported by highly skilled, experienced, and dedicated staff. It would be grossly inefficient and extremely difficult to achieve the goals of such programs through a number of relatively small and uncoordinated grants with 2- to 5-year timelines.

The civic education programs (We the People and related programs), authorized by the EDA, are: cost effective; validated by independent research; effective in raising student academic achievement in schools throughout the country; implemented nationwide in every congressional district; administered locally by dedicated volunteers; supported by professional development for teachers; providers of free, high-quality curricular materials for students and teachers; and supported by Congress and numerous national, State, and local public- and private-sector groups.

Furthermore, the Cooperative Education Exchange Program's international civics programs promote U.S. foreign policy objectives in more than 80 countries, encourage respect for human rights, and promote commitment to democratic values and principles in emerging democracies.

BENEFITS OF THE DOMESTIC PROGRAMS

Cost-effective civic education in every congressional district. Over 22 years, the EDA has ensured the civic education of more than 30 million students nationwide. On average, in each congressional district the existing program annually supports a total of 5,700 students; in 190 classes at the elementary, middle, and high school levels; and at a cost of $7.20 per student—far less than the retail cost of one history or civics textbook.

NOTE: The program currently reaches approximately 2.5 million students each year. It is highly unlikely that a competitive, relatively small grant program would reach as many students in every congressional district of the Nation as cost effectively as the We the People Programs.

Proven Impact on Student Outcomes.—The We the People Programs are independently proven to be effective. Evaluations by the Educational Testing Service, Stanford University, RMC Research Corporation, and others have shown that the We the People Programs have had a statistically significant positive effect on student knowledge, skills, dispositions, and behaviors (see www.civiced.org/research).

NOTE: To place the funding for these programs in a competitive grant program would be to discard proven programs developed and implemented with Federal dollars in favor of numerous smaller programs that lack any independent evidence of proven effectiveness.

National Network.—The We the People Programs have grassroots community support in every congressional district. They are implemented by a national civic education network of 120 public- and private-sector organizations in all 50 States and the District of Columbia and 123 representatives of local education agencies or civic-minded community groups at the congressional district level.

NOTE: In every State, the We the People Programs are supported by an extensive network of civic educators and community volunteers who administer the programs and raise funds to support local program activities. This network would cease to exist if its funding were to be placed in a competitive grant program.

Effective Use of Federal Dollars.—Approximately 70 percent of the funding for the program is distributed equitably to every congressional district. The funds provide free curricular materials for elementary, middle, and high schools; professional-development programs for teachers; and funding at the State and congressional district levels for the implementation of curricular programs in civic education.

NOTE: A competitive program of relatively small grants would not result in such an effective and equitable distribution of resources. Instead, many congressional districts would receive little or no assistance in implementing civic education programs.

In addition, funding relatively large nationwide programs—such as the We the People Programs—compared to funding numerous smaller programs is more likely to be cost effective in controlling administrative costs and providing more funding for programmatic costs. As noted above, approximately 70 percent of the funds the Center received for its USED-supported programs were spent for programmatic

costs throughout the United States. The remaining 30 percent consists of staff and benefits (approximately 20 percent) and general administrative costs (approximately 10 percent). Of the staff costs, some are for general administration, but a considerable amount is for technical assistance to State and local programs for such purposes as professional development and evaluation.

Curriculum Backed by Professional Development of Teachers.—The Center sponsors professional development activities throughout the Nation with the assistance of a national network of directors, mentor teachers, and scholars. These activities range in length from less than 1 day to 7 days. Participants explore content, teaching methods, and assessment strategies. Free materials are provided for participants.

Innovative Content and Methods.—The We the People program is the first curriculum based entirely on constitutional principles and history. Students take part in a competition on constitutional topics that takes the form of simulated congressional hearings. This is an educational innovation that works. There is no other civic education competition in the world comparable to the We the People program.

NOTE: Elimination of directed EDA funding for We the People would mean the elimination of district, State, and national simulated congressional hearings, during which students compete in a test of knowledge and understanding of contemporary and historical issues surrounding the Constitution. These hearings have inspired students to choose lives of active citizenship, public service, and civic engagement.

Adherence to Authorizing Language.—Congress recognized the national need for programs that develop a reasoned commitment to American constitutional democracy and the ability of young people to participate competently and responsibly in the political life of the Nation. The programs supported under the EDA have demonstrated their efficacy in promoting such goals.

Note: To eliminate support for these proven, effective programs and place their funding into a competitive grant program would be to withdraw the long-term investment of the Federal Government in programs proven to yield high returns. Federal funding would instead be spent on unproven programs with unpredictable outcomes.

BENEFITS OF THE INTERNATIONAL PROGRAMS

Promoting U.S. Foreign Policy Objectives Abroad.—The Cooperative Education Exchange Program's civics and economics programs help to institutionalize democratic ideals in more than 80 emerging and established democracies worldwide. These highly successful programs, helping to meet the U.S. foreign policy objectives of promoting democracy, human rights, and an understanding of the principles of market economies and their relationship to democracy are not mentioned in the ED alternative, thereby ignoring the intent of Congress to support these critical programs.

International Network for Democracy Promotion.—The Civitas International Exchange Program created a network of international public- and private-sector organizations and colleagues and their American counterparts in 30 States. The members of this network work in unison to translate and adapt civics textbooks to help educational systems in emerging democracies teach democratic principles and values. Without the support of the EDA, the network would be eliminated and highly effective programs in these emerging democracies would be deprived of the support needed for their institutionalization. It is estimated that these programs reach 1.5 million students each year at a cost of $3 per student.

CONCLUSION

The Education for Democracy Act programs have been highly scrutinized by Congress since their inception in 1987 and have undergone multiple authorizations in the law and annual approval in the appropriations process. They have survived multiple sessions of Congress and several administrations, including initiatives to downsize and reinvent Government. Recent "Dear Colleague" letters in support of the EDA routinely received the support of more than 100 members of the House and nearly half of the Senate. There are compelling reasons for this support that ultimately reflect a simple truth—the programs have a proven track record of success in furthering support for democracy; fostering competent and responsible participation by students in the political life of their communities, States, and nations; raising student academic achievement; improving teacher quality; and providing schools with free, exemplary curricular programs and technical assistance.

SUPPORT FOR A COMPETITIVE CIVIC EDUCATION GRANT PROGRAM

The Center supports the establishment in ED of a competitive grant program in civics and government in addition to continued support for the current programs.

There are many other public- and private-sector agencies working in the field of civic education worthy of support. A large percentage of these groups are colleagues and participants in the Center's domestic networks. A new, competitive grant program could result in the development and promulgation of new ideas and programs to enhance the field. Such support from both the public and private sectors, in fact, gave the Center its start in 1965. The Center is working with representatives of other organizations in the field to support the inclusion of a competitive grant program in the reauthorization of the Elementary and Secondary Education Act.

PREPARED STATEMENT OF THE CROHN'S AND COLITIS FOUNDATION OF AMERICA

Mr. Chairman and members of the subcommittee, thank you for the opportunity to submit testimony on behalf of the 1.4 million Americans living with Crohn's disease and ulcerative colitis. My name is Gary Sinderbrand and I have the privilege of serving as the Chairman of the National Board of Trustees for the Crohn's and Colitis Foundation of America. CCFA is the Nation's oldest and largest voluntary organization dedicated to finding a cure for Crohn's disease and ulcerative colitis—collectively known as inflammatory bowel diseases.

Let me express at the outset how appreciative we are for the leadership this subcommittee has provided in advancing funding for the National Institutes of Health. Hope for a better future for our patients lies in biomedical research and we are grateful for the recent investments that you have made in this critical area.

Mr. Chairman, Crohn's disease and ulcerative colitis are devastating inflammatory disorders of the digestive tract that cause severe abdominal pain, fever and intestinal bleeding. Complications include arthritis, osteoporosis, anemia, liver disease and colorectal cancer. We do not know their cause, and there is no medical cure. They represent the major cause of morbidity from digestive diseases and forever alter the lives of the people they afflict—particularly children. I know, because I am the father of a child living with Crohn's disease.

Seven years ago, during my daughter, Alexandra's sophomore year in college, she was taken to the ER for what was initially thought to be acute appendicitis. After a series of tests, my wife and I received a call from the attending GI who stated coldly: Your daughter has Crohn's disease, there is no cure and she will be on medication the rest of her life. The news froze us in our tracks. How could our vibrant, beautiful little girl be stricken with a disease that was incurable and has ruined the lives of countless thousands of people?

Over the next several months, Alexandra fluctuated between good days and bad. Bad days would bring on debilitating flares which would rack her body with pain and fever as her system sought equilibrium. Our hearts were filled with sorrow as we realized how we were so incapable of protecting our child.

Her doctor was trying increasingly aggressive therapies to bring the flares under control.

Asacol, Steroids, Mercaptipurine, Methotrexate and finally Remicade. Each treatment came with its own set of side effects and risks. Every time A would call from school, my heart would jump before I picked up the call in fear of hearing that my child was in pain as the flares had returned. Ironically, the worst call came from one of her friends to report that A was back in the ER and being evaluated by a GI surgeon to determine if an emergency procedure was needed to clear an intestinal blockage that was caused by the disease. Several hours later, a brilliant surgeon at the University of Chicago, removed over a foot of diseased tissue from her intestine. The surgery saved her life, but did not cure her. We continue to live every day knowing that the disease could flare at any time with devastating consequences.

Mr. Chairman, I will focus the remainder of my testimony on our appropriations recommendations for fiscal year 2011.

RECOMMENDATIONS FOR FISCAL YEAR 2011

Centers for Disease Control and Prevention

Inflammatory Bowel Disease Epidemiology Program

As I mentioned earlier, CCFA estimates that 1.4 million people in the United States suffer from IBD, but there could be many more. We do not have an exact number due to these diseases' complexity and the difficulty in identifying them. Mr. Chairman, we are extremely grateful for your leadership in providing funding over the past 5 years for an epidemiology program focused on IBD at the Centers for Disease Control and Prevention. This program is the only one of its kind in our long fight against IBD and its accomplishments have been applauded by the CDC. Unfortunately, the President's fiscal year 2011 budget proposal recommends that this

highly successful program be eliminated. CCFA strongly disagrees with the administration's position and urges the subcommittee to provide full funding for this important research in fiscal year 2011.

CCFA has been a proud partner with CDC in conducting the research funded under the epidemiology program. For the first 2 years of the project the Foundation worked collaboratively with Kaiser Permanente in California to better understand the incidence and prevalence of IBD, the natural history of the disease, and why patients respond differently to the same therapy. This research has resulted in 11 publications to date and another 11 papers to be submitted to high-quality peer-reviewed journals. Topics include but are not limited to the following:

—Incidence and Prevalence of IBD;
—Patterns of Care and Outcomes in IBD;
—Qualitative study of provider opinions;
—Utilization of biologics (Infliximab);
—Disparities in Mortality;
—Myelosuppression during Thiopurine Therapy for Inflammatory Bowel Disease: Implications for Monitoring Recommendations;
—Severity and Flare Algorithms;
—Disparities in Surveillance for Colorectal Cancer;
—Pediatric Epidemiology.

In 2007, our focus shifted to the establishment of the "Ocean State Crohn's & Colitis Area Registry" or OSCCAR. Under the leadership of Dr. Bruce Sands, this study is being conducted jointly by investigators at the Massachusetts General Hospital and Rhode Island Hospital/Brown University. The State of Rhode Island is an excellent location to conduct a population-based IBD study because (1) it is a small state geographically; (2) it has a diverse ethnic and socioeconomic population that does not tend to migrate out of State: and (3) a small number of gastroenterologists treat essentially all IBD patients within the State. Since 2007, Dr. Sands has been able to recruit virtually all GI physicians in Rhode Island to refer patients into the study. To date, almost 200 patients have been recruited. All of this progress will be lost if the program is eliminated in 2011.

The goals of the OSCCAR study moving forward are to: (1) describe the age and sex adjusted incidence rate of Crohn's disease and ulcerative colitis; (2) describe variations in presenting symptoms among children, men and women with newly diagnosed disease; (3) identify factors that predict resistance to steroids, including clinical characteristics and blood test markers that could be useful to treating physicians; (4) identify predictors of the need for surgery; and (5) describe factors that predict either impaired quality of life or a benign course of disease.

Mr. Chairman, to ensure that this important epidemiological work moves forward in fiscal year 2011, CCFA recommends an appropriation of $686,000 (level funded from fiscal year 2010).

PEDIATRIC INFLAMMATORY BOWEL DISEASE PATIENT REGISTRY

Mr. Chairman, the unique challenges faced by children and adolescents battling IBD are of particular concern to CCFA. In recent years we have seen an increased prevalence of IBD among children, particularly those diagnosed at a very early age. To combat this alarming trend CCFA, in partnership with the North American Society for Pediatric Gastroenterology, Hepatology and Nutrition, has instituted an aggressive pediatric research campaign focused on the following areas:

—*Growth/Bone Development*.—How does inflammation cause growth failure and bone disease in children with IBD?
—*Genetics*.—How can we identify early onset Crohn's disease and ulcerative colitis?
—*Quality Improvement*.—Given the wide variation in care provided to children with IBD, how can we standardize treatment and improve patients' growth and well-being?
—*Immune Response*.—What alterations in the childhood immune system put young people at risk for IBD, how does the immune system change with treatment for IBD?
—*Psychosocial Functioning*.—How does diagnosis and treatment for IBD impact depression and anxiety among young people? What approaches work best to improve mood, coping, family function, and quality of life.

The establishment of a national registry of pediatric IBD patients is central to our ability to answer these important research questions. Empowering investigators with HIPPA compliant information on young patients from across the Nation will jump-start our effort to expand epidemiologic, basic and clinical research on our pe-

diatric population. We encourage the subcommittee to support our efforts to establish a Pediatric IBD Patient Registry with the CDC in fiscal year 2011.

NATIONAL INSTITUTES OF HEALTH

Throughout its 40-year history, CCFA has forged remarkably successful research partnerships with the NIH, particularly the National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK), which sponsors the majority of IBD research, and the National Institute of Allergy and Infectious Diseases (NIAID). CCFA provides crucial "seed-funding" to researchers, helping investigators gather preliminary findings, which in turn enables them to pursue advanced IBD research projects through the NIH. This approach led to the identification of the first gene associated with Crohn's—a landmark breakthrough in understanding this disease.

Mr. Chairman, NIDDK-sponsored research on IBD has been a remarkable success story. In 2008, a consortium of researchers from the United States, Canada, and Europe identified 21 new genes for Crohn's disease. This discovery, funded in part by the NIDDK, brings the total number of known genes associated with Crohn's disease to more than 30 and provides new avenues for the development of promising treatments. We are grateful for the leadership of Dr. Stephen James, Director of NIDDK's Division of Digestive Diseases and Nutrition, for aggressively pursuing this and other promising areas of research.

CCFA's scientific leaders, with significant involvement from NIDDK, have developed an ambitious research agenda entitled "Challenges in Inflammatory Bowel Diseases." In addition, CCFA-affiliated investigators played a leading role in developing the recommendations on IBD in the new NIH National Commission on Digestive Diseases strategic plan. We look forward to working with the NIDDK to advance the cutting-edge science called for in these two roadmaps.

Mr. Chairman, I also wanted to thank you and your colleagues for the unprecedented support you provided to the NIH as part of the American Recovery and Reinvestment Act. IBD research has benefited substantially from that investment with more than 15 IBD-specific projects receiving ARRA funding. This portfolio includes grants focused on; pediatric IBD, clinical diagnostics, basic research on the mechanisms of chronic inflammation and the role of the intestinal barrier in IBD, genetics, and new therapeutic approaches. This research has the potential to dramatically improve the quality of life for our patients and we thank you for making this possible.

For fiscal year 2011, CCFA joins with other voluntary patient and medical organizations in recommending an appropriation of $35 billion for the NIH. Once again Mr. Chairman, thank you very much for the opportunity to submit our views for your consideration.

PREPARED STATEMENT OF THE CHARLES R. DREW UNIVERSITY OF MEDICINE AND SCIENCE

Mr. Chairman and members of the subcommittee, thank you for the opportunity to present you with testimony. The Charles Drew University is distinctive in being the only dually designated Historically Black Graduate Institution and Hispanic Serving Institution in the Nation. We would like to thank you, Mr. Chairman, for the support that this subcommittee has given to our University to produce minority health professionals to eliminate health disparities as well as do groundbreaking research to save lives.

The Charles Drew University is located in the Watts-Willowbrook area of South Los Angeles. Its mission is to prepare predominantly minority doctors and other health professionals to care for underserved communities with compassion and excellence through education, clinical care, outreach, pipeline programs, and advanced research that makes a rapid difference in clinical practice. The Charles Drew University has established a national reputation for translational research that addresses the health disparities and social issues that strike hardest and deepest among urban and minority populations.

Health Resources and Services Administration (HRSA)

Title VII Health Professions Training Programs.—The health professions training programs administered by the HRSA are the only Federal initiatives designed to address the longstanding under representation of minorities in health careers. HRSA's own report, "The Rationale for Diversity in the Health Professions: A Review of the Evidence," found that minority health professionals disproportionately serve minority and other medically underserved populations, minority populations tend to receive better care from practitioners of their own race or ethnicity, and non-English speaking patients experience better care, greater comprehension, and greater likeli-

hood of keeping follow-up appointments when they see a practitioner who speaks their language. Studies have also demonstrated that when minorities are trained in minority health professions institutions, they are significantly more likely to: (1) serve in medically underserved areas; (2) provide care for minorities; and (3) treat low-income patients.

Minority Centers of Excellence (COE).—The purpose of the COE program is to assist schools, like Charles Drew University, that train minority health professionals, by supporting programs of excellence. The COE program focuses on improving student recruitment and performance; improving curricula and cultural competence of graduates; facilitating faculty and student research on minority health issues; and training students to provide health services to minority individuals by providing clinical teaching at community-based health facilities. For fiscal year 2011, the funding level for COE should be $33.6 million.

Health Careers Opportunity Program (HCOP).—Grants made to health professions schools and educational entities under HCOP enhance the ability of individuals from disadvantaged backgrounds to improve their competitiveness to enter and graduate from health professions schools. HCOP funds activities that are designed to develop a more competitive applicant pool through partnerships with institutions of higher education, school districts, and other community based entities. HCOP also provides for mentoring, counseling, primary care exposure activities, and information regarding careers in a primary care discipline. Sources of financial aid are provided to students as well as assistance in entering into health professions schools. For fiscal year 2011, the HCOP funding level of $35.6 million is suggested.

National Institutes of Health's (NIH) Contribution to Fighting Health Disparities

National Institute on Minority Health and Health Disparities (NIMHD) .—The NIMHD is charged with addressing the longstanding health status gap between under-represented minority and nonminority populations. The NIMHD helps health professional institutions to narrow the health status gap by improving research capabilities through the continued development of faculty, labs, telemedicine technology and other learning resources. The NIMHD also supports biomedical research focused on eliminating health disparities and developed a comprehensive plan for research on minority health at NIH. Furthermore, the NIMHD provides financial support to health professions institutions that have a history and mission of serving minority and medically underserved communities through the COE program and HCOP. For fiscal year 2011, $500 million is recommended for NIMHD to support these critical activities.

Research Centers At Minority Institutions (RCMI)

RCMI at the National Center for Research Resources (NCRR) has a long and distinguished record of helping institutions like The Charles Drew University develop the research infrastructure necessary to be leaders in the area of translational research focused on reducing health disparities research. Although NIH has received some budget increases over the last 5 years, funding for the RCMI program has not increased by the same rate. Therefore, the funding for this important program grow at the same rate as NIH overall in fiscal year 2011.

Extramural Facilities Construction

Mr. Chairman, one issue that sets The Charles Drew University and many minority-dedicated institutions apart from the major universities of this country is the facilities where research takes place. The need for research infrastructure at our Nation's minority serving institutions must also remain strong to maximize efforts to reduce health disparities. The current authorization level for the Extramural Facility Construction program at the NCRR is $250 million. The law also includes a 25 percent set-aside for "Institutions of Emerging Excellence" (many of which are minority institutions) for funding up to $50 million. In fiscal year 2011, we respectfully request.

Department of Health and Human Services' Office of Minority Health (OMH)

Specific programs at OMH include assisting medically underserved communities, supporting conferences for high school and undergraduate students to interest them in health careers, and supporting cooperative agreements with minority institutions for the purpose of strengthening their capacity to train more minorities in the health professions. For fiscal year 2011, I recommend a funding level of $75 million for OMH to support these critical activities.

Strengthening Historically Black Graduate Institutions—Department of Education

The Department of Education's Strengthening Historically Black Graduate Institutions program (title III, part B, section 326) is extremely important to MMC and

other minority serving health professions institutions. The funding from this program is used to enhance educational capabilities, establish and strengthen program development offices, initiate endowment campaigns, and support numerous other institutional development activities. In fiscal year 2011, an appropriation of $75 million is suggested to continue the vital support that this program provides to historically black graduate institutions.

Conclusion

Despite all the knowledge that exists about racial/ethnic, socio-cultural and gender-based disparities in health outcomes, the gap continues to widen. Not only are minority and underserved communities burdened by higher disease rates, they are less likely to have access to quality care upon diagnosis. As you are aware, in many minority and underserved communities preventative care and research are inaccessible either due to distance or lack of facilities and expertise. As noted earlier, in just one underserved area, South Los Angeles, the number and distribution of beds, doctors, nurses and other health professionals are as parlous as they were at the time of the Watts Rebellion, after which the McCone Commission attributed the so-named "Los Angeles Riots" to poor services—particularly access to affordable, quality healthcare. The Charles Drew University has proven that it can produce excellent health professionals who "get" the mission—years after graduation they remain committed to serving people in the most need. But, the university needs investment and committed increased support from Federal, State, and local governments and is actively seeking foundation, philanthropic, and corporate support.

Even though institutions like The Charles Drew University are ideally situated (by location, population, community linkages, and mission) to study conditions in which health disparities have been well documented, research is limited by the paucity of appropriate research facilities. With your help, the Life Sciences Research Facility will translate insight gained through research into greater understanding of disparities and improved clinical outcomes. Additionally, programs like Title VII Health Professions Training programs will help strengthen and staff facilities like our Life Sciences Research Facility.

We look forward to working with you to lessen the huge negative impact of health disparities on our Nation's increasingly diverse populations, the economy and the whole American community.

Mr. Chairman, thank you again for the opportunity to present testimony on behalf of The Charles Drew University. It is indeed an honor.

PREPARED STATEMENT OF THE CHILDREN'S ENVIRONMENTAL HEALTH NETWORK

The Children's Environmental Health Network (CEHN) appreciates the opportunity to support fiscal year 2011 appropriations for activities that protect children from environmental hazards. CEHN appreciates the wide range of needs that you must consider for funding. We urge you to give priority to those programs that protect and promote children's environmental health. In so doing, you will improve not only our children's health, but also their educational outcomes and their future.

CEHN was created to promote a healthy environment and to protect the fetus and the child from environmental health hazards. Every day, children are exposed to a mix of chemicals, most of them untested for their effects on developing systems. In general, children have unique vulnerabilities and susceptibilities to toxic chemicals. In some cases, an exposure which may cause little or no harm to an adult may lead to irreparable damage to a child. Thus it is vital that the Federal programs and activities that protect children from environmental hazards receive adequate resources.

Global Climate Change and Public Health.—We strongly urge the subcommittee to designate $50 million for the Department of Health and Human Services (HHS) to help the public prepare for and adapt to the potential health effects of global climate change in fiscal year 2011. Global climate change presents major challenges to public health. Children will be the first and worst hit by climate change. Young children are almost 85 percent of the estimated 150,000+ climate change-related deaths/year that are already occurring in low-income nations, according to the World Health Organization. Children in communities that are already disadvantaged will be the most harmed. Recent studies have detailed the multiple ways in which climate change may harm children. It is imperative that the Federal Government undertake efforts to mitigate and adapt to climate change.

Centers for Disease Control and Prevention (CDC) and the National Center for Environmental Health (NCEH).—As the Nation's leader in health promotion and disease prevention the CDC should receive top priority in Federal funding. CEHN is

grateful for your support in the past and urges you to support a funding level of $8.8 billion for CDC's core programs in fiscal year 2011.

CEHN is supportive of all NCEH programs and especially its efforts to continue and expand its biomonitoring program and to continue its national report card on exposure information. A vital CDC responsibility in pediatric environmental health is to assist in filling the major information gaps that exist about children's exposures. CEHN believes it is especially critical for the NCEH to gather and publish expanded information in the report card on children's exposures.

CEHN strongly supports increased funding for CDC's Environmental Health Laboratory, which allows us to measure with great precision the actual levels of more than 450 chemicals and nutritional indicators in people's bodies. This information helps public health officials to determine which population groups are at high risk for exposure and adverse health effects, assess public health interventions, and monitor exposure trends over time.

Among its many recent accomplishments, CDC has funded three States for State biomonitoring activities. We enthusiastically support these State biomonitoring efforts, but were disappointed that another 21 quality State proposals were turned down due to lack of funding.

Unfortunately, the President's fiscal year 2011 budget would cut this program by $1.3 million. CEHN supports a $19.6 million increase for the Environmental Health Laboratory in fiscal year 2011: $10 million to fund 7–10 grantees to conduct biomonitoring; $7.6 million for intramural activities such as increasing the number of chemicals CDC measures and improving quality assurance at the State laboratories awarded biomonitoring funds; and $2 million for the National Report on Biochemical Indicators of Diet and Nutrition in the U.S. Population.

National Environmental Public Health Tracking Program.—The CDC's public health tracking program helps to track environmental hazards and the diseases they may cause, coordinating and integrating local, State, and Federal health agencies' collection of critical health and environmental data. The Web-based National Environmental Public Health Tracking Network launched this past summer. CEHN strongly supports this program.

Data on children's "real world" exposure and disease are critically needed. Since children spend hours every day in school and child care, we urge you to direct the Tracking Program to include grants for pilot methods for tracking children's health in schools and child care settings.

To date, 24 grantees have received funds from the CDC for health tracking networks. Health officials in all States need integrated health and environmental data. We urge the subcommittee to provide $50 million for the Health Tracking Program in fiscal year 2011.

National Institute of Environmental Health Sciences (NIEHS).—The NIEHS is the leading Institute conducting research to understand how the environment influences the development and progression of human disease. Thus it is a vital institution in our efforts to understand how to protect children, whether it is identifying and understanding the impact of substances that are endocrine disruptors or understanding childhood exposures that may not affect health until decades later.

NIEHS's National Toxicology Program is the leading Federal program studying the toxicity of environmental agents in our environment; a major focus of this program is endocrine disrupting chemicals. NIEHS is studying the health effects of global climate change. The Institute has taken the lead among Federal agencies to develop a comprehensive research plan to respond to the significant consequences that climate change is expected to have on human health. CEHN asks you to provide $779.4 million for NIEHS in fiscal year 2011.

Children's Environmental Health Research Centers of Excellence.—The Children's Environmental Health Research Centers, jointly funded by the Environmental Protection Agency (EPA) and NIEHS, play a key role in providing the scientific basis for protecting children from environmental hazards. With their modest budgets (unchanged over more than 10 years), these centers generate valuable research. A unique aspect of these centers is the requirement that each center actively involves its local community in a collaborative partnership, leading both to community-based participatory research projects and to the translation of research findings into child-protective programs and policies.

The scientific output of these centers has been outstanding. The Congress recognized this last year, when it supported increased funding, resulting in the upcoming addition of a child care component and additional research. These goals call for a continued effort, yet the administration's fiscal year 2011 budget proposal did not continue this funding. We strongly urge that the subcommittee reinstate these funds and direct NIEHS to sustain this effort.

Unfortunately, almost all of the existing 12 centers are currently operating on no-cost extensions and only 5 of the existing centers are to be renewed. If centers are shuttered, we will lose access to valuable populations such as children with asthma or children growing up with pesticide exposure in farm communities. We will lose the ability to learn about issues like early puberty concerns, exposures in school settings, and pre-adolescent and adolescent outcomes.

National Children's Study (NCS).—NCS is examining the effects of environmental influences on the health and development of more than 100,000 children across the United States, following them from before birth until age 21. This landmark study—involving a consortium of agencies—will form the basis of child health guidance, interventions, and policy for generations to come. This study may be the only means that we will have to understand the links between exposures and the health and development of children and to identify the antecedents for a healthy adulthood.

We urge the subcommittee to assure stable support for this study, recognizing that the necessary components of the study are resource intensive. It is vital, however, that this study proceed and also guarantee that scientists, clinicians, and policy makers will have a complete archive of the study's exposure measurements.

A study of this scope calls for the participation of multiple agencies. We urge the subcommittee to assure that the NCS remains a collaborative study that retains on its original environmental focus, responsive to its mission and to the lead agencies, in and out of the National Institutes of Health.

CEHN also asks the subcommittee to direct that protocols are in place for measuring exposures in child care and school settings. It is critically important to understand how school and child care exposures differ from home exposures very early in the NCS.

Pediatric Environmental Health Specialty Units (PEHSUs).—Funded by the ATSDR and the EPA, the PEHSUs form a valuable resource network, with a center in each of the U.S. Federal regions. PEHSU professionals provide medical consultation to healthcare professionals on a wide range of environmental health issues. PEHSUs also provide information and resources to school, child care, health and medical, and community groups. PEHSUs assist policymakers by providing data and background on local or regional environmental health issues and implications for specific populations or areas. These centers, all based in universities, have done tremendous work on very limited budgets. We urge the subcommittee to fully fund ATSDR's portion of this program's fiscal year 2011 budget of $1.8 million.

Environmental Health in Schools.—Each school day, about 20 percent of the total U.S. population spend a full week inside schools. Unfortunately, many of our school facilities are shoddy or "sick" buildings whose environmental conditions harm children's health and undermine attendance, achievement, and productivity.

No agency is authorized to intervene to protect children from environmental hazards in schools. Thus, every day we require our children to spend hours in an environment where they and their parents have no options, alternatives or recourse if the environment is not healthy. Thus, CEHN urges the subcommittee to provide full funding for the aspects of the Clean, Green and Healthy Schools Initiative in its jurisdiction. Agencies need adequate resources to assure their participation in the vital cross-agency work of this initiative.

A formal partnership between HHS, the Department of Education, and EPA to coordinate their pediatric environmental health efforts would leverage resources and be beneficial for children's health and research. Providing resources for the newly re-vitalized Interagency Task Force on Children's Environmental Health would support such a partnership.

Environmental Health in Child Care Settings.—60 percent of preschoolers—13 million children—are in child care. This youngest and most vulnerable population can enter care as early as 6 weeks of age and be in care for more than 40 hours per week. Yet little is known about the environmental health status of these centers. CEHN is working to correct these gaps.

We urge the subcommittee to bring the child care environment into the Clean, Green and Healthy Schools Initiative by providing additional resources and direction focused on this important environment.

We ask the subcommittee to direct the HHS Assistant Secretary for Children and Families to report on the Administration for Children and Families activities that protect children from environmental hazards in child care settings, especially in the Office of Head Start.

In conclusion, investments in programs that protect and promote children's health will be repaid by healthier children with brighter futures, an outcome we can all support. That is why CEHN asks you to give priority to these programs. Thank you for the opportunity to testify on these critical issues.

PREPARED STATEMENT OF THE CYSTIC FIBROSIS FOUNDATION

On behalf of the Cystic Fibrosis Foundation and the 30,000 people with cystic fibrosis (CF), we are pleased to submit the following testimony regarding fiscal year 2010 appropriations for cystic fibrosis-related research at the National Institutes of Health (NIH) and other agencies.

ABOUT CF

CF is a life-threatening genetic disease for which there is no cure. The bodies of people with CF produce abnormally thick, sticky mucus that clogs the lungs, results in fatal lung infections and obstructs the pancreas, making it difficult for patients to absorb nutrients from food. Since its founding, the Cystic Fibrosis Foundation has maintained its focus on promoting research and improving treatments for CF. More than thirty drugs are now in development to treat CF; some treat the basic defect of the disease, while others target its symptoms. Through the research leadership of the Cystic Fibrosis Foundation, the life expectancy of individuals with CF has been boosted from less than 6 years in 1955 to 37 years today. Although life expectancy has improved dramatically, we continue to lose young lives to this disease. In the past 5 years, the Cystic Fibrosis Foundation has invested more than $660 million in its medical programs of drug discovery, drug development, research, and care focused on life-sustaining treatments and a cure for CF. A greater investment is necessary, however, to accelerate the pace of discovery and development of CF therapies. This testimony focuses on the investment required to rapidly and efficiently discover and develop new CF treatments aimed at controlling and curing CF.

SUSTAINING THE FEDERAL INVESTMENT IN BIOMEDICAL RESEARCH

This subcommittee and Congress are to be commended for their steadfast support for biomedical research and their commitment to NIH, particularly the effort to double the NIH budget between fiscal year 1999 and fiscal year 2003 as well as the significant investment provided by the American Recovery and Reinvestment Act (ARRA) in 2009. These increases in funding brought a new era in drug discovery that has benefited all Americans. Congress must adequately fund the NIH so that it can capitalize on scientific advances in order to maintain the momentum generated by the doubling of funds and the infusion from ARRA.

The flat-funding of the NIH since 2003 has decreased purchasing power, limiting the pursuit of critical research. The Cystic Fibrosis Foundation joins the Coalition for Health Funding to recommend all health discretionary spending be increased $67.1 billion in fiscal year 2011, or $9.3 billion more than the fiscal year 2010 levels. This increased investment will help maintain the NIH's ability to fund essential biomedical research today that will provide the care and cures of tomorrow. If the subcommittee is not able to recommend funding at this level, Congress should advise the NIH to focus on contributing funds to research partnerships that will accelerate therapeutic development to improve people's lives.

STRENGTHENING CLINICAL RESEARCH AND DRUG DEVELOPMENT

The Cystic Fibrosis Foundation has been recognized for its unique research approach which encompasses everything from basic research through phase III clinical trials, and has created the infrastructure required to accelerate the development of new CF therapies. As a result, we now have a pipeline of more than thirty potential therapies which are being examined to treat people with CF. As a prime example, in February 2010, Caystonr a new much-needed antibiotic that combats recurrent lung infections, arrived in the hands of people with CF. This new treatment is a direct result of the Foundation's innovative research agenda, advancing from bench to bedside through the Foundation's research program which speeds the creation of new CF therapies. Our successes, and specifically our Therapeutics Development Network discussed below, can serve as a map for the development of new treatments for other diseases.

The Foundation is a leader in creating a clinical trials network to achieve greater efficiency in clinical investigation. Because the CF population is small, a higher proportion of people with the disease must partake in clinical trials than in most other diseases. This unique challenge prompted the Foundation to streamline our clinical trials processes. As a result, research conducted by the Foundation is more efficient than ever before and we are a model for other disease groups. We applaud the efforts by the Nation's health agencies to encourage greater efficiency in clinical research and we are hopeful that the subcommittee will direct the national health agencies to pay special attention to advances in treatment methods and mechanisms

for translating basic research across Institutes into therapies that can benefit patients.

Development of Rare Disease Research Networks

The subcommittee should direct the NIH and other agencies to allocate additional funds for innovative therapeutics development models including the Therapeutics for Rare and Neglected Diseases (TRND) and Cures Acceleration Network (CAN) programs as well as for clinical research to meet the demand for testing promising new therapies for CF and other diseases. Support should also be directed toward the continuation of other rare disease research networks, such as the NIH's pediatric liver disease consortium.

The CF Foundation's established clinical research program, the Therapeutics Development Network (TDN), plays a pivotal role in accelerating the development of new treatments to improve the length and quality of life for CF patients. Lessons learned from the TDN's centralization of data management and analysis and data safety monitoring in the TDN will be useful in designing clinical trial networks for other diseases. Dr. Francis Collins, Director of the NIH, has specifically cited the TDN as an exemplar for TRND. Coupled with the newly established CAN, the time between discovery and development of drugs and therapies can be accelerated if these programs are fully funded.

Providing for the U.S. Food and Drug Administration (FDA)

We urge the subcommittee to increase funding for the FDA to ensure that the Agency has the necessary resources and funding to effectively evaluate new and emerging treatments. In order to be effective, the FDA needs not only an adequate number of reviewers of new treatments, but also those with the appropriate skills and expertise, particularly for rare diseases like CF. Additional support for the FDA through increased funding not only assures that the Nation has a safe and effective supply of drugs and devices, but also that the agency can give the necessary attention to reviewing treatments that treat small populations but serve specific unmet medical needs, such as Caystonr.

The CF Foundation applauds the appointment of Dr. Anne Pariser as the new Associate Director for Rare Diseases in the FDA's Center for Drug Evaluation and Research's Office of New Drugs. We are pleased to see this new position held by such a capable and competent administrator. Similarly, we applaud the regulatory science initiative formed by the NIH and the FDA with the goal of accelerating the development and use of new approaches to evaluate drug safety, efficacy, and quality and urge the subcommittee to strongly support this type of collaboration. Support for coordination between new programs like TRND and CAN throughout the national health agencies leverages the Federal investment in new research, facilitating swifter development and delivery of new medical treatments.

Supporting Translational Research and Investigators

A significant discrepancy persists between the first award funding granted to clinical laboratory investigators and that granted to basic laboratory investigators. The difference is even greater for second awards and prolonged funding of clinical investigators. The NIH must maintain support for translational research and the investigators piloting those projects. Without this support, the NIH stands to lose an entire generation of clinically trained individuals committed to clinical research. The "generation gap" that would be created by the loss of these clinical researchers would affect the ability of the NIH to conduct world-class clinical investigation and jeopardize the standing of the United States as the world's premiere source for biomedical research.

The Clinical and Translational Science Awards (CTSA)

We urge the NIH to enhance the Clinical and Translational Science Awards (CTSA), a program designed to transform the way in which clinical and translational research is conducted. Such an increased emphasis on clinical translation can enable researchers to provide new treatments more efficiently to patients. For example, at Seattle Children's Hospital, a CTSA program has been instrumental in identifying best practices for efficient clinical trial participation and improving clinical outcomes in care for CF. Tremendous effort has brought institutions together to rally around this program and similar programs at other institutions, yet current funding levels make it difficult for the full complement of programs to be funded. Additionally, key to the success of the CTSAs is the development of cost-sharing mechanisms like the General Clinical Research Centers (GCRC), which allowed institutes to reduce their research budgets by having investigators use the GCRC when clinical care was made available at no additional cost. In order to maxi-

mize the potential of the CTSA, multiple institutes within the NIH must be able to provide financial resources for critical programs such as this.

Alterative Models for Institutional Review Boards (IRB)

We are pleased that the Department of Health and Human Services has encouraged the exploration of alternative models of IRBs, including central IRBs, by the CTSA. We encourage Congress to urge the Department to demonstrate more aggressive leadership in persuading all academic institutions to accept review by a central IRB—without insisting on parallel and often duplicative review by their own IRB—at least in the case of multi-institutional trials in rare diseases. Such oversight could help provide greater expertise to improve trial design and enable critical research to move forward in a timelier manner without undermining patient safety.

Research Compensation for Supplemental Security Income

An additional impediment in our effort to accelerate the development of new therapies is the Social Security Administration's current Supplemental Security Income (SSI) rules, which count research compensation for participation in a clinical drug study as income for determining SSI. This policy creates an unnecessary barrier to clinical trial participation for a significant number of people with CF, and thus severely limits efforts to develop new therapies. S. 1674, the Improving Access to Clinical Trials Act of 2009, would allow the Social Security Administration to disregard any income received from compensation for clinical trials when determining eligibility for programs like SSI. Support from the subcommittee on resolving this disincentive toward clinical research is appreciated.

Partnership with the National Center for Research Resources (NCRR)

The CTSA program, administered by the NCRR, encourages novel approaches to clinical and translational research, enhances the utilization of informatics, and strengthens the training of young investigators. Recently, however, the NCRR decided to reject funding for disease-specific networks in favor of those without a disease focus. As a result of this policy, some of the best clinical research consortia are prohibited from competing for NCRR grants, including but not limited to the CF TDN. We urge the NCRR to reverse this decision.

SUPPORTING DRUG DISCOVERY

The Cystic Fibrosis Foundation's clinical research is fueled by a vigorous drug discovery effort—early stage translational research of promising strategies to find successful treatments for this disease. Several research projects at the NIH will expand our knowledge about the disease, and could eventually be the key for controlling or curing CF.

Opportunities in Animal Models

The Cystic Fibrosis Foundation is encouraged by the NIH's investment in a research program at the University of Iowa to study the effects of CF in a pig model. The program, funded through research awards from both NHLBI and the Cystic Fibrosis Foundation, bears great promise to help make significant developments in the search for a cure. While a company has been established to produce the animals, the infrastructure and extensive animal husbandry required to keep the animals alive and conduct research on them is available at few academic institutions. We urge additional funding to create a facility that would enable researchers from multiple institutions to conduct research with these models.

Facilitating Scientific Data Connections

An explosion of data is emerging from "big science" projects such as the Human Genome Project and the International HapMap Project. We encourage investments by NIH into the development of systems that permit the linkage of gene expression, protein expression, and protein interaction data from independent laboratories. While construction of such an interface would be difficult, it would undoubtedly facilitate generations of new ideas and open new areas of medically important biology.

Increasing Investment in Inflammatory Response Research

CF, like diseases such as inflammatory bowel disease, chronic bronchitis, and rheumatoid arthritis, causes an intense inflammatory response. The Cystic Fibrosis Foundation enthusiastically supports investments by the NIH to gain a greater understanding of neutrophil-driven inflammatory responses, which would lead to improved methods of safely interfering with the inflammatory process and contributing to the health and well being of the U.S. population.

Supporting High Throughput Screening

The subcommittee should urge the NIH to continue to fund high throughput screening initiatives in keeping with Common Fund priorities. Support for the follow-up and optimalization of compounds identified through this type of screening can help to bridge the development gap and bring about more drugs that can make it to patients' bedsides.

Funding Systems Biology Platforms

In order to rapidly accelerate the identification of potential biomarkers and understand the mechanisms of action of CFTR function, data generated from multiple laboratories and scientific centers must be integrated. To address this, the Cystic Fibrosis Foundation has partnered with a systems biology company called GeneGo to generate a CF-focused systems biology platform to illustrate the various effects of CFTR dysfunction in multiple cell systems. The CF Foundation urges NIH to provide additional funding to support research efforts aimed at leveraging systems biology platforms to integrate multiple disciplines within the CF research community in order to accelerate drug development and biomarker validation for CF.

Small Business Innovation Research Program at NIH

Small Business Innovation Research (SBIR) program grants allocated by the NIH have helped many small biotechnology and pharmaceutical companies to develop vital treatments for a variety of diseases. The SBIR program could provide further support by directing that a portion of all grants awarded be used for rare disease research. With such a small portion of the population likely to purchase the drugs, research to produce drugs to treat rare diseases is often considered too large a financial risk to take on. By directing even small dollar grants to develop drugs for these diseases, Congress can eliminate some of the risk that keeps biotechnology and pharmaceutical companies from developing drugs for rare diseases.

The NIH has wisely focused on translational research as a touchstone for ensuring the relevance of the agency to the American public. The CF Foundation is the perfect example of this notion, having devoted our own resources to developing treatments through drug discovery, clinical development, and clinical care. Several of the drugs in our pipeline show remarkable promise in clinical trials and we are increasingly hopeful that these discoveries will bring us even closer to a cure. Encouraged by our successes, we believe the experience of the CF Foundation in clinical research can serve as a model of drug discovery and development for research on other orphan diseases and we stand ready to work with NIH and congressional leaders. On behalf of the Cystic Fibrosis Foundation, we thank the subcommittee for its consideration.

PREPARED STATEMENT OF CHILDREN AND ADULTS WITH ATTENTION-DEFICIT/HYPERACTIVITY DISORDER

Background

At the Centers for Disease Control and Prevention (CDC) 1999 conference titled "Attention Deficit Hyperactivity Disorder: A Public Health Perspective," more than 150 experts gathered to discuss the public health concerns related to AD/HD and to explore areas for future research. The conference developed a public health research agenda which included recommendations on the establishment of: a resource for both professionals and the public regarding what is known about the epidemiology of AD/HD; an avenue of dissemination of educational materials related to the diagnosis of and intervention opportunities for AD/HD to primary care physicians, nurse practitioners, physicians assistants, mental health providers, and educators; collaborations with other organizations to educate and promote what is known about AD/HD interventions, appropriate standards of practice, their effectiveness, and their safety; and a resource to the public for accurate and valid information about AD/HD and evidence-based interventions.

Congress responded to this research agenda in fiscal year 2002 by providing resources for the CDC to begin a partnership with CHADD [1] to develop the National Resource Center on AD/HD (NRC)—a significant development in recognizing the unique challenges faced by individuals with AD/HD across the lifespan.

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[1] Children and Adults with Attention-Deficit/Hyperactivity Disorder (CHADD) was founded by parents in 1987 in response to the frustration and sense of isolation experienced by parents and their children. CHADD is the leading national nonprofit organization for children and adults with AD/HD, providing the public and providers with education, advocacy, and support.

The NRC's goals include improving the health and quality of life of individuals with AD/HD and their families; raising awareness and facilitating access to scientifically valid information and support services; and improving the understanding of the impact of AD/HD among healthcare specialists, educators, employers, and individuals with AD/HD. The NRC fulfills these goals by disseminating evidence-based research on AD/HD through a variety of mechanisms, including:

—a Web site (www.help4adhd.org) receiving on average 130,000 visits each month;

—a national call center, staffed by five professional health information specialists, including one bilingual health information specialist. The health information specialists responded to 9,364 individual inquiries during the last year on 17,115 different topical issues from parents, adults with AD/HD, mental health professionals, and educators;

—partnerships with minority health organizations to reach underserved populations;

—a series of more than 25 "What We Know" fact sheets on AD/HD, in both English and Spanish; and

—a comprehensive library and online bibliographic database of more than 4,100 evidence-based journal articles and reports on AD/HD.

The overwhelming demand for information and support on AD/HD by the public and the professional community has created an unprecedented need for additional resources to keep pace with the requests for information received by the NRC and to provide outreach and resources to unserved and underserved populations.

What is AD/HD?

A 2005 report by the CDC found that parents reported approximately 7.8 percent of school-age children (4 to 17 years) had a diagnosis of Attention-Deficit/Hyperactivity Disorder (AD/HD).[2] Other evidence-based studies have documented that more than 70 percent of children with AD/HD will continue to experience symptoms of AD/HD into adolescence, and almost 65 percent will exhibit AD/HD characteristics as adults.[3] In addition, up to two-thirds of children with AD/HD will have at least one co-occurring disability with 50 percent of these children having a co-occurring learning disability.

Only half of all children with AD/HD receive the necessary treatment, with lower diagnostic and treatment rates among girls, minorities and children in foster care. If untreated or inadequately treated, AD/HD can have serious consequences, increasing an individual's risk for school failure, unemployment, interpersonal difficulties, other mental health disorders, substance and alcohol abuse, injury, antisocial and illegal behavior, contact with law enforcement, and shortened life expectancy.[4] The availability of appropriate services and access to treatment can help individuals with AD/HD avoid negative outcomes and lead successful lives.

Fiscal Year 2011 Appropriations Request

The NRC has met and continues to meet the goals of improving the health and quality of life for individuals with AD/HD and their families; raising awareness and facilitating access to evidence-based information and support services; and improving the understanding of the impact of AD/HD among healthcare specialists, educators, employers, and individuals with AD/HD.

Both the National Institutes of Health Consensus Conference on AD/HD (Nov. 1998) and the Centers for Disease Control and Prevention Conference on Public Health and AD/HD (Sept. 1999) concluded that AD/HD is a serious public health concern that needs to be addressed because of the potential economic burden associated with AD/HD. Numerous peer reviewed journal articles have documented the significant healthcare cost of individuals with AD/HD.[5]

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[2] Centers for Disease Control and Prevention. (2005). *Mental Health in the United States: Prevalence of Diagnosis and Medication Treatment for Attention-Deficit/Hyperactivity Disorder*. Retrieved March 25, 2005, from http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5434a2.htm.

[3] Dulcan, M., and the Work Group on Quality Issues. (1997, October). AACAP official action: Practice parameters for the assessment and treatment of children, adolescents, and adults with Attention-Deficit/Hyperactivity Disorder. *Journal of the American Academy of Child and Adolescent Psychiatry, Supplement*, 36(10), 85S–121S.

[4] Barkley, R. A. (1997). *ADHD and the nature of self-control*. New York: The Guilford Press.

[5] Cuffe, S.P., Moore, C.G., & McKeown, R. (2009). ADHD and health services utilization in the National Health Survey. *Journal of Attention Disorders*, 12(4), 330–340; Chan, E., Zhan, C., & Homer, C.J. (2002). Health care use and costs for children with Attention-Deficit/Hyperactivity Disorder, *Archives of Pediatrics & Adolescent Medicine*, 156, 504–511; Rowland, A.S., Umbach, D.M., Stallone, L., Naftel, J., Bohlig, E.M., & Sandler, D. P. (2002). Prevalence of medi-

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In "AD/HD in Adults: What the Science Says," Barkley, Murphy & Fisher discuss the results of the few empirical studies that have been conducted regarding occupational functioning of clinic-referred adults with AD/HD.[6] "Although opinions abound on the topic in trade books on ADHD in adults, there is very little research on the occupational functioning of clinic-referred adults with ADHD" (p. 276). One study conducted at UMASS found that adults with a diagnosis of AD/HD are more likely to self-report and have employers report difficulties with occupational functioning than their clinic-referred or community counterparts. In addition, the Milwaukee study (2006) found that individuals diagnosed as having AD/HD as children that persists until age 27 tend to be more severely affected in occupational functioning than clinic-referred adults or community counterparts. In addition, another study conducted by Biederman & Faraone (2006) concluded that individuals with AD/HD are less likely to be employed full time (34 percent of individuals with AD/HD compared to 59 percent of individuals without AD/HD).[7] In addition, the study found that the household incomes of adults over the age of 25 were significantly lower among individuals with AD/HD when compared to individuals without AD/HD regardless of academic achievement or personal characteristics. The results of these three studies indicate the need for further research into the impact of AD/HD on the occupational functioning of adults and how best to reasonably accommodate their disability in the workplace because more than 30 percent of requested accommodations are at no cost to the employer but yet according to Biederman & Faraone the total cost of work loss among men and women with AD/HD is $2.6 billion, or 53 percent of the total $13 billion cost of adult ADHD in the United States.

Last year, the AD/HD line item was funded at $1.751 million. We are requesting a $400,000 increase in the AD/HD line item, which will result in a $200,000 increase in the NRC. Historically, half of the increase to the AD/HD line item has been used to fund research on AD/HD. The $200,000 increase to the NRC will allow the NRC to further develop its outreach to the African-American and Hispanic-Latino communities, and most importantly during this current economic climate to initiate an employment information specialist service.

Requested Report Language for Fiscal Year 2011

The subcommittee continues to support the activities of the CDC's NCBDDD and the National Resource Center (NRC) on AD/HD and has provided $2,151,000 to continue this support, including $1,075,500 to maintain and expand the activities at the NRC as it responds to the overwhelming demand for information and support services, reaches special populations in need, and most importantly during this current economic climate, provides support for a health information specialist focused on employment to assist individuals with AD/HD to lead successful, economically self-sufficient, and independent lives integrated into their communities with the necessary accommodations and supports.

PREPARED STATEMENT OF THE COALITION FOR HEALTH SERVICES RESEARCH

The Coalition for Health Services Research (CHSR) is pleased to offer this testimony regarding the role of health services research in improving our Nation's health. The Coalition's mission is to support research that leads to accessible, affordable, high-quality healthcare. As the advocacy arm of AcademyHealth, the Coalition represents the interests of 3,800 researchers, scientists, and policy experts and 150 organizations that produce and use health services research.

Healthcare in the United States has the potential to dramatically improve people's health, but often falls short and costs too much. Health services research is used to understand how better to finance the costs of care, measure and improve the quality of care, and improve coverage and access to affordable services. It provides patients, providers, payers, and policymakers with the tools needed to make healthcare:

—Affordable by decreasing cost growth to sustainable levels.

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cation treatment for Attention Deficit-Hyperactivity Disorder among elementary school children in Johnston County, North Carolina, *American Journal of Public Health*, 92(2), 231–234; Ray, T.G., Levine, P., Croen, L.A., Bokhari, F.A.S., Hu., T., & Habel, L.A. (2006). Attention-Deficit/Hyperactivity Disorder in children, *Archives of Pediatrics & Adolescent Medicine, 160*, 1063–1069.

[6] Barkley, R.A., Murphy, K.R., & Fischer, M. (2008). *ADHD in Adults: What the Science Says*. New York: The Guilford Press.

[7] Biederman, J.,& Faraone, S.V. (2006). *The effects of attention-deficit/hyperactivity disorder on employment and household income*. MedGenMed, 8(3),12, Retrieved March 25, 2005, from http://www.medscape.com/viewarticle/536264.

—Efficient by decreasing waste and overpayment and monitoring the cost-effectiveness of care.
—Safe by decreasing preventable medical errors, monitoring public health, and improving preparedness.
—Effective by evaluating programs and outcomes and promoting evidence-based innovations.
—Equitable by eliminating disparities in health and healthcare.
—Accessible, by connecting people with the healthcare they need when they need it.
—Patient-centered by increasing patient engagement in and satisfaction with the care received.

Indeed, health services research has been changing the face of U.S. healthcare, uncovering critical challenges confronting our nation's healthcare system. For example, the 2000 Institute of Medicine (IOM) report *To Err Is Human* found that up to 98,000 Americans die each year from medical errors in the hospital. Health services research also found that disparities and lack of access to care in rural and inner cities result in poorer health outcomes. And it demonstrated that obesity accounts for more than $92 billion in medical expenditures each year and has worse effects on chronic conditions than smoking or problem drinking.

But health services research does not just lift the veil on the problems plaguing U.S. healthcare; it also seeks ways to address them. Health services research offers guidance on implementing and making the best use of health information technology and getting the best care at the best value. Health services research framed the debate over healthcare reform in Massachusetts—forming the basis for that State's 2006 health reform legislation—and was instrumental in shaping comprehensive national health reform through The Patient Protection and Affordable Care Act. As health reform is implemented over the next few years, health services research will be needed more than ever to monitor and evaluate the new law's impact on the healthcare system and the health status of Americans. Do Americans have better access to healthcare? Are the measures projected to bend the healthcare cost curve downward having the desired effect? Are patients more engaged in healthcare decisionmaking? Is care better coordinated across providers? Health services research will provide the answers to these and other important questions.

For the last 7 years, the Coalition has collected data to track the Federal Government's expenditures for health services research and health data. Information provided to us by the principal funders of health services research and data—including the Agency for Healthcare Research and Quality (AHRQ), the National Institutes of Health (NIH), the Centers for Disease Control and Prevention (CDC), and the Centers for Medicare and Medicaid Services (CMS)—indicates that the field of health services research and data has operated with diminished purchasing power for years. Up until 2008, overall spending on healthcare continued to rise faster than the rate of inflation—from $1.4 trillion in 2000 to nearly $2.3 trillion in 2008. Despite the recent increase in Federal funding for health services research and data—$1.8 billion in fiscal year 2009—the total Federal investment still accounted for only 0.078 percent of the $2.3 trillion we spend on healthcare annually.

The CHSR greatly appreciates the subcommittee's recent efforts to increase the Federal investment in health services research and comparative effectiveness research through the fiscal year 2010 Omnibus Appropriations Act and the American Recovery and Reinvestment Act of 2009. This funding provides a new high watermark for the field and represents the largest-ever single funding increase in health services research. With comprehensive health reform now a reality, we ask the subcommittee to continue strengthening the capacity of the health services research field to address the pressing challenges America faces in providing access to high-quality, cost-effective care for all its citizens.

AHRQ

AHRQ is the lead Federal agency charged with supporting unbiased, scientific research to improve healthcare quality, reduce costs, advance patient safety, decrease medical errors, and broaden access to essential services. Recent years' steady, incremental increases for AHRQ's Effective Health Care Program, as well as the $300 million provided to AHRQ in the American Recovery and Reinvestment Act, have helped AHRQ generate more comparative effectiveness research and expand the infrastructure needed to increase capacity to produce this evidence. However, funding for AHRQ's broader health services research portfolio has languished as funding for AHRQ's base has remained relatively flat. To balance the recent investments in AHRQ's comparative effectiveness research, we recommend that:

—AHRQ's broader health services research portfolio should not be sacrificed for the sole benefit of comparative effectiveness research. The entirety of the Presi-

dent's requested budget increase will support "patient-centered health research" (i.e., comparative effectiveness research) while funding for programs in AHRQ's broader research portfolio are cut or flat-funded to support a more robust comparative effectiveness research portfolio. The full spectrum of health services research on healthcare cost, quality, and access is essential to ensure that research on "what works" is implemented in ways that support broader health reform efforts.

—Congress should continue to place priority on investigator-initiated research and should target funding for innovative, competitive grants in fiscal year 2011. The President's proposed budget does not fund new investigator-initiated research grants at AHRQ in fiscal year 2011. The Coalition is grateful to the subcommittee for its leadership in recognizing the value of investigator-initiated research at AHRQ. The Coalition requests that you continue this investment in fiscal year 2011 and sustain the momentum for competition and innovation you have cultivated over several years.

—Congress should target more funding for pre- and postdoctoral training grants to increase capacity to respond to growing public and private sector demand for health services research. At the direction of Congress, AHRQ doubled its investment in training grants for the next generation of researchers in the last year. Still, training grants for new researchers fall far short of what is needed across all disciplines to meet growing public and private sector demand for health services research. As the lead agency for health services research, AHRQ requires more funding to develop the next generation of health services researchers—both physician and nonphysician researchers.

While targeted funding increases in recent years have moved AHRQ in the right direction, more core funding is needed to help AHRQ fulfill all aspects of its mission. We join the Friends of AHRQ—a coalition of more than 250 health professional, research, consumer, and employer organizations that support the agency—in supporting the President's requested funding level of $611 million.

Centers for Disease Control and Prevention (CDC)

Housed within the CDC, the National Center for Health Statistics (NCHS) is the Nation's principal health statistics agency, providing critical data on all aspects of our healthcare system. With the subcommittee's leadership in securing steady and sustained funding increases for NCHS over the last 3 fiscal years, NCHS is rebuilding after years of underinvestment that forced the elimination of data collection and quality control efforts, threatened the collection of vital statistics, stymied the adoption of electronic systems, and limited the agency's ability to modernize surveys to reflect changes in demography, geography, and health delivery. We join the Friends of NCHS—a coalition of more than 250 health professional, research, consumer, industry, and employer organizations that support the agency—in endorsing the President's fiscal year 2011 request of $162 million, a funding level that will build on your previous investments and put the agency on track to become a fully functioning, 21st century, national statistical agency.

The Patient Protection and Affordable Care Act recognizes the need for linking the medical care and public health delivery systems by authorizing a new CDC research program to study the delivery of public health services. If funded in fiscal year 2011, this program will support the examination of evidence-based practices relating to prevention; analyze the translation of interventions from academic to real-world settings; and identify effective strategies for organizing, financing, or delivering public health services in real-world community settings by, for example, comparing State and local health department structures and systems in terms of effectiveness and costs. The Coalition urges you to appropriate $50 million for this important program in fiscal year 2011, enabling us to study ways to improve the efficiency and effectiveness of public health service delivery.

In addition, the Coalition urges you to provide the CDC's important Public Health Research portfolio and Prevention Research Centers—a network of academic health centers that conduct public health research—with at least $35 million for Public Health Research and at least $35 million for Prevention Research Centers in fiscal year 2011. These programs—which seek ways to develop, translate, and disseminate research to address obesity, diabetes, and heart disease; healthy aging and youth development; cancer risk; and health disparities—have been virtually flat-funded since fiscal year 2006. At a time when chronic diseases persist as the primary drivers of escalating healthcare costs, greater investment in public health research is needed to identify evidence-based solutions to curbing the prevalence of these diseases.

Centers for Medicare and Medicaid Services (CMS)

Steady funding decreases for the Office of Research, Development and Information, together with an increasingly earmarked budget, have hindered CMS's ability to meet its statutory requirements and conduct new research to strengthen public insurance programs—including Medicare, Medicaid, and the Children's Health Insurance Program—which together cover nearly 100 million Americans and comprise 45 percent of America's total health expenditures. As these Federal entitlement programs continue to pose significant budget challenges for both Federal and State governments, it is critical that we adequately fund research to evaluate the programs' efficiency and effectiveness and seek ways to manage their projected spending growth.

The Coalition supports an increase in CMS's discretionary research and development budget from $36 in fiscal year 2010 to a base fiscal year 2011 funding level of $47 million, consistent with the President's request. This funding is a critical down payment to help CMS recover lost resources and restore research to evaluate its programs, analyze pay for performance and other tools for updating payment methodologies, and further refine service delivery methods.

In addition, the Coalition supports the President's fiscal year 2011 request of $110 million for a new data improvement initiative at CMS. This investment would enhance the quality and timeliness of data, support health reform initiatives such as value-based purchasing and comparative effectiveness research, improve payment accuracy, and enhance systems security. The Coalition supports the President's efforts to improve data quality, timeliness, and access and encourages Congress to appropriate funding so that the research community will be able to access CMS's valuable data to enhance these Federal programs and ultimately reduce mandatory spending.

NIH

NIH reported that it spent $1.1 billion on health services research in fiscal year 2009—roughly 3.6 percent of its entire budget—making it the largest Federal sponsor of health services research. For fiscal year 2011, the Coalition recommends a health services research base funding level of at least $1.27 billion—3.6 percent of the $35 billion sought by the broader health community for NIH. The Coalition believes that NIH should increase the proportion of its overall funding that goes to health services research from 3.6 to 5 percent to ensure that discoveries from clinical trials are effectively translated into health services. We also encourage NIH to foster greater coordination of its health services research investment across its Institutes.

In conclusion, the accomplishments of health services research would not be possible without the leadership and support of this subcommittee. As you know, the best healthcare decisions are based on relevant data and scientific evidence. With important health reforms now undergoing implementation, health services research will continue to yield valuable scientific evidence in support of improved quality, accessibility, and affordability of healthcare. We urge the subcommittee to accept our fiscal year 2011 funding recommendations for the Federal agencies funding health services research and health data.

PREPARED STATEMENT OF THE COALITION OF NORTHEASTERN GOVERNORS

The Coalition of Northeastern Governors (CONEG) is pleased to submit this testimony for the record to the Senate Subcommittee on Labor, Health and Human Services, and Education, and Related Agencies regarding fiscal year 2011 appropriations for the Low-Income Home Energy Assistance Program (LIHEAP).

The Governors appreciate the subcommittee's continued support for LIHEAP, and we thank you for providing $5.1 billion in fiscal year 2010 funding for the program. The Governors recognize the considerable fiscal challenges facing the subcommittee this year. However, as the number of households seeking heating and cooling assistance continues to increase nationwide, we urge you to provide fiscal year 2011 funding for the core LIHEAP block grant program at least at the most recent authorized level of $5.1 billion, as well as provide sufficient contingency funds to address unforeseen energy emergencies. Providing this funding level through the block grant program provides the certainty that States need to implement an effective program.

LIHEAP is a vital safety net for millions of vulnerable low-income households—the elderly and disabled living on fixed incomes, the working poor and newly unemployed, and families with young children. Under this targeted program, the majority of households receiving assistance have incomes of less than $8,000 a year. These

households have the highest energy burden, spending more than 16 percent of their income on home energy compared to 3 percent for non-low-income households.

This disproportionate energy burden experienced by vulnerable low-income families continues. In recent years, the increase in the cost of home energy has far outpaced both the rate of inflation and the increase in household income.[1] The share of income that elderly households spend on housing costs and out-of-pocket healthcare expenditures has increased substantially in the last two decades.[2] LIHEAP is an effective tool for helping these households better manage the financial pressures of unaffordable home energy costs, through assistance in paying bills as well as making their homes and heating systems safer and more efficient.

While some national economic reports are hopeful, the current situation remains challenging for these low-income households as the costs of essential household expenses including home energy and food remain high. This is particularly true in the Northeast where a greater percentage of households use delivered heating fuels, such as home heating oil, propane and kerosene, than in any other region of the country. These households are more vulnerable to price volatility, making it more difficult for families to manage their household budgets. Households using deliverable fuels tend to have an extremely high energy burden, with historically higher energy bills than those using other heating sources. The average annual heating bill for all LIHEAP recipients was $717 in 2007. However, the average annual heating bill for households using home heating oil was $1,686, and the average heating bill for propane users was $1,052.[3] This pattern continues. Even as the price of some home energy prices stabilize, the Energy Information Administration finds that home heating oil prices have increased 20 percent more than last year.[4] In addition, households that rely upon delivered fuels do not have the benefit of a program comparable to a utility service shut-off moratorium. If a household cannot afford to purchase the home heating fuel, the delivery truck simply does not come.

The number of households receiving LIHEAP assistance continues to reach record levels. According to the National Energy Assistance Directors' Association (NEADA), 8.3 million households received heating assistance in 2009, compared to 6.1 million in 2008. States expect that number to grow to more than 9.5 million in 2010. Many of these applicants have never requested help before, but are facing extraordinary economic hardship due to increased unemployment and layoffs. Yet, this is only a small portion of the eligible households.

As spring approaches and utility shut-off moratoria end, too many families are in danger of having their utility service terminated for nonpayment. According to NEADA, approximately 4.3 million households were shut off from power in fiscal year 2009 up from 4.1 million in 2008. In fiscal year 2009 approximately 12.5 million households were at least 30 days behind in their utility bills. The effects on these vulnerable households can be deadly. Numerous studies have found that the elderly and very young children are at risk for serious health consequences from prolonged exposure to home temperatures that are either too cold in the winter or too hot in the summer.

States in the Northeast already incorporate various administrative strategies that allow them to deliver maximum program dollars to households in need. These include using uniform application forms to determine program eligibility, establishing a one-stop shopping approach for the delivery of LIHEAP and related programs, sharing administrative costs with other programs, and using mail recertification. Opportunities to further reduce LIHEAP administrative costs are limited, since they are already among the lowest of the human service programs.

In spite of these State efforts to stretch Federal and State LIHEAP dollars, the need for the program is far too great. Increased, predictable and timely Federal funding is vital for LIHEAP to assist the Nation's vulnerable, low-income households faced with exorbitant home energy bills. The CONEG Governors urge the subcommittee to provide at least $5.1 billion in regular block grant funding for LIHEAP in fiscal year 2011 as well as sufficient contingency funds to address unforeseen energy emergencies. This sustained level of funding will help States to provide meaningful assistance to households in need as millions of low-income citizen's struggle

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[1] *Short and Long-Term Perspectives: The Impact on Low-Income Consumers of Forecasted Energy Price Increases in 2008 and a Cap-and-Trade Carbon Policy in 2030*, Oak Ridge National Laboratory, December 2007.

[2] *Recipiency Targeting Analysis for Elderly and Young Child Households*, prepared for the Office of Community Services' Division of Energy Assistance by APPRISE Incorporated, December 2008.

[3] *LIHEAP Home Energy Notebook for Fiscal Year 2007*, U.S. Department of Health and Human Services, Administration for Children and Families, Office of Community Services, Division of Energy Assistance, June 2009.

[4] *Short-Term Energy Outlook*, Energy Information Administration, March 2010.

with unaffordable home energy bills. LIHEAP can continue to provide a vital safety net protecting these vulnerable households from the potentially deadly heat and cold.

PREPARED STATEMENT OF THE CORPORATION FOR PUBLIC BROADCASTING

Chairman Harkin, Ranking Member Cochran, and members of the subcommittee, thank you for allowing me to submit testimony on behalf of our Nation's public media system.

As you know, the Corporation for Public Broadcasting (CPB), a private, nonprofit corporation created by the Public Broadcasting Act of 1967, is the steward of the Federal Government's investment in public broadcasting. We support the operations of more than 1,100 locally owned and operated public television and radio stations nationwide. Throughout the United States, public broadcasting, or what should more accurately be called "public media," engages citizens on-air, on-line, and on the ground with information they can use to improve their lives and strengthen their local communities. As commercial media becomes increasingly consolidated, a key strength of public media remains its design: a decentralized set of stations, each with deep local roots and maintaining individual service strategies tailored to the unique needs of its local community.

Public broadcasting was born in an earlier moment of profound change and transition. In the 1950s and 1960s a new media technology was diffusing quickly: the television. Around it grew a movement to use the new medium, as well as existing radio technology, for educational purposes, and public broadcasting was born. Today, nearly a half-century after the signing of the Public Broadcasting Act, we are making a similar transition from public broadcasting to the "Public Media 2.0" the President called for during his campaign. As we leverage our legacy to become a leader in the new and ever-changing media landscape, public media has focused its efforts through a strategic framework comprising the "Three Ds": Digital, Diversity, and Dialogue.

Innovation on Digital Platforms

As an outgrowth of its dedication to universal service, public media is embracing a range of digital delivery methods to reach all Americans, wherever and whenever they seek information. Because of its reach, its availability for free, and its unmatched efficiency in point-to-multipoint communications, over-the-air service remains an essential part of the public media portfolio. At the same time, public broadcasters are evolving into true multi-platform media entities by creating content and services, some related to and some entirely independent from broadcast content, that capitalize on the power of broadband and other digital technologies. For example:

—KQED's (San Francisco) QUEST is a new multimedia series about the people behind Bay Area science and environmental issues which utilizes all of KQED's media platforms, educational resources and extraordinary partnerships, and includes a half-hour weekly HD television program, weekly radio segments, an innovative Web site and education guides.

—Public Broadcasting Atlanta is developing Lens on Atlanta, an on-line portal that invites citizens to create and participate in blogs, wikis, forums, petitions, and surveys, and engages institutions and Government entities around Atlanta to listen and participate.

—Many public radio stations have expanded the reach of their cultural programming by investing in and creating substantial Internet music services with significant audiences. Examples include WAMU's Bluegrass Country, WKSU's Folk Alley, WXPN's Xponential, and KCRW's Eclectic24.

In addition to these local station efforts, public broadcasting's national organizations have been moving for some time to leverage the power of digital media. For example:

—CPB is funding the creation of Local Journalism Centers, combining our and participating stations' resources for a ground-breaking approach to news gathering and distribution. The seven centers will form teams of multimedia journalists, who will focus on issues of particular relevance to each region, and their in-depth reports will be presented regionally and nationally via digital platforms, community engagement programs and broadcasts.

—In October 2009, NPR initiated Argo, a new multi-media journalism project, funded by CPB and the Knight Foundation. The 2-year project is designed to strengthen public media's local journalism, build a significant online audience, and develop a common publishing platform that will better support public me-

dia's online needs. NPR is working with a dozen selected public television and radio stations to launch Web sites for each station that go in-depth on selected topics or "verticals."

—In September 2008, PBS launched its PBS KIDS GO! video player, featuring hundreds of video clips and dozens of full-length episodes. Since launch, the site is averaging 1.3 million streams per week, and 9 million unique visitors a month. In December 2009 alone, children watched more than 87.5 million streams across the PBS KIDS family of Web sites, its highest total ever, putting it on track to be one of the most popular video sites in the world.

—CPB is funding the development of the American Archive, which ultimately will restore, digitize, and preserve public broadcasting's deteriorating collections of local television and radio content. We expect to have 40,000 hours of local and national television and radio content available to the American public with in 18 months.

Content That Reflects the Nation's Diversity

Equally central to public media's universal service mission is providing individuals of every ethnicity and economic and social background, particularly those that are underserved by commercial media, relevant and engaging content. The ability to transmit multiple streams of digital programming over the air, combined with the nearly boundless capabilities of broadband, enable local and national public media entities to deliver content that truly reflects America's diversity. CPB is constantly expanding its relationships with diversity partners to both broaden its reach and to allow greater opportunities, on a variety of platforms, for underrepresented groups. Among these efforts:

—CPB provides ongoing support to, among others: the National Minority Consortia, which provides seed money to producers of multicultural content; the Independent Television Service, which champions independently produced programming targeting underserved audiences; Koahnic Broadcast Corporation, the leader in bringing Native voices to Alaska and the nation through the only urban Native public radio station and its national production and distribution center (Native Voice One) in Albuquerque; and Radio Bilingue, the only national distributor of Spanish-language public radio programming, which is now developing a transmedia service in Los Angeles targeting a young, English-speaking, and highly diverse audience. We also funded the creation of Native Public Media in 2004 to build and advance Native access to, ownership of, and participation in media, especially radio.

—In fiscal year 2010, we are creating within our multi-year PBS National Program Service agreement (which supports primetime and children's programming) a Diversity and Innovation Fund, which will support major content development projects that examine topics of interest to diverse audiences or that employ new, lower-cost production models.

—CPB funds the National Black Programming Consortium's annual New Media Institute, a unique professional development program designed to introduce producers to the latest in digital media production, marketing, and distribution. The program includes a collaboration website where journalists can showcase their work, find and share public domain stock, share best practices, and brainstorm together on innovative future citizen media projects.

—Through projects such as the Public Radio Talent Quest, CPB has identified a new generation of public broadcasting talent—Public Media 2.0 producers—who appeal to new audiences and produce multimedia content for a variety of platforms. For example, Glynn Washington, a winner of the Talent Quest, produces a new multimedia series, Snap Judgment, that combines his unique brand of storytelling with innovative technology to explore the decisions people make in moments of crisis.

Services That Foster Dialogue Between Public Media and the American People

Public media's localism remains more relevant than ever as commercial media are increasingly owned and operated by entities outside of their local communities—but the nature of our service to local communities is shifting in the digital age. Critical to public media's future will be its ability to collaborate and serve as an active resource and trusted partner to more diverse communities, in new ways. Public media entities are quickly adapting to the new paradigm. For example, as part of a comprehensive local/national response to the Nation's economic woes, CPB is supporting a number of in-depth community engagement projects, including:

—*Facing the Mortgage Crisis*.—Fifty-seven stations are participating in this multi-million dollar national project designed to help the country's hardest-hit regions cope with an avalanche of mortgage foreclosures. Based on an extremely

successful model developed by KETC–TV in St. Louis, stations are working with key community partners, such as United Way's 2–1–1 call centers, to create content on-air and online that helps families to avoid or mitigate home foreclosures.

—*Engaging Communities on the Economy*.—CPB is supporting the work of 37 stations working with partners to address other pressing economic issues, such as joblessness, hunger, loss of health insurance and family stress. These projects serve diverse audiences, from seniors to recent immigrants to teenagers.

CPB's Requests for Appropriations

Public media stations continue to evolve, both operationally and more importantly in the myriad ways they serve their communities. Stations are committed to reaching viewers and listeners on whatever platform they use—from smart phones to iPads to radios to TV sets. But new opportunities come with a cost. While stations can and will continue to adapt and thrive in the digital age, without sufficient support they cannot live up to the potential of the new technologies. As the Federal Communications Commission's recently-issued National Broadband Plan noted, "Today, public media is at a crossroads . . . [it] must continue expanding beyond its original broadcast-based mission to form the core of a broader new public media network that better serves the new multi-platform information needs of America. To achieve these important expansions, public media will require additional funding."

CPB Base Appropriation (Fiscal Year 2013).—CPB requests a $604 million advance appropriation for fiscal year 2013. Stations have been faced with flat CPB funding for the better part of the past decade, and the impact of this lack of an even inflationary increase (until fiscal year 2010) has been magnified by the economic conditions of the last few years. As public media seeks to make the transition to a truly digital enterprise, the Federal share of station funding has never been more critical. CPB distributes its advance appropriation in accordance with a statutory formula, under which almost 72 percent of funds go directly to local public television and radio stations, as well as discretionary support for the creation of programming for radio, television and new media and on projects that benefit the entire public broadcasting community. Added together, these efforts account for 95 percent of the funds appropriated to CPB; we are limited by law to an administrative budget of 5 percent. The Federal appropriation accounts for under 15 percent of the entire cost of public broadcasting, but it is a vital core that leverages support from State and local governments, universities, businesses, foundations, and especially viewers and listeners of local public television and radio stations.

CPB Digital (Fiscal Year 2011).—CPB requests $59.5 million in digital funding for fiscal year 2011. With this funding, CPB will continue its mission to fund stations' efforts to adapt to audience demands for educational, cultural and news and information content, regardless of platform. As the Administration noted in its fiscal year 2011 budget request, while CPB Digital will continue to fund station "equipment" such as digital transmitters and translators, "the majority of this funding will be utilized to fund projects to enhance multi-platform content creation, delivery and storage, such as the American Archive, which by converting content to digital format, will ensure that the vast archives of public broadcasting content will not be lost due to physical media deterioration." Though needs remain, as local stations' conversion to digital broadcasting ramps down, CPB Digital funding for broadcast equipment will continue to diminish, and the Department of Commerce's Public Telecommunications Facilities Program (PTFP) can resume its role as the primary Federal source for local station equipment funding.

Ready To Learn (Fiscal Year 2011).—CPB is requesting $32 million in fiscal year 2011 for Ready To Learn (RTL), a Department of Education program with a nearly 20-year proven record of using the power and reach of public television's children's programming to raise the reading levels of children ages 2–8 who live in high-poverty environments. Today, Ready To Learn is a partnership between CPB, PBS, WGBH (Boston), WTTW (Chicago), Sesame Workshop, leading researchers and public television stations nationwide. We strongly disagree with the administration's proposed consolidation of RTL into an umbrella literacy program and instead believe that the difference this program has made on children's lives makes continued dedicated Federal support imperative. An appropriation of $32 million in fiscal year 2011 will enable RTL content and accompanying materials to be created and tested on a faster timeline, and will enable more communities to become involved in existing station-based outreach activities.

Mr. Chairman and Ranking Member, thank you again for allowing CPB to submit this testimony. For nearly a half-century, public broadcasting has provided a safe place for millions of children to learn and unparalleled access to news and information; given voice to diverse points of view; and convened community dialogues. As

the times have changed, so too have the technologies available to provide service to communities across our country. The challenge before us is how best to incorporate new capabilities into the public interest and service for all of our diverse citizenry, especially during these challenging economic times. With your continued support, we are ready to meet this challenge.

PREPARED STATEMENT OF THE CORPORATION FOR SUPPORTIVE HOUSING

The Corporation for Supportive Housing (CSH) is a nonpartisan, nonprofit organization that helps communities build permanent supportive housing (PSH). We have offices in 12 States (California, Arizona, Texas, Illinois, Indiana, Ohio, Minnesota, Michigan, New Jersey, New York, Connecticut, and Rhode Island) and the District of Columbia and have a presence in several others. We work with communities and States to reorient systems and align resources to create permanent supportive housing and end and prevent chronic homelessness. Although many people experiencing homelessness may only need rental or income supports to become and stay housed, a significant and intractable subset of people experiencing homelessness need (in addition to rental assistance or affordable housing) intensive (wrap-around) supportive services such as substance use treatment, mental health services, healthcare to manage chronic diseases, and case management services.

Most PSH providers receive at least a portion of the funds necessary to build or secure housing from the Department of Housing and Urban Development (HUD). Unfortunately, the Department of Health and Human Services has not made an equivalent commitment to funding the services component of PSH. As a result, PSH providers have few places to turn to for the funding needed to provide the wrap-around supportive services needed to keep chronically homeless individuals housed. Organizations and local government agencies patch together a combination of State, local, foundation and privately raised funds to pay for the vital social services chronically homeless populations must have to stay housed. These funds are often limited in amount and short-term in nature. In order to build the PSH units needed to end chronic homelessness, the Department of Health and Human Services must increase its investment in local permanent supportive housing projects. To this end, CSH recommends the following:

—Allocate $120 million for services for people experiencing homelessness within the Programs of Regional and National Significance (PRNS) accounts of both SAMHSA's Center for Mental Health Services and Center for Substance Abuse Treatment. This includes the President's proposal for $15.8 million to fund a joint HHS/HUD homeless program.
—Increase funding for the Projects for Assistance in Transition from Homelessness (PATH) program to $75 million.
—Provide $3.28 billion for the Community Health Center program, this would result in $278 million for the Health Care for the Homeless program.
—Fund the Mental Health Services Block Grant (change name) at $521 million, a $121 million increase.
—Fund the Substance Abuse Prevention and Treatment Block Grant at $2.008 billion a $289 million increase over fiscal year 2009.

Background

While HUD has made significant housing investments, there is a need for HHS to increase its role in providing services resources for organizations to create permanent supportive housing. A majority of chronically homeless individuals live with and face continuing barriers to permanent housing due to serious mental illness, substance use disorders or chronic health conditions and to retain housing must have access services that require HHS expertise.

We know permanent supportive housing works. Over 80 percent of permanent supportive housing residents remain housed after the first year. Other studies have shown decreased mortality rates, reduced use of alcohol and other drugs, lower HIV viral loads, and improved health among chronically homeless people due to placement into supportive housing. In addition, work CSH has done targeting frequent users of health, jails or prisons illustrates the cost effectiveness of PSH. In California, we implemented the Frequent Users of Health Services Initiative (FUHSI). Through this study, we found that by placing clients into PSH we reduced their emergency room costs by 59 percent, reduced their inpatient days by an average of 62 percent and reduced average inpatient charges by 69 percent.

Our project targeting frequent users of jails and prisons has shown similar results. The Frequent Users of Services Enhancement (FUSE) Initiative is a joint project between the New York City Departments of Corrections and Homeless Serv-

ices with assistance from the Department of Health and Mental Hygiene and the New York City Housing Authority. By assisting ex-offenders and providing permanent supportive housing to those who need it, NYC was able to help clients reduce jail stays by 53 percent and reduce shelter stays by 92 percent. For the 100 people served, the FUSE initiative was able to offset nearly $3,000 in both jail and shelter costs per client, not to mention reducing costly emergency health services utilization.

In addition, there are several other subpopulations of those experiencing homelessness that would benefit from increased social services oriented funding. On a small scale, SAMHSA programs have targeted youth, veterans and families to ensure that all people experiencing homelessness who could benefit from mental health and substance use treatment can receive specialized support. However, without increased funding, communities will not be able to fully implement the permanent supportive housing model and continue to end homelessness in America.

Detailed Program Descriptions

SAMHSA Support Services for Permanent Supportive Housing Projects

CSH recommends allocating $120 million for services in permanent supportive housing within SAMHSA's Center for Mental Health Services and Center for Substance Abuse Treatment.

Years of reliable data and research demonstrate that the most successful intervention to solve chronic homelessness is linking housing to appropriate support services. Current SAMHSA investments in homeless programs are highly effective and cost-efficient. The Administration obviously recognizes this and included a new initiative the Homeless and Services for Homeless Persons Demonstration. This joint HUD/HHS partnership is an important first step to integrating housing and services resources to ease organizations' ability to access Federal funding. It also shows an understanding that housing and services is what is needed to end homelessness. This program is estimated to cost $15.8 million. CSH asks that this initiative be fully funded in the appropriations process and that Congress include additional funds to ensure that current grantees can continue their work and new grants can be awarded. We look forward to working with Congress and the Administration to implement this initiative and ensure that it is properly evaluated.

Projects for Assistance in Transition from Homelessness (PATH)

CSH recommends that Congress increase PATH funding to $75 million and adjust the funding formula to increase allocations for small states and territories.

PATH provides outreach to eligible consumers and ensures that those consumers are connected with mainstream services, such as Supplemental Security Income (SSI), Medicaid, and welfare programs.

PATH supported programs served over 135,007 people through outreach in fiscal year 2008. Of those for whom a diagnosis was reported, approximately 35 percent had schizophrenia and other psychotic disorders, and 47 percent had affective disorders such as depression. Also, 60 percent had co-occurring substance use disorders.

One issue that needs consideration, under the PATH formula grant, approximately 30 States share in the program's annual appropriations increases. The remaining States and territories receive the minimum grant of $300,000 for States and $50,000 for territories. These amounts have not been raised since the program was authorized in 1991. To account for inflation, the minimum allocation should be raised to $600,000 for States and $100,000 for territories. Amending the minimum allocation requires a legislative change. If the authorizing committees do not address this issue, we hope that appropriators will explore ways to make the change through appropriations bill language.

Community Health Centers and Health Care for the Homeless (HCH) Programs

CSH recommends $3.28 billion in the Community Health Center program within Health Resource Services Administration. This would result in $278 million for the HCH program.

Persons living on the street suffer from health problems resulting from or exacerbated by being homeless, such as hypothermia, frostbite, and heatstroke. In addition, they often have infections of the respiratory and gastrointestinal systems, tuberculosis, vascular diseases such as leg ulcers, and hypertension.[1] Healthcare for

[1] Harris, Shirley N, Carol T. Mowbray and Andrea Solarz. *Physical Health, Mental Health and Substance Abuse Problems of Shelter Users*. Health and Social Work, Vol. 19, 1994.

the homeless programs are vital to prevent these conditions from becoming fatal. Congress allocates 8.7 percent of the Consolidated Health Centers account for HCH projects.

Mental Health Services Block Grant

CSH recommends that Congress appropriate $486.9 million for the Community Mental Health Performance Partnership Block Grant.

The Mental Health Block Grant provides flexible funding to States to provide mental health services. Ending homelessness requires Federal, State and local partnerships. Additional mental health funds will give States the resources to improve their mental health system and serve all people with mental health disorders better, including homeless populations. For example, block grant funds can be used to pay for services linked to housing for homeless people, thereby meeting the match requirements for projects funded through Shelter Plus Care or the Supportive Housing Program.

Substance Abuse Prevention and Treatment (SAPT) Block Grant

CSH joins our partners in recommending that Congress appropriate $1.929 billion for the SAPT Block Grant.

The SAPT Block Grant is the primary source of Federal funding for substance abuse treatment and prevention for many low-income individuals, including those experiencing homelessness. Studies have shown that half of all people experiencing homelessness have a diagnosable substance use disorder. States need more resources to implement proven treatment strategies and work with housing providers to keep homeless populations, especially chronically homeless populations, stably housed.

Conclusion

Homelessness is not inevitable. As communities implement plans to end homelessness, they are struggling to find funding for the services that homeless and formerly homeless clients need to maintain housing. The Federal investments in mental health services, substance abuse treatment, employment training, youth housing, veterans' services, and case management discussed above will help communities create stable housing programs and change social systems which will end homelessness for millions of Americans.

PREPARED STATEMENT OF THE CLOSE UP FOUNDATION

Mr. Chairman, my name is Timothy S. Davis, President and CEO of the Close Up Foundation and I submit this testimony in support of our $5 million appropriations request for the Close Up Fellowship Program that is funded through a grant from the Department of Education, Office of Innovation and Improvement.

Close Up Foundation is a nonprofit, nonpartisan civic education organization dedicated to the idea that, within a democracy, informed, active citizens are essential to a responsive government. Close Up's mission is to inform, inspire, and empower students and their teachers to exercise their rights and accept the responsibilities of citizens in a democracy. Close Up's experiential methodology emphasizes that democracy is not a spectator sport, and provides young people with the knowledge and skills to participate in the democratic process.

Close Up fulfills its mission with exciting, hands-on programs for students and their teachers in Washington. Close Up uses the city as a living classroom, giving students unique access to the people, processes and places that make up our Nation's capital. Our students are a diverse group—coming from every State and beyond and from all walks of life. More than 650,000 have graduated from our experiential programs.

Three core principles of Close Up are: (1) family income should not be a barrier to a students participation; (2) commitment to diversity—outreach should reach a broad cross section of young people; and (3) enrollment should be open to all students, not just student leaders or high academic achievers.

The Close Up Fellowship Program provides for financial assistance to economically disadvantaged students and their teachers to participate on week-long Close Up Washington civic education programs. The Fellowship Program, authorized in Federal law since 1972 and currently under Section 1504 of the No Child Left Behind Act, has been annually funded through a U.S. Department of Education grant for more than 35 years. The program provides financial assistance to economically disadvantaged high school and middle schools students and their teachers. Close Up makes every effort to ensure the participation of students from rural, small town and urban areas and gives special consideration to students with special educational

needs, including students with disabilities, ethnic minority students, and students with migrant parents. Student fellowship recipients are selected by their schools and must qualify according to the income eligibility guidelines established by Close Up.

Close Up Fellowship Program recipients participate in Close Up Washington civic education programs with all other Close Up participants. Student fellowship recipients participate in the Washington High School Program, the Washington Middle School, and the Program for New Americans. There is no special programming for Fellowship recipients nor are they identified or singled out in any manner. Fellowship recipients add diversity to the student body on Close Up programs. The fellowship program thus benefits not only the recipient but all Close Up student program participants.

Close Up provides a Federal fellowship to a select group of teachers who work with economically disadvantaged students on a Close Up program. Close Up teachers participate in the Close Up Program for Educators, a program which "trains the trainers". Teachers take ideas and methodologies for teaching and engaging young people in civic activities and put them to use in their schools and communities.

The teacher is the essential link to reaching students of diverse backgrounds. Close Up believes that any effort to improve and promote civic involvement among young people must begin with inspired and well-prepared teachers. It is from this inspired corps of teachers that a multiplier effect in civic learning and engagement is produced. Teachers who participate in the teacher program leave inspired and informed and convey a similar attitude to their students. In a survey of teachers who participated on the Close Up Program for Educators in spring 2009, 95 percent of the teachers who responded indicated that they returned to their schools feeling "inspired and reinvigorated" after completing the Close Up program.

Close Up is grateful to the United States Congress for its long-standing support of the Close Up Fellowship Program through the appropriations process. Tens of thousands of young people have been able to participate on Close Up Washington civic education programs as a result of the Federal funding.

Close Up's fiscal year 2011 request is based its desire to significantly increase the number of economically disadvantaged young people who participate on Close Up Washington civic education programs. The funds, which assist the disadvantaged and provide seed money for at-risk schools and communities to participate on these life transforming programs, are more important now than ever. Given the economic climate it has become even more challenging for communities to raise the necessary funds for participation on Close Up programs. The Federal funding bridges that gap and Close Up feels that with aggressive outreach into economically distressed communities we can continue to provide these experiences to our young people.

Close Up civic education programs also helps to fill a gaping hole in the civic education of our Nation's youth. In a recent survey of high school teachers, 83 percent reported that emphasis on standardized tests has made it difficult to teach practical citizenship skills in the classrooms. As the teaching of social studies and civics has given way to STEM subjects, programs like Close Up become an even more important as a supplement to classroom teaching.

Close Up's appropriations request reflects the increasing cost of providing these important Washington programs. The cost of airfare, accommodations, food and local transportation skyrocketed during the decade the Close Up Fellowship funding remained flat at under $1.5 million. The increase in the appropriations amount to $1.942 million in fiscal year 2008 has helped combat a small portion of those increased costs but still results in a sharp decrease in the number of economically disadvantaged students that Close Up has been able to serve. We believe that during hard economic times it is even more imperative for the Federal Government to invest in the civic education of young people. And, by investing in a Close Up education, the Government also greatly supports economic sectors such as transportation and hospitality which are suffering in the downturn.

Senators have the opportunity to meet with Close Up groups from their States during Close Up "Capitol Hill Day". You see the excitement and pride as our students gain confidence to express their views on the public policy issues that most directly affect their lives. Through their workshops, seminars, and experience of being in Washington, Close Up instills these students with the knowledge and skills to become active citizens in our democracy.

Many of your constituents would not be able to participate in this life altering program without the benefit of the Close Up Fellowship Program. There is no better investment that we can make in our Nation's future than in building educated and responsible citizens, one person at a time.

Close Up respectfully requests that the Senate Appropriations Subcommittee on Labor, Health and Human Services, and Education and Related Services appropriate $5 million for the Close Up Fellowship Program.

PREPARED STATEMENT OF THE DYSTONIA MEDICAL RESEARCH FOUNDATION

Dystonia is a neurological movement disorder characterized by involuntary muscle spasms that cause the body to twist, repetitively jerk, and sustain postural deformities. Dystonia can affect movement in several different ways; focal dystonias affect specific parts of the body, while generalized dystonia affects multiple parts of the body at the same time. Some forms of dystonia are genetic, but can also be caused by injury or illness. Although dystonia is a chronic and progressive disease, it does not impact cognition, intelligence, or shorten a person's life span. Conservative estimates indicate that between 300,000 and 500,000 individuals suffer from some form of dystonia in North America alone. Dystonia does not discriminate, affecting all demographic groups. There is no known cure for dystonia and treatment options remain limited.

Although little is known regarding the causes and onset of dystonia, two therapies have been developed and proved particularly useful to control patients' symptoms. Botulinum toxin (Botox/Myobloc) injections and deep brain stimulation have shown varying degrees of success alleviating dystonia symptoms. More research is needed to fully understand the onset and progression of the disease, in order to better treat patients. Until a cure is discovered, the development of management therapies remains vital.

Deep Brain Stimulation (DBS)

Deep brain stimulation (DBS) is a surgical procedure originally developed to treat Parkinson's disease, but is now being applied to severe cases of dystonia. A neurostimulator, or "brain pacemaker", is surgically implanted to deliver electrical stimulation to the areas that control movement. While the exact reasons for effectiveness are unknown, the electrical stimulation blocks abnormal nerve signals that cause debilitating muscle spasms and contractions.

DBS was approved for use by dystonia patients in 2003 and has since drastically improved the lives of many individuals. Results have ranged from quickly regaining the ability to walk and speak, to regaining complete control over one's body and returning to an independent life as an able-bodied person. DBS is currently used to treat severe cases of generalized dystonia, but with increased research may also be a promising treatment for those suffering from focal dystonias. Surgical interventions are a crucial and active area of dystonia research, and must be pursued in the development of new treatment options.

Botulinum Toxin Injections (Botox/Myobloc)

The introduction of botulinum toxin as a therapeutic tool in the late 1980s revolutionized the treatment of dystonia by offering a new, localized method to significantly relieve symptoms for many people. Botulinum toxin, a biologic, is injected into specific muscles where it acts to relax the muscles and reduce excessive muscle contractions.

Botulinum toxin is derived from the bacterium Clostridium botulinum. It is a nerve "blocker" that binds to the nerves that lead to the muscle and prevents the release of acetylcholine, a neurotransmitter that activates muscle contractions. If the message is blocked, muscle spasms are significantly reduced or eliminated, providing considerable relief from the patient's symptoms.

Injections of botulinum toxin should only be performed by a physician who is trained to administer this treatment. The physician administering treatment may palpate the muscles carefully, trying to ascertain which muscles are over-contracting and which muscles may be compensating. In some instances, such as in the treatment of laryngeal dystonia, a team approach including other specialists may be required.

For selected areas of the body, and particularly when injecting muscles that are difficult or impossible to palpate, guidance using an electromyograph (EMG) may be necessary. For instance, when injecting the deep muscles of the jaw, neck, or vocal cords, an EMG-guided injection may improve precision since these muscles cannot be readily palpated. An EMG measures and records muscle activity and may help the physician locate overactive muscles.

Injections into the overactive muscle are done with a small needle, with 1 to 3 injections per muscle. Discomfort at the site of injections is usually temporary, and a local anesthetic is sometimes used to minimize any discomfort associated with the injection. Many dystonia patients frequently rely on botulinum toxins injections to

maintain their improved standard of living due to the fact that the benefits of the treatment peak in approximately 4 weeks and lasts just 3 or 4 months. Currently, FDA approved forms of botulinum toxin include Botox and Myobloc.

DMRF supports the recent "follow-on" biologics or biosimilars provisions included in the Patient Protection and Affordable Care Act. This creates a regulatory pathway for biosimilars at the Food and Drug Administration (FDA). This will help remove significant cost barriers to treatment for dystonia patients and maintain strong patient protections, while providing incentive for the development of new biologic treatments.

Dystonia and the National Institutes of Health (NIH)

Currently, dystonia research at NIH is conducted through the National Institutes on Neurological Disorders and Stroke (NINDS), the National Institute on Deafness and Other Communication Disorders (NIDCD), the National Eye Institute (NEI), and the Office of the Director.

National Institute on Neurological Disorders and Stroke (NINDS)

The majority of dystonia research at NIH is conducted through NINDS. NINDS has utilized a number of funding mechanisms in recent years to study the causes and mechanisms of dystonia. These grants cover a wide range of research included gene discovery, the genetics and genomics of dystonia, the development of animal models of primary and secondary dystonia, molecular and cellular studies inherited forms of dystonia, epidemiology studies, and brain imaging. DMRF works to support NINDS in conducting critical research and advancing understating of dystonia.

National Institute on Deafness and Other Communication Disorders (NIDCD)

NIDCD has funded many studies on brainstem systems and their role in spasmodic dysphonia. Spasmodic dysphonia is a form of focal dystonia, and involves involuntary spasms of the vocal cords causing interruptions of speech and affecting voice quality. Our understanding of spasmodic dysphonia has been greatly enhanced by research initiatives at NIDCD, like the brainstem systems studies. DMRF encourages partnerships between NINDS and NIDCD to further dystonia research.

National Eye Institute (NEI)

NEI focuses some of its resources on the study of blepharospasm. Blepharospasm is an abnormal, involuntary blinking of the eyelids from an unknown cause that is associated with abnormal function of the basal ganglion. The condition can progress to the point where facial spasms develop. While myectomy surgery, botulinum toxin injections, and oral medication can help manage some of the symptoms of blepharospasm, further study by NEI is needed to develop more predictable treatment options.

Rare Diseases Clinical Research Network (RDCRN)

The second phase of the RDCRN at NIH provided funding for an additional 19 grants aimed at studying the natural history, epidemiology, diagnosis, and treatment of rare diseases. This includes the Dystonia Coalition, which will facilitate collaboration between researchers, patients, and patient advocacy groups to advance the pace of clinical research on cervical dystonia, blepharospasm, spasmodic dysphonia, craniofacial dystonia, and limb dystonia. Working primarily through NINDS and the Office of Rare Disease Research in the Office of the Director, the RDCRN holds great hope for advancing understanding and treatment of primary focal dystonias.

After years of near-level funding for NIH, the $10.4 billion provided in the American Recovery and Reinvestment Act (ARRA) helped reinvigorate biomedical research efforts. However, as those funds come to an end, DMRF joins the greater biomedical research community in its concern that research funding will "fall off the cliff." In order to prevent the loss of research spearheaded under ARRA, continued support for initiatives like the Cures Acceleration Network (CAN) included in the recent healthcare reform legislation are vital as we push for rapid translation of basic science into clinical treatments.

For fiscal year 2011, DMRF recommends a funding increase of at least 12 percent for NIH and its Institutes and Centers.

For fiscal year 2011, DMRF recommends that the NIH expand dystonia research through the National Institute on Neurological Disorders and Stroke, the National Institute on Deafness and Other Communication Disorders, the National Eye Institute, and the National Institute on Child Health and Human Development.

For fiscal year 2011, DMRF recommends continued partnerships on dystonia research between the Office of Rare Disease Research, the Rare Diseases Clinical Research Network, and the dystonia patient community.

For fiscal year 2011, DMRF recommends appropriating $500 million for the Cures Acceleration Network, as authorized in the Patient Protection and Affordable Care Act.

The Dystonia Medical Research Foundation (DMRF)

The Dystonia Medical Research Foundation was founded over 30 years ago and has been a membership-driven organization since 1993. Since our inception, the goals of DMRF have remained: to advance research for more effective treatments of dystonia and ultimately find a cure; to promote awareness and education; and support the needs and well being of affected individuals and their families.

Thank you for the opportunity to present the views of the dystonia community, we look forward to providing any additional information.

PREPARED STATEMENT OF THE ELDER JUSTICE COALITION

As your subcommittee considers the fiscal year 2011 Labor, Health and Human Services, and Education, and Related Agencies appropriations bills, the nonpartisan, 622-member Elder Justice Coalition, urges you to provide first year funding for the Elder Justice Act that was included in the final healthcare reform bill signed by President Obama. By doing so, the nation will have substantially improved our ability to better combat elder abuse, neglect and exploitation as well as to protect the health of older adults.

The Elder Justice Act has authorized funding of approximately $777 million over 4 years. We strongly recommend that an appropriation of $195 million for fiscal year 2011 be included in the Labor, Health and Human Services, and Education, and Related Agencies appropriations bill.

Its most direct and immediate impact would provide urgently needed support for State and local governments for adult protective services (APS), the front line of fighting elder abuse. Of the APS agencies in 30 States responding to a recent national survey of APS programs, 60 percent reported their budgets had been cut an average of 14 percent, while two-thirds reported an average increase of 24 percent in reports of abuse. In the Elder Justice Act, $100 million is authorized for APS programs for fiscal year 2011.

Funding for the Elder Justice Act would also provide much needed support for long-term care ombudsmen at the State and local levels who respond to complaints of abuse and neglect in the Nation's long-term care facilities. The number of very complex cases being referred to long-term care ombudsman has been steadily increasing. As well, there continues to be a very disturbing increase in the frequency and severity of regulatory agency citations for egregious violations by long-term care providers. Ombudsmen are needed now more than ever in nursing homes, board and care facilities, and in assisted living communities.

Elder abuse is a very serious health issue. According to research funded by the National Institute of Justice, almost 11 percent of people ages 60 and older, or 5.7 million, suffered from some form of abuse within the past year alone. Other studies have shown that elder victims of abuse, neglect and exploitation have three times the risk of dying prematurely.

The Elder Justice Act promotes the safety and well-being of older adults and their families. We urge you to fully fund the Elder Justice Act for fiscal year 2011.

PREPARED STATEMENT OF THE ELDERCARE WORKFORCE ALLIANCE

Mr. Chairman and members of the subcommittee: We are writing on behalf of the Eldercare Workforce Alliance (EWA),[1] which is comprised of 28 national organizations united to address the immediate and future workforce crisis in caring for an aging America. As the Subcommittee begins consideration of funding for programs in fiscal year 2011, the Alliance asks that you consider $68,723,162 in funding for the geriatrics health professions and direct-care worker training programs that are authorized under titles VII and VIII of the Public Health Service Act as follows:

—$49,697,421 million for Title VII Geriatrics Health Professions Programs;

—$3,333,333 million for direct care workforce training; and

—$15,692,408 million for Title VIII Comprehensive Geriatric Education Programs.

These programs are integral to ensuring that America's healthcare workforce is prepared to care for our rapidly expanding population of older adults.

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[1] The positions of the Eldercare Workforce reflect a consensus of 75 percent of its members. This testimony reflects the consensus of the Alliance and does not necessarily represent the position of individual Alliance member organizations.

The first of the baby boomers will begin to turn 65 in 2011. Within 20 years, 1 in 5 Americans will be older than 65 and 20 percent of those Americans will have one or more chronic conditions. Yet there is a growing shortage of clinicians with special training in geriatrics and an even greater shortage of the geriatrics faculty needed to train the entire workforce.

In 2008, the Institute of Medicine issued a ground-breaking report, Retooling for an Aging America: Building the Health Care Workforce that spotlighted these shortages and their impact on care. The report called for an expansion of geriatrics faculty development awards to include other disciplines of the interdisciplinary team, increased training for the direct-care workforce, and other efforts to create a healthcare workforce that is competent to care for older adults. The Eldercare Workforce Alliance was established to ensure that the IOM recommendations are heard.

The enactment of the Patient Protection and Affordable Care Act (PPACA) was a historic moment for healthcare in this country. The Act makes important strides toward addressing the severe and growing shortages of healthcare providers with the skills and training to meet the unique healthcare needs of our Nation's growing aging population.

The Act includes provisions championed by Senator Kohl (D-WI) and Representative Schakowsky (D-IL) from their legislation, the Retooling for an Aging America Act (S. 245 and H.R. 468). These provisions implement key recommendations of the IOM report to enhance existing and establish new geriatrics programs in an effort to build the capacity of the healthcare workforce needed to care for older adults.

While we very much appreciate the funding for the Title VII Geriatrics Health Professions programs that President Obama included in his fiscal year 2011 budget, the current request does not reflect the full amount of funding needed to advance the geriatrics workforce priorities established under the PPACA.

We urge you to fund the geriatrics training programs adequately in fiscal year 2011 so that we can immediately begin to realize the healthcare workforce goals set forth in health reform. Specifically, we request $68,723,162 in funding for the following programs under titles VII and VIII of the Public Health Service Act:

Title VII Geriatrics Health Professions—Appropriations Request: $49,697,421

The Title VII Geriatrics Health Professions Programs, administered by the Health Resources and Services Administration (HRSA), are a highly effective investment in ensuring that older adults receive high quality healthcare now and in the future. These programs—the Geriatric Academic Career Awards (GACAs), the Geriatric Education Center (GEC) program, and geriatric faculty fellowships—are the only Federal programs that: (1) seek to increase the number of faculty with geriatrics expertise in a variety of disciplines; and (2) offer critically important training to the entire healthcare workforce focused on improving the quality of care we offer to America's elders. Together, they improve the diversity of the healthcare workforce and recruit and retain healthcare professionals in medically underserved areas. Furthermore, title VII funding for geriatrics training address the crisis created by the severe and growing shortage of geriatrics health professionals in the United States.

—*Geriatric Academic Career Awards (GACA)*.—Under health reform, eligibility for these awards has been expanded to include a number of new disciplines in addition to physicians. Disciplines now eligible for the Award include faculty from dentistry, nursing, pharmacy, psychology, social work, and other allied disciplines as determined by the Secretary. HRSA is moving immediately to implement the expansion of the program, which will undoubtedly increase the demand for these awards. EWA advocated for this expansion and we now want to ensure that there is adequate funding to meet the increased demand given the greater number of disciplines that will be participating. This program currently funds 77 GAC Awardees and we are requesting fiscal year 2011 funding for 250 awards.

—*Geriatric Education Centers (GEC)*.—Under health reform, Congress has approved a supplemental grant award program that will train additional faculty through a mini-fellowship program and requires that those faculty provide training to family caregivers and direct care workers. Our funding request includes support for the core work of 48 GECs and for the 24 GECs that would be funded to undertake this work though the supplemental grants program.

—*Geriatric Training Program for Physicians, Dentists, and Behavioral and Mental Health Professions*.—This program supports training additional faculty in medicine, dentistry, and behavioral and mental health so that they have the expertise, skills and knowledge to teach geriatrics and gerontology to the next generation of health professionals in their disciplines. Our funding request includes support for 10 institutions to continue this important faculty development program.

—*Geriatric Career Incentive Awards Program*.—Under health reform, Congress has authorized grants to foster greater interest among a variety of health professionals in entering the field of geriatrics, long-term care, and chronic care management. Our funding request includes support for implementation of this new program.

Title VII Direct-Care Worker Training Program—Appropriations Request: $3,333,333

Direct-care workers help older people carry out the basic activities of daily living and are critical to ensuring an adequate geriatrics workforce. Experts estimate that the United States will need to fill one million new direct care positions within this decade.

—*Training Opportunities for Direct Care Workers*.—Under health reform, Congress has approved a program, administered by HHS, that will offer advanced training opportunities for direct care workers. These opportunities are critical to the overall success of healthcare reform. Our funding request includes support for the Department of Labor to establish this unique grants-program and support community colleges as they look to increase the geriatrics knowledge and expertise of this workforce.

Title VIII Geriatrics Nursing Workforce Development Programs—Appropriations Request: $15,692,408

These programs, administered by the Health Resources and Service Administration are the primary source of Federal funding for advanced education nursing, workforce diversity, nursing faculty loan programs, nurse education, practice and retention, comprehensive geriatric education, loan repayment, and scholarship. In 2008, more than 51,657 nurses and nursing students were supported through these programs.

—*Comprehensive Geriatric Education Program*.—This program supports additional training for nurses who care for the elderly; development and dissemination of curricula relating to geriatric care; and training of faculty in geriatrics. It also provides continuing education for nurses practicing in geriatrics. Our funding request includes ongoing support for this critical program.

—*Traineeships for Advanced Practice Nurses*.—Under health reform, the Comprehensive Geriatric Education Program is being expanded to include advanced practice nurses who are pursuing long-term care, geropsychiatric nursing or other nursing areas that specialize in care of elderly. Our funding request includes funds that would offer 200 traineeships to nurses under this newly implemented program.

Without additional funds in these programs, we will fail to ensure that America's healthcare workforce will be prepared to care for older Americans. We understand that the Committee faces difficult budget decisions. However, we strongly believe that by investing in these programs, which create geriatrics faculty and offer the training that is needed to ensure a competent workforce, we will be delivering better care to America's seniors. Healthcare dollars will be saved from better healthcare coordination and health outcomes, and the workforce will grow as more people are trained, recruited, and retained in the field of geriatrics.

On behalf of all the members of the Eldercare Workforce Alliance, we commend you on your past support for geriatric workforce programs and ask that you join us in expanding the geriatrics workforce at this critical time—for all older Americans deserve quality of care, now and in the future.

Thank you for your consideration.

Prepared Statement of the Federation of Associations in Behavioral and Brain Sciences

Thank you for the opportunity to provide testimony in support of NIH-funded research. The Federation of Associations in Behavioral and Brain Sciences (FABBS) represents 22 scientific societies with an interest in promoting human potential and well-being by advancing the sciences of mind, brain, and behavior. Research covering the spectrum from genes and molecules, to the brain and mind, and to behavior, social relationships, culture and the environment are necessary to provide a full understanding of health and disease.

NIH is supporting research that will lead to ground-breaking discoveries that will improve health and save lives. An essential part of the overall research portfolio is research on the mind, brain, and behavior. Basic and applied research that examines how the mind functions, its relation to behavior and society, and its underlying biology are critically important in understanding, preventing, and treating disease.

Important transformations are occurring in science. Scientists often work at different levels of analysis by examining, for example, the impact of genes on health or alternatively, the influence of culture on health. Both are necessary to address central questions about health and illness. Increasingly, however, scientists are also exploring the margins and bringing to bear multiple disciplines, tools, technologies, and approaches to inform their work. All are necessary if we are to truly understand the human condition and, in turn, enhance human health, potential, and productivity.

The Role of Emotions, Cognitions, and Environment in Health and Illness

NIH is supporting the best research both within and across disciplines to better understand the contributors to illness and disease. In one program of research, investigators are attempting to understand the mechanisms—neural, hormonal, cellular, genetic—by which loneliness gets under the skin to affect health, and importantly, how the mind can modulate these health outcomes. Humans are social beings and spend about 80 percent of their time, on average, with other people. Much research has shown that people who are socially isolated, or perceive that they are socially isolated, have poorer health outcomes. Specifically, loneliness has been associated with increased duration and extent of illnesses ranging from the common cold to depression to heart disease. The affected factors contributing to these effects include diminished immune system responses, elevated blood pressure, and even changes in gene expression. This new field of social neuroscience is illuminating how the social environment affects cognition, emotion, personality processes, brain, biology, and health.

Research in this area suggests that the risks associated with developing heart disease that are posed by social isolation may be as high as those posed by high cholesterol, high blood pressure, and even smoking. Research has also shown that perceptions of being alone may be more harmful to health than actually being alone. By understanding the mechanisms by which social networks, mental processes, and biology are linked, efforts can be made to translate this work more readily into clinical contexts.

NIH is also supporting highly innovative research to better understand emotions, since emotional states are central to mental and physical health. With funding from the NIH Director's Pioneer Award, one investigator is examining the complex mental and physical processes in emotions. What is the physiological state giving rise to an emotion, and how does the mind make meaning of the physical state? How does the mind control emotions, and what role does context play in emotions? Simply put, emotions may not be simple reflexes that turn on parts of the brain, but are likely much more complex. Emotional disturbances exact a huge toll on patients, and this research has the potential to transform our understanding of a broad area of science.

Complex medical problems require approaches that draw upon a range of scientific areas to address health challenges. These research programs illustrate some of the exciting new work in the mind, brain, and behavioral sciences funded by NIH.

The Importance of Fundamental Research at NIH

NIH investments in basic research are a critical part of the overall research portfolio at NIH. A basic understanding of how cells and genes function is a necessary building block. The same is true for fundamental research in the mind, brain, behavior sciences. As Dr. Collins has noted, NIH's mission is "science in pursuit of fundamental knowledge about the nature and behavior of living systems and the application of that knowledge to extend healthy life and to reduce the burdens of illness and disability."

We commend NIH for its leadership in developing research initiatives that will build a base of knowledge to inform many public health challenges facing this country—from cancer, heart disease, and HIV to diabetes and childhood obesity. One such initiative, called OPPNET for Opportunity Network, was launched in November 2009 by NIH Director Francis Collins M.D., Ph.D. The new trans-NIH initiative will provide funding for emerging areas in the behavioral and social sciences, similar to the research described above. OPPNET will build upon existing NIH investments to create a body of knowledge about the nature of behavior, the underlying mental and physical processes, and how social factors influence it. As with basic research on genes and molecules, this research is a necessary building block upon which many other advances in science will be possible.

Initiating health-promoting behaviors and maintaining positive changes remain a central question in health research. Behavior has a pervasive impact on health, and despite advances in the science, significant and sustained behavior change remains elusive. Given its importance, NIH is investing in a new cross-NIH and cross-dis-

ciplinary research agenda on the basic science of behavior change. The goal is to "radically move this science forward." Key themes identified by scientists for a new research agenda include integrating the science at multiple levels (i.e., brain, person, and environment) such that behavior changes can be seen at a population level. Also, there is a need to better understand the basic mechanisms of behavior change, examine key opportunities for changing behavior at various points in the lifespan, and to target multiple behaviors at once since unhealthy behaviors can have common underlying processes. The Science of Behavior Change is one of seven new NIH Common Fund initiatives, one in which NIH is pushing science to cross traditional disciplinary and topical boundaries. These basic science initiatives are supported by multiple Institutes across NIH.

