S. HRG. 111–850

Senate Hearings

Before the Committee on Appropriations

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

Fiscal Year 2010

111*th* CONGRESS, FIRST SESSION

H.R. 3293

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, 2010 (H.R. 3293)

S. HRG. 111–850

DEPARTMENTS OF LABOR, HEALTH AND HUMAN SERVICES, AND EDUCATION, AND RELATED AGENCIES APPROPRIATIONS FOR FISCAL YEAR 2010

HEARINGS

BEFORE A

SUBCOMMITTEE OF THE

COMMITTEE ON APPROPRIATIONS UNITED STATES SENATE

ONE HUNDRED ELEVENTH CONGRESS

FIRST SESSION

ON

H.R. 3293

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, 2010, 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 APPROPRIATIONS FOR FISCAL YEAR 2010

WEDNESDAY, MAY 13, 2009

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

The subcommittee met at 9:47 a.m., in room SD–138, Dirksen Senate Office Building, Hon. Tom Harkin (chairman) presiding.

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

DEPARTMENT OF LABOR

OFFICE OF THE SECRETARY

STATEMENT OF HON. HILDA L. SOLIS, SECRETARY

OPENING STATEMENT OF SENATOR TOM HARKIN

Senator HARKIN. Good morning. The Subcommittee on Labor, Health, Human Services, Education and related agencies will come to order. I'm very pleased to welcome Secretary Solis in her first appearance before this subcommittee. Welcome Madam Secretary, and again, congratulations on your appointment to this very important position.

It's been less than 4 months since President Obama took the oath of office, and inherited our current economic crisis, the likes of which we haven't seen since the Great Depression. In January, our Nation was shedding more than 600,000 jobs a month, millions more working part time because they could not find full-time work. Businesses were slowing down. It was in this context that Secretary Solis began her tenure as our Nation's 25th Secretary of Labor.

Madam Secretary, as you're well aware, the Department of Labor (DOL) carries out a critical mission that is particularly important in these challenging times. The Department must ensure that the Nation's public workforce development system is providing employers with access to a skilled workforce. We need to enforce our Nation's laws on establishing safe workplaces and work for economic security, but also in this time, worker retraining, job retraining for so many workers that have been displaced.

I think we've paid too little attention to some of these priorities. Previous budget requests have routinely cut funding for job training and under-invested in Occupational Safety and Health Admin-

istration (OSHA) and the Mine Safety and Health Administration (MSHA) and the Employment Standards Administration (ESA). I am pleased to say that the fiscal year 2010 budget request before this subcommittee is a very welcome change and appears to be consistent with my view of the important work supported by the Department of Labor.

For the first time in 9 years, the budget request does not include a devastating cut in funding for the International Labor Affairs Bureau (ILAB). I want to thank you, Secretary Solis, for proposing a $91 million budget for ILAB, an increase of $5 million over the 2009 funding level.

As I mentioned during your confirmation hearing, ILAB is a very important priority for me. I think it sends an important message around the world, the United States will help lead the fight against the worst forms of child labor.

And this funding is particularly critical, as economic challenges around the world push back against the progress that's been made in recent years, in getting children out of dangerous workplaces and back into the classroom. As you know, this is the 10th anniversary of the adoption of ILO Convention 182, and I'm hopeful that the Department of Labor, under your leadership, will commemorate this historic occasion. In fact, I was in Seattle with President Clinton when he—when we became a signatory to that, and then later traveled with President Clinton to Geneva when it was adopted by the ILO, in Geneva. That was 10 years ago. So I hope we at least do something to commemorate this 10th anniversary. For myself, I will be in Geneva on that day, so I won't be here to celebrate, but I hope that we have some commemoration of it here.

I also want to thank you for your support of worker protection agencies, where the budget proposes to bring staffing levels back to those supported at the end of the Clinton administration. Enforcement staff levels are down by one-third at the Wage and Hour Division, and below the fiscal year 2001 level at OSHA.

Many years have passed without issuing a single ergonomic citation, even though musculoskeletal disorders constitute one-third of all workplace injuries. It developed an enhanced enforcement program that was "enhanced" in name only, and record low workplace injury rates were highlighted, despite the first comprehensive analysis revealing an apparent under accounting of workplace injuries.

Madam Secretary, I look forward to working with you to change the direction of the Department of Labor's worker protection agencies, to ensure they have sufficient resources and the right strategy for carrying out their important work.

And again, I'd like to work with you to improve employment opportunities for individuals with disabilities. We've talked about that issue—another longstanding priority of mine. I appreciate your proposed $37 million budget for the Office of Disability Employment Policy (ODEP). That's an increase of $10 million over the 2009 level.

Data now being released by the Department's Bureau of Labor Statistics reveal that roughly 80 percent of individuals with disabilities are not in the labor force. This is really unacceptable, 19 years after the passage of the Americans With Disabilities Act. So we must improve this situation.

And I look forward to working with you to ensure that ODEP can carry out its mission, and work effectively with other agencies in the Government to ensure that the policies of our government foster improved employment opportunities for individuals with disabilities.

Madam Secretary, enacting the 2010 Labor appropriations bill will not be an easy task. There are many worthy health, education, and labor programs competing for a limited discretionary allocation. Some will suggest that the deficit is too big, so Congress should simply cut spending. Others will express concern about programs not increased enough or proposed for elimination, especially during tough times when we need to support our workers and our workforce.

Again, I do have some questions I will ask about the proposal to eliminate funding for the Work Incentives Grant Program and tight funding request for Job Corps. However, I believe the budget proposal before us establishes the right priorities for our Nation and will move us towards safer workplaces and a better skilled workforce.

Madam Secretary, again, welcome to the subcommittee. I look forward to your testimony on the budget request.

And I would yield now to our distinguished ranking member, Senator Cochran.

STATEMENT OF SENATOR THAD COCHRAN

Senator COCHRAN. Mr. Chairman, thank you very much.

Welcome, Madam Secretary, to this first hearing of our committee, and with your serving as Secretary, we congratulate you on your assumption of these important responsibilities and we look forward to working with you to help make sure that we do approve the funding levels and the programs under the jurisdiction of the Department of Labor that are important to our Nation's workforce and to our Nation-at-large. It's a big undertaking—it's a big building over there, too, isn't it?

Anyway, I remember when Elizabeth Dole, I think, was there. No, she was at HHS. Elizabeth Dole was there. Her husband, of course, tended to be quick-witted and sometimes he said things that he wished he had taken back. And he made some comment about how large the building was and how many people work here. And somebody said, "About half of them."

He said, "About half of them." Anyway, I shouldn't be trying to tell Bob joke—Bob Dole jokes. They don't work for me.

But, we know that you've indicated that there will be $135 million in this budget for a new Career Pathways program which, as I understand it, will take the place of the community-based job training activities of the Department. It will be interesting to hear what your thoughts are about how that would be a step forward.

Also, there's some increases, as you point out, in programs—or as the chairman pointed out in his comments, and we'll—we'll look carefully at those too, but we appreciate your cooperation with our subcommittee and coming here to help us understand the budget request.

Senator HARKIN. Thank you very much, Senator Cochran.

Secretary Solis, again, welcome. Your statement will be made a part of the record, in its entirety. We were advised we may have a vote around 10:30 a.m., but I don't know if that's still true or not, but we'll try to see if we can move ahead.

So, please proceed as you so desire, Madam Secretary.

SUMMARY STATEMENT OF HON. HILDA L. SOLIS

Secretary SOLIS. Thank you very much, Chairman Harkin and Senator Cochran. It's good to be here before you. And also Senator Murray and the other subcommittee members, who I understand may be coming in and out today.

I'm happy to be here today, before your subcommittee. I want to thank you for the invitation to testify and present you with the President's fiscal year 2010 budget, the request for the Department of Labor.

And I'd like to just summarize my remarks and ask that my testimony also be entered into the record formally.

And, just to begin with, I want to outline what our fiscal year 2010 overall three major priorities are.

And they are, as you said, Senator Harkin, to begin with, worker protection. We're beginning to restore the capacity of the programs that protect workers' health, safety, pay, and benefits.

Second, a green recovery. What do I mean? I mean implementing new and innovative ways to promote economic recovery by working toward energy independence, and increasing competitiveness of our Nation's workforce.

And third, accountability and transparency. We will ensure that all of our programs are carried out in way that is accountable, transparent to our stakeholders and to the public.

And in all these efforts, I'm committed to fostering diversity, to ensuring that our programs are accessible to previously underserved populations, including those in rural communities. And I'm particularly proud that the fiscal year 2010 budget begins to restore programs protections for workers. The fiscal year 2010 budget, the Department of Labor is requesting $1.7 billion for worker protection programs.

As you said earlier, Senator Harkin, it's about a 10 percent increase for worker protection, which is above the fiscal year 2009 level. We're adding 878 enforcement positions. The budget will return our worker protection efforts to a level not seen since 2001. And we're increasing our capacity—so dramatically in a single year—which I know is unprecedented. But we're ready with an aggressive comprehensive hiring plan that will be implemented as soon as the fiscal year 2010 funding is available.

I want to highlight three agencies where the increases are most substantial due to the erosion in enforcement capacity over the last 8 years.

The additional resources provided for the Wage and Hour Division will allow the Agency to do the following: improve compliance in low-wage industries that employ vulnerable workers; increase its focus on reducing repeat violations; and strategically conduct compliant investigations.

Second, the increase for OSHA will allow us to add 213 new staff, such as enforcement personnel, standard writers, and bilin-

gual staff to address the changing demographics in the workplace, as well as increase funding for our State program grants.

Third, to promote equal opportunity in Federal contracting, through expansion of the Office of Contract Compliance Programs. The number compliance officers there will go to 213 FTE.

The increases in our enforcement programs will require, also, legal services and support for the Office of the Solicitor, where we also request an increase.

And I'm hopeful that the Congress will meet our worker protection program request, to allow the Department to meet its responsibility to all American workers.

And as you are aware, DOL is currently using Recovery Act funds for a range of activities that provide transitional benefits, job training, and placement assistance to unemployed workers. Our fiscal year 2010 request supplements Recovery Act funding through targeted investments in employment and training programs.

For dislocated workers, a $71 million increase will go to the National Reserve Account, which will help to fund National Emergency Grants, allowing for targeted response to large-scale worker dislocations, as we're experiencing now.

Through a new Career Pathways Innovation Fund, we will fund grants to community colleges and other educational institutions to help individuals advance up career ladders in growth sectors like healthcare and IT.

For green jobs, the budget requests $50 million for enhanced apprenticeship and competitive grants. We'll also pursue strategies to equip all our training programs to provide training in the new green economy. And we've included funding, also, for the Bureau of Labor Statistics (BLS), to produce valuable information to help us define green jobs.

Within our request for pilots and demonstrations, the budget also includes an investment of $50 million for transitional jobs, to help young and noncustodial parents gain employment experience and sustainable employment. The budget also includes $114 million to expand the capacity of the Youth Build Program, to train low-income at-risk youth.

And the request for the Veterans Employment and Training Services contains strategic investments that will allow the Agency to reach out to homeless veterans, including those who are women; make employment workshops available to families of veterans and transitioning servicemembers; and to restructure our existing training grants to focus on green jobs.

These innovative strategies will supplement our core workforce security programs that are extremely sensitive to economic conditions, including an increase of $860 million for the newly expanded Trade Adjustment Assistance Program, and $3.2 billion for State grants to fund the Administration of Unemployment Insurance, to support the increased demand on our State programs.

In addition to providing States with the resources to cover increased workloads, our approach includes increased funding for reemployment and eligibility assessment, to help claimants return to work as soon as possible.

I know that you share the belief that I do, that spending tax dollars wisely is very important to our mission and our core goals of

putting American workers back to work. A number of our budget proposals support the goals of accountability and I'd like to name them.

A new $15 million Workforce Data Quality initiative, which will help us develop data to understand the effect of education and training on worker advancement. A $5 million increase in job training program evaluations, which will help us understand which approaches are effective and will help inform the direction of future programs. And an additional $5 million program evaluation initiative, that will help the Department examine all of our programs, not just in employment and training.

And I'd like to say just a few words about some other programs that I know you're interested in. First, the budget provides an increase of $10 million for the Office of Disability Employment Policy. The increase will allow us to build on the lessons we learned through the Work Incentive Grant demonstration, and it will allow us to promote opportunities for individuals with disabilities, particularly young people in employment apprenticeship program, pre-apprenticeship programs and community service activities.

And second, the budget request, as you stated, Mr. Chairman, will provide an increase of $5.3 million for the Bureau of Labor International Affairs, ILAB. With these funds, ILAB will be able to step up monitoring and oversight of labor rights, through closer monitoring and reporting on labor conditions worldwide, particularly with our trading partners, while also maintaining ILAB's Child Labor and Worker Rights grant activities.

PREPARED STATEMENT

In conclusion, I'm committed to ensuring that these new efforts, along with all the programs supported by the Department's fiscal year 2010 budget, will demonstrate that we are putting our workers first, not just our workers, but their families. I ask for your support on this request and would be happy to respond to any of your questions.

[The statement follows:]

PREPARED STATEMENT OF HILDA L. SOLIS

Chairman Harkin, Ranking Member Cochran, and members of the subcommittee, thank you for the invitation to testify today. I appreciate the opportunity to discuss the President's fiscal year 2010 budget request for the Department of Labor (DOL).

The total request for the Department in fiscal year 2010 is $104.5 billion and 17,477 Full-Time Equivalent (FTE) employees, of which $15.9 billion is before the subcommittee. Of that amount, $13.3 billion is requested for discretionary budget authority. Our budget request will build on the $4.8 billion in discretionary and $33.5 billion in mandatory resources included for the Department in the American Recovery and Reinvestment Act (Recovery Act).

It is no secret that the economy is struggling. Investing in our Nation's workforce and creating a positive environment for new jobs is a critical component of the President's efforts to restart our economy. For its part, the Department of Labor is deploying its Recovery Act resources to help ease the burden of unemployment and put people back to work by:

—Providing more training and employment opportunities for seniors, unemployed adults, and dislocated workers;
—Providing Summer Jobs and full-year opportunities for youth;
—Spurring new Green Jobs training investments, to prepare workers to succeed in the new green economy;
—Enhancing and expanding the Unemployment Compensation and Trade Adjustment Assistance programs;

—Launching a new program that informs workers and their families of their rights under the Recovery Act to COBRA premium assistance; and
—Initiating additional worker protections to ensure that economic activity spurred by the Recovery Act occurs in workplaces that are safe, healthful, and respect workers' rights.

The resources requested in our fiscal year 2010 budget will build on and leverage the efforts begun this year with the Recovery Act. The Department's fiscal year 2010 budget will promote continued economic recovery and strengthen the health, safety, and competitiveness of our Nation's diverse workforce.

FISCAL YEAR 2010 PRIORITIES

While building on the efforts begun under the Recovery Act, the Department's fiscal year 2010 budget features three overall priorities: beginning to restore the capacity of our programs that protect workers' safety and health, pay, and benefits; launching new and innovative ways to promote economic recovery and the competitiveness of our Nation's workers; and ensuring that our programs are carried out in a way that is accountable and transparent to the public and our stakeholders.

RESTORING WORKER PROTECTION PROGRAMS

The 2010 budget includes $1.7 billion in discretionary funds and 10,182 FTE for DOL's worker protection activities. This funding level is $150 million (10 percent) and 878 FTE above the fiscal year 2009 enacted level, and returns the worker protection programs to their fiscal year 2001 staffing levels. The request will restore capacity in our worker protection programs, which have languished for years. The Department has developed an aggressive, comprehensive hiring plan for its worker protection agencies, which it will deploy as soon as the fiscal year 2010 appropriation is available. Our plan places a special emphasis on hiring multilingual inspectors and investigators to allow the worker protection personnel to match the languages used in the workplace.

Employment Standards Administration

The Department's Employment Standards Administration (ESA) administers and enforces laws that protect the rights and welfare of American workers. The fiscal year 2010 budget request for administrative expenses for ESA is $503 million and 4,538 FTE. This represents an increase of $63 million (14 percent) and 493 FTE above the fiscal year 2009 enacted level.

Wage and Hour Division

The Wage and Hour Division is responsible for the administration and enforcement of a wide range of worker protection laws, including the Fair Labor Standards Act, Family and Medical Leave Act, Migrant and Seasonal Agricultural Worker Protection Act, worker protections provided in several temporary nonimmigrant visa programs, and prevailing wage requirements of the Davis-Bacon Act and the Service Contract Act. The Wage and Hour Division protects more than 135 million workers in more than 7.3 million establishments.

The fiscal year 2010 budget requests $227.7 million and 1,571 FTE for the Wage and Hour Division, an increase of $35 million and 288 FTE from the fiscal year 2009 enacted level. It includes resources to help revive its customer service focus by supporting improved complaint intake and more in-depth complaint investigation processes. In fiscal year 2010, the Wage and Hour Division will hire additional investigators to:

—Strengthen enforcement resources on behalf of vulnerable workers;
—Verify future compliance of prior violators; and
—Conduct high-quality, responsive complaint investigations strategically, to increase protections for the greatest number of workers.

The fiscal year 2010 budget request for the Wage and Hour Division excludes $45 million in estimated fee revenue from DOL's portion of the H–1B and L visa fraud prevention fee authorized by the 2004 H–1B Visa Reform Act. Because of the statutory limits on the use of these funds, DOL has been unable to spend all of the fees, and each year carries unspent balances. The fiscal year 2010 budget proposes to cancel $30 million of these balances as an offset to new discretionary spending. The administration is also proposing legislation, through the Department of Homeland Security, to amend the Immigration and Nationality Act to expand the permissible uses for the Department of Labor to use the H–1B and L fraud fees to carry out expanded enforcement activities under the H1B and L, as well as provide a stable source of funding for enforcement of the H–2B program.

Office of Federal Contract Compliance Programs

The fiscal year 2010 budget request for the Office of Federal Contract Compliance Programs (OFCCP) totals $109.5 million and 798 FTE, an increase of $27 million (33 percent) and 213 FTE from the fiscal year 2009 level. OFCCP is responsible for ensuring equal employment opportunity and nondiscrimination in employment for businesses contracting with the Federal Government. In fiscal year 2010, OFCCP will carry out this mandate by conducting compliance evaluations to identify instances of systemic discrimination in the workplace, with a special focus on construction reviews and on-site evaluations related to veterans and individuals with disabilities. The fiscal year 2010 request includes $2 million for a new case management system to replace the agency's existing case management system (the OFCCP Information System), which was developed over 20 years ago and is inadequate to meet today's enforcement needs. The new system will improve the monitoring of noncompliant contractors and improve the effectiveness of OFCCP's enforcement activities.

Office of Workers' Compensation Programs

The fiscal year 2010 discretionary budget request for administration of the Office of Workers' Compensation Programs (OWCP) totals $108.5 million and 890 FTE to support the Federal Employees' Compensation Act (FECA) ($95.3 million) and the Longshore and Harbor Workers' Compensation program ($13.2 million).

The OWCP budget also includes mandatory funding totaling $51.2 million and 305 FTE to administer Part B of the Energy Employees Occupational Illness Compensation Program Act (EEOICPA), and $60 million and 293 FTE for Part E of the Act. EEOICPA provides compensation and medical benefits to employees or survivors of employees of the Department of Energy (DOE) 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 DOE or DOE contractor facilities.

Lastly, OWCP's fiscal year 2010 budget includes $37.5 million in mandatory funding and 195 FTE for its administration of Parts B and C of the Black Lung Benefits Act, and $58.1 million and 127 FTE in FECA Fair Share administrative funding. The request for FECA Fair Share includes an increase of $4.95 million to upgrade technology, improve customer service, and increase productivity.

Office of Labor-Management Standards

The fiscal year 2010 budget request for the Office of Labor-Management Standards (OLMS) totals $40.6 million and 266 FTE. This is a net reduction of $4.38 million and 31 FTE from the fiscal year 2009 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 the Department'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 resources requested in fiscal year 2010 will allow OLMS to continue to accomplish its core mission. The reduction in FTE will occur through the transfer of staff to other ESA programs and attrition. The budget would shift those resources to other worker protection agencies that have faced increased workload in the face of diminished resources.

Employee Benefits Security Administration

The Employee Benefits Security Administration (EBSA) protects the integrity of pensions, health plans, and other employee benefits for more than 150 million workers. The fiscal year 2010 budget request for EBSA is $156.1 million and 910 FTE, an increase of $13 million (9 percent) and 75 FTE compared to the fiscal year 2009 level. The requested resources will help rebuild the foundation of EBSA's enforcement efforts, allowing an additional 600 civil and criminal investigations and increasing indictments by an estimated 6 percent.

Occupational Safety and Health Administration

The fiscal year 2010 budget request for the Occupational Safety and Health Administration (OSHA) is $563.6 million and 2,360 FTE. The budget requests an additional $50.6 million and 213 FTE, and proposes program increases to restore OSHA's capacity to enforce statutory protections, provide technical support, promulgate safety and health standards, and strengthen safety and health statistics. The fiscal year 2010 request supports an additional:

—130 safety and health inspectors (a 10 percent increase from fiscal year 2009);

—25 whistleblower investigators (a 33 percent increase);
—$13.84 million for State Program grants (a 15 percent increase);
—13 FTE to strengthen OSHA's capacity to quickly respond to the sudden emergence of safety and health hazards, such as a pandemic influenza; and
—20 FTE to restore OSHA's rulemaking capabilities, allowing the Agency to simultaneously address multiple complex longstanding and emerging regulatory issues.

These additional resources will restore OSHA's enforcement presence in the Nation's workplace, support National and Local Emphasis Programs, and allow the agency to hire multilingual investigators to address language barriers in enforcement.

Mine Safety and Health Administration

The fiscal year 2010 budget request for the Mine Safety and Health Administration (MSHA) is $353.7 million and 2,376 FTE. The request will allow MSHA to continue implementing the historic Mine Improvement and New Emergency Response (MINER) Act, the most sweeping mine safety legislation in 30 years.

The fiscal year 2010 budget includes an increase of $1.3 million specifically targeted for 15 additional Metal and Nonmetal FTE to address the projected 12 percent increase in workload in the aggregates mining sector. 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 continue infrastructure improvements at the National Mine Health and Safety Academy. The request also allows MSHA to continue its work to enhance mine rescue and emergency operations.

Office of the Solicitor

The fiscal year 2010 budget includes $125.2 million and 679 FTE for the Office of the Solicitor (SOL). This amount includes $117.4 million in discretionary resources and $7.8 million in mandatory funding. The Solicitor's Office provides the legal services that support the Department, particularly the Department's enforcement programs. The fiscal year 2010 budget includes an increase of $14.8 million that will support an additional 82 FTE to provide expanded legal support for DOL client agencies, and provide $5.3 million for information technology and legal support infrastructure. The additional staff will better enable SOL to provide increased enforcement litigation, more timely legal opinions, and legal support for rulemaking. The $5.3 million request for infrastructure will increase SOL's litigation efficiency and improve its case management and reporting system.

Pension Benefit Guaranty Corporation

For administrative expenses of the Pension Benefit Guaranty Corporation (PBGC), the fiscal year 2010 budget requests $464.1 million and 931 FTE, an increase of $19.3 million over the fiscal year 2009 level. In fiscal year 2010, PBGC will strive to prevent unnecessary and avoidable terminations of underfunded pension plans, to mitigate the risk of losses to the insurance program, and to enhance recoveries in bankruptcy for the benefit of plan participants and the insurance funds. The request includes an additional $15 million to help PBGC respond to the threat posed by the struggling economy to defined benefit pension plans. These funds will support actuarial and financial advisory services to better understand the exposure and risk faced by the pension insurance program. In addition, $500,000 and three FTE are requested to increase the capacity of the Office of Inspector General to investigate PBGC's benefit payment, asset management, and contracting operations.

The budget also includes a change to the appropriations language that "triggers" the availability of additional administrative funds if there are unanticipated pension plan termination-related expenses. Because of concerns that a large plan failure late in the fiscal year would trigger additional funds that could not be fully obligated within the fiscal year, the budget proposes to make these triggered funds available for 2 years.

INNOVATIVE WORKFORCE TRAINING STRATEGIES

The fiscal year 2010 budget request for the Department's Employment and Training Administration (ETA) is $8.7 billion in discretionary funds and 812 FTE, not including the 131 FTE associated with the foreign labor certification application fees.

We are grateful to the Congress for providing funding for the employment and training programs in the Recovery Act. This funding provides the basis of an aggressive plan to put Americans back to work. Our fiscal year 2010 budget request will

supplement Recovery Act funding with the targeted investments highlighted in this section. I am particularly excited about the use of innovative strategies and programs designed to increase the skills and competitiveness of the American workforce, including segments of the population that have been underserved in the past.

Dislocated Workers

The budget requests an increase of $71.1 million in the Dislocated Worker National Reserve to fund National Emergency Grants. This will enable ETA to provide additional, targeted resources to aid in the re-employment of dislocated workers, as current projections indicate that there will continue to be high levels of unemployment into fiscal year 2010.

The economy, along with a major expansion of eligibility and benefits enacted as part of the Recovery Act, is also the primary factor in the request for an increase of $860 million for the Trade Adjustment Assistance program, which will support training and income support for trade-impacted workers. States that assist workers who lose jobs will also receive $3.2 billion for the administration of unemployment insurance based on estimates of claims workload for the fiscal year.

Career Pathways Innovation Fund

The fiscal year 2010 budget requests $135 million for the Career Pathways Innovation Fund, which is a $10 million increase over the amount awarded in fiscal year 2009 through Community-Based Job Training Grants. Competitive grants provided by the new fund will continue the support for community colleges provided by Community-Based Job Training Grants, but will focus on career pathway programs at community colleges. These programs help individuals of varying skill levels enter and pursue rewarding careers in high-demand and emerging industries.

Career pathway programs are clear sequences of coursework and credentials, each leading to a better job in a particular field, such as healthcare, law enforcement, and clean energy. These programs have multiple entry and exit points and often include links to services, such as basic adult education and English-as-a-Second Language classes, which make them accessible to individuals who are not yet prepared to enroll in college courses. Career pathways are a relatively new strategy for community colleges, but several existing programs have shown promising outcomes.

The Department will work with the Department of Education as it develops and implements this new initiative, especially to gain insight into curriculum development, the importance of credit transferability, and linkages between community colleges and K–12 education.

Green Jobs

The budget requests $50 million for a Green Jobs Innovation Fund, which will complement the competitive grant awards made through the $500 million appropriation included for high growth and emerging industry sectors under the Recovery Act. The Department is considering several targeted strategies for these funds, including: (1) enhanced apprenticeship opportunities in green industry sectors and occupations; (2) competitive grants for green career pathways, focusing on developing educational opportunities in green industries; and (3) incentives for innovative partnerships that connect community-based organizations in underserved communities with the workforce investment system to promote career advancement in green industry sectors.

YouthBuild

The fiscal year 2010 budget includes $114 million, an increase of $44 million, or 64 percent, over the fiscal year 2009 enacted level for YouthBuild to provide competitive grants to local organizations for the education and training of approximately 7,100 disadvantaged youth ages 16–24. Under these grants, youth will participate in classroom training and learn construction skills by helping to build affordable housing. In fiscal year 2010, the Department will continue the "green" transition of YouthBuild by encouraging connections with other Federal agencies involved in creating green jobs, such as the Department of Housing and Urban Development (HUD) and the Department of Energy in order to leverage resources and new "green" opportunities for YouthBuild participants.

Transitional Jobs

The fiscal year 2010 budget proposes $50 million 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 will target noncustodial parents to strengthen their workforce skills and experience, and help the children who rely on them for support. The Department will

carry out this demonstration collaboratively with other Federal agencies, such as the Departments of Health and Human Services and Justice. We will work with partner agencies to develop and implement a rigorous evaluation strategy for this demonstration.

Reintegration of Ex-offenders

The fiscal year 2010 budget requests $115 million, an increase of $6.5 million over the fiscal year 2009 enacted level, for a program that brings together projects for adult and youth offenders. A portion of the funding will be used to support ex-offender programs under the Second Chance Act, and provide job training, mentoring, and transitional services to ex-offenders. The funding will also support grants to target juvenile and young adult offenders, and youth highly at risk of involvement in crime and violence.

Strengthening Unemployment Insurance Integrity and Promoting Re-employment

The economic downturn has placed great stress on the Unemployment Insurance (UI) system, which finances the unemployment compensation program. In addition to financing the administration of State workloads, the administration is committed to protecting the financial integrity of the UI system, and to helping unemployed workers return to work as promptly as possible. Our approach includes:

—A total of $50 million in discretionary funding, an increase of $10 million over the fiscal year 2009 enacted level, to expand 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. This initiative has helped UI beneficiaries find jobs faster and reduced payments to ineligible individuals.

—A package of legislative changes that would prevent, identify, and collect UI overpayments and delinquent employer taxes. We estimate that these legislative proposals would reduce overpayments by $3.9 billion and employer tax evasion by $300 million over 10 years.

In addition, the administration will seek reform of the UI program's permanent Extended Benefit (EB) feature to improve its efficiency as an automatic economic stabilizer and streamline administration. 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

The fiscal year 2010 budget proposes $575 million for the Senior Community Service Employment Program (SCSEP), which will enroll some 90,000 low-income seniors in part-time, minimum wage community service jobs. The request includes an additional $3.5 million over the fiscal year 2009 enacted level to finance the increase in the Federal minimum wage that will occur on July 24, 2009. ETA will focus its technical assistance efforts on transitioning seniors in programs funded by the Recovery Act into the regular 2010 program with minimal disruption.

Job Corps

The budget includes $1.7 billion to operate a nationwide network of 124 Job Corps centers in fiscal year 2010. Job Corps provides training to address the individual needs of at-risk youth and ultimately equip them to become qualified candidates for the world of work. Job Corps received $250 million from the Recovery Act, which it is using to fund shovel-ready construction projects that stimulate job growth in center communities. In addition, the Recovery Act 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

When it comes to training and employment, we will never forget our commitment to our veterans. For the Department's Veterans' Employment and Training Service (VETS), the fiscal year 2010 budget request is $255 million and 234 FTE. The fiscal year 2010 budget includes $35 million for the Homeless Veterans Reintegration Program (HVRP), an increase of $9 million (34 percent) above fiscal year 2009. The request will allow the program to provide employment and training assistance to an additional 7,200 homeless veterans, with an increased emphasis on aiding homeless women veterans. The budget also includes a $2 million increase for Veterans Workforce Investment Programs to provide services to veterans that will result in new skills and employment in Green Jobs. In addition, the budget requests an increase of $3.5 million to expand access to the Transition Assistance Program (TAP) for spouses and family members (including those with limited English proficiency). TAP

Workshops play a key role in reducing jobless spells and helping servicemembers transition successfully to civilian employment.

I place a strong priority on ensuring that the innovative programs I have described above are available to persons in all communities across our Nation, including those living in rural communities. I am eager to partner with my colleagues in the Cabinet and you to ensure this happens.

ENSURING ACCOUNTABILITY AND TRANSPARENCY

Spending tax dollars wisely helps the Department 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 the Department of Labor. Our fiscal year 2010 budget supports those goals.

Workforce Data Quality Initiative

The fiscal year 2010 budget requests $15 million for a Workforce Data Quality Initiative of competitive grants to support the development of longitudinal data systems that integrate education and workforce data. Longitudinal data systems track individuals as they progress through the education system and into the workforce. Some States have developed comprehensive systems that link individuals' demographic information, high school transcripts, college transcripts, and quarterly wage data. These data systems can provide valuable information to consumers, practitioners, policymakers, and researchers about the performance of education and workforce development programs.

The Department will work to develop this grant program with input from the Department of Education. Grants will help States to incorporate workforce information into their longitudinal data systems, as well as undertake activities to improve the quality and accessibility of performance data reported by training providers. Improving information available from training providers is crucial to helping consumers make informed decisions when choosing among training programs.

A Renewed Commitment to Program Evaluation

In recent years, the Department's evaluation capacity has eroded, and it has funded too few high-quality evaluations of its programs. The administration and the Department recognize the need to conduct a rigorous evaluation agenda to determine which programs and interventions work and inform its policy, management, and resource allocation decisions. The fiscal year 2010 budget provides $5 million for a new Department-wide initiative to support rigorous evaluations across the Department of Labor. The new initiative will allow expansion of evaluation activities to other programs, with a priority on large, lightly examined, and/or high-priority programs. In addition, the budget requests an increase of $5 million for ETA's evaluation budget for job training and employment programs. As part of this initiative, the Department of Labor would look to build partnerships with the academic community and other outside parties to leverage private-sector research activities; make public its research and evaluation agenda, and develop the agenda based on feedback from the public, Congress, and its stakeholders.

OTHER PROGRAMS

Bureau of Labor Statistics

In order to maintain the development of timely and accurate statistics on major labor market indicators, the fiscal year 2010 budget provides the Bureau of Labor Statistics (BLS) with $611.6 million and 2,416 FTE. This funding level provides BLS with the necessary resources to continue producing sensitive and critical economic data, including the Consumer Price Index (CPI) and the monthly Employment Situation report. In addition, the fiscal year 2010 budget includes an increase of $8 million and 10 FTE to produce new data on employment and wages for businesses whose primary activities can be defined as "green," and produce information on the occupations involved in green economic activities.

Office of Disability Employment Policy

The fiscal year 2010 budget provides the Office of Disability Employment Policy (ODEP) with a total of $37 million and 49 FTE, an increase of $10 million (39 percent) over fiscal year 2009. With the increase, ODEP will support a new initiative that builds upon the lessons learned through the Work Incentive Grant demonstration Disability Navigators, and focuses on working with employers, the One-Stop system, and other stakeholders to vigorously promote the hiring, job placement, and retention of individuals with disabilities, particularly youth, in integrated employment, apprenticeship, and pre-apprenticeship programs, and community service activities. The fiscal year 2010 budget also proposes "Add Us In!"—a new grant pro-

gram for minority youth with disabilities who are transitioning from school (secondary or postsecondary) to employment and are interested in entrepreneurship. Financed within ODEP's base budget, the initiative would feature collaboration with minority chambers of commerce.

Bureau of International Labor Affairs

The fiscal year 2010 request for the Bureau of International Labor Affairs (ILAB) is $91.4 million and 95 FTE. The request provides an increase of $5.3 million and 12 FTE to allow ILAB to step up its monitoring and oversight of workers rights. This will involve closer monitoring and reporting on labor conditions worldwide, with a goal of reducing violations of worker rights and incidents of child labor, forced labor, and human trafficking. The fiscal year 2010 budget will maintain ILAB's child labor and worker rights activities at the fiscal year 2009 level

Women's Bureau

The fiscal year 2010 budget includes $10.6 million and 52 FTE for the Women's Bureau. This budget will allow the Women's Bureau to continue its mission of designing innovative projects addressing issues of importance to working women and providing information about programs and polices that help women attain high paying, career ladder jobs in nontraditional fields, including opportunities in green industry sectors and occupations.

CONCLUSION

With the resources we have requested for fiscal year 2010, the Department will step up its enforcement of worker protection laws; provide innovative training and employment programs that promote green investments while ensuring diversity and inclusion; increase employment opportunities for our Nation's veterans and their families; and ensure our programs are accountable and understandable to the public and our stakeholders.

Mr. Chairman, this is an overview of the programs proposed at the Department of Labor for fiscal year 2010. I am happy to respond to any questions that you may have.

Thank you.

Senator HARKIN. Thank you very much, Madam Secretary. Again, I really appreciate the focus you've made getting back in the game on OSHA and worker protections. And what you're doing on dislocated workers, especially during this period of time, and on the green jobs. I just, again, commend you and President Obama for focusing on this area.

And as I understand it, you're looking at the green jobs in different areas and different programs that you have under your jurisdiction. One of those is the Career Pathways Innovation Fund for community colleges. It's been my experience that a lot of these community colleges are the ones that are really in the forefront of developing curricula and teaching our kids these new green jobs technologies.

And so I hope that the Pathways Fund will be used for getting more program information to community colleges for them to use for developing these new careers in renewable energy and wind energy and transportation. There are a lot of different things that they're teaching in the community colleges.

Thank you very much for your increase in ODEP. This is something that we just can't fall back on and we've got to continue our efforts to get more people with disabilities employed. And of course the ILAB on keeping our position, as a leader in the world, and on getting rid of the worst forms of child labor.

I remember—I was driving to work one day and I was listening to—what do I listen to in the morning, 81.5, WAMU—and it was talking about, this was a couple months ago—and about the impact that President Obama has had on young people. And there was—

this inner city school teacher talking about how kids in her classroom were now, paying more attention and taking pride in their schoolwork.

And she had this one kid, she said, who'd been noted as a trouble maker. And this kid said something like, "They say I'm a trouble maker and my teacher says I'm impossible. Well, I want to be possible." And, I think that's the kind of spirit that has come from President Obama, that kids want to be possible.

So, we've got to focus a lot on our minority youth in this country, and their training and their skills, and their education, and making sure that they can become possible, like this one young man said.

So, that's your job. I mean, that's the job that I see at the Department of Labor, what you can do is you can really carry this out and focus on the areas of getting our young people trained for the careers of tomorrow.

EMPLOYMENT OF PERSONS WITH DISABILITIES

The only questions I have is on the employment of persons with disabilities. You requested $10 million over last year, I thank you for that. But, then again, we look at a $17 million Disability Navigators Program that was funded through the Work Incentives Grants.

Now those Disability Navigator Grants were often used to increase physical and program accessibility at your one-stop centers. Well, that's going away and now we have a $10 million increase. So, am I really looking at a $7 million decrease in funding?

I'm just concerned about the wide-ranging problems with accessibility and participation of job seekers with disabilities in the one-stop system. Can you assure me that this issue, which was previously the focus of the Disability Navigators—that was funded under the Work Incentives Grant program—will continue to be a priority of this Department?

Secretary SOLIS. Mr. Chairman, Senator Harkin, yes. I would say that one of the things that—and please keep in mind that I have only been in office, not even 3 months yet, and I did come in at a time when the budget was somewhat already being prepared.

Senator HARKIN. Right.

Secretary SOLIS. So, it was very interesting to be in those discussions. But I continue to remain very supportive of the notion that we have to really fully integrate services for our disabled population, at every point in our agency, where we can. So, not just at the one-stops, but also in our efforts—and I think I may have mentioned this at our confirmation hearing—we're going to see an unusually large number of returning veterans, that are going to have severe brain injury and traumatic stress.

We also need to expand what we do with the disabled community, in addition to those that are currently here and have not found employment. And I would hope that our State agencies will work with us now, because these demonstration programs that you note, the Navigator Program, have been in existence—and they were supposed to be demonstration projects—the funding has now been fully exercised there. My hope is to get, and our directives are, that the State agencies will pick up that responsibility, as well.

So, I'm going to do whatever I can to make sure that happens, and then hopefully work with this subcommittee to see that we can increase our efforts to collaborate, not just within DOL, but also with DOE, and with other agencies, the Veterans Administration as well, to see how we can expand the services and work intersegmentally with these other agencies, and also have pools of money, where we can do a little bit better targeting.

I think this is going to be a great opportunity for us. I'm very excited. Once I have my leadership in place in ODEP, that we're going to have, I think, some very innovative strategies to bring back to you in this subcommittee.

Senator HARKIN. I appreciate that. Well, I look forward to working with you in that area.

I have another question, but I will do it in another round if we have time. At this point, I just yield to Senator Cochran.

GULFPORT JOBS CORPS CENTER

Senator COCHRAN. Mr. Chairman, thank you very much.

Madam Secretary, we appreciate the call you made the other day to advise us of the release of—of funds under the National Emergency Grants (NEG)—there are more acronyms in this budget than in any budget—it's the National Emergency Grant, and it was an extension of a grant that had been made and approved to the State of Mississippi by the Department of Labor. And they had requested additional funding, and your call indicated that that had been approved. And I just wanted to thank you for that, and encourage the Department to continue to monitor the needs that exist on the Mississippi Gulf Coast, as a result of Hurricane Katrina.

One example, is a Job Corps center that was destroyed in the hurricane, and it has not been rebuilt. We were hopeful that funds would be made available for the Gulfport Jobs Corps Center. And it was scheduled to be opened, reopened in August of this year. There's an interim modular building, I think, being used right now for about 150 students, but we hope that that can be accelerated and we can move toward a completion of that center at an early date.

Do you have anything in your notes about that?

Secretary SOLIS. Yes, I do, Senator Cochran. And, I realize that I also inherited this—this challenge, and we will work diligently to try to really streamline the process so that we can get this up and moving in, hopefully, a shorter timeframe; 2011, I believe is what we're looking at, to fully operate the Job Corps Center. And meanwhile, as you said, we do have other transitional modulars that are out there to help with the different Job Corps students that need assistance.

I do want to mention that during Katrina and the recovery effort, that the Youth Build Program was very, very involved in helping to provide assistance, construction, other types of exercises that they were fully involved in. So our programs are working, and I just wanted to report that to you, that we're watching and monitoring and want to continue to work with you and to see that this Job Corps Program is fully implemented and that it's up to speed and ready to go, in a shorter period of time.

Senator COCHRAN. Well, we appreciate your personal interest in that goal, and thank you for your attention to that. We had in our committee report that that Youth Build Program, which specifically was actively engaged in the construction of new homes and helping rebuild neighborhoods and communities all along the Gulf of Mexico. So, we appreciate that.

DISLOCATED WORKER PROGRAM

There was a decrease in funding, that we were advised about, for the State of Mississippi of 50.4 percent, a reduction which amounts to $13.8 million below the amount the State received in WIA funds in fiscal year 2008. I'm advised that funds are distributed to States based on the State's unemployment rate and the rise in its unemployment rate compared—as compared with other States.

I think what has happened is, that in other States, unemployment rates have increased over the previous years, at a higher level than they did in Mississippi, and so our State ended up getting a decrease in funding, as compared with—with the funds received from other States. Is there any—is there any plan to address that or to make a request for supplemental funding, so that a State can be held harmless? The unemployment rate is still high, there are probably more people unemployed than there were last year, but because other States have much higher unemployment rates, Mississippi loses money and it gets transferred to other States. That's the way I read that.

Secretary SOLIS. Yes.

Senator COCHRAN. Is that the way that program works?

Secretary SOLIS. Unfortunately, you hit it right on the nose, Senator. The program you're talking about is Dislocated Worker Funding, and it's a formula-based funding. So, those formulas are set by—by you, the Senate and the Congress. And unfortunately, I understand this is an issue that we may want to address as we go through WIA reauthorization. I know some members are very concerned about this. And I also agree that something has to be done.

In my request, before you, I'm asking for an additional $71 million in the NEG, so we can address this issue as soon as we can. That isn't the cure-all though; the long-term problem is we have to fix the formula so that when crises like this occur. We are hoping to be able to not penalize States and hold them harmless when they're—when you see continuing unemployment rate that just is not going down over a period of 2 years.

The program wasn't intended to fund as many States in this manner, is what I believe, and so, yes, this is a crisis and we have to take measures to modify that. So I will work—I would love to work with you, Senator, and with this subcommittee, and other members who have already expressed concern about this issue.

Senator COCHRAN. Thank you very much.

Senator HARKIN. Thank you, Senator Cochran.

Senator Murray.

Senator MURRAY. Thank you very much.

And, Secretary Solis, welcome to this subcommittee. Thank you for your conversation yesterday and for all the work that you are doing. I really appreciate you having this hearing today.

Following up on Senator Cochran, I had a question on the same thing, because this does have to do with the distribution of the WIA funds for the Dislocated Worker Program. When we originally set up the formula for this, it was meant to be dynamic so that it could react to the ebb and flow of a turbulent economy, but the formula has actually now impacted some States in a negative way. And we are going to have to figure out how to do that in the future, so that we don't end up in a situation—my State is estimated to lose about $200 million under the current challenge that we've got.

You mentioned using some of the NEG to fill in the gaps. Do you need an additional appropriation from the Senate bill to do that or are you going to use what you currently have until we can meet those obligations?

Secretary SOLIS. Senator Murray, thank you for your question. We're going to try to exhaust the $1.2 billion that's—that has been provided in the Recovery Act, and I'm assuming that that may go more quickly than we assume. So, we are requesting the $71 million to help—to help that.

Senator MURRAY. Okay, could you let us know where you are with that formula—or with the NEG grants and where the shortfalls are, and when you expect to hit them, because a number of States have been impacted?

Secretary SOLIS. Absolutely.

Senator MURRAY. Okay, thank you.

PELL GRANTS FOR UNEMPLOYED WORKERS

I wanted to ask you—on Friday, the President announced an initiative to ensure that those who are unemployed will be eligible for Pell Grants. Has your budget team and the budget team of the Department of Education (DOE) come up with an estimate of the amount of funds that will be necessary to carry out that extension?

Secretary SOLIS. Senator Murray, as I spoke with you regarding this issue, we are—we are now looking at how this program will be implemented. I don't have that figure in front of me at this moment, because our staff is working on that now. But I know this is something that—I know you have a great deal of concern and I expressed to you that I—through your leadership, we want to work with you to make sure that we do the best, in terms of implementing this, and try to do the best, in terms of delivery and efficiency.

I think it's an exciting program. I'm not sure quite how DOE and ourselves will have all the mechanics, but I know our staff is working on it. It's an exciting topic, but I have similar concerns that you might have.

Senator MURRAY. I agree that it's much needed and, you know, in the right direction. I just want to know what our—our cost is going to be and how that's going to be appropriated or if it will come from other funds. So if you can work with the Department of Education and come back and let us know what the costs of that are going to be.

Are you considering expanding that to immediate family members or does the proposal include immediate family members, children of unemployed workers, or is it just the worker themselves?

Secretary SOLIS. I don't have all the specific details because this has just been rolled out Friday, but my understanding, it's for unemployed workers—we haven't really discussed what other family members would be impacted.

So, certainly I will get back to you as soon as I can, and possibly later today.

Senator MURRAY. Okay, I appreciate that very much.

FUNDS FOR JOB CORPS

Also, I wanted to ask you about the funds for Job Corps, which is the largest program in the Federal Government to help our at-risk youth. It targets some of our hardest-to-serve 16 to 24-year-olds, many of them with criminal records, most of them with poor reading and math skills, and probably with very limited attachment to any kind of school or labor market.

I have been told that this is a time when our young adults are facing the worst job market since World War II, so I am following the Job Corps very closely; I think it's a very important part of our dealing with that challenge. It's a public/private partnership with 94 of the 122 Job Corps Centers that are run today by corporations and private, not-for-profit organizations, and it is a competitively awarded contract. I think it's a really good program.

I was concerned it was flat-funded in your budget request. Do you think this is a program that needs to have some increased cost, particularly at this economic time when a lot of our kids are facing some real challenges?

Secretary SOLIS. I think that what we're looking at right now is still the $37 million that was provided through the Recovery Act. That was a substantial increase, overall. So, that also does set somewhat of a precedent.

What I'm looking at now is trying to make sure that we can, also as Senator Harkin was saying earlier, the chairman, about trying to make sure that these programs really have career ladders, that we also look at opportunities to go to a community college, or a tech or vocational school and get a certificate, but also green these programs. So, that's also going to take additional focus and funds.

Job Corps programs, I think, are wonderful. I've seen them in effect even here in the District, in D.C., and they're not all green jobs—obviously you have people that are going into healthcare, and I think that there's—it's worthwhile to have a discussion, to see how there can be some innovation provided in Job Corps.

I think their goal, the focused population that they have, is well-meaning. But I do think there can be more that we can provide, in terms of assistance.

Yesterday, when I spoke before the Appropriations Committee in the House, there were concerns, also, about funding that may not be as exuberant at this time——

Senator MURRAY. I appreciate that the Economic Recovery package has money for this, but if we don't have long-term, sustained requests for beyond the timeframe of the Economic Recovery package, we're going to be in a very bad place.

So, this is something I care a lot about, Mr. Chairman, and I hope we can work it out.

Secretary SOLIS. Senator Murray, if I can just explain, also, one of the things I would like to do as Secretary of Labor, is to put Job Corps back with the other programs in the Employment and Training Administration.

Senator MURRAY. I saw that proposal, actually.

Secretary SOLIS. And really try to make more meaningful, what we're doing with all of our youth. So there is more coordination, there's no overlap, and that we really focus in, in a more meaningful way. And this will be a good opportunity, and that's a prerogative that I have as Secretary of Labor.

PREPARED STATEMENT

Senator MURRAY. Okay, very good. I appreciate that.

Thank you.

[The statement follows:]

PREPARED STATEMENT OF SENATOR PATTY MURRAY

Thank you, Mr. Chairman, for holding this hearing to examine the President's fiscal year 2010 budget proposal for the Department of Labor.

I would also like to extend my appreciation to Secretary Solis for coming before this subcommittee to discuss the administration's proposal.

America's working families are facing some of the toughest economic challenges in a generation. As of last month, more than 13 million people were unemployed in this country. And, we've lost 5.7 million jobs since the recession began.

Too many parents are forced to choose between going to work and taking care of a sick child. Families are struggling to pay tuition, or keep food on the table—and many depend on weekly unemployment insurance benefits because the pool of jobs has dried up in their communities.

America's working families are looking for hope, and they are looking for a champion. Hope that they'll be able to stand on their own once again, and a champion to stand up for them when they aren't able to stand up for themselves.

And I believe that a restored and focused Labor Department can do just that—it can help the millions of unemployed job seekers find training for careers in new, growing industries. It can help them access the benefits they need to get by until they can stand on their own again. It can help keep them safe and healthy in the workplace, and guard against unfair labor practices. And, it can be their advocate at the highest levels of the administration during this economic recovery.

I believe that this administration is committed to making working families a priority once again in this country.

And, for the most part, the President's budget proposal for the Department of Labor reflects that commitment.

As the chair of the Subcommittee on Employment and Workplace Safety, I was particularly encouraged to see the significant investments in labor protections and workplace safety and health across the Department. I was pleased to see a proposal to strengthen State Occupational Safety and Health Administration (OSHA) programs, like the one in my home State of Washington, that extend the work of national OSHA, but, for too long, have not had sufficient resources.

And, I'm glad to see a renewed investment in quality data, evaluation, and reports so that Congress and the public can clearly see which efforts work and which don't.

I was also pleased to see an effort to move Job Corp back to the Employment and Training Administration where it belongs.

And as the author of the Promoting Innovations to the 21st Century Act, a bill focused on career pathways for young people, I was very pleased to see a focus on pathways under the Workforce Investment Act programs.

While I'm very pleased with most of the budget, I do have some concerns about the priorities reflected in the Workforce Investment Act proposed levels.

I appreciate the fact that the Department did not cut these funds, but I had hoped for a significant investment in job training programs—particularly as our Nation works to recover from this recession.

I fought for the Recovery Act to include a $4.2 billion investment in jobs training, a much needed shot in the arm for a system that's been neglected during the last administration and had its capacity to serve large numbers of job seekers severely diminished.

And while this was a strong step in the right direction, I believe that we need to do more to rebuild the system's capacity and adequately serve our workers.

For example, those areas that are rebuilding their summer youth programs with the investment we made in the Recovery Act, may not be able to sustain them at the recommended 2010 levels.

I hope that as we move forward and learn more about the impacts of the Recovery Act funds, that you will work with me and this subcommittee to strengthen and focus our investments in education and training for America's workers.

As we've discussed several times, I'm committed to reauthorizing the Workforce Investment Act. And I want to ensure we're investing in our workers to help them get the training they need to fill the high-skill, high-wage jobs of the future, and help get our economy back on track.

I'm also concerned that the proposal for Job Corps funding levels sends the wrong message. It's a valuable program that serves as a second chance for many youth in our country, and in these tough economic times I think it should be a priority.

And, while the funding levels for the Senior Community Service Employment Program received a bump, it only covers the minimum wage increase. And, it still serves less than 1 percent of the eligible population, low-income older workers who struggle to find jobs. I hope that you will work with Congress to find a solution that strengthens this program moving forward.

I look forward to hearing from you today, Secretary Solis, and to our continued partnership.

Senator HARKIN. Thank you, Senator Murray.

Senator Pryor.

Senator PRYOR. Thank you, Mr. Chairman.

COBRA PREMIUM ASSISTANCE PROGRAM

Madam Secretary, let me start with a question that is more immediate, and that is on the COBRA Premium Assistance program, I think you mentioned it in your opening statement.

We've had—and I'm sure that the other Senators have had—lots of calls and concerns and confusion about—from unemployed workers—about the COBRA provision in the Recovery Package. Can you just give the subcommittee, here, a little update on the initiative you're working on, and how the effort is going to be set up?

Secretary SOLIS. There is—thank you, Senator—there is a lot of interest in the program. In fact, reports we're getting back from our regional offices is that there's an overwhelming number of individuals, participants, who want to know how to get involved in the program. And it is——

Senator PRYOR. We get a lot of those calls, too.

Secretary SOLIS. There's a lot of calls. In fact, I'm not quite sure that our systems are really prepared to receive all of those incoming calls.

I know that there will be—that we are anticipating that there will probably be a process that may prolong itself in terms of appeals that might be made, because there also has to be substantiation of where the individual was working. So, that will require some backup, or it will happen as a consequence of all of these calls.

So, I am concerned about that, and our staff is doing everything we can. I don't have my full leadership in place, yet, so that's also been a hindrance, because I have to rely on the current staff that are there.

So, it's a challenge, but it's one that I know we are very, very focused on, and we'd like to get back to you with more details.

UNEMPLOYMENT OVERPAYMENTS

Senator PRYOR. Okay, let me ask, if I can, about unemployment insurance. There's a—in the budget the administration puts forward an idea to reduce unemployment overpayments by about $3.9 billion. What is going on in this system where, you know, it sounds like $3.9 billion, you've got a lot of people who are overpaying every year. Can we fix that system? Do you feel like the Department of Labor is on top of that?

Secretary SOLIS. That is going to be a priority for this Department. This also came up yesterday in our hearings before the House appropriators, and it is something that we know we will need resources to do a better job to focus here, to go after those fraudulent claims and collect that money.

So, it will be a priority for this new administration.

EMPLOYMENT STATISTICS

Senator PRYOR. One of the things that your Department does, it may be kind of mundane, but that's important to a lot of people that statistics are tracked by the Bureau of Labor Statistics. I know, last year we had someone calling our office, they were trying to get a handle on—I think it may have been on an economic development issue, I don't recall right now, but they were trying to get a handle on some real specific statistics for Arkansas. And basically, I think what they wanted was local employment statistics, and the Bureau of Labor Statistics told us that they're no longer collecting or disseminating the specific statistic my constituent wanted.

And I notice in the budget there's an $8 million increase for the BLS, Bureau of Labor Statistics—do you know if you are going to restore some of the things that you used to do? Do you know anything about that?

Secretary SOLIS. Senator, I don't know specifically about the response with respect to your State, but certainly the monies that we are requesting will go into also helping to look at jobs in the green industry, but also looking at where we are not doing a good job in terms of gathering data on disabilities, on different populations.

And certainly, one of my concerns, as a former member of the House, was always wanting to have a quick response in terms of what our cities, our locales, what those figures were. And I can tell you in all honesty, that I would always look up in my local paper, what the local States have, because they typically have the best information. I know that our Bureau coordinates, but we need to have a better approach to having that more immediately.

So, I know I will be working very closely, I think this is something very important, and we do have to reconfigure what, I believe, some of the priorities are in the BLS. And of course, this is going to be a challenge, and we'll need to work closely on this.

Senator PRYOR. Great, thank you.

VETERANS' EMPLOYMENT AND TRAINING SERVICE

And the last question I had was about, something that's a follow-up to one of your earlier questions and your opening statement, the Veterans' Employment and Training Service—you have the request

of $225 million. Do you feel like that's sufficient, given the fact that we have so many folks coming back from Iraq and Afghanistan and given the tempo that the military's been at, recently. Do you feel like that $255 million is sufficient?

Secretary SOLIS. Senator, I want to be as honest as I can. I still have yet to be able to place my leadership team together in that particular unit, so I'm awaiting that. But my personal commitment is that we need to do everything we can to coordinate with other Federal agencies. We certainly have a key component in helping to help folks that are coming back to get back into their job, and we're finding that a lot of veterans are not being re-employed. That is going to, obviously, take a lot of effort, and hours to do that.

But we also want to expand how we work with veterans and with their families and their spouses. That's an initiative that the President's wife, Michelle Obama, is also taking on, which I take very seriously.

So, I want to try to integrate as many things as I can with the current resources and the other agencies that can help us do that. Because it's going to—it's going to require what I would say are more wrap-around services, to really help address the issues of these returning soldiers.

So I agree with you, this has to be a priority, and we'd like to work with you to see how we can really formalize a good program, because this is going to be ongoing.

PREPARED STATEMENT

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

[The statement follows:]

PREPARED STATEMENT OF SENATOR MARK PRYOR

Thank you Chairman Harkin and Senator Cochran for holding this subcommittee hearing concerning the budget request for the United States Department of Labor.

I appreciate Secretary Hilda Solis appearing before this subcommittee today.

The Department of Labor is responsible for protecting wages and working conditions for 135 million workers in more than 7.3 million workplaces.

As the country faces its most profound economic downturn since the Great Depression, it is critical that we meet our responsibilities to unemployed workers and that we take the steps necessary to ensure that workers are trained or retrained in the skills that are needed to keep our country competitive.

I look forward to hearing Secretary Solis' testimony and having the opportunity to ask questions.

Senator HARKIN. Thank you, Senator Pryor.

FAIR LABOR STANDARDS ACT

Madam Secretary, in March I held a hearing on the Department's oversight of what we call the 14–C Program under the Fair Labor Standards Act. And this arose out of a terrible situation that was uncovered in my State of Iowa.

The 14–C Program, as you know, is a program that allows employers to pay subminimum wages—subminimum wages—to individuals with disabilities, especially individuals with intellectual disabilities—because they maybe can't produce as much. They have a program that allows them to pay subminimum wages; it's been in the law for a long time.

Now, here's what happened, though. In this situation which came to light, and it's been going on for many years, like 30-some years—individuals with intellectual disabilities, what we might call mentally retarded in the past, were hired by a company in Texas—Henry's Turkey Service. They were put on a bus and shipped to Iowa, to work at a Turkey plant in southeast Iowa. These were all men. They were then put up in a kind of a rooming house, which was an old abandoned schoolhouse, and they got up at 3 or 4 in the morning, got on a bus, went to work there at this plant. Many of them worked right alongside of the other workers, doing the same work that the workers were doing.

They were housed in this schoolhouse—I think the monthly rental on that whole school is, like, $600 a month, for the whole building. And yet each of these—how many were there? Twenty-some individuals, were charged $1,200 a month for their rent. And that was taken out of their pay—that was taken out of their pay.

And so this situation was uncovered, but that—the thing that was startling was not—was how bad this was, but the fact that it had gone on for years, and no one knew about it.

And then the more I dug into it, the more I found out. This company—their 14–C application had expired, and you have to get it renewed every couple of years. And it expired, and yet nothing was done—it just expired.

And so the hearing I held was on this issue of, how could this happen? And how many people is the country are we talking about? Is this just some isolated little incident that we don't need to change anything for?

Well, a GAO report I found out about indicated in 2001, (GAO–01–886) there were approximately 424,000 workers in America, paid subminimum wages. These are people with intellectual disabilities, mental retardation, most of them.

Well, it's also come to my attention that the Department of Labor—this Department of Labor—really has a minimal number of people working on this, and it's all done by paper. They send the paper out, the employer fills it out, sends it back in and says, "Yes, I'm under the 14–C Program," and that's it, then they file it, and that's it.

Federal inspectors had been at this plant once, some years ago, and nothing was done. It wasn't until a local worker, a State worker had uncovered this that it all came to light what was going on. People—some of these men had been working there for, like, 20 years, and had nothing to show for it—they had no retirement, they had no benefits, they had nothing. Some of them work in there every day, 8 hours a day, 40 hours a week, sometimes overtime, and some of them had, like $6 a month leftover. I mean, this was a scandal. And it just—you think, how could that happen in America?

Well, I tell you this story because it's something I want to work with you on, and we've got to get a better handle on this 14–C Program. And I'm developing some legislation. But I think there's a lot that can be done administratively on this, to tighten down and make sure that people who are applying for 14–C exemptions actually are doing what they say they're doing. That the people qualify,

and that they really are doing work at a reduced rate, you know what I'm saying, they're not as productive.

I'm not against the 14–C Program, don't get me wrong. It can be a good thing for a lot of people with severe disabilities to actually have some employment. But, obviously, if they can't produce much, then you pay them a little bit less—I understand that.

But, I wanted to make sure that they're actually—are they actually, really, so disabled that they can not make at least the minimum wage, or more, if you get my point.

Secretary SOLIS. Yes.

Senator HARKIN. Somebody has to make those determinations. It's all done by paper, now, we have no inspectors, going out there and checking up on this and finding out what's going on, so how widespread this is? I don't know. I just know from my 2001 report that there's approximately 424,000 workers at GAO.

So we need monitoring, and bring this up to ask you, and your Department to get people paying attention to this. I would like to come back with you on this to find out what it is, administratively, that you can do, and what it is that we need to do legislatively to fix this.

So I hope we can have cooperation on this, and also your attention to this one factor. These are the most vulnerable people in our society, and the fact that they can be treated like this is just unconscionable.

So, I hope we can work with you on that.

Secretary SOLIS. Senator, thank you for your comments, and I too was horrified when I read the article, and articles surrounding this issue.

And I know that in the last 8 years, we have not had sufficient investigators in the Wage and Hour Division, and hopefully our budget request will help us begin to address that, so we could put real bodies, real investigators out in the field, to look at these kinds of industries that take advantage of these most vulnerable populations.

And I want to thank you for your leadership in drawing to our attention the fact that we need to do more collaboration on the 14–C applications, along with trying to collaborate better with the Social Security Administration also, so that we can identify who these individuals are, and also who is drawing down the 14–C applications so that we do get rid of the bad actors, and that we send a strong message that this is not going to be tolerated.

So, I want to work with you on it, I'll be excited to hear what ideas you have surrounding the program.

Senator HARKIN. Okay, thank you very much, Madam Secretary.

Senator Pryor, do you have any more questions?

SENATE CONFIRMATIONS

Well, Madam Secretary, we have no more questions here, if we have other questions, we'll submit them in writing, but again, do you have anything that you want to draw our attention to, here, regarding your budget, that you think that we didn't cover that you would like to bring up?

Secretary SOLIS. Well, there is one concern that I have, and that is just that I know that we're a new administration, and it's hard

right now to process the number of people that we'd like to bring in to help with our leadership in our Department.

Yesterday, I was asked this question by Chairman Obey—he asked me, facetiously—how many people we have actually gotten through the process and confirmed by the Senate, and I could only tell him two, and one of them is sitting behind me here.

So, you know that we have a tremendous effort ahead of us, and we want to be able to show that we're working effectively, transparently, but also accountable to you. I would just ask, and urge, the members of the Senate, if you can pass that along, that would be appreciated.

Senator HARKIN. Well, do you have some pending up here, right now?

Secretary SOLIS. We do.

Senator HARKIN. How many?

Secretary SOLIS. Two, we have two.

Senator HARKIN. Two that are pending, right now?

Secretary SOLIS. Yes.

Senator HARKIN. Are they before our subcommittee? Not, I mean, not this subcommittee—the other committee I'm on.

Secretary SOLIS. Before the HELP Committee.

Senator HARKIN. The other committee I'm on, the HELP Committee, right?

Secretary SOLIS. Some of you have, yes, yes.

Senator HARKIN. They're pending before that?

Secretary SOLIS. Yes, before the HELP Committee. Yes.

Senator HARKIN. Two pending before the HELP Committee.

Secretary SOLIS. Any effort and energy would be much appreciated.

Senator HARKIN. Okay, we'll look at that.

Secretary SOLIS. Thank you.

Senator HARKIN. We'll see if we can get that done as soon as possible.

Secretary SOLIS. Thank you for your indulgence.

[CLERK'S NOTE.—Senator Inouye has submitted information about economic dislocation now taking place in American Samoa which will be inserted into the record.]

Mr. Chairman and Madam Secretary: I would like to draw your attention to the economic dislocation now taking place in a remote part of the Nation—American Samoa—which is often treated as an after-thought. As you are aware, the Congress, under Public Law 110–28 (May 25, 2007), increased the Federal minimum wage. At that time, investigation into unlawful lobbying activities learned of employment abuses by American garment manufacturing interests in the western Pacific. This led the Congress to include in Public Law 110–28 an immediate $0.50 cent increase of the hourly minimum wage in the Commonwealth of the Northern Marianas as of July 24, 2007 with an additional $0.50 cent increase every May 25 thereafter until the hourly rate matches the Federal rate of $7.25.

In the rush to legislate, the Congress applied the same mandate to American Samoa without much consideration at all. In so doing, the Congress ended the biennial administrative minimum wage increases for American Samoa and imposed on this territory the fixed increases set for the Marianas. Unlike the Marianas, American Samoa was subject to the minimum wage requirement in the Federal Fair Labor Standards Act of 1938. Recognizing the territory's developing economy, Congress had directed that the minimum wage in American Samoa should reach parity with the States "as rapidly as is economically feasible without curtailing employment." The Fair Labor Standards Act thus applied to American Samoa the same statutory process that had gradually raised the minimum wage in the Virgin Islands and Puerto Rico to match the regular Federal rate. Under this procedure, your De-

partment had adjusted the minimum wage rate in American Samoa every 2 years based on economic development in different sectors.