Using its modest budget, the Office of Behavioral and Social Sciences Research (OBSSR), created by Congress in 1993, continues to play a key role in coordinating and facilitating initiatives across the Institutes. In addition, OBSSR identifies new and promising opportunities for the behavioral and social sciences to help advance NIH's mission. Projects underway or in the pipeline include improving our knowledge of the interplay among behavior, environmental factors (particularly social environment), and genomic/epigenetic factors in health illness; applying complex systems modeling to understanding and ameliorating health disparities; promoting initiatives in health literacy and community-based participatory research in medically underserved populations; and identifying prevention strategies for healthcare that are both grounded in science and cost-effective.

Translating Basic Behavioral and Social Science Discoveries

NIH's investments in basic research will lead to discoveries that can be translated for use in clinical settings. Indeed, NIH is increasingly turning its attention to this process. As NIH Director, Dr. Collins has made this 1 of his 5 priorities. Likewise, behavioral and social scientists at NIH are examining the opportunities and challenges for translating promising findings from these sciences for use in community and clinical care settings. For example, efforts to translate basic behavioral and social science research findings into behavioral interventions to reduce obesity will inform a critical public health challenge facing this country. Translational research will improve our ability to convert basic science discoveries into meaningful community and clinical interventions.

Building Research Capacity in All Sciences

The sciences of mind, brain, and behavior are critical to the health and well-being of our Nation's citizens and, in turn, the Nation's prosperity. The development and progression of many illnesses and health problems such as heart disease, diabetes, and obesity depend on behavior. In addition, advancing knowledge in the behavioral and social sciences is increasingly requiring technical expertise. For example, to understand the workings of the mind, scientists must be able to utilize fMRI, MEG, and EEG tools. Investing in research and training in the behavioral and social sciences, as well as research and training that involve behavioral and social scientists and cross disciplinary boundaries, will address current needs and help prepare the next generation of researchers. The Nation must build capacity in all sciences and at all educational levels to address health needs and remain competitive.

Fiscal Year 2011 Funding Request for NIH

This is an incredible time for science. Investments by Congress in 2009 and a commitment by the administration to science are allowing mid-career and senior scientists to remain at work on complex health problems facing our society, while also attracting a new generation of scientists to become engaged and excited about careers in science. In addition, new discoveries within scientific disciplines and across disciplinary boundaries, are keeping the U.S. competitive. These investments are making a difference back home, both in dollars that support research positions at local universities and in the innovations that improve health throughout our communities.

Investments in science will continue to spur economic growth now and well into the future. We urge this subcommittee to support $35 billion for the National Institutes of Health in the fiscal year 2011 appropriation.

PREPARED STATEMENT OF THE FEDERATION OF AMERICAN SOCIETIES FOR EXPERIMENTAL BIOLOGY

On behalf of the Federation of American Societies for Experimental Biology (FASEB), I respectfully request an appropriation of $37 billion for the National In-

stitutes of Health (NIH) in fiscal year 2011. Sustained and predictable public support for biomedical research is needed to accelerate the pace of discovery, improve the health of our Nation's citizens, and contribute to the economic revitalization of our country.

As a Federation of 23 scientific societies, FASEB represents more than 90,000 life scientists and engineers, making us the largest coalition of biomedical research associations in the United States. FASEB's mission is to advance health and welfare by promoting progress and education in biological and biomedical sciences, including the research funded by NIH, through service to its member societies and collaborative advocacy. FASEB enhances the ability of scientists and engineers to improve—through their research—the health, well-being, and productivity of all people.

Due to the prior Federal investment in NIH, researchers have made critical advances that have saved and improved the lives of millions of Americans and provided doctors with cutting-edge tools to prevent and treat costly and devastating diseases including:

—*Type 2 Diabetes*.—In the United States, about 11 percent of adults—24 million people—have diabetes, and up to 95 percent of them have type 2 diabetes. An additional 57 million overweight adults have glucose levels that are higher than normal but not yet in the diabetic range, a condition that substantially raises the risk of a heart attack or stroke and of developing type 2 diabetes in the next 10 years. Researchers have recently demonstrated, based on a decade of data collection, that intensive lifestyle changes aimed at modest weight loss reduced the rate of developing type 2 diabetes by 34 percent in people at high risk for the disease. Intensive lifestyle changes consisted of lowering fat and calories in the diet and increasing regular physical activity to 150 minutes per week. Participants received training in diet, exercise (most chose walking), and behavior modification skills.

—*Melanoma*.—Drawing on the power of DNA sequencing, NIH researchers identified a new group of genetic mutations involved in the deadliest form of skin cancer, melanoma. This discovery is particularly encouraging because some of the mutations, which were found in nearly one-fifth of melanoma cases, reside in a gene already targeted by a drug approved for certain types of breast cancer. In the United States and many other nations, melanoma is becoming increasingly more common. A major cause of melanoma is thought to be sun exposure; the ultraviolet radiation in sunlight can damage DNA and lead to cancer-causing genetic changes within skin cells.

—*Seasonal and Pandemic Flu*.—Scientists have identified a small family of lab-made proteins that neutralize a broad range of influenza A viruses, including the H1N1 flu viruses, the 1918 pandemic influenza virus, and H5N1 avian virus. These human monoclonal antibodies, identical to infection-fighting proteins derived from the same cell lineage, also were found to protect mice from illness caused by H5N1 and other influenza A viruses. Because large quantities of monoclonal antibodies can be made relatively quickly, these influenza-specific monoclonal antibodies potentially could be used in combination with antiviral drugs to prevent or treat the flu during an influenza outbreak or pandemic.

—*Stroke*.—Scientists have identified a previously unknown connection between two genetic variants and an increased risk of stroke, providing strong evidence for the existence of specific genes that help explain the genetic component of stroke.

—*Heart Disease*.—There has been a 63 percent reduction in deaths from heart disease, and more than 1 million lives are saved each year by therapies developed to prevent heart attack and stroke.

—*Cancer*.—Since 2002, the number of deaths from cancer has decreased steadily. In the past 30 years, survival rates for childhood cancers have increased from less than 50 percent to more than 80 percent.

—*HIV/AIDS*.—This disease has been transformed from an acute, fatal illness to a chronic condition; the prophylactic use of anti-virals prevented almost 350,000 deaths worldwide in 2005. In the United States, deaths from AIDS dropped nearly 70 percent between 1995 and 2000. Life expectancy for those infected with HIV has increased by 10 years.

The completion of the Human Genome Project and the resulting reductions in genome sequencing costs are another example of how the prior investment in research has both dramatically increased the pace of discovery and harnessed the power of technology. Genome sequencing brings us to the threshold of personalized medicine, where knowledge of our own individual genetic makeup can be used to target cures and identify the most effective therapies for individuals. Researchers are at the beginning of a whole new era of pharmacogenomics that will identify methods to tailor

treatments and scientifically match therapies to individual circumstances in ways that were inconceivable a few years ago.

Knowledge of an individual's genetic make-up has already been effective in determining which drugs work best with certain cases of AIDS, breast cancer, acute lymphoblastic leukemia, and colon cancer. The number of new research proposals is expected to expand dramatically as researchers exploit this exciting line of inquiry, yet continued progress toward that goal depends on sustained and predictable funding support for the NIH.

Sustainable Budget Growth Will Maximize the Return on Investment

Additional funding is needed to fully develop the knowledge we have gathered to date and to apply that knowledge in clinical settings. The research engine needs a predictable, sustained investment in science to maximize our return on investment. The discovery process—while producing tremendous value—often takes a lengthy and unpredictable path. Recent experience has demonstrated how cyclical periods of rapid funding growth followed by periods of stagnation are disruptive to training, careers, long-range projects, and ultimately to scientific progress. In 2011 and beyond, we need to make sure that the total funding available to NIH does not decline and that we can resume a steady, continuous growth that will enable us to complete President Obama's vision of doubling our investment in basic research.

The most painful consequence of failing to continue the robust investment in research will be the delay in relief to those suffering from the burdens of disease. Long-term plans for Federal investment in science facilitate coordination and planning, encourage investments by the private sector, attract new talent, reduce the startup costs of projects, and eliminate the possibility of waste that could result from abrupt termination of valuable scientific investigations.

Prosperity and Quality of Life Are Shaped By Investments in Science

As a Nation, we currently find ourselves confronting a number of unprecedented social and economic challenges, and once again our leaders have turned to research in the quest for solutions to these vexing problems. Funds from the American Recovery and Reinvestment Act (ARRA) have inspired the creative energies of research teams across the Nation. These new resources, coming after many years during which our capacity for research was eroded by flat budgets, are a lifeline for new ideas, research personnel, and progress.

ARRA funding was only appropriated for a 2-year period, and we face a major shortfall when these funds have been spent. Returning to pre-ARRA funding levels presents a frightening prospect for those whose hopes for a brighter future rest with medical research. It will also be a setback for the scientists who have contributed so much of their time and talent to this quest. It is critical that we invest now to sustain the excitement in research, maximize the return on our prior investments, and continue the innovative pipeline of medical and technological advancements that Federal science agencies have always fostered.

Despite the fragile economy, now is not the time to pull back from our historic commitment to investigation and discovery. Our leadership in science and engineering has made us the envy of the world. However, we must nurture our research investment to benefit from the knowledge that we have gained and ensure that continued progress is not curtailed. President Obama has recognized the importance of continuing support for the NIH in his proposed budget for fiscal year 2011.

A half-century of public investment in NIH has dramatically advanced the health and improved the lives of Americans and of people around the globe. Unfortunately, millions of Americans and their families still suffer from the ravages of disease and cannot wait for new treatments, therapies, and prevention strategies. Sustained and predictable public support for biomedical research is needed now more than ever. We recognize that this subcommittee has the especially difficult task of providing funding for a wide range of critical human service programs and thank you for your prior support of the research enterprise. Nonetheless, additional resources are needed to pursue the unprecedented level of scientific opportunities available today and uphold the Nation's role as a leader in medical research. Therefore, FASEB recommends an appropriation of $37 billion for NIH fiscal year 2011.

PREPARED STATEMENT OF THE FRIENDS OF NIAAA

Mr. Chairman and members of the subcommittee: The Friends of the National Institute on Alcohol Abuse and Alcoholism, a coalition of scientific and professional societies, patient groups, and other organizations committed to preventing and treating alcohol use disorders as well as understanding the causes and public health consequences of alcoholism and alcohol use disorders, is pleased to provide testimony

in support of the NIAAA's extraordinary work. The coalition does not receive any Federal funds.

The National Institute on Alcohol Abuse and Alcoholism (NIAAA) is the lead agency for U.S. research on alcohol abuse, alcoholism, and other health and developmental effects of alcohol use. Its mission is to support research, and then translate and disseminate research findings to reduce alcohol-related problems. NIAAA funds 90 percent of all alcohol research in the United States. From fetal alcohol syndrome to alcohol dependence, and from liver cirrhosis to alcohol poisoning, the consequences of alcohol misuse are widespread and costly, and affect individuals of every age, ethnic background, and socioeconomic status. Drinking too early, too fast, too much, and/or too often can lead to acute and chronic consequences for the drinker as well as outcomes affecting the health and well-being of others and society-at-large.

Approximately 18 million Americans meet the criteria for a diagnosis of alcohol dependence (alcoholism) or alcohol use disorders (AUD), and 40 percent of Americans have direct family experience with alcohol use disorders or dependence. Annually, 80,000 deaths are attributable to alcohol, as are approximately one-third of all fatal car crashes, one-half of all homicides, one-third of all suicides, and one-third of all hospital admissions. In fact, excessive alcohol consumption is the third leading preventable cause of death in the United States. AUDs cost the Nation $235 billion annually, nearly 80 percent more than the costs related to all other addictive drugs.

Because of the critical importance of alcohol research for the health and economy of our Nation, we write to you today to request your support for a modest 2.7 percent increase for NIAAA in the fiscal 2011 Labor, Health and Human Services, and Education, and Related Agencies appropriations bill. That would bring total funding for NIAAA in fiscal year 2011 to $474,649,000. This work deserves continuing, strong support from Congress. The following is a list of key new NIAAA initiatives that could be pursued with additional investment, and a short summary of significant NIAAA accomplishments and successes.

NIAAA initiatives for fiscal year 2011:

—NIAAA will continue to support research on the mechanisms by which alcohol causes damage to, as well as pharmacologic agents that lessen alcohol's adverse effects on, the developing embryo and fetus. Resources will also be directed towards the development of biomarkers, which could be used to detect alcohol exposure in pregnant women.

—New initiatives in fiscal year 2011 will support several broad National Institutes of Health themes, including applying genomics and other high throughput technologies to understand fundamental biology, and to uncover the causes of specific diseases, translating science into new and better treatments and putting science to work for the benefit of healthcare reform.

—NIAAA will support the continuing development of a screening guide for use with children and adolescents to assess for risk of alcohol use and alcohol use disorders. In addition, NIAAA is planning a new research initiative on pharmacotherapy for adolescents and young adults with severe alcohol use disorders and major co morbidities, as well as behavioral interventions that target young individuals along the continuum of alcohol-related behaviors.

—In fiscal year 2011, NIAAA will continue to promote and disseminate its Web-based booklet Rethinking Drinking. NIAAA is planning a new initiative exploring the effects of community interventions on alcohol related outcomes in young adults. Research has demonstrated that comprehensive community interventions that typically involve multiple levels of city government, environmental policy change and community involvement, among other factors, may reduce alcohol-related problems among adolescents and young adults, including college students.

—NIAAA is planning a new initiative on developing effective pharmacological and behavioral treatments for individuals who have alcohol use disorders and co-existing other drug, psychiatric, and/or physical disorders. NIAAA will also support studies aimed at risk reduction, early identification and diagnosis of harmful alcohol use and personalized treatment. Additional funds will be committed for research on the underlying mechanisms of alcohol-induced liver injury and the identification of biomarkers of alcohol-induced tissue injury. These studies are expected to reveal new therapeutic targets, inform strategies for preventing tissue injury, facilitate early diagnosis, and improve the prognosis for alcohol-related liver disease.

A Partial List of Important NIAAA Innovations

Advancing the Understanding of the Mechanisms and Consequences of Prenatal Alcohol Exposure

The Friends of NIAAA commends the Institute for its research to enhance our ability for early identification of and interventions with prenatal alcohol affected children; exploring nutritional and pharmacological agents that could lessen alcohol's adverse effects on the developing embryo/fetus; and research on how alcohol disrupts normal embryonic and fetal development. Research has shown that the severity of alcohol-related effects on the developing fetus is affected by the timing and level of maternal alcohol consumption, maternal nutritional status, and maternal hormones. One of the key challenges facing clinicians is the ability to recognize women who are drinking in pregnancy and the infant who has been exposed prenatally to alcohol during pregnancy. Recently there have been advances in methodologies for the measurement of nonoxidative metabolites of alcohol providing new opportunities for monitoring alcohol exposure.

Understanding the Effects of Alcohol use on the Developing Body and Brain, and the Interplay of Development, Genes and Environment on Adolescent Alcohol use

As adolescence (ages 0–17) is the time of life during which drinking, binge drinking (drinking five or more drinks on one occasion), and heavy drinking (binge drinking five or more times in the past 30 days) all ramp up dramatically, the Friends of NIAAA is pleased that the Institute is vigorously focused on these concerns. Given that alcohol use is pervasive among adolescents and the association between early initiation and future alcohol problems, NIAAA is developing empirically based guidelines and recommendations for screening children and adolescents to identify risk for alcohol use especially for younger children; alcohol use, and alcohol use disorders. NIAAA is also supporting studies to integrate intervention for underage alcohol use into primary healthcare. Research has shown that during adolescence, the brain undergoes significant growth and remodeling. This finding, coupled with the results of multiple studies showing a strong association between early initiation of alcohol use and future alcohol dependence, raises concerns about alcohol's effects on the developing adolescent brain.

Specifically, the issues are whether persistent changes in neural and behavioral function result from adolescent alcohol use, and whether processes that confer adaptability of the adolescent brain to its environment also make it more vulnerable to alcohol-induced changes in structure and/or function, especially in terms of setting it up for future dependence. Complementing NIAAA's ongoing pilot studies with humans to determine if alcohol can disrupt, co-opt and/or alter normal developmental processes in the brain, NIAAA is also planning an initiative to study persistent alcohol-induced changes in the brain in animal models.

Pioneering Risk Assessment, Universal and Selective Prevention, and Early Intervention and Treatment for Young Adults

Given the pervasiveness of high-risk drinking and early alcohol dependence occurring among young adults, efforts to alter drinking trajectories at this stage have life-changing potential and can significantly reduce the burden of illness resulting from alcohol-related problems. Recent research has demonstrated that college-aged individuals respond well to Web-based screening and self-change programs, resulting in reductions in adverse alcohol-related consequences. Making alcohol screening and brief intervention a routine procedure in primary care and other settings is a high-priority of NIAAA.

Exploring Pharmacologic Interventions for Alcohol-use Disorders

In addition to its role in alcohol dependence, excessive alcohol consumption can have toxic effects on virtually every organ system in the body resulting in liver and heart disease, pancreatitis, fetal abnormalities, brain damage, and an increased risk for esophageal and liver cancer. Liver disease in particular claims 37,000 lives annually, about 40 percent of which are due to excessive alcohol use. Currently the only treatment for liver cirrhosis—the end stage of alcoholic liver disease—is liver transplantation which is impacted by limited availability of matching organs, high medical costs, and increased risk for future health complications. Intervening early in the disease process continues to be an important priority of NIAAA, and research is moving us closer to developing medications that can slow or even reverse disease progression and/or mitigate health consequences. For example, preliminary research has shown that administration of the dietary supplement S-adenosylmethionine (SAMe) may reverse disease symptoms in individuals with early stage liver disease and pre-empt cirrhosis. A phase 2 clinical trial testing the effects of this compound is currently underway. NIAAA and NIDDK are co-funding a project focused on de-

veloping small molecules to reverse alcoholic liver fibrosis, as well as liver damage resulting from obesity and metabolic syndromes. Animal studies evaluating prenatal and early postnatal supplementation with the nutrient choline, a molecule important to the structure and function of cell membranes, have shown reduced severity of certain behavioral and physical effects of prenatal alcohol exposure. For alcohol dependence, NIAAA is moving medications that promote abstinence and/or reduction in heavy drinking through the medications development pipeline via its early phase 2 clinical trials program. These include trials for quetiapine, a mood stabilizing drug, completed in late fiscal year 2009 and for levetiracetam, an antiepileptic medication, initiated in late fiscal year 2009.

Improving the Identification of Mechanisms by Which Alcohol and its Metabolites Cause Tissue and Organ Pathologies, and the Development of Treatment Strategies for Alcohol Dependence Tailored to Specific Populations and for Individuals With Co-Existing Psychiatric and Medical Disorders

Over the past four decades, numerous scientific advances have been made in identifying the pathologic effects of alcohol and its metabolic products on the brain, liver, heart, pancreas, and immune and endocrine systems. Recently, NIAAA has taken a systems biology approach, investigating how perturbation of one organ system by alcohol influences other organ systems, leading to a cascade of effects throughout the body. Alcohol consumption sets in motion a number of signaling processes which operate directly and indirectly on multiple systems in the body. For example, one mechanism by which alcohol negatively impacts the liver and brain is through signaling molecules released from the gut. The gut normally contains bacteria whose outer membranes consist primarily of large amounts of molecules known as lipopolyscaccharides (LPS). Alcohol increases gut "leakiness" allowing LPS to travel throughout the body, resulting in inflammation in both the brain and liver. Liver inflammation then triggers the release of cytokines, signaling molecules that promote further inflammation in the brain. Gut "leakiness" may also be the mechanism by which alcohol disrupts immune function. Another target of alcohol may be the hypothalamic pituitary adrenal axis (HPA axis), a major part of the neuroendocrine system that regulates reactions to stress and many body processes, including digestion, the immune system, mood and emotions, sexuality, and energy storage and expenditure. Considering the human body as a complex network in which perturbations of one organ system alters interactions with other organ systems thereby affecting the functions of each, will enable the development of treatments that address the source(s) of alcohol-induced tissue and organ damage.

The Friends of NIAAA commends the National Institute on Alcohol Abuse and Alcoholism for making significant progress in these and many other vital areas of research that are essential to the health and well-being our Nation.

Thank you, Mr. Chairman, and the subcommittee, for your support for the National Institute on Alcohol Abuse and Alcoholism.

PREPARED STATEMENT OF THE FRIENDS OF NICHD

The Friends of the National Institute of Child Health and Human Development (NICHD) is a coalition of more than 100 organizations, representing scientists, physicians, healthcare providers, patients, and parents, concerned with the health and welfare of women, children, families, and people with disabilities. We are pleased to submit testimony to support the extraordinary work of the Eunice Kennedy Shriver National Institute of Child Health and Human Development.

We would like to thank Chairman Harkin, Ranking Member Cochran, and the Congress for its continued support of the National Institutes of Health (NIH) and interest in building on the investments made in predictable and sustained, long-term growth in NIH funding in the fiscal year 2011 budget and beyond. To ensure that progress in basic, translational and clinical research is sustained, the Coalition joins the Ad Hoc Group for Medical Research in supporting a fiscal year 2011 appropriation of at least $35 billion, an increase of $2.6 billion for NIH.

The Coalition has a particular interest in the important research conducted and supported by the NICHD. Since its establishment in 1963, the NICHD has made great strides in meeting the objectives of its broad biomedical and behavioral research mission. The NICHD mission and portfolio includes a focus on women's health and human development, including research on child development, before and after birth; maternal, child, and family health; learning and language development; reproductive biology and population issues; and medical rehabilitation.

Although the NICHD has made significant contributions to the well-being of children, women, and families, much remains to be done. With sufficient resources, the

NICHD could build upon the promising initiatives described in this testimony and produce new insights into human development and solutions to health and developmental problems for the world and for the Nation—including the families living in your districts. For fiscal year 2011, the Friends of NICHD support an appropriation of at least $1.495 billion for NICHD.

New Discoveries

Adding to its strong record of progress over the past 45 years, recent advances by the NICHD have contributed to the health and well-being of our Nation and world. Several highlights are:

Tracking Brain and Behavioral Development.—The NICHD is one of the leading Institutes in the NIH Magnetic Resonance Imaging (MRI) Study of Normal Brain Development. The study tracks brain and behavioral development in 500 healthy children from diverse backgrounds birth to age 18. The latest findings show that children appear to have reached adult levels of performance on basic cognitive and motor skills by age 11 or 12. Long-term, the goal is to link these behavioral data to MRI scans of the children's brains. Together, the two data sets will allow researchers to view how the brain grows and reorganizes itself, and to explore the structural changes. The database will also serve as a reference to better understand what goes wrong in children with genetic disorders, language and learning difficulties, prenatal exposure to alcohol or drugs or other brain injury.

Preterm Birth Risk Factors.—Researchers funded by the NICHD identified DNA variants in mothers and fetuses that appear to increase the risk for preterm labor and delivery. The current findings add to the evidence that individual genetic variation may account for why preterm labor occurs in some pregnancies and not in others. The findings may one day lead to new strategies to identify those at risk for preterm birth, and to ways to reduce the occurrence of preterm birth among those at risk.

Treating Mild Gestational Diabetes Reduces Birth Complications.—NICHD funded researchers found the first conclusive evidence that treating pregnant women who have even the mildest form of gestational diabetes can reduce the risk of common birth complications among infants, as well as blood pressure disorders among mothers. Specifically, women treated for mild gestational diabetes had smaller, leaner babies less likely to be overweight and less likely to experience shoulder dystocia, an emergency condition in which the baby's shoulder becomes lodged inside the mother's body during birth. Treated mothers were also less likely to undergo cesarean delivery, to develop high blood pressure during pregnancy, or to develop pre-eclampsia, a life-threatening complication of pregnancy that can lead to maternal seizures and death.

Future Research Opportunities

Although the studies mentioned above have unquestionably made significant contributions to the well-being of our children and families, there is still much to discover about ways to improve health, learning, and quality of life. Progress in the following research areas can only be achieved with adequate Federal investments.

Severe, Early Adverse Pregnancy Outcomes.—Women with severe, early adverse pregnancy outcome, such as multiple losses, demises, and severe preeclampsia, are at increased risk for long-term chronic health problems, including hypertension, stroke, diabetes, and obesity. Studies have shown that women who have had preeclampsia are more likely to develop chronic hypertension, to die from cardiovascular disease and to require cardiac surgery later in life. In addition, approximately 50 percent of women with gestational diabetes will develop diabetes later in life. Pregnancy can be considered as a window to future health and the immediate postpregnancy period provides a unique opportunity for prevention of chronic diseases later in life. Studies to identify women at risk for long-term morbidity, and to develop strategies to prevent long-term adverse outcomes in these women are urgently needed.

Preterm Birth.—Preterm birth is a serious and growing public health problem that affects more than 500,000 babies each year. It is the leading cause of neonatal death and about half of all premature births have no known cause. A key strategy recommended by the Institute of Medicine and experts convened for the Surgeon General's Conference on the Prevention of Preterm Birth is to create integrated transdisciplinary research centers to build the knowledge base needed for development of effective interventions to prevent prematurity. These new centers would serve as a national resource for investigators to design new research approaches and strategies to address the serious and growing problem of preterm birth.

National Children's Study.—The National Children's Study is the largest and most comprehensive study of children's health and development ever planned in the

United States. Currently, the "vanguard centers" are recruiting pregnant women and more than 150 children have been born into the study. When fully implemented, this study will follow a representative sample of 100,000 children from across the United States from before birth until age 21. The data generated will inform the work of scientists in universities and research organizations, helping them identify precursors to disease and to develop new strategies for prevention and treatment. Identifying the root causes of many childhood diseases and conditions, including preterm birth, asthma, obesity, heart disease, injury and diabetes, will reduce healthcare costs and improve the health of children. The Friends of NICHD thank the subcommittee for funding the NCS through the NIH Office of the Director in fiscal year 2010, and urge the subcommittee to provide $194.4 million for the study in fiscal year 2011.

Newborn Screening Translational Research Network.—The network is designed to improve newborn screening, the care of patients with disorders identified through screening, and deepen understanding of conditions for which screening should be made available. By contributing to our understanding of patients with genetic diseases, this network will accelerate research in diseases related to newborn screening and greatly improve the process by which public health decisions are made about the expansion of newborn screening.

Unraveling Genetic Basis of Autism.—NICHD is capitalizing on advances in genetics research by participating in the Autism Genome Project (AGP), a public-private collaboration involving more than 120 scientists and 50 institutions in 19 countries. The first study to emerge from AGP implicated components of the brain's glutamate chemical messenger system and a previously overlooked site on chromosome 11. Based on 1,168 families with at least 2 affected members, the genome scan also adds to evidence that tiny, rare variations in genes may heighten risk for autism spectrum disorders. The spectrum of disorders collectively known as autism affects as many as one in 150 Americans resulting in impaired thinking processes, emotional and social abilities, and motor control. So far, the only known cause of autism for which there is a verifiable blood test is Fragile X; further research on this disorder would provide understanding of the function of this gene (FMR1) as well as others that cause autism. With NIH support, the AGP is pursuing studies to identify specific genes and gene variants that contribute to vulnerability to autism. These include explorations of interactions of genes with other genes and with environmental factors, and laboratory research aimed at understanding how candidate susceptibility genes might work in the brain to produce the disorders.

Education and School Readiness Research.—NICHD continues to build its portfolio of research on how children acquire the emotional, social and academic skills necessary to succeed in school and beyond; however more work is needed in four particular areas: (1) Neurological processing disorders—how they impact learning and literacy, particularly in reading comprehension for grades 4–8, so that early intervention may improve learning and academic outcomes for young adults; (2) learning delays and language development—how to distinguish if they are caused by language barriers versus possible learning disabilities in school-age children; (3) math disabilities—where they reside in the brain, how they impact learning over time and what we can do to remediate and intervene with those who have them; and (4) school readiness—how to develop better measures of the social and emotional bases which will inform our early education programs. The combination of study in these four areas will help inform the Nation's education and innovation agenda to support and grow a competitive workforce.

Family Research.—As the family is the primary context for child development, the NICHD has played a significant role in examining the dramatic changes in family structure in the United States over the last 40 years. Scientists are currently focused on developing new study designs to better understand the family processes that transcend the traditional home environment, including the role of absent fathers, the contributions of grandparents and others outside the immediate family. Recognizing that so many parents are also in the workforce, NICHD is moving forward on its Work, Family, Health and Well-Being Initiative. The long-range goals of the initiative are to identify workplace interventions that can improve health by improving the ability of the worker to successfully meet both work and family demands.

Intellectual and Developmental Disabilities.—Ongoing support of the research in mental retardation and developmental disabilities being undertaken at the Eunice Kennedy Shriver Intellectual and Developmental Disabilities Research Centers (IDDRC) is essential. Many disorders are being studied by the IDDRC such as Down syndrome, Fragile X syndrome, Rett syndrome, and autism. Genetic and biomedical advances over the past few years hold the promise for understanding the threats

to healthy and full development and ultimately to the prevention and amelioration of the impact of many disabilities.

Obesity.—NICHD is integrally involved in research into the origins of obesity in childhood. Next to tobacco use, diet and exercise represent the areas in which prevention efforts will have the greatest impact in reducing the socioeconomic and societal burdens of the obesity epidemic. More developmental research needs to be focused on understanding the interplay among behavioral, social and physical environment, and biological factors that lead to obesity so that effective and appropriate interventions can be developed earlier in the life cycle.

Rehabilitation Research.—The NICHD houses the National Center for Medical Rehabilitation Research (NCMRR). This Center fosters the development of scientific knowledge needed to enhance the health, productivity, independence, and quality-of-life of people with disabilities. A primary goal of Center-supported research is to bring the health related problems of people with disabilities to the attention of the best scientists in order to capitalize upon the myriad advances occurring in the biological, behavioral, and engineering sciences.

SIDS.—Though the NICHD has made remarkable progress in reducing the rate of SIDS, SIDS remains the leading cause of death in infants from 1 month of age to 1 year. More research and public education is needed to address the large number of babies dying of asphyxiation and suffocation in unsafe adult bed-sharing situations. Additional support is also needed to expand the work of NICHD's Stillbirth Collaborative Research Network, where for the first time we are finding answers that may ultimately lead to prevention of many of these 26,000 devastating losses, many of which are late term and yet unexplained.

Conclusion

The potential contributions of the Institute to the lives of countless individuals are limited only by the resources available for carrying out its vital mission. This is why the Friends of NICHD ask you to provide an appropriation of $1.495 billion to the Institute. Our Nation and the world will continue to benefit from your promise to improving health and scientific advancement long after the doubling effort is over.

We thank you, Mr. Chairman, and the subcommittee, for your support of the Eunice Kennedy Shriver National Institute of Child Health and Human Development, and thank you for the opportunity to share these comments.

PREPARED STATEMENT OF THE FRIENDS OF THE NATIONAL INSTITUTE ON AGING

Chairman Harkin and members of the subcommittee, thank you for the opportunity to provide testimony regarding the crucial role of the National Institute on Aging (NIA) within the National Institutes of Health (NIH) and the need for increased appropriations in the fiscal year 2011 budget to ensure sustained, long-term growth in aging research.

The Friends of the NIA is a coalition of 50 academic, patient-centered and not-for-profit organizations that conduct, fund, or advocate for scientific endeavors to improve the health and quality of life for Americans as we age. As a coalition, we support the continuation and expansion of NIA research activities and seek to raise awareness about important scientific progress in the area of aging research currently guided by NIA.

My testimony today demonstrates the relevance of the work of the NIA to each and every American, as well as opportunities for future progress that are dependent on congressional action to build upon the unprecedented $10.4 billion in the American Recovery and Reinvestment Act (ARRA) for NIH research and training activities in fiscal year 2011.

The Relevance of the Work of the NIA

NIH is the primary funder of biomedical research in this country and as such, NIA leads the Federal effort to advance biomedical and behavioral research in aging. NIA leads the national scientific effort to understand the nature of aging in order to promote the health and well-being of older adults. NIA's mission is threefold: (1) Support and conduct genetic, biological, clinical, behavioral, social, and economic research related to the aging process, diseases and conditions associated with aging, and other special problems and needs of older Americans; (2) Foster the development of research- and clinician-scientists for research on aging; and (3) Communicate information about aging and advances in research on aging with the scientific community, healthcare providers, and the public. The NIA carries out this mission by supporting both extramural research at universities and medical centers across the United States and vibrant intramural research at the NIA's laboratories

in Baltimore and Bethesda, Maryland. The work of the NIA focuses not only on diseases and conditions of aging but also on the processes underlying the aging process itself and as such, the research conducted by NIA-funded scientists has relevance for each and every person in America, regardless of age.

Forward Momentum: ARRA Funding and the NIA

The bolus of funding provided by ARRA has made it possible for NIA-funded researchers to make progress towards key research questions related to health and aging. As a result of ARRA funding, NIA-funded scientists have been able to intensify their research efforts in areas of critical importance to aging and health, including but not limited to the following:

Understanding how Alzheimer's Disease develops and progresses.	Investigating the ways in which Alzheimer's Disease (AD) and vascular disease may adversely affect one other in the hopes of identifying strategies for preventing dementia.[1]
	Examining the ways that energy metabolism influences brain aging by looking for correlations among brain imaging patterns, dementia, and metabolic measures in aging and in people with AD.[2]
Identifying genetic and other risk factors for Alzheimer's Disease.	Using genome-wide association studies to compare the genomes of individuals with and without AD to identify potential genetic risk.[3]
Seeking new ways of screening for and detecting Alzheimer's Disease.	Identifying best practices for cerebrospinal fluid sample collection and attempting to identify AD biomarkers in cerebrospinal fluid before the onset of symptoms.[4]
	Comparing the effectiveness of brain imaging and blood biomarkers to diagnose AD.[5]
Discovering possible prevention and treatment strategies for Alzheimer's Disease.	Elucidating the long-term effect of naproxen and other NSAIDS on cognitive health by following participants in the Alzheimer's Disease Anti-inflammatory Prevention Trial (ADAPT) to.[6]
	Determining whether compounds that manipulate the histone code may have therapeutic value for AD and other neurological disorders.[7]
Enhancing neuroimaging methods and tools	Developing software to simplify the analysis of complex brain-image data relating to the structure and function of the human brain.[8]
	Developing a ''network diagram'' that links genetic information with underlying brain circuitry in the neural systems controlling behavior and emotion to improve our understanding of the connectivity of circuits that are disturbed in neurologic conditions, including mental illness, autism, Parkinson's disease, Alzheimer's disease, and addiction.[9]
Preventing neuroinflammation	Developing a safe and effective vaccine for the treatment of AD that will not cause an inflammatory response in the brain.[10]
Understanding the impact of economic concerns on older adults.	Examining trends in demography, economics, health, and health care of the elderly by evaluating the effects of medical technology on costs and examining changes in survival, health, and well-being among older people over time.[11]
	Examining the financial circumstances of older Americans, including work and retirement behavior, health and functional ability, and policies that influence individual well-being.[12]
Improving the quality of patient care	Evaluating the effectiveness of feeding tubes in the hospital setting to reduce weight loss among older adults with dementia.[13]
	Describing risk factors and long-term consequences of adverse medical events or medical injuries among older adults.[14]

Preparing the next generation of researchers	Recruiting and training doctoral-level students in health services research to prepare them for careers as independent scientists.[15] Recruiting new faculty members to enhance the capacity for transdisciplinary research on aging that examines how social context and the healthcare system interact to impact health outcomes for older adults.[15]

[1] 1 F32 AG031620–01A2—Nozomi Nishimura (NY).
[2] 3 K23 NS058252–04S1—Jeffrey Burns (KS).
[3] 2 R01 AG016208–10A2—Alison Goate (MO); 1 RC2AG036528–01—Gerard Schellenberger (PA); 1 RC2 AG036650–01—Denis A. Evans, Jill R. Murrell, and Philip De Jager (IL).
[4] 1 RC2 NS069502–01—Howard Schulman (NC); 1 RC1 AG035654–01—David Holtzman (MO).
[5] 1 RC1 AG036208–01—Orly Lazarov (IL).
[6] 2 U01 AG015477–06A2—John Breitner (WA).
[7] 1 RC1 AG035711–01—Li-Huei Tsai (MA).
[8] 2 R01 AG013743–13A1—Edward Herskovits. (PA).
[9] 1 RC1 NS069152–01—Julie R. Korenberg (contact), Tolga Tasdizen (UT).
[10] 3 R01 AG20159–08S1—Cynthia Lemere (MA).
[11] 3 P30 AG017253–10S1—Alan Garber (CA).
[12] 3 P30 AG012810–16S1 and 16S2—David A. Wise (MA).
[13] 1 RC1 AG036418–01—Joan Teno (RI).
[14] 1 R21 AG031983–01A1—Mary Carter (WV).
[15] 2 T32 AG023482–06—Vincent Mor (RI).
[16] 1 P30 AG036459–01—David Meltzer (IL).

With a sustained investment in the NIH funding base, these and other NIA-funded projects will yield breakthroughs in the screening, prevention and treatment of a host of age-associated diseases and conditions. With the fiscal year 2011 budget, Congress has the opportunity to increase the forward momentum of NIA-funded scientists towards achieving these much-needed breakthroughs.

The Challenges and Opportunities Ahead

A key challenge is maintaining the positive momentum set into motion by Congress through ARRA. Between fiscal year 2003 and fiscal year 2009, scientists saw a series of nominal increases and cuts that amounted to flat funding for NIH and a 12.9 percent reduction in constant dollars for the NIA. Six years of flat funding for the NIH took a toll on scientific progress in America—projects were sidelined, promising grants went unfunded, and countless life-saving discoveries went undiscovered. With the infusion of funding from ARRA NIH researchers are regaining some of the ground lost during that time period. NIA is poised to accelerate the scientific discoveries that we as a nation are counting on America's leading researchers to achieve. With millions of Americans facing the loss of their functional abilities, their independence, and their lives to diseases like Alzheimer's Disease, Parkinson's Disease, Amyotrophic Lateral Sclerosis, and Frontotemporal Dementia, there is a pressing need for a robust and sustained investment in the work of NIH and by extension, NIA. In every community in America, healthcare providers depend upon NIA-funded discoveries to help their patients and caregivers lead healthier and more independent lives. In those same communities across America, parents are hoping NIA-funded discoveries will help their children have a brighter future, free from the diseases and conditions of aging that plague our Nation today.

We do not yet have the knowledge needed to predict, pre-empt, and prevent the broad spectrum of diseases and conditions associated with aging. We do not yet have the knowledge needed about disease processes to understand how best to prevent, diagnose, and treat diseases and conditions of aging, nor do we have the knowledge needed about the complex relationships between biology, genetics, and behavioral and social factors related to aging. We do not yet have a sufficient pool of new investigators entering the field of aging research. Bold, visionary, and sustainable investments in the NIA will make it possible to achieve measurable gains in these areas sooner rather than later.

The member groups of the Friends of the National Institute of Aging respectfully urge this subcommittee to provide sustained support for biomedical and behavioral research by increasing NIA funding by a minimum of 7 percent in fiscal year 2011 to correspond with the overall funding increase to NIH. NIA and the health-enhancing and life-saving biomedical, behavioral and social research it supports require bold, visionary, and sustainable funding to succeed in transforming the health of our Nation. Americans depend upon the NIA to facilitate the acceleration of discoveries to prevent, treat, and potentially cure a wide range of debilitating age-related diseases and conditions. NIA-supported scientists are poised to make breakthroughs in the prevention and treatment of a host of age-associated diseases and conditions, but in order to achieve these powerful results, meaningful investments in aging research must be made now.

While the Friends of the NIA recognizes that there is enormous competition for congressional appropriations, we believe that an increase in funding for the NIH will yield unprecedented returns in terms of accelerating the rate of basic discovery and stimulating the rapid development of interventions with the potential to offer significant public health benefits for our aging population.

Mr. Chairman, the Friends of the NIA thanks you for this opportunity to outline the challenges and opportunities that lie ahead as you consider the fiscal year 2011 appropriations for the NIH. We would be happy to furnish additional information upon request.

PREPARED STATEMENT OF THE FSH SOCIETY, INC.

Mr. Chairman, it is a great pleasure to submit this testimony to you today.

My name is Daniel Paul Perez, of Bedford, Massachusetts, and I am testifying today as President & CEO of the FSH Society, Inc. (facioscapulohumeral muscular dystrophy) and as an individual who has this common and most prevalent form of muscular dystrophy. My testimony is about the profound and devastating effects of a disease known as facioscapulohumeral muscular dystrophy which is also known as facioscapulohumeral muscular disease, FSH muscular dystrophy (FSHD) and the urgent need for increased National institutes of Health (NIH) funding for research on this disorder. For men, women, and children the major consequence of inheriting the most prevalent form of muscular dystrophy, FSHD, is a lifelong progressive and severe loss of all skeletal muscles. FSHD is a terrible, crippling, and life-shortening disease. No one is immune, it is genetically and spontaneously (by mutation) transmitted to children and it affects entire family constellations.

FSHD is The Most Prevalent Form of Muscular Dystrophy

It is a fact that FSHD is published in the scientific literature as the most prevalent muscular dystrophy in the world. The incidence of FSHD is conservatively estimated to be 1 in 14,000. The prevalence of the disease, those living with the disease, ranges to 2 or 3 times as many as that number based on our increasing experiences with the disease and more available and accurate genetic diagnostic tests.

The French Government research agency, INSERM (Insitut National de la Santé et de la Recherche Medicale) is comparable to the U.S. National Institutes of Health (NIH), and it recently published prevalence data for hundreds of diseases in Europe. Notable is the "Orphanet Series" reports covering topics relevant to all rare diseases. The "Prevalence or reported number of published cases listed in alphabetical order of disease" November 2008—Issue 10 report can be found at Internet Web site (http://www.orpha.net/orphacom/cahiers/docs/GB/Prevalence_of_rare_diseases_by_alphabetical_list.pdf). This publication contains new epidemiological data and modifications to existing data for which new information has been made available. This new information ranks facioscapulohumeral muscular dystrophy (FSHD) as the most prevalent muscular dystrophy followed by Duchenne (DMD) and Becker Muscular dystrophy (BMD) and then in turn myotonic dystrophy (DM). FSHD is historically presented as the third most prevalent muscular dystrophy in the Muscular Dystrophy Community Assistance, Research and Education Amendments of 2001 and 2008 (the MD–CARE Act). This new data ranks FSHD as the first and most prevalent form of muscular dystrophy.

Estimated prevalence	(Cases/100,000)
Facioscapulohumeral muscular dystrophy (FSHD)	7/100,000
Duchenne (DMD) and Becker Muscular dystrophy (BMD)	5/100,000
Steinert myotonic dystrophy (DM)	4.5/100,000

NIH Muscular Dystrophy Funding Has Quadrupled Since Inception of the MD CARE Act

Figures from the online RCDC RePORT and the NIH Appropriations History for Muscular Dystrophy report historically provided by NIH/OD Budget Office & NIH OCPL show that from the inception of the MD CARE Act 2001, funding has nearly quadrupled from $21 million to $83 million in fiscal year 2009 for muscular dystrophy.

NIH Funding of FSHD has Remained Level Since the Inception of the MD CARE Act

In fiscal year 2009, FSHD was 6.02 percent of the total muscular dystrophy funding ($5 million/$83 million). The previous year FSHD was 5.3 percent of the total

muscular dystrophy funding ($3 million/$56 million). FSHD funding has simply kept its ratio in the NIH funding portfolio and has not grown in the last 8 years.

NIH FSHD FUNDING ANMD APPROPRIATIONS

[Dollars in millions]

Fiscal year	FSHD research	FSHD percentage of MD
2002	$1.3	5
2003	1.5	4
2004	2.2	6
2005	2	5
2006	1.7	4
2007	3	5
2008	3	5
2009	5	6

Sources: NIH/OD Budget Office, NIH OCPL, and NIH RCDC RePORT.

We highly commend the Director of the NIH on the ease of use and the accuracy of the Research Portfolio Online Reporting Tool (RePORT) report "Estimates of Funding for Various Research, Condition, and Disease Categories (RCDC)" with respect to reporting projects on facioscapulohumeral muscular dystrophy.

FSHD: The Most Prevalent Form of Muscular Dystrophy is Drastically Underfunded at NIH

Now, FSHD is published as the most prevalent muscular dystrophy, and given the extraordinary interest of the scientific and clinical communities in its unique disease mechanism, it defies credibility that it still remains the most prevalent and one of the most underfunded dystrophies at the NIH and in the Federal research agency system (CDC, DOD, and FDA).

In 2009, the most prevalent muscular dystrophy, FSHD, received $5 million from NIH. In 2009, the second most prevalent dystrophy, Duchenne (DMD) and Becker Muscular dystrophy (BMD) type, received $33 million from NIH. In 2009, the third most prevalent dystrophy myotonic dystrophy (DM), received $13 million from NIH.

The MD CARE Act 2008, mandates the NIH Director to intensify efforts and research in the muscular dystrophies, including FSHD, across the entire NIH. It should be very concerning that in the last 8 years muscular dystrophy has quadrupled to $83 million and that FSHD has remained on average at 5 percent of the NIH muscular dystrophy portfolio. FSHD is certainly still far behind when we look at the breadth of research coverage NIH-wide.

It is now time to examine why FSHD receives such a disproportional and inverse level of funding despite its equal burden of disease and highest prevalence. It is crystal clear, if not completely black and white, that we are not achieving the goals of parity in funding as expected by the mandates set forth in the MD CARE Acts 2001/2008 and by the NIH Action Plan for the Muscular Dystrophies as submitted to the Congress by the NIH.

We would like to commend the program staff at the NIH for the excellent progress made in FSHD and the extraordinary progress made in increasing muscular dystrophy funding. We are very pleased with the efforts of NIH staff and Muscular Dystrophy Coordinating Committee (MDCC) on behalf of the community of patients and their families with muscle disease and the research community pursuing solutions for all of us. We recognize in particular the efforts and hard work of the following NIH staff: Story Landis, Ph.D., Executive Secretary, MDCC and Director, National Institute of Neurological Disorders and Stroke (NINDS); John D. Porter, Ph.D., Executive Secretary, MDCC and Program Director, Neuromuscular Disease, Neurogenetics Cluster and the Technology Development Program, NINDS; Stephen I. Katz, M.D., Ph.D., Director, National Institute of Arthritis and Musculoskeletal and Skin Disease (NIAMS); Glen H. Nuckolls, Ph.D., Extramural Programs, Musculoskeletal Diseases Branch, NIAMS; James W. Hanson, M.D., Director of the Center for Developmental Biology and Perinatal Medicine, Eunice Kennedy Shriver National Institute of Child Health and Human Development (NICHD); and, Ljubisa Vitkovic, M.D., Ph.D., Mental Retardation and Developmental Disabilities Branch, DHHS NIH NICHD.

Efforts of excellent program staff and leadership at NIH, excellent reviewers and study sections, excellent and outstanding researchers both working on FSHD and submitting applications to the NIH, and extraordinary efforts of the volunteer health agencies working in this area have not yet enabled FSHD funding to increase

at the NIH. It is time for requests, contracts ands calls for researcher proposals on FSHD to bootstrap existing FSHD research worldwide.

I am here once again to remind you that FSHD is taking its toll on your citizens. FSHD illustrates the disparity in funding across the muscular dystrophies and recalcitrance in growth in more than 20 years despite consistent pressure from appropriations language and Appropriations Committee questions, and an authorization from Congress mandating research on FSHD.

The pace of discovery and numbers of leading experts in the field of biological science and clinical medicine working on FSHD are very rapidly expanding. Many leading experts are now turning to work on FSHD not only because it is one of the most complicated and challenging problems seen in science, but because it represents the potential for great discoveries, insights into stem cells and transcriptional processes and new ways of treating human disease.

Areas of Scientific Opportunity in FSHD That Need NIH Funding

The majority of the international FSHD clinical and research community recently came together at the DHHS NIH NICHD Boston Biomedical Research Institute Senator Paul D. Wellstone MD CRC for FSHD. Almost 90 scientists working on FSHD globally met at the 2009 FSH Society FSHD International Research Consortium, held on Monday, November 9, 2009, and Tuesday, November 10, 2009. The summary and recommendations of the group state the following:

During the past two decades, the FSHD research has made steady progress to unravel the molecular basis of this common muscle disease. The main line of research has focused on the extremely complex (epi)genetic enigma. This complexity has fascinated experts involved in related research. At the present moment the FSHD research field is covering a variety of multidisciplinary and complementary approaches. Although the exact details of the molecular genetic basis of FSHD are still not in place, the general picture is coming into focus. Within 1–2 years, evidence-based intervention strategies are on the drawing-board and trials are planned. To be prepared for this new FSHD era, we need to accelerate the efforts in the following areas—

Patients and Clinical Trials Readiness

There is a need for well-characterized registries with uniform data collection. NIH U54 Wellstone MD CRC, NIH registries, and patient organizations are key to this process. These groups and registry and patient organizations are instrumental for:

—Work on natural history—identification of phenotype modifiers (genetic and environmental)
—Identification of the FSHD2 gene (contraction-independent FSHD)
—Bio-banking (cell lines etc.)
—Development of tools and assays to measure clinical trials endpoints

Epigenetics/Genetics

This line of work will be instrumental to pinpoint the real identity of FSHD1A (chromosome-4-linked cases) and FSHD1B (nonchromosome-4-linked cases). This information will form the basis for evidence-based intervention.

—Modifying genes for FSHD1 (large inter-individual variation in symptoms)
—Identify the FSHD2 gene (common molecular pathway with FSHD1)
—Further work on the chromatin structure/function relationship

Biomarkers for Clinical Therapy

There is obvious need for monitoring intervention.

—Systems biology approaches
  —transcriptomics, proteomics, metabolomics, etc.
—In situ (RNA, protein) to detect cellular heterogeneity
—Non-invasive monitoring (MRI etc.)

Model Systems

Urgent need for more specific model systems for mechanistic, intervention work and advancement to clinical trials.

—Cellular models
  —Biopsies—for well characterized FSHD cell lines
  —Mosaics—isogenic and clonal lines
  —Induced pleuropotent stem cells (iPS)
—Animal
  —Mouse—inducible/humanized mouse etc.
  —Other species

Molecular, Cellular, and Genomic

Myogenesis in normal and FSHD muscle (myoblasts/myotubes)
Cell cycling
Dynamics of muscle satellite cells
RNA iso-forms and alternative splicing (FRG1, DUX4, others)
—Genome wide (normal versus FSHD)
Chromatin structure at 4q35
Downstream gene targets

OUR REQUEST TO THE NIH APPROPRIATIONS SUBCOMMITTEE

We request this year in fiscal year 2011, immediate help for those of us coping with and dying from FSHD. We ask NIH to fund research on facioscapulohumeral muscular dystrophy (FSHD) at a level of $25 million in fiscal year 2011.

We implore the Appropriations Committee to request that the Director of NIH, the Chair, and Executive Secretary of the Federal advisory committee Muscular Dystrophy Coordinating Committee mandated by the MD CARE Act 2008, to increase the amount of FSHD research and projects in its portfolios using all available passive and pro-active mechanisms and interagency committees.

We ask that Congress ask NIH to consider increasing the scope and scale of the existing DHHS U.S. NIH Senator Paul D. Wellstone Muscular Dystrophy Cooperative Research Centers (U54) to double or triple their size—they are financially under-powered as compared to their potential. These centers have provided an excellent catalyst for progress in funding and a greater seriousness in the endeavor of treating muscular dystrophy. We ask Congress to request of NIH the development of mechanisms to help expand work from the center of the NIH Wellstone Centers outward to address needs and priorities of the scientific communities.

Given the knowledge base and current opportunity for breakthroughs in treating FSHD it is inequitable that only 4 of the 12 NIH institutes covering muscular dystrophy have a handful of research grants for FSHD. We request that the Director of the NIH be more proactive in facilitating grant applications (unsolicited and solicited) from new and existing investigators and through new and existing mechanisms, special initiatives, training grants and workshops—to bring knowledge of FSHD to the next level.

Thanks to your efforts and the efforts of your subcommittee, Mr. Chairman, the Congress, the NIH and the FSH Society are all working to promote progress in facioscapulohumeral muscular dystrophy. Our successes are continuing and your support must continue and increase.

Mr. Chairman, thank you for this opportunity to testify before your subcommittee.

PREPARED STATEMENT OF FAMILY VOICES, INC.

I am grateful for this opportunity to submit written testimony on behalf of Family Voices, Inc., an organization of families whose children have special healthcare needs and/or disabilities. Family Voices aims to achieve family-centered care for all children and youth with special healthcare needs and/or disabilities. Through our national network, we provide families tools to make informed decisions, advocate for improved public and private policies, build partnerships among professionals and families, and serve as a trusted resource on healthcare.

Family Voices respectfully asks the subcommittee to provide $10 million in funding for Family-to-Family Information Centers (F2F HICs) for Federal fiscal year 2011. In addition, we request that funding for the title V Maternal and Child Health Services Block Grant be increased to $730 million for Federal fiscal year 2011.

FAMILY-TO-FAMILY HEALTH INFORMATION CENTERS

F2F HICs are statewide, family-led information and referral centers that provide families with information about how to obtain and finance healthcare for their children/youth with special healthcare needs (CYSHCN), including disabilities and chronic medical conditions like cerebral palsy, epilepsy, or asthma. The Deficit Reduction Act of 2005 mandated that Federal grants be provided ($3 million in fiscal year 2007, $4 million in fiscal year 2008, and $5 million in fiscal year 2009) to create a F2F HIC in every State and the District of Columbia by fiscal year 2009. The Patient Protection and Affordable Care Act provided $5 million in each of fiscal years 2010–2012 to maintain these F2F HICs at their current levels of funding.

The needs of CYSHCN are chronic and complex and, thus, securing and paying for their care is often a struggle. F2F HICs provide life-altering information to families in crisis; simply enrolling in Medicaid for a newborn in need of expensive crit-

ical care can be an arduous task. Most of the staff at F2F HICs are members of families whose children have special healthcare needs. This unique perspective allows them to provide advice, offer a multitude of resources, and tap into a network of other families and professionals for support and information. In addition, they help healthcare providers to understand the various public programs available for their patients, and assist in dealing with private insurers. In fact, about one-third of requests to F2F HICs are from healthcare professionals. The centers also aim to ensure that each child has a "medical home," and that partnerships are built between healthcare professionals and the families of CYSHCN, thereby improving the quality of care.

At the present level of funding—$5 million total—each site receives only $95,700 per year. Although hundreds of thousands of families are being served by F2F HICs, the level of funding is not sufficient to serve all of the families and providers who need assistance in each State. As discussed in more detail below, an increase to $10 million is needed to assist more families of CYSHCN and healthcare providers who need these services; to expand training and technical assistance to grantees; and to make these valuable services available to additional regions and populations. Moreover, the healthcare system navigation function provided by F2F HICs will be of increased importance now that healthcare reform has been enacted.

There is a great need for Family-to-Family Health Information Centers (F2F HICs).

An estimated 22 percent of U.S. household with children have at least one child with special healthcare needs—that is more than 10 million children—and that number appears to be growing. Among these families, 38 percent do not have adequate insurance to pay for services their children need; 20 percent of these families pay $1,000 or more per year in out-of-pocket expenses. These problems are exacerbated among families of ethnic, racial, and cultural minorities because their access to coverage and care is significantly more limited.

It is very difficult for families to figure out how to finance their children's care, given the great expense and complexity of potential funding sources—private insurance, Medicaid, SCHIP, State Maternal and Child Health programs, the school system—each with different eligibility and coverage criteria. It can also be difficult to find sources of care, given the shortage and maldistribution of pediatric subspecialists.

Additional funding is needed to sustain the current scope of work, and to expand F2F HICs to territories and tribal organizations.

Currently, F2F HICs are being funded at $5 million. This money funds 51 existing centers, one in each State and one in the District of Columbia, at approximately $95,700 a year—barely enough to cover one staff member or two part-time employees, and not enough to serve all the families who need assistance. All States could use more funding to reach more families. States with large populations in particular need larger grants in order to serve the families within their States.

In addition, the number of centers should be expanded to serve territories and Native American populations, which have their own unique healthcare systems. It is anticipated that over the next several years, 10 new grantees could be established in order to meet the needs of these distinct populations. These new grantees would require operating funds, and would necessitate additional costs for oversight and technical assistance.

Additional funding is needed to provide technical assistance to grantees.

There are currently no designated dollars to provide structured technical assistance to funded F2Fs. A very small amount of the funds remaining after State distributions ($21,000 in the past year) has been used to assist in planning and coordinating a technical assistance meeting. Substantial technical assistance for developing, assisting and coordinating F2F programs, provided through a national, experienced, family-run organization, in coordination with regional family-run organizations, is needed to grow the capacity and ensure the quality of the F2Fs to best meet the needs of families of CYSHCN navigating complex healthcare systems.

Healthcare reform will further necessitate the services of F2F HICs.

Healthcare reform will require the services of the F2F HICs more than ever, as families whose children have special healthcare needs attempt to maneuver a new and complex system of insurance and care. The F2Fs HICs are expert in the unique needs of this sizeable population. Family-to-Family Health Information Centers within each State will be the best-positioned organizations to serve as navigators for families of CYSHCN—a role that has been identified in healthcare reform bills as necessary to ensure that the goals of the reform are met and maximized.

F2F HICs receive less funding than a comparable educational assistance program—Parent Training and Information Centers.

Over 25 years ago, the Federal Government recognized the complexities faced by families whose children need or might need special education services, and created a nationwide system of support and technical assistance for these families—Parent Training and Information Centers (PTIs).

Families with children who have special healthcare needs face equal and additional challenges when faced with maneuvering the healthcare system—a system much more complex than the special education system, which is governed by one law (IDEA), whereas the healthcare system consists of a myriad of private and public insurance programs, benefits, waivers, limitations, networks, and cost-sharing.

In fiscal year 2009, the PTIs were funded at $27 million, versus the $5 million in funding for the F2F HICs, despite the fact that they serve a very similar population.

The F2F HIC program has demonstrated its effectiveness and value.

Although they operate on shoe-string budgets, F2F HICs are able to help many families: from July 2008 to May 2009, the 41 F2F HICs then in existence trained and assisted more than 665,000 families of CYSHCN by helping them to navigate community services, partner with health professionals, find financing for care, and access a medical home. In addition, F2F HICs trained and assisted over 320,000 healthcare professionals in helping families with CYSHCN. On average, each F2F HIC collaborated with 14 State-level programs and 10 community-based organizations.

The value and potential of F2F HICs has been established by outside evaluators:

"Family-to-Family Centers nationwide provide important information and assistance to families of CYSHN as well as the professionals who care for them, often with very limited staff and resources."—Thomson Medstat, June 2006

"By helping families to provide a consumer perspective on program and policy issues, F2F HICs are helping States to develop more effective ways to assist families with CYSHCN. Ultimately, the F2F HICs goal is to improve health and functional outcomes for families with CYSHCN. To the extent families understand what is available for their children and use services effectively, outcomes for their children will improve. These benefits go well beyond the children and families. Children whose outpatient needs are met and whose parents are able to meet their daily care needs are less likely to require hospital or emergency room care. Children who obtain home and community long-term care services are less likely to need costly institutional care. Congress has recognized the value of F2F HICs by authorizing funds to establish one in every State. These highly effective organizations require a stable source of funding to sustain outreach and referral services, information development and dissemination, and education and training initiatives."—Research Triangle Institute, April 2006.

Perhaps more compelling are the stories of families who have been assisted by F2F HICs. An example is provided from Louisiana, where the F2F HIC assisted a family who had two children with severe disabilities. Both children had private health insurance and Medicaid for secondary coverage. The private health insurance company began requiring their enrollees to use an out-of-State mail-order pharmacy for their regularly renewed medications. This meant that the family was no longer able to use Louisiana Medicaid as a secondary insurer because the out-of-State pharmacy was not a Louisiana Medicaid provider. The family was faced with over $500 per month in additional costs because they could not access their Medicaid coverage. The Louisiana F2F HIC worked with the State Medicaid Director so that this family could submit the balance of the costs and receive their sorely needed benefits.

For the above reasons, we respectfully request that a $10 million appropriation be provided for F2F HICs for fiscal year 2011.

TITLE V MATERNAL AND CHILD HEALTH BLOCK GRANT

As you know, one of the missions of the title V Maternal and Child Health Block Grant is to serve children with special healthcare needs. State MCH programs for CYSHCN help to build an infrastructure to ensure the provision of family-centered, community-based coordinated care for children with chronic conditions and disabilities. They have strong connections to pediatric specialists and the best available data on the needs of these children and their families. Due to years of reduced investment, however, the MCH Block Grant is at its lowest funding level since 1993, $662 million. The program—and the populations it serves—deserves increased funding to fulfill its valuable missions. Therefore, Family Voices respectfully requests that the Congress provide $730 million for the Title V Maternal and Child Health Block Grant program for fiscal year 2011.

PREPARED STATEMENT OF GOODWILL INDUSTRIES INTERNATIONAL

Mr. Chairman, Ranking Member, and members of the subcommittee, on behalf of Goodwill Industries International (GII), I appreciate this opportunity to submit written testimony on Goodwill's priorities for funding programs administered by the U.S. Departments of Labor, Health and Human Services, and Education.

GII represents 159 local and autonomous Goodwill Industries agencies in the United States that help people with barriers to employment to participate in the workforce. One of Goodwill Industries' greatest strengths continues to be its entrepreneurial approach to sustaining its mission. In 2008, the Goodwill Industries network raised nearly $3.7 billion through its retail, contracts, and mission services operations. Nearly 83 percent of the funds Goodwill Industries raised in 2009 was used to supplement government investments, resulting in nearly than 2 million different people served by local Goodwill agencies, including more than 155,000 job placements. In addition to our efforts to help people find jobs and advance in careers, Goodwill understands that many people need additional supportive services—child care, reliable transportation, stable housing, counseling, and assistance in adjusting to the workplace, assistive technology—to ensure their success.

Especially during such trying economic times, Goodwill Industries understands the difficult challenge that appropriators face as they struggle to stretch limited resources to support an ever-increasing list of national priorities. As the Nation struggles to recover from the worst recession since the Great Depression and unemployment stubbornly hovers near 10 percent, Goodwill Industries' remains committed to partnering with stakeholders at the Federal, State, and local levels by contributing the resources and expertise of local Goodwill agencies in support of public efforts and investments.

While our agencies care about a range of Federal funding streams, GII believes that Federal investment in the Workforce Investment Act, Vocational Rehabilitation, the Senior Community Service Employment Program (SCSEP), Green Jobs, and TANF will help the Goodwill network to do more for the people in communities across the country who are struggling to overcome employment barriers. Furthermore, Goodwill supports the administration's proposal to increase funding to strengthen enforcement of wage and hour standards. Goodwill urges Congress to provide adequate funding in fiscal year 2011 for these critical programs.

Workforce Investment Act

Funding for the Workforce Investment Act's adult, dislocated worker, and youth formulas is one of Goodwill's top funding priorities for fiscal year 2011. Goodwill agencies and their community partners are on the front lines of this recovery effort assisting people with employment barriers, including individuals with disabilities, older workers, and welfare recipients who are struggling to find and keep jobs at a time when unemployment is at its highest rate experienced in a generation.

Of the nearly 2 million people served by local Goodwill agencies in the United States in 2009, nearly 160,000 people were referred to local Goodwill agencies for employment services through the Workforce Investment Act (WIA) and State Vocational Rehabilitation agencies. Many local Goodwill agencies are one-stop lead operators, or operators in association with other service providers, and are active on State and local workforce boards.

As members of this Subcommittee know, the administration's fiscal year 2011 budget proposes to launch a Workforce Innovation Fund to "support and test promising approaches to training, and breaking down program silos, building evidence about effective practices, and investing in what works." Goodwill believes that this idea is promising, is very interested in the details, and is encouraged by the Administration's efforts to increase interagency collaborations and leverage resources provided by community-based organizations.

Goodwill strongly believes, however, that the proposed Workforce Innovation Funds should be paid for with funds in addition to, rather than at the expense of, existing WIA formula funds—in fiscal year 2011 and beyond. We understand that this subcommittee's funding allocation will be extremely tight as a result of the President's call for a discretionary budget freeze. However, it should be noted that the President's budget request for WIA programs is 7 percent less in actual dollars than in fiscal year 2002, a time when the unemployment rate was less than half of what jobseekers are experiencing today.

Goodwill believes that the workforce system is vastly underfunded and that the preservation of WIA's formula funding streams should be a high priority. Therefore, Goodwill urges Congress to sustain WIA's adult, dislocated worker, and youth funding streams at current funding levels at a minimum before dedicating funding to the administration's proposed WIA Innovation Fund.

VR Funding

Goodwill Industries has a long history of helping people with disabilities to participate in the workforce despite the challenges their disabilities present. Years of inadequate funding for Vocational Rehabilitation have left the system stretched much too thin to serve all who are eligible for assistance. As a result, more than half of the 80 State VR agencies have Orders of Selection, a provision within the Rehabilitation Act that requires State VR agencies, when faced with a shortage of funds to meet the demand for services, to prioritize the provision of services to eligible people based on the severity of people's disabilities. In addition, reduced funding for WIA has placed an additional strain on mandatory partner programs, including VR, which are being asked to contribute more funding to pay for infrastructure and other costs associated with the operation of one-stop centers.

Goodwill Industries supports the President's intent to increase multi-system collaboration and support for youth with disabilities who are transitioning from education to the workforce. However, Goodwill is concerned that the President's fiscal year 2011 budget proposal would consolidate VR programs in order to achieve these goals. First, the President proposes to eliminate VR's supported employment State grant program to create a supported employment program for youth who are transitioning from education to the workforce. For more than two decades, Goodwill has offered supported employment as a part of its service array. According to GII's Annual Statistical Report, participation in local Goodwill agencies' supported employment programs has grown dramatically in recent years from providing 270,000 coaching sessions in 2007 to 630,000 sessions in 2009.

Furthermore, the administration's budget proposes to eliminate funding for VR's Projects With Industry and the migrant and seasonal farmworker program. The administration asserts that services provided by these programs will continue under the VR State grants funds and would eliminate duplication. The resulting savings would be used to help pay for increased collaboration between the Department of Education, the Department of Labor and other agency heads. As noted earlier, Goodwill is intrigued by the administration's proposal to stimulate system collaboration by creating a Workforce Innovation Fund; however, Goodwill opposes paying for the Workforce Innovation Fund by eliminating or reducing funding for critical programs for people with barriers to employment. Therefore, Goodwill urges you to preserve funding for VR.

Senior Community Service Employment Program (SCSEP)

According to the Bureau of Labor Statistics, the unemployment rate for older workers older 65 years old is at the highest levels since the Department started keeping records in 1948. The Senior Community Service Employment Program (SCESP) helps provide low-income older workers with community services employment and private sector job placements. Goodwill is one of the newest SCSEP grantees. In 2009, SCSEP participants contributed nearly 1.2 million community service hours and our private sector placements averaged a starting wage of $8.67 per hour. In addition, as a result of the Recovery Act, which allowed Goodwill to start enrolling more participants in April 2009, SCSEP participants provided and additional 140,000 community service hours and our private sector placements started at $8.31 per hour.

Goodwill recognizes and very much appreciates the monumental investment that the Congress has placed on helping older workers to survive the economic crisis. Congress has demonstrated its commitment to older workers by providing an additional $120 million for SCSEP in the Recovery Act, and a $250 million increase in fiscal year 2010. These funds have allowed local Goodwill agencies to better address our waiting list of participants and help many more older workers with part-time employment.

Goodwill is concerned that the President's budget seeks to cut this program by 27 percent, as these older workers have multiple barriers to employment and will be among the last rehired as the economy improves. Goodwill urges the subcommittee to reject the administration's proposed cuts to SCSEP. At a minimum Congress should sustain funding for SCSEP at its fiscal year 2010 level, $825 million, so that the program can continue to better meet the needs of the increasing number of low-income older workers.

Green Jobs

Goodwill believes that the green jobs sector has great potential for increasing employment opportunities in high-growth fields for people with employment barriers and many Goodwill agencies are helping workers learn skills that will help them secure jobs in energy efficiency and alternative energy industries. We greatly appreciated the subcommittee's inclusion of $500 million for sectoral initiatives focused

on green-related industries in the Recovery Act, and are thrilled that Goodwill Industries International and four local Goodwill agencies have been selected by DOL to provide training and placement in the renewable energy and energy efficiency sectors. Goodwill urges you to appropriate $85 million for green jobs as requested by the administration.

Enforcement of Wage and Hour Standards

Goodwill favors increased enforcement of the Fair Labor Standards Act, specifically section 14(c) which allows for the use of a special minimum wage certificate to employee individuals with disabilities that directly impair their productivity. As such, Goodwill supports the President's budget proposal of $244.2 million and 1,672 full-time employees for the Wage and Hour Division to support targeted investigations focusing on industries where misclassification is common.

Goodwill thanks you for considering these requests, and looks forward to working with you to help government meet the serious challenges our Nation faces.

PREPARED STATEMENT OF THE HEPATITIS APPROPRIATION PARTNERSHIP

The Hepatitis Appropriations Partnership (HAP) is a coalition that represents hepatitis community-based organizations, public health officials, health providers, national hepatitis and HIV organizations, and diagnostic, pharmaceutical and biotechnology companies. We work with policy makers and public health officials to increase Federal leadership and support for viral hepatitis prevention, testing, education, research, medical management, and treatment.

As you craft the fiscal year 2011 Labor, Health and Human Services, and Education, and Related Agencies Appropriations legislation, we urge you to consider the following critical funding needs of viral hepatitis programs:

Specific funding needs:

—We are requesting an increase of $30.7 million for a total of $50 million for the Centers for Disease Control and Prevention (CDC) Division of Viral Hepatitis (DVH);

—At least $20 million for an adult hepatitis B vaccination initiative through the CDC section 317 Vaccine Program;

—$10 million for the Substance Abuse and Mental Health Services Administration (SAMHSA) to fund a project within the Programs of Regional and National Significance (PRNS) to reach persons who use drugs with viral hepatitis prevention services;

General funding needs:

—Increase funding for Community Health Centers to increase their capacity to serve people with chronic viral hepatitis;

—Increase funding for the Ryan White Program to adequately cover persons coinfected with viral hepatitis through additional case management, provider education, and coverage of viral hepatitis drug therapies;

—Increase funding for the National Institutes of Health to support their Action Plan for Liver Disease Research

SPECIFIC FUNDING NEEDS

Division of Viral Hepatitis

—Fiscal year 2011 request: $30.7 million

The recently released Institute of Medicine (IOM) report, Hepatitis and Liver Cancer: A National Strategy for Prevention and Control of Hepatitis B and C found that the public health response needs to be significantly ramped up. The IOM report attributes low public and provider awareness to the lack of public resources. Seventeen of the 22 recommendations in the report are specific to CDC DVH and State health departments. In order to implement these recommendations to improve the Federal response, resources must be increased to health departments which are the backbone of the Nation's public health system and coordinate the response to these epidemics.

President Obama's budget proposal includes a $1.8 million increase for the DVH at CDC, which is woefully insufficient to address infectious diseases of this magnitude. While operating on the smallest Division budget for the prevention of infectious diseases within CDC, DVH will never be able to sufficiently prevent and manage these epidemics under its current fiscal constraints. States and cities receive an average funding award from DVH of $90,000. This is only enough for a single staff position and is not sufficient for the provision of core prevention services. These services are essential to preventing new infections, increasing the number of people who know they are infected, and following up to help those identified to remain

healthy and productive. We believe this increase is an important first step to making hepatitis prevention services more widely available. The expanded services should include hepatitis B and C education, counseling, testing, and referral in addition to delivering hepatitis A and B vaccine, and establishing a surveillance system of chronic hepatitis B and C.

Section 317 Vaccine Program

—Fiscal year 2011 request: $20 million

CDC identified funds through program cost savings in the section 317 Vaccine Program, allocating $20 million in fiscal year 2008 and $16 million in fiscal year 2009 for purchase of the hepatitis B vaccine for high-risk adults. We commend CDC for prioritizing high-risk adults with this initiative, but relying on the availability of these cost savings is not enough. Additionally, this initiative does not support any infrastructure or personnel and health departments need additional funding to support the delivery of this vaccine. We request a continuation of $20 million in fiscal year 2011 for an adult hepatitis B vaccination initiative through the CDC's section 317 Vaccine Program.

Substance Abuse and Mental Health Services Administration

—Fiscal year 2011 Request: $10 million

Persons who use drugs are disproportionately impacted by hepatitis B and C. The Substance Abuse and Mental Health Services Administration (SAMHSA) Center for Substance Abuse Prevention (CSAP) and Center for Substance Abuse Treatment are uniquely positioned to reach populations at risk for hepatitis B and C. The existing infrastructure of substance abuse prevention and treatment programs in the United States provides an important opportunity to reach Americans at risk or living with viral hepatitis. We urge you to provide $10 million to SAMHSA to fund a project within the Programs of Regional and National Significance (PRNS) to reach persons who use drugs with viral hepatitis prevention services.

GENERAL FUNDING NEEDS

Medical Management and Treatment

Access to available treatments and support services are critical to combat viral hepatitis mortality. While we are supportive of the President's efforts to modernize and expand access to healthcare, we also support increased funding for existing safety net programs. Low-income patients who are uninsured or underinsured can and do seek services at Community Health Centers (CHCs). With the growing importance of CHCs as a safety net in providing frontline support for these individuals, we support increasing resources for CHCs to increase their capacity to serve people with chronic viral hepatitis.

Many low-income individuals co-infected with viral hepatitis and HIV can obtain services through the Ryan White Program, however only half of the State AIDS Drug Assistance Programs (ADAPs) are able to provide viral hepatitis treatments to co-infected clients. We urge you to increase Ryan White funding so States can provide adequate coverage for co-infected clients. Increased resources are also needed to improve provider education on viral hepatitis medical management and treatment, to cover additional case management for patients undergoing treatment and to allow more States to add viral hepatitis therapies and viral load tests to their ADAP formularies. While Ryan White providers offer lifesaving care to co-infected clients, they also have the expertise and infrastructure to provide limited services to viral hepatitis mono-infected clients.

Research

Finally, research is needed to increase understanding of the pathogenesis of hepatitis B and C. Further research to improve hepatitis B and C treatments that are currently difficult to tolerate and have low "cure" rates are also needed. The development of clinical strategies to slow the progression of liver disease among persons living with chronic infection, especially to those who may not respond to current treatment must be addressed. With effective vaccines against hepatitis A and B, it is important to continue to work towards the development of a vaccine against hepatitis C infection. The Liver Disease Branch, located within the National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK) at the National Institutes of Health (NIH), has developed an Action Plan for Liver Disease Research. We request full funding for NIH to support the recommendations and action steps outlined in this Action Plan for Liver Disease Research.

It is absolutely essential and urgent that we act aggressively to address the threat of viral hepatitis in the United States. In 2007 alone, the CDC estimated that 43,000 Americans were newly infected with hepatitis B and 17,000 with hepatitis

C. Unfortunately, it is believed that these estimates of hepatitis B and C infections are just the tip of the iceberg. Most people living with hepatitis B and over three-fourths of people living with hepatitis C do not know that they are infected. It is estimated that the baby boomer population currently accounts for 2 out of every 3 cases of chronic hepatitis C. It is also estimated that this epidemic will increase costs by billions of dollars to our private insurers and public systems of health such as Medicare and Medicaid, and account for billions lost due to decreased productivity from the millions of American workers suffering from chronic hepatitis B and C.

As you continue to draft the fiscal year 2011 Labor, Health and Human Services, and Education, and Related Agencies Appropriations bill, we ask that you consider a generous increase for viral hepatitis prevention to counter several years of flat or inadequate growth in funding. A strong public health response is needed to meet the challenges of these costly infectious diseases. The viral hepatitis community welcomes the opportunity to work with you and your staff on this important issue.

PREPARED STATEMENT OF THE HEPATITIS B FOUNDATION

Mr. Chairman, my name is Dr. Timothy Block, and I am the President and Co-Founder of the Hepatitis B Foundation (HBF) and its research institute, the Institute for Hepatitis and Virus Research. I also serve as the president of the Pennsylvania Biotechnology Center and am a professor at Drexel University College of Medicine. My wife Joan, and I, and another couple, Paul and Janine Witte, from Pennsylvania started HBF almost 20 years ago to find a cure for this serious chronic liver disease and provide information and support to those affected.

Thank you for giving HBF the opportunity to provide testimony to the subcommittee as you begin to consider funding priorities for fiscal year 2011. We are grateful to the members of this subcommittee for their interest and strong leadership for efforts to control and find cures for hepatitis B.

Today, the HBF is the only national nonprofit organization solely dedicated to finding a cure and improving the lives of those affected by hepatitis B worldwide through research, education, and patient advocacy. Our scientists focus on drug discovery for hepatitis B and liver cancer, and early detection markers for liver cancer. HBF staff manages a comprehensive Web site which receives almost 1 million visitors each year, a national patient conference and outreach services. HBF public health professionals conduct research initiatives to advance our mission.

The hepatitis B virus (HBV) is the world's major cause of liver cancer—and while other cancers are declining, liver cancer is the fastest growing in incidence in the United States. Without intervention, as many as 100 million worldwide will die from a HBV-related liver disease, most notably liver cancer. In the United States, up to 2 million Americans have been chronically infected and more than 5,000 people die each year from complications due to HBV.

HBV is 100 times more infectious than the HIV/AIDS virus. Yet, hepatitis B can be prevented with a safe and effective vaccine. Unfortunately, for those who are chronically infected with HBV, the vaccine is too late. There are, however, promising new treatments for HBV. We are getting close to solutions but lack of sustained support for public health measures and scientific research is threatening progress. The growing incidence of liver cancer, while most other cancer rates are on the decline, represents examples of serious shortcomings in our system. In the United States, 20,000 babies are born to mothers infected with HBV each year, and as many as 1,200 newborns will be chronically infected with HBV. More needs to be done to prevent new infections.

INSTITUTE OF MEDICINE (IOM) REPORT

In January of this year, the Institute of Medicine (IOM) issued a report titled *Hepatitis and Liver Cancer: A National Strategy for Prevention and Control of Hepatitis B and C*. This report outlined a national strategy for prevention and control of hepatitis B and C. The report concludes that the current approach to the prevention and control of viral hepatitis is not working and unless further action is taken thousands more Americans will die each year from liver cancer, or liver disease associated with these preventable diseases. In response to this monumental report, the Department of Health and Human Services Office of the Secretary has convened an inter-departmental task-force to address the public health challenge of viral hepatitis. HBF is very supportive of the Task Force and is hopeful that their recommendations will result in actions to address the chronic underfunding of viral hepatitis prevention programs within the Department.

Mr. Chairman, as you know the two Federal agencies that are critical to the effort to help people concerned with hepatitis B are: the Centers for Disease Control and Prevention (CDC), and the National Institutes of Health CDC (NIH).

CDC

CDC's Division of Viral Hepatitis (DVH), the centerpiece of the Federal response to controlling, reducing, and preventing the suffering and deaths resulting from viral hepatitis, is chronically underfunded. DVH is included in the National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention at the CDC, and is responsible for the prevention and control of viral hepatitis. DVH is currently funded at $19.3 million, $6 million less than its funding level in fiscal year 2003, which does not allow for the provision of core prevention services. The HBF joins the hepatitis community and urges a fiscal year 2011 funding level for DVH of $50 million.

The responsibility for addressing the problem of hepatitis should not lie solely with the DVH . In view of the preventable nature of these diseases, HBF feels that the National Center for Chronic Disease Prevention should also include a targeted effort focused on the prevention of chronic viral hepatitis which adversely impacts 5 million Americans. We urge that the subcommittee include $2 million in the National Center for Chronic Disease Prevention to initiate a focused program on chronic viral hepatitis.

Furthermore, there are 400 million people chronically infected with hepatitis B worldwide, with more than 120 million of these individuals in China. While hepatitis B transmission requires direct exposure to infected blood, worldwide misinformation about the disease has fueled inappropriate discrimination against individuals with this vaccine-preventable bloodborne and treatable disease. HBF urges the subcommittee to instruct the CDC to initiate global programs to increase the rate of vaccination, reduce mother-child transmission, and promote educational programs to prevent the disease and to reduce discrimination targeted against individuals with the disease.

NIH

We depend upon the NIH to fund research that will lead to new and more effective interventions to treat people with hepatitis B and liver cancer. HBF joins with the Ad Hoc Group for Biomedical Research and requests a funding level of $35 billion for NIH in fiscal year 2011.

We thank the subcommittee for their continued investment in NIH in fiscal year 2010. Sustaining progress in medical research is essential to the twin national priorities of smarter healthcare and economic revitalization. With additional investment, the Nation can seize the unique opportunity to build on the tremendous momentum emerging from the strategic investment in NIH made through the 2009 American Recovery and Reinvestment Act (ARRA). NIH invested those funds in a range of potentially revolutionary new avenues of research that will lead to new early screenings and new treatments for disease.

In fiscal year 2009, NIH spent approximately $57 million on hepatitis B funding overall (ARRA and non-ARRA funds), and estimates that in fiscal year 2010 $54 million will be spent. An additional $40 million per year could make transformational advances in research leading to better treatments for HBV. The HBF recommends that an additional $40 million be allocated for HBV research in fiscal year 2010 and that overall NIH funding total $35 billion.

The current leadership of the NIH has performed admirably with the limited resources they are provided; however, more is needed. While a number of cancers have achieved 5-year survival rates of over 80 percent and the average 5-year survival rate for all cancers has increased from 50 percent in 1971 to 66 percent, significant challenges still remain for other types of cancers, particularly the most deadly forms of cancer. In fact, nearly half of the 562,340 cancer deaths in 2009 were caused by eight forms of cancer with 5-year relative survival rates of less than 50 percent: ovary (45.5 percent), brain (35.0 percent), myeloma (34.9 percent), stomach (24.7 percent), esophagus (15.8 percent), lung (15.2 percent), liver (11.7 percent), and pancreas (5.1 percent). It is no coincidence that cancers with significantly better 5-year survival rates, such as breast, prostate, colon, testicular, and chronic myelogenous leukemia, also have early detection tools, and in many cases, several effective treatment options thanks to research programs championed and supported by Congress. By contrast, research into the cancers with the lowest 5-year survival rates has been relatively underfunded, and as a result, these cancers have no early detection or treatment tools.

HBF requests that the establishment of a targeted cancers program at the National Cancer Institute (NCI) for the high-mortality cancers. It should include a

strategic plan for progress, an annual report from NCI to Congress, and a new grant program specifically focused on the deadly cancers. Additionally, HBF urges a stronger focus on liver cancer and urges the funding of a series of Specialized Programs of Research Excellence (SPOREs) focused on liver cancer. While SPOREs currently exist for every other major cancer, none currently exist that are focused on liver cancer.

SUMMARY AND CONCLUSION

While the HBF recognizes the demands on our Nation's resources, we believe the ever-increasing health threats and expanding scientific opportunities continue to justify higher funding levels for the CDC's DVH and NIH.

Significant progress has been made in developing better treatments and cures for the diseases that affect humankind due to your leadership and the leadership of your colleagues on this subcommittee. Significant progress has also similarly been made in the fight against hepatitis B.

In conclusion, we specifically request the following for fiscal year 2011:

—Fund the CDC's DVH at $50 million;
—$2 million in the National Center for Chronic Disease Prevention to initiate a focused program on chronic viral hepatitis;
—Initiate global programs at the CDC to increase the rate of vaccination, reduce mother-child transmission and promote educational programs to prevent the disease and to reduce discrimination targeted against individuals with the disease;
—Provide $35 billion for NIH, including a $40 million increase per year for hepatitis B research;
—Establish a targeted cancers program at the NCI; and
—Fund a series of Specialized Programs of Research Excellence (SPOREs) focused on liver cancer at the NCI.

HBF appreciates the opportunity to provide testimony to you on behalf of our constituents and yours.

Thank you.

LETTER FROM THE HIV HEALTH AND HUMAN SERVICES PLANNING COUNCIL OF NEW YORK

APRIL 16, 2010.

Hon. TOM HARKIN,
Subcommittee on Labor, Health and Human Services, and Education, and Related Agencies, Washington, DC.

DEAR SENATOR HARKIN: On behalf of the HIV Health and Human Services Planning Council of New York City, I write to urge you to increase funding for Ryan White Programs by $810.5 million more than the fiscal year 2010 appropriated levels in the fiscal year 2011 Labor, Health and Human Services, and Education, and Related Agencies; Transportation and Housing and Urban Development, and Related Agencies; and Financial Services and General Government appropriations bills.

The HIV Health and Human Services Planning Council of New York is comprised of people living with HIV/AIDS, advocates, physicians, and service providers and prioritizes the allocation of Ryan White funds for treatment and care services for PLWHAs. Council Members are well versed in the challenges confronting people living with this illness and know that Ryan White HIV/AIDS Programs provide life-extending medical care, mental health and drug treatment, and support services to approximately 577,000 low-income, uninsured and underinsured individuals and families affected by HIV/AIDS each year. Your proposed fiscal year 2011 budget requests $2.33 billion for the Ryan White Program, but Planning Council members believe that more funding is needed in order to maintain a comprehensive system of care. Specifically, Planning Council members recommend the following increases:

—*Part A.*—An increase of $225.9 million for grants to eligible metropolitan areas and transitional grant areas;
—*Part B.*—An increase of $55.9 million for care grants to State, territories, and emerging communities;
—*Part B AIDS Drug Assistance Program.*—An increase of $370.1 million to provide life-saving medications to more than 166,000 individuals already enrolled in the program and the hundreds that are currently on waiting lists in 11 States;

—*Part C*.—An increase of $131 million for early intervention services and capacity development grants;
—*Part D*.—An increase of $7 million for women, infants, youth, and their families;
—*Part F/Dental*.—An increase of $5.4 million for Dental School Reimbursement Programs and the Community-Based Dental Partnership Program; and
—*Part F/AETC*.—An increase of $15.2 million for AIDS Education and Training Centers.

My fellow Planning Council members join me in thanking you for your support and commitment to improving the lives of people living with HIV/AIDS and strongly encourage you to increase the amount of money to support treatment and care services.

Sincerely yours,

CHARLES W. SHORTER, MSW,
Community Co-Chair.

PREPARED STATEMENT OF THE HIV MEDICINE ASSOCIATION

The HIV Medicine Association (HIVMA) of the Infectious Diseases Society of America represents more than 3,700 physicians, scientists and other healthcare professionals who practice on the frontline of the HIV/AIDS pandemic. Our members provide medical care and treatment to people with HIV/AIDS throughout the United States, lead HIV prevention programs and conduct research to develop effective HIV prevention and treatment options. We work in communities across the country and around the globe as medical providers and researchers dedicated to the field of HIV medicine. We appreciate the fiscal challenges that Congress currently faces, but the state of the economy makes it imperative that our Nation have a strong healthcare safety net, effective programs for preventing infectious diseases like HIV and a vibrant scientific research agenda.

The U.S. investment in HIV/AIDS programs has revolutionized HIV care globally making HIV treatment one of the most effective medical interventions available. A robust research agenda and rapid public health implementation of scientific findings have transformed the HIV epidemic, reducing morbidity and mortality due to HIV disease by nearly 80 percent in the United States. The Ryan White program has played a critical role in ensuring that many low-income people with HIV have access to lifesaving HIV treatment. However, the impact of our diminished investment in public health and research programs over the last several years has taken its toll in communities across the country. HIV clinics are cutting hours and services while the number of their new HIV patients continues to increase dramatically in some areas.

Implementation of healthcare reform and the administration's plans for a National HIV/AIDS Strategy offer promise for making significant progress in reducing the impact of the domestic HIV epidemic. However, their success will depend on adequate investments in shoring up the frayed healthcare safety net, prevention and public health and research programs. The funding requests in our testimony largely reflect the consensus of the Federal AIDS Policy Partnership, a coalition of HIV organizations from across the country, and are estimated to be the amounts necessary to sustain and strengthen our investment in combating HIV disease.

Center for Disease Control and Prevention's (CDC) National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP)

HIVMA strongly supports an increase of $1.13 billion in funding for the CDC's NCHHSTP with an increase of $878 million for HIV prevention and surveillance, an increase of $30.7 million for viral hepatitis and $76.3 million for tuberculosis prevention.

Every 9½ minutes a new HIV infection happens in the United States with more than 60 percent of new cases occurring among African Americans and Hispanic/Latinos. Despite the known benefit of effective treatment, 21 percent of people living with HIV in the United States are still not aware of their status and as many as 36 percent of people newly diagnosed with HIV progress to AIDS within 1 year of diagnosis. An infusion of HIV prevention funding is critical to restore and enhance HIV prevention programs by increasing support for cooperative agreements with State and local health departments; optimizing core surveillance cooperative agreements with health departments and expanding HIV testing in key healthcare and nonhealthcare venues by funding testing infrastructure and the purchase of approved testing devices, including rapid HIV tests and confirmatory testing and supporting linkage to care. A failure to invest now in HIV prevention will be costly.

The CDC estimates that the 56,300 new HIV infections each year in the United States may result in $56 billion in medical care and lost productivity.

While we appreciate that the President proposed a $31 million increase for HIV prevention at the CDC, a much more robust investment is needed to significantly reduce the number of new HIV occurring annually in the United States. We strongly support the CDC initiative to integrate HIV screening into medical care as an important component of the prevention portfolio. Increased HIV screening with linkage to care and treatments will help lower HIV incidence and prevalence in the United States. Effective treatment reduces the virus to very low levels in the body, and there is a growing body of evidence suggesting that treatment can reduce risk of HIV transmission. Furthermore through education, counseling and treatment, individuals who are aware that they have HIV are more likely to adopt behaviors to prevent transmission of the virus. The transmission rates among people who know their status is 1.7 percent to 2.4 percent compared to transmission rates of 8.8 percent to 10.8 percent for those who are unaware they are infected with HIV. A significant investment of Federal resources is necessary to support State health departments, medical institutions, community health centers and other community based organizations with implementing these programs and for their full potential to be realized—particularly in light of steep State budget cuts.

Identifying people with HIV earlier through routine HIV testing and linking them to HIV care saves lives and also is more cost effective for the healthcare system. One study found that people living with HIV disease receiving care at the later stages of the disease expended 2.6 times more in healthcare dollars than those receiving treatment according to the standard of care recommended in the Federal HIV treatment guidelines.

Finally, we also must increase support for science-based, comprehensive sex education programs. We are pleased that Congress took important steps in the fiscal year 2010 appropriations process to discontinue funding for unproven abstinence-only sex education programs and shift those funds to support comprehensive, age-appropriate sex education programs. We also support shifting administration of those funds to the Department of Health and Human Services' Office of Adolescent Health. However, we are concerned that by focusing the funding on teenage pregnancy prevention alone, and not including the equally important health issues of STIs and HIV, both the administration and Congress missed an opportunity to provide true, comprehensive sex education that promotes healthy behaviors and relationships for all young people, including lesbian, gay, bisexual, and transgender youth. We urge the subcommittee to adopt report language that broadens the scope of the new teen pregnancy prevention program to include an explicit focus on prevention of STDs including HIV.

CDC—Tuberculosis

Tuberculosis is the major cause of AIDS-related mortality worldwide. Two years ago, Congress passed landmark legislation in the Comprehensive Tuberculosis Elimination Act of 2008. This bill authorizes a number of actions that will shore up State TB control programs, enhance U.S. capacity to deal with the serious threat of drug-resistant tuberculosis, and escalate our efforts to develop urgently needed "tools," such as drugs, diagnostics and vaccines. Realizing these goals will require additional resources. Unfortunately, the Administration has proposed a cut of $1.2 million for domestic TB control. At a minimum, it is critical that the authorized funding level of $220.5 million be appropriated for the CDC Division of TB Elimination. The bill also separately authorized $100 million for development of TB diagnostics, treatments and prevention tools, which HIVMA also supports for inclusion in fiscal year 2011 appropriations.

Two years ago, Congress passed landmark legislation—the Comprehensive Tuberculosis Elimination Act of 2008—Public Law 110–873 that authorizes a number of actions that will shore up State TB control programs, enhance U.S. capacity to deal with the serious threat of drug-resistant tuberculosis and escalate our efforts to develop urgently needed new "tools" in the form of drugs, diagnostics and vaccines. It is critical that the $220.5 million in funding authorized for fiscal year 2011 in this important law is appropriated for the CDC Division of TB Elimination. This represents an increase of $76.3 million more than current funding levels. Funding to support the prevention, control and elimination of tuberculosis must increase substantially if we are going to make headway against this deadly disease and to address the emerging threat of highly drug resistant tuberculosis.

CDC—Viral Hepatitis

Funds are urgently needed to provide core public health services and to track chronic cases of hepatitis. Hepatitis is a serious co-infection for nearly one-third of

our HIV patients. We strongly urge you to boost funding for viral hepatitis at the CDC by $31 million for a total funding of $50 million.

HIV/AIDS Bureau of the Health Resources and Services Administration

We strongly urge you to increase funding for the Ryan White program by $811 million in fiscal year 2011 with at least an increase of $131 million for part C for a total Ryan White appropriation of $3.1 billion. Ryan White Part C funds comprehensive HIV care and treatment—the medical services that are directly responsible for the dramatic decreases in AIDS-related mortality and morbidity over the last decade. While the patient caseload in part C programs has been rising, funding for part C has effectively decreased due to flat funding and funding cuts at the clinic level. Part C programs expect a continued increase in patients due to higher diagnosis rates and economic-related declines in insurance coverage. During this economic downturn people with HIV across the country are relying on part C comprehensive services more than ever. The HIV medical clinics funded through part C have been in dire need of increased funding for years, but new pressures are creating a crisis in communities across the country. An increase in funding is critical to prevent additional staffing and service cuts and ensure the public health of our communities.

Minimal annual increases in Ryan White Part C allocations have lagged behind rapid cost increases in all aspects of healthcare delivery programs, leaving part C programs operating at a deficit while struggling to meet growing patient need. Part C programs provide comprehensive primary care to more than 240,000 HIV patients—which represents an increase of more than 30 percent in less than 10 years. Part C clinics are laying off staff, curtailing critical services such as laboratory monitoring, creating waitlists, and operating on a 4-day work week just to get by. For fiscal year 2011, HIVMA joins the Ryan White Medical Provider Coalition, The CAEAR Coalition, and the American Academy of HIV Medicine to request a $131 million funding increase for Part C programs. These funds are urgently needed to provide HIV care and treatment to Part C patients nationwide. HIVMA strongly supports the effort led by the Ryan White Medical Providers Coalition to double funding for Ryan White Part C programs by fiscal year 2012. These funds are critical to meet the needs of HIV patients served by Part C programs around the country.

Agency for Health Care Quality and Research (AHRQ)

HIVMA strongly urges full funding of $1.95 million for the HIV Research Network (HIVRN), which represents the only significant HIV work being done at AHRQ. The HIVRN is a consortium of 18 HIV primary care sites co-funded by AHRQ and HRSA to evaluate healthcare utilization and clinical outcomes in HIV infected children, adolescents and adults in the United States. The Network analyzes and disseminates information on the delivery and outcomes of healthcare services to people with HIV infection. These data help to improve delivery and outcomes of HIV care in the United States and to identify and address disparities in HIV care that exist by race, gender, and HIV risk factor. The HIVRN is a unique source of information on the cost and cost-effectiveness of HIV care in the United States at a time when data on comparative cost and effectiveness of healthcare is particularly needed to inform health systems reform and the development and implementation of a National HIV/AIDS Strategy. The HHS budget retained the HRSA share of HIVRN funding ($.4 million), but inexplicably zeroed out the AHRQ funding for the program, without any policy rationale for eliminating it.

National Institutes of Health (NIH)—Office of AIDS Research

HIVMA strongly supports an increase of at least $4 billion for all research programs at the NIH, including at least a $500 million increase for the NIH Office of AIDS. This level of funding is vital to sustain the pace of research that will improve the health and quality of life for millions of Americans. HIVMA strongly supported the infusion of NIH research dollars included in the economic recovery bill. The desperately needed funding came at a critical time to sustain our Nation's scientific research capacity while stimulating the economy in communities across the country. Prior to the boost in NIH funding, the declining U.S. investment in biomedical research had taken its toll in deep cuts to clinical trials networks and significant reductions in the numbers of high-quality, investigator-initiated grants that were approved. With only 1 in 4 research applications receiving funding, the pipeline for critical discoveries and HIV scientists has been dwindling and our role as a leader in biomedical research is at serious risk.

Our past investment in a comprehensive portfolio was responsible for the dramatic gains that we made in our HIV knowledge base, gains that resulted in reductions in mortality from AIDS of nearly 80 percent in the United States and in other

countries where treatment is available. Gains that also helped us to reduce the mother to child HIV transmission rate from 25 percent to nearly 1 percent in the United States and to very low levels in other countries where treatment is available.

A continued robust AIDS research portfolio is essential to sustain and to accelerate our progress in offering more effective prevention technologies; developing new and less toxic treatments; and supporting the basic research necessary to continue our work developing a vaccine that may end the deadliest pandemic in human history. The sheer magnitude of the number of people affected by HIV—more than 1 million people in the United States; more than 33 million people globally—demands a continued investment in AIDS research if we are going to truly eradicate this devastating disease. We believe a high priority should be research to discover novel prevention strategies, to improve available treatment strategies, to aid prevention and to maximize the benefits of antiretroviral therapy, especially in the populations disproportionately affected by HIV in the United States and in resource-limited settings.

Historically, our Nation has made significant strides in responding to the HIV pandemic here at home and around the world, but we have lost ground in recent years, particularly domestically, as funding priorities have shifted away from public health and research programs. We appreciate the many difficult decisions that Congress faces this year, but urge you to recognize the importance of investing in HIV prevention, treatment and research now to avoid the much higher cost that individuals, communities and broader society will incur if we fail to support these programs. We must seize the opportunity to limit the toll of this deadly infectious disease on our planet and to save the lives of millions who are infected or at risk of infection here in the United States and around the globe.

PREPARED STATEMENT OF THE HEPATITIS OUTBREAKS NATIONAL ORGANIZATION FOR REFORM (HONOREFORM)

Mr. Chairman and members of the subcommittee: As President and Co-Founder of Hepatitis Outbreaks National Organization for Reform (HONOReform), I want to take this opportunity to thank you for the leadership role this subcommittee has played on healthcare acquired infections (HAIs). HONOReform is a nonprofit foundation that advances the lessons learned in hepatitis outbreaks and seeks to prevent future healthcare-associated hepatitis epidemics through education and policy reform.

The Centers for Disease Control and Prevention (CDC) estimates there are 1.7 million infections resulting in approximately 99,000 deaths annually in the United States, making HAIs the fourth-leading cause of death. Beyond the human toll, there is an enormous financial burden to our healthcare system.

We are deeply concerned with the rise in the number of disease outbreaks related to the reuse of syringes and misuse of multidose vials in the outpatient setting. In the January 2009 edition of the Annals of Internal Medicine, an article by the CDC, revealed the occurrence of 33 outbreaks of viral hepatitis in healthcare settings over the last decade. All of these documented outbreaks occurred in nonhospital settings and involved failure on the part of healthcare providers to adhere to basic infection control practices, most notably by reusing syringes and other equipment intended for single use.

I am a victim of what was the largest single source outbreak of hepatitis C in U.S. history, until 2008 when an outbreak that potentially exposed more than 63,000 patients to hepatitis C occurred in Las Vegas, Nevada. In 2001, I contracted hepatitis C through an oncology clinic (nonhospital setting), in Fremont, Nebraska as I was fighting to survive breast cancer for the second time. Ninety-eight other patients from the oncology clinic became infected with hepatitis C. The nurse would reuse the syringe for port flushes, which would then contaminated a 500cc saline bag. The saline bag was used for other patients, which in turn became the source of infection for multiple cancer patients. This improper practice was repeated on a regular basis over a 2-year period.

I utilized my malpractice settlement to establish HONOReform in 2007 to put an end to these completely preventable outbreaks. More than 100,000 patients seeking healthcare and treatment have received letters notifying them of potential exposure to hepatitis and HIV due to improper injection practices in the last 10 years. In April 2009, two outbreaks in New Jersey, a cancer clinic and hospital, and an outbreak at a South Dakota outpatient urology clinic, conducted large patient notifications which further illustrates that this problem requires immediate action to protect the citizens that are accessing our healthcare system each day.

Moreover, these hepatitis outbreaks are entirely preventable when healthcare providers adhere to proper infection control procedures. A 2002 study by the American Association of Nurse Anesthetists (AANA) found that 1 percent of practitioners felt it was acceptable to reuse a syringe for multiple patients and more than 30 percent of healthcare providers believed it was acceptable to reuse a syringe on the same patient if the needle is changed.

Mr. Chairman, beyond the significant risk posed to the physical health of patients, even the receipt of a notification of potential exposure can cause significant mental anguish and lead to an even greater danger—a loss of faith in the medical system by the public. Victims feel that they have been personally violated and betrayed by those to whom they entrusted their health. We, as a Nation, cannot afford to ignore the issue and hope it goes away.

Through its foundation, HONOReform has joined forces with the Accreditation Association for Ambulatory Health Care, AANA, Association for Professionals in Infection Control and Epidemiology, Ambulatory Surgery Foundation, Becton, Dickinson and Company, CDC, CDC Foundation, Nebraska Medical Association, and the Nevada State Medical Association, to establish the One & One Campaign. The One & Only Campaign, which is currently being piloted in New York and Nevada, is an effort aimed at re-educating healthcare providers that syringes and other medical equipment must not be reused and empowering patients to ask the right questions when seeking healthcare. If patients are knowledgeable about injection safety, they will be empowered to speak up in their provider's office to ask if they are getting "One Needle, One Syringe, and Only One Time."

Each of these requests will have a profound impact on all patients and consumers. They are aimed at reducing the knowledge gap for providers, empowering patients, tracking HAIs to limit the spread of disease, and improving the quality and standards of care in our Nation's ambulatory care facilities. By focusing on prevention, this subcommittee can realize savings for healthcare systems and promote increased patient safety for all Americans.

Mr. Chairman, we respectfully request that the subcommittee continue supporting prevention efforts at CDC, and HHS to help prevent future hepatitis and HIV outbreaks through the following two fiscal year 2011 appropriations requests:

Supporting CDC's Division of Healthcare Quality and Promotion

HONOReform requests $26 million for CDC Division of Healthcare Quality and Promotion to address outbreaks and promote innovative ways to adhere to injection safety and infection control guidelines.

The CDC provides national leadership in surveillance, outbreak investigations, laboratory research, and prevention of healthcare-associated infections. The transition of healthcare delivery from primarily acute care hospitals to other healthcare settings (e.g., home care, ambulatory care, free-standing specialty care sites, long-term care) requires that common principles of infection control practice be applied to the spectrum of healthcare delivery settings. In light of the recent healthcare-associated transmissions of HCV in Denver, Colorado, Las Vegas, Nebraska, North Carolina, New York City, Long Island, and Grand Rapids, Michigan, the CDC needs additional resources to use the knowledge gained through these activities to detect infections and develop new strategies to prevent healthcare-associated transmission of blood borne pathogens.

Provider Education and Awareness ($5 million)

Funds to develop safe practice tools for additional inpatient and outpatient healthcare settings in conjunction with key partners and stakeholders. This will include training tools to be used by professional organizations and accreditation and licensing groups to increase adherence to recommendations. Funds will assist in dissemination and use of tools to aid in implementing State HAI Action Plans. Funds to expand the One & Only injection safety education and awareness campaign, provide educational materials to all 50 States through State health departments' HAI coordinators implement a national media launch to promote awareness of the One & Only Campaign in collaboration with the Safe Injection Practices Coalition and State health departments; and evaluate the impact of the Campaign. Funds to expand implementation of CMS surveys of injection safety practices in ambulatory surgical centers to all outpatient settings.

Engineering and Innovation ($7 Million)

Funds to support the CDC in promoting private-sector and academic healthcare solutions to injection safety and infection control problems. This funding will enable the CDC to engage with industry and academia through extramural grant mechanisms to:

—Examine current technologies and practices that eliminate the risk of human error through unsafe injection practices;
—Identify and develop fast tracked safety engineered-solutions for next generation products; and
—Demonstrate effectiveness of new technology to support inclusion in Federal guidelines.

Detection, Tracking, and Response ($14 million)

Funds to expand augmentation of CMS survey capacity in outpatient settings to strengthen State capacity to detect infections that indicate errors in injection practices. These funds will enable the CDC, in collaboration with CMS, to expand surveillance in States by providing training tools for surveyors, health department staff and epidemiologists to improve methods of monitoring adherence to correct practices and to provide tools for investigation, response and intervention strategies. Funds to assist State and local health departments implement State HAI Action Plans, including detection and tracking in order to investigate outbreaks of healthcare-associated infections and other adverse events related to injection safety.

Funds to enable the CDC to provide assistance and respond to outbreaks resulting from the re-use of syringes as requested by health departments and health systems. Funds to the CDC to develop CDC Toolkits of best practices for patient notifications and postnotification support and best practices for investigations and detecting clusters of outbreaks, to be used by State and local health departments and healthcare systems.

Encouraging HHS To Focus on HAIs in the Outpatient Setting

HONOReform requests $1 million for the Department of Health and Human Services (HHS) to expand its current focus for reducing HAIs from hospitals to outpatient settings with the development of an action plan to reduce HAIs in outpatient settings with a specific focus on injection safety. HONOReform is concerned with the number of HAIs occurring in office-based settings, such as ambulatory care centers, infusion centers, and endoscopy clinics, due to a lack of adherence to basic infection control procedures. In 2 years, more than 150,000 patients in the United States have received ominous letters from public health officials warning of possible exposure to deadly diseases like hepatitis and HIV because their providers failed to follow fundamental safety measures.

The increased frequency of such outbreaks was highlighted in the February 2010 article, "U.S. Outbreak Investigations Highlight the Need for Safe Injection Practices and Basic Infection Control", published in Clinics in Liver Disease. The article attributed these outbreaks to lapses in basic infection control (i.e., syringe reuse and misuse of single dose and multidose vials).

HAIs in the Outpatient Setting ($1 million)

Funds to expand HHS' current focus for reducing healthcare-associated infections (HAIs) from hospitals to outpatient settings with the development and implementation of an action plan to reduce HAIs in unlicensed outpatient settings and Health Resources and Services Administration Community Care Centers including a specific focus on injection safety. Funds to increase education, certifications, and continuing education of medical, nursing, and allied health professionals, including State-based certification, related to injection safety.

PREPARED STATEMENT OF THE HEALTH PROFESSIONS AND NURSING EDUCATION COALITION

The members of the Health Professions and Nursing Education Coalition (HPNEC) are pleased to submit this statement for the record in support of $600 million in fiscal year 2011 for the health professions education programs authorized under titles VII and VIII of the Public Health Service Act and administered through the Health Resources and Services Administration (HRSA). HPNEC is an informal alliance of more than 60 national organizations representing schools, programs, health professionals, and students dedicated to ensuring the healthcare workforce is trained to meet the needs of our diverse population.

As you know, the title VII and VIII health professions and nursing programs are essential components of the Nation's healthcare safety net, bringing healthcare services to our underserved communities. These programs support the training and education of healthcare providers to enhance the supply, diversity, and distribution of the healthcare workforce, filling the gaps in the supply of health professionals not met by traditional market forces. Through loans, loan guarantees, and scholarships to students, and grants and contracts to academic institutions and nonprofit organi-

zations, the title VII and VIII programs are the only Federal programs designed to train providers in interdisciplinary settings to meet the needs of special and underserved populations, as well as increase minority representation in the healthcare workforce.

We are thankful to the subcommittee for the increases provided for many title VII and title VIII programs in the fiscal year 2010 Omnibus Appropriations bill (Public Law 111–117). These investments are crucial to addressing the existing and looming shortages of healthcare professionals in this country and are key to ensuring the Nation's healthcare professionals are able to care for the medically underserved. The Patient Protection and Affordable Care Act (Public Law 111–148) updated and restructured the existing title VII and title VIII programs to improve their efficiency, effectiveness, and accountability, and reauthorized them at funding levels reflective of the health workforce needs of the Nation. In addition to reauthorizing the existing health professions programs, the legislation authorizes several new programs and initiatives under titles VII and VIII designed to mitigate health workforce challenges and expand the scope of the programs to additional fields. HPNEC encourages an investment in these new programs that supplements the support for the core title VII and title VIII programs. These investments will be critical to ensuring that the healthcare workforce can accomplish the goals of healthcare reform.

We are grateful to President Obama for highlighting the need to strengthen the health professions workforce as a national priority; however, significant strides must still be made to ensure that all Americans have access to the health professionals they need. According to HRSA, an additional 31,000 health practitioners are needed to alleviate existing professional shortages. Combined with faculty shortages across health professions disciplines, racial/ethnic disparities in healthcare, and a growing, aging population, these needs strain an already fragile healthcare system. Because of the time required to train health professionals, we must make appropriate investments today to ensure that the title VII and title VIII programs are able to continue strengthening the country's safety net for the healthcare needs of the medically underserved.

The existing title VII and title VIII programs can be considered in seven general categories:

—The purpose of the Minority and Disadvantaged Health Professionals Training programs is to improve healthcare access in underserved areas and the representation of minority and disadvantaged healthcare providers in the health professions. Minority Centers of Excellence support programs that seek to increase the number of minority health professionals through increased research on minority health issues, establishment of an educational pipeline, and the provision of clinical opportunities in community-based health facilities. The Health Careers Opportunity Program seeks to improve the development of a competitive applicant pool through partnerships with local educational and community organizations. The Faculty Loan Repayment and Faculty Fellowship programs provide incentives for schools to recruit underrepresented minority faculty. The Scholarships for Disadvantaged Students make funds available to eligible students from disadvantaged backgrounds who are enrolled as full-time health professions students.

—The Primary Care Medicine and Dentistry programs, including General Pediatrics, General Internal Medicine, Family Medicine, General Dentistry, Pediatric Dentistry, and Physician Assistants, provide for the education and training of primary care physicians, dentists, and physician assistants to improve access and quality of healthcare in underserved areas. Two-thirds of all Americans interact with a primary care provider every year. Approximately one-half of primary care providers trained through these programs go on to work in underserved areas, compared to 10 percent of those not trained through these programs. The General Pediatrics, General Internal Medicine, and Family Medicine programs provide critical funding for primary care training in community-based settings and have been successful in directing more primary care physicians to work in underserved areas. They support a range of initiatives, including medical student training, residency training, faculty development and the development of academic administrative units. The General Dentistry and Pediatric Dentistry programs provide grants to dental schools and hospitals to create or expand primary care dental residency training programs, while the Dental Public Health Residency programs are vital to the Nation's dental public health infrastructure. Recognizing that all primary care is not only provided by physicians, the primary care cluster also provides grants for Physician Assistant programs to encourage and prepare students for primary care practice in rural and urban Health Professional Shortage Areas. And finally, the primary care cluster enhances the efforts of osteopathic medical schools to continue to empha-

size primary care medicine, health promotion, and disease prevention, and the practice of ambulatory medicine in community-based settings.

—Because much of the Nation's healthcare is delivered in areas far removed from health professions schools, the Interdisciplinary, Community-Based Linkages cluster provides support for community-based training of various health professionals. These programs are designed to provide greater flexibility in training and to encourage collaboration between two or more disciplines. These training programs also serve to encourage health professionals to return to such settings after completing their training. The Area Health Education Centers (AHECs) provide clinical training opportunities to health professions and nursing students in rural and other underserved communities by extending the resources of academic health centers to these areas. AHECs, which have substantial State and local matching funds, form networks of health-related institutions to provide education services to students, faculty and practitioners. Geriatric Health Professions programs support geriatric faculty fellowships, the Geriatric Academic Career Award, and Geriatric Education Centers, which are all designed to bolster the number and quality of healthcare providers caring for our older generations. Given America's burgeoning aging population, there is a need for specialized training in the diagnosis, treatment, and prevention of disease and other health concerns of older adults. The Allied Health Project Grants program represents the only Federal effort aimed at supporting new and innovative education programs designed to reduce shortages of allied health professionals and create opportunities in medically underserved and minority areas. Health professions schools use this funding to help establish or expand allied health training programs. The need to address the critical shortage of certain allied health professionals has been acknowledged repeatedly. For example, this shortage has received special attention given past bioterrorism events and efforts to prepare for possible future attacks. The Graduate Psychology Education Program provides grants to doctoral, internship and postdoctoral programs in support of interdisciplinary training of psychology students with other health professionals for the provision of mental and behavioral health services to underserved populations (i.e., older adults, children, chronically ill, and victims of abuse and trauma, including returning military personnel and their families), especially in rural and urban communities.

—The Health Professions Workforce Information and Analysis program provides grants to institutions to collect and analyze data on the health professions workforce to advise future decisionmaking on the direction of health professions and nursing programs. The Health Professions Research and Health Professions Data programs have developed a number of valuable, policy-relevant studies on the distribution and training of health professionals, including the National Sample Survey of Registered Nurses, the Nation's most extensive and comprehensive source of statistics on registered nurses.

—The Public Health Workforce Development programs are designed to increase the number of individuals trained in public health, to identify the causes of health problems, and respond to such issues as managed care, new disease strains, food supply, and bioterrorism. The Public Health Traineeships and Public Health Training Centers seek to alleviate the critical shortage of public health professionals by providing up-to-date training for current and future public health workers, particularly in underserved areas. Preventive Medicine Residencies, which receive minimal funding through Medicare GME, provide training in the only medical specialty that teaches both clinical and population medicine to improve community health. Dental Public Health Residency programs are vital to the Nation's dental public health infrastructure.

—The Nursing Workforce Development programs under title VIII provide training for entry-level and advanced degree nurses to improve the access to, and quality of, healthcare in underserved areas. These programs provide the largest source of Federal funding for nursing education, providing loans, scholarships, traineeships, and programmatic support to 77,395 nursing students and nurses in fiscal year 2008. Healthcare entities across the Nation are experiencing a crisis in nurse staffing, caused in part by an aging workforce and capacity limitations within the educational system. Each year, nursing schools turn away tens of thousands of qualified applications at all degree levels due to an insufficient number of faculty, clinical sites, classroom space, clinical preceptors, and budget constraints. At the same time, the need for nursing services and licensed, registered nurses is expected to increase significantly over the next 20 years. The Advanced Education Nursing program awards grants to train a variety of advanced practice nurses, including nurse practitioners, certified nurse-midwives, nurse anesthetists, public health nurses, nurse educators, and nurse adminis-

trators. For example, this funding has been instrumental in doubling nurse anesthesia graduates in the last 8 years. However, even though the number of graduates doubled, the vacancy rate for nurse anesthetists has remained the same at 12 percent, due to a retiring nursing profession and an aging population requiring more care. Workforce Diversity grants support opportunities for nursing education for students from disadvantaged backgrounds through scholarships, stipends, and retention activities. Nurse Education, Practice, and Retention grants are awarded to help schools of nursing, academic health centers, nurse-managed health centers, State and local governments, and other healthcare facilities to develop programs that provide nursing education, promote best practices, and enhance nurse retention. The Loan Repayment and Scholarship Program repays up to 85 percent of nursing student loans and offers full-time and part-time nursing students the opportunity to apply for scholarship funds. In return these students are required to work for at least 2 years of practice in a designated nursing shortage area. The Comprehensive Geriatric Education grants are used to train RNs who will provide direct care to older Americans, develop and disseminate geriatric curriculum, train faculty members, and provide continuing education. The Nurse Faculty Loan program provides a student loan fund administered by schools of nursing to increase the number of qualified nurse faculty.

—The loan programs under Student Financial Assistance support financially needy and disadvantaged medical and nursing school students in covering the costs of their education. The Nursing Student Loan (NSL) program provides loans to undergraduate and graduate nursing students with a preference for those with the greatest financial need. The Primary Care Loan (PCL) program provides loans covering the cost of attendance in return for dedicated service in primary care. The Health Professional Student Loan (HPSL) program provides loans covering the cost of attendance for financially needy health professions students based on institutional determination. The NSL, PCL and HPSL programs are funded out of each institution's revolving fund and do not receive Federal appropriations. The Loans for Disadvantaged Students program provides grants to health professions institutions to make loans to health professions students from disadvantaged backgrounds.

These programs work collectively to fulfill their unique, three-pronged mission of improving the supply, diversity, and distribution of the health professions workforce. While HPNEC members are keenly aware of the fiscal pressures facing the subcommittee, we respectfully urge support for funding of at least $600 million for the title VII and VIII programs, an investment essential not only to the development and training of tomorrow's healthcare professionals but also to our Nation's efforts to provide needed healthcare services to underserved and minority communities. We also encourage an investment in the new programs and responsibilities authorized in the Patient Protection and Affordable Care Act to supplement the investment in the existing core programs. We greatly appreciate the support of the subcommittee and look forward to working with Members of Congress to reinvest in the health professions programs in fiscal year 2011 and into the future.

PREPARED STATEMENT OF THE HOME SAFETY COUNCIL

INTRODUCTION

Chairman Harkin, Vice Chairman Cochran, and members of the subcommittee, thank you for the opportunity to submit testimony on the fiscal year 2011 appropriations for the Centers for Disease Control and Prevention's (CDC) National Center for Injury Prevention and Control (NCIPC).

I am Patricia Adkins, chief operating officer and director of public policy for the Home Safety Council (HSC) which is located in Washington, DC.

ABOUT THE HOME SAFETY COUNCIL

The mission of the HSC is to help prevent and reduce the nearly 20,000 deaths and 21 million medical visits each year from such hazards as falls, poisoning, fires and burns, choking and suffocation, and drowning. Through national programs, partnerships, and the support of volunteers, HSC educates people of all ages to help keep them safer in and around their homes.

Our vision for our Nation is safer homes that provide the opportunity for all individuals to lead healthy, active, and fulfilling lives.

INCREASED FUNDING FOR CDC'S NCIPC

CDC's NCIPC has the mission of preventing injuries and violence, and reducing their consequences. It strives to help every American live his or her life to its fullest potential. Funds are utilized by NCIPC for intramural and extramural research and in assisting State and local health agencies in implementing injury prevention programs.

HSC and a coalition of 30 like-minded nonprofit organizations are requesting an increase of $20 million to the "Unintentional Injury Prevention" account to begin to comprehensively address the large-scale growth of older adult falls.

Ultimately, success in reducing the number and severity of older adult falls will be reached through partnerships with Federal, State, and local agencies along with the cooperation of many nongovernmental organizations.

WHY INJURY PREVENTION IS A CRITICAL ELEMENT OF HEALTH CARE REFORM

In 1998, the National Academy of Sciences stated—"Injury is probably the most under-recognized public health threat facing the nation today."

Each year, injuries resulting from a wide variety of physical and emotional causes—motor vehicle crashes, sports trauma, violence, poisoning, fires and falls—keep millions of children and adults from achieving their goals and making the most of their talents and abilities.

This is what we know:

—Nationally and in every State in the United States, injuries are the leading cause of death in the first 44 years of a person's life.

—Nearly 30 million people are treated for injuries in U.S. emergency departments each year. This is an average of 55 people each minute.

—In a single year, injury and violence will cost the United States $406 billion. This total lifetime cost includes $80 billion in medical care costs and $326 billion in productivity losses, including lost wages and benefits and the inability to perform normal household functions.

These three statistics clearly show the consequences of injuries and its major burden on the healthcare system.

Fortunately, injury research has proven that there are steps that can be taken to prevent injuries and increase the likelihood for full recovery when they do occur. By incorporating these strategies into our communities and everyday activities, we can help to ensure that Americans remain healthy and live their lives to the fullest potential.

PROTECTING OLDER ADULTS FROM INJURY

We all want a society where people, including our older citizens, can live healthy and productive lives. A key component of achieving this is helping older adults avoid injuries. There are actions we can take to prevent injuries and premature death to our parents, grandparents, and friends. Some of the most important include preventing older adults from falling and being injured in fires or motor vehicle crashes.

One of the injuries affecting the quality of life for older adults is falls. Falls are the leading cause of fatal and nonfatal injuries for those 65 and older. Each year, 1.8 million older adults are treated in emergency departments. Every day, 5,000 adults 65 and older are hospitalized due to fall-related injuries, and every 35 minutes, an older adult dies from a fall-related injury.

We know one of the greatest financial challenges facing the U.S. Government, its citizens, and their employers is the rising cost of healthcare services needed by older Americans. CDC reports that $80.2 billion is spent annually for medical treatment of injuries, of which fully $19.2 billion ($12 billion for hospitalization, $4 billion for emergency department visits, and $3 billion for outpatient care) is for treating older adults injured by falls. That's almost one-quarter of all healthcare expenses for injuries each year spent on older adult falls and the majority of these expenses are paid by CMS through Medicare. If we cannot stem this rate of increase, it is projected that the direct treatment costs will reach $54.9 billion annually in 2020, at which time the cost to Medicare would be $32.4 billion.

While falls are a threat to the health and independence of older adults and can significantly limit their ability to remain self-sufficient, the opportunity to reduce falls among older adults has never been better. Today there are proven interventions and strategies that can reduce falls and in turn help older adults live better and longer. Studies show that prescription medications have an effect on balance. A medication review and adjustment is a simple, cost-effective way to help prevent a fall. Additionally, older adults who actively participate in physical exercise and receive vision exams are at a lower risk for falling. These evidence-based interven-

tions can help save healthcare costs and greatly improve the lives of older adults. The costs are small compared to the potential for savings. For every $1 invested in a comprehensive falls prevention program for an older adult, it returns close to a $9 benefit to society.

HOW CONGRESS CAN HELP

Congress took a major step forward in preventing older adult falls with passage of the Safety of Seniors Act of 2007 (S. 845 and Public Law 110–202) which authorized increased research, education, and demonstration projects. Further evidence of support included the passage of two Senate Resolutions in 2008 and 2009 recognizing National Falls Prevention Awareness Day each September. For the good intentions of Congress to bear fruit, an appropriation of $20 million is needed for fiscal year 2011 for CDC's NCIPC.

NCIPC's funding in this area is severely inadequate to address the scale of human suffering and the impact of falls on our healthcare system. Additional funding would enable NCIPC to expand research, evaluation of demonstrations, public education, professional education, and policy analysis. At present, CDC can only allocate $2 million per year to address a problem costing $19.2 billion a year. The benefits of increased funding would be enormous, vastly improving the quality of life for those 65 and older and greatly reducing healthcare costs for falls and related disabilities.

Increased funding for older adult falls prevention efforts is supported by a broad-based coalition of nonprofit organizations and a growing number of State falls prevention coalitions that are dedicated to improving the safety and health of older Americans.

CDC ACTIVITY IN FALLS PREVENTION AMONG OLDER ADULTS

If the CDC NCIPC's falls prevention budget is increased by $20 million, the next steps would be to:

—Develop additional program demonstrations to test and replicate the most cost effective interventions to reduce the risk of falls;

—Undertake additional extramural research into the causes of falls; and

—Develop more public education programs to raise awareness about falls and what individuals, family members, professionals, nonprofit organizations, and the private sector can do to reduce them.

On behalf of HSC, thank you for the opportunity to share our fiscal year 2011 appropriations request for the CDC NCIPC on the very costly, but often preventable problem of falls among older adults.

PREPARED STATEMENT OF THE HUMANE SOCIETY OF THE UNITED STATES

On behalf of The Humane Society of the United States (HSUS) and the Humane Society Legislative Fund, and our joint membership of more than 11 million supporters nationwide, we appreciate the opportunity to provide testimony on our top funding priority for the Labor, Health and Human Services, and Education, and Related Agencies Appropriations Subcommittee in fiscal year 2011.

BREEDING OF CHIMPANZEES FOR RESEARCH

The HSUS requests that no Federal funding be appropriated for the breeding of chimpanzees for research. The basis of our request can be found below.

—The National Center for Research Resources (NCRR) of the National Institutes of Health (NIH), responsible for the oversight and maintenance of federally owned chimpanzees, placed a moratorium on funding the breeding of federally owned and supported chimpanzees in 1995, primarily due to the excessive costs of lifetime care of chimpanzees in laboratory settings. NCRR made this moratorium permanent in 2007. As a result, no federally owned chimpanzees should have given birth or sired infants since 1995 and no federally owned chimpanzees should have a date of birth later than 1995. We have discovered, however, that the Government has provided millions of dollars in recent years for chimpanzee breeding. Therefore, we seek to ensure that neither the NIH nor any other Federal agency provides funding for breeding of Government-owned chimpanzees due to the future financial implications to the Government and taxpayers of continuing to do so, particularly during this difficult economic time.

—According to records obtained from the New Iberia Research Center (NIRC), 42 federally owned females and 9 federally owned males have been used for breeding since the 1995 moratorium was put into place. Furthermore, at least 29 in-

fants were born to a federally owned mother and/or federally owned father since 1995 and 27 federally owned chimpanzees have a date of birth after 1995.

—There is evidence that chimpanzees being bred by the NIRC—through their contract with the National Institute of Allergy and Infectious Diseases (NIAID)—are owned or supported by NCRR, and as a result, in violation of NCRR's breeding moratorium.

—The cost of maintaining chimpanzees in laboratories is exorbitant, totaling up to $28 million each year for the current population of approximately 800 federally owned or supported chimpanzees (up to $67 per day per chimpanzee; more than $1,000,000 per chimpanzee's 60-year lifetime). Breeding of additional chimpanzees into laboratories will only perpetuate a number of burdens on the Government.

—The United States currently has a surplus of chimpanzees available for use in research due to overzealous breeding for HIV research and subsequent findings that they are a poor HIV model.[1]

—Expansion of the chimpanzee population in laboratories only creates more concerns than presently exist about their quality of care.

—Use of chimpanzees in research raises strong public concerns.

Background and History

Beginning in 1995, the National Research Council (NRC) confirmed a chimpanzee surplus and recommended a moratorium on breeding of federally owned or supported chimpanzees[1], who now number approximately 800 of the more than 1,000 total chimpanzees available for research in the United States. On May 22, 2007 the NCRR of NIH announced a permanent end to the funding of chimpanzee breeding, which applies to all federally owned and supported chimpanzees. Further, it has also been noted that "a huge number" of chimpanzees are not being used in active research protocols and are therefore "just sitting there."[2] If no breeding is allowed, it is projected that the Government will have almost no financial responsibility for the chimpanzees it owns within 30 years due to the age of the population—any breeding today will extend this financial burden to 60 years.

There is no justification for breeding of additional chimpanzees for research; therefore lack of Federal funding for breeding will ensure that no breeding of federally owned or supported chimpanzees for research will occur in fiscal year 2011.

Concerns Regarding Chimpanzee Care in Laboratories

A 9-month undercover investigation by The HSUS at University of Louisiana at Lafayette New Iberia Research Center (NIRC)—the largest chimpanzee laboratory in the world—revealed some chimpanzees living in barren, isolated, conditions and documented more than 100 alleged violations of the Animal Welfare Act at the facility in regards to chimpanzees. The U.S. Department of Agriculture (USDA) and NIH's Office of Laboratory Animal Welfare have since launched formal investigations into the facility and NIRC was cited for several violations of the Animal Welfare Act during an initial site visit.

Aside from the HSUS investigation, inspections conducted by the USDA demonstrate that basic chimpanzee standards are often not being met. Inspection reports for other federally funded chimpanzee facilities have reported violations of the Animal Welfare Act in recent years, including the death of a chimpanzee during improper transport, housing of chimpanzees in less than minimal space requirements, inadequate environmental enhancement, and/or general disrepair of facilities. These problems add further argument against the breeding of even more chimpanzees.

Chimpanzees Have Often Been a Poor Model for Human Health Research

The scientific community recognizes that chimpanzees are poor models for HIV because chimpanzees do not develop AIDS. Similarly, chimpanzees do not model the course of the human hepatitis C virus yet they continue to be used for this research, adding to the millions of dollars already spent without a sign of a promising vaccine. According to the chimpanzee genome, some of the greatest differences between chimpanzees and humans relate to the immune system[3], calling into question the validity of infectious disease research using chimpanzees.

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[1] NRC (National Research Council) (1997) *Chimpanzees in research: strategies for their ethical care, management and use*. National Academies Press: Washington, D.C.

[2] Cohen, J. (2007) Biomedical Research: The Endangered Lab Chimp. Science. 315:450–452.

[3] The Chimpanzee Sequencing and Analysis Consortium/Mikkelsen, TS, et al.,(1 September 2005) Initial sequence of the chimpanzee genome and comparison with the human genome, Nature 437, 69–87.

Ethical and Public Concerns About Chimpanzee Research

Chimpanzee research raises serious ethical issues, particularly because of their extremely close similarities to humans in terms of intelligence and emotions. Americans are clearly concerned about these issues: 90 percent believe it is unacceptable to confine chimpanzees individually in Government-approved cages (as we documented during our investigation at NIRC); 71 percent believe that chimpanzees who have been in the laboratory for more than 10 years should be sent to sanctuary for retirement [4]; and 54 percent believe that it is unacceptable for chimpanzees to "undergo research which causes them to suffer for human benefit." [5]

We respectfully request the following bill or committee report language:

"The Committee directs that no funds provided in this Act be used to support the breeding of chimpanzees for research."

We appreciate the opportunity to share our views for the Labor, Health and Human Services, and Education, and Related Agencies Appropriations Act for fiscal year 2011. We hope the subcommittee will be able to accommodate this modest request that will save the Government a substantial sum of money, benefit chimpanzees, and allay some concerns of the public at large. Thank you for your consideration.

HIGH THROUGHPUT SCREENING, TOXICITY PATHWAY PROFILING, AND BIOLOGICAL INTERPRETATION OF FINDINGS

NIH—Office of the Director

In 2007, the National Research Council published its report titled "Toxicity Testing in the 21st Century: A Vision and a Strategy." This report catalyzed collaborative efforts across the research community to focus on developing new, advanced molecular screening methods for use in assessing potential adverse health effects of environmental agents. It is widely recognized that the rapid emergence of omics technologies and other advanced technologies offers great promise to transform toxicology from a discipline largely based on observational outcomes from animal tests as the basis for safety determinations to a discipline that uses knowledge of biological pathways and molecular modes of action to predict hazards and potential risks.

In 2008, NIH, NIEHS, and EPA signed a memorandum of understanding [6] to collaborate with each other to identify and/or develop high throughput screening assays that investigate "toxicity pathways" that contribute to a variety of adverse health outcomes (e.g., from acute oral toxicity to long-term effects like cancer). In addition, the MOU recognized the necessity for these Federal research organizations to work with "acknowledged experts in different disciplines in the international scientific community." Much progress has been made, but there is still a significant amount of research, development and translational science needed to bring this vision forward to where it can be used with confidence for safety determinations by regulatory programs in the Government and product stewardship programs in the private sector. In particular, there is a growing need to support research to develop the key science-based interpretation tools which will accelerate using 21st century approaches for predictive risk analysis. We believe the Office of the Director at NIH can play a leadership role for the entire U.S. Government by funding both extramural and intramural research.

We respectfully request the following committee report language:

"The Committee supports the implementation of the National Research Council's report 'Toxicity Testing in the 21st Century: A Vision and a Strategy' to create a new paradigm for risk assessment based on use of advanced molecular biological methods in lieu of animal toxicity tests and urges the National Institutes of Health to play a leading role by funding relevant intramural and extramural research projects. Current activities at the NIH Chemical Genomics Center, National Institute of Environmental Health Sciences and the Environmental Protection Agency show considerable potential and the NIH Director should explore opportunities to augment this effort by identifying possible additional resources that could be directed to key extramural research projects."

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[4] 2006 poll conducted by the Humane Research Council for Project Release & Restitution for Chimpanzees in laboratories.

[5] 2001 poll conducted by Zogby International for the Chimpanzee Collaboratory.

[6] http://www.genome.gov/pages/newsroom/currentnewsreleases/ntpncgcepamou121307finalv2.pdf.

PREPARED STATEMENT OF THE HARLEM UNITED COMMUNITY AIDS CENTER, INC.

Harlem United Overview

Harlem United Community AIDS Center, Inc. (Harlem United) is a community-based, nonprofit organization providing comprehensive, integrated care to individuals and families living with HIV/AIDS in Upper Manhattan area of New York City and its nearby boroughs.

Harlem United provides a full range of medical, social, and supportive services to people living with HIV/AIDS whose diagnoses are often complicated by addiction, mental illness, and homelessness. Harlem United utilizes a comprehensive model of care that includes HIV testing; treatment and education; primary medical care; substance use counseling; mental health services; and an array of expressive therapies. Each year we touch the lives of more than 6,000 people through our services and myriad locations, including two AIDS Adult Day Health Care centers. At these centers, patients receive medication management, healthcare monitoring, case management, substance abuse services, nutritional services, and health education. We are proud that we deliver evidence-based, outcome-driven, comprehensive, medically endorsed care in a cost-effective and supportive setting.

Harlem United is very concerned about increasing HIV incidence among men who have sex with men (MSM) of all races and ethnicities. Harlem United's Black Men's Initiative endeavors to reduce rates of HIV infection and transmission of sexually transmitted infections (STIs) among young Black and Latino MSM in New York City. Our Education and Training Department works with populations and individuals at increased risk for HIV infection, such as MSM, to increase knowledge and skills to prevent HIV transmission and improve HIV-related health outcomes. Our programs include evidence-based HIV prevention interventions, comprehensive risk-reduction counseling, confidential HIV rapid testing and STI screenings, primary care, mental health, and supportive housing services many of which specialize in mobilizing effective responses for Black and Latino MSM.

HIV/AIDS and MSM

MSM account for nearly half of the more than 1 million people living with HIV in the United States and half of all new HIV infections in the United States each year. While the Centers for Disease Control and Prevention (CDC) estimates that MSM account for just 4 percent of the U.S. male population aged 13 and older, the rate of new HIV diagnoses among MSM in the United States is more than 44 times that of other men and more than 40 times HIV diagnoses among women. MSM is the only risk group in the United States in which new HIV infections are increasing.[1]

As the CDC's fiscal year 2011 Congressional Justification noted, MSM of all races/ethnicities are at increased risk, but substantial racial/ethnic disparities do exist among MSM, with Black and Hispanic MSM bearing the greatest burden of the disease. The most alarming HIV infection increases are occurring among MSM ages 13–29 and 45 and older.[2] Despite having lower infection rates than older MSM, younger MSM are more likely to have an undiagnosed HIV infection. HIV infection among MSM is facilitated by a number of factors including STIs, substance use, and community fatigue with HIV prevention messages. CDC should work with community leaders to inform methodology for communicating about HIV burden in MSM communities that encourages, rather than discourages, greater adoption of effective HIV prevention strategies.

According to the CDC, recent increases in syphilis have largely been seen among MSM and syphilis is associated with a two-to-five fold increased risk of HIV. Higher rates of gonorrhea, which also facilitates HIV acquisition and transmission, have been documented among MSM who are HIV-infected. Thus, more needs to be done to address STIs and HIV for MSM given their elevated risk for infection. CDC data published in 2005 suggest that as few as 1 in 5 MSM received individual or group-level HIV prevention interventions in the prior year.[3]

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[1] "CDC Fact Sheet: HIV and AIDS among Gay and Bisexual Men," Centers for Disease Control and Prevention (March 2010). Available at http://www.cdc.gov/nchhstp/newsroom/docs/FastFacts-MSM-FINAL508COMP.pdf.

[2] "Fiscal Year 2011 Centers for Disease Control and Prevention Justification of Estimates for Appropriations Committees," Department of Health and Human Services, 74. Available at http://cdc.gov/fmo/topic/Budget%20Information/appropriations__budget__form__pdf/FY2011__CDC__CJ__Final.pdf.

[3] "Fiscal Year 2011 Centers for Disease Control and Prevention Justification of Estimates for Appropriations Committees," 74.

CDC Program for MSM

In the fiscal year 2011 budget, the President has requested $27 million for CDC to undertake targeted HIV and STI prevention efforts for MSM. We understand this initiative will build on an effort begun in 2008, when the CDC provided $4 million in supplemental funding to 51 health departments to re-assess and strengthen their plans to address HIV among MSM in their jurisdictions. Harlem United is pleased that the CDC will expand this focused initiative to prevent HIV through holistic and integrated approaches to protect the health of gay, bisexual, and other MSM. We applaud this multiyear effort to prevent new HIV infections, reduce the acquisition of STIs, and address substance abuse. Harlem United hopes that additional resources will be directed to this effort as they are identified.

Studies show that the majority of individuals who are aware of their HIV-positive diagnosis proactively make changes to their behavior to prevent further spread of HIV. Increased access to routine HIV testing, irrespective of risk, is a key policy priority for Harlem United; as such, we hope that the expanded MSM effort will complement the 2010 HIV Expanded Testing Initiative focused on MSM.

We anticipate that the additional resources requested for fiscal year 2011 by the President will expand HIV testing and prevention services to more MSM who need them, improve monitoring for co-infections among MSM and HIV-infected persons, and support the development and refinement of intervention services specifically for MSM. Based upon the racial and ethnic burden of HIV/AIDS among Hispanic and Black MSM and Harlem United's strong commitment to serve this population, we are pleased that the CDC efforts will be focused on these populations.

Social determinants are an essential component to determining HIV vulnerability among MSM. Effective HIV prevention strategies must be mobilized simultaneously on an individual and community-level to successfully reduce HIV vulnerability and infections. We encourage CDC to utilize these new resources to promulgate a full continuum of HIV prevention interventions which provide MSM with an array of strategies that will best enable them to protect their sexual in the various ways they might experience HIV-risk in their lives. Harlem United maintains that HIV prevention among MSM should include the following initiatives:

—Increase capacity among existing community-based organizations whose primary focus is HIV prevention among MSM, particularly MSM of color, or have programs which focus primarily on HIV prevention among MSM;

—Targeted social and sexual network based HIV testing approaches, inclusive of Internet-based outreach;

—Peer-driven linkage to care initiatives that strive to connect newly diagnosed and lost-to-care HIV-positive MSM to high-quality and affordable healthcare; and

—Culturally competent social marketing campaigns which reach beyond HIV testing and condom use to educate MSM communities about strategies to protect themselves from HIV reflective of existing community risk behaviors.

Finally, given the alarming disparity of HIV and syphilis incidence among MSM, we also urge the CDC to assemble an MSM advisory group that would provide guidance to decisionmaking officials in the Division of HIV/AIDS Prevention on barriers to implementation and best practices to be replicated. Further, this advisory group would work with CDC to integrate HIV and STI prevention and screening programs in clinical and community-based settings.

We urge Congress to fulfill the President's request of $27 million for the CDC's MSM HIV and STI program and ensure that available resources reach communities and populations who need them most.

Conclusion

We very much appreciate the opportunity to provide written testimony in support of our Nation's efforts to prevent HIV/AIDS among gay, bisexual, and other MSM at the CDC. While President Obama's budget certainly reflects his commitment to the domestic fight against HIV/AIDS, any increase in funding Congress provides to the CDC program aimed at preventing HIV/AIDS and STIs among MSM would be greatly appreciated and would help us further our efforts to reverse the ever growing HIV epidemic in Harlem, other New York neighborhoods, and across the Nation.

Harlem United is a member of the Federal AIDS Policy Partnership and joins in the coalition's funding requests with respect to domestic HIV/AIDS prevention funding and its call for increased funding for the Ryan White Care Act programs.

Harlem United stands ready to be a resource for the subcommittee and its staff with respect to HIV/AIDS prevention, the care and treatment of individuals living with HIV/AIDS, and the provision of supportive services for individuals living with HIV/AIDS and the homeless.

PREPARED STATEMENT OF THE INTERNATIONAL FOUNDATION FOR FUNCTIONAL GASTROINTESTINAL DISORDERS

Thank you for the opportunity to present the views of the International Foundation for Functional Gastrointestinal Disorders (IFFGD) regarding the importance of functional gastrointestinal (GI) and motility disorders research.

Established in 1991, the IFFGD is a patient-driven nonprofit organization dedicated to assisting individuals affected by functional GI disorders, and providing education and support for patients, healthcare providers, and the public at large. The IFFGD also works to advance critical research on functional GI and motility disorders, in order to provide patients with better treatment options, and to eventually find a cure. The IFFGD has worked closely with NIH on a number of priorities, including the NIH State-of-the-Science Conference on the Prevention of Fecal and Urinary Incontinence in Adults through NIDDK, the National Institute of Child Health and Human Development (NICHD), and the Office of Medical Applications of Research (OMAR). I have served on the National Commission on Digestive Diseases (NCDD), which released a long-range road map for digestive disease research in 2009, entitled Opportunities and Challenges in Digestive Diseases Research: Recommendations of the National Commission on Digestive Diseases.

The need for increased research, more effective and efficient treatments, and the hope for discovering a cure for functional GI and motility disorders are close to my heart. My own personal experiences as someone suffering from functional GI and motility disorders motivated me to establish the IFFGD 19 years ago. I was shocked to discover that despite the high prevalence of these conditions among all demographic groups worldwide, such an appalling lack of dedicated research existed. This lack of research translates into a dearth of diagnostic tools, treatments, and patient supports. Even more shocking is the lack of awareness among both the medical community and the general public, leading to significant delays in diagnosis, frequent misdiagnosis, and inappropriate treatments including unnecessary medication and surgery. It is unacceptable for patients to suffer unnecessarily from the severe, painful, life-altering symptoms of functional GI and motility disorders due to a lack of awareness and education.

The majority of functional GI disorders have no cure and treatment options are limited. Although progress has been made, the medical community still does not completely understand the mechanisms of the underlying conditions. Without a known cause or cure, patients suffering from functional GI disorders face a lifetime of chronic disease management, learning to adapt to intolerable, disruptive symptoms. The medical and indirect costs associated with these diseases are enormous; estimates range from $25—$30 billion annually. Economic costs spill over into the workplace, and are reflected in work absenteeism and lost productivity. Furthermore, the emotional toll of these conditions affects not only the individual but also the family. Functional GI disorders do not discriminate, effecting all ages, races and ethnicities, and genders. These diseases account for significant lost opportunities for the individual as well as for society.

Irritable Bowel Syndrome (IBS)

IBS, one of the most common functional GI disorder, strikes all demographic groups. It affects 30 to 45 million Americans, conservatively at least one out of every 10 people. Between 9 to 23 percent of the worldwide population suffers from IBS, resulting in significant human suffering and disability. IBS is a chronic disease is characterized by a group of symptoms that may vary from person to person, but typically include abdominal pain and discomfort associated with a change in bowel pattern, such as diarrhea and/or constipation. As a "functional disorder", IBS affects the way the muscles and nerves work, but the bowel does not appear to be damaged on medical tests. Without a definitive diagnostic test, many cases of IBS go undiagnosed or misdiagnosed for years. It is not uncommon for IBS suffers to have unnecessary surgery, medication, and medical devices before receiving a proper diagnosis. Even after IBS is identified, treatment options are sorely lacking, and vary widely from patient to patient. What is known is that IBS requires a multidisciplinary approach to research and treatment.

IBS can be emotionally and physically debilitating. Due to persistent pain and bowel unpredictability, individuals who suffer from this disorder may distance themselves from social events, work, and even may fear leaving their home. Stigma surrounding bowel habits may act as barrier to treatment, as patients are not comfortable discussing their symptoms with doctors. Because IBS symptoms are relatively common and not life-threatening, many people dismiss their symptoms or attempt to self-medicate using over-the-counter medications. In order to overcome these barriers to treatment, ensure more timely and accurate diagnosis, and reduce

costly unnecessary procedures, educational outreach to physicians and the general public remain key.

Fecal Incontinence

At least 12 million Americans suffer from fecal incontinence. Incontinence is neither part of the aging process nor is it something that affects only the elderly. Incontinence crosses all age groups from children to older adults, but is more common among women and in the elderly of both sexes. Often it is a symptom associated with various neurological diseases and many cancer treatments. Yet, as a society, we rarely hear or talk about the bowel disorders associated with spinal cord injuries, multiple sclerosis, diabetes, prostate cancer, colon cancer, uterine cancer, and a host of other diseases.

Damage to the anal sphincter muscles; damage to the nerves of the anal sphincter muscles or the rectum; loss of storage capacity in the rectum; diarrhea; or pelvic floor dysfunction can cause fecal incontinence. People who have fecal incontinence may feel ashamed, embarrassed, or humiliated. Some don't want to leave the house out of fear they might have an accident in public. Most attempt to hide the problem for as long as possible. They withdraw from friends and family, and often limit work or education efforts. Incontinence in the elderly burdens families and is the primary reason for nursing home admissions, an already huge social and economic burden in our increasingly aged population.

In November of 2002, IFFGD sponsored a consensus conference entitled, Advancing the Treatment of Fecal and Urinary Incontinence Through Research: Trial Design, Outcome Measures, and Research Priorities. Among other outcomes, the conference resulted in six key research recommendations including more comprehensive identification of quality of life issues; improved diagnostic tests for affecting management strategies and treatment outcomes; development of new drug treatment compounds; development of strategies for primary prevention of fecal incontinence associated with childbirth; and attention to the process of stigmatization as it applies to the experience of individuals with fecal incontinence.

In December of 2007, IFFGD collaborated with NIDDK, NICHD, and OMAR on the NIH State-of-the-Science Conference on the Prevention of Fecal and Urinary Incontinence in Adults. The goal of this conference was to assess the state of the science and outline future priorities for research on both fecal and urinary incontinence; including, the prevalence and incidence of fecal and urinary incontinence, risk factors and potential prevention, pathophysiology, economic and quality of life impact, current tools available to measure symptom severity and burden, and the effectiveness of both short and long term treatment. For fiscal year 2010, IFFGD urges Congress to review the Conference's Report and provide NIH with the resources necessary to effectively implement the report's recommendations.

Gastroesophageal Reflux Disease (GERD)

Gastroesophageal reflux disease, or GERD, is a common disorder affecting both adults and children, which results from the back-flow of acidic stomach contents into the esophagus. GERD is often accompanied by persistent symptoms, such as chronic heartburn and regurgitation of acid. Sometimes there are no apparent symptoms, and the presence of GERD is revealed when complications become evident. One uncommon but serious complication is Barrett's esophagus, a potentially precancerous condition associated with esophageal cancer. Symptoms of GERD vary from person to person. The majority of people with GERD have mild symptoms, with no visible evidence of tissue damage and little risk of developing complications. There are several treatment options available for individuals suffering from GERD. Nonetheless, treatment response varies from person to person, is not always effective, and long-term medication use and surgery expose individuals to risks of side-effects or complications.

Gastroesophageal reflux (GER) affects as many as one-third of all full term infants born in America each year. GER results from an immature upper gastrointestinal motor development. The prevalence of GER is increased in premature infants. Many infants require medical therapy in order for their symptoms to be controlled. Up to 25 percent of older children and adolescents will have GER or GERD due to lower esophageal sphincter dysfunction. In this population, the natural history of GER is similar to that of adult patients, in whom GER tends to be persistent and may require long-term treatment.

Gastroparesis

Gastroparesis, or delayed gastric emptying, refers to a stomach that empties slowly. Gastroparesis is characterized by symptoms from the delayed emptying of food, namely: bloating, nausea, vomiting or feeling full after eating only a small amount of food. Gastroparesis can occur as a result of several conditions, including being

present in 30 percent to 50 percent of patients with diabetes mellitus. A person with diabetic gastroparesis may have episodes of high and low blood sugar levels due to the unpredictable emptying of food from the stomach, leading to diabetic complications. Other causes of gastroparesis include Parkinson's disease and some medications, especially narcotic pain medications. In many patients the cause of the gastroparesis cannot be found and the disorder is termed idiopathic gastroparesis. Over the last several years, as more is being found out about gastroparesis, it has become clear this condition affects many people and the condition can cause a wide range of symptom severity.

Cyclic Vomiting Syndrome

Cyclic vomiting syndrome (CVS) is a disorder with recurrent episodes of severe nausea and vomiting interspersed with symptom free periods. The periods of intense, persistent nausea, vomiting, and other symptoms (abdominal pain, prostration, and lethargy) lasts hours to days. Previously thought to occur primarily in pediatric populations, it is increasingly understood that this crippling syndrome can occur in a variety of age groups including adults. Patients with these symptoms often go for years without correct diagnosis. The condition leads to significant time lost from school and from work, as well as substantial medical morbidity. The cause of CVS is not known. Better understanding, through research, of mechanisms that underlie upper gastrointestinal function and motility involved in sensations of nausea, vomiting and abdominal pain is needed to help identify at risk individuals and develop more effective treatment strategies.

Support for Critical Research

IFFGD urges Congress to fund the NIH at level of $35 billion for fiscal year 2011, an increase of 12 percent over fiscal year 2010. This funding level will help preserve the initial investment in healthcare innovation established by the American Recovery and Reinvestment Act of 2009. Strengthening and preserving our Nation's biomedical research enterprise fosters economic growth, and supports innovations that enhance the health and well-being of the American people.

Concurrent with overall NIH funding, the IFFGD supports growth of research activities on functional GI and motility disorders, particularly through NIDDK and the Office of Research on Women's Health (ORWH). Increased support for NIDDK and ORWH will facilitate necessary expansion of the research portfolio on functional GI and motility disorders necessary to grow the medical knowledge base and improve treatment. Such support would also expedite the implementation of recommendations from the National Commission on Digestive Diseases.

Following years of near level-funding at NIH, research opportunities have been negatively impacted across all NIH Institutes and Centers, including NIDDK. With the expiration of funding from the American Recovery and Reinvestment Act of 2009, medical researchers run the risk of "falling off a cliff", stalling, if not losing promising research from that 2 year period. For this reason, the IFFGD encouraged support for initiatives such as the Cures Acceleration Network (CAN), authorized in the Patient Protection and Affordable Coverage Act. The IFFGD urges the Subcommittee to show strong leadership in pursuing a substantial funding increase for CAN through the fiscal year 2011 appropriations process.

Thank you for the opportunity to present the views of the functional GI disorders community.

LETTER FROM THE INDUSTRIAL MINERALS ASSOCIATION—NORTH AMERICA

APRIL 12, 2010.

Hon. TOM HARKIN,
Chairman, Subcommittee on Labor, Health and Human Services, and Education, and Related Agencies, Washington, DC.

Hon. THAD COCHRAN,
Ranking Member, Subcommittee on Labor, Health and Human Services, and Education, and Related Agencies, Washington, DC.

DEAR CHAIRMAN HARKIN AND RANKING MEMBER COCHRAN: I write to request additional appropriations for the Department of Labor's Mine Safety and Health Administration (MSHA). Specifically the Industrial Minerals Association—North America (IMA–NA) requests a one-time appropriation of $3.6 million to improve MSHA's communication capabilities, specifically videoconferencing capabilities, and $1.7 million annually thereafter to maintain and operate these enhanced communications capabilities. This funding level is adequate to establish enhanced communications

capabilities at 20 sites nationally and capable of reaching directly fully 80 percent of MSHA's approximately 2,500 employees.

It generally is recognized that mine inspectors need to stay abreast of the latest developments in mine safety, be informed of changes in regulatory standards and interpretations, be able to learn from mine incidents from various parts of the country, and feel a sense of connectedness with their headquarters in Arlington, Virginia. In light of recent tragic events in West Virginia, these constituent components of MSHA's mission take on added poignancy. To accomplish these important tasks, MSHA needs a state-of-the-art communications system. MSHA should be able to instantly and effectively communicate with, train, and retrain its inspectors over distance.

You may be aware that the Department of Labor's Office of Inspector General recently released an audit report regarding "Journeyman Mine Inspectors Do Not Receive Mandated Periodic Retraining." Report Number 05–10–001–06–001 (http://www.oig.dol.gov/public/reports/oa/2010/05-10-001-06-001.pdf). The additional appropriations requested for enhanced communications capabilities could go a long way toward addressing issues raised in this report.

The communications systems relied upon by MSHA are antiquated and ineffective. MSHA is relying on dated communications and IT infrastructure that is decades behind the capabilities of those they regulate. They also are substandard when compared to those of the National Institute for Occupational Safety and Health, the mine safety and health research agency that supports MSHA's mission. This is not acceptable.

Similarly, MSHA's ability to perform meaningful stakeholder education and outreach demands state-of-the-art communications systems. Adequately trained inspectors and consistency of enforcement are necessary components of MSHA's mission and the lack of appropriate information technology infrastructure frustrates their full implementation. Less than full implementation frustrates stakeholders. For instance, the enhanced communications capability requested could allow a mine operator at a locally convenient site to consult with MSHA officials at a distant site. Similarly, the enhanced communications capabilities could be used broadly, permitting MSHA to educate stakeholders and perform industry outreach by district, regionally and nationally, benefiting mine operators and miners alike.

IMA–NA respectfully requests your support for additional funding to improve MSHA's communication capabilities, specifically videoconferencing capabilities.

The IMA–NA is a trade association organized to advance the interests of North American companies that mine or process industrial minerals. These minerals are used as feedstocks for the manufacturing and agricultural industries and are used to produce essential products. Industrial minerals are critical to the manufacture of glass, ceramics, paper, plastics, rubber, insulation, pharmaceuticals, and cosmetics. They also are used to make foundry cores and molds used for metal castings, and in paints, filtration, metallurgical applications, refractory products and specialty fillers. The IMA–NA membership includes producers of ball clay, barite, bentonite, borates, calcium carbonate, diatomite, feldspar, industrial sand, magnesia, mica, soda ash (trona), talc, wollastonite and other minerals. IMA–NA's membership also includes many of the suppliers to the industrial minerals industry, including equipment manufacturers, railroads and trucking companies, and consultants. Finally, the following hyperlink will direct you to our Web site, which provides additional information on this important mining sector (http://www.ima-na.org).

Thank you for your timely consideration of this request.

Sincerely,

MARK G. ELLIS,
President.

PREPARED STATEMENT OF THE INTERSTATE MINING COMPACT COMMISSION

We are writing in support of the fiscal year 2011 budget request for the Mine Safety and Health Administration (MSHA), which is part of the U.S. Department of Labor. In particular, we urge the subcommittee to support a full appropriation for grants to States for safety and health training of our Nation's miners pursuant to section 503(a) of the Mine Safety and Health Act of 1977. MSHA's budget request for state grants is $8.941 million. This is the same amount that has been appropriated for State training grants by Congress over the past 2 fiscal years and, as such, does not fully consider inflationary and programmatic increases being experienced by the States. We therefore urge the subcommittee to restore funding to the statutorily authorized level of $10 million for State grants so that States are able

to meet the training needs of miners and to fully and effectively carry out State responsibilities under section 503(a) of the act.

The Interstate Mining Compact Commission (IMCC) is a multi-state governmental organization that represents the natural resource, environmental protection, and mine safety and health interests of its 24 member States. The States are represented by their Governors who serve as commissioners.

IMCC's member States are concerned that without full funding of the State grants program, the federally required training for miners employed throughout the United States will suffer. States are struggling to maintain efficient and effective miner training and certification programs in spite of increased numbers of trainees and the incremental costs associated therewith. State grants have flattened out over the past several years and are not keeping place with inflationary impacts or increased demands for training. The situation is of particular concern given the enhanced, additional training requirements growing out of the recently enacted MINER Act and MSHA's implementing regulations.

As you consider our request to increase MSHA's budget for State training grants, please keep in mind that the States play a particularly critical role in providing special assistance to small mine operators (those coal mine operators who employ 50 or fewer miners or 20 or fewer miners in the metal/nonmetal area) in meeting their required training needs.

We appreciate the opportunity to submit our views on the MSHA budget request as part of the overall Department of Labor budget. Please feel free to contact us for additional information or to answer any questions you may have.

PREPARED STATEMENT OF THE INTERNATIONAL MYELOMA FOUNDATION

The International Myeloma Foundation (IMF) appreciates the opportunity to submit written comments for the record regarding fiscal year 2011 funding for myeloma cancer programs. The IMF is the oldest and largest myeloma foundation dedicated to improving the quality of life of myeloma patients while working toward prevention and a cure

To ensure that myeloma patients have access to the comprehensive, quality care they need and deserve, the IMF advocates on-going and significant Federal funding for myeloma research and its application. The IMF stands ready to work with policymakers to advance policies and programs that work toward prevention and a cure for myeloma and for all other forms of cancer.

Myeloma Background

Myeloma is a cancer in the bone marrow affecting production of red cells, white cells, and stem cells. It is also called "multiple myeloma" because multiple areas of bone marrow may be involved. Myeloma is the second most common blood cancer after lymphomas and its prevalence appears to be is increasing significantly. At any one time there are over 100,000 myeloma patients undergoing treatment for their disease in the United States. In 2009, 20,580 Americans were diagnosed with myeloma and 10,580 lost their battle with this disease.

Although the incidence of many cancers is decreasing, myeloma cases are increasing in incidence. Once almost exclusively a disease of the elderly, myeloma is now being found in increasing numbers in people under the age of 65, and it is not uncommon for patients to be diagnosed in their 30s. IMF-funded research suggests that much of this increase is being caused by environmental toxins. To give just one example supporting this hypothesis, relatively recent published reports in the peer-reviewed literature have identified a disproportionate incidence of myeloma among clean-up and rescue workers at the 9/11 World Trade Center site.

In recent years significant gains have been made, extending myeloma patients' lives and improving their quality of life. Furthermore, progress begun in myeloma is already helping patients with other blood cancers and even solid tumors. Now it's important to maintain that momentum.

—There is no cure for myeloma

—Remissions are not permanent

—Additional treatment options are essential

At the same time, even while they live with the disease, myeloma patients can suffer debilitating fractures and other bone disorders, severe side effects of certain treatments, and other problems that profoundly affect their quality of life, and significantly impact the cost of their healthcare.

Sustain and Seize Cancer Research Opportunities

Myeloma research is producing extraordinary breakthroughs—leading to new therapies that translate into longer survival and improved quality of life for

myeloma patients and potentially those with other forms of cancer as well. Myeloma was once considered a death sentence with limited options for treatment, but today myeloma is an example of the progress that can be made and the work that still lies ahead in the war on cancer. Many myeloma patients are living proof of what innovative drug development and clinical research can achieve—sequential remissions, long-term survival, and good quality of life. Our Nation has benefited immensely from past Federal investment in biomedical research at the National Institutes of Health (NIH) and the IMF advocates $33.349 billion for NIH in fiscal year 2011.

A study in the Journal of Clinical Oncology projects that the number of new cancer cases diagnosed each year will jump 45 percent in the next 20 years. In multiple myeloma an even greater increase (57 percent) is projected, and we are already seeing increasing diagnoses in patients under age 65 including patients in their 30s, in what was once a rare disease of the elderly.

While a number of cancers have achieved 5-year survival rates of over 80 percent since passage of the National Cancer Act of 1971, significant challenges still remain for other cancers. In fact, more than half of the 562,340 cancer deaths in 2009 were caused by just eight forms of cancer with 5-year survival rates of 45 percent or less—of which myeloma is one. Yet, myeloma and these other cancers have historically also received the least amount of Federal funding. As we have seen mortality rates of diseases such as breast cancer, prostate cancer, AIDS, and childhood leukemia greatly reduced through targeted, comprehensive, and well-funded programs that have led to earlier detection and superior forms of treatment, so too must we shine a brighter light on myeloma and the other seven deadly cancers to achieve this same goal for them. The IMF urges Congress to allocate $5.957 billion to the National Cancer Institute (NCI) in fiscal year 2011 to continue our battle against myeloma.

Boost Our Nation's Investment in Myeloma Prevention, Early Detection, and Awareness

As the Nation's leading prevention agency, the Centers for Disease Control and Prevention (CDC) plays an important role in translating and delivering at the community level what is learned from research. Therefore, the IMF advocates $6 million for the Geraldine Ferraro Blood Cancer Program. Authorized under the Hematological Cancer Research Investment and Education Act of 2002, this program was created to provide public and patient education about blood cancers, including myeloma.

With grants from the Geraldine Ferraro Blood Cancer Program, the IMF has successfully promoted awareness of myeloma, particularly in the African-American community and other underserved communities. IMF accomplishments include the production and distribution of more than 4,500 copies of an informative video which addresses the importance of myeloma awareness and education in the African-American community to churches, community centers, inner-city hospitals, and Urban League offices around the country, increased African-American attendance at IMF Patient and Family Seminars (these seminars provide invaluable treatment information to newly diagnosed myeloma patients), increased calls by African-American myeloma patients, family members, and caregivers to the IMF myeloma hotline, and the establishment of additional support groups in inner city locations in the United States to assist underserved areas with myeloma education and awareness campaigns. Furthermore, the more than 90 IMF-affiliated patient support groups in the United States also made this effort their main goal during Myeloma Awareness Week in October 2005.

An allocation of $6 million in fiscal year 2011 will allow this important program to continue to provide patients—including those populations at highest risk of developing myeloma—with educational, disease management and survivorship resources to enhance treatment and prognosis.

Conclusion

The IMF stands ready to work with policymakers to advance policies and support programs that work toward prevention and a cure for myeloma. Thank you for this opportunity to discuss the fiscal year 2011 funding levels necessary to ensure that our Nation continues to make gains in the fight against myeloma.

PREPARED STATEMENT OF THE JEFFREY MODELL FOUNDATION

Mr. Chairman and members of the subcommittee: Thank you for the opportunity to present this testimony to the subcommittee. My husband Fred and I created the Jeffrey Modell Foundation in 1987 in memory of our son, Jeffrey, who died at the

age of 15 as a result of a life long battle against one of the estimated 160 primary immunodeficiency (PI) diseases.

The Jeffrey Modell Foundation is an international organization with its headquarters in New York City. In the 24 years since we established it, the Foundation has grown into the premier advocacy and service organization on behalf of people afflicted with PI diseases. As a demonstration of the extent to which the JMF leads in the field, please consider the following:

—The Foundation has created Jeffrey Modell Research and Diagnostic Centers at 72 academic and teaching hospitals from coast to coast in the United States and throughout the world. They are located on every continent. In addition, we are affiliated with more than 415 referring physicians at 171 academic medical centers in 59 countries and 169 cities, again located on every continent throughout the world.

—The Foundation conducts a National Physician Education and Public Awareness Campaign, currently funded with approximately $3.1 million appropriated by this subcommittee to the Centers for Disease Control and Prevention (CDC) and awarded by competitive contract to the Foundation. To date, the Foundation has leveraged the Federal money to generate in excess of $125 million in donated media with hundreds of thousands of placements on television, radio, print, and other public media, as well as a 30-minute program produced for PBS. The Campaign has also included physician symposia, conducted for CME credits in locations throughout the country. It has also included mailings to physicians in a variety of specialist and primary care fields, including pediatrics and several pediatric specialties, family practice, and internal medicine, as well as school nurses, clinical and registered nurses and daycare centers.

—In addition, the Jeffrey Modell Foundation has been the leader in advancing newborn screening for some of the most severe forms of PI. Working with the CDC, National Institutes of Health (NIH), UCSF and private industry, we helped fund the development of a newborn screening test that was pilot tested in Wisconsin. The results were so successful that Wisconsin and Massachusetts have now implemented population-based screening of every baby born in their States. Then, in January of this year, we were successful in having the Secretary's Advisory Committee for Children with Heritable Disorders add this test to the core panel of 29 newborn screening tests recommended for the States to utilize. It is the first test to be added since the core panel was created in 2005. The test is already saving lives and we know that as more states adopt it, many more will be saved.

First and foremost, Mr. Chairman, we want to thank you and all the members of this subcommittee on both a personal and a professional level. Personal because whenever we come to Washington, whether it is to testify here before the subcommittee or to meet with the members of the subcommittee individually in their offices, every Member of Congress and every member of your staffs are unfailingly polite, courteous, interested, and caring. The warm and understanding response that we receive makes this a labor of love for us.

And, professional because over the 12 years that we have been coming to Washington, we have been given the opportunity to build a partnership with the Congress, CDC, NIH, as well as with our own supporters in the private sector, including industry and other concerned donors. We believe that we have maximized the benefits for patients from the support that this subcommittee has afforded us. I would like to take a few minutes to discuss where we are, where we are going with your continued support, and some changes that are need in the President's budget request to help us help patients.

PI Education and Awareness Program

This subcommittee is currently providing CDC with $3.1 million for physician education and public awareness of immunodeficiencies for fiscal year 2010. This is part of an overall budget of $12.3 million for the Office of Public Health Genomics, which uses the remaining $9.2 million for its operations.

Since the Campaign's inception, it has generated more than $125 million in donated media, including television and radio spots, magazine ads, billboards, airport signs, and other print media. It has also enabled us to generate additional funding from the private sector—both individuals and the pharmaceutical industry. To this point, every $1 of Federal funds provided by the subcommittee to this program has been leveraged into more than $10 for this education and awareness program.

Most importantly, Mr. Chairman, I am delighted to report to you that the program that this subcommittee has funded is having exactly the impact that all of us hoped it would when it was created. Allow me to give you some specifics.

Surveying the physicians at the Jeffrey Modell Centers Referral Network we have learned that the number of patients referred, diagnosed and treated has doubled every year since the program's inception. The negative health outcomes of undiagnosed cases—infections, hospital and physician visits, and similar costs—decrease an average of 70 percent for diagnosed patients.

But, it is fair of this subcommittee to ask "so what?" What difference does it make to the health of these patients if they are now in treatment? What is the real impact in a real world sense on the patients that are found?

The economic impact of PI diagnosis has been carefully assessed comparing the costs of treatment before diagnosis and after. In round numbers what we learned was that the average annual cost of healthcare for an undiagnosed patient is $103,000 per year. The same costs for the same patients in the year after diagnosis are $23,000. The gross annual savings to the healthcare system is $80,000 per patient.

Mr. Chairman, this program is working and we are delighted. But this is where the problem comes along. The President's budget for fiscal year 2011 reduces funding for the Office of Public Health Genomics from $12.3 million to $11.7 million. Further it eliminates the line item created by this subcommittee to fund the education and awareness program. While CDC has indicated its support for continuing the program, the only guarantee that will happen is if you act.

For this reason, we are asking that you take three modest steps as you are assembling the Chairman's mark for the bill:

—First, restore the total line item for the Office of Public Health Genomics to its fiscal year 2010 level of $12,308,000.

—Second, break that money out into two separate lines, as its now—$9,201,000 for the Office and $3,107,000 for PI Education and Awareness.

—Third, so that there is no misunderstanding, include a paragraph of Committee Report language that says:

"The subcommittee believes that the education and awareness program for primary immunodeficiencies has been a model of public-private cooperation and therefore has restored the current structure for the Office of Public Health Genomics budget. The program's success in leveraging public money for private investment has resulted in a huge return on the Federal dollar, led to reduced health disparities, and will save lives as the program directs greater attention to newborn screening."

Newborn Screening Program

As described above, early diagnosis is critical to the health of patients and to saving the healthcare system money. And, there are few better examples of early diagnosis than newborn screening. The JMF has worked long and hard to support the development of a newborn screening program for some of the most severe and deadly forms of PI.

Early detection of these diseases through newborn screening is critical because bone marrow transplants cure more than 98 percent of infants who have the procedure before developing any serious infections. The treatment costs less than $10,000. However, if an infant receives a transplant after developing severe infections, the success rate is only between 60 and 70 percent; the costs associated with the treatment of these infants can be as high as $1 million during their lifetime.

As described above, the Secretary's Advisory Committee on Children with Heritable Disorders has recommended to the Secretary that this test be added to the core panel that forms the basis of newborn screening in States throughout the Nation. It is the first time the list has ever been amended since it was created 5 years ago. The Jeffrey Modell Foundation is proud to have played a role in this advancement for babies and we are urging the Secretary to accept the recommendation promptly.

Once she has done so, newborn screening officials in numerous States have advised us that they will move forward with including this test in their States. At that time, the Foundation is committed to moving forward with the production of educational materials for State labs and families that will provide the information they need to consider the results of the test their baby is having. The funds for the education and awareness program are critical for making the most of this important improvement in public health.

Conclusion

With the support the Jeffrey Modell Foundation has received from this subcommittee over the years, we have been able to increase the public's awareness of PI and most importantly improve and save lives. We are grateful for your past and continued support. While we understand that the subcommittee must make difficult

decisions in this fiscal environment, please remember that the Foundation has successfully leveraged Federal dollars to expand the reach of all of our activities. Frankly, the collaboration between the Federal government and the Jeffrey Modell Foundation has been a model for successful public-private collaborations. The impact of every Federal dollar spent on the education and awareness campaign and on newborn screening has been exponentially increased by our commitment to bring the Foundation's resources to bear.

We ask again that you restore the funding to fiscal year 2010 levels; break out PI Education and Awareness into a separate line item; and include the report language provided to assure that this program maximizes its impact.

Mr. Chairman, again, we are delighted to have the opportunity to present to the subcommittee and stand ready to work with you.

PREPARED STATEMENT OF KNOWLEDGE ALLIANCE

On behalf of Knowledge Alliance, we are pleased to submit this testimony to the subcommittee regarding our recommendations for the fiscal year 2011 Labor, Health and Human Services, and Education, and Related Agencies appropriations bill as they relate to the U.S. Department of Education.

Knowledge Alliance is a nonprofit, nonpartisan trade association dedicated to expanding the use of research-based knowledge in policy and practice in K–12 education. We are a strong and dynamic community of highly successful education organizations and agencies, all of which are constantly looking for new and better ways to support high-quality education research, development, dissemination, technical assistance, and evaluation at the Federal, regional, State, tribal, and local levels.

Much of our collective work is focused on advancing the effective use of research-based knowledge as catalyst for innovation and transformation in K–12 education and as a central organizing concept for education reform moving forward. We firmly believe that the effective creation, translation, and application of research-based knowledge can significantly accelerate and bring to scale nationwide efforts to improve academic performance and close achievement gaps for all students. Effective knowledge use also helps advance the national initiatives to transform education into an evidence-based field and enhance the implementation of the American Recovery and Reinvestment Act (ARRA), the Elementary and Secondary Education Act (ESEA) and the Education Sciences Reform Act.

CRITICAL CHALLENGES

We believe that now is the time to intensify the focus on creating, translating, and applying research-based knowledge into useful tools that will improve classroom policies and practices in all schools for the following critical reasons:

Seriously Deficient Investments in Education R&D.—ESEA requires educators to use instructional practices and innovations supported by research, but the Department of Education spends less than 1 percent of its budget on research, development and statistics, the smallest of any Cabinet-level agency.

[in billions of dollars]

Federal department/agency	Fiscal year 2009 research and development request
Defense	$80.7
Health and Human Services	29.9
NASA	10.7
Energy	10.6
National Science Foundation	5.2
Agriculture	2
Commerce	1.2
Homeland Security	1.1
Transportation	901
Veterans Affairs	884
Interior	617
Environmental Protection Agency	550
Education	324

Source: American Association for the Advancement of Science.

This low level of investment means that education is ill equipped to rapidly develop, deliver, and scale innovations as is done in other sectors through R&D. The

bottom line is that schools and students will suffer without an increased investment in developing and testing research-based practices.

Rapidly Expanding Capacity Crisis.—According to a recent Center on Education Policy report, about one-third of U.S. public schools did not make AYP in school year 2008–2009. In nine States and the District of Columbia, at least half the public schools did not make AYP in 2008–2009. In a majority of the States (35 including D.C.), at least one-fourth of the schools did not make AYP. States and districts currently lack the sufficient funds, staff, and expertise to address the growing demand to support low-performing schools. This capacity crisis only exacerbates the complex challenges of transforming low-performing schools and preparing all schools for the next generation of learning.

Urgent Need for Solutions.—Federal education policy has evolved in phases over the past 15 years. The focus on standards and assessments in the late 1980s and early 1990s spawned major attention on the alignment of standards, curriculum, and assessments in the 1990s, which played a role in the current emphasis on accountability. The next logical step in this standards-based continuum is a more comprehensive and vigorous focus on solutions to bring about real school improvement by providing significant new resources and expertise targeted to turning around low-performing schools and to building a knowledge-based capacity and infrastructure for sustained improvement.

RECOMMENDATIONS

Our appropriations proposal for fiscal year 2011 calls for greater Federal investments in research-based programs to help States and districts respond to the rapidly increasing needs We urge a stronger and more comprehensive Federal effort to respond both to the greater demand for knowledge-based solutions and to the underfunded supply of well-tested practices and programs. Specifically, we propose the following:

TOP PRIORITY: A KNOWLEDGE, INNOVATION, AND IMPROVEMENT PACKAGE

We urge you to consider six essential and interrelated programs as a knowledge-innovation-improvement package:

Comprehensive Centers

Recommendation: $67.3 million ($10 million increase more than President's request for fiscal year 2011).

Our proposed recommendation includes an increase of $500,000, or 20 percent, of additional funding for each Comprehensive Center which would enable the 16 regional centers to expand their capacity building work with SEAs in such areas as resource allocation, data use, teacher effectiveness and school improvement. In addition, the proposed increase would support the five content centers school improvement efforts in providing in-depth, specialized support in five key areas focusing on assessment and accountability, instruction, teacher quality, innovation and improvement and high schools. The increase would also enable the Centers to help States sustain their one-time ARRA school improvement efforts.

Regional Educational Laboratories

Recommendation: $80.6 million ($10 million increase more than President's request for fiscal year 2011).

The Regional Educational Laboratory Program is composed of a network of 10 laboratories that serve the education reform and school improvement needs of designated regions through rigorous research studies and rapid response reports. Our proposed increase would expand a special triage "urgent response" system to address the most pressing, immediate educational reform issues in each region. This request, if fulfilled, would enable the labs to further support the crucial initiatives that are being implemented via the ARRA.

Research, Development, and Dissemination

Recommendation: $261 million (same as the President's request for fiscal year 2011).

Our recommendation would allow IES to continue to fund more high-quality applications under existing programs of research, development, and dissemination in areas where the knowledge of learning and instruction is inadequate. This recommendation would also enable IES to invest in new grants to support evaluations at the State and district level to evaluate whether reforms undertaken with funds awarded under ARRA are producing the desired improvements on student achievement and other critical outcomes. Finally, the recommended boost of $175 million

would create a sustainable venture fund for investing in what works in education reform, as conceived in ARRA.

School Turnaround Grants

Recommendation: $900 million (same as the President's request for fiscal year 2011).

The $354.4 million increase requested for the School Turnaround Grants (currently School Improvement Grants) program would help build State and local capacity to identify and implement effective interventions to turn around their lowest-performing schools. The proposed increase would create a sustainable base for long-term school improvement efforts.

Investing in Innovation Fund

Recommendation: $500 million (same as the President's request for fiscal year 2011).

The request would support a newly authorized ESEA program, modeled after the i3 program authorized by the ARRA. The proposed request would also provide a substantial Federal investment for scaling and sustaining evidence based innovations. The request is a bold step in the right direction in building from and on a knowledge base for reform.

Race to the Top

Recommendation: $1.35 billion (same as the President's request for fiscal year 2011).

The request would support a newly authorized ESEA program, modeled after the Race to the Top program authorized by the ARRA. The program would create incentives for State and local reforms and innovations designed to support comprehensive reforms that lead to significant improvements in student achievement and close the achievement gaps. The program would also encourage the broad identification, dissemination, adoption, and the use of effective policies and practices.

IMPORTANT SUPPORT: PROGRAMS CONTRIBUTING TO INNOVATION AND IMPROVEMENT

We recommend continued support for the following programs which will play an increasingly significant role in State and local efforts to respond to the escalating demand for school improvement and solutions.

—21st Century Community Learning Centers Recommendation: $1.16 billion (same as the President's request)
—Education for Homeless Children and Youth Recommendation: $65.4 million (same as the President's request)
—English Language Acquisition Recommendation: $800 million (same as the President's request)
—Even Start Recommendation: $66.4 million (same as fiscal year 2010)
—High School Graduation Initiative Recommendation: $100 million ($50 million increase more than fiscal year 2010)
—Improving Teacher Quality State Grants Recommendation: $2.94 billion (same as fiscal year 2010)
—Math Science Partnerships (ED) Recommendation: $180.5 million ($1.5 million increase more than fiscal year 2010)
—National Center for Education Statistics Recommendation: $117 million (same as the President's request)
—Parental Information and Resource Centers Recommendation: $39.4 million (same as fiscal year 2010)
—Smaller Learning Communities Recommendation: $88 million (same as fiscal year 2010)
—Special Education Research and Evaluation programs Recommendation: $82 million (same as the President's request)
—Statewide Data Systems Recommendation: $100 million (same as the President's request)
—Striving Readers Recommendation: $370 million ($120 million increase more than fiscal year 2010)
—Technology State Grants Recommendation: $100 million (same as fiscal year 2010)

In total, we believe it has never been more important to expand the Federal supported knowledge-innovation-improvement infrastructure and to deliver research-based solutions to schools with the greatest needs to improve. Congress is uniquely positioned to turn the page on past efforts and to lead us into a new era of innovation and transformation of our public school system.

Indeed now is the time to unleash America's ingenuity to solve our most pressing education problems, deliver break-the-mold solutions to our schools, and guide a new knowledge and innovation revolution in teaching and learning.

Thank you for your consideration.

PREPARED STATEMENT OF THE LIONS CLUBS INTERNATIONAL FOUNDATION

I would like to begin by thanking Chairman Tom Harkin, Ranking Member Thad Cochran and members for the opportunity to provide this testimony on spending priorities before the Labor, Health and Human Services, and Education, and Related Agencies Subcommittee. I would also like to congratulate you, Mr. Chairman, and your colleagues, for examining the way service organizations can collaborate with the Federal Government in meeting pressing community needs for improved health and education services.

Lions Clubs International represents the largest and most effective NGO service organization presence in the world. Awarded and recognized as the #1 NGO organization for partnership globally by The Financial Times 2007, Lions Clubs International also holds the highest four star (highest) rating from the CharityNavigator.com (an independent review organization). Lions and its official charity arm, Lions Clubs International Foundation (LCIF), have been world leaders in serving the vision, hearing, youth development, and disability needs of millions of people in America and around the world, and we work closely with other NGOs such as Special Olympics International to accomplish our common service goals. Since LCIF was founded in 1968, it has awarded more than 9,000 grants, totaling more than $640 million for service projects ranging from affordable hearing aids to diabetes-prevention.

Our current 1.3 million-member global membership, representing over 200 countries, serves communities through the following ways: protect and preserve sight; provide disaster relief; combat disability; promote health; and serve youth. The 14,000 individual Lions Clubs representing 400,000 individual citizens in North America are constantly expanding to add new programs its volunteers are working to bring health services to as many communities as possible.

Some of our major collaborative partners include: Habitat for Humanity, Special Olympics, the U.S. National Eye Institute, CADCA (Community Anti-Drug Coalition of America), Service Nation and many others.

Today, we face many complex challenges in the health and education sector, from preventable diseases that cause blindness in children to bullying, violence, and drug use among school-aged children. I will offer a brief summary of my remarks through an overview of where Lions Clubs International is involved in programs under the general jurisdiction of the Labor, Health and Human Services, and Education, and Related Agencies Subcommittee, and where we recommend areas where Federal partnerships should be maintained and strengthened.

HEALTH AND HUMAN SERVICES

Domestic Sight Services.—Through our network of foundations and programs across America, Lions remains the single largest provider of charitable vision care, eyeglasses and hearing care services to needy and indigent people. Some of our major sight initiatives include:

—The Sight for Kids Program in collaboration with Johnson and Johnson. The program has provided 6 million vision screenings and eye-health education programs for children.

—Core 4 Preschool Vision Screening program enables Lions to conduct screenings for children in preschools. The program strives to deliver early detection and treatment for the most common vision disorders that can lead to amblyopia or "lazy eye." LCIF has also provided grants and services to those affected by eye conditions that cannot be improved medically.

—Last August Lions Clubs sponsored "United We Serve Health Week" Signature Events around the country. These Health Week efforts, in conjunction with the White House, were effective in bringing awareness to vision health issues.

Vision Health Recommendations

Last year, the U.S. House overwhelmingly passed H.R. 577, the Vision Care for Kids Act, a bill that provides for comprehensive eye examinations to eligible children who have been screened, and to provide treatment or services to these children. We strongly support efforts to pass the Senate companion bill, Senator Kit Bond's S. 259.

Our network of clubs, foundations and institutions continue to supplement public health efforts in this area through free vision screenings, fittings for eyeglasses, free prescription eyeglasses, and health education programs. The Lions eye-screening program for our youngest and most vulnerable citizens has potential to expand output with the securing of significant support from policymakers in States and districts with strong Lions Club participation. This is particularly relevant in providing mobile eye screening programs for glaucoma and amblyopia treatment and follow up services in areas that are economically disadvantaged and include high-risk urban and rural populations.

There is recent congressional support for the continuation and expansion of collaborative efforts between the Office of Head Start and stakeholders to ensure that all Head Start enrollees receive vision screening services and other resources available to them in their community. This is an effective means of ensuring that congressionally directed funding serve the communities where mobile screening units and preschool testing is most needed in a cost-effective manner. Again, for many localities in need of screening services, there is ample opportunity to expand comprehensive vision screening services so that no children are "left to fall through the cracks."

Special Olympics "Healthy Athletes" Program

Lions Clubs International is a central part of a global team of healthcare volunteers who participate in the Special Olympics Healthy Athletes program. The Opening Eyes program is a vision and eye health screening program that has provided some 100,000 visions screenings for Special Olympic Athletes. More than 40,000 Special Olympic athletes have received free prescription eyeglasses to date.

Lions supports further congressional funding for "Healthy Athletes" and its crucial mission to: improve access and healthcare for Special Olympics athletes; make referrals to local health practitioners when appropriate; train healthcare professionals and students about the needs and care of people with intellectual disabilities; collect, analyze and disseminate data on the health status and needs of people with intellectual disabilities; and advocate for improved health policies and programs for people with intellectual disabilities.

Lions Affordable Hearing Aid Project (AHAP)

Lions Clubs International is committed to fighting hearing loss as well as blindness. By listening to community health organizations across the country, Lions Clubs International and their volunteer members became aware of the lack of quality and affordable hearing care, especially for people with incomes below or at 200 percent of the poverty level. Many people have been unable to access other personal and family resources to purchase hearing aids, and have been denied State and Federal assistance. Lions Clubs 14 centers have been working to expand output in this area as demand continues to rise with a network of mobile health units and community based programs that screen more than 2 million people each year and provide hearing aids to 14,000 low income patients.

The statistics are unacceptable: 31 million persons in the United States experience some form of hearing loss, yet only 7.3 million opt to use hearing aids. According to audiology researchers, the market penetration for hearing aids is about 23.6 percent. For every four patients that enter a practice needing hearing aids, only one will purchase them. The median price tag is $1,900 (2005) for a digital hearing aid and prices go as high as $4,000. State Foundations, public health departments, and aging departments are in need of assistance in this area.

With the recent 25–30 percent increase in people seeking assistance for hearing aids, there is an immediate public imperative to address the problem. Federal dollars are stretched, but Federal support in this area would have significant public health dividends in difficult economic times.

"LIONS QUEST"/EDUCATION PROGRAMS

Lions Clubs International's youth development initiatives, known collectively as "Lions Quest," have been a prominent part of school-based K–12 programs since 1984. Fulfilling its mission to teach responsible decisionmaking, effective communications and drug prevention, Lions Quest has been involved in training more than 350,000 educators and other adults to provide services for more than 11 million youth in programs covering 43 States. LCIF currently invests more than $2 million annually in supporting life skills training and service learning, and that funding is matched by local Lions, schools, and other partners.

Lions Quest curricula incorporate parent and community involvement in the development of health and responsible young people in the areas of: life skills development (social and emotional learning), character education, drug prevention, service

learning, and bullying prevention. There is even a physical fitness component to this program that can assist Federal goals of reducing obesity in school-aged children.

These Lions Quest programs provide strong evidence of decreased drug use, improved responsibility for students own behavior, as well as stronger decisionmaking skills and test scores in math and reading. In August 2002, Lions Quest received the highest "Select" ranking from the University of Illinois at Chicago-based Collaborative for Academic, Social and Emotional Learning (CASEL) for meeting standards in life skills education, evidence of effectiveness and exemplary professional development.

Lions Quest has extensive experience with Federal programs. Lions Quest Skills for Adolescence received a "Promising Program" rating from the U.S. Department of Education Safe and Drug Free Schools and a "Model" rating from the U.S. Department of Health and Human Services Substance Abuse and Mental Health Services Administration (SAMHSA).

Lions Quest also has extensive experience of partnering with State service commissions to reach more schools and engage more young people in service learning. Successful partnerships have been active in Michigan, New York, Oklahoma, Tennessee, and West Virginia with progress being made in Texas and Ohio.

Service Learning Initiatives

Lions Quest has also pursued Learn and Serve Grant funding to support implementation of Lions Quest programming in several States. We strongly support Congressional efforts to fund the Edward M. Kennedy Serve America Act that was signed into law 1 year ago. The Serve America Act authorizes the Corporation for National and Community Service to expand existing programs and add several new programs and initiatives to provide service learning school-based programs for students as well as Innovative and Community-Based Service-Learning Programs and Research. Another program of value that was authorized by the Edward M. Kennedy Act is the Social Innovation Fund that provides growth capital and other support so that the most effective programs can be identified.

Social and Emotional Learning (SEL) Programs

In addition, Lions Clubs recommends Congressional support for social and emotional learning (SEL) programs that stimulate growth among schools nationwide through distribution of materials and teacher training, and to create opportunities for youth to participate in activities that increase their social and emotional skills. Not only do SEL curricula contribute to the social and emotional development of youth, but they also provide invaluable support to students' school success, health, well-being, peer and family relationships, and citizenship. While still conducting scientific research and reviewing the best available science evidence, over time Lions Clubs and its SEL partners have increasingly worked to provide SEL practitioners, trainers and school administrators with the guidelines, tools, informational resources, policies, training, and support they need to improve and expand SEL programming.

Overall, SEL training programs and curricula have outstanding benefits for school-aged children:

—SEL prevents a variety of problems such as alcohol and drug use, violence, truancy, and bullying. SEL programs for urban youth emphasize the importance of cooperation and teamwork.

—Positive outcomes increase in students who are involved in social and emotional learning programming by an average of 11 percentile points over other students.

—With greater social and emotional desire to learn and commit to schoolwork, participants benefit from improved attendance, graduation rates, grades, and test scores. Students become caring, concerned members of their communities.

CONCLUSION

Lions Clubs remains committed to domestic activities such as major sight initiatives and positive youth development and youth service programs. Today we face great health and educational challenges, and Lions Clubs International understands the importance not only of community service but of instilling those values among members of our next generation. The success of nonprofit entities such as Lions Clubs show what the service sector can do for economic and social development of communities that are especially hard hit by the recession, and we are committed to forming more effective alliances and partnerships to increase our domestic impact. We look forward to working with you and your colleagues on taking up these important challenges.

PREPARED STATEMENT OF THE MONTGOMERY COUNTY STROKE ASSOCIATION

I am Flora Ingenhousz, a psychotherapist in private practice in Silver Spring, Maryland. I have always been in excellent health and live an active, healthy lifestyle. Doctors always commented on my low blood pressure and my excellent cholesterol numbers. But, I suffered a stroke. It was a shock to me and my family, friends, and clients.

One morning 4 years ago, when doing a load of laundry, I had no idea how to set the dials, despite the fact that I had used these dials weekly for the last 10 years. I stood there for what seemed an eternity before I figured out how to set them.

Next I went to do yoga. In one of the poses, I noticed my right arm was hanging limp. When my husband asked me a question, my answer was just the opposite of what I wanted to say. I caught my error and tried again, but it soon became clear that something was wrong. My symptoms kept getting worse.

When we walked into the emergency room (ER), my right leg was weak, and I could not sign my name at the desk. Twelve hours later, I could not move my right side, and my speech was reduced to yes and no. Not a good thing for a psychotherapist, where language is a primary tool.

In the ER, a CT scan showed a hemorrhagic or bleeding stroke where an artery burst, destroying millions of brain cells within minutes, affecting my speech and my ability to perform activities like dressing in the correct order. Also, my right arm and leg were extremely weak. However, I could understand everything, and I was never completely paralyzed. But, I was scared.

I was in intensive care for 4 days of observation and lots of testing, but the tests provided no answers. Two days after my stroke, while still in intensive care, I started occupational, physical, and speech therapy. It was extremely challenging to feed myself with my right hand, requiring all my concentration. After a meal or brushing my teeth, I was exhausted. Speaking was the hardest of all. My brain seemed devoid of words.

After being stabilized, I was transferred to the National Rehabilitation Hospital. For a week, I endured speech, physical, occupational, and recreational therapies.

Speech therapy was the hardest, but also the most important given my profession. Several times, the speech therapist challenged me to the brink of tears.

After a week at the Rehabilitation Hospital, I went home and to outpatient therapies. Speech therapy lasted the longest. After being discharged from speech therapy, I still had deficits in my organizational skills and abstract thinking.

As I struggled with starting to see my clients again, I slid into a deep depression. I was not confident that I could continue to practice. For months, I saw no point in living. Recovery from my post-stroke depression was harder than the recovery of my arms and legs and even speech.

Being a psycho-therapist, I know how to treat depression, so I went to a psychiatrist who prescribed anti-depressant medication and, I also found a psychotherapist.

After months on anti-depressants and excellent psychotherapy, my depression began to lift. I continue on the drugs and to see my psychotherapist. Emotionally, the aftermath of my stroke cut deep.

I am fortunate that 4 years post-stroke, I am back to full-time practice. I lead support groups for stroke survivors and caregivers through the Montgomery County Stroke Association and serve on its Board. I also lecture on stroke, stroke prevention, and stroke recovery. I founded "Hope after Stroke"—individual and family counseling for stroke survivors and caregivers. In addition, I have participated in NIH studies about stroke recovery.

Once again, I am in excellent health and have resumed my active life style. I thank my brain for having the capacity to work around the dead cells. But most of all, I thank my therapists for my recovery. Their ability to zero in so effectively would not have been possible without NIH research.

Because stroke is a leading cause of death and disability and major cost to society, I urge you to provide stroke research with a significant funding increase. I am concerned that NIH continues to invest only 1 percent of its budget in stroke research.

Thank you.

PREPARED STATEMENT OF MENTOR/NATIONAL MENTORING PARTNERSHIP

Chairman Harkin and Ranking Member Cochran, I thank you for the opportunity on behalf of MENTOR/National Mentoring Partnership to submit written testimony in support of resources for youth being mentored or in need of a caring, screened, and trained mentor. Specifically, we ask your continued support for the:

—Mentoring Children of Prisoners program, and

—Serve America Act programs that support youth mentoring.

First, we thank you for previous support of the U.S. Department of Health and Human Services' (HHS) Mentoring Children of Prisoners program and request that you include level funding for the program in fiscal year 2011. MENTOR has appreciated the support of the subcommittee in previous years, in funding this competitive grant program at roughly $50 million since fiscal year 2004. We applaud President Obama for including level funding in his fiscal year 2011 budget for this program at $49.3 million.

This authorized program provides competitive grants to local mentoring organizations to help them match children of incarcerated parents with caring adult mentors. As noted by the Administration for Children and Families, Faith-Based and Community Initiative,[1] more than 2 million children and youth in the United States have at least one parent in a Federal or State correctional facility. Furthermore, the Initiative writes:

"In addition to experiencing disruption in the relationship with their parent, these young people often struggle with the economic, social, and emotional burdens of the incarceration. Data indicate that mentoring programs can help young people, including those with incarcerated parents, by reducing their first-time drug and alcohol use, improving their relationships and academic performance, and reducing the likelihood that they will initiate violence. In addition, mentoring programs can provide these children with opportunities to develop a trusting relationship with a supportive adult and a stable environment that can promote healthy values and strong families."

In addition, since 2007, MENTOR/National Mentoring Partnership has served as the administrator of the Mentoring Children of Prisoners: Caregiver's Choice voucher demonstration project (Federal Grant #90CV0457). Caregiver's Choice allows caregivers and parents the opportunity to directly connect their children with quality mentoring programs. Programs that meet quality standards created by experts—in mentoring and working with families of the incarcerated—have been selected to take part. This 3-year demonstration project has consistently met its goals.

We ask for your continued support to ensure that HHS honors all mentoring relationships established between eligible children and enrolled programs under the Mentoring Children of Prisoners program.

Second, the mentoring field as a stream of service was provided a boost through the passage and enactment of the Edward M. Kennedy Serve America Act. We support President Obama's fiscal year 2011 budget request for Serve America Act Programs under the Corporation for National and Community Service. This includes $914.3 million for AmeriCorps, $60 million for the Social Innovation Fund, $10 million for the Volunteer Generation Fund, $40.2 million for Learn and Serve America, and $221 million for Senior Corps.

As enacted, the Serve America Act provides many more opportunities to support quality mentoring. For example, mentoring is an eligible activity for those engaged in the newly expanded AmeriCorps, Volunteers In Service To America (VISTA), and Retired and Senior Volunteer Programs (RSVP), as well as the newly created Education Corps and Veterans' Corps. In addition, Mentoring Partnerships, which support the expansion of quality mentoring in many States throughout the country, are now eligible for funding through the National Service Trust Program and Volunteer Generation Fund.

Now that it is authorized, it is doubly important that the act's provisions be funded properly in fiscal year 2011 and beyond. Mentoring programs and our national network of Mentoring Partnerships already rely on the tremendous contributions that AmeriCorps and VISTA volunteers make, as mentors to youth in need and staff support at those organizations. Indeed, in its fiscal year 2011 budget justification,[2] the Corporation notes mentoring several times in its fiscal year 2009 performance outcomes, such as in an increase to 65,696 children of prisoners mentored through VISTA—well above its target of 50,000 for fiscal year 2009. The boost in service represented by the Serve America Act would allow programs and Partnerships to make an even more meaningful impact in our communities and help us close the gap of 15 million young people who want and need high-quality mentoring relationships.

Background on MENTOR and Youth Mentoring.—MENTOR is the Nation's leading advocate and resource for mentoring, delivering the research, policy recommendations, advocacy, and practical performance tools that facilitate the expansion of mentoring initiatives. We believe that, with the help and guidance of an adult mentor, each child can unlock his or her potential.

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[1] http://www.acf.hhs.gov/programs/fbci/progs/fbci__mcp.html

[2] http://www.nationalservice.gov/pdf/2011__budget__justification.pdf

For nearly two decades, MENTOR has worked to expand the world of quality mentoring. In cooperation with a national network of Mentoring Partnerships and with more than 4,700 mentoring programs nationwide, MENTOR helps connect young Americans who want and need caring adults in their lives with the power of mentoring.

We build the infrastructure that enables mentoring programs to flourish, and we leverage resources and provide tools that local mentoring programs need to operate high-quality mentoring. We also assist mentoring programs nationwide in building greater awareness of the need for mentors, and raising the profile of mentoring among corporate leaders, foundation executives, policymakers, and researchers.

Three million young people are currently benefiting from the guidance of caring adult mentors under our system. And through the combined efforts of the mentoring field, we seek to close the mentoring gap so that the 15 million children who currently need mentors also can benefit from caring mentors.

It is on behalf of these 4,700 mentoring programs, the national network of Mentoring Partnerships, and 15 million children who need mentors all across our country that we submit this testimony today.

Benefits of Mentoring.—Youth mentoring is a simple, yet powerful concept: an adult provides guidance, support, and encouragement to help a young person achieve success in life. Mentors serve as role models, advocates, friends, and advisors.

Mentoring today offers many options—the traditional one-to-one format, team and group mentoring, peer mentoring, and even online mentoring. And mentoring programs are run by nonprofit community-based organizations, schools, faith-based organizations, local government agencies, workplaces, and more.

Numerous program evaluations have demonstrated that high-quality mentoring relationships can lead to a range of positive outcomes. A meta-analysis of 55 mentoring program evaluations (DuBois et al., 2002) found benefits of participation in the areas of emotional/psychological well-being, involvement in problem/high-risk behavior, and academic outcomes. Looking at a broader range of outcomes, Eby, Allen, Evans, Ng and DuBois (2008) conducted a meta-analysis of 40 youth mentoring evaluations, and found that youth in mentoring relationships fared significantly better than nonmentored youth. Likewise, a recent large randomized evaluation of BBBSA's newer, school-based mentoring (Herrera, Grossman, Kauh, Feldman, and McMaken, 2007) revealed improvements in mentored youth's academic performance, perceived scholastic efficacy, school misconduct, and attendance relative to a control group of nonmentored youth. In short, mentoring is an effective strategy that addresses both the academic and nonacademic needs of struggling young people. It can help ensure that students come to school and are ready and able to learn.

Mentoring's Impact on the Drop Out Rate.—Mentoring addresses a particular challenge facing our Nation today: the high rate at which young people drop out of high school. Nearly one-third of all high school students drop out before receiving their diploma, a rate which approaches 50 percent for minority students. Research on the dropout rate shows that young people can fail to graduate for a wide variety of reasons, including: lack of connection to the school environment, lack of motivation or inspiration, chronic absenteeism, lack of parental involvement, personal reasons such as teen pregnancy, and failing in school.[3] [4]

We know that young people who drop out will face a future of unemployment, Government assistance, and even criminal involvement. We need to help these young people before they reach the point of dropping out of high school. Fortunately, youth mentoring can play in important role in addressing the issues young people face within the learning environment. Research demonstrates that many of the impacts of mentoring can directly address the underlying causes of our Nation's dropout crisis. Specific impacts of mentoring include:

—Mentored youth feel greater competence in completing their schoolwork,[5] which is linked to higher levels of classroom engagement and higher grades.[6]

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[3] Bridgeland, John M. et al. (2006). The Silent Epidemic: Perspectives of High School Dropouts. Civic Enterprises in Association with Peter D. Hart Research Associates for the Bill & Melinda Gates Foundation.

[4] Harmacek, Marilyn, ed. (2002). Youth Out of School: Linking Absences to Delinquency. 2nd Edition. Colorado: The Colorado Foundation for Families and Children.

[5] Linnehan, F. (2005) "The relation of a work-based mentoring program to the academic performance and behavior of African American students," Journal of Vocational Behavior, 59(3).

[6] Utman, C. H. (1997). Performance effects of motivational state: A meta-analysis. Personality and Social Psychology Review, 1, 170–182.

—School-based mentoring enhances connectedness to schools, peers and society,[7] and mentored youth have more positive attitudes toward school and teachers.[8]
—Evaluations of mentoring programs indicated that both one-to-one mentoring and group mentoring result in better school attendance for mentored youth.[9]
—Mentored youth experience improvements in parental relationships and their own sense of self-worth.[10]
—Mentored youth are significantly less likely to participate in high-risk behaviors, including substance abuse, carrying a weapon, unsafe sex, and violent behaviors.[11]

Mentoring is an important tool to help address dropout risk factors and help ensure that young people are supported in their effort to graduate from high school and make a successful transition to adulthood.

High-quality Mentoring Generates the Strongest Impact.—Like any youth-development strategy, mentoring works best when measures are taken to ensure quality and effectiveness. Money, personnel, and resources are required to initiate and support quality mentoring relationships. The average per-child expenditure for a mentoring match that adheres to The Elements of Effective Mentoring Practice™—the mentoring industry standard—is between $1,000 and $1,500 per year, depending on the program model.

Successful mentoring programs must have well-trained staff familiar with the needs of the community. One-third of mentoring programs indicate that hiring and retaining quality staff can be a challenge due to low salaries. A recruitment campaign must be conducted to attract volunteers, as many programs have young people on their waiting lists for mentors.

Program staff must interview each potential volunteer, check references and perform criminal background checks. Thorough background checks alone can cost as much as $50–$90 per volunteer. Once the screening process is complete, each mentor must receive first-rate training before being matched with a mentee. The work of the mentoring program does not end with the first meeting of the mentor and young person—both require ongoing support, monitoring, and guidance.

All of these elements are critical because research clearly links program quality with positive outcomes. According to Dr. Jean Rhodes, professor of psychology at University of Massachusetts at Boston, careful screening, training, and ongoing support are essential to the longevity of mentoring relationships and to the ultimate success of mentoring relationships.

Rhodes also found that the longer a mentoring relationship lasts, the greater the positive, long-lasting effect it has on a young person. Other researchers in the field have substantiated her findings.[12] In essence, when properly prepared and supported, a mentor is more likely to connect with the young person and to stick with the relationship when times get hard.

Need for Federal Dollars.—The mentoring field needs continued access to Federal funds if we are to be able to serve more children, and serve them well. Once again, America has a wide mentoring gap of nearly 15 million young people. The demand for mentoring far exceeds the current capacity of local mentoring programs and the number of adults who volunteer as mentors, and thousands of children sit on waiting lists for mentors. As noted above, it takes financial resources to be able to adhere to mentoring best practices and provide quality mentoring experiences to young people.

On behalf of the thousands of mentoring programs and millions of mentored children across the country, we commend you for your past support of mentoring and national and community service funding. We strongly encourage you to continue this wise investment in our young people and in our country. Thank you for your consideration.

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[7] Karcher, M.J. (2005). "The effects of school-based mentoring and high school mentors' attendance on their younger mentees' self-esteem, social skills and connectedness." Psychology in the Schools.

[8] Jekielek, Susan M. et al. (2002). Mentoring: A Promising Strategy for Youth Development. ChildTrends Research Brief, Washington, DC.

[9] Sipe, Cynthia L. (1999). Mentoring Adolescents: What have we learned? Contemporary Issues in Mentoring, Grossman, Jean Baldwin (ed), Public/Private Ventures.

[10] Jekielek, Susan M., et al. (2002). Mentoring Programs and Youth Development: A Synthesis. ChildTrends, Washington, DC.

[11] Beier, Rosenfeld, Spitalny, Zansky, and Bontemmpo. (2000). "The potential role of an adult mentor in influencing high-risk behaviors in adolescents." Archives of Pediatric Medicine 15.

[12] Dubois, D.L. (2000) "Effectiveness of Mentoring Programs for Youth: A Meta-analytic Review," *American Journal of Community Psychology*, 30(2). and Public/Private Ventures (2000). *Mentoring School-Age Children: Relationship Development in Community-Based and School-Based Programs*.

PREPARED STATEMENT OF MENDED HEARTS, INCORPORATED

I am Robert A. Scott, National Advocacy Chairman for Mended Hearts, Inc., a national heart disease support group with more than 275 chapters across the United States and Canada. In 2009, accredited Mended Hearts volunteers visited 187,183 patients and families and are serving 430 hospitals throughout the United States.

As I am a walking testimony of the benefits of National Institutes of Health (NIH) supported heart research, I would like to share my story with you. In 1998, at age 48, I suffered my first heart attack while playing volleyball. While at Woonsocket, Rhode Island's Landmark Medical Center, doctors diagnosed me as suffering a so-called silent heart attack. I learned that as many as 4 million Americans may experience this type of episode—a heart attack with no warning just like I had.

After being stabilized, I was transferred to Roger Williams Hospital, in Providence, Rhode Island for a heart catheterization—the gold standard for diagnosis of heart problems. The procedure showed that I had a blockage in my artery that required a stent to open it. Also, it showed that the lower chamber of my heart was damaged, resulting in congestive heart failure that could be controlled with medicine. A stent was inserted in my artery in Rhode Island Hospital.

In 1999, I received another heart catheterization in Miriam Hospital in Providence, Rhode Island because of the damage to my heart from the silent heart attack. However, this time, I was told that my artery could not be repaired with a stent and that I needed heart bypass surgery the next morning. Calling me a high-risk patient because of my age and my weakened heart, my surgeon encouraged me to find a doctor in Boston because my heart might not start again. However, he assured me that if this happens they had a device that could keep me alive for only 7 hours. Thank goodness, he told me that in Boston they had another device that could keep me alive for 7 months while they located a replacement heart. In less then 10 hours I went from the possibility of needing another stent, heart bypass surgery, and a heart transplant. My journey with heart disease continued.

My next stop was to visit my local cardiologist in Woonsocket who estimated my survival rate at 20 percent, but he thought I would make it. Thankfully, he was right and I survived heart bypass surgery.

But my journey didn't end there. My congestive heart failure was causing my heart to beat irregularly, so I received an implantable defibrillator to control the problem in 2002. However, this device had to replaced in Rhode Island nearly 4 years later.

My story continues in 2007 where I started experiencing daily chest pain and shortness of breath. Yet another heart catheterization, showed that, I needed an additional stent, but this time in Miriam. After the procedure, the doctor told me the original heart bypass surgery was no longer effective. Although I was scared, my doctors comforted me by explaining that a new medical innovation could save my life—a drug eluting stent. My doctor explained that it could open up the original blockage from my silent heart attack. He added that if these state-of-the art stents had been available in 1998, I would not have had to have the heart bypass surgery.

Despite previous treatments, I once again was faced with cardiovascular disease in February 2009. This time it was a stroke warning sign. While driving, I suddenly felt dizzy, so pulled my car over to stop. The next thing I knew, I had passed out for a very short time and felt numb on the right side of my face. This scared me enough that I drove myself to the hospital which just happened to be on the same street where I stopped my car. Upon arrival, I was a little confused and was later admitted into the hospital. The next day, my cardiologist told me I had a transient ischemic attack (TIA). My doctor said there was no need for a stress test and because of my heart condition I should have another cardiac catheterization. The catheterization showed that one of my arteries had minor blockage, so the doctor placed another stent in my artery. To date, I have not experienced another TIA.

Today, heart attack, stroke, and other cardiovascular disease remain our Nation's most costly and number 1 killer and a major cause of disability. Thanks to medical research supported by the NIH, I am alive today. I am concerned that NIH continues to invest only 4 percent of its budget on heart research and a mere 1 percent on stroke research when there are so many people in our country just like me. Enhanced NIH funding dedicated to heart and stroke research will bring us closer to a cure for these often deadly and disabling diseases.

PREPARED STATEMENT OF THE MEDICAL LIBRARY ASSOCIATION

SUMMARY OF RECOMMENDATIONS FOR FISCAL YEAR 2011

Continue the commitment to the National Institutes of Health (NIH) and the National Library of Medicine (NLM) by increasing funding levels 12 percent to $35 billion for NIH and $402 million for NLM.

Continue to support the NIH public access policy, which requires that all final, peer-reviewed manuscripts are made available through NLM's PubMed central database within 12 months of publication and support the establishment of similar policies in other Federal agencies.

Continue to support the medical library community's important role in NLM's outreach, telemedicine, disaster preparedness, and health information technology (health IT) initiatives and the implementation of healthcare reform.

MLA is a nonprofit, educational organization with more than 4,000 health sciences information professional members worldwide. Founded in 1898, MLA provides lifelong educational opportunities, supports a knowledge base of health information research, and works with a global network of partners to promote the importance of quality information for improved health to the healthcare community and the public.

AAHSL is comprised of the directors of the libraries of 142 accredited American and Canadian medical schools belonging to the Association of American Medical Colleges (AAMC). AAHSL's goals are to promote excellence in academic health sciences libraries and to ensure that the next generation of health professionals is trained in information-seeking skills that enhance the quality of healthcare delivery.

Together, MLA and AAHSL address health information issues and legislative matters of importance through a joint legislative task force and a Government Relations Committee.

THE IMPORTANCE OF FUNDING INCREASES FOR NLM

We are pleased that the fiscal year 2010 appropriations package contained funding increases for NIH and NLM and bolstered their baseline budgets. We encourage the subcommittee to continue to provide meaningful annual increases for NIH and NLM in the coming years, and recommend a 12 percent increase for fiscal year 2011.

Recovery funding and the fiscal year 2010 budget increases stimulated the economy and biomedical research. In the case of NLM, Recovery Act funding allowed timely and much-needed increases in support for leading edge research and training in biomedical informatics—the kinds of programs that will influence future developments in health information technology. In fiscal year 2011 and beyond, it will be critical to augment NLM's baseline budget to accommodate expansion of its information resources, services, and programs, which must collect, organize, and make accessible rapidly expanding volumes of biomedical knowledge, including the influx of data from high-throughput genome sequencing systems and genome-wide association studies. Increased funding will also position NLM to strengthen its contributions to successful implementation of recent congressional priorities related to healthcare reform, health information technology, drug safety through its efforts to: enhance access to the results of comparative effectiveness research, maintain and disseminate health information technology standards, and to expand its clinical trial registry and results database in response to legislative requirements.

GROWING DEMAND FOR NLM'S BASIC SERVICES

As the world's foremost digital library and knowledge repository in the health sciences, NLM provides the critical infrastructure in the form of data repositories and online integrated services, such as GenBank and PubMed that are helping to revolutionize medicine and advance science to the next important era which includes individualized medicine based on an individual's unique genetic differences. PubMed, with more than 20 million citations to the biomedical literature, is the world's most heavily used source of information about published results of biomedical research, and GenBank, with its international partners, has become the definitive source of gene sequence information.

These collections stand at more than 11.4 million items—books, journals, technical reports, manuscripts, microfilms, photographs, and images. Without NLM our Nation's medical libraries would be unable to provide the quality information services that our Nation's health professionals, educators, researchers, and patients have come to expect.

SUPPORT AND EXTEND PUBLIC ACCESS

The Appropriations Committee has shown unprecedented foresight and leadership by using the annual spending bills as the vehicle to establish a mandatory public access policy at the NIH. This highly beneficial policy, which requires all NIH-funded researchers to deposit their final, peer-reviewed manuscripts in NLM's PubMed Central database within 12 months of publication, is improving access to timely and relevant scientific information, stimulating discovery, informing clinical care, and improving public health literacy. We ask the Committee to remain a strong voice in support of the NIH policy, and to support the extension of public access policies to other Federal science and education agencies. MLA and AAHSL strongly support the expansion of public access policies to other agencies, because it would bring the benefits of public access to other fields of research and because research in other fields is increasingly relevant to biomedicine.

SUPPORT AND ENCOURAGE NLM PARTNERSHIPS WITH THE MEDICAL LIBRARY COMMUNITY

Outreach and Education

NLM's outreach programs are of particular interest to both MLA and AAHSL. These activities are designed to educate medical librarians, health professionals and the general public about NLM's services and to train them in the most effective use of these services. Furthermore, NLM's emphasis on outreach to underserved populations assists the effort to reduce health disparities among large sections of the American public. One example of NLM's leadership is the "Partners in Information Access" program, which is designed to improve the access of local public health officials to information needed to prevent, identify and respond to public health threats. With nearly 6,000 members in communities across the country, the National Network of Libraries of Medicine (NNLM) is well positioned to ensure that every public health worker has electronic health information services that can protect the public's health.

MLA and AAHSL applaud the success of NLM's outreach initiatives, particularly those initiatives that reach out to medical libraries and health consumers. We ask the subcommittee to encourage NLM to continue to coordinate its outreach activities with the medical library community in fiscal year 2011.

EMERGENCY PREPAREDNESS AND RESPONSE

MLA and AAHSL are pleased that NLM has established a Disaster Information Management Research Center to expand NLM's capacity to support disaster response and management initiatives, as recommended in the NLM Board of Regents Long Range Plan for 2006–2016. Presently, libraries are a significant, but underutilized resource for community disaster planning and management efforts, which NLM can help to deploy.

NLM has the ability to work with health sciences libraries across the country to provide health professionals and the public with access to needed health and environmental information by: (1) quickly compiling web pages on toxic chemicals and environmental concerns; (2) rapidly providing funds, computers and communication services to assist librarians in the field who were restoring health information services to displaced clinicians and patients; and (3) rerouting interlibrary loan requests from the afflicted regions through the NLM.

HEALTH IT AND BIOINFORMATICS

NLM has played a pivotal role in creating and nurturing the field of medical informatics, which is the intersection of information science, computer science, and healthcare. Health informatics tools include computers, clinical guidelines, formal medical terminologies, and information and communication systems. For nearly 35 years, NLM has supported informatics research. The importance of NLM's work in health IT continues to grow as the Nation moves toward more interoperable health IT systems. A leader in supporting, licensing, developing and disseminating standard clinical terminologies for free U.S.-wide use (e.g., SNOMED), NLM works closely with the Office of the National Coordinator for Health Information Technology (ONCHIT) to promote the adoption of interoperable electronic records.

MLA and AAHSL encourage the subcommittee to continue their strong support of NLM's medical informatics and genomic science initiatives, at a point when the linking of clinical and genetic data holds increasing promise for enhancing the diagnosis and treatment of disease. MLA and AAHSL also supporting health information technology initiatives in ONCHIT and the Agency for Healthcare Research and Quality that build upon initiatives housed at NLM.

BUILDING AND FACILITY NEEDS

The tremendous growth in NLM's basic functions related to the acquisition, organization and preservation of an ever-expanding collection of biomedical literature, combined with its growing contributions to healthcare reform, health information technology, drug safety, and exploitation of genomic information is straining the Library's physical resources. NLM now houses 1,100 staff in a facility built to accommodate only 650. This increase in the volume of biomedical information and in the number of personnel has led to a serious space shortage. The NLM Board of Regents has assigned the highest priority to supporting the acquisition of a new facility. Further, Senate Report 108–345 that accompanied the fiscal year 2005 appropriations bill acknowledged that the design for the new research facility at NLM had been completed, and the subcommittee urged NIH to assign a high priority to this construction project so that the information-handling capabilities and biomedical research are not jeopardized.

MLA and AAHSL encourage the subcommittee to continue its strong support of NLM's goals in order to strengthen the Library's ability to provide support for implementation of healthcare reform. At a time when medical and health science libraries across the nation face growing financial and space constraints, ensuring that NLM continues to serve as the archive of last resort for biomedical collections is critical to the medical library community and the public we serve.

Thank you for the opportunity to present the views of the medical library community.

PREPARED STATEMENT OF MEHARRY MEDICAL COLLEGE

Mr. Chairman and members of the subcommittee, thank you for the opportunity to present my views before you today. I am Dr. Wayne J. Riley, President and CEO of Meharry Medical College in Nashville, Tennessee. I have previously served as vice-president and vice dean for health affairs and governmental relations and associate professor of medicine at Baylor College of Medicine in Houston, Texas and as assistant chief of medicine and a practicing general internist at Houston's Ben Taub General Hospital. In all of these roles, I have seen firsthand the importance of minority health professions institutions and the title VII Health Professions Training programs.

Mr. Chairman, time and time again, you have encouraged your colleagues and the rest of us to take a look at our Nation and evaluate our needs over the next 10 years. I took you seriously and came here prepared to offer my best judgments. First, I want to say that it is clear that health disparities among various populations and across economic status are rampant and overwhelming. Over the next 10 years, we will need to be able to deliver more culturally relevant and culturally competent healthcare services. Bringing healthcare delivery up to this higher standard can serve as our Nation's own preventive healthcare agenda keeping us well positioned for the future.

Minority health professional institutions and the title VII Health Professions Training programs address this critical national need. Persistent and severe staffing shortages exist in a number of the health professions, and chronic shortages exist for all of the health professions in our Nation's most medically underserved communities. Our Nation's health professions workforce does not accurately reflect the racial composition of our population. For example, African Americans represent approximately 15 percent of the U.S. population while only 2–3 percent of the Nation's healthcare workforce is African American.

There is a well-established link between health disparities and a lack of access to competent healthcare in medically underserved areas. As a result, it is imperative that the Federal Government continue its commitment to minority health profession institutions and minority health professional training programs to continue to produce healthcare professionals committed to addressing this unmet need.

An October 2006 study by the Health Resources and Services Administration (HRSA), entitled "The Rationale for Diversity in the Health Professions: A Review of the Evidence" found that minority health professionals serve minority and other medically underserved populations at higher rates than nonminority professionals. The report also showed that; minority populations tend to receive better care from practitioners who represent their own race or ethnicity, and non-English speaking patients experience better care, greater comprehension, and greater likelihood of keeping follow-up appointments when they see a practitioner who speaks their language. Studies have also demonstrated that when minorities are trained in minority health profession institutions, they are significantly more likely to: (1) serve in rural

and urban medically underserved areas; (2) provide care for minorities; and (3) treat low-income patients.

As you are aware, title VII Health Professions Training programs are focused on improving the quality, geographic distribution and diversity of the healthcare workforce in order to continue eliminating disparities in our Nation's healthcare system. These programs provide training for students to practice in underserved areas, cultivate interactions with faculty role models who serve in underserved areas, and provide placement and recruitment services to encourage students to work in these areas. Health professionals who spend part of their training providing care for the underserved are up to 10 times more likely to practice in underserved areas after graduation or program completion.

Institutions that cultivate minority health professionals have been particularly hard-hit as a result of the cuts to the title VII Health Profession Training programs in fiscal year 2006 and fiscal year 2007 Funding Resolution passed earlier this Congress. Given their historic mission to provide academic opportunities for minority and financially disadvantaged students, and healthcare to minority and financially disadvantaged patients, minority health professions institutions operate on narrow margins. The cuts to the title VII Health Professions Training programs amount to a loss of core funding at these institutions and have been financially devastating.

Mr. Chairman, I feel like I can speak authoritatively on this issue because I received my medical degree from Morehouse School of Medicine, a historically black medical school in Atlanta. I give credit to my career in academia, and my being here today, to title VII Health Profession Training programs' Faculty Loan Repayment Program. Without that program, I would not be the president of my father's alma mater, Meharry Medical College, another historically black medical school dedicated to eliminating healthcare disparities through education, research and culturally relevant patient care.

Minority Centers of Excellence (COE).—COEs focus on improving student recruitment and performance, improving curricula in cultural competence, facilitating research on minority health issues and training students to provide health services to minority individuals. COEs were first established in recognition of the contribution made by four historically black health professions institutions (the Medical and Dental Institutions at Meharry Medical College; The College of Pharmacy at Xavier University; and the School of Veterinary Medicine at Tuskegee University) to the training of minorities in the health professions. Congress later went on to authorize the establishment of "Hispanic", "Native American" and "Other" Historically black COEs. For fiscal year 2011, I recommend a funding level of $33.6 million for COEs.

Health Careers Opportunity Program (HCOP).—HCOPs provide grants for minority and nonminority health profession institutions to support pipeline, preparatory, and recruiting activities that encourage minority and economically disadvantaged students to pursue careers in the health professions. Many HCOPs partner with colleges, high schools, and even elementary schools in order to identify and nurture promising students who demonstrate that they have the talent and potential to become a health professional. Over the last three decades, HCOPs have trained approximately 30,000 health professionals including 20,000 doctors, 5,000 dentists and 3,000 public health workers. For fiscal year 2011, I recommend a funding level of $35.6 million for HCOPs.

National Institutes of Health (NIH): Extramural Facilities Construction.—Mr. Chairman, if we are to take full advantage of the recent funding increases for biomedical research that Congress has provided to NIH over the past decade, it is critical that our Nation's research infrastructure remain strong. The current authorization level for the Extramural Facility Construction program at the National Center for Research Resources is $250 million. The law also includes a 25 percent set-aside for "Institutions of Emerging Excellence" (many of which are minority institutions) for funding up to $50 million. Finally, the law allows the NCRR Director to waive the matching requirement for institutions participating in the program. We strongly support all of these provisions of the authorizing legislation because they are necessary for our minority health professions training schools. In fiscal year 2011, please fund this program at least at $50 million.

Research Centers in Minority Institutions (RCMI).—The RCMI program at the National Center for Research Resources has a long and distinguished record of helping our institutions develop the research infrastructure necessary to be leaders in the area of health disparities research. Although NIH has received unprecedented budget increases in recent years, funding for the RCMI program has not increased by the same rate. Therefore, the funding for this important program grow at the same rate as NIH overall in fiscal year 2011.

Strengthening Historically Black Graduate Institutions—Department of Education.—The Department of Education's Strengthening Historically Black Graduate

Institutions program (title III, part B, section 326) is extremely important to MMC and other minority serving health professions institutions. The funding from this program is used to enhance educational capabilities, establish and strengthen program development offices, initiate endowment campaigns, and support numerous other institutional development activities. In fiscal year 2011, an appropriation of $75 million is suggested to continue the vital support that this program provides to historically black graduate institutions.

National Institute on Minority Health and Health Disparities (NIMHD).—NIMHD is charged with addressing the longstanding health status gap between minority and nonminority populations. The NIMHD helps health professional institutions to narrow the health status gap by improving research capabilities through the continued development of faculty, labs, and other learning resources. The NIMHD also supports biomedical research focused on eliminating health disparities and develops a comprehensive plan for research on minority health at the NIH. Furthermore, the NIMHD provides financial support to health professions institutions that have a history and mission of serving minority and medically underserved communities. For fiscal year 2011, I recommend a funding level of $500 million for the NIMHD.

Department of Health and Human Services' Office of Minority Health (OMH).—Specific programs at OMH include:

—Assisting medically underserved communities with the greatest need in solving health disparities and attracting and retaining health professionals;

—Assisting minority institutions in acquiring real property to expand their campuses and increase their capacity to train minorities for medical careers;

—Supporting conferences for high school and undergraduate students to interest them in health careers; and

—Supporting cooperative agreements with minority institutions for the purpose of strengthening their capacity to train more minorities in the health professions.

The OMH has the potential to play a critical role in addressing health disparities. For fiscal year 2011, I recommend a funding level of $75 million for the OMH.

Mr. Chairman, please allow me to express my appreciation to you and the members of this subcommittee. With your continued help and support, Meharry Medical College along with other minority health professions institutions and the title VII Health Professions Training programs can help this country to overcome health and healthcare disparities. Congress must be careful not to eliminate, paralyze or stifle the institutions and programs that have been proven to work. Meharry and other minority health professions schools seek to close the ever widening health disparity gap. If this subcommittee will give us the tools, we will continue to work towards the goal of eliminating that disparity as we have done for 1876.

Thank you, Mr. Chairman, for this opportunity.

PREPARED STATEMENT OF THE MARCH OF DIMES FOUNDATION

The 3 million volunteers and 1,400 staff members of the March of Dimes Foundation appreciate the opportunity to submit the Foundation's Federal funding recommendations for fiscal year 2011. The March of Dimes is a national voluntary health agency founded in 1938 by President Franklin D. Roosevelt to support research and services related to polio. Today, the Foundation works to improve the health of women, infants and children by preventing birth defects, premature birth and infant mortality through research, community services, education, and advocacy. The March of Dimes is a unique partnership of scientists, clinicians, parents, members of the business community, and other volunteers affiliated with 51 chapters and 213 divisions in every State, the District of Columbia and Puerto Rico. Additionally, in 1998, March of Dimes established its Global Programs to extend its mission overseas through partnerships with countries to deliver interventions directed at reducing birth defects and preterm birth. The March of Dimes recommends the following funding levels for programs and initiatives that are essential investments in the future of health of the Nation's children.

PRETERM BIRTH

According to a 2009 report from the National Center for Health Statistics (NCHS), the primary reason for the higher infant mortality rate in the United States compared to European nations is the greater percentage of preterm births—12.4 percent in the United States compared to 6.3 percent in Sweden. This suggests that preterm birth prevention is central to lowering the U.S. infant mortality rate. Moreover, the Institute of Medicine estimated that preterm birth cost the United States more than $26 billion in 2005, with costs continuing to climb each year.

In June 2008, the U.S. Surgeon General sponsored a conference to develop a research agenda to address the costly and serious problem of preterm birth. More than 200 of the country's foremost researchers, representing a diversity of backgrounds and expertise, met for 2 days and created an action plan of needed steps. Within these steps, there are several cross-cutting themes including recommendations to enhance biomedical and epidemiological research and to strengthen our Nation's vital statistics program. The March of Dimes funding requests enumerated below are based on the recommendations of the Surgeon General's Conference.

National Institutes of Health—Office of the Director

The March of Dimes commends members of the Committee for supporting the National Children's Study (NCS) by including $193.8 million in the fiscal year 2010 Consolidated Appropriations Act. For fiscal year 2011, the Foundation supports the President's funding recommendation and urges the subcommittee to maintain its commitment to this vital study by providing $194.4 million. Currently in the pilot phase, the NCS is tracking the more than 150 children born to study participants. The data from this important effort will inform the work of scientists in universities and research organizations across the Nation and around the world, helping them identify precursors to disease and to develop new strategies for prevention and treatment. The first data generated by the NCS will provide information concerning disorders of birth and infancy including preterm birth and its health consequences. The Foundation remains committed to supporting a well-designed NCS that promotes research of the very highest quality.

Eunice Kennedy Shriver National Institute of Child Health and Human Development (NICHD)

The March of Dimes recommends a funding increase of at least 12.5 percent for NICHD in fiscal year 2011. This increase in funding will enable NICHD to maintain the momentum and investments made with support provided through the Recovery Act. It will also enable the Institute to expand its support for preterm birth-related research and to initiate establishment of a network of integrated transdisciplinary research centers as recommended by the Institute of Medicine and the experts who participated in the Surgeon General's Conference. The causes of preterm birth are multi-factorial and necessitate a collaborative approach integrating many disciplines. These new centers would serve as a national resource for investigators to design and to share new research approaches and strategies to comprehensively address the problems of preterm birth.

Centers for Disease Control and Prevention (CDC)—Preterm Birth

The National Center for Chronic Disease Prevention and Health Promotion, Division of Reproductive Health works to promote optimal reproductive and infant health. In 2009, CDC created a robust research agenda to prevent preterm birth by improving National and State data to track preterm births; developing, implementing, and evaluating methods for prevention; understanding the problem of late preterm birth; and conducting etiologic and epidemiologic studies of early preterm birth. For fiscal year 2011, the March of Dimes recommends a $6 million increase in the preterm birth line to strengthen national data systems and to expand research on very early as well as late preterm births as authorized by the PREEMIE Act (Public Law 109–450).

Centers for Disease Control and Prevention—National Center for Health Statistics

The National Center for Health Statistics (NCHS) national vital statistics program collects birth data that is used to monitor the Nation's health status, set priorities and evaluate health programs. It is imperative that data collected by NCHS is comprehensive and timely. Currently, only 75 percent of States and territories use the 2003 birth certificate format and only 65 percent have adopted the 2003 death certificate. Consistent with the President's budget request, the Foundation recommends allocating $11 million specifically to the National Vital Statistics System to help support modernization of the State and territorial vital statistics infrastructure without undermining the scope and quality of data collected nationally.