Public Law 110–28, however, scrapped this procedure and mandated annual increases without regard to economic sustainability in American Samoa. In a subsequent report to Congress your Department noted the fragile condition of economic development in the American Samoa. In view of the territory's level of development, the Department observed that the mandated wage increase for American Samoa is equivalent to imposing a $16.50 Federal minimum wage requirements on the States. Your Department diplomatically added: "General experience in the U.S. and elsewhere has shown that potential adverse employment effects of minimum wage increases can be . . . offset to some degree by an expanding economy that is generating net employment growth. In a declining economy, any adverse effects on employment will not be offset."

Although the Congress has ignored this report, the Department's assessment has proven all too accurate. The adverse employment effects are seen in the fish canning industry which directly and indirectly provides one-half to two-thirds of employment in American Samoa. This is particularly the case, since low-cost foreign competitors provide the same product at far lower prices. One canner in American Samoa has instituted severe employment cutbacks and the other canner will soon move its operations to a foreign country with lower costs.

I would like to submit into the record, a letter I recently received from Congressman Eni Faleomavaega, requesting emergency assistance for American Samoa. Under the American Recovery and Reinvestment Act of 2009, Congress appropriated funds and authorized your Department to deal with economic dislocations just as in this case. I, therefore, urge you and your Department to consider the economic adjustment American Samoa faces and to extend the necessary assistance authorized under the Recovery Act.

ENI F.H. FALEOMAVAEGA
AMERICAN SAMOA

COMMITTEE ON FOREIGN AFFAIRS
CHAIRMAN
SUBCOMMITTEE ON ASIA, THE PACIFIC, AND THE GLOBAL ENVIRONMENT
SUBCOMMITTEE ON THE WESTERN HEMISPHERE

COMMITTEE ON NATURAL RESOURCES
SUBCOMMITTEE ON INSULAR AFFAIRS
SUBCOMMITTEE ON FISHERIES, WILDLIFE AND OCEANS
SUBCOMMITTEE ON ENERGY AND MINERAL RESOURCES

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May 7, 2009

The Honorable Daniel K. Inouye
Chairman
Senate Committee on Appropriations
S-131
Washington, D.C. 20510

Dear Chairman Inouye:

Aloha Dan

I am writing to request your support of an emergency set aside of $20 million in the FY10 appropriations for soon to be displaced workers in American Samoa due to Chicken of the Sea/Samoa Packing's recent decision to close its tuna canning operations in the Territory by September of this year. Enclosed for your information is a copy of Chicken of the Sea's announcement made public on Friday, May 1, 2009.

While some have suggested that the cannery is leaving due to minimum wage increases, the company has made it clear that minimum wage is only one of many reasons that influenced its decision and, frankly speaking, I believe minimum wage was the least of its reasons, especially considering that the company is relocating to Lyons, Georgia where effective July 24, 2009, minimum wage rates are $7.25 per hour, compared to American Samoa's current rate of $4.26 and American Samoa's projected rate of $4.76 per hour effective July 2009.

Put another way, upon leaving American Samoa, Chicken of the Sea will immediately pay tuna cannery workers in Georgia almost twice as much as it paid Samoan workers, and this is disappointing given that Samoan workers spent the last 50-years making Chicken of the Sea one of the most profitable brands of canned tuna in America.

Yet, given our history with the tuna industry, I am not surprised. More than 50-years ago in 1956, Chicken of the Sea's once parent company, Van Camp Seafoods, actively lobbied the U.S. Congress to suppress wage rates in American Samoa. Commenting on the company's desire to pay Samoan workers 27-cents per hour as opposed to the then prevailing minimum wage rate of $1 per hour, Van Camp stated, *"The company has found that it takes from 3 to 5 Samoan workers to perform what 1 continental worker in the United States will do. It is therefore felt that this justifies a lower rate for Samoans."*

email: faleomavaega@mail.house.gov

Over 50-years later, Chicken of the Sea leaves American Samoa with the same attitude, justifying lower rates for Samoans while soon to be paying workers in Georgia almost double the money. Therefore, I am not one to believe the hype that minimum wage increases drove Chicken of the Sea to do business in another location. Truth is, Samoans have not received a significant wage increase for more than a decade, until the recent enactment of P.L. 110-28.

With the enactment of P.L. 110-28, I fully supported a one-time increase of 50-cents per hour for our Samoan workers. From the outset, I also opposed escalator clauses, or automatic increases, as mandated by P.L. 110-28, given the uncertainty of the economic status of the Territory. As you are aware, per the mandate of P.L. 110-28, the U.S. Department of Labor (DOL) conducted an 8-month study of the Territory's economy and concluded that automatic increases would be harmful, but the report was harshly criticized by Chairman Miller and Senator Kennedy for not addressing the issues raised in the law.

In response to the DOL's findings, Governor Togiola and, I with the support of the Fono, sought your assistance in 2008 and 2009 to include, in the omnibus or supplemental appropriations bills, language to eliminate escalator clauses. Regrettably, neither Senator Kennedy nor Chairman Miller would support your efforts or ours. This is why last year I also requested your support of a one-time set aside of emergency funds for American Samoa and CNMI to offset the automatic minimum wage increases. Unfortunately, it was not possible for this request to be supported by the House or Senate.

Now, with the announcement of Chicken of the Sea/Samoa Packing's closing, I am once more seeking your assistance in setting aside emergency funds for American Samoa. The reason for this request is because other factors including rising energy and fuel costs and the crash of the global economy are severely impacting any company's ability to do business in the Territory. Corporate greed and mismanagement are also factors that have affected both tuna canning operations in the Territory.

For years, StarKist and Chicken of the Sea have paid their executives top-notch salaries with benefits, but not once in our 50-year history has StarKist or Chicken of the Sea ever offered profit-sharing incentives or stock options to our workers. Instead, our cannery workers were given a case of wahoo at Christmas and a turkey at Thanksgiving and told that their wages must remain below the federal minimum wage rate.

While suppressing Samoan wages, both tuna canneries employed poor marketing strategies, in part, enabling Bumble Bee to become the number one selling brand of tuna in the country. In a December 9, 2008 meeting with Mr. Kim Jae-Chul, Chairman and CEO of Dongwon, who recently purchased StarKist for some $363 million, he informed Governor Togiola and I and other local leaders that figures showed a 20% decrease in production due to a 20% drop in sales after Dongwon took over from Del Monte, a drop that Del Monte officials who are managing StarKist through an agreement with Dongwon attribute to marketing reasons.

On Sunday, May 3, 2009, Chicken of the Sea executives went on Donald Trump's reality game show and asked a playboy model, a poker player, a country singer, and a comedian to come up with a new marketing jingle to promote the company's products. When a company has to turn to celebrity apprentices, not to endorse its products, but to re-write its marketing campaign, something has gone terribly wrong in the marketing department.

Since Samoan workers are not responsible for marketing or sales, my suggestion to both companies was to cut the jobs and benefits of those at corporate headquarters who are responsible for bottom line losses rather than the jobs and benefits of Samoan workers who are the backbone of the industry. Also, I suggest that both companies be honest with ASG regarding their reasons for job cuts and/or relocation. Both companies recently reported to the U.S. Department of Labor that the tuna market

is presently focused on sealed foil packages rather than traditional canned tuna. However, to my knowledge, neither cannery has shifted production in American Samoa from cans to pouches so that we could grow with the industry, and it is clear that the tuna industry as we once knew it in American Samoa is coming to an end.

So that American Samoa would be prepared for this day that years ago I warned would come, I encouraged our local leaders to put a plan in place to diversify American Samoa's economy, in accordance with the recommendations of the American Samoa Economic Advisory Commission which issued its historic report in 2002. In 1999, at my request, and at a cost of $600,000 from Congress, a U.S. Department of the Interior Secretarial Commission was established to examine American Samoa's economic condition and make recommendations to ASG and the Department of the Interior on how to diversify and expand American Samoa's economy. This was the first time in American Samoa's 100-year relationship with the United States that a Secretarial Commission was established.

This Secretarial Commission was supported by Presidents Bill Clinton and George W. Bush, chaired by the former Governor of Hawaii John Waihee, and administered by the U.S. Department of the Interior. Governor Togiola served as a commission member. I served as an ex officio member.

In conjunction with the people of American Samoa, the Commission, over about a two -year time period, developed an economic plan which offered specific recommendations on how to diversify the Territory's local economy based on the will of the people. In fact, over 8,000 people were surveyed at the request of the Commission by the American Samoa Community College. In April 2002, the Secretarial Commission issued its final report. To date, the U.S. Department of the Interior has failed to move forward on this plan and I must say our local government officials have also not acted.

This aside, at a minimum, I was hopeful that ASG would have required more of both tuna canneries as lease agreements were negotiated during the course of the past 20 years. I had especially hoped that ASG would have included at the heart of its lease agreements unemployment packages for our workers in the case of layoffs or closures.

After all these years, ASG has chosen not to participate in the federal Unemployment Insurance (UI) program. Under terms of the UI program, when eligible workers lose their jobs, the UI program may provide them with income support for 6 months based on certain calculations. These unemployment benefits are paid out of a federal trust fund. However, the money for the trust fund comes from taxes States impose on employers.

The State of Hawaii, for example, has protected its workers by taxing employers like Hawaiian Air. The State of Hawaii then sends a portion of those taxes to the federal government to hold in trust for workers who may become unemployed should Hawaiian Air lay off some of its workers. Once a worker is laid off, that worker can apply for unemployment benefits and the federal government will send that worker a check from the trust fund.

When workers in American Samoa get laid off, they are not eligible for UI benefits because ASG has not sent any money to the federal government to hold in trust for our local workers. Since ASG chose not to have the federal government hold money in trust for our workers, I am hopeful that ASG has held those funds in trust at the local level from the taxes it has collected from StarKist and Chicken of the Sea so that our workers can seek immediate relief and unemployment checks come September.

To supplement whatever local trust fund ASG may have in place, I am working with the federal government to see what additional benefits we can provide for our workers, including those who have legal status in American Samoa. But given that the federal government has spent the past 50-years subsidizing both tuna canneries, I am not sure how successful federal efforts might be. For the past two

years, my office worked to obtain a $33 million federal income tax break for both canneries at a time when the United States is faced with an unprecedented financial crisis. Prior to this extension, each cannery received over $5 million per year in federal tax breaks for almost 20 years, which equates to well over $200 million, not to mention the tax breaks they got for the 20 or so years preceding this.

It is also my understanding that ASG offers both canneries local tax breaks, the terms of which I believe should be made public and to which I have not been made privy. If, on the other hand, our local tuna canneries paid taxes to ASG, I am hopeful that these records will be made public so that our workers will know whether or not ASG set aside some of these funds in trust for our workers in case of unemployment. With the tuna canneries present in American Samoa for more than 50-years and extracting billions from our Territory, I am very hopeful that ASG established a local trust fund for our workers, and that our canneries paid taxes.

I have always believed our canneries should have been required to pay local taxes to help build our schools and medical facilities. I also do not believe our canneries should have ever been permitted to deny our workers' health care benefits. But every Special Industry Committee appointed by the U.S. Department of Labor to determine wage rates in American Samoa voted against our workers and in favor of the tuna canneries.

Despite the federal and local favoritism shown our canneries, Chicken of the Sea has now announced that it will leave American Samoa and make a $20 million investment to revamp an existing factory in Georgia. And despite having been provided every incentive to stay in American Samoa, Chicken of the Sea will now pay tuna cleaners in Georgia twice as much as the company ever paid our Samoan workers. As for the minimum wage increase our workers recently received, the increase equates to a raise of only ten-cents per hour every year for the past ten years. On this point, our people deserved better. At a minimum, our workers deserved equal pay to that of their Georgia counterparts.

Nonetheless, I deeply regret that I have to inform you of Chicken of the Sea's closure in American Samoa. In response to this bad news, I am hopeful that you will be able to set aside $20 million in the FY2010 appropriations bill to be used to provide emergency financial relief to affected workers and to offset higher energy, food, and fuel costs that will be associated with the plant closure. Given that more than 80% of American Samoa's private sector economy is dependent either directly or indirectly on StarKist and Chicken of the Sea which employ more than 5,150 people, or 74 percent, of the workforce, and also considering that *"a decrease in production or departure of one or both of the two canneries in American Samoa could devastate the local economy resulting in massive layoffs and insurmountable financial difficulties,"* I am certain that this request will be supported by our local leaders who I have copied on this letter.

I have also contacted the House Ways and Means Committee to request how we can bring ASG under the umbrella of the unemployment insurance program. If ASG has failed to establish a trust fund for our unemployed workers, then I am hopeful that Congress will step in and mandate that ASG establish such a trust fund for Samoan workers who deserve protection.

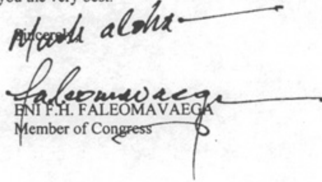
I am also contacting the U.S. Department of Labor to request national emergency grants. What the outcome of these requests will be, I do not know at this time because Samoa Packing's current workforce consists of 2,172 active employees of which 274, or 13%, are American Samoans, 87%, or 1,821 workers are Western Samoans, and 3.5%, or 77 employees, are other foreign nationals. The total payroll for all workers for the cannery including benefits annually is approximately $22-$23 million.

Before any action can be taken, I have been informed that ASG will have to certify the legal status of our workers at Chicken of the Sea/Samoa Packing. Even though most of our tuna cannery workers are from Western Samoa, many of them are married to U.S. nationals and U.S. citizens and, for

purposes of helping these families, I will ask Governor Togiola and the Fono to send me the necessary immigration documentation showing that these workers do have legal status so that we may move forward with a request for federal assistance.

I will also ask Governor Togiola what local measures ASG has in place to provide assistance for our workers since ASG opted out of the federal UI program. Whatever challenges we may face, I am certain that our people will pull together in this time of crisis. Even so, we would deeply appreciate your support as we work to build a bridge to a new future.

Next week, I will be meeting with Bumble Bee's top executive, Mr. Chris Lischewski, and I will keep you apprised of his insights and interests in American Samoa. In the interim, I thank you for your consideration of this request and wish you the very best.



ENI F.H. FALEOMAVAEGA
Member of Congress

Enclosure

cc:
Governor Togiola Tulafono
Lt. Gov. Faoa Sunia
President Gaoteole Palaie, and Senators
Speaker Savali T. Ale, and Representatives

ADDITIONAL COMMITTEE QUESTIONS

Senator HARKIN. The subcommittee will be submitting any additional questions for your response.

[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

WIA DISLOCATED WORKER FORMULA

Question. When comparing regular 2009 program year allocations with 2008 program year allocations, several States, including Iowa, will experience reductions under the Workforce Investment Act (WIA) Dislocated Worker formula. Iowa's unemployment rate is not as high as other States and began seeing job loss and increasing unemployment claims at the end of calendar year 2008 which has continued into 2009. However, under the 2009 program year allocations Iowa will receive a cut of 15 percent comparing the regular 2008 allocation with the regular 2009 allocation.

What is the Department's view of the current dislocated worker formula and whether it effectively targets resources to the communities and States most impacted by recent economic dislocations? What changes could be taken during WIA reauthorization to ensure that States have more certainty about the level of funding they will have from year-to-year, while more effectively targeting formula funds to States and local communities that are experiencing recent significant dislocations?

Answer. The WIA funding formula for dislocated workers was adopted from the one established under Job Training Partnership Act in 1982 and has not been revised since WIA's enactment in 1998. Although the formula focuses on targeting the funds to those States hardest hit by worker dislocations, wide fluctuations in funding amounts—such as those experienced with the program year 2009 allocations—are not good for the workforce system or the workers served by it. Features such as "hold harmless" or "stop gain" amounts could be built into the formula to moderate large fluctuations in funding on a year-to-year basis. A recent Government Accountability Office review provided Congress with several recommendations regarding WIA funding formulas. We look forward to working with the Congress through WIA reauthorization to examine these recommendations and other options for updating and improving the dislocated worker funding formula.

CONTRACTING AUTHORITY UNDER WIA

Question. The Recovery Act provided local workforce boards 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.

While it is still early in implementation of the Recovery Act, what has been the Department of Labor's (DOL) observation on the use of this authority? Does it provide an effective and efficient mechanism for providing support for training at the local level?

Answer. This provision was very well received by the workforce system. However, it is too early to determine the effectiveness of this provision since we do not yet have information on its use. We will be reviewing the effectiveness of this authority and its use as part of our overall evaluation of the implementation of workforce provisions under the Recovery Act.

WORKFORCE DATA QUALITY INITIATIVE

Question. The budget includes a request for $15 million for a workforce data quality initiative. Since 2003, the subcommittee has supported funding at the Department of Education for Statewide Longitudinal Data systems. The 2009 appropriations act and Recovery Act included the authority for the Department of Education to make awards under this program for systems that included postsecondary and workforce information and provided more than $300 million for this purpose. How is the Department of Labor working with the Department of Education to ensure that the grant application for awards under the Recovery Act incorporate a request for proposals that would integrate useful workforce information into these systems? Haven't States received grants for this purpose under the recent Department of Education competition? The budget request also mentions that the $15 million request would be available to undertake "activities to improve the quality and accessibility of performance data reported by training providers". What specific activities would be supported under such a grant solicitation and how much of the $15 million request would DOL reserve for such activities?

Answer. The Department of Labor has an active partnership with the Department of Education (ED) to assure that our respective initiatives are not duplicative and represent value-added investments in building longitudinal data systems that link education and workforce databases at the State level.

The Department of Labor (DOL) has already provided ED with information about the various workforce data systems that currently exist, as well as information about initiatives such as the Employment and Training Administration-supported Administrative Data Research and Evaluation project that uses longitudinal administrative data for employment and training research and analysis. DOL has also aided ED in shaping its ARRA-funded solicitation as it pertains to effectively linking workforce and education databases. DOL will engage in a similar consultation with ED as the solicitation for the Workforce Data Quality (WDQ) initiative is developed.

I am requesting $15 million for the WDQ in the fiscal year 2010 budget. The WDQ would focus on improving the quality of State workforce information and databases, so that workforce data are ready to be linked to educational data with funding provided by ED. Thus, the WDQ initiative would enhance, rather than duplicate, the Department of Education's investments. Specific activities that would be supported under the grant solicitation include the following:

—The WDQ would provide resources to help States promote improvements in the quality and accessibility of performance data reported by training providers. Consistent and accurate data from providers about the services they offer and how these services impact their customers when they enter the labor market are crucial to informing researchers and consumers. Activities funded by the grants might include technical assistance to training providers or the development of a user-friendly interface to help training providers more easily report information on employment outcomes.

—Grant funds may be used to enhance State workforce longitudinal administrative data systems by improving interoperability with education data or expanding the types of workforce data they contain. For example, Unemployment Insurance (UI) wage records, which are the primary source of workforce data, do not contain information on many Government or military employees, so some States have linked UI wage records to additional workforce data.

Other focus areas of the WDQ would be developed in consultation with the ED to avoid counterproductive duplication of content and to assure that the WDQ investment adds to the robustness of State longitudinal data systems.

DOL REVIEW OF EX-OFFENDER PROGRAMS

Question. The congressional budget justification indicates that the Department is conducting a thorough review of current grants for ex-offender programs and will develop, in cooperation with the Department of Justice, a detailed plan for fiscal year 2010 funding.

What were the findings from the DOL review of ex-offender programs? Specifically, what is the Department's proposal for allocating the requested funding for ex-offender activities? Please indicate which activities are new and what requested resources pay for continuation costs of current activities.

Answer. The Department has not yet completed its review of current ex-offender projects, but plans to complete its review in the next few months. Following its completion, we will coordinate with the Department of Justice to develop a detailed plan for fiscal year 2010 funding. As indicated in our congressional justification, we plan to continue funding both adult offender projects and youthful offender projects in fiscal year 2010. The Department is also considering a new grant competition to fund programs for juvenile offenders based on the civic justice corps model, which would offer youth paid opportunities for community service work along with intensive case management, life skills development, and job training.

TRANSITIONAL JOBS PROGRAMS

Question. The budget proposes $50 million to demonstrate and evaluate transitional job program models and requests the authority to transfer some or all of these funds to the Departments of Health and Human Services and Justice. Transitional jobs programs have been supported in part by Temporary Assistance to Needy Families, Food Stamp, Employment and Training, Child Support Enforcement, WIA, youth programs, prisoner re-entry funds, and a variety of other city and State funds.

Given that existing funding streams have supported and do support transitional jobs programs, what is gained by creating a new program to support transitional jobs? If there are limitations to the support for transitional jobs under existing programs, what changes in statute or regulation would need to be made to allow current funding streams/systems to more effectively support transitional jobs? What specific activities and corresponding dollar amounts would be involved in the requested transfer authority, if Congress were to appropriate funds as proposed in the budget request?

Answer. The Department of Labor recognizes that other agencies have supported transitional jobs programs and that evaluations have shown this to be a promising intervention. In the program year 2010 budget, the Department is proposing to model how services and resources available through the workforce system can be utilized to increase workforce participation, primarily for noncustodial parents including young parents. The Department plans to work collaboratively with other agencies, particularly the Department of Health and Human Services, to implement a rigorous demonstration and evaluation to determine which program model or models have the greatest impact on participants' employment outcomes. A designated funding stream for transitional jobs is important so that the demonstration can be structured to provide evidence of program impacts that will be helpful to policymakers.

The Department proposes using $50 million for this initiative from the Pilots, Demonstrations, and Research line item, as authorized by the WIA. The Department will use the majority of these funds for competitive grants to demonstrate new models and a smaller but significant portion to fund the evaluation.

MONITORING ONE-STOP ACCESS BY INDIVIDUALS WITH DISABILITIES

Question. Under work incentive grants which are proposed for elimination, the congressional budget justification states that "ETA is monitoring One-Stop Career Centers to assess access by and services provided to individuals with disabilities".

How many monitoring visits or contacts have been conducted to date, and how many are planned for program years 2009 and 2010? What has this monitoring found on the issues of access and services for individuals with disabilities, including specifically physical and programmatic barriers?

Answer. Part of the Employment and Training Administration's (ETA's) routine monitoring of grants, which includes Workforce Investment Act (WIA) and Employment Service funds, includes determining if grantees' locations and facilities are physically accessible and usable by disabled individuals. This monitoring is conducted throughout the country by staff in ETA's six regional offices. Monitoring is done using the ETA Core Monitoring Guide and ETA Grant Management Desk Reference as reference documents, and the monitoring is done both in the office (desk

audits, review of submitted reports, and provision of technical assistance), and on-site, periodically. Any findings related to accessibility are resolved through ETA's usual process of follow-ups and technical assistance. Historically, this approach has been successful but in a case where access continues to be problematic ETA would consult with the Department's Civil Rights Center to identify a resolution.

On-site monitoring visits are scheduled each fiscal year in a regional work plan, and the frequency of State visits is based, in part, on the availability of resources. Each State receives an in-person comprehensive review of all ETA programs every 3 years. Technical assistance is provided in response to requests, or in response to any identified deficiency in complying with Federal law or other program reporting or outcomes.

In program year 2009, ETA monitored 25 States and plans to monitor 23 States in program year 2010. A sample of local areas (at least two to three per State) are also reviewed in this process and visits to One-Stop Centers are made. ETA reviews 50–75 One-Stop Centers per year as part of this comprehensive review process. Accessibility is specifically evaluated on-site and any compliance problems would be documented in the review report prepared and submitted to the State. The regional office keeps all issues open until they are successfully resolved in accordance with Federal law and requirements.

Additionally, Regional Offices also monitor discretionary grants such as the Disability Program Navigator (DPN). Ten DPN grants were monitored in program year 2009 and 16 DPN grants are slated to be reviewed in program year 2010. Any issues detected with accessibility through these reviews at the One-Stop Centers would also be identified.

In program year 2010, ETA expects increased monitoring activity related to the Recovery Act. In preparation and as part of its technical assistance efforts related to implementation of the Recovery Act, ETA performed readiness assessments and consultations. Part of theses activities involved asking the States and territories if their One-Stops and all other service options were accessible to persons with disabilities. In response to this question, 51 of the 53 States/territories that responded stated that their One-Stops are accessible.

Beyond the Federal monitoring activities discussed above, WIA nondiscrimination regulations require State and local area recipients of WIA funds to designate Equal Opportunity (EO) Officers. These WIA recipients and EO officers have an independent obligation to process complaints, monitor compliance with nondiscrimination laws, and ensure violations are remedied. The Department of Labor's Civil Rights Center provides training to these State and local EOs during annual development conferences held in the Washington, DC area and various States.

Question. What actions has ETA taken or does it plan to take to address the documented fragmentation of services that has been found in a Government Accountability Office report?

Answer. I believe the report you are referencing is the Government Accountability Office (GAO) report on Federal Disability Programs (GAO 08–635) released in May 2008. This report found that individuals with disabilities often experience a fragmented Federal disability system. Although the report contained no specific recommendations for the Department of Labor, I agree that increased Federal coordination to better serve individuals with disabilities is extremely important and beneficial.

The Disability Navigator Program has successfully served as the Department's model for addressing such fragmentation of services by helping One-Stop staff identify the full spectrum of available Federal, State, and local resources and services for persons with disabilities and the employers who hire them. Seven years of dedicated funding for this pilot program have successfully demonstrated this approach to support more integrated service provision for persons with disabilities, and ETA is now taking steps to ensure that States and localities continue this approach as part of their regular One-Stop Career Center activities.

For fiscal year 2010, I have requested an increase of $10 million over fiscal year 2009 for the Office of Disability Employment Policy (ODEP). This increase will support a new initiative that builds upon the lessons learned by the Disability Navigators, and focuses on working with employers, the One-Stop system, labor-management organizations, and other stakeholders to vigorously promote the hiring, job placement and retention of individuals with disabilities, particularly youth, in integrated employment, apprenticeship, and pre-apprenticeship programs, and community service activities that help build skills for employment.

In their report, GAO also recommended that all Federal stakeholders and Congress work together to construct a process for developing a cost-effective Federal strategy that would integrate services and support to individuals with disabilities. I look forward to future opportunities to work with Congress and other Federal

agencies to consider steps to better coordinate and align services to individuals with disabilities.

Question. The congressional budget justification also states that "ETA expects to continue to see a significant increase in workforce service levels to job seekers with disabilities in the One-Stop Career Center system, even with termination of program funding." Specifically, what actions does ETA intend to take to make this statement a reality?

Answer. While the Department has recommended phasing out direct funding for this demonstration, it is actively working with States to utilize other Federal and State resources available to support the Navigator model, including Wagner-Peyser Act (Employment Service) funding, funding available for One Stop Career Centers to become Employment Networks under the Ticket to Work Program, and other sources. This administration remains strongly commitment to ensuring that individuals with disabilities receive the training and other support services that they need to obtain employment and succeed in the workplace. The Department recognizes that in an economic downturn and a tight labor market, individuals with more barriers to employment could be left behind. The Department is working to ensure all disadvantaged populations continue to have access to the resources of the public workforce system and benefit from the new infusion of resources provided by the American Recovery and Reinvestment Act. Some specific strategies include requiring States to specify how they will ensure disadvantaged populations continue to be a point of focus in modifications to their WIA and Wagner-Peyser Act State Plan that describe their Recovery Act strategies. In addition, we will provide ongoing technical assistance to the workforce system through webinars and other means and, in fact, have already produced a webinar with a focus on how to ensure individuals with disabilities are served with these new resources.

RE-EMPLOYMENT ELIGIBILITY ASSESSMENTS

Question. The 2010 budget request includes $50 million to continue support for Reemployment and Eligibility Assessments, an increase of $10 million over the fiscal year 2009 level. What is the current condition of State UI technology systems and how will these funds (and requested national activities funds) help improve improper payment prevention, detection and collection efforts?

Answer. States' UI technology systems vary widely. However, we know that many State systems are 30 or more years old, use outdated technology, and have been difficult to modify to accommodate the Emergency Unemployment Compensation program, the Federal Additional Compensation program, and payment of Extended Benefits in States where that program has not triggered on since the early 1980s. These older systems have also had difficulty in quickly expanding capacity to the extent needed to process current workloads.

The Department will use a portion of the requested funds to provide States the opportunity to implement technology-based systems that can help expand their capabilities to prevent, detect, and recover improper payments. Data matching systems, in particular, are a cost-effective method of preventing and detecting improper payments. These funds will allow States to enhance their current infrastructure and develop and implement new data matching systems to expand current capabilities.

A few examples of such integrity-related systems include: (1) data matching systems, e.g., the National Directory of New Hires, among both Federal and State agencies, which help States to detect unreported earnings while an individual is filing for UI (the largest cause of improper UI payments) and help to detect other issues that may impact UI eligibility; and (2) internal data matching such as matching/analyzing transaction data for patterns that may indicate improper action by agency personnel. These new systems and system enhancements can make the States' integrity-related activities more accurate, cost effective, and expeditious.

National Activities funds help States prevent, detect, and collect improper payments, primarily by supporting various activities, such as (1) the telecommunications network that links States with each other for data matching purposes as well interstate and combined wage claim processing; and (2) the use of new technology, such as the development and implementation of a State information data exchange system to support the electronic reporting of information from employers about why individuals no longer work for them, which is expected to improve the quality and timeliness of initial eligibility determinations based on the reason for an individual's job separation (incorrect initial eligibility determinations are the second largest cause of improper payments in the program).

ADMINISTRATION OF WORK OPPORTUNITY TAX CREDIT

Question. The 2010 budget request includes $18.52 million for administration of the work opportunity tax credit. The congressional budget justification notes that backlogs exist in a number of States.

Is the requested amount sufficient to keep pace with the recent expansions of the program that have been enacted by Congress and eliminate current backlogs?

Answer. The funding level has increased slightly, as shown in the table below. The Department will be monitoring the impact of the addition of two new target populations on workload.

[In thousands of dollars]

Fiscal year	Funding
2005	17,856
2006	17,677
2007	17,677
2008	17,368
2009	18,520

While the WOTC did not receive dedicated Recovery Act funds to assist with the new workload, States can choose to use Wagner-Peyser Recovery Act funds for this purpose, in addition to helping individuals find jobs and developing and delivering quality labor market and career guidance information.

In the meantime, we are working with States with the highest backlogs to determine their key challenges and tailor technical assistance to those States to address their backlogs, including peer-to-peer technical assistance on automation strategies for States that have not automated their processes and help in addressing any challenges they face in getting necessary verification information from partner programs who have the necessary data.

Question. What administrative actions and technical assistance will be provided to increase the timeliness of the certification process?

Answer. As a result of backlogs in many States that resulted from a variety of administrative challenges, including lengthy hiatuses in the program, and as a result of the two newly added targeted populations, the Employment and Training Administration is currently undertaking a comprehensive program review, including assessments of the current costs to run the program; whether the funding formula utilized is the appropriate one; and whether the reporting and data collection processes ensure that we have the best information for monitoring the program.

To support State implementation of the new Recovery Act provisions, in the immediate future we will conduct webinars on the new target groups authorized by the Recovery Act and the revised reporting forms for the program.

Question. Could ETA establish systems that would allow employers to file the prescreening IRS Form 8850 electronically?

Answer. A number of States have improved electronic systems that allow for more automated, streamlined processing. Many of these States have indicated that processing times have been significantly reduced by eliminating data entry and other time-intensive manual processes. However, other States have indicated that more updated automation processes are needed. ETA will review this and determine whether Federal assistance in electronic filing is warranted.

WAGE AND HOUR DIVISION

Question. The budget request includes $240.960 million for enforcement of wage and hour standards, which is an increase of $30.862 million and 288 Full Time Equivalents (FTE) over the 2009 level. What is the Department's plan (timeline and associated activities) for hiring these additional staff? How will the Department identify the geographic areas and industries in which to deploy these additional staff? How are community resources and community-based organizations engaged by the Wage and Hour Division (WHD) to ensure that workers are paid wages due them? What actions is WHD taking or planning this year and in 2010 to strengthen enforcement of the 14(c) provision of the Fair Labor Standards Act? What is the amount of resources dedicated to 14(c) enforcement in the current year and planned for 2010?

Answer. The WHD enacted fiscal year 2009 budget represents a $17,434,000 increase over the fiscal year 2008 enacted level and increases the agency's FTE ceiling from 1,208 in fiscal year 2008 to 1,283 in fiscal year 2009. In order to reach the 1,283 FTE ceiling for fiscal year 2009, WHD is hiring 170 new staff which includes

162 new investigators. These new hires should be on-board before the end of fiscal year 2009.

A number of key factors were used to determine how to allocate these additional staff among WHD's five regions. Those criteria included:

—The rate of attrition over the last 8 years;
—The percent of directed investigations in low-wage industries;
—The percent of total incoming complaints;
—The percent of low-wage minimum wage violations;
—The percent of low-wage overtime wage violations; and
—The strength of State laws and State law enforcement.

In addition, WHD is now hiring an additional 116 staff, 100 of which will be investigators, to ensure that contractors performing work on American Recovery and Reinvestment Act (ARRA) projects are in compliance with the applicable prevailing wage laws. WHD will use trained and experienced investigators for ARRA-related enforcement and compliance assistance and will charge their related costs to the ARRA funding. This, in turn, will allow WHD to finance the 100 new investigator positions. These new investigators are allocated to WHD offices by State in proportion to the number of estimated jobs created and/or saved by ARRA funding. We expect these new hires to be on-board no later than mid-September 2009.

The President's fiscal year 2010 request includes an increase of $30,862,000 and 288 FTE, the large majority of which will be investigators. The requested FTE ceiling is 1,571. Given the ongoing fiscal year 2009 and ARRA hiring, WHD will be close to the fiscal year 2010 ceiling early in the fiscal year. If the fiscal year 2010 requested FTE ceiling is not enacted, WHD will slow attrition hiring to ensure that it stays within fiscal year 2010 FTE ceiling. The fiscal year 2010 requested increase in FTEs will bring WHD back to pre-fiscal year 2001 investigator staffing levels. WHD will use the same criteria in fiscal year 2010 as it uses in fiscal year 2009 to allocate additional staff in the five WHD regions.

The President's request also includes resources to help WHD continue the revival of customer service by supporting improved complaint intake and more in-depth complaint investigation processes and resources to strengthen enforcement on behalf of vulnerable workers. If enacted, the budget will allow WHD to increase its coordination with stakeholders such as community organizations and employ other strategies that will improve its customer service.

WHD has spent investigative, administrative, training, and educational resources over the last several years in an effort to increase employer compliance with the Fair Labor Standards Act (FLSA) section 14(c) program. Section 14(c) certified employers represent less than 0.07 percent of the approximately 7 million FLSA covered workplaces in the United States.; however, they represent 0.56 percent of WHD investigations of employers conducted each year and 2.17 percent of all directed or noncomplaint based investigations conducted each year. Over the last several years, WHD's regional and district offices have developed enforcement and education initiatives to promote compliance with this program within their respective geographic areas. On average over the last 5 years, WHD has conducted more than 180 section 14(c) investigations. Those efforts will continue in fiscal year 2010 as WHD plans to repeat the investigation-based compliance survey of section 14(c)-certified employers to determine if compliance among section 14(c)-certified employers has improved over the 2002 levels.

NATIONAL EMPHASIS PROGRAM ON RECORDKEEPING

Question. The 2009 appropriations act included additional funds for OSHA to explore and address an apparent lack of completeness of the OSHA Log of Work-related Injuries and Illnesses. The congressional budget justification indicates that a National Enforcement Program (NEP) on Recordkeeping is currently under development. When will this NEP be issued and implemented, and how will these additional funds be utilized? How much funding is included in the 2010 budget request to continue this work or initiate additional activities? What activities will this funding support?

Answer. The NEP is currently under National Council of Field Labor Locals (NCFLL) review, generally the final step in the review of NEPs before implementation, and is expected to be in place by August 1, 2009. The NEP is designed to identify underrecorded and misrecorded injuries and illnesses in selected establishments, and to enforce the agency's recordkeeping requirements. The Bureau of Labor Statistics, which is producing its own report on the potential underreporting of injuries and illnesses, was consulted during the drafting of the NEP.

In fiscal year 2009, OSHA will dedicate the $1,000,000 provided in the agency's appropriation to improve recordkeeping enforcement. Beginning in fiscal year 2009,

OSHA plans to conduct at least 350 programmed inspections over the course of the NEP—a significant increase over historical inspection totals—to investigate the accuracy of the information employers are required to record on the OSHA 300 log. The agency will issue citations and penalties, as appropriate, for recordkeeping violations found as a result of the inspections conducted under this NEP in fiscal year 2009 and future years. The NEP will target establishments that operate in historically high injury and illness rate industries, as identified by the Bureau of Labor Statistics, but have reported low rates of injuries and illnesses. The program will also include establishments in the construction and poultry processing industries, due to the inherently high-hazard nature of the work in those industries, and due to questions that have been raised regarding recordkeeping practices in those industries.

Assessments of the accuracy of establishment-specific recordkeeping data will include interviews with employers, employees, company recordkeepers, first-aid providers, and healthcare providers; the assessment will also include a review of relevant records and documentation, such as medical records, workers' compensation records and first-aid records.

As part of this initiative, OSHA will also provide more intensive training to its Compliance Safety and Health Officers (CSHOs) on identifying potential problems in recordkeeping data and systems through a mandatory course on recordkeeping. The agency's Training Institute staff are beginning to revise the core curriculum for CSHOs to include a week-long rigorous training course. The agency will direct necessary resources for inspections and to fully train its compliance staff in fiscal year 2010.

OSHA will also evaluate the NEP to determine what steps or measures and additional resources, if any, are needed to improve recordkeeping.

HIRING AT OSHA

Question. The budget request includes $19.569 million for safety and health standards, which is an increase of $2.365 million and 20 FTE over the 2009 level. What is the Department's plan (timeline and associated activities) for hiring these additional staff?

Answer. The agency will build on its aggressive hiring efforts in fiscal year 2009 to jumpstart the hiring of positions in fiscal year 2010, and is ready to move on the first day that fiscal year 2010 appropriated funds are available to begin filling all additional standards positions. The agency has historically realized significant interest from highly qualified applicants for employment opportunities for these positions, which has also been evident in the current fiscal year. In terms of recruitment and hiring, the agency is prepared to fill vacant positions with the aid of announcements that are published in various trade journals and other professional publications, as appropriate, and is working with the Department's Civil Rights Center to identify other venues where potential applicants may be present. Announcements are also strategically shared with the various colleges, universities, and professional associations whose students and members have the desired skills and abilities for the specific positions. OSHA will also make use of various human resource authorities and strategies, such as recruitment bonuses and student loan repayment, as appropriate, to meet hiring needs.

Question. The budget request includes $227.149 million for Federal enforcement, which is an increase of $29.203 million and 160 FTE over the 2009 level. What is the Department's plan (timeline and associated activities) for hiring these additional staff?

Answer. OSHA plans to build on fiscal year 2009 and Recovery Act hiring to jump-start the hiring of fiscal year 2010 enforcement personnel. The agency is ready to move on the first day that fiscal year 2010 appropriated funds are available to begin filling all additional enforcement positions. The majority of these FTE are compliance safety and health officer positions distributed across OSHA's 10 regional offices through assessing need by the injury and illness rates of industry sectors and number of covered establishments in those sectors. The agency will make full use of various human resource tools, including Federal Career Intern appointments, recruitment bonuses and student loan repayment, as appropriate, and work with professional organizations, colleges and universities to reach interested and qualified candidates. In addition, the agency plans to seek qualified candidates for enforcement positions that will address the increasing need for bilingual language skills by participating in job fairs and utilizing OSHA information booths to promote job opportunities in the agency.

SEVERE VIOLATORS ENFORCEMENT PROGRAM

Question. In March of this year, the Office of Inspector General (IG) issued an audit that raised several issues with the Enhanced Enforcement Program (EEP). Is the Severe Violators Inspection Program a replacement for the EEP? If so, how will this new program incorporate the best of the EEP as well as the IG findings into account in designing this new program? How will this request enable OSHA to move forward on ergonomics-related enforcement activities?

Answer. OSHA's EEP will be replaced with a new program that is now tentatively called the Severe Violators Enforcement Program (SVEP). The agency has created a task force composed of regional administrators, two deputy regional administrators, Department of Labor attorneys, and OSHA's Directorate of Enforcement Programs staff, among others. The task force met in May 2009 to begin designing a new program to address certain employers and known, often-found hazards. The task force will continue to work on creating the SVEP and determining how to implement the program. OSHA expects to issue a field directive for the new program by the end of this summer.

The SVEP will not be especially linked to ergonomics-related enforcement activities, except in instances in which employers with ergonomic hazards at their worksites are identified through the Task Force's criteria.

SURVEY OF OCCUPATIONAL INJURIES AND ILLNESSES

Question. The 2009 appropriations act included additional funds for Bureau of Labor Statistics (BLS) to explore and address a potential undercount of injury and illness data.

How much funding is included in the 2010 budget request for BLS to continue this work or initiate additional activities? What activities will this funding support?

Answer. The 2010 request includes $1.3 million for the continuation of activities regarding a potential Survey of Occupational Injuries and Illnesses (SOII) undercount in three areas: matching research, employer interviews, and a multiple data source pilot. Results for all three of these activities, begun in 2009, will be ready by 2012 with interim results available on some topics earlier.

—*Matching Research.*—This work includes matching SOII data with workers' compensation data to understand what types of workers' compensation cases do not appear in BLS data. Most of the matching will take place in 2010 and early 2011, with BLS and the States conducting further research into the types of injuries and illnesses that are in the workers' compensation records, but not in the SOII, beginning in 2010.

—*Employer Interviews.*—Sampled employers will be interviewed about factors that affect recording cases on OSHA logs and the filing of workers' compensation claims. The interviews will focus on certain areas where recordkeeping might be difficult or unclear. Establishments will be selected for interview (partly based on the results of the matching research described above) in 2010 and 2011.

—*Multiple Data-source Pilot.*—BLS plans to work with a small number of State partners to pilot the use of multiple data sources to enumerate two types of injuries: workplace amputations and carpal tunnel syndrome cases that, unlike amputations, are less clearly linked to the workplace. The data gathering and analysis will begin in 2010 and extend through 2011.

For additional information on these topics, please see the recently submitted letter report.

PROGRAM DIRECTION AND SUPPORT

Question. The budget increase includes $34.125 million for program direction and support (PDS), an increase of $11.294 million over the 2009 level. This increase includes $2.35 million for the Office of the Recovery for Auto Communities and Workers. How much is being spent for the Office in 2009 and from what funding source? Please identify the PDS offices that will be supported with the balance of increased funds in 2010 and explain why such a large increase is needed.

Answer. The Office of the Recovery for Auto Communities and Workers budget for fiscal year 2009 is budgeted at $710,000 and eight staff. Because of the severe constraints facing the PDS activity in fiscal year 2009, this fiscal year, we are sending an addendum to the American Recovery and Reinvestment Act Operating Plan to use funds appropriated to Departmental Management (DM) under Public Law 111–8. This program will be entirely funded from Recovery Act dollars in fiscal year 2009.

In fiscal year 2010, $2.35 million is requested to annualize operations begun in fiscal year 2009 as well as expand the program to meet anticipated needs of this industry and associated community impacts. The balance of the increase is associated with restoring the PDS activity back to the basic level of funding needed for each office that is funded through this activity (i.e., the immediate Office of the Secretary, Office of the Deputy Secretary, Office of Congressional and Intergovernmental Affairs, Office of Public Affairs, Office of the Assistant Secretary for Policy, Office of Public Liaison, Office of Faith-Based Programs, and Office of Small Business Programs).

In fiscal year 2008, Congress enacted a $5.3 million (18.7 percent) reduction to the PDS budget activity, compared to the fiscal year 2007 funding level. To partially restore funding and provide for adequate policy direction, the Department reprogrammed $3.506 million from other DM budget activities. In fiscal year 2009, Congress enacted a budget for PDS equal to the fiscal year 2008 level. The fiscal year 2009 enacted funding level for DM PDS represents the lowest level of funding for this activity since 1999. Adjusted for inflation, the enacted level is the lowest level ever for PDS going back to fiscal year 2003. To address this problem in fiscal year 2009, the Department is executing a reprogramming within the DM account to shift $3 million to the PDS activity.

Historically, PDS funding supports 130–150 FTE. While this level has varied from year-to-year since fiscal year 1993, the fiscal year 2010 President's budget request supports this historical trend by including 152 FTE for this budget activity.

OFFICE OF THE SOLICITOR

Question. Please provide a breakdown of legal services workloads by office, as well as the 2009 and 2010 request Office of the Solicitor (SOL) staffing levels by office. At the 2010 request level for the SOL, matters pending under both the litigation and opinion/advice workload increase over the 2009 level. Why, and what is the impact of these pending levels?

Answer. *Legal Services Workloads by SOL Office*.—Submitted with this response is the breakdown of the entire legal services workload for all clients by each SOL division, region, and subregional office for the period from fiscal year 2005 through May 31, 2009, as reflected in the hours recorded by attorneys and paralegals. These figures do not include senior managers and administrative support staff, who do not record work hours in the SOL time distribution system. Also, included is a tabulation of the number of Mine Safety and Health Administration (MSHA) cases received by SOL's various regions and divisions and hours recorded by attorneys and paralegals on MSHA matters during fiscal year 2008 and the first two quarters of fiscal year 2009.

LITIGATION MATTERS

Office	Received					Concluded					Pending				
	Fiscal year 2005	Fiscal year 2006	Fiscal year 2007	Fiscal year 2008	Fiscal year 2009[1]	Fiscal year 2005	Fiscal year 2006	Fiscal year 2007	Fiscal year 2008	Fiscal year 2009[1]	Fiscal year 2005	Fiscal year 2006	Fiscal year 2007	Fiscal year 2008	Fiscal year 2009[1]
ARLINGTON	971	1,687	1,151	1,764	822	1,131	1,012	1,314	1,060	659	1,134	1,920	1,675	2,387	2,668
ATLANTA	1,013	986	818	1,330	649	1,101	1,080	1,000	913	545	781	766	680	1,124	1,232
BLLLS	1,018	931	1,316	873	623	1,167	1,000	1,178	1,206	643	867	800	1,061	722	770
BOSTON	604	548	709	677	351	858	564	523	720	400	670	679	891	833	800
CHICAGO	1,066	1,110	900	1,102	545	1,077	1,105	808	902	663	746	569	694	813	772
CLEVELAND	766	642	526	523	352	853	728	507	607	316	400	357	407	317	352
CRLM	193	150	117	142	107	308	254	147	144	95	236	134	130	120	127
DALLAS	1,236	1,034	1,062	1,181	730	1,248	1,068	1,014	1,025	865	725	736	741	786	719
DENVER	493	506	457	887	310	421	500	355	759	342	368	376	510	619	613
ETLS	367	202	272	444	446	301	410	742	345	346	902	622	210	270	359
FEEWC	277	301	306	222	159	246	313	337	225	137	510	491	344	269	280
FLS	88	94	56	47	22	41	92	40	47	12	254	185	217	205	189
HONORS	72	43	52	41	54	18	....	200	....	....	236	269	126	162	216
KANSAS CITY	692	621	540	887	419	636	716	549	535	475	420	275	310	712	601
LOS ANGELES	462	411	328	422	149	420	431	375	271	161	233	2,895	197	319	301
MALS	68	200	107	37	37	97	187	150	105	20	200	170	129	108	77
MSH	370	285	240	319	163	190	214	476	395	205	524	593	363	190	224
NASHVILLE	1,375	1,514	1,412	2,020	1,008	2,855	1,853	1,787	1,583	966	1,943	2,069	2,111	2,533	2,764
NEW YORK	1,090	1,170	894	1,061	743	1,097	1,172	1,096	1,023	790	631	674	572	592	595
OLC	6	....	....	....	....	27	....	100	....	....	102	102	1	1	1
OSH	105	167	191	167	62	115	77	178	171	17	80	181	186	131	172
PBSD	322	413	270	119	123	348	506	104	317	161	480	375	449	221	170
PHILADELPHIA	1,168	1,129	1,074	1,567	821	1,055	1,035	1,145	1,138	815	725	803	731	1,117	1,057
SAN FRANCISCO	643	722	643	755	338	591	754	539	698	334	384	328	488	530	553
SEATTLE	419	355	312	472	210	440	424	289	318	242	221	180	253	357	351
TOTAL	14,884	15,221	13,753	17,059	9,243	16,641	15,495	14,953	14,507	9,209	13,772	16,549	13,476	15,438	15,963

[1] Fiscal year 2009 actuals through 5/31/09.

Note: *Litigation.*—The process of resolving legal controversies through a court of law or adjudicative administrative board.
Matter.—Something for which the receiving office has demonstrated responsibility (i.e., is authorized to take action) for providing legal services and which is referred from any source for possible action.

OPINION/ADVICE MATTERS

Office	Received					Concluded					Pending				
	Fiscal year 2005	Fiscal year 2006	Fiscal year 2007	Fiscal year 2008	Fiscal year 2009[1]	Fiscal year 2005	Fiscal year 2006	Fiscal year 2007	Fiscal year 2008	Fiscal year 2009[1]	Fiscal year 2005	Fiscal year 2006	Fiscal year 2007	Fiscal year 2008	Fiscal year 2009[1]
ARLINGTON	19	24	11	7	20	15	24	16	6	13	7	9	6	6	14
ATLANTA	354	337	238	150	66	310	359	271	184	57	135	113	99	54	54
BLLLS	35	5	19	43	43	11	14	16	29	23	113	53	22	37	51
BOSTON	80	70	49	68	33	84	96	40	85	41	74	49	65	47	43
CHICAGO	195	259	137	163	137	171	259	208	159	125	110	91	29	22	37
CLEVELAND	34	31	38	29	9	37	45	31	35	11	14	3	18	11	5
CRLM	751	486	483	479	330	695	668	502	470	286	301	103	118	157	132
DALLAS	245	125	92	154	100	232	123	92	161	103	73	69	64	32	30
DENVER	34	10	114	118	77	39	14	91	116	72	18	16	53	66	51
ETLS	808	658	542	656	526	545	861	859	688	374	708	548	295	259	346
FEEWC	468	393	643	590	328	419	393	670	576	214	190	134	181	132	206
FLS	914	793	654	668	310	633	785	693	570	189	1,036	565	638	732	723
HONORS	96	14	16	14	28	15	....	578	....	....	641	605	44	57	87
KANSAS CITY	194	282	211	188	133	128	301	193	147	83	124	65	95	184	182
LOS ANGELES	4	5	5	5	4	5	4	6	5	2	1	120	3	....	2
MALS	782	802	1,250	1,378	880	355	837	2,284	1,374	367	2,124	2,068	1,079	1,566	1533
MSH	278	258	351	388	343	245	60	1,245	483	208	1,146	1,344	438	357	454
NASHVILLE	92	121	91	103	64	68	86	117	82	53	44	74	62	63	78
NEW YORK	91	150	99	135	85	56	132	104	94	92	62	66	52	121	72
OLC	610	644	683	764	272	85	4	9,541	192	102	9,011	9,653	814	1,376	1531
OSH	1,484	1,228	1,088	1,168	739	1,295	950	1,120	1,321	509	436	674	445	219	432
PBSD	515	473	543	549	385	502	502	612	658	311	112	59	105	103	186
PHILADELPHIA	77	78	85	63	53	75	86	86	63	56	22	12	23	25	11
SAN FRANCISCO	110	163	103	84	64	119	138	99	70	59	34	41	43	56	65
SEATTLE	14	46	29	16	10	15	41	29	11	16	2	6	5	9	5
TOTAL	8,284	7,455	7,574	7,980	5,039	6,154	6,782	19,503	7,579	3,366	16,538	16,540	4,796	5,691	6,330

[1] Fiscal year 2009 actuals through 5/31/09.

Note: *Opinion.*—The interpretations of law and regulations that SOL attorneys are requested to provide.
Advice.—A request (oral or written) for information from the general public or client agency relating to a specific matter of law.
Matter.—Something for which the receiving office has demonstrated responsibility (i.e., is authorized to take action) for providing legal services and which is referred from any source for possible action.

REGULATION MATTERS

Office	Received					Concluded					Pending				
	Fiscal year 2005	Fiscal year 2006	Fiscal year 2007	Fiscal year 2008	Fiscal year 2009[1]	Fiscal year 2005	Fiscal year 2006	Fiscal year 2007	Fiscal year 2008	Fiscal year 2009[1]	Fiscal year 2005	Fiscal year 2006	Fiscal year 2007	Fiscal year 2008	Fiscal year 2009[1]
ARLINGTON	....	....	....	....	....	....	....	....	....	....	....	....	....	....	....
ATLANTA	....	....	....	....	....	....	....	....	....	....	....	....	....	....	....
BLLLS	3	1	....	1	1	1	3	....	1	....	5	2	1	1	2
BOSTON	....	....	....	....	....	....	....	....	....	....	....	....	....	....	....
CHICAGO	....	....	....	....	....	....	....	....	....	....	....	....	....	....	....
CLEVELAND	....	....	....	....	....	....	....	....	....	....	....	....	....	....	....
CRLM	10	11	9	5	....	14	15	7	8	1	8	5	6	3	1
DALLAS	....	....	....	....	....	....	....	....	....	....	....	....	....	....	....
DENVER	....	....	....	....	....	....	....	....	....	....	....	....	....	....	....
ETLS	10	7	9	8	12	1	16	16	12	9	34	25	17	14	17
FEEWC	2	2	....	3	....	3	2	1	....	....	1	1	4	2	3
FLS	4	6	2	6	5	4	3	8	1	2	16	14	11	12	16
HONORS	9	9	2	5	2	2	....	18	....	....	18	27	11	16	18
KANSAS CITY	....	....	....	....	....	....	....	....	....	....	....	....	....	....	....
LOS ANGELES	....	....	....	....	....	....	....	....	....	....	....	....	....	....	....
MALS	4	....	....	1	....	1	....	20	3	....	23	23	2	3	....
MSH	15	10	13	12	7	6	....	41	17	21	55	65	39	36	16
NASHVILLE	....	....	....	....	....	....	....	....	....	....	....	....	....	....	....
NEW YORK	....	....	....	....	....	....	....	....	....	....	....	....	....	....	....
OLC	1	....	....	....	....	....	....	6	....	....	6	6	....	....	....
OSH	30	16	13	46	33	44	21	21	46	13	52	42	30	30	51
PBSD	43	41	44	39	5	40	35	51	33	6	24	27	27	26	22
PHILADELPHIA	....	....	....	....	....	....	....	....	....	....	....	....	....	....	....
SAN FRANCISCO	....	....	....	....	....	....	....	....	....	....	....	....	....	....	....
SEATTLE	....	....	....	....	....	....	....	....	....	....	....	....	....	....	....
TOTAL	131	103	92	126	65	116	95	189	121	52	242	237	148	143	146

[1] Fiscal year 2009 actuals through 5/31/09.

Note: *Regulation.*—All workload matters that are related to the development and promulgation of regulations and standards.
Matter.—Something for which the receiving office has demonstrated responsibility (i.e., is authorized to take action) for providing legal services and which is referred from any source for possible action.

CLIENT MSHA CASES RECEIVED

Office	Fiscal year 2008					Fiscal year 2009		
	Q1	Q2	Q3	Q4	Fiscal year total	Q1	Q2	Fiscal year to date
ARLINGTON	275	275	375	364	1,289	244	142	386
ATLANTA	67	201	145	138	551	67	56	123
BOSTON	12	27	49	22	110	8		8
CHICAGO	63	102	149	104	418	85	59	144
CLEVELAND		7	25	20	52	11	10	21
DALLAS	52	75	85	93	305	44	30	74
DENVER	172	262	196	206	836	122	56	178
FEEWC	4	2	1	1	8	2		2
HONORS							22	22
KANSAS CITY	11	93	166	39	309	38	13	51
LOS ANGELES	15	116	23	23	177	14	12	26
MALS	12	22	25	13	72	17	8	25
MSH	153	162	196	213	724	222	173	395
NASHVILLE	323	376	352	363	1414	325	268	593
NEW YORK	16	20	21	18	75	7	4	11
OSH						1		1
PHILADELPHIA	127	161	321	229	838	200	77	277
SAN FRANCISCO	57	61	84	65	267	39	17	56
SEATTLE	64	40	50	73	227	18	23	41
GRAND TOTAL	1,423	2,002	2,263	1,984	7,672	1,464	970	2,434

CLIENT MSHA HOURS CHARGED

Office	Fiscal year 2008					Fiscal year 2009		
	Q1	Q2	Q3	Q4	Total	Q1	Q2	Fiscal year to date
ARLINGTON	2,476.75	2,878.00	2,937.00	3,272.50	11,564.25	2,708.50	2,804.25	5,512.75
ATLANTA	835.50	847.50	880.75	1,111.00	3,674.75	1,004.50	797.75	1,802.25
BLLLS			.50		.50			
BOSTON	432.00	385.50	418.00	702.75	1,938.25	485.25	510.50	995.75
CHICAGO	1,343.25	1,692.00	1,894.50	2,438.50	7,368.25	1,674.50	1,674.50	3,349.00
CLEVELAND		79.00	220.50	297.50	597.00	286.25	290.25	576.50
CRLM		1.00			1.00			
DALLAS	978.00	819.75	1,257.50	1,171.50	4,226.75	857.75	1,041.50	1,899.25
DENVER	1,498.75	1,947.25	1,728.00	2,108.75	7,282.75	1,886.50	1,814.25	3,700.75
ETLS				6.75	6.75			
FEEWC	80.75	97.50	202.75	47.25	428.25	237.50	263.75	501.25
FO	.50		3.50	4.75	8.75	42.00		42.00
HONORS	.50				.50	63.75	468.50	532.25
KANSAS CITY	332.75	438.25	797.50	817.50	2,386.00	688.25	847.75	1,536.00
LOS ANGELES	174.00	234.50	407.50	387.25	1,203.25	290.75	309.25	600.00
MALS	160.25	195.75	251.25	153.25	760.50	570.75	755.25	1,326.00
MSH	7,752.50	8,627.75	9,189.25	9,457.25	35,026.75	8,265.75	8,256.25	16,522.00
NASHVILLE	2,816.25	3,742.00	3,146.25	3,286.25	12,990.75	3,513.75	2,985.50	6,499.25
NEW YORK	220.50	237.00	265.25	345.25	1,068.00	217.25	84.75	302.00
OSH	.00	.00	1.00	.00	1.00	.25	.00	.25
PBS	40.00				40.00			
PHILADELPHIA	2,602.50	3,575.50	4,286.25	4,081.00	14,545.25	3,603.00	4,526.25	8,129.25
SAN FRANCISCO	1,170.25	1,035.25	1,117.25	1,132.00	4,454.75	1,005.75	925.50	1,931.25
SEATTLE	400.25	426.50	792.50	616.00	2,235.25	415.25	303.75	719.00
GRAND TOTAL	23,315.25	27,260.00	29,797.00	31,437.00	111,809.25	27,817.25	28,659.50	56,476.755

Fiscal Year 2009 and Fiscal Year 2010 Staffing Levels by SOL Office.—SOL is increasing its appropriated FTE level to a projected maximum of approximately 646 FTE by the end of fiscal year 2009, and further increasing to approximately 679 FTE during fiscal year 2010. These additional FTE are almost entirely attorneys and legal support staff dedicated to supporting the enforcement and other legal services required by the Department. SOL's fiscal year 2009 appropriation has enabled the agency to continue to pay for 22 additional FTE that were added in fiscal year 2007 and fiscal year 2008 in response to the dramatic increase in MSHA-related matters being received by SOL. As the result of an memorandum of understanding signed in October 2008 between MSHA and SOL, the level of SOL's MSHA caseload is stabilizing. This stabilization is enabling SOL's regions to provide more attention to MSHA's most important cases and needed legal enforcement support and other services to OSHA, EBSA, WHD, OFCCP, and other DOL agencies.

The current intention is that SOL's FTE complement will be assigned, as follows. The fiscal year 2010 assignments are tentative, and subject to further review.

SOL offices	Fiscal year 2008	Fiscal year 2009	Fiscal year 2010
Immediate office	....	10	8
Office of Legal Counsel	....	13	13
Honors program	....	7	15
National office divisions:			
Management and Administrative Legal Services	....	57	60
Black Lung Longshore Legal Services	....	29	30
Civil Rights and Labor-Management	....	33	34
Employment Training Legal Services	....	25	26
Fair Labor Standards	21	25	26
Federal Employees' and Energy Workers' Compensation	....	13	14
Mine Safety and Health	31	31	31
Occupational Safety and Health	33	36	37
Plan benefits security	35	40	42
Regions:			
Region 1—Boston	....	28	29
Region 2—New York	....	37	39
Region 3—Philadelphia	....	53	56
Region 4—Atlanta	....	53	57
Region 5—Chicago	....	47	48
Region 6—Dallas	33	36	
Region 7—Kansas City	....	38	39
Region 8—San Francisco	....	38	39

Note. Most of the enforcement and other litigation that supports ESA and OSHA takes place in the SOL regional offices.

Matters Pending.—The short answer to the query regarding the reason for, and impact of the continuing increases in "matters pending" projected for the end of fiscal year 2009 and of fiscal year 2010 is that although SOL expects to be able to conclude more matters during the same periods as the result of additional FTE, the number of "matters pending" is projected to increase at an even greater rate.

The impact is that SOL will continue to have to take action in those matters that more directly impact the strategies and goals of the Secretary and client agencies, and not attend to all pending matters. A more detailed explanation follows:

The category of "matters pending" represents the actual or projected number of legal matters that are pending in SOL at the end of a fiscal year. SOL calculates this workload statistic in each of the three primary categories of work that the agency performs: litigation, opinion/advice, and regulatory work. During the past several fiscal years (fiscal year 2007 and fiscal year 2008), SOL has experienced an actual increase in the number of pending matters in all three categories, as follows:

Matters pending	Fiscal year 2007	Fiscal year 2008	Fiscal year 2009	Fiscal year 2010
Litigation	12,826	17,200	19,949	22,468
Opinions/advice	3,948	4,737	5,175	5,518
Regulations	128	150	157	144

The "matters pending" category for any given fiscal year results from adding the total number of "matters pending" at the end of the prior fiscal year, plus the total "matters received" during the fiscal year, and then subtracting from that number the total "matters concluded" by SOL during the fiscal year.

Because SOL has experienced a growth in overall workload over the past several years, and because of increases in enforcement-related FTE in SOL's client agencies, as well as worker protection law enforcement activity, SOL initially projects continuing increases in this workload statistic for fiscal year 2009 and fiscal year 2010. The magnitude of the projected increases in this statistic have, however, been significantly influenced by another factor: the increase in SOL FTE during fiscal year 2009 from a current level of about 610 to approximately 646 by the end of this fiscal year; and an additional increase to approximately 679 FTE by the end of fiscal year 2010.

Because of these projected FTE increases, using fiscal year 2008 actual "matters concluded" as a base, SOL also projects that it will be able to conclude an additional 906 matters in fiscal year 2009, and an additional 3,299 matters in fiscal year 2010. While an inflexible correlation between output and numbers of FTE is not possible, due to the wide variation in the size and complexity of legal matters and the varying arrival dates of new FTE, this overall 12 percent increase in output between fiscal year 2008 and fiscal year 2010 corresponds with the 11 percent increase in FTE from the current level of about 610 to the projected level of 679 in fiscal year 2010. This increase in SOL's capacity to conclude matters has lowered the projected increase in "matters pending" at the end of fiscal year 2009 and fiscal year 2010.

However, because our projections regarding increased capacity resulting from increased FTE are not as large as the projected increases in workload, the agency still projects a net increase in the "matters pending" at the end of the current fiscal year, and fiscal year 2010.

The impact of this continuing increase in the projected work load for SOL will require the agency to work intensively with the Secretary and client agencies to ensure that SOL's resources are focused on the matters that are most significant in advancing the goals of the Department and its agencies. Put simply, SOL will continue to be required to "triage" matters so as to take action regarding those that are more critical to the successful achievement of the Secretary's goals and DOL agency strategies.

UPDATED WORKLOAD SUMMARY

	Fiscal year 2008 actual	Fiscal year 2009 target	Fiscal year 2010 target
Legal services:			
Litigation:			
Matters received	17,059	17,997	18,987
Matters concluded	14,507	14,870	16,506
Matters pending	15,438	18,565	21,046
Regulation:			
Matters received	126	139	139
Matters concluded	121	133	140
Matters pending	143	149	148
Opinion/advice:			
Matters received	7,980	8,419	8,882
Matters concluded	7,579	8,110	8,860
Matters pending	5,691	6,000	6,022
Budget activity total	94,900	108,364	125,226

FLEX-OPTIONS PROJECT AT THE WOMEN'S BUREAU

Question. In the congressional budget justification, the Department states that it intends to continue and improve the Flex-Options project at the Women's Bureau. How much is currently spent on this project and how much is included in the 2010 budget request? What has been the experience with this project and associated outcomes? What changes are being considered for the project?