Health Resources and Services Administration—Healthy Start

The Healthy Start Initiative is a collection of community-based projects focused on reducing infant mortality, low birthweight and racial disparities in perinatal outcomes. Communities with Healthy Start programs have seen significant improvements in health outcomes; therefore the March of Dimes recommends a funding level for these projects of $120 million in fiscal year 2011.

BIRTH DEFECTS

An estimated 120,000 infants in the United States are born with birth defects each year. Genetic or environmental factors, or a combination, can cause a birth defect; however, the causes of 70 percent of birth defects remain unknown. Investing additional Federal resources in research to unveil the causes and prevent, or reduce, the incidence of birth defects is sorely needed.

CDC National Center on Birth Defects and Developmental Disabilities (NCBDDD)

The NCBDDD conducts programs to protect and improve the health of children by preventing birth defects and developmental disabilities and by promoting optimal development and wellness among children with disabilities. For fiscal year 2011, the March of Dimes requests an overall funding level of $163 million, a $20 million increase over fiscal year 2010, for NCBDDD. Within that increase, we encourage the committee to allocate $5 million for support of birth defects research and surveillance and an additional $2 million for folic acid education. This is a sound public health investment that will promote wellness and prevention, reduce health disparities, support the creation of new educational materials for consumers and their families and will enable CDC to better facilitate transition to adulthood for children with disabilities.

Sustaining the investment in the National Birth Defects Prevention Study—the largest case-controlled study of birth defects ever conducted—is needed to support genetic analysis of the samples already obtained. In 2009, CDC educated healthcare providers through the dissemination of more than 10 reports which resulted from this Study. Among the topics were the risk factors for birth defects such as maternal smoking, obesity and antidepressant use during pregnancy.

NCBDDD also supports State-based birth defects tracking systems and programs to prevent and treat affected children. Surveillance forms the backbone of a vital, functional and responsive public health network. Due to current the current fiscal crises being faced by many States, funding for some of these systems is in jeopardy. Increased investment from the Federal Government is necessary to ensure continued investment in birth defects surveillance programs.

Finally, NCBDDD is conducting a national education campaign aimed at increasing the number of women consuming appropriate amounts of folic acid. CDC estimates that up to 70 percent of neural tube defects could be prevented if all women of childbearing age consume 400 micrograms of folic acid daily. To achieve the full prevention potential of folic acid, CDC's national public and health professions education campaign must be expanded.

NEWBORN SCREENING

Newborn screening is a vital public health activity used to identify and treat genetic, metabolic, hormonal and functional disorders in newborns. Screening detects conditions in newborns that, if left untreated, can cause disability, mental retardation, serious illness or even death. Across the Nation, State and local governments are experiencing significant budget shortfalls; due to this fiscal pressure, newborn screening programs are threatened by funding cuts. While the ramifications—such as discontinuing screening for certain conditions or postponing the purchase of necessary technology—can vary by State, any funding cut in this essential program puts infants at risk for permanent disability or even death. An additional $5 million for HRSA's heritable disorders program, as authorized by the Newborn Screening Saves Lives Act (Public Law 110–204), is necessary to increase support for State efforts to upgrade existing programs, to acquire state-of-the-art technology and to increase capacity to reach and educate health professionals and parents on newborn screening programs and follow-up services.

CLOSING

Thank you for the opportunity to testify on the federally supported programs of highest priority to the March of Dimes. The Foundation's volunteers and staff in every State, the District of Columbia and Puerto Rico look forward to working with Members of the Subcommittee to secure the resources needed to improve the health of the Nation's mothers, infants and children.

MARCH OF DIMES FISCAL YEAR 2011 FEDERAL FUNDING PRIORITIES

[In millions if dollars]

Program	Fiscal year 2010 funding	March of Dimes rec
National Institutes of Health (Total)	31,089	35,000
National Children's Study	193.8	194.4
Common Fund	544	612
National Institute of Child Health and Human Development	1,329	1,495
National Human Genome Research Institute	516	581
National Center on Minority Health and Disparities	212	239
Centers for Disease Control and Prevention (Total)	6,475	8,800
Birth Defects Research & Surveillance	21.342	26.342
Folic Acid Campaign	3.1	5.1
Immunization	562	865.6
Polio Eradication	102	102
Preterm Birth	2	8
National Center for Health Statistics	139	162
Health Resources and Services Administration (Total)	7,483	9,150
Maternal and Child Health Block Grant	662	730
Newborn Screening	10	15
Newborn Hearing Screening	19	19
Consolidated (Community) Health Centers	2,146	2,560
Healthy Start	105	120
Agency for Healthcare Research and Quality	397	611

PREPARED STATEMENT OF THE MOREHOUSE SCHOOL OF MEDICINE

Mr. Chairman and members of the subcommittee, thank you for the opportunity to present my views before you today. I am Dr. John E. Maupin, president of Morehouse School of Medicine (MSM) in Atlanta, Georgia. I have previously served as president of Meharry Medical College, executive vice-president at MSM, as director of a community health center in Atlanta, and deputy director of health in Baltimore, Maryland. In all of these roles, I have seen firsthand the importance of minority health professions institutions and the Title VII Health Professions Training programs.

I want to say that minority health professional institutions and the Title VII Health Professionals Training programs address a critical national need. Persistent and sever staffing shortages exist in a number of the health professions, and chronic shortages exist for all of the health professions in our Nation's most medically underserved communities. Furthermore, our Nation's health professions workforce does not accurately reflect the racial composition of our population. For example while blacks represent approximately 15 percent of the U.S. population, only 2–3 percent of the Nation's health professions workforce is black. Morehouse is a private school with a very public mission of educating students from traditionally underserved communities so that they will care for the underserved. Mr. Chairman, I would like to share with you how your subcommittee can help us continue our efforts to help provide quality health professionals and close our Nation's health disparity gap.

There is a well-established link between health disparities and a lack of access to competent healthcare in medically underserved areas. As a result, it is imperative that the Federal Government continue its commitment to minority health profession institutions and minority health professional training programs to continue to produce healthcare professionals committed to addressing this unmet need.

An October 2006 study by the Health Resources and Services Administration, entitled "The Rationale for Diversity in the Health Professions: A Review of the Evidence" found that minority health professionals serve minority and other medically underserved populations at higher rates than nonminority professionals. The report also showed that; minority populations tend to receive better care from practitioners who represent their own race or ethnicity, and non-English speaking patients experience better care, greater comprehension, and greater likelihood of keeping follow-up appointments when they see a practitioner who speaks their language. Studies have also demonstrated that when minorities are trained in minority health profession institutions, they are significantly more likely to: (1) serve in rural and urban medically underserved areas; (2) provide care for minorities; and (3) treat low-income patients.

As you are aware, Title VII Health Professions Training programs are focused on improving the quality, geographic distribution, and diversity of the healthcare workforce in order to continue eliminating disparities in our Nation's healthcare system. These programs provide training for students to practice in underserved areas, cultivate interactions with faculty role models who serve in underserved areas, and provide placement and recruitment services to encourage students to work in these areas. Health professionals who spend part of their training providing care for the underserved are up to 10 times more likely to practice in underserved areas after graduation or program completion.

Given the historic mission, of institutions like MSM, to provide academic opportunities for minority and financially disadvantaged students, and healthcare to minority and financially disadvantaged patients, minority health professions institutions operate on narrow margins. The slow reinvestment in the Title VII Health Professions Training programs amounts to a loss of core funding at these institutions and have been financially devastating.

Mr. Chairman, I feel like I can speak authoritatively on this issue because I received my dental degree from Meharry Medical College, a historically black medical and dental school in Nashville, Tennessee. I have seen first hand what title VII funds have done to minority serving institutions like Morehouse and Meharry. I compare my days as a student to my days as president, without that title VII, our institutions would not be here today. However, Mr. Chairman, since those funds have been slowly replenished, we are standing at a cross roads. This subcommittee has the power to decide if our institutions will go forward and thrive, or if we will continue to try to just survive. We want to work with you to eliminate health disparities and produce world class professionals, but we need your assistance.

Minority Centers of Excellence (COE).—COEs focus on improving student recruitment and performance, improving curricula in cultural competence, facilitating research on minority health issues, and training students to provide health services to minority individuals. COEs were first established in recognition of the contribution made by four historically black health professions institutions (the Medical and Dental Institutions at Meharry Medical College; The College of Pharmacy at Xavier University; and the School of Veterinary Medicine at Tuskegee University) to the training of minorities in the health professions. Congress later went on to authorize the establishment of "Hispanic", "Native American" and "Other" Historically black COEs. For fiscal year 2011, I recommend a funding level of $33.6 million for COEs.

Health Careers Opportunity Program (HCOP).—HCOPs provide grants for minority and nonminority health profession institutions to support pipeline, preparatory, and recruiting activities that encourage minority and economically disadvantaged students to pursue careers in the health professions. Many HCOPs partner with colleges, high schools, and even elementary schools in order to identify and nurture promising students who demonstrate that they have the talent and potential to become a health professional. Over the last three decades, HCOPs have trained approximately 30,000 health professionals including 20,000 doctors, 5,000 dentists and 3,000 public health workers. For fiscal year 2009, I recommend a funding level of $35.6 million for HCOPs.

National Institutes of Health (NIH): Extramural Facilities Construction

Mr. Chairman, if we are to take full advantage of the recent funding increases for biomedical research that Congress has provided to NIH over the past decade, it is critical that our Nation's research infrastructure remain strong. The current authorization level for the Extramural Facility Construction program at the National Center for Research Resources is $250 million. The law also includes a 25 percent set-aside for "Institutions of Emerging Excellence" (many of which are minority institutions) for funding up to $50 million. Finally, the law allows the NCRR Director to waive the matching requirement for institutions participating in the program. We strongly support all of these provisions of the authorizing legislation because they are necessary for our minority health professions training schools.

There was 2-year funding in the stimulus bill for extramural facilities, but we need a sustained effort to help with our research and infrastructure enterprises. I ask that the fiscal year 2011 L–HHS bill include at least $50 million for this program.

Research Centers in Minority Institutions (RCMI).—The RCMI program at the National Center for Research Resources has a long and distinguished record of helping our institutions develop the research infrastructure necessary to be leaders in the area of health disparities research. Although NIH has received unprecedented budget increases in recent years, funding for the RCMI program has not increased by the same rate. Therefore, the funding for this important program grow at the same rate as NIH overall in fiscal year 2011.

Strengthening Historically Black Graduate Institutions—Department of Education.—The Department of Education's Strengthening Historically Black Graduate Institutions program (title III, part B, section 326) is extremely important to MMC and other minority serving health professions institutions. The funding from this program is used to enhance educational capabilities, establish and strengthen program development offices, initiate endowment campaigns, and support numerous other institutional development activities. In fiscal year 2011, an appropriation of $75 million is suggested to continue the vital support that this program provides to historically black graduate institutions.

National Institute on Minority Health and Health Disparities (NIMHD).—The NIMHD is charged with addressing the longstanding health status gap between minority and nonminority populations. The NIMHD helps health professional institutions to narrow the health status gap by improving research capabilities through the continued development of faculty, labs, and other learning resources. The NIMHD also supports biomedical research focused on eliminating health disparities and develops a comprehensive plan for research on minority health at the NIH. Furthermore, the NIMHD provides financial support to health professions institutions that have a history and mission of serving minority and medically underserved communities through the Minority Centers of Excellence program. For fiscal year 2011, I recommend a funding level of $500 million for the NCMHD.

Department of Health and Human Services' Office of Minority Health (OMH).—Specific programs at OMH include: (1) Assisting medically underserved communities with the greatest need in solving health disparities and attracting and retaining health professionals; (2) Assisting minority institutions in acquiring real property to expand their campuses and increase their capacity to train minorities for medical careers; (3) Supporting conferences for high school and undergraduate students to interest them in health careers; and (4) Supporting cooperative agreements with minority institutions for the purpose of strengthening their capacity to train more minorities in the health professions.

The OMH has the potential to play a critical role in addressing health disparities, and with the proper funding this role can be enhanced. For fiscal year 2011, I recommend a funding level of $75 million for the OMH.

Mr. Chairman, please allow me to express my appreciation to you and the members of this subcommittee. With your continued help and support, MSM along with other minority health professions institutions and the Title VII Health Professions Training programs can help this country to overcome health and healthcare disparities. Congress must be careful not to eliminate, paralyze, or stifle the institutions and programs that have been proven to work. MSM and other minority health professions schools seek to close the ever widening health disparity gap. If this subcommittee will give us the tools, we will continue to work towards the goal of eliminating that disparity as we have since our founding day.

Thank you, Mr. Chairman, and I welcome every opportunity to answer questions for your records.

PREPARED STATEMENT OF THE NORTH AMERICAN BRAIN TUMOR COALITION

National Institutes of Health (NIH)

It is my pleasure as Chair of the North American Brain Tumor Coalition to submit this statement in favor of a strong Federal investment in biomedical research, an investment that is critically important to improving the treatments for brain tumors. For individuals with brain tumors, the possibility of surviving their diagnosis with a good quality of life depends on research and development of new treatments. Our recommendations to the subcommittee are intended to advance that research.

The North American Brain Tumor Coalition and Its Members

The North American Brain Tumor Coalition is a network of nine brain tumor organizations. Our members are the Brain Tumor Awareness Organization; Brain Tumour Foundation of Canada; Children's Brain Tumor Foundation; Florida Brain Tumor Association; Michael Quinlan Brain Tumor Foundation; National Brain Tumor Society; Preuss Foundation; Southeastern Brain Tumor Foundation; and Voices Against Brain Cancer.

Many of the members of the Coalition raise private funds to support brain tumor research, while also undertaking patient and family support initiatives. Almost all of our members disseminate educational materials about brain tumors, and many also have forums for collaboration and cooperation among brain tumor researchers. The diversity of our organizations reflects the serious and far-reaching impact of brain tumors on patients and their families. We are pleased to have a Canadian or-

ganization in the Coalition, an important sign of international collaboration among brain tumor organizations. The fact that the Coalition includes organizations outside the United States is also a recognition of the fact that brain tumors respect no borders.

The North American Brain Tumor Coalition brings these diverse organizations together to focus on advocacy on behalf of those with brain tumors. We are dedicated to improving the prognosis and quality of life for brain tumor patients. In order to achieve these goals, there must be an increased investment in research to understand the causes of brain tumors, improve brain tumor treatments, and strengthen neuro-rehabilitation services for those treated for brain tumors.

Brain Tumors and Their Impact

Brain tumors are not a single disease; there are approximately 126 types of primary brain tumors. The diversity of brain tumors contributes to the complexity of research in this field. Many of the 126 tumors classified as "brain tumors" are not in the brain but instead arise from structures that are associated with the brain. These include tumors of the membranes covering the brain (referred to as meningiomas) or adjacent cranial and paraspinal nerves (schwannomas). Brain tumors may be benign (most meningiomas are benign) to highly aggressive (glioblastomas). Both children and adults are diagnosed with brain tumors.

It is estimated that there will be more than 62,000 cases of primary malignant and nonmalignant brain and central nervous system tumors in the United States in 2010.[1] There will be approximately 10,000 primary brain tumors in Canada in 2010. In 2010, it is estimated that 4,030 new primary brain tumors (malignant and nonmalignant) will be diagnosed in children in the United States in 2010. Of the 4,030 new cases, an estimated 2,880 will be in children under the age of 15.[1]

Approximately 612,000 Americans are living with a primary brain tumor.[2]

The American Cancer Society estimates that almost 12,920 deaths in 2009 will be attributed to primary malignant brain tumors.[3] This total does not include those who will die from primary nonmalignant brain tumors.

Many tens of thousands—140,000 or more—are diagnosed with metastatic brain tumors each year. Many tumor types can spread to the brain, but the most common are lung cancer, breast cancer, melanoma, kidney cancer, bladder cancer, and testicular cancer. It is estimated that metastatic brain tumors occur in 10 to 30 percent of adult cancers, and in one-fourth of all cancers that metastasize.[4]

These statistics about incidence, prevalence, and mortality are important, but they do not fully convey the burden of brain tumors. For many brain tumor patients, treatments are inadequate. Those who receive treatments that do extend their lives may nonetheless experience serious side-effects from their brain tumors and treatment, side-effects that require intervention. In addition, a diagnosis with a brain tumor does not only affect the patient; it also has a profound effect on the patient's family and friends.

A study published in the Annals of Internal Medicine on April 6, 2010, describes the impact of a cancer diagnosis on children. The study notes that there have been significant improvements in treatments for some pediatric cancers. However, cancer treatments often cause serious health problems, including but not limited to second cancers and heart conditions. The researchers used computer models to estimate what happens to childhood cancer survivors and determined that survivors of brain cancer died about 18 years earlier than the general population. This study underscores the problems confronted by brain tumor patients who "survive" their diagnosis.

The Challenges of Brain Tumor Treatment and Research

In a report dated 2000, the Brain Tumor Progress Review Group, convened by the National Cancer Institute (NCI) and National Institute of Neurological Disorders and Stroke (NINDS), stated that the difficulty in treating brain tumors relates to the unique biology of the brain, including the fact the brain is enclosed in a bony canal that allows little room for tumor growth, brain tumors invade normal tissue and make surgical removal impossible, brain tumors are protected by the blood-brain barrier, the brain is rich in expressed genes and therefore is a fertile field for growth of brain tumors, and brain tumors appear to be less susceptible to attack by the immune system than tumors in other organs.

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[1] Central Brain Tumor Registry, 2004–2006.

[2] Porter KR, McCarthy BJ, Freels S, et al., Prevalence estimates for primary brain tumors in the US by age, gender, behavior, and histology. Neuro-Oncology, In press.

[3] American Cancer Society, Cancer Facts & Figures 2009, Atlanta, 2009.

[4] Medline Plus, National Library of Medicine, accessed on April 7, 2010.

The complexity and diversity of brain tumors make the work of brain tumor researchers very difficult. For this reason, an aggressive and balanced approach to brain tumor research is necessary. The research effort must be strongly supported by NIH, as described below.

NABTC Recommendations for NIH Funding

The North American Brain Tumor Coalition supports the recommendations of many other biomedical research and patient advocacy organizations that NIH funding be increased to $35 billion in fiscal year 2011. This amount is necessary to sustain the commitment of the American Recovery and Reinvestment Act and prevent disruptions in the work of outstanding scientists committed to a wide range of research topics. The Coalition understands that this is a very aggressive recommendation in the current economic and budget climate, but this ambitious level of funding is necessary if additional advances in basic and applied science are to be achieved.

A recent accomplishment in brain tumor research underscores the need for additional resources and a sustained Federal commitment in order to realize improvements in the quality of treatments for many diseases and quality of life for those who are diagnosed with those diseases. The Cancer Genome Atlas (TCGA) at NCI announced in January 2010 that researchers in TCGA Research Network had determined that glioblastoma multiforme (GBM) is not a single disease but four distinct molecular subtypes. In announcing the research findings, TCGA said that the research might lead to a more personalized approach to GBM, one of the deadliest of all brain tumors.

The North American Brain Tumor Coalition applauds the important research finding of TCGA but also notes that the finding points to the need for additional research, including:

—Work to understand the molecular classification of other brain tumors, in addition to GBM;
—Research to translate basic research findings into treatment approaches;
—Identification of agents that might be evaluated in brain tumors, including those that are newly subject to a molecular classification scheme; and
—Clinical testing of possible new agents for brain tumor treatment.

In short, the findings of TCGA point the way to a new approach to brain tumor treatment, but we have only taken the first step in a long journey to effective, personalized brain tumor treatments.

This translates to the need for a balanced research program that includes the following elements:

—Support for investigator-initiated research so that new and promising ideas from the Nation's leading brain tumor researchers can be tested;
—Funding for The Cancer Genome Atlas and other efforts that are advancing the molecular classification of disease;
—Resources for translational programs to translate basic findings into new treatments; for brain tumor research, this means the continuation of the Specialized Programs of Research Excellence (SPOREs) and the adult and pediatric brain tumor consortia;
—Support for clinical trials through the brain tumor consortia, cooperative groups, and cancer centers; and
—Aggressive and creative support for research on the late and long-term effects of brain tumor treatment, including research on interventions for these side effects.

We recommend that medulloblastoma be added to the list of cancers identified for further study through The Cancer Genome Atlas. We also encourage innovative strategies for data sharing in the SPORE program, including across SPORE sites. Research foundations and patient advocacy organizations are pioneering creative means for sharing clinical and research data, and we encourage NCI to consider some of these models for their applicability to SPORE sites and other research settings.

NABTC Recommends Strategies for Encouraging Collaboration

Brain tumor treatment is complex and multi-disciplinary, and research on these tumors must also have these characteristics. NCI and NINDS have established and supported a collaborative venture, the Neuro-Oncology Program, which takes a collaborative and cooperative approach to brain tumor research.

This cooperative research approach is absolutely critical for brain tumors, but it will yield benefits for many other diseases as well. The Coalition applauds the leadership of the NIH Director in encouraging collaborative ventures that yield communication and collaboration among Institutes. We also recommend that more funding

mechanisms be created to facilitate this sort of cooperation among academic research institutions seeking NIH funding.

Urgency in the Brain Tumor Research Program

It is necessary to keep a long view in biomedical research, sustaining funding levels and preventing disruptions in research. However, it is also important to have a sense of urgency about the pace of research. The 5-year relative survival rate for primary malignant brain tumors is 33.6 percent for males and 37 percent for females. For these individuals, time is precious and the research effort—literally their lifeline—must be accelerated as much as possible.

PREPARED STATEMENT OF THE NATIONAL ASSOCIATION OF COUNTY AND CITY HEALTH OFFICIALS

SUMMARY

The National Association of County and City Health Officials (NACCHO) represents the Nation's 2,800 local health departments (LHDs). These governmental agencies work every day in their communities to prevent disease, promote wellness, and protect the health of the entire community. LHDs have a unique and distinctive role and set of responsibilities in the larger health system and within every community. The Nation depends upon the capacity of LHDs to play this role well.

The Nation's current recession further diminishes the ability of LHDs to measure population-wide illness, organize efforts to prevent disease and prolong quality of life and to serve the public through programs not offered elsewhere. Repeated rounds of budget cuts and layoffs in LHDs continue to erode capacity. A series of NACCHO surveys found that in 2008–2009, 23,000 jobs have been lost in LHDs, which represents a 15 percent cut in the local public health workforce.

LHDs continue to respond to increased challenges; including H1N1 influenza, an increasing incidence of chronic disease and outbreaks of foodborne illness during a time of growing budget challenges. To help maintain the stability of LHDs, the Federal government should increase its investment in the following programs in fiscal year 2011 appropriations: Public Health Emergency Preparedness, Advanced Practice Centers, Preventive Health and Health Services Block Grant, Healthy Communities and the Health Prevention Corps. Programs authorized by the health reform law should also be funded to the extent possible in fiscal year 2011 appropriations.

Public Health Emergency Preparedness

NACCHO Request.—$1.152 billion (including pandemic influenza preparedness).

President's Budget Fiscal Year 2011.—$758 million (Public Health Emergency Preparedness).

Emergency Supplemental Funds for H1N1 Influenza.—$1.3 billion.

Fiscal Year 2010 Funding.—$761 million (Public Health Emergency Preparedness).

The safety and well-being of America's communities is dependent on the capacity of their health departments to respond in any emergency that threatens human health, whether it is an act of bioterrorism, an influenza pandemic such as occurred in 2009–2010, or a natural disaster. The Centers for Disease Control and Prevention (CDC) has explicitly adopted an "all-hazards" approach to preparedness, recognizing that the capabilities necessary to respond to differing public health threats have many common elements.

NACCHO requests $1.152 billion in funding for fiscal year 2011, which reflects continued funding for local and State preparedness activities under the Pandemic and All-Hazards Preparedness Act along with additional support necessary to sustain the capabilities that were put into place in 2009 to respond to the H1N1 flu epidemic, made possible through $1.3 billion in Federal emergency supplemental funding.

With recent progress in nationwide preparedness and ongoing challenges, including the next flu season, now is not the time to reduce Federal funding that helps health departments continue their progress and address new, emerging threats. Especially when LHDs are under great stress from the loss of 15 percent of their workforce over the last 2 years, the Nation cannot afford to lose the gains made by recent Federal investment in public health. A loss of readiness is inevitable if the level of Federal investment is reduced.

The enhanced capabilities enabled by pandemic influenza supplemental funding in 2009 will improve the response to other potential epidemics of infectious disease. At the same time, continuous training and exercising of all health department staff so that they are all ready for the next emergency must continue. Incorporating pan-

demic influenza preparedness into the context of all-hazards preparedness is the most efficient use of limited resources and will fully enable maintenance of the current level of preparedness and flexibility to alter priorities as needed when other public health threats emerge.

Advanced Practice Centers

NACCHO Request.—$5.4 million.
President's Budget.—$5.3 million.
Fiscal Year 2010 Funding.—$5.3 million.

The mission of the Advanced Practice Center (APC) program is to promote innovative and practical solutions that enhance the capabilities of all LHDs to prepare for, respond to, and recover from public health emergencies. With locations in eight different geographic areas of the United States, the APC program supports and strengthens LHDs by developing and disseminating resources focused on helping them address gaps in local-level preparedness and improve responsiveness to address myriad health hazards. An increase in funding to $5.4 million would allow the tools produced through this program to reach more LHDs.

Preventive Health and Health Services Block Grant

NACCHO Request.—$131 million.
President's Budget Fiscal Year 2011.—$102 million.
Fiscal Year 2010 Funding.—$102 million.

LHDs are leaders in efforts to stop preventable health threats from occurring. Obesity, heart attack, and accidental injury are all examples of preventable health problems LHDs work on every day. The Preventive Health and Health Services (PHHS) block grant program is a longstanding source of funding for these efforts.

The increasing prevalence of costly and preventable chronic health conditions represents a threat to America's health and economy. According to the CDC, the medical care costs of people with chronic diseases account for more than 75 percent of the Nation's healthcare costs. The emerging epidemic of overweight and obesity is associated with $117 billion in annual direct medical expenses and indirect costs, including lost productivity, which impairs our economic competitiveness during a period of severe economic decline. Increased funding of $131 million in fiscal year 2011 for the Preventive Health and Health Services Block Grant would allow local and State health departments to increase their efforts to focus on community priorities aimed at reversing the increase in preventable disease rates.

Healthy Communities

NACCHO Request.—$30 million.
President's Budget Fiscal Year 2011.—$22.4 million.
Fiscal Year 2010 Funding.—$22.8 million.

The Healthy Communities program is dedicated to supporting local communities in implementing evidence-based interventions and policy, systems, and environmental changes necessary to help communities prevent chronic diseases and their risk factors.

To reverse unfavorable trends in the prevalence and health consequences of chronic diseases, communities work in collaboration with LHD leadership to address such issues as affordable and accessible healthy food options, safe places for physical activity, and the need for targeted strategies that address and reduce health disparities. Changes in the local environment facilitate healthy choices and go hand in hand with education about how to be healthier.

The Healthy Communities program mobilizes community leadership and resources to transform the local environments where people live, work and play to stem the growth of chronic disease. CDC anticipates the cumulative impact of the Healthy Communities program to reach more than 300 communities by fiscal year 2011. With increased funding of $30 million in fiscal year 2011, more communities can be reached with this innovative program.

Health Prevention Corps

NACCHO Request: $10 million.
President's Budget.—$10 million.

According to the President's budget, the Health Prevention Corps program will "recruit new talent into service for State and LHDs and provide the building blocks for creating a stronger, interdisciplinary workforce." These funds are meant to create a foundation for the program by establishing a management plan for staffing and program administration, convening stakeholders to establish the program framework, and developing a curriculum for Corps members. A shortage of public health professionals is a constant challenge for LHDs and this program will help

to build a supply of new personnel offering their talents and skills to local communities.

PROGRAMS ASSOCIATED WITH HEALTH REFORM

The Patient Protection and Affordable Care Act authorized a number of new programs that will be beneficial to public health and LHDs. The health reform law provides an opportunity to focus on maintaining and creating health through support of community prevention programs. The law also includes programs that will help to strengthen the public health workforce which was challenged by shortages even prior to layoffs and attrition caused by recent budget cuts. Programs such as Public Health Loan Repayment and Mid-Career Training grants, Epidemiological and Laboratory Capacity Grants, Community Transformation Grants, Healthy Living, Aging Well and the Diabetes Prevention Program would fill tremendous needs at the local level and should be funded to the extent possible in the fiscal year 2011 appropriations process.

PREPARED STATEMENT OF THE NATIONAL ASSOCIATION OF CHILDREN'S HOSPITALS

On behalf of the National Association of Children's Hospitals (N.A.C.H.) and the Nation's free-standing children's hospitals, I respectfully request that the Labor, Health and Human Services, and Education, and Related Agencies Appropriations Subcommittee provide the fully authorized funding level of $330 million for the Children's Hospitals Graduate Medical Education (CHGME) program in fiscal year 2011.

With the subcommittee's leadership, Congress has worked to provide equitable funding for the Nation's independent children's teaching hospitals through the CHGME program. An appropriation of $330 million would meet the program's authorization level and ensure that children's hospitals will receive equitable funding compared to the Federal support that other teaching hospitals receive through Medicare.

In 2006, Congress reauthorized the CHGME program with nearly unanimous bipartisan support. Since then the Labor, Health and Human Services, and Education, and Related Agencies Appropriations Subcommittee has provided strong, consistent funding for CHGME. In fiscal year 2010, Congress appropriated the highest amount the program has ever received at $317.5 million. President Obama recognized the importance of CHGME in his fiscal year 2011 budget request and maintained funding at $317.5—$7.5 million above his request for fiscal year 2010.

CHGME is a targeted, fiscally responsible, slow-growth program that is integral to ensuring a stable future for children's hospitals and the pediatric workforce. Congress created CHGME in 1999 because it recognized the importance of a well-trained pediatric workforce and understood the disparity in Federal graduate medical education (GME) support that existed between adult teaching hospitals and independent children's teaching hospitals. At that time, independent children's teaching hospitals were effectively left out of Federal GME support provided through Medicare because they treat children and not the elderly. In fact, children's hospitals were at a serious financial disadvantage, receiving less than 0.5 percent of the Federal GME support of other teaching hospitals. Medicaid GME payments, which are left to the discretion of States to provide and are well below the costs related to training, did not fill the gap.

Congress also understood when it created CHGME that the disparity in GME support under Medicare jeopardized an already precarious pipeline of pediatric specialists. As a result of congressional foresight and commitment to this program, CHGME has played a critical role in addressing the Nation's serious shortage of pediatric specialists.

Independent children's teaching hospitals, which represent less than 1 percent of all hospitals, train 35 of all general pediatric residents, half of all pediatric specialty fellows, the great majority of pediatric researchers, and many other physicians who require pediatric training. In addition, they provide half of all hospital care to seriously ill children and serve as the Nation's premier pediatric research centers.

CHGME funding now provides children's hospitals with about 80 percent of the GME support that Medicare provides to adult teaching hospitals. The funding has enabled children's hospitals to expand pediatric training programs, improve the quality and depth of their training, and prevent a net decline in the number of pediatric residents. Since the program's inception, children's hospitals have more than doubled the number of total pediatric specialty residents in response to local, regional, and national needs and children's hospitals have increased the number of new training programs by approximately 50 percent. These gains were achieved de-

spite the cap on CHGME funds and caps on the number of full-time equivalent residents that could be counted for purposes of CHGME payment in accordance with Medicare rules.

Unfortunately, shortages in the pediatric workforce still remain, particularly in pediatric specialty care. The National Association of Children's Hospitals and Related Institutions' (NACHRI) 2009 Pediatric Subspecialty Survey found a strong connection between pediatric specialty shortages, long-term vacancies and children's access to timely and appropriate healthcare. According to the survey, national shortages contribute to vacancies in children's hospitals that commonly last 12 months or longer for a number of pediatric specialties, including pediatric neurology, developmental-behavioral pediatrics, pediatric endocrinology, pediatric pulmonology, and pediatric gastroenterology.

Sick children bear the brunt of the shortages of pediatric specialists. Wait times for scheduling appointments with pediatric specialists often exceeds the prevailing national benchmark of 2 weeks. In fact, at least half of children's hospital survey respondents reported wait times far longer than 2 weeks. For example:

—68 percent of children's hospitals experience difficulty scheduling endocrinology visits; the average wait time is more than 10 weeks;

—61 percent report difficulty scheduling neurology visits; the average wait time is 9 weeks; and

—50 percent report difficulty scheduling developmental pediatrics visits; the average wait time is more than 13 weeks. This exceptionally long wait time is of particular concern given the rise in autism-related disorders among the Nation's children.

A January 2010 Wall Street Journal article, "For Severely Ill Children, a Dearth of Doctors," put a human face on the NACHRI survey findings and described the impact of these shortages on a young patient and his family. "Three-year old Kenneth Jones, for example, was born in Alaska with a rare gastrointestinal disorder that made him unable to absorb protein. He had to travel 3 hours to see one pediatric GI specialist in the state-a doctor who left a year later. The family moved to Oregon for work-related reasons and found a clinic that could provide complete care for the disorder—in Ohio, at a Cincinnati Children's Hospital clinic where they had to wait 7 months for Kenneth's first appointment. 'There are so few pediatric GIs out there and so many children that need to be seen that you just have to wait in line,' says Kenneth's mother, Lauren Jones. 'That's the hardest thing to endure for a parent with a sick child who needs help right away.' "

CHGME has allowed children's hospitals to begin to address the large gap that exists between families' need for pediatric specialty care and the supply. In fact, free-standing children's hospitals that receive CHGME funding have accounted for 65 percent of the growth in pediatric specialty programs.

By strengthening children's hospitals' training programs and the Nation's pediatric workforce, CHGME benefits all children, not just those treated at independent children's teaching hospitals. CHGME funds indirectly strengthen children's hospitals' roles as pediatric centers for excellence, the safety net for low-income children, and the leading centers of pediatric research. Children's hospitals are at the center of scientific discovery as a result of their strong academic programs supported by CHGME and advanced life-saving clinical research. Children's teaching hospitals' scientific discoveries have helped children survive diseases that were once fatal, such as polio and cancer. Furthermore, as a result of scientific research breakthroughs at children's teaching hospitals, children now can grow and thrive with disabilities and chronic health conditions, such as congenital heart disease, cystic fibrosis, cerebral palsy, juvenile diabetes, and spina bifida, and become economically self-supporting adults and valuable members of their communities.

CHGME is a sound investment. With full funding, CHGME will help to ensure a stable future for the Nation's children's hospitals and the pediatric workforce. With that support, children's hospitals will continue to be centers for excellence and be able to provide the highest-quality healthcare to all children.

Once again, thank you for your past support for this critical program. On behalf of N.A.C.H., its member hospitals, and the children and families they serve, I respectfully ask you to provide $330 million for CHGME in fiscal year 2011 to support the continued progress that has been made in CHGME. As the Nation embarks on the implementation of the landmark health reform legislation, it is imperative that we have a strong pediatric workforce with a sufficient pool of specialists to meet the unique healthcare needs of all children.

PREPARED STATEMENT OF THE NATIONAL ASSOCIATION OF COMMUNITY HEALTH CENTERS

INTRODUCTION

Chairman Harkin, Ranking Member Cochran, and members of the subcommittee: My name is Dan Hawkins, and I am the Senior Vice President of the National Association of Community Health Centers (CHC). On behalf of CHCs and the more than 20 million patients served nationwide, as well as the volunteer board members, staff, and countless members of the health center movement, I want to thank you for this subcommittee's unyielding support for health centers and your dedication to the health center mission of providing affordable, accessible primary healthcare to all Americans.

As you know, Congress recently passed the Patient Protection and Affordable Care Act (Affordable Care Act)—a law that is historic by any measure. The law endeavors to ensure that for the first time, all Americans will have access to quality healthcare. From the community health center perspective, we are incredibly humbled at the charge the new law gives to health centers: to become the healthcare home for millions of newly insured patients, even as we maintain our high standards of openness to all and a focus on achieving quality that is second to none.

Health centers were started 45 years ago because their founders knew that an urgent intervention was needed to deal with the crisis of access in America. Today, health centers have been called upon again, this time to expand our proven system of care rapidly to ensure that as our nation extends coverage to millions of Americans, the promise of coverage truly equals care. With your continued support, health centers stand ready to deliver and to reach the goals that Congress has set out: providing care to 40 million Americans by 2015.

About CHCs

Today, health centers serve more than 20 million patients in nearly 8,000 communities. Health centers serve as the family doctor and healthcare home for 1 in 8 uninsured individuals, and 1 in every 5 low-income children.

Federal law requires that every health center be governed by a patient-majority board, which means care is truly patient-centered and patient-driven. Health centers must be located in a designated Medically Underserved Area, and must provide comprehensive primary care services to anyone who comes in the door, regardless of ability to pay.

As health leaders as well as providers in their communities, health centers believe that they have an obligation to work to prevent disease and improve the lives and health of their patients and their communities. For this reason, health centers have been pioneers in improving healthcare quality, particularly in the area of chronic disease management. Through the Health Resources and Services Administration's Health Disparities Collaboratives, the majority of health centers have worked to improve their delivery systems and to more effectively educate patients on the self-management of their conditions such as cancer, diabetes, asthma, and cardiovascular disease. Health centers participating in the Collaboratives almost unanimously report that health outcomes for their patients have dramatically improved. Published studies have documented these outcomes, including one study on the Diabetes Collaboratives where evidence showed that over a lifetime, the incidence of blindness, kidney failure, and coronary artery disease was reduced.[1]

Health centers not only improve health and save lives, they also cost significantly less, saving the health system overall. In South Carolina, a study showed that diabetic patients enrolled in the State employees' health plan treated in non-CHC settings were four times more costly than those in the same plan who were treated in a community health center. The health center patients also had lower rates of emergency room use and hospitalization.[2] In fact, literally dozens of studies done over the past 25 years, have concluded that health center patients are significantly less likely to use hospital emergency rooms or to be hospitalized for ambulatory care-sensitive conditions, and are therefore less expensive to treat than patients treated elsewhere.[3] A recent national study done in collaboration with the Robert

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[1] Huang, E, Zhang, Q, Brown, S. E.S., Drum, M, Meltzer, D, Chin, M. (2007). The Cost-Effectiveness of Improving Diabetes Care in U.S. federal Qualified Community Health Centers. Health Services Research, 42, (6p1), 2174–2193.

[2] Proser M. "Deserving the Spotlight: Health Centers Provide High-Quality and Cost-Effective Care." October–December 2005 Journal of Ambulatory Care Management 28(4):321–330.

[3] Rust G., et al. "Presence of a Community Health Center and Uninsured Emergency Department Visit Rates in Rural Counties." Journal of Rural Health, Winter 2009 25(1):8–16; Dobson D, et al. "The Economic and Clinical Impact of Community Health Centers in Washington State:

Graham Center found that people who use health centers as their usual source of care have 41 percent lower total healthcare expenditures than people who get most of their care elsewhere.[4] As a result, health centers saved the healthcare system $18 billion last year alone.

Funding Background

Over the last decade, this subcommittee has been at the forefront of expanding access to primary care in America and changing the way primary care is delivered through its expansion of the Health Centers Program. This expansion effort brought access to care to millions who were previously medically disenfranchised. Since 2001, this subcommittee has nearly doubled the investment in the Health Centers program. In that time, more than 3,500 new health center sites have been created, and more than 10 million new patients have gained access to care in a health center. It is your commitment that has proven what we in the health centers movement knew to be true: that our patient-centered, community-based health center model of care is the best way for Americans to receive primary care.

Impact of Health Reform

The passage of comprehensive health reform builds on this subcommittee's efforts by envisioning yet another expansion of the Health Centers Program over the next 5 years. The law creates a Community Health Center Fund containing $11 billion in new funding for health centers over the next 5 years. We believe this funding will allow health centers to grow to serve 40 million Americans by the end of fiscal year 2015. This investment will ensure that as more Americans become insured, they will actually have a healthcare home in their community in which to access care.

Fiscal Year 2011 Request

The CHC Fund has the potential to fundamentally and positively change the way primary care is delivered in this country. However, in order for the CHC Fund to have its intended impact, it is critical that the discretionary funding level of the Health Centers Program at least meet the fiscal year 2010 level of $2.19 billion. Keeping the discretionary funding base at least at the fiscal year 2010 level will allow the CHC Fund to be fully utilized for new health centers, expanded medical, oral, behavioral, and pharmacy services at existing health centers, and allow the continuation of desperately needed ARRA Increased Demand for Services funding to health centers who have already expanded care to almost 2 million new patients over the last year.

Conclusion

At this historic moment for the health centers movement, I am deeply proud to be speaking for CHCs nationwide. I have personally seen the power of health centers to lift the health and the lives of individuals and families in our most underserved communities. Thanks to your longstanding support, health centers have revo-

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Analyses of the Contributions to Public Health and Economic Implications and Benefits for the State and Counties." Dec 2008 Community Health Network of Washington and Washington Association of Community and Migrant Health Centers; McRae T. and Stampfly R. "An Evaluation of the Cost Effectiveness of Federal Qualified Health Centers (FQHCs) Operating in Michigan." October 2006 Institute for Health Care Studies at Michigan State University. www.mpca.net. Falik M, Needleman J, Herbert R, et al. "Comparative Effectiveness of Health Centers as Regular Source of Care." January–March 2006 Journal of Ambulatory Care Management 29(1):24–35; Proser M. "Deserving the Spotlight: Health Centers Provide High-Quality and Cost-Effective Care." October–December 2005 Journal of Ambulatory Care Management 28(4):321–330; Politzer RM, et al. "The Future Role of Health Centers in Improving National Health." 2003 Journal of Public Health Policy 24(3/4):296–306; see also, e.g., Politzer RM, et al. "Inequality in America: The Contribution of Health Centers in Reducing and Eliminating Disparities in Access to Care." 2001 Medical Care Research and Review 58(2):234–248; Falik M, et al. "Ambulatory Care Sensitive Hospitalizations and Emergency Visits: Experiences of Medicaid Patients Using Federal Qualified Health Centers." 2001 Medical Care 39(6):551–56; Starfield, Barbara, et al, "Costs vs. Quality in Different Types of Primary Care Settings," Journal of the American Medical Association 272,24 (December 28, 1994): 1903–1908; Stuart, Mary E., et al, "Improving Medicaid Pediatric Care," Journal of Public Health Management Practice 1(2) (Spring, 1995): 31–38; Utilization and Costs to Medicaid of AFDC Recipients in New York Served and Not Served by Community Health Centers, Center for Health Policy Studies (1994); Stuart, Mary E., and Steinwachs, Donald M., (Johns Hopkins Univ. School of Public Health and Hygiene), "Patient-Mix Differences Among Ambulatory Providers and Their Effects on Utilization and Payments for Maryland Medicaid Users," Medical Care 34,12 (December 1993): 1119–1137; Health Services Utilization and Costs to Medicaid of AFDC Recipients in California Served and Not Served by Community Health Centers, Center for Health Policy Studies/SysteMetrics (1993).

[4] NACHC and the Robert Graham Center. Access Granted: The Primary Care Payoff. August 2007. www.nachc.com/access-reports.cfm.

lutionized primary care community by community and we are ready to do even more. In light of the passage of health reform, health centers stand ready to live up to the incredible trust that has been placed in us. With your support, we look forward to ensuring that the Government's investment in reform translates into improved health and wellness for the Nation for years to come.

PREPARED STATEMENT OF THE NATIONAL ALLIANCE FOR EYE AND VISION RESEARCH

EXECUTIVE SUMMARY

National Alliance for Eye and Vision Research (NAEVR) requests fiscal year 2011 National Institutes of Health (NIH) funding at $35 billion, which reflects a $3 billion increase more than President Obama's proposed funding level of $32 billion. Funding at $35 billion, which reflects NIH's net funding levels in both fiscal year 2009 and fiscal year 2010, ensures it can maintain the number of multi-year investigator-initiated research grants, the cornerstone of our Nation's biomedical research enterprise.

The vision community commends Congress for $10.4 billion in NIH funding in the American Recovery and Reinvestment Act (ARRA), as well as fiscal year 2009 and fiscal year 2010 funding increases that enabled NIH to keep pace with biomedical inflation after 6 previous years of flat funding that resulted in a 14 percent loss of purchasing power. Fiscal year 2011 NIH funding at $35 billion enables it to meet the expanded capacity for research—as demonstrated by the significant number of high-quality grant applications submitted in response to ARRA opportunities—and to adequately address unmet need, especially for programs of special promise that could reap substantial downstream benefits, as identified by NIH Director Francis Collins, M.D., Ph.D. in his top five priorities. As President Obama has stated repeatedly, including at a visit to the NIH in September 2009, biomedical research has the potential to reduce healthcare costs, increase productivity, and ensure the global competitiveness of the United States.

NAEVR requests that Congress improve upon the President's proposed 2.5 percent National Eye Instutute (NEI) increase—the second smallest increase of all Institutes and Centers—especially if it does not increase overall NIH funding above the President's request.

In 2009, Congress spoke volumes in passing S. Res. 209 and H. Res. 366, which acknowledged NEI's 40th anniversary and designated 2010–2020 as The Decade of Vision, in which the majority of 78 million Baby Boomers will turn 65 years of age and face greatest risk of aging eye disease. This is not the time for a less-than-inflationary increase that nets a loss in the NEI's purchasing power, which eroded by 18 percent in the fiscal year 2003–2008 timeframe. NEI-funded research is resulting in treatments and therapies that save vision and restore sight, which can reduce healthcare costs, maintain productivity, ensure independence, and enhance quality of life.

FISCAL YEAR 2011 NIH FUNDING AT $35 BILLION ENABLES THE NEI TO BUILD UPON THE IMPRESSIVE RECORD OF BASIC AND CLINICAL COLLABORATIVE RESEARCH THAT MEETS NIH'S TOP FIVE PRIORITIES AND WAS FUNDED THROUGH FISCAL YEAR 2009–2010 ARRA AND INCREASED "REGULAR" APPROPRIATIONS

NEI's research addresses the pre-emption, prediction, and prevention of eye disease through basic, translational, epidemiological, and comparative effectiveness research which also address the top five NIH priorities, as identified by Dr. Collins: genomics, translational research; comparative effectiveness; global health, and empowering the biomedical enterprise. NEI continues to be a leader within the NIH in elucidating the genetic basis of ocular disease—NEI Director Paul Sieving, M.D., Ph.D., has reported that one-quarter of all genes identified to date through collaborative efforts with the National Human Genome Research Institute (NHGRI) are associated with eye disease/visual impairment.

NEI received $175 million of the $10.4 billion in NIH ARRA funding. As a result, NEI's total funding levels in the fiscal year 2009–2010 timeframe were $776 million and $794.5 million, respectively. In fiscal year 2009, NEI made 333 ARRA-related awards, the majority of which reflect investigator-initiated research that funds new science or accelerates ongoing research, including ten Challenge Grants. Several examples of research, and the reasons why it is important, include:

—*Biomarker for Neovascular Age-related Macular Degeneration (AMD).*—Researchers will use a recently discovered biomarker for choroidal neovascularization—the growth of abnormal blood vessels into the retina and responsible for 90 percent of vision loss associated with AMD—to develop an

early detection method to minimize vision loss. Why important? AMD is the leading cause of vision loss in the United States, especially in the elderly.

—*Cellular Approach to Treating Diabetic Retinopathy (DR)*.—Researchers propose to develop a clinical treatment for diabetic retinopathy—in which diabetes damages small blood vessels in the retina, causing them to leak—that uses stem cells from the patient's own blood that have been activated outside of the body and then returned to repair damaged vessels in the eye. Why important? DR is the leading cause of vision loss in younger Americans, and its incidence is disproportionately higher in African Americans, Latinos, and Native Americans.

—*Small Heat Shock Proteins as Therapeutic Agents in the Eye*.—Researchers propose to develop new drugs to prevent or reverse blinding eye diseases, such as cataract (clouding of the lens), that are associated with the aggregation of proteins. Research will focus on the use of small "heat shock" proteins that facilitate the slow release and prolonged delivery of targeted macromolecules to degenerating cells of the eye. Why important? Delivering effective, long-lasting therapies through a minimally invasive route into the eye is a major challenge.

—*Identification of Genes and Proteins That Control Myopia Development*.—Researchers propose to identify targets that will facilitate development of interventions to slow or prevent myopia (nearsightedness) development in children. Identifying an appropriate myopia prevention target can reduce the risk of blindness and reduce annual life-long eye care costs. Why important? More than 25 percent of the U.S. population has myopia, costing $14 billion annually, from adolescence to adulthood.

—*Comparison of Interventions for Retinopathy of Prematurity (ROP)*.—In animal studies, researchers will simulate Retinopathy of Prematurity—a blinding eye disease that affects premature infants—and then study novel treatments that involve modulating the metabolism of the retina's rod photoreceptors. Why important? ROP affects 15,000 children a year, about 400–600 of whom progress to blindness, at an estimated lifetime cost for support and unpaid taxes of $1 million each.

—*The NEI Glaucoma Human genetics collaBORation, NEIGHBOR*.—This research network, in which seven U.S. teams will lead genetic studies of the disease, may lead to more effective diagnosis and treatment. Researchers were primarily funded through ARRA supplements. Why important: Glaucoma, a complex neurodegenerative disease that is the second leading cause of preventable blindness in the United States, often has no symptoms until vision is lost.

—*Comparative Effectiveness of Interventions for Primary Open Angle Glaucoma (POAG)*.—Researchers will evaluate existing data on the effectiveness of various treatment options for primary open angle glaucoma—many emerging from past NEI research. Why important? POAG is the most common form of the disease, which disproportionately affects African Americans and Latinos.

In addition to ARRA funding, the "regular" appropriations increases in fiscal year 2009–2010 enabled the NEI to continue to fund key research networks, such as the following:

—The African Descent and Glaucoma Evaluation Study (ADAGES), which is designed to identify factors accounting for differences in glaucoma onset and rate of progression between individuals of African and European descent.

—The Diabetic Research Clinical Research Network's initiation of new trials comparing the safety and efficacy of drug therapies as an alternative to laser treatment for diabetic macular edema and proliferative diabetic retinopathy.

—The Neuro-Ophthalmology Research Disease Investigator Consortium (NORDIC), which will lead multi-site observational and treatment trials, involving nearly 200 community and academic practitioners, to address the risks, diagnosis, and treatment of visual dysfunction due to increased intracranial pressure and thyroid eye disease.

The unprecedented level of fiscal year 2009–2010 vision research funding is moving our Nation that much closer to the prevention of blindness and restoration of vision. With an overall NIH funding level of $35 billion, which translates to an NEI funding level of $794.5 million, the vision community can accelerate these efforts, thereby reducing healthcare costs, maintaining productivity, ensuring independence, and enhancing quality of life.

IF CONGRESS DOES NOT INCREASE FISCAL YEAR 2011 NIH FUNDING ABOVE THE PRESIDENT'S REQUEST, IT IS EVEN MORE VITAL TO IMPROVE UPON THE PROPOSED 2.5 PERCENT INCREASE FOR NEI

The NIH budget proposed by the administration and developed by Congress during the very first year of the Congressionally-designated Decade of Vision should not

contain a less-than-inflationary increase for the NEI due to the enormous challenges it faces in terms of the aging population, the disproportionate incidence of eye disease in fast-growing minority populations, and the visual impact of chronic disease (e.g., diabetes). If Congress is unable to fund NIH at $35 billion in fiscal year 2011 (NEI level of $794.5 million) and adopts the President's proposal, the 2.5 percent increase in funding must be increased to at least an inflationary level of 3.2 percent to prevent any further erosion in NEI's purchasing power. NEI funding is an especially vital investment in the overall health, as well as the vision health, of our Nation. It can ultimately delay, save, and prevent health expenditures, especially those associated with the Medicare and Medicaid programs, and is, therefore, a cost-effective investment.

VISION LOSS IS A MAJOR PUBLIC HEALTH PROBLEM: INCREASING HEALTHCARE COSTS, REDUCING PRODUCTIVITY, DIMINISHING LIFE QUALITY

The NEI estimates that more than 38 million Americans age 40 and older experience blindness, low vision, or an age-related eye disease such as AMD, glaucoma, diabetic retinopathy, or cataracts. This is expected to grow to more than 50 million Americans by year 2020. The economic and societal impact of eye disease is increasing not only due to the aging population, but to its disproportionate incidence in minority populations and as a co-morbid condition of chronic disease, such as diabetes.

Although the NEI estimates that the current annual cost of vision impairment and eye disease to the United States is $68 billion, this number does not fully quantify the impact of direct healthcare costs, lost productivity, reduced independence, diminished quality of life, increased depression, and accelerated mortality. The continuum of vision loss presents a major public health problem and financial challenge to the public and private sectors.

ABOUT NAEVR

The National Alliance for Eye and Vision Research (NAEVR) is a 501(c)4 nonprofit advocacy coalition comprised of 55 professional, consumer, and industry organizations involved in eye and vision research. Visit NAEVR's Web site at www.eyeresearch.org.

PREPARED STATEMENT OF THE NATIONAL ASSOCIATION OF LOCAL BOARDS OF HEALTH

We strongly urge you to consider funding in the area of Public Health Systems and Services Research (PHSSR). This is an emerging field that is experiencing rapid growth. Research in this area is in its infancy with tremendous potential to grow as a field of study, while at the same time is of great benefit to the public. The National Association of Local Boards of Health (NALBOH) has both contributed to and benefited from research in PHSSR along with forming collaborative partnerships with organizations having similar interests, thereby complimenting and building on the work of others such as the National Association of County and City Health Officials (NACCHO) and the Association of State and Territorial Health Officials (ASTHO).

Specifically, one of these collaborative efforts has been the data harmonization project. Through this project, a large, collective database is being formed that researchers, boards of health, health departments and the public can use when developing educational materials and resources, fostering partnerships, and making more streamlined efforts to advance public health at the local level. Members of local boards of health are leaders on which their communities, cities, and counties rely; therefore it is critical to ensure that board members have adequate training and resources available to them so they can fulfill the duties of their positions, making evidence-based decisions.

One way that we can assess the needs of boards is through the NALBOH profile survey. A web-based survey will be conducted in 2010 extending a mail survey that was conducted in 2008. This survey provides a voice for the more than 3,200 local boards of health encompassing more than 20,000 members nationwide. The information gathered through this survey and similar projects conducted by NALBOH and its collaborators demonstrates areas in which local boards of health need training, provides a description of the duties and responsibilities of these boards, and supplies a description of the member demographic composition of these boards.

Additionally, NALBOH has on-going Public Health Systems and Services Research projects. One project is conducting a survey of state boards of health to provide a description of these boards and their duties. This survey will help to fill a void of such data. Other projects include assessing the processes by which board of

health members are appointed. A more thorough understanding of this process will allow NALBOH and its partners to assist in ensuring that the best interests of the public are served as board of health members are appointed. Governance legal authority of local boards of health is being explored to determine whether local board of health members understand their statutory authority, how they perceive this authority, and how this is related to their board's effectiveness.

We urge you to provide financial support for these valuable programs.

PREPARED STATEMENT OF THE NATIONAL ALLIANCE ON MENTAL ILLNESS

Chairman Harkin and members of the subcommittee, I am Mike Fitzpatrick, Executive Director of the National Alliance on Mental Illness (NAMI). I am pleased today to offer NAMI's views on the subcommittee's upcoming fiscal year 2011 bill. NAMI is the Nation's largest grassroots advocacy organization representing persons living with serious mental illnesses and their families. Through our 1,100 affiliates in all 50 States, we support education, outreach, advocacy and research on behalf of persons with serious mental illnesses such as schizophrenia, manic depressive illness, major depression, severe anxiety disorders, and major mental illnesses affecting children.

The cost of mental illness to our Nation is enormous. It is estimated that the direct and indirect cost of untreated mental illness to our Nation exceeds $80 billion annually. However, these direct and indirect costs do not measure the substantial and growing burden that is imposed on "default" systems that are too often responsible for serving children and adults with mental illness who lack access to treatment. These costs fall most heavily on the criminal justice and corrections systems, emergency rooms, schools, families, and homeless shelters. Moreover, these costs are not only financial, but also human in terms of lost productivity, lives lost to suicide and broken families. Investment in mental illness research and services are—in NAMI's view—the highest priority for our Nation and this subcommittee.

National Institute of Mental Health (NIMH) Research Funding

NIMH is the principal Federal agency charged with funding biomedical research on serious mental illnesses. To inspire and support research that will continue to make a difference for people living with mental illnesses, and ultimately, promote recovery, NIMH developed a strategic plan in 2009 to guide future research efforts. The overarching objectives of the strategic plan are to: (1) promote discovery in the brain and behavioral sciences to fuel research on the causes of mental disorders; (2) chart mental illness trajectories to determine when, where and how to intervene; (3) develop new and better interventions that incorporate the diverse needs and circumstances of people with mental illnesses; and (4) strengthen the public health impact of NIMH-supported research.

Translating Research Advances into New Treatments

It is critical for us to move beyond the current universe of palliative treatments for serious mental illness. Even with optimal care, some children and adults living with serious mental illness will not be able to achieve recovery (as defined as permanent remission). As NIMH Director Dr. Tom Insel has noted, consumers and families need rapid, effective treatments that target the core pathophysiology of serious mental illnesses and the tools for early detection. Mental illness research can develop new diagnostic markers and treatments, but this will require defining the pathophysiology of these illnesses. NIMH now has the research tools necessary. Now is the time to set an ambitious goal of finding cures to these extremely disabling illnesses. However, NIMH must have the resources it needs to support this critical research agenda.

American Recovery and Reinvestment Act (ARRA) Investments

NAMI would like to draw the subcommittee's attention to two specific critical investments NIMH is making as part of the ARRA and collaborations with the Department of Defense. The first is the Recovery After an Initial Schizophrenia Episode (RAISE) study which is being financed (in part) with $368 million in ARRA funds. RAISE is the first ever large-scale trial exploring early and aggressive treatment integrating a variety of different therapies to reduce the symptoms and prevent the gradual deterioration of functioning that is characteristic in schizophrenia. The second is Study to Assess Risk and Resilience in Service Members (STARRS)—a joint Army-NIMH study of suicide and mental health among military personnel. Army STARRS will identify—as rapidly as possible—modifiable risk and protective factors related to mental health and suicide. It also will support the Army's ongoing efforts to prevent suicide and improve soldiers' overall well being.

Continuing the Federal Investment in Mental Illness Research

The President is proposing $1.541 billion for basic scientific and clinical research at the NIMH. This is a $51 million increase above the current fiscal year 2010 level of $1.489 billion. While this is below the expected increase in biomedical research inflation, it is a tremendous accomplishment and endorsement of the importance of investment in medical research in a budget that proposes an overall freeze in domestic discretionary spending.

For fiscal year 2011, NAMI supports the recommendations of the Ad Hoc Group on Medical Research for an overall NIH funding level of $36 billion (a 12 percent increase more than fiscal year 2010). For NIMH, NAMI recommends a similar 12 percent increase, up to $1.683 billion—$143 million above the President's request and $193.6 million above the fiscal year 2010 appropriation.

Funding for Programs at SAMHSA's Center for Mental Health Services (CMHS)

Mr. Chairman, as our Nation continues to struggle through this current economic downturn and States struggle with diminished revenues, we are experiencing unprecedented strain in mental health service budgets. Since 2009, we have seen a combined total of nearly $1.8 billion cut from State mental health authority (SMHA) budgets. In a number of States the spending reduction for mental health exceeds 20 percent of the entire SMHA budget. A few examples of the scale of these cuts to State mental health budgets include:

—*Ohio*.—Combined State mental health authority cuts from 2009 through 2011 of 36.2 percent across the board or a $191.3 million reduction.

—*Rhode Island*.—A total percentage cut of 34 percent from 2007 to 2009 (from a statewide budget of $82.1 million to $54.5 million)—as a result the State is experiencing a 65 percent increase in the number of children with Serious Emotional Disturbance boarding in public emergency rooms.

—*Illinois*.—Since 2009, 10,000 low-income children and adults have lost access to community-based mental healthcare.

—*Kansas*.—New admissions to the State's public psychiatric hospitals have been frozen for the remainder of 2010 and nine of the State's 27 Community Mental Health Centers are in operating deficits and in jeopardy of being closed (most of these agencies serve rural health professional shortage areas).

—*Mississippi*.—The Governor has proposed an $18 million cut this year that would result in the closing of six crisis centers and four Department of Mental Health facilities including two inpatient psychiatric hospitals.

When investments in treatment, support and recovery are slashed to this extreme degree, the costs to society and to Government do not go away. Instead, the costs just get passed along far more expensively in terms of public spending and far less successfully in terms public health:

—Half of all lifetime mental illnesses begin by age 14 and without access to early diagnosis and treatment, we end up paying much more for special education, private placements, substance abuse and juvenile detention.

—Without access to community-based treatment and support, we end up paying much more for secondary medical symptoms, homelessness, addiction, broken families, extended hospital emergency admissions, nursing home beds, jails, and prisons.

—Without access to mental healthcare, our national and State economies lose billions of dollars every year in unemployment, under-employment and lost productivity.

—Without access to treatment and recovery, people with serious mental illnesses are destined to die 25 years sooner than the general population.

At NAMI we refer to this as "spending money in all the wrong places" as the burden of untreated mental illness is shifted and hidden but no less at taxpayers expense.

It is imperative that programs at the Center for Mental Health Services (CMHS) at SAMHSA help States respond to the individual crises they are facing in trying to manage such deep reductions to community mental health budgets in a time of rising demand—both respect to the needs of the existing population of people living with serious mental illness and new populations at risk of anxiety, depression and psychosis.

In particular, this subcommittee must expand investment in the Mental Health Block Grant (MHBG) for fiscal year 2011. Funding for the MHBG has been frozen at its current level of $420 million since fiscal year 2000. NAMI urges the subcommittee to respond to this crisis at the State level by increasing funding for the Mental Health Block Grant by $100 million to $520 million in fiscal year 2011.

NAMI would also recommend the following priorities for CMHS for fiscal year 2011:

—Support the President's proposal to increase the PATH Homeless Formula Grant program to $70 million (a proposed $5 million increase above fiscal year 2010),
—Support the President's proposal for a $5 million increase for the Children's Mental Health program, boosting funding up to $126 million, and
—Support the President's proposal for a $6 million increase for suicide prevention activities at CMHS (up to $54.2 million), including funding for the Garrett Lee Smith Memorial Act.

Addressing Chronic Homelessness and Mental Illness

SAMHSA's homeless programs fill a gap created by a preference for funding housing capital needs over the critically important services that are necessary for programs to be effective. In the recent competition conducted by SAMHSA the agency received more than 500 qualified applications, of which the agency was only able to fund 68. The interest and capacity of providers to put these Federal dollars to work and end homelessness for thousands of homeless individuals should demonstrate to Congress a clear mandate to significantly increase funding for SAMHSA's homeless programs.

The current fiscal year 2010 funding level of SAMHSA homeless programs is $75 million. This is divided between two accounts: $32.25 million within the Center for Mental Health Services (CMHS) and $42.75 within the Center for Substance Abuse Treatment (CSAT). The President's budget proposes an increase of $12.1 million, $7.446 million for CMHS and $4.610 million for CSAT.

The President's 2011 budget proposal includes a new Homeless Initiative Program. This is a HUD/HHS partnership creating two demonstration programs, including one that couples Housing Choice Vouchers with services funding by Medicaid and SAMHSA. The Medicaid funds are mandatory spending and do not require an appropriations amount. However, the SAMHSA contribution must be appropriated and the President proposes $15.8 million. This funding includes the $12.1 million proposed SAMHSA homeless services increase and an additional $3.7 million from existing CSAT resources.

NAMI applauds the administration's recognition that the Federal Government can do a better job helping communities couple housing and services funding. This is a good first step. However, we are concerned that the chronically homeless demonstration would take $3.7 million from existing resources and only States with existing 1115 Medicaid waivers can apply. NAMI urges this subcommittee to ensure that an optimal number of States and public housing authorities, who administer Housing Choice Vouchers, can use the Medicaid and SAMHSA funding available for this program to more effectively target chronically homeless individuals living with mental illness.

Overall, NAMI urges this subcommittee to provide $120 million in SAMHSA homeless programs for essential mental health and substance use treatment services linked to permanent supportive housing for chronically homeless individuals and families. This request would increase funding by $45 million more than the fiscal year 2010 funding level. NAMI also supports the President's recommendation for $15.8 million for SAMHSA's portion of the administration's Homeless Initiative Program for fiscal year 2011.

Continue Progress on Addressing the Social Security Disability Claims and Appeals Backlog

Mr. Chairman, people with mental illness and other severe disabilities have been bearing the brunt of the backlog crisis for disability claims and appeals at Social Security. Behind the numbers are individuals with disabilities whose lives have unraveled while waiting for decisions—families are torn apart; homes are lost; medical conditions deteriorate; once stable financial security crumbles; and many individuals die. NAMI congratulates this subcommittee on the progress made since 2008 with the appropriation for SSA's Limitation on Administrative Expenses (LAE), boosting it to $11.447 billion for fiscal year 2010. This investment, along with ARRA funds to improve information technology has allowed SSA to hire new staff, reduce processing times and make progress on the reducing the disability claims backlog. NAMI urges the subcommittee to continue this progress and support the President's recommendation for an LAE of $12.521 billion for fiscal year 2011.

Conclusion

Chairman Harkin, thank you for the opportunity to share NAMI's views on the Labor, Health and Human Services, and Education, and Related Agencies Subcommittee's fiscal year 2011 bill. NAMI's consumer and family membership thanks you for your leadership on these important national priorities.

PREPARED STATEMENT OF THE NATIONAL AHEC ORGANIZATION

The National AHEC Organization (NAO) is the professional organization representing Area Health Education Centers (AHECs). Our message is simple:

—The Area Health Education Center program is effective and provides vital services and national infrastructure.

—Area Health Education Centers are the workforce development, training and education machine for the nation's healthcare safety-net programs.

AHEC is one of the Title VII Health Professions Training programs, originally authorized at the same time as the National Health Service Corps (NHSC) to create a complete mechanism to provide primary care providers for Community Health Centers (CHCs) and other direct providers of healthcare services for underserved areas and populations. The plan envisioned by creators of the legislation was that the CHCs would provide direct service. The NHSC would be the mechanism to fund the education of providers and supply providers for underserved areas through scholarship and loan repayment commitments. The AHEC program would be the mechanism to recruit providers into primary health careers, diversify the workforce, and develop a passion for service to the underserved in these future providers, i.e., Area Health Education Centers are the workforce development, training and education machine for the Nation's healthcare safety-net programs. The AHEC program is focused on improving the quality, geographic distribution and diversity of the primary care healthcare workforce and eliminating the disparities in our Nation's healthcare system.

AHECs develop and support the community based training of health professions students, particularly in rural and underserved areas. They recruit a diverse and broad range of students into health careers, and provide continuing education, library and other learning resources that improve the quality of community-based healthcare for underserved populations and areas.

The Area Health Education Center program is effective and provides vital services and national infrastructure. Nationwide, in 2006, AHECs introduced more than 308,000 students to health career opportunities, and more than 41,000 mostly minority and disadvantaged high school students received more than 20 hours each of health career programs and academic enhancement. AHECs support health professional training in more than 19,000 community based practice settings, and more than 111,000 health professional students received training at these sites. Further, over 368,000 health professionals received continuing education through AHECs. AHECs perform these education and training services through collaborative partnerships with Community Health Centers (CHCs) and the National Health Service Corps (NHSC), in addition to Rural Health Clinics (RHCs), Critical Access Hospitals, (CAHs), Tribal clinics and Public Health Departments.

While our partner programs, the National Health Service Corps and the Community Health Centers program have received much recognition of late and are identified as Presidential Initiatives, the AHEC program has been overlooked. AHEC is designed to meet the needs of the communities it serves, and to bridge the resources of universities, state and Federal programs, bringing those resources to the community. As a program with a national network, AHEC has a significant infrastructure. This infrastructure can provide the mechanism for information dissemination for Clinical and Translational Services to reduce the time it takes for bench science findings to become part of medical practice. AHECs can deliver minority health programs and already focus on recruiting minorities into health careers.

In the past decade many new programs have been developed by Federal initiatives which compete with the mission of AHEC and utilize Federal resources to duplicate the AHEC infrastructure. Public resources would be better spent by utilizing the national network that AHEC represents, rather than reproducing the infrastructure through the creation of other programs.

AHEC was recently reauthorized in the Patient Protection and Affordable Care Act of 2010. We were pleased to that this program was reauthorized for the first time since 1998, and reauthorized at $125 million.

Community Health Centers and the National Health Service Corps

CHCs are dedicated to providing preventive and ambulatory healthcare to uninsured and underinsured populations. A March 2006 study published in the Journal of the American Medical Association (JAMA) found that CHCs report high percentages of provider vacancies, including an insufficient supply of dentists, pharmacists, pediatricians, family physicians and registered nurses. These shortages are particularly pronounced in CHCs that serve rural areas. The study serves as an important reminder that the success of CHCs is highly dependent upon a well-trained clinical staff to provide care. Because title VII programs, including AHECs, have a success-

ful record of training providers to work in underserved areas, the study recommends increased support for the Title VII Health Professions Training programs as the primary means of alleviating the health professions shortage in rural CHCs. In 2006, 46 percent of AHEC training sites were CHCs, and an additional 25 percent of placements were in Rural Health Clinics.

The scope of collaborative activities between AHECs and CHCs is substantial and the populations served through these activities are culturally and geographically diverse.

The interrelationships between AHECs and CHCs are numerous, and the added-value to the community from the unique contributions of each is undeniable in terms of access to quality healthcare.

AHECs collaborate with CHCs by:

—Assisting CHCs with the development of community boards of directors and often serving as board members;

—Recruiting health professionals/staff;

—Facilitating clinical training opportunities for health professions students/trainees within CHC clinic sites;

—Conducting continuing education programs and other library and learning resources for health and human services professionals employed at CHC clinic sites.

AHECs also undertake a variety of programs related to the placement and support of National Health Service Corps scholars and loan repayment recipients. NHSC scholars and loan repayment recipients commit to practicing in an underserved area, and are focused on improving health by providing comprehensive team-based healthcare that bridges geographic, financial and cultural barriers. As contractors of the NHSC Student/Resident Experiences and Rotations in Community Health (SEARCH) program, AHECs help to expand the NHSC by placing students and residents in rotations in rural areas. These students and residents are then more likely to return to rural and underserved areas as a NHSC scholar or loan repayment recipient since health professionals who spend part of their training providing care for rural and underserved populations are 3 to 10 times more likely to practice in rural and underserved areas after graduation or program completion.

AHECs frequently place health professions students in sites that are approved for NHSC personnel. NHSC scholars and loan repayers serve as preceptors or these students. These sites give the students a view of working in communities with great need, seeing the potential for a fulfilling career, thus strengthening the connection between these students and service to the underserved through the NHSC.

Justification for Recommendations

By improving the quality, geographic diversity, and diversity of the healthcare workforce, the United States can eliminate healthcare disparities. An October 2006 study by the Health Resources and Services Administration (HRSA) entitled "The Rationale for Diversity in the Health Professions: A Review of the Evidence" shows the importance of the programs like AHEC. This study found that minority health professionals disproportionately serve minority and other medically underserved populations, minority populations tend to receive better care from practitioners of their own race or ethnicity, and non-English speaking patients experience better care, greater comprehension, and greater likelihood of keeping follow-up appointments when they see a practitioner who speaks their own language.

In order to continue the progress that the Title VII Health Professions Training programs, especially AHECs, have already made towards their goal, an additional Federal investment is required. NAO recommends that the AHEC program is funded at $125 million, consistent with its recent reauthorization amount.

PREPARED STATEMENT OF THE NATIONAL ASSOCIATION FOR PUBLIC HEALTH STATISTICS AND INFORMATION SYSTEMS

The National Association for Public Health Statistics and Information Systems (NAPHSIS) welcomes the opportunity to provide this written statement for the public record as the Labor, Health and Human Services, and Education, and Related Agencies Appropriations Subcommittee prepares its fiscal year 2011 appropriations legislation. NAPHSIS represents the 57 vital records jurisdictions that collect, process, and issue birth and death records in the United States and its territories, including the 50 States, New York City, the District of Columbia and the 5 territories. NAPHSIS coordinates the activities of the vital records jurisdictions among the jurisdictions and with Federal agencies by developing standards, promoting consistent

policies, working with Federal partners, and providing technical assistance to the jurisdictions.

NAPHSIS respectfully requests that the subcommittee provide the National Center for Health Statistics' (NCHS) National Vital Statistics System $11 million in fiscal year 2011—consistent with the President's request—to support the States and territories as they implement the 2003 birth and death certificates and electronic data collection systems.

Collection of birth and death data through vital records is a State function and thus governed under State laws. NCHS purchases birth and death data from the States to compile national data on vital events—births, deaths, marriages, divorces, and fetal deaths. These data are used to monitor disease prevalence and our nation's overall health status, develop programs to improve public health, and to evaluate the effectiveness of those interventions. For example, birth data have been used to:

—Establish the relationship of smoking and adverse pregnancy outcomes;
—Link the incidence of major birth defects to environmental factors;
—Establish trends in teenage births;
—Determine the risks of low birth weight; and
—Measure racial disparities in pregnancy outcomes.

Just as fundamentally, death data are used to:

—Monitor the infant mortality rate as a leading international indicator of the Nation's health status;
—Track progress and regress in reducing mortality from the leading causes of death, such as heart disease, cancer, stroke, and diabetes;
—Document racial disparities; and
—Otherwise provide sound information for programmatic interventions.

Most recently, vital statistics have grabbed headlines with Amnesty International's report of increases in pregnancy related deaths.

Years of chronic underfunding at NCHS have threatened the collection of these important data on the national level, to the extent that in fiscal year 2007, NCHS would have been unable to collect a full 12 months of vital statistics data from States. Had the subcommittee not intervened with a small but critical budget increase to continue vital statistics collection, the United States would have been the first Nation in the industrialized world to be without a complete year's worth of vital data. Countless national programs and businesses that depend on vital events information would have been immeasurably affected.

Since that time, the subcommittee has continually supported NCHS's vital statistics cooperative with the States. NAPHSIS and the broader public health community deeply appreciate these efforts. This year, we are pleased the President is following the subcommittee's lead in seeking to build a 21st century national statistical agency, requesting a $23 million increase for NCHS in fiscal year 2011, including $11 million targeted for the modernization of the National Vital Statistics System. This increase will support states as they upgrade their outdated and vulnerable paper-based vital statistics systems, addressing critical needs for activities that have been on hold or curtailed because of budget constraints.

As we make significant strides in implementing and meaningfully using health information technology, it is imperative that we similarly invest in building a modern vital statistics system that monitors our citizens' health, from birth until death. The requested $11 million in funding will move us toward a timelier and more comprehensive vital statistics infrastructure where all states collect the same data and all States collect these data electronically. Two forms of birth and death certificates are in use by States—the older 1989 standard certificate and the newer 2003 standard certificate This more recent birth certificate revision includes data on insurance and access to prenatal care, education level of parents, labor and delivery complications, delivery methods, congenital anomalies of the newborn, maternal morbidity, mother's weight and height, breast feeding status, maternal infections, and smoking during pregnancy, among other factors. The 2003 death certificate includes data on smoking-related, pregnancy-related, and job-related deaths.

Currently, only 75 percent of the States and territories use the 2003 standard birth certificate and 65 percent have adopted the 2003 standard death certificate. Many States continue to rely on paper-based records, a practice which compromises the timeliness and interoperability of these data. Jurisdictions that had planned and budgeted to upgrade their certificates and systems have seen funding for these projects erode as States face severe budget shortfalls. These jurisdictions need the Federal Government's help to complete building a 21st century vital statistics system. The President's requested down payment will help in this regard, allowing all jurisdictions to implement the 2003 birth certificate and electronic birth record systems. Approximately $30 million is needed to modernize the death statistics system;

but the President's request of $3 million is nonetheless an important first step. However, we request that the subcommittee not require a State match for funds to modernize death certificates, as proposed by the President. NAPHSIS's members most in need of Federal support have indicated that a State-match requirement would inadvertently prevent jurisdictions from applying for these funds. Indeed, if States had available funds to invest in system improvements they would do so.

As the historic Patient Protection and Affordable Care Act is implemented, the vital statistics purchased by NCHS from States are needed more than ever to track Americans' health and evaluate our progress in improving it. The President's request of $11 million for the National Vital Statistics System will lead to vast improvements in data collection and further enable us to better compare critical information on a local, State, regional, and national basis. Without additional funding, a potential erosion of State data infrastructure and lack of standardized data will undeniably create enormous gaps in critical public health information and may have severe and lasting consequences on our ability to appropriately assess and address critical health needs.

NAPHSIS appreciates the opportunity to submit this statement for the record and looks forward to working with the subcommittee.

PREPARED STATEMENT OF THE NATIONAL ASSOCIATION OF PEOPLE WITH AIDS AND VILLAGECARE

The National Association of People with AIDS (NAPWA) and VillageCare are submitting joint written comments on the appropriations for domestic HIV programs for Federal fiscal year 2011. Overall, NAPWA and VillageCare believe that the President's request for fiscal year 2011 spending on domestic HIV programs, while including some increases in funding, is insufficient to meet the needs of persons living with HIV/AIDS in this country. We urge you to increase funding for domestic HIV/AIDS programs in the fiscal Labor, Health and Human Services, and Education, and Related Agencies; Transportation and Housing and Urban Development, and Related Agencies; and Financial Services and General Government bills for the upcoming fiscal year.

Founded in 1983, NAPWA is the first coalition of people living with HIV/AIDS in the world, as well as the oldest AIDS organization in the United States. NAPWA is a trusted, independent voice representing the more than 1 million people living with HIV/AIDS in America.

VillageCare is a community-based organization serving seniors, persons living with HIV and AIDS, and others who face chronic and disabling conditions. Founded in New York's Greenwich Village nearly 35 years ago, the not-for-profit organization developed some of the first care and program responses to the AIDS epidemic in the 1980s, and has created a number of innovative programs and services, including the first AIDS day treatment program in the country and the largest AIDS skilled nursing facility.

With more than 56,000 new HIV infections annually and the United States already having more than 1.1 million people living with HIV, coupled with the rising cost of medical care and other services, we urgently need to allocate sufficient resources to address unmet care and treatment needs of persons living with HIV. It is estimated that 29 percent of persons living with HIV/AIDS in the United States are uninsured. The HIV epidemic also continues to have a disproportionate impact on communities of color and on low-income individuals.

For nearly a decade, the HIV epidemic in the United States has faced serious underfunding, as the previous administration chose not to focus priorities on the Nation's own HIV challenges. Increases in funding are desperately needed to make up for these years of neglect.

While passage of healthcare reform promises to contribute significantly to filling the gap in health coverage, the most critical provisions in the new law do not kick in until 2014. This means that over the next 4 years, there will be persons living with HIV who will have to wait for access to treatment that could save their lives.

During this gap in time, it is vital for Congress to act to fill the void in resources that would connect people to care.

We offer the following recommendations where Congress can move to address vital HIV care and treatment needs.

Increase Funding in the Ryan White Program by $810.8 Million, for Total Funding of $3,101.5 Billion

This includes a breakdown of funding as follows:

—*Part A.*—Increase of $225.9 million for total of $905 million.

—*Part B: Care*.—Increase of $55.9 million for a total of $474.7 million.
—*Part B: AIDS Drug Assistance Program*.—Increase of $370.1 million for a total of $1,205.1 million.
—*Part D*.—Increase of $131 million for a total of $337.9 million.
—*Part F: AIDS Education Training Centers*.—Increase of $15.2 million for a total of $50 million.
—*Part F: Dental*.—Increase of $5.4 million for a total of $19 million.
—*Part F: Special Projects of National Significance*.—Support funding of $25 million (level funding).

In many regions of the country, financing through Ryan White is often the only means to pay for healthcare and supportive services for many persons living with HIV/AIDS. Unfortunately, the President's proposed funding for the Ryan White HIV/AIDS program was increased by only $40 million, with many parts of the Ryan White program remaining flat-funded. Advocates in the HIV community have called upon the administration to provide at least $810 million in new resources to meet growing demand. The Nation needs continued aggressive action if we are to close the gap in access to treatment and care that exists for many persons living with HIV. Ryan White programs serve approximately 577,000 low-income, uninsured, and underinsured individuals each year. For many people living with HIV, Ryan White-funded programs are the sole lifeline to HIV care, treatment and services.

Support Emergency Supplemental Funding in Fiscal Year 2010 for the AIDS Drug Assistance Program (ADAP) in the Amount of $126 Million

Eleven States have waiting lists with more than 850 people waiting to get access to life saving HIV medications. In addition, many States have greatly restricted the drugs covered by the ADAP and restricted eligibility so that fewer people quality for ADAP benefits. Urgent, immediate emergency supplemental ADAP funding that would flow to these programs during the current fiscal year will help address this crisis.

Expand Access to Housing by Increasing Housing Opportunities for People With AIDS (HOPWA) Funding by $75 Million, for a Total of $410 Million

Access to safe and affordable housing is essential to improving individual health outcomes and promoting public health. Improved housing status is strongly associated with increased access and adherence to care and with lowered rates of HIV risk behaviors. Demand for AIDS housing far exceeds availability and increased HOPWA funding is needed to support efforts to address this critical component of the HIV care continuum. In the light of flat funding across many Federal programs, the President's proposed HOPWA increase of $5 million is far too small to make any meaningful impact on the rising numbers of persons who are without access to stable housing.

Increase Efforts To Respond to the Disproportionate Impact of HIV Among Communities of Color by Increasing Funding for the Minority AIDS Initiative (MAI) by $207.1 Million, for Total Funding of $610 Million

Targeted funding is urgently needed to address the huge disparities in HIV infection among communities of color. MAI funding improves access to culturally and linguistically appropriate outreach, education, prevention, care and treatment programs and services.

Support new Investments in HIV Prevention Education by Increasing Funding at the Centers for Disease Control and Prevention (CDC) by $878 Million, for Total Funding of $1,606 Million

A significant increase in funding of HIV prevention initiatives is needed to reduce the number of new HIV infections, which have remained unchanged at about 56,000 per year since 2001. State and local health departments and community-based organizations need adequate resources to strengthen and expand HIV testing, outreach and prevention education programs.

Increase Funding for AIDS Research at the National Institutes of Health (NIH) by $410 Million, for Total Funding of $3.5 Billion

A lack of sufficient funding for the NIH has slowed important research efforts aimed at ending the HIV/AIDS epidemic in the United States. To reverse this trend, funding increases are needed for the Office of AIDS Research at NIH.

Support the $1.4 Million in Appropriations for National HIV/AIDS Strategy Implementation, Coordination, Evaluation, and Monitoring

The National Strategy will be unveiled this year and this appropriation will be needed to achieve its goals. As National HIV/AIDS Strategy implementation begins,

Congress must renew this $1.4 million appropriation, which is contained in the Financial Services and General Government appropriations bill. In each of fiscal year 2009 and fiscal year 2010, Congress appropriated $1.4 million for the White House Office of National AIDS Policy to help fund the cost of developing a comprehensive national HIV/AIDS strategy.

VillageCare and NAPWA look forward to working with Congress and the administration to find more resources to address the significant unmet need for HIV primary medical care and supportive services that exists across the United States. We and others in the HIV community were extremely pleased with the steps taken by the Obama administration in the first year. The President has expressed and demonstrated leadership on behalf of the HIV community with such actions as the 4-year extension of the Ryan White Care Act and ending the HIV travel ban.

At the same time, the Federal budget for fiscal year 2011 will need significant modification and additions if we are to fulfill the vision of the President and others to end the AIDS epidemic in the United States.

Thank you.

PREPARED STATEMENT OF THE NATIONAL ASSEMBLY ON SCHOOL-BASED HEALTH CARE

I am grateful for this opportunity to submit written testimony on behalf of the National Assembly on School-Based Health Care, an organization representing the interests of school-based health centers (SBHCs). SBHCs ensure that 1.7 million children and adolescents across the country gain access to comprehensive medical care, mental health services, preventive care, social services, and youth development. These services are provided without concern for students' ability to pay in a location that meets children and adolescents where they are: at school.

The Patient Protection and Affordable Care Act (Public Law111–148) includes a Federal authorization for SBHCs in section 4101(b)—a huge victory for vulnerable children and adolescents and for SBHCs. Secretary Sebelius agrees: "We are thrilled that part of the [health reform] legislation calls for an expanded foot print of school-based health clinics . . . I can't think of a better way to deliver primary care and preventive care to not only students but their families than through school-based clinics." [1]

However, the School-Based Health Clinic authorization needs to be appropriated if SBHCs are to continue to serve our Nation's youth. Until funds are appropriated, only limited Federal support exists for SBHC operations, leaving little hope for the expansion that is called for by Secretary Sebelius.

SBHCs are designed to meet the healthcare needs of students, and are considered one of the most effective strategies for delivering high quality, comprehensive, and culturally competent primary and preventive care to children and adolescents. At SBHCs, developmentally appropriate health services are provided by qualified health professionals, incorporating the principles and practices of pediatric and adolescent healthcare recommended by the American Medical Association, the American Academy of Pediatrics, and the American Association of Family Physicians. A recent study showed that SBHCs have positive impacts on student achievement—particularly increasing grade point averages and attendance.[2]

We respectfully request a $50 million appropriation to fund the SBHC authorization for Federal fiscal year 2011. These funds could provide the full operations budget of up to 200 school-based health centers for a year, but will likely be used to support many more. In the current economic climate, many State programs are struggling to maintain support for the SBHCs they currently fund, much less expand operations. We hear with increasing frequency from SBHCs about the need for expanded primary care hours, oral health, and expanded mental health services. Regrettably, some SBHCs have already had to close their doors, due to lack of funding for healthcare services.

We would also like to share our concern that without support for the operational costs needed to support a clinic, the effectiveness of the capital money already allocated to SBHCs in the Affordable Care Act under section 4101(a) will be greatly limited. The funds allocated in section 4101(a), although important, are limited to capital improvements and equipment purchases. Expenditures for healthcare services

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[1] U.S. Department of Health and Human Services Secretary Kathleen Sebelius, during her opening plenary remarks at the Coalition for Community School's national forum in Philadelphia; April 7, 2010.

[2] "Impact of School-Based Health Center Use on Academic Outcomes," Journal of Adolescent Health 46 (2010) 251–257.

and personnel are specifically excluded. The present risk and largest difficulty for SBHCs is the cost of care. The capital funds could allow some SBHCs to be built or expanded, but clinics need a sustainable source of operations funding in order to provide services for the children and adolescents who depend on them for care.

Only a fraction (28 percent) of SBHCs can be supported in any way by the funds allocated in the healthcare reform legislation for community health centers. The majority of SBHCs are sponsored by entities ineligible for community health center funding, such as hospitals.

The original House-passed bill identified a $50 million appropriation for the newly authorized school-based health center program. These funds will give critical resources to communities that desire to open health clinics at their schools and keep their existing clinics open.

For the above reasons, we respectfully request that a $50 million appropriation be provided for the SBHC Authorization for fiscal year 2011. Thank you for this opportunity.

PREPARED STATEMENT OF THE NATIONAL ALLIANCE OF STATE & TERRITORIAL AIDS DIRECTORS

The National Alliance of State and Territorial AIDS Directors (NASTAD) represents the Nation's chief State health agency staff who have programmatic responsibility for administering HIV/AIDS and viral hepatitis healthcare, prevention, education, and supportive service programs funded by State and Federal Governments.

On behalf of NASTAD, we urge your support for increased funding for Federal HIV/AIDS and viral hepatitis programs in the fiscal year 2011 Labor, Health and Human Services, and Education, and Related Agencies Subcommittee bill. We ask the subcommittee on Labor, Health and Human Services, and Education to demonstrate its commitment to addressing the domestic HIV epidemic and ramp up support for a much larger blood-borne epidemic, that of chronic viral hepatitis. We thank you once again for the increases provided to HIV/AIDS and hepatitis programs in fiscal year 2010 and ask for consideration of the following critical funding needs for HIV/AIDS, viral hepatitis and STD programs in fiscal year 2011.

HIV/AIDS Care and Treatment Programs

The Health Resources and Services Administration (HRSA) administers the $2.2 billion Ryan White Program that providing health and support services to more than 500,000 HIV-positive individuals. NASTAD requests a minimum increase of $426 million in fiscal year 2011 for State Ryan White part B grants, including an increase of $56 million for the part B Base and $370 million for AIDS Drug Assistance Programs (ADAPs). With these funds States and territories provide care, treatment, and support services to persons living with HIV/AIDS. People living with HIV need access to trained HIV clinicians, life-saving and life-extending therapies, and a full range of support services to live as healthy a life as possible and to ensure adherence to complicated treatment regimens. All States are reporting to NASTAD that they are seeing a significant increase in the number of individuals seeking part B Base and ADAP services. In 2008, it is estimated that ADAPs nationwide served nearly 165,000 HIV-infected individuals, nearly one-quarter of people with HIV/AIDS estimated to be receiving care. This is due to a number of factors including, increased testing efforts and unemployment.

State ADAPs provide medications to low-income individuals with HIV disease who have limited or no coverage from private insurance or Medicaid. With the rise in unemployment and individuals losing their insurance, ADAPs are increasingly in crisis. As of April 2010, 10 States report that 859 individuals are on a waiting list to receive their life-sustaining medications through ADAP:

—*Idaho*.—25 individuals
—*Iowa*.—62 individuals
—*Kentucky*.—191 individuals
—*Montana*.—17 individuals
—*North Carolina*.—356 individuals
—*South Carolina*.—33 individuals
—*South Dakota*.—32 individuals
—*Tennessee*.—55 individuals
—*Utah*.—74 individuals
—*Wyoming*.—14 individuals

Sixteen States have additional cost containment measures in place or are anticipating implementing measures.

ADAPs with Other Cost-containment Strategies (instituted since April 1, 2009)

—*Arizona*.—Reduced formulary
—*Arkansas*.—Reduced formulary, lowered financial eligibility to 200 percent of FPL
—*Colorado*.—Reduced formulary
—*Hawaii*.—Individuals with CD4>350 not currently on ARV therapy are not being enrolled
—*Iowa*.—Reduced formulary
—*Kentucky*.—Reduced formulary
—*Missouri*.—Reduced formulary
—*North Carolina*.—Reduced formulary
—*North Dakota*.—Cap on Fuzeon
—*Utah*.—Reduced formulary, lowered financial eligibility to 250 percent of FPL
—*Washington*.—Client cost sharing, reduced formulary (for uninsured clients only)

ADAPs Considering New/Additional Cost-containment Measures (before March 31, 2011)

Arizona.—Waiting list
Hawaii.—Waiting list
Illinois.—Waiting list, reduced formulary, lowered financial eligibility, capped enrollment, monthly expenditure cap
Kentucky.—Reduced formulary
Louisiana.—Capped enrollment
North Carolina.—Lowered financial eligibility
North Dakota.—Waiting list, reduced formulary, capped enrollment, annual expenditure cap
Oregon.—Waiting list, reduced formulary
South Dakota.—Reduced formulary
Wyoming.—Lowered financial eligibility, annual expenditure cap

In fiscal year 2009, 48 percent of ADAPs experienced cuts in State contributions to their programs and at least 35 percent of programs are anticipating cuts to their ADAPs in fiscal year 2010. Program restrictions can lead to dangerous treatment interruptions, which encourage drug resistance and discourage patient retention in care, both of which have profound effects on public health. As discretionary programs, ADAPs are dependent on annual Federal and State appropriations to serve all those in need of treatment.

Ryan White part B Base programs include ambulatory medical services, case management, laboratory services, and primary care networks that improve the overall HIV care systems in States. Primary care and the provision of drug treatments are inextricably linked. People living with HIV need access to trained HIV clinicians and a full range of support services to live as healthy a life as possible to ensure adherence to complicated treatment regimens. Unfortunately, limited funding has resulted in waits of up to 6 months for a primary care visit.

HIV/AIDS Prevention and Surveillance Programs

NASTAD requests an increase of $181 million for State and local health department cooperative agreements in order to provide comprehensive prevention programs. To be successful, health departments must expand outreach, HIV testing, and linkage into care targeting high-risk populations including gay men of all races, black women, persons who inject drugs, and youth. Additional resources must be directed to build capacity and provide technical assistance to enable community-based organizations and healthcare providers to implement evidence-based behavior change interventions and HIV testing recommendations. In order to maximize prevention efforts, partners of persons being tested need to be identified, notified, and counseled. In addition, health departments need resources to educate the mass public by reinforcing accurate, evidence-based information and beginning to reduce the stigma associated with the disease.

An estimated 56,300 new infections occur every year while State and local HIV prevention cooperative agreements have been cut by $23 million over the last decade. NASTAD surveyed States and found that in fiscal year 2009, State HIV/AIDS programs were cut by $170 million. Seventy-four percent of States responding to NASTAD's survey reported cuts to HIV prevention programs. States also reported that almost 200 HIV/AIDS staff positions have been cut or gone unfilled. These cuts make the Federal resources for prevention all the more critical to mounting an effective response to the epidemic.

The Nation's prevention efforts must match our commitment to the care and treatment of infected individuals. State and local public health departments know

what to do to prevent new infections, they just need the resources. First and foremost we must address the devastating impact on racial and ethnic minority communities. To be successful, we must expand outreach and HIV testing efforts targeting high-risk populations including gay and bisexual men of all races, racial and ethnic minority communities, substance users, women and youth. But, testing alone can never end the epidemic. All tools in the prevention arsenal must be supported. Additional resources must be directed to build capacity and provide technical assistance to enable community-based organizations and healthcare providers to implement evidence-based behavior change interventions and HIV testing recommendations. In order to maximize prevention efforts, partners of persons being tested need to be identified, notified, and counseled. With 21 percent of HIV-infected persons unaware that they have HIV, increased funding for testing and partner services will avert millions in unnecessary healthcare costs. In addition, health departments need resources to educate the mass public by reinforcing accurate, evidence-based information and beginning to reduce the stigma associated with the disease.

NASTAD also supports the President's request of $26.9 million for a new initiative targeting gay men and other men who have sex with men (MSM). We believe this funding should come out of HIV funding and not STD and viral hepatitis increases as proposed.

NASTAD requests that $48 million be allocated to health departments to maintain the Expanded Testing Initiative (ETI). In fiscal year 2009, CDC awarded $40.2 million to 20 States and 5 cities to support routine testing in clinical settings targeting highly impacted populations, particularly African Americans. In fiscal year 2010, the ETI will be expanded to 24 States and 6 cities funded at $47.5 million targeting African Americans, Latinos, gay and bisexual men of all races, and persons who inject drugs. NASTAD supports maintaining $48 million for health departments of the $65 million for the entire initiative so that more individuals can learn of their HIV status and be linked into care. NASTAD also support the President's request of $10 million for Program Collaboration and Service Integration (PCSI) to all health departments to integrate prevention services for HIV, STD, viral hepatitis, and TB at the client level.

Viral Hepatitis Prevention Programs

NASTAD requests an increase of $30.7 million for a total of $50 million in fiscal year 2011 for the CDC's Division of Viral Hepatitis (DVH) to enable State and local health departments to provide basic core public health services for viral hepatitis. Funds are needed for hepatitis B and C counseling, testing, and medical referral. States receive on average $90,000 for adult hepatitis prevention. DVH provides $5 million to fund the position of an Adult Viral Hepatitis Prevention Coordinator in 49 States, 5 cities, and the District of Columbia. This is only enough for the position and not for the provision of prevention services. Therefore, NASTAD requests a doubling of funding to the state adult viral hepatitis prevention coordinators from $5 to $10 million.

Due to lack of funding, CDC must treat hepatitis outbreaks as sentinel events rather than systematically addressing hepatitis B and C epidemics with more than 6 million Americans infected. Addressing one outbreak at a time is not cost-effective nor is it preventive. The first step to controlling infectious diseases such as hepatitis B and C is establishing a surveillance system to monitor disease incidence, prevalence, and trends. While there is no vaccine for hepatitis C, investing in hepatitis A and B vaccines is essential to providing prevention for high-risk adults and the elimination of both diseases. Hepatitis disproportionately impacts minorities and must be addressed in the context of health disparities. Approximately half of persons with chronic HBV are Asian Americans. Furthermore, HBV is most prevalent among immigrants from HBV-endemic countries (Asia and sub-Saharan Africa) who were infected at birth or childhood. Of the 24,000 HBV-infected women who give birth every year, half are Asian Americans. HCV infection is 2 to 3 times as prevalent in African Americans as it is in whites.

The recently released IOM report, Hepatitis and Liver Cancer: A National Strategy for Prevention and Control of Hepatitis B and C found that the public health response needs to be significantly ramped up. IOM's report attributes low public and provider awareness to the lack of public resources. The report makes 17 out of 22 recommendations specific to State health departments. In order to implement these recommendations to improve the Federal response, resources must be increased to health departments who provide the frontline response to these epidemics. For example, hepatitis C is the most common blood-borne, chronic viral disease in the United States with up to 4 million Americans suffering from chronic HCV infection-nearly four times the amount of those with HIV. Although transmission of hepatitis C has significantly decreased in the United States over the past 20 years, the inci-

dence of liver disease and liver cancer is rising, as persons infected with hepatitis C decades ago begin to develop complications of their infection. Without increased resources for counseling, testing and medical referral services, the CDC predicts that deaths due to HCV will double by 2020.

STD Prevention Programs

NASTAD supports an increase of $213.5 million for a total of $367.4 million in fiscal year 2011 for STD prevention, treatment and surveillance activities undertaken by state and local health departments. CDC's Division of STD Prevention has prioritized four disease prevention goals-Prevention of STD-related infertility, STD-related adverse pregnancy outcomes, STD-related cancers and STD-related HIV transmission. STD prevention programs at CDC have been cut by $6 million since fiscal year 2004 while the number of persons infected continues to climb. CDC estimates that 19 million new infections occur each year, almost half of them among young people ages 15 to 24. In one year, the United States spends more than $8 billion to treat the symptoms and consequences of STDs. Untreated STDs contribute to infant mortality, infertility, and cervical cancer. Additional Federal resources are needed to reverse these alarming trends and reduce the Nation's health spending.

Minority AIDS Initiative

NASTAD also supports total funding of $610 million for the Minority AIDS Initiative (MAI) in fiscal year 2011. The MAI provides targeted resources to address the HIV/AIDS epidemic in hard-hit communities of color. MAI resources supplement the funding to states to address the epidemic in these communities. The data from CDC on the disproportionate impact on African American continues to be staggering. Support for the MAI along with the traditional funding streams that serve these populations is essential.

Comprehensive Sex Education

NASTAD supports the teen pregnancy prevention initiative and asks that it be expanded to include prevention of HIV and STDs and funded at the President's request of $134 million. Programs targeted to youth in and out of school require an inter-departmental approach through the collaboration of HHS agencies, including the Agency for Children and Families, CDC's Division of Adolescent and School Health, and the Office of Population Affairs. We also support an increase of $20 million, for a total of $60.2 million, for the Division of Adolescent and School Health's HIV Prevention Education Program to increase access to evidence-based and comprehensive approach to sex education. Programs targeted to youth in and out of school require an inter-departmental approach through the collaboration of HHS agencies, including the Office of Adolescent Health, the Office of Population Affairs, the Agency of Children and Families, and CDC's Division of Adolescent and School Health.

As you craft the fiscal year 2011 Labor, Health and Human Services, and Education appropriations bill, we ask that you consider all of these critical funding needs. National Alliance of State and Territorial AIDS Directors thanks the Chairman, Ranking Member, and members of the subcommittee, for their thoughtful consideration of our recommendations. Our response to the HIV, viral hepatitis and STD epidemics in the United States defines us as a society, as public health agencies, and as individuals living in this country. There is no time to waste in our Nation's fight against these infectious and often chronic diseases.

PREPARED STATEMENT OF THE NATIONAL ASSOCIATION OF WORKFORCE BOARDS

Thank you for the opportunity to comment on the administration's proposed 2011 budget for the Department of Labor. The National Association of Workforce Boards (NAWB) is a member association, which represents a majority of the 575 local employer-led Workforce Investment Boards and their nearly 13,000 employer member volunteers.

We write in support of the administration's fiscal year 2011 overall appropriations request for the Training and Employment Services account under the Department of Labor. Adequate funding for the public workforce system has never been more critical. We are in the midst of the worst economic downturn in our lifetimes and the public workforce system has been stretched to its capacity, but continues to respond during this time of crisis.

Our employment crisis is not expected to ease in the foreseeable future. The annual Economic Report of the President released in February indicated that unemployment would remain above 8 percent through 2012. Federal Reserve Chairman

Ben Bernanke was also pessimistic in his testimony before the Joint Economic Committee on April 14 regarding any large scale employment growth in the near term:

"As you know, the labor market was particularly hard hit by the recession. Recently, we have seen some encouraging signs that layoffs are slowing and that employment has turned up. Manufacturing employment increased for a third month in March, and the number of temporary jobs—often a precursor of more permanent employment—has been rising since last October. New claims for unemployment insurance continue on a generally downward trend. However, if the pace of recovery is moderate, as I expect, a significant amount of time will be required to restore the 8½ million jobs that were lost during the past 2 years. I am particularly concerned about the fact that, in March, 44 percent of the unemployed had been without a job for 6 months or more. Long periods without work erode individuals' skills and hurt future employment prospects. Younger workers may be particularly adversely affected if a weak labor market prevents them from finding a first job or from gaining important work experience".

Workforce Investment Act programs have been on the front lines of assisting job seekers impacted by the recession. Over the past year, the Workforce Investment Act (WIA) system has seen over 7.6 million American workers turn to it for help in navigating the labor market in search of jobs and/or the training individuals need to be competitive in their labor market. This is a 60.2 percent increase in the number of people served through Employment and Training Administration programs over the previous year. In comparison, 4.1 million workers were assisted during the same period the previous year.

Despite six job seekers nationally for every available job, those who received WIA services were likely to find jobs, with the likelihood increasing the higher the service level:

Performance Results:
—Workforce Investment Act Adult Program:
  —Entered Employment Rate—68.1 percent
  —Employment retention rate—83.3 percent
—Average 6 months' earnings—$14,695
—Workforce Investment Act Dislocated Worker Program:
  —Entered employment rate—70 percent
  —Employment retention rate—85.9 percent
  —Average 6 months' earnings—$16,304
—Workforce Investment Act Youth Program:
  —Placement in employment or education rate—66.7 percent
  —Attainment of degree or certificate rate—58.2 percent

The ability of the pubic workforce system to maintain this level of success on behalf of job seekers and employers seeking skilled workers is incumbent upon the continuation of adequate funding. We encourage the subcommittee to fund WIA formula programs at a minimum at the administration's request levels, as we expect to continue to face the challenges brought about by high unemployment for the foreseeable future.

Workforce Innovation Fund

We applaud the administration's proposal for a $322 million Workforce Innovation Fund. We believe that the State and local workforce boards have developed a host of promising practices since WIA was enacted in 1998, particularly in helping address the large numbers of persons dislocated during this recession or shut-out of the labor market due to a lack of appropriate skills. The Workforce Innovation Fund will allow local areas to engage with community partners and quickly scale effective practices on behalf of jobseekers in need.

However, we strongly urge the subcommittee to fully fund the administration's request for WIA formula programs before allocating funding for the Workforce Innovation Fund, as these formula funds are essential to our ability to provide services to job seekers at the local level around the Nation.

The protection of the WIA formula programs is particularly important this year with the diminution of the remaining workforce funding in the American Recovery and Reinvestment Act, which have been heavily invested in providing training for job seekers. The bulk of these funds have been fully obligated at the local level, leaving little funding to commit for new trainees who seek services in the coming year. This funding "cliff" will provoke a large measure of frustration for individuals who are seeking services and are eligible, but for whom there are no funds available.

We suspect this is a well hidden policy issue since our current system of financial tracking counts expenditures but lacks the capacity to account for monies that are obligated by contract but not invoiced by the provider and paid by the fiscal agent.

Summer Youth employment

While our testimony is focused on fiscal year 2011 funding, we would be remiss if we did not express our appreciation for the Chairman's inclusion of ARRA funding for WIA Youth programs which allowed 313,000 young people to have summer jobs last year who otherwise would not have been employed. Most of these ARRA funding for WIA Youth have been expended at this point, but local workforce programs are in the process of preparing for another expanded summer youth program with the limited funds they currently have available.

We hope that any emergency spending bill enacted this work period will include additional funding for WIA Youth programs to allow us to better address the looming crisis we are facing in youth employment this summer.

Policy Riders

NAWB would strongly encourage the subcommittee to continue the policy riders that prohibit the redesignation of local areas or changes to the definition of administrative costs until WIA is reauthorized. There have been instances where there has been arbitrary action to reconfigure local areas and NAWB believes these riders will prevent any State v. local conflict until reauthorization.

We urge the subcommittee to continue to provide the support necessary for the workforce system to help our jobseekers retool for employment in high demand sectors and maintain our global competitiveness.

Thank you for the opportunity to testify.

PREPARED STATEMENT OF THE NURSING COMMUNITY

The Nursing Community is a forum for professional nursing and related organizations to collaborate on a wide spectrum of healthcare and nursing issues including practice, education, and research. These 53 organizations are committed to promoting America's health through nursing care. Collectively, the Nursing Community represents more than 850,000 Registered Nurses (RNs), Advanced Practice Registered Nurses (APRNs), nurse executives, nursing students, nursing faculty, and nurse researchers. Together, our organizations work collaboratively to increase funding for the Nursing Workforce Development programs, authorized under title VIII of the Public Health Service Act (42 U.S.C. 296 et seq.) so that American nurses have the support needed to provide high-quality care to their patients.

The National Nursing Shortage Continues to Impact Quality Care

Since 1998, the United States has experienced a significant shortage of RNs, which has dramatically impacted the quality of care provided by our Nation's healthcare delivery system. In March 2007, a comprehensive report initiated by the Federal Agency for Healthcare Research and Quality was released on Nursing Staffing and Quality of Patient Care. The authors found that the shortage of RNs, in combination with an increased workload, poses a potential threat to the quality of nursing care. In settings with inadequate nurse staffing, patient safety was compromised. However, increases in RN staffing were associated with reductions in hospital-related mortality and failure to rescue, as well as reduced lengths of stay. A robust supply of well-educated nurses is essential to ensure that all Americans receive quality healthcare and that our Nation has the nurses necessary to meet the current and future demands.

The demand for nurses will continue to grow as the baby-boomer population ages, nurses retire, and the need for healthcare intensifies. According to the U.S. Bureau of Labor Statistics (BLS), nursing is the Nation's top profession in terms of projected job growth with more than 581,000 new nursing positions being created through 2018 (a 22 percent increase in the workforce). Further, BLS analysts project that more than 1 million new and replacement nurses will be needed by 2016.

Currently, RNs comprise the largest group of health professionals with approximately 3.1 million providers offering essential care to patients in a variety of settings, including hospitals, long-term care facilities, community or public health areas, schools, workplaces, and home care. In addition, many nurses receive graduate degrees that allow them to practice autonomously as APRNs; become nurse faculty, nurse researchers, nurse administrators, and public health nurses; and work in the policy area to help shape healthcare delivery. With the new health reform law focused on creating a system that will increase access to quality care, emphasize prevention, and decrease cost, it is critical that a substantial investment be made

in our healthcare workforce, particularly an investment in nurses. RNs and APRNs are vital to ensuring direct availability to high-quality, cost-effective healthcare in a reformed system. Nurses are involved in every aspect of healthcare, and if the nursing workforce is not strengthened, the healthcare system will continue to suffer.

Reversing the Nursing Shortage: A Federal Solution

Throughout previous nursing shortages, particularly in the 1960s and 1970s, the Federal Government has offered relief to nursing schools and students to reverse the negative trend. In particular, the Nursing Workforce Development programs offered viable solutions to nursing shortages, expanded nursing school programs, increased the number of nurse faculty, and helped ensure nurses were practicing in areas with a critical shortage. As Congress searches for programs to address the nursing shortage now and in the future, the title VIII programs have been and continue to be a proven solution.

Nursing Workforce Development Programs

The Nursing Workforce Development programs have supported the supply and distribution of qualified nurses to meet our Nation's healthcare needs since 1964. Over the last 46 years, these programs have addressed all aspects of nursing shortages—education, practice, retention, and recruitment. The title VIII programs bolster nursing education at all levels, from entry-level preparation through graduate study, and provide support for institutions that educate nurses for practice in rural and medically underserved communities. Between fiscal year 2006 and 2008, the title VIII programs supported 214,575 nurses and nursing students as well as numerous academic nursing institutions, and healthcare facilities. Today, the title VIII programs are essential to solving the current national nursing shortage.

Title VIII Effectiveness

Results from the American Association of Colleges of Nursing's (AACN) 2009–2010 Title VIII Student Recipient Survey included responses from 1,420 students who noted that these programs played a critical role in funding their nursing education. The survey showed that three-quarters of the students receiving title VIII funding are attending school full-time. By supporting full-time students, the title VIII programs are helping to ensure that students enter the workforce without delay. The programs also address the current demand for primary care providers. A high percentage of the students surveyed (49.1 percent) reported that their career goal is to become a nurse practitioner. Approximately 80 percent of nurse practitioners provide primary care services throughout the United States. Additionally, the nurse faculty shortage continues to inhibit the ability of nursing schools to increase student capacity and address the shortage. Of the students who responded to the survey, 40.5 percent stated their ultimate career goal was to become nurse faculty.

Nursing Students Supported by Title VIII Funding

Of the title VIII student recipients surveyed, 39 percent reported that they received between $1,001–$3,000 in funding over 1 year. Sixty-seven percent reported that this funding supported a portion of their tuition, and 35.8 percent reported that the funding was dedicated to books and educational materials. Fifty-two percent of the students responded that the title VIII funding paid for 25 percent or less of their total student loans. Of those students, 26 percent stated that the funding paid for less than 5 percent of their total nursing student loans. When asked how the title VIII programs could be improved, the overwhelming response from students was to increase the funding in order to provide higher levels of support for their education.

Nursing students rely upon support through title VIII to complete their degree and offset their considerable educational expenses. Continued and increased support for the title VIII programs can help address the demand for nursing services.

The Nursing Community respectfully request $267.3 million (a 10 percent increase) for the Nursing Workforce Development programs authorized under title VIII of the Public Health Service Act in fiscal year 2011. Last year, your subcommittee provided a significant funding boost for title VIII that helped support the Loan Repayment program and Scholarship and Nurse Faculty Loan program. These increases will bolster the pipeline of nurses and nurse faculty, which is so critical to reversing the nursing shortage. We feel it is extremely important to maintain last year's funding level for these critical programs in fiscal year 2011 and direct the 10 percent requested increase for the four title VIII program that have not kept pace with inflation since fiscal year 2005. The Advanced Education Nursing, Nursing Workforce Diversity, Nurse Education, Practice, and Retention, and Comprehensive Geriatric Education programs expand nursing school capacity and increase patient access to care. These programs would greatly benefit from the 10 percent in-

crease awarded in proportion to their fiscal year 2010 funding level. Below is a description of these four critical programs.

Advanced Education Nursing (AEN) Grants (section 811) support the preparation of RNs in master's and doctoral nursing programs. The AEN grants help to prepare our Nation's nurse practitioners, clinical nurse specialists, nurse midwives, nurse anesthetists, nurse educators, nurse administrators, public health nurses, and other nurse specialists requiring advanced education. In fiscal year 2008 (most current data available), these grants supported the education of 5,649 students.

—AEN Traineeships assist graduate nursing students by providing full or partial reimbursement for the costs of tuition, books, program fees, and reasonable living expenses. In fiscal year 2008, this funding helped support 6,675 graduate nurses and APRNs.

—Nurse Anesthetist Traineeships (NAT) support the education of students in nurse anesthetist programs. In some States, Certified Registered Nurse Anesthetists (CRNAs) are the sole anesthesia providers in almost 100 percent of rural hospitals. Much like the AEN Traineeships, the NAT provides full or partial support for the costs of tuition, books, program fees, and reasonable living expenses. In fiscal year 2008, the program supported 2,145 future CRNAs.

Workforce Diversity Grants (section 821) prepare disadvantaged students to become nurses. This program awards grants and contract opportunities to schools of nursing, nurse managed health centers, academic health centers, State or local governments, and nonprofit entities looking to increase access to nursing education for disadvantaged students, including racial and ethnic minorities under-represented among RNs. In fiscal year 2008, the program supported 11,638 students.

Nurse Education, Practice, and Retention Grants (section 831) help schools of nursing, academic health centers, nurse-managed health centers, State and local governments, and healthcare facilities strengthen programs that provide nursing education. In fiscal year 2008, the priority areas under this program supported 42,761 with an additional 455 students supported by the Integrated Nurse Education Technology program.

Comprehensive Geriatric Education Grants (section 855) are awarded to schools of nursing or healthcare facilities to better provide nursing services for the elderly. These grants are used to educate RNs who will provide direct care to older Americans, develop and disseminate geriatric curriculum, prepare faculty members, and provide continuing education. In fiscal year 2008, this program supported 6,514 nurses and nursing students.

Without an adequate supply of nurses to care for our Nation, including our growing aging population, the healthcare system is not sustainable. The Nursing Community's request of $267.3 million in fiscal year 2011 for the HRSA Nursing Workforce Development programs will help ensure access to quality care provided by America's nursing workforce.

Members of the Nursing Community Submitting this Testimony

Academy of Medical-Surgical Nurses
American Academy of Ambulatory Care Nursing
American Academy of Nurse Practitioners
American Academy of Nursing
American Association of Colleges of Nursing
American Association of Nurse Anesthetists
American College of Nurse Practitioners
American College of Nurse-Midwives
American Nurses Association
American Organization of Nurse Executives
American Psychiatric Nurses Association
American Society for Pain Management Nursing
Association of Community Health Nursing Educators
Association of Nurses in AIDS Care
Association of periOperative Registered Nurses
Association of Rehabilitation Nurses
Association of Women's Health, Obstetric and Neonatal Nurses
Commissioned Officers Association of the U.S. Public Health Service
Dermatology Nurses' Association
Gerontological Advanced Practice Nurses Association
Hospice and Palliative Nurses Association
Infusion Nurses Society
National Association of Clinical Nurse Specialists
National Association of Hispanic Nurses
National Association of Nurse Practitioners in Women's Health
National Association of Pediatric Nurse Practitioners
National Black Nurses Association
National Nursing Centers Consortium
National Organization of Nurse Practitioner Faculties
National Student Nurses' Association, Inc.
Nurses Organization of Veterans Affairs

Oncology Nursing Society
Preventive Cardiovascular Nurses Association
Public Health Nursing Section, American Public Health Association
Society of Urologic Nurses and Associates
Wound, Ostomy and Continence Nurses Society

PREPARED STATEMENT OF THE NATIONAL COUNCIL FOR DIVERSITY IN THE HEALTH PROFESSIONS

Mr. Chairman and members of the subcommittee, thank you for the opportunity to present my views before you today. I am Dr. Wanda Lipscomb, President of the National Council for Diversity in the Health Professions (NCDHP) and the Director of the Center of Excellence for Culture Diversity in Medical Education at Michigan State University. NCDHP, established in 2006, is a consortium of our Nation's majority and minority institutions that once house the Health Resources and Services (HRSA) Minority Centers of Excellence (COE) and Health Careers Opportunities Programs (HCOP) when there was more funding. These institutions are committed to diversity in the health professions. In my professional life, I have seen firsthand the importance of health professions institutions promoting diversity and the Title VII Health Professions Training programs.

Mr. Chairman, time and time again, you have encouraged your colleagues and the rest of us to take a look at our Nation and evaluate our needs over the next 10 years. I want to say that minority health professional institutions and the Title VII Health Professionals Training programs address a critical national need. Persistent and severe staffing shortages exist in a number of the health professions, and chronic shortages exist for all of the health professions in our Nation's most medically underserved communities. Furthermore, our Nation's health professions workforce does not accurately reflect the racial composition of our population. For example while blacks represent approximately 15 percent of the U.S. population, only 2–3 percent of the Nation's health professions workforce is black. Mr. Chairman, I would like to share with you how your committee can help NCDHP continue our efforts to help provide quality health professionals and close our Nation's health disparity gap.

There is a well-established link between health disparities and a lack of access to competent healthcare in medically underserved areas. As a result, it is imperative that the Federal Government continue its commitment to minority health profession institutions and minority health professional training programs to continue to produce healthcare professionals committed to addressing this unmet need.

An October 2006 study by the Health Resources and Services Administration (HRSA), entitled "The Rationale for Diversity in the Health Professions: A Review of the Evidence" found that minority health professionals serve minority and other medically underserved populations at higher rates than nonminority professionals. The report also showed that; minority populations tend to receive better care from practitioners who represent their own race or ethnicity, and non-English speaking patients experience better care, greater comprehension, and greater likelihood of keeping follow-up appointments when they see a practitioner who speaks their language. Studies have also demonstrated that when minorities are trained in minority health profession institutions, they are significantly more likely to: (1) serve in rural and urban medically underserved areas; (2) provide care for minorities; and (3) treat low-income patients.

As you are aware, Title VII Health Professions Training programs are focused on improving the quality, geographic distribution and diversity of the healthcare workforce in order to continue eliminating disparities in our Nation's healthcare system. These programs provide training for students to practice in underserved areas, cultivate interactions with faculty role models who serve in underserved areas, and provide placement and recruitment services to encourage students to work in these areas. Health professionals who spend part of their training providing care for the underserved are up to 10 times more likely to practice in underserved areas after graduation or program completion.

Institutions that cultivate minority health professionals, like the NCDHP members, have been particularly hard-hit as a result of the cuts to the Title VII Health Profession Training programs in fiscal year 2006, fiscal year 2007, and fiscal year 2008. Given their historic mission to provide academic opportunities for minority and financially disadvantaged students, and healthcare to minority and financially disadvantaged patients, minority health professions institutions operate on narrow margins. The cuts to the Title VII Health Professions Training programs amount to a loss of core funding at these institutions and have been financially devastating.

We have been pleased to see efforts to revitalize both COE and HCOP in recent fiscal years, but it is important to fully fund the programs at least at the fiscal year 2004 level so that more diversity is achieved in our health professions.

Earlier this year with the passage of health reform, the Congress showed the importance of the many of the title VII programs, including the COE and HCOP, by reauthorizing the programs.

COE.—COEs focus on improving student recruitment and performance, improving curricula in cultural competence, facilitating research on minority health issues and training students to provide health services to minority individuals. COEs were first established in recognition of the contribution made by four historically black health professions institutions (the Medical and Dental Institutions at Meharry Medical College; The College of Pharmacy at Xavier University; and the School of Veterinary Medicine at Tuskegee University) to the training of minorities in the health professions. Congress later went on to authorize the establishment of "Hispanic", "Native American" and "Other" Historically black COEs. For fiscal year 2011, I recommend a funding level of $33.6 million for COEs.

HCOP.—HCOPs provide grants for minority and nonminority health profession institutions to support pipeline, preparatory and recruiting activities that encourage minority and economically disadvantaged students to pursue careers in the health professions. Many HCOPs partner with colleges, high schools, and even elementary schools in order to identify and nurture promising students who demonstrate that they have the talent and potential to become a health professional.

Collectively, the absence of HCOPs will substantially erode the number of minority students who enter the health professions. Over the last three decades, HCOPs have trained approximately 30,000 health professionals including 20,000 doctors, 5,000 dentists and 3,000 public health workers. For fiscal year 2011, I recommend a funding level of $35.6 million for HCOPs.

Mr. Chairman, please allow me to express my appreciation to you and the members of this subcommittee. With your continued help and support, NCDHP member institutions and the Title VII Health Professions Training programs can help this country to overcome health and healthcare disparities. Congress must be careful not to eliminate, paralyze or stifle the institutions and programs that have been proven to work. NCDHP seeks to close the ever widening health disparity gap. If this subcommittee will give us the tools, we will continue to work towards the goal of eliminating that disparity everyday.

Thank you, Mr. Chairman, and I welcome every opportunity to answer questions for your records.

PREPARED STATEMENT OF THE NATIONAL FEDERATION OF COMMUNITY BROADCASTERS

Thank you for the opportunity to submit testimony to this subcommittee regarding the appropriation for the Corporation for Public Broadcasting (CPB). As the President and CEO of the National Federation of Community Broadcasters (NFCB), I speak on behalf of 250 community radio stations and related individuals and organizations across the country. Nearly half our members are rural stations and half are controlled by people of color. In addition, our members include many Low Power FM stations that are putting new local voices on the airwaves. NFCB is the sole national organization representing this group of stations which provide independent, local service in the smallest communities of this country as well as the largest metropolitan areas. In summary, in this testimony, NFCB:

—Thanks the subcommittee for its role in providing $25 million station fiscal stabilization in light of the difficult economy in last year's appropriation;
—Requests $604 million in funding for CPB for fiscal year 2013 and requests that advance funding for CPB is maintained to preserve journalistic integrity and facilitate planning and local fundraising by public broadcasters;
—Supports CPB activities in facilitating programming and services to the radio "minority consortia" dedicated to Native American, Latino and African-American radio stations;
—Requests $59.5 million in fiscal year 2011 for conversion of public radio and television to digital technology;
—Supports CPB's funding for rural stations and assistance with new technologies and requests report language regarding rural and minority stations in this regard
—Supports CPB programs focused on ensuring public radio is able to fulfill its important mission of public safety during emergencies; and
—Supports CPB's role as a convener that can address questions and important future trends across all public media.

Community radio fully supports the forward funding appropriation of $604 million in Federal funding for the Corporation for Public Broadcasting in fiscal year 2013. Money allocated to the Corporation for Public Broadcasting assists NFCB member stations throughout the country through community service grants. Community service grants are the core way that CPB uses to support radio stations—particularly targeted to stations offering the first public radio service to a community in a rural area, or to stations serving particular demographic constituencies. CPB's focus on these areas is critical to ensuring that public radio does not focus solely on higher-income audiences, but serves every American no matter their background or their location. These targeted stations provide critical, life-saving information to their listeners and are often in communities with very small populations and limited economic bases, thus the community is unable to financially support the station without Federal funds. For example, these stations offer programming in languages other than English or Spanish, they can offer emergency information targeted for a particular geographic area, and can offer in-depth programming on public health issues.

In larger towns and cities, sustaining grants from CPB enable Community Radio stations to provide a reliable source of noncommercial programming about the communities themselves. Local programming is an increasingly rare commodity in a nation that is dominated by national program services and concentrated ownership of the media. CPB funding allows an alternative to exist in these larger markets. And with large newspaper shedding journalists, local community radio may be one of the only outlets able to pick up the slack in coverage of local political matters.

For more than 30 years, CPB appropriations have been enacted 2 years in advance. This insulation has allowed pubic broadcasting to grow into a respected, independent, national resource that leverages its Federal support with significant local funds. Knowing what funding will be available in advance has allowed local stations to plan for programming and community service and to explore additional nongovernmental support to augment the Federal funds. Most importantly, the insulation that advance funding provides is of critical importance in eliminating both the risk of and the appearance of undue interference with and control of public broadcasting.

Community radio supports CPB activities in facilitating programming to Native American, Latino, and African-American radio stations. CPB has played a critical role in providing support and assistance to radio stations serving communities of color, particularly communities that could be better served by noncommercial radio. While CPB has long supported television programming focused on underserved communities, its programs for radio are newer and are very welcome. Given the importance and accessibility of radio in many underserved communities, NFCB urges the subcommittee to endorse the long-term viability of these radio minority consortia.

Specifically, with important support from CPB, Native Public Media (NPM) has burst on to the scene to ensure that Native Americans have access to noncommercial broadcast and new technologies alike. NPM has worked in the last few years to facilitate applications for noncommercial radio stations by almost 40 applicants from tribal and native entities, bringing many of these service areas within the reach of a public radio signal for the first time. NPM has undertaken research to identify the spectrum allocations currently serving Indian Country in order to target better service in the future, releasing a report called The New Media, Technology and Internet Use in Indian Country: Quantitative and Qualitative Analyses, which included a usage survey and case study that contains the first valid and credible data on Internet use among Native Americans. In addition, NPM was able to play a critical role in ensuring that tribal entities have the ability to obtain new radio stations in the future by successfully demonstrating to the FCC the need and legal justification for a tribal priority in radio.

In addition, in the last year the newest minority consortium has been started—the Latino Public Radio Consortium. The Latino Public Radio Consortium is an organization that represents and supports 33 public radio stations. It recognizes that Latinos are underrepresented in the Nation's public broadcasting institutions, decisionmaking structures, that there is little programming in English or in Spanish produced by Latinos or with a Latino focus and, as a consequence, Hispanics are vastly underrepresented among public radio's news and public affairs audiences.[1] To illustrate, a study by Station Resource Group's Grow the Audience project showed

[1] Latino Public Radio Consortium, Brown Paper, p. 1 available at http://www.latinopublicradioconsortium.org/index.php?s=41.

that, for public radio to acquire a representative share of the college-educated market for Latinos, it would need to triple its audience.[2]

During this funding year the Consortium has established the communications and governance structure to enable the Hispanic stations to support each other and to develop additional resources. An important new project that is indicative of future work is the development of Historias, a partnership with Story Corps, a national oral history project of the Library of Congress and public radio. Through this collaboration, Story Corps Historias will gather and record 900 individual interviews with Latinos around the country.

This year CPB is funding new services for African American public radio stations designed to improve and increase public media's service to the American public. NFCB believes that this project, like the other consortia, is vital to ensure that all Americans benefit from public funds and the breadth and depth of public radio. In addition to the minority consortia, CPB supports Satélite Radio Bilinge which provides 24 hours of programming to stations across the United States and Puerto Rico addressing issues of particular interest to the Latino population in Spanish and English. CPB also supports Native Voice One (NV1), which is distributing politically and culturally relevant programming to Native American stations.

Community radio supports $59.5 million in fiscal year 2011 for the conversion to digital technology. While public television's digital conversion needs were mandated by the FCC, public radio is converting to digital to provide more public service and to keep up with commercial radio. The Federal Communications Commission has approved a standard for digital radio transmission that will allow multicasting. This development of second and third audio channels will potentially double or triple the service that public radio can provide listeners, particularly in unserved and underserved communities. In addition, public radio is in great need of CPB's leadership and resources to transition to new media platforms, in particular through such projects as the American Archive, which will make existing programming accessible to all and on all platforms.

Community radio supports CPB's funding for rural stations and assistance with new technologies. For the past few years, CPB has increased support to rural stations and committed resources to help public radio take advantage of new technologies such as the Internet, satellite radio and digital broadcasting. We support these new technologies so that we can better serve the American people, but want to ensure that smaller stations with more limited resources are not left behind in this technological transition. We ask that the Subcommittee include language in the appropriation that will ensure that funds are available to help the entire public radio system, particularly rural and minority stations, utilize new technology.

A good example of CPB's role is the Public Media Innovation grant CPB gave KAXE, one of NFCB's rural members, a chance to experiment with the concept of becoming "a web operation that owned a radio station." PMI described this project as one of the most visionary proposals they funded. As part of the grant, KAXE began the development of Northern Community Internet, which would provide hyper-local news content to more than a dozen communities in northern Minnesota. Through this project, KAXE learned many important things about how to create content that is relevant and accessible across a web site, radio station, and social media. The journalists involved continue to be very interested in the project, even though the current pilot is over.

Community radio supports CPB programs focused on ensuring public radio is able to fulfill its important mission of public safety during emergencies. CPB funding has supported an important new project led by NFCB called Station Action for Emergency Readiness (SAFER). NFCB, in partnership with NPR and with support from CPB, has developed a step-by-step manual that stations can use to develop and/or supplement their own emergency readiness plans; a set of digital tools that stations can embed in their own websites to keep community members informed; and links to national and local resources that can supplement station's coverage. This project was inspired by the experience of NFCB member WWOZ in New Orleans as a result of Katrina and was furthered by the work of NFCB member KWMR in Point Reyes Station, California. KWMR is small and local community and provided absolutely critical life-saving information to its community during terrible floods of 2004–2005.

Community radio supports CPB's role as a convener that can address questions and important future trends across all public media. CPB plays an extremely important role in the public and Community Radio system: it convenes discussions on critical issues facing us as a system. They support research so that we have a better

[2] Station Resource Group, Grow the Audience, Listening by Black and Hispanic College Graduates (2008) at p. 17, available at http://www.srg.org/GTA/GTA%20Black%20Hispanic%20Report.pdf.

understanding of how we are serving listeners. And, they provide funding for programming, new ventures, expansion to new audiences, and projects that improve the efficiency of the system. This is particularly important at a time when there are so many changes in the radio and media environment with media consolidation and new distribution technologies.

Thank you for your consideration of our testimony. If the subcommittee has any questions or wishes to follow up on any of the points expressed above, please contact:

PREPARED STATEMENT OF THE NATIONAL COALITION FOR LITERACY

Mr. Chairman and members of the subcommittee, thank you for the opportunity to submit the views of the National Coalition for Literacy on appropriations for adult education and family literacy, under the Workforce Investment Act, title II.

The National Coalition for Literacy represents 24 national organizations concerned about adult education and family literacy. We request a significant increase in funding and investment for adult education and family literacy to at least $750 million in order to address critical, immediate needs, such as:

—*Clear Waiting Lists*.—It would cost at least $160 million to clear existing waiting lists for instruction.

—*Increase Access to Adult English Language Learning Programs*.—We need to create opportunities for more than 11 million immigrants to learn English.

—*Increase Access to Professional Development*.—Adult education practitioners need increased access to professional development in order to ensure quality services.

—*Improve Professional Quality of the Adult Education Workforce*.—Eighty percent of teachers are part time; thousands are volunteers. We must create the conditions needed to attract and retain a full-time workforce.

—*Create a National Center for Adult Education, Literacy, and Workforce Skills*.[1] A Center would address the continued need for research and innovation in our field.

These critical, urgent needs require scaled investments that will provide adults important opportunities to acquire the skills they need to find family sustaining work.

Need and Demand for Adult Education

The 2003 National Assessment of Adult Literacy found that there are approximately 93 million adults in the United States who do not have the literacy skills to reach their full potential. Thirty million adults have such low levels of literacy that it impedes their ability to fully function at home, at work, and in society. One in seven adults in our Nation can barely read a newspaper, a job application, a prescription label, or an election ballot.[2] Many live in poverty, experience complex health problems, and have extreme difficulty supporting their children's education. Eleven million adults cannot communicate in English.

Taking into consideration all Federal, State, and local and philanthropic funding, the adult education system serves only 2.5 million of 93 million adults each year who would benefit from literacy and English language instruction. Despite this, adult education has been nearly flat funded for a decade. An increase in fiscal year 2009–10 was a one-time adjustment to correct for a funding calculation error that occurred from 2003–2008.

According to this year's congressional justification, the administration built its budget request on 2006 waiting list data.[3] However, the National Council of State Directors of Adult Education has since published a March 2010 report, demonstrating that waiting lists and wait time have doubled in the last 2 years, during this economic crisis. Seventy-two percent of the programs reporting, from 50 of the 51 States and territories, confirmed waiting lists. Approximately 160,000 adults want to access services but cannot.[4] Additionally, community-based and volunteer literacy programs around the country report increased demand for services while traditional sources of funding are becoming more scarce.

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[1] NCL Proposal for a National Center for Adult Education, Literacy, and Workforce Skills http://www.ncladvocacy.org/NationalCenterPolicyPrinciples__FINAL.pdf.

[2] ProLiteracy www.proliteracy.org.

[3] Congressional Justification for Career, Technical, and Adult Education 2010 http://www2.ed.gov/about/overview/budget/budget11/justifications/n-careered.pdf.

[4] 2009–2010 Adult Student Waiting List Survey http://www.ncladvocacy.org/2010AdultEducationWaitingListReport.pdf.

The congressional justification also cited 2000 census data demonstrating an 11 percent dropout rate nationwide. Adult education programs serve as a key pipeline for these dropouts, keeping them on course to a high school equivalent and postsecondary education or job training. Adult education provides a last resort for helping these youths get back on track.

Investing in Adult Education is a Workforce Investment

We commend the administration for proposing to invest more through the Workforce Innovation Fund. Adult education and job training can underpin economic recovery and open opportunities for low-skilled workers by helping today's workforce develop the skills they need for both work and community life. As literacy and educational attainment rise, so do adults' income and chances of stable employment.

According to the Bureau of Labor Statistics, unemployment decreases as education levels increase: [5]

Unemployment rate in 2008 (percentage)	Education attained	Median weekly earnings in 2008 (dollars)
2	Doctoral degree	$1,561
1.7	Professional degree	1,531
2.4	Master's degree	1,233
2.8	Bachelor's degree	1,012
3.7	Associate degree	757
5.1	Some college, no degree	699
5.7	High-school graduate	618
9	Less than a high school diploma	453

Note: Data are 2008 annual averages for persons age 25 and over. Earnings are for full-time wage and salary workers.
Source: Bureau of Labor Statistics, Current Population Survey.

The Bureau of Labor Statistics estimates that by 2013, 90 percent of the fastest-growing jobs, 60 percent of all new jobs, and 40 percent of manufacturing jobs will require some form of postsecondary education. However, only 2 percent of this need can be met by high school graduates.[6] 94 percent of today's workforce will still be in the workforce in 2013; we must increase the skills of the current adult workforce for these high-demand jobs. Adult education is an important re-entry point for unemployed and underemployed adults who wish to raise their basic education skills or improve their English. However, the adults who want to become job and career-ready for these high-skilled, high-demand jobs are unable to get into instruction.[7]

Meeting the President's College Graduation Goal

The President has articulated a goal of the United States having the highest proportion of college graduates in the world by 2020. Even if every State reached the same levels of high school graduation and college enrollment for high school graduates as the highest-performing States, we would not reach this goal without a substantial effort to bring adult education students into the pipeline.

English Language Acquisition

We must create opportunities for immigrants to learn English and civics by building and enhancing the capacity of current adult education programs. Between 1970 and 2005, the U.S. foreign-born population tripled to an estimated 35.8 million individuals, accounting for 12.4 percent of the country's population. At least 67 percent of the growth in the U.S. workforce in the past 3 years is comprised of new immigrants. It is estimated that between 2010–2030 first and second generation immigrants together will account for all the growth in the U.S. workforce.[8] According to U.S. Census Bureau estimates, nearly 1 in 5 adults in the United States speaks a language other than English at home, and more than 17 million speak English less than "very well." [9]

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[5] Education Pays, Bureau of Labor Statistics http://www.bls.gov/emp/ep__chart__001.htm.
[6] U.S. Census, www.census.gov.
[7] Investing in the Adult Workforce http://www.ncladvocacy.org/StateAlignmentInitiativesVolumeII/InvestingInTheAdultWorkforce.doc.
[8] Kirsch, I., Braun, H., Yamamoto, K. (2007) America's Perfect Storm: Three Forces Changing Our Nation's Future. Princeton, NJ: Education Testing Service.
[9] U.S. Census Bureau (2003). Language Use and English-Speaking Ability: 2000. Washington, DC: Author.

Investing in Quality

Increasing funds to clear waiting lists is a start. But if the adult education system is to help prepare adults for 21st century jobs, transition adults to college, and meet or exceed performance goals, we must invest in quality of the profession as well as the numbers of learners served. The 21st century adult educator needs to:

—Prepare adults to be digital age learners using existing and new technologies.
—Prepare adults with the basic adult literacy and critical thinking skills they need to be competitive in the 21st century workforce.
—Teach adults with learning and other disabilities to close the life outcomes gap.
—Prepare adults to transition into postsecondary and vocational credit-bearing classes.
—Instruct a linguistically diverse classroom to improve their language proficiency.
—Increase political literacy and civic participation among our nation's adults.
—Strengthen programs to be scalable and flexible to meet new demands in communities.

Only 1 in 5 adult education teachers are full time; thousands are volunteers; most are funded on year-to-year grant programs. Stable job status that facilitates a dedicated, professional workforce is critical to raising student achievement outcomes. Career ladders are virtually nonexistent in adult education; a national credential in adult education does not exist. Many practitioners are not paid to attend professional development opportunities in order to meet these demands upon them. Developing the professional quality of the workforce is vital if we are to help adult learners achieve. We must increase access to professional development, provide credentialing and career advancement opportunities, improve working conditions, and conduct research in professional development. Increasing appropriations will allow the field to do that.

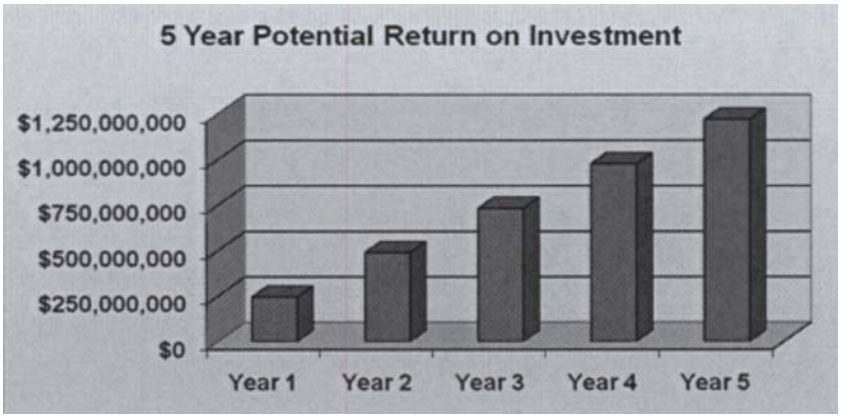
Return on Investment

Adult education is a good investment. On January 21, 2010, the United States Department of Labor's Bureau of Labor Statistics reported that there was a $9,828 wage differential for full-time workers with a high school diploma (or GED) over those who did not graduate.[10] The following is the potential return on investment for adults in 2008–2009 who received a GED in adult education programs. Over a 5-year period, the original $39,164,868 spent on the 165,637 GED students shows a potential return on investment of $1,220,910,325 (3,017 percent).

Number of GEDs achieved in 2008–2009	[1] $165,637
Average dollars invested in student	$236.45
Total	$39,164,868
Number of GEDs achieved in 2008–2009	165,637
Income differential	$9,828
Total increase in taxable income per year	$1,627,880,436
Federal tax rate (percent)	15
Potential return on investment per year	$244,182,065
One-year return on investment (percent)	523
Potential 5-year return on investment	$1,220,910,325

[1] Office of Vocational and Adult Education reporting Web site. Retrieved February 16, 2010.

[10] Bureau of Labor Statistics (January 2010). Retrieved February 16, 2010 from http://www.bls.gov/news.release/wkyeng.nr0.htm.



The current levels of funding have not and will not allow the field to grow to serve more adults, to improve and innovate practice, and meet existing and increasing demands. For these reasons, we strongly urge the Senate Appropriations Subcommittee on Labor, Health and Human Services, and Education, and Related Agencies to support a significant increase for programs provided by the Adult Education and Family Literacy Act, to at least $750 million or more.

PREPARED STATEMENT OF THE NATIONAL CONSUMER LAW CENTER

The Federal Low Income Home Energy Assistance Program (LIHEAP)[1] is the cornerstone of Government efforts to help needy seniors and families avoid hypothermia in the winter and heat stress (even death) in the summer. LIHEAP is an important safety net program for low-income, unemployed, and underemployed families struggling in this economy. The demand for LIHEAP assistance remains at record high levels. In fiscal year 2010, the program is expected to help a record 9 million low-income households afford their energy bills, a 15 percent increase from the prior fiscal year. In light of the crucial safety net function of this program in protecting the health and well-being of low-income seniors, the disabled, and families with very young children, we respectfully request that LIHEAP be fully funded at its authorized level of $5.1 billion for fiscal year 2011 and that advance funding of $5.1 billion be provided for the program in fiscal year 2012.

Home Energy Bills Remain High at a Time When Unemployment and Underemployment is at Record High Levels

Residential heating expenditures remain at high levels. U.S. average residential heating expenditures this winter are expected to be around the same for natural gas, about 24 percent higher for heating oil, 21 percent higher for propane, and 23 percent higher for electricity when compared to the 5-year average for 2003–2008.[2] The years of steady, high-energy bills are hitting low-income households struggling in this serious economic downturn. Low-income residential consumers, on average, pay a substantial amount of their income on residential energy, especially when compared to non-low-income households, 13.5 percent versus 3.6 percent, respectively.[3] Because LIHEAP is targeted to the most vulnerable low-income households, LIHEAP recipient households have an average energy burden of 16 percent.[4]

The number of households that are struggling to make ends meet remains very high. According a Pew Economic Policy Group report, in March 2010 more than 44 percent of the 15 million unemployed Americans had been unemployed for 6 months

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[1] 42 U.S.C. §§ 8621 et seq.

[2] Derived from data in the Energy Information Agency, Short-Term Energy Outlook (March 2010), Table WF01.

[3] US HHS, ACF, OCS, *LIHEAP Home Energy Notebook For Fiscal Year 2007*, June 2009 at Table A–3b. *Residential energy: Average annual expenditure, by amount (dollars) and mean individual burden (percent of income), for all, non-low-income, low income, and LIHEAP recipient households, by Census region and main heating fuel, fiscal year 2007.*

[4] *Id.*

or longer.[5] This is the highest rate of long-term unemployment since World War II. The "underemployment" rate in March 2010 is 16.9 percent.[6] CBO's budget and economic outlook report projects that unemployment will average 9.5 percent in fiscal year 2011.[7] The hardship low-income households face is also apparent in the data below on the number of households falling behind.

States' Data On Electric and Natural Gas Disconnections and Arrearages Show That More Households Are Falling Behind

States are Predicting Record LIHEAP Participation.—With the downturn in the economy, the States continue to experience record demand for LIHEAP assistance. NEADA reports that for fiscal year 2010, 17 States have projected increases in participation of at least 20 percent, with Mississippi estimating a 68 increase, followed by Washington (42 percent), Michigan (38 percent), Nevada (34 percent), New Jersey (31 percent), West Virginia (28 percent), Colorado (26 percent), Kansas (25 percent), New Hampshire (25 percent), Wisconsin (25 percent), Montana (21 percent), California (20 percent), Oregon (20 percent), South Carolina (20 percent), South Dakota (20 percent), Texas (20 percent) and Rhode Island (20 percent).[8] As jobs lag behind economic recovery, we fully expect the need for fully funded LIHEAP program in the States in fiscal year 2011.

The steady and dramatic rise in residential energy costs has resulted in increases in electric and natural gas arrearages and disconnections. The National Energy Assistance Directors' Association reports that households experiencing natural gas shut offs increased from 4.1 million in 2008 to 4.3 million in 2009.[9]

Although there are winter utility shut-off moratoria in place in many States, not every home is protected against energy shut-offs in the middle of winter. As we approach the lifting of winter shut-off moratoria, we expect to see a wave of disconnections as households are unable to afford the cost of the energy bills. Low-income families are falling further behind as we endure year after year of rising home energy prices. We expect the disconnection peaks to grow and the gap between disconnections and reconnections to also grow, especially in light of the economic challenges faced by the unemployed and underemployed workers.

California.—California has experienced a dramatic increase in LIHEAP participation from fiscal year 2008 to fiscal year 2010, with 166,000 households served in fiscal year 2008; 434,000 in fiscal year 2009 and projects serving 521,000 in fiscal year 2010.[10] The rise in the State's unemployment and foreclosure rates led the State Division of Ratepayer Advocates (DRA) to take a look at whether households are able to maintain access to natural gas and electric service. DRA found that low-income residential customers were experiencing a 19 percent increase in disconnections over the past year and that the disparity between low-income disconnections and non-low-income disconnections is the worst in 3 years.[11] In February 2010, the California Public Utilities Commission opened a docket to address electric and natural gas disconnections.[12]

Iowa.—Iowa has experienced a steady increase in enrollment for the regular LIHEAP program from fiscal year 2008 to fiscal year 2010 with 85,000 households

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[5] Pew Economic Policy Group Fiscal Analysis Initiative, *A Year or More: The High Cost of Long-Term Unemployment*, April 2010, Executive Summary.

[6] *Id.* Underemployment captures workers who became discouraged and stopped looking for work, older workers who opted to retire early instead of seeking work, young people delaying entering the work force and those workers who want full-time work, but have been forced to accept part-time work instead.

[7] CBO, *The Budget and Economic Outlook: Fiscal Years 2010 to 2020*, January 2010 at Summary Table 2.

[8] NEADA press release, *Record Numbers of Households Seek Assistance: States Call for the Release of Emergency Funds and Supplemental Assistance*, February 22, 2010. (Hereinafter, "NEADA Feb. 22, 2010 Press Release.")

[9] NEADA press release, *Record Number of Households Receive Energy Assistance: Shut-Offs Exceed 4.3 million Households in 2009*, December 18, 2009. See also Sandra Sloane, Mitchell Miller, Beverly Barker, Lisa Colosimo, "2008 Individual State Report by NARUC Consumer Affairs Subcommittee on Collections Data Gathering" (approved on Nov. 17, 2008 by the NARUC Consumers Affairs Committee). This national survey found that almost 40 million electricity and natural gas residential consumers held nearly $8.7 billion in past due accounts at the end of the 2007–2008 Winter heating season. The survey also concluded that in calendar year 2007, 8.7 million residential consumers had their electricity or natural gas service terminated for failing to pay their bills, with 3.6 million who remained disconnected as of May 2008.

[10] NEADA Feb. 22, 2010 Press Release.

[11] California Division of Ratepayer Advocates, *Status of Energy Utility Service Disconnections in California*, November 2009, Executive Summary and pages 5 and 10.

[12] CPUC, *Order Instituting Rulemaking To Establish Ways to Improve Customer Notification and Education to Decrease the Number of Gas and Electric Utility Service Disconnections*, R.10–02–005, Issued February 5, 2010.

served in fiscal year 2008; 95,000 in fiscal year 2009 and 100,000 projected in fiscal year 2010.[13] The average monthly number of LIHEAP households in arrears in fiscal year 2009 was 12 percent higher than the monthly average over the 5-year period from fiscal year 2004 through fiscal year 2008. However, as a testament to the importance of LIHEAP, the average monthly number of all households in arrears in fiscal year 2009 was 14 percent higher than the monthly average for all households in arrears over the previous 5-year period.[14]

Ohio.—Ohio has experienced a steady and dramatic demand for low-income energy assistance. The number of households entering into the State's low-income energy affordability program, the Percentage of Income Payment Program (PIPP), increased 6 percent from January 2009 to January 2010.[15] The increase is an even more dramatic 98 percent between January 2003 and January 2010. The total dollar amount owed (arrearage) by low-income PIPP customers increased 5 percent from January 2009 to January 2010 and 118 percent when comparing PIPP customer arrears from January 2003 to January 2010. Ohio has experienced a steady increase in enrollment for the regular LIHEAP program from fiscal year 2008 to fiscal year 2010 with 387,000 households served in fiscal year 2008; 394,000 in fiscal year 2009 and projects 418,000 in fiscal year 2010.[16]

Pennsylvania.—Pennsylvania has also experienced a steady increase in enrollment for the regular LIHEAP program from fiscal year 2008 to fiscal year 2010, with 371,000 households served in 2008; 547,000 in fiscal year 2009, and a projected 602,000 in fiscal year 2010.[17] Utilities in Pennsylvania that are regulated by the Pennsylvania Public Utility Commission (PA PUC) have established universal service programs that assist utility customers in paying bills and reducing energy usage. Even with these programs, electric and natural gas utility customers find it difficult to keep pace with their energy burdens. The PA PUC estimates that more than 21,029 households entered the current heating season without heat-related utility service. This number includes about 3,992 households who are heating with potentially unsafe heating sources such as kerosene or electric space heaters and kitchen ovens. In mid-December 2009, an additional 14,332 residences where electric service was previously terminated were vacant and more than 7,438 residences where natural gas service was terminated were vacant. In 2009, the number of terminations increased 65 percent compared with terminations in 2004. As of December 2009, 18.2 percent of residential electric customers and 15.8 percent of natural gas customers were overdue on their energy bills.[18]

LIHEAP Is a Critical Safety Net Program for the Elderly, the Disabled and Households With Young Children

Dire Choices and Dire Consequences.—Recent national studies have documented the dire choices low-income households face when energy bills are unaffordable. Because adequate heating and cooling are tied to the habitability of the home, low-income families will go to great lengths to pay their energy bills. Low-income households faced with unaffordable energy bills cut back on necessities such as food, medicine and medical care.[19] The U.S. Department of Agriculture has released a study that shows the connection between low-income households, especially those with elderly persons, experiencing very low food security and heating and cooling seasons when energy bills are high.[20] A pediatric study in Boston documented an increase in the number of extremely low weight children, age 6 to 24 months, in the 3 months following the coldest months, when compared to the rest of the year.[21]

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[13] NEADA Feb. 22, 2010 Press Release and Iowa Bureau of Energy Assistance.
[14] Based on data provided by the Iowa Bureau of Energy Assistance.
[15] Public Utilities Commission of Ohio.
[16] NEADA Feb. 22, 2010 Press Release.
[17] *Id.*
[18] Pennsylvania Public Utilities Commission.
[19] See e.g., National Energy Assistance Directors' Association, *2008 National Energy Assistance Survey*, Tables in section IV, G and H (April 2009) (to pay their energy bills, 32 percent of LIHEAP recipients went without food, 42 percent went without medical or dental care, 38 percent did not fill or took less than the full dose of a prescribed medicine, 15 percent got a payday loan). Available at http://www.neada.org/communications/press/2009-04-28.htm.
[20] Mark Nord and Linda S. Kantor, *Seasonal Variation in Food Insecurity Is Associated with Heating and Cooling Costs Among Low-Income Elderly Americans*, The Journal of Nutrition, 136 (Nov. 2006) 2939–2944.
[21] Deborah A. Frank, MD et al., *Heat or Eat: The Low Income Home Energy Assistance Program and Nutritional and Health Risks Among Children Less Than 3 years of Age*, AAP Pediatrics v.118, no.5 (Nov. 2006) e1293–e1302. See also, Child Health Impact Working Group, *Unhealthy Consequences: Energy Costs and Child Health: A Child Health Impact Assessment Of Energy Costs And The Low Income Home Energy Assistance Program* (Boston: Nov. 2006) and

Continued

Clearly, families are going without food during the winter to pay their heating bills, and their children fail to thrive and grow. A 2007 Colorado study found that the second leading cause of homelessness for families with children is the inability to pay for home energy.[22]

When people are unable to afford paying their home energy bills, dangerous and even fatal results occur. In the winter, families resort to using unsafe heating sources, such as space heaters, ovens and burners, all of which are fire hazards. Space heaters pose 3 to 4 times more risk for fire and 18 to 25 times more risk for death than central heating. In 2007, space heaters accounted for 17 percent of home fires and 20 percent of home fire deaths.[23] In the summer, the inability to keep the home cool can be lethal, especially to seniors. According to the CDC, older adults, young children and persons with chronic medical conditions are particularly susceptible to heat-related illness and are at a high risk of heat-related death. The CDC reports that 3,442 deaths resulted from exposure to extreme heat during 1999–2003.[24] The CDC also notes that air-conditioning is the number one protective factor against heat-related illness and death.[25] LIHEAP assistance helps these vulnerable seniors, young children and medically vulnerable persons keep their homes at safe temperatures during the winter and summer and also funds low-income weatherization work to make homes more energy efficient.

LIHEAP is an administratively efficient and effective targeted health and safety program that works to bring fuel costs within a manageable range for vulnerable low-income seniors, the disabled and families with young children. LIHEAP must be fully funded at its authorized level of $5.1 billion in fiscal year 2011 in light of high home energy costs and the increased need for assistance to protect the health and safety of low-income families by making their energy bills more affordable during this economic downturn. In addition, fiscal year 2012 advance funding would facilitate the efficient administration of the State LIHEAP programs. Advance funding provides certainty of funding levels to States to set income guidelines and benefit levels before the start of the heating season. States can also plan the components of their program year (e.g., amounts set aside for heating, cooling and emergency assistance, weatherization, self-sufficiency, and leveraging activities).

PREPARED STATEMENT OF THE NATIONAL COALITION FOR OSTEOPOROSIS AND RELATED BONE DISEASES

Mr. Chairman and members of the subcommittee: Thank you for the opportunity to submit testimony to this subcommittee. The National Coalition for Osteoporosis and Related Bone Diseases ("Bone Coalition") was organized in the early 1990s and is dedicated to increasing Federal research funding for bone diseases through advocacy and education. The Bone Coalition members are five leading national bone disease groups, consisting of two professional societies and three national voluntary health organizations: American Academy of Orthopaedic Surgeons; American Society for Bone and Mineral Research; National Osteoporosis Foundation; Osteogenesis Imperfecta Foundation; and The Paget Foundation.

Bone diseases do not discriminate. Osteoporosis and related bone diseases affect people of all ages, ethnicities, and gender. Related bone diseases include Paget's disease of bone, osteogenesis imperfecta, and a number of rare bone diseases. Osteoporosis is a condition in which the bones become weak and can break from a minor fall, or in serious cases, from a simple action such as a sneeze. About 10 million Americans already have the disease, and another 34 million people have low bone density, which puts them at risk for osteoporosis and bone fractures. Approximately 80 percent of those affected by osteoporosis are women.

Bone diseases drastically affect the way people function. Individuals who suffer broken bones as a result of osteoporosis can suffer severe pain, loss of height, and stooped posture that can affect breathing and digestion. One in five patients who walked before their hip fracture needs long-term care afterward. It is interesting to note that although the rate of hip fractures is 2 to 3 times higher in women, after

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the Testimony of Dr. Frank Before the Senate Committee on Health, Education, Labor and Pensions Subcommittee on Children and Families (March 5, 2008).

[22] Colorado Interagency Council on Homelessness, *Colorado Statewide Homeless Count Summer, 2006*, research conducted by University of Colorado at Denver and Health Sciences Center (Feb. 2007).

[23] John R. Hall, Jr., *Home Fires Involving Heating Equipment* (Jan. 2010) at ix and 33. Also, 40 percent of home space heater fires involve devices coded as stoves.

[24] CDC, "Heat-Related Deaths—United States, 1999–2003" MMWR Weekly, July 28, 2006.

[25] CDC, "Extreme Heat: A Prevention Guide to Promote Your Personal Health and Safety" available at http://emergency.cdc.gov/disasters/extremeheat/heat_guide.asp.

1 year, the death rate in men is nearly twice as high. Studies conclude that musculoskeletal disorders and diseases are the leading cause of disability in the United States. Studies further indicate that more than 1 in 4 Americans have a musculoskeletal condition requiring medical attention. The annual direct and indirect costs for bone and joint health are $849 billion—which is 7.7 percent of the U.S. gross domestic product. Bone health is critical to the overall health and quality of life for Americans, and greater efforts are needed from Congress, States, providers, and patients to address the burdens associated with osteoporosis and related bone diseases. Information regarding the impact of bone diseases is included at the end of this statement.

National Institutes of Health (NIH) Funding

The Bone Coalition is grateful for the additional funding the President has included in his budget for the NIH. His agenda recognizes the role that medical research plays in building better healthcare and economic revitalization. We join the hundreds of organizations dedicated to health and medical research to now urge Congress to provide additional funds—$35 billion—for the NIH. This increase will create substantial opportunities for scientific and health advances as well as provide a key economic role in communities across the Nation. In addition, even with NIH's budget increase proposed by the President, not all NIH Institutes and programs will receive proportional increases. The Bone Coalition encourages the subcommittee to provide a proportional increase in funding to the National Institute of Arthritis and Musculoskeletal and Skin Diseases. The Coalition would like to draw attention to areas of bone disease research which merit funding.

An internal analysis of fiscal year 2009 NIH funded grants revealed only 1 percent of the NIH budget was allotted toward bone research. This statistic is startling when one considers the number of individuals afflicted with bone diseases. Bones provide mobility, support, and protection for the body. The previous statistics mentioned in this testimony describe a compelling reason to support bone disease research. Furthermore, without additional bone disease research, the costs associated with treating bone diseases will continue to burden our healthcare system.

The Coalition has identified several areas where supplemental research is needed and urges the NIH Institutes and other agencies to give priority consideration to the below research topics.

Office of the Director.—The Coalition urges NIH to make support research that leads to targeted therapies to improve the density, quality, and strength of bone for all Americans. We also encourage investments in mechanisms that foster increased interdisciplinary research between bone and muscle, fat, and the central nervous system, as well as research that improves the identification of populations who might require earlier treatment because they are at risk of rapid bone loss due to obesity, diabetes, chronic renal failure and low glomerular filtration rates, cancer, HIV, conditions that affect absorption of nutrients or medications, and addiction to tobacco, alcohol or other opiates.

Furthermore, the Coalition urges NIH to support research on the effects of bone therapies on the skeleton, including factors predisposing individuals to osteonecrosis of the jaw and atypical subtrochanteric fractures of the femur. Regarding cancer and bone, studies need to be expanded on prevention and repair of bone defects caused by cancer cells and the biology of tumor dormancy and therapeutic resistance. Further studies are needed to determine optimal levels of calcium and Vitamin D to achieve optimal bone health as well as the relationship between Vitamin D and morbidity and mortality in chronic kidney disease. Other research needs include: knowledge to advance the ability to diagnose and treat bone diseases and disorders through bone imaging; advancing tissue engineering strategies to replace and regenerate bone and soft tissue; developing assessments for determining fracture risk; and better defining the causes of age-related bone loss and fractures, reduced physical performance and frailty.

Finally, the Coalition encourages NIH to expand genetics and other research on rare bone diseases, including: osteogenesis imperfecta, Paget's disease of bone, fibrous dysplasia, osteopetrosis, fibrous ossificans progressiva, melhoreostosis, X-linked hypophosphatemic rickets, multiple hereditary exostoses, multiple osteochondroma, Gorham's disease, and lymphangiomatosis.

National Institute of Arthritis and Musculoskeletal and Skin (NIAMS).—The Coalition suggests additional research is needed into the pathophysiology of bone loss in diverse populations in order to develop targeted therapies to reduce fractures and improve bone density, bone quality, and bone strength. This includes resolving what are appropriate levels of calcium and vitamin D for bone health at different life stages. Research is also needed in the assessment of bone microarchitecture and remodeling rates for determining fracture risk, anabolic approaches to increase bone

mass, novel molecular and cell-based therapies for bone and cartilage regeneration, and discerning the clinical utility of new, noninvasive bone imaging techniques to measure bone architecture and fragility. Support for studies on the molecular basis of bone diseases such as Paget's disease, osteogenesis imperfecta and other rare bone diseases should also be a priority.

National Cancer Institute (NCI).—The Coalition requests continued research on how to repair bone defects caused by cancer cells, mechanisms by which cancer cells affect the bone's endogenous cells, and the biology of tumor dormancy and the role of tumor stroma in conferring therapeutic resistance. Additionally, research is needed to discern the impact of metastasis on the biomechanical properties of bone, how inadequate levels of vitamin D affect bone as a result of hard and soft tissue sarcoma, and the mechanisms by which bone marrow derived cells and tumor associated macrophages can influence metastatic growth, survival and therapeutic resistance.

National Institute on Aging (NIA).—The Coalition encourages research to better define the causes of age-related bone loss and fractures, reduced physical performance and frailty, including identifying epigenetic changes, with the aim of translating basic and animal studies into novel therapeutic approaches. Critical research is also needed on changes in bone structure and strength with aging, periosteal biology, identifying cell autonomous changes versus alterations in the bone microenvironment and the relationship of age-related changes in other organ systems and their affects/interactions with bone. The prevention and treatment of other metabolic bone diseases, including osteogenesis imperfecta, glucocorticoid-induced osteoporosis, and bone loss due to kidney disease should also be priority research areas.

National Institute of Child Health and Human Development (NICHD).—The Coalition urges research in the new, emerging field of metabolic disease and bone in children and adolescents, especially childhood obesity, anorexia nervosa and other eating disorders. Research is also needed on what the optimal Vitamin D levels should be in children to achieve maximal bone health, and the implications of chronic or seasonal Vitamin D deficiency to the growing skeleton. Development and testing of therapies and bone building drugs for pediatric patients are also a pressing clinical need.

National Institute of Dental and Craniofacial Research (NIDCR).—The Coalition urges continued research support on the effects of systemic bone active therapeutics on the craniofacial skeleton, including factors predisposing individuals to osteonecrosis of the jaw, as well as novel approaches to facilitate bone regeneration.

National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK).—The Coalition supports research on the relationship between Vitamin D and morbidity and mortality in chronic kidney disease. Research is also needed on the value of anti-resorptive therapies, the link between renal insufficiency and diabetic bone disease, the differences in calcification of blood vessels, the mechanisms of metastasis of renal cell carcinoma, and diseases that occurs in patients with end stage chronic renal disease on hemodialysis.

National Institute of Neurological Disorders and Stroke (NINDS).—The Coalition encourages research support into the pathophysiology of spinal cord, brachial plexus, and peripheral nerve injuries in order to develop targeted therapies to improve neural regeneration and functional recovery.

National Institute of Biomedical Imaging and Bioengineering (NIBIB).—The Coalition encourages critical research to advance our ability to treat bone diseases and disorders through bone imaging, as well as managing the loss of bone and soft tissue associated trauma by advancing tissue engineering strategies to replace and regenerate bone and soft tissue.

Mr. Chairman and members of the subcommittee, the Bone Coalition appreciates the subcommittee's work over the years, especially your recognition of the need to fund research addressing disease prevention and treatment. With your assistance, NIH could provide the Federal support to ensure that bone research and bone health are priorities.

Thank you for the opportunity to submit testimony to the subcommittee.

PREPARED STATEMENT OF THE NATIONAL COALITION OF STD DIRECTORS

The National Coalition of STD Directors is a nonprofit, nonpartisan association of public health sexually transmitted (STD) program directors in the 65 CDC directly funded project areas, which includes all 50 States, 7 cities, and 8 U.S. territories. As the only national organization with a constituency that provides frontline STD services, NCSD is the leading national voice for strengthening STD prevention,

research and treatment. These efforts include advocating for effective policies, strategies, and sufficient resources, as well as increasing awareness of the medical and social impact of STDs.

We appreciate this opportunity to provide the subcommittee with information about the health crisis caused by the persistent and staggeringly high rates of STDs in the United States and about the programs of the Centers for Disease Control and Prevention (CDC) that combat these diseases.

The United States has the highest STD rates in the industrialized world, with more than 19 million people contracting an STD annually. In 1 year, our Nation spends more than $8.4 billion to treat the symptoms and consequences of STDs. The indirect costs are higher, including lost wages and productivity, as well as human costs such as anxiety, shame, anger, depression, and the challenges of living with infertility or cancer. The health consequences of STDs include: chronic pain, infertility, pregnancy complications, pelvic inflammatory disease, cervical cancer, birth defects and increased vulnerability to HIV, the virus that causes AIDS. Persons with a pre-existing STD have a 3 to 5 fold increased risk of acquiring HIV through sexual contact. In addition, studies have shown that HIV-infected persons who are also infected with other STDs are more likely to transmit HIV. Comprehensive STD treatment can reduce the likelihood of HIV transmission.

STDs have a disproportionate impact on young people, women, men who have sex with men (MSM) and racial and ethnic minorities. Of the approximately 19 million new STD infections each year, nearly half are among young people ages 15 to 24. Chlamydia, which leads to infertility, is the most frequently reported disease in the United States. Nearly 1 million women will have a severe case of pelvic inflammatory disease due to STDs. The transmission of STDs to babies—prenatally, during birth or after—can cause serious life-long complications including physical disabilities, developmental disabilities and death. Men who have sex with men (MSM) have historically experienced high rates of all STDs, including HIV/AIDS. In 2008, 63 percent of all primary and secondary syphilis cases were among MSM. The syphilis rate among males is now five times the rate among females, a dramatic disparity that did not exist a decade ago, when rates were nearly equivalent between the sexes. This trend suggests that the increase in cases among men have been primarily among men who have sex with men. Persons of color, particularly African-Americans, American Indians/Alaskan Natives, and Hispanics are also at higher risk of contracting STDs. In 2008, the rate of Chlamydia among African Americans was 9 times that of whites, for American Indian/Alaskan Natives it was 5 times higher than whites, and for Hispanics it was 3 times higher than whites. African American women experience syphilis rates 15 times higher than white women. Socioeconomic, cultural, and linguistic barriers to quality healthcare and STD prevention and treatment services have likely contributed to a higher prevalence and incidence of STDs among racial and ethnic minorities.

While rates of STDs in this country have continued to skyrocket, Federal funding for CDC's Division of STD Prevention has declined more than 22 percent since fiscal year 2003, when adjusted for inflation to 2009 U.S. dollars. For every $1 spent on STD prevention, $43 is spent each year on STD-related costs. In addition, for every $1 spent on research, $92 is spent each year on STD-related costs.

The National Coalition of STD Directors requests an fiscal year 2011 funding level of $367.4 million, an increase of $213.5 million, for the STD prevention, treatment, and surveillance programs of the CDC. These funds will significantly enhance the CDC's ability to reduce STD rates across the country.

Public Health Infrastructure (+$33 million)

Federal funding for CDC's Division of STD Prevention has been relatively flat for the past 15 years. The combined effect of this, along with steadily increasing rates of STDs and more recently, dramatic State, and local budget cuts due to the economic crisis, STD programs are in crisis mode and stretched thinner than ever. STD programs have had to cut staff, dramatically cut clinical services or close clinic doors altogether, and eliminate critical services such as free condom distribution programs. The public health infrastructure must be rebuilt and modernized. Investments in training, information and surveillance systems, public health laboratories, and better diagnostic technologies would increase efficiency, ensure program effectiveness and protect the health of future generations.

Public Health Workforce (+$25 million)

A critical piece of rebuilding the public health infrastructure is scaling up the public health workforce. One quarter of the current public health workforce will be eligible to retire by 2012. We must invest now in training and retraining the next generation of public health professionals. This is particularly critical for STD pro-

grams. The underpinning of all STD programs is the Disease Intervention Specialist (DIS), who provide partner services to individuals infected with STDs, their partners, and to other persons who are at increased risk for STD infection. DIS are specially trained public health workers who are responsible for locating, counseling and coordinating the testing of individuals exposed to an STD. DIS complete an intensive CDC training course, which provides a strong foundation in field investigation techniques, both on the ground and on the Internet. In some States, DIS also assist in the HIV Partner Services (PS) program, by assisting newly HIV-infected individuals with informing their partners of their status and encouraging those partners to seek HIV counseling, testing and related prevention services. DIS also provide surge capacity during an emergency response, such as the H1N1 outbreak. The versatile expertise of DIS make them indispensable during a public health crisis, but also highlight the need for increased resources to support the training and hiring of new DIS. The current economic crisis has forced many States to freeze the hiring of new DIS and even lay off DIS, in spite of increasing STD cases. Between 1999 and 2009, STD programs across the nation have experienced a 20 percent reduction in DIS staff.

Expand Chlamydia Screening and Infertility Prevention (+$61.5 million)

Chlamydia is the most commonly reported disease in the United States, as well as the primary cause of infertility. The Infertility Prevention Project (IPP), a collaborative effort between CDC and Office of Population Affairs within HHS, has been working to reduce STD related infertility for 15 years. IPP provides funding to screen low-income women for chlamydia and gonorrhea in STD and family planning clinics. This project is a major success story in STD prevention, having been highly successful in reducing new cases of chlamydia and gonorrhea in areas where it has been implemented. However, additional resources are needed to bring this project to scale and reach a greater number of at-risk women. Chlamydia screening has also been shown to be extremely cost effective. Among 21 evidence-based clinical services recommended by the U.S. Preventive Service Task Force (USPSTF), chlamydia screening for young women ranked among the top 5 as having the most health benefits and best value for the dollar.

Additional Federal resources would help support increased chlamydia screening in the public sector, expand school-based and correctional-based screening, as well as initiate a series of demonstration projects in the private sector aimed at increasing private sector screening rates.

Gonorrhea Control and Health Disparities Reduction (+$40 million)

Gonorrhea is the second most commonly reported infectious disease in the United States. African Americans are the most heavily impacted by this disease, with overall rates 20 times greater than that of whites in 2008. African American men aged 15 to 19 years old experience gonorrhea rates 40 times higher than white men in the same age group. An increasing issue of concern in the treatment of gonorrhea is antimicrobial drug resistance. In 2007, 14.6 percent of all gonorrhea cases demonstrated resistance, while 39 percent of the cases specifically among MSM demonstrated resistance. In 2007, CDC revised its gonorrhea treatment guidelines to include a single class of antibiotics.

Additional Federal resources would be used to monitor antimicrobial resistant gonorrhea and test alternate or new drug regimens, initiate culturally competent social marketing campaigns, increase screening and partner services in hyperendemic areas, and develop demonstration research projects to determine the effectiveness and cost-effectiveness of gonorrhea prevention and control interventions.

Syphilis Elimination (+$44 million)

The rates of primary and secondary syphilis, the most infectious stages of the disease, decreased throughout the 1990s, and in 2000 reached an all-time low. However, since 2000 as STD funding has declined, the syphilis rate in the United States has increased by 114 percent. Since 1999, the Syphilis Elimination Effort (SEE), a collaboration between CDC and State, local, and nongovernmental partners, has worked to eliminate syphilis from all areas of the country and reduce long-standing health disparities. These strategies include: expanded surveillance and outbreak response activities, rapid screening and treatment in and out of medical settings, expanded laboratory services, strengthened community involvement and agency partnerships, and enhanced health promotion. These efforts have shown to be successful, but must be funded adequately. A 2008 study suggested that SEE funding in a given year was associated with subsequent declines (over the following 2 years) in syphilis rates in a given State. The greater a State's per capita syphilis elimination funding in a given year, the greater the decline in syphilis rates in subsequent years. While the activities of SEE have proven themselves to be effective, they must

be adequately and consistently funded to ultimately eliminate this disease in the United States.

Additional Federal resources for SEE would be prioritized for increased screening, particularly among HIV positive persons and pregnant women, the development and evaluation of rapid diagnostic tests, implementation of social marketing campaigns targeted towards men who have sex with men (MSM) and minority populations, and expanded screening in correctional facilities.

Build a Response to Viral STDs (Herpes, HPV, Hepatitis B) (+$10 million)

More than 45 million Americans, almost 26 percent of the U.S. population, are infected with herpes simplex virus (HSV), a treatable but incurable viral STD. Improved treatment of HSV is fundamental to reducing the rates of transmission. Individuals with herpes are more susceptible to acquiring HIV. An estimated 20 million Americans are infected with human papillomavirus (HPV), the cause of about 90 percent of all cervical cancer cases. CDC would utilize additional funds to monitor the HPV vaccine introduction and behavioral impact of HPV vaccine through demonstration projects and an expansion of an existing, multi-level, multi-year behavioral research project. The most common source of hepatitis B virus (HBV) infection among adults is sexual contact. Funding is needed to expand prevention efforts on HPV and HBV and to deliver education on the availability of preventive vaccines.

The National Coalition of STD Directors also supports the President's fiscal year 2011 funding request of $133.7 million for the Teen Pregnancy Prevention Initiative, within the Office of Adolescent Health (OAH).

We need to invest in programs that provide all of our young people with complete, accurate, and age-appropriate sex education that helps them reduce their risk of HIV, other STDs, and unintended pregnancy. In these tight budget times, we are pleased that the President's fiscal year 2011 budget increased funding for the new teen pregnancy prevention initiative. However, by focusing the funding on teen pregnancy prevention, and not including the equally important health issues of STDs and HIV, we think the administration has missed an opportunity to provide true, comprehensive sex education that promotes healthy behaviors and relationships for all young people, including LGBT youth. So many negative health outcomes are inter-related and we need to strategically and systemically provide youth with the information and services they need to make responsible decisions about their sexual health. We request that the teen pregnancy prevention initiative be broadened to address HIV and other STDs, in addition to the prevention of unintended teen pregnancy. We are pleased that the President's budget has once again included zero funding for failed abstinence-only-until-marriage programs and we encourage the subcommittee not to include funding for these ineffective programs.

We urge the subcommittee to substantially increase resources to protect our Nation from the devastating consequences of STDs. The CDC has developed programs that have significantly reduced STD rates and the associated costs to society. We know how to prevent, control, and treat sexually transmitted diseases; however, without additional funds, the CDC cannot establish these programs to scale in all 50 States, U.S. territories, and directly funded cities.

PREPARED STATEMENT OF THE NATIONAL COUNCIL OF STATE DIRECTORS OF ADULT EDUCATION

Mr. Chairman, thank you for the opportunity to submit testimony regarding the need for additional appropriations for adult education programs.

Adult education programs serve a large number of our Nation's at-risk citizens, from those who are unemployed to immigrants who lack the literacy skills needed to succeed in their new home country.

At the present time our country is heavily investing in efforts to put Americans back to work. For many of our Nation's unemployed, their jobs have disappeared, only to be replaced by new jobs with requirements they cannot meet because they have low literacy skills and lack a high school diploma.

To meet the needs of these individuals, adult education programs across the Nation are partnering with programs under title I of the Workforce Investment Act to develop career pathways that integrate adult education and occupational training programs. In addition, there are programs focused on transitioning participants from adult education programs to postsecondary education.

But current funding levels, coupled with funding from the State and local level, prevent us from serving more than 2.3 million individuals a year. A 2010 survey demonstrates that there are waiting lists in every State. According to the National Assessment of Adult Literacy, there are approximately 93 million individuals who

lack the literacy skills to reach their full potential. Thirty million individuals are at the lowest level of literacy and cannot perform basic tasks such as reading a bus schedule.

With the wide gap between the number of Americans who are in need of improved literacy/education skills and the number that can be served by the current system, we strongly encourage you to increase funding for adult education programs to $750 million which would enable us to at least erase the waiting list.

Mr. Chairman, adult education programs help put Americans back to work, provide new immigrants with English language skills, assist in transitioning individuals to higher education, and provide parents with the skills they need to help their children succeed in school.

Adult education programs provide a wide range of services to many individuals but are currently limited in the number of individuals we can serve because of limited funding. While we understand the budget is tight, we believe increased funding for adult education will provide a strong return on your investment in our programs while we serve undereducated adults.

Thank you again for the opportunity to submit testimony regarding funding for adult education programs.

PREPARED STATEMENT OF THE NATIONAL DOWN SYNDROME SOCIETY

Mr. Chairman and members of the subcommittee: As Vice President of the National Down Syndrome Society, I want to take this opportunity to thank you for the leadership role this Subcommittee has played over the years in supporting and creating awareness on Down syndrome. I am pleased to offer the following written testimony regarding appropriation requests for Down syndrome in fiscal year 2011.

There are more than 400,000 people living with Down syndrome in the United Statement, and about 5,000 babies, or 1 in 800, that are born each year. Down syndrome occurs in people of all races and economic levels, and it is the most frequently occurring chromosomal condition. The incidence of births of children with Down syndrome increases with the age of the mother. But due to higher fertility rates in younger women, 80 percent of children with Down syndrome are born to women under 35 years of age.

Advancements in the treatment of health problems have allowed people with Down syndrome to enjoy fuller and more active lives, and become more integrated into the economic and social structures of our communities. Unfortunately, while progress has also been made in public policies that enhance the lives of individuals with Down syndrome, barriers still exist, making it difficult for people to access adequate healthcare, housing, employment and education.

We have been working with Congress for decades to address these challenges and advance public policies that promote the acceptance and inclusion of individuals with Down syndrome and other genetic disorders, and help them to achieve their full potential in all aspects of their lives.

Mr. Chairman, we understand the challenges the subcommittee faces in prioritizing requests, we believe that funding the requirements of the Prenatally and Postnatally Diagnosed Conditions Awareness Act of 2007 (Public Law 110–374) is imperative given the significant impact Down syndrome has on families and communities across the country and the great potential for improvements in quality of life for them and others with chromosomal disorders. On behalf of the National Down Syndrome Society, we recommend that you appropriate $5 million in the fiscal year 2011 to the Centers for Disease Control & Prevention (CDC) to implement the requirements of the Prenatally and Postnatally Diagnosed Conditions Awareness Act of 2007.

As you know, Congress passed the Prenatally and Postnatally Diagnosed Conditions Awareness Act of 2007 in October of 2008. This new law seeks to ensure that pregnant women receiving a positive prenatal diagnosis of Down syndrome and parents receiving a postnatal diagnosis will receive up-to-date, scientific information about life expectancy, clinical course, intellectual and functional development, and prenatal and postnatal treatment options. It offers referrals to support services such as hotlines, websites, informational clearinghouses, adoption registries, parent support networks and Down syndrome and other prenatally diagnosed conditions programs. The goal is to create a sensitive and coherent process for delivering information about the diagnosis across the variety of medical professions and technicians, to avoid any conflicting, inaccurate or incomplete information. Also, the legislation would promote the rapid establishments of links to community supports and services for parents who choose to take their baby with Down syndrome home or for those who choose to have their child adopted.

It is estimated that more than 1,000 prenatal tests are available or in development. Included among them are tests for conditions that are not life-threatening, could be helped by surgery or medical care, or don't appear until adulthood. The prognoses for people with some prenatally diagnosable disabilities have been improving markedly in recent years, leaving medical professionals scrambling to keep up with changing data and the need to communicate complex information to the more than 4 million women who are now offered prenatal screening and testing and must weigh this information in order to give informed consent for these new procedures.

As recently reported in an article entitled "Changing Practice of Obstetricians", published in the American Journal of Obstetrics and Gynecology in April 2009, only 36 percent of obstetricians feel "well qualified to counsel patients who screen positive" for Down syndrome. About half (51 percent) thought the training they received during residency regarding screening and diagnosis for Down syndrome was adequate, whereas 40 percent thought it was less than adequate and 9 percent thought it was comprehensive. Only "29 percent of physicians provide the pregnant woman with printed educational materials" if the fetus is diagnosed with Down syndrome.

In another study also published in the American Journal of Obstetrics and Gynecology, the largest and most comprehensive study on prenatally diagnosed Down syndrome to date, recommendations made by mothers included: screening results should be clearly explained as a risk assessment, not as a "positive" or "negative" result; physicians should discuss all reasons for prenatal diagnosis including reassurance, advance awareness before delivery of the diagnosis of Down syndrome, adoption, as well as pregnancy termination; up-to-date information on Down syndrome should be available; results from amniocentesis or CVS, chorionic villi sampling, should, whenever possible, be delivered in person, with both parents present; sensitive language should be used when delivering a diagnosis of Down syndrome; if obstetricians rely on genetic counselors or other specialists to explain Down syndrome, sensitive, accurate, and consistent messages must be conveyed; contact with local Down syndrome support groups should be offered, if desired. A 29-member Down Syndrome Diagnosis Study Group published an article in the American Journal of Medical Genetics in 2009 which added to the previously mentioned recommendations. This study recommended that the conversation where in the diagnosis was delivered should provide answers to the questions: What is Down Syndrome? What causes the condition? What healthcare conditions go along with the condition? What are realistic expectations for a child with Down syndrome living today? Also the study recommends that healthcare professionals should use non-directive language and the healthcare professionals should arrange for a follow-up appointment with the parents, including any desired meetings with subspecialists.

By including $5 million in the fiscal year 2011 Labor, Health & Human Services, Education, and Related Agencies Appropriations Bill, the Department of Health and Human Services (HHS) will be able to fund its responsibilities to:

—Collect and distribute information relating to Down syndrome and other prenatally or postnatally diagnosed conditions;

—Coordinate the provision of supportive services for patients receiving a positive diagnosis of a prenatally or postnatally diagnosed condition; and

—Oversee the new requirements for healthcare providers established by the law. The funding is also needed to carry out the requirement that the CDC assist State and local health departments to integrate testing results into surveillance systems.

Mr. Chairman, thank you for your time and attention. Given the considerable impact this condition has on families and communities across the country, the promise of further assistance and improving research outcomes for individuals with Down syndrome is crucial. We are thrilled beyond measure that Congress enacted this legislation and hope that funding this request will help to shift the way the Nation regards individuals with disabilities. Through providing accurate, updated information about diagnosable conditions like Down syndrome to pregnant women, the expectation is that individuals and families will make better, more informed decisions. But the bigger impact will be better understanding on the part of the American people about the nature of disability and the value of these citizens to their families, their communities and to our country. Should you have any questions or require additional information, please feel free to call on me.

PREPARED STATEMENT OF THE NATIONAL ECZEMA ASSOCIATION

Dear Chairman Harkin: Chairman Harkin and Members of the Senate Appropriations Subcommittee on Labor, Health and Human Services, Education and Related

Agencies, I am Julie Block, Chief Executive Officer of the National Eczema Association (NEA).

As member of the Senate who strongly value the role of the National Institutes of Health (NIH), I am writing first to express to you my deep gratitude for your past support. The NIH is our Nation's preeminent medical research institution and represents our best hope for finding cures, improving treatments, and gaining a better understanding of the diseases and conditions that affect millions of Americans. On behalf of the NEA, I respectfully request your continued support for NIH funding.

I would also like to thank you for inviting us to submit testimony on our own behalf. The NEA is a 501(c)(3) nonprofit organization that receives no Federal grants or sub grants, nor do we receive Federal contracts or subcontracts. Our mission is to help improve the health and quality of life of persons living with eczema/atopic dermatitis, including those who have the disease and their loved ones. This is a family disease. Through programs focused on advocacy, education, and research, we involve both public and private sectors in addressing these needs. In these current times, there is much the public does not know or understand about how devastating this disease can be.

There are many types of eczemas, with atopic dermatitis (AD) recognized as the most severe and chronic. Atopic dermatitis is a genetic skin disease that affects over 30 million people in the United States; 10 percent of the American populations have some form of atopic dermatitis.

Atopic dermatitis falls into a category of disease called atopy, which includes asthma and hay fever. The three together are known as the "Atopic Triad." Atopic dermatitis almost always begins in childhood, usually during infancy. However, it is important to remember that atopic dermatitis is not just a childhood disease, as is commonly believed. For most people afflicted with the disease it becomes a lifelong sentence. The skin becomes dry, scaly, red and intensely itchy. It cracks, bleeds, weeps, and often gets infected.

For many patients with eczema, one of the worst consequences of the disease is the isolation and withdrawal from other people and community. Patients are often treated as if they were lepers even though atopic dermatitis is not contagious. Some patients choose not to have children, fearful of passing on a life of suffering to yet another generation. Some patients feel this choice so strongly they submit to voluntary sterilization in young adulthood. Atopic dermatitis is an extremely isolating disease, regardless of whether that isolation stems from internal or external factors, and many severe atopics do not leave their homes.

Others, like the young heroine of the story I'm about to relate, somehow find within themselves the courage to keep going, to keep fighting, to keep believing there is a place for them in the larger community. I hope her story not only inspires you, but inspires you to action.

This is Angeline's story. Angeline is an adult atopic, having eczema since birth. Her nickname in school was "Spot"—she would hide in the bathrooms during recess and lunchtime and scratch. She would try with all her might not to scratch during class, not to flake skin over her desk, not to crack and bleed. Constant, intolerable, itching has led to lifelong use of steroid treatments, both orally and topically, to assuage the itching and "treat" the eczema wounds. The constant itching, skin flaking off in sheets, dead, dry skin, and oozing abhorrent looking skin are just part of everyday life for Angeline.

Her eczema has resulted in severe infections, and this physical trauma is accompanied by a level of psychic trauma few of us ever have to confront. She has had too many days when she can literally not get out of bed—the skin gets so bad that it eventually becomes a huge task to even move her legs and arm joints. On top of all that, her skin looks absolutely gruesome.

Angeline has shed many tears, and at times wondered how she would go on. The years of bandaged hands to stop the scratching, steroid withdrawal, bank accounts spent on creams and miracle cures, vitamins and doctors appointments. When will it end? Some days Angeline is not at all available to "face the world".

And people will tell you eczema is just a rash!

As Angeline's story suggests, doctors, researchers, and scientists consistently underestimate the emotional consequences of this disease, its treatments, and its complications. The general public understands it even less. Before we can offer alternatives that will truly improve the quality of life for eczema sufferers, we must understand the disease mechanism and how it works. Committed physicians and ongoing research gives us all hope.

The NEA is dedicated to raising awareness of these issues. The Association publishes a quarterly newsletter called The Advocate, oversees a volunteer Support Network program, distributes educational materials to patients and medical profes-

sionals, and conducts an annual Patient and Family Conference. As vocal advocates for atopic patients and their families, our staff attends several professional meetings each year, and educates governmental officials at local, State and national levels to provide input to the budget, research, and policy decisions about atopic dermatitis/eczema patients. In past years, the NEA educated public officials during the Government's smallpox vaccination campaign regarding the life-and-death consequences to atopic patients. We have been on Capitol Hill for NIAMS day many years in a row as a member of the National Institutes of Arthritis and Musculoskeletal and Skin Diseases Coalition to educate legislators on our disease.

The NEA can boast many exciting accomplishments, including over $400,000 spent on eczema research since the inception of its research program in 2004. One of the NEA-funded grants to Dr. Gil Yosipovitch, MD of Wake Forest University has resulted in a major NIH grant to continue his work on itch. We anticipate yet another NIH award for NEA-funded research to continue exciting work on prevention of atopic dermatitis in high-risk infants.

The NIH and the research it supports are critical to the advancement of improved atopic dermatitis/eczema treatment and eventual cure. As part of the Coalition of Skin Disease, we believe that when a cure is found for any of these skin diseases, there is a good chance it will improve our ability to find a cure for other diseases. The recent boost in NIH funding in 2009 and 2010 was a very important step toward regaining the lost potential of the last several years.

As you work to finalize the fiscal year 2011 appropriations, on behalf of the NEA, I respectfully request a funding increase of at least 7 percent for the National Institutes of Health (NIH) compared to the fiscal year 2010 baseline level.

Help us give eczema patients and their families hope for the pleasure of everyday life, and being good in the skin their in!

And again, thank you for your past support of biomedical research funding.

PREPARED STATEMENT OF THE NATIONAL FEDERATION OF COMMUNITY BROADCASTERS

Thank you for the opportunity to submit testimony to this subcommittee regarding the appropriation for the Corporation for Public Broadcasting (CPB). As the President and CEO of the National Federation of Community Broadcasters (NFCB), I speak on behalf of 250 community radio stations and related individuals and organizations across the country. Nearly half our members are rural stations and half are controlled by people of color. In addition, our members include many low power FM stations that are putting new local voices on the airwaves. NFCB is the sole national organization representing this group of stations which provide independent, local service in the smallest communities of this country as well as the largest metropolitan areas. In summary, in this testimony, NFCB:

—Thanks the subcommittee for its role in providing $25 million station fiscal stabilization in light of the difficult economy in last year's appropriation;
—Requests $604 million in funding for CPB for fiscal year 2013 and requests that advance funding for CPB is maintained to preserve journalistic integrity and facilitate planning and local fundraising by public broadcasters;
—Supports CPB activities in facilitating programming and services to the radio "minority consortia" dedicated to Native American, Latino, and African-American radio stations;
—Requests $59.5 million in fiscal year 2011 for conversion of public radio and television to digital technology;
—Supports CPB's funding for rural stations and assistance with new technologies and requests report language regarding rural and minority stations in this regard
—Supports CPB programs focused on ensuring public radio is able to fulfill its important mission of public safety during emergencies; and
—Supports CPB's role as a convener that can address questions and important future trends across all public media.

Community radio fully supports the forward funding appropriation of $604 million in Federal funding for CPB in fiscal year 2013. Money allocated to the Corporation for Public Broadcasting assists NFCB member stations throughout the country through community service grants. Community service grants are the core way that CPB uses to support radio stations—particularly targeted to stations offering the first public radio service to a community in a rural area, or to stations serving particular demographic constituencies. CPB's focus on these areas is critical to ensuring that public radio does not focus solely on higher-income audiences, but serves every American no matter their background or their location. These targeted stations provide critical, life-saving information to their listeners and are often in communities

with very small populations and limited economic bases, thus the community is unable to financially support the station without Federal funds. For example, these stations offer programming in languages other than English or Spanish, they can offer emergency information targeted for a particular geographic area, and can offer in-depth programming on public health issues.

In larger towns and cities, sustaining grants from CPB enable community radio stations to provide a reliable source of noncommercial programming about the communities themselves. Local programming is an increasingly rare commodity in a nation that is dominated by national program services and concentrated ownership of the media. CPB funding allows an alternative to exist in these larger markets. And with large newspaper shedding journalists, local community radio may be one of the only outlets able to pick up the slack in coverage of local political matters.

For more than 30 years, CPB appropriations have been enacted 2 years in advance. This insulation has allowed pubic broadcasting to grow into a respected, independent, national resource that leverages its Federal support with significant local funds. Knowing what funding will be available in advance has allowed local stations to plan for programming and community service and to explore additional nongovernmental support to augment the Federal funds. Most importantly, the insulation that advance funding provides is of critical importance in eliminating both the risk of and the appearance of undue interference with and control of public broadcasting.

Community radio supports CPB activities in facilitating programming to Native American, Latino, and African-American radio stations. CPB has played a critical role in providing support and assistance to radio stations serving communities of color, particularly communities that could be better served by noncommercial radio. While CPB has long supported television programming focused on underserved communities, its programs for radio are newer and are very welcome. Given the importance and accessibility of radio in many underserved communities, NFCB urges the subcommittee to endorse the long-term viability of these radio minority consortia.

Specifically, with important support from CPB, Native Public Media (NPM) has burst on to the scene to ensure that Native Americans have access to noncommercial broadcast and new technologies alike. NPM has worked in the last few years to facilitate applications for noncommercial radio stations by almost 40 applicants from tribal and native entities, bringing many of these service areas within the reach of a public radio signal for the first time. NPM has undertaken research to identify the spectrum allocations currently serving Indian country in order to target better service in the future, releasing a report called The New Media, Technology and Internet Use in Indian Country: Quantitative and Qualitative Analyses, which included a usage survey and case study that contains the first valid and credible data on Internet use among Native Americans. In addition, NPM was able to play a critical role in ensuring that tribal entities have the ability to obtain new radio stations in the future by successfully demonstrating to the FCC the need and legal justification for a tribal priority in radio.

In addition, in the last year the newest minority consortium has been started—the Latino Public Radio Consortium. The Latino Public Radio Consortium is an organization that represents and supports 33 public radio stations. It recognizes that Latinos are under-represented in the Nation's public broadcasting institutions, decisionmaking structures, that there is little programming in English or in Spanish produced by Latinos or with a Latino focus and, as a consequence, Hispanics are vastly underrepresented among public radio's news and public affairs audiences.[1] To illustrate, a study by Station Resource Group's Grow the Audience project showed that, for public radio to acquire a representative share of the college-educated market for Latinos, it would need to triple its audience.[2]

During this funding year the Consortium has established the communications and governance structure to enable the Hispanic stations to support each other and to develop additional resources. An important new project that is indicative of future work is the development of Historias, a partnership with Story Corps, a national oral history project of the Library of Congress and public radio. Through this collaboration, Story Corps Historias will gather and record 900 individual interviews with Latinos around the country.

This year CPB is funding new services for African-American public radio stations designed to improve and increase public media's service to the American public.

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[1] Latino Public Radio Consortium, Brown Paper, p.1 available at http://www.latinopublic radioconsortium.org/index.php?s=41.

[2] Station Resource Group, Grow the Audience, Listening by Black and Hispanic College Graduates (2008) at p. 17, available at http://www.srg.org/GTA/GTA%20Black%20Hispanic%20 Report.pdf.

NFCB believes that this project, like the other consortia, is vital to ensure that all Americans benefit from public funds and the breadth and depth of public radio. In addition to the minority consortia, CPB supports Satélite Radio Bilingüe which provides 24 hours of programming to stations across the United States and Puerto Rico addressing issues of particular interest to the Latino population in Spanish and English. CPB also supports Native Voice One (NV1), which is distributing politically and culturally relevant programming to Native American stations.

Community radio supports $59.5 million in fiscal year 2011 for the conversion to digital technology. While public television's digital conversion needs were mandated by the FCC, public radio is converting to digital to provide more public service and to keep up with commercial radio. The Federal Communications Commission has approved a standard for digital radio transmission that will allow multicasting. This development of second and third audio channels will potentially double or triple the service that public radio can provide listeners, particularly in unserved and underserved communities. In addition, public radio is in great need of CPB's leadership and resources to transition to new media platforms, in particular through such projects as the American Archive, which will make existing programming accessible to all and on all platforms.

Community radio supports CPB's funding for rural stations and assistance with new technologies. For the past few years, CPB has increased support to rural stations and committed resources to help public radio take advantage of new technologies such as the Internet, satellite radio and digital broadcasting. We support these new technologies so that we can better serve the American people, but want to ensure that smaller stations with more limited resources are not left behind in this technological transition. We ask that the subcommittee include language in the appropriation that will ensure that funds are available to help the entire public radio system, particularly rural and minority stations, utilize new technology.

A good example of CPB's role is the Public Media Innovation grant CPB gave KAXE, one of NFCB's rural members, a chance to experiment with the concept of becoming "a web operation that owned a radio station." PMI described this project as one of the most visionary proposals they funded. As part of the grant, KAXE began the development of Northern Community Internet, which would provide hyper-local news content to more than a dozen communities in northern Minnesota. Through this project, KAXE learned many important things about how to create content that is relevant and accessible across a Web site, radio station, and social media. The journalists involved continue to be very interested in the project, even though the current pilot is over.

Community radio supports CPB programs focused on ensuring public radio is able to fulfill its important mission of public safety during emergencies. CPB funding has supported an important new project led by NFCB called Station Action for Emergency Readiness (SAFER). NFCB, in partnership with NPR and with support from CPB, has developed a step-by-step manual that stations can use to develop and/or supplement their own emergency readiness plans; a set of digital tools that stations can embed in their own Web sites to keep community members informed; and links to national and local resources that can supplement station's coverage. This project was inspired by the experience of NFCB member WWOZ in New Orleans as a result of Katrina and was furthered by the work of NFCB member KWMR in Point Reyes Station, California. KWMR is small and local community and provided absolutely critical life-saving information to its community during terrible floods of 2004–2005.

Community radio supports CPB's role as a convener that can address questions and important future trends across all public media. CPB plays an extremely important role in the public and Community Radio system: it convenes discussions on critical issues facing us as a system. They support research so that we have a better understanding of how we are serving listeners. And, they provide funding for programming, new ventures, expansion to new audiences, and projects that improve the efficiency of the system. This is particularly important at a time when there are so many changes in the radio and media environment with media consolidation and new distribution technologies.

Thank you for your consideration of our testimony.

PREPARED STATEMENT OF THE NATIONAL HEALTH CARE FOR THE HOMELESS COUNCIL

The National Health Care for the Homeless Council respectfully asks the Senate Committee on Appropriations to strengthen and expand the Nation's health centers by appropriating the $2.4 billion for the Consolidated Health Centers Program in fiscal year 2011, as included in the administration's budget proposal.

The National Health Care for the Homeless Council is a membership organization engaged in education and advocacy to improve healthcare for homeless persons and all Americans. We represent 111 organizational members, including 100 Health Care for the Homeless (HCH) projects, and more than 700 individuals who provide care to people experiencing homelessness throughout the country.

Homelessness and Health.—Poverty, lack of affordable housing, and the lack of comprehensive health insurance are among the underlying structural causes of homelessness. For those struggling to pay for housing and other basic needs, the onset of a serious illness or disability easily can result in homelessness following the depletion of financial resources. The experience of homelessness causes poor health, and poor health is exacerbated by restricted access to appropriate healthcare—which only prolongs homelessness. Additional barriers to healthcare access include lack of transportation, inflexible clinic hours, complex requirements to qualify for public health insurance, and mandatory unaffordable co-payments for various services.

Mainstream healthcare safety net providers often fail to meet the needs of homeless people. In the absence of universal healthcare, the Federal Government supports a separate healthcare system for low-income and uninsured people. Community Health Centers and publicly funded mental health and addictions programs form the core of this healthcare safety net. Unfortunately, limited resources, lack of experience with this population, and insufficient linkages to a full range of health and supportive services seriously restrict the ability of mainstream providers to meet the unique needs of people experiencing homelessness.

The Federal HCH Program—administered by the Health Resources and Services Administration (HRSA)—currently supports 207 HCH projects in all 50 States, the District of Columbia, and Puerto Rico. Congress established Health Care for the Homeless in 1987 to provide targeted services for people experiencing homelessness, including primary and behavioral healthcare along with social services, as well as intensive outreach and case management to link clients with appropriate resources. Approximately 70 percent of those served by HCH projects lack comprehensive health insurance. The HCH program has been reauthorized three times, most recently in 2008 with passage of the Health Care Safety Net Act. HCH projects served more than 1 million patients in 2009—a sizable number, but far below the estimated 4 million Americans who annually experience homelessness. Authorizing language designates 8.7 percent of the total health center appropriation to support the HCH program.

Community Health Centers.—Over the past several years, the expansion of community health centers has received bipartisan support from Members of Congress, to include through the American Recovery and Reinvestment Act of 2009. Federally Qualified Health Centers (FQHCs) consistently have proven their effectiveness in delivering comprehensive medical care to underserved populations. Though health centers currently serve more than 16 million people annually, at least 56 million Americans—both insured and uninsured—face inadequate access to primary care due to a shortage of physicians and other providers. Without sufficient access to care, the health problems of the insured and underinsured are exacerbated, resulting in costly treatment, medical complications, and even premature death.

Investments in Community Health Centers contained the Patient Protection and Affordable Care Act will also be a significant tool that will help clinics grow to meet the needs of patients seeking primary care, especially as the Medicaid expansion provisions are enacted in 2014. This Medicaid expansion will be a greatly needed improvement for our homeless patients, since most are currently ineligible for coverage.

Within the current economic context, a massive unmet need remains for health center resources despite years of incremental expansion through the Health Center Growth Initiative. The deteriorating economy leaves more Americans unemployed, at risk of homelessness, and in need of health services. According to the Department of Labor, the unemployment rate was 9.7 percent in March 2010. Given the prevalence of employer-sponsored health coverage, high unemployment leaves many Americans without health coverage, thus creating a greater need for safety net services provided by community health centers.

Fiscal Year 2011 Appropriations.—In recognition of the growing need for primary healthcare services, the House Committee on Appropriations along with other Members of Congress has been supportive of strengthening and expanding community health centers. In the President's fiscal year 2011 budget proposal, the Community Health Center program receives $2.4 billion—$290 million above the fiscal year 2010 appropriation. This includes a total of $209 million (8.7 percent) for the HCH program.

To continue strengthening the Nation's health center infrastructure, we encourage the Senate Committee on Appropriations Subcommittee on Labor, Health and Human Services, and Education, and Related Agencies to appropriate the $2.4 billion for the Community Health Center program (including $209 million for the HCH program), as contained in the administration's fiscal year 2011 budget proposal.

The National Council applauds Congress for its strong support of community health centers. We thank Chairman Harkin and the Senate Committee on Appropriations Subcommittee on Labor, Health and Human Service, and Education, and Related Agencies for your consideration of this testimony.

PREPARED STATEMENT OF THE NATIONAL KIDNEY FOUNDATION

The National Kidney Foundation (NKF) appreciates the opportunity to present public witness testimony for the written record in support of fiscal year 2011 funding for the Centers for Disease Control and Prevention.

Kidney disease is the ninth leading cause of death in the United States. More than 26 million American adults are estimated to have some level of chronic kidney disease (CKD), yet most of them are undiagnosed. Early detection and treatment can prevent or slow the progression to irreversible kidney failure, or end-stage renal disease (ESRD). Many do not even reach end stage; late-stage CKD patients are far more likely to die of cardiovascular disease than to reach ESRD, and early detection is beneficial here also.

Approximately 70 percent of new ESRD cases are directly attributable to diabetes or hypertension (with diabetes alone the cause of nearly half of all new cases annually). Furthermore, ESRD increases dramatically with age, and the prevalence among racial and ethnic minorities is much higher than among whites. Medicare covers dialysis or transplantation regardless of age or other disability (the only disease-specific coverage under the program) and the ESRD Program has saved millions of lives. However, the cost is substantial and disproportionate to the Medicare population. Less than 7 percent of the Medicare population carries a diagnosis of CKD, but they account for 21 percent of Medicare expenditures.

Despite the social and economic impact, no national public health program focusing on early detection and treatment of CKD existed until 2005, when Congress provided funding for fiscal year 2006 to initiate a Chronic Kidney Disease Program at the CDC. The CKD program, which has received approximately $2 million annually, will build capacity and infrastructure at CDC for a kidney disease public health program. The objectives of the initiative are to assess and monitor the burden of CKD and its risk factors; develop methods to identify high risk populations; develop public health strategies to prevent the development of CKD and reduce its progression to kidney failure; and, develop models to assess the economic burden of CKD.

In 2008 and 2009, the CDC and NKF collaborated on a demonstration project to detect individuals with or at high risk of CKD. The CKD Health Evaluation and Risk Information Sharing project (CHERISH) uses diabetes, hypertension, and age (older than 50) as risk factors to select participants for the screenings. Eight screenings of more than 800 individuals in four States detected CKD in over one-quarter of the individuals, who demonstrate the need for better risk factor control of high blood pressure, diabetes, and high cholesterol. Awareness of kidney disease remains very low.

Early detection and intervention of chronic kidney disease is not difficult and intervention tools to treat early CKD are widely available. The level of progression to chronic kidney failure or ESRD and the rate of premature cardiovascular death are unacceptable. Continued support, as requested by the administration in its 2011 budget request, will promote comprehensive public health approaches in CKD by the CDC, including screening, surveillance, economic analysis, coordination with ongoing internal activities (cardiovascular disease and stroke prevention, diabetes, obesity, family history/genetics, communicable disease such as hemodialysis catheter infections), interagency collaboration (NIH, AHRQ, and HHS) and ultimately implementation through state departments of health to impact care, improve outcomes and reduce costs.

PREPARED STATEMENT OF THE NATIONAL MINORITY CONSORTIA

The National Minority Consortia (NMC) submits this statement on the fiscal year 2013 appropriation for the Corporation for Public Broadcasting (CPB). The NMC is a coalition of five national organizations dedicated to bringing the unique voices and perspectives from America's diverse communities into all aspects of public broadcasting and to other media, including content transmitted digitally over the Inter-

net. The role we fulfill in this regard has been crucial to public broadcasting's mission for more than 30 years. We are unique as organizations and as a coalition of organizations in the services we provide in access, training, and support for important and timely public interest content to our communities and to public broadcasting. We ask the subcommittee to:

—Direct CPB to increase its efforts for diverse programming with commensurate increases for minority programming and for organizations and stations located within underserved communities;

—Direct CPB to establish a percentage basis for biennial funding of the NMC to permit long-range financial and strategic planning;[1]

—Direct CPB to establish an annual "report card" on diversity to track efforts to better represent the full breadth of the American people and their experiences through public television, public radio and nonprofit media online;

—Direct CPB to publish on the Internet clear and enforced guidelines for all CPB-directed funding, including funds jointly administered by PBS and NPR, and end the closed-door funding processes historically in place, especially as the current practices favor existing relationships and can be seen as biased against minority applicants, in particular.

Report Language.—We ask for report language, specifically an addition to report language from the fiscal year 2006 Appropriations Act (and also included in the fiscal year 2007 Senate report), which recognizes the contribution of the NMC and directs that the CPB partnership with us be expanded. The Report stated:

"The Committee recognizes the importance of the partnership CPB has with the National Minority Public Broadcasting Consortia, which helps develop, acquire, and distribute public television programming to serve the needs of African American, Asian American, Latino, Native American, Pacific Islander, and many other viewers. As many communities in the Nation welcome increased numbers of citizens of diverse ethnic backgrounds, the local public television stations should strive to meet these viewers' needs. With an increased focus on programming to meet local community needs, the Committee encourages CPB to support and expand this critical partnership." (S. Rpt. 109–103, p. 298)

We request that the above language be modified to direct CPB to increase its funding of the NMC and the various minority radio consortia to a level equal, in the aggregate, to 20 percent of funds allocated to television production.

Fiscal Year 2013 Appropriation.—We support a fiscal year 2013 advance appropriation for CPB of $604 million, which recognizes the need to develop content that reaches across traditional media boundaries, such as those separating television and radio. However, we feel strongly that should CPB receive this appropriation, CPB should be directed to engage in transparent and fair funding practices that guarantee all applicants equal access to these public resources. In particular, we urge Congress to direct CPB to insert language in all of its funding guidelines that encourages and rewards public media that fully represents and reaches a diverse American public.[2]

While public broadcasting continues to uphold strong ethics of responsible journalism and thoughtful examination of American history, life and culture, including the ways we are a part of a global society, it has not kept pace with our rapidly changing public as far as diversity is concerned. Members of minority groups continue to be underrepresented on both the programming and oversight levels within public broadcasting as well as on the content production side. There are fewer than five executives of diverse background at the highest levels in the three leading organizations within public broadcasting. This is unacceptable in America today, where minorities comprise more than 35 percent of the population.

Public broadcasting has the potential to be particularly important for our Nation's growing minority and ethnic communities, especially as we transition to a broadband-enabled, 21st century workforce that relies on the skills and talent of all of our citizens. While there is a niche in the commercial broadcast and cable world

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[1] Currently funding for the NMC, in the aggregate, represents only 1.2 percent of CPB's request. We suggest increasing that percentage to an amount equal to not less than 20 percent of the amount requested for television programming, or approximately $20 million, to be split equally among the five groups listed here and beginning immediately upon enactment of this legislation.

[2] According to the 2008 Public Radio Tech Survey, 90 percent of public radio listeners are White. Of those, 84 percent are college educated, with 48 percent having graduate degrees. This compares to just 9 percent of Americans who have postgraduate degrees. It is therefore mandatory that we prioritize actually "reaching" a diverse audience of Americans and not simply reflecting diverse and often misleading staffing numbers to measure public media's effectiveness in serving all of the American taxpayers that fund CPB.

for quality programming about our communities and our concerns, it is in the public broadcasting sphere where minority communities and producers should have more access and capacity to produce diverse high-quality programming for national audiences. We therefore, urge Congress to insert strong language in this act to ensure that this is the case and that these opportunities are made available to minorities and other underserved communities.

About the NMC.—With primary funding from the CPB, the NMC serves as an important component of American public television as well as content delivered over the Internet. By training and mentoring the next generation of minority producers and program managers as well as brokering relationships between content makers and distributors (such as PBS, APT, and NETA), we are in a perfect position to ensure the future strength and relevance of public television and radio television programming from and to our communities. However, these efforts are vulnerable because of chronic underfunding and lack of meaningful and ongoing representation within CPB's decisionmaking processes. This instability, coupled with what is essentially a decrease in our funding over time, are the primary reasons that have led to a public media that has become less diverse over the past 5 years.[3]

This is obviously not the case in the rest of America. With minority populations already estimated at more than 35 percent of the U.S. population, it is more important that our public institutions reflect this reality.

Individually, each NMC organization is engaged in cultivating ongoing relationships with the independent producer community by providing technical assistance and program funding, support and distribution. Often the funding we provide is the initial seed money for a project, thus allowing it to develop. We also provide numerous hours of programming to individual public television and radio stations, programming that is beyond the production reach of most local stations. To have a real impact, we need funding that recognizes and values the full extent of minority participation in public life.

While the NMC organizations work on projects specific to their communities, the five organizations also work collaboratively. An example of a joint production in which the NMC provided the initial seed money is "Unnatural Causes: Is Inequality Making Us Sick?", a multi-part series that uncovers the roots of racial and socioeconomic disparities in health and spotlights community initiatives to achieve health equality. Our seed money enabled the project to go forward and to attract additional funding. We are also co-producers of and presenters in this series, which originally aired in 2008 and was rebroadcast just this year. Additionally, we jointly funded an online initiative around the Presidential election in 2008 and continue to explore as a group other topics of national importance.

CPB Funds for the NMC.—The NMC receives funds from two portions of the CPB budget: organizational support funds from the Systems Support and programming funds from the Television Programming funds. The organizational support funds we receive are used for operations requirements and also for programming support activities and for outreach to our communities and system-wide within public broadcasting. The programming funds are re-granted to producers, used for purchase of broadcast rights and other related programming activities. Each organization solicits applications from our communities for these funds. A brief description of our organizations follows:

Center for Asian American Media.—CAAM's mission is to present stories that convey the richness and diversity of Asian-American experiences to the broadest audience possible. We do this by funding, producing, distributing, and exhibiting works in film, television, and digital media. Over our 25-year history we have provided funding for more than 200 projects, many of which have gone on to win Academy, Emmy and Sundance awards, examples of which are Daughter from Danang; Of Civil Rights and Wrongs: The Fred Korematsu Story; and Maya Lin: A Strong Clear Vision. CAAM presents the annual San Francisco International Asian American Film Festival and distributes Asian American media to schools, libraries, and colleges.

Latino Public Broadcasting (LPB).—LPB supports the development, production, and distribution of public media content that is representative of Latino people, or addresses issues of particular interest to Latino Americans. LPB provides a voice to the diverse Latino community throughout the United States. Since its creation in 1998 by Edward James Olmos, LPB has provided more than 200 hours of pro-

[3] CPB funding for the NMC remained flat for 13 years until fiscal year 2008, at approximately $1 million per year per consortia. At that time, we received a one-time increase of $150,000 per organization. In fiscal year 2009, we received another one-time increase of approximately $500,000 each, but have been told that does not reflect a permanent increase. Over this same 13-year period, CPB's budget nearly doubled.

gramming to public television, including Roberto Clemente, the Sundance award winners Farmingville and El General, and Emmy-nominated The Life and Times of Frida Kahlo. LPB has organized more than 100 workshops for the advancement of Latino producers and launched the first Latino anthology series on public television, VOCES, which aired its second season in 2009 on PBS stations across the country. LPB has received the Imagen Award and the National Council of La Raza's Alma Award.

The National Black Programming Consortium (NBPC).—NBPC develops, produces, and funds television and more recently audio and online programming about the Black experience for American public media outlets. Since its founding in 1979, NBPC has provided hundreds of broadcast hours documenting African- American history, culture, and experience to public television and launched major initiatives that have brought important public media content to diverse audiences. In 2006, NBPC launched the New Media Institute (NMI) a program designed to train makers of public media to provide real value to communities using digital platforms. Currently, NBPC is preparing to launch the Public Media Corps, a highly visible, national, broadband-based program designed to extend the reach of taxpayer funded diverse content into the digital realm, to recruit the next generation of content makers, innovators and other stakeholders coming from all of America's communities, and to empower all Americans with relevant, critical, and timely information.

Native American Public Telecommunications (NAPT).—NAPT shares Native stories with the world through support of the creation, promotion, and distribution of Native media. Founded in 1977, through various media-public television and radio, and the Internet-NAPT brings awareness of Indian and Alaska Native issues. Through the CPB-funded Production Fund, 5 to 10 new projects are supported each year. Last year, we worked with American Experience in the award winning We Shall Remain, a five-part Native history series. NAPT operates the AIROS Native Network, a 24/7 Internet radio station that features music, news, interviews, documentaries, and audio theater. We also feature downloadable podcasts with Native filmmakers, musicians, and tribal leaders. VisionMaker Video is now the premier source for quality Native educational and home videos. Profits made from video sales are invested in new NAPT productions. All aspects of our programs encourage the involvement of young people to learn more about careers in the media—to be the next generation of storytellers. Through our location at the University of Nebraska—Lincoln, we offer student employment, internships, and fellowships. Reaching the general public and the global market is the ultimate goal for the dissemination of Native-produced media.

Pacific Islanders in Communications (PIC).—Since 1991, PIC has delivered programs and training that bring voice and visibility to Pacific Islander Americans. PIC presented the broadcast premier of the award-wining film, Whale Rider, on PBS—the story of young girl who confronts years of tribal tradition to fulfill her destiny as the leader of her people. Other PBS broadcasts include Time and Tide, about the devastating effects of global warming on the Pacific Islands and Polynesian Power the story of Pacific Islanders in the NFL. Currently PIC is developing a multi-part series, Expedition: Wisdom, in partnership with the National Geographic Society. PIC offers a wide range of development opportunities for Pacific Island producers through travel grants, seminars and media training. Producer training programs are held in the U.S. territories of Guam and American Samoa, as well as in Hawai'i, on a regular basis.

Thank you for your consideration of our recommendations. We see new opportunities to increase diversity in programming, production, audience, and employment in the new media environment, and we thank Congress for support of our work on behalf of our communities.

PREPARED STATEMENT OF THE NATIONAL MARFAN FOUNDATION

Mr. Chairman, thank you for the opportunity to submit testimony regarding the fiscal year 2011 budget for the National Heart, Lung and Blood Institute, the National Institute of Arthritis, Musculoskeletal and Skin Diseases, and the Centers for Disease Control and Prevention. The National Marfan Foundation is grateful for the subcommittee's strong support of the National Institutes of Health (NIH) and the Centers for Disease Control and Prevention, particularly as it relates to life-threatening genetic disorders such as Marfan syndrome. Thanks in part to your leadership we are at a time of unprecedented hope for our patients.

It is estimated that 200,000 people in the United States are affected by Marfan syndrome or a related condition. Marfan syndrome is a genetic disorder of the connective tissue that can affect many areas of the body, including the heart, eyes, skel-

eton, lungs and blood vessels. It is progressive condition and can cause deterioration in each of these body systems. The most serious and life-threatening aspect of the syndrome is a weakening of the aorta. The aorta is the largest artery carrying oxygenated blood from the heart. Over time, many Marfan syndrome patients experience a dramatic weakening of the aorta which can cause the vessel to dissect and tear.

Early surgical intervention can prevent a dissection and strengthen the aorta and the aortic valves. If preventive surgery is performed before a dissection occurs, the success rate of the procedure is more than 95 percent. If surgery is initiated after a dissection has occurred, the success rate drops below 50 percent. Aortic dissection is a leading killer in the United States, and 20 percent of the people it affects have a genetic predisposition, like Marfan syndrome, to developing the complication. Fortunately, new research offers hope that a commonly prescribed blood pressure medication might be effective in preventing this frequent and devastating event.

FISCAL YEAR 2011 APPROPRIATIONS RECOMMENDATIONS

National Institutes of Health

Mr. Chairman, NMF joins with other voluntary patient and medical organizations in recommending an appropriation of $35 billion for the National Institutes of Health in fiscal year 2011. This level of funding will ensure continued expansion of research on rare diseases like Marfan syndrome and build upon the significant investment provided to the NIH in the American Recovery and Reinvestment Act.

National Heart, Lung and Blood Institute

Pediatric Heart Network Clinical Trial

NMF applauds the National Heart, Lung and Blood Institute for its leadership in advancing a landmark clinical trail on Marfan syndrome. Under the direction of Dr. Lynn Mahoney and Dr. Gail Pearson, the Institute's Pediatric Heart Network has spearheaded a multicenter study focused on the potential benefits of a commonly prescribed blood pressure medication (losartan) on aortic growth in Marfan syndrome patients.

Dr. Hal Dietz, the Victor A. McKusick Professor of Genetics in the McKusick-Nathans Institute of Genetic Medicine at the Johns Hopkins University School of Medicine, and the director of the William S. Smilow Center for Marfan Syndrome Research, is the driving force behind this groundbreaking research. Dr. Dietz uncovered the role that the growth factor TGF-beta plays in aortic enlargement, and demonstrated the benefits of losartan in halting aortic growth in mice. He is the reason we have reached this time of such promise and NMF is proud to have supported Dr. Dietz's cutting-edge research for many years.

Over the past 4 years, more than 500 Marfan syndrome patients (age 6 months to 25 years) have been enrolled in this study. Patients are randomized onto either losartan or atenolol (a beta blocker that is the current standard of care for Marfan patients with an enlarged aortic root). We are on schedule to meet the trial's enrollment target of 604 patients by the end of this year. This is a noteworthy accomplishment in itself given the rarity of Marfan syndrome. We anxiously await the results of this first-ever clinical trial for our patient population. It is our hope that losartan will emerge as the new standard-of-care and greatly reduce the need for surgery in at-risk patients.

Mr. Chairman, NMF is proud to actively support the losartan clinical trial in partnership with the Pediatric Heart Network. Throughout the life of the trial we have provided support for patient travel costs, coverage of select echocardiogram examinations, and funding for ancillary studies. These ancillary studies will explore the impact that losartan has on other manifestations of Marfan syndrome.

Evaluation of Surgical Options for Marfan Syndrome Patients

Mr. Chairman, we are grateful for the subcommittee's recommendations in the fiscal year 2010 bill encouraging NHLBI to support research on surgical options for Marfan syndrome patients.

For the past several years, the NMF has supported an innovative study looking at outcomes in Marfan syndrome patients who undergo valve-sparing surgery compared with valve replacement. Initial findings were published last year in the Journal of Thoracic and Cardiovascular Surgery. Some short term questions have been answered, most importantly that valve-sparing can be done safely on Marfan patients by an experienced surgeon. The consensus among the investigators however is that long-term durability questions will not be answered until patients are followed for 10 years.

As a result, the principal investigators involved in the study recently submitted an RO–1 grant proposal to the NHLBI seeking support for this effort. Confirming the utility and durability of valve sparing procedures will save our patients a host of potential complications associated with valve replacement surgery. We encourage the subcommittee to continue its support for this much-needed research in fiscal year 2011.

NHLBI "Working Group on Research in Marfan Syndrome and Related Conditions"

In 2007, NHLBI convened a "Working Group on Research in Marfan Syndrome and Related Conditions." Chaired by Dr. Dietz, this panel was comprised of experts in all aspects of basic and clinical science related to the disorder. The panel was charged with identifying key recommendations for advancing the field of research in the coming decade. The recommendations of the Working Group are as follows—

"Scientific opportunities to advance this field are conferred by technological advances in gene discovery, the ability to dissect cellular processes at the molecular level and imaging, and the establishment of multi-disciplinary teams. The barriers to progress are addressed through the following recommendations, which are also consistent with Goals and Challenges in the NHLBI Strategic Plan.

—Existing registries should be expanded or new registries developed to define the presentation, natural history, and clinical history of aneurysm syndromes.

—Biological and aortic tissue sample collection should be incorporated into every clinical research program on Marfan syndrome and related disorders and funds should be provided to ensure that this occurs. Such resources, once established, should be widely shared among investigators.

—An Aortic Aneurysm Clinical Trials Network (ACTnet) should be developed to test both surgical and medical therapies in patients with thoracic aortic aneurysms. Partnership in this effort should be sought with industry, academic organizations, foundations, and other governmental entities.

—The identification of novel therapeutic targets and biomarkers should be facilitated by the development of genetically defined animal models and the expanded use of genomic, proteomic and functional analyses. There is a specific need to understand cellular pathways that are altered leading to aneurysms and dissections, and to develop robust in vivo reporter assays to monitor TGFb and other cellular signaling cascades."

We look forward to working closely with NHLBI to pursue these important research goals and ask the Subcommittee to support the recommendations of the Working Group.

National Institute of Arthritis and Musckuloskeletal and Skin Diseases

NMF is proud of its longstanding partnership with the National Institute of Arthritis and Musculoskeletal and Skin Diseases. Dr. Steven Katz has been a strong proponent of basic research on Marfan syndrome during his tenure as NIAMS director and has generously supported several "Conferences on Heritable Disorders of Connective Tissue." Moreover, the Institute has provided invaluable support for Dr. Dietz's mouse model studies. The discoveries of fibrillin-1, TGF-beta, and their role in muscle regeneration and connective tissue function were made possible in part through collaboration with NIAMS.

As the losartan trail continues to move forward, we hope to expand our partnership with NIAMS to support related studies that fall under the mission and jurisdiction of the Institute. One of the areas of great interest to researchers and patients is the role that losartan may play in strengthening muscle tissue in Marfan patients. We would welcome an opportunity to partner with NIAMS on this and other research.

Centers for Disease Control and Prevention

Mr. Chairman, we are very grateful to you and the subcommittee for your support of a Marfan syndrome awareness project currently being developed by the NMF and the CDC. One of the most important things we can do to prevent untimely deaths from aortic aneurysms is to increase awareness of Marfan syndrome and related connective tissue disorders. Our collaboration with the CDC in fiscal year 2010 will enable us to expand our outreach to the general public and healthcare providers and ultimately save lives.

It is a hopeful time in our community as we reach out to at-risk populations about the cardiovascular complications associated with Marfan syndrome. Just last month, the American College of Cardiology and the American Heart Association issued landmark practice guidelines for the treatment thoracic aortic aneurysms and dissections. The NMF is promoting awareness of the new guidelines in collaboration

with other organizations through a new Coalition known as TAD; the Thoracic Aortic Disease Coalition. We hope to partner with the CDC in fiscal year 2011 to increase awareness of the guidelines so all patients will be adequately diagnosed and treated.

For fiscal year 2011, NMF joins with the CDC Coalition in recommending an appropriation of $8.8 billion for the CDC. We also join with the Friends of the National Center on Birth Defects and Developmental Disabilities in recommending a funding level of $163.5 million for NCBDD in 2011. NCBDD and its single-gene disorders program serve as the home within CDC for the Marfan syndrome community.

PREPARED STATEMENT OF THE NATIONAL POSTDOCTORAL ASSOCIATION

Mr. Chairman and members of the subcommittee: Thank you for this opportunity to testify in regard to the fiscal year 2011 funding for the National Institutes of Health (NIH). We are writing today in regard to support for postdoctoral scholars, specifically in support of the 6 percent increase in NIH training stipends, as requested in the President's budget.

Background: Postdocs are the Backbone of U.S. Science and Technology

According to estimates by The National Science Foundation (NSF) Division of Science Resource Statistics, there are approximately 89,000 postdoctoral scholars in the United States [1]. The NIH and the NSF define a "postdoc" as: An individual who has received a doctoral degree (or equivalent) and is engaged in a temporary and defined period of mentored advanced training to enhance the professional skills and research independence needed to pursue his or her chosen career path. The number of postdocs has been steadily increasing. The incidence of individuals taking postdoc positions during their careers has risen, from about 25 percent of those with a pre-1972 doctorate to 46 percent of those receiving their doctorate in 2002–2005 [2]. Moreover, the number of science and engineering doctorates awarded each year is steadily rising with doctorates awarded in the medical/life sciences almost tripling between 2003 and 2007 [3].

Postdocs are critical to the research enterprise in the United States and are responsible for the bulk of the cutting edge research performed in this country. Consider the following:

—Fully 43 percent of first authors on Science papers are postdocs.[4]

—According to the National Academies, postdoctoral researchers "have become indispensable to the science and engineering enterprise, performing a substantial portion of the Nation's research in every setting."[5]

—Postdoctoral training has become a prerequisite for many long-term research projects.[6] In fact, the postdoc position has become the de facto next career step following the receipt of a doctoral degree in many disciplines.

—The retention of women and under-represented groups in scientific research depends upon their successful and appropriate completion of the postdoctoral experience.

—Postdoctoral scholars carry the potential to solve many of the world's most pressing problems; they are the principal investigators of tomorrow.

Unfortunately, postdocs are routinely exploited. They are paid a low wage relative to their years of training and are often ineligible for workman's compensation, disability insurance, paid maternity or paternity leave, employer-sponsored medical benefits, and retirement accounts.

The NPA advocates for policies that support postdoctoral training. We advocate for policy change within the research institutions that host postdoctoral scholars. More than 150 institutions, including the National Institutes of Health (NIH) and the National Science Foundation (NSF) have adopted portions of the NPA's recommended practices.

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[1] National Science Foundation Division of Science Resource Statistics. (January 2010). Science and engineering indicators 2010. Arlington, VA: National Science Board.

[2] Ibid.

[3] Ibid.

[4] Davis, G. 2005. Doctors without orders. American Scientist 93(3, supplement). http://postdoc.sigmaxi.org/results/.

[5] COSEPUP. (June 2001). Enhancing the postdoctoral experience for scientists and engineers. Washington, D.C.:National Academy Press. p. 10.

[6] COSEPUP. (June 2001). Enhancing the postdoctoral experience for scientists and engineers. Washington, D.C.: National Academy Press. p. 11.

Problem: Postdoc Salaries/Stipends Don't Meet Cost-of-Living Standards

The NIH leadership has been aware that these stipends are too low since 2001, after the publication of the results of the study Enhancing the Postdoctoral Experience for Scientists and Engineers conducted by The National Academies' Committee on Science, Engineering and Public Policy (COSEPUP). In response, the NIH pledged (1) to increase entry-level stipends to $45,000 by raising the stipends at least 10 percent each year and (2) to provide automatic cost-of-living increases each year thereafter to keep pace with inflation.

Without sufficient appropriations from Congress, the NIH has not been able to fulfill its pledge. In 2007, the stipends were frozen at 2006 levels and since then have only been raised twice: by 1 percent each year in 2009 and 2010. The 2010 entry-level training stipend is $37,740, the equivalent of a GS–8 position in the Federal Government (NIH Statement NOT–OD–10–047), despite the postdocs' advanced degrees and specialized technical skills. Furthermore, this stipend remains far short of the promised $45,000. Certainly, it is not reflective of any cost-of-living increases.

The NPA's research has shown that the NIH training stipends are used as a benchmark by research institutions across the country for establishing compensation for postdoctoral scholars. In order to keep the "best and the brightest" scientists in the U.S. research enterprise, the NPA believes that it is extremely important that Congress appropriate funding for the 6 percent increase in training stipends.

Please consider the following requests from scientists in other countries:

—In 2009, the NPA was approached by a scientist from Qatar for help in recruiting U.S. scientists, and the Qatar Foundation is prepared to offer compensation and benefits that would far exceed those received by most postdocs in the United States.

—Scientists from Canada, China, Japan, and Australia, among other countries, have been seeking the NPA's advice and have asked the NPA to establish partnerships with their organizations.

And the following statistics:

—Although the 2007 U.S. expenditures on Research and Development (R&D) exceeded that of any other country/region, from 1996 to 2007, the U.S. R&D/GDP ratio held steady, while China's ratio doubled.[7]

—From 1996 to 2007, the R&D growth rate for the Asia/Pacific region increased from 24 to 31 percent, while the North American region's growth rate decreased from 40 to 35 percent.[8]

—From 1996 to 2007, the United States average annual growth of R&D expenditures averaged 5 percent, whereas China's average annual growth topped 20 percent.[9]

If the United States is to stay competitive in the global research enterprise, there needs to be continued, steady increases in NIH funding. If the U.S. research enterprise is to keep the best and brightest of postdoctoral scholars, there needs to be a significant increase in training stipends, sooner rather than later.