Answer. Launched in 2004, the Women's Bureau Flex-Options project encourages business owners of all sizes and types to establish or expand workplace flexibility policies and programs such as telecommuting, part-time work, job-sharing, and compressed workweeks.

For fiscal year 2009, the Women's Bureau will spend approximately $2 million on the Flex-Options project and plans to spend a similar amount in fiscal year 2010. Flex-Options has the equivalent of over 12 FTEs, spanning national and regional office activities, dedicated to the project, as well as national and regional contractors who also support Flex-Options. The contracts, which total $200,000–$300,000 annu-

ally, help manage the website, create and distribute newsletters and a Flex-Options toolkit, as well as work with companies to set up flexible workplace options.

While the Department has not conducted an impact evaluation to determine the outcomes of the project (e.g., whether it increases the number of programs or employees that have access to new flexible policies/programs), the number of employers participating in the Flex-Options project has increased each year. Over the life of the project, Flex-Options has assisted over 800 employers in creating or expanding more than 1,800 workplace flexibility policies, affecting 1 million employees.

In addition to reaching out to more employers, the Bureau is also expanding outreach and educational efforts to State/local governments and university consortiums of employers to promote workplace flexibility as a way to achieve environmental goals (e.g., improved air quality) or meet economic challenges. In 2008, Flex-Options had successful partnerships with the cities of Houston and Atlanta to encourage city governments in supporting flexible workplace options. The Women's Bureau is continuing to work with local governments in 2009, as well as expanding to university consortiums in 2010.

Workplace flexibility is a powerful response to the needs of millions of women and men who face the challenge of trying to balance the demands of their jobs and the needs of their families. It is also a vital tool that progressive companies are using to get work done, and it is a tool that can be used as a strategic component of any workplace contingency plan.

ILAB FUNDING

Question. The Bureau of International Labor Affairs (ILAB) is requesting an increase of more than $5 million and 12 FTEs in the fiscal year 2010 budget request. To which ILAB office or offices and for what activities would ILAB allocate these additional staffing resources requested under the budget request? ILAB has approximately 140 projects in more 80 countries around the world. Does the requested increase provide additional funds/FTEs to oversee this significant investment of taxpayer resources?

Answer. ILAB's budget has been constrained in recent years, while its mandates have expanded significantly. This budget increase allows ILAB to more fully and effectively meet its responsibilities. One of the primary purposes of the increased funding and FTEs is to increase ILAB's capacity to address the implementation of the labor commitments in U.S. FTAs—an area that has not been adequately supported in the past. ILAB will also strengthen its oversight, monitoring, and evaluation functions and reinforce its research activities to ensure that ILAB reporting is more analytical and strategically useful to Congress and the public.

Roughly $1.56 million of the additional $5 million requested in fiscal year 2010 will be used to fund 12 new FTEs. The Bureau will hire comparative labor law experts, development and labor economists and international relations officers. The Bureau also plans to hire a career Associate Deputy Undersecretary to assist with the overall management and operation of the Bureau. ILAB will use about $2 million for monitoring, enforcement, and cooperative activities and $1.44 million for research and reporting.

The fiscal year 2010 funding increase ensures effective oversight of our extensive technical assistance programs to combat child labor and improve working conditions overseas, improved reporting on child labor, forced labor, human trafficking, and other core labor standards, and improvements in the labor diplomacy portfolio of the Bureau.

ILAB'S PROJECT PORTFOLIO

Question. In the 2009 appropriations act, Congress stated its intention for ILAB to have sufficient funding to effectively oversee, monitor, audit, and evaluate ILAB's project portfolio. How would the fiscal year 2010 budget request allocate funding to ensure that this priority is addressed, particularly in the child labor project portfolio which is the most significant part of ILAB's project portfolio?

Answer. The 2010 budget request includes additional funding and FTEs to ensure that ILAB has the resources needed to properly oversee, monitor, audit, and evaluate its ongoing technical cooperation programs, including those to combat exploitive child labor. ILAB's experience has demonstrated the importance of funding for such oversight in order for ILAB to assess project performance, take corrective actions where necessary, and as a result, to maximize the impact of the funding ILAB allocates for these projects. Funds requested in the fiscal year 2010 budget reflect ILAB's understanding of the actual costs associated with such oversight activities, and ILAB believes the requested level of resources will allow ILAB to fulfill its responsibilities related to program oversight.

ILAB FUNDING

Question. The congressional budget justification notes that ILAB plans to significantly improve its ability to monitor labor issues in Free Trade Agreement (FTA) countries, provide a strengthened mechanism for enforcement of trade agreements, develop cooperative activities with FTA partners, and research facts relating to specific labor situations and submissions. Please indicate what specific actions ILAB intends to take and how it will work with other Federal agencies to carry-out these activities? Does the President's budget include funding for other Federal agencies that will be transferred to ILAB in support of this effort? If so, how much funding is included in the budget request and for what activities?

Answer. The requested increase of $5,000,000 would enable ILAB to develop systematic monitoring and analysis of labor issues in FTA countries. It includes additional staff that has the expertise to collect, analyze, and engage with partner countries to address deficiencies in labor law and practice. It also includes resources to provide cooperative assistance to trade partners to address labor deficiencies, such as providing expert assistance from DOL or other recognized sources. Importantly, when engagement and cooperation are not sufficient, the additional resources would enable ILAB to pursue enforcement of the labor obligations of the FTAs, including use of dispute settlement provisions. The labor obligations of our FTAs should be enforced just as our commercial obligations have been.

In order to carry out these activities, ILAB will have the primary responsibility for conducting the proposed monitoring and analysis of labor issues. However, ILAB will work closely with labor officers in U.S. missions, and relevant staff at USTR, State, and other agencies. For example, the Department of Labor will take the lead in developing annual labor-related strategic plans of engagement for each FTA partner, which will be coordinated with USTR, State, and other relevant agencies to address labor issues in trade partner countries. On enforcement issues involving FTA obligations, ILAB will work closely with USTR on developing and pursuing dispute settlement cases. While these activities would represent a shift in focus to more active U.S. Government engagement on labor issues, the burden of the activity would rest with ILAB. ILAB would not be assuming functions that are already being carried out by other Federal agencies.

DEPARTMENTAL PROGRAM EVALUATIONS

Question. The 2010 budget request includes $5 million to, among other things, fund high-quality evaluations of its programs, including those outside of job training and employment. Specifically, what activities are under consideration for evaluation, if the requested funds are provided? How would the $5 million request be allocated among this initiative's activities, including new evaluations, high standards in evaluations funded by the Department, building evaluation capacity in the Department and making sure evaluations/research findings inform policymakers and program managers?

Answer. The $5 million for Departmental Program Evaluations is to conduct high-quality evaluations of DOL programs beyond job-training and employment services, which are currently evaluated using resources appropriated to the Employment and Training Administration. At this point, an evaluation agenda has not been finalized, but priority will be given to large, lightly examined, and/or high-priority programs. This effort could be focused on any of the worker protection agencies. There will also be an effort to ensure the rigor of evaluations Department-wide.

PERFORMANCE TARGETS FOR ODEP

Question. Under the budget proposal, the performance targets for the Office of Disability Employment Policy (ODEP) go down from the results achieved in fiscal year 2008. In the case of the number of policy-related documents, there is a reduction from 44 in fiscal year 2008 to 32 in fiscal year 2010; for formal agreements, the reduction is 26 in fiscal year 2008 to 22 in fiscal year 2010 and for effective practices the reduction is 37 in fiscal year 2008 to 23 in fiscal year 2010. What has been the impact of ODEP's policy documents, formal agreements, and effective practices? Do these document and agreements impact disability employment policies across the Federal Government? Will the Department explain why a reduction in performance is estimated for ODEP?

Answer. ODEP's annual performance output measures are designed to capture the annual results of the agency as it works to develop policy for implementation across the Federal Government that will reduce barriers to employment for people with disabilities. ODEP has been tracking effective practices since fiscal year 2004 and policy documents and formal agreements since fiscal year 2006. ODEP created out-

put measures that recognize that policy development often occurs across fiscal years. ODEP's annual targets are based on an average of 3 prior years of results, plus 10 percent. The targets are set with this formula to account for fluctuations in resources or other anomalies that could impact ODEP's performance. As it does every year, at the end of fiscal year 2009, ODEP will assess its performance and revise its annual performance output targets as necessary. Under its new leadership, ODEP also plans to revisit its performance measures.

Since its creation in fiscal year 2001, ODEP has developed policy documents, established a wide range of formal agreements, and identified, validated, and assisted with the replication of effective practices. These activities have helped to reduce barriers to employment that exist in workforce systems, workplaces, and in employment-related supports programs and services (e.g., transportation, healthcare, technology). ODEP's results have influenced policy and practice within the Department of Labor and across the Federal Government, State and local governments, nongovernmental organizations, and large and small businesses. A few examples of ODEP's work with regard to disability employment policies across the Federal Government over ODEP's history are included below.

ODEP's work with adult-focused workforce systems is exemplified by the development and implementation of the WIA section 188 Memorandum and Checklist. This formal agreement signed by the Department's Office of the Assistant Secretary for Administration and Management, ODEP, and ETA provided One-Stop Career Centers with measurable ways to comply with section 188 of the WIA and documented strategies for One-Stop Career Center staff and other workforce system personnel to more effectively respond to the needs of people with disabilities.

ODEP's work with youth-focused workforce systems is demonstrated by the Transition Programs and Services: High School/High Tech and Vocational Rehabilitation Information Memorandum (RSA–IM–07–08). This policy document was developed under ODEP's leadership in collaboration with the Departments of Health and Human Services and Education (OSERS/RSA). It provides information to State Vocational Rehabilitation agencies about ODEP's High School/High Tech program as a comprehensive transition program model with a number of promising practices that is based upon the Guideposts to Success, also developed by ODEP.

ODEP has worked to influence employer policy through the Office of Federal Contractor Compliance Programs (OFCCP) Directive, Transmittal Number: 281, OFCCP ORDER NO.: ADM Notice/Other—Federal Contractor's Online Application Selection System. This policy document, developed by ODEP's leadership in collaboration with OFCCP, provides guidance on enforcing section 503 of the Rehabilitation Act of 1973 and the Vietnam Era Veterans' Readjustment Assistance Act of 1974 (VEVRAA). It requires that all compliance evaluations include a review of the contractor's online application systems to ensure that the contractor is providing equal opportunity to qualified individuals with disabilities and disabled veterans.

Finally, a result of ODEP's effort and collaboration with the Bureau of Labor Statistics is the recent and historical publication of the unemployment rate for people with disabilities as part of the Current Population Survey. ODEP's leadership in collaboration with the BLS and the Census resulted in this significant accomplishment. This data will be used by agencies in the Department, other Federal agencies, and other stakeholders critical to addressing disability and employment issues.

DISABILITY NAVIGATORS INITIATIVE

Question. The fiscal year 2010 congressional budget justification indicates that a comprehensive evaluation of the Disability Navigators initiative is in the works and scheduled to be completed sometime around the end of 2010. Yet the budget proposes to establish a new $10 million Competitive One-Stop Grant program based on the lessons learned from the Disability Navigator program. Specifically, what lessons learned would the Department of Labor apply in this new program? Using what evaluation were these lessons learned?

Answer. Although the comprehensive evaluation of the Disability Navigators initiative will not be completed until late fiscal year 2010, the Department has identified numerous sources of interim data and other feedback to support moving to the next step for this critical effort. These sources include the ETA Forum on Disability Program Navigator (DPN) Initiative—Role and Impact (June 2009), and evaluations of ODEP's Customized Employment demonstration projects housed in One-Stop Career Centers that coordinated with Disability Program Navigators to ensure meaningful and effective service to customers with disabilities (Evaluation of Disability Employment Policy Demonstration Programs: A Synthesis of Key Findings, Issues, and Lessons Learned—Customized Employment Program Priority Area, WESTAT, October 2007; Employers and Workers: Creating a Competitive Edge, Summary Re-

port on Customized Employment Grants and Workforce Action Grants, National Center on Workforce and Disability/Adult, July 2007).

The DPN initiative has two purposes for ensuring that job seekers with disabilities receive meaningful service at One-Stop Career Centers. These include (1) the responsibility to ensure the appropriate provision of service to individuals, and (2) the responsibility to reach out to and coordinate with other systems and agencies identified under the WIA, as well as reach out to and coordinate with additional systems that provide specific service to people with disabilities. The overall goal is more effective coordination and integration of resources and customer support across multiple systems—an essential charge of the WIA and a critical need for people with disabilities.

In particular, based on available information the DPN initiative identified effective practices for serving people with disabilities that touch on all aspects of One-Stop operations: marketing and outreach; orientation; assessment; service coordination; service delivery; and business services. Central to these practices was the concept of the One-Stop as the hub of activity and support for workforce entry, securing needed supports and leveraging funding across multiple systems, and ensuring effective job placement. In their work, the navigators found that people with disabilities benefited from their expertise in navigating multiple social service systems. If a job seeker required assistance with transportation or housing, or assistance accessing needed Social Security or Medicaid benefits, the navigator often became the "go-to" person. Based on this preliminary evidence, there is a continued need to equip One-Stop Career Center staff to help individuals with disabilities navigate across service systems.

The case examples and informal feedback from the field have underscored the value of integrating the navigator function into One-Stop operations and the need for ETA to take the lessons learned to a national scale. ODEP is analyzing data and feedback on the DPN initiative and the agency's own external evaluations of projects housed in One-Stop Career Centers, to determine specific next steps in building a system responsive to the needs of job seekers with disabilities. A partnership between ETA and ODEP in this regard offers unique opportunities for the provision of national technical assistance and rapid dissemination of information to the field, as well as additional feedback based on the continued experiences of One-Stops as they develop effective and fully accessible services and facilities for all job seekers.

IMPROVING THE EMPLOYMENT PROCESS FOR INDIVIDUALS WITH DISABILITIES

Question. The 2010 congressional budget justification also indicates that "ODEP will partner with the Department of Education's Rehabilitative Services Administration and others to develop policy and effective practices to improve One-Stop employment outcomes for individuals with Disabilities." What specific actions would the 2010 budget request support? To date, what specific policies or practices has ODEP developed in support of this effort?

Answer. In 2010, ODEP will partner with the U.S. Department of Education's Rehabilitative Services Administration (RSA) and others to undertake a new $10,000,000 competitive grant program that will focus on One-Stops, and work with employers, labor-management partnerships, labor unions, and other stakeholders to improve the employment process for individuals with disabilities utilizing pre-apprenticeship and apprenticeship programs, and career-related community service opportunities. In developing this program, ODEP will build upon the lessons learned from the Disability Navigator Program, and other ODEP projects as they relate to effectively coordinating training and the delivery of other needed services to people with disabilities within the One-Stop system. In addition, ODEP will work with ETA to identify policies and practices that have proven effective in the development of meaningful partnerships with community-level partners that provide employment-related services to youth and adults with disabilities.

With regard to what specific policies or practices ODEP has developed in support of this effort, the following are noteworthy. ODEP collaborated with ETA in drafting and issuing a Self-Employment Training for Workforce Investment Act Clients—Technical Employment Guidance Letter (TEGL) 16–04 2005 describing the authorities provided by the WIA for One-Stops to provide entrepreneurship training and to identify resources that can support the efforts of people with disabilities to start businesses.

ODEP collaborated with DOL's ETA and its Civil Rights Center to jointly develop and issue the WIA section 188 Memorandum and Checklist. The checklist provides a uniform procedure for measuring compliance with those provisions of section 188 of the Workforce Investment Act of 1998 and the implementing regulations (29 CFR Part 37) that pertain to persons with disabilities for physical, programmatic, and

communication accessibility. Any technical assistance provided by ODEP to the One-Stops will use this checklist as a resource.

ODEP has worked with ETA's Office of Apprenticeship in 2009 to research, test, and evaluate innovative systems models for providing inclusive integrated apprentice training in a high-growth industry to youth and young adults with disabilities, aged 16 to 27, including those with the most significant disabilities, that utilize the increased flexibilities detailed in DOL's newly released apprenticeship regulations regarding the provision of training and interim credentialing. ODEP implemented a 6-year demonstration to advance customized employment in One-Stop Career Centers. Lessons learned from this initiative will be used to design the next step in creating a universally accessible workforce development system.

In the summer of 2009, ODEP and ETA's Office of Apprenticeship will issue a joint Training and Employment Notice. This notice will disseminate a white paper and toolkit developed through ODEP's research and technical assistance activities which focus on expanding apprenticeship opportunities for youth and young adults with disabilities. The white paper entitled Improving Transition Outcomes of Youth with Disabilities by Increasing Access to Apprenticeship Opportunities, which is geared to policymakers, provides an overview of the Registered Apprenticeship system in the United States, explores current trends in apprenticeship, and examines opportunities for youth, including those with disabilities. In addition, it identifies obstacles to expanding participation of youth with disabilities in apprenticeship programs and provides strategies for addressing these obstacles. The toolkit, entitled Youth with Disabilities Entering the Workforce Through Apprenticeship, is intended to provide service providers with useful information about apprenticeship as an employment strategy for youth and young adults with disabilities.

As the result of a 3-year ODEP-initiated effort with DOL's Office of Apprenticeship, and the Employment Standards Administration's WHD, the Office of Apprenticeship added language to their new regulations to allow apprenticeship programs to be customized to provide intermediate levels of certification for apprentices to demonstrate their level of proficiency in apprenticeable occupations.

In planned future activities, ODEP will build on its prior policy efforts to support entrepreneurs with disabilities through technical assistance and grants. ODEP will fund a workforce-systems focused cooperative agreement to support mentoring opportunities for young people with disabilities from minority communities who are transitioning from school (secondary or postsecondary) and interested in entrepreneurship. In developing this initiative, ODEP will partner with stakeholders in the public and private sectors, including minority Chambers of Commerce, and leverage existing resources on mentoring and entrepreneurship developed by ODEP. ODEP will also work with ETA to evaluate the physical and programmatic accessibility of the One-Stop Center system, and partner with ETA and Labor's Civil Rights Center as appropriate to address any identified deficiencies through the expansion and adoption of universal strategies, the provision of targeted technical assistance, and other corrective measures deemed necessary.

JOB CORPS OPERATIONS

Question. The budget indicates that $8 million of the $16.923 million increase for Job Corps will be for the opening of the Milwaukee Job Corps center, with the remaining $8.923 million for the remaining 123 Job Corps centers. is this amount sufficient to offset the rising costs of operating Job Corps centers?

Answer. The fiscal year 2010 request for Job Corps Operations is $1,557,199,000, an increase of $16,923,000 over the 2009 enacted level. This request will allow Job Corps to serve more youth than in 2009, support anticipated increases in fixed costs at centers, and fund cost-of-living increases for Federal staff at 28 Agency-operated centers. Only Federal employees at the Agency-operated centers are eligible to receive the federally mandated cost-of-living increases.

The fiscal year 2010 request supports 44,950 student slots-an increase of 495 over the 2009 targeted level. The request includes funding for additional slots at the new Milwaukee Job Corps Center, scheduled to open in program year 2010. The fiscal year 2010 request also provides increases for some critical activities including funding for workload increases for Outreach/Admissions and Career Transition contracts. It also supports the anticipated increases in fixed costs at centers, such as utilities and GSA vehicle rental, and includes sufficient funds for mandated cost-of-living increases for the Federal staff at the 28 Agency-operated centers. Job Corps remains committed to improving program efficiency without compromising the basic services, such as academic and career technical training, provided to our enrollees.

Additionally, Job Corps will use $36 million in Recovery Act funds to support critical IT infrastructure and operations needs. The Recovery Act funds designated for

green jobs training will allow us to realize operational savings in the areas of Career Technical Skills Training supplies and materials for hands-on training projects. It will allow the program to increase the provision of green jobs training so that at-risk youth who participate in Job Corps will be well situated to benefit from the new green economy.

Question. How will centers achieve the vision of building a standards-based education and training system under the budget request?

Answer. It will be a challenge, but the Department remains committed to improving program efficiency without compromising basic services, such as academic and career technical training, provided to our enrollees. While Job Corps' legislative mission remains the same—to educate and train promising youth to be productive workers and citizens—how Job Corps performs this mission is being significantly transformed. At the heart of Job Corps' new direction is the implementation of a Standards-based Education and Training System leading to industry-recognized credentials and certifications for students, staff, and programs, and the system-wide structural and organizational changes concerning professional development, policy, technology and related areas essential to achieving the transformation. Job Corps' transformation is occurring incrementally and over time in four phases. Job Corps has recently completed phase two, the development of 38 national Career Technical Training programs which have been revised and aligned with industry standards and certifications. In phase three, Job Corps will extend the implementation of these programs to all centers system-wide. By program year 2010, the Department of Labor expects Job Corps to begin phase four, the full-scale, nationwide implementation of a fully-tested, evidence-based National Model of standards-based education and training.

Question. Are there specific cost-savings or efficiencies that the Department believes can be implemented? If so, please explain what they are and how much can be save through these initiatives.

Answer. Job Corps intends to achieve cost savings and efficiencies through the use of energy efficient construction methods, fleet reduction and the increased use of alternative fuel vehicles. As a result, we estimate a savings of up to $5 million annually.

The recently awarded Iowa Job Corps Center construction project will utilize energy efficiencies such as a ground source heat pump, upgraded wall and roof insulation, lighting controls, high-efficiency lighting, Energy Star equipment, and low flow plumbing fixtures. By building to these specifications Job Corps estimates that annual energy costs at this center will be reduced by $82,000 annually compared to construction that does not incorporate these efficiencies.

Job Corps will gain vehicle efficiencies by simultaneously reducing the overall size of its fleet while increasing the number of alternative fuel vehicles (AFVs). Recovery Act funds are being used to purchase electric vehicles for use at each Job Corps center. These American-made electric vehicles will supplant petroleum-based vehicles currently in use on centers in such areas as maintenance, security, administration, and program operations. The net result for centers and for Job Corps is greater fleet efficiency and lower carbon emissions for the same vehicle miles driven.

SLOT REALLOCATIONS AT JOB CORPS CENTERS

Question. The congressional justification also indicates that in fiscal year 2009 that "slots will be re-allocated from centers with continuing low on-board strength to high-performing centers that have been successful in the recruitment and retention of students." What standards will be adopted for such reallocations for both low on-board strength and high-performing centers?

Answer. Job Corps longstanding position is that it is not prudent to allow some centers to maintain empty training slots year after year when there are centers with waiting lists. To ensure that there are opportunities for all students wanting to enroll in the program, reallocating slots from centers that underutilize slots promotes an effective use of funds. Job Corps will conduct a detailed analysis of the low on-board strength (OBS) centers to determine the appropriate number of slots that should be moved from one center operator's contract and added to another. The analysis examines on-board-strength data and the performance data for all centers to determine those centers with continuing low OBS and their performance levels. Implementation of slot reallocation will coincide with the start of a new contract year for the center to ensure that there are minimal disruptions in service. The most recent analysis of low on-board strength was done in early 2007 and at that time, there were nearly 4,000 empty training slots across the program. Centers with low OBS had slots reallocated to other centers, including New Orleans, Little Rock, and Cleveland.

Question. How much would be reallocated in 2009 under this reallocation strategy?

Answer. No determination has been made for program year 2009 yet. The Office of Job Corps will present options to the Office of the Secretary for program year 2009.

Question. Would this same strategy be needed in fiscal year 2010 at the requested funding level?

Answer. There may be a need to utilize the same strategy in 2010 if it is determined that there are still centers that are unable to fill their allocated training slots and there are still waiting lists.

QUESTIONS SUBMITTED BY SENATOR DANIEL K. INOUYE

RESPONDING TO WORKER DISPLACEMENT IN AMERICAN SAMOA

Question. As a result of Public Law 110–28, the minimum wage was increased in American Samoa and the Commonwealth of the Northern Mariana Islands (CNMI) by $0.50 per hour on July 24 and July 25, 2007, respectively. While opposed by the Congressional Delegates and Governors representing both territories, Public Law 110–28 also mandated automatic increases of $0.50 per hour every year thereafter until 2014 for American Samoa, and 2015 for the CNMI.

After conducting an 8-month study of both economies, as mandated by Public Law 110–28, the U.S. Department of Labor (DOL) concluded that automatic increases would be harmful to both economies, although each economy was able to sustain the first increase. Given Chicken of the Sea's recent announcement to close its operations in American Samoa which will lead to the displacement of more than 2,100 workers, will the DOL support congressional action to place a hold on future increases until such time as the Government Accountability Office (GAO) can conduct a new study, due in April 2010, regarding the impact of past, present, and future increases on both economies?

Answer. The Department must correct a misunderstanding of its report on the impact of the minimum wage increases on the economies of American Samoa and the CNMI. The DOL report produced during the prior administration was undertaken shortly after the first increases in the minimum wage, which limited the Department's ability to measure the impact. The report did not explicitly recommend a roll back. My staff has reviewed the report and based on the lack of detailed data they have concluded that it is very difficult to separate possible effects of the minimum wage increases from the effects of other economic forces. As noted in the report, the ability of the Department to fully assess and project the impacts of increases in the minimum wages applicable to American Samoa and the CNMI was constrained by the short timeframe available for observation of emerging effects and by the lack of timely labor market data for both territories. The fact that the increases are scheduled to be implemented gradually over an extended period of years is reason to expect that adverse impacts, if any, will be minimized, and the increase in earnings and spending power of island households as a result of the minimum wage increase will benefit the local economies.

The closing of Chicken of the Sea's operations in American Samoa cannot be directly attributed to the expected minimum wage increase because the company moved its operations to the State of Georgia, where the higher Federal minimum wage applies. (The Federal minimum wage is currently scheduled to increase to $7.25 on July 24 of this year, while the American Samoan minimum wage for the fish canning and processing industry will remain at $4.76).

Currently, the GAO is conducting a study of the impact of the minimum wage increase on American Samoa and the CNMI. The Department will certainly consider any legislation proposed by the Congress.

Question. According to Congressman Faleomavaega, until passage of Public Law 110–28 and due to the territory's unique and fragile economy, DOL Special Industry Committees historically determined minimum wage rates in American Samoa. Would the administration support the Congressman's position of reinstating a modified version of Special Industry Committees for American Samoa and the CNMI in lieu of automatic increases as now mandated by Public Law 110–28?

Answer. The Department will consider any legislation proposed by the Congress.

Question. I am advised by Congressman Faleomavaega that more than 2,100 workers in American Samoa will be displaced in September of this year when Chicken of the Sea relocates to Lyons, Georgia. Would the DOL support efforts to redirect a portion of the stimulus funds, held by DOL for American Samoa, to unemployed workers for purposes of job training and unemployment compensation, in view of the

fact that the American Samoa government does not participate in the Unemployment Insurance program?

Answer. The Department is aware of the worker displacement occurring in American Samoa, but does not have the authority to allow Recovery Act funds to be used as a substitute for unemployment insurance benefits. However, the Department recommends that the American Samoa government consider submitting a National Emergency Grant proposal that could provide job training, needs related payments, and other employment services to assist workers affected by the Chicken of the Sea relocation. Our office of Congressional and Intergovernmental Affairs and the Employment and Training Administration have had several discussions with Government officials about the process for applying for such a grant.

QUESTIONS SUBMITTED BY SENATOR PATTY MURRAY

FURTHER COLLABORATION WITH THE DEPARTMENT OF EDUCATION

Question. I am concerned about those in our workforce that are not prepared for a turbulent, knowledge-based, technology-driven economy because they do not have the basic skills required by business to succeed in tomorrow's workplace. While 25 percent of today's jobs require a postsecondary credential or degree, an estimated 45 percent of all new jobs over the next decade will require such postsecondary credentials. More than 12 million adults without high school credentials are in the labor force today, and over 1 million young adults drop out of high school each year. We are the only highly developed democracy where young adults are less likely to have completed high school than the previous generation. I believe that adult education and literacy is a very important component of the workforce system.

Have you and Secretary Duncan discussed how both departments can better meet the needs of the ever growing list of those seeking and needing adult education services—including basic education, English language training, and high school diploma preparation, to succeed in careers?

Answer. The Departments of Labor and Education have a long history of collaboration and have developed venues that will allow both Departments to continue to work together to find better and more effective ways to meet the needs of adults seeking education services. We have begun working with the Department of Education to develop proposed principles for re-authorizing WIA in order to ensure that education and training activities are delivered in a manner that provides the best results of these joint investments. In addition, both Departments are active members of the Adult Learning Strategies Workgroup. This workgroup serves to identify and integrate Federal programs and services to develop new service models and promote adult education and literacy.

Recently, Labor issued Training and Employment Guidance Letter 14–08 directing that Workforce Investment Act (WIA) funds included in the Recovery Act may be used for adult education, including basic or English language education, as delivered through community colleges and other high-quality public programs and community organizations that provide such services. Secretary Duncan and I are working to ensure that other substantial investments made possible by the Recovery Act, such as the $500 million made available for grants in the renewable energy and energy efficiency industries, will include provisions promoting services with a focus on degree or certificate attainment for low-income and displaced workers, and for high school dropouts. To support these efforts the Departments of Education, Energy, and Labor have entered into a Memorandum of Understanding (MOU) intended to strengthen communication and the partnerships among the three Departments. Some of the activities that will result from the MOU include: (1) each Department notifying the other two Departments of relevant awards made with Recovery Act or appropriated funds; (2) each Department disseminating information about relevant programs and activities carried out by the other two Departments; and (3) the Departments working together to develop mutually supportive and reinforcing projects with aligned goals to ensure the development of career ladders, lattices, and pathways for jobs in energy efficiency and renewable energy fields.

Another example of our collaboration concerns the next round of Community-Based Job Training grants, funded by our fiscal year 2009 appropriations. The grants have historically focused on expanding the capacity of community colleges to deliver training for high-growth industries. As we shape the next competition, we will work to ensure that connections to basic education services are available through these grants so that individuals who need to obtain a high school diploma or equivalent before progressing to postsecondary level education can do so. This approach will align with the fiscal year 2010 budget's proposal for a "Career Pathways

Innovation Fund" where we would emphasize basic education, English as a Second Language and other remediation that prepares individuals to take clear sequences of coursework to obtain credentials that lead to better jobs. As part of this initiative, we will work with the Department of Education to help develop program requirements.

Finally, I believe that two of the key components of WIA reauthorization will be creating a system where adults can move easily between the labor market and further education and training in order to advance in their careers and the close alignment of every level of education and training with economic realities. In the months ahead, I look forward to working with Secretary Duncan and Congress to take advantage of the opportunities created by WIA reauthorization to identify strategies that will better promote and provide adult education services to those who need them.

WIA YOUTH ACTIVITIES

Question. I commend you for your Department's timely Recovery Act guidance to the workforce community regarding the use of Workforce Investment Act (WIA) formula funds. Your guidance accurately reflects our statutory mandate. We want to ensure these workforce funds are spent well and utilized during this time of economic crisis.

Unfortunately, the state of our economy has worsened dramatically since that time, and employment prospects for youth look particularly bleak this summer, which is why Congress dedicated $1.2 billion in the Recovery Act for the Department of Labor to help at risk youth—with a particular focus on providing jobs this summer. I know that your staff has been working with State and local areas, encouraging them to run robust summer jobs programs this year.

What can you tell us about your expectations this summer?

Answer. During the summer of 2009, the Employment and Training Administration (ETA) expects to serve between 200,000 to 250,000 youth in summer employment, funded by Recovery Act WIA youth funds. Based on State and local readiness reviews, local areas are ready to implement robust summer employment opportunities this summer, despite the short implementation time. ETA expects most local areas to spend roughly 70 percent of their WIA Youth Recovery Act funds on summer employment during the summer of 2009. Some local areas report plans to spend their entire allocation of WIA Youth Recovery Act funds on summer employment this summer. ETA also expects many local areas to implement some form of "green" work experiences this summer, although developing "green" opportunities will take time and may not be widespread during the summer of 2009.

Question. Should States and local areas rebuild and offer robust summer jobs programs in 2009 with funds from the Recovery Act, I'm concerned that they may not be able to sustain them at the recommended 2010 level. As we move forward and learn about the impact of the Recovery Act funds, will you work with me and my colleagues to support a robust summer jobs program in 2010?

Answer. States and local workforce areas are energized with the renewed focus on summer employment opportunities. Local areas should be able to use a combination of remaining Recovery Act funds, remaining regular WIA youth funds from program year 2009, and program year 2010 WIA youth funds to continue operating summer employment opportunities during the summer of 2010.

HIGH-GROWTH JOB TRAINING INITIATIVES

Question. As you know, the Recovery Act included $250 million for competitive grants to better help meet the need for health care workers. I know that the Department is working hard to announce a grant solicitation in late spring or early summer for projects that train workers in the high demand sectors for the healthcare field such as nursing and allied health, where skilled worker shortages are expected to reach crisis proportions with the retirement of the baby boomers.

How is the Department of Labor coordinating this effort with the $500 million that was allocated to the Department of Health and Human Services (HHS) for health jobs in the Recovery Act?

Answer. Across the board, the Department is working with our Federal partners to connect our workforce development dollars with other agencies' research, infrastructure and workforce development dollars. We already have a collaborative working relationship with HHS, including the Health Resources and Services Administration, and are reaching out to others to coordinate our Recovery Act investments. For example, we anticipate linking to the newly created Office of the National Coordinator for Health Information Technology to better understand the job creation and skill needs that will occur as a result of those investments. Our goal is not only to

link the $250 million for training in high growth industries, but to also link the Recovery Act WIA formula funding to opportunities that are represented by the resources available through HHS for healthcare jobs.

Question. How can we maximize and better coordinate the health workforce initiatives being undertaken by both Departments in the fiscal year 2010 budget?

Answer. The best way to maximize and coordinate both Recovery Act and funding through the normal appropriations process is through partnership activities. There are many opportunities to share information across systems, promote leveraging of resources at the local level, and collaborate on workforce solutions for the healthcare industry broadly. One approach that the Department of Labor has pursued in partnership with HHS and other Federal agencies is supporting States' efforts to convene and develop partnerships among providers from different programs and funding sources—either around a specific sector (such as nursing education capacity) or a specific population (such as disadvantaged youth). This effort has fostered a collaborative approach to problem-solving at the State and local level, which is where an integrated approach can have significant impact.

TRANSITIONING VETERANS INTO CIVILIAN EMPLOYMENT

Question. Veterans and returning servicemembers have a difficult time transitioning to civilian employment for a number of reasons. And, I believe that it's our shared responsibility to ensure that those who have sacrificed for us on the battle field are fully supported as they re-enter civilian life and seek a new career or return to their former job. Part of helping ease that transition is creating seamless service provision for these members across the Federal Government.

I was glad to see that this budget request includes additional funds for the Veterans' Employment and Training Services Administration and other veterans' employment programs at the Department of Labor. But I'm concerned that the agencies that serve our veterans need to do more to align their services and ease the burden on servicemembers seeking their rightfully earned benefits.

How will you work with the Department of Veterans Affairs, the Department of Defense, and other agencies to help ensure veterans transition successfully into civilian employment?

Answer. The Department of Labor along with the Departments of Defense (to include the Military Services), Veterans Affairs, and Homeland Security has an active Transition Assistance Steering Committee that oversees the Transition Services provided by these Departments to transitioning servicemembers. This Committee is responsible for recent improvements to Transition Services, which includes a standardized Transition Assistance Employment Workshop and the requirements for attendees to develop a resume. Based on the recommendations of the Committee the Department of Labor will conduct a TAP Review to assess the current curriculum and assess its relevancy and recommend changes and improvements.

Question. How will you work with ODEP and other agencies within the Department to address the needs of veterans and servicemembers who suffer a disabling injury during their service and their families who care for them during this time who may fear putting their jobs at risk? I am particularly interested in your thoughts on how we can better help veterans with TBI successfully transition into the civilian world of work.

Answer. VETS works closely with the Office of Disability and Employment Policy (ODEP). In consultation with VETS, ODEP established the Department's America's Heroes at Work program. This program addresses the employment challenges of returning servicemembers living with Post Traumatic Stress Disorder (PTSD) and/or Traumatic Brain Injury (TBI). The americasheroesatwork.gov web site for employers and the workforce development system, helps returning servicemembers affected by TBI and/or PTSD succeed in the workplace—particularly servicemembers returning from Iraq and Afghanistan. The VETS National Office is located adjacent to that of ODEP, which facilitates collaboration on projects serving the employment needs of disabled veterans. In recent years VETS and ODEP have been among the sponsors of the annual U.S. Business Leaders Network (USBLN) conference.

A key employment initiative for which VETS has employed expertise and assistance from the ODEP is the Recovery and Employment Assistance Lifelines Program (REALifelines). REALifelines is a program sponsored by the U.S. Department of Labor, military medical transition centers, and career workforce agencies located in hometowns across the country. The program supports the economic recovery and reemployment of transitioning wounded and injured servicemembers and their families by identifying barriers to employment or re-employment and addressing those needs at the earliest point possible during transition from military service. ODEP has provided expertise to VETS regarding supporting and assistive services for this

population of veterans. A venue for discussing associated issues is an ODEP America's Heroes at Work Committee on which VETS is a permanent member. The REALifelines program links servicemembers with local professionals in their hometown communities to support their economic recovery and re-employment through a range of services. As part of the program, wounded and injured servicemembers, and their spouses, are eligible for services offered at more than 3,000 One-Stop career centers of the Employment and Training Administration's Workforce Investment System.

COMMUNITY SERVICE EMPLOYMENT FOR OLDER AMERICANS

Question. The Senior Community Service Employment Program (SCSEP) is the only program at the Department of Labor that provides intensive services for low-income older workers. Its dual mission of both community service and employment is unique and highly effective, especially during these tough economic times. However, I am concerned that despite the worst unemployment levels for older workers since World War II, the Department's budget recommended a less than 1 percent increase for this program in 2010. Congress did provide $120 million in additional funds for SCSEP in the Recovery Act, but the program is still only able to serve less than 1 percent of the eligible population. And our low-income seniors are hurting.

What plans do you have to strengthen and enhance the SCSEP program?

Answer. The Recovery Act provided SCSEP with an additional $120 million through the end of program year 2009. The regular program increase for program year 2010 will maintain the program at its current level. The program year 2009 funding and program year 2010 requested funding are each sufficient to fund 59,316 participant slots in the regular program per year, or approximately 91,000 individual persons each year, depending on the program turnover rate and the ability of participants to find unsubsidized employment.

The Recovery Act funding will support approximately 13,000 additional participants in program year 2009 and cover increased participant wages due to the July 24, 2009 increase in the Federal minimum wage. The total number of individuals served with Recovery Act funds is also dependent on the turnover rate and ability of participants to transition to unsubsidized employment.

The Department intends to continue its effort begun last year to focus technical assistance on the lower performing grantees, helping them to appropriately evaluate and diagnose their performance issues to lead to more effective improvement strategies. The Department has begun utilizing more online training opportunities for grantees through Webinars and other electronic tools, thus enabling grantees to receive needed technical assistance at any time. Technical assistance is also focused on ensuring grantees effectively coordinate the delivery of services including encouraging better services for older workers at One-Stop Career Centers.

In an effort to serve participants more effectively, the Department required in the 2006 competition for national grantees that national grantee service areas be more contiguous and less duplicative of other service providers. As a follow-up to this effort, the Department intends to work with the State and territorial grantees to consider more efficient assignment of their service areas which will encourage management efficiencies. This will need to be accomplished on a State-by-State basis before the next national grantee competition in 2011.

Question. What plans do you have to better serve older workers through the One Stop Career Center network?

Answer. The Department will soon launch an initiative to increase the public workforce system's capacity to effectively serve an aging worker population, as well as to train workers age 55 and older for jobs in high growth, high-demand industries that are critical to regional economies. The Department plans to award $10 million in grant funds to 10 organizations that connect older Americans to career opportunities through the "Aging Worker Initiative: Strategies for Regional Talent Development."

The Department has developed a protocol on serving older workers aimed at the workforce system to articulate the various roles and responsibilities of all the stakeholders, including the One Stop Career Centers, the State and local Workforce Boards, mature worker intermediaries and service providers, business and industry employers, and the Department itself. This protocol was shared through Training and Employment Notice 16–04, Protocol for Serving Older Workers, and subsequently posted on our website for ongoing access. In the coming year, the Department plans to reinforce the activities articulated in the protocol.

The Department has also encouraged enhanced services to older workers through the One Stop Career Center network through technical assistance that combined

workshops and through online assistance on www.workforce3one.org, ETA's knowledge sharing and learning platform. Nearly 50,000 stakeholders from the workforce system use this Web site to participate in online learning events (Webinars); to learn about promising practices or new research on workforce topics; and to engage in networking opportunities with workforce system peers. In the past 3 years, ETA has hosted numerous Webinars on effective strategies for serving older workers and current issues impacting older workers, such as displacement.

Question. Will you be willing to work with Congress to do so?

Answer. The Department will be happy year to work with Congress to ensure our programs are strengthened and enhanced to effectively serve older workers.

CAREER PATHWAYS INNOVATION FUND

Question. I am very interested in your Career Pathways Innovation Fund proposal in your 2010 budget request. As you know, developing career pathways is an important focus for me, and I look forward to working with you on this important initiative. I believe that we need to create strong career ladders that can help our students and current workers, regardless of their skill levels, move up the economic ladder.

How do you envision the workforce system, community colleges, and our education systems coordinating with employers and labor organizations in high demand or emerging industry sectors to accomplish the goals of this program?

Answer. We appreciate your interest in creating strong career ladders and helping workers advance in their careers. You are correct that partnerships will be key to implementing this new initiative. This initiative is the outgrowth of an industry sector approach to workforce solutions. Business, industry, and labor define competencies and skills and work collaboratively with education partners to map corresponding education and career pathways with supporting curriculum to achieve industry recognized credentials. The community college is the focus of this initiative, but there is an expectation that the development of successful career pathways program will require engagement with business and industry, the full spectrum of education partners, labor organizations, the workforce system, and others. There will also be a need to ensure that not only traditional students, but also dislocated workers and transitioning adults have access to the pathways. The workforce system is a key partner for this purpose. The Department intends to structure the competitive grant process to require these strategic partnerships.

WORK INCENTIVE GRANT PROGRAM

Question. We have heard much in a recent series of Workforce Investment Act listening sessions about the challenges many job seekers with disabilities have in accessing one stop services and through the centers and through their programs. Together with some of my colleagues, we sponsored these sessions where stakeholders in the system could provide feedback about what has worked and should be refined and retained to help workers, job seekers and industry; what key challenges need to be addressed; and what innovative policy ideas should be considered to modernize the WIA as we move forward with re-authorization.

One of the key ways to improve accessibility for one stop services was the disability navigator system supported through the Work Incentive Grant program. While I understand the rationale for eliminating this program after a 7-year "pilot," I'm concerned about the continuation of services provided by disability navigators or other promising practices to help individuals with disabilities through the One Stop system. And your budget states your expectation that there will be an increase in workforce service levels to job seekers with disabilities through the One Stop Career Center system in 2010.

What are your plans to ensure that the State and local area One Stop service delivery networks meet this expectation, and how will you know whether it is met?

Answer. While the Department has recommended phasing out direct funding for this program, it is actively working with States to utilize other available Federal and State resources to support the Disability Program Navigator model, such as Wagner-Peyser funding, and funding for participation as a Ticket to Work Employment Network. The administration and the Department continue to have a strong commitment to ensure that individuals with disabilities receive the services they need to be successful in the workplace.

Furthermore, the Department recognizes that in an economic downturn and a tight labor market, individuals with more barriers to employment have the potential to be left behind. The Department is working to ensure all disadvantaged populations continue to have access to the resources of the public workforce system and benefit from the new infusion of resources provided by the Recovery Act. Specifi-

cally, the Department is requiring States specify how they will ensure a continued focus on disadvantaged populations (which include individuals with disabilities) in modifications to their WIA and Wagner-Peyser State Plans, which outline their Recovery Act strategies. In addition, we provide continuous technical assistance to the workforce system through Webinars and other means and have already produced a webinars focusing on how to ensure individuals with disabilities are served with these new resources.

I have also requested an increase of $10 million over fiscal year 2009 for the Office of Disability Employment Policy. This increase will support a new initiative that builds upon the lessons learned through the Disability Navigator Program, and focuses on working with employers, the One-Stop system, and other stakeholders to vigorously promote the hiring, job placement and retention of individuals with disabilities, particularly youth, in integrated employment, apprenticeship and pre-apprenticeship programs, and community service activities.

Question. Will you keep us informed of the system's progress in serving job seekers with disabilities?

Answer. The Department will be happy year to continue to communicate with Congress on its service delivery strategies and initiatives for serving job seekers with disabilities.

NONCOMPETITIVE GRANTS

Question. Over the past 3 years there have been reports by the General Accountability Office, Congressional Research Service, and the Department of Labor Inspector General about the excessive awarding of noncompetitive grants during the previous administration. This was the subject of my subcommittee hearing last September and at several previous Appropriations subcommittee hearings. Congress followed-up by writing language into the Labor HHS appropriations bill to require competitive grant making.

What will be the Department's approach to noncompetitive grants under your leadership?

Answer. The Department of Labor embraces the value of the competitive grant making process as the best vehicle through which to select those entities most qualified to carry out its discretionary grant programs effectively. We plan to carefully review each request for renewal of noncompetitive awards provided under the last administration through the Department's published guidance regarding competitive exceptions, with an eye to increasing the use of competitive grants.

The Department will comply with the Federal Grant and Cooperative Agreement Act, but also recognizes the occasional need to apply legal exceptions to its general competitive award policy to achieve specific program benefits. In such instances, the Department has established and implemented a management process to review proposed exceptions to competitive procedures for grants and contracts to ensure that they are fully justified. Specifically, a Procurement Review Board, consisting of senior staff from four agencies, reviews the proposed noncompetitive actions and makes a recommendation to the Chief Acquisition Officer for final disposition.

The Department of Labor is also committed to the principles identified in the President's March 4, 2009 memorandum to agencies regarding the use of contracts, and will seek to improve the effectiveness of acquisition practices and the results achieved from contracts by maximizing the use of competition where appropriate.

WIA DISLOCATED WORKERS FORMULA

Question. As we discussed at the hearing, I share the concern of other members about the 2009 WIA Dislocated Worker funding distribution that, because of the formula factors, meant that some States that are hurting the most saw a reduction in their funds. While Congress considers how to remedy this issue in reauthorization, these States will need relief. One of the purposes of the National Emergency Grants (NEG) under WIA is to address situations like this.

I appreciate your support on this issue, and I want to be clear on your intent to use some of the NEG funds you received through ARRA and fiscal year 2009 appropriations for this purpose.

Do you plan to use NEG funds to help States who have a high rate of unemployment, particularly those greater than the national average, and who have received less WIA dislocated worker formula funds in the fiscal year 2009 distribution compared to the fiscal year 2008 distribution through no fault of their own? If so, what are your plans for doing so, and how soon could States expect to see those funds?

Answer. While the Department does not plan to provide on a routine basis NEGs to States that received less program year 2009 WIA formula funds than they did in program year 2008, the Department is prepared to provide NEGs when signifi-

cant worker dislocation events create a need that cannot reasonably be expected to be accommodated within the ongoing operations of the WIA Dislocated Worker formula program, including the discretionary resources available to the States. Once the affected States demonstrate significant usage of both their program year 2008 WIA Dislocated Worker formula funds and their Recovery Act formula allocations, the Department will consider NEG applications to temporarily expand service capacity at the State and local levels by providing funding assistance in response to significant economic events.

In addition, a new type of NEG was created after the passage of the Recovery Act, to address the dynamics associated with this particular economic downturn. Based on the extraordinary effect that the economic downturn has had on the labor market and available re-employment resources, requests can be made for NEG funds to replenish WIA Dislocated Worker formula funds where the applicant has spent 95 percent of both their current program year and Recovery Act Dislocated Worker formula funds. In the event that a State or local area is nearly out of WIA Dislocated Worker formula funds, this type of NEG can be used to provide the same services available under a State or local area's WIA Dislocated Worker formula program until additional WIA Dislocated Worker formula resources are made available.

Question. After reviewing the amount of funds you need to provide temporary relief to these States and ensuring you have funds in reserve for unexpected layoffs or disasters, please inform the Senate Appropriations Committee if you need additional funds and how much.

Answer. The Department believes with the combination of fiscal year 2009 National Reserve and Recovery Act resources, adequate funding is available to support the use of NEGs as described above. We would also appreciate the support of the Committee for the increase of $71 million that is requested in fiscal year 2010 for the Dislocated Worker National Reserve, as these resources will be critical to meeting the needs of dislocated workers into the subsequent program year.

QUESTIONS SUBMITTED BY SENATOR RICHARD J. DURBIN

FARM LABOR CONDITIONS

Question. How do you consider farm labor conditions in the United States? The Department of Labor has not been very engaged in the issues associated with farm labor. What do you see as the Department of Labor's role moving forward?

Answer. Although conditions may have improved for some agricultural workers, these workers continue to be among the most vulnerable in the workforce. According to a 2008 United States Department of Agriculture (USDA) report (Kandel, W. "Profile of Hired Farmworkers, A 2008 Update." USDA, ERS Economic Research Report No. 60, July, 2008. (38)), farmworkers remain "among the most economically disadvantaged working groups in the United States." and "poverty among farmworkers is more than double that of all wage and salary employees." The report goes on to note that not only do farmworkers face workplace hazards similar to those found in other industrial settings, they confront a number of additional hazards, such as pesticide exposure, sun exposure, inadequate sanitary facilities, and crowded and/or substandard housing.

Being from the State of California, I have a personal interest in ensuring that this Department does all it can do to protect the welfare of those workers who plant our crops, harvest our vegetables, and put food on the tables of homes across this country. The President's fiscal year 2010 budget request for the Department's Wage and Hour Division will enable that agency to restore its investigator levels to those seen prior to 2001. These new investigators will support our goal of increasing compliance with and strengthening enforcement of the labor standards that protect vulnerable workers and in particular, farmworkers. Coupled with this emphasis on vigorous enforcement, the Wage and Hour Division will continue its outreach efforts to community groups that assist farmworkers, so that those groups can help educate agricultural workers about their rights and about their employers' obligation to provide a safe and fair workplace for them.

Our commitment to protecting farmworkers is evidenced by the recent action the Department took to ensure that the regulations governing worker protections under the Immigration and Nationality Act's H–2A temporary nonimmigrant agricultural worker program adequately protect the workers in this program. For that reason, on May 29, 2009, we announced the suspension of the H–2A regulations promulgated under the prior administration effective June 29, 2009. Unfortunately, on June 29, 2009, the United States District Court for the Middle District of North Carolina preliminarily enjoined the suspension.

COALITION OF IMMOKALEE WORKERS

Question. The Coalition of Immokalee Workers (CIW) is a community-based organization of mainly Latino, Mayan Indian, and Haitian immigrants working in low-wage jobs throughout the State of Florida.

They organize for the following: a fair wage, better and cheaper housing, stronger laws and stronger enforcement against those who would violate workers' rights, the right to organize on our jobs without fear of retaliation, and an end to indentured servitude in the fields.

If you are aware of the CIW's efforts to improve conditions in Immokalee, can you speak to the market-based, voluntary compliance approach—Campaign for Fair Food—spearheaded by the CIW and embraced by food industry leaders?

Answer. The Campaign for Fair Food was initiated in April 2001 when the Coalition of Immokalee Workers' farmworkers, who were harvesting tomatoes for suppliers of retail food corporations, called for a nation-wide consumer boycott of Taco Bell restaurants and products. Over the next few years, the campaign was able to obtain agreements with large purchasers of tomatoes including Taco Bell, McDonald's, Bon-Appetit, Whole Foods Market, and Burger King to improve conditions for field workers. These agreements increased the wages by a penny a pound and led to additional monitoring of field conditions.

We understand that the premises of the Campaign for Fair Food are that:

—Retail food corporations have a responsibility to improve the wages of farmworkers because their procurement practices have helped to suppress those wages at a sub-poverty level.

—Farmworkers must be full partners with retail food corporations—and the growers that supply them—in protecting and advancing their own rights (such as the right to overtime and the right to organize), as a matter of human dignity and effectiveness in changing the conditions in the fields.

—Consumers have a responsibility to influence retail food corporations to ensure the human rights and dignity of the men and women harvesting produce through purchasing decisions, shareholder actions, and shared public witness.

The Department applauds all efforts to increase wages and improve working conditions for farmworkers and looks forward to working in concert with such organizations to further better the lives of the laborers that feed families across this country and others.

Question. I have been working closely with the CIW regarding the conditions found on tomato farms in Florida. Would you be willing to look further into the situation in Immokalee, Florida?

Answer. I will review the conditions in Florida and the Department will investigate as appropriate.

SUBCOMMITEE RECESS

Senator HARKIN. Thank you very much, Madam Secretary.

The subcommittee will stand recessed.

[Whereupon, at 10:39 a.m., Wednesday, May 13, 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 2010

THURSDAY, MAY 21, 2009

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

The subcommittee met at 10:29 a.m., in room SD–138, Dirksen Senate Office Building, Hon. Tom Harkin (chairman) presiding.

Present: Senators Harkin and Shelby.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

NATIONAL INSTITUTES OF HEALTH

STATEMENT OF RAYNARD S. KINGTON, M.D., Ph.D., ACTING DIRECTOR, NATIONAL INSTITUTES OF HEALTH

ACCOMPANIED BY:

JOHN E. NIEDERHUBER, M.D., DIRECTOR, NATIONAL CANCER INSTITUTE

ELIZABETH G. NABEL, M.D., NATIONAL HEART, LUNG, AND BLOOD INSTITUTE

ANTHONY S. FAUCI, M.D., DIRECTOR, NATIONAL INSTITUTE OF ALLERGY AND INFECTIOUS DISEASES

OPENING STATEMENT OF SENATOR TOM HARKIN

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

This morning we will examine the President's proposed fiscal year 2010 budget for the National Institutes of Health (NIH). We'll also discuss the $10.4 billion that was provided for NIH in the Recovery Act.

I would say at the outset these are exciting times for NIH. After several years of stagnant funding, the Recovery Act has breathed new life into the field of biomedical research. The new Challenge Grant Program alone has generated more than 20,000 applications from researchers across the country, far more than anyone expected.

The scientific advances that result from this funding will probably take some time to gauge but in the meantime, I expect it to have a tremendous impact on the economy. Every time a researcher gets a grant, it supports an average of six or seven jobs. That's not just one researcher by himself or herself. It's lab techni-

cians, post-doc fellows and research assistants, and then there's the ripple effect of the research itself.

Maybe this grant leads to a new compound that a pharmaceutical company wants to develop into a new drug and that means more money in our economy. Maybe an entrepreneur uses some breakthrough to form a spin-off company. That stimulates the economy, also.

I just want to note for the record, I don't want any of you here at the table to take this wrongly, but all of this money won't just go to Bethesda. It goes to researchers in every State and it helps the entire country.

But while there's a great deal of optimism about the next 2 years, there's also a concern about what happens after the Recovery Act funding runs out in the year 2011. After 2 years of healthy budgets, will we then have a cliff effect where we just kind of fall again?

That's one of the questions I will want to discuss with our witnesses today.

At this point, I know Senator Cochran is also on our Defense Committee hearing mark-up and will probably be here later, but I'll leave the record open for his opening statement at this point and any other statements that any members of the subcommittee might have.

This morning we have Dr. Raynard S. Kington who was named Acting Director of the National Institutes of Health on October 31 of last year, before that he was Deputy Director for 5 years under Dr. Zerhouni.

Dr. Kington received his B.S. and M.D. degrees from the University of Michigan and a Ph.D. from the University of Pennsylvania, and I just want to add that, Dr. Kington, I know you've served in this capacity probably longer than you thought you were going to have to serve. But by every account that I have seen, you have done a great job in running this agency and I just want to thank you for this period of service and for all the previous service, Dr. Kington.

Also at the table is Dr. Anthony Fauci, the Director of the National Institute of Allergy and Infectious Diseases. Again, I don't know if you've ever kept count of how many times have you appeared before this subcommittee, Tony, going back all these years? But again, welcome.

Dr. Fauci came to NIH in 1968, after completing his residency at the New York Hospital, Cornell Medical Center. He received his M.D. degree from Cornell University Medical College.

Dr. Elizabeth Nabel is the Director of the National Heart, Lung, and Blood Institute, appointed to that position in 2005, received her M.D. from Cornell University Medical College, and prior to coming to NIH, Dr. Nabel was the Chief of Cardiology and Director of the Cardiovascular Research Center at the University of Michigan.

Dr. John Niederhuber is the Director of the National Cancer Institute, a graduate of Bethany College in West Virginia, received his medical degree from Ohio State, and prior to coming to NIH, Dr. Niederhuber was a Professor of Surgery and Oncology at the University of Wisconsin School of Medicine.

I know other Directors are here this morning. Dr. Lawrence Tabak at the National Institute of Dental and Craniofacial Research is here. Dr. Tabak is here.

Dr. John Ruffin from the National Center on Minority Health and Health Disparities.

Dr. Steven Katz, the National Institute of Arthritis and Musculoskeletal and Skin Diseases, Dr. Katz is here, yes.

Dr. Story Landis of the National Institute of Neurological Diseases and Stroke, Dr. Landis.

Dr. Richard Hodes, National Institute of Aging. Nice to see you again.

Dr. Griffin Rodgers from the National Institute of Diabetes and Digestive and Kidney Diseases, NIDDK.

And Dr. Thomas Insel, National Institute of Mental Health, also here, too.

Thank you all for being here.

Now, I had a series of really wonderful hearings last year where we brought down something like three directors at a time, and I wanted to do that this year, but because of healthcare reform that we're working on and I also wear another hat, we're trying to get the reauthorization of the Child Nutrition bill through, so there's just a lot of things piled up on us right now, so I don't have that luxury.

I think it's very important that we hear from the Directors of these Institutes in a more indepth session. I will just say, Dr. Kington, it's my intent, consistent with what we have to do here in the Senate this year, that maybe we can catch up on this later on. I'm still hopeful that maybe this fall some time, if we get our healthcare reform bill through and we have a little bit more time I would come back and hopefully revisit that and reprise what we did again last year.

I just don't have the time to do it now, but sometime this fall. So I say to you and the other directors it is my intent to do that. Okay?

Well, with that, Dr. Kington, we'll turn to you for your statement. I just would say that all of your statements will be made a part of the record in their entirety and if you'd just summarize them in 5 minutes or so, I'd certainly appreciate it.

Dr. Kington.

SUMMARY STATEMENT OF DR. RAYNARD S. KINGTON

Dr. KINGTON. Thank you. Mr. Chairman, it's a privilege to appear before you today to present the National Institutes of Health budget request and to discuss the priorities of NIH for fiscal year 2010 and beyond.

Again, I would like to thank all of my colleagues whom you've noted who are here joining me today and we would welcome the opportunity to come back and have further discussions whenever it is convenient.

First, I want to express my gratitude to Congress and the president for the support reflected in the recent appropriation of $10.4 billion in the American Recovery and Reinvestment Act (ARRA) for NIH expenditure and the 3.2 percent increase in the annual fiscal year 2009 appropriations for NIH.

The continued trust that you place in the NIH to make the discoveries that will lead to better health for everyone is appreciated.

I thank you on behalf of the many scientists who we are able to support and more than 3,000 research institutions throughout the United States and on behalf of the public who count on our research to help detect, treat and prevent hundreds of diseases and conditions.

As noted, I have submitted my testimony for the record and will just highlight key points for you now.

FISCAL YEAR 2010 BUDGET REQUEST

The budget request embodies the President's fundamental goal of increasing overall Federal investment in biomedical research as well as the President's particular emphasis on accelerating research in the areas of cancer and autism in fiscal year 2010.

The budget request provides $31 billion, an increase of $443 million or 1.4 percent over fiscal year 2009, to help fill in gaps in our fundamental understanding of health and disease. This request will increase funding for research project grants by $243 million.

The request supports an estimated 9,849 new and competing research project grants, about the same level as in fiscal year 2009, which will provide a success rate in 2010 of about 20 percent.

The fiscal year 2010 President's budget request includes the following priorities. For cancer research, an increase of investment across the NIH to over $6 billion reflecting the first year of an 8-year strategy to double cancer research by fiscal year 2017. This request represents an increase of $268 million or 5 percent over an estimated fiscal year 2009.

For autism research, the NIH will contribute $141 million of the $211 million department-wide initiative on autism. Working with the Centers for Disease Control and Prevention and the Health Resources Service Administration, we will use these funds to support research into the causes of and treatment for autism spectrum disorders. For NIH this represents an increase of $19 million or about 16 percent above the estimated fiscal year 2009 level.

ECONOMIC AND SCIENTIFIC BENEFITS OF ARRA

I expressed earlier my gratitude to the President and Congress for their support of the NIH with ARRA. It is time that the ARRA funds be provided to NIH to stimulate the economy and advance biomedical and behavioral research. The biomedical research community is not spared from the recent downturn in the economy. This is worrisome not only because it means fewer jobs but also because innovation and a constant influx of young talent are crucial to the Nation's economic success and a robust biomedical research enterprise.

We are moving quickly to identify the best science and support it with an additional $10.4 billion provided by ARRA to NIH and to obligate it within the next 2 years. We have already started selecting projects to receive the funding. To date NIH has begun obligating more than $375 million worth of ARRA support to a wide array of important projects. We expect the number of actions to increase exponentially over the coming weeks and months.

For example, NIH ARRA funding is already supporting research to construct a reference sequence dataset for the Human Microbiome Project. This genomic survey project promises to lay the foundation for future advances to understand the impact that microbes in the human body have on health and disease.

Another funded project seeks to develop molecular targeting to improve the delivery and efficacy of treatments for deadly brain tumors known as glial blastomas.

Still another ARRA grant will support a Pittsburgh lab that has been developing a minimally invasive surgical approach for removing intracerebral hematomas, deadly bruises on the brain. In this case ARRA funds have allowed the lab to reopen and the staff newly returned to their benches to continue their potentially lifesaving studies.

Furthermore, your funding decisions sent a strong message to scientists in the field and to bright young people who may one day choose a career as scientists that the United States is working to support outstanding research and outstanding scientists.

Just yesterday the Baltimore Sun published a story on the impact of ARRA funding and here's a quote from the article:

> "There are a lot of really good ideas that were dying on the vine because they weren't getting funding," said James Hughes, Vice President for Research and Development at the University of Maryland, Baltimore, "but with the stimulus money, Hughes estimates that his medical, pharmacy, dental, and nursing schools could see as much as an additional $100 million over the next 2 years, money that will not only further research but would create hundreds of good jobs."

I am certain that similar scenarios are occurring throughout the country and will continue to do so over the next 2 years as we implement this act. Here's only a sampling of the important work that we will support with the ARRA funds.

For example, we will expand our current understanding of a wide array of diseases and conditions, including diabetes, various forms of cancer, addiction, glaucoma, infectious diseases, heart and lung diseases, arthritis, kidney disease and mental disorders.

In addition, we will expand our efforts in community-based research with special focus on minority and under-served populations, and make further investments into the potential applications of nano technology.

Just to review briefly, the ARRA funding to NIH will be used in the following ways. The legislation allocated $1.3 billion for the National Center for Research Resources with $1 billion identified for extramural construction and renovation and $300 million targeted for shared instrumentation and other large capital research equipment.

The positive impact of the support for institutions and researchers will be extraordinary, providing broader access to the state of our equipment. Funding for extramural construction and renovation will result in jobs in construction and a number of trades in the building industry.

Shared instrumentation will improve the quality and even the speed of work that is done and build collaboration in ways that will accelerate discovery. Shared scientific instrumentation, including such resources as advanced real-time imaging tools, will allow sci-

entists to image the brain in action in ways that have not been possible before.

You appropriated $8.2 billion to NIH, of which $7.4 billion was distributed through the Office of the Director to Institutes and Centers of NIH and to the common fund for the direct support of biomedical research. The remaining $800 million was distributed by the Office of the Director to fund specific research challenges of scientific priorities at the Institutes and Centers.

Our current projections are that NIH activities with these funds will support more than 7,000 new awards, most of which will be for 2 years of scientific research.

In addition, $400 million transferred to NIH from the Agency for Healthcare Research and Quality as directed under ARRA and will be used to support comparative effectiveness research. The remaining $500 million will be used to fund high-priority repairs, improvements, and construction on the NIH Bethesda campus to enable the highest-quality research to be conducted.

Let me review how NIH will be using ARRA dollars in direct support of science.

NIH developed a nimble approach to investing the money quickly and with the greatest impact. For example, we are in the process of scrutinizing approximately 14,000 grant applications we received in our last round of review, applications that were already highly meritorious and approved by advisory councils at each Institute and Center, applications that despite their merit we could not fund before.

We are now identifying and planning to fund some of these scientifically meritorious applications for 2 years where the scientific plan is appropriate for a 2-year award instead of the usual 4-year award.

NIH has already issued a number of new funding announcements. In particular, we've made targeted grant announcements to stimulate research in high-priority exempt areas. An excellent example is research funding opportunities related to autism, a disease that affects so many families across the United States.

NIH has committed $60 million of research funding, in addition to a $141 million in the base budget request, to address the differences across autism spectrum disorders. Resources will help develop and test diagnostic screening tools, assess risk for exposures, test early interventions and adapt existing pediatric treatments for older groups with autism spectrum disorders.