Solution: Keep the NIH's Original Promise To Raise the Minimum Stipends

In the 2010 NIH budget request, H.R. 3293 contained a 2-percent increase in the NRSA Stipend level. The Senate version of the bill contained no increase. In December 2009 the House-Senate Subcommittee reached a consensus and approved a 1-percent increase in the NRSA stipend level.

The NPA would ask the subcommittee to recognize that such small increases are simply not enough. We ask the subcommittee to honor the President's request (NIH Summary of the Fiscal Year 2011 President's Budget):

Ruth L. Kirschstein National Research Service Awards.—A total of $824.4 million, which is a 6 percent increase more than the fiscal year 2010, will be directed to training stipends. This increase sends a clear message to both existing and "would be" scientists that their efforts are valued.

The NPA believes it is fair, just, and necessary to reward the new scientists who will do the bulk of the research discovering cures for disease and developing new technologies to improve the quality of life for millions of people in the United States. Accordingly, we also recommend that the NIH:

—Review the base stipend amount in terms of what it should be today, 9 years after the pledge was made.

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[7] National Science Foundation Division of Science Resource Statistics. (January 2010). Science and engineering indicators 2010. Arlington, VA: National Science Board.

[8] Ibid.

[9] Ibid.

—Provide cost-of-living adjustments for postdoctoral scholars located in regions with higher costs of living.
—Develop a funding mechanism to provide supplemental funding for postdoctoral scholars on research grants that would help to ensure equitable compensation for all of the NIH-funded postdoctoral scholars.

Finally, 10 years have passed since the National Academies' COSEPUP study on the postdoc. The NPA applauds the changes that have taken place to improve the postdoc situation but also recognizes that many serious issues remain unresolved that may, and most probably will, negatively affect the future U.S. research workforce. Thus, the NPA recommends that the Senate mandates and appropriate funds for a follow-up study that would provide information about the state of the postdoctoral community today.

Thank you for your consideration.

PREPARED SATEMENT OF THE NATIONAL PSORIASIS FOUNDATION

INTRODUCTION AND OVERVIEW

The National Psoriasis Foundation (the Foundation) appreciates the opportunity to submit written testimony for the record regarding fiscal year 2011 Federal funding needs for psoriasis and psoriatic arthritis research. The Foundation serves as the world's largest patient-driven, nonprofit, voluntary organization committed to finding a cure for and eliminating the devastating effects of psoriasis and psoriatic arthritis through research, advocacy, and education. Psoriasis—the Nation's most prevalent autoimmune disease, affecting as many as 7.5 million Americans—is a genetic, chronic, inflammatory, painful, disfiguring, and life-altering disease that requires life-long, sophisticated medical intervention and care. Psoriasis imposes serious adverse effects on affected individuals and families, and 30 percent of people with psoriasis also develop psoriatic arthritis, which causes pain, stiffness, and swelling in and around the joints and can lead to permanent disability.

The Foundation seeks to advance public and private efforts to improve treatment of psoriasis and psoriatic arthritis, identify a cure and ensure that all people with psoriasis and psoriatic arthritis have access to the medical care and treatment options they need to live normal lives with the highest possible quality of life. We work with policymakers at the local, State, and Federal levels to advance policies and programs that will reduce and prevent suffering from psoriasis and psoriatic arthritis. To that end, we are most grateful that, in fiscal year 2010, Congress addressed the need to collect epidemiological data about psoriasis, by appropriating $1.5 million for researchers at the Centers for Disease Control and Prevention's (CDC) National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP) to begin the process of developing a national psoriasis and psoriatic arthritis data collection and patient registry. Considerable progress has been made, in the short amount of time since the initial appropriation, to develop this registry in a thoughtful and deliberate manner. We respectfully request that Congress continue to support this important initiative, by appropriating $2.5 million in fiscal year 2011 to allow this national psoriasis data collection initiative to move into the implementation phase. With additional fiscal year 2011 funding, researchers can begin to collect data and increase our understanding of the co-morbidities, such as diabetes and heart attack, which are associated with psoriasis; examine the relationship of psoriasis to other public health concerns (e.g., smoking and obesity); and gain important insight into the long-term impact and treatment of psoriasis and psoriatic arthritis.

In addition, the Foundation supports the President's fiscal year 2011 budget request for a $1 billion increase in funding for the National Institutes of Health (NIH). The Foundation urges the subcommittee to provide a total fiscal year 2011 allocation of $32.2 billion to NIH; this funding will help support new investigator-initiated research grants for genetic, clinical, and basic research related to the understanding of the cellular and molecular mechanisms of psoriasis and psoriatic arthritis, as well as studies to expand on our nascent understanding of psoriasis and psoriatic arthritis patients' myriad co-morbid conditions.

THE IMPACT OF PSORIASIS AND PSORIATIC ARTHRITIS

Psoriasis typically first strikes between the ages of 15 and 25, but can develop at any time and usually lasts a lifetime. Total direct and indirect healthcare costs of psoriasis are calculated at more than $11.25 billion annually, with work loss accounting for 40 percent of the cost burden. There is mounting evidence that people with psoriasis are at elevated risk for myriad other serious, chronic, and life-threat-

ening conditions. Although data still are emerging on the relationship of psoriasis to other diseases and their ensuing costs to the medical system, it is clear that psoriasis goes hand-in-hand with psoriatic arthritis and other co-morbidities, such as Crohn's disease, diabetes, metabolic syndrome, obesity, hypertension, heart attack, cardiovascular disease, and liver disease. Recent studies have found that people with severe psoriasis have a 50 percent higher mortality risk and die 3 to 6 years younger than those who do not have psoriasis. Studies have found that psoriasis causes as much disability as other major chronic diseases, and individuals with psoriasis are twice as likely to have thoughts of suicide as people without psoriasis or with other chronic conditions.

Despite some recent breakthroughs, many people with psoriasis and psoriatic arthritis remain in need of effective, safe, long-term, and affordable therapies to allow them to live normally and improve the overall quality of their lives. Due to the nature of the disease, patients have to cycle through available treatments, which often stop working. While there are an increasing number of methods to control the disease, there is no cure. Often the treatments have serious side effects and can pose long-term risks for patients (e.g., suppress the immune system, deteriorate organ function, etc.). The lack of viable, long-term methods of control for psoriasis could be addressed through an increased Federal commitment to epidemiological, genetic, clinical and basic research. NIH and CDC research, taken together, hold the key to improved treatment of these diseases, better diagnosis of psoriatic arthritis and eventually a cure for psoriatic conditions.

THE ROLE OF CDC IN PSORIASIS AND PSORIATIC ARTHRITIS RESEARCH

Despite our increased understanding of the auto-immune underpinnings of psoriasis and its treatments, there is a dearth of population-based epidemiology data on psoriatic disease. The majority of existing epidemiological studies of psoriasis are based on case reports, case series and cross-sectional studies. Several analytical studies have been performed to identify potentially modifiable risk factors (e.g., smoking, diet, etc.) and some have yielded conflicting, or inconsistent, results. In addition, most case-controlled studies have been hospital-based, or specialty clinic-based, and, therefore, are limited in their value. Broadly representative population-based studies of psoriasis are lacking and needed.

There is enormous opportunity to investigate the epidemiology of psoriasis, as there are still wide gaps in our knowledge of this disease. For example, there is a critical need to better understand the natural progress of chronic plaque psoriasis in order to identify which patients may experience spontaneous remissions and which patients may experience flares of their disease—and when and why. Large, broadly representative population-based studies can expand our understanding of the potential risk factors for developing psoriasis, and future interventional trials can determine if altering modifiable risk factors, such as smoking and obesity, leads to a lower risk of psoriasis. Research into triggers and causes of psoriatic disease is also likely to be useful in determining advancements for other auto-immune disorders. Finally, determining the relative importance of psoriasis, its treatments and its associated behaviors with the risk of developing co-morbidities—such as cardiovascular disease, cancer, and other diseases—will allow health professionals to better counsel patients and help them interpret long-term safety of novel therapies for psoriasis. The data collection and registry underway at the CDC will significantly advance our understanding of psoriatic disease and help answer some of the most pressing and perplexing questions facing researchers, clinicians, and patients.

PSORIASIS AND PSORIATIC ARTHRITIS RESEARCH AT NIH

It has taken nearly 30 years to understand that psoriasis is, in fact, not solely a disease of the skin but also of the immune system. In recent years, scientists have finally identified the immune cells involved in psoriasis. The last decade has seen a surge in our understanding of these diseases accompanied by new drug development. Scientists are poised as never before to make major breakthroughs.

Within the NIH, the National Institute of Arthritis and Musculoskeletal and Skin Diseases, the National Center for Research Resources, the National Human Genome Research Institute, and the National Institute of Allergy and Infectious Diseases are the principal Federal Government agencies that currently support—or have funded—psoriasis research. Additionally, research activities that relate to psoriasis or psoriatic arthritis also have been undertaken at the National Cancer Institute; however, the Foundation maintains that many more NIH Institutes and Centers have a role to play, especially with respect to the myriad co-morbidities of psoriasis, as noted earlier. Although overall NIH funding levels improved for psoriasis research in fiscal year 2010, and funding was boosted through stimulus funding awards of

$3 million in fiscal year 2009 and (an estimated) $2 million in fiscal year 2010, the Foundation remains concerned that, generally, total NIH funding is not keeping pace with psoriasis and psoriatic arthritis research needs. Further, the Federal Government's investment in psoriasis and psoriatic arthritis research is not commensurate with the impact of the disease. An analysis of longitudinal Federal funding data shows that, on average, NIH has spent approximately $1 per person with psoriasis—per year—over the past decade. We commend NIH for the increased fiscal year 2009 psoriasis research investment, which is currently estimated at approximately $1.70 per psoriasis patient. According to Psoriasis Foundation scientific advisors, approximately $37.5 million in NIH sponsored grants (about $5 per psoriasis patient per year) over 5 years is the Federal biomedical investment needed to achieve the next phase of progress toward improved psoriasis and psoriatic arthritis treatments and a cure.

Adequate investment in psoriasis and psoriatic arthritis research in fiscal year 2011 and beyond is imperative, because a rare convergence of findings reached through various research studies only recently has elucidated new ideas about the mechanisms involved in psoriasis. Greater funding of genetics, immunology, and clinical research focused on understanding the mechanisms of psoriasis and psoriatic arthritis is needed. Key areas for additional support and exploration include: studying the genetic susceptibility of psoriasis; developing animal models of psoriasis; identifying the environmental and lifestyle triggers for psoriasis; understanding the relationship of psoriasis to co-morbidities, such as heart attack, diabetes, increased mortality, and lymphoma; identifying and examining immune cells and inflammatory processes involved in psoriasis; examining the relationship between psoriasis and mental illnesses, such as depression and suicidal ideation; and elucidating psoriatic arthritis specific genes and other biomarkers.

FUNDING REQUEST SUMMARY

The Foundation recognizes that Congress and the Nation currently face unprecedented fiscal challenges. However, we also believe that greater fiscal year 2011 investment in biomedical and epidemiologic research at NIH and CDC will prove stimulative to the economy, by supporting researchers and academic institutions across the Nation. Further, researchers are poised, as never before, to bear fruit with regard to the development of new, safe, effective, and long-lasting treatments and—ultimately—a cure for psoriasis and psoriatic arthritis. We thank the Subcommittee in advance for providing the following fiscal year 2011 funding allocations:

—$2.5 million to the NCCDPHP within the CDC to continue to collect data on psoriasis and psoriatic arthritis and to implement a patient registry to improve the knowledge base of the longitudinal impact of these diseases on the individuals they affect, as well as increase understanding of disease triggers and comorbid conditions; and

—$32.2 billion to NIH and its Institutes and Centers with encouragement to expand their psoriasis and psoriatic arthritis research portfolios, with an emphasis on understanding more about common co-morbid conditions.

CONCLUSION

On behalf of the Foundation's Board of Trustees and the 7.5 million individuals who suffer from psoriasis and psoriatic arthritis, whom we represent, thank you for affording us the opportunity to submit written testimony regarding the fiscal year 2011 funding levels necessary to ensure that our Nation adequately addresses the needs of those who suffer with psoriasis and psoriatic arthritis, by improving therapies and eventually finding a cure. We believe that additional research undertaken at the NIH, coupled with epidemiologic efforts at the CDC, will help advance the Nation's efforts to improve treatments and identify a cure for psoriatic conditions. Please feel free to contact us at any time; we are happy to be a resource to subcommittee members and your staff. We very much appreciate the subcommittee's attention to, and consideration of, our fiscal year 2011 requests.

PREPARED STATEMENT OF NATIONAL PUBLIC RADIO

Thank you Chairman Harkin and Senator Cochran for the opportunity to support funding for public broadcasting. As NPR's president and CEO, I am testifying on behalf more than 850 public radio station partners, producers and distributors of public radio programming including American Public Media (APM), Public Radio International (PRI), the Public Radio Exchange (PRX), and many stations, both

large and small that create and distribute content through the Public Radio Satellite System (PRSS).

The public radio system and the tens of millions of Americans who listen to public radio programming every week are grateful, Chairman Harkin and Senator Cochran, for your decades of support for public broadcasting funding. We are also grateful for the additional $25 million in funding provided by Congress last year to help stations offset the devastating financial impact of the country's economic crisis.

Public radio's service to America is a story of continuing success, increasing dedication to news, journalism, public affairs and cultural programming, and expanding deployment of technology to improve our reach and impact. The nearly 34 million people tuning weekly into public radio programming is more than the total combined circulation of USA Today, the Wall Street Journal, The New York Times, Los Angeles Times, The Washington Post, and the next top 62 newspapers. Twenty-five NPR member stations in the top 30 markets rank in the top three most listened to stations for news. We are serving the American public through our broadcast stations, through our websites and Internet streaming and through applications for the iPhone, iPad, Droid, Blackberry, and other mobile devices.

Consider the contributions made by these public radio stations whose local public service illustrates a system-wide commitment to community service:

—*Iowa Public Radio*.—WOI AM and FM at Iowa State University, WSUI–AM and KSUI–FM at the University of Iowa, and KUNI–FM and KHKE–FM at the University of Northern Iowa are at the center of the newly consolidated State operation. With combined revenues of about $6 million annually and about 60 employees, roughly one-third of staff is devoted to news. Iowa Public Radio enhances civic and cultural connections across the State, strengthening communities and reflecting Iowa's sense of place. The weekend program Iowa Roots is aired statewide and features stories, music and talk with traditional artists from a variety of ethnic, geographic, occupational, and religious groups found in Iowa.

—*WXPR*.—A community-licensed public radio station with studios in Rhinelander, WXPR serves about a 70-mile diameter area of Wisconsin, plus some bits of Michigan's Upper Peninsula. On the air since 1983, WXPR would never have been built, nor continued to serve the local community today without the continuing effort and generosity of many people in the Northwoods, plus the support of the Corporation for Public Broadcasting. WXPR is proud to provide the only radio service to large, sparsely populated rural areas of the State and is planning to expand coverage with two small repeater stations in Ironwood and Iron Mountain, Michigan.

—*Mississippi Public Broadcasting*.—More than 127,000 Mississippians listen to MPB radio programming each week. More than 7,000 blind and print-impaired people in the State use the Radio Reading Service of Mississippi through MPB which provides on-the-air readings of newspapers, books and magazines for persons who are unable to read the printed word, either because of visual handicaps or because of other physical handicaps, such as the inability to turn pages. MPB also serves as primary source of emergency information and news during crisis situations and was nationally recognized for its coverage during Hurricanes Gustav, Rita, and Katrina.

—*Minnesota Public Radio (MPR)*.—MPR operates a regional network of 38 stations, covering Minnesota and parts of Wisconsin, the Dakotas, Michigan, Iowa, and Idaho. With 850,000 listeners each week, MPR has the largest audience of any regional public radio network and an expanding news department of 76 that is committed to improving local and regional coverage. MPR is a leader in classical and current music, and in a growing online news service, NewsQ.

Stations like these, operating in every State and congressional district in the country, have become living embodiments of journalistic excellence, providing news, information, and cultural programming as other sources of media are contracting or retreating from local coverage. Many are the only locally owned and operated news organization in their community.

Public Funds for Public Media

The Corporation for Public Broadcasting (CPB) is an indispensable public funding source for public radio, accounting for roughly 12 percent of an average public radio station's annual budget. The public broadcasting community is urging Congress to appropriate $604 million in 2-year advanced funding for fiscal year 2013.

Journalism, news, information, and cultural programming are the cornerstones of public radio. And we are expanding in these areas, as many commercial news organizations contract. For example, public broadcasting stations have launched Local Journalism Centers (LJCs), combining funds from CPB and resources of 27 station

entities to expand and improve journalism on the regional level. A primary goal of this initiative is to replace some of the traditional newsgathering capacity that has been lost amid the recent cutbacks, to take full advantage of developing technology in order to nourish and support the creation of new journalistic endeavors, and to ensure that there are no barriers to the distribution of public media content.

A second recent joint initiative—Project Argo—is aimed at bringing expanding information on topics critical to communities and the Nation. This project, supported by CPB and the John S. and James L. Knight Foundation, provides a pilot group of 12 NPR stations with the resources to expand original reporting, and to curate, distribute and share online content about high-interest, specialized subjects. The 2-year pilot will help a dozen stations establish themselves as definitive sources of news on a topic selected by each one as most relevant to its community, such as city politics, the changing economy, healthcare, immigration, and education. These online reports will help fill the growing gap in local news offerings.

Digital Funding

Broadcasting's Digital Transition

Broadcasting remains the principle distribution path for public radio programs. By the end of 2009, 463 stations were on the air with digital signals and more than 180 were multicasting (sending out two or more program streams) to their communities and listeners. Recent action by the Federal Communications Commission permitting public radio stations to boost HD signal power and provide expanded signal coverage creates another compelling reason to continue conversion funding. Many public radio stations will be seeking to boost power to better serve their communities in the coming year. Public broadcasting's funding request to continue our digital transformation in fiscal year 2011 is $59.5 million.

Public Radio is using digital broadcasting as a tool to improve and broaden the reach of our programming to poorly served and un-served audiences. Radio reading services for the blind and deaf are becoming more accessible. Stations' service to communities during times of local and regional emergencies will benefit from digital broadcasting's more flexible and adaptable features. Digital broadcasting technology has enabled public radio stations to:

—*Provide Increased Local Services to Communities*.—Stations are doubling and tripling programming offerings by multicasting through HD radio channels 2 and 3 options while super-serving existing and new groups of listeners.

—*Increase the Diversity of Programming by Providing Additional Content for Current Audience*.—Use of HD radio channels 2 and 3 means more news programming options, music and entertainment for listeners. The additional HD radio channels allow stations to add public affairs programming, educational instruction, international news, specialty music streams (jazz, classical, bluegrass, folk, rock, pop, international, etc.), and non-English language news.

—*Bring the Content Rich World of Public Radio to Blind and Deaf Audiences*.—Relying often on small armies of volunteers, more than 120 stations provide 24-hour life-line service consisting of news education and readings from daily newspapers and magazine articles. Text information services such as emergency warnings and public service alerts may also be incorporated into the signal to enable display of this data.

The New Network: Internet, Web and Mobile Platforms

The 1967 Public Broadcasting Act Gave Enduring Reality to two Important Concepts.—Public funds for public broadcasting and the creation of a national, independent, not-for-profit network of television and radio broadcasters to serve the American public. More than four decades later, as public broadcasting's embrace of new technologies to serve and engage a wider and more diverse audience quickens its transformation into Public Media, a New Network for the digital era must be fostered. This New Network, built upon a Public Media Platform and utilizing the success and assets of public broadcasting as its core, will enable the next generation of content creation and distribution so that the American public can benefit from a larger vision of service from Public Media.

Public radio is embracing the networked environment as a primary platform for audience and community service. To ensure that the American public continues to have free and universal access to public media content, high-speed and affordable broadband access is simply a necessity. Congressionally appropriated digital transition funds are essential to help ensure our success in providing a larger, more diverse and more inclusive service to the American public.

Among the many station and national network initiatives underway, these are worth highlighting:

—*NPR's API*.—In July 2008, NPR released an open Application Programming Interface, (API), a new pathway for content and functions to be widely shared on the web. NPR was one of the first major national media organizations to launch an API and it is an integral component of our mission to create a more informed public. It allows public radio stations and individual users to play a direct role in broadening web access to public radio content. The principle of openness encompassed in this web tool is a fundamental extension of the standards of free and universal access that are common to more traditional distribution of public radio content. Utilization of the API by stations enables the creation of content that more closely matches local community needs and interests, and facilitates diverse, more creative presentations of content, again to connect local information needs with content generated by other, collaborating communities.

—*The Public Media Platform*.—Realizing public media's full potential requires a strategic investment in an information architecture that brings together fragmented digital assets. The Public Media Platform, under development by NPR in partnership with CPB, APM, PRI, PBS and the Public Radio Exchange (PRX), will allow content from a wide variety of independent and institutional producers to be combined in a common back-end system; and then for that content to be extracted and displayed on a wide variety of digital platforms based on business rules set by the producers. It is in essence and in practice the digital equivalent of the satellite distribution network that serves public radio's broadcast audience with the powers of search, social media tools, analytics, and data.

Thank you again for continuing to support funding for public service media.

PREPARED STATEMENT OF THE NATIONAL PRIMATE RESEARCH CENTERS

The Directors of the eight National Primate Research Centers (NPRCs) respectfully submit this written testimony for the record to the Senate Appropriations Subcommittee on Labor, Health and Human Services, Education, and Related Agencies. The NPRCs appreciate the commitment that the members of this subcommittee have made to biomedical research through your strong support for the National Institutes of Health (NIH), and recommend that you maintain this support for NIH in fiscal year 2011 by providing an increase of 3.5 percent more than fiscal year 2010. Within this proposed increase the NPRCs also respectfully request that the subcommittee provide the National Center for Research Resources (NCRR) with the resources to continue a robust construction, renovation, and instrumentation grant program as begun through the American Recovery and Reinvestment Act, which as explained in this testimony, would help to ensure that the NPRCs and other animal research resource programs continue to serve effectively in their role as a vital national resource. Additionally, the NPRCs request that Congress provide NCRR no less than $86,412,000 for the NPRC P51 (base grant) program, the amount equal to the President's budget request. This program supports a portion of the operational costs of the eight NPRCs.

The NPRCs' Role as a National Resource and in the NIH Director's Five Themes

The NPRCs collaborate as a transformative and innovative network to support the best science and act as a resource to the biomedical research community as efficiently as possible. There is an exceptional return on investment in the NPRC program; $10 is leveraged for every $1 of research support for the NPRCs. It is important to sustain funding for the NPRC program and the NIH as a whole to continue to grow and develop the innovative plan for the future of NIH. The NPRCs have a commitment from NCRR to develop a 5-year strategic plan to further enhance the capabilities of the NPRCs by building on current progress.

NIH Director Dr. Francis Collins laid out his vision for the future of the agency in terms of five "themes." The NPRCs as a consortium and as a resource to the biomedical research community currently play an important role in each of the five themes.

High-throughput Technologies.—The NPRCs have been leading the development of a new Biomedical Informatics Research Network (BIRN) for linking brain imaging, behavior, and molecular informatics in nonhuman primate preclinical models of neurodegenerative disease. Using the cyberinfrastructure of the BIRN project for data-sharing, this project will link research and information to other primate centers, as well as other geographically distributed research groups.

Translational Research.—Nonhuman primate models bridge the divide between basic biomedical research and implementation in a clinical setting. Currently, 7 of

the 8 NPRCs are affiliated with and collaborate with the NCRR Clinical and Translational Science Awards (CTSA) Program through their host institution. Specifically, the nonhuman primate models at the NPRCs often provide the critical link between research with small laboratory animals and studies involving humans. As the closest genetic model to humans, nonhuman primates serve in the development process of new drugs, treatments, and vaccines, to ensure safe and effective use for the Nation's public.

Using Science To Enable Healthcare Reform.—Animal models are an essential tool for bridging basic biomedical research and patient healthcare, and the NPRCs are a national resource which supports the achievement of this goal. The network of the eight NPRCs is taking a leadership role to encourage collaboration among researchers and healthcare providers across disciplines and institutions, with the goal of advancing biomedical knowledge and improving human health.

Global Health.—Primate models are necessary for research on global infectious diseases. Primates have served as the best model for various types of HIV research, and their availability for use has resulted in at least 14 licensed anti-viral drugs for treatment of HIV infection. Primate models will continue to be necessary to defend the world against possible future epidemics such as SARS, West Nile Virus, and avian flu; and they are critical to current efforts to create vaccines for Ebola and Marburg viruses, and for infectious agents that could be used by terrorists. They also serve as the best model for development of vaccines for tuberculosis and malaria.

Although the number of chimpanzees essential to biomedical research is very few, chimpanzees remain the only valid research model for developing vaccines that prevent infection by the hepatitis C virus, from which millions of people worldwide suffer. Researchers do not embark upon the use of chimpanzees in research without due consideration, and are acutely aware of the ethical challenges and moral responsibilities of such research. But the fact remains that chimpanzee models have led to major medical advances; as a case in point, thanks to chimpanzee research, there are vaccines for hepatitis A and B.

Reinvigorating the Biomedical Research Community.—The success of the U.S. Government's efforts in enhancing public health is contingent upon the quality of research resources that enable scientific research ranging from the most basic and fundamental to the most highly applied. Biomedical researchers have relied on one such resource—the National Primate Research Centers—for nearly 50 years for research models and expertise with nonhuman primates. The NPRCs are highly specialized facilities that foster the development of nonhuman primate animal models and provide expertise in all aspects of nonhuman primate biology. NPRC facilities and resources are currently used by more than 2,000 NIH-funded investigators around the country.

The NPRCs are also supportive of getting students interested in the biomedical research workforce pipeline at an early age. For example, Yerkes NPRC supports a program that connects with local high schools and colleges in Atlanta, Georgia, and invites students to participate in research projects taking place at their field station location.

The Need for Facilities Support

As exemplified in the NPRCs' role in the future direction of NIH, the program is a vital resource for enhancing public health and spurring innovative discovery. In an effort to address many of the concerns within the scientific community regarding the need for funding for infrastructure improvements, the NPRCs support the continuation of a robust construction and instrumentation grant program at NCRR.

The NPRCs thank Congress for appropriating $1.3 billion of NIH Recovery Act funds for construction (C06), renovation (G20), and instrumentation (S10) grants. The number of applications received by NCRR illustrated the pent up need for facilities funding in the biomedical research community. Some of our centers received awards but a number of primate centers (and many other animal facilities) did not.

Animal facilities, especially primate facilities, are expensive to maintain and are subject to abundant "wear and tear." In prior years, funding was set aside that fulfilled the infrastructure needs of the NPRCs and other animal research facilities. The NPRCs ask the subcommittee to provide an appropriation of no less than $125 million to NCRR for construction and renovation of animal facilities through C06 and G20 programs. Without proper infrastructure, the ability for animal facilities, including the NPRCs, to continue to meet the high demand of the biomedical research community will be unattainable.

Thank you for the opportunity to submit this written testimony and for your attention to the critical need for primate research and the continuation of infrastruc-

ture support, as well as our recommendations concerning funding for NIH in the fiscal year 2011 appropriations bill.

PREPARED STATEMENT OF THE NATIONAL RESPITE COALITION

Mr. Chairman, I am Jill Kagan, Chair of the ARCH National Respite Coalition, a network of respite providers, family caregivers, State and local agencies and organizations across the United States who support respite. Twenty-five State respite coalitions are also affiliated with the NRC. This statement is presented on behalf of the these organizations, as well as the Lifespan Respite Task Force, a coalition of more than 80 national and 100 State and local groups who supported the passage of the Lifespan Respite Care Act (Public Law 109–442). Together, we are requesting that the subcommittee include funding for the Lifespan Respite Care Program administered by the U.S. Administration on Aging in the fiscal year 2011 Labor, Health and human Service, and Education, and Related Agencies appropriations bill at its modest authorized level of $94.8 million. This will enable:

—State replication of best practices in Lifespan Respite systems to allow all family caregivers, regardless of the care recipient's age or disability, to have access to affordable respite, and to be able to continue to play the significant role in long-term care that they are fulfilling today;
—Improvement in the quality of respite services currently available;
—Expansion of respite capacity to serve more families by building new and enhancing current respite options, including recruitment and training of respite workers and volunteers; and
—Greater consumer direction by providing family caregivers with training and information on how to find, use and pay for respite services.

WHO NEEDS RESPITE?

In 2009, a national survey found that more than 65 million family caregivers are providing care to individuals of any age with disabilities or chronic conditions (Caregiving in the U.S. 2009. Bethesda, MD: National Alliance for Caregiving and Washington, DC: AARP, 2009). It has been estimated that these family caregivers provide $375 billion in uncompensated care, an amount almost as high as Medicare spending ($432 billion in 2007) and more than total spending for Medicaid, including both Federal and State contributions and both medical and long-term care ($311 billion in 2005) (Gibson and Hauser, 2008).

While the aging population is growing rapidly, increasing the need for family caregiver support for this age group, the majority of family caregivers are caring for someone under age 75 (56 percent); 28 percent of family caregivers care for someone between the ages of 50–75, and 28 percent are caring for someone under age 50, including children (NAC and AARP, 2009). Family caregiving is not just an aging issue, but also a lifespan issue for the majority of the Nation's families.

Compound this picture with the growing number of caregivers known as the "sandwich generation" caring for young children as well as an aging family member. It is estimated that between 20 and 40 percent of caregivers have children under the age of 18 to care for in addition to a parent or other relative with a disability. And in the United States, 6.7 million children, with and without disabilities, are in the primary custody of an aging grandparent or other relative.

Families of the wounded warriors—those military personnel returning from Iraq and Afghanistan with traumatic brain injuries and other serious chronic and debilitating conditions—are at risk for limited access to respite. Together, these family caregivers are providing an estimated 80 percent of all long-term care in the United States. This percentage will only rise in the coming decades with an expected increase in the number of chronically ill veterans returning from war, greater life expectancies of individuals with Down's Syndrome and other disabling and chronic conditions, the aging of the baby boom generation, and the decline in the percentage of the frail elderly who are entering nursing homes.

WHAT IS RESPITE NEED?

State and local surveys have shown respite to be the most frequently requested service of the Nation's family caregivers (Evercare and NAC, 2006). Yet respite is unused, in short supply, inaccessible, or unaffordable to a majority of the Nation's family caregivers. The 2009 NAC/AARP survey of caregivers found that a majority (51 percent) have medium or high levels of burden of care, measured by the number of activities of daily living with which they provide assistance, and 31 percent of all family caregivers were identified as "highly stressed". Half of all family care-

givers (53 percent) say that their caregiving takes time away from family and friends. Of those who sacrificed this time, 47 percent feel high emotional stress. Moreover, the 2009 survey found that despite the fact that among caregivers' most frequently reported unmet needs were "finding time for myself" (32 percent), "managing emotional and physical stress" (34 percent), and "balancing work and family responsibilities" (27 percent), only 11 percent of caregivers of adults 18+ make use of respite. This represents an increase from 5 percent in 2004, but still far less than the percentage who could benefit from respite. Of six proposed national policies or programs presented to help caregivers, 3 in 10 selected respite as the preferred service (NAC and AARP, 2009). According to another survey in 2006, the percentage of family caregivers able to make use of respite in rural areas was only 4 percent (Easter Seals and NAC, 2006). In a study of a nationally representative profile of noninstitutionalized children ages 0–17 who were receiving support from the Supplemental Security Income (SSI) program because of a disability, only 8 percent reported using respite, but three-quarters of families had unmet respite needs (Rupp, K, et al, 2005–2006).

Barriers to accessing respite include reluctance to ask for help, fragmented and narrowly targeted services, cost, and the lack of information about how to find or choose a provider. Even when respite is an allowable funded service, a critically short supply of well-trained respite providers may prohibit a family from making use of a service they so desperately need.

Twenty of 35 State-sponsored respite programs surveyed in 1991 reported that they were unable to meet the demand for respite services. The 25 State coalitions and other National Respite Network members confirm that long waiting lists or turning away of clients because of lack of resources is still the norm. A study conducted by the Family Caregiver Alliance identified 150 family caregiver support programs in all 50 States and Washington, DC, funded with State-only or State/Federal dollars. Most of the funding comes from the Federal National Family Caregiver Support Program. As a result, programs are administered by local area agencies on aging, primarily serve the aging, and provide only limited respite, if at all. Only about one-third of the 150 identified programs serve caregivers who provide care to adults age 18–60 who must meet stringent eligibility criteria. As the report concluded, "State program administrators see the lack of resources to meet caregiver needs in general and limited respite care options as the top unmet needs of family caregivers in the States."

While most families take great joy in helping their family members to live at home, it has been well documented that family caregivers experience physical and emotional problems directly related to caregiving responsibilities. Three-fifths of family caregivers age 19–64 surveyed recently by the Commonwealth Fund reported fair or poor health, one or more chronic conditions, or a disability, compared with only one-third of noncaregivers (Ho, Collins, Davis and Doty, 2005). A study of elderly spousal caregivers (aged 66–96) found that caregivers who experience caregiving-related stress have a 63 percent higher mortality rate than noncaregivers of the same age (Schulz and Beach, December 1999).

For the millions of families of children with disabilities, respite has been an actual lifesaver. However, for many of these families, their children will age out of the system when they turn 21 and they will lose many of the services, such as respite, that they currently receive. In fact, 46 percent of U.S. State units on aging identified respite as the greatest unmet need of older families caring for adults with lifelong disabilities.

Disparate and inadequate funding streams exist for respite in many States. But even under the Medicaid program, respite is allowable only through State waivers for home and community-based care. Under these waivers, respite services are capped and limited to narrow eligibility categories. Long waiting lists are the norm.

Respite may not exist at all in some States for adult children with disabilities still living at home, or individuals under age 60 with conditions such as ALS, MS, spinal cord or traumatic brain injuries, or children with serious emotional conditions. In Tennessee, a young woman in her twenties gave up school, career and a relationship to move in and take care of her 53 year-old mom with MS when her dad left because of the strain of caregiving without any support.

RESPITE BENEFITS FAMILIES AND IS COST SAVING

Respite has been shown to be a most effective way to improve the health and well-being of family caregivers that in turn helps avoid or delay out-of-home placements, such as nursing homes or foster care, minimizes the precursors that can lead to abuse and neglect, and strengthens marriages and family stability. A recent report from the U.S. Department of Health and Human Services prepared by the Urban

Institute found that higher caregiver stress among those caring for the aging increases the likelihood of nursing home entry. Reducing key stresses on caregivers, such as physical strain and financial hardship, through services such as respite would reduce nursing home entry. (Spillman and Long, USDHHS, 2007)

Budgetary benefits that accrue from respite are just as compelling. Delaying a nursing home placement for just one individual with Alzheimer's or other chronic condition for several months can save thousands of dollars. In an Iowa survey of parents of children with disabilities, a significant relationship was demonstrated between the severity of a child's disability and their parents missing more work hours than other employees. It was also found that the lack of available respite interfered with parents accepting job opportunities. (Abelson, A.G., 1999)

Moreover, data from ongoing research at Oklahoma State University found that the number of hospitalizations, as well as the number of medical care claims decreased as the number of respite days increased (Fiscal Year 1998 Oklahoma Maternal and Child Health Block Grant Annual Report, July 1999). A Massachusetts social services program designed to provide cost-effective, family-centered respite care for children with complex medical needs found that for families participating for more than 1 year, the number of hospitalizations decreased by 75 percent, physician visits decreased by 64 percent, and antibiotics use decreased by 71 percent (Mausner, S., 1995).

In the private sector, the most recent study by Metropolitan Life Insurance Company and the National Alliance for Caregivers found that U.S. businesses lose from $17.1 billion to $33.6 billion per year in lost productivity of family caregivers (MetLife and National Alliance for Caregiving, 2006). Offering respite to working family caregivers could help improve job performance and employers could potentially save billions

LIFESPAN RESPITE CARE PROGRAM WILL HELP

The Lifespan Respite Care Act is based on the success of statewide Lifespan Respite programs in Oregon, Nebraska, Wisconsin, and Oklahoma. Arizona and Texas both recently passed State legislation to establish Lifespan Respite Programs, but Arizona's program was cut due to State budget shortfalls. Twelve States, including Arizona, began implementation in 2009 with the first wave of Federal Lifespan Respite funding.

Lifespan Respite, which is a coordinated system of community-based respite services, helps States use limited resources across age and disability groups more effectively. Pools of providers can be recruited, trained and shared, administrative burdens can be reduced by coordinating resources, and savings used to fund new respite services for families who may not qualify for any existing Federal or State program.

The first State Lifespan Respite programs in Oregon, Nebraska, Wisconsin, and Oklahoma provide best practices on which to build a national respite policy. The programs have been recognized by the National Conference of State Legislatures, which recommended the Nebraska program as a model for State solutions to community-based long-term care, the National Governors Association, and the President's Committee for People with Intellectual Disabilities. The White House Conference on Aging recommended Congressional support for the Lifespan Respite Care Act.

The purpose of the law is to expand and enhance respite services, improve coordination, and improve respite access and quality. Under a competitive grant program, States are required to establish State and local coordinated Lifespan Respite care systems to serve families regardless of age or special need, provide new planned and emergency respite services, train and recruit respite workers and volunteers and assist caregivers in gaining access to services. Those eligible would include family members, foster parents or other adults providing unpaid care to adults who require care to meet basic needs or prevent injury and to children who require care beyond that required by children generally to meet basic needs.

The Federal Lifespan Respite program is administered by the U.S. Administration on Aging, Department of Health and Human Services (HHS). AoA provides competitive grants to State agencies in concert with Aging and Disability Resource Centers working in collaboration with State respite coalitions or other State respite organizations. The program was authorized at $53.3 million in fiscal year 2009 rising to $95 million in fiscal year 2011. Congress appropriated $2.5 million in fiscal year 2009 and again in fiscal year 2010. In fiscal year 2009, 12 States received 36-month $200,000 grants to implement Lifespan Respite. In these States, that represents less than $.18 per caregiver.

The administration recommended $5 million for Lifespan Respite as part of its Middle Class Initiative. We are heartened to see that support for family caregiving

is recognized as a critical component of a typical family's economic and social well-being. However, the focus of the administration's request was on support for family caregivers of the aging population. While this is an issue of growing concern, we must not neglect that fact that at least half of the Nation's family caregivers are caring for someone with MS, ALS, traumatic brain or spinal cord injury, mental health conditions, developmental disabilities or cancer who are under the age of 60 and $5 million will not address their need for respite. This is also the population most likely to be ineligible for any existing State or Federal respite resources.

No other Federal program mandates respite as its sole focus. No other Federal program would help ensure respite quality or choice, and no current Federal program allows funds for respite start-up, training, or coordination or to address basic accessibility and affordability issues for families. We urge you to include $94.8 million in the fiscal year 2011 Labor, Health and Human Services, and, Education, and Related Agencies appropriations bill so that Lifespan Respite Programs can be replicated in the States and more families, with access to respite, will be able to continue to play the significant role in long-term care that they are fulfilling today.

PREPARED STATEMENT OF THE NATIONAL REACH COALITION FOR THE ELIMINATION OF HEALTH DISPARITIES

The National REACH Coalition represents more than 40 communities and coalitions in 22 States working to eliminate racial and ethnic health disparities and improve the health of African American, Asian Pacific Islander, Native American, and Latino populations and communities. The coalition is an outgrowth of the Racial and Ethnic Approaches to Community Health (REACH U.S.) 2010 initiative, started a decade ago by the Centers for Disease Control and Prevention (CDC). REACH programs are on the front lines, providing coordination and leadership for the advancement and translation of community-based participatory research into evidence-based practices, policies, and community empowerment.

For the fiscal year 2011 funding cycle the National REACH Coalition encourages the Labor, Health and Human Services, and Education, and Related Agencies (Labor-HHS) Subcommittee to increase funding for the Racial and Ethnic Approaches to Community Health program to $60 million, an increase of $20.356 million more than fiscal year 2010.

The NRC gratefully acknowledges the strong bipartisan support that the Senate Subcommittee on Labor-HHS has provided to the REACH U.S. program in recent years, most REACH programs were not eligible for additional funding provided by the American Recovery and Reinvestment Act and yet are working in communities that are among the hardest hit by the recession. With significant budget challenges at the State/local levels, REACH programs provide an important safety net to help eliminate racial and ethnic health disparities and close the health equity gap.

Chronic diseases are the Nation's leading causes of morbidity and mortality and account for 75 percent of every $1 spent on healthcare in the United States. Collectively, they account for 70 percent of all deaths nationwide. Thus, it is highly likely that nearly 3 of 4 persons living in your district will be likely to develop a chronic condition requiring long-term and costly medical intervention. Moreover, chronic diseases account for the largest health gap among racial and ethnic minority populations. African Americans have higher mortality rates for cardiovascular disease and stroke, and cancer of the lung, colon/rectum, breast, cervix, and prostate than Whites, American Indians/Alaska Natives, Asian/Pacific Islanders, and Hispanic Americans.

REACH U.S. programs are working hard to eliminate these health disparities and many have proven success in their communities. Collectively as the National REACH Coalition, our programs have engaged hundreds of local coalition members and touched the lives of thousands of program participants in this nationwide campaign against health disparities. As a result, the REACH communities are testing, evaluating and implementing practice and evidence-based interventions that reduce the human and financial cost of these preventable diseases and associated risk factors by:

—In South Carolina, the REACH Charleston and Georgetown Diabetes Coalition reports that a 21 percent gap in blood sugar testing between African Americans and whites has been virtually eliminated. Amputations among African-American males with diabetes have been reduced by more than 33 percent. Each avoided amputation avoids at least $40,000 in expenditures; expanding this program could substantially reduce South Carolina's annual diabetes-related financial burden of more than $900 million.

—The REACH for Wellness program in Georgia's Atlanta Empowerment Zone reports that from 2002 to 2004 the percentage of adults who regularly participated in moderate to vigorous physical activity increased from 25.4 percent to 28.7 percent; the percentage who reported checking their total blood cholesterol increased from 69.1 percent to 79.7 percent, and the percentage of adults who smoked decreased from 25.8 percent to 20.8 percent.
—The REACH Alabama Breast and Cervical Cancer Coalition in Macon County reports that disparities in mammography screening between white and African American women decreased from 15 percent to 2 percent from 1998 to 2003.
—In Massachusetts, the Greater Lawrence Family Health Center, a REACH Center of Excellence in Eliminating Health Disparities, has been able to demonstrate long-term disparity reductions among Latinos on five measures of diabetic care and outcomes.
—Data from the REACH Risk Factor Survey show that the REACH program is having a significant impact in key areas of risk reduction and disease management:
  —From 2001 to 2004, African Americans transitioned from being less likely to more likely than whites to have their cholesterol checked.
  —In REACH communities, the sizable gap in cholesterol screening between Hispanics and the national average is closing.
  —In REACH communities, the proportion of American Indians with high blood pressure who take medication increased from 67 percent in 2001 to 74 percent in 2004.
  —Cigarette smoking among Asian men in REACH communities decreased from 35 percent in 2001 to 24 percent in 2004.

REACH U.S. communities have spent the last decade leveraging CDC funding with public private partnerships in order to effectively address health disparities. Using innovative science-based approaches we have demonstrated that health disparities once considered expected are not intractable. REACH U.S. has provided a sound return on investment, but we could do a lot more. In 2007, more than 200 communities applied for funding in the last CDC REACH U.S. program application cycle, but only 40 were funded. While we are extremely grateful for the $4 million increase REACH U.S. received in fiscal year 2010, without additional support REACH U.S. will not be able to extend its successful, cost-effective evidence- and practice-based programs to communities bearing a disproportionate share of the national chronic disease burden.

Providing a $20.356 million increase, for a total of $60 million in fiscal year 2011 for REACH U.S. programs will ensure investment and sustainability in the bread and butter of prevention and wellness programs—community-led and community-driven interventions. Furthermore, health disparities and health equity will continue to be addressed and REACH U.S. programs will have the ability to be expanded in our Nation's most underserved communities. We strongly urge the subcommittee to consider this request to strengthen the capacity of the REACH U.S. program.

We thank you for this opportunity to present our views to this subcommittee. We look forward to working with you to improve the health and safety of all Americans.

PREPARED STATEMENT OF THE NATIONAL RECREATION AND PARK ASSOCIATION

Thank you Chairman Harkin, Ranking Member Cochran, and other honorable members of the subcommittee for the opportunity to submit written testimony on the importance of funding the Centers for Disease Control and Prevention's (CDC) Healthy Communities Program. We respectfully request funding of $30 million in the fiscal year 2011 Labor, health and Human Services, and Education, and Related agencies appropriations bill.

NRPA is a 501(c)3 national nonprofit organization with more than 21,000 members. We represent both citizens and park and recreation professionals. Our mission is to advance parks, recreation and environmental conservation for the benefit of all people. Because we represent the public park and recreation agencies in the United States, we touch the lives of more than 300 million people in virtually every community. Park and recreation agencies play a major role in the fight against obesity and are poised and capable of doing even more through the creation of new cross-cutting partnerships that promote health lifestyle choices for children and adults.

Our Nation currently faces an obesity epidemic that is claiming the lives of adults and children. According to the CDC, the obesity rate in children ages 6 to 11 doubled from 6.5 percent in 1980 to 17 percent in 2006; and tripled among those ages

12 to 19 to 17.6 percent during the same time period. More than one-third of U.S. adults—more than 72 million people—were obese in 2005–2006.

Obesity also has a crippling effect on our Nation's economy and is largely responsible for the exuberant rise in healthcare costs. CDC reports that data from the 1998 and 2006 Medical Expenditure Panel Surveys (MEPS) revealed that obesity increased medical costs by 37 percent from 1998 to 2006. A 2009 study released by RTI, a nonprofit research firm, showed that obese Americans cost the country about $147 billion in weight-related medical bills in 2008, double what it was a decade ago. Obesity now accounts for about 9.1 percent of medical spending in our country.

The obesity and chronic disease epidemics plaguing our Nation did not manifest themselves overnight. These epidemics grew to be national issues of concern by impacting one individual, one family, and one community at a time. A multitude of factors such as lack of physical activity, poor diet, and excessive tobacco and alcohol use have led to this national epidemic. The good news is that many of the health risk factors that contribute to the development of chronic disease and obesity are preventable. However, the only way we will truly reduce obesity is to employ a comprehensive strategy that addresses these factors where people live, work, learn and recreate. In order for us to effectively combat these epidemics, local communities must be armed with the necessary tools and resources to implement policy, environmental and systematic changes geared towards promoting increased physical activity, nutritious foods, and the prevention of chronic disease in children, youth, and adults.

Investment in prevention and wellness was one of President Obama's eight core principles guiding healthcare reform. Congress also stressed the importance of prevention at the community level throughout the health reform debate and through inclusion of various prevention measures in the Patient Protection and Affordable Care Act and Education Affordability Reconciliation Act. The economics of community level prevention are clear. As noted by the Trust For America's Health, for an investment of $10 per person per year in proven community-based programs to increase physical activity, improve nutrition, and prevent smoking and other tobacco use, the country could save more than $16 billion annually within 5 years. This is a return of $5.60 for every $1 spent. Prevention programs provide proven returns on investment. We are asking this subcommittee to further invest in prevention through increased fiscal year 2011 appropriations for CDC's Healthy Communities Program.

Through its Healthy Communities program, CDC facilitates the collaboration of local and State health departments, national organizations with extensive reach into communities and a wide range of community leaders and stakeholders to develop, activate and spread policy, systems and environmental changes that prevent chronic disease by changing behavior and increasing the opportunities for healthier lifestyles. These community leaders and stakeholders represent local elected officials, city and county health officials, tribal programs, parks and recreation departments, local YMCAs, health-related coalitions, and education, business, health, planning, and transportation sectors. This collaboration results in proven community-based programs and environmental changes that encourage people to be more physically active, improve nutrition, and abstain from tobacco use.

To date, more than 240 communities have received funding and technical support through CDC's Healthy Communities Program which has resulted in measurable changes at the local level. An additional 170 communities will receive funding to improve the health of their communities during the next 3 years.

Davenport, Iowa has recently received Healthy Communities funding, and has allowed the formation of a broad coalition of stakeholders that has begun work to prevent chronic disease. In Davenport, Iowa the top five leading causes of death are heart disease (26.6 percent), cancer (23 percent), other conditions (19.7 percent), stroke (7.8 percent), and chronic lung/respiratory disease (6.3 percent). Efforts to reverse these trends include identifying means of increasing the usage of Davenport parks and trails; promoting healthier lifestyles in workplaces by engaging employers in encouraging employees to use stairs instead of elevators; making all Davenport parks tobacco-free; and increasing student wellness in Davenport schools by revising school wellness policies.

Chicago, Illinois is a great example of the impact and success of the Healthy Communities program. The city has noted that 26 percent of their children and 25 percent of their adult populations are obese by national standards. Contributing to the poor health of this community is the lack of opportunities for physical activity and the fact that the west side of Chicago lacks grocery stores which has caused it to become a "food desert". This, in turn causes residents to utilize fast food chains and convenience stores as a main source of nourishment. Recognizing the health and financial implications of an obese population, Chicago is taking proactive steps to en-

sure a healthier a community. The park district has introduced new fitness classes in parks throughout the city and is now offering a minimum of 60 minutes of moderate to vigorous activity for all children's programs offered through parks. Through the leadership of the Mayor's office, a healthy vending policy has been initiated at all park facilities and the park district is implementing community produce gardens which will be maintained by local youth. Additionally, smoking has been banned on all Chicago Park District Property, indoors and out including beaches. Thanks to funding provided through CDC's Healthy Communities program, the city of Chicago will be able to implement more policy, systems and environmental changes, such as these, to combat chronic disease and obesity throughout the city.

Funding for the CDC's Healthy Communities program is vital to successfully combating chronic disease and obesity at the local level in communities across the country. Previous funding levels have been inadequate. The Healthy Communities program has gone from $46.6 million in fiscal year 2005 to only $22.7 million in fiscal year 2010. As a result, hundreds of eligible communities have applied for highly competitive projects but remain unfunded due to limited Federal resources.

Given the health implications and the fiscal hardship associated with chronic disease and obesity, we can no longer afford to be a nation that simply treats the problem. Now, more than ever Congress must increase its investment in community prevention programs such as this. NRPA respectfully requests that this committee provide increased funding for CDC's Healthy Communities program to $30 million in the fiscal year 2011 appropriations bill.

Thank you for this opportunity to submit testimony.

PREPARED STATEMENT OF THE NATIONAL SLEEP FOUNDATION

Summary of Fiscal Year 2011 Recommendations

Provide $2 million in funding for sleep activities within the Community Health Promotion account within the Chronic Disease Program at the Centers for Disease Control and Prevention (CDC). Expanded funding for sleep and sleep disorder-related activities would allow the CDC fund additional States to collect essential national and State-specific surveillance data; to support targeted public awareness initiatives; to create training materials for healthcare professionals; and build and test public health interventions.

Mr. Chairman and members of the subcommittee, thank you for allowing me to submit testimony on behalf of the National Sleep Foundation (NSF). I am Dr. Frankie Roman, Chair of the NSF's Government Affairs Committee and a sleep specialist at Ohio Sleep Disorder Centers, in Akron, Ohio. NSF is an independent, nonprofit organization that is dedicated to improving public health and safety by achieving understanding of sleep and sleep disorders, and by supporting sleep-related education, research, and advocacy. We work with sleep medicine and other healthcare professionals, researchers, patients and drowsy driving advocates throughout the country as well as collaborate with many Government, public, and professional organizations with the goal of preventing health and safety problems related to sleep deprivation and untreated sleep disorders.

Sleep problems, whether in the form of medical disorders or related to work schedules and a 24/7 lifestyle, are ubiquitous in our society. It is estimated that sleep-related problems affect 50 to 70 million Americans of all ages and socioeconomic classes. Sleep disorders are common in both men and women; however, important disparities in prevalence and severity of certain sleep disorders have been identified in minorities and underserved populations. Despite the high prevalence of sleep disorders, the overwhelming majority of sufferers remain undiagnosed and untreated, creating unnecessary public health and safety problems, as well as increased healthcare expenses. Annual surveys conducted by NSF show that more than 60 percent of adults have never been asked about the quality of their sleep by a physician, and fewer than 20 percent—have ever initiated such a discussion.

Additionally, Americans are chronically sleep deprived as a result of demanding lifestyles and a lack of education about the impact of sleep loss. Sleepiness affects vigilance, reaction times, learning abilities, alertness, mood, hand-eye coordination, and the accuracy of short-term memory. Sleepiness has been identified as the cause of a growing number of on-the-job accidents, automobile crashes and multi-model transportation tragedies.

According to the National Highway Traffic Safety Administration's 2002 National Survey of Distracted and Drowsy Driving Attitudes and Behaviors, an estimated 1.35 million drivers have been involved in a drowsy driving crash in the previous 5 years. According to NSF's 2009 Sleep in America poll, 54 percent of people admit that they have driven drowsy at least once in the past year, with 28 percent report-

ing that they do so at least once a month or more. A large number of academic studies and Government reports have linked lost productivity, poor school performance, and major public health problems to chronic sleep loss and sleep disorders.

The 2006 Institute of Medicine (IOM) report, Sleep Disorders and Sleep Deprivation: An Unmet Public Health Problem, found the cumulative effects of sleep loss and sleep disorders represent an under-recognized public health problem and have been associated with a wide range of negative health consequences, including hypertension, diabetes, depression, heart attack, stroke, and at-risk behaviors such as alcohol and drug abuse—all of which represent long-term targets of the Department of Health and Human Services (HHS) and other public health agencies. Moreover, the personal and national economic impact is staggering. The IOM estimates that the direct and indirect costs associated with sleep disorders and sleep deprivation total hundreds of billions of dollars annually.

Sleep science and Federal reports have clearly detailed the importance of sleep to health, safety, productivity and well-being, yet studies continue to show that millions of Americans remain at risk for serious health and safety consequences of untreated sleep disorders and inadequate sleep, due to a lack of awareness, community interventions, and inadequate screening. Unfortunately, despite recommendations in numerous Federal reports, there is a lack of epidemiological data, large clinical trials and no on-going national educational programs regarding sleep issues aimed at the general public, healthcare professionals, underserved communities or major at-risk groups.

NSF believes that every American needs to understand that good health includes healthy sleep, just as it includes regular exercise and balanced nutrition. Sleep must be elevated to the top of the national health agenda in order to adequately address other national public health problems mentioned above. We need your help to make this happen.

Our biggest challenge is bridging the gap between the established sleep science best practices and the level of knowledge about sleep held by healthcare practitioners, educators, employers, and the general public. Because resources are limited and the challenges great, we think creative and new partnerships are needed to fully develop sleep awareness, education and clinical training initiatives. Consequently, the NSF has spearheaded important initiatives to raise awareness of the importance of sleep to the health, safety, and well-being of the Nation. One of our most important partnerships in these efforts is with the Centers for Disease Control and Prevention (CDC).

For the last 7 years, Congress has recommended that the CDC support activities related to sleep and sleep disorders. As a result, CDC's National Center for Chronic Disease Prevention and Health Promotion has been collaborating with NSF and more than twenty voluntary organizations and Federal agencies to form the National Sleep Awareness Roundtable (NSART), which was officially launched in March of 2007. Congress also provided specific funding for these efforts for the past 3 years.

In fiscal year 2008, Congress provided $818,000 for activities related to sleep and sleep disorders, including CDC's participation in NSART and incorporating sleep-related questions into established CDC surveillance systems. With this funding, CDC included one core sleep question in its national data collection efforts in 2008 and has provided grants to 8 States to include an optional sleep module in their data collection efforts through the Behavioral Risk Factor Surveillance System (BRFSS). Recent analysis of the core data found that more than 1 in 10 Americans report having insufficient sleep or rest every day for the past 30 days. Significantly, sleep problems were found to be more prevalent in southeastern States in what is commonly referred to as the "stroke belt." This region has an unusually high incidence of stroke, cardiovascular disease, diabetes, obesity, depression, and quality of life, which are associated with inadequate sleep quality and quantity. The CDC is currently recruiting up to 14 States and hopes to expand the data collection to all 50 States if appropriate funding is obtained.

CDC also included one question in the Youth Risk Behavior Surveillance System (YRBSS). Of note, the YRBSS has already revealed that only one-third of high-school students get 8 or more hours of sleep on an average school night, far below the recommended 9.25 hours. This new data will provide important information on the prevalence of sleep disorders and enable researchers to better address the complex interrelationship between sleep loss and comorbid conditions such as obesity, diabetes, depression, hypertension, and drug and alcohol abuse.

Additionally, CDC and NSART supported and actively participated in NSF's ongoing national public awareness initiatives including National Sleep Awareness Week and Drowsy Driving Prevention Week. The year, with CDC's support and guidance, NSF launched a new initiative called Sleep Health and Safety Conference 2010 de-

signed to educate clinicians and other healthcare professionals about sleep disorders in order to increase better diagnosis and treatment.

In fiscal year 2009, Congress provided $900,000 to the CDC for sleep activities. CDC plans to expand the number of States it is able to fund for BRFSS data collection and provide support for national public and professional awareness initiatives as well as activities of the National Sleep Awareness Roundtable.

Although the CDC has taken initial steps to begin to consider how sleep affects public health issues, the agency needs additional resources to take appropriate actions, as recommended by the IOM and other governmental reports. Expanded funding for sleep and sleep disorder-related activities would allow the CDC to create much needed educational programs for schools and occupational settings and training materials for current and future health professionals; build and test public health interventions; expand surveillance and epidemiological activities; and create further fellowships and research opportunities. The following are detailed scenarios for various funding levels.

—$2 million:

—*Expand Surveillance on BRFSS*.—CDC could double the number of grants it provides to States to use the optional sleep module and include more core questions in the nationwide data collection through the Behavioral Risk Factor Surveillance System. CDC would also expand its participation in and funding of national public and professional initiatives aimed at promoting sleep as a health behavior, treatment of obstructive sleep apnea, and drowsy driving as well as the goals and activities of the National Sleep Awareness Roundtable.

—*Public Education*.—CDC could support the development of a national sleep health communications campaign that use targeted approaches for delivering sleep-related messages, especially in public schools and workplaces. Currently, no such programs exist.

NSF and members of the National Sleep Awareness Roundtable believe that an ongoing partnership with CDC is critical to address the enormous public health impact of sleep and sleep disorders. We hope that the subcommittee will provide funding of $2,000,000 to the CDC to execute programs as outlined here.

Thank you again for the opportunity to present you with this testimony.

PREPARED STATEMENT OF THE NATIONAL TECHNICAL INSTITUTE FOR THE DEAF

I am pleased to present the fiscal year 2011 budget request for NTID, one of eight colleges of RIT, in Rochester, New York. Created by Congress by Public Law 89–36 in 1965, we provide university technical and professional education for students who are deaf and hard-of-hearing, leading to successful careers in high-demand fields for a sub-population of individuals historically facing high rates of unemployment and under-employment. We also provide baccalaureate and graduate level education for hearing students in professions serving deaf and hard-of-hearing individuals. As of fall 2009, NTID served a total 1,474 students from across the nation, including 1,307 deaf and hard-of-hearing students and 167 hearing students. NTID students live, study and socialize with more than 15,000 hearing students on the RIT campus.

NTID has fulfilled our mission with distinction for 42 years.

BUDGET REQUEST

As shown below, NTID's fiscal year 2011 budget request was $66,252,000 in operations and $3,640,000 in construction, for a total of $69,892,000; the President's request is $63,037,000 in operations and $1,640,000 in construction, for a total of $64,677,000.

FISCAL YEAR 2011 BUDGET REQUEST STATUS

[In thousands of dollars]

	Operations	Construction	Total
NTID request	66,252	3,640	69,892
President's request	63,037	1,640	64,677
Difference	3,215	2,000	5,215

For the last 2 fiscal years (2009 and 2010), NTID's operations budget has been level-funded at $63,037,000; the President's recommended budget for fiscal year 2011 would mark a third consecutive year of level funding.

For these past 2 years, NTID has been able to absorb level-funding in operations primarily due to two factors: (1) a self-initiated budget-reduction/revenue enhancement campaign from fiscal year 2003 through fiscal year 2007; and (2) a withholding of salary increased by RIT for fiscal year 2010. However, realized savings from the campaign now have been re-allocated and are no longer available, and RIT recently has announced a 2 percent salary increase for fiscal year 2011.

While NTID certainly would benefit from a budget increase to support upcoming strategic initiatives (see below), we understand the resource challenges facing the subcommittee this year. While an additional $1,640,000 beyond the President's recommended operations funding for fiscal year 2011 is needed, we are amenable to meeting this need by shifting funds designated in the President's 2011 budget from construction to operations. This would ensure NTID stays within the total allocation proposed in the President's 2011 budget of $64,677,000, and still fully meet our Operations needs. We will seek alternative funding for needed construction items.

ENROLLMENT

In fiscal year 2010 (fall 2009), we attracted the largest enrollment in our 42-year history. Truly a national program, NTID enrolls students from all 50 States. Our current enrollment is 1,474. Over the last 3 years our enrollment has increased 18 percent (224 students). For fiscal year 2011, NTID anticipates maintaining this record high enrollment level. Our enrollment history over the last 5 years is shown below:

NTID ENROLLMENTS: FIVE-YEAR HISTORY

Fiscal year	Deaf/hard-of-hearing students				Hearing students			Grand total
	Undergrad	Grad RIT	MSSE	Subtotal	Interpreting program	MSSE	Subtotal	
2006	1,013	53	38	1,104	116	36	152	1,256
2007	1,017	47	31	1,095	130	25	155	1,250
2008	1,103	51	31	1,185	130	28	158	1,353
2009	1,212	48	24	1,284	135	31	166	1,450
2010	1,237	38	32	1,307	138	29	167	1,474

STUDENT ACCOMPLISHMENTS

For our graduates, 95 percent have been placed in jobs commensurate with the level of their education (using the Bureau of Labor Statistics methodology). Of our fiscal year 2007 graduates (the most recent class for which numbers are available), 63 percent were employed in business and industry, 29 percent in education/nonprofits, and 8 percent in government.

Graduation from NTID has a demonstrably positive effect on students' earnings over a lifetime, and results in a noteworthy reduction in dependence on Supplemental Security Income (SSI), Social Security Disability Insurance (SSDI), and public assistance programs. In fiscal year 2007, NTID, the Social Security Administration, and Cornell University examined approximately 13,000 deaf and hard-of-hearing individuals who applied and attended NTID over our entire history. We learned that graduating from NTID has significant economic benefits. By age 50, deaf and hard-of-hearing baccalaureate graduates earned on average $6,021 more per year than those with associate degrees, who in turn earned $3,996 more per year on average than those who withdrew before graduation. Students who withdrew earned $4,329 more than those who were not admitted. Students who withdrew experienced twice the rate of unemployment as graduates.

The same studies showed 78 percent of these individuals were receiving SSI benefits at age 19, but when they were 50 years old, only 1 percent of graduates drew these benefits, while on average 19 percent of individuals who withdrew or were not admitted continued to participate in the SSI program. Graduates also accessed SSDI, an unemployment benefit, at far lesser rates than students who withdrew; by age 50, 34 percent of nongraduates were receiving SSDI, while 22 percent of baccalaureate graduates and 27 percent of associate graduates were receiving them. Considering the reduced dependency on these Federal income support programs, the Federal investment in NTID returns significant societal dividends.

NTID clearly makes a significant, positive difference in earnings, and in lives.

STRATEGIC INITIATIVES BEGINNING FISCAL YEAR 2011

NTID has just completed Strategic Decisions 2020, a strategic plan based on our founding mission statement. This statement sets forth our institutional responsibility to work with students to develop their academic, career, and life-long learning skills as future contributors in a rapidly changing world. It also recognizes our role as a special resource for preparing individuals who are deaf and hard-of-hearing, for conducting applied research in areas critical to the advancement of individuals who are deaf and hard-hard-of hearing, and for disseminating our collective and cumulative expertise.

Strategic Decisions 2020 establishes key initiatives responding to future challenges and shaping future opportunities. These initiatives, scheduled for implementation beginning in fiscal year 2011, include:

—Pursuing enrollment targets and admissions and programming strategies that will result in increasing numbers of our graduates achieving baccalaureate degrees and higher, while maintaining focus and commitment to quality associate-level degree programs leading directly to the workplace;

—Improving services to under-prepared students through working with regional partners to implement intensive summer academic preparation programs in selected high-growth, ethnically diverse areas of the country. Through this initiative, NTID will identify those students demonstrating promise for success in career-focused degree-level programs and beyond, and provide consultation to others regarding postsecondary educational alternatives;

—Expanding NTID's role as a National Resource Center of Excellence regarding the education of deaf and hard-of-hearing students in senior high school (grades 10, 11, and 12) and at the postsecondary level education. Components of this role as a National Resource Center of Excellence will include:

—*Center for Excellence in STEM Education*.—NTID currently is working to develop an externally funded Center of Excellence on STEM Education for Deaf and Hard of Hearing Students. This is an example of making our expertise available nationally and enhancing deaf and hard-of-hearing students' access to STEM fields.

—*NTID Research Centers*.—NTID will organize research resources into Research Centers focused on the following strategic areas of research: Teaching and Learning; Communication; Technology, Access, and Support Services; and Employment and Adaptability to Social Changes and the Global Workplace.

—*Outreach Programs Extending*.—Outreach activities to junior and senior high school students who are deaf and hard-of-hearing, many of who represent AALANA populations, to expand their horizons regarding a college education.

We also support other colleges and universities serving students who are deaf and hard-of-hearing, as well as postcollege adults who are deaf and hard-of-hearing.

—Enhancing efforts to become a recognized national leader in the exploration, adaptation, testing, and implementation of new technologies to enhance access to, and support of, learning by deaf and hard-of-hearing individuals.

NTID BACKGROUND

Academic Programs

NTID offers high-quality, career-focused associate degree programs preparing students for specific well-paying technical careers. A cooperative education component ties closely to high demand employment opportunities. NTID also is expanding the number of its transfer associate degree programs, currently numbering seven, to better serve the higher achieving segment of our student population seeking bachelors and masters degrees in an increasingly demanding marketplace. These transfer programs provide seamless transition to baccalaureate studies in the other colleges of RIT. In support of those deaf and hard-of-hearing students enrolled in the other RIT colleges, NTID provides a range of access services (including interpreting, real-time speech-to-text captioning, and note-taking) as well as tutoring services. One of NTID's greatest strengths is our outstanding track record of assisting high-potential students to gain admission to, and graduate from, the other colleges of RIT at rates comparable to their hearing peers.

Student Life

Our activities foster student leadership and community service, and provide opportunities to explore a wide range of other educational interests. Emphasis is placed on coordination between academic faculty and student development professionals in supporting college success for students.

SUMMARY

It is extremely important that our funding be provided at the full level requested by the President as we continue our mission to prepare deaf and hard-of-hearing people to enter the workplace and society. We ask only that the funds provided by the President for Construction be moved into operations.

Our alumni have demonstrated that they can achieve independence, contribute to society, earn a living, and live a satisfying life as a result of NTID. Research shows that NTID graduates over their lifetimes are employed at a much higher rates, earn substantially more (therefore, paying significantly more in taxes), and participate at a much lower rate in SSI, SSDI, and public assistance programs than those who withdraw or who apply but do not attend NTID.

We are hopeful that the members of the subcommittee will agree that NTID, with its long history of successful stewardship of Federal funds and outstanding educational record of service with people who are deaf and hard-of-hearing, remains deserving of your support and confidence.

PREPARED STATEMENT OF THE NATIONAL WILDLIFE FEDERATION

Mr. Chairman, members of the subcommittee, on behalf of the National Wildlife Federation (NWF), our Nation's largest conservation advocacy and education organization, and our more than 4 million members and supporters, I thank you for the opportunity to provide funding recommendations for the Department of Education, Department of Labor (DOL), and the Corporation for National and Community Service (CNCS).

We believe that the overall Federal investment in environmental and sustainability education programs nationwide—pennies per capita—is woefully inadequate. While NWF supports numerous programs under the jurisdiction of this subcommittee, the purpose of this testimony is to recommend levels of funding for specific sustainability education at institutions of higher education, education and training for clean energy and "green" jobs, environmental education at the K–12 level, and national service programs that we believe are vital to NWF's mission to inspire Americans to protect wildlife for our children's future. The National Wildlife Federation also supports climate change education and environmental education programs across the Federal agencies at the U.S. Forest Service, Environmental Protection Agency, National Science Foundation, National Aeronautics and Space Administration, National Oceanic and Atmospheric Administration, and U.S. Department of the Interior.

SUMMARY OF RECOMMENDATIONS

[In millions of dollars]

Agency	Program	Fiscal year 2011 recommendation	Fiscal year 2010 level
Education	University Sustainability Program	$50	[1]
	Healthy High Performance Schools	25	
Labor	Green Jobs Act	125	$50
CNCS	Clean Energy Service Corps	100	

[1] See under Department of Education.

Funding for these programs is supported broadly through the Campaign for Environmental Literacy's Green Education Budget and the conservation community's Green Budget documents.

The Need for Environmental Education and Sustainability Education

As our Nation moves towards a clean energy economy and creates new "green jobs," we must ensure that our education and training infrastructure keeps pace. Congress and President Obama have stated their desire to pass comprehensive climate change legislation this year, a priority that the National Wildlife Federation strongly supports. To be successful and remain competitive as a Nation in a new clean energy economy, we must have an environmentally literate and well-trained citizenry that has the knowledge and skills to find new and innovative solutions to protect our planet. While public awareness and concern about global warming continues to rise, the vast majority of the public does not understand how climate change works, how it impacts their lives and careers, and how their decisions and actions contribute to it.

Educating Americans about climate change is a huge opportunity for our Nation to prepare today's leaders, and the leaders of tomorrow, to implement the solutions created through comprehensive climate change legislation. Unfortunately, some still mistakenly see environmental protection programs as a costly burden on prosperity. In fact, the challenge posed is an entrepreneur's dream. Addressing global warming will generate millions of good new jobs and put the United States at the exciting forefront of a new clean energy economy. The successful transition to this new green economy hinges on education and training. This testimony focuses on key programs that educate and train Americans at institutions of higher education, in our Nation's K–12 schools, through conservation corps programs that educate and train at-risk youth for careers in clean energy, and through green workforce education and training programs at the Department of Labor.

DEPARTMENT OF EDUCATION

University Sustainability Program

The National Wildlife Federation supports funding the University Sustainability Program (USP) at $50 million in fiscal year 2011. Interest in sustainability is exploding on college campuses across the Nation, and institutions are making remarkable changes to try to reduce campus carbon footprints and energy use. However, despite increasing interest and demand from students, sustainability education programs on college campuses are on the decline according to a comprehensive study released in August 2008 by the National Wildlife Federation and Princeton Survey Research Associates International, called the "Campus Environment 2008: A National Report Card on Sustainability in Higher Education." Environmental curriculum requirements are slipping and today's students may be less environmentally literate when they graduate than their predecessors.

Congress authorized a new University Sustainability Program (USP) at the Department of Education as part U of the Higher Education Opportunity Act of 2008 (H.R. 4137). This program has the potential for high impact, high visibility, broad support within higher education, and is responsive to an important national trend in higher education. Sustainability on college campuses is critical, from education in the classroom to facility operations. Higher education produces almost all of the Nation's leaders in all sectors and endeavors, and many college campuses are virtually small cities in their size, environmental impact, and financial influence. Campuses use vast amounts of energy to heat, cool, and light their facilities. In all, the Nation's 4,100 campuses educate or employ around 20 million individuals and generate more than 3 percent of the Nation's GDP. The economic clout of these schools is further multiplied by the hundreds of thousands of business suppliers, property owners, and other commercial and nonprofit entities involved with higher education. Funding for the newly authorized USP is critical to help provide difficult-to-get seed

funding to launch sustainability education programs and to help support mainstream higher education associations in including sustainability in their work with their member institutions.

In fiscal year 2010 Congress appropriated $28.8 million for the University Sustainability Program and five other programs as "invitational priorities" under the Fund for Improvement in Postsecondary Education. We recommend that in fiscal year 2011 Congress fund the University Sustainability Program as a standalone program at $50 million.

Healthy High Performance Schools Program

The National Wildlife Federation supports funding the Healthy High Performance Schools Program at $25 million in fiscal year 2011. The Healthy High Performance Schools Program seeks to facilitate the design, construction and operation of high performance schools: environments that are not only energy and resource efficient, but also healthy, comfortable, well lit, and containing the amenities for a quality education. This grant program is critical at a time when energy costs for America's elementary and secondary schools are skyrocketing. The No Child Left Behind Act (Public Law 107–110, title 5, part D, subtitle 18) authorized grants to State education agencies to advance the development of "healthy, high performance" school buildings. This program has yet to be funded by Congress. While it would seem to be a given that we are providing our children with a healthy learning environment, many of the Nation's 150,000 public school buildings fall far short of this standard. Research clearly shows that improving specific factors such as school indoor environmental quality improves attendance, academic performance, and productivity.

Pre-K–12 Environmental Education—No Child Left Inside Act

While not yet authorized, the National Wildlife Federation strongly supports authorization of and full funding at $100 million per year for the No Child Left Inside (NCLI) Act (H.R. 2054), which the support of more than 1,600 national, State and local organizations representing more than 45 million Americans. The central new policy in this legislation is the incentive for States to create or update a State Environmental Literacy Plan. Environmental Literacy Plans can be developed to meet the needs of each State and systemically advance environmental education through the pre-K–12 education system. These State plans in NCLI support training and professional development opportunities for teachers and capacity building for environmental education at both the State and district level. In the past 12 years, an impressive base of research has been developed that demonstrates the positive effects that environmental and nature education programs have on improving academic performance and overall student learning. These data, collected from many peer-reviewed sources, include: improved statewide test results, higher scores in science and mathematics, higher student interest in science, greater real-world relevancy, fewer discipline problems in the classroom, and a more even playing field for students in under-resourced schools.

The House passed a modified version of the bill in the 110th Congress by a bipartisan vote of 293–109. This strong support continues today with 90 current sponsors of H.R. 2054. Additionally, the Department of Education's A Blue Print for Reform: The Reauthorization of the Elementary and Secondary Education Act seeks to encourage schools to provide a well-rounded education through grants that support strengthening teaching and learning in environmental education. In fiscal year 2011, "environmental education" was also included in the President's budget request under a "Well-Rounded Education."

The National Wildlife Federation also supports a priority for funding green career and technical education programs and initiatives at the Department of Education.

DEPARTMENT OF LABOR

The National Wildlife Federation supports a priority for green jobs education and training at the Department of Labor through the Workforce Investment Act's Energy Efficiency and Renewable Energy Worker Training Program and the Community Based Job Training Program. NWF believes that community colleges are critical partners in training and educating the next generation of Americans for green jobs.

Energy Efficiency and Renewable Energy Worker Training Program

The National Wildlife Federation supports funding the Energy Efficiency and Renewable Energy Worker Training Program at $125 million in fiscal year 2011. NWF greatly appreciates this subcommittee's first-time investment in Green Jobs Education and Training in the recent American Recovery and Reinvestment Act and the $50 million provided in fiscal year 2010. This unprecedented investment will help

jumpstart the education and training needed to prepare Americans for the clean energy economy. We hope that the Committee will continue to fund this program, authorized by the Green Jobs Act (GJA), title X of the Energy Independence and Security Act, at $125 million in fiscal year 2011. NWF believes it is important to make annual investments in this program through the regular appropriations process, in addition to necessary infusions of funding through stimulus and supplemental bills. This program identifies needed skills, develops training programs, and trains workers for jobs in a range of green industries, but has a special focus on creating "green pathways out of poverty" and responds to already existing skill shortages.

CORPORATION FOR NATIONAL AND COMMUNITY SERVICE

Clean Energy Service Corps

The National Wildlife Federation supports funding the Clean Energy Service Corps at $100 million in fiscal year 2011. The Clean Energy Service Corps, building on the legacy of the depression-era Civilian Conservation Corps and modeled after today's Service and Conservation Corps, will address the Nation's energy and environmental needs while providing work and service opportunities, especially for disadvantaged youth ages 16–25.

CONCLUSION

Providing Federal support for environmental education, sustainability education, green jobs education and training and green national service programs is critical for securing our new clean energy future and preparing the next generation for the challenges and opportunities ahead. Thank you again for providing the National Wildlife Federation with the opportunity to provide testimony.

PREPARED STATEMENT OF THE OVARIAN CANCER NATIONAL ALLIANCE

The Ovarian Cancer National Alliance (the Alliance) appreciates the opportunity to submit comments for the record regarding the Alliance's fiscal year 2011 funding recommendations. We believe these recommendations are critical to ensure advances to help reduce and prevent suffering from ovarian cancer. For 13 years, the Alliance has worked to increase awareness of ovarian cancer and advocated for additional Federal resources to support research that would lead to more effective diagnostics and treatments.

As an umbrella organization with 49 State and local organizations, the Alliance unites the efforts of survivors, grassroots activists, women's health advocates and healthcare professionals to bring national attention to ovarian cancer. Our sole mission is to conquer ovarian cancer.

According to the American Cancer Society, in 2009, more than 22,000 American women were diagnosed with ovarian cancer and approximately 15,000 lost their lives to this terrible disease. Ovarian cancer is the fifth leading cause of cancer death in women. Currently, more than half of the women diagnosed with ovarian cancer will die within 5 years. While ovarian cancer has early symptoms, there is no early detection test. Most women are diagnosed in stage III or stage IV, when survival rates are low. If diagnosed early, more than 90 percent of women will survive for 5 years, but when diagnosed later, less than 30 percent will.

In addition, only a few treatments have been approved by the Food and Drug Administration (FDA) for ovarian cancer treatment. These are platinum-based therapies and women needing further rounds of treatment are frequently resistant to them. More than 70 percent of ovarian cancer patients will have a recurrence at some point, underlying the need for treatments to which patients do not grow resistant.

For all of these reasons, we urgently call on Congress to appropriate funds to find solutions.

As part of this effort, the Alliance advocates for continued Federal investment in the Centers for Disease Control and Prevention's (CDC) Ovarian Cancer Control Initiative. The Alliance respectfully requests that Congress provide $10 million for the program in fiscal year 2011.

The Alliance also fully supports Congress in taking action on educating Americans about ovarian cancer through providing funding for Johanna's Law: The Gynecologic Cancer Education and Awareness Act (Public Law 109–475). The Alliance respectfully requests that Congress provide $10 million to implement Johanna's Law in fiscal year 2011.

Further, the Alliance urges Congress to continue funding the Specialized Programs of Research Excellence (SPOREs), including the five ovarian cancer sites.

These programs are administered through the National Cancer Institute (NCI) of the National Institutes of Health (NIH). The Alliance respectfully requests that Congress provide $5.795 to the National Cancer Institute for fiscal year 2011.

CENTERS FOR DISEASE CONTROL AND PREVENTION (CDC)

The Ovarian Cancer Control Initiative

As the statistics indicate, late detection and, therefore, poor survival are among the most urgent challenges we face in the ovarian cancer field. The CDC's cancer program, with its strong capacity in epidemiology and excellent track record in public and professional education, is well positioned to address these problems. As the Nation's leading prevention agency, the CDC plays an important role in translating and delivering at the community level what is learned from research, especially ensuring that those populations disproportionately affected by cancer receive the benefits of our Nation's investment in medical research.

Prompted by efforts from leaders of the Alliance and championed by Representative Rosa DeLauro—with bipartisan, bicameral support—Congress established the Ovarian Cancer Control Initiative at the CDC in November 1999. Congress' directive to the agency was to develop an appropriate public health response to ovarian cancer and conduct several public health activities targeted toward reducing ovarian cancer morbidity and mortality.

The CDC's Ovarian Cancer Control conducts research about early detection, treatment and survivorship nationwide to increase understanding of ovarian cancer. Some ongoing research includes studying: the relationship between recorded symptoms, time to diagnosis, and ovarian cancer histology, the availability of gynecologic oncologists for ovarian cancer care, and frequency of symptoms in women aged 65 years and older with ovarian cancer as compared to a matched cohort of cancer-free women, among many other research projects.

Johanna's Law: The Gynecologic Cancer Education and Awareness Act

It is critical for women and their healthcare providers to be aware of the signs, symptoms and risk factors of ovarian and other gynecologic cancers. Often, women and providers mistakenly confuse ovarian cancer signs and symptoms with those of gastrointestinal disorders or early menopause. While symptoms may seem vague—bloating, pelvic or abdominal pain, increased abdominal size and bloating and difficulty, eating or feeling full quickly, or urinary symptoms (urgency or frequency)—they can be deadly without proper medical intervention.

In recognition of the need for awareness and education, Congress unanimously passed Johanna's Law in 2006, enacted in early 2007. This law provides for an education and awareness campaign that will increase providers' and women's awareness of all gynecologic cancers including ovarian.

Thanks to funding under Johanna's Law, more women are learning how to identify the signs and symptoms of gynecologic. The CDC have developed and disseminated over 275,000 fact sheets on gynecologic cancers in English and Spanish, created a Web page dedicated to information about these diseases that receive more than 1,500 hits a day, and are producing public service announcements for television scheduled to air beginning in September 2010. We must ensure that lifesaving information about gynecologic cancers continues to reach women.

With continued funding, the CDC will be able to continue to print and distribute brochures, maintain and update the Web resources, develop additional educational materials such as posters for physician offices, complete continuing education materials for healthcare providers, and reach out to women beyond the original 40–60 year-old initial target group.

NCI

Specialized Programs of Research Excellence (SPORE) in the National Institutes of Health

The SPOREs were created by the NCI in 1992 to support translational, organ site-focused cancer research. The ovarian cancer SPOREs began in 1999. There are five currently funded Ovarian Cancer SPOREs located at the MD Anderson Cancer Center, the Fred Hutchinson Cancer Research Center, the Fox Chase Cancer Center, the Dana Farber/Harvard Cancer Center and the Mayo Clinic Cancer Center.

These SPORE programs have made outstanding strides in understanding ovarian cancer, as illustrated by their more than 300 publications as well as other notable achievements, including the development of an infrastructure between Ovarian SPORE institutions to facilitate collaborative studies on understanding, early detection and treatment of ovarian cancer.

Clinical Trials

The NCI supports clinical research—the only way to test the safety and efficacy of potential new treatments for ovarian cancer. Two recent studies from NCI clinical trials show the impact of intraperitoneal chemotherapy in treating ovarian cancer (when chemotherapy is introduced directly into the woman's abdominal cavity, rather than her bloodstream) and the importance of ultrasound expertise in properly diagnosing the disease.

NCI supports the Gynecology Oncology Group, a more than 50-member collaborative focusing on cancers of the female reproductive system. In 2007 alone, GOG published 23 articles about ovarian cancer.

SUMMARY

The Alliance maintains a long-standing commitment to work with Congress, the administration, and other policy makers and stakeholders to improve the survival rate for women with ovarian cancer through education, public policy, research, and communication. Please know we appreciate and understand that our Nation faces many challenges and Congress has limited resources to allocate; however, we are concerned that without increased funding to bolster and expand ovarian cancer education, awareness and research efforts, the Nation will continue to see growing numbers of women losing their battle with this terrible disease.

On behalf of the entire ovarian cancer community—patients, family members, clinicians, and researchers—we thank you for your leadership and support of Federal programs that seek to reduce and prevent suffering from ovarian cancer. Thank you in advance for your support of $10 million in fiscal year 2011 funding for the CDC's Ovarian Cancer Control Initiative and $10 million in fiscal year 2011 funding for Johanna's Law as well as your continued support of the SPORES program, an appropriation of $5.795 billion to NCI.

PREPARED STATEMENT OF THE ONCOLOGY NURSING SOCIETY

The Oncology Nursing Society (ONS) appreciates the opportunity to submit written comments for the record regarding fiscal year 2011 funding for cancer- and nursing-related programs. ONS, the largest professional oncology group in the United States, composed of more than 37,000 nurses and other health professionals, exists to promote excellence in oncology nursing and the provision of quality care to those individuals affected by cancer. As part of its mission, ONS honors and maintains nursing's historical and essential commitment to advocacy for the public good.

In 2009, an estimated 1.48 million Americans will be diagnosed with cancer, and more than 562,340 will lose their battle with this terrible disease; at the same time the national nursing shortage is expected to worsen. Overall, age is the number one risk factor for developing cancer. Approximately 77 percent of all cancers are diagnosed at age 55 and older.[1] Despite these grim statistics, significant gains in the war against cancer have been made through our Nation's investment in cancer research and its application. Research holds the key to improved cancer prevention, early detection, diagnosis, and treatment, but such breakthroughs are meaningless, unless we can deliver them to all Americans in need. Moreover, a recent survey of ONS members found that the nursing shortage is having an impact in oncology physician offices and hospital outpatient departments. Some respondents indicated that when a nurse leaves their practice, they are unable to hire a replacement due to the shortage—leaving them short-staffed and posing scheduling challenges for the practice and the patients. These vacancies in all care settings create significant barriers to ensuring access to quality care.

To ensure that all people with cancer have access to the comprehensive, quality care they need and deserve, ONS advocates ongoing and significant Federal funding for cancer research and application, as well as funding for programs that help ensure an adequate oncology nursing workforce to care for people with cancer. ONS stands ready to work with policymakers at the local, State, and Federal levels to advance policies and programs that will reduce and prevent suffering from cancer and sustain and strengthen the Nation's nursing workforce. We thank the subcommittee for its consideration of our fiscal year 2011 funding request detailed below.

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[1] American Cancer Society. *Cancer Facts and Figures 2009*. http://www.cancer.org/downloads/STT/500809web.pdf.

Securing and Maintaining an Adequate Oncology Nursing Workforce

Oncology nurses are on the front lines in the provision of quality cancer care for individuals with cancer—administering chemotherapy, managing patient therapies and side-effects, working with insurance companies to ensure that patients receive the appropriate treatment, providing treatment education and counseling to patients and family members, and engaging in myriad other activities on behalf of people with cancer and their families. Cancer is a complex, multifaceted chronic disease, and people with cancer require specialty-nursing interventions at every step of the cancer experience. People with cancer are best served by nurses specialized in oncology care, who are certified in that specialty.

As the overall number of nurses is expected to decline in the coming years, we likely will experience a commensurate decrease in the number of nurses trained in the specialty of oncology. With an increasing number of people with cancer needing high-quality healthcare, coupled with an inadequate nursing workforce, our Nation could quickly face a cancer care crisis of serious proportion, with limited access to quality cancer care, particularly in traditionally underserved areas. A study in the New England Journal of Medicine found that nursing shortages in hospitals are associated with a higher risk of complications—such as urinary tract infections and pneumonia, longer hospital stays, and even patient death.[2] Without an adequate supply of nurses, there will not be enough qualified oncology nurses to provide the quality cancer care to a growing population of people in need, and patient health and well-being could suffer.

Of additional concern is that our Nation also will face a shortage of nurses available and able to conduct cancer research and clinical trials. With a shortage of cancer research nurses, progress against cancer will take longer because of scarce human resources coupled with the reality that some practices and cancer centers' resources could be funneled away from cancer research to pay for the hiring and retention of oncology nurses to provide direct patient care. Without a sufficient supply of trained, educated, and experienced oncology nurses, we are concerned that our Nation may falter in its delivery and application of the benefits from our Federal investment in research.

ONS greatly appreciates the increase in funding in fiscal year 2010. This represents an investment in patient care. ONS joins our colleagues from all nursing sectors and specialties to request $267.3 million, a 10 percent increase over last year's level, for the Health Resources and Services Administrations (HRSA) title VIII programs in fiscal year 2011. The title VIII programs received a substantial increase in fiscal year 2010. Funding for these programs increased from $171.03 million to $243.872 million, a 42.6 percent increase. In particular the Nursing Faculty Loan Program received a 117 percent increase and the Loan Repayment and Scholarship program received a 152 percent increase. However, the Advanced Education Nursing, Nursing Workforce Diversity, Comprehensive Geriatric Education, and Nurse Education, Practice, and Retention programs, which help complement the Loan Repayment and Scholarship programs, have not kept pace with inflation since fiscal year 2005 and did not receive any increases last year. Therefore, ONS along with the Nursing Community is requesting that the 10 percent increase in funding be awarded to these four programs.

With additional funding in fiscal year 2011, the HRSA Workforce Development Programs will have much-needed resources to address the multiple factors contributing to the nationwide nursing shortage. Advanced nursing education programs play an integral role in supporting registered nurses interested in advancing in their practice and becoming faculty. As such, these programs must be adequately funded in the coming year.

ONS strongly urges Congress to provide HRSA with a minimum of $267.3 million in fiscal year 2011 to ensure that the agency has the resources necessary to fund a higher rate of nursing scholarships and loan repayment applications and support other essential endeavors to sustain and boost our Nation's nursing workforce. Nurses—along with patients, family members, hospitals, and others—have joined together in calling upon Congress to provide this essential level of funding. The National Coalition for Cancer Research (NCCR), a nonprofit organization comprised of 23 national cancer organizations, and One Voice Against Cancer (OVAC), a collaboration of 39 national nonprofit organizations, are also advocating $267.3 million in fiscal year 2011 for the Nurse Reinvestment Act. ONS and its allies have serious concerns that without full funding, the Nurse Reinvestment Act will prove an empty

[2] Needleman J., Buerhaus P., Mattke S., Stewart M., Zelevinsky K. "Nurse-Staffing Levels and the Quality of Care in Hospitals." *New England Journal of Medicine* 346:, (May 30, 2002): 1715–1722.

promise, and the current and expected nursing shortage will worsen, and people will not have access to the quality care they need and deserve.

Sustain and Seize Cancer Research Opportunities

Our Nation has benefited immensely from past Federal investment in biomedical research at the National Institutes of Health (NIH). ONS has joined with the broader health community in advocating a 13.5 percent increase ($35.210 billion) for NIH in fiscal year 2011. This level of investment will allow NIH to sustain and build on its research progress, while avoiding the severe disruption to advancement that could result from a minimal increase. Cancer research is producing amazing breakthroughs—leading to new therapies that translate into longer survival and improved quality of life for cancer patients. In recent years, we have seen extraordinary advances in cancer research, resulting from our national investment, which have produced effective prevention, early detection, and treatment methods for many cancers. To that end, ONS calls upon Congress to allocate $5.795 billion to the National Cancer Institute (NCI), as well as $240 million to the National Center for Minority Health and Health Disparities in fiscal year 2011 to support the battle against cancer.

The National Institute of Nursing Research (NINR) supports basic and clinical research to establish a scientific basis for the care of individuals across the life span—from management of patients during illness and recovery, to the reduction of risks for disease and disability and the promotion of healthy lifestyles. These efforts are crucial in translating scientific advances into cost-effective healthcare that does not compromise quality of care for patients. Additionally, NINR fosters collaborations with many other disciplines in areas of mutual interest, such as long-term care for older people, the special needs of women across the life span, bioethical issues associated with genetic testing and counseling, and the impact of environmental influences on risk factors for chronic illnesses, such as cancer. ONS joins with others in the nursing community and NCCR in advocating a fiscal year 2011 allocation of $160 million for NINR.

Boost Our Nation's Investment in Cancer Prevention, Early Detection, and Awareness

Approximately two-thirds of cancer cases are preventable through lifestyle and behavioral factors and improved practice of cancer screening. Although the potential for reducing the human, economic, and social costs of cancer by focusing on prevention and early detection efforts remains great, our Nation does not invest sufficiently in these strategies. The Nation must make significant and unprecedented Federal investments today to address the burden of cancer and other chronic diseases, and to reduce the demand on the healthcare system and diminish suffering in our Nation, both for today and tomorrow.

As the Nation's leading prevention agency, the Centers for Disease Control and Prevention (CDC) plays an important role in translating and delivering, at the community level, what is learned from research. Therefore, ONS joins with our partners in the cancer community in calling on Congress to provide additional resources for the CDC to support and expand much-needed and proven effective cancer prevention, early detection, and risk reduction efforts. Specifically, ONS advocates the following fiscal year 2011 funding levels for the following CDC programs:

—$255 million for the National Breast and Cervical Cancer Early Detection Program;
—$65 million for the National Cancer Registries Program;
—$50 million for the Colorectal Cancer Prevention and Control Initiative;
—$50 million for the Comprehensive Cancer Control Initiative;
—$25 million for the Prostate Cancer Control Initiative;
—$5 million for the National Skin Cancer Prevention Education Program;
—$10 million for the Gynecologic Cancer and Education and Awareness (Johanna's Law);
—$10 million for the Ovarian Cancer Control Initiative; and
—$6 million for the Geraldine Ferraro Blood Cancer Program.

Conclusion

ONS maintains a strong commitment to working with Members of Congress, other nursing and oncology groups, patient organizations, and other stakeholders to ensure that the oncology nurses of today continue to practice tomorrow, and that we recruit and retain new oncology nurses to meet the unfortunate growing demand that we will face in the coming years. By providing the fiscal year 2011 funding levels detailed above, we believe the subcommittee will be taking the steps necessary to ensure that our Nation has a sufficient nursing workforce to care for the patients of today and tomorrow and that our Nation continues to make gains in our fight against cancer.

PREPARED STATEMENT OF THE POPULATION ASSOCIATION OF AMERICA/ASSOCIATION OF POPULATION CENTERS

Introduction

Thank you, Chairman Harkin, Ranking Member Cochran, and other distinguished members of the subcommittee, for this opportunity to express support for the National Institutes of Health (NIH), the National Center for Health Statistics (NCHS), and Bureau of Labor Statistics (Bureau).

Background on the Population Association of America/Association of Population Centers (PAA/APC) and Demographic Research

The PAA is a scientific organization comprised of more than 3,000 population research professionals, including demographers, sociologists, statisticians, and economists. The APC is a similar organization comprised of 40 universities and research groups that foster collaborative demographic research and data sharing, translate basic population research for policy makers, and provide educational and training opportunities in population studies. Population research centers are located at public and private research institutions nationwide.

Demography is the study of populations and how or why they change. Demographers, as well as other population researchers, collect and analyze data on trends in births, deaths, and disabilities as well as racial, ethnic, and socioeconomic changes in populations. Major policy issues population researchers are studying include the demographic causes and consequences of population aging, trends in fertility, marriage, and divorce and their effects on the health and well being of children, and immigration and migration and how changes in these patterns affect the ethnic and cultural diversity of our population and the Nation's health and environment.

The NIH mission is to support research that will improve the health of our population. The health of our population is fundamentally intertwined with the demography of our population. Recognizing the connection between health and demography, the NIH supports extramural population research programs primarily through the National Institute on Aging (NIA) and the Eunice Kennedy Shriver National Institute on Child Health and Human Development (NICHD).

NIA

According to the Census Bureau, by 2029, all of the baby boomers (those born between 1946 and 1964) will be age 65 years and older. As a result, the population age 65–74 years will increase from 6 percent to 10 percent of the total population between 2005 and 2030. This substantial growth in the older population is driving policymakers to consider dramatic changes in Federal entitlement programs, such as Medicare and Social Security, and other budgetary changes that could affect programs serving the elderly. To inform this debate, policymakers need objective, reliable data about the antecedents and impact of changing social, demographic, economic, and health characteristics of the older population. The NIA Division of Behavioral and Social Research (BSR) is the primary source of Federal support for research on these topics.

In addition to supporting an impressive research portfolio, that includes the prestigious Centers of Demography of Aging and Roybal Centers for Applied Gerontology Programs, the NIA BSR program also supports several large, accessible data surveys. One of these surveys, the Health and Retirement Study (HRS), has become one of the seminal sources of information to assess the health and socioeconomic status of older people in the United States. Since 1992, the HRS has tracked 27,000 people, providing data on a number of issues, including the role families play in the provision of resources to needy elderly and the economic and health consequences of a spouse's death. HRS is particularly valuable because its longitudinal design allows researchers: (1) the ability to immediately study the impact of important policy changes such as Medicare Part D; and (2) the opportunity to gain insight into future health-related policy issues that may be on the horizon, such as HRS data indicating an increase in pre-retirees self-reported rates of disability. In 2011, HRS will collect biomarkers, enhancing its ability to track the onset and progression of diseases and conditions affecting the elderly.

Currently, the NIA payline is 9 percent, and its operating line is flat. As research costs increase, NIA faces the prospect of funding fewer grants to sustain larger ones in its commitment base. With additional support in fiscal year 2011, the NIA BSR program could fully fund its large-scale projects, including the existing centers programs and ongoing surveys, without resorting to cost-cutting measures, such as cutting sample size, while continuing to support smaller investigator initiated projects. NIA could also sustain training and research opportunities for new investigators—

especially those who received funding from the American Recovery and Reinvestment Act (ARRA).

NICHD

Since its establishment in 1968, the Eunice Kennedy Shriver NICHD Center for Population Research has supported research on population processes and change. Today, this research is housed in the Center's Demographic and Behavioral Sciences Branch (DBSB). The Branch encompasses research in four broad areas: family and fertility, mortality and health, migration and population distribution, and population composition. In addition to funding research projects in these areas, DBSB also supports a highly regarded population research infrastructure program and a number of large database studies, including the Fragile Families and Child Well Being Study, New Immigrant Study, and National Longitudinal Study of Adolescent Health.

NIH-funded demographic research has consistently provided critical scientific knowledge on issues of greatest consequence for American families: work-family conflicts, marriage and childbearing, childcare, and family and household behavior. However, in the realm of public health, demographic research is having an even larger impact, particularly on issues regarding adolescent and minority health. Understanding the role of marriage and stable families in the health and development of children is another major focus of the NICHD DBSB. Consistently, research has shown children raised in stable family environments have positive health and development outcomes. Policymakers and community programs can use these findings to support unstable families and improve the health and well being of children.

One of the most important programs the NICHD DBSB supports is the Population Research Infrastructure Program (PRIP). Through PRIP, research is conducted at private and public research institutions nationwide. The primary goal of PRIP is "to facilitate interdisciplinary collaboration and innovation in population research, while providing essential and cost-effective resources in support of the development, conduct, and translation of population research." Population research centers supported by PRIP are focal points for the demographic research field where innovative research and training activities occur and resources, including large-scale databases, are developed and maintained for widespread use.

With additional support in fiscal year 2011, NICHD could restore full funding to its large-scale surveys, which serve as a resource for researchers nationwide. Furthermore, the NICHD could apply additional resources toward improving its funding payline, which has been as low as the 10th percentile prior to the recent infusion of ARRA funds. Additional support could be used to support and stabilize essential training and career development programs necessary to prepare the next generation of researchers and to support and expand proven programs, such as PRIP.

NCHS

Located within the Centers for Disease Control (CDC), the NCHS is the Nation's principal health statistics agency, providing data on the health of the U.S. population and backing essential data collection activities. Most notably, NCHS funds and manages the National Vital Statistics System, which contracts with the States to collect birth and death certificate information. NCHS also funds a number of complex large surveys to help policy makers, public health officials, and researchers understand the population's health, influences on health, and health outcomes. These surveys include the National Health and Nutrition Examination Survey (NHANES), National Health Interview Survey (HIS), and National Survey of Family Growth. Together, NCHS programs provide credible data necessary to answer basic questions about the state of our Nation's health.

Despite recent steady funding increases, NCHS continues to feel the effects of long-term funding shortfalls, compelling the agency to undermine, eliminate, or further postpone the collection of vital health data. For example, in 2009, sample sizes in HIS and NHANES were cut, while other surveys, most notably the National Hospital Discharge Survey, were not fielded. In 2009, NCHS proposed purchasing only "core items" of vital birth and death statistics from the States (starting in 2010), effectively eliminating three-fourths of data routinely used to monitor maternal and infant health and contributing causes of death. Fortunately, Congress and the new administration worked together to give NCHS adequate resources and avert implementation of these draconian measures. Nonetheless, the agency continues to operate in a precarious state.

The administration recommends NCHS receive $161.9 million in fiscal year 2011. PAA and APC, as members of The Friends of NCHS, support the administration's request. The increased funding will be used to support a number of initiatives, including: (1) restore the National Health Interview Survey to 87,000; (2) fund 12

months of vital statistics data collection; and (3) implement re-engineered Web-based birth certificate data in 6 States and 4 territories; and (4) phase in electronic death certificate registration in States willing to enter a cost-sharing arrangement with the agency.

BLS

During these turbulent economic times, data produced by the BLS are particularly relevant and valued. PAA and APC members have relied historically on objective, accurate data from the BLS. In recent years, our organizations have become increasingly concerned about the state of the agency's funding.

We are pleased the administration has requested BLS receive a total of $645 million in fiscal year 2011. According to the agency, this funding level would enable BLS to improve the Consumer Expenditure Survey and reduce variance in the Consumer Price Index. Also, BLS could improve data used to measure occupational wage and employment growth and identify trends policymakers need to understand the turbulent labor market. Finally, the agency could support its work on developing an alternative poverty measure.

Summary of Fiscal Year 2011 Recommendations

As members of the Ad Hoc Group for Medical Research, PAA and APC are asking Congress to provide NIH with an appropriation of $35 billion in fiscal year 2011—$3 billion more than the administration's request. Although the administration's request for NIH reflects inflation, we feel NIH needs additional support to sustain the new research capacity created by ARRA.

PAA and APC, as members of the Friends of NCHS, ask that NCHS receive $161.9 million in fiscal year 2011, This funding is needed to maintain and improve the Nation's vital statistics system and to sustain and update the agency's major health survey operations.

Finally, we ask you to support the administration's request, $645 million, for the BLS, in fiscal year 2011.

Thank you for considering our requests and for supporting Federal programs that benefit the population sciences.

PREPARED STATEMENT OF THE PHYSICIAN ASSISTANT EDUCATION ASSOCIATION

On behalf of its membership, the 149 accredited physician assistant (PA) education programs in the United States, the Physician Assistant Education Association (PAEA) is pleased to submit these comments on the fiscal year 2011 appropriations for PA education programs that are authorized through title VII of the Public Health Service Act.

PAEA is a member of the Health Professions and Nursing Education Coalition (HPNEC) and we support the HPNEC recommendation for funding of at least $600 million in fiscal year 2011 for the health professions education programs authorized under title VII and VIII of the Public Health Service Act and administered through the Health Resources and Services Administration (HRSA).

PAEA is grateful to the subcommittee for the recent funding increases for Title VII Health Professions programs in the Consolidated Appropriations Act, 2010 (Public Law 111–117) and for your support of Title VII health professions programs.

Need for Increased Federal Funding

Faculty development is one of the profession's critical needs. In order to attract the best qualified to teaching, PA education programs must have the resources to train faculty in academic skills, such as curriculum development, teaching methods, and laboratory instruction. The challenges of teaching are broad and varied and include understanding different pedagogical theories, writing instructional objectives, and learning and applying educational technology. Most educators come from clinical practice and these skills are essential to transitioning to teaching. Educators are a critical element of meeting the Nation's demand for an increased supply of primary care clinicians.

Generalist training, workforce diversity, and practice in underserved areas are key priorities identified by HRSA. It is increasingly important that the health workforce better represents America's changing demographics, as well as addresses the issues of disparities in healthcare. PA programs have been successful in attracting students from underrepresented minority groups and disadvantaged backgrounds. Studies have found that health professionals from underserved areas are 3 to 5 times more likely to return to underserved areas to provide care.

Physician Assistant Practice

Physician assistants (PAs) are licensed health professionals who practice medicine as members of a team with their supervising physicians. PAs exercise autonomy in medical decisionmaking and provide a broad range of medical and therapeutic services to diverse populations in rural and urban settings. In all 50 States, PAs carry out physician-delegated duties that are allowed by law and within the physician's scope of practice and the PA's training and experience. Additionally, PAs are delegated prescriptive privileges by their physician supervisors in all 50 States, the District of Columbia, and Guam. This allows PAs to practice in rural, medically underserved areas where they are often the only full-time medical provider.

Physician Assistant Education

There are currently 149 accredited PA education programs in the United States, which together graduate nearly 6,000 PA students each year. PAs are educated as generalists in medicine; their flexibility allows them to practice in more than 60 medical and surgical specialties. More than one-third of PA program graduates practice in primary care.

The average PA education program is 27 months in length. Typically, 1 year is devoted to classroom study and approximately 15 months is devoted to clinical rotations. The typical curriculum includes 400 hours of basic sciences and nearly 600 hours of clinical medicine.

The profession is expected to continue to grow as a result of the projected shortage of physicians and other healthcare professionals, the growing demand for professionals from an aging population, and the continuing strong PA applicant pool, which has grown by more than 10 percent each year since the year 2000. The Bureau of Labor Statistics projects a 39 percent increase in the number of PA jobs between 2008 and 2018. With its relatively short initial training time and the flexibility of generalist-trained PAs, the PA profession is well-positioned to help fill projected shortages in the numbers of healthcare professionals.

Currently there are almost 20 new PA programs in the accreditation pipeline. The continued growth of the profession heightens the need for additional resources. Additional resources will help meet the challenges of recruiting qualified faculty, shortages of preceptors and clinical sites, and the need to continue our work to increase the diversity of faculty and program applicants.

Title VII Funding

Title VII funding is the only opportunity for PA programs to apply for Federal funding and plays a crucial role in developing and supporting PA education programs.

Title VII funding fills a critical need for curriculum development and faculty development. Funding enhances clinical training and education, assists PA programs with recruiting applicants from minority and disadvantaged backgrounds, and funds innovative programs that focus on educating a culturally competent workforce. Title VII funding increases the likelihood that PA students will practice in medically underserved communities with health professional shortages. The absence of this funding would result in the loss of care to patients in underserved areas.

Title VII support for PA programs has been strengthened with the enactment of the Patient Protection and Affordable Health Care Act (Public Law 111–148), which provides a 15 percent carve out in the appropriations process for PA programs. This funding will enhance capabilities to train a growing PA workforce and is likely to increase the applicant pool for faculty positions as a result of PA programs now being eligible for faculty loan repayment. Huge loan burdens serve as barriers for PAs' entry into academia.

Here we provide several examples of how PA programs have used Title VII funds to creatively expand care to underserved areas and populations, as well as to develop a diverse PA workforce.

—One Texas program has used its PA training grant to support the program at a distant site in an underserved area. This grant provides assistance to the program for recruiting, educating, and training PA students in the largely Hispanic South Texas and mid-Texas/Mexico border areas and supports new faculty development.

—A Utah program has used its PA training grant to promote interprofessional teams—an area of strong emphasis in the Patient Protection and Affordable Care Act—by creating a model geriatric curriculum that includes didactic and clinical education. The grant has also allowed the program to optimize its relationship with three service-learning partners and develop new partnerships with three service-learning sites.

—An Alabama program used its PA training grant to update and expand the current health behavior educational curriculum and HIV/STD training. They were also able to include PA students from other programs who were interested in rural, primary care medicine for a 4-week comprehensive educational program in HIV disease diagnosis and management.
—A South Carolina program has developed a model program that offers a 2-year academic fellowship for recent PA graduates with at least 1 year of clinical experience. To further enhance an evidence-based approach to education and practice, two specific evidence-based practice projects were embedded in the fellowship experience. Fellows direct and evaluate PA students' involvement in the "Towards No Tobacco" curriculum, aimed at fifth graders, and the PDA Patient Data experience, aimed at assessing healthcare services.

Recommendations on Fiscal Year 2011 Funding

The Physician Assistant Education Association requests the Appropriations Committee to support funding for title VII and VIII health professions programs at a minimum of $600 million for fiscal year 2011. This level of funding is crucial to support the Nation's demand for primary care practitioners, particularly those who will practice in medically underserved areas and serve vulnerable populations. Additionally we encourage support for the new programs and responsibilities contained in the Patient Protection and Affordable Care Act (Public Law 111–148), including a minimum of $10 million to support PA education programs. We thank the members of the subcommittee for their continued support of the health professions and look forward to your continued support of solutions to the Nation's health workforce shortage. We appreciate the opportunity to present the Physician Assistant Education Association's fiscal year 2011 funding recommendation.

Prepared Statement of the Patient Alliance for Neuroendocrineimmune Disorders Organization for Research and Advocacy

Dear Chairman of the subcommittee on Labor, Health and Human Services, and Education, and Related Agencies: On behalf of our organization I want to share with you a matter of great importance to our patient advocacy organization. It is related to the CFS Advisory Committee (CFSAC), a congressional committee overseen by the Department of Health and Human Services established to provide science-based advice and recommendations to the Secretary of Health and Human Services and the Assistant Secretary for Health on a broad range of issues and topics pertaining to chronic fatigue syndrome (CFS). It has been at least 6 years since our organization has attended and provided input during CFSAC meeting and yet not one single crucial recommendation has been implemented or enacted. Currently the CFSAC is due to expire on September 5, 2010.

We need to call you attention why is so important that this appropriation committee provide funding for research, patient care, physician education, and clinical trial within a center of excellence format. The CFSAC has consistently year after year as far back as September 2004 recommended the following:

In September 2004—Recommendation 1.—We would urge the DHHS to direct the NIH to establish five Centers of Excellence within the United States that would effectively utilize state of the art knowledge concerning the diagnosis, clinical management, treatment and clinical research of persons with CFS. These Centers should be modeled after the existing Centers of Excellence program, with funding in the range of $1.5 million per center per year for 5 years.

In August 2005—Recommendation 1.—We would urge the DHHS to direct the NIH to establish five Centers of Excellence within the United States that would effectively utilize state-of-the-art knowledge concerning the diagnosis, clinical management, treatment, and clinical research of persons with CFS. These Centers should be modeled after the existing Centers of Excellence program, with funding in the range of $1.5 million per center per year for 5 years.

In November 20–21, 2006.—The Committee skipped recommending again because it was told that it needed to wait till the Secretary of Health could reply on the earlier recommendations therefore CFSA then provided recommendation 3—The committee recommends that CFS be included in the Roadmap Initiative of the NIH.

In May 16–17, 2007—Recommendation 1.—There have been basic science advances which should be leading to new treatment strategies, yet progress in translating these advances into effective treatments has been slow. This is in large part due to a complete lack of clinical care centers and research centers. Investigators are frustrated by a lack of access to representative patient populations, and patients are frustrated by a lack of accessible expert clinical treatment centers. Funding

mechanisms to develop new centers for either clinical care or centers for research are shrinking, but the needs of this underserved very ill patient population are unmet and growing.

Therefore, the CFSAC recommends that the Secretary use the resources and talent of the agencies that make up the HHS to find ways to meet these needs. One starting point is our request that the HHS establish 5 regional clinical care, research, and education centers, centers which will provide care to this critically underserved population, educate providers, outreach to the community, and provide effective basic science, translational and clinical research on CFS. The advisory committee understands that fiscal exigencies have to date prevented the formation of these previously recommended centers, but it is our hope the Secretary will use the full weight of his office to effectively fund this program through existing funding mechanisms that might be available or new programs."

In November 28–29, 2007.—CFSAC voted unanimously to send the following recommendations to the Assistant Secretary for Health for transmittal to the Secretary:

—It is recommended that a representative of AHRQ be added as an ex officio member to CFSAC effective immediately, but at least in advance of the next CFSAC meeting. The next CFSAC meeting is scheduled to be held in May 2008.

—It is recommended that the CDC effort on CFS be restructured to reflect a broader expertise on the multifaceted capabilities required to execute a comprehensive program that incorporates the following elements:

  —an extramural effort directed by the Office of the Director;

  —sufficient funds for a program for which the authority and accountability is housed at the level of a coordinating center director;

  —a lab-based component that maintains the current search for biomarkers and pathophysiology;

  —the recommendations of the external CDC Blue Ribbon panel, including developing, analyzing, and evaluating new interventions and continuing support for longitudinal studies; and

  —an expanded patient, healthcare provider, and family caregiver education effort that is managed by staff with appropriate expertise in clinical and public education strategies.

In May 5–6, 2008.—The committee unanimously recommended 4 items. For the purpose of my testimony I quote: "CFSAC recommends to the Secretary of Health and Human Services that the Administrator of HRSA communicate with each Area Health Education Center (AHEC) regarding the critical need for provider education of CFS. HRSA has the potential to disseminate information on CFS to a wide range of providers, communities and educational institutions. HRSA should inform these groups that persons with CFS represent an underserved population and that there is a dramatic need for healthcare practitioners who can provide medical services to CFS patients. HRSA should further inform these groups that the CDC offers a web based CME program on CFS at www.cdc.gov/cfs; and encourage AHEC providers to participate in this CME program. Additionally, HRSA should alert AHECs of the availability of a CDC CFS provider toolkit."

In October 28–29, 2008.—Several recommendations were made. For the purpose of our testimony we quote:

—"It is recommended that DHHS solicit the Department of Education's cooperation on issues relating to pediatric CFS.

—"It is recommended that the Transition report to the new Administration and Secretary include the background of the CFSAC and CFS and a list of the recommendations that have been developed by this Committee over the past two chartered periods, with any action taken on each point.

—"CFSAC endorses the planned State of the Knowledge Conference to be developed by the NIH.

—"CFSAC recognizes that much can be done to ensure that every child with CFS has the best possible access to support and treatment and asks that the Secretary facilitate a taskforce or working group to establish an ongoing interagency and interdepartmental effort to coordinate school, family, financial, and healthcare support for children and young adults with CFS."

In October 29–30, 2009—Recommendation 1.—Establish Regional Centers funded by DHHS for clinical care, research, and education on CFS. (Resubmitted from May 2009)

As you can see, year after year, the same recommendation is being made, and yet there has not been any progress for the past 6 years in the most important recommendation from the CFSAC to the Secretary of Health regarding chronic fatigue syndrome. Therefore we urge you—our congressional leadership—to ensure funding for the Neuroendocrineimmune (NEI) Center™ and to the Whittemore Peterson In-

stitute. Please allocate funding for scientific research, clinical trials, patient registry, physician education, public education and social services to an estimated 20 million Americans stricken with neuroendocrineimmune disorders such as chronic fatigue syndrome (CFS) and related illnesses. Throughout the United States, day after day we witness great suffering being inflicted on individuals, children, teenagers, adults and the elderly. We witness children being taken from their families simply because they "have failed to find a primary physician to treat their child" (*Baldwin Family* vs. *DSS Buncombe County, North Carolina*). Too much suffering because it seems that no one in our government cares to take courageous step and stand up for individuals with CFS.

We urge you to provide funding to The NEI Center™, a patient-driven community initiative in the State of New Jersey (hopefully in Florida as well), which will address all of the issues mentioned on the CFSAC recommendation in addition to addressing patient's quality of life issues. The cornerstone of the NEI Center™ (www.neicenter.com) is that discoveries and advances made in any one of the neuroendocrineimmune illnesses: chronic fatigue syndrome (CFS), myalgic encephalomyelitis or encephalopathy (ME), fibromyalgia (FM), Gulf War syndrome/illness (GWS/GWI), multiple chemical sensitivity (MCS), environmental illness (EI), chronic or persistent Lyme disease (CLD–PLD), Alzheimer's Disease (AD), and autism, will be applicable and beneficial to other neuroendocrineimmune illnesses, thereby bringing us closer to a cure.

I ask you why hasn't this crucial issue be addressed promptly? Why has our government failed to address such injustice? I urge you to stand by the side of millions of Americans who presently do not have a voice. Their future depends on your vision. Help us to restore their health and their hopes. Please provide funding to the NEI Center™ and or similar efforts in the United States. This committee has the power. You can do it. And as one of the many individuals stricken with CFS, I thank you for this opportunity to share the plight of so many. We need a hero, and you have the opportunity to demonstrate vision, courage and foresight by allocating funding for future centers of excellence for CFS and other neuroendocrineimmune disorders. Thank you.

Prepared Statement of the Program for Appropriate Technology in Health

Program for Appropriate Technology in Health (PATH) appreciates the opportunity to submit written testimony regarding fiscal year 2011 funding for global health research and development to the Senate Labor, Health and Human Services, and Education, and Related Agencies Appropriations Subcommittee. PATH is an international nonprofit organization that creates sustainable, culturally relevant solutions, enabling communities worldwide to break longstanding cycles of poor health. By collaborating with diverse public- and private-sector partners, we help provide appropriate health technologies and vital strategies that change the way people think and act.

The ongoing struggle to improve global health relies on the availability of health interventions and technologies designed to prevent, diagnose, and treat disease. Although some effective interventions already exist, many more will be necessary if existing gains against infectious disease and other global health burdens are to be maintained and expanded. The drugs currently available for use against diseases that disproportionately impact the developing world are often too expensive for use in impoverished countries, and are also subject to disease resistance. Vaccines for many of these infectious diseases do not yet exist and diagnostic equipment, vaccine delivery devices, microbicides, contraceptives, and other health technologies appropriate for the developing world are in many cases not available or affordable. Achieving sustainable progress in the struggle to improve global health will require developing new health technologies, and creating or strengthening infrastructures that facilitate their availability to those who need them most.

Such discoveries will require increased funding for global health research and development (R&D). Although the U.S. Government remains one of the most important investors in the development of new technologies, the need overshadows the contribution.

When looking at U.S. spending on R&D writ large over the last four decades, Federal spending on all R&D, expressed as a percentage of gross domestic product (GDP), has declined by more than 60 percent: from just under 2 percent of GDP in

1965 to less than 1 percent in 2007.[1] During a speech delivered in early 2009, President Obama expressed a desire to reverse that trend by requesting a Federal R&D budget of $147.6 billion for fiscal year 2010 and by setting a goal of increasing national investment in R&D to more than 3 percent of GDP.[2] Seizing upon this momentum, in fiscal year 2010 Congress appropriated $150.4 billion for national research and development—a 2.4 percent increase from 2009 funding. While global health R&D is just one component of the overall national R&D budget, PATH thanks you for this allocation and believes that this is a significant step towards achieving our country's global health goals.

Robust and sustained R&D funding is crucial to continued global health advancements. Developing a single drug—from basic discovery to clinical testing to product licensure—can cost as much as $800 million and may take up to a decade.[3] Developing more complex products may take even longer and be even more expensive—as much as $1.2 billion.[4] R&D costs rise as products advance through clinical testing. In order to test whether a vaccine is safe and effective in humans, for example, researchers require thousands of volunteers and hundreds of health workers. As a result, late-stage trials are typically more expensive to complete than earlier trials.

Effective diagnosis at, or near, the point of care enables better application of available treatment, avoids overuse of antibiotics that can promote resistant strains of pathogens, and allows healthcare workers to track outbreaks and mobilize resources quickly. Several programs funded in the Labor, Health and Human Services, and Education, and Related Agencies appropriations bill make a particularly critical contribution to point-of-care diagnostics, a research area that is key to improving health in the developing world. In low-resource settings, where many diagnostic tests are difficult to perform and laboratories are often inaccessible, there is great opportunity to make significant improvements to global health through the development and use of appropriate point-of-care diagnostics. In poor countries, healthcare facilities can be far away from the widely dispersed populations they serve. Specialized equipment, personnel, and safe waste-disposal systems are often not available. Without diagnostic testing, healthcare professionals have to rely solely on symptoms to diagnose and treat illness—an imperfect method given the similarity of symptoms among many diseases. This lack of clarity puts individuals, communities, and the world in danger. Incorrect diagnoses can harm people and even cost lives. And from a global perspective, ineffectively treated disease can become a starting point for epidemic or pandemic outbreaks.

The National Institutes of Health (NIH) and the Centers for Disease Control and Prevention (CDC) continue to make significant contributions to the development of new health technologies. Generally speaking, NIH carries out the critical basic and preclinical research that provides the foundation for new product discovery and development, supports and conducts clinical trials of promising products, and develops the in-country research capacity of developing world partners. CDC monitors and tracks infectious diseases worldwide, provides those involved in the control and prevention of such diseases with the critical intelligence they need to implement their programs effectively, supports researchers in their work by helping to direct their efforts towards the areas with the greatest potential for benefit, and warns researchers when new trends or disease strains emerge.

Without sufficient funding for NIH and CDC, much of the cutting-edge R&D being performed on point-of-care diagnostics for the developing world would not be taking place. While many commercial and nonprofit groups are working on diagnostic technologies, they are not necessarily doing so with an eye toward the developing world. For example, their efforts often target diseases that mainly concern wealthier countries, or they assume that sophisticated laboratories and trained personnel will be available to complement and operate their diagnostics. In contrast, diagnostic technologies for malaria, enteric diseases, neglected diseases such as Chagas disease, and other conditions whose heaviest burden falls on the developing world do not have a significant commercial market to incentivize research and development. Without investment by the U.S. Government, efforts to develop lower cost, easy to use, and appropriate diagnostic technologies-and by doing so improve care and re-

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[1] National Science Foundation. *Gross domestic product and research and development (federally funded, non-Federal, and total): 1953–2007*. Arlington, VA: NSF; 2008. Available at: http://www.nsf.gov/statistics/nsf08318/pdf/tab13.pdf.

[2] Speech to NAS, April 27, 2009. http://www.whitehouse.gov/the__press__office/Remarks-by-the-President-at-the-National-Academy-of-Sciences-Annual-Meeting/.

[3] Conference Report to Accompany H.R. 2997. September 30, 2009. http://www.rules.house.gov/111/LegText/111__agcr__txt.pdf, p. 84.

[4] Tufts Center for the Study of Drug Development. Research Milestones. June 19, 2009. http://csdd.tufts.edu/Research/Milestones.asp http://www.accessdata.fda.gov/scripts/opdlisting/oopd/index.cfm.

duce the development of drug resistance—would be hindered significantly. Expanding funds for these agencies would provide a powerful boost to point-of-care diagnostic development and availability.

One promising area of innovation is nucleic acid (NA) amplification and detection, which is the most accurate way to diagnose many diseases that affect global health. Low-cost, highly accurate tests of this type are usually not available in low-resource settings. The small numbers of centralized laboratories that exist in developing countries tend to be in urban areas and cater primarily to the affluent. In contrast, rural healthcare facilities commonly have only basic equipment, and health workers have limited training and little ability to maintain equipment and handle reagents. Unreliable electric power to run the tests is also a major obstacle.

Research conducted by PATH with support from NIH and CDC has pointed to the technical feasibility of a new, low-cost, disposable diagnostic platform for NA tests that can be used for detection of a wide variety of infectious diseases, including infant HIV and tuberculosis (TB). Other combinations of diagnostic technologies are also being explored with support from USAID and private funders. Small, portable, low-cost, instrument-free NA amplification tests that do not require electricity would have a vital impact on the ability of health workers and clinicians in developing countries to correctly and quickly diagnose disease. Patients who come from long distances and often cannot wait a few days to receive test results would be able to receive a diagnosis and treatment regimen on site at the point of care. Such tests could potentially replace the need for multi-million dollar central laboratory facilities.

Another area where agencies funded by this subcommittee are making a significant contribution to global health is the ongoing effort to develop and test malaria vaccines. Malaria is a devastating parasitic disease transmitted through the bite of infected Anopheles mosquitoes. More than one-third of the world's population is at risk of malaria, with approximately 250 million cases and 1 million deaths per year. The vast majority of these deaths occur among African children under the age of 5. A malaria vaccine is desperately needed to confront this deadly disease and its impact in the developing world. While consistent use of effective insecticides, insecticide-treated nets, and malaria medicines saves lives, eradicating or even significantly reducing the impact of malaria will require additional interventions, including vaccines. Immunization is one of the most effective health interventions available. Just as it was necessary to use vaccines to control polio and measles in the United States, vaccines are needed as part of an effective control strategy for malaria.

Several Federal agencies are involved in R&D for malaria vaccines, in partnership with the PATH Malaria Vaccine Initiative (MVI). NIH supports much of the basic research that underpins malaria drug and vaccine development efforts; the National Institute of Allergy and Infectious Diseases, an institute within NIH, is a particularly central player in malaria vaccine development efforts. CDC performs epidemiological research and international disease surveillance of malaria, providing critical data on the prevalence and spread of each of the four strains of the malaria parasite and the effectiveness of existing interventions.

Indeed, many promising vaccine concepts would never have emerged from the laboratory without the research performed by Government scientists. Government-sponsored research is also critical to eliminating from consideration less promising approaches. Due in part to investments by the U.S. Government, there is one malaria vaccine candidate that, if proven, is just 5 years or so from introduction. In May 2009, RTS,S—developed by GlaxoSmithKline Biologicals—entered a large-scale phase 3 clinical trial, which is typically one of the final steps before licensure. The trial is being conducted at 11 African study centers in seven countries. Two of the centers, both in Kenya, are partnered with U.S. Government agencies, including the CDC and the Walter Reed Army Institute of Research. Results from one phase 2 clinical study show that RTS,S reduced the risk of clinical malaria by 53 percent in children aged 5 to 17 months. Although this is exciting news, it represents not an end, but a beginning for malaria vaccine development. In order to develop more effective vaccines towards the ultimate goal of eradication, increased investment in research and development at NIH and CDC must continue.

The U.S. Department of Health and Human Services is also using its investments in science and technology to facilitate pandemic influenza preparedness. With support from the Biomedical Advanced Research and Development Authority (BARDA), PATH is supporting the enhancement of sustainable influenza vaccine production capacity in Vietnam as part of global preparedness efforts for a future pandemic. We are collaborating with various partners in Vietnam, including the Government of Vietnam and vaccine manufacturers, to assist in the production and clinical evaluation of affordable, high-quality influenza vaccines. The project builds upon sup-

port that BARDA is currently providing to the World Health Organization to assist Vietnam in preparing for eventual licensure and commercial-scale manufacturing of influenza vaccines and is an important step toward increasing local and regional vaccines supplies. This is part of a long-term strategy of international capacity building. As the H1N1 outbreak demonstrated, the emergence of a pandemic strain is unpredictable and the public health response needs are to rapidly create, manufacture, and distribute novel vaccines. Because of global travel and our interconnected world, international cooperation on influenza preparedness has direct relevance for health here in the United States.

Continued progress in our Nation's effort to improve global health requires the development of new tools and technologies, which are heavily reliant on research performed and supported by NIH, CDC, and BARDA. For these reasons, we respectfully request robust funding for NIH, CDC, and BARDA to allow the agencies to maximize global health efforts, which each has stated as a priority for fiscal year 2011. Funding for these agencies is critical to moving forward research on HIV/AIDS, TB, malaria, and other diseases which disproportionately impact low-income countries. We support the President's budget request as the minimum amount needed for the Labor, Health and Human Services, and Education, and Related Agencies account for fiscal year 2011.

We very much appreciate the subcommittee's consideration of our views, and we stand ready to work with subcommittee members and staff to ensure continued support for these important issues which are essential to achieving our country's global health goals.

PREPARED STATEMENT OF PREVENT BLINDNESS AMERICA

Funding Request Overview

Prevent Blindness America (PBA) appreciates the opportunity to submit written testimony for the record regarding fiscal year 2011 funding for vision related programs. As the Nation's leading nonprofit, voluntary organization dedicated to preventing blindness and preserving sight, PBA maintains a long-standing commitment to working with policymakers at all levels of government, organizations, and individuals in the eye care and vision loss community, and other interested stakeholders to develop, advance, and implement policies and programs that prevent blindness and preserve sight. PBA respectfully requests that the subcommittee provide the following allocations in fiscal year 2011 to help promote eye health and prevent eye disease and vision loss:

—$5 million for the Vision Health Initiative at the Centers for Disease Control and Prevention (CDC);

—$1.2 million in fiscal year 2011 to support the Maternal and Child Health Bureau's (MCHB) National Universal Vision Screening for Young Children's Coordinating Center (Center);

—$730 million in fiscal year 2011 for the title V Maternal and Child Health (MCH) Services Block Grant; and

—Increased fiscal year 2011 funding for the National Eye Institute (NEI).

Introduction and Overview

Vision-related conditions affect people across the lifespan from childhood through elder years. Good vision is an integral component to health and well-being, affects virtually all activities of daily living, and impacts individuals physically, emotionally, socially, and financially. Loss of vision can have a devastating impact on individuals and their families. An estimated 80 million Americans have a potentially blinding eye disease, 3 million have low vision, more than 1 million are legally blind, and 200,000 are more severely visually blind. Vision impairment in children is a common condition that affects 5 to 10 percent of preschool age children. Vision disorders (including amblyopia ("lazy eye"), strabismus ("cross eye"), and refractive error are the leading cause of impaired health in childhood.

Of serious concern is that the NEI reports "the number of Americans with age-related eye disease and the vision impairment that results is expected to double within the next three decades." [1] Among Americans age 40 and older, the four most common eye diseases causing vision impairment and blindness are age-related macular degeneration (AMD), cataract, diabetic retinopathy, and glaucoma.[2] Refrac-

[1] "Vision Problems in the U.S.: Prevalence of Adult Vision Impairment and Age-Related Eye Disease in America," Prevent Blindness America and the National Eye Institute, 2008.

[2] Ibid.

tive errors are the most frequent vision problem in the United States—an estimated 150 million Americans use corrective eyewear to compensate for their refractive error.[3] Uncorrected or undercorrected refractive error can result in significant vision impairment.[4]

While half of all blindness can be prevented through education, early detection, and treatment, it is estimated that the number of blind and visually impaired people will double by 2030, if nothing is done to curb vision problems. To curtail the increasing incidence of vision loss in America, PBA advocates sustained and meaningful Federal funding for: programs that help promote eye health and prevent eye disease, vision loss, and blindness; needed services and increased access to vision screening; and vision and eye disease research. We thank the subcommittee for its consideration of our specific fiscal year 2011 funding requests, which are detailed below.

CDC's Vision Health Initiative: Helping To Save Sight and Save Money

The financial costs of vision impairment to our country's fiscal health are staggering. PBA estimates that the annual costs of adult vision problems in the United States are approximately $51.4 billion.[5] The annual cost of untreated amblyopia—reduced vision in an eye that has not received adequate use during early childhood—is approximately $7.4 billion in lost productivity.[6] NEI estimates that in 2003 the total direct and indirect costs of visual disorders and disabilities in the United States were approximately $68 billion, and with each passing year these costs continue to escalate.[7] Vision care services consistently have been found to help prevent blindness, reduce vision loss, improve quality of life and well-being, increase productivity, and reduce costs and burdens on the Nation's healthcare system. Therefore, the Nation must increase access to—and awareness of the importance of—vision screenings and linkage to appropriate care for at-risk and underserved populations, as is provided by the CDC's Vision Health Initiative.

The CDC reports that "vision disability is one of the top ten disabilities among adults 18 years and older and the single most prevalent disabling condition among children."[8] Effective public health initiatives can dramatically decrease the number of Americans who have vision loss or low vision. Initially funded by Congress in fiscal year 2003, the CDC's Vision Health Initiative has worked in a cost-effective way to identify, screen, and link to appropriate care individuals at risk for vision loss. This public-private partnership combines the resources of the CDC, chronic disease directors, State and local agencies on aging, and nonprofit organizations such as PBA. Highlights of the significant work of the CDC's Vision Health Initiative include:

—Supporting the eye evaluation component of the National Health and Nutrition Examination Survey (NHANES) that provides current, nationally representative data and helps assess progress for vision objectives contained within Healthy People 2010 and the future efforts for Healthy People 2020.

—Utilizing applied public health research to address the economic costs of vision disorders and develop cost-effectiveness models for eye diseases among various populations. Estimating the true economic burden is essential for informing policymakers and for obtaining necessary resources to develop and implement effective interventions.

—Aiding in the translation of science into programs, services, and policies and in coordinating service activities with partners in the public, private, and voluntary sectors.

  —Under the leadership of researchers at Johns Hopkins University investigating the best methods for identifying patients who need eye care services and providing linkages to follow-up care within community health centers.

  —In coordination with researchers at Duke University evaluation of strategies in primary care and pediatric settings to improve the detection of childhood vision conditions and diseases.

—Providing data analyses and a systematic review of interventions to promote screening for diabetic retinopathy and reviewing access to and utilization of vision care in the United States.

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[3] Ibid.

[4] Ibid.

[5] "The Economic Impact of Vision Problems," Prevent Blindness America, 2007.

[6] "Our Vision for Children's Vision: A National Call to Action for the Advancement of Children's Vision and Eye Health, Prevent Blindness America," Prevent Blindness America, 2008.

[7] Ellwein Leon. Updating the Hu 1981 Estimates of the Economic Costs of Visual Disorders and Disabilities.

[8] "Improving the Nation's Vision Health: A Coordinated Public Health Approach," Centers for Disease Control, 2006.

—Developing the first optional Behavioral Risk Factor Surveillance System (BRFSS) vision module and introducing it into State use in 2005 to gather information about access to eye care and prevalence of eye disease and eye injury. Five States implemented the module in 2005, and 11 States began using the module in 2006.

In fiscal year 2010, PBA requested $4.5 million to sustain and expand the Vision Health Initiative. In the final fiscal year 2010 Consolidated Appropriations Act, Congress allocated $3.229 million a $7,000 increase from fiscal year 2009. PBA understands the budgetary challenges facing Congress and the Nation and, as such, appreciates this much-needed funding. However, with the demographics of eye disease, we strongly feel that a greater investment in the Vision Health Initiative must be made, so we can mount an adequate effort to address the growing public health threat of preventable vision loss among older Americans, low-income, and underserved populations.

To that end, PBA respectfully requests the subcommittee provide a $5 million allocation for the Vision Health Initiative. This level of investment will help the CDC sustain and expand its efforts to address the growing public health threat of preventable vision loss among at-risk and underserved populations. Additional fiscal year 2011 resources will support: strengthen State-based public health efforts to address vision and eye health; development of additional evidence-based public health interventions that improve eye health among the Nation's most at-risk and underserved; and expand initiatives to address the growing problem of diabetes among children and the associated impacts of diabetic retinopathy, which can develop later in life.

Investing in the Vision of Our Nation's Most Valuable Resource—Children

While the risk of eye disease increases after the age of 40, eye and vision problems in children are of equal concern, due to the fact that, if left untreated, they can lead to permanent and irreversible visual loss and/or cause problems socially, academically, and developmentally. Although more than 12.1 million school-age children have some form of a vision problem, only one-third of all children receive eye care services before the age of 6.[9] Approximately 80 percent of what a child learns is done so visually.[10] As such, good vision is essential for educational progress, proper physical development and athletic performance, and healthy self-esteem in growing children. Yet, according to a CDC report, only 1 in 3 children in America has received eye care services before the age of 6.

In 2009, the Maternal and Child Health Bureau created the National Universal Vision Screening for Young Children Coordinating Center, a national vision health collaborative effort aimed at developing the public health infrastructure necessary to promote eye health and ensure access to a continuum of eye care for young children. PBA is requesting $1.2 million in fiscal year 2011 for the National Universal Vision Screening for Young Children Coordinating Center.

With this level of funding, the Center, will continue to:

—Partner with public and private entities—including State title V programs for Children with Special Health Care Needs, pediatricians and primary care providers, families and parent organizations, professional societies and associations, Family-to-Family Health Information Centers, and State and community agencies such as Healthy Start, Head Start, and elementary schools—to expand the cadre of key stakeholders interested in promoting young children's vision health and improving early identification of vision problems in young children.

—Develop and implement a statewide strategy to achieve universal screening of children by age 4.

—Determine a mechanism for uniform collection and reporting of children's vision care and eye health data.

With fiscal year 2011 funding, the Center also will be able to:

—Broaden partnerships and expand coordination between the Center, the State agencies that administer the title V Maternal and Child Health Block Grant, and other State public health entities to improve the early identification of vision problems in children.

—Support a consensus conference involving MCHB, CDC, the Agency for Healthcare Research and Quality, NEI, and the Office of Head Start to establish national standards for vision screening in young children.

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[9] "Our Vision for Children's Vision: A National Call to Action for the Advancement of Children's Vision and Eye Health, Prevent Blindness America," Prevent Blindness America, 2008.

[10] Ottar WL, Scott WK, Holgado SI. Photoscreening for amblyogenic factors. *J Pediatr Ophthalmol Strabismus*. 1995; 32:289–295.

In addition, States need increased resources to sustain and expand the provision of critical healthcare services to millions of pregnant women, infants, and children, including those with vision and eye care needs. Beyond direct services, the Maternal and Child Health (MCH) Services Block Grant supports vital public health services and systems that promote optimal health and help prevent disease. Therefore, Prevent Blindness America supports appropriating $730 million in fiscal year 2011 for the title V MCH Services Block Grant.

Advance and Expand Vision Research Opportunities

PBA calls upon the subcommittee to increase its support for the NEI to bolster its efforts to identify the underlying causes of eye disease and vision loss, improve early detection and diagnosis of eye disease and vision loss, and advance prevention and treatment efforts. Research is critical to ensure that new treatments and interventions are develop to help reduce and eliminate vision problems and potentially blinding eye diseases facing consumers across the country. In 2009, Congress commended the NEI's leadership in basic and translational research through H. Res. 366 and S. Res. 209, which recognized NEI's 40 years as the National Institutes of Health Institute that leads the Nation's commitment to save and restore vision. The resolutions also designated 2010–2020 as the Decade of Vision in recognition of the increasing health and economic burden of eye disease, mainly as a result of an aging population.

The NEI will be able to continue to grow its efforts to:

—Expand capacity for research, as demonstrated by the significant number of high-quality grant applications submitted in response to ARRA opportunities.

—Address unmet need, especially for programs of special promise that could reap substantial downstream benefits, as identified by new NIH Director Dr. Francis Collins.

—Fund research to reduce healthcare costs, increase productivity, and ensure the continued global competitiveness of the United States.

By increasing funding for the NEI at the NIH, essential efforts to identify the underlying causes of eye disease and vision loss, improve early detection and diagnosis of eye disease and vision loss, and advance prevention, treatment efforts, and health information dissemination will be bolstered.

Conclusion

On behalf of PBA, our Board of Directors, and the millions of people at risk for vision loss and eye disease, we thank you for the opportunity to submit written testimony regarding fiscal year 2011 funding for the CDC's Vision Health Initiative, the Maternal and Child Health Bureau's National Universal Vision Screening for Young Children Coordinating Center and title V MCH Block Grants and the NEI. Please know that PBA stands ready to work with the subcommittee and other Members of Congress to advance policies that will prevent blindness and preserve sight. Please feel free to contact us at any time; we are happy to be a resource to subcommittee members and your staff. We very much appreciate the subcommittee's attention to—and consideration of—our requests.

PREPARED STATEMENT OF THE PANCREATIC CANCER ACTION NETWORK

Mr. Chairman and members of the subcommittee: First and foremost, I want to thank you for your leadership and support for medical research carried out under the auspices of the National Institutes of Health (NIH). Your continuing support recognizes that the basic resource of this country is its people, and the Nation's strength can be no greater than the health of its citizenry.

On behalf of the patients, families and scientists who make up the Pancreatic Cancer Action Network, I especially thank you for helping to shine a spotlight on the fourth leading cause of cancer death in the United States and one of the most lethal forms of cancer: pancreatic cancer. Your vigilance and encouragement is helping to correct that situation. Unfortunately, of the more than 42,000 diagnosed with pancreatic cancer last year, statistically, 76 percent died within 12 months of their diagnosis and 95 percent will die within 5 years. We therefore still have a long way to go before the diagnosis does not nearly guarantee a death sentence. And we have a long way to go before the only major cancer with a 5-year survival rate still in the single digits enjoys the progress made against so many other forms of cancer.

Two years ago some of you and your colleagues met with Dr. Randy Pausch, whose book, The Last Lecture, inspired millions of us to live our dreams. He inspired us even though he was facing his toughest life challenge; he was battling pancreatic cancer.

Dr. Pausch's last appearance on Capitol Hill was in March 2008. He died 4 months later. His message was that we must change the research paradigm at NIH by providing more funding for the hardest research problems like pancreatic cancer because if we tackle the hardest problems, it will help us solve the easier problems.

Since Dr. Pausch's death there has been increased publicity of this deadly disease with the subsequent diagnosis and death of actor Patrick Swayze, and the diagnosis of U.S. Supreme Court Justice Ruth Bader Ginsberg. Despite this publicity, the cold, hard fact remains that the number of new cases diagnosed and the number of deaths caused by pancreatic cancer are increasing. In fact, according to some experts, the number of new pancreatic cancer cases was projected to rise by 12 percent in 2009, and to grow by 55 percent by the year 2030. These are startling numbers. We must take action now to not only change the current statistics, but to ensure that we have the tools for the future.

But what patients, families, and advocates find most troubling is that while remarkable progress has been made against so many other forms of cancer, the progress we have made to detect or treat pancreatic cancer has changed little over the past 40 years:

—There is no early detection for pancreatic cancer and many of the risk factors are benign. As a result, the disease is usually diagnosed in its late stages, often after it has metastasized to other organs.

—There are no effective treatment options, except for a surgical procedure called the Whipple that only approximately 15 percent of all pancreatic cancer patients are eligible for and 80 percent of patients who have the surgery have a recurrence and die within 5 years.

So, why has progress in pancreatic cancer been so slow in coming? The answer is two-fold. The pancreas is complex and, because of its location, a difficult organ to study. But frankly, the real obstacle is the failure to make this a priority. Despite the fact that pancreatic cancer is the fourth-leading cause of cancer death in the United States, historically less than 2 percent of the National Cancer Institute's (NCI's) budget is devoted to research in this field. I have included for the record a chart of NCI funding for the top five cancer killers—which includes pancreatic cancer—and their respective survival rates. This chart demonstrates in very dramatic fashion that there is a clear correlation between low investment in research and poor survival rates. When an investment has been made, the 5-year survival rates reflect those efforts.

In the absence of a concerted, well-focused scientific agenda, promising research applications go unfunded; opportunities to explore early screening techniques and more effective therapeutic agents are forgone; and investigators become discouraged and move to other fields of study.

Recommendations

How can the problem be corrected? Yes, funding for the NCI must be increased. In that regard, we join with our partners in the One Voice Against Cancer Coalition to ask that you provide $5.79 billion in funding for the NCI in fiscal year 2011—an increase of $691 million over the fiscal year 2010 appropriation.

But steps must also be taken to mount a sustainable research effort against pancreatic cancer. Far more resources—money which will attract more scientists—must be brought to bear in order to find early detection tools and more effective treatments. To those ends, we strongly recommend that:

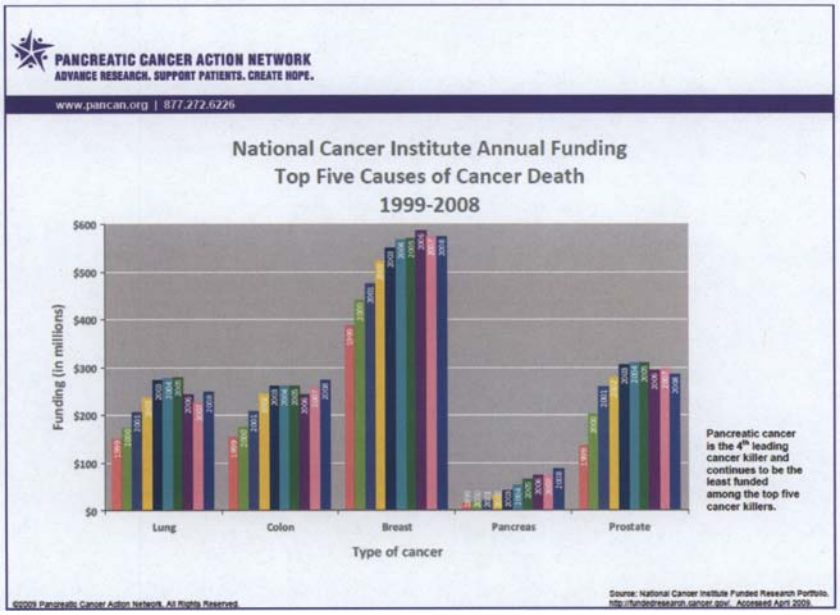
—a pancreatic cancer research grant program be established, like the program outlined in the H.R. 745 The Pancreatic Cancer Research and Education Act, to support prioritized research projects focused on basic research, finding more precise diagnostic and early detection tools and innovative clinical trials on promising therapeutic agents;

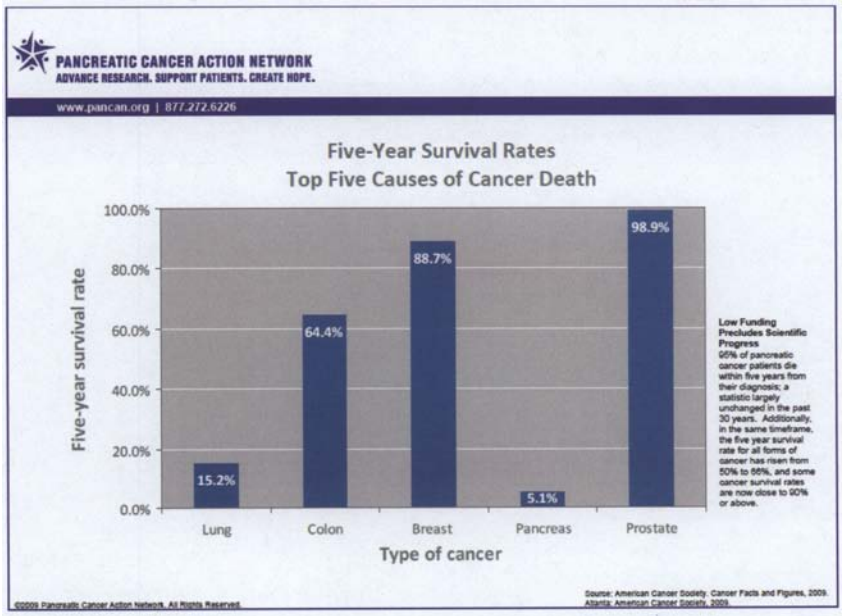
—a policy of "exceptions" funding for grant applications whose primary focus is on pancreatic cancer needs to be re-instituted at the NCI; and

—there must be more pancreatic cancer experts included on scientific review panels.

Though the pool of NCI-funded researchers investigating pancreatic cancer has gradually expanded in recent years, it still remains disproportionately miniscule when compared to the number of researchers in the other leading cancer fields. The recommendations I have outlined will help remedy that problem. They will also challenge the research community to rely less on "safe bets" and tackle difficult, high-risk problems, such as pancreatic cancer.

Thank you for your time and consideration.





PREPARED STATEMENT OF THE PEW CHILDREN'S DENTAL CAMPAIGN

The Pew Children's Dental Campaign, a campaign of the Pew Center on the States, would like to thank the Subcommittee Chairman for allowing the submission of this testimony in support of fiscal year 2011 appropriations for oral health programs.

The Pew Campaign works primarily at the State level to ensure that more children receive dental care and benefit from policies proven to prevent tooth decay. We are also mounting a national campaign to raise awareness of the problem, recruit influential leaders to call for change, and showcase states that have made progress and can serve as models for pragmatic, cost-effective reform.

The Cost of Delay, recently released by The Pew Center on the States, found that 10 years after the 2000 report by the U.S. Surgeon General called dental disease a "silent epidemic," too little has changed. The report finds that two-thirds of the States are failing to ensure that disadvantaged children get the dental healthcare they need. The good news is that this problem can be solved. At a time when State budgets are strapped, children's dental health presents a rare opportunity for Federal policy makers to make meaningful investments without breaking the bank-while delivering a strong return to taxpayers.

The consequences of poor dental health among children are far worse—and longer lasting—than most policy makers and the public realize.

—*Early growth and development*.—Having healthy baby teeth is vital to proper nutrition and speech development and sets the stage for a lifetime of dental health.

—*School readiness and performance*.—In a single year, more than 51 million hours of school may be missed because of dental-related illness.

—*Overall health*.—A growing body of research indicates that periodontal disease—gum disease—is linked to cardiovascular disease, diabetes and stroke.

—*Economic consequences*.—An estimated 164 million work hours each year are lost because of dental disease. Dental problems can hinder a person's ability to get a job in the first place

Adequately funding Federal oral health programs will provide critical resources to States to plan, develop, coordinate, and operate cost-effective dental programs that prevent dental disease. Two ongoing Federal grant programs housed in the Centers for Disease Control and Prevention and the Human Resources and Services Administration directly support The Pew Campaign's goals, as do several new oral health prevention and workforce programs established by Public Law 111–148—Patient Protection and Affordable Care Act.

The Pew Center on the States asks that the Subcommittee consider the following fiscal year 2011 funding requests:

Support the expansion of established Federal grant programs:

—*CDC State Grants Program, Surveillance, and Technical Assistance—Division of Oral Health*.—With CDC support, States can better promote oral health and efficiently administer scarce resources, monitor oral health status and problems, and conduct and evaluate prevention programs. This funding is critical to a State's ability to prevent problems before they occur, rather than treating them when they are painful and expensive. These programs also support State community water fluoridation programs and school-based dental sealant programs.

For example, research shows that community water fluoridation offers one of the greatest return-on-investment of any preventive healthcare strategy. For most cities, every $1 invested in water fluoridation saves $38 in dental treatment costs. More than $1 billion could be saved annually if the remaining water supplies in the United States were fluoridated, according to the Centers for Disease Control.

Pew supports expansion of this grant program to $33 million per year in order to reach all 50 States and the District of Columbia; an increase of $18 million more than the fiscal year 2010 appropriation.

This program is authorized under section 4102 of Public Law 111–148 as an amendment to the Public Health Service Act. Funding for this program fits the criteria for uses of the Public Health and Prevention Fund (fiscal year 2011 = $750 million). Please recommend and approve the transfer of $18 million of the Public Health and Prevention Fund to fulfill the program's authorization to support all 50 States.

HRSA Dental Health Improvement Grants.—This program provides grants to States to support oral health workforce activities, under section 340G of the Public Health Service Act, and provide the opportunity for States to implement a range of innovative approaches to improve access to oral health services including, projects that address the oral health workforce needs of underserved areas in both urban and rural locations. For example, Florida used its Human Resources and Services Agency workforce grant for a task force that resulted in a regulatory change to expand the use of hygienists to improve the efficiency of sealant programs. Kansas is using these resources for several objectives, including promoting extended care permit utilization for dental hygienists and funding loan repayment programs for professionals working in underserved areas among other goals.

Pew supports a grant program that is funded to reach all 50 States and the District of Columbia at a level of $20 million per year.

Fully fund newly authorized or expanded oral health prevention programs in Public Law 111–148:

School-based Sealant Programs—Establishment of school-based dental sealant programs.—The law requires that each of the 50 States and territories receive a grant for school-based dental sealant programs as well as to provide funding to Indian tribes. Sealants-clear plastic coatings applied by a hygienist or dentist-cost one-third as much as filling a cavity, and have been shown after just one application to prevent 60 percent of decay in molars. In The Cost of Delay, Pew finds that only 17 States have sealant programs that reach even one-quarter of their high-risk schools, and 11 reported having no programs at all.

This program is authorized under section 4102 of Public Law 111–148 as an amendment to the Public Health Service Act and is an eligible use of funding from the Public Health and Prevention Fund (fiscal year 2011 = $750 million). Please recommend and approve the transfer of $312.5 million of the Public Health and Prevention Fund to fulfill the program authorization to fund all 50 states. The estimated cost for fiscal year 2011 provides for rapid acceleration and start-up funding along with information technology and evaluation. The annual costs in fiscal year 2013 and beyond should be significantly less as the programs integrate with insurance payment options. This estimate assumes full funding of the CDC State Grants Program request (above) to support the additional expertise and management necessary for these programs.

Alternative Dental Health Care Providers Demonstration Project.—The law establishes/authorizes a 5-year, demonstration program beginning within 2 years of enactment (no later than March 23, 2012) to train or employ alternative dental healthcare providers in order to increase access to dental healthcare services in rural and other underserved communities. Each grant shall equal not less than $4 million (for the life of the project).

Pew requests $16 million for the first year of this program with at least a 2-year period of availability. The $16 million will allow up to four eligible entities to plan and implement a demonstration project funded at $4 million over the 5-year project. Pew supports ramping up the appropriations for this program in fiscal year 2012 to support additional eligible entities to apply for demonstration projects.

The U.S. Department of Health and Human Services has designated more than 4,000 areas across the country as Dental Health Professional Shortage Areas (DHPSAs). More than 46 million people live in DHPSAs across the United States, an estimated 30 million of whom lack access to a dentist.

In 2006, roughly 4,500 new dentists graduated from the United States' 56 dental schools. But it would take more than 6,600 dentists choosing to practice in DHPSAs to provide care for those 30 million people. More than 10 percent of those are needed in Florida alone, where it would take at least 751 new dentists to close the access gap.

These dentist shortages are projected to worsen. Although several dental schools have opened in the past few years, the number of dentists retiring every year will soon exceed the number of new dentists graduating and entering practice. In 2006, more than one-third of all practicing dentists were older the age of 55 and edging toward retirement. The Federal expansion of Medicaid and public insurance including dental services will also compound the relative shortage of dentists and further limit access to care. In 2009, Minnesota became the first state in the country to authorize a new primary care dental provider called a dental therapist at both a basic and advanced level. At least 12 States are considering similar models.

Oral Healthcare Prevention Education Campaign.—The law establishes a 5-year national, public education campaign that is focused on oral healthcare prevention and education. The campaign is required to use science-based strategies to convey oral health prevention messages that include, but are not limited to, community water fluoridation and dental sealants.

This program is authorized under section 4102 of Public Law 111–148 as an amendment to the Public Health Service Act and is an eligible use of funding from the Public Health and Prevention Fund (fiscal year 2011 = $750 million). Please recommend and approve the transfer of $2 million of the Public Health and Prevention Fund to fulfill the program mandate. This estimate assumes that planning and testing of messages occurs during fiscal year 2011 while the major public education campaign would take place in fiscal year 2012 and beyond.

In total the Pew Center on the States asks the committee to make the following investment in improving oral health for children in the fiscal year 2011 budget:

[In millions of dollars]

	Amount
Total fiscal year 2011 request	383.5
Increase over 2010 appropriations for existing programs	351
Amount of increase funded by the Prevention and Public Health Fund	332.5
Increased investment in oral health out of the 302(b) subcommittee budget allocation	51

By making targeted Federal investments in effective policy approaches, States can help eliminate the pain, missed school hours and long-term health and economic consequences of untreated dental disease among kids. A handful of States are leading the way, but all States can and must do more to ensure access to dental care for America's children most in need. Thank you for your consideration of this testimony.

PREPARED STATEMENT OF THE PULMONARY HYPERTENSION ASSOCIATION

Mr. Chairman, thank you for the opportunity to submit testimony on behalf of the Pulmonary Hypertension Association (PHA).

I would like to extend my sincere thanks to the subcommittee for your past support of pulmonary hypertension (PH) programs at the National Institutes of Health (NIH), Centers for Disease Control and Prevention, and Health Resources and Services Administration. These initiatives have opened many new avenues of promising research, helped educate hundreds of physicians in how to properly diagnose PH, and raised awareness about the importance of organ donation and transplantation within the pulmonary hypertension (PH) community.

I particularly want to thank the subcommittee for the unprecedented support you provided to the NIH as part of the American Recovery and Reinvestment Act. PH research has benefited substantially from that investment with more than 17 PH-specific projects receiving ARRA funding.

I am honored today to represent the hundreds of thousands of Americans who are fighting a courageous battle against a devastating disease. Pulmonary hypertension is a serious and often fatal condition where the blood pressure in the lungs rises to dangerously high levels. In PH patients, the walls of the arteries that take blood from the right side of the heart to the lungs thicken and constrict. As a result, the right side of the heart has to pump harder to move blood into the lungs, causing it to enlarge and ultimately fail.

PH can occur without a known cause or be secondary to other conditions such as: collagen vascular diseases (i.e., scleroderma and lupus), blood clots, HIV, sickle cell, or liver disease. PH impacts patients of all races, genders, and ages. Preliminary data from the REVEAL Registry suggests that the ratio of women to men who develop PH is 4:1. Patients develop symptoms that include shortness of breath, fatigue, chest pain, dizziness, and fainting. Unfortunately, these symptoms are frequently misdiagnosed, leaving patients with the false impression that they have a minor pulmonary or cardiovascular condition. By the time many patients receive an accurate diagnosis, the disease has progressed to a late stage, making it impossible to receive a necessary heart or lung transplant.

PH is chronic and incurable with a poor survival rate. Fortunately, new treatments are providing a significantly improved quality of life for patients with some managing the disorder for 20 years or longer.

Nineteen years ago, when three PH patients found each other, with the help of the National Organization for Rare Diseases, and founded the Pulmonary Hypertension Association, there were less than 200 diagnosed cases of this disease. It was virtually unknown among the general population and not well known in the medical community. They soon realized that this was unacceptable, and formally established PHA, which is headquartered in Silver Spring, Maryland.

I am pleased to report that we are making good progress in our fight against this deadly disease. Six new therapies for the treatment of PH have been approved by the FDA in the past 10 years.

THE PULMONARY HYPERTENSION COMMUNITY

Mr. Chairman, I am privileged to serve as the President of the Pulmonary Hypertension Association and to interact daily with the patients and family members who are seeking to live their lives to the fullest in the face of this deadly, incurable disease.

Carl Hicks is a former Army Ranger and a retired Colonel who led the first battalion into Iraq during the first Iraq war. Every member of his family was touched by pulmonary hypertension after the diagnosis of his daughter Meghan in 1994. I share their story here, in Carl's own words:

"'We're sorry Colonel Hicks, your daughter Meaghan has contracted primary pulmonary hypertension. She likely has less than a year to live and there is nothing we can do for her.'

"Those words were spoken in the spring of 1994 at Walter Reed Army Medical Center. They marked the start down the trail of tears for a young military family that, only hours before, had been in Germany. My family's journey down this trail hasn't ended yet, even though Meaghan's fight came to an end with her death on January 30, 2009. She was 27.

"Pulmonary hypertension struck our family, as it so often does, without warning. One day, we had a beautiful, healthy, energetic 12-year old gymnast, the next, a child with a death sentence being robbed of every breath by this heinous disease. The toll of this fight was far-reaching. Over the years, every decision of any consequence in the family was considered first with regards to its impact on Meaghan and her struggle for breath.

"The investment made by our country in my career was lost, as I left the service to stay nearer my family. The costs for Meaghan's medical care, spread over the nearly 14 years of our fight, ran well into the seven figures. Meghan even underwent a heart and dual-lung transplant. These challenges, though, were nothing compared to the psychological toll of losing Meaghan who had fought so hard for something we all take for granted, a breath of air."

Over the past decade, treatment options, and the survival rate, for pulmonary hypertension patients have improved significantly. As Meaghan's story illustrates, however, courageous patients of every age lose their battle with PH each day. There is still a long way to go on the road to a cure and biomedical research holds the promise of a better tomorrow.

Thanks to congressional action, and to advances in medical research largely supported by the NHLBI and other government agencies, PH patients have an increased chance of living with their pulmonary hypertension for many years. However, additional support is needed for research and related activities to continue to develop treatments that will extend the life expectancy of PH patients beyond the NIH estimate of 2.8 years after diagnosis.

FISCAL YEAR 2011 APPROPRIATIONS RECOMMENDATIONS

National Heart, Lung and Blood Institute

In 2008, World Health Organization's Fourth World Symposium on Pulmonary Hypertension brought together PH experts from around the world. According to these leading researchers, we are on the verge of significant breakthroughs in our understanding of PH and the development of new and advanced treatments. Fifteen years ago, a diagnosis of PH was essentially a death sentence, with only one approved treatment for the disease. Thanks to advancements made through the public and private sector, patients today are living longer and better lives with a choice of seven FDA approved therapies. Recognizing that we have made tremendous progress, we are also mindful that we are a long way from where we want to be in (1) the management of PH as a treatable chronic disease, and (2) a cure.

We are grateful to the National Heart, Lung and Blood Institute for their leadership in advancing research on PH. Our Association is proud to jointly sponsor investigator training grants (K awards) with NHLBI aimed at supporting the next generation of pulmonary hypertension researchers.

Moreover, we were very pleased that NHLBI recently convened some of the community's leading scientists for a Working on Group on Pulmonary Hypertension. This panel is charged with developing recommendations that will guide PH research in the coming years. An overview of the Working Group's plan will be published in the American Journal of Respiratory and Critical Care Medicine this year and we encourage the subcommittee to support its implementation by NHLBI.

Mr. Chairman, expanding clinical research remains a top priority for patients, caregivers, and PH investigators. We are particularly interested in establishing a pulmonary hypertension research network. Such a network would link leading researchers around the United States, providing them with access to a wider pool of shared patient data. In addition, the network would provide researchers with the opportunities to collaborate on studies and to strengthen the interconnections between basic and clinical science in the field of pulmonary hypertension research. Such a network is in the tradition of the NHLBI, which, to its credit and to the

benefit of the American public, has supported numerous similar networks including the Acute Respiratory Distress Syndrome Network and the Idiopathic Pulmonary Fibrosis Clinical Research Network. We encourage the NHLBI to move forward with the establishment of a PH network in fiscal year 2011.

For fiscal year 2011, PHA joins with other voluntary patient and medical organizations in recommending an appropriation of $35 billion for NIH. This level of funding will ensure continued expansion of research on rare diseases like pulmonary hypertension and build upon the significant investment made in the NIH as part of the American Recovery and Reinvestment Act.

Centers for Disease Control and Prevention

Mr. Chairman, we are grateful to you and the subcommittee for providing funding in fiscal year 2010 for the continuation of PHA's Pulmonary Hypertension Awareness Campaign. We know for a fact that Americans are dying due to a lack of awareness of PH, and a lack of understanding about the many new treatment options. This unfortunate reality is particularly true among minority and underserved populations. More needs to be done to educate both the general public and healthcare providers if we are to save lives.

To that end, PHA has utilized the funding provided through the CDC to: (1) launch a successful media outreach campaign focusing on both print and online outlets; (2) expand our support programs for previously underserved patient populations; and: (3) establish PHA Online University, an interactive curriculum-based Web site for medical professionals that targets pulmonary hypertension experts, primary care physicians, specialists in pulmonology/cardiology/rheumatology, and allied health professionals. The site is continually updated with information on early diagnosis and appropriate treatment of pulmonary hypertension. It serves as a center point for discussion among PH-treating medical professionals and offers Continuing Medical Education and CEU credits through a series of online classes.

"Gift of Life" Donation Initiative at HRSA

PHA applauds the success of the Health Resources and Services Administration's "Gift of Life" Donation Initiative. This important program is working to increase organ donation rates across the country. Unfortunately, the only "treatment" option available to many late-stage PH patients is a lung, or heart and lung, transplantation. This grim reality is why PHA established "Bonnie's Gift Project."

"Bonnie's Gift" was started in memory of Bonnie Dukart, one of PHA's most active and respected leaders. Bonnie battled with PH for almost 20 years until her death in 2001 following a double lung transplant. Prior to her death, Bonnie expressed an interest in the development of a program within PHA related to transplant information and awareness. PHA will use "Bonnie's Gift" as a way to disseminate information about PH, transplantation, and the importance of organ donation, as well as organ donation cards, to our community.

PHA has had a very successful partnership with HRSA's "Gift of Life" Donation Program in recent years. Collectively, we have worked to increase organ donation rates and raise awareness about the need for PH patients to "early list" on transplantation waiting lists. For fiscal year 2011, PHA recommends an appropriation of $30 million for this important program.

LETTER FROM PUBLIC HEALTH—SEATTLE AND KING COUNTY

March 19, 2010.

Hon. TOM HARKIN,
Chairman, Subcommittee on Labor, Health and Human Services, and Education, and Related Agencies
Washington, DC.

Hon. THAD COCHRAN,
Ranking Member, Subcommittee on Labor, Healthy and Human Services, and Education, and Related Agencies,
Washington, DC.

DEAR SENATORS HARKIN AND COCHRAN: As a large public health agency serving King County, Washington we urge your subcommittee to invest in programs that provide all of our Nation's youth with comprehensive, medically accurate, and age-appropriate sex education that helps them reduce their risk of unintended pregnancy, HIV, and other sexually transmitted infections (STIs).

For the first time in more than a decade, the Nation's teen pregnancy rate rose 3 percent in 2006. During this time, teens were receiving less information about contraception in schools and their use of contraceptives was declining. While making

up only one-quarter of the sexually active population, young people aged 15–24 account for roughly half of the approximately 19 million new cases of STIs each year. Those aged 13–24 account for one-sixth of new HIV infections, the largest share of any group.

We are pleased that the President's fiscal year 2011 budget request once again included funding for more comprehensive and evidence-based approaches to sex education. However, by focusing the funding on teen pregnancy prevention, and not including the equally important health issues of STIs including HIV, the administration has missed an opportunity to provide true, comprehensive sex education that promotes healthy behaviors and relationships for all young people, including lesbian, gay, bisexual, and transgender youth. We must strategically and systemically provide young people with all the information and services they need to make responsible decisions about their sexual health. Therefore, we request that the teen pregnancy prevention initiative be broadened to address STIs, including HIV, in addition to the prevention of unintended teen pregnancy.

Most of the evidence-based programs that have been proven effective at reducing risk factors associated with unintended teenage pregnancy and STIs by delaying sexual activity and increasing contraceptive use emphasize abstinence as the safest choice and also discuss contraceptive use as a way to avoid pregnancy and sexually transmitted infections, including HIV. In light of the evidence and recognizing more than half of young people have had sexual intercourse by the age of 18 and are at risk of both unintended pregnancy and STIs, we request that the subcommittee direct the Office of Adolescent Health to prioritize funds to programs that are more comprehensive in scope insofar as they encourage abstinence but also encourage young people to always use condoms or other contraceptives when they are sexually active. Leading public health and medical professional organizations—including the American Medical Association, the American Academy of Pediatrics, the Society of Adolescent Medicine, and the American Psychological Association—support a comprehensive approach to educating young people about sex. In addition, the vast majority of parents want the Federal Government to fund programs that are medically accurate, age-appropriate, and educate youth about both abstinence and contraception.

Congress should continue to act in the best interest of young people by supporting public health and education policies that are comprehensive, rooted in the best science, and reflect mainstream values. We urge you to include in the Subcommittee on Labor, Healthy and Human Services, and Education, and Related Agencies appropriations bill the strongest possible initiative that will meet the needs of all young people and help them achieve healthier and safer lives.

Sincerely,

MATTHEW GOLDEN, MD, MPH,
Director, HIV/STD Program,
Public Health—Seattle and King County.

PREPARED STATEMENT OF THE PKD FOUNDATION

Mr. Chairman, Ranking Member, and members of the subcommittee: Thank you for the opportunity to provide testimony on behalf of the PKD Foundation and the more than 600,000 Americans and 12.5 million people world-wide suffering from polycystic kidney disease (PKD). This subcommittee's commitment to advancing the great work of the National Institutes of Health (NIH) is legendary, and it must be continued. To meet that need, the PKD Foundation supports funding NIH at $35 billion in fiscal year 2011. Underfunding NIH will only slow the pace and progress of scientific discoveries for PKD patients and all people living with a life-threatening disease or chronic condition.

The PKD Foundation also supports an appropriation of $500 million to the newly authorized Cures Acceleration Network (CAN) as established under the Patient Protection and Affordable Care Act (Public Law 11–148; title X: sec. 10409). In order to help bridge the biomedical research "valley of death," CAN and other innovative initiatives aimed at improving translational research and regulatory science at NIH must be fully funded.

PKD Essentials

Polycystic kidney disease or PKD is one of the world's most prevalent, life-threatening, genetic diseases affecting more than 600,000 Americans including newborns, children and adults regardless of gender, age, race or ethnicity. With the presence of PKD, cysts develop in both kidneys, leading to an increase in kidney size and weight. Cysts can range in size from a pinhead to a grapefruit or a football. They

may also cause a normal kidney to grow from the size of a person's fist to that of a football or a basketball and weigh as much as 38 pounds each. Early in the disease, patients often do not experience symptoms and many do not realize they have PKD until other organs become affected. Deterioration in every PKD patient varies, but ultimately more than half will end up in renal failure and require dialysis or a kidney transplant. Currently, there is no treatment or cure for PKD.

PKD Research Today

PKD is the most therapy-ripe of all kidney diseases; research in PKD is progressive and robust. According to Dr. Francis Collins, NIH Director and former director of the Human Genome Research Institute, PKD research offers a tremendous "return on investment." Dr. Collins called "PKD [is] one of the hottest, most promising areas of research in all of biochemistry." In 1994, scientists discovered the genes that cause PKD, and currently, more than 20 clinical trials are underway to help uncover a treatment.

Even with such success, PKD research is at a critical juncture. Akin to other diseases and chronic conditions, PKD researchers, patients and families are facing the biomedical research "valley of death," the chasm in which basic research can languish. The "valley of death" is the point in the drug development pipeline where scientists work to develop prototype designs or invest in preclinical development. Because these processes are risky, funding is inconsistent and good ideas are often stopped in their tracks. The PKD Foundation seeks to overcome this chasm by developing systems to help advance and investing in translational research.

The PKD Foundation believes there are three components necessary for bridging the "valley of death." Those include: (1) purpose driven research with milestone gated research targets; (2) catalyzing and de-risking the drug development process to help encourage pharmaceutical and biotechnology companies and major donors to invest; and, (3) mobilizing impatient patients who will not accept the status quo.

Efforts to Bridge the "Valley of Death"

On February 24, 2010, the NIH and the Food and Drug Administration (FDA) announced a collaborative initiative aimed at accelerating the drug development process by helping translate basic science into the availability of new and innovative drugs and devices. The NIH–FDA Initiative involves two interrelated scientific disciplines: translational research and regulatory science. Translational research involves shaping basic scientific discoveries into potential treatments. Regulatory science focuses on developing and using tools and standards to more efficiently aid in the development of therapeutic products. Improved regulatory science will help the FDA more effectively evaluate products for their safety and efficacy and help NIH scientists better understand what types of data and information should be collected for advancing basic research through the drug development process.

The PKD Foundation fully supports this initiative and applauds the Department of Health and Human Services (HHS) for taking a bold step in addressing a lagging component in the drug development process. Both translational research and regulatory science are imperative for turning basic biomedical discoveries into therapies that will improve the health and well-being of patients. Providing a platform for purpose driven research is a necessary step in building a bridge over the "valley of death."

In addition to the NIH–FDA Initiative on translational and regulatory science, the PKD Foundation applauds Congress for authorizing the Cures Acceleration Network (CAN) through the Patient Protection and Affordable Care Act. Housed within the Office of the Director of NIH, CAN will work to bridge the "valley of death" by helping identify and advance basic research via translational scientific discoveries through a new grant making system.

The PKD Foundation is confident that the role and programmatic functions of CAN will help address the unmet needs of our impatient patients. We are optimistic that CAN will help catalyze and de-risk the drug development process, thereby encouraging pharmaceutical and biotechnology companies to reach back and invest in developing safe and effective therapies. In order to realize the great potential of CAN, the PKD Foundation urges the Subcommittee to fund CAN at its $500 million authorizing level.

Conclusion

The NIH–FDA Initiative on translational and regulatory science and the Cures Acceleration Network are innovative ideas aimed at bridging the biomedical research "valley of death." Coupling these innovative public endeavors with the efforts of private entities, such as the PKD Foundation's Drug Discovery Project, should help PKD patients and families rest a bit easier. Together we are working to advance the basic science and understanding of PKD, speed the discovery of treat-

ments, and perhaps one day find a cure for PKD. To that end, the PKD Foundation supports $35 billion for NIH in fiscal year 2011 and $500 million for the Cures Acceleration Network. Funding NIH and its important initiatives and programs is one key to the future success of PKD research. Thank you.

PREPARED STATEMENT OF PROLITERACY WORLDWIDE

Chairman Harkin, Vice Chairman Cochran, and members of the subcommittee, on behalf of the millions of adult learners working to improve their basic skills and pursue greater economic opportunity for themselves and their families, thank you for the opportunity to provide written testimony regarding the President's fiscal year 2011 budget request for adult education and family literacy, provided for under the Workforce Investment Act, title II. We would be pleased to testify and participate in any future hearings regarding adult literacy and basic education.

At a time when millions of Americans are struggling to find work and billions of dollars are being invested in job creation and in retraining our workforce, it is essential to also invest in adult learning in order to maximize our return on these investments and put more American families on the road to self-sufficiency and economic security. We strongly urge you to provide at least $750 million for Adult Basic and Literacy Education in fiscal year 2011 to better assist the one in seven adults nationally who struggle with illiteracy.

Background: ProLiteracy

ProLiteracy Worldwide is the world's oldest and largest organization of adult literacy and basic education programs in the United States. ProLiteracy traces its roots to two premiere adult literacy organizations: Laubach Literacy International and Literacy Volunteers of America, Inc. In 2002, these two organizations merged to create ProLiteracy.

ProLiteracy now represents more than 1,200 community-based organizations and adult basic education programs in the United States, and we partner with literacy organizations in 50 developing countries. In communities across the United States, these organizations use trained volunteers, teachers, and instructors to provide one on one tutoring, classroom instruction, and specialized classes in reading, writing, math, technology, English language skills, job-training and workforce literacy skills, GED preparation, and citizenship. Our members are located in all 50 States and in the District of Columbia. Through education, training and advocacy, ProLiteracy supports the frontline work of these organizations through regional conferences and other training events; credentialing; and the publication of materials and products used to teach adults basic literacy and English as a second language and to prepare adults for the U.S. citizenship exam and GED tests.

The Urgent Need to Invest in Adult Education

In 2003, the U.S. Department of Education conducted the National Assessment of Adult Literacy (NAAL) in order to gauge the English reading and comprehension skills of individuals in the United States older than the age of 16 on daily literacy tasks such as reading a newspaper article, following a printed television guide, and completing a bank deposit slip. The results indicated that 30 million adults—14 percent of this country's adult population—had below basic literacy skills; that is, their ability to read was so poor, they could not complete a job application without help or follow the directions on a medicine bottle. An additional 63 million adults read only slightly better.

Due to funding constraints, the adult education system currently only has the capacity to serve approximately 2.5 million of these 93 million adults each year. Adult education has been nearly flat funded for a decade, seeing only a modest overall increase from 2001–2009.[1]

The high percentage of low-literate adults can be connected to almost every socioeconomic problem this country faces. According to the U.S. Department of Education, an estimated 60 percent of prison inmates are barely literate. Struggling readers are also more likely to be unemployed and require public assistance. Low literacy also has a significant impact on public health and healthcare costs. The 2003 U.S. Department of Education National Assessment of Adult Literacy (NAAL) estimates that 36 percent of the adult U.S. population has Basic or Below Basic health literacy levels. Low health literacy is a major source of economic inefficiency in the U.S. healthcare system: it is estimated that the cost of low health literacy

[1] U.S. Department of Education Budget History http://www2.ed.gov/about/overview/budget/history/edhistory.pdf.

to the U.S. economy is between $106 billion to $238 billion annually. This represents between 7 percent and 17 percent of all personal healthcare expenditures.[2]

The Proposed Adult Basic and Literacy Education Budget

The proposed fiscal year 2011 budget includes several significant features that we strongly support. First, the President requested $612.3 million for State grants for adult education through the Workforce Investment Act (WIA), title II, an increase of $30 million compared to the 2009 appropriation. While ProLiteracy welcomes this overall increase to base funding, we agree with the National Coalition for Literacy's (of which we are a member) request for at least $750 million for title II of WIA in fiscal year 2011, for the following reasons:

—Although the President's proposal does increase base funding, it is actually a $15.9 million decrease from last year's total appropriation because of a one-time adjustment to correct for a funding calculation error that occurred from 2003–2008. Many States will receive a lower appropriation than in fiscal year 2010, at a time when many States are dramatically cutting funding at the State and local levels due to budget deficits.

—The President's proposal would not substantially increase the current number of students being served. We estimate that an increase to $750 million would serve an additional 500,000 students—still a very small percentage of the millions of adults in the United States in need of adult literacy services, but a substantial and measurable boost in the number of adults ready to succeed in postsecondary education or occupational training.

—We support the President's goal of having the highest proportion of college graduates in the world by the year 2020. However, even if every State's graduation rates reached the level of the highest-performing States, we cannot reach the President's goal without a substantial increase in the number of out of school adults entering into postsecondary education. Adult education and literacy programs are an important component in the development of a broader pipeline of learners entering into postsecondary education.

Workforce Innovation

In addition to an increase in State funding, the administration's budget includes a proposal to establish a new Partnership for Workforce Innovation between the Department of Labor (DOL) and the Department of Education (ED), providing a total of $321 million to support jointly administered competitive Adult and Youth Innovation grants to States and localities to test and replicate innovative workforce practices. A $30 million increase to the Office of Vocational and Adult Education's (OVAE) National Leadership funding represents OVAE's contribution to the fund.

ProLiteracy applauds the administration's commitment to innovation. We urge the subcommittee to ensure that innovation funding will benefit adults at all skill levels, particularly the millions who are estimated to possess less than basic literacy skills. In order for these adults benefit from this fund, we recommend the following:

—Both the Adult and Youth Workforce Innovation Funds should encourage integration between title I and II programs.

The Workforce Innovation Fund is a unique opportunity for the DOL and ED to develop coordinated approaches to build upon what works at a scale that can make a tangible difference to jobseekers. We suggest that the DOL and ED funds be combined to expand successful, integrated approaches to serving the lowest level learners and ensure eligible entities under this funding stream have a demonstrated capacity of serving adult learners.

Adult education providers should also be eligible to apply for the funding contributed by DOL to both the Workforce Innovation Fund and the Youth Innovation Fund. This would help address a common criticism that Workforce Investment Act title I and II programs are too disconnected from each other and fail to provide well-integrated workforce development and adult education services. Grants to local adult literacy providers, working in partnership, for example, with local workforce investment boards, could develop more effective replicable practices to improve the lowest level learners placement and retention in employment.

We also recommend that any definition of underserved populations in the DOL Workforce Innovation Fund include adult learners, particular those at the lowest levels of literacy, and that eligible entities under this funding stream should include those with a demonstrated capacity of serving adult learners via services that are linked to income, work, and academic supports and to better connect these systems with employers and postsecondary education.

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[2] Low health literacy: implications for national health policy. Available at: http://npsf.org/askme3/pdfs/Case__Report__10__07.pdf.

Also, because a significant number of young adults ages 16–24 receive education services from adult education programs, we recommend that the DOL's Youth Innovation Fund explicitly define adult and family literacy services as an allowable education activity under this funding stream.

—Eligibility for Workforce Innovation Fund grants should include community-based organizations and other entities with demonstrated capacity to assist adults at the lowest literacy levels and their families, and include wraparound services.

—The need for innovation should not come at the expense of the existing WIA title II formula funds.

As noted above, while the President is calling for an overall increase to base funding, some States will receive a substantially smaller appropriation—at a time when many States are dramatically cutting funding at the State and local level due to budget deficits. ProLiteracy urges the subcommittee to ensure that the Workforce Innovation Fund is funded on top of annual WIA formula funds, rather than as a carve out of existing formula funds.

Thank you for the opportunity to present this testimony. We would be happy to respond to any questions that you may have.

PREPARED STATEMENT OF THE RAILROAD RETIREMENT BOARD

Mr. Chairman and members of the subcommittee: We are pleased to present the following information to support the Railroad Retirement Board's (RRB) fiscal year 2011 budget request.

The RRB administers comprehensive retirement/survivor and unemployment/sickness insurance benefit programs for railroad workers and their families under the Railroad Retirement and Railroad Unemployment Insurance Acts. The RRB also has administrative responsibilities under the Social Security Act for certain benefit payments and Medicare coverage for railroad workers. During the past year, the RRB has also administered special economic recovery payments and extended unemployment benefits under the American Recovery and Reinvestment Act of 2009 (ARRA), and more recently, extended unemployment benefits under the Worker, Homeownership, and Business Assistance Act of 2009.

During fiscal year 2009, the RRB paid $10.5 billion, net of recoveries, in retirement/survivor benefits and vested dual benefits to about 589,000 beneficiaries. We also paid $154.1 million in net unemployment/sickness insurance benefits under the Railroad Unemployment Insurance Act to more than 40,000 claimants. In addition, the RRB paid benefits on behalf of the Social Security Administration amounting to $1.3 billion to about 115,000 beneficiaries, and we paid about $129.5 million in Economic Recovery Payments and $10.3 million in temporary extended unemployment benefits under ARRA to about 518,700 beneficiaries and 3,100 claimants, respectively.

PROPOSED FUNDING FOR AGENCY ADMINISTRATION

The President's proposed budget would provide $110,573,000 for agency operations, which would enable us to maintain a staffing level of 891 full-time equivalent staff years in 2011. The proposed budget would also provide $1,500,000 for information technology investments. This includes $850,000 for costs related to an upgrade of the agency's mainframe computer. The remaining IT funds would be used for information security and privacy, E-Government initiatives, systems modernization, network operations, and some infrastructure replacement.

AGENCY STAFFING

The RRB's dedicated and experienced workforce is the foundation for our tradition of excellence in customer service and satisfaction. Like many Federal agencies, however, the RRB has a number of employees at or near retirement age. Nearly 70 percent of our employees have 20 or more years of service at the agency, and about 40 percent of the current workforce will be eligible for retirement by fiscal year 2012.

To prepare for expected staff turnover in the near future, we are focusing on activities related to workforce planning and development. During the past year, the agency drafted a formal human capital plan that adheres to guidance issued by the Office of Personnel Management. The plan identifies demographic features of the agency's workforce and the skills needed to fulfill our mission. The plan also establishes a framework of actions over the next few years to recruit, retain, and develop talented employees. We have also drafted a succession plan that specifies staffing

needed to meet organizational goals, identifies competency gaps and develops strategies to address overall human capital needs.

In connection with these workforce planning efforts, our budget request for fiscal year 2011 includes a legislative proposal to enable the RRB to utilize various hiring authorities available to other Federal agencies. Section 7(b)(9) of the Railroad Retirement Act contains language requiring that all employees of the RRB, except for one assistant for each board member, must be hired under the competitive civil service. We propose to eliminate this requirement, thereby enabling the RRB to use various hiring authorities offered by the Office of Personnel Management.

INFORMATION TECHNOLOGY IMPROVEMENTS

In recent years, we have undertaken a series of strategic measures to improve computer processes and better position the RRB for the future. First, the agency moved to a relational database environment, and then optimized the data that reside in the legacy databases. In fiscal year 2009, we began a multi-year initiative to modernize our application systems, starting with Medicare processing systems. This effort will enable the RRB to maintain the capability of our business operations in the event of expected staff turnover, and to upgrade agency systems by building on the improvements that we have already completed. Much of the work related to this initiative will be completed by in-house staff. Our budget request for fiscal year 2011 includes $150,000 for minimal contractual services related to the initiative.

In order to keep pace with these planned improvements, it will be necessary to increase the capacity of our mainframe computer. In fiscal year 2008, a new mainframe computer was installed with scalability to provide for additional processing capacity as demand increases. Since then, demand for additional processing capacity has increased an average of 18 percent each year with the completion of various automation initiatives. Our fiscal year 2011 budget request includes $850,000 to upgrade the RRB's mainframe computer software in order to meet the rising demand for capacity.

Our proposed budget also includes an additional $500,000 for other information technology investments. This funding will provide for essential equipment and services needed to maintain our network operations and infrastructure in fiscal year 2011, and to continue with other initiatives, such as E-Government and information security and privacy.

The President's proposed budget includes $57 million to fund the continuing phase-out of vested dual benefits, plus a 2 percent contingency reserve, $1,140,000, which "shall be available proportional to the amount by which the product of recipients and the average benefit received exceeds the amount available for payment of vested dual benefits."

In addition to the requests noted above, the President's proposed budget includes $150,000 for interest related to uncashed railroad retirement checks.

FINANCIAL STATUS OF THE TRUST FUNDS

Railroad Retirement Accounts.—The RRB continues to coordinate its activities with the National Railroad Retirement Investment Trust (Trust), which was established by the Railroad Retirement and Survivors' Improvement Act of 2001 (RRSIA) to manage and invest railroad retirement assets. Pursuant to the RRSIA, the RRB has transferred a total of $21.276 billion to the Trust. All of these transfers were made in fiscal years 2002 through 2004. The Trust has invested the transferred funds, and the results of these investments are reported to the RRB and posted periodically on the RRB's Web site. The market value of Trust-managed assets on September 30, 2009, was approximately $23.3 billion, a decrease of $2 billion from the previous year. Since its inception, the Trust has transferred approximately $8.9 billion to the RRB for payment of railroad retirement benefits.

In June 2009, we released the 24th Actuarial Valuation, including the annual report on the railroad retirement system required by section 22 of the Railroad Retirement Act of 1974, and section 502 of the Railroad Retirement Solvency Act of 1983. The actuarial valuation indicates that cash flow problems occur only under the most pessimistic assumption. Even under that assumption, the cash flow problems do not occur until the year 2031. The long-term stability of the system, however, is not assured. Under the current financing structure, actual levels of railroad employment and investment performance over the coming years will determine whether additional corrective action is necessary.

Railroad Unemployment Insurance Account.—The equity balance of the Railroad Unemployment Insurance (RUI) Account at the end of fiscal year 2009 was $27.8 million, a decrease of $72.1 million from the previous year. The RRB's latest annual report on the financial status of the railroad unemployment insurance system was

issued in June 2009. The report indicated that even as maximum daily benefit rates rise 43 percent (from $61 to $87) from 2008 to 2019, experience-based contribution rates are expected to keep the unemployment insurance system solvent, except for small, short-term cash flow problems in 2010 and 2011 under the moderate and pessimistic assumptions. Projections show a quick repayment of loans even under the most pessimistic assumption.

Unemployment levels are the single most significant factor affecting the financial status of the railroad unemployment insurance system. However, the system's experience-rating provisions, which adjust contribution rates for changing benefit levels, and its surcharge trigger for maintaining a minimum balance, help to ensure financial stability in the event of adverse economic conditions. No financing changes were recommended at this time by the report.

Due to the increased level of unemployment insurance payments during fiscal year 2009 and anticipated for fiscal year 2010, loans from the Railroad Retirement (RR) Account to the RUI Account became necessary beginning in December 2009. Transfers from the RR Account to the RUI Account through February 2010 amounted to $24.5 million. Current projections indicate that additional loans from the RR Account to the RUI Account during fiscal year 2010 could amount to approximately $43.5 million, for a total of $68 million during the fiscal year.

In conclusion, we want to stress the RRB's continuing commitment to improving our operations and providing quality service to our beneficiaries. Thank you for your consideration of our budget request. We will be happy to provide further information in response to any questions you may have.

PREPARED STATEMENT OF THE RAILROAD RETIREMENT BOARD

Mr. Chairman and members of the subcommittee: My name is Martin J. Dickman and I am the Inspector General for the Railroad Retirement Board. I would like to thank you, Mr. Chairman, and the members of the subcommittee for your continued support of the Office of Inspector General.

BUDGET REQUEST AND BACKGROUND INFORMATION

I wish to describe our fiscal year 2011 appropriations request and our planned activities. The Office of Inspector General (OIG) respectfully requests funding in the amount of $8,936,000 to ensure the continuation of its independent oversight of the Railroad Retirement Board (RRB).

The RRB's central mission is to pay accurate and timely benefits. During fiscal year 2009, the RRB paid approximately $10.5 billion in retirement and survivor benefits to 589,000 beneficiaries. RRB also paid roughly $154.1 million in net unemployment and sickness insurance benefits to almost 24,000 unemployment insurance beneficiaries and 18,000 sickness insurance beneficiaries.

The RRB contracts with a separate Medicare Part B carrier, Palmetto GBA, to process the Medicare Part B claims of qualified railroad retirement beneficiaries. As of September 30, 2009, there were about 468,000 such beneficiaries enrolled in the Medicare Part B program through the RRB. During fiscal year 2009, Palmetto, GBA paid over $900 million in benefits.

During fiscal year 2011, the OIG will focus on areas affecting program performance; the efficiency and effectiveness of agency operations; and areas of potential fraud, waste, and abuse.

OPERATIONAL COMPONENTS

The OIG has three operational components: the immediate Office of the Inspector General, the Office of Audit (OA), and the Office of Investigations (OI). The OIG conducts operations from several locations: the RRB's headquarters in Chicago, Illinois; an investigative field office in Philadelphia, Pennsylvania; and three domicile investigative offices located in Arlington, Virginia; Houston, Texas; and San Diego, California. These domicile offices provide more effective and efficient coordination with other Inspector General offices and traditional law enforcement agencies with which the OIG works joint investigations.

OFFICE OF AUDIT

It is OA's mission to:

—promote economy, efficiency, and effectiveness in the administration of RRB programs and

—detect and prevent fraud and abuse in such programs.

To accomplish its mission, OA conducts financial, performance, and compliance audits and evaluations of RRB programs. In addition, OA develops the OIG's response to audit related requirements and requests for information.

During fiscal year 2011, OA will focus on areas affecting program performance; the efficiency and effectiveness of agency operations; and areas of potential fraud, waste, and abuse. OA will continue its emphasis on long-term systemic problems and solutions, and will address major issues that affect the RRB's service to rail beneficiaries and their families. OA has identified four broad areas of potential audit coverage:

—Financial accountability;
—Railroad Retirement Act & Railroad Unemployment Insurance Act benefit program operations;
—Railroad Medicare Program Operations, including activities of Palmetto, GBA; and
—Security, privacy, and information management.

During fiscal year 2011, OA must accomplish the following mandated activities with its own staff:

—Audit of the RRB's financial statements pursuant to the requirements of the Accountability of Tax Dollars Act of 2002 and
—Evaluation of information security pursuant to the Federal Information Security Management Act (FISMA).

During fiscal year 2011, OA will complete the audit of the RRB's fiscal year 2010 financial statements and begin its audit of the agency's fiscal year 2011 financial statements. OA contracts with a consulting actuary for technical assistance in auditing the RRB's "Statement of Social Insurance" which became basic financial information effective for fiscal year 2006. In fiscal year 2011, the cost of this contract is expected to increase significantly over the current contract amount.

In addition to performing the annual evaluation of information security, OA also conducts audits of individual computer application systems which are required to support the annual FISMA evaluation. Our work in this area is targeted toward the identification and elimination of security deficiencies and system vulnerabilities, including controls over sensitive personally identifiable information.

OA undertakes additional projects with the objective of allocating available audit resources to areas in which they will have the greatest value. In making that determination, OA considers staff availability, current trends in management, congressional and Presidential concerns.

OFFICE OF INVESTIGATIONS

OI focuses its efforts on identifying, investigating, and presenting benefit fraud cases for prosecution. OI conducts investigations, throughout the United States, relating to the fraudulent receipt of RRB disability, unemployment, sickness, retirement/survivor, and Railroad Medicare benefits. OI investigates railroad employers and unions when there is an indication that they have submitted false reports to the RRB. OI also investigates allegations regarding agency employee misconduct and threats against RRB employees. Investigative efforts can result in criminal convictions, administrative sanctions, civil penalties, and/or the recovery of program benefit funds.

OI's investigative results for fiscal year 2009 are:

Item	Amount
Civil judgments	29
Indictments/informations	78
Convictions	48
Recoveries/collections	$7,056,086

OI initiates cases based on information from a variety of sources. The agency conducts computer matching of employment and earnings information reported to State governments and the Social Security Administration with RRB benefits paid data. Referrals are made to OI if a match is found. OI also receives allegations of fraud through the OIG Hotline, contacts with State, local and Federal agencies, and information developed through audits conducted by the OIG's Office of Audit.

Presently, disability and Railroad Medicare fraud cases constitute more than 60 percent of OI's total caseload. These cases often involve complicated schemes and result in the recovery of substantial funds for the agency's trust funds. They also require considerable time and resources such as travel by special agents to conduct surveillance, numerous witness interviews, or more sophisticated investigative tech-

niques. Additionally, these fraud investigations are extremely document-intensive and involve complicated financial analysis.

During fiscal year 2011, OI anticipates an ongoing caseload of more than 400 investigations. OI will continue to coordinate its efforts with agency program managers to address vulnerabilities in benefit programs that allow fraudulent activity to occur and will recommend changes to ensure program integrity. OI plans to continue proactive projects to identify fraud matters that are not detected through the agency's program policing mechanisms.

CONCLUSION

In fiscal year 2011, the OIG will continue to focus its resources on the review and improvement of RRB operations and will conduct activities to ensure the integrity of the agency's trust funds. This office will continue to work with agency officials to ensure the agency is providing quality service to railroad workers and their families. The OIG will also aggressively pursue all individuals who engage in activities to fraudulently receive RRB funds. The OIG will continue to keep the subcommittee and other members of Congress informed of any agency operational problems or deficiencies.

The OIG sincerely appreciates its cooperative relationship with the agency and the ongoing assistance extended to its staff during the performance of their audits and investigations. Thank you for your consideration.

PREPARED STATEMENT OF THE RYAN WHITE MEDICAL PROVIDERS COALITION

INTRODUCTION

I am Dr. Kathleen Clanon, an HIV physician and Medical Director of the HIV ACCESS program in Oakland, California. I am submitting written testimony on behalf of the Ryan White Medical Providers Coalition.

Thank you for the opportunity to discuss the important HIV/AIDS care conducted at Ryan White Part C-funded programs nationwide. Specifically, the Ryan White Medical Provider Coalition, the HIV Medicine Association, the CAEAR Coalition, and the American Academy of HIV Medicine estimate that approximately $407 million is needed to provide the standard of care for all part C program patients. (This estimate is based on the current cost of care and the number of patients that part C clinics serve.) While these are exceptionally challenging economic times, we request $338 million for Ryan White Part C programs in fiscal year 2011. This $131 million funding increase would help meet the goal of providing the standard of care to all patients who need it.

The Ryan White Medical Providers Coalition was formed in 2006 to be a voice for medical providers across the Nation delivering quality care to their patients through part C of the Ryan White program. We represent every kind of program, from small and rural to large urban sites in every region in the country. We speak for those who often cannot speak for themselves and we advocate for a full range of primary care services for these patients. Sufficient funding for part C is essential to providing appropriate care for individuals living with HIV/AIDS.

Part C of the Ryan White Program funds comprehensive HIV care and treatment, services that are directly responsible for the dramatic decreases in AIDS-related mortality and morbidity over the last decade. The Centers for Disease Control and Prevention estimate that there are more than 1.1 million persons living with HIV/AIDS, and in 2008 approximately 240,000, or almost 1 in 4, of these individuals received services from part C medical providers—a dramatic 30 percent increase in patients in less than 10 years.

The recent passage of healthcare reform is a great achievement, but many of the legislation's provisions and programs will not take effect for several years. In the meantime, part C clinics need additional resources today to continue delivering lifesaving and cost-effective care to the growing number of people living with HIV.

THE COST OF CARE IS REASONABLE; THE REIMBURSEMENT FOR CARE ISN'T

On average it costs $3,501 per person per year to provide the comprehensive outpatient care and treatment available at part C-funded programs, including lab work, STD/TB/Hepatitis screening, ob/gyn care, dental care, mental health and substance abuse treatment, and case management. Part C funding covers only a small percentage of the total cost of this comprehensive care, with some programs receiving $450 (12 percent of the total cost) or less per patient per year to cover the cost of care.

PART C PROGRAMS SAVE BOTH LIVES AND MONEY

Investing in part C services improves lives and saves money. In the United States, nearly 50 percent of persons living with HIV/AIDS who are aware of their status are not in regular care. Early and reliable access to HIV care and treatment both helps patients with HIV live relatively healthy and productive lives and is more cost effective. One study from the Part C Clinic at the University of Alabama at Birmingham found that patients treated at the later stages of HIV disease required 2.6 times more healthcare dollars than those receiving earlier treatment meeting Federal HIV treatment guidelines.

PATIENT LOADS ARE INCREASING AT AN UNSUSTAINABLE RATE

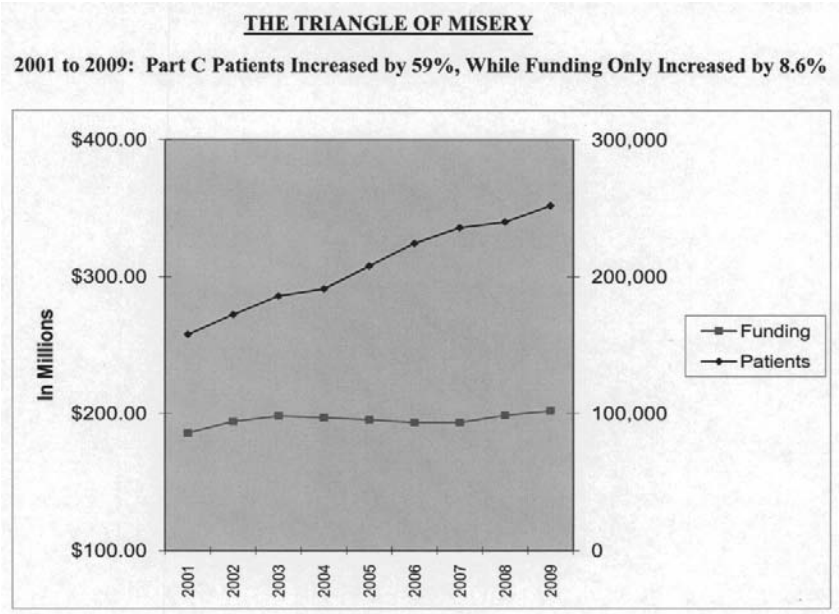
Patient loads have been increasing at part C clinics nationwide, despite the fact that there has not been significant new Federal funding, and in many cases, State and/or local funding has been cut. A steady increase in patients has occurred on account of higher diagnosis rates and declining insurance coverage resulting in part from the economic downturn. The CDC reports that the number of HIV/AIDS cases increased by 15 percent from 2004 to 2007 in 34 States.[1]

For example, a clinic in Henderson, North Carolina, has seen its patient load increase almost nine fold from 35 patients in 2000 to nearly 300 today, yet the clinic is receiving less funding now than 10 years ago. This clinic is the only facility of its kind for people with HIV within 45 miles and it is struggling to deliver the complex care these patients need. At another clinic in Greensboro, North Carolina, the number of patients more than doubled from 321 patients in 2002 to more than 800 in 2009. The clinic continues to deliver care in the same space with the same staffing as in 2002 despite the 250 percent increase in patients. Meeting this growing demand requires the maximum effort of existing staff, and position vacancies prevented enrollment of new patients for several months during 2009. In Sonoma County, California, funding has become so scarce that the Part C Clinic there is closing its doors, forced to patch together new medical homes in other locations for 350 patients.

Our patients struggle in times of plenty, and during this economic downturn they have relied on part C programs more than ever. While these programs have been underfunded for years, State and local economic pressures are creating a crisis in our communities. Clinics are discontinuing primary care and other critical medical services, such as laboratory monitoring; suffering eviction from their clinic locations; operating only 4 days per week; and laying off staff just to get by. Years of nearly flat funding combined with large increases in the patient population and the recent economic crisis are negatively impacting the ability of part C providers to serve their patients.

The following graph demonstrates the growing disparity between funding for part C and the increasing patient population. I refer to this gap between funding and patients as the "Triangle of Misery" because it represents both the thousands of patients who deserve more than we can offer and the part C programs nationwide that are struggling to serve them with shrinking resources.

[1] Centers for Disease Control and Prevention. HIV/AIDS Surveillance Report, 2007. Vol. 19. U.S. Department of Health and Human Services, Centers for Disease Control and Prevention; 2009:5. www.cdc.gov/hiv/topics/surveillance/resources/reports/.



CONCLUSION

These are challenging economic times, and we recognize the severe fiscal constraints Congress faces in allocating limited Federal dollars. However, Congress itself has recognized the need to substantially increase part C funds in its recent passage of the reauthorization of the Ryan White Program in September 2009. In this law, Congress recommended funding Ryan White Part C Programs at $259 million in fiscal year 2011, a $52 million increase more than the fiscal year 2010 funding level.

The significant financial and patient pressures that we face in our clinics at home propel us to request a substantial Federal investment of $338 million in fiscal year 2011 for Ryan White Part C programs to support medical providers nationwide in delivering appropriate and effective HIV/AIDS care to their patients. Thank you for your time and consideration of our request.

PREPARED STATEMENT OF THE SPINA BIFIDA ASSOCIATION AND SPINA BIFIDA FOUNDATION

FUNDING REQUEST OVERVIEW

The Spina Bifida Association (SBA) and the Spina Bifida Foundation (SBF) respectfully request that the subcommittee provide the following allocations in fiscal year 2011 to help improve quality-of-life for people with Spina Bifida:

—$7.5 million for the National Spina Bifida Program within the National Center on Birth Defects and Developmental Disabilities at the Centers for Disease Control and Prevention (CDC) to support existing program initiatives and allow for the further development of the National Spina Bifida Patient Registry.

—$5.126 million for the CDC's national folic acid education and promotion efforts to support the prevention of Spina Bifida and other neural tube defects.

—$26.342 million to strengthen the CDC's National Birth Defects Prevention Network.

—$163.5 million in overall funding for the CDC's National Center on Birth Defects and Developmental Disabilities.

—$611 million for the Agency for Healthcare Research and Quality (AHRQ).
—$32.2 billion for the National Institutes of Health (NIH) to support biomedical research.

BACKGROUND AND OVERVIEW

On behalf of the estimated 166,000 individuals and their families who are affected by all forms of Spina Bifida—the Nation's most common, permanently disabling birth defect—SBA and SBF appreciate the opportunity to submit written testimony for the record regarding fiscal year 2011 funding for the National Spina Bifida Program and other related Spina Bifida initiatives. SBA is a national voluntary health agency, working on behalf of people with Spina Bifida and their families through education, advocacy, research and service. The SBF assists SBA in its fundraising and advocacy efforts. SBA and SBF stand ready to work with Members of Congress and other stakeholders to ensure our Nation mounts and sustains a comprehensive effort to reduce and prevent suffering from Spina Bifida.

Spina Bifida, a neural tube defect, occurs when the spinal cord fails to close properly within the first few weeks of pregnancy and most often before the mother knows that she is pregnant. Over the course of the pregnancy—as the fetus grows—the spinal cord is exposed to the amniotic fluid, which increasingly becomes toxic. It is believed that the exposure of the spinal cord to the toxic amniotic fluid erodes the spine and results in Spina Bifida. There are varying forms of Spina Bifida occurring from mild—with little or no noticeable disability—to severe—with limited movement and function. In addition, within each different form of Spina Bifida the effects can vary widely. Unfortunately, the most severe form of Spina Bifida occurs in 96 percent of children born with this birth defect.

The result of this neural tube defect is that most people with it suffer from a host of physical, psychological, and educational challenges—including paralysis, developmental delay, numerous surgeries, and living with a shunt in their skulls, which seeks to ameliorate their condition by helping to relieve cranial pressure associated with spinal fluid that does not flow properly. As we have testified previously, the good news is that after decades of poor prognoses and short life expectancy, children with Spina Bifida are now living into adulthood and increasingly into their advanced years. These gains in longevity, principally, are due to breakthroughs in research, combined with improvements generally in healthcare and treatment. However, with this extended life expectancy, our Nation and people with Spina Bifida now face new challenges, such as transitioning from pediatric to adult healthcare providers, education, job training, independent living, healthcare for secondary conditions, and aging concerns, among others. Individuals and families affected by Spina Bifida face many challenges—physical, emotional, and financial. Fortunately, with the creation of the National Spina Bifida Program in 2003, individuals and families affected by Spina Bifida now have a national resource that provides them with the support, information, and assistance they need and deserve.

As is discussed below, the daily consumption of 400 micrograms of folic acid by women of childbearing age, prior to becoming pregnant and throughout the first trimester of pregnancy, can help reduce the incidence of Spina Bifida, by up to 70 percent. However, 3,000 pregnancies are affected by Spina Bifida, resulting in 1,500 babies born each year with the condition, and, as such, with the aging of the Spina Bifida population and a steady number of affected births annually, the Nation must take additional steps to ensure that all individuals living with this complex birth defect can live full, healthy, and productive lives.

COST OF SPINA BIFIDA

It is important to note that the lifetime costs associated with a typical case of Spina Bifida—including medical care, special education, therapy services, and loss of earnings—are as much as $1 million. The total societal cost of Spina Bifida is estimated to exceed $750 million per year, with just the Social Security Administration payments to individuals with Spina Bifida exceeding $82 million per year. Moreover, tens of millions of dollars are spent on medical care paid for by the Medicaid and Medicare programs. Efforts to reduce and prevent suffering from Spina Bifida will help to not only save money, but will also save—and improve—lives.

IMPROVING QUALITY-OF-LIFE THROUGH THE NATIONAL SPINA BIFIDA PROGRAM

Since, 2001, SBA has worked with Members of Congress and staff at the CDC to help improve our Nation's efforts to prevent Spina Bifida and diminish suffering—and enhance quality-of-life—for those currently living with this condition. With appropriate, affordable, and high-quality medical, physical, and emotional care, most people born with Spina Bifida likely will have a normal or near normal life expect-

ancy. The CDC's National Spina Bifida Program works on two critical levels—to reduce and prevent Spina Bifida incidence and morbidity and to improve quality-of-life for those living with Spina Bifida.

The National Spina Bifida Program established the National Spina Bifida Resource Center housed at the SBA, which provides information and support to help ensure that individuals, families, and other caregivers, such as health professionals, have the most up-to-date information about effective interventions for the myriad primary and secondary conditions associated with Spina Bifida. Among many other activities, the program helps individuals with Spina Bifida and their families learn how to treat and prevent secondary health problems, such as bladder and bowel control difficulties, learning disabilities, depression, latex allergies, obesity, skin breakdown, and social and sexual issues. Children with Spina Bifida often have learning disabilities and may have difficulty with paying attention, expressing or understanding language, and grasping reading and math. All of these problems can be treated or prevented, but only if those affected by Spina Bifida—and their caregivers—are properly educated and given the skills and information they need to maintain the highest level of health and well-being possible. The National Spina Bifida Program's secondary prevention activities represent a tangible quality-of-life difference to the 166,000 individuals living with all forms of Spina Bifida, with the goal being living well with Spina Bifida.

An important resource to better determine best clinical practices and the most cost effective treatments for Spina Bifida is the National Spina Bifida Registry, now in its second year. Nine sites throughout the Nation are collecting patient data, which supports the creation of quality measures and will assist in improving clinical research that will truly save lives, while also realizing a significant cost savings.

In fiscal year 2010, SBA requested that $7 million be allocated to support and expand the National Spina Bifida Program. In the final fiscal year 2010 Omnibus Appropriations Act, Congress provided $6.242 million for this program, a slight increase following 3 years of essentially flat funding. SBA understands that the Congress and the Nation face unprecedented budgetary challenges and, as such, appreciates this modest increase. However, the progress being made by the National Spina Bifida Program must be sustained and expanded to ensure that people with Spina Bifida—over the course of their lifespan—have the support and access to quality care they need and deserve. To that end, SBA respectfully urges the subcommittee to Congress allocate $7.5 million in fiscal year 2011 to the program, so it can continue and expand its current scope of work; further develop the National Spina Bifida Patient Registry; and sustain the National Spina Bifida Resource Center. Increasing funding for the National Spina Bifida Program will help ensure that our nation continues to mount a comprehensive effort to prevent and reduce suffering from—and the costs of—Spina Bifida.

PREVENTING SPINA BIFIDA

While the exact cause of Spina Bifida is unknown, over the last decade, medical research has confirmed a link between a woman's folate level before pregnancy and the occurrence of Spina Bifida. Sixty-five million women of child-bearing age are at-risk of having a child born with Spina Bifida. As mentioned above, the daily consumption of 400 micrograms of folic acid prior to becoming pregnant and throughout the first trimester of pregnancy can help reduce the incidence of Spina Bifida, by up to 70 percent. There are few public health challenges that our Nation can tackle and conquer by nearly three-fourths in such a straightforward fashion. However, we must still be concerned with addressing the 30 percent of Spina Bifida cases that cannot be prevented by folic acid consumption, as well as ensuring that all women of childbearing age—particularly those most at-risk for a Spina Bifida pregnancy—consume adequate amounts of folic acid prior to becoming pregnant.

Since 1968, the CDC has led the Nation in monitoring birth defects and developmental disabilities, linking these health outcomes with maternal and/or environmental factors that increase risk, and identifying effective means of reducing such risks. The good news is that progress has been made in convincing women of the importance of folic acid consumption and the need to maintain a diet rich in folic acid. This public health success should be celebrated, but still too many women of childbearing age consume inadequate daily amounts of folic acid prior to becoming pregnant, and too many pregnancies are still affected by this devastating birth defect. The Nation's public education campaign around folic acid consumption must be enhanced and broadened to reach segments of the population that have yet to heed this call—such an investment will help ensure that as many cases of Spina Bifida can be prevented as possible.

SBA is the managing agent for the National Council on Folic Acid, a multi-sector partnership reaching more than 100 million people a year with the folic acid message. The goal is to increase awareness of the benefits of folic acid, particularly for those at elevated risk of having a baby with neural tube defects (those who have Spina Bifida themselves, or those who have already conceived a baby with Spina Bifida). With additional funding in fiscal year 2011, CDC's folic acid awareness activities could be expanded to reach the broader population in need of these public health education, health promotion, and disease prevention messages. SBA advocates that Congress provide additional funding to CDC to allow for a targeted public health education and awareness focus on at-risk populations (e.g., Hispanic-Latino communities) and health professionals who can help disseminate information about the importance of folic acid consumption among women of childbearing age.

In addition to a $7.5 million fiscal year 2011 allocation for the National Spina Bifida Program, SBA urges the subcommittee to provide $5.126 million for the CDC's national folic acid education and promotion efforts to support the prevention of Spina Bifida and other neural tube defects; $26.342 million to strengthen the CDC's National Birth Defects Prevention Network; and $163.5 million to fund the National Center on Birth Defects and Developmental Disabilities.

IMPROVING HEALTHCARE FOR INDIVIDUALS WITH SPINA BIFIDA

As you know, AHRQ's mission is to improve the outcomes and quality of healthcare, reduce healthcare costs, improve patient safety, decrease medical errors, and broaden access to essential health services. AHRQ's work is vital to the evaluation of new treatments, which helps ensure that individuals living with Spina Bifida continue to receive state-of-the-art care and interventions. To that end, we request a $611 million fiscal year 2011 allocation for AHRQ, so it can continue to provide guidance and support to the National Spina Bifida Patient Registry and help improve quality of care and outcomes for people with Spina Bifida.

SUSTAIN AND SEIZE SPINA BIFIDA RESEARCH OPPORTUNITIES

Our Nation has benefited immensely from our past Federal investment in biomedical research at the NIH. SBA joins with other in the public health and research community in advocating that NIH receive increased funding in fiscal year 2011. This funding will support applied and basic biomedical, psychosocial, educational, and rehabilitative research to improve the understanding of the etiology, prevention, cure and treatment of Spina Bifida and its related conditions. In addition, SBA respectfully requests that the Subcommittee include the following language in the report accompanying the fiscal year 2011 LHHS appropriations measure:

"The Committee encourages NIDDK, NICHD, and NINDS to study the causes and care of the neurogenic bladder in order to improve the quality of life of children and adults with Spina Bifida; to support research to address issues related to the treatment and management of Spina Bifida and associated secondary conditions, such as hydrocephalus; and to invest in understanding the myriad co-morbid conditions experienced by children with Spina Bifida, including those associated with both paralysis and developmental delay."

CONCLUSION

Please know that SBA and SBF stand ready to work with the Subcommittee and other Members of Congress to advance policies and programs that will reduce and prevent suffering from Spina Bifida. Again, we thank you for the opportunity to present our views regarding fiscal year 2011 funding for programs that will improve the quality-of-life for the 166,000 Americans and their families living with all forms of Spina Bifida.

PREPARED STATEMENT OF STATUS C UNKNOWN

Status C Unknown (SCU) is a nonprofit organization. SCU's mission is to educate those impacted by HCV about treatment options and promote enhanced HCV awareness among the general public, healthcare communities, and policymakers. Our strategic focus is prevention education, support and advocacy. We are a multi-program organization with primary focus on legislative activities and programs, both statewide and nationally. We have led the way in hepatitis C advocacy since 2005 in collaboration and partnerships with other community based organizations, service providers, New York State Department of Health (NYSDOH) and New York City Department of Health and Mental Hygiene (NYC DOHMH).

As you craft the fiscal year 2011 Labor-HHS-Education appropriations legislation, we urge you to consider the following critical funding needs of viral hepatitis programs:

Specific funding needs:

—We are requesting an increase of $30.7 million for a total of $50 million for the Centers for Disease Control and Prevention (CDC) Division of Viral Hepatitis (DVH).

—At least $20 million for an adult hepatitis B vaccination initiative through the CDC Section 317 Vaccine Program.

—$10 million for the Substance Abuse and Mental Health Services Administration (SAMHSA) to fund a project within the Programs of Regional and National Significance (PRNS) to reach persons who use drugs with viral hepatitis prevention services.

General funding needs:

—Increase funding for Community Health Centers to increase their capacity to serve people with chronic viral hepatitis;

—Increase funding for the Ryan White Program to adequately cover persons co-infected with viral hepatitis through additional case management, provider education and coverage of viral hepatitis drug therapies;

—Increase funding for the National Institutes of Health to support their Action Plan for Liver Disease Research.

Specific Funding Needs

Division of Viral Hepatitis—Fiscal Year 2011 Request: $30.7 million

The recently released Institute of Medicine (IOM) report, "Hepatitis and Liver Cancer: A National Strategy for Prevention and Control of Hepatitis B and C" found that the public health response needs to be significantly ramped up. The IOM report attributes low public and provider awareness to the lack of public resources. Seventeen of the 22 recommendations in the report are specific to CDC DVH and State health departments. In order to implement these recommendations to improve the Federal response, resources must be increased to health departments which are the backbone of the Nation's public health system and coordinate the response to these epidemics.

President Obama's budget proposal includes a $1.8 million increase for the Division of Viral Hepatitis (DVH) at CDC, which is woefully insufficient to address infectious diseases of this magnitude. While operating on the smallest Division budget for the prevention of infectious diseases within CDC, DVH will never be able to sufficiently prevent and manage these epidemics under its current fiscal constraints. States and cities receive an average funding award from DVH of $90,000. This is only enough for a single staff position and is not sufficient for the provision of core prevention services. These services are essential to preventing new infections, increasing the number of people who know they are infected, and following up to help those identified to remain healthy and productive. We believe this increase is an important first step to making hepatitis prevention services more widely available. The expanded services should include hepatitis B and C education, counseling, testing, and referral in addition to delivering hepatitis A and B vaccine, and establishing a surveillance system of chronic hepatitis B and C.

Section 317 Vaccine Program—Fiscal Year 2011 Request: $20 million

CDC identified funds through program cost savings in the Section 317 Vaccine Program, allocating $20 million in fiscal year 2008 and $16 million in fiscal year 2009 for purchase of the hepatitis B vaccine for high-risk adults. We commend CDC for prioritizing high-risk adults with this initiative, but relying on the availability of these cost savings is not enough. Additionally, this initiative does not support any infrastructure or personnel and health departments need additional funding to support the delivery of this vaccine. We request a continuation of $20 million in fiscal year 2011 for an adult hepatitis B vaccination initiative through the CDC's Section 317 Vaccine Program.

Substance Abuse and Mental Health Services Administration—Fiscal Year 2011 Request: $10 Million

Persons who use drugs are disproportionately impacted by hepatitis B and C. The Substance Abuse and Mental Health Services Administration (SAMHSA) Center for Substance Abuse Prevention (CSAP) and Center for Substance Abuse Treatment (CSAT) are uniquely positioned to reach populations at risk for hepatitis B and C. The existing infrastructure of substance abuse prevention and treatment programs in the United States provides an important opportunity to reach Americans at risk or living with viral hepatitis. We urge you to provide $10 million to SAMHSA to

fund a project within the Programs of Regional and National Significance (PRNS) to reach persons who use drugs with viral hepatitis prevention services.

General Funding Needs

Medical Management and Treatment

Access to available treatments and support services are critical to combat viral hepatitis mortality. While we are supportive of the President's efforts to modernize and expand access to healthcare, we also support increased funding for existing safety net programs. Low-income patients who are uninsured or underinsured can and do seek services at Community Health Centers (CHCs). With the growing importance of CHCs as a safety net in providing frontline support for these individuals, we support increasing resources for CHCs to increase their capacity to serve people with chronic viral hepatitis.

Many low-income individuals co-infected with viral hepatitis and HIV can obtain services through the Ryan White Program, however only half of the State AIDS Drug Assistance Programs (ADAPs) are able to provide viral hepatitis treatments to co-infected clients. We urge you to increase Ryan White funding so States can provide adequate coverage for co-infected clients. Increased resources are also needed to improve provider education on viral hepatitis medical management and treatment, to cover additional case management for patients undergoing treatment and to allow more states to add viral hepatitis therapies and viral load tests to their ADAP formularies. While Ryan White providers offer lifesaving care to co-infected clients, they also have the expertise and infrastructure to provide limited services to viral hepatitis mono-infected clients.

Research

Finally, research is needed to increase understanding of the pathogenesis of hepatitis B and C. Further research to improve hepatitis B and C treatments that are currently difficult to tolerate and have low "cure" rates are also needed. The development of clinical strategies to slow the progression of liver disease among persons living with chronic infection, especially to those who may not respond to current treatment must be addressed. With effective vaccines against hepatitis A and B, it is important to continue to work towards the development of a vaccine against hepatitis C infection. The Liver Disease Branch, located within the National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK) at the National Institutes of Health (NIH), has developed an Action Plan for Liver Disease Research. We request full funding for NIH to support the recommendations and action steps outlined in this Action Plan for Liver Disease Research.

It is absolutely essential and urgent that we act aggressively to address the threat of viral hepatitis in the United States. In 2007 alone, the CDC estimated that 43,000 Americans were newly infected with hepatitis B and 17,000 with hepatitis C. Unfortunately, it is believed that these estimates of hepatitis B and C infections are just the tip of the iceberg. Most people living with hepatitis B and more than three-fourths of people living with hepatitis C do not know that they are infected. It is estimated that the baby boomer population currently accounts for two out of every three cases of chronic hepatitis C. It is also estimated that this epidemic will increase costs by billions of dollars to our private insurers and public systems of health such as Medicare and Medicaid, and account for billions lost due to decreased productivity from the millions of American workers suffering from chronic hepatitis B and C.

As you continue to draft the fiscal year 2011 Labor, Health and Human Services, and Education, and Related Agencies appropriations bill, we ask that you consider a generous increase for viral hepatitis prevention to counter several years of flat or inadequate growth in funding. A strong public health response is needed to meet the challenges of these costly infectious diseases. The viral hepatitis community welcomes the opportunity to work with you and your staff on this important issue.

PREPARED STATEMENT OF THE SOCIETY FOR NEUROSCIENCE

INTRODUCTION

Mr. Chairman and Members of the Subcommittee, I am Michael E. Goldberg, M.D. I am the David Mahoney Professor of Brain and Behavior, in the Departments of Neuroscience, Neurology, Psychiatry, and Ophthalmology; as well as the Director of the Mahoney-Keck Center for Brain and Behavior Research at Columbia University and President of the Society for Neuroscience (SfN). My area of specialization

is the physiology of cognitive processes: visual attention, spatial perception, and decisionmaking.

On behalf of the 40,000 members of the Society for Neuroscience, I would like to thank you for your past support of neuroscience research at the National Institutes of Health (NIH). Research funded by NIH has returned significant dividends in terms of improved patient care as well as the development of prevention programs for brain and nervous system disorders. In this testimony, I will highlight how taxpayers have benefited from this investment, and how a sustained investment can enhance medical research, health, and economic strength.

FISCAL YEAR 2011 BUDGET REQUEST

The entire scientific community is deeply grateful for the historic investment in NIH through the American Recovery and Reinvestment Act (ARRA), which is now funding high quality research, while creating and preserving jobs. This investment in innovation and science is not only setting a path to new discoveries, but also helping to stimulate the national and local economies, preserving or creating an estimated 50,000 new high-wage, hi-tech jobs at a critical time for U.S. research, and producing an estimated 2.5 return on investment for local communities. To continue this exciting scientific and economic momentum and maintain the current research capacity, the Society respectfully requests that Congress provide a fiscal year 2011 appropriation in the amount of $35 billion for NIH. This level of funding will build on the research activities supported by the regular 2010 appropriations and ensure that the Nation's universities do not lose scientific ground, and be forced to lay off thousands of U.S. scientists and their support staffs, when the ARRA funding ends this year. A strong investment in the scientific enterprise will ensure that there is not a dramatic drop in research activity and more job losses, as well as serve strong encouragement to keep our young researchers in the training pipeline and keep the programmers, technicians, and engineers so critical to biomedical research in their jobs.

WHAT IS THE SOCIETY FOR NEUROSCIENCE?

The Society for Neuroscience (SfN) is a nonprofit membership organization of basic scientists and physicians who study the brain and nervous system. SfN's mission is to:

—Advance the understanding of the brain and the nervous system.
—Provide professional development activities, information, and educational resources for neuroscientists at all stages of their careers.
—Promote public information and general education about the nature of scientific discovery and the results and implications of the latest neuroscience research.
—Inform legislators and other policymakers about new scientific knowledge and recent developments in neuroscience research and their implications for public policy, societal benefit, and continued scientific progress.

WHAT IS NEUROSCIENCE?

Neuroscience is the study of the nervous system—including the brain, the spinal cord, and networks of sensory nerve cells, or neurons, throughout the body. Humans contain roughly 100 billion neurons, the functional units of the nervous system. Neurons communicate with each other by sending electrical signals long distances and then releasing chemicals called neurotransmitters which cross synapses—small gaps between neurons.

The nervous system consists of two main parts. The central nervous system is made up of the brain and spinal cord. The peripheral nervous system includes the nerves that serve the neck, arms, trunk, legs, skeletal muscles, and internal organs.

Critical components of the nervous system are molecules, neurons, and the processes within and between cells. These are organized into large neural networks and systems controlling functions such as vision, hearing, learning, breathing, and, ultimately, all of human behavior.

Through their research, neuroscientists work to:

—Describe the human brain and how it functions normally.
—Determine how the nervous system develops, matures, and maintains itself through life.
—Find ways to prevent or cure many devastating neurological and psychiatric disorders.

NIH-FUNDED BRAIN RESEARCH SUCCESSES

The funds provided in the past have helped neuroscientists make significant progress in diagnosing and treating neurological disorders. Today, thanks to NIH-funded research, scientists and healthcare providers have a much better understanding of how the brain functions.

The following are a few of the many success stories in neuroscience research:

—*Post-traumatic Stress Disorder (PTSD)*.—For years it was thought that those who survived or witnessed a trauma should be able to tough it out and move on. But scientific studies funded by the NIH helped reveal that PTSD is a serious brain disorder with biological underpinnings. Healthcare practitioners today are better able than ever to help those who have suffered a traumatic event to cope, thanks to research over the past 20 years. Yet much remains to be done, and this research must continue aggressively in light of returning veterans' healthcare needs in coming generations. NIH-funded studies on the brain chemicals and structures altered in PTSD offer particular hope for developing effective treatments. One approach is to target the corticotrophin-releasing factor (CRF), a brain chemical that plays a crucial role in coordinating the body's response to stress. And NIH-funded studies showed that drugs called selective serotonin reuptake inhibitors improved the memory of patients with PTSD and reduced shrinkage of brain tissue in the part of the brain involved in memory and emotion, helping PTSD patients better deal with traumatic memories.

—*Age-related Macular Degeneration*.—As you grow older, you may some day notice your vision becoming blurry or distorted. Straight lines appear wavy, and it becomes more difficult to recognize familiar faces. These signs may point to age-related macular degeneration, or AMD, the leading cause of blindness and vision impairment among older Americans. AMD is a form of neurodegeneration that affects the light-sensitive nerve cells in the retina at the back of the eye. AMD causes nerve cells in the macula, the central region of the retina, to break down, and abnormal deposits accumulate beneath the retina. Many elderly people with AMD become socially isolated from friends and family and can no longer participate in the activities they once enjoyed. Thanks to work supported by NIH, scientists have made rapid advances in understanding AMD and are beginning to develop new treatments. Getting older remains the strongest risk factor, but scientists now know that AMD results from a complex interaction among genetic and environmental factors. For example, smoking increases the risk. One recent NIH study found that supplementing the diet with high levels of antioxidants and zinc reduced patients' risk of developing the advanced form of AMD disease by about 25 percent. The first drug to treat AMD was approved by the FDA in 2000. When this drug is activated by the application of laser light, it eliminates the faulty blood vessels underneath the retina and reduces further loss of vision. Doctors also may treat the disease directly with laser surgery, destroying new blood vessels and sealing leaks. Scientists have found important similarities between deposits that form in the eye in AMD and deposits in the brain in age-related neurodegenerative diseases such as Alzheimer's and Parkinson's. The deposits are found in some types of kidney disease as well. Because the effects of treatments are easier to visualize in the eye, studies of AMD may lead to improved treatment of these other diseases.

—*New Treatments From Nature's Poisons*.—Neuroscientists have uncovered an unlikely source of new treatments for neurological disorders and diseases—the toxins and venoms of fish, snails, frogs, scorpions, and other creatures of land and sea. Brain researchers are finding that what makes these poisonous substances dangerous in the wild may also make them useful tools in the clinic. Already, they are helping to relieve chronic pain, and they may one day prove effective in treating brain cancer. One deadly venom—that of the giant yellow Israeli scorpion aptly nicknamed the "deathstalker"—is being studied as a possible tool in the treatment of glioma, the most common type of brain tumor. Each year, about 22,000 Americans are diagnosed with this quickly spreading cancer, and many die within 12 months. Glioma cells spread throughout the brain, including into its narrowest spaces, with the help of special ion channels not found in healthy brain cells. A chemical in the deathstalker's venom, chlorotoxin, binds to these ion channels, an action that slows down the cancer's growth without harming nearby healthy cells. Other research suggests that chlorotoxin may be able to help kill gliomas and perhaps other cancerous tumors through a different mechanism—by shutting off their blood supply. A non-narcotic synthetic form of a poisonous compound found in the venom of cone snails is already helping to relieve chronic neuropathic pain in humans. Neuroscientists are currently investigating whether other chemicals in cone

snail venom might help block the surge of electrical brain activity that triggers epileptic seizures.