While few trials can be completed in 2 years, the ARRA funds will be important for jumpstarting projects and building the foundation for longer-term autism research.

NIH has created a number of new programs that will spur new areas of research and trigger an almost immediate influx of research dollars into communities across the Nation.

For example, we've introduced the Challenge Grants, the Grant Opportunity or GO Grants, Signature Initiatives, a program to encourage the recruitment of new faculty to conduct research, and a program to hire students and science teachers to work in research laboratories.

For the Challenge Grants, we issued the largest request for applications in NIH history, which is saying something, to initiate the

program. The 220-page solicitation lists 237 scientific topics in 15 broad scientific areas. As noted, we initially expected to devote approximately $200 million to this effort, funding the best proposals from a pool of around 15,000, we initially estimated. However, upon receiving well over 20,000 applications, we now anticipate devoting substantially more than that.

The magnitude of the response demonstrates the breadth and depth of the scientific capacity that exists across the United States, capacity awaiting only financial support to be actualized. It is inspiring to witness the scope and creativity of American scientists.

Here are only a few examples of Challenge Grant topics. New advances in biosensors and lab on a chip technology to create novel ways to measure the health effects of contaminants in the environment and develop high-tech blood and tissue analysis techniques, new approaches to better understand persistent HIV–1 infections in patients receiving antiretroviral therapy, and enhancing research in the bioethics field.

Another new program is the Grant Opportunity Program or GO Grants. The GO Grant Program which was designed to complement the Challenge Grants will support large-scale research projects. These large-scale projects will accelerate critical breakthroughs early in applied research on cutting edge technologies and new approaches to improve the interactions among multidisciplinary, interdisciplinary research teams. The applications are due on May 29th of this year and I know that we've received already more than 2,400 letters of intent from potential applicants.

NIH is also identifying a number of Signature Initiatives that will support exceptionally creative and innovative projects and programs to address major challenges in biomedical research in public health. The initiatives will cover new scientific opportunities in nano technology, genome-wide association studies, health disparities, arthritis, diabetes, autism, genetic risk for Alzheimer's disease, regenerative medicine, oral fluids as biomarkers, and HIV vaccine research.

In addition to direct support from the Institutes and Centers ARRA funds, the Office of The Director will also support at least $30 million from its ARRA funds for these signature projects.

We've also announced a new program to support newly trained faculty to conduct research. This will help address the need to support early career scientists who are one of NIH's top priorities. Funding will be provided to hire, provide appropriate start-up packages, and develop pilot research projects for newly independent investigators. The applications for this program are due to NIH May 29, as well.

We are particularly delighted to tell you about our expanded summer program for teachers and students from all 50 States and the District of Columbia. NIH will use $35 million of ARRA dollars to support short-term jobs over 2 summers for over 3,700 individuals. Most of these will be high school and undergraduate students, though the number also includes several hundred elementary, middle, high school, and community college science educators.

This laboratory experience around the country will provide several thousand Americans with the opportunity to experience the ex-

traordinary world of research. We hope this experience will spark the desire of many of these students to become scientists.

We are mindful that a top priority for the use of ARRA funds by NIH is to create and preserve jobs as well as to increase purchasing power in all corners of the country. We firmly believe that we can do this while carrying out the core NIH mission and without compromising our commitment to fund the very best scientific research ideas.

We will fulfill ARRA's comprehensive reporting requirements, including jobs created and preserved, tracking of all projects and activities and trend analysis. To track all of the NIH ARRA-related activities, I invite you to go to our Web site, www.nih.gov, which we will update regularly.

In summary, groundbreaking discoveries are most often built on the foundation of many incremental advances that bring us closer to early diagnoses, better treatments and other public health improvements expected by Congress and the American public.

Because of the ARRA funds, there will be more discoveries across the country next year and many years thereafter. These findings will yield better understanding of the major diseases and disorders, including those I touched on today, and hundreds more, as well as providing keys to living healthier lives.

As I said in my opening comments, we are grateful for the commitment to biomedical research and all the promise it brings to the people here in the United States and around the world. We have employed a number of innovative strategies to quickly and wisely invest ARRA funds. We still stimulate the economy, create jobs and advance science.

Most importantly, however, ARRA will help contribute to our principal mission: to make scientific discoveries that will improve people's health.

PREPARED STATEMENTS

I will be pleased to answer any questions that you might have.
[The statements follow:]

PREPARED STATEMENT OF RAYNARD S. KINGTON

Good morning, Mr. Chairman and distinguished members of the subcommittee.

It is a privilege for me to appear before you today to present the National Institutes of Health (NIH) budget request and to discuss the priorities of NIH for fiscal year 2010 and beyond.

First, I want to express our gratitude for your and the President's support as reflected in the recent appropriation of $10.4 billion in the American Recovery and Reinvestment Act (ARRA) for NIH expenditure and the 3.2 percent increase in annual fiscal year 2009 appropriations for NIH. The continued trust that you place in NIH to make the discoveries that will lead to better health for everyone is appreciated.

I thank you on behalf of the many scientists we are able to support at more than 3,000 research institutions throughout the 50 States and United States territories; and on behalf of the public, who count on our research to help detect, treat, or prevent hundreds of diseases and conditions.

As you well know, research conducted and supported by the NIH touches people's lives every day. NIH is the largest single engine for outstanding biomedical research in this country—and the world. Not only does NIH have an impact globally, it also has a lasting impact at the community level, bringing intellectual and economic growth to towns and cities across America.

Fiscal Year 2010 Budget Request

The budget request embodies the President's fundamental goal of increasing overall Federal investment in basic research and development as well as particular emphasis on accelerating research in the areas of cancer and autism in fiscal year 2010.

The budget request provides $31 billion, an increase of $443 million or 1.4 percent over fiscal year 2009, to help fill gaps in our fundamental understanding of health and disease. NIH Research Project Grants (RPGs) support scientists to discover the fundamental underpinnings of complex human biology through investigator-initiated research, the mainstay of creativity in science. This request will increase funding for RPGs by $243 million. The request supports an estimated 9,849 new and competing RPGs, about the same level as fiscal year 2009.

The fiscal year 2010 President's budget request includes the following priorities:

Cancer Research.—Increases the investment across NIH to over $6 billion for cancer research across NIH, reflecting the first year of an 8-year strategy to double cancer research by fiscal year 2017. The fiscal year 2010 request represents an increase of $268 million or 5 percent over the estimated fiscal year 2009 level.

Autism Research.—Invests $141 million of the $211 million Department-wide initiative on autism. This total amount includes the Centers for Disease Control and Prevention and Health Resources Services Administration for research into the causes of and treatments for autism spectrum disorders. For NIH, this represents an increase of $19 million or 16 percent above the estimated fiscal year 2009 level.

Economic and Scientific Benefits of ARRA

I expressed earlier my gratitude to the President and Congress for their support of NIH with ARRA. It is timely that ARRA funds be provided to the NIH to stimulate the economy and advance biomedical and behavioral research. The biomedical research community has not been spared from the drastic downturn in the economy. This is worrisome not only because it means fewer jobs, but also because innovation and a constant influx of young talent are crucial to the Nation's economic success and a robust biomedical research enterprise.

We are moving quickly to identify the best science and support it with the additional $10.4 billion provided by ARRA to the NIH, and obligate it within the next 2 years. Moreover, your decision sends a strong signal to the scientists in the field, and to bright young people who may one day choose science as a career, that the United States is working to support outstanding research and outstanding scientists.

To demonstrate the impact ARRA will have at the individual level, I would like to share with you the following: One of our program directors received an email after enactment of ARRA in response to news that an applicant's grant application was being considered for funding with ARRA money.

Here is an excerpt from the email (with names deleted):

"Forgot to say that we gave a termination letter last Friday to my longtime (5 years) postdoc. His job has been saved. He is going to be thrilled to hear about his change in fortune! I also would like to hire a technician with the new funds, since at present I do not have one."

Let me highlight some of the important work that we will support with ARRA funds. For example, we will rapidly expand our current understanding of the genetic changes associated with a wide range of diseases and conditions, including addiction, Alzheimer's disease, various forms of cancer, chronic pain, diabetes, glaucoma, heart and lung diseases, kidney disease, and mental disorders, through genetic analysis of existing, well characterized population cohorts. We will take steps toward using this genetic information to better inform the modification of disease for those patients most at risk, principally through lifestyle factors and personal health behaviors.

In addition, our efforts to expand community-based research efforts, with special focus on minority and underserved patients, will be accelerated through catalytic grants designed to enhance interrelationships among academic health centers, community organizations, and community healthcare clinical centers. Evaluation of the health and safety risks of nanoscale products is critical as nanomaterials are being used in applications as diverse as medical devices, drug delivery, cosmetics, and textiles. Biological, physical, and chemical characterization of selected nanomaterials will be conducted to both inform the establishment of standards for health and safety and developing computational models for the prediction of long-term secondary effects.

Just to review briefly, the ARRA provided NIH funding in the following ways:

—It allocated $1.3 billion for the National Center for Research Resources, with $1 billion identified for extramural construction and renovation, and $300 million targeted for shared instrumentation and other large capital research equipment. The positive impact of this support for institutions and researchers will be extraordinary, providing broader access to state-of-the-art equipment. Funding for extramural construction and renovation will result in jobs in construction and a number of trades in the building industry. Shared instrumentation will improve the quality and even the speed of the work that is done, and build collaboration in ways that will accelerate discovery. Shared instrumentation, including such resources as advanced real-time imaging tools, will allow scientists to image the brain in action or enable them to see separate proteins that play a role in health and disease.

—It appropriated $8.2 billion to NIH, of which $7.4 billion will be distributed through the NIH Office of the Director, to the Institutes and Centers of NIH, and to the common fund for the support of biomedical research. The remaining $800 million will be distributed by the Office of the Director to fund specific challenges and scientific priorities at the Institutes and Centers.

—In addition, $400 million transferred to NIH by the Agency for Healthcare Research and Quality (AHRQ), as directed under ARRA, will be used to support comparative effectiveness research.

—The remaining $500 million will be used to fund high-priority repairs, improvements, and construction on the NIH campus to enable the highest quality research to be conducted.

How Will NIH Accomplish This Task

NIH is determined to seize the opportunity afforded by the infusion of ARRA resources to develop a nimble approach to investing the money quickly with the greatest impact. This opportunity is too important for us to conduct "business as usual." It demands that we employ the best possible approaches to ensure progress at in an accelerated pace, with the most efficient and effective use of resources. For example, we are scrutinizing the 14,000 grant applications we received in our last round of review—applications that were already deemed highly meritorious and approved by Advisory Councils at each Institute and Center—applications that, despite their merit, we could not fund before. We are now starting to fund those scientifically meritorious applications for 2 years, where the scientific plan is appropriate for a 2-year award instead of the usual 4-year award. Also, every Institute and Center is identifying scientific priorities that can be funded through administrative supplements. Administrative supplements will accelerate the progress of a promising grant, typically by adding support for postdoctoral scientists and graduate students and key pieces of equipment

The NIH team is proud of the trust placed in it to be a part of the economic recovery process. NIH will work tirelessly to support the goals and intent of ARRA, with wise resource investments in science.

NIH has created a number of new programs that will spur new areas of research and trigger an almost immediate influx of research dollars into communities across the Nation. For example, NIH created a new program called the Challenge Grant award. To jump start this program, we issued the largest Request for Applications in our history. This 220-page document lists numerous scientific topics in 15 broad scientific areas, including: bioethics, translational science, genomics, health disparities, enhancing clinical trials, behavioral change and prevention, and regenerative medicine—areas that would benefit from a jumpstart or in which a scientific challenge needs to be overcome. The Office of the Director expects to devote at least $200 million of these funds to this effort.

I will highlight only a few examples of the Challenge Grant topics that could be further explored:

—New advances in biosensors and lab-on-chip technology to create novel ways to measure the body burden and sub-clinical health effects of emerging contaminants in the environment in large study populations. Additional research funds could support field testing of the most promising sensors and analysis techniques through collaboration with existing epidemiologic studies taking advantage of both new and banked tissue specimens.

—There is increasing evidence that suggests that HIV–1 infected individuals experience similar immunologic changes as the uninfected elderly. This may be due to persistent stimulation of the immune cells. It is not clear whether antiretroviral therapy can reverse this process. Research will aim to compare the effectiveness of different treatment regimens in reversing or preventing accelerated aging that appears in the immune and other body systems.

—Studies are needed to assess the impact and ethical considerations of conducting biomedical and clinical research internationally in resource-limited countries.

Another new program is what we call the Grand Opportunity Program, or "GO grants." The purpose of this program is to support high-impact ideas that require significant resources for a discrete period of time to lay the foundation for new fields of investigation. The GO program will support large-scale research projects that accelerate critical breakthroughs, early and applied research on cutting-edge technologies, and new approaches to improve the synergy and interactions among multidisciplinary and interdisciplinary research teams. Applicants may propose to address either a specific research question or propose the creation of a unique infrastructure/resource designed to accelerate scientific progress. For those projects that span the missions of multiple Institutes, Centers, and Offices (ICs), support may come from ARRA funds allocated to the Common Fund.

NIH will identify a number of signature initiatives that will support exceptionally creative and innovative projects and programs—and potentially transformative approaches to major challenges in biomedical research. The initiatives will cover new scientific opportunities in nanotechnology, genome-wide association studies, health disparities, arthritis, diabetes, autism, and the genetic risk for Alzheimer's disease, regenerative medicine, oral fluids as biomarkers, and HIV vaccine research.

Each IC is developing at least one signature initiative, and a number will be done in partnership across ICs and/or the Office of the NIH Director. The areas being developed include an Office of the Director-led set of catalytic awards to enhance community-based research efforts to ensure that we are able to reach segments of our Nation that are too often overlooked in clinical research.

In addition, considerable investment is expected to be made to understand the genetics of a wide range of specific diseases and conditions, as well as second generation "deep DNA sequencing" of very large and well-defined national patient cohorts to identify disease causing genetic variants. Using new technology developed with NIH-support, "deep sequencing" allows analysis of genome sequence from many individuals to provide greater insight about subtle genetic variations than could previous methods, and does so at lower cost." An initiative to modify disease risk-based on genome-wide association findings is also being planned. Complementing this will be initiatives to accelerate biomarker discovery and validation.

Also, NIH will use other funding mechanisms, such as the Academic Research Enhancement Award, or AREA grants, that support small research projects in the biomedical and behavioral sciences conducted by faculty and students in health professional schools and other academic components that have not been major recipients of NIH research grant funds. A research program to support new faculty, called the "Core Centers for Enhancing Research Capacity in U.S. Academic Institutions," will address the need for more bioethicists and provide opportunities for young scientists, who are one of NIH's top priorities for support. The Core Center grants are designed to establish innovative programs of excellence by providing scientific and programmatic support for research by promising investigators. They provide funding to hire, provide appropriate start-up packages, and develop pilot research projects for newly independent investigators, with the goal of augmenting and expanding the institution's biomedical research base. We must invest today to ensure tomorrow's scientific discoveries.

ARRA Funds for Administrative Supplements

U.S. institutions and investigators with active NIH research grants may request administrative supplements for the purpose of accelerating the pace of scientific research through the programs and activities of their peer-reviewed projects. These supplements seek to promote job creation and retention, as well as scientific progress at NIH-funded institutions, by providing researchers with the means to employ, for example, postgraduate students or to enhance capacity for data analysis.

We are particularly delighted to tell you about our expanded summer program for teachers and students across America. Funds will provide short-term summer jobs for high school and undergraduate students—as well as elementary, middle, high school and community college science educators in laboratories around the country—work that will not only provide summer income, but will also provide several thousand young people with the opportunity to experience the world of research, and I hope will spark their desire to become scientists.

In addition to administrative supplements, U.S. research institutions and scientists with active NIH Research Grants may submit revision applications (so-called "competitive supplements") to support a significant expansion of the scope or research protocol of currently approved and funded projects.

The Economic Benefits

We are mindful that a top priority for the use of ARRA funds by NIH is to create and preserve jobs, as well as increase purchasing power in all corners of the country. We firmly believe that we can do this while carrying out the core NIH mission, and without compromising our commitment to fund the best scientific research ideas. In keeping with the ARRA reporting requirements, we are asking recipients to document key economic benefits, such as jobs created and retained. A study indicates that, on average, every NIH grant supports 6 to 7 in-part or full scientific jobs.[1] Another study suggests that every dollar spent by NIH in local communities around the Nation is leveraged on average three times its original amount, if you look at the national "economic multiplier" effect.[2] These grants pay the salaries of scientists and technicians. The scientists and technicians, in turn, purchase goods and services in the communities in which they work and live.

ARRA: Risk Management

NIH has implemented a risk management program in compliance with OMB guidelines that addresses the identification and assessment of proper controls over financial reporting and operations processes. In the financial arena, the risk program includes reviews of financial reporting at the transaction level that are conducted by both internal and external auditors. In the operations arena, the program includes internal assessments of systems and processes that support both intramural and extramural research.

The Scientific Benefits

The advancement of science is a gradual process. Groundbreaking discoveries are most often built on the foundation of many gradual advances that bring us closer to diagnosis, treatments, and other public health improvements expected by Congress and the American public. Because of ARRA funds, there may be many such discoveries across the country next year and many years thereafter. These discoveries could yield better understanding of the major diseases and disorders such as heart disease, cancer, neurodegenerative illnesses, autism, arthritis, mental health, chronic, acute and rare diseases, and diseases related to addiction or behavior.

We are committed to ensuring that ARRA funds will produce benefits to the economy, to scientific knowledge, and ultimately aid in improving the health of the Nation. As an agency, we are well-equipped to disburse these resources, to handle the increase in workload, and award grants expeditiously to the best scientists in the world.

Again, NIH is grateful for your trust and commitment to biomedical research and all the promise it brings to people here in the United States and around the world. We have employed a number of innovative strategies to quickly and wisely invest ARRA funds. We will provide you and the public with regular updates and reports to ensure full transparency and accountability for how these funds are being spent. Americans deserve to know the impact of their tax dollars—on science, on the economy, and the Nation's health. In addition, we look forward to working with you on the fiscal year 2010 budget request.

I would be pleased to answer any questions that you might have.

PREPARED STATEMENT OF JOHN E. NIEDERHUBER

Mr. Chairman and Members of the subcommittee: Thank you for the opportunity to offer testimony on behalf of the National Cancer Institute (NCI) and the National Cancer Program.

I am pleased to present the President's fiscal year 2010 budget request for the NCI of the National Institutes of Health (NIH). The fiscal year 2010 budget includes $5,150,170,000, which is $181,197,000 more than the fiscal year 2009 appropriation of $4,968,973,000.

DOUBLING CANCER RESEARCH

The fiscal year 2010 budget reflects the President's prioritization of biomedical research supported by NIH. The budget is the first year of an 8-year strategy to dou-

[1] "Estimating the Number of Senior/Key Personnel Engaged in NIH Supported Research," study issued October 2008. Study funded by the NIH Evaluation Set-Aside Program, 07–5002–OD–ORIS–OER, administered by the Evaluation Branch, Division of Evaluation and Systematic Assessment, OPASI, Office of the Director, National Institutes of Health.

[2] "In Your Own Backyard: How NIH Funding Helps Your State's Economy," published by Family USA (A Global Health Initiative Report). June 2008.

ble the NIH-wide cancer research budget and includes over $6 billion for this purpose. The budget balances the President's commitment to cancer research with that of research in other areas.

NIH's fiscal year 2010 budget will build upon the unprecedented $10 billion provided in the American Recovery and Reinvestment Act of 2009, which will support new NIH research on a wide array of diseases, condition, and disorders in 2009 and 2010.

Because cancer research involves the dissection and understanding of perhaps the most basic functions of human cell growth and differentiation, cancer research will always produce many serendipitous discoveries. Such discoveries involving the most basic properties of human cells have historically contributed to our understanding of the basic biology underlying almost all diseases.

In addition, cancer research also involves technology development that will benefit research in a number of disease areas. For example, cancer research includes a major effort to understand the complete genetic alterations that result in abnormal cell growth. This effort in whole genome sequencing is a major driver in the development of sequencing technology that we believe will lead to our ability in the next 2–3 years to perform whole genome sequencing in a matter of hours for less than $1,000.

Numerous other Institutes and Centers contribute their expertise to fundamental research on biological processes, technologies and tools, and work collaboratively with NCI to fund important research in cancer. For example, much of what has been learned at NCI in controlling tobacco usage is now being applied to study and address the growing health burden of obesity. NIH will work to ensure that cancer research resources are allocated responsibly, effectively, in accordance with peer review principles, and on the basis of sound science and cancer relevance.

MOVING PAST A LEGACY OF FEAR

One of the great American voices on behalf of biomedical research was Mary Lasker. A well-known figure in Washington politics and government, Mrs. Lasker was a driving force behind the creation of several Institutes of the NIH and a key player in the formulation and passage of the National Cancer Act of 1971. Among her towering accomplishments, however, one stands out, perhaps because of its simplicity. In the years after World War II, cancer, she once remarked, remained "a word you simply could not say out loud." Mary Lasker changed that. She persuaded David Sarnoff, the powerful head of the Radio Corporation of America—RCA—to allow the utterance on the airwaves of that single, chilling word.

Today, we feel no compulsion to avoid speaking its name; yet few would argue that we fear cancer less in 2009 than we did 50 or 100 years ago. Cancer will befall approximately 1 of 2 American men and 1 of 3 American women. Its diagnosis engenders thoughts of mortality, of debilitating treatments, of diminished quality of life, of lingering burdens on loved ones, of personal financial peril.

This major health problem is fueled by an aging, more heterogeneous population. A study published in April 2009 by the University of Texas M.D. Anderson Cancer Center estimated that the number of new cancer cases in the United States each year will increase by 45 percent over the next two decades, to 2.3 million per year by 2030.

It is thus quite understandable when the public and those responsible for health care ask if we are investing enough to advance the science needed to avert such predictions. Since 1971, the Federal Government, private foundations, and companies have spent approximately $200 billion on cancer research. This investment has led to our understanding of many of cancer's numerous complexities; has resulted in a steady decline in the annual overall cancer mortality—and has increased the number of cancer survivors to more than 12 million Americans. NCI's budget request and its research projects are consistent with the President's multi-year commitment for cancer and autism. Aggressive programs in screening and prevention have greatly reduced the incidence of a number of cancers. For example, NCI led efforts to eliminate the use of tobacco has resulted in a 1.9 percent decrease per year from 1992 to 2003 in male lung cancer incidence rates. This has accelerated to a 3.3 percent decline per year over the period from 2003 to 2006. Despite these advances, it is evident that a greater investment than ever is needed to continue the dissection of the fundamental biology underlying the initiation of abnormal cell growth and its progression to invasive and metastatic disease.

THE POWER OF THE GENOME

Cancer is an extremely complex disease of altered genes. These changes within the cells of our body take many forms—and are both inherited and acquired, as we

live out our lives. Since the completion of the Human Genome Project in 2003, the knowledge of the genetic alterations associated with cancer has grown exponentially. Vastly improved technologies are making it possible to study the genomes of thousands of individuals, in the search for common abnormalities that point to risk of cancer. Likewise, one of NCI's signature projects, The Cancer Genome Atlas (TCGA), is studying the genetic changes associated with the development of several cancer types, including lung, ovarian, and brain cancers. The success of this pilot program is leading NCI to expand TCGA's scope to the sequencing of 20 to 25 tumor types. Sequencing these tumors in more than 200 patients per tumor type, coupled with whole genome scans of large population cohorts, is uncovering important information about cancer risk and patient-specific profiles unique to disease. Within just 5 years, some have suggested, whole genome deep sequencing will be part of virtually every laboratory cancer experiment, and within a decade, such deep genomic sequencing will be commonplace for patients.

At this moment, the results of this deep probing of the genetic basis of cancer remain, in most cases, fascinatingly powerful information. How we turn that information—sometimes referred to as code—into new methods of prevention, early detection, and treatment of cancer will require a major infusion of new resources. We must convert this coded information, which is stored in large data sets, into a clear interpretation and understanding of the functional biological alterations these genetic changes impart. NCI is working to fill this large gap in our knowledge, through a well-considered, coordinated blueprint appropriate for a new era of medicine. It begins with new discoveries at the level of the gene and ends at the patient's bedside.

NCI is preparing to bring together a network of investigators, whose work will begin after genomic sequencing is completed, taking information generated by TCGA and allied projects and turning that data into new knowledge of biologic function. The goal will be to identify potential new therapeutic targets in molecular pathways and physical processes that are, today, considered "undruggable." This network will be virtual: a consortium of researchers primarily at research universities who will be offered the chance to participate in collaborative projects, often partnering between institutions. These projects will be prioritized on the basis of potential patient impact and technical feasibility—assigned to investigator sites on a competitive basis, each with a project manager.

The targets that will come forward from this functional biology consortium will be somewhat akin to a key piece of a jigsaw puzzle. It will be necessary to find the adjoining pieces—the new drugs, biologics, and other therapeutics—that connect. When potential new targets emerge, NCI will then employ its state-of-the art, high-throughput capacity to screen thousands of previously identified compounds, both natural and synthetic, to identify the exact piece to complete the puzzle.

In many cases, new therapies will require refinement, for example, to make them water soluble, or to create mass-producible versions of a natural product. Another virtual network, the Chemical Biology Consortium, will provide the necessary chemistry and chemists to optimize further development of these new anti-cancer agents. NCI will then be able to have those new agents produced in small batches for refinement and testing—using best manufacturing principles—and move them into preclinical testing, including toxicology screening.

Early phase clinical trials will follow. NCI has conducted the first of a new kind of trial called Phase 0, which uses a small number of carefully selected patients who, after receiving small doses of new drugs, are studied, in real time, at the molecular level, to see if the new medication is reaching and affecting its target. Phase 0 trials will allow for significantly earlier decisions on whether to move forward with Phase 1 trials.

It is not only Phase 0 trials that will require well characterized patients. As genomic characterization of the populace comes closer to becoming standard medical practice, NCI is taking steps on the leading edge of that transition, creating the first of a national network of patient characterization centers that will centrally conduct genomic and genetic characterization. Always employing the latest technologies and standardized protocols, these facilities will serve wide geographic areas, bringing together genomics and genetics, proteins and proteomics, all in the interest of matching a genetically characterized patient and his or her characterized tumor to appropriate and optimal therapeutic solutions.

The NIH Clinical Center; NCI's Specialized Programs of Research Excellence; the NCI Community Cancer Centers Program; Cooperative Groups; the Community Clinical Oncology Program; and the NCI-designated Cancer Centers network will all be key players in establishing a highly characterized national cohort of patients who can be easily matched with potential new agents.

DEVELOPING ELECTRONIC HEALTH RECORDS

Creating an integrated, 21st century translational science program will require data integration and a national commitment for the cancer electronic health record. NCI's cancer Biomedical Informatics Grid, better known as caBIGT, and its companion BIG Health Consortium, are leaders in this Federal effort, working to develop a unified biomedical information infrastructure, along with data standards and protocols for electronic medical records that are consistent with the Federal Government's national health IT efforts. Through caBIG, NCI is helping both large facilities from the NCI-designated Cancer Centers network and local facilities in the NCI Community Cancer Centers Program develop electronic records.

In addition, accomplishing the scale-up of TCGA and the genetic characterization of our patients—with data integration through caBIG—will require biospecimens collected using standardized protocols, tissue characterization, cataloging, and analysis, all coordinated by NCI's caHUB initiative.

A WIDE-RANGING EFFORT

This plan will require the contributions of biologists, chemists, informaticians, and clinical scientists devoted to a clear path from discovery to patient. This is not only the nature of translation; it will be a model for the study of many diseases and, ultimately, a model of 21st century healthcare. This platform is a vision for a new way of thinking. But it is not an unrealistic concept. It is an action plan: a roadmap for what we have begun to assemble this year, making the optimal use of every new resource.

In 2008, NCI began a series of meetings with theoretical physicists and mathematicians, designed to bring unique perspectives to the problem of cancer. The result is a new network of physical sciences—oncology centers, soon to launch, which will study physical forces—heat, stress, and cellular evolution, just to name a few—in cancer. This network is an exciting frontier in cancer research, which we fervently believe will be further proof that scientific collaboration pays great dividends.

NCI's goal is to make cancer a chronic condition one can live with, and not die from. We will continue to find better ways to prevent cancer's development and for the earliest detection, when a tumor is limited to a very small number of cells. We will continue to develop new therapies with fewer side-effects and greater quality of life. We will continue to study environmental causes of cancer. We will continue efforts to better understand the behaviors that increase cancer risk, and we will continue to follow those who have survived cancer, to understand the reasons why they are so often at risk for subsequent malignancies. These efforts will require coordinated programs and the continued work of a remarkable national cadre of individual laboratory investigators.

NCI is committed to paying dividends on behalf of every American. We no longer fear speaking the word cancer. Yet, our work is far from finished, and NCI remains committed to making every effort to advance a vastly different medical future.

Thank you for the opportunity to provide you this testimony. I look forward to the opportunity to take your questions.

PREPARED STATEMENT OF ELIZABETH G. NABEL

Mr. Chairman and members of the subcommittee: I am pleased to present the President's fiscal year 2010 budget request for the National Heart, Lung, and Blood Institute (NHLBI) of the National Institutes of Health (NIH). The fiscal year 2010 budget of $3,050,356,000 includes an increase of $34,667,000 over the fiscal year 2009 appropriated level of $3,015,689,000.

The NHLBI provides global leadership for a research and education program to promote prevention and treatment of heart, lung, and blood diseases. The vision is to enhance the health of all individuals and thereby enable them to lead longer and happier lives. The work of Institute is guided by the goals and approaches outlined in its strategic plan, which was completed and published in September 2007 and submits that its research projects re consistent with the President's multi-year commitment for cancer and autism.

This statement describes several initiatives that are being undertaken during the current fiscal year and outlines a number of opportunities to be addressed in fiscal year 2010.

STEM CELL CONSORTIUM

Recent advances in knowledge, coupled with development of new technologies and reagents, have set the stage for rapid progress in the field of regenerative biology

and medicine. The NHLBI is capitalizing on this extraordinary opportunity through formation of a Progenitor Stem Cell Biology Consortium that includes leading scientists in the fields of cardiovascular, pulmonary, and hematopoietic cell biology working closely with experts in the general field of progenitor cell biology. Its goal is to identify and characterize progenitor cell lineages, to direct the differentiation of stem and progenitor cells to desired cell fates, and to develop strategies to address the challenges presented by the transplantation of such cells. The Institute will fund 6 research hubs and 1 administrative coordinating center in fiscal year 2009, with plans for a total support period of 7 years.

CLINICAL TRIAL OF HYPERTENSION MANAGEMENT STRATEGIES

A new clinical trial, the Systolic Blood Pressure Intervention Trial (SPRINT), was launched in fiscal year 2009. The health benefits of lowering blood pressure in individuals with hypertension have been well demonstrated, and current practice strives to achieve a systolic blood pressure (SBP) level below 140 mmHg for most patients. However, epidemiological evidence suggests that the optimal SBP goal may be even lower. SPRINT will enroll about 7,500 individuals with hypertension or pre-hypertension, randomly assign them to a SBP goal of <120 mmHg or <140 mmHg, and assess cardiovascular disease outcomes. The potential public health impact of this work is substantial, given the multi-millions of people in this country and worldwide who suffer from high blood pressure.

ASTHMA NETWORK

The NHLBI has for many years supported highly successful clinical research networks designed to fill gaps in science and address emerging areas of concern in the management of asthma. Upon the anticipated end of the current funding period for the asthma networks, the Institute convened a workshop to obtain advice from key scientific leaders on a network structure that would sustain the past success and meet future clinical research needs. As a result of its recommendations, the Institute is establishing AsthmaNet, a clinical research network that will develop and conduct clinical trials of new treatment and management approaches in pediatric and adult populations. Launched in fiscal year 2009, AsthmaNet will include multiple clinical centers and one data coordinating center. The NHLBI's plans for promoting use of shared resources and promoting programmatic and scientific efficiency in the network coincide with the expansion of the NIH Roadmap initiative to Re-engineer the Clinical Research Enterprise through the Clinical and Translational Science Award program.

HEMOGLOBINOPATHIES DATA SYSTEM

The NHLBI is developing and implementing a national data system and biospecimen repository on people with sickle cell disease, thalassemia, and hemoglobin E disease. It will be designed to collect, analyze, interpret, and disseminate State-specific data on the epidemiology, clinical characteristics, healthcare utilization, and community resources of patients with these conditions. The system will support research, information dissemination, policy decisions, healthcare planning, and provider training at the social, State, and national levels. This fiscal year 2009 initiative is being conducted via an interagency agreement with the CDC.

CARDIAC TRANSLATIONAL RESEARCH IMPLEMENTATION PROGRAM (C–TRIP)

A new program has been designed to accelerate the movement of laboratory discoveries to the bedside of patients with heart failure or arrhythmias. C–TRIP is a two-stage project to speed translation of promising new therapeutic interventions derived from basic research through well-designed clinical trials to demonstrate safety and efficacy. Two-year stage 1 exploratory planning grants, to be awarded in fiscal year 2010, will support feasibility studies, analysis of existing data, preparation for regulatory clearances, team-building, development of clinical management tools and recruitment strategies, and finalization of protocols. Subsequently, stage 2 grant applications will be considered for the conduct of the safety and efficacy trials.

NEW PROGRAMS TO PREVENT AND TREAT CHILDHOOD OBESITY

Obesity is a major cause of morbidity and mortality, and effective interventions are urgently needed to address this increasingly prevalent public health menace. A new research consortium will test the efficacy of innovative approaches to prevent weight gain among normal-weight young children and to prevent additional weight gain or facilitate weight loss among obese adolescents.

A second fiscal year 2010 initiative will examine outcomes associated with existing community programs designed to reduce childhood obesity by improving children's diet and physical activity. One research unit will be funded to serve as a study coordinating center, which will work with the National Collaborative on Childhood Obesity Research to design and implement the research. The study will establish common metrics for evaluation of the programs and examine outcomes associated with program policies, environments, educational activities, dietary and physical activity regimens, and other factors. The goal is to inform national and local policy for control of childhood obesity.

RESUSCITATION OUTCOMES CONSORTIUM (ROC) RENEWAL

In 2004 the NHLBI, the American Heart Association, the U.S. Department of Defense, and several Canadian health agencies established the ROC to design and conduct studies of promising experimental strategies to resuscitate patients who experience out-of-hospital cardiac arrest or life-threatening trauma. The ROC brings together investigators, hospitals, emergency medical services (EMS), and local communities to address the unique characteristics of this research and ensure the efficient translation of proven strategies into clinical practice. In addition to supporting new trial protocols, the 2010 renewal will develop information to define and improve prehospital best practices, facilitate public health efforts for the prevention of emergency life-threatening conditions, and improve EMS delivery and training.

PREMATURITY AND RESPIRATORY OUTCOMES PROGRAM (PROP)

The new PROP will promote collaborative, innovative research to identify mechanisms, and associated biomarkers of respiratory disease risk of premature infants who are ready for discharge from the neonatal intensive care unit. Increased survival of very premature infants is leading to increasing numbers of children with chronic lung disease that often results in multiple readmissions. Currently no objective measures exist that can be used to predict which premature newborns will have persistent respiratory problems after discharge from the hospital. This cooperative, multidisciplinary scientific group will investigate hypotheses on the molecular mechanisms that make certain premature newborns prone to develop recurrent respiratory disease, with the long-term goal of improving outcomes in the first year of life.

NHLBI PROTEOMICS INITIATIVE

The Institute will continue to invest substantial resources in the use of proteomic approaches and technologies to develop a greater understanding of pathway and interactions that influence heart, lung, and blood diseases. Planned for fiscal year 2010 is a combined renewal of the NHLBI Proteomic Centers and the NHLBI Clinical Proteomic Program, both of which terminate in September 2009. Each of seven centers will focus on proteomic technology development and molecular mechanistic and functional studies related to a specific clinical need, problem, or disease. The ultimate goal of this work is to bring greater precision, reliability, and sensitivity to detection, diagnosis, treatment, and prevention strategies for the individual patient.

We are delighted to have the opportunity to pursue these exciting new research avenues. I would be pleased to answer any questions the subcommittee may have.

PREPARED STATEMENT OF ANTHONY S. FAUCI

Mr. Chairman and members of the subcommittee: I am pleased to present the President's fiscal year 2010 budget request for the National Institute of Allergy and Infectious Diseases (NIAID), of the National Institutes of Health (NIH). The fiscal year 2010 budget includes $4,760,295,000, which is $57,723,000 more than the fiscal year 2009 appropriation of $4,702,572,000.

NIAID conducts and supports biomedical research to understand, treat, and prevent infectious and immune-mediated diseases of domestic and global concern, including HIV/AIDS, tuberculosis, malaria, neglected tropical diseases, emerging and re-emerging infectious diseases. NIAID's budget request and its research projects are consistent with the President's multi-year commitment for cancer and autism. As economies and societies around the world have become increasingly interdependent, responding to emerging infectious diseases, such as the 2009-H1N1 influenza virus, as well as to long-established health challenges such as neglected tropical diseases, has taken on new urgency. As we address infectious diseases in a global context, we have the added benefit of contributing to preparedness against

the threat of bioterrorism and naturally occurring disease outbreaks. Meanwhile, our ongoing research on domestic health challenges such as HIV/AIDS, influenza, and asthma, allergies, and other immune-mediated diseases continues to yield important advances. Using a multidisciplinary approach that engages academic, industry, governmental, and nongovernmental partners, NIAID remains committed both to basic immunology and infectious disease research and the application of this knowledge to the development of strategies to detect, prevent, and treat these diseases.

The research activities of NIAID will become more important than ever, as current and as-yet unrecognized health threats, particularly in the context of the inevitability of emerging and re-emerging infectious diseases, will require new diagnostic, preventive, and therapeutic interventions. These new tools promise to have a great impact on the public health over the next two decades.

We have long known that the threats posed by infectious microbes do not remain static, but change over time as new microbes emerge and familiar ones re-emerge with new properties or in new settings. This will not change in the coming decades. Addressing these global threats requires that we consider infectious diseases not through the lens of individual diseases, infections, or microbes in a vacuum, but by understanding how diseases interact in people with multiple health issues. Only then can we develop the tools for a comprehensive and practical approach to global health.

Tuberculosis (TB) is a prototypic example of a re-emerging threat as an increase in the prevalence of drug-resistant forms of TB presents major challenges to the control of this disease. TB also is an example of a disease that often occurs with other infectious diseases such as HIV/AIDS—people co-infected with TB and HIV appear to have a more rapid and deadly disease course. Recently, NIAID-supported clinical trials have shown that mortality among TB patients co-infected with HIV is remarkably reduced when antiretroviral (ARV) therapy is provided at the same time as TB therapy. Additional studies are under way to determine optimal strategies for the prevention, treatment, and diagnosis of TB in the setting of HIV infection. NIAID continues to conduct and support research to create a foundation of knowledge for the discovery of new diagnostics, drugs and vaccines for TB, including drug-resistant TB. The Institute's support for public-private partnerships has been instrumental in linking research across sectors to build a robust pipeline of tools to combat TB.

Malaria continues to exact a devastating toll on individuals worldwide, mostly among children in sub-Saharan Africa. Compounding the problem is the emergence of drug-resistant malaria parasites and insecticide-resistant mosquito vectors. In 2008, the Institute released the NIAID Strategic Plan for Malaria Research and the NIAID Research Agenda for Malaria. The Plan and Agenda outline our efforts to accelerate control and move toward eradication of malaria through biomedical research, including the development of prevention modalities, promising drugs and vaccine candidates. Accomplishing these goals will require the support and cooperation of malaria researchers and other organizations to build on the foundation of NIAID's basic research program in malaria. Over the next two decades, we hope to have a major impact on global TB and malaria burden through the development of vaccines that protect against these infectious killers.

Seasonal influenza, which changes slightly every year, is the classic example of a re-emerging infectious disease. Influenza viruses also can undergo more drastic genetic changes that periodically enable them to evade pre-existing immunity and cause a pandemic, such as the deadly influenza pandemic in 1918 that killed more than 50 million people worldwide. NIAID has seen significant progress in its influenza research program, particularly in the area of pandemic influenza preparedness. This progress has prepared the Institute to respond rapidly to the newly identified 2009-H1N1 influenza virus, which has emerged as a public health threat in the United States, Mexico, and throughout the world. NIAID-funded researchers have responded quickly to this new threat, characterizing the virus and preparing for the development of a vaccine and other countermeasures.

Nearly 28 years since the first cases of AIDS were documented, the terrible burden of HIV/AIDS continues to grow. The 2.7 million new infections worldwide in 2007 underscore the continuing urgency of the global AIDS pandemic, and sobering HIV/AIDS statistics in the District of Columbia remind us that the AIDS epidemic here in the United States demands our strongest efforts. Over the past two decades, NIH and NIAID—supported by Congress and by this subcommittee—have devoted substantial resources to the fight against HIV/AIDS.

Worldwide, for every two people who receive ARV treatment, five others are newly infected. Therefore, our first priority in the fight against HIV/AIDS is prevention. NIAID-supported investigators have made great strides in advancing our under-

standing of the modalities of effective prevention, including those that prevent mother-to-child transmission of HIV. NIAID-supported research recently determined that medically supervised circumcision of adult males markedly reduces the risk of HIV acquisition through heterosexual intercourse for at least 3.5 years after the procedure, demonstrating long-term efficacy of male circumcision as a prevention tool. Research conducted by our Microbicide Trials Network found the microbicide gel PRO 2000 to be safe and showed the first suggestion of potential efficacy among several clinical trials with other products. Of course, the most powerful prevention tool would be a safe and effective HIV vaccine. In response to the significant challenges that United States and international vaccine investigators have experienced in HIV vaccine development, NIAID has expanded our basic vaccine discovery research portfolio to provide the knowledge necessary to identify a viable HIV vaccine candidate. Our hope is that these advances in HIV prevention research will become part of a comprehensive HIV prevention "toolkit" that will markedly decrease new infections over the next two decades.

In addition to these prevention modalities, NIAID is boldly advancing three new approaches to HIV prevention. Together with Government and nongovernmental partners, the Institute is investigating the feasibility of pre-exposure prophylaxis (PrEP) for HIV prevention, which involves providing ARVs to HIV-negative individuals who are at high risk of HIV infection. Second, recent modeling data have shown that aggressive HIV testing and treatment potentially could reduce the number of new HIV cases by 95 percent in the next decade; NIAID is evaluating critical research questions that underpin the validity of this voluntary "test and treat" approach. Finally, NIAID is expanding its efforts to find a cure for HIV/AIDS. Through research to improve our basic understanding of HIV viral latency, we hope to achieve long-term HIV remission following discontinuation of effective therapy—a "functional" cure—or, ultimately, a complete eradication of residual virus.

Since the acceleration of our biodefense research program in fiscal year 2003, NIAID has achieved major successes in the development of countermeasures against significant bioterrorism threats. Some countermeasures have been fully developed and are stockpiled or available for use in an emergency; others in the pipeline have been transferred to the HHS Biomedical Advanced Research and Development Authority for advanced development. Promising candidate countermeasures in development include ST–246, a smallpox drug candidate that has protected animals from an otherwise lethal exposure to live poxviruses.

Equally important, NIAID has developed a physical and intellectual research infrastructure that has been critical to our ability to respond to new and re-emerging infectious diseases. This year, the Institute recompeted the Regional Centers of Excellence for Biodefense and Emerging Infectious Diseases, which comprise a network of 11 regionally based, multi-institutional centers engaged in interdisciplinary research to develop vaccines, therapeutics, adjuvants and diagnostics for biodefense and emerging infectious diseases.

Autoimmune diseases, allergic diseases, asthma, rejection of transplanted organs, and other immune-mediated disorders are significant causes of chronic disease and disability in the United States and throughout the world. NIAID-supported research in immunology and immune-mediated diseases has led to significant advances in our understanding of the mechanisms underlying these diseases and in the development of strategies to detect, prevent, and treat them.

For example, food allergies affect the health and quality of life of many Americans, particularly young children. NIAID remains committed to basic research and clinical studies to advance the understanding of food allergy and food allergy-associated anaphylaxis. In June 2008, NIAID awarded 12, 2-year grants, totaling $2.5 million, to investigators to lead high-impact, innovative studies of food allergy under the Exploratory Investigations in Food Allergy initiative. Cosponsored with the Food Allergy and Anaphylaxis Network, the Food Allergy Project, and the U.S. Environmental Protection Agency, this program supports innovative pilot studies on the mechanisms of food allergy, with a goal of attracting new investigators to the field of food allergy research. We plan to renew this program in fiscal year 2010.

NIAID also continues to support clinical trials to prevent the development of food allergies and to reverse established allergy to milk, eggs, and peanuts. Lastly, NIAID, in collaboration with professional societies, advocacy groups, and other Federal agencies, is developing clinical guidelines to provide guidance to medical practitioners on the diagnosis, management, and treatment of food allergies.

For more than six decades, NIAID has conducted and supported basic research on infectious and immune-mediated diseases that has underpinned the development of vaccines, therapeutics, and diagnostics. These, in turn, have improved health and saved millions of lives in the United States and around the world. Through partnerships with academic, industry, governmental, and nongovernmental partners, the

Institute will continue to leverage these fundamental discoveries into the tools needed to achieve a healthy world.

PREPARED STATEMENT OF DR. ROGER I. GLASS, DIRECTOR, FOGARTY INTERNATIONAL CENTER

Mr. Chairman and members of the subcommittee: I am pleased to present the President's budget for the Fogarty International Center (FIC) of the National Institutes of Health (NIH). The fiscal year 2010 budget of $69,227,000 includes an increase of $536,000 more than the fiscal year 2009 appropriated level of $68,691,000.

Over the past year, Congress has renewed its commitment to confronting global health issues, recognizing that these investments will not only improve the health and well-being of all, but also enhance U.S. stature abroad, economic development, and U.S. competitiveness. As the recent H1N1 virus outbreak illustrates, solving health problems in an interconnected world requires greater international collaboration than ever before. To effectively confront complex health issues that transcend national boundaries, scientific collaborations must be continually developed and nurtured. Research advances are more likely to occur when investigators study diseases on-site, and U.S. scientists partner with international scientists to develop health interventions that are responsive to local and international needs and priorities. This model requires a critical mass of trained, in-country scientists and capable institutions that are uniquely positioned to address local study populations and to support sustainable collaborations with U.S. and other investigators.

Since its inception, the Fogarty International Center (FIC) has been the focal point for global health at the NIH. FIC supports and facilitates global health research conducted by U.S. and foreign investigators, builds collaborations between U.S. and health research institutions worldwide, and trains the next generation of scientists to address global health needs. FIC-supported research and research training programs address a wide range of diseases and needs, including HIV/AIDS, malaria, Tuberculosis and other infectious diseases; noncommunicable diseases, such as brain disorders and cancer; and cross-cutting areas that foster sustainable research environments, including research ethics and informatics for health research. In 2008, FIC launched a strategic plan that addresses emerging areas of science and shifting disease burdens, and strengthens the global health research workforce in the United States and around the world.

ADDRESSING THE RISING BURDEN OF NONCOMMUNICABLE DISEASE

Rapidly developing countries like India, Brazil, Mexico, China, and Bangladesh have seen life expectancies grow for the past 40 years. Population forecasts now predict that by 2030, 1 out of 8 people will be 65 or more than 1 billion adults. In addition, poorly balanced nutrition, less physical activity, and tobacco use are all on the rise in developing countries as a result of poverty, industrialization, urbanization and global marketing of goods and products. With increasing longevity, convergence of risk factors and diseases blurs the distinction between disease burdens in developing and developed countries, and calls for a common health research agenda. International research collaborations to study these diseases in highly endemic areas accelerate scientific advances on how to prevent and treat them. In response to this trend, FIC established the new Millennium Promise Awards in Non-Communicable Disease Program in partnership with several other NIH Institutes, designed to support research training in low- and middle-income countries in fields related to cancer, stroke, lung diseases, obesity, and environmental factors.

According to the World Health Organization, tobacco use kills 5.4 million people every year—an average of 1 person every 6 seconds. Almost half the world's children breathe air polluted by 8 causes of death in the world. If current smoking patterns continue, this number will rise to 8 million in 2030, with approximately 80 percent of the deaths occurring in developing countries. FIC, in partnership with the National Cancer Institute and the National Institute on Drug Abuse, is helping to address this rising epidemic through its International Tobacco and Health Research and Capacity Building Program. This program enhances the ability of scientists in low- and middle-income nations to understand risk factors for smoking uptake, particularly in youth, to develop effective prevention and mitigation programs, and to identify the most effective implementation and communications strategies to reduce the negative impacts of smoking on populations. The knowledge gained and effective interventions developed abroad through the Tobacco Program will also benefit U.S. populations who share common risk factors with low-resource communities in developing countries.

The continuing burden of infectious disease in low-income populations, as well as the rapid rate at which microbial agents can evolve, adapt and develop resistance to antibiotics, demand that FIC continue to invest in infectious disease research and training. In particular, FIC will continue to support interdisciplinary research that develops predictive models and principles governing the transmission dynamics of infectious disease agents. This will result in increased capacity to forecast outbreaks and improved understanding of how diseases like the H1N1 flu emerge and re-emerge, and strategies to control them.

ADVANCING IMPLEMENTATION SCIENCE

Unprecedented resources are being invested in interventions that have been proven safe and effective, although many have not been implemented on a wide scale due to logistical, cultural, financial, and other barriers. Bridging the gap between effective interventions and improved health outcomes will in large part depend on a cadre of local scientists who can ask and answer questions regarding what works, what does not, and why, in particular settings. To advance this area of science FIC supports research training for scientists who can generate knowledge to improve scale-up of interventions and help identify the most effective ways to translate research findings into clinical and public health practice.

For example, FIC's International Clinical, Operational, and Health Services AIDS/TB Research Training Program is developing a network of researchers who are studying how to best apply research knowledge and new technologies related to HIV/AIDS and TB in clinical and community settings. With support from this program, scientists in Haiti have developed a new masters degree in public health program at a Haitian university and are training the personnel needed to monitor and evaluate the implementation of a new country-wide program to provide a standardized package of HIV care and prevention to 300,000 people per year.

MAINTAINING U.S. LEADERSHIP IN GLOBAL HEALTH RESEARCH

If we are to continue to lead in biomedical research, then U.S. researchers must be supported to effectively participate in international science. Biomedical research has always been an inherently international enterprise. Many significant scientific advances have resulted from research conducted by teams of scientists working across international borders. For example, U.S. and local scientists together pioneered the development of oral rehydration therapy (ORT) for treatment of cholera. ORT is now the first line treatment for childhood dehydration worldwide and recommended for treatment of every American child with diarrhea. In this era of globalization, this trend will not only continue, but will likely become stronger. It will also require a well-trained cadre of U.S. health scientists who are able to work seamlessly in diverse settings.

To this end, FIC support strengthens the ability of U.S. academic institutions to engage in the global scientific marketplace. The vast majority of FIC awards support scientists in U.S. institutions, who in turn collaborate with colleagues in foreign institutions. Additionally, FIC is capitalizing on the burgeoning interest in global health on U.S. university campuses through two innovative programs. First, we are providing a launching pad for American health sciences students and junior researchers to build relationships abroad and to address critical global health research questions through the Fogarty International Clinical Research Scholars Program (FICRS). This program responds to the acute need for future clinical investigators who can help translate basic research advances into clinical practice on a global scale. This next generation of clinical researchers will require hands-on experience in conducting clinical trials and clinical research in countries where the disease burdens are highest. The FICRS provides highly motivated U.S. graduate students in the health sciences and medical residents or fellows 1 year of mentored clinical research training at distinguished low- and middle-income country research institutions. Each U.S. student is paired with a foreign student, who also receives training as an equal partner, thus strengthening scientific capacity in the United States and abroad simultaneously. Several NIH Institutes partner with FIC in the effort, and therefore, the program includes a wide breadth of research areas, including cancer, maternal and child health, and extensively drug-resistant TB.

An increasing number of U.S. and foreign academic research institutions are welcoming the opportunity to use their substantial creative resources to make a significant and lasting difference in global health. As scientific problems become more complex, there is a need for team and systems approaches to tackle important health challenges. To help catalyze this approach in academic research institutions, Fogarty's Framework Programs for Global Health support the development of multidisciplinary global health programs on campuses in the United States and in low-

and middle-income countries. This innovative program develops new curricula and degree programs that cut across departments and schools to create a pipeline for a new generation of researchers schooled in multiple fields to address global health challenges. Schools representing more than 17 different disciplines participate in the program including, engineering, environmental sciences, journalism, business, law, medicine and public health.

Congressman Fogarty was prescient in arguing that the needs and rewards of global health research will benefit the United States as well as the global community. FIC is extending his vision, given that international trade, travel and communications have created a truly interdependent world. As we look to the next two decades, we envision a world in which a global scientific workforce is equipped with the knowledge and the skills to better prevent and treat disease as a result of rigorous global research. This workforce will form the backbone of research institutions in the United States and abroad, which will be effectively linked with each other through years of sustained productive research and training collaborations. Working towards this vision moves us closer to the ideal of global health—one that reflects the aspiration of all people to live long and healthy lives.

PREPARED STATEMENT OF DR. JOSEPHINE P. BRIGGS, DIRECTOR, NATIONAL CENTER FOR COMPLEMENTARY AND ALTERNATIVE MEDICINE

Mr. Chairman and members of the subcommittee: I am pleased to present the President's fiscal year 2010 budget request for the National Center for Complementary and Alternative Medicine (NCCAM) of the National Institutes of Health (NIH). The fiscal year 2010 budget includes $127,241,000, which is $1,770,000 more than the comparable fiscal year 2009 appropriation of $125,471,000.

In December 2008, the NCCAM, in conjunction with the National Center for Health Statistics, released data from the 2007 National Health Interview Survey (NHIS).[1] The survey is the most comprehensive and reliable information to date on the use of complementary and alternative medicine (CAM) in the United States. The 2007 NHIS data confirm that millions of Americans—38 percent of U.S. adults and 1 in 9 children—use CAM to promote health and wellness and to address specific conditions such as chronic pain.

The NHIS data affirm the public health importance of NCCAM's mission to develop an evidence base for the integration of CAM with conventional healthcare and to disseminate research results to the public and healthcare professionals. Since its founding 10 years ago, NCCAM has created a nationwide CAM research enterprise, built on sound scientific principles, that enables the rigorous study of CAM. Among NCCAM's accomplishments are a Centers of Excellence program at leading biomedical research institutions; standards for quality and stability for the natural products used in research; and the development of tools and methodologies to discover the potential benefits and risks of CAM modalities. Today, under NCCAM's leadership, partnerships between biomedical research institutions and CAM institutions and practitioners are engaged in state-of-the-art scientific research. NCCAM-supported CAM research has resulted in more than 3,300 peer-reviewed publications. Professional associations, such as the American College of Physicians and the American Academy of Orthopedic Surgeons are now able to use CAM research findings to inform their practice guidelines. NCCAM will continue to meet the challenges of building the evidence base for CAM interventions through its rigorous research, research training, and outreach endeavors. NCCAM's budget request and its research projects are consistent with the President's multi-year commitment for cancer and autism.

A STRUCTURED APPROACH TO ANSWERING KEY QUESTIONS

CAM research is a promising scientific endeavor that requires multidisciplinary basic, translational, and clinical trial collaborations. In fiscal year 2010, NCCAM will fund awards under a new initiative, Partnerships for Complementary and Alternative Medicine Clinical Translational Research. This initiative, which replaces the NCCAM Developmental Centers for Research on CAM program, will foster such collaborations at CAM institutions and create tools and methodologies for research.

NCCAM investigations span the continuum of research areas: basic (How does the therapy affect the body?); translational (Do we have the methods and tools to detect and measure the modality's effects?); efficacy (Is there evidence of safety and benefit

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[1] Barnes PM, Bloom B, Nahin R. CDC National Health Statistics Report#12. Complementary and Alternative Medicine Use Among Adults and Children: United States, 2007. December 10, 2008.

under optimal research conditions?); and effectiveness (How well does the CAM practice work in the "real world" and in comparison to other treatments?). NCCAM has strong programs in all four of these areas; its current research strategy places particular emphasis on strengthening effectiveness research.

AREA OF PROMISE AND INVESTMENT: MANAGING CHRONIC PAIN

The 2007 NHIS data indicate that chronic pain is, by far, the most common health problem for which Americans turn to CAM. NCCAM-supported basic, translational, and clinical research is using state-of-the-art neuroscience, brain imaging, and novel study designs to demonstrate that mind-body medicine approaches, such as massage, chiropractic, and acupuncture, affect pain perception and to understand how patient expectancy and practitioner reassurance may have an impact on pain management. For example, using functional magnetic resonance imaging (fMRI) and positron emission tomography (PET), basic researchers are developing important insights into how acupuncture affects specific pain networks in the brain. In addition, emerging data, such as the recent report in the Annals of Internal Medicine that massage therapy and simple touch may provide pain relief for advanced cancer patients, point to the promise of mind-body practices. NCCAM is focusing on developing the evidence base for the use of nonpharmacologic CAM practices for pain management.

Chronic back pain is a problem for millions of Americans, and costs associated with it total at least $50 billion annually. [2] It is often difficult to treat, and medications used to address it can have troubling side effects. Certain CAM therapies, such as acupuncture, chiropractic, massage, and yoga, show promise in treating chronic back pain. In May 2009, NCCAM is sponsoring, with other NIH Institutes and Centers, a workshop on nonpharmacologic interventions for the treatment of chronic back pain, bringing together experts to identify gaps in the CAM evidence base and opportunities for future research. NCCAM plans to fund awards in fiscal year 2010 under a new initiative, Effectiveness Research—CAM Interventions and Chronic Back Pain. This initiative will support studies of CAM approaches to address a range of outcomes for back pain, such as reduced dependency on narcotics.

AREA OF PROMISE AND INVESTMENT: TRANSLATIONAL TOOLS

Basic and translational (i.e., "bench-to-bedside") research is especially challenging for CAM mind-body practices, acupuncture, and body-based and manipulative therapies, because current scientific methods may not adequately capture and measure the effects of these therapies. To decipher these practices' potential physiological effects and enable scientists to study them in clinical trials, better scientific tools, metrics, and methodologies must be developed. In fiscal year 2010, NCCAM will fund awards under its initiative, Program for Translational Tools for CAM Clinical Research. The research supported under this initiative will improve the quality and reproducibility of CAM clinical investigations.

AREA OF PROMISE AND INVESTMENT: NATURAL PRODUCTS

According to the 2007 NHIS, almost 40 million U.S. adults and 2.850 million children use natural products to manage their health and wellness. Given the widespread use of dietary supplements, NCCAM's research into the safety and efficacy of natural products remains a public health priority.

NCCAM-supported studies, including collaborations under the NIH Botanical Research Centers program, demonstrate the promise of natural products research. For natural products, basic and translational research remains critical precursors to large-scale clinical trials. A recent study by the University of Maryland and Rutgers University elucidated an immune system mechanism of action of green tea polyphenols on rheumatoid arthritis. In another study, Duke University researchers reported that bromelain, an enzyme derived from pineapple stems, reduced inflammation resulting from Crohn's disease and ulcerative colitis.

Although natural products research shows great promise, product quality remains a significant issue. In July 2008, an NCCAM-funded study in the Journal of the American Medical Association reported that one-fifth of Internet-available Ayurvedic medicines contained detectable levels of lead, mercury, and arsenic. The authors also found evidence for benefit of industry-established standards for quality in reducing levels of toxic metals. NCCAM has led the scientific community in requiring that all natural products used in its research undergo quality and stability screen-

[2] Low Back Pain Fact Sheet; National Institute of Neurological Disorders and Stroke, National Institutes of Health, Department of Health and Human Services, July 2003.

ing to ensure that the research is safe and reproducible. Ongoing collaborations with the dietary supplement industry are important to this effort. Equally important are NIH partnerships in the development of an evidence base for natural products.

MAKING WISE DECISIONS: OUTREACH

Studies confirm that consumers do not tell their doctors that they use CAM, and doctors do not ask their patients about CAM use. To ensure safe, coordinated care NCCAM developed its time to talk patient and provider education program. NCCAM also partnered with the National Institute on Aging to develop a CAM section on NIH Senior Health, the NIH Web site especially for older adults.

In fiscal year 2009, NCCAM will initiate a new educational section of its Web site (nccam.nih.gov) to provide health professionals with evidence-based information and clinical practice guidelines on CAM use. NCCAM also cosponsored the North American Research Conference on Complementary and Integrative Medicine, on May 12–15, 2009. This international meeting of scientists and CAM and conventional practitioners highlighted the emerging science on CAM and future directions for research.

NCCAM: LOOKING TO THE FUTURE

There are areas of considerable promise and potential for the field of CAM research, and NCCAM will focus its resources to ensure that they will be optimally directed. The Center has begun to develop its next strategic plan, seeking the input of the scientific community as well as its diverse community of stakeholders. As a first step in this process, the Center has convened a Blue Ribbon Panel to consider future directions for its intramural research program.

Thank you for the opportunity to testify. I would be pleased to answer the subcommittee's questions.

PREPARED STATEMENT OF DR. BARBARA M. ALVING, DIRECTOR, NATIONAL CENTER FOR RESEARCH RESOURCES

Mr. Chairman and members of the subcommittee: It is a privilege to present to you the President's budget request for the National Center for Research Resources (NCRR) for fiscal year 2010. The fiscal year 2010 budget of $1,252,044,000 includes an increase of $25,781,000 more than the fiscal year 2009 appropriated level of $1,226,263,000. NCRR's funding priorities for fiscal year 2010 include expansion of the Clinical and Translational Science Awards (CTSA) program. Additionally, NCRR will sustain the range of activities supported by the Center's other major programs, including the Research Centers in Minority Institutions, the Institutional Development Awards, the National Primate Research Centers, and the Biomedical Technology Research Centers.

The mission of the NCRR, as one of the 27 Institutes and Centers of the National Institutes of Health (NIH), is to provide support and training for researchers that extend from the laboratory to clinical trials and into dissemination of prevention strategies and treatments that will impact communities as well as patients.

APPRECIATION FOR INVESTMENT IN RESEARCH INFRASTRUCTURE

On behalf of NCRR and the research community, I extend our appreciation to the President and the Congress for the $1.6 billion allocated to our Center as American Recovery and Reinvestment Act (ARRA) funding. We will ensure that the $1 billion for extramural construction funding and the $300 million in shared instrumentation funds are invested wisely at academic institutions throughout the Nation. The NCRR is using the additional ARRA funding to supplement awards in the Institutional Development Award (IDeA) program, the Research Centers in Minority Institutions (RCMI) program, the Clinical and Translational Science Award (CTSA) program, as well as other NCRR programs.

BUILDING A MATRIX FOR CLINICAL AND TRANSLATIONAL RESEARCH

The NCRR, through its stewardship of the IDeA, RCMI, and CTSA programs, is linking investigators and communities by supporting and encouraging collaborations for training, sharing of data, accelerating advances in research and clinical informatics, and dissemination of best practices for community engagement. For example, the University of Washington CTSA is partnering with academic institutions in IDeA States to create greater opportunities to reach underserved populations. CTSAs are also connecting with RCMIs: Emory University (Atlanta) is partnering with Morehouse School of Medicine; Vanderbilt University (Nashville, Tennessee is

partnering with Meharry Medical College; and Weill Cornell Medical College (New York) is partnering with Hunter College.

Led by NCRR, the CTSA program is a partnership between the NIH and a national consortium of 39 academic health centers and research institutions to build academic homes for clinical and translational research. The CTSA program is designed to translate more efficiently the rapidly evolving knowledge developed in basic biomedical research into treatments to improve human health. Additionally, the CTSAs are training a new generation of clinical and translational researchers to excel in the interdisciplinary, team science environment.

The momentum of the national CTSA consortium continues to build as new connections are rapidly emerging within, across, and beyond the consortium. In the last year, 15 new CTSAs joined the consortium, adding representation from 5 new States, additional pediatric expertise, and greater informatics capabilities. When the program is fully implemented, the NCRR expects to fund CTSA awards at 60 institutions at a total cost of $500 million per year. As the CTSA program increases in complexity and size, institutions are forming regional consortia to focus on shared goals with greater efficiency.

The CTSA institutions are using business principles and practices to improve the processes involved in translational research. Investigators and core facilities directors at the CTSA at Yale University are increasing efficiencies and reducing redundancies by using Web-based resources and systems to maximize the use of their core research facilities, which include imaging, informatics, and genomic. Thanks to this integration, researchers now have improved access to sophisticated technologies and valuable expertise with less administrative burden.

The CTSA consortium has identified five strategic goals: (1) to develop strategies and resources to move laboratory discoveries into early clinical testing (T1 translation); (2) to reduce complexities and improve ways clinical and translational research is conducted; (3) to enhance training and career development of clinical and translational investigators; (4) to encourage consortium-wide collaborations; and (5) to improve the health of communities across the Nation.

FOSTERING T1 TRANSLATIONAL RESEARCH

The potential to accelerate research discoveries from the bench into early clinical studies (T1) usually requires preclinical studies, those studies that involve the appropriate animal models. Currently, researchers with expertise in animal models (including mouse, rat, and nonhuman primate models) are working with CTSA investigators on pilot projects that focus on cardiovascular disease, ovarian cancer, and other diseases. NCRR and its National Primate Research Centers are working closely with National Institute of Allergies and Infectious Diseases and the NIH Office of AIDS Research to ensure that adequate numbers of animals and resources are available to meet the need for development of new AIDS vaccines.

NCRR's Biomedical Technology Research Centers are cutting-edge interdisciplinary centers that create transformative technological and computational infrastructure for biomedical research. The CTSAs are leveraging the expertise of investigators in these centers to conduct a wide range of translational research, from cell biology to clinical imaging.

LEVERAGING PARTNERSHIPS TO BENEFIT BIOMEDICAL SCIENCE

The CTSAs are realizing returns on their research discoveries by securing patents and licensing them. From 2006 to 2008, the CTSAs established more than 350 academic, public, and private partnerships. To achieve its overall mission to speed the translation of scientific discoveries to improve human health, the CTSAs are establishing innovative partnerships with industry to accelerate the development of treatments, diagnostics, and devices. For example, the CTSA at Scripps Research Institute is collaborating with Qualcomm to develop and clinically validate biosensors—tiny devices that measure body functions—and other wireless healthcare technologies. Similarly, the Oregon Health and Science University is partnering with Intel to apply wireless and mobile technology with various sensors to enable earlier detection and treatment of life-threatening events for diabetics and individuals at high risk of stroke.

Ensuring that the public is actively engaged in research and benefiting from research findings is a key component of the CTSA program. One example of ways CTSAs are improving the health of their communities is a collaborative effort in Houston, which is helping children in two inner-city neighborhoods make healthier lifestyle choices and reduce their risk of obesity. CTSAs in Chicago have joined forces to ensure active participation from their communities throughout all stages of research—from project design to results dissemination. Similarly, connections be-

tween the CTSA consortium and NCRR's Science Education Partnership Award program are growing, helping to inspire the next generation of researchers. As an example, the University of Pittsburgh CTSA and Science Education Partnership Award investigators hosted an outreach event for middle school students, featuring a mobile science laboratory.

IMPROVING RESEARCH INFORMATICS

NCRR continues to support informatics tools and resources to enhance research collaboration. For example, NCRR is funding a Biomedical Informatics Research Network coordinating center at the University of Southern California to enhance data sharing among the network's research centers and other researchers. Through an ARRA-funded initiative, NCRR will facilitate interdisciplinary collaboration and scientific exchange by developing tools and infrastructure that will help connect basic, clinical, and translational investigators and students with other researchers that share their interests or who could benefit from their expertise. NCRR also plans to support development of an animal models informatics resource to provide researchers with one-stop access to information related to animal models of human disease.

EXPANDING RESEARCH CAPACITY

NCRR is enhancing the capabilities of RCMIs to conduct clinical and translational science through the RCMI Infrastructure for Clinical and Translational Research Awards. Funding may be used for out-patient clinical resources, biostatistical support, core laboratories, and patient-oriented research infrastructure. This award is a reorganization of previous RCMI programmatic activities and will enhance research capacity, improve collaboration between translational and clinical researchers, facilitate multidisciplinary training and career development and enable seamless interactions with CTSAs.

The IDeA program fosters health-related research and increases the competitiveness of investigators in 23 States and Puerto Rico. NCRR's previous investments in developing research capacity through its IDeA program have resulted in additional funding opportunities for investigators. For example, the University of Kansas recently received $9.6 million in grants from non-Federal sources for drug development efforts; the expertise that provided the foundation for this award grew, in part, from funding for a center of excellence in the IDeA program.

This snapshot of NCRR's programs and activities demonstrates our continuing commitment to advancing clinical and translational research. NCRR's budget request and its research projects are consistent with the President's multi-year commitment to finding cures for cancer and autism. By encouraging collaboration among our clinical and translational programs, NCRR is maximizing the Nation's investment to translate research discoveries into improved treatments for patients.

PREPARED STATEMENT OF DR. PAUL A. SIEVING, DIRECTOR, NATIONAL EYE INSTITUTE

Mr. Chairman and members of the subcommittee: I am pleased to present the President's budget request for the National Eye Institute (NEI). The fiscal year 2010 budget of $695,789,000 includes an increase of $7,309,000 more than the fiscal year 2009 appropriation level of $688,480,000.

OPHTHALMIC GENETICS

The loss of sight affects us in fundamental ways, threatening independence, mobility, and quality of life. Many eye diseases strike later in life. Thus, as life expectancy has increased, more Americans have become susceptible to vision loss and blindness. One such disease, age-related macular degeneration (AMD), is the leading cause of vision loss in the United States. AMD causes a progressive loss of light-sensing cells in the macula, the center of the retina, making it difficult to read, recognize faces, drive a car, or perform even simple tasks that require hand-eye coordination. Based on published study data, 8 million older Americans are at risk to develop advanced AMD.

Advanced AMD can take two distinct forms, either geographic atrophy or wet AMD. In geographic atrophy, large areas of the retina atrophy and die. In wet AMD, abnormal blood vessels grow into the retina, leaking blood and serum that damages the retina. Previous studies have found several gene variants, which regulate inflammation, are associated with the "wet" type of AMD. These variants are thought to lead to chronic, overactive inflammatory responses that damage retinal tissue and eventually lead to AMD. Most recently, the first gene associated exclusively with the

geographic atrophy, namely the Toll-like receptor 3 (TLR3) gene, was published. The TLR3 gene encodes a viral sensor which activates immune responses. When TLR3 activates in response to certain viruses, it induces cell death in the retina thus causing geographic atrophy. Alternatively, in humans, it appears that low activity of TLR3 confers protection against geographic atrophy, most likely by sparing the death of retinal cells. This is the first evidence that viral infection may contribute to the development of geographic atrophy. Ongoing work includes screening for viruses in affected individuals as well as developing methods to decrease TLR3 activity in the retina.

Glaucoma is a group of eye disorders that share a distinct type of optic nerve damage, which can lead to blindness. Elevated intraocular pressure is frequently, but not always, associated with glaucoma. Published study data find that approximately 2.2 million Americans have glaucoma and a similar number are unaware that they have developed the disease. Like AMD, glaucoma is a genetically complex disease likely involving many changes in many genes. NEI is committed to exploiting the latest genetic technologies in finding the genes that contribute to this common disorder. To this end, NEI initiated funding for genome-wide association studies, a powerful approach that enables investigators to scan the entire human genome to detect multiple, subtle gene variants that increase the risk of developing this complex, blinding disease. Knowledge of the genetic basis of glaucoma is crucial to developing personalized therapies that target specific genes in order to prevent vision loss.

Each genetic discovery has made it possible to study the implicated gene's function in health and disease. NEI investigators have made considerable progress in understanding the molecular mechanisms of genetic eye disorders and are developing rational therapies that address the molecular cause of the disease. The first success in this translational research effort are the reports of positive results from recent phase I clinical trials of gene transfer in a form of Leber congenital amaurosis, a severe, early onset retinal disease. In the effort to accelerate progress NEI established eyeGENE, a research program that offers genetic testing to patients through a national network of vision research laboratories in exchange for participation in a secure, confidential patient registry and DNA repository. DNA samples and corresponding diagnostic and clinical information are made available to the vision research community to recruit patients for clinical trials and to conduct genetic and molecular studies. eyeGENE represents a new paradigm to personalize medical care in the practice of ophthalmology. Knowledge of an individual's genomic profile will enable patients to make informed decisions about presymptomatic, preventive treatments or highly targeted molecular therapeutics.

TRANSLATIONAL MEDICINE

Neovascularization refers to the growth of new blood vessels. In some diseases, such as diabetic retinopathy and AMD, neovascularization is mistakenly activated and becomes a major pathologic consequence of the disease. Neovascularization can cause severe and irreversible vision loss due to abnormal vessel growth and consequent fluid leakage into the retina. Previous studies have established vascular endothelial growth factor (VEGF) spurs neovascularization and several therapies have been developed to prevent the abnormal activation of the VEGF protein. A recent National Institutes of Health (NIH) supported study reports on the discovery of a protein, Roundabout4 (Robo4), that stabilizes the existing vasculature and prevents neovascularization by inhibiting VEGF activity. Robo4 maintains vascular integrity by inhibiting VEGF-induced cell migration, vessel formation, and permeability. Vascular eye diseases are the most common cause of vision loss in the United States. This study suggests a new and promising therapeutic avenue to control neovascularization by regulating Robo4 activity.

RNA interference is a new approach that has been touted as having great potential for treating many diseases. This method harnesses a naturally occurring process that cells employ to control gene expression. By designing a small, interfering RNA sequence (siRNA), it is thought investigators can target and silence specific genes with specific siRNAs. Vision researchers have developed siRNA sequences to prevent the expression of VEGF in AMD and diabetic retinopathy that have been demonstrated to prevent neovascularization in animal models. However, a recent NEI-supported study suggests that siRNA may not always target the intended gene to initiate RNA interference. This study provides an important cautionary note to the entire field of siRNA that systemic administration of this treatment may have unintended consequences and side effects.

VISUAL NEUROSCIENCE

Although the function of astrocytes, a cell type found in the brain and central nervous system, is not entirely understood, they have long been thought to maintain normal neuronal function. More recent evidence suggests that astrocytes may have some function in neural signaling and processing. Recently, NEI investigators found key evidence that astrocytes also act as a critical intermediary between neurons and local blood flow. In this study, inhibition of astrocyte activity decreased local blood flow. This finding explains why imaging devices, like functional MRI, detect blood flow changes that correspond to neuronal activity. Pathologic changes in astrocytes are implicated in Parkinson's, Alzheimer's, and other neurodegenerative diseases. The specific effect of astrocyte activity on the hemodynamic response provides a basis for the interpretation of functional MRI, adding qualitatively to the clinical and research utility of this powerful imaging tool across the broad spectrum of neurologic disease.

CLINICAL TRIALS AND DIAGNOSTICS

Cataracts (clouding of the ocular lens) remain the primary cause of blindness in the world today. Researchers at NEI and NASA collaborated to develop a dynamic light scattering device which allows clinicians to detect and quantify the amount of unbound alpha crystallin proteins in an intact eye. With this device, it is now possible to safely and reproducibly measure the extent of lens damage and cataract formation caused by oxidative stress to a patient's eye (and perhaps the body) by measuring alpha crystallin reserves. This provides clinicians with the ability to monitor lens health, and may allow preventive or therapeutic actions that delay or eliminate cataract formation and blindness.

Each year approximately 33,000 Americans undergo corneal transplants to replace diseased corneas, the normally transparent tissue that protects the eye and helps focus light on the retina. Corneal transplants are among the most common and successful transplantation procedures in medicine but sufficient donor is not available. Eye banks, the primary source of donor tissue, refrain from harvesting tissue from donors over age 65 because of uncertainty about the integrity of older corneas. However, the recently published Cornea Donor Study (CDS) found that corneal transplants using tissue from older donors, ages 66 to 75, have similar success rates as tissue from younger donors, ages 12 to 65. Based on these findings, the study authors recommend that the age limit for donor tissue should be expanded to 75. The CDS study gives eye banks, transplant surgeons, and patients confidence in the use of older donor tissue. This finding should help eye banks keep pace with the demand for corneal tissue.

MEDICINE OF THE FUTURE

Development of an artificial cornea will provide an abundant source of nonimmunogenic tissue for transplantation. Cell transplantation has prevented vision loss in rodent models of retinal disease. It is likely that these efforts will culminate in viable forms of regenerative medicine for eye disease. Genomic medicine will allow us to predict susceptibility to disease and pre-empt it with a variety of gene-based therapies. Gene transfer will likely become an option to treat many retinal degenerative diseases. We will have the opportunity to restore ambulatory vision to the blind through new prosthetic devices that reproduce vision electronically. Such devices will allow those with untreatable conditions to maintain independence and mobility. While there is much work ahead, current research efforts to treat and cure eye disease are very promising.

CANCER RESEARCH PORTFOLIO

NEI funds basic research on cell biology, development and the regulation of blood vessel growth where findings could have relevance to our understanding and treatment of cancer. NEI also supports a phase III clinical trial on the treatment of retinoblastoma, a cancerous, blinding and potentially fatal eye disease. Consistent with the fiscal year 2010 NIH priority to expand cancer research funding, NEI will increase its fiscal year 2010 commitment to this portion of the portfolio by 4.4 percent.

PREPARED STATEMENT OF DR. ALAN E. GUTTMACHER, ACTING DIRECTOR, NATIONAL HUMAN GENOME RESEARCH INSTITUTE

Mr. Chairman and members of the subcommittee: I am pleased to present the President's fiscal year 2010 budget request for the National Human Genome Research Institute (NHGRI) of the National Institutes of Health (NIH). The fiscal year 2010 budget includes $509,594,000, which is $7,227,000 more than the fiscal year 2009 appropriation of $502,367,000.

NHGRI's budget request and its research projects are consistent with the President's multi-year commitment for cancer.

WINDFALL OF DISCOVERIES OF THE GENETIC BASIS OF DISEASE

The Nation's previous investments in the Human Genome Project and the International HapMap Project have moved research forward into many diseases with unprecedented speed. HapMap-enabled genome-wide association studies (GWAS) identify a stunning number—more than 130 in 2008 alone—of genetic factors associated with major causes of morbidity and mortality in the United States, such as autism, diabetes, cardiovascular disease, lung and prostate cancer, and inflammatory bowel disease. Identification of gene variants associated with disease raises the possibility of using genetic testing, in combination with family history information, to identify susceptible, pre-symptomatic subjects for screening and preventive therapies. It also provides key new understanding of the gene-environment interactions and biological pathways that lead to disease, thus providing new insights into treatment and prevention.

THE CANCER GENOME ATLAS

Initiated in fiscal year 2007, the TCGA is a pilot project, jointly supported and led by the NHGRI and the National Cancer Institute (NCI) that applies a comprehensive, large-scale genomic analysis approach to cancer research. TCGA is designed to develop and test the complex scientific and technological approaches needed to identify the mutations and other genomic changes associated with various types of cancer. Three NHGRI-supported sequencing centers provide genomic sequencing capability for the TCGA. In fiscal year 2008, the first major results of this pilot project were obtained for the most common form of brain cancer, glioblastoma multiforme. Another very exciting result was an unexpected observation that points to a potential mechanism of resistance to a common chemotherapy drug used for brain cancer. These first results from the TCGA pilot project represent an exciting indication of the value of the multi-dimensional analysis of the molecular characteristics in human cancer. In the next 1 to 2 years, the focus of TCGA will be on two other common cancers, squamous cell lung cancer and ovarian cancer, as well as further analysis of glioblastoma (brain cancer), as well as potential scale up to deal with many other forms of cancer.

MEDICAL SEQUENCING

The NHGRI's medical sequencing program aims to drive continued technology improvement (lowering the cost of genome sequencing) and to produce data useful to biomedical research. Seven studies are currently underway to identify the genes responsible for several relatively rare, "single-gene" diseases and to survey the range of gene variants that contribute to certain common diseases. In fiscal year 2008, a number of medical sequencing projects were initiated: (1) Sequencing the genomic regions identified in genome-wide association studies as containing genetic components underlying common diseases, such as diabetes, breast cancer, schizophrenia, or Crohn's disease; (2) Sequencing the genomes of important human pathogens, such as those that cause malaria and sleeping sickness, and their invertebrate vectors (in collaboration with the National Institute of Allergy and Infectious Disease; and (3) the TCGA project.

PERSONALIZED GENOMIC MEDICINE

In addition to basic research underway to support medical applications of genomics, two clinical genomics initiatives launched in fiscal year 2007 are now in full stride. The first, ClinSeq, is a pilot study aimed at developing technological and procedural approaches to facilitate large-scale medical sequencing in a clinical research setting. The second, the Multiplex Initiative, is a study intended to provide genetic susceptibility testing for several common health conditions, such as cardiovascular disease and osteoporosis, to evaluate patients' reactions to the testing and receipt of results.

THE 1000 GENOMES PROJECT

The 1000 Genomes Project builds on the human haplotype map developed by the International HapMap Project to produce a much more comprehensive view of genomic variation. In fact, it aims to find almost all the variants in the genome, including those that contribute to disease risk. The 1000 Genomes Project will map not only the single-letter differences in people's DNA, called single nucleotide polymorphisms, but also will produce a high-resolution map of larger differences in genome structure called structural variants, which are rearrangements, insertions, deletions, or duplications of DNA segments. The importance of these structural variants has become increasingly clear from surveys completed in the past 18 months that demonstrate that differences in genome structure may play a role in susceptibility to such conditions as mental retardation and autism.

The project includes large-scale implementation of several new sequencing platforms to capitalize on the cost reductions emerging from evolving technologies, described in the journal Nature Biotechnology in October 2008. Using standard DNA sequencing strategies, the effort would likely cost more than $500 million. However, the cost of the project is expected to be far lower to the program—$30 million to $50 million—due to the project's pioneering implementation of new technologies.

LARGE-SCALE SEQUENCING

Currently, 197 genomes are either in the pipeline or have been completed by the NHGRI-supported large-scale sequencing centers, which are world leaders, renowned for their cost-effective and high-quality work. Completed in fiscal year 2009, the most recent study of a cow was an important development in agriculture that may lead to higher-quality beef and milk production and possibly lower carbon dioxide emissions. Ongoing sequencing targets include several nonhuman primates, mammals, fungi, and multiple strains of yeast.

THE $1,000 GENOME

The NHGRI's continuing commitment to the development of innovative sequencing technologies, which reduces the cost and increases the speed of DNA sequencing, fuels the swift pace of genomic discoveries. In the past year, several groups have demonstrated the ability to work with individual DNA strands and read individual DNA bases. These two breakthroughs are being combined to deliver the ability to sequence DNA isolated directly from cells without any processing apart from purification. This is one technology with promise to achieve the goal of sequencing a genome for $1,000 by 2014, NHGRI's original goal.

GENOMIC FUNCTION

The NHGRI supports research to identify and characterize the function of all parts of our genome and to understand their biological relevance. Efforts to uncover functional elements are not limited to the human genome, since understanding the genomes of other, "model," organisms also can give insight into the structure and function of the human genome.

Following a successful pilot project, the NHGRI implemented a full-scale ENCyclopedia of DNA Elements (ENCODE) Project in fiscal year 2007 to examine the entire human genome for sequence-based functional elements. Concurrently, the NHGRI initiated modENCODE, which has similar goals for the analysis of the genomes of two important model organisms. This program will take advantage of the small, more manageable genomes of these organisms to unlock the function of the many genes they share with humans.

ETHICAL, LEGAL, AND SOCIAL IMPLICATIONS

The NHGRI supports six Centers of Excellence in Ethical, Legal, and Social Implications (ELSI) Research. The Centers focus on issues surrounding large-scale genomics research and emerging genetic technologies. The NHGRI continues to support ELSI research as a core aspect of our research portfolio in an effort to anticipate and address the societal issues that will continue to arise as we learn ever more about the human genome and its contributions to human health and disease.

MOVING FORWARD

The NHGRI recently began two new programs to harness genomic knowledge and technology to help patients whose needs are not met by existing scientific and medical programs. Launched in 2008, the Undiagnosed Diseases Program (UDP), jointly led by the NHGRI, the NIH Clinical Center, and the Office of Rare Diseases Re-

search, focuses on the most puzzling medical cases referred to the NIH by physicians across the Nation. The NIH Therapeutics for Rare and Neglected Diseases (TRND) Program, launched in fiscal year 2009, builds upon the technology and strategies of high-throughput genomics to identify and shepherd novel therapeutics for diseases where the risks of failure are currently too high for the private sector, but the human need is too great to ignore. These conditions by definition either occur in fewer than 200,000 Americans or in the developing world, limiting the profit motive for industry. UDP and TRND exemplify how the country can leverage the advances funded and developed by the NHGRI and the NIH to drive the development of more personalized, predictive, pre-emptive, and participatory diagnostic and therapeutic options, improving health outcomes for all Americans.

PREPARED STATEMENT OF DR. RICHARD J. HODES, DIRECTOR, NATIONAL INSTITUTE ON AGING

Mr. Chairman and members of the subcommittee: I am pleased to present the President's fiscal year 2010 budget request for the National Institute on Aging (NIA) of the National Institutes of Health (NIH). The fiscal year 2010 budget includes $1,093,143,000, which is $12,347,000 more than the fiscal year 2009 appropriation of $1,080,796,000.

Our Nation is currently in the midst of an unprecedented demographic shift. The number of Americans ages 65 and older is expected to double within 25 years. In less than 50 years, the number of "oldest old"—people ages 85 and older—will more than quadruple. As record numbers of Americans reach retirement age and beyond, profound changes will occur in our economic, healthcare, and social systems.

The NIA leads a national effort to understand the nature of aging and the diseases and conditions that are more common among older adults and to develop interventions that will help older adults enjoy robust health and independence, remain physically active, and continue to make positive contributions to their families and communities. We support and conduct a comprehensive and integrated portfolio of genetic, biological, clinical, behavioral, and social research related to the aging process, healthy aging, and diseases and conditions that often increase with age.

UNDERSTANDING HEALTHY AGING AND DISEASE AND DISABILITY

Modern medicine and new insights into lifestyle and other environmental influences are allowing a growing number of people to remain healthy and socially and emotionally vital into advanced ages, and NIA remains at the forefront of the Nation's efforts to identify the genetic, physical, emotional, and environmental factors that contribute to healthy old age. For example, researchers on the NIA-supported Long Life Family Study are analyzing data from families with two or more siblings over age 79 to identify factors that may contribute to long and healthy life, and the Longevity Consortium brings together leading researchers to facilitate the discovery, confirmation, and understanding of genetic determinants of longevity. NIA intramural investigators are continuing the SardiNIA Project to search for genes associated with nearly 100 traits in a small, genetically homogeneous population and the Age, Gene/Environment Susceptibility (AGES) Study to explore genetic susceptibility and gene/environment interactions that contribute to various health outcomes in old age.

NIA's biology programs are wide ranging and address organs, systems, and processes throughout the body. For example, the Institute supports research on long-term weight maintenance, diet composition, and energy balance as well as the role of nutrition in the prevention of common age-related conditions such as heart disease and cancer. NIA is also collaborating with the National Institute of Allergy and Infectious Diseases to support research to better understand the mechanisms underlying age-related decline of the thymus, an organ that produces white blood cells known as T cells, a critical component of the body's ability to launch a robust immune response against infections. Studies on basic bone biology have led to the surprising finding that the protein Lrp5, an important factor in the process through which new bone is created, regulates bone mass formation through serotonin synthesis in the intestine, and not by acting directly on the bone, as was previously believed. This finding broadens our understanding of bone remodeling and suggests new therapeutic approaches to increase bone mass. Research initiatives to help us better understand mechanisms of anemia, chronic kidney disease, and thyroid dysfunction in the elderly have also been established at NIA, and an advisory "summit" meeting was held in September 2008 to identify areas of scientific opportunity and facilitate the formulation of future plans for research on the underlying biology of aging-related changes.

Cognitive aging is a high-priority research area for NIA. A new focus on brain health, as opposed to the study of specific causes of brain disease and dysfunction, has emerged in recent years and has become an increasingly important paradigm in neuroscience research. NIA is continuing its involvement with the trans-NIH Cognitive and Emotional Health Project to coordinate and accelerate research leading to interventions for neurological health, as well as with the NIH Neuroscience Blueprint Toolbox initiative on the development of assessment tools for cognitive and behavioral health. NIA also continues to support studies of age-related changes in cognition, including grants funded under two new and related research initiatives—one to develop neural and behavioral profiles of normal cognitive aging and one to develop interventions to remediate age-related cognitive decline as distinct from Alzheimer's disease (AD) or related conditions.

PROMOTING HEALTHY AGING AND PREVENTING AGE-RELATED DISEASE AND DISABILITY

NIA is continuing to support the development of interventions to maintain health and prevent age-related disease and disability. For example, NIA-supported researchers are conducting a number of studies aimed at reducing the incidence and severity of falls, the leading cause of both fatal and nonfatal injury among older adults in the United States. Ongoing studies are exploring the association between vitamin D insufficiency and fall risk; examining the effects of neighborhood environmental characteristics on risk of outdoor falls; and focusing on development of strategies to improve strength, balance, and gait in the elderly.

The NIA-supported Advanced Cognitive Training for Independent and Vital Elderly Study was the first randomized, controlled trial to demonstrate long-lasting, positive effects of brief cognitive training to forestall cognitive decline in older adults. However, the training did not improve the participants' ability to tackle everyday tasks. More research is needed to translate the findings from the laboratory into interventions that are effective at home. In 2008, NIA solicited research to convert insights from previous work in cognitive aging into feasible intervention strategies, including cognitive training, lifestyle interventions, dietary interventions, or behavioral change that can be tested in randomized clinical trials. Investigators are encouraged to develop interventions addressing the role of individual differences in cognition, personality, and sociocultural factors in mediating or moderating adherence and outcomes. This research will be active in 2010.

The development of interventions that will extend life span as well as health span is another emerging area of study. Through the innovative Interventions Testing Program, NIA-supported researchers are investigating promising treatments, including diets, pharmaceuticals, and nutritional supplements, that have the potential to extend the life span and delay disease and dysfunction in mice, with the long-term goal of identifying those interventions most likely to have a beneficial effect in humans. Fourteen compounds are currently under study, with 3 more slated to be added in 2009. Testing on these compounds will continue through 2010.

EARLY DETECTION, DIAGNOSIS, AND TREATMENT OF AGE-RELATED DISEASE

Improved technologies as well as advances in our understanding of the mechanisms of disease are allowing for the development of interventions to predict, detect, diagnose, and treat age-related disease and disability. Scientists in NIA's groundbreaking Alzheimer's Disease Neuroimaging Initiative have made a significant step forward in developing a test to diagnose the early stages of AD earlier and more accurately by measuring two biomarkers—tau and beta-amyloid proteins—in cerebrospinal fluid. The investigators found that certain changes in biomarker levels in cerebrospinal fluid may signal the onset of AD. They also established a method and standard for testing of these biomarkers.

NIA currently supports more than 30 clinical trials of interventions to prevent, slow, or treat AD. Interventions under study include a highly promising immune approach; hormonal treatments, including testosterone and raloxifene; diabetes drugs such as metformin and insulin; antioxidants; physical and mental exercise; commonly used psychiatric drugs; and many others. The identification of imaging and biological markers as well as the development of improved clinical and neuropsychological evaluation methods will enable us to perform less expensive, shorter, and more efficient intervention trials.

In addition, NIA supports studies of treatments for a variety of other conditions including new therapies for menopausal hot flashes; hormone supplementation in men with symptoms related to low levels of testosterone; and cognitive behavioral therapy for older adults with arthritis pain and insomnia. A follow-up study to the ground-breaking Diabetes Prevention Program established the efficacy of a lifestyle intervention and drug treatment that can sharply decrease the risk of type 2 diabe-

tes in overweight individuals, which was most pronounced for individuals age 60 or over.

ADDRESSING THE SOCIETAL IMPLICATIONS OF AN AGING POPULATION

The social and economic implications of aging are multi-faceted. NIA supports long-term studies of older Americans covering a wide range of topics, including retirement and economic status, care giving, behavioral medicine, the dynamics of health and functional change at older ages, cognition, and long-term care. These studies include the ongoing Health and Retirement Study, the leading source of combined data on health and financial circumstances of Americans over age 50 and a valuable resource to follow and predict trends and help inform health policy. NIA also supports studies on the social, emotional, cognitive, and motivational processes and neurobiological mechanisms of economic behavior as these influence social, financial, and health-related decisions of middle-aged and older adults.

One of NIA's most urgent priorities is to improve our ability to reduce health disparities and eliminate health inequities among older adults. NIA works to identify ways to reduce health disparities through its Resource Centers for Minority Aging Research, and the Institute has compiled a Web-based toolkit on outreach, recruitment, and retention of minority populations in clinical research on aging. Through the Healthy Aging in Neighborhoods of Diversity Across the Life Span Study, NIA intramural researchers are continuing their efforts to disentangle the complex relationships among race, socioeconomic status, and health outcomes. Other programs, notably the NIA Alzheimer's Disease Centers, have a strong focus on minority health and health disparities in both research and outreach.

Once again, thank you. I welcome your questions.

PREPARED STATEMENT OF DR. KENNETH R. WARREN, DIRECTOR, NATIONAL INSTITUTE ON ALCOHOL ABUSE AND ALCOHOLISM

Mr. Chairman and members of the subcommittee: I am pleased to present the President's fiscal year 2010 budget request for the National Institute on Alcohol Abuse and Alcoholism (NIAAA), of the National Institutes of Health (NIH). The fiscal year 2010 budget includes $455,149,000, which is $4,919,000 more than the fiscal year 2009 appropriation of $450,230,000.

NIAAA's long-range vision for medicine with respect to alcohol-related health issues is that research on the health effects of alcohol will reduce the burden of illness attributable to excessive alcohol consumption thereby enhancing the well-being of individuals at risk, their families, and society-at-large. Through translation of NIAAA supported research findings, we have an unparalleled opportunity to significantly reduce the burden of illness due to alcohol-related problems. We are especially appreciative of the American Recovery and Reinvestment Act funds which will accelerate our progress. NIAAA's budget request and its research projects are consistent with the President's multi-year commitment for cancer and autism.

CURRENT SCOPE OF THE PROBLEM AND RESEARCH

According to the Centers for Disease Control and Prevention, alcohol is the third leading cause of preventable death in the United States. Even more important from a public health perspective, alcohol misuse negatively affects the quality of life for millions of Americans. According to the World Health Organization, alcohol is one of the top 10 causes of Disability Adjusted Life Years in the United States and contributes to a number of the other leading causes. Alcohol problems cost the United States an estimated $185 billion annually, with almost half the cost resulting from lost productivity due to alcohol-related disabilities.[1] According to NIAAA's National Epidemiological Survey on Alcohol and Related Conditions, more than 18 million people ages 18 and older suffer from alcohol abuse or dependence and only 7 percent of them receive any form of treatment. Furthermore, heavy drinkers, who are not dependent, but nevertheless at risk for adverse health and psychosocial outcomes, are seldom identified. The consequences of alcohol misuse can affect both drinkers and those around them at all stages of life, from damage due to alcohol exposure of the developing embryo, to injuries, to tissue and organ damage resulting from chronic, heavy alcohol use. Therefore, to achieve its goal of reducing the heavy burden of illness from alcohol misuse, NIAAA's research focus must be broader than

[1] Harwood, H. Updating Estimates of the Economic Costs of Alcohol Abuse in the United States: Estimates, Update Methods and Data (2000).

simply reducing alcohol-related mortality; it must encompass reducing the risk for all adverse alcohol-related outcomes at all stages of life.

Research supported by NIAAA has reframed our understanding of alcohol dependence in several ways by demonstrating that: (1) it is a developmental disorder that often has its roots in childhood and adolescence; (2) the highest prevalence of alcohol dependence in the U.S. general population occurs in 18–24 year olds; (3) there is substantial variation in the severity and chronicity of dependence among individuals; and (4) a large percentage of individuals with alcohol dependence are highly functional in society, and therefore go largely unnoticed by the healthcare system.

These findings underscore the opportunity to: (1) be able to better predict which individuals are at risk for future dependence by understanding the complex interplay between genetic, environmental, and developmental factors; (2) pre-empt future problems through research-based prevention efforts for children and adolescents as well as screening and guidance for people of all ages about how drinking patterns, especially binge drinking, relate to adverse health outcomes; (3) conduct research to develop treatment options that are personalized to individual needs and lifestyles; and (4) engage individuals, communities, and professional groups to be actively participatory in shaping the future of healthcare as it relates to alcohol misuse.

OUTLOOK FOR THE FUTURE

NIAAA is revolutionizing alcohol treatment by providing evidence-based options for addressing the full range of alcohol- related problems. For example, research has shown the value of alcohol screening in primary care and mental health settings to help patients understand the risks associated with different drinking patterns. NIAAA has developed tools that clinicians can use to screen and intervene in these settings. Moving treatment of less severe forms of alcohol dependence into mainstream medical care will decrease stigma, improve availability, accessibility, and appeal of treatment options, and ultimately reduce the number of people who suffer with dependence. Alcohol-dependent patients will benefit from NIAAA's research focusing on the development of new treatments including behavioral therapies and medications that will shorten the duration, number, and severity of episodes of dependence and prevent, for most, the development of chronic, relapsing dependence. Studies suggest that as a result of these types of intervention, most people with mild to moderate dependence will recover.

Patients with more severe and/or relapsing dependence, are more complex to treat and often need multi-faceted, personalized addiction services that may include medications, counseling, psychotherapy, and case management. These patients often have other health (infectious diseases, mental illness, and liver disease) and psychosocial (family, marital, and workplace) problems, some that are the direct result of their alcohol misuse. Comprehensive treatment must take all of these into account. NIAAA-supported research will continue to develop and refine treatment options for these individuals, both for their alcohol dependence as well as the many adverse health consequences that may result. Collectively, these changes in the approach to treatment of alcohol problems will substantially reduce the public health burden of heavy drinking and alcohol use disorders.

Ensuring that appropriate research-based guidance about alcohol use for special populations, including pregnant women, is available and will result in a dramatic reduction in the incidence of fetal alcohol spectrum disorders, the most severe forms of which produce lifelong disability, and may also decrease the incidence of Sudden Infant Death Syndrome. NIAAA research will continue to inform this guidance, including information about the risks of alcohol exposure to the developing embryo and fetus, and will make it accessible to primary healthcare providers and obstetricians. For pregnant women who drink despite the best advice, research is focused on developing nutritional and/or pharmacological agents that may lessen the negative effects of alcohol exposure.

Biomarkers, stemming from NIAAA-supported genetic and epigenetic research, will be available that: (1) predict individual risk for future alcohol dependence; (2) assess progression of at risk drinking through dependence; and (3) track damage to tissue and organs. These tools will enhance the ability of healthcare providers to offer guidance to patients about their drinking patterns and determine appropriate healthcare based on individual risk factors. A repertoire of medications will facilitate treatment tailored to the needs of the patient. Personalized treatment including medications and behavioral therapies will be based on individual genetic make-up, desired drinking outcomes, attention to co-occurring disorders, ease of compliance, and other factors.

MOVING FORWARD

NIAAA supported biomedical and behavioral research is supporting the research that will contribute to realizing the vision outlined above. Ongoing studies, as well as new initiatives, will provide the scientific knowledge and tools, to improve our ability to predict which individuals are at increased risk for alcohol-related problems including dependence, pre-empt the harm from alcohol misuse, and provide personalized treatment.

The integration of routine alcohol screening, and where appropriate, brief intervention and/or referral to specialty treatment into primary healthcare for all ages is central to reducing consequences of alcohol misuse. NIAAA will continue to develop teaching and training tools to increase the usage of A Clinician's Guide: Helping Patients Who Drink Too Much. NIAAA has also recently launched Rethinking Drinking, a new Web site, and booklet that provides information and tools to help individuals change harmful drinking patterns, either on their own or by helping them reach the decision to seek help. NIAAA is also developing guidance on screening and brief intervention for children and adolescents, recognizing that criteria developed for adults may not fit the needs or behaviors of youth.

Medications development remains a central focus of the Institute. Emerging data are changing the way we look at alcohol dependence, guiding us to be more strategic about the medications we test, the way we test and design them, and how we determine the subpopulations of patients most likely to benefit from them. For example, new understanding of the relationship between withdrawal induced anxiety and relapse has provided additional targets for drug development to minimize relapse. Broadening the desired treatment outcome, from targeting only abstinence to including reduction in heavy drinking, is also influencing the medications that are being tested as well as how they are tested. Other compounds that may mitigate tissue and organ damage are under study.

Most individuals with alcohol dependence do not access treatment yet many of them recover without the benefit of professional care or facilitated self-help. NIAAA continues to investigate the process leading to a decision to stop drinking or to seek help. In concert with a broader NIH Roadmap Initiative, NIAAA is currently supporting studies to understand mechanisms of change away from harmful health behaviors.

Given our current state of knowledge and what we are learning from ongoing studies, we are optimistic that we can substantially reduce the burden of illness for alcohol-related problems and the suffering it brings to individuals, their families and society at large.

PREPARED STATEMENT OF DR. STEPHEN I. KATZ, DIRECTOR, NATIONAL INSTITUTE OF ARTHRITIS AND MUSCULOSKELETAL AND SKIN DISEASES

Mr. Chairman and members of the subcommittee: I am pleased to present the President's fiscal year 2010 budget for the National Institute of Arthritis and Musculoskeletal and Skin Diseases (NIAMS) of the National Institutes of Health (NIH). The fiscal year 2010 budget includes $530,825,000, which is $5,953,000 more than the fiscal year 2009 appropriation of $524,872,000.

INTRODUCTION

As the primary Federal agency for supporting medical research on diseases of the bones, joints, muscles, and skin, the NIAMS touches the lives of nearly every American. For example, the U.S. Bone and Joint Decade notes that 1 in 2 people will experience back pain each year, and 1 in 5 will have pain that affects their ability to work. The National Arthritis Data Working Group estimates that 21 percent of adults have arthritis in at least one joint, a figure that is likely to grow as the population ages. Likewise, 1 of every 2 women and 1 in 4 men aged 50 years and older suffer fractures each year because of osteoporosis; researchers project that the number of osteoporotic fractures in the United States will grow from 2 million to more than 3 million in the next two decades. The NIAMS is committed to preventing disabilities and reducing costs associated with these and other conditions through balanced basic, translational, and clinical research investments.

As the Institute sets priorities, it is considering how recent advances have positioned its research community for discoveries to prevent disease and improve each American's life. It is soliciting input from researchers, healthcare providers, patients, and the public on promising areas of inquiry; pressing scientific needs; programs to ensure a continuing supply of well-trained researchers; and strategies to eliminate health disparities. An important consideration is how investigators can

engage in multidisciplinary opportunities. Chronic pain, for example, is an aspect of many diseases that are part of the NIAMS portfolio; staff are exploring partnerships through the Trans-NIH Pain Consortium. Prospects for stem cell research are growing rapidly as researchers isolate stem cells from skin and other organs, and as more lines become available under the Nation's policy for Federal support of embryonic stem cell research.

Consistent with the Federal commitment to double NIH-wide cancer research spending, the NIAMS will continue to pursue collaborations with the National Cancer Institute in support of high-quality projects that relate directly to diseases and organ systems within the NIAMS mission, particularly the bones and the skin. Already, the NIAMS supports research on mechanisms underlying skin cancers, and investigators have uncovered a strategy that kills tumor cells with less damage to healthy skin.

PREVENTIVE MEDICINE

Research to identify susceptibilities to and initial symptoms of disease, and to develop strategies to slow disease progression, is a NIAMS priority. Building on findings that early, aggressive therapy alters the course of rheumatoid arthritis (RA), NIAMS is comparing treatments against a related disease-juvenile idiopathic arthritis.

The NIAMS and the National Institute on Aging lead the Osteoarthritis Initiative (OAI), a public-private partnership to identify and evaluate biomarkers of osteoarthritis (OA). NIH and its partners, with input from the Food and Drug Administration, launched the OAI in 2001. More than 1,100 researchers worldwide have accessed OAI data to explore issues such as differences in OA progression, or why only some people with X-ray evidence of OA develop pain. In 2010, the NIH will extend the OAI for 6 years. It expects the OAI to suggest approaches for slowing joint damage, facilitate clinical testing of interventions and allow clinicians to identify risk factors for OA development, predict severity, and personalize treatments for their patients.

COMPLEX GENETIC DISEASES

The NIAMS community is benefiting from another public-private partnership, the Genetic Association Information Network (GAIN). Since GAIN's inception, NIAMS investigators have been involved in its Collaborative Association Study of Psoriasis, an ambitious effort to combine genetic and clinical information from people affected by psoriatic skin disease and psoriatic arthritis. The project has yielded a wealth of data that researchers are using to develop diagnosis, treatment, and prevention strategies.

NIAMS-funded investigators have uncovered genetic susceptibility markers of alopecia areata and other autoimmune or auto-inflammatory skin and joint diseases, including lupus. Collaboration among United States and European researchers recently linked a component of the immune system and RA. At the NIH Clinical Center, sample collection has begun for a genomic analysis of Behçet's disease, a complex disorder of inflammation affecting skin, eyes, gastrointestinal tract, lungs, vasculature, and joints.

COLLABORATIONS AND TEAM SCIENCE

Behçet's disease is one of many conditions researchers are studying through the new NIH-wide Center for Human Immunology, Autoimmunity, and Inflammation. NIAMS' intramural program is taking a leadership role in the Center. Collaborations among scientists from several NIH Institutes who are studying related disease systems will facilitate studies about conditions associated with defective immune or inflammatory responses, and will allow them to apply their results to the development of interventions and, ultimately, disease prevention strategies.

In collaboration with orthopaedic surgeons at the Walter Reed Army Medical Center, NIAMS researchers recently discovered that tissue commonly discarded as waste contains special cells that feature many of the same properties as adult stem cells. The cells can be used for regenerative medicine, such as treating war-traumatized muscle, without subjecting patients to additional surgeries and related complications.

The NIAMS participates in the multi-Institute Senator Paul D. Wellstone Muscular Dystrophy Cooperative Research Centers program. In addition to conducting research, scientists at the Centers maintain core resources that all who are studying muscular dystrophy can use. A group of NIAMS-funded muscle researchers showed that defects in blood vessel constriction are associated with the severe fatigue that people with muscular dystrophy experience; mouse experiments suggest that com-

pounds with FDA-approval for other conditions may improve symptoms. Other scientists uncovered molecules that confer many of the benefits of exercise, at least in mice; the findings might lead to treatments for conditions that leave patients unable to exercise.

The scale and complexity of today's research problems and their solutions demand that the NIH explore new models for team science. In fiscal year 2008, the NIAMS started a program, Building Interdisciplinary Research Teams (BIRT), to promote partnerships among fields that share interests, but historically do not interact. Because collaborations proposed in the first round of applications suggested that modest investments in the program will provide great dividends, the NIAMS opened BIRT up to additional communities and expects to make another set of awards at the end of fiscal year 2009.

In the past year, the NIAMS has made considerable progress in leading a trans-NIH partnership with the National Aeronautics and Space Administration. By designating the U.S. portion of the International Space Station (ISS) as a National Laboratory, Congress underscored the significance that Americans place on the ISS' research potential. The NIH shares this belief and, for the next 3 years, will accept applications for studies that use the ISS for experiments directly related to the NIH goals of understanding human physiology and promoting the public's health.

CLINICAL STUDIES

One element of improving the Nation's health is to support clinical studies on which physicians can rely when discussing treatment options with patients. Before the Spine Patient Outcomes Research Trial (SPORT), many who had low back pain were conflicted about surgery. Now, patients can be assured that surgery relieves pain from herniated disks, but—if the pain is tolerable and not worsening—it will likely subside without surgery. Similarly, people who have pain due to spinal stenosis (a narrowing of the spinal column that occurs with age) are likely to benefit more from surgery than from noninvasive treatments such as physical therapy; but, they are not causing more damage if they adopt a "wait-and-see" approach before committing to an operation. Recently, SPORT offered guidance to help people who suffer from herniated disks personalize their treatment decisions by reporting that study participants who had surgery on an upper lumbar disk improved more than those with damage further down.

For decades, the NIAMS has invested heavily in efforts to understand fracture risk and to uncover strategies to prevent and treat bone loss. Although physicians now have an array of medications for people who are at risk of osteoporosis, many patients fail to benefit fully because they do not follow the treatment regimens. Because a method to improve compliance could immediately slow the growing health and economic burden that osteoporosis places on society, the NIAMS is funding research in this area.

CONCLUSION

The discoveries and activities highlighted above are just a few examples of research that will continue to benefit Americans from all walks of life. In partnership with Government and private entities, the NIAMS also develops and distributes science-based health information directly to patients, healthcare providers, and the public. The Institute will continue outreach to diverse populations through research, training, and information dissemination. Collectively, NIAMS programs have spurred understanding of many common, chronic, and costly diseases. Looking forward to the next decades, this progress provides a foundation for an era in which the burden of these debilitating conditions is reduced and—with time, continued support from the American public, and the dedication of our Nation's researchers—eliminated for millions of affected adults, children, and families.

PREPARED STATEMENT OF DR. RODERIC I. PETTIGREW, DIRECTOR, NATIONAL INSTITUTE OF BIOMEDICAL IMAGING AND BIOENGINEERING

Mr. Chairman and members of the subcommittee: I am pleased to present the President's fiscal year 2010 budget request for the National Institute of Biomedical Imaging and Bioengineering (NIBIB) of the National Institutes of Health. The fiscal year 2010 budget includes $312,687,000, which is $4,479,000 more than the fiscal year 2009 appropriation of $308,208,000.

The NIBIB is leading the development of revolutionary technologies that will help transform medicine in the United States and around the world. It has primary responsibility for uniting the engineering and physical sciences with the life sciences

to bring about new ways of thinking that will accelerate discovery and technology development. With a global vision and a public health mission, the Institute is working to develop technologies that enable personalized healthcare, early detection of disease, and treatments that are minimally invasive, cost-effective and widely accessible.

TRANSLATING TECHNOLOGY INTO PRACTICE

Ultimately, NIBIB seeks to expand the translation of technological advances into solutions that improve human health by reducing disease and enhancing quality of life. To accomplish this goal, NIBIB continues to fund bold and far-reaching projects that facilitate discovery and translate discovery to clinical practice. NIBIB-supported scientists in the innovative Quantum Grants Program are making extraordinary progress to develop new technologies and modalities for the diagnosis, treatment, or prevention of disease that will result in practical healthcare benefits for the Nation.

CHANGING HEALTHCARE DELIVERY THROUGH POINT-OF-CARE (POC) TECHNOLOGIES

Testing at the point of initial contact, or "point-of-care," rather than at specialized centers or hospitals utilizes state-of-the-art diagnostics and information systems that can be used in the doctor's office or even at home. Consequently, the use of POC devices can also help patients monitor their wellness in preventive medicine. The POC approach to health care delivery can significantly improve the quality and reduce the cost of health care by: providing earlier diagnosis of disease when treatment is more effective and less costly; making modern medicine available to those who lack access to regular care, such as people in rural settings or developing countries; combining cutting-edge diagnostic and communication technologies to bring patients into more frequent and regular contact with health care providers; and enabling a patient-centered process with home-based monitoring.

The NIBIB currently funds a network of four POC Technologies Research Centers that target the development of new POC technologies for early and rapid detection of strokes, detection of sexually transmitted diseases, rapid multi-pathogen detection for national disaster readiness, and diagnosis of infections that can be used in low-resource settings among underserved populations. Additionally, the NIBIB and the Department of Biotechnology (DBT) of the Ministry of Science and Technology of the Republic of India held a joint workshop on Low-Cost Diagnostic and Therapeutic Medical Technologies in November 2008 in Hyderabad, India. The workshop was a result of a bilateral agreement between the NIBIB and DBT to develop low-cost technologies to improve the quality of healthcare for underserved populations. Point-of-care testing is becoming a vital part of the world's healthcare delivery system, and is a key to reducing healthcare costs while maximizing accessibility for everyone.

HEALTH INFORMATION TECHNOLOGY

Health information technology research that enables the integration of clinical data, medical image diagnostic and treatment data with the patient's medical history in a comprehensive electronic medical record will improve clinical decision-making. The ability to connect and exchange diagnostic information and medical images between healthcare providers, clinics, and hospitals will help provide the timely information that is needed for effective healthcare and will help reduce unnecessary, excessive, and duplicative procedures. A patient-centered approach to comprehensive electronic health records will allow patients access to their health information. This will enable patients to play an active role in their own wellness by enabling them to ask knowledgeable questions about treatment options. Additionally, patients are also empowered to provide this information to any and all healthcare providers as needed, independent of their location or where the medical data was created or stored. The NIBIB supports research in new technologies to address issues such as: interoperability of data systems, compatibility of computer software across medical institutions; security of data during transmission; HIPPA compliance; and availability of affordable data systems for patient care providers.

MICROCHIP CAPTURES EARLY CIRCULATING CANCER CELLS

NBIB's budget request and its research projects are consistent with the President's multi-year commitment for Cancer. Malignant cancers shed cells that enter the circulation, travel to other areas of the body, and often grow into secondary tumors, or metastases. Indeed, metastases are responsible for the great majority of cancer deaths. It is estimated that 70,000 men per year are diagnosed with recur-

rent prostate cancer after prostatectomy, as shown by rising prostate surface antigens. For these men, the ability to detect and characterize the malignant cells in the blood may enable personalized therapy. Researchers are developing a technology to facilitate quantitative detection of circulating tumor cells (CTCs). They have engineered a microchip with a large surface area of an adhesion molecule that binds CTCs from whole blood, making detection of CTCs more reliable than previous approaches. They are analyzing molecular and genomic information in the CTC's to identify new biomarkers to customize treatments that are personalized for the patients and to predict treatment outcomes. The NIBIB-supported research has the potential to eliminate or greatly reduce cancer deaths due to metastases.

REGENERATING BRAIN TISSUE TO PROMOTE STROKE RECOVERY

Brain cells can be irreversibly damaged in a matter of minutes when the blood supply carrying oxygen and glucose is interrupted in a stroke. Individuals who have had a stroke may experience partial paralysis or problems with awareness, attention, learning, judgment, memory, or speech. An international team of researchers from Baylor College of Medicine, Rice University, London's National Institute of Medical Research, King's College of London, and Edinburgh University is integrating cutting-edge imaging, biological, and engineering techniques to map and understand normal brain regions that are responsible for generation of new neurons in the adult. The ultimate goal is to bioengineer a cellular system mimicking these brain regions that can eventually be used to replace and/or drive repair of stroke-damaged tissue.

MINIATURE ARTIFICIAL KIDNEY REPLACES TRADITIONAL DIALYSIS

Nearly one-half of a million people in the United States suffer from end-stage renal disease (ESRD), and the incidence rate of this disease has been steadily increasing for over 25 years. Kidney transplantation provides the best option for ESRD patients, but a shortage of donors means that most patients never make it to the top of a waiting list. The alternative is dialysis, which is expensive, inconvenient, far less effective, and significantly lowers the patient's quality of life. An interdisciplinary group of researchers has envisioned a way to improve management of ESRD by developing an implantable, self-regulating, bioartificial kidney capable of filtering toxins from the blood as well as replacing some of the metabolic functions of a healthy kidney. Such an implantable bioartificial kidney could substitute for transplantation and will truly be a quantum leap in healthcare, giving hope, independence, and mobility to the 350,000 patients presently tethered to thrice-weekly in-center dialysis.

INSULIN-PRODUCING CELLS FROM AMNIOTIC FLUID STEM CELLS TREAT DIABETES

More than 1 million people in the United States suffer from type 1 diabetes, which is caused by the destruction of insulin-producing pancreatic islet cells. Currently available insulin therapy by itself does not cure the disease or prevent many of its long-term complications. Transplantation of islet cells has shown promise, but there is a shortage of donors, and the process is expensive, inefficient, and requires life-long immunosuppression. Researchers from Wake Forest University and the University of Miami have combined their expertise in stem cell differentiation and in vivo islet cell transplant studies to explore a new approach using amniotic fluid stem cells. The team has successfully isolated amniotic fluid stem cells and generated insulin-producing, islet-like cells in vitro. Future work will determine whether these cells are able to function and survive in animal models of diabetes. If successful, this approach could potentially provide a curative treatment for type 1 diabetes through transplantation using cells produced from amniotic stem cells.

MOLECULAR THERANOSTICS: NEW TECHNOLOGIES FOR THE DIAGNOSIS AND TREATMENT OF DISEASES

The concept of combining a therapeutic with a diagnostic agent is rapidly evolving and goes beyond traditional diagnostic tests that screen or confirm the presence of a disease. With specialized molecular imaging techniques and biomarkers, theranostics might predict risks of disease, diagnose disease, and monitor therapeutic response leading to real-time, cost-effective treatment. NIBIB supports a number of teams that are developing novel theranostics and approaches that can be applied in clinical studies of human patients. A team of chemists and neurosurgeons at the University of Michigan is developing highly specific, dye-loaded nanoparticles capable of delivering targeted photosensitizers to improve the survival of brain tumor patients. This technique will allow neurosurgeons to visualize the

brain tumors for surgical resection of the main tumor mass while eradicating remaining tumor cells through a process known as photodynamic therapy. These particles also contain imaging contrasting agents to visualize response to therapy.

PREPARED STATEMENT OF DR. NORA D. VOLKOW, DIRECTOR, NATIONAL INSTITUTE ON DRUG ABUSE

Mr. Chairman and members of the subcommittee: I am pleased to present the President's fiscal year 2010 budget request for the National Institute on Drug Abuse (NIDA) of the National Institutes of Health (NIH). The fiscal year 2010 budget includes $1,045,384,000, which is $12,625,000 more than the fiscal year 2009 appropriation of $1,032,759,000.

Drug abuse and addictions are preventable conditions, yet continue to cause immeasurable human suffering, with associated societal costs estimated to exceed one-half a trillion dollars annually in the United States. Tobacco use alone is responsible for more than 400,000 deaths per year, and is the leading cause of preventable death in the United States. NIDA's budget request and its research projects are consistent with the President's multi-year commitment for cancer. For example, NIDA has active programs to hasten the development of new, more effective treatments for nicotine addiction that can dramatically reduce the prevalence of diseases like lung cancer and emphysema, which mean an early death for many smokers. Other NIDA-supported research advances have contributed to steady declines in both licit and illicit drug use over the years, particularly among our Nation's youth. Our latest Monitoring the Future (MTF) survey of drug use patterns and trends among 8th, 10th, and 12th graders reveals, for example, that tobacco use has declined continuously since its peak in the mid-1990s, and is presently at its lowest level since the first MTF survey in 1975. However, if we are to fully eradicate drug abuse and addictions, we must find novel approaches to prevent drug abuse (including smoking) among the significant fraction of youth who, because of strong genetic and/or environmental propensity, appear refractory to current efforts. Additional challenges include the growing abuse of prescription medications, including opioid analgesics (e.g., painkillers), stimulants (e.g., ADHD medications), and CNS depressants (sleep and anxiety medications). NIDA is committed to closely monitoring these trends and to furthering the development of innovative strategies to counter them, including the widespread dissemination of screening and early intervention tools for medical settings to increase the medical community's participation in identifying and treating substance abuse disorders.

ADDICTION MEDICATIONS: CHANGING THE CULTURE OF TREATMENT

NIDA's accelerating rate of discovery is beginning to spur the advent of better medications and behavioral interventions to counteract drug-induced changes in brain function. Among the strategies NIDA supports for medications development are those to: counter stress responses, which frequently trigger relapse to drug use; strengthen executive function and inhibitory control so that drug abusers can better control their urge to take drugs; and interfere with drug-conditioned memories to prevent relapse when drug abusers are exposed to environments they associate with drug use. Other research includes development of vaccines, or antibody-based approaches, which can block both illicit and licit drugs (e.g., nicotine) from ever reaching the brain, thereby inhibiting their rewarding effects. In the context of nicotine addiction, this approach may help prevent smokers from escalating to addiction and/or facilitate abstinence in those who seek to quit. It also complements ongoing efforts to discover new, more effective medications through conducting screens of novel compounds and chemical libraries and applying promising findings to help people achieve abstinence from tobacco and other addictive substances.

To accelerate progress in combating substance use disorders, there must also be social change to recognize that people who suffer from addiction require medical treatment. Presently, addiction treatment occurs largely outside of mainstream medicine, even though drugs undermine overall health, frequently appearing alongside other medical and psychiatric conditions. To help change this culture, NIDA is providing knowledge of associated brain dysfunctions and developing and deploying effective addiction medications. As these efforts succeed, the consequent medicalization of drug abuse and addiction will allow (1) clinicians to respond to their patients' needs more effectively and in a more personalized fashion; (2) insurance companies to become increasingly responsible for the coverage of treatments that can dramatically improve overall health; and (3) pharmaceutical companies to be incentivized to develop novel addiction medications. As the stigma of addiction wanes, the dissemination of proven treatments will expand to include the popu-

lations that need them the most, such as those involved in the criminal justice system, half of whom meet the criteria for drug abuse or dependence, according to estimates from the Department of Justice. Broader treatment access for drug-addicted offenders will help them to successfully transition back into society, dramatically reducing not just drug abuse, but also criminal recidivism.

GENES AND ENVIRONMENT: HIGH PAY-OFF RESEARCH

A steady flow of genetic discoveries is uncovering previously unsuspected genes whose products may be involved in the addiction process and therefore present good candidates for medication development. They also herald the advent of more personalized interventions based on a patient's genetic profile. And, because genes influence both vulnerability and resilience to substance abuse and other mental disorders, genetic data will further our understanding of the basic mechanisms underlying the disease of addiction, as well as its frequently associated comorbid conditions.

But genes do not act in isolation; rather, they work in tandem with developmental and environmental factors to determine a person's drug abuse vulnerability. Therefore, NIDA is encouraging more research to understand how genes might mitigate or amplify social influences that affect individual choices and behaviors related to substance abuse. Conversely, environmental elements, such as parenting quality, home conditions, stress, diet, pollutants, and, of course, exposure to drugs of abuse, can regulate gene expression. Uncovering the mechanisms behind these so called epigenetic effects, offers a path to alleviate and perhaps even override a genetic predisposition by adjusting environmental variables.

One approach NIDA is pursuing is the merging of genomic and brain morphology (i.e., brain structure) data in order to understand how genes influence human brain development. Such data would be invaluable as a basis for understanding the contribution of specific genes to neuropsychiatric disorders and how exposure to certain environmental factors can trigger disease in those who are genetically vulnerable. This research would, in turn, open the door to next-generation pharmaceuticals that could target and perhaps even prevent or reverse disease processes. The recent discovery of histone demethylases—a new family of genome modifying enzymes—is just one example of a set of proteins that could be targeted for medications development.

Also critical to substance abuse prevention and treatment is the development of reliable assays for drug exposure and addiction vulnerability. Although tests of bodily fluids or hair and surveys using self-report questionnaires are used routinely, their value is compromised by their limited reliability, low sensitivity, and narrow scope. NIDA will encourage research to find reliable biomarkers—or indicators of a biological response/vulnerability to drug exposure—for assay development. The ability to quantify thousands of biomarkers in a consistent, expeditious, and affordable manner will yield revolutionary new approaches to the prevention and personalized treatment of substance abuse.

THE RELEVANCE AND IMPACT OF COMORBID CONDITIONS

NIDA research has demonstrated that drug abuse cannot be treated in isolation from associated concerns, such as criminal behavior, mental and physical health status, social functioning, and HIV/AIDS. A robust and consistent effort to tap into and integrate different sources of knowledge will be needed to design and implement effective interventions in the future. This will be particularly important for members of the military and their families, who may be facing difficult challenges related to substance abuse in the coming years. Many are returning from active duty with post-traumatic stress disorder (PTSD) and/or chronic pain conditions, both of which can be comorbid with drug abuse and require comprehensive treatment interventions. In response to these projections NIDA will increase our research investment in this area and collaborate with the Veteran's Administration, the Substance Abuse and Mental Health Administration (SAMHSA), and other NIH Institutes—NIMH, NCI, NIAAA, and NHLBI—in developing a responsive and forward-looking research agenda.

UNDERSTANDING THE DYNAMICS OF DRUG ABUSE AND HIV

NIDA's recent revamping of its HIV/AIDS research strategy better addresses the critical need for new therapies for drug abusers with HIV and for research designed to uncover more about the complex medical consequences, such as neuroAIDS. Initiatives in this area will help elucidate the effects of genetic variations on disease progression, and on how drugs of abuse and medications (for drug addiction and HIV) interact with both host and viral genes. To further such innovations, NIDA has established the Avant-Garde Award for exceptionally creative researchers offer-

ing transformative approaches to major challenges in biomedical and behavioral research on drug abuse and HIV/AIDS. Awardees are undertaking diverse approaches, such as evaluating the effectiveness of expanded access to highly active antiretroviral therapy in decreasing new cases of HIV infection among injection drug users. Evidence to date suggests the utility of this approach for injection drug users and their partners; if widely adopted, it could also help stem the HIV epidemic around the world. In addition, NIDA is promoting research on HIV screening and on how to best integrate testing and counseling into drug abuse treatment settings, among criminal justice populations, and in other countries that have been hit especially hard by the epidemic. Learning one's HIV-positive status reduces risk behaviors and, when linked to HAART, makes the person a less efficient vector for spreading the disease.

In sum, the health of our Nation and its leadership role in bringing science to bear on drug abuse and addiction depend on our ability to continue to support promising biomedical research that can bring with it enduring and transformative public health changes not just to this country but to the rest of the world. Thank you for this opportunity, and I will be pleased to answer any questions you may have.

PREPARED STATEMENT OF DR. JAMES F. BATTEY, JR., DIRECTOR, NATIONAL INSTITUTE ON DEAFNESS AND OTHER COMMUNICATION DISORDERS

Mr. Chairman and members of the subcommittee: I am pleased to present the President's fiscal year 2010 budget request for the National Institute on Deafness and Other Communication Disorders (NIDCD) of the National Institutes of Health (NIH). The fiscal year 2010 budget includes $413,026,000, which is $5,767,000 more than the fiscal year 2009 appropriation of $407,259,000.

The NIDCD conducts and supports research and research training in the normal and disordered processes of hearing, balance, smell, taste, voice, speech, and language. Last year, NIDCD celebrated its 20th anniversary. Over the past two decades, extraordinary research opportunities have led to scientific breakthroughs in the study of genes, proteins, sensory and supporting cells, and molecular processes that directly affect our understanding of communication disorders. NIDCD-supported scientists have also made substantial progress in behavioral studies that increase our understanding of how communication processes impact health. NIDCD's budget request and its research projects are consistent with the President's multiyear commitments to cancer and autism research. The following are notable research highlights built upon two decades of NIDCD support.

HAIR CELL REGENERATION

Our ability to hear relies on sensory cells in the inner ear, called hair cells. Hair cells can be damaged by disease, injury, aging, or exposure to certain drugs. When enough hair cells are damaged, an individual experiences hearing loss. Although fish, amphibians, and birds can spontaneously regenerate new hair cells to replace damaged ones, mammals (including humans) cannot. NIDCD-supported research into the development of the mammalian inner ear has led to a better understanding of which cells in a developing embryo become hair cells, and which become supporting cells that help maintain the hair cells. These basic studies have provided the foundations for more recent advances. For example, NIDCD-supported scientists have identified specific genes that determine an inner ear hair cell's fate. Building on these studies,

NIDCD-supported scientists were able to regenerate new hair cells in laboratory mammalian animal models, and restore hearing in some cases. These promising results provide hope that we might someday be able to regenerate functioning hair cells in humans.

PREVENTING NOISE-INDUCED HEARING LOSS

Prevention of noise-induced hearing loss is another important goal for the NIDCD. Approximately 15 percent of Americans between the ages of 20 and 69—an estimated 26 million American adults—have high-frequency hearing loss caused by exposure to loud sounds or noise at work or during leisure activities. Since the sensory hair cells of the inner ear do not spontaneously regenerate in humans, preventing noise damage to these cells is critical for long-term health. In October 2008, NIDCD launched a new public education campaign called "It's a Noisy Planet. Protect Their Hearing." The campaign is designed to increase awareness among parents of children ages 8 to 12—or "tweens"—about the causes and prevention of noise-induced

hearing loss. With this information, parents and other adults can encourage children to adopt healthy habits that will help them protect their hearing for life.

IMPROVING TECHNOLOGIES TO TREAT HEARING LOSS AND BALANCE DISORDERS

The NIDCD supports many research efforts to develop or improve technologies for the treatment of hearing loss and balance disorders. The cochlear implant is an electronic device that provides a sense of sound to individuals who are profoundly deaf or severely hard-of-hearing. Cochlear implants process sounds from the environment by directly stimulating the auditory nerve, bypassing the malfunctioning cells in the inner ear. Sustained NIH support has greatly improved this technology so that, with the appropriate training and support, deaf and severely hard-of-hearing individuals who receive a cochlear implant can enjoy an enhanced quality of life by participating more fully in society. Currently, cochlear implants are most successful in children who receive them at a young age, when the brain is still in an active phase of language development. NIDCD-supported scientists are investigating the benefits of bilateral cochlear implantation, in which a cochlear implant is fitted into both ears. Results show that individuals receiving two cochlear implants are significantly better at localizing sounds and hearing speech in a noisy room compared to individuals with one implant. In addition, within 1 to 2 years after implantation, children with two cochlear implants will have learned how to locate sounds, and most will be able to localize sounds better than children with only one implant.

Much like hearing, our sense of balance relies on hair cells arranged in specialized structures within the inner ear, which together make up our vestibular system. Vestibular hair cells are susceptible to damage by the same mechanisms as hearing hair cells—drugs, trauma, and infection—and their dysfunction can lead to dizziness or balance problems. Building on lessons learned from cochlear implant research and technology, NIDCD-supported scientists are now working to develop an implanted device to help partially restore a person's sense of balance. Although the prototype vestibular implant is still being used in animal studies, it has the potential to benefit more than 90 million Americans who experience dizziness or balance problems in the future.