The above success stories required a close working collaboration between the basic researcher discovering new knowledge and the clinical-physician researcher translating those discoveries into new and better treatments. Much other research in neuroscience is dedicated to understanding basic phenomena, which, although motivated by clinical problems, are not yet at the stage where they can be translated into cures. For example, patients with lesions in the parietal lobe, a part of the cerebral cortex, are devastated by deficits in visual attention and spatial perception. NIH-supported research in my own laboratory has illuminated much of the signal processing by which the parietal lobe enables subjects to locate objects in space and attend to them. We now understand why patients with parietal lesions behave as they do; helping them is the next step. Other groups in the Mahoney-Keck Center at Columbia University are doing NIH-supported research into the basic mechanisms of how subjects assign value to objects in the world, and make choices based on that value. A clinically relevant example of these processes is the question of why a drug addict assigns high value to drugs and then decides to acquire them. This research will illuminate the neurobiology of processes like drug-seeking, and may lead to better treatment,

CONCLUSION

The field of neuroscience research holds great potential for addressing the numerous neurological illnesses that strike more than 50 million Americans annually. As noted by my institution's (Columbia University) Mind, Brain and Behavior Initiative: "In the 20th century, scientists discovered a great deal about the brain. They discovered what happens to individual neurons when memories are made and created powerful tools to image brain function. But while they made great strides toward understanding molecules, cells, and brain circuitry, scientists continue to unearth how these circuits come together in systems to record memories, illuminate sight and produce language. We have entered an era in which knowledge of nerve cell function has brought us to the threshold of a more profound understanding of behavior and of the mysteries of the human mind. Many believe that the next level of understanding will come from analyses not of single cells but of ensembles of neurons whose concerted actions must underlie the complexity of human behavior and thought. Neural circuits must, in some way, account for high-level functions such as memory, self-awareness, language, joy, depression, and anger. Taking this research to the next level through collaborations with the social sciences will illuminate and identify the role of social interactions in normal and abnormal brain function." However, this can only be accomplished by a consistent and strong funding source.

An NIH appropriation of $35 billion for fiscal year 2011 is required to take this research to the next level in order to improve the health of Americans and to sustain the Nation's global competitiveness. Additionally, the new research capacity must be sustained to realize the scientific outcomes initiated by the Recovery Act dollars and to ensure the next generations of scientists will have opportunities in research. A strong scientific investment not only produces ground breaking medical treatments and discoveries; it supports national economic recovery, by creating thousands of jobs and forming the foundation for a stronger national economy based on technology and innovation.

Thank you for the opportunity to submit this testimony.

PREPARED STATEMENT OF THE SOCIETY FOR HEALTHCARE EPIDEMIOLOGY OF AMERICA

The Society for Healthcare Epidemiology of America (SHEA) appreciates this opportunity to express its support for Federal efforts to prevent and reduce healthcare-associated infections. SHEA was founded in 1980 to advance the application of the science of healthcare epidemiology. The Society works to achieve the highest quality of patient care and healthcare personnel safety in all healthcare settings by applying epidemiologic principles and prevention strategies to a wide range of quality-of-care issues. SHEA is a growing organization, strengthened by its membership in all branches of medicine, public health, and healthcare epidemiology.

SHEA and its members are committed to implementing evidence-based strategies to prevent healthcare-associated infections (HAIs). SHEA members have scientific expertise in evaluating potential strategies for eliminating preventable HAIs. We collaborate with a wide range of infection prevention and infectious diseases societies, specialty medical societies in other fields, quality improvement organizations,

and patient safety organizations in order to identify and disseminate evidence-based practices.

Our principal partners in the private sector are sister societies such as the Infectious Diseases Society of America and the Association of Professionals in Infection Control and Epidemiology. The Centers for Disease Control and Prevention (CDC), its Division of Healthcare Quality Promotion and the Federal Healthcare Infection Practices Advisory Committee, and the Council of State and Territorial Epidemiologists (CSTE) have been invaluable Federal partners in the development of guidelines for the prevention and control of HAIs and in their support of translational research designed to bring evidence-based practices to patient care. Further, collaboration between experts in the field (epidemiologists and infection preventionists), CDC and the Agency for Healthcare Research and Quality (AHRQ) plays a critical role in defining and prioritizing the research agenda. In 2008, SHEA aligned with the Joint Commission and the American Hospital Association to produce and promote the implementation of evidence-based recommendations in the Compendium of Strategies to Prevent Healthcare-Associated Infections in Acute Care Hospitals (http://www.shea-online.org/about/compendium.cfm). The Society also contributes expert scientific advice to quality improvement organizations such as the Institute for Healthcare Improvement, the National Quality Forum, and State-based task forces focused on infection prevention and public reporting issues.

SHEA applauds the Congress for its support of HAI prevention and reduction activities through the American Recovery and Reinvestment Act (ARRA) in 2009. SHEA continues to collaborate with the Department of Health and Human Services (HHS) and the CDC to translate agency goals and objectives for HAI funds into actions at the bedside that can achieve meaningful reductions in preventable HAIs. However, there is a critical need for ongoing congressional support of a national prevention strategy to address a problem estimated by CDC to be one of the top ten causes of death in the Nation and one that poses a significant economic burden on the Nation's healthcare system.

CDC

The CDC plays a critical role in public health protection through its health promotion, prevention, preparedness, and research activities. As you consider fiscal year 2011 funding levels for the CDC, SHEA urges your support of at least $8.8 billion for CDC's "core programs" to ensure that the agency is able to carry out its prevention mission and to assure an adequate translation of new research into effective State and local programs. CDC's leadership was especially critical in efforts to provide support and guidance to State and local health departments as well as the public in its response to the 2009 H1N1 influenza virus. In addition to maintaining a strong public health infrastructure and protecting Americans from public health threats and emergencies, SHEA strongly believes that CDC programs play a vital role in reducing healthcare costs, improving the public's health, and providing much-needed unbiased education on HAIs and their prevention.

SHEA is particularly concerned about CDC's Infectious Diseases program budget, which supports critical management and coordination functions for infectious diseases research, policy development, and intervention programs including related specific epidemiology and laboratory activities. SHEA recommends an fiscal year 2011 funding level of $2.3 billion for CDC's Infectious Diseases programs.

Within the Emerging and Zoonotic Infectious Disease programs' proposed budget, the agency's Antimicrobial Resistance budget would be cut dramatically by $8.6 million, or just more than 50 percent. This vital program is necessary to help combat the rising crisis of drug resistance, one of the most pressing problems and greatest challenges that healthcare providers will confront during the coming decade. As bacteria and other micro-organisms are becoming more resistant to antimicrobials, our current therapeutic options are dwindling and research and development of new antibiotics is lagging. For the first time since the discovery and introduction of penicillin in the 1940s, we are dangerously close to a return to the pre-antibiotic era.

Antimicrobial resistance is a very real problem that extends to every segment of the healthcare community. Yet the President's fiscal year 2011 budget would allow only 20 State/local health departments and healthcare systems to be funded for surveillance, prevention, and control of antimicrobial resistance, down from 48 this past year. It would also eliminate all grants to States for the successful Get Smart in the Community program to combat improper uses of antibiotics. These cuts would be devastating at a time when we need to be fully committed to the goals of antimicrobial stewardship, to the research needed to define the most effective interventions and to educating the next generation of stewards.

CDC's antimicrobial resistance activities including State-based and local surveillance and educational initiatives are so critical to protecting Americans from serious

and life-threatening infections that SHEA urges you to double funding for CDC's antimicrobial resistance activities to at least $40 million in fiscal year 2011.

SHEA strongly supports the proposed fiscal year 2011 increase of $12.3 million in the Preparedness, Detection and Control of Infectious Diseases line item to allow for the expansion of the National Healthcare Safety Network from 2,500 to 5,000 hospitals. SHEA believes that protecting and improving resources for implementation of programs that standardize measurement of appropriate HAI outcomes and performance measures should be a priority. Our most valuable resource in this regard is NHSN, a voluntary, secure, Internet-based surveillance system that integrates and expands patient and healthcare personnel safety surveillance systems. Many States consider NHSN to be the best option for implementing standardized reporting of HAI data. It is an enormously important national resource and effective funding and support is essential to expand its implementation. The proposed increase will allow CDC to build on progress made with fiscal year 2009 ARRA funds to leverage the NHSN and support the dissemination of HHS evidence-based practices within hospitals to reduce these infections and save lives. These funds are also intended to allow CDC to build the workforce capacity, laboratory facilities, and skills sets within State and local health departments to enhance the ability to detect and control emerging infectious diseases. It should be noted that this funding level is not sufficient to sustain the NHSN and State and local health department activities in this area.

SHEA urges you to increase the funding for CDC's budget line for Emerging Infections by $25 million in fiscal year 2011. In fiscal year 2010, $11.7 million of this budget line were allocated to the Division of Healthcare Quality and Promotion. The additional $25 million should be used to support State and local health department HAI surveillance and prevention activities and provide a means for sustaining and expanding the important HAI initiatives that have been started using ARRA funds. Given the condition of State economies, it is unlikely that State funding will be available and the benefits of most programs will be lost at the end of 2011 without continued Federal support. As we seek to strengthen our public health infrastructure and reorient our health system toward prevention and preparedness, a strong Federal role should be part of a comprehensive approach to reduce HAIs and costs in line with the goals of healthcare reform.

On a related note, recognizing that currently 21 States mandate the use of NHSN for State public reporting and this number is expected to grow, immediate efforts should be made to enable interfaces between electronic health records (EHRs) and NHSN. In this way, additional burdens are not placed upon healthcare entities from either an infection prevention and control or information technology (IT) perspective as the desirability for national database integration proceeds.

SHEA is pleased with the proposed establishment and funding ($10 million) of a new workforce program, the Health Prevention Corps, within the CDC to enhance the capacity of the public health infrastructure to respond to current and emerging health threats. This program is intended to recruit new talent for State/local health departments with a focus on disciplines with known workforce shortages, such as epidemiology. This investment is very timely, as a recently released report from the CSTE documented a 10 percent decline in the number of State-based epidemiologists over the last 3 years, with a 40 percent deficit in the overall number of epidemiologists needed for full capacity across the 50 States. Clearly, our ability to reduce and prevent HAIs is highly dependent upon a continued strong investment in hospital infrastructure and qualified personnel for infection prevention and control.

National Institutes of Health (NIH)

SHEA is very pleased that ARRA infused the NIH with billions of dollars for research projects that will enable growth and investment in biomedical research and development, public health, and healthcare delivery. The NIH is the single-largest funding source for infectious diseases research in the United States and the lifesource for many academic research centers. The NIH-funded work conducted at these centers lays the ground work for advancements in treatments, cures, and medical technologies. We applaud Congress for acknowledging the impact of scientific research in stimulating the economy. It is critical that we maintain this momentum for medical research capacity. Accordingly, SHEA supports an overall funding level of $35 billion for NIH in fiscal year 2011.

While SHEA is very pleased with the proposed major investment in Agency for Healthcare Research and Quality (AHRQ) for research focused on HAIs (discussed below), support for basic, translational, and epidemiological HAI research has not been a priority of the NIH. Despite the fact that HAIs are among the top 10 annual causes of death in the United States, scientists studying these infections have received relatively less funding than colleagues in many other disciplines. In 2008,

NIH estimated that it spent more than $2.9 billion on funding for HIV/AIDS research, approximately $2 billion on cardiovascular disease research, about $664 million on obesity research and, by comparison, National Institute of Allergy and Infectious Diseases (NIAID) provided $18 million for MRSA research. SHEA believes that as the magnitude of the HAI problem becomes part of the dialogue on healthcare reform, it is imperative that the Congress and funding organizations put significant resources behind this momentum.

The limited availability of Federal funding to study HAIs has the effect of steering young investigators interested in pursuing research on HAIs toward other, better-funded fields. While industry funding is available, the potential conflicts of interest, particularly in the area of infection-prevention technologies, make this option seriously problematic. These challenges are limiting professional interest in the field and hampering the clinical research enterprise at a time when it should be expanding.

Our discipline is faced with the need to bundle, implement, and adhere to interventions we believe to be successful while simultaneously conducting basic, epidemiological, pathogenetic and translational studies that are needed to move our discipline to the next level of evidence-based patient safety. The current convergence of scientific, public and legislative interest in reducing rates of HAIs can provide the necessary momentum to address and answer important questions in HAI research. SHEA strongly urges you to enhance NIH funding for fiscal year 2011 to ensure adequate support for the research foundation that holds the key to addressing the multifaceted challenges presented by HAIs.

AHRQ

SHEA strongly supports the proposed investment of $34 million by AHRQ in fiscal year 2011 to reduce and prevent HAIs. Funds made available through AHRQ (and CDC) should be used, in part, for translational research projects that can allow more rapid integration of science into practice. As an example, this could involve use of funds to support positions through which large collaboratives could be supported in States not currently part of AHRQ or Health Research and Educational Trust projects (for example, Public Health Research Institute and Keystone, which have achieved successful reductions in device-associated infections). Experts in the field (Epidemiologists and Infection Preventionists), in collaboration with CDC and the AHRQ, should be engaged in order to further define and prioritize the research agenda. As we strive to eliminate all preventable HAIs, we need to identify the gaps in our understanding of what is actually preventable. This distinction is critical to help guide subsequent research priorities and to help set realistic expectations. SHEA believes in the importance of conducting basic, epidemiological and translational studies (to fill basic and clinical science gaps). While health services research (i.e., successful implementation of strategies already known or suspected to be beneficial) may provide some immediate short-term benefit, to achieve further success, a substantial investment in basic science, translational medicine, and epidemiology is needed to permit effective and precise interventions that prevent HAIs.

SHEA thanks the subcommittee for this opportunity to share our priorities with respect to fiscal year 2011 funding for HHS, CDC, NIH, and AHRQ. SHEA is pleased to serve as a resource to the committee going forward on issues related to healthcare epidemiology.

PREPARED STATEMENT OF THE SEXUALITY INFORMATION AND EDUCATION COUNCIL OF THE UNITED STATES

SIECUS, the Sexuality Information and Education Council of the United States, has served as a strong national voice for sexuality education, sexual health, and sexual rights for more than 45 years.

SIECUS affirms that sexuality is a fundamental part of being human, one that is worthy of dignity and respect. We advocate for the right of all people to accurate information, comprehensive education about sexuality, and sexual health services. SIECUS works to create a world that ensures social justice and sexual rights.

PRESIDENT'S TEEN PREGNANCY PREVENTION INITIATIVE AT THE OFFICE OF ADOLESCENT HEALTH

As an organization committed to the health and education of our Nation's young people, we urge the subcommittee to invest in programs that provide all of our Nation's youth with comprehensive, medically accurate, and age-appropriate sex education that helps them reduce their risk of unintended pregnancy, HIV, and other sexually transmitted infections (STIs), as well as teach them about healthy relation-

ships and communication and decisionmaking skills so they can make responsible decisions and lead safe and healthy lives.

For the first time in more than a decade, the Nation's teen pregnancy rate rose 3 percent in 2006. During this time, teens were receiving less information about contraception in schools and their use of contraceptives was declining. Moreover, while making up only one-quarter of the sexually active population, young people aged 15–24 account for roughly one-half of the approximately 19 million new cases of sexually transmitted infections (STIs) each year. Those aged 13–24 account for one-sixth of new HIV infections, the largest share of any age group.

We are pleased that the President's fiscal year 2011 budget request once again included funding for more comprehensive and evidence-based approaches to sex education. However, by focusing the funding on teen pregnancy prevention, and not including the equally important health issues of STIs including HIV, the Administration has missed an opportunity to provide true, comprehensive sex education that promotes healthy behaviors and relationships for all young people, including lesbian, gay, bisexual, and transgender (LGBT) youth. We must strategically and systemically provide young people with all the information and services they need to make responsible decisions about their sexual health. Therefore, we request that the teen pregnancy prevention initiative be broadened to address STIs, including HIV, in addition to the prevention of unintended teen pregnancy.

Most of the evidence-based programs that have been proven effective at reducing risk factors associated with unintended teenage pregnancy and STIs by delaying sexual activity and increasing contraceptive use emphasize abstinence as the safest choice and also discuss contraceptive use as a way to avoid pregnancy and STIs, including HIV. In light of the evidence and recognizing more than one-half of young people have had sexual intercourse by the age of 18 and are at risk of both unintended pregnancy and STIs, we request that the committee direct the Office of Adolescent Health to prioritize funds to programs that are more comprehensive in scope insofar as they encourage abstinence but also encourage young people to always use condoms or other contraceptives when they are sexually active.

Leading public health and medical professional organizations—including the American Medical Association, the American Academy of Pediatrics, the Society of Adolescent Medicine, and the American Psychological Association—support a comprehensive approach to educating young people about sex. Focusing on more comprehensive approaches is both good policy and good politics. It is good policy because it is based on scientific considerations and takes into account the reality of teens' lives. In sharp contrast to abstinence-only-until-marriage programs, there is strong evidence that more comprehensive approaches do help young people both to withstand the pressures to have sex too soon and to have healthy, responsible, and mutually protective relationships when they do become sexually active. Importantly, the evidence is strong that sex education programs that promote abstinence as well as the use of condoms do not increase sexual behavior. Studies show that when teens are educated about condoms and have access to the method, levels of condom use at first intercourse increase while levels of sex stay the same.

Moreover, the CDC's Task Force on Community Preventive Services recently reviewed Comprehensive Risk Reduction programs and found sufficient evidence to recommend their use and support a conclusion that Comprehensive Risk Reduction interventions can have a beneficial effect on public health. The recommendation is based on sufficient evidence of effectiveness in: reducing a number of self-reported risk behaviors, including (1) engagement in any sexual activity, (2) frequency of sexual activity, (3) number of partners, and (4) frequency of unprotected sexual activity; (5) increasing the self-reported use of protection against pregnancy and STIs; and (6) reducing the incidence of self-reported or clinically-documented sexually transmitted infections.

In addition, the vast majority of parents want the Federal Government to fund programs that are medically accurate, age-appropriate, and educate youth about both abstinence and contraception. Nationwide polls show that 8 in 10 voters want young people to receive a comprehensive approach to sex education that includes teaching about both abstinence and contraception. Furthermore, according to the results of a 2005–2006 nationally representative survey of U.S. adults, published in the Archives of Pediatrics and Adolescent Medicine, there is far greater support for comprehensive sex education than for the abstinence-only approach, regardless of respondents' political leanings and frequency of attendance at religious services. Overall, 82 percent of those polled supported a comprehensive approach, and 68 percent favored instruction on how to use a condom; only 36 percent supported abstinence-only programs.

In these tight budget times, we are pleased that the President's fiscal year 2011 budget increased funding for the new teen pregnancy prevention initiative by $19.2

million, for a total of $133.7 million. We urge the committee to fund the initiative at least at the President's requested level of $133.7 million. We are also pleased that the President's budget has once again included zero dedicated funding for failed abstinence-only-until-marriage programs, and we encourage the subcommittee not to include funding for these ineffective programs.

Congress should continue to act in the best interest of young people by supporting public health and education policies that are comprehensive, rooted in the best science, and reflect mainstream values.

HIV PREVENTION AT THE CENTERS FOR DISEASE CONTROL AND PREVENTION (CDC)

President Obama proposed an increase of $31 million for HIV prevention programs at the Centers for Disease Control and Prevention (CDC). While we are grateful for this proposed increase during such difficult economic times, this amount is far from what is needed to reduce the number of new infections in the United States, which still stands at more than 56,000 per year. State and local health departments and community-based organizations need increased resources to strengthen and expand outreach, education, HIV testing, and prevention programs targeting high-risk populations. The CDC believes that in order to adequately address the HIV epidemic in this Nation, an additional $878 million is needed over each of the next 5 years. We are requesting an increase of $878 million for a total of $1.6 billion for CDC HIV prevention activities in fiscal year 2011.

With increased funding, other crucial prevention efforts can be augmented such as the delivery and evaluation of behavioral interventions, social marketing campaigns, surveillance, and other preventative education programs. Community based organizations and State and local health departments are all facing severe financial challenges. Through budget cuts, hiring freezes, layoffs, and furloughs, health departments across the Nation continue to curtail core public health functions including those that prevent the spread of HIV and other infectious diseases. Additional Federal resources are absolutely necessary if we are to reverse the increase of new infections. Investing in HIV prevention will result in billions of dollars in reduced healthcare costs in the future. Moreover, given the strong epidemiological link between HIV and other STDs, including high rates of co-infection among certain populations such as African Americans and men who have sex with men, an increased investment in STD programs (through the Division of STD Prevention) is an essential component of scaling up HIV prevention efforts. The cost of treating new cases of HIV each year that is attributable to Chlamydia, gonorrhea, syphilis, and genital herpes is more than $1 billion per year.

We also request an increase of $20 million, for a total of $60.2 million, for the Division of Adolescent and School Health's HIV Prevention Education. Recent estimates suggest that while representing 25 percent of the ever sexually active population, 15–24 year-olds acquire nearly one-half of all new STDs. Each year, one in four sexually active teenagers contracts a sexually transmitted disease. In addition, nearly 15 percent of the 56,000 annual new cases of HIV infections in the United States occurred in youth ages 13 through 24 in 2006. This means that an average of one young person every hour of every day is infected with HIV in the United States. It is essential that we provide schools with the resources they require to build and strengthen their capacity to improve child and adolescent health.

TITLE X FAMILY PLANNING PROGRAM AT THE OFFICE OF POPULATION AFFAIRS

We request that funding for the title X family planning program be increased to $700 million over the next 5 years, beginning with an increase of $76.5 million in fiscal year 2011.

Title X is a vital part of our Nation's healthcare infrastructure. The Institute of Medicine (IOM), in their recent review of the program, found title X to be a "valuable program" providing "critical services" to those in need, but also noted that the program is not currently receiving the funds needed to fulfill its mission. As the Administration and Congress work to reform our healthcare system, the President has stated that we must build on what works. Title X is a prime example of the type of successful programs that should be expanded. We appreciate the President's leadership in providing a $10 million increase for title X in his fiscal year 2011 budget request. However, in spite of the program's critical role and proven effectiveness, funding for title X continues to fall well short of what is needed.

Title X serves nearly 5 million low-income women and men at more than 4,500 health centers each year. Title X services help women and men plan the number and timing of their pregnancies, thereby helping to prevent nearly 1 million unintended pregnancies each year, nearly one-half of which would otherwise end in abortion. In addition to providing contraceptive services and supplies, title X health cen-

ters provide basic preventive health services, education, and counseling. For example, in 2007, title X centers provided 2.2 million Pap tests and 2.4 million clinical breast exams. Not only do the services provided through title X promote public health, they also save tax dollars. For every public dollar invested in title X, $4.02 is saved in Medicaid-related costs alone.

CONCLUSION

We urge you to include in the Labor, Health and Human Services, and Education, and Related Agencies appropriations bill the strongest possible teen pregnancy prevention and sex education initiative that will meet the needs of all young people and help them achieve healthier and safer lives. We also urge you to adequately fund HIV prevention at the CDC and the title X family planning program so that the health goals of our Nation can be met.

PREPARED STATEMENT OF THE SOCIETY FOR MATERNAL-FETAL MEDICINE

Mr. Chairman and members of the subcommittee: The Society for Maternal-Fetal Medicine is pleased to have the opportunity to submit testimony in support of the fiscal year 2011 budget for the Eunice Kennedy Shriver National Institute of Child Health and Human Development (NICHD). We are grateful for your strong and sustained commitment to the National Institutes of Health (NIH), in particular the NICHD. Through the programs of the NICHD, ground-breaking research advances have been made that have changed the practice of obstetrics.

Established in 1977, the Society for Maternal-Fetal Medicine (SMFM) is dedicated to improving maternal and child outcomes; and raising the standards of prevention, diagnosis, and treatment of maternal and fetal disease.

Maternal-fetal medicine specialists, also known as MFM specialists, perinatologists and high-risk pregnancy physicians, are highly trained obstetricians/gynecologists with advanced expertise in obstetric, medical, and surgical complications of pregnancy and their effects on the mother and fetus. The complex problems faced by these mothers may lead to death or problems, both short-term and life-long for both the mothers and their babies. Only through research can complications involving the mother or unborn fetus be understood, treated, prevented and eventually solved.

The mission of NICHD is to ensure that every child is born healthy and that women suffer no harmful effects from reproductive processes. NICHD supports a blend of basic, clinical, translational, and multidisciplinary research studies that address a myriad of issues in pregnancy such as:

—*Preterm Birth*.—Preterm birth (delivery before 37 weeks' gestation) is associated with increased risks of death in the immediate newborn period as well as in infancy, and can cause long-term complications including devastating disabilities. About 20 percent of premature babies die within the first year of life, and although the survival rate is improving, many preterm babies have life-long disabilities, including cerebral palsy, mental retardation, respiratory problems, and hearing and vision impairment. Preterm birth occurs in nearly 13 percent of all deliveries in the United States, a higher rate than in other developed countries (5–9 percent). The total cost of preterm birth in the United States is $26 billion a year, according to a 2006 report of the Institute of Medicine.

—*Stillbirth*.—Stillbirth defined as the death of a fetus at 20 or more weeks of gestation, complicated nearly 26,000 pregnancies in the United States in 2005. Considerable racial disparity exists—stillbirth is more than twice as common among African Americans than Caucasian women (11.1 versus 4.8 per 1,000). Other maternal risk factors for stillbirth include advanced age, obesity, and coexisting medical disorders such as diabetes or hypertension. The possible impact of environmental exposures on stillbirth risk remains unknown. Of known stillbirth causes, the most common are genetic abnormalities, alterations in the number or structure of the chromosomes, maternal infection, hemorrhage, and problems with the umbilical cord or placenta. However, the cause remains unknown in about one-half of all stillbirths.

—*Hypertensive Diseases in Pregnancy*.—High blood pressure (hypertension) during pregnancy endangers the health of both the mother and the baby and is increasingly common as women delay pregnancy until they are older, and as they are more frequently overweight. Hypertension in pregnancy is the second leading cause of maternal death in the United States, accounting for 15 percent of all deaths. For the mother, it is associated with early delivery, increased need for labor induction because of pregnancy complications, stroke, pulmonary or heart failure, and death. The likelihood and severity of these complications in-

creases as the severity of the hypertension increases, and if pre-eclampsia develops. Pre-eclampsia is characterized by high blood pressure and the presence of protein in the urine. Its cause, or causes, remains one of the greatest mysteries in obstetrics and is a major cause of maternal, fetal, and neonatal mortality worldwide.

—*Pregestational and Gestational Diabetes*.—The hormonal changes of pregnancy can seriously worsen pre-existing diabetes and often bring about a diabetic state (gestational diabetes) in predisposed women. Whether diabetes mellitus existed before conception or gestational diabetes develops during pregnancy, maternal glucose intolerance can have significant medical consequences for both mother and baby. Poorly controlled diabetes is associated with miscarriage, congenital malformations, abnormal fetal growth, stillbirth, obstructed labor, increased cesarean delivery, and neonatal complications. Up to 200,000 pregnancies are affected by gestational diabetes each year.

Great strides are being made through NICHD-supported research to address the complex situations faced by mothers and their babies. One of the most successful approaches for testing research questions related to preterm birth is the NICHD research networks, which allow researchers from across the country to coordinate their work and share data. The networks deal with different aspects of the problem of preterm birth and its consequence. For example:

—*Maternal-Fetal Medicine Units Network*.—To achieve a greater understanding and pursue development of effective treatments for the prevention of preterm births, low birth weight infants and medical complications during pregnancy, in 1986 the NICHD established the Maternal-Fetal Medicine Units Network (MFMU). The MFMU Network has changed obstetrical practice by identifying new effective therapies and putting an end to practices that are not useful. It is the only national research infrastructure capable of performing the much needed large trials that provide the evidence on which sound medical practice is based. The MFMU Network is also the ideal vehicle to collaborate with other NIH networks, as well as international networks in order to improve global health. Since its inception, the Network has made several exciting scientific advancements and has been able to rapidly turn laboratory and clinical research into diagnostic examinations and treatment procedures that directly benefit those affected.

—A major advance in the prevention of preterm birth has been the use of progesterone in the second and third trimesters, which resulted in a substantial reduction in the rate of preterm delivery among women who had a previous preterm birth and also reduced the risk of newborn complications. The annual savings of preventing recurrent preterm delivery by progesterone treatment in the United States has been estimated at more than $2 billion. Research into progesterone use in women with other risk factors is continuing. So far studies have shown that progesterone treatment is not effective in twin or triplet pregnancies, but it may reduce the rate of preterm birth in women with a short cervix. If effective for this indication, progesterone treatment would be particularly helpful for identifying women at risk in their first pregnancy. Ongoing study is needed to identify the optimal populations for treatment and the best treatment regimens.

—A significant development in clinical care, antenatal corticosteroid administration promotes fetal lung maturity. It is one of the most effective means of preventing newborn complications, including respiratory distress, intraventricular hemorrhage, and death, when preterm birth occurs. Though a single course of treatment is effective if given before preterm birth, the effect appears to decline over time if the pregnancy remains undelivered. Research over the past decade has shown that repeated doses of antenatal corticosteroids, either weekly or on alternate weeks, is associated with negative effects on fetal growth that could potentially outweigh their benefits. Current research is evaluating the potential benefits of a single "rescue course" of corticosteroids for undelivered women who have a second episode of threatened preterm delivery.

—Large trials have suggested that magnesium sulfate treatment, given when preterm delivery is expected before 32–34 weeks, results in a reduction in cerebral palsy. Because cerebral palsy is the most prevalent chronic motor disability, with an estimated lifetime cost of nearly $1 million per individual, its prevention is of great significance to patients, their family and to society. While current evidence is encouraging, further study is needed to determine the optimal treatment regimen and which pregnancies would benefit most from this intervention.

Though novel and important research areas have emerged to improve the outcomes of mothers and babies, there are still many challenges that face us:

—*Translation of Genomics and Proteomics into Preterm Birth and Stillbirth*.—Preterm birth and stillbirth represent two of the most important complications of pregnancy. Prevention of preterm birth and stillbirth depends on identifying women at risk and understanding the mechanisms of disease. It is imperative that NICHD take advantage of high throughput technologies to understand the causes of preterm birth and stillbirth and support genomics, proteomics, and metabolomics studies focusing on prediction and prevention of preterm birth and stillbirth, as well as the use of existing biobanks. The promise of these new technologies is that a better understanding of the biologic processes involved in pregnancy and pregnancy complications will lead to improved prediction, prevention, and treatment strategies that will improve maternal and infant health.

—*Severe, Early Adverse Pregnancy Outcomes*.—Women with severe, early adverse pregnancy outcome, such as multiple losses, demises, and severe pre-eclampsia, are at increased risk for long-term chronic health problems, including hypertension, stroke, diabetes, and obesity. Studies have shown that women who have had pre-eclampsia are more likely to develop chronic hypertension, to die from cardiovascular disease and to require cardiac surgery later in life. In addition, approximately 50 percent of women with gestational diabetes will develop diabetes later in life. Pregnancy can be considered as a window to future health and the immediate postpregnancy period provides a unique opportunity for prevention of chronic diseases later in life. Studies to identify women at risk for long term morbidity, and to develop strategies to prevent long term adverse outcomes in these women are urgently needed.

—*Maternal Fetal Medicine Units (MFMU)Network*.—Vigorous support of the MFMU Network is needed so that therapies and preventive strategies that have significant impact on the health of mothers and their babies will not be delayed. Until new options are created for identifying those at risk and developing cause specific interventions, preterm birth will remain one of the most pressing problems in obstetrics.

As the subcommittee moves forward with deliberations on the fiscal year 2011 budget, we urge you to provide greater resources to NIH, and in particular to NICHD. Research is the cornerstone for improving our understanding of the physiology and pathophysiology of pregnancy, the interrelationship between the mother and fetus, the impact of medical conditions on pregnancy and the impact of medical diseases and pregnancy outcomes on the long term health of both mother and child. With your support, researchers can continue to peel away the layers of complex problems of pregnancy that have such devastating consequences.

Recommendations.—The Society for Maternal Fetal Medicine recommends:

—An appropriation of $35 billion for the NIH in fiscal year 2011.

—A funding level of $1.5 billion for NICHD.

—NICHD sustain the research investment in the MFMU Network to facilitate resolution of the myriad of problems that affect high-risk mothers and their fetuses.

—NICHD support genomics, proteomics, and metabolomics studies focusing on prediction and prevention of preterm birth and stillbirth.

—NICHD identify women at risk for long-term morbidity and develop strategies to prevent long-term adverse outcomes.

Thank you for the opportunity to present our views.

PREPARED STATEMENT OF THE SOCIETY FOR PUBLIC HEALTH EDUCATION

The Society for Public Health Education (SOPHE) is a professional health education organization founded in 1950 to promote the health of all people by stimulating research on the theory and practice of health behavior; translating sound science into practice; and supporting high-quality standards for professional preparation. SOPHE is the only independent professional organization devoted exclusively to health education and health promotion. SOPHE's 4,000 national and chapter members work daily to improve health outcomes and promote wellness in a variety of settings, including schools, universities, healthcare organizations, corporations, voluntary health agencies and Federal, State, and local government. There are currently 20 SOPHE chapters covering more than 30 States and regions across the country.

SOPHE's broad membership enables us to advocate and understand the need for increased resources targeted at the most pressing public health issues. For the fiscal year 2011 funding cycle, SOPHE encourages the Labor, Health and Human Serv-

ices, Education, and Related Agencies (Labor-HHS) Subcommittee to increase funding for public health programs that focus on preventing chronic disease and other illnesses; eliminating health disparities; and promoting the coordinated school health model. In particular, SOPHE would like to request the following fiscal year 2011 funding levels for Labor-HHS programs:

—$969.85 million for the National Center for Chronic Disease Prevention and Health Promotion;
—$50 million for the Centers for Diseases Control and Prevention (CDC) and CDC Racial and Ethnic Approaches to Community Health (REACH U.S.) program;
—$77.64 million for CDC Division of Adolescent and School Health, $33.9 million of which shall be specifically appropriated for the coordinated school health program; and
—$30 million for the CDC Healthy Communities Program.

SOPHE gratefully acknowledges the strong bipartisan support that the Senate Labor-HHS Subcommittee has provided to the CDC in recent years, including the funding dedicated to the Prevention and Wellness Fund in the American Recovery and Reinvestment Act of 2009. The field of health education and health promotion, which is some 100 years old, uses sound science to plan, implement, and evaluate interventions that enable individuals, groups, and communities to achieve personal, environmental, and population health. There is a robust, scientific evidence-base documenting not only that various health education interventions work but that they are also cost-effective. These principles serve as the basis for our support for the programs outlined below.

Preventing Chronic Disease

The data are clear: chronic diseases are the Nation's leading causes of morbidity and mortality and account for 75 percent of every dollar spent on healthcare in the United States. Collectively, they account for 70 percent of all deaths nationwide. Thus, it is highly likely that 3 of 4 persons living in the districts of the Labor-HHS Subcommittee members will develop a chronic condition requiring long-term and costly medical intervention in their lifetime. In 2008, heart disease and stroke were estimated to cost $448 billion in medical expenditures and lost productivity. In 2009, U.S. healthcare expenditures exceeded $7,200 for every man, woman, and child, primarily for diagnosis and treatment of chronic diseases.

SOPHE is requesting a fiscal year 2011 funding level of $969.85 million for CDC's National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP) in order to adequately address the cost of chronic disease care and prevent it from further burdening our Nation's citizens and productivity. NCCDPHP is at the forefront of the U.S. efforts to prevent and control chronic diseases. The Center was substantially cut in 2006, and then has essentially been level-funded and has decreasing resources due to across the board rescissions—while chronic disease rates have continued to soar.

Studies show that spending as little as $10 per person on proven preventive interventions could save the country more than $16 billion in just 5 years. The public overwhelmingly supports increased funding for disease prevention and health promotion programs. Small investments now in community-led, innovative programs will help to increase our Nation's productivity and performance in the global market; decrease rates of infant mortality, deaths due to cancer, cardiovascular disease, diabetes, and HIV/AIDS, and; increase immunization rates.

SOPHE is requesting a fiscal year 2011 funding level of $30 million for CDC's Healthy Communities Program to advance policy and environmental change strategies in support of healthy eating, active living, and chronic disease and obesity prevention. Through the Healthy Communities Program, CDC collaborates with local and State health and park departments, national organizations with extensive community outreach, and community leaders to prevent chronic disease. Among the many successes of the program since its inception are restoring physical education to the school day; requiring physical activity and healthy snacks in child care sites; changing zoning requirements to include sidewalks to promote physical activity; and enhancing farmers markets and community gardens to for wider access to fruits and vegetables.

Chronic disease prevention programs, like those delivered by NCCDPHP, are especially needed among our Nation's youth. In the last 20 years, the percentage of overweight youth has more than doubled, and for the first time in two centuries, children may have a shorter life expectancy than their parents. Fifteen percent of children and adolescents are overweight and more than one-half of these children have at least one cardiovascular disease risk factor, such as elevated cholesterol or high blood pressure. Almost 80 percent of young people do not eat the recommended five servings of fruits and vegetables each day. Daily participation in high school

physical education classes dropped from 42 percent in 1991 to 32 percent in 2001. Patterns of poor nutrition, lack of physical activity, and other behaviors such as alcohol and tobacco use established during youth often continue into adulthood and contribute markedly to costly, chronic conditions.

CDC's Coordinated School Health Programs have been shown to be cost-effective in improving children's health, their behavior, and their academic success. This funding builds bridges between State education and public health departments to coordinate health education, nutritious meals, physical education, mental health counseling, health services, healthy school environments, health promotion of faculty, and parent and community involvement. Gallup polls show strong parental, teacher, and public support for school health education.

SOPHE urges this subcommittee to support an appropriation of $33.9 million in fiscal year 2010 for CDC's Division of Adolescent and School Health, Coordinated School Health Programs. In 2008, 43 States (plus five tribal governments and four territorial education agencies) applied for such funding; however, because of limited resources, only 22 States and 1 tribal government were funded. A funding level of $33.9 million would allow capacity building grants to an additional of up to 17 States (from 23 to 40).

Chronic diseases account also for the largest health gap among populations and increase health disparities among racial and ethnic minority groups. As the U.S. population becomes increasingly diverse, the Nation's health status will be heavily influenced by the morbidity of racial and ethnic minority communities. African Americans, Alaskan Natives, American Indians, Asian Americans, Hispanic Americans, and Pacific Islanders are more likely than whites to have poorer health and to die prematurely, especially from chronic conditions.

SOPHE strongly urges an allocation of $50 million for CDC's REACH U.S. initiative to eliminate health disparities among urban and rural communities in the areas of cardiovascular disease, immunizations, breast and cervical cancer screening and management, diabetes, HIV infections/AIDS, and infant mortality. A funding level of $50 million would allow for the distribution of monies to support at least 10 2-year planning grants for communities to implement evidence- and practice-based approaches to reducing chronic disease rates.

Launched in 2007, REACH U.S. is the next evolution of REACH 2010, which was developed by HHS and CDC to find "out of the box" community-driven solutions to address health disparities. REACH U.S. is unique because it works across public and private sectors to conduct community based prevention research and demonstration projects that address social determinants of health. REACH U.S. programs are time-tested, community-led interventions that have proven success in decreasing health disparities. President Obama highlighted a need to address health disparities in his fiscal year 2011 budget blueprint, and with increased funding REACH U.S. programs can address his call to action.

Thank you for this opportunity to present our views to this subcommittee. We look forward to working with you to improve the health and quality of life for all Americans.

PREPARED STATEMENT OF THE SOCIETY FOR WOMEN'S HEALTH RESEARCH

On the behalf of the Society for Women's Health Research (SWHR) and the Women's Health Research Coalition (WHRC), we are pleased to submit the following testimony in support of Federal funding of biomedical research, and specifically women's health research.

SWHR, a national nonprofit organization based in Washington DC, is widely recognized as the thought leader in research on sex differences and is dedicated to improving women's health through advocacy, education, and research. SWHR was founded in 1990 by a group of physicians, medical researchers, and health advocates who wanted to bring attention to the myriad of diseases and conditions that affect women uniquely.

In 1999, the WHRC was established by SWHR to give a voice to scientists and researchers from across the country that are committed to improving women's health research. WHRC now has more than 650 members, including leaders within the scientific community and medical researchers from many of the country's leading universities and medical centers, as well as leading voluntary health associations, and pharmaceutical and biotechnology companies.

SWHR and WHRC are committed to advancing the health of women through the discovery of new, targeted scientific knowledge. We believe that sustained funding for biomedical and women's health research programs conducted and supported

across the Federal agencies is absolutely essential if we are to meet the health needs of women, and men, and advance the Nation's research capability.

In this testimony we address the clinical successes and financial hardships of five key agencies and subgroups doing the important work of sex-based research: National Institutes of Health (NIH), NIH's Office of Research on Women's Health (ORWH), Health and Human Services' Office of Women's Health (HHS), the Centers for Disease Control and Prevention (CDC), and the Agency for Healthcare and Research Quality (AHRQ). If America wants to remain a leader in healthcare advancement, if we are serious about the advancement of personalized medicine, if we are ready to stop wasting healthcare dollars on inappropriate treatments or the costs that come with guessing versus knowing-then we implore Congress to supply these agencies with the tools needed to accomplish these goals.

National Institutes of Health

Past congressional investment and support for NIH has positioned the United States as the world leader in biomedical research and has provided a direct and significant impact on women's health research and the careers of women scientists over the last decade. The 111th Congress saw the importance of increasing funds to NIH in the 2009 American Recovery and Reinvestment Act (ARRA). This funding is having an enormous impact on research and research facilities throughout the United States, creating new jobs, new innovations and improved technologies. However, the U.S.'s position as world leaders in biomedical research is threatened by a budget that does not continue to provide significant funding to NIH. Flat-lining NIH funding, or worse, cutting funds and not keeping up with inflation, threatens the developments started by ARRA, and puts the innovative research practices and reputation that America is known for in jeopardy.

When faced with budget cuts, NIH has shown that it is left with no other option but to reduce the number of grants it is able to fund. When not including the one-time ARRA infusion of funds, the number of new grants funded by NIH had dropped steadily with budgets growing at less than that of inflation since fiscal year 2003. A shrinking pool of available grants has a significant impact on scientists who depend upon NIH support to cover both salaries and laboratory expenses to conduct high-quality biomedical research, putting both medical advancement and job creation at risk. Failure to obtain a grant decreases publishing of new finds and decreases the number of scientists gaining experience in research, both reducing a scientist's likelihood of achieving tenure in a university setting. New and less established researchers are forced to consider other careers, the end result being the loss in academia of the skilled bench scientists and researchers so desperately needed to sustain America's cutting edge in biomedical research.

SWHR recommends Congress to set a laudable goal of reaching $40 billion in NIH funding in the next 3 years. To meet this goal, SWHR urges you to exceed the administration's fiscal year 2011 request of a $1 billion increase and to allocate an additional $3 billion in funding for the NIH in fiscal year 2011, resulting in a total research budget of $34 billion.

In addition, SWHR requests that Congress strongly encourage the NIH to utilize ARRA funding as well as appropriated dollars to ensure that women's health research receives resources sufficient to meet the health needs of all women. SWHR further recommends that NIH, with the funds provided, report sex differences in all research findings. With the tools the NIH already has available, it should seek to expand its inclusion of women in basic, clinical and medical research to phase I, II, and III studies. By currently only mandating sufficient female subjects in phase III, science misses out on the chance to look for variability by sex in the early phases of research, where scientists look at treatment safety and determine safe dose levels for new medications. By raising the bar, NIH can continue to serve as a role model for industry research, as well as other nations. Only by gaining more information on how therapies work in women will medicine be able to advance more targeted and effective treatments for all patients, men and women alike.

Only within the past decade have scientists begun to uncover significant biological and physiological differences between women and men, as it impacts health and medicine. Sex-based biology, the study of biological and physiological differences between women and men, has revolutionized the way that the scientific community views the sexes. Sex differences play an important role in disease susceptibility, prevalence, time of onset, and severity and are evident in cancer, obesity, heart disease, immune dysfunction, mental health disorders, and many other illnesses. Medications can have different effects in woman and men, based on sex specific differences in absorption, distribution, metabolism, and elimination. It is imperative that research addressing these important differences be supported and encouraged. Congress clearly recognizes these important sex differences and NIH should as well.

Office of Research on Women's Health

The NIH's Office of Research on Women's Health (ORWH) has a fundamental role in coordinating women's health research at NIH: advising the NIH Director on matters relating to research on women's health and sex and gender research; strengthening and enhancing research related to diseases, disorders, and conditions that affect women; working to ensure that women are appropriately represented in research studies supported by NIH; and developing opportunities for and support of recruitment, retention, re-entry and advancement of women in biomedical careers. ORWH is currently implementing recommendations from the NIH working group on Women in Biomedical Careers to maximize the potential of female biomedical scientists and engineers in both the NIH and external research community.

Two highly successful programs supported by ORWH that are critical to furthering the advancement of women's health research are Building Interdisciplinary Research Careers in Women's Health (BIRCWH) and Specialized Centers of Research on Sex and Gender Factors Affecting Women's Health (SCOR). The BIRCWH program, created in 2000, is an innovative, trans-NIH career development program that provides protected research time for junior faculty by pairing them with senior investigators in an interdisciplinary mentored environment. SCORs, established in 2003, are designed to increase the transfer of basic research findings into clinical practice by housing laboratory and clinical studies under one roof. These programs benefit the health of both women and men through sex and gender research, interdisciplinary scientific collaboration, and provide tremendously important support for young investigators in a mentored environment. Each BIRCWH receives approximately $500,000 a year, most of which comes from the ORWH budget but is also supported by many NIH Institutes and Centers. Each SCOR program costs $1 million per year and results in unique research.

Additionally, Advancing Novel Science in Women's Health Research (ANSWHR) was created by ORWH in 2007 to promote innovative new concepts and interdisciplinary research in women's health research and sex/gender differences. ORWH also has the Research Enhancement Awards Program (REAP) to support meritorious research on women's health that just missed the IC pay line and a Partnership with the National Library of Medicine to identify overarching themes, specific health topics, and research initiatives into women's health. ORWH, through successful collaboration with the NIH ICs, provides research funding for: breast cancer, HPV vaccines, uterine leiomyoma, vulvodynia, irritable bowel syndrome, stroke, substance abuse, eating disorders including obesity, menopause, microbicides, chronic pain syndromes, autoimmune disorders, muscular skeletal disorders, and health disparities among many other issues.

In order for ORWH's programs and research grants to continue to expand and thrive, Congress must direct that NIH continue its support of ORWH and provide it with $2 million dollar budget increase, bringing its fiscal year 2011 total to $44.9 million.

Health and Human Services' (HHS) Office of Women's Health (OWH)

The HHS OWH is the Government's champion and focal point for women's health issues. It works to redress inequities in research, healthcare services, and education that have historically placed the health of women at risk. Without OWH's actions, the task of translating research into practice would and will be only more difficult and delayed.

Under HHS, several agencies have Federal offices specific to women's health. Agencies currently with offices, advisors, or coordinators for women's health or women's health research include the Food and Drug Administration, Centers for Disease Control and Prevention, Agency for Healthcare Quality and Research, Indian Health Service, Substance Abuse and Mental Health Services Administration, Health Resources and Services Administration, and Centers for Medicare and Medicaid Services. It is imperative that these offices are funded at levels adequate for them to perform their assigned missions, and are sustainable so as to support needed changes in the long term. We ask that the Committee Report reflect Congress's supports of the permanent existence of these various Federal women's health offices, recommending that they are appropriately funded on a permanent basis to ensure that these programs can continue and be strengthened in the coming fiscal year.

It is only through continued and increased funding that the OWH will be able to achieve its goals. The budget for fiscal year 2010, as in recent years, flatlined OWH budget at $33.7 million. This was, in essence, a decrease, due to inflation. Considering the amount and impact of women's health programs from OWH, we urge Congress to provide an increase of $2 million for the HHS OWH, a total $35.7 million requested for fiscal year 2011.

Centers for Disease Control and Prevention (CDC)

SWHR supports the national and international work of the CDC, and especially the work of CDC's OWH. While aware of unavoidable cuts in many sectors of the fiscal year 2011 budget, SWHR is concerned that the proposed CDC budget cuts and project eliminations jeopardize a number of programs that benefit women, leaving them with even fewer options for sound clinical information. Research and clinical medicine are still catching up from decades of a male-centric focus, and when diseases strike women, there is a paucity of basic knowledge on how diseases affect female biology, a lack of drugs that have been adequately tested in women, and now even fewer options for information through the many educational outreach programs of the CDC.

Cutting funding for programs on blood disorders, specifically for von Willebrand's disease, which has disproportionate impact on women, ending awareness campaigns on gynecological cancers funded by Johanna's Law, and eliminating specific funds dedicated to projects on Inflammatory Bowel Disease and Interstitial Cystitis (IC) will all result in women losing an advocate and a partner in advancing women's health. The proposed cuts to IC programs, in particular, equate to a loss of approximately half of its budget. These reductions translate to more than just a significant cut in total CDC budget. They create losses in jobs and in advocacy efforts led by patients suffering from these diseases, particularly IC, and their advocacy organizations, eliminating important education toward diagnosis and treatment. SWHR hopes that there will be serious consideration of the impact eliminating these programs will have on women, and men, who suffer these diseases, and encourages reviewing alternate sources of funding as a means to continue these important programs. The total savings realized by eliminating these programs is less than one half of 1 percent of the total programmatic resources budget for the CDC, and their elimination will have ramifications on patients and providers, as well as incalculable effects on advocacy groups, jobs, and information campaigns.

Agency for Healthcare and Research Quality (AHRQ)

The Agency for Healthcare Research and Quality's work serves as a catalyst for change by promoting the results of research findings and incorporating those findings into improvements in the delivery and financing of healthcare. Through AHRQ's research projects, lives have been saved. For example, it was AHRQ who first discovered that women treated in emergency rooms are less likely to receive life-saving medication for a heart attack. AHRQ funded the development of two software tools, now standard features on hospital electrocardiograph machines, which have improved diagnostic accuracy and dramatically increased the timely use of "clot-dissolving" medications in women having heart attacks.

While AHRQ has made great strides in women's health research, its budget has been dismally funded for years, though targeted funding increases in recent years for dedicated projects, including funds from ARRA, are moving AHRQ in the right direction. However, more core funding is needed to help AHRQ continue doing the research that helps patients and doctors make better medical decisions.

AHRQ's budget for fiscal year 2009 was $372 million, $397 million for fiscal year 2010. Such modest annual increases will not offer results that improve decision-making by doctors and patients for improved health outcomes. This agency has been operating under a major shortfall for years. Decreased funding seriously jeopardizes the research and quality improvement programs that Congress mandates from AHRQ. We recommend Congress fund AHRQ at the administration's proposed $611 million for fiscal year 2011, an increase of $214 million more than the fiscal year 2010 level. The lion's share of this increase will appropriately focus on patient-centered health research. This will ensure that adequate resources are available for high-priority research, including women's healthcare, sex and gender-based analyses, and health disparities-information that can help to better personalize treatments and improve outcomes for female and male patients nationwide.

Summary of Recommendations

—NIH fiscal year 2011—Additional $3 billion funding, $34 billion total. Increased focus on women's health research. Inclusion of women in all phases of NIH research.
—OWHR fiscal year 2011—Additional $2 million funding, $44.9 million total.
—HHS fiscal year 2011—Permanent funding of Federal women's health offices throughout HHS. Additional $2 million for OWH, $35.7 million total.
—CDC fiscal year 2011—Restored or alternate funding for 4 select projects.
—AHRQ fiscal year 2011—Match the administration's proposed budget of $611 million.

In conclusion, SWHR and the WHRC would like to thank the Chair and this subcommittee for its strong record of support for medical and health services research and its unwavering commitment to the health of the Nation through its support of peer-reviewed research. We look forward to continuing to work with you to build a healthier future for all Americans.

PREPARED STATEMENT OF THE TRUST FOR AMERICA'S HEALTH

My name is Jeff Levi, and I am Executive Director of Trust for America's Health (TFAH), a nonprofit, nonpartisan organization dedicated to saving lives by protecting the health of every community and working to make disease prevention a national priority.

As you craft the fiscal year 2011 Labor, Health and Human Services, Education, and Related Agencies appropriations bill, I hope that you will include robust funding for prevention and preparedness programs at the Centers for Disease Control and Prevention (CDC) and the Office of the Assistant Secretary for Preparedness and Response (ASPR) in order to promote health and help protect Americans from natural and manmade threats and disasters. Moreover, as you work with the Department of Health and Human Services to allocate funding from the Prevention and Public Health Fund, I urge you to use this funding to support the long-term transformation of the Nation's public health system.

Community Prevention

The United States spends more than any other Nation in the world on healthcare costs but lags behind other nations in certain indicators of health. To improve health across the country, we must transform communities to remove barriers to healthy lifestyles and ensure that Americans have access to healthy environments, nutritious foods and venues for physical activity. TFAH was pleased with the unprecedented investment that was made in community prevention via the American Recovery and Reinvestment Act (ARRA). Through its Communities Putting Prevention to Work Initiative, we'll begin to sow the seeds of transformation. In addition, programs at the CDC, in particular Healthy Communities and Racial and Ethnic Approaches to Community Health Across the U.S. (REACH–U.S.), prioritize the health of communities and support innovative approaches to addressing disparities and improving health. In fiscal year 2011, TFAH supports a total of $52 million for the Healthy Communities Program and $60 million for the REACH program to expand these successful programs to additional communities.

School Health

More than 23 million children in the United States are overweight or obese. To improve their health, we must reach them where they spend a great deal of time, and that includes schools. The Division of Adolescent and School Health's (DASH) Coordinated School Health Program provides funding to 22 States and one tribal government to strengthen the ability of State and local education agencies to address critical health issues, including obesity, asthma, tobacco use, HIV, STDs, and teen pregnancy, by building the capacity of funded partners to support science-based, cost-effective health programming. The President's fiscal year 2011 budget proposes to increase funding for DASH by $3.875 million. We strongly support an increase for DASH's School Health Program and hope that at a minimum, the program will receive an additional $20 million in fiscal year 2011 to enable CDC to fund 15 additional State education agencies and 25 additional local education agencies to reach more children and youth through quality school health programs.

Pandemic Influenza

The recent H1N1 flu outbreak demonstrated how rapidly a new strain of flu can emerge and spread around the world. H1N1 provided a real-world test that showed our strengths and vulnerabilities to respond to a major infectious disease outbreak. Prior pandemic preparedness investments resulted in the development of medical countermeasures that have been used in the H1N1 response. In addition, supplemental appropriations have been used for response activities, including vaccine production, distribution and administration; antiviral drugs; surveillance; communications and community mitigation; and laboratory support for virus detection. TFAH supports continuing funding for our annual pandemic flu preparedness activities in fiscal year 2011 at CDC ($156 million), the National Institutes of Health (NIH) ($35 million), the Food and Drug Administration (FDA) ($45 million) and the Office of the Secretary ($66 million) in order to strengthen our preparedness and response during any future outbreaks.

TFAH also urges appropriators to explore means to incorporate pandemic preparedness funds for State and local health departments into annual funding streams, such as the CDC Public Health Emergency Preparedness and ASPR Hospital Preparedness Program cooperative agreements. There is no annually recurring funding to support State and local pandemic preparedness. Yet, pandemic and all-hazards preparedness requires sustainable lab capacity, modernized disease surveillance systems, a well-trained workforce, effective medical countermeasures delivery and administration, surge capacity, and continuous exercising and improvement of response plans.

Another critical funding stream is the Biomedical Advanced Research and Development Authority (BARDA), which provides incentives and guidance for research and development of products to counter bioterrorism and pandemic flu. The President's budget proposes $476 million for BARDA, with funding made available from current BioShield Special Reserve Fund balances. These funds would support research on countermeasures for biological threat agents, volatile nerve agents and radiological and nuclear threats. TFAH supports an increase in funding for BARDA and recommends that in fiscal year 2011, at least $500 million is provided, with the acknowledgement that higher levels of funding must ultimately be allocated and sustained.

Global Disease Detection (GDD)

Despite remarkable breakthroughs in medical research and advancements in immunization and treatments, infectious diseases are undergoing a global resurgence that threatens health. It is estimated that newly emerging and re-emerging infectious diseases will continue to kill at least 170,000 Americans annually. CDC's GDD Program helps recognize infectious disease outbreaks, improve the ability to control and prevent outbreaks, and detect emerging microbial threats. For fiscal year 2011, TFAH recommends $56 million for the GDD Program to enable CDC to increase the number of GDD centers and expand capacity at existing Centers. Funding would bring Thailand, Kenya, China and Guatemala to full capacity, support Egypt and Kazakhstan as basic centers and establish four additional developing centers.

Environmental Health

An additional area of interest for TFAH is the connection between our environment and our health. CDC's Environmental Health Laboratory performs biomonitoring measurements—the direct measurement of people's exposure to toxic substances in the environment. By analyzing blood, urine, and tissues, scientists can measure actual levels of chemicals in people's bodies, and determine which population groups are at high risk for exposure and adverse health effects, assess public health interventions, and monitor exposure trends over time. TFAH supports an additional $19.6 million for the Environmental Health Laboratory's biomonitoring capacity in fiscal year 2011 in order to fund 7 to 10 grantees to conduct biomonitoring, increase the number of chemicals measured in CDC's National Report on Human Exposure to Environmental Chemicals, enable CDC to provide training and quality assurance for State laboratories awarded funds, and support the National Report on Biochemical Indicators of Diet and Nutrition.

Another important program, the National Environmental Health Tracking Network, enhances our understanding of the relationship between environmental exposures and the incidence and distribution of disease. The Tracking Network helps build our capacity to respond to environmental health issues and helps document links between environmental hazards and chronic disease. The National Network launched in July of 2009. CDC now funds just 22 States and one city to build and implement State-based tracking networks that will feed into the National Network. One additional State will be funded due to the increase in the fiscal year 2010 appropriations for this program. In order for the Network to be truly national in scope, it must be expanded to all States. To build toward that vision, TFAH recommends providing $50 million for CDC's Environmental and Health Outcome Tracking Network to expand it to up to 13 additional grantees and support the continued development of a sustainable Network.

TFAH is also concerned about the potential health effects of climate change, including injuries and fatalities related to severe weather events and heat waves; infectious diseases; allergic symptoms; respiratory and cardiovascular disease; and nutritional and water shortages. TFAH was appreciative of the $7.5 million included in fiscal year 2010 for the Climate Change Program at CDC. To enable CDC to fund 20–25 States and localities for climate change needs assessment and planning, in addition to supporting other climate change preparedness activities, TFAH recommends at least $15,000,000 for CDC's Climate Change Program in fiscal year

2011. Ultimately, $50 million is needed to develop a credible and effective Climate Change Program.

Public Health Workforce

A final area of critical importance to our Nation's health is our public health workforce. The latest job loss survey by the National Association of County and City Health Officials (NACCHO) found that local health departments lost 8,000 jobs in the second half of 2009—compounding the loss of another 8,000 positions in the first half of the year. To address the workforce shortages in State and local health departments, the President's budget proposes a new workforce program, the Health Prevention Corps, which will recruit new talent into service for State and local health departments. The program will target disciplines with known shortages, such as epidemiology, environmental health and laboratory. Fiscal year 2011 funding would be used to establish a management plan for staffing and program administration, convene stakeholders to establish the program framework, and develop a curriculum for Corps members. TFAH supports the President's request of $10 million for the Health Prevention Corps in fiscal year 2011.

The Prevention and Public Health Fund

The Prevention and Public Health Fund, established by the Patient Protection and Affordable Care Act (Public Law 111–148), provides $500 million in fiscal year 2010 and $750 million in fiscal year 2011 for programs authorized by the Public Health Service Act for prevention, wellness, and public health activities. This funding should be used to support the long-term transformation of the Nation's public health system. Investments from the Fund should be used in a manner that leverages change throughout the public health system—with a move away from a stove-piped, disease-by-disease approach to one that addresses the determinants of health in a cross-cutting manner.

The overarching goal should be to optimize the health of everyone by creating healthier, more resilient communities, through policy, systems, organizational, and environmental change. Investments from the Fund should be science informed or evidence based, have measurable health outcomes and policy goals, promote innovation, focus on the determinants of health and health equity, and be held accountable. The National Prevention Strategy should become the basis for defining the goals of a transformed public health system, identifying gaps in the current system, and how the Fund can be used to help close these gaps.

Expenditure of Initial Funds

As the National Prevention Strategy is developed over the next year, expenditures under the Fund for fiscal year 2010 and fiscal year 2011 should be consistent with the following categories of expenditure, which were included in the House-passed bill. These include:

—*Community Prevention*.—A focus on community prevention is the centerpiece of a transformed public health system. The focus should reflect cross-cutting approaches to reducing the risks that affect health and safety. In addition to chronic diseases, attention should be given to other critical health issues, such as injury and violence prevention, reproductive health, infectious diseases, emergency preparedness, mental health, birth defects and developmental disabilities, and environmental health. While State and local health departments must be central players in community prevention, grant funding is also needed to support the work of nongovernmental organizations.

—*Core Capacity (For Both Health Departments and Others Doing Community Prevention)*.—Health departments have varying levels of expertise and competency to design and manage community interventions that focus on policy, systems, organizational, and environmental change. All health departments should be supported in their efforts to expand the role of community prevention in addressing the health needs of their populations, but particular effort should be made to close the geographic gap in capacity to build healthier, safer, and more resilient communities. This can be done at least in part through the support of the accreditation process, which is focused on building these capacities and thresholds. Even with accreditation, we will need to provide funding to build a public health workforce able to serve in these accredited health departments.

—*Research, Development, and Dissemination of Best Practices*.—There is a continuing need to expand the science base of prevention, with particular emphasis on translation into practice and data to do appropriate program evaluation. This would include ramping up the capacity of the task forces on community and clinical prevention, creating the research and technical support for innovation in community prevention, and establishing the newly authorized program in

public health services and systems research, with a particular emphasis on data collection and analysis.

PREPARED STATEMENT OF THE THE AIDS INSTITUTE

Dear Chairman Harkin and members of the subcommittee: The AIDS Institute, a national public policy research, advocacy, and education organization, is pleased to comment in support of critical HIV/AIDS and Hepatitis programs as part of the fiscal year 2011 Labor, Health and Human Services, and Education, and Related Agencies appropriation measure. We thank you for your support of these programs over the years, and trust you will do your best to adequately fund them in the future in order to provide for and protect the health of many Americans.

HIV/AIDS

HIV/AIDS remains one of the world's worst health pandemics in history. According to the Centers for Disease Control and prevention (CDC), 583,298 people have died of AIDS in the United States. In 2008, the CDC announced that its estimate of new infections per year is now 56,300, which is 40 percent higher than previous estimates. That translates into a new infection every 9½ minutes. At the end of 2007, an estimated 1.1 million people in the United States were living with HIV/AIDS.

The AIDS Institute, working in coalition with other AIDS organizations, has developed funding request numbers for each of these domestic AIDS programs. We ask that you do your best to adequately fund them at the requested level.

We are keenly aware of budget constraints and competing interests for limited dollars. Unfortunately, despite the growing need, domestic HIV/AIDS programs have experienced only very minor increases in recent years. We are pleased that President Obama continues to focus on domestic HIV/AIDS programs and has proposed increases for prevention and treatment. We hope you will support the President's desire and increase funding for these important public health programs. Federal funding is particularly critical at this time since State and local budgets are being severely cut during this economic downturn. Many States and local governments have greatly cut their HIV prevention and HIV/AIDS care programs at the very same time demand for services are escalating.

Below are The AIDS Institute's program requests and supporting explanation:

Centers for Disease Control and Prevention—HIV Prevention and Surveillance

[In millions of dollars]

	Amount
Fiscal year 2010	728
Fiscal year 2011 community request	1,606

New infections are particularly occurring in certain populations, including African-American men and women and men who have sex with men. In order to address the specific needs of these populations and the increased number of people infected, CDC is going to need additional funding. Currently, the United States spends only about 4 percent of its domestic HIV/AIDS spending on prevention.

The AIDS Institute is extremely supportive of President Obama's budget request to "begin a focused initiative to prevent HIV through holistic and integrated approached to protect the health of gay, bisexual, and other MSM." We congratulate the President for proposing additional funding and for focusing it on gay men, which represent a majority of HIV cases in the United States and is the only group in which HIV incidence is increasing.

Unfortunately, the $31 million increase for fiscal year 2011 requested by the President is far from what is needed to significantly reduce the number of new HIV infections. According to the CDC's professional judgment budget, an additional $878 million for each of the next 5 years is necessary to improve HIV prevention efforts and reduce HIV transmission in the United States. Therefore, The AIDS Institute supports an increase for CDC HIV prevention funding by $878 million in fiscal year 2011.

This additional funding would be targeted toward: (1) Increasing HIV testing and the number of people who are reached by effective prevention programs; (2) developing new tools to fight HIV with scientifically proven interventions; and (3) improving systems to monitor HIV and related risk behaviors, and to evaluate prevention programs.

Investing in prevention today will save money tomorrow. Every case of HIV that is prevented saves, on average, $1 million of lifetime treatment costs for HIV. The CDC estimates that the cost of treating the estimated 56,300 new HIV infections in 2006 will translate into $9.5 billion in annual future medical costs.

At a time when State and local HIV prevention budgets are being cut, just to keep at the current funding levels will require a level of resources greater than what has been proposed. The AIDS Institute is concerned about any effort that would actually reduce the level of HIV prevention dollars at the State level. That is why we are opposed to language requested by the administration that would allow States to move up to 10 percent of its CDC funding, including HIV funding, to address the top six leading causes of death.

Ryan White HIV/AIDS Programs

[In millions of dollars]

	Amount
Fiscal year 2010	2,290.9
Fiscal year 2011 community request	3,101.5

The centerpiece of the Government's response to caring and treating low-income people with HIV/AIDS is the Ryan White HIV/AIDS Program. Ryan White currently serves more than half a million low-income, uninsured, and underinsured people each year. In fiscal year 2010, the Program received an increase of $53 million, or just 2.3 percent. This increase does not even cover the rate of inflation. The AIDS Institute urges you to provide substantial funding increases to all parts of the Ryan White Program. Consider the following:

—Caseload levels are increasing. People are living longer due to lifesaving medications; there are more than 56,000 new infections each year; and increased testing programs will identify 12,000 to 20,000 new people infected with HIV each year. With rising unemployment, people are losing their employer-sponsored health coverage.

—State and local budgets are experiencing cutbacks due to the economic downturn. A recent survey by the National Alliance of State and Territorial AIDS Directors found that State HIV/AIDS funding reductions totaling more than $170 million occurred in 29 States during fiscal year 2009. The situation for this year and next will be even worse. Thirty-three States who participated in the survey anticipate a decrease in State funding this year.

—There are significant numbers of people in the United States who are not receiving life-saving AIDS medications. An IOM report concluded that 233,069 people in the United States who know their HIV status do not have continuous access to Highly Active Antiretroviral Therapy.

Specifically, The AIDS Institute requests the following funding levels for each part of the Program:

—Part A provides medical care and vital support services for persons living with HIV/AIDS in the metropolitan areas most affected by HIV/AIDS. We request an increase of $225.9 million, for a total of $905 million.

—Part B base provides essential services including diagnostic, viral load testing and viral resistance monitoring and HIV care to all 50 States, the District of Columbia, Puerto Rico, and the territories. We are requesting a $55.9 million increase, for a total of $474.7 million.

—The AIDS Drug Assistance Program (ADAP) provides life-saving HIV drug treatment to more than 150,000 people, the majority of whom are people of color (59 percent) and very poor (74 percent are at or below 200 percent of the Federal poverty level). Currently, ADAPs are experiencing unprecedented growth. The monthly growth of 1,271 clients is an increase of 80 percent from fiscal year 2008 when ADAPs experienced an average monthly growth of 706 clients. Due to a lack of funding, States have instituted waiting lists and have reduced the number of drugs on their formularies, reduced eligibility and capped enrollment. There are currently 859 people in 10 States on ADAP waiting lists. In order to address the ADAP funding crisis, which will grow even worse in fiscal year 2011, we are requesting an increase of $370.1 million for a total of $1,205.1 million.

—Part C provides early medical intervention and other supportive services to more than 248,000 people at more than 380 directly funded clinics. We are requesting a $131 million increase, for a total of $337.9 million.

—Part D provides care to more than 84,000 women, children, youth, and families living with and affected by HIV/AIDS. We are requesting a $7 million increase, for a total of $84.8 million.
—Part F includes the AIDS Education and Training Centers (AETCs) program and the Dental Reimbursement program. We are requesting a $15.2 million increase for the AETC program, for a total of $50 million, and a $5.4 million increase for the Dental Reimbursement program, for a total of $19 million.

For fiscal year 2011, the President requested an increase of only $39.5 million, or just 1.7 percent, for the entire Ryan White Program and no increase for Parts A and D of the Program. The AIDS Institute urges the subcommittee to consider the growing needs of all Parts of the Ryan White Program and provide the necessary resources it requires to meet the needs of people living with HIV/AIDS in the United States.

National Institutes of Health—AIDS Research

[In billions of dollars]

	Amount
Fiscal year 2010	3.1
Fiscal year 2011 community request	3.5

The National Institutes Health (NIH) conducts research to better understand HIV and its complicated mutations, discover new drug treatments, develop a vaccine and other prevention programs such as microbicides, and ultimately develop a cure. The critically important work performed by the NIH not only benefits those in the United States, but the entire world. This research has already helped in the development of many highly effective new drug treatments, prolonging the lives of millions of people. As neither a cure nor a vaccine exists, and patients continue to build resistance to existing medications, additional research must continue. NIH also conducts the necessary behavioral research to learn how HIV can be prevented best in various affected communities. We ask the subcommittee to fund critical AIDS research at the community requested level of $3.5 billion.

Comprehensive Sex Education

President Obama and Congress took steps toward implementing comprehensive sexual education in fiscal year 2010 by ending discretionary funded abstinence-only until marriage programs and creating the Teen Pregnancy Prevention Initiative. We urge the Congress to continue no funding for abstinence only education programs. Additionally, we believe the Teen Pregnancy Prevention Initiative should be expanded so that it addresses other aspects of sexual health, including HIV and STD prevention.

Syringe Exchange Programs

By eliminating the Federal funding ban on syringe exchange programs in fiscal year 2010, Congress allowed funding of a proven method to reduce the transmission of HIV and other infectious diseases. The AIDS Institute requests that you work to ensure that this ban is not reinstated.

Minority AIDS Initiative

The AIDS Institute supports increased funding for the Minority AIDS Initiative (MAI), which is funded by numerous Federal agencies. MAI funds services nationwide that address the disproportionate impact that HIV has on communities of color. We are requesting a $207.1 million increase across the MAI's programs, for a total of $610 million.

VIRAL HEPATITIS

The Institute of Medicine (IOM) recently released a report "Hepatitis and Liver Cancer: A National Strategy for Prevention and Control of Hepatitis B and C." It outlines a number of recommendations on how the incidence of Hepatitis B and C infections can be decreased. These recommendations include increased public awareness campaigns, heightened testing and vaccination programs, continued research, along with improved surveillance and other prevention programs.

According to the IOM, 3.5–5.3 million people, or 1–2 percent of the U.S. population are living with chronic Hepatitis B or C. Because of their asymptomatic nature, the vast majority of infected people are unaware of their infection. There are an estimated 43,000 new acute Hepatitis B infections each year in the United States. The CDC estimates that 10 percent of people with Hepatitis B are co-in-

fected with HIV and 25 percent of people with Hepatitis C are co-infected with HIV. Congress currently funds CDC's Viral Hepatitis Division at only $19.3 million. Given the huge impact that Hepatitis B and C have on the health of so many people, and the large treatment costs, The AIDS Institute requests an increase of $30.7 million, for a total of $50 million.

The AIDS Institute asks that you give great weight to our testimony as you deliberate over the fiscal year 2011 appropriation bill.

PREPARED STATEMENT OF THE TRI-COUNCIL FOR NURSING

The Tri-Council for Nursing, comprising the American Association of Colleges of Nursing, the American Nurses Association, the American Organization of Nurse Executives, and the National League for Nursing, respectfully requests $267.3 million (a 10 percent increase) for the Nursing Workforce Development programs authorized under title VIII of the Public Health Service Act (42 USC 296 et seq.) in fiscal year 2011.

The Tri-Council is a long-standing alliance focused on leadership and excellence in the nursing profession. The Nation is currently in the twelfth year of the nurse and nurse faculty shortages, contributing to a workforce deficit that diminishes the quality of patient care in the United States. As the Nation looks towards reforming the healthcare system by focusing on expanding access, decreasing cost, and improving quality, a significant investment must be made in strengthening the nursing workforce.

In fiscal year 2010, your subcommittee provided a considerable funding boost for title VIII that helped support the Loan Repayment and Scholarship program and Nurse Faculty Loan program. These increases will help bolster the pipeline of nurses and nurse faculty, which are so critical to reversing the nursing shortage. It is extremely important to maintain last year's funding level for these crucial programs in fiscal year 2011. The Tri-Council believes the 10 percent requested increase should be directed to the four title VIII programs that have not kept pace with inflation since fiscal year 2005. These programs include the Advanced Education Nursing, Nursing Workforce Diversity, Nurse Education, Practice, and Retention, and Comprehensive Geriatric Education programs, which help expand nursing school capacity and increase patient access to care. The 10 percent increase awarded to these programs in proportion to their fiscal year 2010 funding level would be a wise investment of Federal resources.

FOUR NURSING WORKFORCE GROWTH AREAS: CRITICAL TITLE VIII PROGRAMS THAT PROVIDE SOLUTIONS

A Shortage of Providers Needed to Meet Increasing Healthcare Demands

With healthcare access expanded through the newly passed reforms, more providers will be needed. According to the U.S. Bureau of Labor Statistics (BLS), nursing is the Nation's top profession in terms of projected job growth with more than 581,000 new nursing positions being created through 2018 (a 22 percent increase in the workforce). Moreover, healthcare professionals with knowledge and expertise in primary, transitional, and preventative care will be in great demand. Registered Nurses (RNs), Advanced Practice Registered Nurses (APRNs), and RNs with advanced education have the skills and are licensed to provide these vital services. The Advanced Education Nursing Grants and Traineeships help to educate the next generation of these providers in addition to the faculty who educate them.

Advanced Education Nursing (AEN) Grants (section 811) support the preparation of RNs in master's and doctoral nursing programs. The AEN grants help to prepare our Nation's nurse practitioners, clinical nurse specialists, nurse midwives, nurse anesthetists, nurse educators, nurse administrators, public health nurses, and other nurse specialists requiring advanced education. In fiscal year 2008 (the most recent year for which data are available), these grants supported the education of 5,649 students.

—AEN Traineeships assist graduate nursing students by providing full or partial reimbursement for the costs of tuition, books, program fees, and reasonable living expenses. In fiscal year 2008, this funding helped support 6,675 graduate nurses and APRNs.

—Nurse Anesthetist Traineeships (NAT) support the education of students in nurse anesthetist programs. In some States, Certified Registered Nurse Anesthetists (CRNAs) are the sole anesthesia providers in almost 100 percent of rural hospitals. Much like the AEN Traineeships, the NAT provides full or partial support for the costs of tuition, books, program fees, and reasonable living expenses. In fiscal year 2008, the program supported 2,145 future CRNAs.

Increasing Nursing Diversity to Improve Patient Care

According to an April 2000 report prepared by the National Advisory Council on Nurse Education and Practice, a culturally diverse nursing workforce is essential to meeting the healthcare needs of the Nation's population. However, the initial findings from the 2008 National Sample Survey of Registered Nurses show that while RN graduates entering the profession represent greater cultural diversity, when compared to the U.S. population, the profession still does not represent the current demographics of this country. Nurses from racial and ethnic minorities underrepresented in nursing contribute significantly to the provision of healthcare services and are leaders in the development of models of care that address the unique needs of our Nation's populations. The Workforce Diversity Grants under title VIII help to ensure a nursing workforce is developed to meet the healthcare needs of all patients.

Workforce Diversity Grants (section 821) prepare students from disadvantaged backgrounds to become nurses. This program awards grants and contract opportunities to schools of nursing, nurse-managed health centers, academic health centers, State or local governments, and nonprofit entities looking to increase access to nursing education for disadvantaged students, including racial and ethnic minorities underrepresented among RNs. In fiscal year 2008, the program supported 11,638 students.

Education, Practice, and Retention: Enhancing and Maintaining the Knowledge Base of Nursing

Advances in healthcare technology, practice, and systems influence the way nurses deliver quality care. Like other health professions, nurses must continually expand their knowledge base to adapt to the changing healthcare environment. Higher learning and continued education for nurses are expected of all RNs as the profession strives for excellence in patient care. The Nurse Education, Practice, and Retention Grant program is designed to ensure RNs obtain additional knowledge in the discipline by expanding their entry-level education, improving their practice, and retaining seasoned clinicians in the profession.

Nurse Education, Practice, and Retention Grants (section 831) help schools of nursing, academic health centers, nurse-managed health centers, State and local governments, and healthcare facilities strengthen programs that provide nursing education. The three priority areas under this program help to:

—Expand the enrollment in baccalaureate nursing programs;
—Develop and implement internship and residency programs to encourage and mentor, as well as for the development of specialties;
—Provide education in new technologies, including distance learning methodologies;
—Establish or expand nursing practice arrangements in noninstitutional settings to demonstrate methods to improve access to primary healthcare in medically underserved communities;
—Provide care for underserved populations and other high-risk groups such as older adults, individuals with HIV/AIDS, individuals with substance use disorders, people who are homeless, and those who are victims of domestic violence;
—Provide managed care, quality improvement, and other skills needed to practice in existing and emerging organized healthcare systems;
—Develop cultural competencies among nurses;
—Offer grants for career ladder programs to promote career advancement for nursing personnel and to assist individuals in obtaining education and training required to enter the nursing profession and advance within the profession; and
—Provide grants that enhance patient care delivery systems and are directly related to nursing activities by enhancing collaboration and communication among nurses and other healthcare professionals, and promote nurse involvement in the organizational and clinical decisionmaking processes of a healthcare facility.

In fiscal year 2008, the priority areas under this program supported 42,761 nurses and nursing students.

Increased Nursing Care Needed for an Aging Population

Today, more than at any other time in our Nation's history, nurses face an unprecedented challenge-caring for an aging population that is growing at an exponential rate. According to the U.S. Census Bureau, 36.3 million Americans are older the age of 65, which represents 12 percent of the total population. It has been projected that by 2050, 86.5 million Americans will be older the age of 65. This represents a 147 percent increase between the years 2000 and 2050.

The National Center for Healthcare Statistics has reported that older adults account for 50 percent of hospital days, 60 percent of ambulatory adult primary care visits, 70 percent of all home care visits, and 85 percent of residents in nursing homes. Moreover, 63 percent of newly licensed nurses report that older adults comprise a majority of their patient loads. Clearly, more RNs are needed with expertise in geriatric nursing. The Comprehensive Geriatric Education Grants help to educate the next generation of these practitioners.

Comprehensive Geriatric Education Grants (section 855) are awarded to schools of nursing or healthcare facilities to better provide nursing services for older adults. These grants are used to educate RNs who will provide direct care to older Americans, develop and disseminate geriatric curriculum, prepare faculty members, and provide continuing education. In fiscal year 2008, this program supported 6,514 nurses and nursing students.

With increased funding, these four programs can help address many issues currently impacting the nursing shortage. Therefore, the Tri-Council respectfully request $267.3 million (a 10 percent increase) for the Nursing Workforce Development programs in fiscal year 2011.

PREPARED STATEMENT OF THE ENDOCRINE SOCIETY

The Endocrine Society is pleased to submit the following testimony regarding fiscal year 2011 Federal appropriations for biomedical research, with an emphasis on appropriations for the National Institutes of Health (NIH). The Endocrine Society is the world's largest and most active professional organization of endocrinologists representing more than 14,000 members worldwide. Our organization is dedicated to promoting excellence in research, education, and clinical practice in the field of endocrinology. The Society's membership includes thousands of researchers who depend on Federal support for their careers and their scientific advances.

Each year, the NIH funds thousands of research grants, facilitating the discovery of methods of prevention, treatment, and cure for debilitating diseases that negatively impact the health of the Nation's citizens and fuel rising healthcare costs. Nearly half of all Americans have a chronic medical condition, and these diseases now cause more than half of all deaths worldwide. Deaths attributed to chronic conditions could reach 36 million by 2015 if the trend continues unabated.

Congress and President Obama recognized the contributions of NIH to the health of the Nation and the Nation's economy by awarding the agency more than $10 billion through the American Recovery and Reinvestment Act (ARRA). These funds supported more than 12,000 grants and created more than 50,000 jobs. ARRA funds have allowed the NIH to award grants, including those described in the bulleted list below, which will lead to breakthroughs in hundreds of disease areas, including those chronic diseases that result in the death of so many people each year.

—A project is using information from a clinical trial in people with type 2 diabetes and heart disease to examine the association between fat cell hormones and CVD, including their potential usefulness in prognosis, monitoring effects of therapy, and identifying risk.

—A project will conduct research in mice to develop a vehicle to deliver a specific gene that may prevent type 1 diabetes.

—A grant to provide insights into the mechanisms by which diet and exercise reduce abdominal fatness and improve cardiovascular health in overweight and obese persons with type 2 diabetes. These mechanisms include systemic inflammation, insulin sensitivity, and aerobic and strength fitness.

—Researchers will define how certain carbohydrate molecules affect hormone function, to better understand reproductive development, and development of breast and prostate cancer.

—Scientists will assess how a specific gene helps trigger the development of stem cells into sperm, which could lead to new treatments for male infertility or new contraceptive targets.

—A project will investigate the role of developmental exposure to Bisphenol A (BPA) on obesity and metabolic syndrome.

Most of these grants would not have been funded through the regular grant approval process, and without the ARRA funds, the discoveries that are expected to result from these projects would never have a chance to be made. Furthermore, many of the scientists funded through these grants may never have received the funds necessary to start or continue their careers, including many first-time awardees. As the United States continues to lose its place as the world leader in innovation, we cannot miss out on opportunities to award bright young scientists and engage them in the research process.

Unfortunately, the grants and jobs created will disappear at the end of fiscal year 2010 if Congress does not sustain the momentum created by the ARRA funds with a significant increase in the fiscal year 2011 budget. While it is not feasible to expect that the NIH budget can be increased in 1 year to a level that will sustain the 12,000 grants awarded through the ARRA funds, Congress must do what it can to ensure that NIH receives steady, sustainable, predictable increases that avoid the boom and bust cycle that NIH experienced with the doubling of its budget, and now faces again with the end of the ARRA funds.

The Endocrine Society remains deeply concerned about the future of biomedical research in the United States without sustained support from the Federal Government. The Society strongly supports the continued increase in Federal funding for biomedical research in order to provide the additional resources needed to enable American scientists to address the burgeoning scientific opportunities and new health challenges that continue to confront us. The Endocrine Society recommends that NIH receive $37 billion in fiscal year 2011 to prepare for the poststimulus era and ensure the steady and sustainable growth necessary to continue building on the advances made by scientists during the past decade.

PREPARED STATEMENT OF THE TELEHEALTH LEADERSHIP INITIATIVE

The Telehealth Leadership Initiative (TLI)—a nonprofit organization that represents the telehealth and e-health stakeholders before legislative, administrative, and judicial branches of local, State, and national governments and the entire telehealth community—appreciates the opportunity to submit written testimony to the Senate Labor, Health and Human Services, Education, and Related Agencies Appropriations Subcommittee. We respectfully request that the subcommittee maintain last year's funding levels and continue to provide $11.6 million for the Office for the Advancement of Telehealth (OAT), in the fiscal year 2011 Labor, Health and Human Services, Education, and Related Agencies appropriations bill. These resources will support access to quality healthcare services, through telehealth technologies, for remote, rural and underserved populations.

TELEHEALTH OVERVIEW

Telehealth, also known as telemedicine, is the providing of healthcare, health information, and health education across a distance, using telecommunications technology, and specially adapted equipment. It allows physicians, nurses, and healthcare specialists to assess, diagnose and treat patients without requiring both individuals to be physically in the same location, regardless of whether that distance is across a street, across a city, across the State, or across continents.

There are many applications for telehealth, such as:

—Monitoring patients with chronic conditions or at-risk populations;
—Medical care for home-bound patients or those in rural, remote, or frontier locations;
—Mental telehealth for incarcerated populations;
—Access to medical care in areas with provider shortages;
—Access to healthcare services for those in correctional facilities; and
—Availability of expert consultations via satellite for individuals on the battlefield, cruise ships, space stations, research stations, and other inaccessible locations.

Telehealth has been used to successfully accomplish the following:

—Prevent unnecessary delays in receiving treatment;
—Reduce or eliminate travel expenses;
—Reduce or eliminate the separation of families during difficult and emotional times;
—Utilize the services of healthcare providers in locales where the supply of physicians may be adequate or at a surplus; and
—Allow patients to spend less time in waiting rooms.

Currently, telehealth is practiced in many settings, such as rural hospitals, school districts, home-health settings, nursing homes, cruise ships, on the battlefield, and even on NASA space missions. Telehealth is well-established in certain disciplines, such as radiology and dermatology, and is being expanded in other disciplines, for example, home telehealth, mental telehealth, ocular telehealth, teledermatology, telepathology, telerehabilitation. It is being utilized further for specific populations, including individuals who are incarcerated or live or are stationed in remote locations.

OAT OVERVIEW

The Office for the Advancement of Telehealth (OAT), which is a grant making agency at the Department of Health and Human Services, is responsible for promoting the use of telehealth technologies for healthcare delivery, education, and health information services. Through its programs, OAT helps bring access to care to those living in remote, rural and underserved populations.

REQUESTED FUNDING LEVELS FOR FISCAL YEAR 2011

Over the years, telehealth has improved a patient's access to timely specialty care, reduced medical errors, and saved our healthcare system money. Last year, Congress funded telehealth initiatives at $11.6 million for fiscal year 2010. This year, the TLI urges the Senate to maintain the same funding level for fiscal year 2011.

We feel strongly that an $11.6 million funding level for OAT is essential to ensuring that millions of Americans have access to quality healthcare services. Maintaining these funding levels will allow these programs to continue to work with and support communities, in their efforts to develop cost-effective uses of telehealth technologies.

These initiatives, carried out through OAT, are especially valuable in a time when millions of Americans are struggling to access quality healthcare services.

CREDENTIALING AND PRIVILEGING

In fiscal year 2010, the subcommittee expressed its concern about a process soon to be enforced by the Centers for Medicare and Medicaid Services that would require all telemedicine originating sites where the patient is located to credential and privilege all telemedicine practitioners. For many small hospitals receiving telemedicine services, this could mean credentialing and privileging tens, if not hundreds, of telemedicine practitioners. It is a cost and personnel burden that essentially would force the closure of many telemedicine programs throughout the country. It is the single greatest threat to the expansion of telemedicine.

Since passage of the fiscal year 2010 appropriations, some positive developments have occurred. CMS has reached out to the telemedicine community and appears to be actively seeking a solution to the impact of this credentialing and privileging requirement. We urge the Committee to continue to exert it's oversight on this issue to ensure that CMS develops a workable policy that does not cripple the delivery of telehealth services, while at the same time protects patient safety, a goal that the telehealth community shares with CMS.

CONCLUSION

Thank you for you attention to this important healthcare matter. We know you face many challenges in choosing funding priorities, but we hope you will continue to keep telehealth a priority and maintain last year's funding levels of $11.6 million, in this year's fiscal year 2011 appropriations' process. TLI appreciates the opportunity to share its views, and we thank you for your consideration of our request.

PREPARED STATEMENT OF THE NEPHCURE FOUNDATION

One Family's Story

Mr. Chairman and members of the subcommittee thank you for the opportunity to provide written testimony today, I am Dee Ryan and my husband is Lieutenant Colonel John Kevin Ryan, an Iraq war veteran. I would like to tell you about my 6-year-old daughter Jenna's nephrotic syndrome (NS), a medical problem caused by rare diseases of the kidney filter. When affected, these filters leak protein from the blood into the urine and often cause kidney failure requiring dialysis or kidney transplantation. We have been told by our physician that Jenna has one of two filter diseases called Minimal Change Disease (MCD) or Focal and Segmental Glomerulosclerosis (FSGS). According to a Harvard University report there are presently 73,000 people in the United States who have lost their kidneys as a result of FSGS. Unfortunately, the causes of FSGS and other filter diseases are very poorly understood.

In October 2007, my daughter began to experience general swelling of her body and intermittent abdominal pain, fatigue and general malaise. Jenna began to develop a cough and her stomach became dramatically distended. We rushed Jenna to the emergency room where her breathing became more and more labored and her pulse raced. She had symptoms of pulmonary edema, tachycardia, hypertension, and pneumonia. Her lab results showed a large amount of protein in the urine and a

low concentration of the blood protein albumin, consistent with the diagnosis of FSGS. Jenna's condition did not begin to stabilize for several frightening days.

Following her release from the hospital we had to place Jenna on a strict diet which limited her consumption of sodium to no more than 1,000 mg per day. Additionally, Jenna was placed on a steroid regimen for the next 3 months. We were instructed to monitor her urine protein levels and to watch for swelling and signs of infection, in order to avoid common complications such as overwhelming infection or blood clots. Because of her disease and its treatment, which requires strong suppression of the immune system, Jenna did have a serious bacterial infection several months after she began treatment.

We are frightened by her doctor's warnings that NS and its treatment are associated with growth retardation and other medical complications including heart disease. As a result of NS, Jenna has developed hypercholesterolemia and we worry about the effects the steroids may have on her bones and development. This is a lot for a little girl in kindergarten to endure.

Jenna's prognosis is currently unknown because NS can reoccur. Even more concerning to us is that Jenna may eventually lose her kidneys entirely and need dialysis or a kidney transplant. While kidney transplantation might sound like a cure, in the case of FSGS, the disease commonly reappears after transplantation. And even with a transplant, end stage renal disease caused by FSGS dramatically shortens one's life span.

The NCF has been very helpful to my family. They have provided us with educational information about NS, MCD, and FSGS and the organization works to provide grant funding to scientists for research into the cause and cure of NS.

Mr. Chairman, because the causes of NS are poorly understood, and because we have a great deal to learn in order to be able to effectively treat NS, I am asking you to please significantly increase funding for the NIH. Also, please support the establishment of a collaborative research network that would allow scientists to create a patient registry and biobank for NS/FSGS, and that would allow coordinated studies of these deadly diseases for the first time. Finally, please urge the National Institute of Diabetes and Digestive and Kidney Disease (NIDDK) to continue to focus on FSGS/NS research in general, consistent with the recent program announcement entitled Grants for Basic Research in Glomerular Disease (R01) (PA–10–113).

Mr. Chairman, on behalf of the thousands of people suffering from NS and FSGS and the NephCure Foundation (NCF), thank you for this opportunity to submit this testimony to the subcommittee and for your consideration of my request.

More Research is Needed

We are no closer to finding the cause or the cure of FSGS. Scientists tell us that much more research needs to be done on the basic science behind the disease.

NCF, the University of Michigan, and other important university research health centers have come together along with the National Institutes of Health (NIH) to support the establishment of the Nephrotic Syndrome Rare Disease Clinical Research Network. This network is a new collaboration between research institutions, the NCF, and NIH supporting research on NS and FSGS. This initiative has tremendous potential to make significant advancements in NS and FSGS research by pooling efforts and resources, including populations for clinical trials. The addition of Federal resources to this important initiative is crucial to ensuring the best possible outcomes for the Nephrotic Syndrome Rare Disease Clinical Research Network occur.

NCF is also grateful to the NIDDK for issuing of a program announcement (PA) that serves to initiate grant proposals on glomerular disease; the PA, issued in March 2007, is glomerular-disease specific. The announcement will utilize the R01 mechanism to award researchers funding. In February 2010 the PA was re-released for a further 3 years.

We ask the subcommittee to encourage the ORDR to continue to support the Nephrotic Syndrome Rare Disease Clinical Research Network to expand FSGS research. We also ask the subcommittee to encourage NIDDK to continue to issue glomerular disease program announcements.

Too Little Education About a Growing Problem

When glomerular disease strikes, the resulting NS causes a loss of protein in the urine and edema. The edema often manifests itself as puffy eyelids, a symptom that many parents and physicians mistake as allergies. With experts projecting a substantial increase in nephrotic syndrome in the coming years, there is a clear need to educate pediatricians and family physicians about glomerular disease and its symptoms.

It would be of great benefit for CDC to begin raising public awareness of the glomerular diseases in an attempt to diagnose patients earlier.

We ask the subcommittee to encourage CDC to establish a glomerular disease education and awareness program aimed at both the general public and healthcare providers.

Glomerular Disease Strikes Minority Populations

Nephrologists tell us that glomerular disease strikes African Americans nearly 5 times more frequently than white Americans. No one knows why this is, but some studies have suggested that the MYH9 gene, which is 5 times more prevalent in African Americans, may be linked to susceptibility to FSGS. NIDDK will be sponsoring a conference on this issue on April 19–20, 2010.

We ask that the NIH pay special attention to why this disease affects African Americans to such a large degree and often in a more severe manner. The NCF wishes to work with the NIDDK and the National Center for Minority Health and Health Disparities (NCMHD) to encourage the creation of programs to study the high incidence of glomerular disease within the African-American population.

There is also evidence to suggest that the incidence of glomerular disease is higher among Hispanic Americans than in the general population. An article in the February 2006 edition of the NIDDK publication Recent Advances and Emerging Opportunities, discussed the case of Frankie Cervantes, a 6-year-old boy of Mexican and Panamian descent. Frankie has FSGS received a transplanted kidney from his mother. We applaud the NIDDK for highlighting FSGS in their publication, and for translating the article about Frankie into both English and Spanish. Only through similar efforts at cross-cultural education can the African-American and Hispanic-American communities learn more about glomerular disease.

The Nephrotic Syndrome Rare Disease Clinical Research Network offers an excellent opportunity for NCMHD to collaborate with a wide variety of researchers and institutions to increase knowledge of NS/FSGS. The addition of NCMHD would add additional insight into the minority community, which is so disproportionately impacted by FSGS.

We ask the subcommittee to encourage ORDR, NIDDK, and NCMHD to collaborate on research that studies the incidence and cause of this disease among minority populations. We also ask the subcommittee to urge NIDDK and the NCMHD undertake culturally appropriate efforts aimed at educating minority populations about glomerular disease.

PREPARED STATEMENT OF THE SCLERODERMA FOUNDATION

Mr. Chairman, I am Cynthia Cervantes, I am 12 and in the ninth grade. I live in southern California and in October 2006 I was diagnosed with scleroderma. Scleroderma means "hard skin" which is literally what scleroderma does and, in my case, also causes my internal organs to stiffen and contract. This is called diffuse scleroderma. It is a relatively rare disorder effecting only about 300,000 Americans.

About 2 years ago I began to experience sudden episodes of weakness, my body would ache and my vision was worsening, some days it was so bad I could barely get myself out of bed. I was taken to see a doctor after my feet became so swollen that calcium began to ooze out. It took the doctors (period of time) to figure out exactly what was wrong with me, because of how rare scleroderma is.

There is no known cause for scleroderma, which affects three times as many women as men. Generally, women are diagnosed between the ages of 25 and 45, but some kids, like me, are affected earlier in life. There is no cure for scleroderma, but it is often treated with skin softening agents, anti-inflammatory medication, and exposure to heat. Sometimes a feeding tube must be used with a scleroderma patient because their internal organs contract to a point where they have extreme difficulty digesting food.

The Scleroderma Foundation has been very helpful to me and my family. They have provided us with materials to educate my teachers and others about my disease. Also, the support groups the foundation helps organize are very helpful because they help show me that I can live a normal, healthy life, and how to approach those who are curious about why I wear gloves, even in hot weather. It really means a lot to me to be able to interact with other people in the same situation as me because it helps me feel less alone.

Mr. Chairman, because the causes of scleroderma are currently unknown and the disease is so rare, and we have a great deal to learn about it in order to be able to effectively treat it. I would like to ask you to please significantly increase funding for the National Institute of Health so treatments can be found for other people like

me who suffer from scleroderma. It would also be helpful to start a program at the Centers for Disease Control and Prevention to educate the public and physicians about scleroderma.

SCLERODERMA FOUNDATION

The Scleroderma Foundation is a nonprofit organization based in Danvers, Massachusetts with a three-fold mission of support, education, and research. The Foundation has 21 chapters nationwide and more than 175 support groups.

The Scleroderma Foundation was established on January 1, 1998 through a merger between two organizations, one on the west coast and one on the east coast, which can trace their beginnings back to the early 1970s. The Foundation's mission is to provide support for people living with scleroderma and their families through programs such as peer counseling, doctor referrals, and educational information, along with a toll-free telephone helpline for patients and a quarterly magazine, The Scleroderma Voice.

The Foundation also provides education about the disease to patients, families, the medical community, and the general public through a variety of awareness programs at both the local and national levels. More than $1 million in peer-reviewed research grants are awarded annually to institutes and universities to stimulate progress in the search for a cause and cure for scleroderma. Building awareness of the disease to patients, families, the medical community and the general public to not only generate more funding for medical research, but foster a greater understanding of the complications faced by people living with the disease is a further major focus.

Among the many programs arranged by the Foundation is the Annual Patient Education Conference held each summer. The conference brings together an average of 500 attendees and experts for a wide range of workshops on such topics as the latest research initiatives, coping and disease management skills, caregiver support, and exercise programs.

WHO GETS SCLERODERMA?

There are many clues that define susceptibility to develop scleroderma. A genetic basis for the disease has been suggested by the fact that it is more common among patients whose family members have other autoimmune diseases (such as lupus). In rare cases, scleroderma runs in families, although for the vast majority of patients there is no other family member affected. Some Native Americans and African Americans get worse scleroderma disease than Caucasians.

Women are more likely to get scleroderma. Environmental factors may trigger the disease in the susceptible host. Localized scleroderma is more common in children, whereas scleroderma is more common in adults. However, both can occur at any age.

There are an estimated 300,000 people in the United States who have scleroderma, about one-third of whom have the systemic form of scleroderma. Diagnosis is difficult and there may be many misdiagnosed or undiagnosed cases as well.

Scleroderma can develop and is found in every age group from infants to the elderly, but its onset is most frequent between the ages of 25 to 55. There are many exceptions to the rules in scleroderma, perhaps more so than in other diseases. Each case is different.

CAUSES OF SCLERODERMA

The cause is unknown. However, we do understand a great deal about the biological processes involved. In localized scleroderma, the underlying problem is the overproduction of collagen (scar tissue) in the involved areas of skin. In systemic sclerosis, there are three processes at work: blood vessel abnormalities, fibrosis (which is overproduction of collagen) and immune system dysfunction, or autoimmunity.

RESEARCH

Research suggests that the susceptible host for scleroderma is someone with a genetic predisposition to injury from some external agent, such as a viral or bacterial infection or a substance in the diet or environment. In localized scleroderma, the resulting damage is confined to the skin. In systemic sclerosis, the process causes injury to blood vessels, or indirectly perturbs the blood vessels by activating the immune system.

Research continues to assemble the pieces of the scleroderma puzzle to identify the susceptibility genes, to find the external trigger and cellular proteins driving fibrosis, and to interrupt the networks that perpetuate the disease.

Unfortunately, support for scleroderma research at the National Institutes of Health over the past several years has been relatively flat funded at $20 million in fiscal year 2008, $21 million in fiscal year 2009, and an estimated $22 million in fiscal year 2010. This slow rate of increase is extremely frustrating to our patients who recognize biomedical research as their best hope for a better quality of life. It is also of great concern to our researchers who have promising ideas they would like to explore if resources were available.

TYPES OF SCLERODERMA

There are two main forms of scleroderma: systemic (systemic sclerosis, SSc) that usually affects the internal organs or internal systems of the body as well as the skin, and localized that affects a local area of skin either in patches (morphea) or in a line down an arm or leg (linear scleroderma), or as a line down the forehead (scleroderma en coup de sabre). It is very unusual for localized scleroderma to develop into the systemic form.

Systemic Sclerosis (SSc)

There are two major types of systemic sclerosis or SSc: limited cutaneous SSc and diffuse cutaneous SSc. In limited SSc, skin thickening only involves the hands and forearms, lower legs and feet. In diffuse cutaneous disease, the hands, forearms, the upper arms, thighs, or trunk are affected.

The face can be affected in both forms. The importance of making the distinction between limited and diffuse disease is that the extent of skin involvement tends to reflect the degree of internal organ involvement.

Several clinical features occur in both limited and diffuse cutaneous SSc. Raynaud's phenomenon occurs in both. Raynaud's phenomenon is a condition in which the fingers turn pale or blue upon cold exposure, and then become ruddy or red upon warming up. These episodes are caused by a spasm of the small blood vessels in the fingers. As time goes on, these small blood vessels become damaged to the point that they are totally blocked. This can lead to ulcerations of the fingertips.

People with the diffuse form of SSc are at risk of developing pulmonary fibrosis (scar tissue in the lungs that interferes with breathing, also called interstitial lung disease), kidney disease, and bowel disease.

The risk of extensive gut involvement, with slowing of the movement or motility of the stomach and bowel, is higher in those with diffuse rather than limited SSc. Symptoms include feeling bloated after eating, diarrhea or alternating diarrhea and constipation.

Calcinosis refers to the presence of calcium deposits in, or just under, the skin. This takes the form of firm nodules or lumps that tend to occur on the fingers or forearms, but can occur anywhere on the body. These calcium deposits can sometimes break out to the skin surface and drain whitish material (described as having the consistency of toothpaste).

Pulmonary Hypertension (PH) is high blood pressure in the blood vessels of the lungs. It is totally independent of the usual blood pressure that is taken in the arm. This tends to develop in patients with limited SSc after several years of disease. The most common symptom is shortness of breath on exertion. However, several tests need to be done to determine if PH is the real culprit. There are now many medications to treat PH.

Localized Scleroderma

Morphea

Morphea consists of patches of thickened skin that can vary from half an inch to 6 inches or more in diameter. The patches can be lighter or darker than the surrounding skin and thus tend to stand out. Morphea, as well as the other forms of localized scleroderma, does not affect internal organs.

Linear scleroderma

Linear scleroderma consists of a line of thickened skin down an arm or leg on one side. The fatty layer under the skin can be lost, so the affected limb is thinner than the other one. In growing children, the affected arm or leg can be shorter than the other.

Scleroderma en coup de sabre

Scleroderma en coup de sabre is a form of linear scleroderma in which the line of skin thickening occurs on the forehead or elsewhere on the face. In growing children, both linear scleroderma and en coup de sabre can result in distortion of the growing limb or lack of symmetry of both sides of the face.

An increase in funding for the National Institutes of Health (NIH) to $35 billion.
—An increase for the National Institute of Arthritis and Musculoskeletal and Skin Diseases (NIAMS) concurrent with the overall increase to NIH.
—Committee recommendation encouraging the Centers for Disease Control and Prevention to partner with the Scleroderma Foundation to promoting increased awareness of scleroderma among the general public and healthcare providers.

PREPARED STATEMENT OF THE UNITED TRIBES TECHNICAL COLLEGE

For 41 years, United Tribes Technical College (UTTC) has provided postsecondary career and technical education, job training and family services to some of the most impoverished Indian students from throughout the Nation. Unemployment among the Great Plains tribes, where most of our students are from, typically run at about 75 percent. We are governed by the five tribes located wholly or in part in North Dakota; we are not part of the North Dakota State college system and do not have a tax base or State-appropriated funds on which to rely. We have consistently had excellent retention and placement rates and are a fully accredited institution. Section 117 Perkins funds represent about half of our operating budget and provide for our core instructional programs. The request of the United Tribes Technical College Board is for the following authorized programs:

—$10 million for base funding authorized under section 117 of the Carl Perkins Act (20 U.S.C. 2327). This is $1.8 million above the fiscal year 2010 level. These funds are shared via a formula by UTTC and Navajo Technical College.
—$36 million as requested by the American Indian Higher Education Consortium for title III (section 316) of the Higher Education Act (Strengthening Institutions program) that provides construction funds for facilities at tribally controlled colleges. This is $4 million more than the fiscal year 2010 level. Among UTTC's pressing facility needs is funding for phase II of our science and technology building and for student housing. We are working to cobble together various sources of funding to complete the science and technology building and to build student housing.
—$973 million for the TRIO programs nationally which is $120 million more than the requested amount. This would replace the $57 million in mandatory funding that is expiring for the Upward Bound program plus provide an increase for other TRIO programs.

Base Funding.—Funds requested under section 117 of the Perkins Act above the fiscal year 2010 level are needed to: (1) maintain 100-year-old education buildings and 50-year-old housing stock for students; (2) upgrade technology capabilities; (3) provide adequate salaries for faculty and staff (who have not received a cost of living increase this year and who are in the bottom quartile of salary for comparable positions elsewhere); and (4) fund program and curriculum improvements, including at least three 4-year degree programs.

Acquisition of additional base funding is critical as UTTC has more than tripled its number of students within the past 6 years, but actual base funding for educational services has increased only 25 percent in that period. Our Perkins funding provides a base level of support allowing the college to compete for discretionary contracts and grants leading to additional resources annually for the college's programs and support services.

Title III (Section 316) Strengthening Institutions.—We need title III construction funds for:

—*Science and Technology Building*.—UTTC provides education for more than 1,000 students in 100-year old former military buildings (Fort Abraham Lincoln), along with one 33-year old "skills center" which is inadequate for modern technology and science instruction. We have completed phase I of the building and now look to complete phase II. We have raised $5 million, including $1 million in private funding, $3 million from the U.S. Department of Education and $1 million in borrowed funds. The total project cost is expected to be around $12 million. Our current facility lacks laboratories with proper ventilation and other technologies which are standard in science education. We lack a modern auditorium/lecture hall with features such as computer Internet access and electrical outlets and a library with appropriate computer stations. Our present library has been cited by the accrediting agency as being inadequate.
—*Student Housing*.—We are constantly in need of more student housing, including family housing. We would like to educate more students but lack of housing has at times limited the admission of new students. With the expected completion of a new Science and Math building on our South Campus on land acquired

with a private grant, we urgently need housing for up to 150 students, many of whom have families. New housing on the South Campus could also accommodate those persons we expect to enroll in a new police training programs.

While UTTC has constructed three housing facilities using a variety of sources in the past 20 years, approximately 50 percent of students are housed in the 100-year-old buildings of the old Fort Abraham Lincoln, as well as in duplexes and single-family dwellings that were donated to UTTC by the Federal Government along with the land and Fort buildings in 1973. These buildings require major rehabilitation. New buildings for housing are actually cheaper than trying to rehabilitate the old buildings that now house students.

TRIO Programs.—UTTC currently has no TRIO funding. We are in particular need of funding from the student Support Services Program to improve retention, transfer, and graduation rates for our Pell Grant recipients. Our students need tutoring, mentoring, academic counseling and career development services to help them successfully complete their academic courses of study. Our study body meets the eligibility requirements of TRIO's Student Support Services program.

—83 percent of students meet the low-income criteria for TRIO's Student Support Services.

—68 percent of our students are first generation college attendees.

—17 percent of all UTTC applicants in 2008 had a Graduate Equivalency Diploma.

—74 percent of our students need remediation in math, reading and composition.

—80 percent of our students have Limited English proficiency.

With regard to our students with a Limited English background, we note that although not all UTTC students speak their Native language fluently, many speak forms of English that differ from Standard English because of the influence of other languages' vocabulary, intonation, and vernacular. Although UTTC strongly supports the preservation and use of Native languages, our students tend to have difficulty reading, writing, and speaking the Standard English as is required of them by the College and the workplace.

We also note the January 13, 2009, report of the Department of Education's Office of Vocational and Adult Education on its recent site visit to UTTC (October 7–9, 2008). While some suggestions for improvements were made, the Department commended UTTC in many areas: for efforts to improve student retention; the commitment to data-driven decisionmaking, including the implementation of the Jenzabar system throughout the institution; the breadth of course offerings; collaboration with 4-year institutions; expansion of online degree programs; unqualified opinions on both financial statements and compliance in all major programs; being qualified as a low-risk grantee; having no reportable conditions and no known questioned costs; clean audits; and use of the proposed measurement definitions in establishing institutional performance goals.

Below are some important things we would like you to know about our UTTC:

—*UTTC Performance Indicators*.—UTTC has:

—An 85 percent retention rate.

—A placement rate of 94 percent (job placement and going on to 4-year institutions).

—A projected return on Federal investment of 20-to-1 (2005 study comparing the projected earnings generated over a 28-year period of UTTC Associate of Applied Science and Bachelor degree graduates of June 2005 with the cost of educating them).

—The highest level of accreditation. The North Central Association of Colleges and Schools has accredited UTTC again in 2001 for the longest period of time allowable—10 years or until 2011—and with no stipulations. We are also one of only two tribal colleges accredited to offer accredited on-line (Internet-based) associate degrees.

—More than 20 percent of graduates go on to 4-year or advanced degree institutions.

—*Our Students*.—Our students are from Indian reservations throughout the Nation, with a significant portion of them being from the Great Plains area. Our students have had to make a real effort to attend college; they come from impoverished backgrounds or broken families. They may be overcoming extremely difficult personal circumstances as single parents. They often lack the resources, both culturally and financially, to go to other mainstream institutions. Through a variety of sources, including Perkins funds, UTTC provides a set of family and culturally-based campus services, including: an elementary school for the children of students, housing, day care, a health clinic, a wellness center, several on-campus job programs, student government, counseling, services relating to drug and alcohol abuse and job placement programs. We are currently serving

168 students in our elementary school and 169 youngsters in our child development centers.

—*UTTC Course Offerings and Partnerships With Other Educational Institutions*.—We offer accredited vocational/technical programs that lead to 17 2-year degrees (Associate of Applied Science and 11 1-year certificates, as well as a 4-year degree in elementary education in cooperation with Sinte Gleska University in South Dakota. We intend to expand our 4-year degree programs. While full information may be found on our Web site (www.uttc.edu), among our course offerings are:

—*Licensed Practical Nursing*.—This program results in great demand for our graduates; students are able to transfer their UTTC credits to the North Dakota higher educational system to pursue a 4-year nursing degree.

—*Medical Transcription and Coding Certificate Program*.—This program provides training in transcribing medical records into properly coded digital documents. It is offered through the college's Exact Med Training program and is supported by Department of Labor funds.

—*Tribal Environmental Science*.—This program is supported by a National Science Foundation Tribal College and Universities Program grant. This 5-year project allows students to obtain a 2-year AAS degree in Tribal Environmental Science.

—*Community Health/Injury Prevention/Public Health*.—Through our Community Health/Injury Prevention Program we are addressing the injury death rate among Indians, which is 2.8 times that of the U.S. population. This program has in the past been supported by the IHS, and is the only degree-granting Injury Prevention program in the Nation. Given the overwhelming health needs of Native Americans, we continue to seek resources for training of public health professionals.

—*Online Education*.—Our online education courses provide increased opportunities for education by providing web-based courses to American Indians at remote sites as well as to students on our campus. These courses provide needed scheduling flexibility, especially for students with young children. They allow students to access quality, tribally focused education without leaving home or present employment. We offer online fully accredited degree programs in the areas of Early Childhood Education, Community Health/Injury Prevention, Health Information Technology, Nutrition and Food Service and Elementary Education.

—*Criminal Justice*.—Our criminal justice program leads many students to a career in law enforcement, and as noted elsewhere in this testimony, we are actively working on establishing a police training academy at UTTC.

—*Computer Information Technology*.—This program is at maximum student capacity because of limitations on resources for computer instruction. In order to keep up with student demand and the latest technology, we need more classrooms, equipment and instructors. We provide all of the Microsoft Systems certifications that translate into higher income earning potential for graduates.

—*Nutrition and Food Services*.—We help meet the challenge of fighting diabetes and other health problems in Indian Country through education and research. As a 1994 Tribal Land Grant institution, we offer a Nutrition and Food Services AAS degree in order to increase the number of Indians with expertise in nutrition and dietetics. There are few Indian professionals in the country with training in these areas. We have also established a Diabetes Education Center that assists local tribal communities, our students and staff to decrease the prevalence of diabetes by providing food guides, educational programs, training and materials.

Our Perkins and Bureau of Indian Education funds provide for nearly all of our core postsecondary educational programs. Very little of the other funds we receive may be used for core career and technical educational programs; they are competitive, often one-time supplemental funds which help us provide the services our students need to be successful. We cannot continue operating without Perkins funds.

Thank you for your consideration of our requests.

LIST OF WITNESSES, COMMUNICATIONS, AND PREPARED STATEMENTS

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OFFICE OF THE SECRETARY

DEPARTMENT OF HEALTH AND HUMAN SERVICES

NATIONAL INSTITUTES OF HEALTH

OFFICE OF THE SECRETARY

DEPARTMENT OF LABOR

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