NIDCD also actively supports research to improve hearing aid technology. Improving hearing in noisy environments is a major challenge for hearing aid users. Of the currently available technologies, directional microphones that focus on nearby sounds and filter out sounds further away show the most promise for addressing this problem. NIDCD-supported scientists have successfully completed a prototype of a low-power, highly directional microphone that is modeled on the acute directional hearing of a parasitic fly and is small enough to fit into a hearing aid. The device could offer hearing aid users significant improvement in their ability to listen to conversations amidst background noise. NIDCD's goal is for this research is to lead to the development of hearing aids that are more personalized and better able to restore normal hearing.

IDENTIFYING GENES RESPONSIBLE FOR COMMUNICATION DISORDERS

NIDCD-supported scientists are identifying and describing genes involved in many communication disorders, including autism, dyslexia, stuttering, speech-sound disorders, and hearing loss. Currently, scientists have mapped more than 80 genes responsible for inherited hearing loss. Starting in fiscal year 2009, NIDCD is serving as the lead Institute for an NIH Government Performance and Results Act (GPRA) goal to "identify or study additional genes involved in communication disorders in human and animal models by 2011." To achieve this goal, NIDCD- and other NIH-supported scientists are using the knowledge gained from the Human Genome Project to identify genes that play a role in communication disorders. These efforts will inform scientists as they develop genetic tests to predict communication disorders and personalize treatment plans for individuals affected by them. In a recent study, NIH-supported scientists scanned the human genome for genetic differences between individuals with and without autism. They identified both common and rare genetic factors that affect the risk for developing autism spectrum disorders (ASD). The results suggest that there are specific inherited genes that can cause abnormal connectivity between nerve cells in the brains of people with an ASD. These abnormal connections may be, in part, responsible for their communication difficulties.

AUTISM AND LANGUAGE

According to the American Psychiatric Association, approximately 20–40 percent of individuals with autism spectrum disorders have apparently normal intellectual abilities and relatively intact language skills, but they still have difficulty with the

social aspects of communication. These individuals are categorized as having high-functioning ASD. In order to develop useful and appropriate treatment programs for them, scientists need to know what specific aspects of communication are most impacted. NIDCD-supported scientists have used standardized conversational tests to compare individuals with high-functioning ASD to age-matched individuals without ASD. These comparisons enabled them to identify three main areas of conversational difficulty for individuals with high-functioning ASD: (1) Managing topics—responding in a way that is pertinent to the topic and identifying topics of interest to both parties; (2) Managing information—understanding how much information is enough and knowing what type of information to provide; and (3) Establishing reciprocity—participating in a balanced back-and-forth exchange. Researchers can now use these results to develop personalized treatment programs targeted to improve existing conversational skills and build new skills in the areas of communication that are most affected in individuals with high-functioning ASD.

VOCAL FOLD REGENERATION

The vocal folds—also referred to as vocal cords—are two elastic bands of tissue located in the larynx, or voice box, directly above the trachea, or windpipe. The vocal folds produce voice when air held in the lungs is released and passed through the partially closed vocal folds, causing them to vibrate. Vocal fold scars can result from injury or inflammation, or because of surgery to remove vocal fold nodules or polyps. The scars increase vocal fold stiffness and reduce their ability to vibrate. An individual with scarred vocal folds may have a hoarse, breathy, or low-pitched voice. NIDCD-supported scientists have developed a new class of soft gel material to serve as a scaffold to encourage regeneration of vocal fold tissue. Specific particles within the material can also be modified to bind and slowly release therapeutic drugs within the vocal folds as a way to further encourage regeneration of the tissue. This new material is currently being tested to learn what types of changes, such as particle size, distribution, and so on, will optimize tissue regeneration. Once the gel is optimized in laboratory tests, it may offer a potential future personalized treatment for individuals whose vocal folds have been damaged due to scarring.

Mr. Chairman, I would like to thank you and members of this subcommittee for giving me the opportunity today to present examples of scientific advances made with the support of the NIDCD. I am pleased to try to answer your questions.

PREPARED STATEMENT OF DR. LAWRENCE A. TABAK, DIRECTOR, NATIONAL INSTITUTE OF DENTAL AND CRANIOFACIAL RESEARCH

Mr. Chairman and members of the subcommittee: I am pleased to present the President's fiscal year 2010 budget request for the National Institute of Dental and Craniofacial Research (NIDCR) of the National Institutes of Health. The fiscal year 2010 budget includes $408,037,000 which is $5,385,000 more than the fiscal year 2009 appropriation of $402,652,000.

FACING THE FUTURE

Extraordinary advances have been made in recent years at the interface of traditional scientific disciplines. Multidisciplinary teams of scientists, engineers and clinicians have combined advances in biochemistry, cell and molecular biology, engineering, genetics, and neuroscience to gain a deeper understanding of the mechanisms underlying disease pathogenesis. This has yielded clues for the prediction of those most at risk for disease, approaches to personalized interventions, and strategies to prevent disease progression.

For example, who has not marveled at the complexity of a face? Or how nature designed the mouth and its unique soft and hard tissues as a gateway to the body and, in some creatures, a first line of defense? Among Nature's greatest miracles of design and engineering is the craniofacial complex. Utilizing the many powerful research techniques and tools now available, teams of NIDCR-supported scientists are creating a publicly accessible informatics platform, termed FaceBase, that will enable multiscale analysis of all aspects of craniofacial development. This basic understanding is key to one day preventing and more effectively managing craniofacial defects and disorders. Each year thousands of infants are born with a variety of craniofacial dysmorphologies. While many of these conditions, such as cleft lip and/or palate can be managed surgically and with supportive therapies, others are more challenging to treat. For example, children born with ectodermal dysplasias must deal with either malformed or multiple missing teeth.

The NIDCR's new strategic plan captures the communal spirit required to address complex oral and craniofacial diseases and conditions. It lays out the challenges of the immediate road ahead for dental, oral, and craniofacial research—challenges that our 2010 budget positions us to meet. But above all, our plan lays out the great promise that awaits scientists and the American public in the years ahead.

WIDEN THE SCOPE OF INQUIRY

As the volume of biological information has grown, so, too, have the questions that scientists can ask. No longer must the human body be neatly subdivided into its constituent parts and studied in strict isolation, one organ from another. Biological clues in one part of the body often have application elsewhere in the body.

An excellent example is oral cancer which results in more than 7,500 deaths each year in this Nation. Unlike cancers that arise in the internal organs, tumors of the oral cavity are often readily accessible for biopsy and prompt study. This has allowed a dedicated corps of scientists to make tremendous inroads into defining the molecular errors that trigger the disease. For example, a key signaling pathway, termed Akt-mTOR, is frequently dysregulated in head and neck carcinomas. Their research efforts not only will improve the diagnosis and treatment of oral cancer, it also will provide comparative data and possible new leads for scientists who study other less accessible tumors.

The same is true of research on the microbial biofilm that forms on the hard and soft tissues of the mouth. Oral health researchers have defined more than 600 microbes that inhabit the mouth and have spent generations studying the communal dynamics that contributes to common diseases, such as periodontal disease and tooth decay. This decades-long head start will help to guide research now under way on the other biofilms that form throughout the body. This line of study emerges from the growing recognition that subtle shifts in the composition of the body's biofilms may play a major contributory role in myriad human diseases. Advances are being enabled by powerful new technologies that allow for the more facile sequencing and analysis of microbial genomes. Indeed, microbes that have not yet been cultivated are now amenable to study, in silico, which helps describe the lifestyle of each organism.

NIDCR intends to make considerable investments in genome wide association studies of diseases and conditions affecting the craniofacial complex that will also inform pathology in other regions of the body. For example, an analysis of genes associated with Sjögren's syndrome, an autoimmune disease affecting 1 million or more Americans, will likely provide clues for other diseases such as rheumatoid arthritis or systemic lupus erythematosus. Chronic facial pain, including temporomandibular joint and muscle disorders, has begun to yield its secrets to the efforts of geneticists and neuroscientists. Particularly important are efforts to better understand the transition of acute to chronic pain. Compelling evidence suggests this may be related to neural plasticity, in a manner not dissimilar to mechanisms that underlie memory.

These are but a few of the cross-cutting issues that are now on NIDCR's research agenda. To investigate them vigorously, the NIDCR must continue to encourage innovation and bring to bear the best science possible. But therein lays another challenge.

KEEP THE PIPELINE STRONG

For the Nation's oral health community to tackle NIDCR's ambitious research agenda successfully, it needs tight integration among research, practice, and education. This synergy holds the key to solving the many disorders that affect the oral and craniofacial complex. During 2010, the Institute will continue to emphasize training and career development for oral health professionals, to ensure that we increase a thriving community of dentist-scientists ready to capitalize on the rapid and significant advances occurring in biomedical and behavioral research. At the same time, the Institute must continue to attract scientists from outside its traditional research arenas. We will need to cover all of the scientific bases, from chemists and computer scientists to molecular biologists and mathematicians. All play critical roles and will be invaluable in ensuring that the best science moves rapidly into clinical studies. In an effort to strengthen the pipeline at every stage, the NIDCR is determined to maintain its high level of commitment in 2010 to funding new and early-stage investigators in a wide range of scientific fields.

PROMOTE CLINICAL INNOVATION

Moving forward in the clinical realm will require a great deal of innovative thinking. In 2010, NIDCR will continue to lay the foundation for the next great revolu-

tion in oral healthcare: biology-based dental care. As the name suggests, dentistry will launch molecular-based healthcare over the next several decades. Using salivary-based diagnostics, this new oral health paradigm will provide patients with more precise diagnoses and a greater opportunity to practice prevention. Greater understanding of disease pathogenesis and the variation in individual susceptibility will yield targeted and personalized therapies to treat their conditions more efficiently. This will provide a better chance to maintain their teeth and supporting bone ultimately leading to a lifetime of high-quality health.

To catalyze adoption of these advances, and to further the evidence base of the dental profession, in 2010, the NIDCR will continue to support its Practice Based Research Networks initiative, which now engages hundreds of dentists nationwide in scientific studies.

ADDRESS HEALTH DISPARITIES

As beneficial as biology-based dental care will be one day in improving the oral health of Americans, every effort must be made, now and in the future, to combat oral health disparities. Millions of primarily low-income Americans have yet to benefit fully from advances in dental care, including countless children and their families.

The fiscal year 2010 budget request will allow the NIDCR to maintain strong support for its Centers for Research to Reduce Health Disparities. These Centers continue to demonstrate the value of partnering with communities throughout the research process in order to gain a complete understanding of the factors contributing to dental disease in each community and to develop appropriate intervention strategies. Emerging from this initiative will be a greater focus to identify the many complex factors that contribute to the disparities, targeted, multi-tiered research to address the problem, and coordinated efforts to promote greater awareness of oral disease.

The Institute also plans to continue partnering with the Centers for Disease Control and Prevention to monitor the status of the Nation's oral health. As a part of this effort, the NIDCR will seek to validate new methods to measure and document oral, dental, and craniofacial diseases.

DENTAL CARE IN THE FUTURE

Biology-based dental care will transform the most fundamental principle of the profession: restoration of form and function. No longer will dentists rely as readily on mechanical instruments and ceramo-metallic materials to repair damaged tissue. They will regenerate form and function (a) using the precision of molecular information—or the underlying cause of the disease—as their operational guide and (b) employing the body's own cells and biochemistry as their engineering materials.

Future dentists will possess more powerful optical instruments to visualize and accurately characterize whether near microscopic losses of mineral from a tooth surface will be self-correcting or whether they will progress to full blown decayed lesions. Advances in imaging, genomics and proteomics will allow a clinician to profile the circuitry of a tumor cell biopsied from the mouth. This diagnostic work-up will guide the choice of chemotherapy drugs to those that are most likely to target the internal wiring of the tumor cell and kill it. Targeted treatments will allow the removal of only the cancerous tissues.

In closing, and as highlighted in our 2010 budget justification, the NIDCR will continue to invest in research and research training to meet emerging scientific opportunities and challenges. This budget request will enable us to work towards achieving the four goals outlined in our strategic plan. These goals are attainable, and in striving to meet them, we can realistically expect to improve the Nation's oral health for generations to come.

PREPARED STATEMENT OF DR. GRIFFIN P. RODGERS, DIRECTOR, NATIONAL INSTITUTE OF DIABETES AND DIGESTIVE AND KIDNEY DISEASES

Mr. Chairman and members of the subcommittee: I am pleased to present the President's fiscal year 2010 budget request for the National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK) of the National Institutes of Health (NIH). The fiscal year 2010 budget includes $1,781,494,000, which is $20,156,000 more than the fiscal year 2009 appropriation of $1,761,338,000. Complementing these funds is an additional $150,000,000 also available in fiscal year 2010 from the special statutory Type I Diabetes Research Program for NIDDK.

Our Institute supports research on a wide range of common, chronic, costly, and consequential health problems that affect millions of Americans. These include diabetes and other endocrine and metabolic diseases; digestive and liver diseases; kidney and urologic diseases; blood diseases; obesity; and nutrition research. Additionally, consistent with the President's commitment to increase funding for cancer research, and with the HHS-wide initiatives on autism, NIDDK will support research relevant to these diseases.

GENETIC FACTORS IN COMPLEX DISEASES

Many complex diseases within the NIDDK mission result from interactions amongst multiple genetic and environmental factors. Building upon the wealth of genetic information from the Human Genome Project, basic research on genetic contributors to these diseases lays the foundation for translation of knowledge into clinical settings, where it can be used to better predict and pre-empt disease development, as well as provide more personalized medical care.

For example, the NIDDK supported recent research uncovering six new genetic variants involved in type 2 diabetes. Combined with previous genetic findings, this new knowledge can help to determine who is at risk for this disease and how it might best be treated and prevented. NIDDK research has also recently shown how a genetic variant associated with type 1 diabetes works to alter immune function, enhancing understanding of this disease and highlighting potential targets for therapy. NIDDK also contributed to international research efforts yielding an explosion of new genes or gene regions associated with the inflammatory bowel disease known as Crohn's disease. The total number of known susceptibility genes currently stands at more than 30, each of which promises fresh insights into this disease and its management. Genetic analyses have also identified contributors to other diseases within the NIDDK mission, including nonalcoholic fatty liver disease, liver cancer, and diabetes-related kidney disease. Some of this research addresses populations disproportionately affected by certain diseases. For example, genetic variants were identified that account for much of the burden of nondiabetic kidney disease in African Americans. These studies may lead to future screening strategies and more personalized therapies.

The NIDDK also participates in trans-NIH efforts exploring how genetic factors impact disease. Data from an NIDDK-sponsored study of the genetics of diabetic kidney disease are being analyzed by the Gene Association Information Network to inform disease prevention, diagnosis, and treatment. The NIDDK leads two projects within the Genes, Environment, and Health Initiative, which studies effects of genetic variants on disease risk in response to environmental exposures. The NIH Roadmap Epigenomics Program is researching how epigenetics—or biochemical changes to DNA—can control genes during different stages of development, such as fetal epigenetic responses in the intrauterine environment and the risk of diabetes after birth.

CLINICAL AND POPULATION-BASED RESEARCH

Clinical and population-based research generates important information not only for developing more effective therapies, but also for identifying strategies to preempt disease development—both essential for the future of medical care. NIDDK-sponsored research informs screening efforts to detect early signs of susceptibility and prevent full-blown disease. For example, recent studies have proven the potential of intensive early colonoscopy screening for precancerous polyps in African Americans to reduce their disproportionate colon cancer burden.

NIDDK-sponsored efforts are also testing interventions to address type 2 diabetes related to overweight in both adults and children. Researchers are studying obese adults with type 2 diabetes to observe the effects of lifestyle changes to lower risk of diabetes complications. Similarly, in children, a study is determining if healthier food choices in schools, increased physical activity, and improved awareness of healthy behaviors can reduce weight and lower risk factors for type 2 diabetes—a disease that was once seen only in adults, but has been increasing in American youth.

Obesity continues to be one of our Nation's most pressing health problems. The NIDDK supports a multi-pronged obesity research effort that includes studies of molecular and environmental contributors to feeding behavior and metabolism, processes such as inflammation in metabolic tissues, bariatric surgery and other potential treatments for obesity, and lifestyle interventions to prevent or reverse obesity. For example, a recent study showed that modest reductions in time spent by children watching TV or using the computer have beneficial effects on their weight.

Clinical research is also yielding new insights into the development and management of kidney, urologic, and liver diseases. Recent clinical studies showed the limited effectiveness of drugs to enable vascular access during hemodialysis for kidney failure and for treating chronic kidney disease due to high blood pressure in African-American patients. A multi-center network is investigating causes of the two most common urologic pelvic pain disorders-interstitial cystitis/painful bladder syndrome and chronic prostatitis/chronic pelvic pain syndrome—which may yield new targets for managing these diseases. A new clinical research network conducting translational research on chronic hepatitis B is focused on understanding disease processes and applying this knowledge to more effective treatment and control strategies.

ENHANCING FUTURE HEALTH RESEARCH

The biomedical research enterprise will depend heavily on the next generation of investigators, innovative ideas of individual scientists, and the synergy of public-private partnerships. The NIDDK, along with the wider NIH, will continue its commitment to helping new investigators realize their potential through such efforts as special funding consideration, small grant and career awards, and mentoring workshops. The Institute also remains firmly committed to supporting investigator-initiated research. Public private partnerships through such entities as the foundation for the NIH will continue to expand the reach of NIDDK research.

Strategic planning, analyses of disease burden, and research coordination are tools utilized by the NIDDK to advance research. Recently, the National Commission on Digestive Diseases—for which NIDDK provided leadership and support—released its long-range research plan, identifying challenges and opportunities for digestive diseases research. A separate report on the burden of digestive diseases in the United States was prepared by the NIDDK to inform this research plan. The "NIDDK Prostate Research Strategic Plan," released in 2008, provides recommendations for future research efforts targeting the causes, prevention, and treatment of benign prostate disease.

NIH recently initiated an effort to update its 2004 "Strategic Plan for NIH Obesity Research" in order to review research progress and identify new opportunities. This strategic planning effort is overseen by the NIH Obesity Research Task Force, which I co-chair together with Dr. Elizabeth Nabel, Director of the National Heart, Lung, and Blood Institute.

Coordination to enhance research efforts across the NIH and with research partners in other Federal agencies is also achieved through the work of coordinating committees. The Diabetes Mellitus Interagency Coordinating Committee (DMICC) coordinates diabetes activities across the Federal Government and fosters opportunities for agency collaboration. In its coordinating role, the DMICC encourages Federal research collaborations, minimizes overlap of agency research efforts, and enhances public awareness of diabetes research and health information provided by Federal agencies. The DMICC is the focal point for diabetes research planning efforts.

PROMOTING HEALTH AWARENESS

In addition to supporting health research, the NIDDK remains committed to ensuring that knowledge gained from research is used to promote health awareness. Relevant activities include the National Diabetes Education Program, National Kidney Disease Education Program, Weight-control Information Network, Celiac Disease Awareness Campaign, and programs to promote prevention of obesity and overweight.

Recently, the NIDDK expanded its health information materials with a new Awareness and Prevention series of fact sheets. These publications are designed to raise awareness of diseases such as diabetes, digestive diseases, and kidney and urologic diseases among people not yet diagnosed with these illnesses. Materials produced by the NIDDK are often translated into multiple languages. For example, the Institute is currently developing Asian language materials on hepatitis B to reach people whose origins place them at higher risk—a priority highlighted at the NIH Consensus Development Conference on Management of Hepatitis B in October 2008.

Another resource for promoting health awareness in affected groups is a set of teaching tools for school-based diabetes education in American Indians, who have the highest rates of diabetes in the United States. Through educating American Indian youth about diabetes prevention, these tools aim to reduce the incidence of type 2 diabetes in these young people and their families, as well as encourage entry into health-related careers.

CLOSING REMARKS

A key goal of the NIDDK is to maximize the return on research investments to derive the greatest health and economic benefits. Embedded in the population-based projects I mentioned is a consideration of their cost-effectiveness. As areas of research converge around common disease mechanisms—such as microbial influences on health—and research tools—like genetics-based technologies—opportunities exist to leverage resources and foster collaborations. Past investments in sample repositories and databases can be extended in ancillary and follow-up studies. In these ways, the intrinsic economic benefit of NIDDK-sponsored research can be fully realized.

In closing, I thank the chairman and members of the subcommittee for this opportunity to highlight some of the NIDDK's research and outreach efforts to improve our Nation's health. I would be pleased to answer any questions you may have.

PREPARED STATEMENT OF DR. LINDA BIRNBAUM, DIRECTOR, NATIONAL INSTITUTE OF ENVIRONMENTAL HEALTH SCIENCES

Mr. Chairman and members of the subcommittee: I am pleased to present the President's fiscal year 2010 budget request for the National Institute of Environmental Health Sciences (NIEHS) of the National Institutes of Health. The fiscal year 2010 budget includes $684,257,000, which is $21,437,000 more than the fiscal year 2009 appropriation of $662,820,000.

INTRODUCTION

NIEHS works at the forefront of public health to meet the challenges the field of environmental health sciences faces in the 21st century. Meeting these numerous and demanding challenges is vital to reducing and preventing disease burden across the Nation. As biological sciences generate a deeper understanding of the working of organisms at the molecular and systems levels, opportunities open to advance our knowledge of the effects of environmental exposures—not just the clear and obvious effects, but also the subtle, complex ways human health is affected by the environment. Tackling scientific questions with this level of complexity requires an ongoing evaluation of our ideas and approaches, and an emphasis on integration across disciplines—from computational and molecular, to clinical and public health, and everything in between. Our discoveries translate into improvements in environmental regulation, public health, and clinical practice.

To improve our Nation's health, and to increase the benefits of our health care system, the use of medical interventions must go hand in hand with the adoption of behaviors aimed at disease prevention and wellness promotion. The goal of environmental health sciences is to remove human exposures to deleterious agents before disease processes and dysfunction begins. By advancing our understanding of the interactions of the environment with human health, and opening the door to new ways to prevent disease, NIEHS's investments serve to undergird a recovering economy and to support improvement of the health of our citizens, as well as our healthcare system. NIEHS budget request and research projects are also consistent with the President's multi-year commitment for cancer, autism, and nanotechnology.

NEUROLOGICAL DISORDERS AND THE ENVIRONMENT

There is continued concern that neurological disorders such as autism, attention deficit hyperactivity disorder (ADHD), and adult onset diseases such as Parkinson's and Alzheimer's may be rooted in early exposures to environmental toxicants. NIEHS supports basic research to determine the mechanisms and pathways by which toxicants may bring about neural damage to the developing brain. Some of the key neurotoxicants being studied are metals such as lead, mercury, and manganese; pesticides; tobacco smoke; and polychlorinated biphenyls and polybromated diphenyl ethers used to make insulating and fire retardant products.

With NIEHS support, the Children's Center at the University of California, Davis is conducting the first large-scale human population study of children with autism. These researchers are looking at a wide range of environmental exposures and their effects on early development in more than 1,000 California children. NIEHS researchers are also developing new and improved animal and cellular models for ADHD and autism—models that will help determine how neurotoxic substances may impact brain development and behavior, and may be useful in testing therapies.

ENVIRONMENTAL HEALTH AND SAFETY OF NANOMATERIALS

Engineered nanoscale materials display novel physical, chemical, and biological properties that contribute to new technologies useful for drug delivery systems, tissue engineering, biological and environmental sensor technology, and environmental remediation. By 2015, the global nanotechnology market is projected to exceed $15 billion. Nanotechnology, like all emerging technologies, should create innovation while minimizing risk of adverse health effects, and health effects of exposure should be assessed prior to extensive use. Safety assessment is challenging due to the diversity of materials used to synthesize nanoparticles, as well as the wide range of physical and chemical properties that emerge at the nanoscale. NIEHS and the National Toxicology Program (NTP), which is headquartered at NIEHS, support research on the impact of size and size-dependent properties of nanomaterials on biological response at the systemic, cellular, and molecular levels. This research has begun to demonstrate trends in the relationship of physical and chemical properties to biological response. NIEHS and NTP will continue to support research that increases the understanding of potential health impacts of these novel materials, as well as help to guide development of nano-enabled products to reduce adverse health impacts in our increasingly exposed population.

ENVIRONMENTAL DISRUPTORS OF ENDOCRINE SYSTEMS

Chemicals can mimic the hormones of our endocrine system and disrupt its functions, with potentially adverse effects on health and development. A consensus statement expressing concerns about the possible health effects of one such chemical, Bisphenol A (BPA), was issued by an expert panel as a result of a meeting organized by NIEHS in November 2006.

NTP also recently completed an evaluation of BPA. BPA was selected for evaluation because of the volume produced, widespread human exposure, extensive animal data on reproductive and developmental effects, and growing public concern. BPA is used in plastic water bottles and containers, in some medical tubing, and in the plastic coating inside of food cans, among other uses. Data from the Centers for Disease Control and Prevention showed BPA in 93 percent of 2,517 urine samples from people 6 years and older. The NTP evaluation graded various health concerns on a six-level scale: serious concern for adverse effects; concern; some concern; minimal concern; and negligible concern. NTP concluded there is “some concern” for effects on the development of the brain and behavior, and prostate gland development, in fetuses, infants, and children at current exposures, and “minimal concern” for effects on mammary gland and earlier age of female puberty in fetuses, infants and children at current levels of exposure. As a result of NTP’s work, scientists at the Food and Drug Administration are reviewing their policies on BPA.

In separate NIEHS-supported studies in rats, BPA exposure induced changes in the mammary gland that were time and dose specific, so that, for example, high-dose exposure resulted in architectural modifications in the number of undifferentiated epithelial structures of the breast tissue. High-dose exposures induced changes in genes related to cell differentiation suggesting alterations in the normal development of the gland. These studies are part of the larger NIEHS-National Cancer Institute program of Breast Cancer and Environmental Research Centers; NIEHS expects that these and other research findings will shed light on the ways in which environmental exposures can influence the risk of breast cancer in women.

HEXAVALENT CHROMIUM AND HEALTH

Chromium compounds, such as hexavalent chromium, are widely used in electroplating, stainless steel production, leather tanning, textile manufacturing, and wood preservation. The United States is one of the world’s leading producers of chromium compounds. Hexavalent chromium compounds have been shown to cause lung cancer in humans when inhaled, but it was not known whether these compounds could also cause cancer when ingested; hence they were nominated for NTP toxicity and carcinogenicity testing because of concerns over its presence in drinking water, its potential health effects, and the lack of adequate cancer studies on ingested hexavalent chromium.

NTP studies showed that sodium dichromate dehydrate, a compound containing hexavalent chromium, causes cancer in laboratory animals following oral ingestion. Male and female rats developed malignant tumors in the oral cavity. In mice, the studies showed dose-related increases in the number of benign and malignant tumors in the small intestine. This is the first and only lifetime study that clearly demonstrates the carcinogenicity of hexavalent chromium in rodents after oral exposure.

The results of these studies were closely monitored by many groups, including the affected industries and numerous national and international public health and regulatory agencies. The data will most certainly be used as the basis to develop State and Federal drinking water and soil cleanup standards, and will have significant public health impact on thousands of people exposed to hexavalent chromium in contaminated drinking water and soil.

CONCLUSION

These examples highlight important NIEHS and NTP research on the environmental connection to human disease and stand in for other vital research supported by the Institute. Research, such as the Sister Study, an epidemiological study following a cohort of 50,000 sisters of women diagnosed with breast cancer, promises to produce ground breaking information on the environment's role in the causation of breast cancer.

The field of environmental health sciences is beginning a new chapter of scientific progress, with new and better tools at our disposal, an expanding understanding of the human genome and its relationship with the environment, and young scientists coming into the field who are well-prepared and eager to apply these tools and knowledge to our current scientific challenges. I am honored, as Director of NIEHS and NTP, to facilitate the challenges and opportunities ahead to alleviate suffering and improve human health.

PREPARED STATEMENT OF DR. JEREMY M. BERG, DIRECTOR, NATIONAL INSTITUTE OF GENERAL MEDICAL SCIENCES

Mr. Chairman and members of the subcommittee: I am pleased to present the fiscal year 2010 President's budget request for the National Institute of General Medical Sciences (NIGMS). The fiscal year 2010 budget includes $2,023,677,000, which is $25,876,000 more than the fiscal year 2009 appropriation of $1,997,801,000.

Each year, NIGMS-supported scientists uncover new knowledge about fundamental life processes. While answering basic research questions, these scientists expand our awareness and understanding of how disease takes hold in the body. Institute grantees also develop important new tools and techniques that have research and medical applications. The payoffs from NIGMS research investments are impressive on many fronts. As just one example, 67 scientists have received Nobel Prizes in recognition of the scientific breakthroughs they made with NIGMS support.

GENETIC STUDIES GUIDE TREATMENTS

The future of medicine will center on precise diagnosis and personalized treatments. This is a departure from most of today's medical approaches, which are based on studies of populations and one-size-fits-all statistics derived from them. The ability to pre-emptively tailor healthcare to individuals offers huge potential for increasing the efficiency and effectiveness of efforts to preserve health over the course of a lifetime.

Americans are eager for information that will help them make intelligent, individualized choices about their health. Toward this end, in 2000 NIGMS partnered with a number of other National Institues of Health (NIH) components in launching an effort to determine how genes affect the way people respond to medicines, including antidepressants, chemotherapy agents, and drugs for asthma and heart disease. Since then, studies by this Pharmacogenetics Research Network (PGRN) have shown that genetic information can help predict how beta-blockers, breast cancer medications, and nicotine patches will work in a specific person. In early 2009, PGRN researchers merged data sets from around the world to demonstrate that information about certain genetic variations could aid doctors in determining the proper, personalized dose of warfarin, a blood-thinning drug taken by millions of Americans. This work set the stage for a prospective clinical trial that will test if using such genomic information will make it quicker and easier to get the right dose and furthermore, whether doing so could prevent serious treatment complications like heart attacks, strokes, and internal bleeding.

Other NIGMS-funded genetic studies have revealed surprising roles for RNA. Nobel laureates Andrew Fire and Craig Mello paved the way for this paradigm shift by showing that a process called RNA interference, or RNAi, silences the activity of targeted genes. RNAi is now being widely used both as a research tool and for the development of products that could combat diseases like cancer and HIV. In 2008, other NIGMS-supported scientists won the prestigious Lasker Award for their

groundbreaking discovery of microRNAs, short RNA molecules that regulate gene function using some of the same mechanisms central to RNAi. Our rapidly expanding understanding of RNA's many roles is already providing novel medical insights, such as the linkage of abnormal microRNA levels to cancer and other diseases.

PHYSICAL SCIENCES SHINE LIGHT ON BIOLOGY

The intersections between fields of science—such as those between the physical sciences of physics, chemistry, mathematics, and computer sciences and the biomedical and behavioral sciences—often yield particularly fruitful and high-impact lines of investigation. One timely example is the NIGMS-supported computational modeling tools being used to predict the spread of emerging infectious diseases and the results of possible interventions. These field-spanning approaches provide important insights to help policymakers and public health officials respond to outbreaks, including H1N1 flu.

Further evidence of how basic physical science can greatly contribute to biomedical research is found in nuclear magnetic resonance (NMR). This technique, developed by physicists in the 1930s, underlies the well-known medical procedure of magnetic resonance imaging. But in the laboratory, NMR is the basis of some of the most powerful analytical methods in chemistry and biochemistry. In 2008, NIGMS-funded researchers used NMR to identify a contaminant in several batches of another widely used blood-thinning medicine, heparin. The scientists determined the chemical structure of the contaminant, which was only subtly different from heparin and therefore difficult to find by other methods, and showed how the contaminant could cause severe reactions and even death in humans. As a result of this work, NMR may now be used to screen additional drug preparations for contaminants that are difficult or impossible to detect by other means.

A physics-based technique called X-ray crystallography is also key to understanding molecules that are central to health and disease. Using this approach along with NMR, scientists funded through a coordinated NIGMS effort called the Protein Structure Initiative (PSI), have produced a wealth of information about the shapes of proteins, which are essential to their functioning. Following successful pilot and production phases that included the development of critical tools and techniques, the Institute is now focusing the PSI on structures with specific biological roles and expanding its reach throughout the scientific community. This new direction, called PSI:Biology, will emphasize partnerships between biologists and high-throughput structure determination centers to address important biomedical problems and provide information that will aid the development of new medicines.

Among the advances from chemistry studies are powerful imaging techniques that allow scientists to visualize life processes in unprecedented detail. The discovery and development of green fluorescent protein (GFP) is a case in point. GFP was first purified from jellyfish in 1962, and before long, NIGMS-funded American researchers were finding ways to use this new tool to monitor activities in living cells and organisms. These scientists, who won the 2008 Nobel Prize in chemistry for their insights, put the GFP gene into a variety of organisms, including bacteria and worms. Today, GFP is an essential part of the fabric of biological research and is used, for example, as a key component of powerful drug development tools.

FINDING AND FUNDING INNOVATION

To keep knowledge streaming from the Nation's scientific laboratories, we must be agile in responding to the changing needs of researchers, both individuals and teams. The Institute has been a pioneer in novel funding programs that address the needs of the scientific community and encourage innovation. One good example is Konrad Hochedlinger, who received an NIH Director's New Innovator Award in 2007. This program, which NIGMS developed and administers, jump-starts the careers of unusually creative early stage investigators. Since groundbreaking work in 2007 in which other NIGMS-funded scientists reprogrammed ordinary skin cells to become induced pluripotent stem cells (iPS) this area of inquiry has exploded. Dr. Hochedlinger's project aims to unravel the many details of how reprogramming works. He is currently working on creating "reprogrammable mice" in which every cell can become an iPS cell capable of morphing into any cell type.

Another New Innovator is explaining basic behavioral principles using animal models. Karin Pfennig is studying how different species of toads choose a mate, a decision that has costs and benefits and involves trade-offs. Understanding the fundamental drivers of such "context-specific" behavior may help us treat behavioral disorders in people and address behavioral aspects of disease transmission and spread.

Dr. Pfennig has contributed to the research enterprise in another important way. As part of its commitment to training the next generation of scientists and increasing the diversity of the scientific workforce, NIGMS developed the Institutional Research and Academic Career Development Award (IRACDA). This program gives postdoctoral scientists mentored teaching experiences at minority-serving institutions. Through IRACDA, Dr. Pfennig pursued her own cutting-edge research at the University of North Carolina, Chapel Hill, while also teaching at a historically Black college, North Carolina Central University. Dr. Pfennig, who grew up in a single-parent household with very limited resources, attributes her desire to "give back" to her own great teachers and mentors who challenged her to pursue her ambition to become a scientist. Programs like IRACDA pay lasting dividends on many levels, providing role models for students, preparing future teachers, and promoting partnerships between institutions.

INVESTING TODAY FOR AMERICAN PROSPERITY

In addition to building a solid foundation of knowledge for medical advances, basic biomedical and behavioral research yields tangible economic benefits. NIGMS grants support the salaries and laboratories of thousands of researchers throughout the United States. And NIGMS-funded advances have played a significant role in the development of the multi-billion-dollar biotechnology industry, which is now its own engine of discovery as well as a critical partner to the pharmaceutical industry.

I want to close by affirming the Institute's deep appreciation for the extraordinary opportunities provided by the American Recovery and Reinvestment Act of 2009. In addition to its impact on stimulating the Nation's economy, this legislation will enable scientists to uncover new knowledge that will lead to better health for everyone. We intend to use these funds to support highly meritorious research that could not be funded with our regular appropriations and to further accelerate the tempo of science through targeted supplements to existing grants. NIGMS is also addressing research projects which are consistent with the President's multi-year commitment for cancer and autism. We are also eager to fund creative studies sparked by the new NIH Challenge and Grand Opportunities grant programs, which are designed to focus on health and science problems where significant progress can be expected in 2 years.

Thank you, Mr. Chairman. I would be pleased to answer any questions that the subcommittee may have.

PREPARED STATEMENT OF DR. THOMAS R. INSEL, DIRECTOR, NATIONAL INSTITUTE OF MENTAL HEALTH

Mr. Chairman, and members of the subcommittee: I am pleased to present the President's fiscal year 2010 budget request for the National Institute of Mental Health (NIMH) of the National Institutes of Health (NIH). The fiscal year 2010 budget includes $1,474,676,00, which is $24,185,000 more than the fiscal year 2009 appropriation of $1,450,491,000.

PUBLIC HEALTH BURDEN OF MENTAL ILLNESS

According to the most recent estimates, roughly 12.5 million American adults reported mental illness symptoms so severe as to cause them significant disability in the past year.[1 2] According to the World Health Organization, mental disorders are the leading cause of medical disability in the United States and Canada for people under age 45. In contrast to many other chronic medical conditions, mental disorders typically begin at an early age, usually before the age of 30. Indeed, mental disorders, such as schizophrenia, depression, and bipolar disorder, are increasingly recognized as the chronic medical illnesses of young people. These illnesses also shorten people's lives. Americans with serious mental illness die, on average, 25 years earlier than the general population.[3]

[1] Kessler RC, Chiu WT, Demler O, Walters EE. Prevalence, severity, and comorbidity of twelve-month DSM–IV disorders in the National Comorbidity Survey Replication (NCS–R). *Archives of General Psychiatry*, 2005 Jun;62(6):617–27.

[2] U.S. Census Bureau. *Population Estimates by Demographic Characteristics. Table 2: Annual Estimates of the Population by Selected Age Groups and Sex for the United States: April 1, 2000 to July 1, 2004* (NC–EST2004–02) Source: Population Division, U.S. Census Bureau Release Date: June 9, 2005. http://www.census.gov/popest/national/asrh/

[3] Parks J, Svendsen D, Singer P, Foti ME (Eds.). *Morbidity and mortality among people with serious mental illness*. Alexandria, VA: Medical Director's Council, National Association of State

Continued

The annual economic costs of mental illness in the United States are enormous. The direct costs of mental health treatment represent 6.2 percent of all healthcare spending,[4] which, according to the Centers for Medicare and Medicaid Services, totaled 15.8 percent of the gross domestic product in 2003. Indirect costs associated with mental illness, which include all nontreatment-related costs such as lost earnings, Social Security disability payments, homelessness, and incarceration, account for even greater expenses than the costs of direct mental healthcare. A recent study found that serious mental illnesses cost the United States at least $193 billion annually in lost earnings alone.[5] A conservative estimate places the total direct and indirect annual costs of mental illness at well over $300 billion.[6]

MENTAL DISORDERS ARE CHRONIC BRAIN DISORDERS

NIMH's mission is to transform the understanding and treatment of mental illnesses through basic and clinical research, paving the way for prevention, recovery, and cure. These illnesses can now be studied as brain disorders, as they are becoming more accessible to medical science by using the tools of modern neuroscience. These disorders frequently begin in childhood and are chronic, affecting people of all races and ethnicities, in both rural and urban settings. To prevent a lifetime of disability for millions of Americans, NIMH research is directed toward identifying the biological basis of mental disorders, examining the psychological and social aspects that contribute to the disorders, and pinpointing targets for improved prevention, diagnosis, and treatment.

MENTAL HEALTHCARE IN THE FUTURE

In the future, the practice of medicine will be increasingly predictive, pre-emptive, personalized, and participatory. Genetics and clinical neuroscience will make this possible for mental illnesses. Clinical neuroscience seeks to discover fundamental knowledge about the brain and behavior and to use this knowledge to develop better tools for prevention, diagnosis, and treatment. For instance, biomarkers can detect risk to permit prevention, neuroimaging may facilitate diagnosis, and the discovery of new molecular targets should yield novel treatments. The study of pathophysiology is fundamental for NIMH's mission, which is to use science to transform care: not merely to reduce symptoms among persons with mental illness, but to promote recovery among this population and ultimately to discover pre-emptive interventions that can prevent psychosis, disability, and suicide.

In pursuit of this mission, NIMH is in the process of implementing its new Strategic Plan, which details the scientific priorities that will direct and accelerate mental health research in the years to come. The American Recovery and Reinvestment Act of 2009 (the Recovery Act) directs part of the Nation's stimulus funding to support job creation and retention in the field of biomedical research. These supplemental funds present an exciting opportunity for NIMH, allowing us to jumpstart the groundbreaking science outlined in the Strategic Plan, as well as the strategic plans of the NIH Office of AIDS Research and the Interagency Autism Coordinating Committee (IACC). This commitment will expand our knowledge about the underlying biology of mental disorders and accelerate the development of improved diagnostic measures and treatments. The fiscal year 2010 budget continues support for the IACC. NIH will receive $1 million from the Office of the Secretary to support the Committee.

Mental healthcare in the future will be based on the ability to predict those most at risk, prevent the onset of disorder, and, in cases where prevention is not possible, develop treatments tailored to the individual. This requires collaboration among the diversity of people affected, including mental healthcare providers, researchers, and people with mental illness and their families. An example of NIMH research taking

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Mental Health Directors (NASMHPD). October 2006. http://www.nasmhpd.org/general__files/publications/med__directors__pubs/Technical%20Report%20on%20Morbidity%20and%20Mortaility%20-%20Final%2011–06.pdf

[4] Mark TL, Levit KR, Coffey RM, McKusick DR, Harwood HJ, King EC, Bouchery E, Genuardi JS, Vandivort-Warren R, Buck JA, Ryan K. *National Expenditures for Mental Health Services and Substance Abuse Treatment, 1993–2003*. SAMHSA Publication No. SMA 07–4227. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2007. http://www.samhsa.gov/spendingestimates/SAMHSAFINAL9303.pdf.

[5] Kessler, RC, Heeringa S, Lakoma MD, Petukhova M, Rupp AE, Schoenbaum M, Wang PS, Zaslavsky AM. The individual-level and societal-level effects of mental disorders on earnings in the United States: Results from the National Comorbidity Survey Replication. *Am J Psychiatry*. 2008 Jun; 165(6):703–11.

[6] Insel TR. Assessing the economic cost of serious mental illness. *Am J Psychiatry*. 2008 Jun; 165(6):663–5.

this approach is our recent partnership with the U.S. Army to reduce suicide among soldiers. The high rates of mental health and behavioral adjustment problems among recent U.S. military combat veterans and the increasing rates of suicide among Army soldiers are of growing concern. To address this issue, NIMH and the U.S. Army are collaborating on a $50 million research project, which will be the largest single study NIMH has undertaken on the subject of suicide. The project seeks to strengthen the Army's efforts to reduce suicide among soldiers by identifying the risk and protective factors associated with suicidal thinking and behavior. While targeted for the Army, the study's findings will also inform our understanding of suicide in the other Armed Forces as well as the overall population, leading to more effective prevention and treatment for servicemembers and civilians alike.

While we have long known that mental disorders are brain disorders, recent research has begun to reconceptualize these illnesses as disorders of brain development. Between infancy and adulthood dramatic changes are taking place in the brain, not only in size, but also in structure and function. Understanding these changes and how these trajectories can go off course provides unprecedented promise for the prediction and prevention of mental disorders, as well as opportunities to harness this knowledge to improve treatments for individuals who go on to develop a disorder, either in childhood or in early adulthood. As an example, research on brain development in children with attention-deficit/hyperactivity disorder (ADHD) from the NIMH Intramural program recently reported a striking delay in cortical maturation. Between ages 5 and 15, the maturation of the prefrontal cortex was found to be delayed by roughly 3 years in children with ADHD compared to age-matched children without the disorder. Current studies are now exploring the effects of treatment on the rate of cortical maturation.

The prototype neurodevelopmental disorder for NIMH is autism. Matching the increasing public health urgency of autism, NIMH research over the past year has yielded important discoveries on the pathophysiology of autism spectrum disorders (ASD). Research has shown that different cases of ASD could potentially be traceable to any of 50 or more variations in the genome, alone or in combination, suggesting that ASD may be the final common path for many different genetic abnormalities. Most of the genes implicated are critical for brain development. For example, independent teams of researchers have linked inherited variations in a gene on Chromosome 7, called CNTNAP2, with ASD. CNTNAP2 is part of a family of genes that make proteins that play a key role in building the machinery by which brain cells communicate. One variation of this gene was found to influence the age at which children with ASD say their first word. Another variation was identified that increases the risk for ASD, but mainly when it is inherited from mothers. These studies provide evidence that CNTNAP2, when disrupted, may represent one path to the development of ASD. In addition to breakthroughs in the genetics of autism, recent research has provided new tools for diagnosing autism as early as the first birthday. Early diagnosis is critical because early intervention is associated with the best outcomes.

In order to build upon these research advances, NIMH will be using Recovery Act funding as an opportunity to fuel further research on ASD, including its underlying biology, methods for earlier and more effective diagnosis, and improvements in treatment. The new IACC Strategic Plan for ASD Research provides the scientific goals and benchmarks for this endeavor (www.iacc.hhs.gov). NIMH, in collaboration with other NIH Institutes, has issued a series of funding opportunity announcements (FOA) to address the heterogeneity of ASD. This will be the largest single funding opportunity for ASD research in NIH's history. NIMH may contribute as much as $30 million of the total $60 million of Recovery Act funds that NIH has set aside for this effort (actual expenditures will depend on the proposals received). These FOAs encourage applications for 2-year projects that address ASD measurement, identification of biomarkers and biological signatures, immune and central nervous systems interactions, genetics/genomics, environmental risk factors, and ASD intervention and treatment. Additionally, we will be supporting autism research with Recovery Act funding through NIH's new Challenge Grants in Health and Science Program. This program encourages applications on a diverse range of research topics, such as improving access to services by individuals with ASD and their families and expanding NIH's National Database for Autism Research in order to accelerate the availability of new data for the ASD research community. Finally, NIMH intends to continue to build its investment in autism research via its base budget, which supports a new intramural program for autism research, Autism Centers of Excellence, and a broad range of individual grants for research and training related to ASD.

Understanding the pathophysiology underlying mental disorders will not only lead to the improved prevention, diagnosis, and treatment of the disorders themselves,

but will also help to clarify the relationships that exist between mental disorders and other physical health problems, such as cancer. People with mental disorders smoke cigarettes at twice the rate of those without such a disorder, and they consume 44 percent of all cigarettes smoked in the United States.[7] NIMH research is not only addressing this major public health problem through behavioral studies on smoking cessation techniques in these populations, but is also seeking to understand the underlying causes of smoking behavior. Several studies are examining the link between cognitive function, which is often disrupted in severe mental illness, and its improvement through nicotine use. By gaining better insight into how nicotine influences neural mechanisms, NIMH researchers are hoping to discover new ways of improving cognitive function among people with mental illness, ultimately reducing the severe health consequences associated with tobacco use.

In summary, we are well positioned to fulfill the promise of predictive, preemptive, personalized, and participatory medicine in the future. By using the best tools, funding the best science, listening to our partners, and engaging our communities, we continue to make progress toward our goal of transforming the understanding and treatment of mental illnesses through basic and clinical research, paving the way for prevention, recovery, and cure.

PREPARED STATEMENT OF DR. STORY C. LANDIS, DIRECTOR, NATIONAL INSTITUTE OF NEUROLOGICAL DISORDERS AND STROKE

Mr. Chairman and members of the subcommittee: I am pleased to present the President's fiscal year 2010 budget request for the National Institute of Neurological Disorders and Stroke (NINDS) of the National Institutes of Health (NIH). The fiscal year 2010 budget includes $1,612,745,000, which is $19,401,000 more than the fiscal year 2009 appropriation of $1,593,344,000.

The important and challenging mission of NINDS is to reduce the burden of neurological disorders through research. Hundreds of disorders of the brain, spinal cord, and the nerves of the body affect people of all ages. Collectively, they cause an enormous burden in lost life, disability, and suffering, and cost billions of dollars each year in medical expenses and reduced productivity. The causes of nervous system disorders are diverse; among them are physical forces of traumatic brain injury, slow degeneration of nerve cells in Parkinson's and Alzheimer's disease, gene mutations in brain tumors and inherited diseases, blood vessel block or bleeding in stroke, and toxic effects of treatments for cancer, HIV/AIDS, and other diseases. Compounding the challenge, the brain and spinal cord are intricate in structure, difficult to access, sensitive to intervention, and do not readily repair themselves following damage.

PLANNING FOR THE FUTURE

Over the last 2 years, NINDS has engaged the scientific community and the public in strategic planning to meet these challenges. Planning took a "blue sky" look at the future, but also gave outside experts unprecedented access to data about NINDS programs to inform recommendations of practical steps to better carry out our mission. Even as we finalize the strategic plan and seek further public input, we are implementing recommendations. One major lesson from planning is the importance of program evaluation; based on the results we are reallocating resources to maximize public health impact. Perhaps the most important message for today, however, is not at the level of program details, but about where we stand with respect to the NINDS mission-treatments for neurological disorders are still far from adequate, but research is yielding remarkable progress, and the prospects for the future are very encouraging.

NINDS's budget request and its research projects are consistent with the President's multi-year commitment for cancer and autism.

STROKE

Stroke, the "S" in NINDS, shows how far we have come and how far we have to go. Stroke remains the third leading cause of death in the United States and a major cause of long-term disability. However, American Heart Association statistics show that the age-adjusted stroke death rate decreased by 29.7 percent from 1995 to 2005, and actual stroke deaths declined by 13.5 percent, resulting in thousands of lives saved. Many NIH research studies contributed to the decline by predicting

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[7] Ziedonis D., et al. Tobacco Use and Cessation in Psychiatric Disorders: National Institute of Mental Health Report. *Nicotine Tob Res*, 2008;10: 1–25.

who is at risk for stroke, who will do best on which drug, and whether surgery to clean a carotid artery or repair an aneurysm is worth the risk for a particular patient. Research on stroke prevention is continuing apace, including research on the geographic and racial disparities.

About a decade ago, a NINDS clinical trial demonstrated that appropriate use of the clot buster tPA can restore blood flow to the brain and significantly improve outcome from stroke. New clinical trials are building on this first successful emergency treatment by testing whether ultrasound improves tPA's effectiveness to break up clots in large brain arteries and whether direct injection of tPA into a blocked brain artery or clot retrieval devices may help some patients. Despite its proven benefit, too few people now receive tPA, which must be administered after specialist assessment and within a few hours of a stroke. A trial this year showed that telemedicine can expand access to emergency stroke treatment to areas of the country without specialized stroke centers. A second trial is assessing whether emergency personnel in the field can rapidly deliver a therapy to protect the brain prior to reaching a hospital. Beyond prevention and emergency treatment, a major challenge for stroke, as for traumatic brain injury, is promoting recovery after brain damage has occurred. Rehabilitation that harnesses the brain's "plasticity" is showing promise in people, and trials are assessing the most effective strategies, but there is still a long way to go.

GENES AND BRAIN DISEASES

Although there are hundreds of neurological disorders, common themes unify research across diseases. One lesson of planning is the importance of engaging the insight and ingenuity of researchers throughout the United States to recognize shared disease mechanisms and common therapeutic strategies. Research on genes is one unifying theme that spans many areas of basic and clinical science.

A first wave of progress identified single gene defects that cause more than 200 neurological disorders, and continues with new findings in inherited types of ALS and other diseases. Often, the most immediate benefit of gene findings is genetic tests, which can spare families expensive and frustrating diagnostic odysseys to find out what is wrong with their child. Even when a single gene defect is identified, major obstacles confront therapy to correct the defect, especially in the brain, but there is progress; this year, for example, a preliminary clinical trial established the feasibility of gene transfer to treat Batten disease. Genes can also provide the first foothold on understanding causes and developing drug treatments, leading to rational therapy development programs, as NINDS has underway for muscular dystrophy, spinal muscular atrophy, and other disorders. Although most brain tumors are not inherited, acquired gene defects drive tumor formation. Observing which genes are affected in glioblastoma and other brain tumors is suggesting which tumors respond to which cancer drugs and providing clues to developing more effective treatment.

Recently, scientists have begun to crack the more complex ways that variations in multiple genes together contribute to common neurological disorders and shape individual differences in therapy response. Gene tests show promise for establishing the appropriate dose of the drug warfarin, which is commonly used to prevent stroke in people with certain risk factors. Warfarin now requires frequent blood tests to find the safe and effective dose because of variability among people, and people are at risk until the dose is set. Genome-Wide Association Studies (GWAS) are one method that has associated genes with multiple sclerosis, Parkinson's disease, stroke, and other common disorders. For example, understanding autism is an NIH-wide priority, and

GWAS recently implicated molecules that have been studied in the development of connections among nerve cells, linking a dynamic area of basic research to this disease.

TRANSLATING SCIENTIFIC INSIGHTS TO THERAPIES

NINDS basic and clinical research yield understanding of disease and clinical tools that are essential for therapy development in the private sector. The Institute has also long pursued translational opportunities that are not likely to be targeted by others, whether because bold therapeutic strategies present uncertainty and long development horizons that are not tolerable to investors, rare diseases represent a small market, or developments in surgery and interventions using existing drugs may not recapture investments. The NINDS Intramural program developed the first successful enzyme therapy for inherited disease. Among applied NINDS extramural programs, the Anticonvulsant Screening Program has catalyzed the development of several epilepsy drugs now on the market, and the Neural Prosthesis Program successfully pioneered devices to restore lost nervous system functions. In 2003, NINDS

moved from selective translational research in a few areas, to a broad effort to capitalize on opportunities across all neurological disorders by initiating the Cooperative Program in Translational Research. This program supports academic and small business investigator-initiated preclinical therapy development, using milestone driven funding and peer review expertise and criteria tailored to therapy development. Therapies from this program have received investigational approval from the FDA and are moving to clinical trials. Based on the advice of strategic planning advisory panels, which included industry experts, NINDS has created an Office of Translational Research and recruited a leader who has extensive drug development expertise. The new office will coordinate and focus NINDS applied programs more effectively on therapy development, without reducing NINDS commitment to basic and clinical research that is the foundation for progress. As new opportunities for therapy development emerge, we cannot let them languish in the "valley of death" between the idea and the success.

Progress against two gene disorders that cause nervous system tumors illustrates how basic understanding of disease can drive research toward treatment. In people who have neurofibromatosis type 1, tumors grow within nerves and can cause disabling symptoms by compressing nerve, spinal cord, and other organs. Several years ago NIH-funded investigators discovered gene mutations that cause the disease and developed animal models that mimic the human disorder. After years of work, researchers discovered how the mutant gene causes cells associated with nerves to develop tumors, and then recruit other cell types and blood vessels to the tumor. Once researchers understood the molecular steps, they recognized that the cancer drug Gleevec acts on the same molecules. They are now testing the drug in people who have neurofibromatosis.

Tuberous sclerosis complex is another disorder in which tumors, called tubers, can grow in nearly any tissue, including the brain. Many people with this disease also develop epilepsy or autism. Again, finding genes led to understanding of the molecular steps in disease, and scientists recognized that an available drug, rapamycin, which is used to prevent organ transplant rejection, affects a key molecule in the disease process. Studies in mice that mimic the human disorder were especially encouraging because the results suggest that the disease can be reversed in adults, countering pessimism that the disease produced irreversible affects on brain development. Researchers are exploring whether rapamycin or similar drugs are safe for long-term use, and may also be of benefit for epilepsy or autism from other causes.

THE RESEARCH WORKFORCE

As science progresses, we recognize themes that bring together research on disparate diseases, whether shared disease mechanisms, as in neurodegeneration, therapeutic approaches, as stem cells, or program needs, as translational research. The American Recovery and Reinvestment Act reminds us of another common theme—research is labor intensive. Progress depends on the men and women who do research and their commitment to research that may take decades. To maintain the vigor of NIH and private research, NINDS is committed to making research an attractive and sustainable career for young people who are innovative, intelligent, dedicated, and diverse.

PREPARED STATEMENT OF DR. PATRICIA A. GRADY, DIRECTOR, NATIONAL INSTITUTE OF NURSING RESEARCH

Mr. Chairman and members of the subcommittee: I am pleased to present the President's fiscal year 2010 budget request for the National Institute of Nursing Research (NINR) of the National Institutes of Health (NIH). The fiscal year 2010 budget request includes $143,749,000, which is $1,870,000 more than the fiscal year 2009 appropriation of $141,879,000.

NINR's budget request and its research projects are consistent with the President's multi-year commitment for cancer and autism.

INTRODUCTION

NINR supports clinical and basic research to build the scientific foundation for clinical practice, prevent disease and disability, manage and eliminate symptoms caused by illness, and enhance end-of-life and palliative care. The breadth and depth of NINR's research portfolio is ideally suited to explore some of the most important challenges affecting the health of the American people. An aging population, an increasing incidence of chronic illness, a shortage in the health workforce, and rapidly escalating costs necessitate profound changes in the ways in which we ap-

proach healthcare. These challenges require us to develop new strategies for treating, managing, and preventing illness that are person-centered rather than disease-centered, that focus on pre-empting the development of chronic illness rather than treating it, and that feature the person as an active participant in managing his or her own healthcare. The research supported by NINR can significantly contribute to the evidence base for many of the changes that will occur in healthcare in the coming years and decades. NINR advances science to address current and future challenges through its research programs in health promotion and disease prevention; self-management, symptom management, and caregiving; and end-of-life and palliative care. In addition, NINR maintains a strong commitment to the elimination of health disparities faced by at-risk and underserved populations through continued work to develop culturally appropriate, evidence-based interventions. NINR also trains the next generation of scientists to ensure the development of the innovative research and faculty workforce of the future. The research goals in NINR's strategic plan, changing practice, changing lives, emphasize the areas of public health that demonstrate the greatest needs and in which NINR can have the greatest impact.

Let me now describe our research programs and highlight some of our recent accomplishments.

NINR RESEARCH PROGRAMS

Health Promotion and Disease Prevention

Healthcare professionals and policy leaders have stressed the importance of preventive care to the health of all Americans. NINR supports research to discover new ways to prevent disease and achieve long-term, positive health outcomes in individuals across the lifespan. NINR-supported scientists explore strategies to understand and promote behavioral changes in individuals, evaluate health risks in diverse communities, and assess issues of patient safety. In recent years, successful efforts in the areas of health promotion and disease prevention research have increasingly involved community members in the design and conduct of the study.

NINR research has an impact on clinical practice. In one example, researchers designed, implemented and evaluated a program to address the health burden and costs associated with premature birth, a condition affecting more than 500,000 infants in the United States every year. The Creating Opportunities for Parent Empowerment program (COPE), for parents of premature infants, is an educational-behavioral intervention program that begins 2 to 4 days after admission to a neonatal intensive care unit (NICU) and teaches parents how to care for their premature infant. The researchers found that COPE implementation reduced the length of stay in the NICU by 4 days, for an estimated healthcare cost savings of at least $4,800 per infant. Thus, in addition to improving parent and child outcomes, routine implementation of COPE in NICU's across the United States could possibly save the healthcare system more than $2 billion per year. The results of this study have sparked interest among hospitals and insurers nationwide.

NINR-supported researchers are developing more programs to promote healthy behaviors and prevent disease, including: an outreach intervention designed to reduce HIV-risk among adolescent girls receiving services through community-based health centers; a parent training program designed to promote positive parenting and mental health among low-income ethnic minority families with young children; and a lifestyle-modification program for prehypertensive, middle-aged rural women.

SELF-MANAGEMENT, SYMPTOM MANAGEMENT, AND CAREGIVING

Given the increasing numbers of people living with chronic illness, whether children with diabetes or elders with heart disease, NINR is developing new approaches to help individuals manage their own health conditions, to decrease the effects of adverse symptoms, and to reduce the burden on caregivers. NINR is improving the quality of life of individuals with chronic illness and their families by supporting research related to self-management, symptom management, and caregiving.

Our self-management research explores strategies that help individuals to participate in their own health practices. In one recent example, community "Lay Health Educators" were trained to deliver a health promotion and asthma management program to children in elementary schools from rural towns and unincorporated communities. Children receiving this program demonstrated significant improvements in asthma knowledge, self-management scores, and use of metered dose inhalers. Results from this study suggest that using Lay Health Educators for delivery of an in-school education program may be an effective means for improving children's skills in asthma self-management, especially in hard-to-reach communities.

Our symptom management research focuses on the biological and behavioral aspects of symptoms such as pain and fatigue, with the goal of improving patient health and quality of life. A recent symptom management study aimed to define patient-determined success for treatment of chronic spine pain in four areas: pain, fatigue, emotional distress, and interference with daily activities. This study found that the patients for whom pain was reduced experienced significantly less fatigue, emotional distress, and interference with daily activities. The findings confirm that successful treatment for chronic pain is not viewed by patients exclusively in terms of pain reduction, but also involves a number of additional quality of life factors.

Research Capacity Development

The increasing demand for nurse clinicians, faculty, and scientists, and the inadequate supply of new nurses to meet that need, continue to burden America's health system. NINR builds research capacity and fosters interdisciplinary training for the next generation of scientists in basic, translational, and clinical research through individual and institutional training and career development awards. NINR training strategies focus on the development of nurse scientists and earlier entry into research careers with special consideration given to underrepresented and disadvantaged populations. In addition, innovative training programs at the NIH, such as the NINR Summer Genetics Institute, the NINR Graduate Partnerships Program, and the new BNC fellowship (a joint venture between NINR, the NIH Clinical Center, and the Bravewell Collaborative), all serve to increase the knowledge and experience base of new scientists, and assist them in their transition to long-term research careers.

End-of-life

Faced with a complexity of life-limiting and eventual terminal conditions—whether cancer, heart disease, stroke, or neurodegenerative disorders—the challenges experienced by patients and their families as life draws to a close have refocused attention to the end of life and necessitated a better understanding of the dying process, the associated decisions about treatment, and the quality of care patients receive. Focusing on these topics, NINR end-of-life research seeks through science to improve the understanding of the mechanisms underlying palliation, including pain, fatigue, depression, and related symptoms; enhances communication and decisionmaking processes between patients and family members; and develops effective strategies to optimize care across diverse settings, populations, and cultural contexts.

One recent study explored the relationship between diagnosis and advance directives. As part of a longitudinal study, patients with an expected 2-year survival of less than 50 percent who had either cancer or amyotrophic lateral sclerosis (ALS) were interviewed with the goal of determining whether and how end-of-life discussions differed between clinicians and patients. Results showed that cancer patients were less likely than ALS patients to have had advanced care planning discussions. Although these results may reflect perceptions that ALS has a more predictable disease trajectory, that advanced cancer has a greater number of treatment options, or the presence of differing views about hope, this study highlighted that cancer patients may be less than adequately prepared for end-of-life decisionmaking.

Another recent study examined the life support withdrawal process for patients who died in the intensive care unit (ICU) or within 24 hours of discharge from the ICU, and surveyed family members on their perceptions of the care provided. The researchers discovered that for family members of patients who had an ICU stay of 8 days or more, families were more satisfied with care received when withdrawal of life support occurred in a staggered progression. The outcome of this study indicates that clinicians need to work with the family throughout the patient's ICU stay to provide them with accurate information on which to base decisions, and prepare them emotionally for the possible loss of their loved one.

NINR AND THE AMERICAN RECOVERY AND REINVESTMENT ACT

Funding for scientific research received through the American Recovery and Reinvestment Act of 2009 (ARRA) has provided NINR with an enormous opportunity, not only to assist with the Nation's economic recovery by creating and retaining jobs and enhancing infrastructure, but to advance biomedical and behavioral research in areas of critical importance to the NINR mission. NINR is using the funds from ARRA to support additional research projects, to accelerate ongoing research through supplements to current grants, and to create opportunities for introducing prospective scientists to a research career. The additional science supported by NINR through ARRA will, in the long-term, contribute to improving the health of

the Nation through enhanced prevention and management of chronic illness and disease.

Thank you, Mr. Chairman. I will be happy to answer any questions that the subcommittee might have.

PREPARED STATEMENT OF DR. DONALD A.B. LINDBERG, DIRECTOR, NATIONAL LIBRARY OF MEDICINE

Mr. Chairman and members of the subcommittee: I am pleased to present the President's fiscal year 2010 budget request for the National Library of Medicine (NLM) of the National Institutes of Health (NIH). The fiscal year 2010 budget includes $334,347,000, which is $3,576,000 more than the comparable fiscal year 2009 appropriation of $330,771,000.

NLM, the world's largest biomedical library and the developer of electronic information services, delivers trillions of bytes of data to millions of users daily. Every day 3.5 terabytes of data are downloaded to users. By making research results—from DNA sequences to clinical trials data to published scientific articles and consumer health information—readily available, the Library magnifies the positive impact of the NIH's investment in the creation of new knowledge. By organizing increasing amounts and types of biomedical and health information, the NLM fuels new research discoveries, informs patient care decisions, helps people exert control over their health and healthcare, and AIDS disaster preparedness and response.

The NLM is a key enabler for important congressional, NIH, and Department of Health and Human Services (HHS) initiatives. NLM's budget request and its research projects are consistent with the President's multi-year commitment for cancer and autism. Current priorities include: increasing the transparency of clinical trials in ClinicalTrials.gov; enhancing public access to NIH-funded peer-reviewed manuscripts in the PubMed Central archive; making results of Genome-Wide Association Studies (GWAS) available in dbGaP to improve the understanding of genetic and environmental factors underlying human disease; supporting and distributing standard terminologies for electronic health records and clinical research data, including genetic tests, within NLM's Unified Medical Language System; conducting biomedical informatics research on health applications of information technology; and developing specialized information resources for use in emergency and disaster response.

To be useful, NLM's information services must be known and readily accessible. The Library's outreach program relies heavily on the 5,800-member National Network of Libraries of Medicine (NN/LM) and on exhibitions, events, and varied media to bring the message about NLM's free, high-quality health information resources to communities across the Nation. The NN/LM comprises academic health sciences libraries, hospital libraries, public libraries, and community-based organizations. They form an efficient way to make the published output of biomedicine easily accessible by scientists, health professionals, and the public and to develop partnerships with community organizations and underserved populations.

SCIENTIFIC INFORMATION RESOURCES

The NLM's National Center for Biotechnology Information (NCBI) meets the challenge of collecting, organizing, storing, analyzing, and disseminating scientific data by designing, developing, and distributing the tools, databases and technologies that are enabling the genetic discoveries of the 21st century. Celebrating 20 years since its enactment, the Center is at the hub of international interchange of molecular biology and genomic information, with Web sites accessed several million times a day.

In addition to the widely known GenBank and PubMed/MEDLINE databases, the NCBI provides a wide array of genomic resources and is a valued collaborator throughout the NIH. The recent discovery of a novel H1N1 influenza virus highlights the value of the specialized virus resource that NCBI developed with the National Institute of Allergy and Infectious Diseases. It links vaccine researchers to genomic data about the influenza virus. The PubChem repository fills a critical need in the Molecular Libraries Roadmap Initiative, with information on more than 40 million "small molecules" that are crucial in drug development. The dbGaP database, which links genotype data with phenotype information from clinical research studies to support identification of genetic factors that influence health, is the public repository for the trans-NIH GWAS project. NIH's mandatory Public Access Policy ensures scientific articles written by NIH-funded authors are deposited in PubMed Central and linked to other scientific information.

The Lister Hill National Center for Biomedical Communications leads research to create and improve biomedical communications systems, technologies, and networks. The Center recently completed a major expansion of ClinicalTrials.gov, in response to the congressional mandate. The system now maintains a registry of clinical trials involving FDA-regulated drugs, biologics, and devices and starting last September, began collecting summary results of trials of FDA-approved products. ClinicalTrials.gov currently contains data on more than 70,000 trials in 166 countries and is searched by more than 500,000 people every month.

The NLM's two research centers collaborate on improving standards for genetic and genomic testing. The NCBI provides a database of reference values to assist in quality control of genomic tests. The Lister Hill Center is helping to expand the Logical Observation Identifiers Names Codes standard to cover genetic and newborn screening tests already in routine clinical and public health use.

Electronic health records with advanced decision-support capabilities—and connections to relevant health information—will be essential to achieving personalized medicine and will also help people manage their own health. NLM supported much of the seminal research work on electronic records, clinical decision support and health information exchange. NLM is the HHS coordinating body for clinical terminology standards and supports development and dissemination of key standards for U.S. health information exchange. The Lister Hill Center is actively engaged in research on next generation electronic health records to facilitate patient-centered care, clinical research, and public health. This work has already resulted in tools that are helping system developers, including some at the Centers for Medicare and Medicaid Services, to incorporate the use of standards into health information systems.

INFORMATION SERVICES FOR THE PUBLIC

In addition to providing researchers and health care providers with access to scientific information, the NLM also serves the public—from elementary school children to senior citizens. The Library's main consumer health portal is MedlinePlus, available in both English and Spanish. In fiscal year 2008, there were more than 750 million MedlinePlus pages viewed by more than 132 million unique visitors from 229 countries. In addition to more than 725 "health topics," MedlinePlus has interactive tutorials for persons with low literacy, medical dictionaries, a medical encyclopedia, directories of hospitals and providers, surgical videos and links to the scientific literature. A "Go Local" feature links users to information about services in their communities. Today, there is go local coverage for approximately 44 percent of the U.S. population and expansion is an important goal for the Library in fiscal year 2010.

In 2009, the NLM celebrated its second year of producing the NIH MedlinePlus magazine, an outreach effort made possible with NIH and Friends of the NLM support. The free magazine is widely distributed to the public via physician offices, libraries, and other locations, with a readership of up to 5 million nationwide. A Spanish/English version, NIH MedlinePlus Salud (the Spanish word for "health"), was launched in January 2009 to address the specific health needs of the growing Hispanic population.

NLM also produces an array of specialized consumer health Web resources. Genetics Home Reference provides understandable information about genetic conditions and related genes or chromosomes. The Household Products Database provides easy-to-understand data on potential health effects of more than 2,000 ingredients contained in more than 8,000 common household products. The Dietary Supplements Labels Database has information from labels of more than 3,000 brands of dietary supplements, with links to authoritative sources of information.

ENSURING ACCESS TO INFORMATION IN TIMES OF DISASTER

NLM is committed to ensuring uninterrupted access to critical information services in the event of disaster or emergency. NLM's new Disaster Information Management Research Center is building on proven emergency backup and response mechanisms within the NN/LM to promote effective use of libraries and specially trained librarians—disaster information specialists—in disaster management efforts. The Center also collaborates with the Navy National Medical Center, Suburban Hospital Healthcare System, and NIH Clinical Center in the Bethesda Hospital Emergency Preparedness Partnership. The Partnership will provide hospital surge capacity for the national capitol area and create a surge model for use across the Nation. Recent studies found such capabilities lacking in major metropolitan areas. NLM coordinates R&D for this model and investigates new methods for sharing health information for disaster preparedness and response.

NLM also develops advanced information services and tools to assist emergency responders when disaster strikes. NLM's TOXNET, a cluster of databases covering toxicology, hazardous chemicals, and toxic releases, provides a foundation for services to first responders, such as Wireless Information System for Emergency Responders and Chemical Hazard Event Medical Management (CHEMM). CHEMM builds on the Library's successful collaboration with the HHS Office of Public Health Preparedness, the National Cancer Institute, and the centers for disease prevention and Control to develop the Radiation Event Medical Management (REMM) system. NLM is also developing a tool for identification of post traumatic stress disorder and mild traumatic brain injury.

In summary, the NLM is well-positioned to contribute to the Nation's health—by making increasing amounts of scientific data available to researchers and health practitioners, by improving the Nation's healthcare information infrastructure, by providing the public with access to authoritative information to maintain their personal health, and by enabling health sciences libraries to make substantial contributions to disaster information management. All of these activities will depend on a strong and diverse workforce for biomedical informatics research, systems development, and innovative service delivery. To that end, the NLM will continue its longstanding support for postgraduate education and training of informatics researchers and health science librarians.

Prepared Statement of Dr. Jack E. Whitescarver, Director, Office of AIDS Research

Mr. Chairman and members of the subcommittee: I am pleased to present the President's fiscal year 2010 budget request for the trans-National Institutes of Health (NIH) AIDS research program of the NIH. The fiscal year 2010 budget includes $3,055,494,000, which is $45,155,000 more than the fiscal year 2009 appropriation of $3,010,339,000.

THE AIDS PANDEMIC

More than 33 million people around the world are estimated to be currently living with HIV/AIDS infection. More than 25 million men, women, and children have already died.

The pandemic affects the future of families, communities, military preparedness, national security, political stability, national economic growth, agriculture, business, healthcare, child development, and education in countries around the globe. As a result of multilateral and bilateral programs in low- and middle-income countries, almost 3 million people now have access to antiretroviral drug treatment. However, for every 1 person who starts taking antiretroviral drugs, another 3 become infected.

In the United States, HIV/AIDS remains an unrelenting public health crisis. The Centers for Disease Control and Prevention (CDC) reports more than 1.1 million people are infected with the virus, with approximately 56,300 new infections each year. According to CDC statistics, African-American men and women and gay and bisexual men of all races and ethnicities are the most affected groups in the United States. It is estimated that 1 out of every 20 individuals in the District of Columbia is HIV infected—a vivid example of the impact of AIDS on minority populations in the United States.

THE TRANS-NIH AIDS RESEARCH PROGRAM

The NIH AIDS research program is the largest in the world—a unique and complex multi-Institute, multi-disciplinary, global research program. Perhaps no other disease so thoroughly transcends every area of clinical medicine and basic scientific investigation. AIDS research is carried out by nearly all of the NIH Institutes and Centers in accordance with their mission. This diverse research portfolio requires an unprecedented level of scientific coordination and management of research. The Office of AIDS Research (OAR) was authorized to plan, coordinate, evaluate, and budget all NIH AIDS research, functioning as an "institute without walls," allowing NIH to pursue a unified research program to prevent and treat HIV infection and its associated complications. OAR has established comprehensive trans-NIH planning, portfolio analysis, and budgeting processes to identify the highest priority areas of scientific opportunity, enhance collaboration, minimize duplication, and ensure that precious research dollars are invested effectively and efficiently. The research priorities that frame this trans-NIH budget request were established through the annual OAR strategic planning process, involving scientists from NIH, other

Government agencies, academia, industry, and nongovernmental organizations, as well as community representatives.

FISCAL YEAR 2010 RESEARCH PRIORITIES: PREVENTION RESEARCH

Prevention of HIV infection is NIH's highest priority for HIV-related research. Disappointing results from recent clinical studies of HIV vaccine and microbicide candidates underscore the need for additional discovery (basic) research on HIV and the host immune response. Biomedical and behavioral interventions are urgently needed to reach individuals at risk, particularly in racial and ethnic populations in the United States, in international settings, among women, and among men who have sex with men. Priority areas include:

—*Microbicides.*—Microbicides, antimicrobial products that can be applied topically for the prevention of HIV and other sexually transmitted infections, may offer one of the most promising primary preventive interventions. NIH supports a comprehensive microbicide research program that includes the screening, discovery, development, preclinical testing, and clinical evaluation of microbicide candidates, as well as fundamental research aimed at understanding how HIV transverses mucosal membranes and infects cells. NIH supports behavioral and social science research on the acceptability and use of microbicides among different populations. In fiscal year 2010, NIH will increase funding for the design, development, and evaluation of microbicide candidates.

—*Vaccines*.—The best long-term hope for controlling the AIDS pandemic is the development of safe, effective, and affordable AIDS vaccines. AIDS vaccine research remains a high priority to ensure that new and innovative concepts continue to advance through the pipeline. NIH supports a broad AIDS vaccine research portfolio encompassing basic, preclinical, and clinical research. The disappointing results from clinical studies of the Merck HIV vaccine candidate indicate a critical need to reinvest in basic research studies on the virus and host immune responses that can inform the development of new and innovative vaccine concepts; as well as the development of improved animal models to conduct pre-clinical evaluations of vaccine candidates. In fiscal year 2010, NIH will fund additional basic research on HIV and host responses, as well as the design and development of new vaccine concepts and the pre-clinical/clinical development of vaccine candidates in the pipeline.

—*Behavioral Research*.—NIH supports research to further our understanding of how to change the behaviors that lead to HIV acquisition, transmission, and disease progression—including preventing their initiation—and how to maintain protective behaviors once they are adopted. In addition, NIH supports research aimed at better understanding the social and cultural factors associated with HIV risk or protection, particularly in communities at high risk of HIV acquisition. This research will contribute to the implementation of a broader range of preventive and/or therapeutic strategies.

FISCAL YEAR 2010 PRIORITIES: THERAPEUTICS RESEARCH

Antiretroviral treatment has resulted in improved immune function in patients who are able to adhere to the treatment regimens and tolerate the toxicities associated with antiretroviral drugs; and it has delayed the progression of HIV disease, extending the time between initial infection and the development of AIDS. However, a growing proportion of patients receiving therapy are demonstrating treatment failure, experiencing serious drug toxicities and side effects, and developing drug resistance. A critical area of research is the use of antiretroviral therapy as prevention. This includes evaluating the use of therapeutic regimens after exposure to HIV (postexposure prophylaxis), as well as testing the concept of the use of antiretroviral therapy in high-risk individuals prior to HIV exposure (pre-exposure prophylaxis).

Epidemiologic studies have revealed a number of co-infections and co-morbidities associated with long-term HIV disease, including tuberculosis, hepatitis C, malignancies, metabolic disorders, cardiovascular disease, and neurologic disorders. A better understanding of the underlying etiology of these HIV-associated conditions will lead to better prevention and treatment strategies. NIH supports a comprehensive therapeutics research program to design, develop, and test drugs and drug regimens to prevent and treat HIV infection and its associated co-infections and comorbidities.

Translational and clinical studies also are needed to transform fundamental research results into improved strategies for preventing and treating these HIV-associated complications, including research on drug resistance, drug toxicities, pharmacogenomics, adherence, and the interrelatedness of HIV and nutrition.

DISCOVERY RESEARCH: ENABLING INNOVATION

A renewed emphasis on discovery research is essential to enable innovation, address critical gaps, and capitalize on emerging scientific opportunities. Groundbreaking strides have been made towards understanding the fundamental steps in the lifecycle of HIV, the host-virus interactions, and the clinical manifestations associated with HIV infection and AIDS. However, additional research is needed to further the understanding of the virus and how it causes disease, including studies to delineate how gender, age, ethnicity, and race influence vulnerability to infection and HIV disease progression. NIH-supported genomics studies and breakthroughs in sequencing the human genome provide new opportunities to apply these valuable tools to the search for new HIV prevention and therapeutics strategies. OAR proposes to capitalize on those opportunities by providing funds for new, exciting areas of investigation, including studies utilizing genomics tools to investigate the immune response to HIV infection.

RESEARCH TRAINING AND COMMUNITY OUTREACH

NIH must continue to support training programs for United States and international researchers to build the critical capacity to conduct AIDS research both in racial and ethnic communities in the United States and in developing countries. NIH funded programs have increased the number of training positions for AIDS-related research, including programs specifically designed to recruit individuals from underrepresented populations into research careers and to build research infrastructure at minority-serving institutions in the United States. The changing pandemic and the increasing number of HIV infections among women and in racial and ethnic populations of the United States, particularly in African-American and Latino/Hispanic communities, also underscore the need to disseminate HIV research findings and other related information to communities at risk.

SUMMARY

NIH-sponsored HIV/AIDS research continues to provide the important scientific foundation necessary to design, develop, and evaluate new and better vaccine candidates, therapeutic agents and regimens, and prevention interventions. NIH will continue to focus on the need for comprehensive strategies to decrease HIV transmission and improve treatment options and treatment outcomes in affected vulnerable populations in the United States, and in international settings. These interventions will address the co-occurrence of other sexually transmitted diseases, hepatitis, drug abuse, and mental illness; and consider the role of culture, family, and other social factors in the transmission and prevention of these disorders.

The NIH investment in AIDS research is reaping even greater dividends in unraveling the mysteries surrounding many other infectious, malignant, neurologic, autoimmune, and metabolic diseases. AIDS research has provided an entirely new paradigm for drug design, development, and clinical trials to treat viral infections. Drugs developed to prevent and treat AIDS-associated opportunistic infections also provide benefit to patients undergoing cancer chemotherapy or receiving anti-transplant rejection therapy. AIDS research also is providing a new understanding of the relationship between viruses and cancer. We are deeply grateful for the support the administration and this subcommittee have provided to our efforts.

Senator HARKIN. Dr. Kington, thank you very much for your opening statement, and I see we've been joined by Senator Shelby. Did you have an opening statement?

STATEMENT OF SENATOR RICHARD C. SHELBY

Senator SHELBY. Mr. Chairman, I'm glad to join you. I look forward to the hearing. I'll be in and out of here. We have some other Appropriations subcommittee hearings, but I do have a statement that I'd like to be made part of the record and I do have some questions that I'm going to have to leave and come back to ask those questions, unless you let me go.

[The statement follows:]

PREPARED STATEMENT OF SENATOR RICHARD C. SHELBY

Mr. Chairman, thank you. I appreciate you having this hearing today to discuss the vital mission carried out by the National Institutes of Health (NIH).

We live in a world where there are thousands of debilitating and life-threatening diseases—all that could use additional funding for research and clinical trials. We must continue to work towards the goal of increasing the overall Federal investment in basic research and development.

I support additional funding for NIH research, but in particular, I would like to emphasize today the importance of accelerating research in the area of Cystic Fibrosis (CF).

CF is a life-threatening genetic disease for which there is no cure.

But there is promise for people with CF—and that promise is in research.

Federal funding for medical research should accelerate the process of discovery and clinical development of new therapies for the treatment of disease. Yet, there is a significant discrepancy persisting between funding for clinical versus basic laboratory research.

Support for clinical research is particularly important for rare diseases, which often suffer from a lack of start-up funding needed to overcome the initial discovery phase of drug development and move into advanced stages of research.

Clinical research programs like the Cystic Fibrosis Foundation's Therapeutics Development Network have produced innovative new therapies for that disease. Led by research institutions including the University of Alabama at Birmingham, this national network allows multiple therapeutic approaches to be pursued simultaneously, accelerating the development of new treatments for the disease.

Dr. Kington coordinated networks such as the Cystic Fibrosis Therapeutics Development Network provide special insights regarding the most efficient means of conducting clinical trials.

Senator HARKIN. I have some, but, I mean, if you have to go to another——

Senator SHELBY. Senator Mikulski and I have a NASA hearing.

Senator HARKIN. Well, why don't you go ahead then? I'll hold mine and you go ahead and ask your questions.

CYSTIC FIBROSIS

Senator SHELBY. Thank you, Mr. Chairman.

Mr. Chairman, I thank you for the work you've done in chairing this subcommittee, and I continue to work with you.

We live in a world where there are thousands, everybody knows this, especially our panelists, we live in a world where there are thousands of debilitating and life-threatening diseases and they all could use additional funding for research and clinical trials, and I believe we must work toward the goal of increasing the overall Federal investment in basic research and development, and I applaud Senator Harkin in his work in this regard.

I personally, as a member of this subcommittee, support additional funding for NIH research, but in particular, today just for a few minutes, I would like to emphasize the importance of accelerating research in the area of cystic fibrosis.

Cystic fibrosis, as the panel knows, is a life-threatening genetic disease for which there is no cure but there is promise for people and that promise is in research.

Federal funding for medical research should accelerate the process of discovery and clinical development of new therapies for the treatment of this disease and others, yet there is a significant discrepancy existing between the funding for clinical research versus basic laboratory research.

Support for clinical research, as I understand it, is particularly important for rare diseases which often suffer from a lack of start-

up funding needed to overcome the initial discovery phase of drug development and move into advanced stages of research.

Clinical research programs, like the Cystic Fibrosis Foundation's Therapeutics Development Network, have produced in the way of new therapies for that disease. Led by research institutions, including the University of Alabama at Birmingham, this national network allows multiple therapeutic approaches to be pursued simultaneously, accelerating the development of new treatments for the disease.

Dr. Kington, coordinating networks, such as the Cystic Fibrosis Therapeutics Development Network, provide special insights regarding the most efficient means of conducting clinical trials.

Under your leadership, will the NIH increase Federal funding for these types of research?

Dr. KINGTON. Let me start off with a general answer and then I'll ask Dr. Nabel to comment, as well.

Senator SHELBY. Okay.

Dr. KINGTON. I think, in general, we agree that there are a lot of opportunities for us to accelerate the translation of scientific advances in the basic level into real treatments and interventions and diagnostic strategies at the bedside. We know that there are particular challenges for less common diseases.

In fact, we just announced yesterday a new initiative to help facilitate that translation and the Cystic Fibrosis community in many ways is held up as a good example of how a community affected by a disease can work collaboratively with the research community to facilitate translation and we're committed to helping that in any way we can.

Dr. Nabel, would you like to comment, as well?

Dr. NABEL. I appreciate your question. The NIH is very concerned about rare genetic disorders, like cystic fibrosis, and, indeed, I think if we can take a minute and really reflect upon the progress that's been made in cystic fibrosis, it's really been remarkable over the past decade.

We've gone from discovering the gene which causes the majority of cystic fibrosis, particularly the mutation, the CFTR gene. We know now that that gene leads to a protein that doesn't unfold properly. This protein is responsible for clearing secretion in the airways and in other tissues and when that protein doesn't unfold it can't lead to the clearance of secretions, mucous builds up, that gets infected and the sequela start.

What's very interesting is that the gene led to the understanding of what we call the molecular pathway that causes the disease. Understanding that molecular pathway then led to a search for new therapeutics that perhaps you're familiar with, and that search has now come up with two compounds, we call them small molecules, that are in clinical testing which directly affect the molecular pathway and, indeed, you probably saw Dr. Rootman's article in the New Yorker a couple of weeks ago and the remarkable report by several individuals who were enrolled in those trials saying how well they feel while taking these new drugs.

So that is, I think, a terrific example of how gene discovery leads to understanding, the molecular pathway leads to the detection of new therapeutics that are now being tested.

Can we do more in this area? Absolutely, absolutely. We're hoping to increasingly fund translational research and new clinical research in this area. The NHLBI currently has a specialized center for clinically oriented research in cystic fibrosis that's analogous to the CF Clinical Networks that you described and so many of those investigators are really the same community of folks.

But we look forward to really building and augmenting this research effort going forward.

Senator SHELBY. Well, I appreciate this. I know you have to start in the lab, but then you've got to move from the lab to the clinics to prove what's going on. So we have to have both, do we not?

Dr. NABEL. Absolutely.

Senator SHELBY. Well, I look forward to working with you, not just on cystic fibrosis, this is my attention for the moment, but in a lot of other diseases, and with Chairman Harkin in this regard.

Mr. Chairman, thank you for taking me out of order, but you know from chairing the subcommittee and being on other subcommittees, we sometimes meet at the same time.

Thank you, Mr. Chairman.

SUCCESS RATE OF ARRA

Senator HARKIN. Thank you, Senator Shelby, and thanks for all your involvement in this subcommittee over many, many years in research, medical research. So thank you very much for that.

Well, Dr. Kington, I want to talk about the Recovery Act and that money, and our budget. The problem is that the flip side of having all these requests come in is that most of them will not be funded. I'm hearing that the success rate for the Challenge Grants could be less than 5 percent.

So how do you keep up a high level of interest when so few researchers will actually get these grants? On the one hand it's a good thing. On the other hand do you discourage a lot of people when they don't get funded?

Dr. KINGTON. This is definitely a concern of ours. It's been interesting to read some of the press coverage which reporters have gone out speaking to scientists and we were pretty clear early on that we had a floor for dollars and that suggested that we would not have our usual success rate because this was a special program.

In spite of that, the scientists saw this as an extraordinary opportunity to actually get on paper interesting ideas in important areas. We believe that even with the substantial increase, I predict that we'll more than double that floor of $200 million, we still won't have a high success rate and there will be many good grants that we won't be able to fund, and there will be consequences for the agency and for the scientific community.

We anticipate that many of the scientists will resubmit those applications within our usual funding sequence. We suspect that we'll be able to fund some of them but our ability to fund even the very best of those applications will depend upon what our budget is in future years.

So it's a concern. I think at the very least it shows this extraordinary untapped supply of great ideas out there in the scientific community and I see that as a good thing.

ARRA AND FUTURE SUPPORT

Senator HARKIN. It seems to me that concerning the program you talked about, the Grant Opportunity Program, the GO Grants, it is my information that the purpose of this program is to support high-impact ideas that require significant resources for a discrete period of time to lay the foundation for new fields of investigation, Yet out of that $10.4 billion, $200 million is designated to GO Grants.

It seems to me that if you put most of the money in the RO1 grants and you do it for 2 years rather than 4 years, what happens after 2 years? Are you just sort of betting out on the cow that we're going to be able to keep that funding up? Because I'm not certain that we can.

I guess my question is, since this was a certain amount of money for a discrete period of time and you have these grants as I just defined them, why wouldn't I see more of that money going to that rather than RO1 grants for 2 years?

Dr. KINGTON. First of all, I think you'll see across the Institutes and Centers wide variation in whether or not—in how the dollars are distributed across these mechanisms and the numbers that we put forth were a floor.

I anticipate that the number will be higher because many Institutes, NHLBI and others, are increasing their commitments already to that stream of dollars and it will depend upon what ideas we see.

This was again a grand experiment in many ways to put out a broad call to see what the best ideas were and not restrict it to dollars, $1 million which was the limit for the Challenge Grants.

So the bottom line is that we think that we'll ultimately end up funding more than what we had initially planned. We believe that it's important to allow flexibility across Institutes and Centers. For some Institutes and Centers, these types of programs will be great opportunities. For others, scientifically it's a stronger case to fund more of the RO1s, but again even the RO1s, our estimate is that about, I think, one-third or so of the dollars probably will go to the existing pool of RO1s, but it varies from Institute to Institute.

Our goal is to make the framework as flexible as possible, but if we have great ideas, we'll put more resources toward the GO Grants and we are anxiously awaiting the applications. We anticipate that we'll get probably—I anticipate probably around 2,000 or so applications when all is said and done and if they're great ideas, we'll do our best to fund them.

Senator HARKIN. That's the GO Grants? That's what you're talking about?

Dr. KINGTON. Yes, the GO Grants, and again we suspect that many of these ideas that aren't funded but are still good will be resubmitted and our ability to fund those will depend upon what our budgets are in the out years.

We'll make the best decisions we possibly can to have the maximum impact of these dollars for science and public health, but again I see this in a very positive light, that we have had this extraordinary energized response by the scientific community.

It really is amazing, speaking to deans and faculty across the country, how excited the scientific community is both about the opportunities, the real opportunities to do work they otherwise couldn't have done, but perhaps even more importantly, about what these dollars said as a reflection of a commitment of the country to invest in biomedical research.

Senator HARKIN. Let me ask you this question. If, in the wisdom of Congress, it was decided that this money was to go out over 2 years, right?

Dr. KINGTON. Yes.

Senator HARKIN. But that's not to say we can't change our minds and it happens.

Dr. KINGTON. Congress can do whatever Congress wants.

Senator HARKIN. We can change our minds. It's occurred to me that, yes, we initially put that out there to be 2 years, but maybe we might want to think about making an exception for NIH, that maybe this money should be more than just a 2-year period of time.

Is that something that you could live with? I mean, would that help in any way or is it so set now for 2 years that we ought to just leave it alone? Rather than thinking about maybe changing it to provide for a longer period of time, say 4 years, to get that money out or something?

Dr. KINGTON. Well, we certainly made all of our decisions based thus far on a 2-year time horizon, but I will concede that having more flexibility probably would be helpful, but we also recognize the unique intent of these dollars and that is to stimulate the economy in the short run, and we believe we can responsibly spend the money in 2 years.

But some flexibility might help us as we sort of work through the process of spending. We might be able to have a benefit from more flexibility, but we will make good decisions even without that flexibility.

Senator HARKIN. Well, I might come back to you on that, not in this hearing but later on, to see if that flexibility might be the best course of action for us to take. Like I said, I don't know. It's just something I've thought about because again I just want to see how we judge the success of the Recovery Act funding.

I mean $10.4 billion within 2 years, but a lot of the results of that won't be known for some time. So I assume that a lot of people say we can judge the success on how many jobs it's created perhaps, if we're looking at it stimulating the economy. That's why the amount of money you put out there for extramural construction is important and getting new equipment in our labs is important, but I think a lot of the success of this will be judged, not just on the immediate jobs created but what's the long-term effect of the money that we provided?

So people say, "Did we get our money's worth?" Well, that's what's led me to think maybe—and I'm not saying this could happen—but maybe we ought to think about more flexibility in that 2-year time frame because I'm really worried. I say this to all of you. I'm really concerned about the cliff.

What's going to happen in 2011? We've got 2010, what 1.4 percent? 1.4 percent increase. You had it up there on the screen. But we funded $30.8 billion, but what happens in 2011 when—if all

these Recovery Act funds come out? I mean that's going to be a pretty hard landing, it seems to me, and, you know, I'm thinking about how do we soften that because I think we might be in a tough budget situation next year as we are this year and so since we've already appropriated this money for the Recovery Act, that we might think about trying to soften the landing a little bit. If you have any thoughts beyond that, of how we soften this a little bit, I'd like to know it, either today or maybe in writing or something later on.

Dr. KINGTON. We'd be happy to do that, and actually I'd welcome any of my colleagues. Just as all politics is local, all science is sort of local, as well, and many of—all of the Institute and Center directors are struggling with this exact same issue of how to responsibly make decisions now, recognizing the uncertainty about the future streams of dollars.

SUPPORT OF PROMISING RESEARCH AND FLEXIBILITY

Senator HARKIN. This is my chance to ask all of you here some questions. I'll start with Dr. Fauci.

Can you point to anything that your Institute is able to do now or can start and finish in 2 years? Is there something that you're able to do now with this Recovery money that you weren't able to do?

I'll ask each of you that. Dr. Fauci, any specific examples of research that you're able to fund that you otherwise might not have been able to?

Dr. FAUCI. Thank you for the question, Mr. Chairman. There are examples of things that we would not be able to fund if we didn't have it and there are examples of things that we can greatly accelerate and we would be able to use monies later on that we could continue it.

The example that I give is one of about three or four, and I'll only give one, is the money that we're putting in to accelerate the process of much more aggressive control of the HIV pandemic related to some novel and important research questions that need to be answered, as bold as trying to develop a functional cure for HIV to accelerating the process of what we call pre-exposure prophylaxis where you actually treat individuals who are in high-risk groups before they get infected.

There is a lot of research—it seems like a very interesting and important concept, but there are some very important research questions to be asked—Does it work? What is the relationship to adherence? Would it lead to resistance? If we can prove the concept, then that concept could transform how we prevent HIV infection.

And the last part of that triad is something that we call test and treat which the money for 2 years will help us accelerate the research endeavor in that we would not be able to do as quickly and we're committed to seeing it to fruition and the test and treat is a very bold concept that was put forth by a group at the World Health Organization about a half a year ago and that is to essentially test everybody and those who are infected, to actually treat them, regardless of where they are in the stage of the disease, with

the thought that if you get the viral load low enough, they will then not infect other people.

That is a very bold concept that will require globally a lot of resources, but the world is looking to the NIH to prove the feasibility of that concept and we're going to do that in a much more rapid way by the money that we have decided to use from the ARRA allotment to get that jumpstarted.

Senator HARKIN. You can't complete that in 2 years, surely, though, can you?

Dr. FAUCI. I might echo what Dr. Kington said. Flexibility in my mind is always something that would be helpful to us, but we still can get a lot done in the 2 years, but if we had more flexibility that would be advantageous to the program.

Senator HARKIN. Okay. Dr. Nabel.

Dr. NABEL. Thank you, Senator Harkin. I'm going to provide you one example of something that we couldn't do without the ARRA money and then another example of things that we can accelerate.

We will use ARRA monies as one-time money to expand our understanding of the genetics of complex diseases. I think this will apply across many of the Institutes but it will certainly apply to Heart, Lung, and Blood.

For example, over the years you've probably heard from NHLBI and ARRA, my predecessors, about the many large, what we call, cohort studies that the NHLBI has studied, the Framingham Heart Study, the Jackson Heart Study, our Hispanic Heart Study.

We've gathered beautiful clinical data for decades, in the case of the Framingham Heart Study 60 years. We now can take that data and combine it with the genetic understanding of the disease to gain new insights into the causation of blood pressure, cholesterol, asthma, COPD, and that's what we intend to do through some of our GO Grants, is to conduct more extensive genetic analysis of these large cohorts which you have helped us to support over the years. That's a one-time activity that we probably could not have afforded to do without the ARRA monies.

In terms of accelerating medical advances, I think Senator Shelby really hit the nail on the head. What we can do with the ARRA money is now begin to accelerate our translational research program. This infusion of money really helps us to focus on a number of mechanisms by which we can help our investigators speed, accelerate the basic advances into clinical trials and in fact, in terms of the Challenge Grants, I think our particular Institute, the last I heard, there was somewhere between 1,900 and 2,000 Challenge Grants just for the NHLBI.

We will supplement what Dr. Kington will fund from the Office of the Director, but many of these are focused on translational research and so we see this as an opportunity now to jumpstart.

We have one particular clinical trial, we call it SPRINT. For many years we thought the target for blood pressure lowering should be 140 over 80 but, you know, that might not be the right target. Maybe we should go a little lower. Maybe if we went lower, we could actually reduce some of the age-related effects of high blood pressure.

So SPRINT is to look at lowering down to 120 over 70, even 120 over 60 as the potential target. We want to look at this in adults

and, importantly, we want to look at this in our adolescents and our children.

You know one of the complications of obesity, many of our kids are becoming diabetic and hypertensive at a very young age and so this ARRA money will help us speed and accelerate the start of that clinical trial, extend it to a broader population, but yes, and then we'll need to fund the out years through appropriated dollars, but that's another example of a very important public health program that we can jumpstart, accelerate with ARRA monies.

Thank you.

Senator HARKIN. Dr. Niederhuber——

Dr. NIEDERHUBER. Thank you, Senator Harkin.

Senator HARKIN [continuing]. Tell us about cancer.

CANCER AND ARRA FUNDS

Dr. NIEDERHUBER. I think I'll echo flexibility. I think that would be helpful to all of us.

But we have some great opportunities, as you know, in terms of novel agents that have been developed but have not yet been able to move into the clinical trials arena, our early phase translational research, and so we're going to use a significant amount of these stimulus dollars, Recovery dollars to actually really jump into the clinic with early phase, first-in-man studies in a number of these new agents. I think that's going to have a significant impact.

Perhaps even more importantly than that is we have had a very successful pilot project that you're aware of, we call it TCGA, in which we've been actually developing the infrastructure to do complete sequencing of cancer. We've had three cancers in that pilot program, glioblastoma, ovarian cancer, and small cell lung cancer.

We've already found some extremely exciting discoveries in doing the sequencing, for example, of glioblastoma, genes that are related to that tumor that we didn't know were related to that tumor in the past.

I have a group of scientists meeting as we speak, yesterday and today, in San Francisco, that are analyzing our data on ovarian cancer and they tell me by phone some very, very exciting discoveries are coming out of that sequencing project.

So, clearly, this is telling us that the direction that we need to go in is to scale this up and that's what we're planning to do and the Recovery dollars will be a great help in our jumpstarting to do other tumors, to do them on a larger scale.

Without question, if we're going to repair this problem, we need to catalog all the defects and the technology is moving so quickly now that we will be able to do that and do that quite effectively over the next few years.

So these Recovery dollars are extremely important to our ability to really scale that up. It's true in cancer but it's true really in all of the diseases that you see here at the table and represented behind me.

RESEARCH PRIORITIES

Senator HARKIN. Okay. A couple of other areas I just wanted to cover with you today. Of the $442 million increase proposed for NIH, $268 million would go for cancer research, $19 million would

go for autism research. That leaves $155 million for everything else, heart disease, Alzheimer's, diabetes, AIDS, stroke, Parkinson's, on and on and on. I want to know if that makes sense.

You know, I know the statistics on cancer. I've fought as hard as anyone for more money for cancer research, but there are other devastating diseases, too, and we hear from these groups almost on a daily basis.

So when we're looking at a small increase, just 1.5 percent, should we put so much of that into just one disease rather than spreading it out more? So there you go.

Dr. Niederhuber, I don't mean to pick on you, but you're on the point on this. I'm saying, you've got a lot of the Recovery monies, but apart from that $442 million, I just question whether so much of it ought to go to two entities.

Dr. KINGTON. Why don't I start off?

Senator HARKIN. I'll leave that to Dr. Kington. Go ahead. Did you want to start off?

Dr. KINGTON. I'll take this one. As you noted, both cancer and autism are important public health challenges. These were priorities of the administration and the President and they're important priorities, and it's also important to note, though, that science in cancer is funded by every single Institute and Center. So it's not just Dr. Niederhuber. Every Institute and Center of the agency funds research related to cancer and we've initiated a strategic planning process, co-chaired by Dr. Niederhuber and Dr. Katz, to bring together all of the agency to think about how to develop a plan for increasing this investment in cancer.

It's also important to know that advances in cancer can help us learn more about basic biology in ways that would be useful for other diseases, as well.

Senator HARKIN. Well, that can be true of just about any disease.

Dr. KINGTON. That's absolutely true. Your point is well taken.

Senator HARKIN. So again, I'm back to square one. Is this a fair allotment of money? Any other observations on that? Do we have to decide ourselves how to allocate this money up here?

I just throw it out there because obviously we're trying to respond in a way to the legitimate interests of a lot of people out there suffering from these illnesses and we've made great advances in a lot of areas.

For instance diabetes, we have made some tremendous advances in diabetes research and others that I mentioned and taxpayers obviously have a right to question that we're putting all of the money in one area.

So I understand that, and I think that those of us here know that the administration proposed this, but we may have a different view on that. That's what I have to say about that.

OVERSIGHT OF OBJECTIVITY

Now, there are a couple of other things I wanted to bring up.

Last year my colleague, Senator Grassley from Iowa on the Finance Committee, requested some investigations into conflicts of interest. In fact, I just saw him this morning. We talked about it again, and he's still looking into that, his staff is looking into that, and we hear about it periodically. It comes up in the press or some-

thing like that, that some extramural researcher has gotten large payments from a private company that could be a potential conflict of interest.

In the fiscal year 2009 omnibus appropriations bill, I included a provision that required HHS to issue "an Advanced Notice of Proposed Rulemaking" which will start the formal process of revising the guidelines. The public comment period for that process started earlier this month.

So I was disturbed to see an article last week in The Chronicle of Higher Education in which an NIH official, I think unnamed, is quoted as saying, "We can't say definitely we would change the regulations."

Well, I don't know. Is that an authoritative statement? I hope not. I don't think that the present situation is working very well right now. So something has got to be changed here on this, Dr. Kington.

Dr. KINGTON. First of all, we absolutely share your commitment to having the agency playing a central role in assuring that there's objectivity in the science that we support which is the key issue here, assuring that first-rate science of the highest quality, objective science, is funded and produced.

We also recognize that there have been a number of cases of investigators that we believe may not have complied with our regulations and as almost all of the associations that have looked into this, as well, have concluded, we think that there are opportunities to strengthen our system of oversight.

The first step in that process is this Advanced Notice of Proposed Rulemaking and I think that the quote—well, I know the quote was taken out of context because, technically, the whole point of starting this process is to ask the question and for us to presume at the beginning the answer might raise serious questions about the whole process and so I think it was a technical response.

I think we've said, I've said personally in a number of settings, as well, that we believe that there are opportunities to strengthen our system of oversight. There are things that we're doing within our current regulation to do just that—increase training and education and strengthening our reporting system. There are lots of things that we're doing now to change fundamentally and improve the way we oversee management of conflicts of interest.

We're committed to doing that in the future and we will take seriously all the comments that we anticipate receiving under this Advanced Notice of Proposed Rulemaking and we're committed to doing the right thing.

Senator HARKIN. Well, I appreciate that. I think we have to be more positive in our approach on this, and on looking at these potential conflicts of interest.

I've been on this subcommittee a long time and I know how difficult it is sometimes because a lot of research is paid for by the private sector, by the private drug companies, and it's good, valid research, and so how do you divide a researcher that has an institute—not an nstitute, but has a lab and they're getting some private money in and—but then they also qualify for an NIH grant. How you separate that out sometimes is pretty darn difficult. So I understand that.

I'm more interested in the conflict of interest in which a person receives monetary income for their own bank account. I'm not so much interested in the lab itself and that money. I'm interested in what an individual might get paid by a drug company or something like that and when they are looking at certain drugs, for which they then recommend certain courses of action.

This has to do with, I think, anti-psychotic drugs mostly and that this individual had been involved in researching it but also—maybe this is a bad choice of words, but promoting the use of these anti-psychotic drugs.

I bring this up because I know that my colleague, Senator Grassley, is going to continue to look at this, as he should, and we have to. We have to be cognizant of this issue and do our best to answer those problems.

Dr. KINGTON. Yes.

H1N1 FLU

Senator HARKIN. The other thing I wanted to ask, Dr. Fauci, and it's sort of a replay of what we went over a couple weeks ago when you were up here, this H1N1.

Where are we now? What are you seeing? Is it kind of dwindling now here?

There was some talk that it might move to the Southern Hemisphere because of wintertime there, then it might come back here again this winter in a more virulent form. I keep wrestling with this problem of developing a vaccine because some of the money that we put in this was to develop a new vaccine. But again if we develop a new vaccine for the H1N1 strain that we see now, but then it comes back this fall and it's different, how are we going to be certain that the vaccine we develop this summer is going to be effective against the strain of flu that might come back this fall?

I'm still wrestling with that. I still don't understand that.

Dr. FAUCI. Okay. So three questions you asked me.

Senator HARKIN. Okay.

Dr. FAUCI. The status, vaccine, and does it change?

Senator HARKIN. There you go.

Dr. FAUCI. Okay. The status of the outbreak right now is that there's still considerable flu activity with H1N1 in the United States and worldwide. A recent outbreak that you read of, I know, in Japan. So there's considerable activity still going on.

The CDC estimates that even though there are about 6,000 reported cases that are confirmed or probable in the United States, it's likely that there are close to 100,000 people that have been infected. You don't pick them up because much of the illness is mild illness, yet there are some serious cases, which causes us to have an appropriate amount of attention to following this.

As I mentioned to you a couple of weeks ago, this is a brand-new virus. It's an H1N1 but a different kind of an H1N1. It has swine origin as well as some avian and human origin. It is brand new. So the inherent unpredictability of influenza is compounded by the fact that we're dealing with a virus that we've never had any experience with before.

Fortunately for us, we're going into a summer season when the conditions, the physical conditions for the spread of an influenza

are minimized, but that doesn't mean that we still are not going to have some considerable problems.

So the bottom line is that this outbreak is still in a dynamic stage and it's not over for us yet for the immediate period of time.

What about the concern of what it might do? The fact that it's out there and it has already manifested its ability to spread from human to human here in the United States, Mexico, Canada, Europe, Japan, et cetera, that the concern is that we have to watch this very carefully from two standpoints.

What happens in the Southern Hemisphere in the next month or two when they enter into their fall and winter, and we're going to watch that very closely because it will tell us what might happen to us next fall and winter for our seasonal flu vaccine time. The reason is that what usually happens, not always but usually is that the Southern Hemisphere flu activity is generally a good reflection of what might happen to us in the Northern Hemisphere in the following season. So we're looking at that very, very carefully.

VACCINES

Vaccine. The process of developing a vaccine has already begun and as I mentioned to you before but just to reiterate it very briefly, it's a multistep process and there are points in that process where there's a decision point, a go or no go.

The first thing you do is you isolate the virus. That's been done. You start to grow it up as a reference strain or seed virus. The CDC is very actively involved in this and should have seeds ready to go out within a reasonable period of time. The prediction is by the end of this month. Hopefully that will be on time.

Once that goes to the pharmaceutical companies, then they make pilot lots for clinical trials which is where the NIH comes in because then we have to ask the question: is it safe, does it induce an immune response that would be predictive of being protective, and what's the right dosage and the number of doses? At the same time, the companies will then start to, were the decision to be a go decision, to start to scale up.

Your concern that bothers you is that if we're starting to make a vaccine for a virus that's circulating now and would likely return again in the fall and winter, what happens if it changes?

Senator HARKIN. Yes.

Dr. FAUCI. That's always a possibility. The likelihood of it changing so much that a vaccine that we're making now would be essentially noneffective is small, not zero, but it's small. That's the reason why the way we set it up in the department with the CDC, FDA, and the NIH is for multiple decision points along the way whether to make it, how much to make and whether to administer it.

I will point out to you that every year when we make a vaccine for seasonal flu, put aside the pandemic for a moment, there's always the risk that the vaccine that you decide to make, that what happens to you the next season, it will change enough not to make a vaccine as effective as you want.

Historically, most of the time we get it right. So we are hoping that we will get it right. I think we will. I don't think there will be that much of a change, but as I mentioned, influenzas are char-

acterized by their unpredictability, but you've got to go with the science that you have, and the science that we have now tells us that this virus that's out there hasn't really changed much over the months that we've been following it.

It started off in Mexico, the first detection in Mexico. We don't know where it started, but the first detection was somewhere in March or so. So we're now a few months into it and the virus seems to be pretty much the same as it's been. It's stayed relatively stable. That doesn't mean it's going to stay that way over the next year, but it has not drifted a lot.

Senator HARKIN. I keep hearing that even the seasonal flu vaccine may offer some immunity.

Dr. FAUCI. No.

Senator HARKIN. No?

Dr. FAUCI. No. This is good news for you, Senator, and me, and that is, it doesn't have—the vaccines that have been used seasonally don't appear to induce antibodies that strongly cross-react at all with the H1N1 that's the new novel H1N1.

But what we are observing is that in the community this virus seems to be selectively more preferentially affecting young people. So the question is, Do old people—older people—have in their body some antibodies or cell-mediated immunity that they acquired from previous exposures to H1N1s over the previous years that are a bit below the radar screen, but that seem to be giving some protection? That's one of the prevailing theories, not proven yet, of why we're seeing it much more in young people.

In fact, when you measure the antibodies in older individuals, a rather significant percentage of them have some cross-reactivity with the virus that's circulating now and the most obvious, though not necessarily proven, but the most logical reason for that is that they've been exposed over the last few decades to an H1N1 that has some similarity to the H1N1 that we're seeing now.

BARKER HYPOTHESIS

Senator HARKIN. Well, I'll have to correct some of the ways I've been saying things then because I've been led to believe maybe some of the immunities we have comes because we've gotten the seasonal flu shots over the last few years, but that's not it. It has to do with our exposures to the influenza virus some time in the past and we've developed antibodies to it. I'll have to correct the way I say that now.

There's only one other area I just want to get into.

First, you all know that we've been working very hard on healthcare reform and the area that I've been involved in, of course, and I've been harping on this for many years is getting into prevention and wellness and focusing on that. I think we're going to have some, I hope, great success in the health reform bill in moving in that direction, which leads me to this next question, and it has to do with some of the information my staff has given me and I've been reading about it, the so-called Barker Hypothesis.

Dr. Barker of Oregon Health and Science University, who did a study that was very interesting—no, sorry, he didn't do a study. He examined other studies and came to some interesting conclusions,

that pre-natal care—how you're taken care of before you are born may have a great impact on what happens to you later in life.

My first initial reaction when I read that was, of course, if you have a low birth weight baby that means you don't get the right kind of nutrients and support during pregnancy. This happens sometimes in poorer families. I can understand that.

But then evidently Dr. Barker factored that in and had accounted for that in his studies. And even accounting for that, it shows up that if you have a low birth weight baby, there were certain twins they followed the one that had the low birth weight had the most problems later on in terms of diabetes, stroke, hypertension, all kinds of things.

So I guess my question is to maybe any body sitting there is, are we doing research? I've just come across this in the last few months and I wonder, are we looking into this? Is NIH doing any research in this area?

Dr. KINGTON. Yes, we are. David Barker is a British physician who in the 1980s began to notice patterns of tracking of looking geographically at mortality rates in England, patterns of mortality that tracked adult cardiovascular mortality with infant birth weight and that was the beginning of this long line of research that has been supported by the agency, including by NICHD, and there are a range of evidence, some—most supported but some not supported, of this hypothesis that has evolved into a more complicated discussion about potential ways in which the intrauterine environment sort of sets trajectories by turning on or off genes or somehow setting trajectories that actually are manifest in late life but start off this trajectory.

The hypothesis is that there's something unique going on in these early stages and it has implications for this entire continuum of potential causal pathways, from smoking now all the way back to shortly after conception and what happens in the intrauterine environment.

It's an interesting hypothesis and generated a great deal of discussion, both in Europe and in the United States, and we fund research related to it. I think it's still to be determined what the implications are for intervention and what we do clinically, the argument being that if we know more about what happens in the intrauterine environment, we might intervene in ways beyond the obvious of good nutrition and prevention and all the things that you noted, better social environments and all the things that we know are good for starting off children beginning healthy lives.

So the jury is still out about what the implications are, if it's correct, and there's a growing evidence base both in humans and in animal models, and we're supporting research and looking forward to seeing more advances in this area and we'd be happy to sort of synthesize some of the findings that we've supported and get back to you about that, as well.

[The information follows:]

THE BARKER HYPOTHESIS

David Barker, an English epidemiologist working at the University of Southampton, noted that the geographical regions of the British Isles reporting high rates of death from coronary heart disease were the same regions that reported high rates of low birth weights. In a landmark study published in the medical journal Lancet

in 1989, Dr. Barker and his colleagues reported on an analysis of serial data collected on 5,654 men in Hertfordshire. They found that the men with the lowest weights at birth had the highest death rates from coronary artery disease. Those with the lowest birth weights had more than twice the mortality rate than those with the highest birth weights.

In seeking to explain the remote outcomes of low birth weight, Dr. Barker developed the Barker Hypothesis, which states: environmental factors that impair growth and development during fetal life and early infancy are risk factors for hypertension, type 2 diabetes, stroke, and coronary disease later in life.

A general explanation for these findings is that birth weight represents an integral of all events that affect development during gestation, including nutrient supply, vascular sufficiency, infection and stress. The key question is to determine mechanistically what happens to the fetus to alter permanently its physiology and metabolism throughout later life.

Studies in animal models are useful in revealing the physiological connections between impaired intrauterine growth and chronic disease later in life. Dr. Lori Woods at the Oregon University of the Health Sciences has shown that reduced maternal protein intake in a rat model impairs the development of the kidney in the offspring, leading to hypertension later in life. In a baboon model Dr. Peter Nathanielsz at the University of Texas at San Antonio has shown that nutrient restriction during fetal life leads to impaired development of insulin manufacture by the beta cells of the pancreas, predisposing the animals to type 2 diabetes later in life.

The most widely accepted mechanism that explains these relationships is the metabolic adaptation that the fetus makes to survive in an intrauterine environment impaired by nutrient insufficiency, such as an increased secretion of cortisol. The survival mechanisms that are useful in the uterus, however, are maladaptive in a plentiful nutritional environment after birth as reported by Barker and his colleagues in two articles in the New England Journal of Medicine in 2004 and 2005. The first showed that low birth weight babies in an East Indian population who gain weight rapidly after birth are at high risk of developing type 2 diabetes in their third decade of life. The second showed that Finnish boys and girls with low birth weight are at increased risk of coronary artery disease later in life, especially those whose tempo of weight gain is greatest in the first decade of life.

The Barker Hypothesis has stimulated new fields of related research on the effects of inimical environmental influences on the development of the brain and body during fetal life and early childhood. One line of investigation suggests that overnutrition during pregnancy also can have untoward effects on offspring later in life. The NIH Obesity Research Task Force has identified this area as a research priority in regard to the development of type 2 diabetes, lipid disorders, and other metabolic disease in offspring. Studies in nonhuman primates have shown that consumption of a high fat-high calorie diet during pregnancy results in extensive fatty liver disease in the offspring, a disorder being seen with increasing frequency in obese adolescents. Maternal obesity has been reported to increase the risk of congenital defects, particularly neural tube defects, in developing offspring.

Other studies suggest that high levels of blood sugar during diabetic pregnancies affect an offspring's risk of obesity and type 2 diabetes later in life. NIH intramural investigators have shown in the Pima population of Arizona that type 2 diabetes in the mother leads to increased risk for type 2 diabetes and obesity in the offspring. Adverse effects of intrauterine exposure to diabetes were also shown recently in a racially and ethnically diverse population of youth; the NIH- and CDC-supported SEARCH study found that children with type 2 diabetes received their diagnosis at an earlier age if their mothers had been diagnosed with diabetes prior to pregnancy.

Another interesting line of research stimulated by the Barker Hypothesis involves the influence of maternal infections and intrauterine exposure to environmental agents on the development of disease in the offspring later in life. Dr. Alan Brown and colleagues at Columbia University have shown that maternal infections with strains of influenza virus type A and B during the first trimester of pregnancy increase the risk of schizophrenia spectrum disorders in the offspring later in life. They also showed a similar effect of maternal infection with toxoplasmosis. Preliminary, unpublished studies by Cohn and colleagues of the Public Health Institute in Berkeley, California, show an association between maternal serum levels of dichlorodiphenyl-trichloroethane and testicular cancer in male offspring later in life. The National Children's Study, currently under way, is designed to assess the effects of such environmental exposures during pregnancy and early childhood on many other aspects of health and disease later in life.

In sum, the Barker Hypothesis, now 20 years old, has led to numerous productive lines of research which have relevance to many NIH Institutes, including the

NICHD, NIDDK, NCI, NINDS, NHLBI, NIEHS, NINR, NIDA, NIAAA, NIAID and the NIMH.

WELLNESS AND PREVENTION

Senator HARKIN. I'm just curious. What Institutes would be the lead?

Dr. KINGTON. Child health, I know, has funded. Aging has funded some, as well, because some of the early studies—the intriguing idea was that something happening in the uterus would be manifest in old age and some of the interesting studies focused on that element of this relationship.

Senator HARKIN. Do you have any idea about when we might be able to really get some body of evidence or something that we could rely on to say for prevention, we ought to be doing this and that pre-natal care and pregnant women ought to take certain factors into account?

I don't know that we have enough to go on right now. I don't know. Do we?

Dr. KINGTON. That's the point. I don't think we've resolved the scientific question enough to translate into a different way of doing what we're doing now, which is a lot of the things that you noted, good nutrition, all the prevention things that we know, pre-natal care, the social environment of pregnant women, all the things that we know are very important for having healthy babies.

I don't think that the science is at a point where that would tell us to do something different or beyond what we know now as best practice. I think we're still ahead of the curve on that, but we're funding research and interesting ideas. It's been bandied about for a couple decades now and the evidence base was growing, not uniform support, but an evidence base and an interesting problem and question.

Maybe Dr. Nabel might want to comment, as well.

Dr. NABEL. Yes, I think the Barker Hypothesis raises in a broader term the concept of when should we begin prevention measures. I think that's probably one of the points you're getting to.

From the cardiovascular and from the diabetes and obesity literature, we do know that the intrauterine environment makes a distinct difference in terms of predisposition toward subsequent diabetes and obesity in the newborn, but it also raises the fact that there's growing recognition among physicians, healthcare providers, that rather than waiting until middle age to focus on risk factor detection and prevention, we've got to shift much earlier and initially we shifted to the young adulthood but now we're increasingly more and more shifting to adolescence and childhood.

In fact, the American Academy of Pediatrics has put out guideline recommendations for detection of cardiovascular risk factors, for example, in pediatric population.

So there's growing recognition. Much of that recognition is built on the science base, that we're beginning to see, serendipitously, risk factors appearing in the pediatric office. When we go back and do natural history studies or observational studies then we can detect it on a scientific level.

So yes, we know that these risk factors are appearing much earlier in life and that now is leading to action programs for detection and risk factor management.

Senator HARKIN. Very good. This is the last one, I promise, but I did want to get this in.

Dr. KINGTON. You may ask as many questions as you like.

COMPARATIVE EFFECTIVENESS RESEARCH

Senator HARKIN. It has to do with comparative effectiveness. Dr. Nabel, this is probably to you.

We provided $1.1 billion for comparative effectiveness in the Recovery Act. I have to admit, I did that and I have a lot of people asking about that. We put $400 million in there and that money is going to be used by NIH.

We also created the Federal Coordinating Council for Comparative Effectiveness Research (CER), which will recommend priorities for this research and I understand you're a member of this Council.

Again, can you tell me something about NIH's plans for the $400 million? What kinds of activities might fall into the category of comparative effectiveness research as far as NIH is concerned? What are you looking at and what are you going to use that money for?

Dr. NABEL. Terrific. Well, thank you, Senator, for the question.

As you know, the NIH has supported work that now fits the definition of comparative effectiveness research for many years, but we're delighted to have this additional money to again do things that we normally could not do or to jumpstart or accelerate other programs.

Dr. Richard Hodes, the Director of the Aging Institute, and I codirect the NIH Comparative Effectiveness Research Coordinating Committee. This is a committee that has brought together senior leadership, Institute Director leadership and deputy director leadership from across the agency to develop plans for that $400 million and again we're enormously grateful.

We are looking at opportunities now that meet the definition of CER and would allow us to conduct research that again will either—something that we normally couldn't do or would jumpstart.

We are looking at several possible mechanisms for supporting that research. One are payline expansions, so studies that Institutes have had to leave on the table because they simply did not have enough funds to initiate it. We're looking at the possibility of supplements that could accelerate enrollment in a trial or add an ancillary study or accelerate a trial in another way.

We anticipate that over the summer we will have a broad number of Challenge Grants because in fact CER was one of the Challenge Grant topics. We anticipate we will have applications in CER, and we also anticipate there may be some GO applications that also meet the definition of CER.

So we continue to meet on a regular basis. We are coordinating our work with the work of AHRQ and the Federal Coordinating Committee. We are working toward one common definition of CER for the department which we anticipate using and we are very cognizant of the fact that we want to make good use of this money. We want to get it right.

We see this as a downpayment toward many CER activities that we would like to continue in the future.

Senator HARKIN. I wanted to get that on the record and thank you very much for your response on that.

I have no further questions. Do you have anything else that any of you would like to bring up before we close this down?

Well, let me just say thank you to all of you and to all of you in the row in the back and to all the Directors of the Institutes.

Again, NIH is just one of our shining examples, I think, of good public policy and what we're using taxpayer dollars for and for all the years I've been privileged to associate with you, I just think you're doing an outstanding job at NIH, all of you.

I thank you very much for your commitment to public service and to public health and to the research that we do at NIH and I always like to continue to say for the record that this is the National Institute of Health. It's not the National Institute of Basic Research. Basic research is important, but we always have to keep in mind we are looking at increasing the health of our people and of humankind in general. It's not just geared toward the American people, and so with all of that research we have to keep thinking about, what's that translational research, what's it going to translate into? Better health for people and I think NIH has done an outstanding job in that through all its years.

So again, my thanks for your public service. I would again say, Dr. Kington, that I just repeat what I said earlier, I'm hopeful that this fall I will have healthcare reform behind us, maybe a little bit more time. It would be my intention and my desire and my intention to reprise again what we did a couple years ago. I'd love to have the Institute Directors down, two or three at a time, for some in-depth look at what the research is doing.

ADDITIONAL COMMITTEE QUESTIONS

I think it's not only good for the record but I think it's good for us to know, me and the staff and the others who are charged with the responsibility of making some of these decisions to know exactly where we are and where some of the new research avenues that are going on in all these different Institutes. So I hope to be able to do that some time this fall.

[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

PANCREATIC CANCERS

Question. Dr. Niederhuber, one of the deadliest forms of cancer—pancreatic cancer—also seems to be one of lowest priorities of the National Cancer Institute (NCI). Pancreatic cancer research accounts for less than 2 percent of the Institute's budget. Last year, the subcommittee asked for a report on how resources will be used to address this problem. Would you tell us what, if anything, is being done to expand the research portfolio for this lethal form of cancer?

Answer. NCI is committed to pursuing a broad research effort for pancreatic cancer. In 2001, NCI convened a Pancreatic Cancer Progress Review Group (PRG) to identify priority areas for research. Since that time, NCI's support for pancreatic cancer research has grown significantly. Based on the recommendations in the PRG report, NCI expanded its portfolio of pancreatic cancer research from $21.8 million in fiscal year 2001 to $87.3 million in fiscal year 2008. Part of this 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 the past 7 years, the number of investigators funded through the standard principal investigator-funding R01 awards has more than doubled, increasing from 34 to 93. The total number of research awards with a pancreatic cancer focus has more than tripled since fiscal year 2000, increasing from 85 projects in fiscal year 2000 to 271 projects in fiscal year 2007.

NCI has also increased the number of Specialized Program of Research Excellence (SPORE) grants with pancreatic cancer components, increasing the investment from one award in fiscal year 2000 to a total of six in fiscal year 2008. SPORE grants support specialized centers that promote interdisciplinary research, moving basic research findings from the laboratory to clinical settings while also bringing clinical findings back to the laboratory environment. SPORE investigators work collaboratively to plan, design, and implement research programs that may impact cancer prevention, detection, diagnosis, and treatment. Five of these SPORE grants were initially awarded shortly after the PRG meetings were held, with the sixth SPORE newly awarded in fiscal year 2008.

NCI continues to support pancreatic cancer research training awards for graduate students, postdoctoral trainees, clinical researchers, and junior faculty, as well as career transition and development awards for established investigators. In fiscal year 2005, an estimated 23 distinct training projects were relevant to pancreatic cancer research and approximately $2.2 million was spent on these projects. In fiscal year 2006, an estimated 31 distinct training projects were relevant to pancreatic cancer research and approximately $2.7 million was spent on these projects. In fiscal year 2007, an estimated 36 distinct training projects were relevant to pancreatic cancer research and approximately $2.8 million was spent on these projects.

NCI implemented a policy in fiscal year 2002 of increasing its payline (percentage of applications that are funded) for research that is related to pancreatic cancer. Initially, NCI's policy called for a 50 percent higher payline for investigator-initiated R01 grant applications with 100 percent relevance to pancreatic cancer. Since fiscal year 2004, grant applications with 50 percent or greater pancreatic cancer relevance were given special consideration for exception funding.

NCI has also developed pancreatic cancer-focused initiatives, including the Pilot Studies in Pancreatic Cancer and the Pancreatic Cancer Cohort Consortium. The Pilot Studies promote innovative multidisciplinary research to increase our understanding of pancreatic cancer biology, etiology, detection, prevention, and treatment. The Pancreatic Cancer Cohort Consortium is a group of investigators from 12 prospective epidemiologic cohorts and 1 case-control study who conducts whole genome scans of common genetic variants in order to identify markers of susceptibility to pancreatic cancer. Pancreatic cancer studies have also been funded within the Mouse Models of Human Cancers Consortium, Novel Technologies for In Vivo Imaging, Cancer Nanotechnology Platform Partnerships, and the Early Detection Research Network.

The Pancreatic Cancer Research Map is a Web-based tool developed for tracking pancreatic cancer research, clinical trials, and investigators. By providing a way to search the pancreatic research portfolio for funding opportunities, investigators, and developments in pancreatic research, the map facilitates and expedites collaborations and networking among researchers focuses on this disease.

Recently, as part of the restructuring of the NCI Clinical Trials Enterprise, NCI formed the Gastrointestinal Intergroup. Pancreatic cancer is one of the gastrointestinal cancers that the group will be looking at as they harmonize an efficient, cost-effective, science-driven, and transparent process that will identify and promote the "Best Science" in gastrointestinal cancer clinical research by addressing the design and prioritization of large phase II studies and phase III trials in these cancers.

PROGRESS IN TREATMENT AND PREVENTION OF PANCREATIC CANCER

The number of therapeutic trials that can be conducted in any cancer type depends upon scientific opportunity, frequency of the disease, and its outcome. NCI has been able to test a large number of drugs intended to treat pancreatic cancer in small trials. Unfortunately, as you know, to date pancreatic cancer has proven to be unresponsive to most drugs and radiation therapies. Less than 20 percent of patients with pancreatic cancer are candidates for surgery, because the disease is often detected in the late stages. Gemcitabine has been a standard treatment for patients with advanced and inoperable pancreatic cancer for a decade. New findings support use of the chemotherapy drug in the adjuvant setting, and patients who re-

ceived the drug gemcitabine after surgery for pancreatic cancer lived 2 months longer than patients who had surgery alone. This study shows that this treatment improves a patient's survival and more than doubles the overall survival 5 years after treatment.

Another study has shown that a new drug combination tested in mice may target the cells responsible for driving some pancreatic tumors. The combination of gemcitabine and the experimental drug tigatuzumab eliminated populations of cancer stem cells and reduced tumor growth in a mouse model of pancreatic cancer. The results provide a rationale for testing the promising combination in patients with this deadly disease. Tigatuzumab is also being tested in a phase II clinical trial with patients who have inoperable, untreated pancreatic cancer.

Ultimately, only a better understanding of the genetics and biology of pancreatic cancer is likely to yield improved therapies. These fundamental breakthroughs are likely to be produced by basic and genetic research into the mechanisms of cancer risk, initiation, growth, and resistance, in which NCI is heavily invested. One such investment is PanScan, a project made up of 12 cohort and 8 case-control studies primarily supported by NCI. The goal of PanScan is to identify the genetic variants that increase the risk of developing pancreatic cancer and refine our understanding of the interactions of tobacco and other nongenetic risk factors with the genetic variants that increase pancreatic cancer risk.

NCI anticipates that these studies will provide fundamental new insights into the genetic underpinnings of pancreatic cancer similar to the recent discoveries resulting from the genome-wide scans of prostate and breast cancers. These findings will inform further biological research that is likely to have clinical applications, including the detection of molecular targets for preventive, diagnostic, and therapeutic interventions. It is expected that the initial findings this study will be published later this year.

NCI is also involved in the Pancreatic Cancer Genetic Epidemiology (PACGENE) Consortium which was developed to identify susceptibility genes in familial pancreatic cancer. The Consortium consists of seven data collection centers, a statistical genetics core, and a pathology/archival genotyping core. PACGENE recruits people with two or more affected blood relatives found through incident pancreatic adenocarcinoma cases, physician referrals, as well as Internet recruitment. Accrual to a database containing core clinical, demographic, lifestyle and family history information from questionnaires is ongoing, along with biospecimen collection. The shared goals and methodologies of data collection of this Consortium will facilitate and accelerate our understanding of the genetic basis of pancreatic cancer.

In addition to genetic research, NCI is also supporting pancreatic cancer research that utilizes nanotechnology. Cancer Nanotechnology Platform Partnerships, a component of NCI's Alliance for Nanotechnology in Cancer, are developing technologies for new products in such areas as molecular imaging and early detection. One partnership is studying the use of nano particles in the diagnosis and therapy of pancreatic cancer, and developing and testing nano particles that will deliver imaging and therapeutic agents to pancreatic tumors.

PREVENTION

There are presently no effective ways to detect early signs of pancreatic cancer. One way to discover susceptibility genes for an inherited disease is to analyze DNA from large families with many affected members. But this strategy does not work with inherited forms of pancreatic cancer, because the disease is so deadly that there are very few large families with adequate numbers of samples.

Researchers at the Johns Hopkins Kimmel Cancer Center have shown for the first time that sequencing the genes in both the normal and the cancer cells of a single patient can reveal genes that are altered in both types of cells. Some of these changes can help identify susceptibility genes.

This strategy offers a new way to find hereditary susceptibility genes, and in the future, these genes could be part of a panel used to evaluate patients with familial pancreatic cancer. A test for predisposing mutations could help identify people at high risk of the disease who could be monitored for precancerous changes, enrolled in screening programs and potentially prevent them from getting pancreatic cancer.

Question. In addition to pancreatic cancer, would you tell us how NCI plans to attack some the other deadly cancers—ones where survival rates remain low?

Answer. In terms of other deadly cancers, the following are the ones with the lowest percentage for 5-year relative survival rate (30 percent or lower).

OVARIAN CANCER

The high-mortality rate stems from an overall lack of early symptoms or screening methods for the disease. As a result, most ovarian cancer patients are diagnosed with advanced stage disease. For fiscal year 2009, NCI is funding 5 SPORE program grants, and the relatively low incidence of this disease, as well as the team concept of the SPORE program, has resulted in a number of Inter-SPORE activities aimed at developing much needed early detection, screening, prevention, and therapeutic tools for ovarian cancer. These supplemental activities are being performed in collaboration with a number of other NCI programs, including Avon Progress for Patients Partnership, the Cancer Genetics Network, the Early Detection Research Network, the Division of Cancer Prevention's Prostate, Lung, Colon, and Ovarian Cancer (PLCO) Screening Trial and the NCI Intramural Program.

The Cancer Genome Atlas (TCGA) is assessing the feasibility of systematically identifying the major genomic changes involved in cancer using state-of-the-art genomic analysis technologies. Ovarian cancer is one of the first cancer types to be studied in the TCGA pilot phase. Early results are revealing genetic changes that could be used to identify those women who may be at risk for developing ovarian cancer, as well as pointing to markers for early detection of the disease when there is a better potential for successful therapy.

NCI's Cancer Nanotechnology Platform Partnerships are developing technologies for several key areas including studies focused on developing multifunctional nanoparticles that can deliver light-activated anticancer compounds specifically to ovarian cancer cells through a partnership at the Massachusetts General Hospital.

The New Drug Combination for Ovarian and Primary Peritoneal Cancers clinical trial is testing the combination of cisplatin, a drug containing platinum, and flavopiridol, which blocks the activity of proteins that help cancer cells grow and spread, in women with ovarian or peritoneal cancer resistant to platinum-based chemotherapy. Flavopiridol can increase the platinum concentrations in cells when administered with cisplatin, and researchers believe that this may lead to a reversal of platinum resistance.

The National Ovarian Cancer Early Detection Program.—Screening and Genetic Study is determining effective screening and genetic testing methods to identify women at increased risk of ovarian cancer. The study is also designed to develop markers for early detection and novel therapies.

LIVER AND BILE DUCT CANCER

Primary liver and bile duct cancers are the fifth most common cause of cancer death in men and the ninth most common cause of cancer death in women. More than 90 percent of all cases occur in men and women age 45 or older. Liver cancer is closely associated with hepatitis virus infections, especially hepatitis B.

A clinical trial, Hepatic Arterial Infusion of Melphalan with Hepatic Perfusion in Treating Patients with Unresectable Liver Cancer, is evaluating the effectiveness of hepatic arterial infusion (delivering chemotherapy directly to the liver) of the drug melphalan combined with hepatic perfusion (delivering chemotherapy to a blood vessel) in patients with liver cancer

The Etiology, Prevention, and Treatment of Hepatocellular Carcinoma program supports research on the etiology of liver cancer, development of animal models, novel prevention approaches, identification of reliable predictors of disease progression, and ways to minimize the morbidity and mortality associated with this disease.

The Tumor Microenvironment Network is exploring the role of the microenvironment, the cells and blood vessels that feed a tumor cell, in tumor initiation and progression. Network investigators are examining the role of inflammation and the microenvironment in the development of liver cancer.

ESOPHAGEAL CANCER

The Prevention Agents Program provides scientific and administrative oversight for chemoprevention agent development from preclinical research to early Phase I studies. The program is currently supporting research on several agents for potential chemoprevention of esophageal cancer.

The interdisciplinary scientists of the Network for Translational Research: Optical Imaging is accelerating translational research in optical imaging and/or spectroscopy. Current efforts include the development of techniques to identify molecular markers for detecting esophageal neoplasia and understanding basic disease mechanisms.

The Cancer Prevention Research Small Grant Program is supporting several research projects focused on esophageal cancer, including studies on esophageal cancer biomarkers, a mouse model of esophageal adenocarcinoma, and the molecular mechanisms involved in the development of Barrett esophagus. The latter is a condition in which the cells lining the lower part of the esophagus have changed or been replaced with abnormal cells that could lead to cancer of the esophagus. The backing up of stomach contents (reflux) may irritate the esophagus and, over time, cause Barrett esophagus.

LUNG CANCER

Lung cancer is the second most common cancer and the most common cause of cancer-related death in both men and women in the United States.

Seven lung cancer-specific Specialized Programs of Research Excellence (SPOREs) are promoting interdisciplinary research and moving basic research results from the laboratory to the clinical setting.

TCGA is assessing the feasibility of systematically identifying the major genomic changes involved in cancer using state-of-the-art genomic analysis technologies. Lung cancer is one of the first cancer types to be studied in the TCGA pilot phase.

PLCO Cancer Screening Trial is determining whether certain cancer screening tests reduce deaths from prostate, lung, colorectal, and ovarian cancers.

NCI's Lung Cancer Program supports research on early detection and treatment. The Lung Cancer Biomarkers Group is developing sets of specimens that can be used to test biomarkers for the early detection or diagnosis of lung cancer.

The Mouse Models of Human Cancers Consortium is developing models of lung cancer to aid in our understanding of lung tumor biology and to facilitate the development and testing of novel therapeutic approaches and methods for early diagnosis.

STOMACH CANCER

The overall incidence of stomach cancer in the United States has declined in the past 75 years. Five gastrointestinal cancer-specific SPOREs are moving results from the laboratory to the clinical setting.

The Tumor Microenvironment Network is exploring the role of the microenvironment, the cells and blood vessels that feed a tumor cell, in tumor initiation and progression. Network investigators are studying the role of inflammation and the tumor microenvironment in stomach cancer.

NCI's Infections and Immunoepidemiology Branch conducts high-impact epidemiologic research on infectious agents and cancer. Researchers are investigating why stomach cancer risk is low in Africa, despite high rates of Helicobacter pylori infection, as well as genetic factors associated with stomach cancer risk.

The Community Clinical Oncology Program (CCOP) and the Minority-Based Community Clinical Oncology Program (MB–CCOP) are comprehensive clinical trial mechanisms that disseminate the latest cancer prevention and treatment research findings to the community. Several CCOP and MB–CCOP groups currently participate in stomach cancer clinical trials.

MYELOMA

Myeloma, also known as multiple myeloma or plasma cell myeloma is the second most common blood cancer in the United States. The myeloma-specific SPORE is moving results from the laboratory to the clinical setting. This program is studying novel myeloma therapies and identifying new markers of this disease.

The Multiple Myeloma Prevention Study is evaluating the use of nonsteroidal anti-inflammatory drugs to modulate biomarkers associated with monoclonal gammopathy of undetermined significance, a condition that sometimes precedes the development of myeloma.

The Quick-trials for Novel Cancer Therapies and Prevention.—Exploratory Grants program expedites clinical translation of basic research discoveries in cancer biology through the development of novel anti-cancer drugs, diagnostic tools, treatments, and prevention strategies. This program currently supports two projects focused on immunotherapy and on improving the effectiveness of stem cell transplants in myeloma patients.

Question. Is NCI considering a plan to specifically and comprehensively address these lethal cancers?

Answer. Nearly half of the over 500,000 expected cancer deaths this year will be caused by 8 forms of cancer with 5-year relative survival rates of less than 50 percent-lung, liver, pancreatic, ovarian, brain, stomach, esophagus cancers and myeloma-and most of these cancers disproportionately affect minorities and under-

served subgroups in the United States. These cancers are often difficult to diagnose early. Cancers of high lethality pose a significant research challenge. These aggressive tumors are usually diagnosed late in their disease course, making the study of early disease progression and promotion, as well as the impact of genetic and environmental exposures, especially difficult.

NCI proposes to increase research on highly lethal cancers by expanding its investment into molecular epidemiological approaches such as the Cohort Consortium-of which the Pancreatic Cancer Cohort Consortium (PanScan) is one component—TCGA and genome-wide association studies to accelerate a fuller understanding of cancer causation and provide scientific direction of early detection, prevention and targeted therapeutic strategies. Molecular interrogation will generate data that can be used to evaluate profiles across the disease spectrum as well as among ethnic and racial populations.

NIH MEDLINE PLUS

Question. This subcommittee has long supported increased efforts by the NIH to provide the public important health information based on the results of the medical research their taxpayer monies support. At my urging, the NLM has increased its commitment to boost the distribution of the NIH MedlinePlus magazine. It is my understanding that a new bilingual version of the magazine, NIH MedlinePlus Salud, has been tested. What steps can be taken to substantially increase the public's access to these publications by getting them to all physician offices, community health clinics, and libraries?

Answer. Distribution of the magazines has increased from 50,000 copies of each issue in 2006 to over 500,000 copies of the English and Spanish versions in 2008. We estimate that the magazines now enjoy a readership of approximately 5 million nationwide. In February 2009, NLM created improved online versions of both magazines, which makes it easy for people to find, use, and email individual articles from the complete set of issues.

To increase distribution of the magazines still further, NLM, other NIH Institutes and Centers, and the Friends of the National Library of Medicine are forming partnerships with other Government agencies and private organizations which have an interest in supporting and enabling distribution of high-quality health information to their respective audiences. For example, the Peripheral Arterial Disease (PAD) Coalition supported the distribution of an additional 250,000 copies of one 2008 issue. In addition, the National Alliance for Hispanic Health is helping to support the production and distribution of NIH MedlinePlus Salud, which is an English/Spanish version. The pilot issue featured Cuban American journalist Cristina Saralegui, who is well known for her Univision talk show, The Cristina Show, as well as her work on behalf of health and wellness causes.

Question. Is this something that could be done with stimulus funding?

Answer. NIH is extremely grateful for the opportunities and funding provided in the American Recovery and Reinvestment Act of 2009 (ARRA) to preserve and create jobs and promote economic recovery by spurring technological advances in science and health. NLM is investigating how it may best use ARRA dollars to support the spirit of the Recovery Act, including increasing the distribution of the NIH MedlinePlus and NIH MedlinePlus Salud magazines.

INTERSTITIAL CYSTITIS

Question. According to NIH's recently revised methods for calculating support levels for various disease research areas, the amount dedicated to interstitial cystitis (IC) is less than half of what NIH previously believed it to be. (NIH originally estimated the fiscal year 2007 funding for IC research to be $23 million; new calculations show that the actual amount was just $10 million.) This is disappointing, given that this condition afflicts more than 8 million Americans.

What are the agency's plans to further basic and clinical research in this area?

Answer. NIH's shift to a new and more consistent process—requested by the Congress—to report on certain diseases and conditions through the Research, Condition, and Disease Categorization (RCDC) system, has indeed led to changes in reported funding levels for a variety of conditions, including IC. There are a number of reasons for these differences, including precise "definitions" for some disease reporting categories under the new system. More information is available on our RCDC Web site, at http://report.nih.gov/rcdc/reasons/. We began using RCDC to report actual funding levels in fiscal year 2008. To ensure transparency during the transition to RCDC, the NIH disease funding table provides a side-by-side comparison of the actual fiscal year 2007 levels produced using the prior method and the levels that would have resulted if RCDC had been implemented that year—thereby illustrating

the effect of the RCDC methodology and clarifying the changes between fiscal year 2007 and fiscal year 2008 resulting from use of this new process. For example, while the actual amount of funding reported for IC in fiscal year 2007 was $23 million, the RCDC analysis of the fiscal year 2007 portfolio reflected annual funding support of $10 million. The actual funding level reported for fiscal year 2008 of $10 million is comparable with the amount identified for fiscal year 2007 using the new RCDC methodology. While the impact of this change has in some instances resulted in significant one-time adjustments, it is important to note that they do not reflect a change in the NIH's commitment to research on IC and other conditions, and will ultimately result in more accurate, consistent reporting across NIH. Research that can lead to improved detection, treatment, or cure for IC remains a high priority for NIH.

QUESTIONS SUBMITTED BY SENATOR DANIEL K. INOUYE

PHARMACY PROGRAM

Question. Dr. Sidney McNairy, Director of the Division of Research Infrastructure, met with the University of Hawaii at Hilo faculty and administrative staff in December 2008. What are we doing or should we be doing to help the new University of Hawaii at Hilo's new pharmacy program meet the objectives set by Dr. McNairy's site visit?

Answer. One of the objectives set forth during Dr. McNairy's visit was to facilitate an expanded role of the University of Hawaii at Hilo in the Institutional Development Award (IDeA) Program's IDeA Networks of Biomedical Research Excellence (INBRE) initiative within National Center for Research Resources (NCRR), a component of the National Institutes of Health (NIH). The long-term objective is to facilitate the development of the research infrastructure in the School of Pharmacy at Hilo and foster collaboration with the Manoa campus.

Subsequent to this visit, Dr. McNairy and his staff set up several teleconferences with the Dean of the School of Medicine at the Manoa campus and the Dean of the School of Pharmacy at Hilo to discuss plans for the development of a joint application to compete for support via the INBRE initiative. As a result, these institutions are developing an application that includes core research facilities and instrumentation at the Hilo campus; support for research projects for junior faculty investigators at Hilo aimed at transitioning them to independent research support; and alterations and renovations at the Hilo campus. The Hawaii INBRE application will also include collaborations with several community colleges and 4-year institutions. Interactions with these latter institutions will provide the School of Pharmacy with an expanded pool of potential candidates for entry into the pharmacy program.

Question. What is being done to anchor these activities and help assure success?

Answer. NCRR staff participates in teleconferences with the Principal Investigator of the proposed Hawaii INBRE to review the details of the funding opportunity announcement (PAR–08–150), answer questions, and provide programmatic advice during the development of the application. The institutions are working toward the submission of this application in fiscal year 2009.

Question. Many initiatives and programs that have recently been launched by the National Cancer Institute (NCI) appear to be based on mechanisms that utilize center-based models. Large awards or cooperative agreements are made to large, well-established institutions and individual researchers. One criticism of such a model has been that it detracts from an already depleted investigator-initiated pool of grants for funding cancer and biomedical research. What steps is the NCI taking to ensure that adequate resources in the form of investigator-initiated research project grants continue to be made available to not only individual investigators but to young and/or new investigators?

Answer. The allocation to investigator-initiated research continues to represent the largest component of the NCI budget. That is a strong demonstration of the commitment the Institute has to investigator-initiated research. Equally strong is the Institute's commitment to first-time investigators. NCI allocated $74 million to pay new competing grant applications from first time investigators in fiscal year 2007 and raised that to $82 million in fiscal year 2008. Research Project Grants (RPGs) represent 44 percent of NCI's fiscal year 2009 budget. NCI intends to increase the number of first-time investigators in fiscal year 2009 using additional American Recovery and Reinvestment Act funds to support the first 2 years of their research project and then continuing their support in years 3–5 with appropriated funds.

INNOVATIVE APPROACHES AND NOVICE RESEARCHERS

Question. What efforts are currently underway to stimulate and support new, novel, and innovative approaches to the detection, treatment, and diagnosis of cancer?

Answer. NIH supports innovative approaches to the detection, treatment, and diagnosis of cancer. NCI established the Innovative Molecular Analysis Technologies (IMAT) program to support the development, technical maturation, and dissemination of novel and potentially transformative next-generation technologies through an approach of balanced, but targeted innovation. The IMAT program utilizes a variety of investigator-initiated research project grant mechanisms while retaining a strong commitment to diversity and to the training of scientists and clinicians in cross-cutting, research-enabling disciplines.

Nanotechnology represents a large number of advanced technologies that promise to change all aspects of 21st century medicine, especially cancer medicine. This is an area that brings scientists from physics, chemistry, mathematics, and engineering together with cancer biologists and oncologists to develop new cancer interventions. NCI launched the Alliance for Nanotechnology for Cancer program in 2004 to capitalize on these technologies. These centers are developing and translating novel nanotechnology-enabled diagnostic, imaging, and therapeutic platforms into clinical practice—which is required to capitalize on our prior investments in the molecular sciences. The original program produced several nano platforms that are currently in preclinical evaluation with a few already in clinical trials. The Alliance is a magnet for young creative scientists. Trained in the molecular sciences, bioinformatics, and physics, these centers have attracted the best—bringing Nobel Prize winners together with scientists that are early in their careers. Together they are creating new training and research opportunities that are driving this emerging field.

Question. Through what mechanisms are such programs funded, and is there a percentage or grant category designated to support the development of novice researchers?

Answer. NCI allocated 17 percent of the competing RPG budget to select grant applications that were identified as filling gaps in the research portfolio or representing novel approaches to research problems. We often refer to the grants funded with that pool as "exceptions" to the regular payline. One-third of that exception pool was allocated to supporting first-time investigators. Those exceptions are used across the portfolio, including in the areas of detection, treatment, and diagnosis.

The NCI Alliance for Nanotechnology in Cancer program, for example, utilizes several mechanisms, including the U54 center mechanism, R25 training center mechanism, K99/R00 fellowships mechanism, and U01 investigator-initiated research project mechanism. Based on comparison of landscape before and after the initial program, there is a clear trend of increased interest in cancer nanotechnology training as NIH fellowship applications supported by the original program (F32/F33) increased significantly since the program began. Postdoctoral students are the largest group participating in the alliance and, in fact, dominate the annual meeting where their research is presented. A similar increasing trend for NCI is seen in both individual training awards (K99) and institutional training awards (T32, R25). When the Alliance for Nanotechnology in Cancer began, the Institute supported a total of 4 individual-initiated grants in the field; that number has increased to 48 (excluding Alliance awardees) during the 5 years that the Alliance has been in place, and the Alliance shows signs of further expansion as more young people enter this new field.

MILITARY RESEARCHERS

Question. The National Institute of Nursing Research (NINR) lists (1) Integrating Biological and Behavioral Science for Better Health; (2) Adopting, Adapting and Generating New Technologies for Better Health Care; (3) Improving Methods for Future Scientific Discoveries; and (4) Developing Scientists for Today and Tomorrow as its 2006–2010 Strategic Goals, with a research emphasis on Promoting Health and Preventing Disease, Improving Quality of Life, Eliminating Health Disparities, and Setting Directions for End-of-Life Research. Historically, military nurse researchers have been unable to compete for funds due to the uniqueness of the population they serve. Considering the ongoing status of conflict in the Middle East and other countries, what efforts are being taken to allow military nurse researchers to actively compete for these funds?

Answer. The NINR strongly encourages all scientists to apply for funding within the NINR areas of research emphasis. There are no funding exclusions based on military status. Currently, the NINR is sponsoring a research initiative entitled,

"Improving Quality of Life of Patients and Family Following a War-Related Traumatic Injury" to develop and test personalized interventions to prevent complications in persons with war-related traumatic injuries during the post hospitalization transition period, with the ultimate goal of improving the health and quality of life of individuals and families following a war-related traumatic injury. NINR is actively involved in the collaboration between the NIH and the Center for Neuroscience and Regenerative Medicine at the Uniformed Services University of the Health Sciences (USHUS) to answer difficult research questions and improve medical care for service members with brain injuries and Post-Traumatic Stress Disorder. Through this collaboration, there are valuable training opportunities for nurse scientists. Other Federal partners collaborating in this effort are the Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury, Army Medical Research Command labs, Navy labs, and the Walter Reed National Military Medical Center.

NINR also has a long-standing relationship with the TriService Nursing Research Program at USHUS to facilitate collaboration and to consult on matters relevant to military nursing research. One of the members of the National Advisory Council for Nursing Research (NACNR) is Capt. Maggie Richard, Ph.D., MSN, NC, USN. Captain Richard is the director of the Human Research Protection Program in the Bureau of Medicine and Surgery, the Department of the Navy. She has served more than 20 years in the Navy Nurse Corps, and is the former head of the Nursing Research Service at the Bethesda National Naval Medical Center. As a member of the NACNR, Captain Richard provides the second level of review of grant applications, and recommends to the Institute Director which applications should be approved and considered for funding.

NINR remains dedicated to supporting clinical and basis research to help improve the health of the Nation, including members of the military service.

NCI AND CIS

Question. While the NCI intends to retain the information service arm of the Cancer Information Service (CIS) (i.e., 1–800–4CANCER service, the Internet, and instant messaging), NCI leadership has decided not to continue funding the CIS Partnership Program beyond the current contract period, ending January 15, 2010. What is NCI's plan for responding to the cancer information, training and technical assistance needs of remote, medically underserved communities and the organizations that serve them, such as those located in Hawaii and the U.S.-Associated Pacific Island jurisdictions?

Answer. Rather than renew the Partnership Program, we have reassessed how NCI can most effectively and efficiently disseminate important cancer information, and engage communities in order to realize an impact in the lives of those we serve. NCI will actively align its community outreach with its community-based research programs and build capacity in communities for the effective delivery of cancer information to their members. Building on the success of projects such as the Imi Hale-Native Hawaiian Cancer Network and the American Samoa Community Cancer Network, as well as the partnership between the University of Hawaii and the University of Guam, NCI will support community-based research programs that will build capacity to meet the needs of the underserved populations.

Beginning in January 2010, NCI will augment community-based research projects to include a community outreach structure that will specifically employ community outreach staff. While it is expected that these staff members will service the outreach needs for those funded projects, NCI is also expecting them to perform activities to address a broader area of needs identified by NCI. The funded projects that will initiate this new model of outreach include the Community Networks Program-II (CNP–II), the Minority Institution/Cancer Center Partnership (MI/CCP), and the NCI Community Cancer Center's Program (NCCCP), representing a total of 66 sites initially.

The establishment of a coordinated outreach network that works within established NCI-supported research programs will provide national geographic coverage for outreach to all populations. The proposed Community Outreach Core within the CNP–II concept will employ health education/community outreach staff to foster activities supporting the community and community partners. A similar approach within the MI/CCP and NCCCP would further augment and reinforce this national outreach network. Within the MI/CCP, for example, all partnerships are encouraged to have outreach programs and activities linking scientific discoveries and implementation of scientific breakthroughs in high-risk populations, and some partnerships are also increasing enrollment of racial/ethnic minorities in clinical trials. The outreach and partnership components of the CIS partnerships can be successfully

integrated and absorbed within the existing community outreach cores of NCI funded research initiatives to enhance and strengthen NCI's ability to educate and engage communities in addressing cancer health disparities within diverse, high-risk populations. NCI will also examine the feasibility of expanding this model to other NCI-funded programs.

NCI already has an outreach and dissemination infrastructure within its Office of Communications and Education that will provide these grantees the necessary technical assistance for communication, dissemination, and outreach. This infrastructure supports the current CIS Partnership Program. They are prepared to provide this national outreach network guidance in the use of best practices, the development of shared resources and tools, and the provision of training and technical assistance to community outreach coordinators in comprehensive cancer control and the delivery of evidence-based outreach activities.

In addition to the establishment of this national outreach network through NCI-funded programs, NCI is already in the process of planning a concept for dissemination, community outreach, and communication. This process, which has been described in responses to previous inquiries on this matter, utilizes a public health planning approach which examines the scientific evidence across areas of cancer control and engages the community throughout the process in feedback loops, and will ultimately yield a concept that aims to reduce the impact of cancer in the most vulnerable communities. Greater details on the planning process for this can be provided upon request.

QUESTION SUBMITTED BY SENATOR HERB KOHL

INCREASING FUNDING AND GREATER NUMBER OF AWARDS

Question. Dr. Kington, I was pleased to see that funding sources for the National Institutes of Health Clinical and Translational Science Awards (CTSA) were increased this year, through both the fiscal year 2009 omnibus appropriations bill and the American Reinvestment and Recovery Act. I am aware that several institutions applying for awards this year, including applicants in my home State of Wisconsin, have received "outstanding" application ratings. Will this increase in funding allow for a greater number of awards to be distributed?

Answer. The funding provided in the Omnibus Appropriations Act, 2009, will support new CTSAs in fiscal year 2009 as the program moves closer to a goal of 60 CTSAs.

The American Recovery and Reinvestment Act (ARRA) funding is being used to allow existing CTSAs to compete for resources to supplement their current activity, plus support other researchers who may apply to leverage current CTSA activities. However, since normal CTSA funding is for 5 years and ARRA funds are limited to 2 years the funding is not able to support new awards.

QUESTIONS SUBMITTED BY SENATOR MARY L. LANDRIEU

SMALL BUSINESS INNOVATION RESEARCH (SBIR) AND SMALL BUSINESS TECHNOLOGY TRANSFER (STTR) PROGRAMS

Question. When the American Recovery and Reinvestment Act (ARRA) passed in February, it contained a short sentence that directly hurt small businesses by exempting two important small business programs. The provision, which provided $8.2 billion to the National Institutes of Health's (NIH), exempted the NIH from the statutory requirement that 2.8 percent of extramural research and development (R&D) money be used for the Small Business Innovation Research (SBIR) and the Small Business Technology Transfer (STTR) programs. As the chair of the Senate Small Business Committee, and as a member of this appropriations subcommittee, I was never consulted or notified about the exemption language which was added in conference. My staff has been told by NIH officials and others that NIH directly requested the exemption. As a result of the exemption, the NIH is not required to award up to $200 million from the ARRA funds to small businesses for research and development. This exemption went directly counter to the principles and goals of ARRA. The recovery effort was supposed to be about creating high-quality jobs, spurring innovation, and giving a boost to businesses across the board. Instead, this language singled out small businesses and slashed the relatively tiny amount they are normally guaranteed. I have several questions for Dr. Kington regarding NIH's request and the exemption: Specifically, who at the NIH requested that ARRA be

exempt from funding the SBIR and STTR programs? Was this request first cleared through you?

Answer. NIH was concerned about the decreasing number of SBIR applications. We had seen nearly a 40 percent decrease in applications during the fiscal years 2004 through 2008. Although the NIH is not required by this law to provide a set amount of ARRA funds toward the SBIR/STTR programs, it is important to note that small businesses are able to apply for and will receive funds. NIH remains committed to the small business community and has been encouraging small businesses to apply for stimulus funds through various funding opportunity announcements that have been released.

Question. From your experience at NIH, would you agree that the SBIR and STTR programs play a vital role in NIH's extramural R&D because of the high levels of innovation that come out of these two programs?

Answer. NIH has supported and continues to support small business and efforts to bring innovations from biomedical research to the taxpayer. NIH research is driving a vibrant community of American small businesses and entrepreneurs in the health enterprise. NIH-funded research leads to patents and spin-off companies across the Nation. Through the SBIR and STTR programs, the NIH helps nurture entrepreneurs as they bring products to the international market that improve health and well-being. Small businesses supported by NIH grants help maintain American economic leadership.

For example, Kinetic Muscles, a small business in Arizona, has developed the Hand Mentor ProT, which is a device designed for neurological rehabilitation of the hand and wrist for people who have suffered strokes or other brain injuries. In partnership with their exclusive distributor, Columbia Scientific, the Hand Mentor ProT is now being used in select HealthSouth rehabilitation hospitals.

Biopsy Sciences of Florida has developed the Bio-SealT and recently sold the technology to Angiotech Pharmaceutics, Inc. (a global specialty pharmaceutical and medical device company). This novel technology was designed to reduce the incidence of postoperative pneumothorax (collapsed lung) in patients who undergo lung biopsy procedures. The technology involves placement of an expanding hydrogel plug along the biopsy needle track during the procedure, closing off the track to subsequent influx of air into the chest during respiration after the biopsy needle is withdrawn. The seal is airtight and the plug is absorbed into the body after healing of the puncture site has occurred.

These are only a few examples of the high level of innovation and the many products that have been developed with NIH SBIR/STTR funding.

Question. From your experience at NIH, would you agree that small businesses doing extramural R&D for the NIH have a proven record of creating jobs?

Answer. Small businesses have long been the engine of U.S. economic growth, generating a significant proportion of new jobs annually, and we believe NIH's SBIR/STTR programs assist with the creation of high-quality jobs. NIH has invested in excess of $5 billion in more than 19,000 projects to over 5,000 small businesses. Past studies of the SBIR program conducted by the NIH and the National Research Council (NRC) have shown small businesses are seen as sources of economic vitality and are especially important as a source of new employment.

Question. Could you please provide, in detail, the steps NIH is taking to make sure small businesses receive an adequate share of ARRA funds?

Answer. NIH has taken several steps to ensure small businesses receive an adequate share of the ARRA funds appropriated to NIH. Outreach efforts have been stepped up to alert small companies of ARRA opportunities. In the last few months, eight SBIR/STTR presentations have been given throughout the country at life science or SBIR/STTR conferences in New Jersey, Indiana, Kentucky, New York, Maryland, Washington, DC, and California. NIH's 11th Annual SBIR/STTR Conference was held at the end of June 2009 in Omaha, Nebraska, and with attendance typically in the hundreds, this was another excellent opportunity to disseminate information about specifically targeted ARRA opportunities to this small business audience.

During the past few months, NIH has strongly encouraged small businesses to apply for several of its funding opportunity announcements (FOAs) that were supported by ARRA, including:

—The NIH Challenge Grants in Health and Science Research or "Challenge Grants" http://grants.nih.gov/grants/guide/rfa-files/RFA–OD–09–003.html

This opportunity focuses on specific knowledge gaps, new technologies, data generation, or research methods that would benefit from an influx of funds to quickly advance the area in significant ways.

—Research and Research Infrastructure "Grand Opportunities" or "GO Grants" http://grants.nih.gov/grants/guide/rfa-files/RFA–OD–09–004.html

This opportunity focuses on developing and implementing critical research innovations to advance their research enterprises, stimulate future growth and investments, and advance public health and health care delivery.

In June, NIH released two additional announcements that explicitly targeted the private sector commercial research community. These included:

—Recovery Act Limited Competition: Biomedical Research, Development, and Growth to Spur the Acceleration of New Technologies (BRDG–SPAN) Pilot Program, http://grants.nih.gov/grants/guide/rfa-files/RFA–OD–09–008.html

This FOA is a pilot program that focuses on the funding gap between promising research and development and transitioning to the market by contributing to the critical funding needed to pursue the next appropriate milestone(s) toward ultimate commercialization. Any U.S.-owned, for-profit enterprise/commercial organization is encouraged to apply for this funding. Please note that applications received under this FOA may be given funding priority if the applicant is associated with an enterprise or commercial organization that is of small size and/or has limited resources.

—Recovery Act Limited Competition: Small Business Catalyst Awards for Accelerating Innovative Research, http://grants.nih.gov/grants/guide/rfa-files/RFA–OD–09–009.html

This opportunity specifically targets the SBIR research community and focuses on accelerating innovation through high- risk, high-reward research and development that has commercial potential and is relevant to the NIH mission. It seeks to encourage fresh research perspectives and approaches and focuses on early-stage ideas that promise to lead to major leaps forward rather than incremental improvements of existing technologies. Only U.S. small business concerns are eligible to submit Phase I SBIR applications, and first-time applicants to NIH may receive funding priority.

In addition to releasing these funding opportunity announcements, the pay-lines at various NIH Institutes and Centers have been extended to reach more meritorious research grants, including those submitted by small businesses. Finally, in March 2009, NIH offered three administrative supplement and competitive revision opportunities for those with active research project grants (including SBIR and STTR). The supplements provided additional funding to accelerate the tempo of scientific research on active grants. Revision awards support a significant expansion of the scope or research protocol of approved and funded projects. Administrative supplements were also offered to provide summer research experiences for students and science educators. SBIR and STTR projects successfully competed. At this time, over 20 SBIR/STTR grantees have been selected to receive administrative supplements to provide summer research experiences for students and/or science educators.

Question. My staff has been told by NIH officials that you are setting up a Pilot program for small businesses with your discretionary ARRA funds. Can you please report to the Senate Small Business Committee on the nature and progress of this Pilot program?

Answer. You are correct, NIH recently announced the ARRA-funded BRDG–SPAN Pilot Program to focus on the gap between research and development and transitioning to the market.

Only U.S.-owned for-profit enterprise/commercial organizations may apply, and although not explicitly limited to small businesses, most of the applications are expected to be submitted by small businesses. Applications received under this funding opportunity may be given funding priority if the applicant is associated with an enterprise/commercial organization that is of small size and/or of limited resources.

In addition, we have another ARRA-funded small business program called the Catalyst Awards, and only U.S. small business concerns are eligible to submit SBIR applications.

Question. I have looked at a number of legislative vehicles, including the fiscal year 2010 Labor HHS Appropriations bill, to make up for the loss of money to small businesses that was created by the small business exemption in ARRA. Can you give me your thoughts on how this money can be made up, whether it be legislatively or through proactive actions by the NIH?

Answer. NIH's current commitments to small business research instill confidence that this research community will receive a fair portion of NIH's extramural funding. This is already in evidence, since a large number of applications were received from small businesses in response to our initial ARRA-supported FOAs, and applications are still being received from small businesses in response to ARRA FOAs that remain open.

QUESTIONS SUBMITTED BY SENATOR ARLEN SPECTER

MATERNAL FETAL MEDICINE RESEARCH NETWORK

Question. I am aware of the critical research conducted by the National Institute of Child Health and Human Development (NICHD) Maternal Fetal Medicine Research Network in the area of preterm birth and maternal complications. What are your plans for this Network in the fiscal year 2010 budget?

Answer. The Maternal Fetal Medicine Units Network (MFMU) is one of the landmark research networks within NICHD. Conducting research that may affect pregnant women and their offspring can present some critical health and ethical issues. Yet improvements in clinical practice and care are dependent on evidence-based research, and the Network was created in response to this need. This research mechanism permits large-scale clinical studies that provide the necessary information to allow healthcare professionals to translate the findings into everyday clinical practice.Specifically, the MFMU Network conducts clinical trials and observational studies in obstetrics to improve maternal and neonatal outcomes. It is essential for each Network participant to conduct this work in the same manner (i.e. following the same protocol) in order to have comparable results that can be applied across the Nation and for different population groups. In addition, preventive measures and interventions can be tested to find out if they work, or just as important, if they do not.

NICHD has spent approximately $170 million since the MFMU Network's inception in 1986. It is re-competed every 5 years to ensure that only the best scientists are funded to do this work. The existing network will expire in fiscal year 2011. The networks scientific success supports considering a new competition in fiscal year 2011. As is typical, decisions regarding extending the Network will be made during development of the 2011 budget. Current projections for fiscal year 2010 are $12.6 million in NICHD funding. Along with a projected $700,000 contribution from NINDS in fiscal year 2010, the total support level comes to $13.3 million.

SALIVARY DIAGNOSTICS

Question. Dental schools, and I have one in my State, are doing some rather exciting research in the area of saliva as a diagnostic tool. Where does this research stand at this point?

Answer. Saliva is a complex mixture of water, antibodies, and other specialized protective proteins, important for maintaining oral health, function, and comfort. It has long been recognized that saliva acts as a mirror of the body's health, in that it contains the full repertoire of proteins, hormones, antibodies, and other substances that are frequently measured in standard blood tests to monitor health and disease. Saliva is easy to collect, even repeatedly if needed, and poses none of the risks, fears, or invasiveness of blood tests.

Saliva has already been used reliably to detect a number of diseases, including HIV, as well as viral hepatitis A, B, and C. It also can be used to monitor a variety of drug levels, including those of marijuana, cocaine, and alcohol. The National Institute of Dental and Craniofacial Research (NIDCR) is supporting efforts to identify and validate biomarkers, and to also support technology to overcome barriers to the widespread use of salivary diagnostics. For example researchers are focused on developing microchip assays for point-of-care delivery, and are making impressive progress at achieving high-sensitivity, high-specificity, miniaturization, automation, portability, low cost, speed, and the ability to assay a large number of samples and biomarkers concurrently.

Last year, scientists funded by NIDCR completed the first full catalogue of proteins present in saliva. This protein dictionary will serve as an essential reference point as scientists continue to validate saliva as a diagnostic fluid. This resource also complements our growing ability to leverage DNA and RNA as biomarkers. For example, in October 2008, NIDCR-supported scientists reported that they could use a panel of 5 RNA biomarkers to accurately detect oral squamous cell carcinoma, a form of oral cancer, more than 90 percent of the time.

Question. Is progress being made?

Answer. Yes, progress is being made. The field of salivary diagnostics combines the power of mathematics, biology, genomics, proteomics, engineering, computer science, and other areas, with the goal of using saliva as a diagnostic fluid for a variety of conditions, from AIDS to cancer to diabetes. Several NIDCR grantees are now working to develop and assemble tiny "labs on a chip" that can precisely measure levels of the various antibodies, antigens, and nucleic acids present in saliva, all of which may indicate a developing disease or condition. In contrast to existing blood tests which require painful needle sticks, salivary tests could be performed on

the spot and rapidly scan oral fluids for the presence or absence of multiple proteins linked to various systemic diseases and conditions. NIDCR is currently supporting the development of devices that will detect infectious diseases, cancer, renal diseases, steroid hormones, and inflammatory markers for cardiovascular and pulmonary diseases. The technologies being developed also will be effective for tracking new, as-yet unidentified biomarkers.

As an illustration of progress in this area, NIDCR scientists recently reported clinical success in detecting C-reactive protein in human saliva with an ultrasensitive microchip assay system. C-reactive protein, a serum protein indicative of inflammation, is elevated in people with periodontal disease and may be predictive of developing heart disease.

Question. Will we be able to go to our dentist and undergo this noninvasive diagnostic test to detect early markers of diseases, such as Alzheimer's disease, pancreatic, and breast cancer?

Answer. This is part of our vision for the future; saliva is easy to collect and poses none of the risks, fears, or invasiveness of blood tests. The miniaturization of detection devices may allow placement of the sentinel device directly in the mouth, yielding real-time surveillance of hundreds of biomarkers that could alert individuals to consult with their health professionals at the earliest moment of disease, or to monitor the progression and recurrence of diseases in patients undergoing treatment. This will enable oral healthcare professionals to assume a more prominent role in primary care and disease prevention that will assume increasing importance as the American population ages. NIDCR will continue to support ongoing studies, as well as new studies including those made possible by American Recovery and Reinvestment Act funding, that will examine the feasibility of developing salivary diagnostic testing for the early markers of a number of diseases, including Alzheimer's disease and several cancers. The recent success of NIDCR-supported researchers in identifying salivary markers for primary Sjögren's syndrome, a chronic autoimmune condition of the salivary and tear glands that affects about 2 million Americans, mainly women, is another example of progress in this area.

Salivary diagnostics could have benefits far beyond medicine and dentistry as well. For example, law enforcement agencies could employ saliva tests both forensically and in the field to determine rapidly whether a person is intoxicated or has recently used illegal drugs. These tests may also be beneficial in determining exposures to environmental, occupational, and biological substances, such as anthrax.

NIH BUDGET WITH PRESIDENTIAL INITIATIVES

Question. The budget presented provides an increase of $174 million for all research except cancer. Will this essentially flat budget funding be sufficient to meet the important research work being conducted by the National Institutes of Health (NIH)?

Answer. We believe that the fiscal year 2010 NIH funding priorities are sound and will ensure the rapid translation of science from the laboratory to the bedside. The budget supports more than 9,800 competing Research Project Grants in addition to exponentially funding cancer as an initiative.

NIH's research categories are not mutually exclusive and individual research projects can be included in multiple categories as in cancer research; we have seen progress in one disease often comes from unrelated areas of investigation, and through the mutual synergy of such research that transformational findings occur. NIH will continue to fund high-quality research in all areas of its portfolio and will continue to effectively use every resource we receive in support of biomedical research.

STEM CELLS

Question. What do you think is necessary in terms of time and funding to make research breakthroughs in stem cell research?

Answer. The NIH has been clear that the best way to make breakthroughs in stem cell research is to pursue all avenues of stem cell research simultaneously as: (1) it is impossible to predict which type of stem cell research (e.g., adult or human embryonic) will ultimately yield the most successful approach in any given stem cell application; and (2) work in both adult and embryonic stem cells continues to inform and facilitate progress in stem cell research.

It is difficult to predict a timeline for scientific breakthroughs or determine a budget that will achieve these breakthroughs for stem cell research or any other type of research. Since 2001, NIH has been the lead Federal agency supporting and conducting human embryonic stem cell (hESC) research, spending over $262 million

on hESC research during this period. This research has significantly enhanced our understanding of the basic biology of these unique cells. For example, the genes required for maintaining pluripotency were determined by studying hESCs which led in 2007 to the breakthrough discovery of human-induced pluripotent stem cells. These cells are now being studied along with adult and hESCs to elucidate the unique characteristics and potential uses of each cell type.

As you are aware, President Barack Obama signed Executive Order 13505 on March 9, 2009, which requires NIH to establish new guidelines for Federal funding of human embryonic stem cell (hESC) research. NIH will issue the final guidelines by July 7, 2009. These new guidelines should increase ethical oversight and the number of responsibly derived hESC lines eligible for Federal funding. We anticipate that NIH will be able to provide support for research using many new hESC lines that were not previously eligible for Federal funding. It is our expectation that the expansion of the number of human embryonic stem cell lines available to scientists funded by NIH will hasten stem cell breakthroughs.

As you know, there has never been a cap on how much NIH could potentially spend on stem cell research, adult or embryonic. Instead, the amount spent depends on the number of highly meritorious stem cell grants that are submitted by the scientific community. The scientific community has told us about additional research that will be enabled by the increase in the number of human embryonic stem cell lines eligible for Federal funding that will result from the new policy. Once the new Guidelines are in place, NIH will assess the research needs and opportunities in stem cell biology and will develop initiatives that meet those needs to capitalize on these opportunities.

LOWER Lp(a)

Question. Several years ago, I asked Dr. L'Enfant about your research for a medication to lower Lp(a). Is there anything new that you can tell me about the status of research toward a medication that lowers Lp(a)?

Answer. Of all the drugs we currently use to treat abnormal lipoproteins, the one that most consistently lowers Lp(a) levels is a drug that has been around quite a while—niacin. Although the National Heart, Lung and Blood Institute (NHLBI) does not ordinarily sponsor drug development, as that is the province of the pharmaceutical companies, we are currently supporting a very important randomized clinical trial called AIM–HIGH. The trial is testing whether an extended release form of niacin (Niaspanr) will improve outcomes in 3,300 patients who have cardiovascular disease and "atherogenic dyslipidemia," a fairly common constellation of lipoprotein abnormalities associated with high cardiovascular risk that often includes high Lp(a) levels. We have funded an ancillary study to the AIM–HIGH trial specifically to learn more about how niacin affects lipoproteins, including Lp(a), and to determine the extent to which the effects may explain any observed improvement in cardiovascular outcomes. The information this study will provide about the role of Lp(a)in cardiovascular disease may help inform subsequent drug development efforts.

CURING CANCER

Question. The cancer community has indicated that $335 billion over the next 15 years is necessary to make real progress toward cancer cures. What do you think is necessary in terms of time, funding, and research breakthroughs to make a real difference in curing cancer?

Answer. The National Cancer Institute (NCI) is currently working with the other Institutes and Centers at NIH to develop an NIH cancer research strategic plan for the proposed plan by President Obama to double cancer research funding over the next 8 years. The strategic plan recognizes that most advances in the field will be made because of the knowledge that cancer is a disease of genomic alterations and of tumor cell evolution.

The NCI is developing a personalized cancer care platform—based upon the knowledge that cancer is a disease of altered genes—that will encompass and enable a drug development platform, from discovery of genetic changes to translation to man. Advanced genome sequencing technology will soon make it possible to completely sequence both normal and disease tissue of individual patients. NCI is developing a comprehensive approach to translate raw genetic information into an intimate understanding of the function of the genetic pathways which can then be used to clearly define targets for manipulating those pathways to inform the development of new targeted interventions. NCI is taking steps to create the first of a small national network of tumor characterization centers that will match a genetically characterized patient's tumor to appropriate and optimal therapeutic solutions. This 21st

century vision for personalized medicine will connect individuals, organizations, institutions, and the concomitant information in a cycle of discovery, development, and clinical care.

As the leader of the National Cancer Program, NCI is building on its history of research success and wisely spending every dollar it receives in a continual effort to foster the best research and to connect the public, private, and academic sectors for effective translation of these discoveries. With the significant funding increases proposed by the President, NCI could realize the promise of personalized cancer care more rapidly by significantly shortening the path between making an innovative discovery in the laboratory to having an effective impact on a patient in the clinic.

In this new era of post-human-genome science, it is clear that multiple new agents will be necessary to target multiple cancer pathways in each unique patient. Small molecules will penetrate cancer cells. New agents will energize the body's immune system to fight tumors. Still other agents will target the seemingly normal tissue of the tumor microenvironment or the tumor initiator cells with "stem-like" characteristics that may lead to cancer's deadly spread. Consequently, we will need to continue to expand discovery of the underlying genetic signatures of cancer and to develop individual recipes of therapy, often using multiple drugs from multiple manufacturers.

It is in the area of developing orphan drugs or combination therapies where industry—concerned about marketability, intellectual property, competition, and liability issues—often fears to tread. NCI must fill that void:

—Through increased funding of the Developmental Therapeutics Program and other allied programs, NCI could greatly expand a cohesive effort to produce small quantities of new agents and begin first-in-human testing, which would, in turn, lead to commercialization at a more rapid pace.

—Through a well-financed, coordinated plan, NCI could importantly restructure how it conducts clinical trials, creating an electronically connected system capable of bringing early phase clinical research to millions more patients, in their home communities.

—Through strategically placed characterization centers, NCI could conduct the intensely technological and specialized testing necessary in an era of targeted agents. This effort could create the standards of tumor analysis required in this new age, and could more effectively address the demands of rapidly changing technology. Examples of needed programs include early phase pharmacodynamic studies, a U.S. oncology tissue bank and certified centralized tumor characterization laboratories.

—Additional development of advanced technologies will allow us further develop nanoparticles designed to penetrate tumors and conduct greater research into the telltale proteins in the body that could be used to enhance early diagnosis. Enhancing technology development in clinical proteomics, systems biology, and increasing our biomedical computing capabilities would accelerate progress against cancer, but could also be applied to understanding other diseases.

—Through greater development of imaging, science could refine and improve the capacity to look inside cells, revealing biological processes in real time. This effort could develop the next generation of tools for early diagnosis, at a time when there are only a few million cancer cells in a patient's body.

Questions Submitted by Senator Thad Cochran

SARCOIDOSIS

Question. Sarcoidosis is a systemic inflammatory disease and one of the most common causes of fibrotic lung disease in the United States. Sarcoidosis can cause chronic debilitating or life-threatening heart, neurological, and internal organ disease and has no safe, effective treatments. In North America, African Americans are about five times more likely to have sarcoidosis than whites, representing a significant national health disparity. Despite the substantial burden of this illness on many (tens of) thousands of Americans of all races, and significant recent progress in our understanding of the illness, the National Institutes of Health (NIH) has supported disproportionately little research for this disease relative to its burden of disease, a disparity that has been increasing over the past decade. What do you believe are the reasons for this disparity and how can it be corrected?

Answer. The National Heart, Lung and Blood Institute (NHLBI) has had a longstanding commitment to funding research on the causes and treatment of sarcoidosis and on genetic predisposition to developing it. In recent years the Institute developed several new initiatives specifically addressing sarcoidosis, including a solici-

tation on granulomatous inflammation in sarcoidosis that resulted in funding of 11 new research projects. The Institute currently supports exciting programs in genomics of sarcoidosis and a new clinical trial on atorvastatin as a disease-modifying agent in pulmonary sarcoidosis. One reason for the funding disparity may be the small numbers of investigators in the country who are interested in conducting research in this complex and multi-organ disease. In addition, applications submitted have not competed well. Some steps we are taking to address this disparity include increasing visibility of sarcoidosis through activities such as radio spots on the disease; developing new research initiatives to address specific aspects of the disease; and working with the Trans NIH Sarcoidosis Working Group, which coordinates sarcoidosis research activities across the NIH. One of its recent activities has been promotion of a workshop on the genetics of sarcoidosis that was held last summer. Workshop recommendations, which have been posted on the NHLBI Web site, include initiation of a community-based study of sarcoidosis that would develop a registry of clinical information about the disease and might also include collection of patient samples for genetic studies. Other recommendations were to promote collaboration on sarcoidosis with NHLBI-funded investigators and the scientific community in Europe and other parts of the world, and to launch a genome-wide association study (GWAS) based on available samples from ACCESS and other existing cohorts. NHLBI staff are following up on these recommendations. Via the NIH solicitation for Challenge grants under the American Recovery and Reinvestment Act (ARRA), the NHLBI requested GWAS on rare lung diseases, including sarcoidosis.

Question. What are the plans of the NHLBI for closing this gap and improving the clinical care and treatment for patients with sarcoidosis?

Answer. Our plan is to support ongoing and new meritorious research through both ARRA and traditional investigator-initiated applications; re-issue an NIH-wide sarcoidosis program announcement, which seeks to stimulate research on the multi-organ manifestations of the disease; continue support of the NHLBI atorvastatin clinical trial; and consider future initiatives based on the NHLBI workshop on genetics of sarcoidosis that was held last summer. A new initiative under consideration addresses cardiac dysfunction associated with sarcoidosis. We are optimistic that these efforts will lead to advances in understanding the origin and pathogenesis of this disease and will improve our ability to diagnose and treat affected individuals.

Questions Submitted by Senator Richard C. Shelby

CLINICAL AND TRANSATIONAL AWARDS

Question. The Clinical and Translational Science Awards (CTSA) is designed to transform how clinical and translational research is conducted, ultimately enabling researchers to provide new treatments more efficiently to patients. Tremendous effort has brought institutions together to rally around this program, yet current funding levels make it difficult for the programs to succeed. Key to the success of the CTSA is the development of cost sharing for use of infrastructure services. An example of this mechanism is the General Clinical Research Centers (GCRC), which allowed institutes to reduce their research budgets by having investigators use the GCRC when clinical care such as inpatient stays, lab tests, and nursing staff was made available at no additional cost. Today, individual investigators must provide funds for clinical care cost sharing from grants funded from other National Institutes of Health (NIH) Institutes. As research becomes more expensive and private capital dries up, it becomes even more critical to ensure support for translational research, that is, research that moves a potential therapy from development to the market. Will the NIH provide the financial resources necessary to maximize the potential of this critical program?

Answer. The CTSA program is providing substantially more funding for clinical research than was available under the GCRC program. The CTSA allows the institution to continue activities that were conducted in the GCRC and add new activities. With a minimum total funding level of $4 million per year, all CTSAs will be able to offer clinical investigators a substantial diversity of resources. The prioritization of resources offered within an institution is determined locally, as are any needs for cost sharing to ensure adequate support for a wide range of activities.

National Center for Research Resources (NCRR) expects to fulfill the charge to transform clinical and translational research within the current overall budget for the program. At $500 million per year when fully implemented, the CTSA program represents a significant increase in infrastructure support over the $340 million allocated to pre-existing NIH clinical research resources (i.e., NCRR K12, GCRC M01,

NIH K30, and Roadmap T32 and K12 programs). To reach the critical mass necessary to transform clinical and translational research, NCRR projects that 60 CTSAs are needed throughout the United States. Diversity in the size, scope, and geographic location of participating institutions will strengthen the CTSA consortium and enhance its national and regional collaborations

CONCLUSION OF HEARING

Senator HARKIN. So again, I thank you all very much, and with that the subcommittee will stand recessed.

Dr. KINGTON. Thank you.

[Whereupon, at 11:49 a.m., Thursday, May 21, 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 2010

WEDNESDAY, JUNE 3, 2009

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

The subcommittee met at 9:30 a.m., in room SD–124, Dirksen Senate Office Building, Hon. Tom Harkin (chairman) presiding.

Present: Senators Kohl, Murray, Landrieu, Reed, Pryor, Specter, and Cochran.

DEPARTMENT OF EDUCATION

OFFICE OF THE SECRETARY

STATEMENT OF HON. ARNE DUNCAN, SECRETARY

ACCOMPANIED BY THOMAS SKELLY, DIRECTOR, BUDGET SERVICE

OPENING STATEMENT OF SENATOR TOM HARKIN

Senator HARKIN. Good Morning. The Labor, Health and Human Services Education Appropriations Subcommittee will come to order. I want to start by welcoming Secretary Duncan. I was honored to chair the confirmation hearing on the other committee on which I sit. But this is his first appearance before this subcommittee, so he's here to talk about money, the taxpayers' money.

AMERICAN RECOVERY AND REINVESTMENT ACT

Every year when Congress considers the President's budget it hears people say it is a critical moment in the Nation's history. In hindsight, some of those moments were probably more important than others, but I would submit when it comes to education, this is truly one of those historic moments. The Recovery Act will add almost $100 billion to the Nation's education system. The largest one-time investment in education in our history, and that's on top of the more than $60 billion in the regular 2009 bill. There has never been this much funding in the Nation's schools before in our history. So we in Congress, especially on this subcommittee, and the Education Department have a special responsibility to make sure that the money is used wisely.

Funding of this scale brings in opportunities both to help to pull our economy out of the recession and to encourage new innovations

in the way we educate our students. But if we are not careful, the money can also be squandered. Therefore, we will spend part of today's hearing talking about the implementation of the Recovery Act so far, what the Department plans to do with the rest of the money for the months ahead.

POSTSECONDARY EDUCATION

We will so consider the President's request for the fiscal year 2010 budget. I think there is much to admire in his proposal, and am especially pleased by his plan to end entitlements for financial institutions that have processed Federal student loans and switch to direct lending, instead. This plan will save billions of dollars a year that can be re-invested, to help middle- and low-income students get a college education.

The President's budget also puts real money behind efforts to improve our Nation's high schools. And the other end of the education spectrum, the budget request makes a strong investment in early learning.

SCHOOL FACILITIES

One area that is not addressed in the President's budget is school repair: renovations, repair, and construction. A last-minute decision to remove funding designated to that purpose in the Recovery Act was, in my opinion, a grave mistake. This money would have created jobs, met a pressing educational need and avoided long outyear funding commitments.

But even though the funding was pulled from the Recovery Act, the need for better school facilities grows with each passing day. I recently introduced the School Building Act of 2009, and I intend to include money for this purpose in the regular fiscal year 2010 appropriations bill.

So, Mr. Secretary, I look forward to hearing your testimony about the President's budget, also the Recovery Act and other items that will come up here.

First, I would yield to Senator Cochran. Thank you.

STATEMENT OF SENATOR THAD COCHRAN

Senator COCHRAN. Mr. Chairman, thank you. I am pleased to join you in welcoming this distinguished Secretary to our subcommittee to review the budget for the next fiscal year. We appreciate your cooperation and look forward to working with you through the year. As we proceed with our deliberations on the budget request, the budget the President has submitted, I would ask, Mr. Chairman, that the balance of my remarks be printed in the record.

Senator HARKIN. Thank you, Senator Cochran. Senator Murray.

STATEMENT OF SENATOR PATTY MURRAY

Senator MURRAY. Thank you very much. Mr. Chairman, Senator Cochran, thank you so much for having this hearing. Secretary Duncan, welcome. I am looking forward to hearing you talk today about the budget request and a wide range of educational challenges that you are addressing, both opportunities and priorities.

These are issues that I have been focused on a very long time, both as an educator and as a member of this subcommittee. So I was very pleased to see that you and the President are preparing to tackle or more appropriately, put a full-court press on a lot of the large issues facing us in education today.

POSTSECONDARY EDUCATION

The budget takes some exciting steps forward. I was very happy to see the College Access and Completion Fund, that will help our students enter and succeed in college. I think that's a promising idea. I look forward to hearing more about that. That's been a long-time issue of mine, especially for disadvantaged students, and Washington State has some innovative work in this area, so I'm looking forward to hearing some comments on that.

I am also very encouraged by the President's goal that every student will complete at least 1 year of postsecondary education. I share that goal, and as a long-time advocate for job training and education programs, it's great to have a strong partner in the White House on that.

I discussed with you earlier one of my innovations to 21st century careers, and looking forward to your work in that area as well.

PROPOSED BUDGET INCREASES

I am pleased that your budget proposal has some significant increases in Pell grants, teacher quality, State grants, school leadership for principals, and literacy efforts. Those are all very important in our work today.

This is a very ambitious education agenda and it comes at a very difficult time. At home, every weekend I go home and I see more headlines about teachers being laid off and the challenges in our educational system. I can tell you that teachers in my home State and across the country are not only worried about their own job security, but the impact on their students, as a lot of our States are facing some very tough times.

PREPARED STATEMENT

So our work on the Recovery package to support our schools is very important, and I look forward to what you have to say about that as well today. And Mr. Chairman, just as a note of personal privilege, I want to just mention, I've got some students from one of our high schools in Washington State, Meadowdale. If you guys could just stand up? They are here all the way across the county and I remind all of us, this is what we are talking about today. So thank you for being here.

Senator HARKIN. Welcome. Where do you say they are from?

Senator MURRAY. Meadowdale High School, Lynnwood, Washington.

And, I would like to quickly mention their names for the record: here with us today is: Joshua Gregory; Aaron Feldhaus; Andy Nguyen; Morgan Buckingham; Samuel Triece; Evan Primm; Robert Baldridge; Matthew Genetiano; Dalia Mendoza; Andrew Prichard; Anwar Bible; Noah Beardsley; and Jacob Grund.

[The statement follows:]

PREPARED STATEMENT OF SENATOR PATTY MURRAY

Thank you Chairman Harkin and Senator Cochran for holding today's hearing to discuss the need to invest in education and prepare our young people to succeed in school and beyond.

I also want to thank Secretary Duncan for joining us today to present the Department's budget request and discuss our wide-range of education challenges, opportunities, and priorities.

I have been focused on these issues for years—both as an educator and as a member of this subcommittee.

And I'm pleased to see that you and the President are preparing to tackle—or maybe more appropriately—put a full-court press on so many of the large, tough issues facing our education system. And this budget certainly takes steps forward on some very exciting education programs.

The College Access and Completion Fund to help students enter and succeed in college is a promising idea. College access and completion, especially for disadvantaged students, has long been a goal of mine, and my home State of Washington has done some particularly innovative work in this area.

Specifically, they have focused on partnerships with State and nonprofit programs to follow up with students throughout college to ensure their success.

I look forward to working with you on the College Access and Completion Fund and keeping in touch as this process moves forward.

I am also encouraged by the President's clear goal to that every student will complete at least 1 year of post-secondary education. I share President Obama's goals, and as a long-time advocate for job training and education programs for our workers, I am glad to have a strong partner in the White House.

To address this goal, I will be re-introducing my bill, the Promoting Innovations to 21st Century Careers Act, that works to bridge the skills gap between what students need to know to be successful and what skills employers, colleges, and communities are looking for.

I am pleased that your budget proposal has significant increases in Pell grants; Teacher Quality State Grants; The School Leadership Program for principals; and literacy efforts.

These are all going to help ensure that our students have access to high-quality education—from early childhood all the way through college.

You and President Obama have taken on an ambitious education agenda, and we know that it comes at a difficult time. Every day there is another front page story somewhere in my state about teachers being laid off or education programs being cut or cancelled.

Teachers are worried about job security and parents are worried about quality or how to pay to send their kids to college.

I am proud that our work together to pass a strong Recovery package is beginning to help States like Washington keep more teachers in their jobs and continue our national commitment to ensuring a quality education for all students.

But as you know well, our long-term economic recovery is going to depend on sustained investments and new and innovative programs that will give our kids the skills to succeed in higher education and careers in the 21st century economy.

I look forward to asking you questions on efforts to build those skills and on the investments proposed in your budget.

Thank you.

Senator HARKIN. Welcome to Washington. Thank you, Senator Murray. Senator Reed.

STATEMENT OF SENATOR JACK REED

Senator REED. Mr. Chairman, I simply want to welcome the Secretary, and also underscore what Senator Murray said about the College Access and Completion Fund, much of which is built on the work that we advised them on last year, and I look forward to the Secretary's comments on how he is going to use the, I believe, gap provisions, and bolster this particular fund. Thank you.

Senator HARKIN. Thank you, very much, Senator Reed. Senator Landrieu.

STATEMENT OF SENATOR MARY L. LANDRIEU

Senator LANDRIEU. Thank you, Mr. Secretary, just briefly, I want to thank you for your early visit right after your confirmation to New Orleans, to see their continued effort to rebuild their school system, not just in the city, but in the region. And most excitingly, Mr. Chairman, to build a brand new school system that's based on large measure on some of the work that has been done in this subcommittee and in our full Appropriations Committee, but now being led by Secretary Duncan and President Obama.

And I just want to comment that some of the same principles about our rebuilding a new, revitalized public school system, we can take from that, and give options and opportunities for the rest of the country, particularly, Mr. Chairman, the focus on expanding our commitment to quality charter schools, which are independent public schools, to some degree, that are showing extraordinary promise across the country. And I want to thank the Secretary for his leadership and just say that this budget is not only a commitment to bold reform, but I am also excited about your commitment to funding and the President's commitment to that goal of reform. Because that didn't happen in the last administration, and I'm very excited that the commitment to funding and the commitment to excellence have been put together, and under your extraordinary leadership, I think we can get it accomplished.

Thank you.

Senator HARKIN. Thank you, Senator Landrieu. Now, Secretary Duncan, welcome. Your statement is being made 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, for your leadership. I have gotten a chance to spend time with many of the subcommittee members and I haven't seen more passion and commitment to education anywhere. So I am very excited at the opportunity to work with you and try and do something dramatically better for the children of our country.

FISCAL YEAR 2010 EDUCATION BUDGET PRIORITIES

Thank you so much for the opportunity to be here today to talk with you about President Obama's fiscal year 2010 budget request.

Senator HARKIN. Mr. Secretary, is your mike on or if it is, can you pull yourself a little bit closer?

Secretary DUNCAN. This budget makes important choices to continue and expand programs that will support our children from cradle to career. It provides the resources necessary to expand access to high quality early childhood programs, to ensure that K–12 schools are preparing their students for success in college and the workplace, and to provide college students with the money they need to pay for college and an assurance that the Federal Government will be there to help them. Together, all of these policies will help our country reach the President's ambitious goal, that by 2020 the United States will once again have the largest proportion of college graduates in the world.

IMPACT OF RECOVERY ACT FUNDS ON EDUCATION

I am extremely grateful for the work you have already done to help our Nation's schools. I look forward to working with you in the future. As you know, in the American Recovery and Reinvestment Act (ARRA), you provided $100 billion to schools and to students. The law provides a great, great start in addressing the needs at every point along the cradle to career spectrum. Thanks to your support, we are able to stave off an education catastrophe and save a generation of children.

As you know, the ARRA had two goals in education: to create and preserve jobs, and to promote school reforms. Even though the Department of Education hasn't yet distributed all of the money provided in the stimulus bill, we are seeing signs that we are meeting the goal of preserving the jobs of teachers and other educators.

We are collecting data on the number of jobs preserved, and can point to several districts where the stimulus funding has made a significant difference.

Because of ARRA, the Los Angeles Unified School District averted almost 3,800 layoffs. In New York City, that number is 14,000 layoffs averted, 139 teachers kept their jobs in Seminole County, Florida, and in Boston, teacher union leaders say the stimulus money ensures that the city won't lay off any teachers. Alabama's State superintendent has said that the stimulus money will help avert all layoffs in his State as well.

I am confident that in just about all our 14,000 districts around the country, the stimulus money will be used to preserve jobs that otherwise would have been lost, or to create jobs they'd never have been able to add if they didn't receive money from the ARRA.

EDUCATIONAL ASSURANCES FOR EDUCATION REFORM

Before this stimulus, we were heading for an educational disaster. With it, we have largely avoided that catastrophe, and now must also work to continue to improve student achievement. I am convinced we have to educate our way to a better economy.

Through ARRA, States are promising to make commitments on policies that we consider to be essential for reform. They will improve the effectiveness of teachers, and work to make sure the best teachers are in the schools that need them the most. They will improve the quality of their academic standards, so that they will lead students down a path that truly prepares them for college, the work force and global competitiveness.

These standards need to be aligned with strong assessments. I am particularly concerned that these assessments accurately measure the achievement of English language learners and students with disabilities. Under the third assurance, States will commit to fixing the lowest performing schools. Finally, they will build or enhance data systems that track student performance from one year to the next, from one school to another, so that those students and their parents know when they are making progress, and when they need extra help. This information must also be put in the hands of educators, so they can use it to improve instruction.

INCREASING INSTRUCTIONAL TIME

Another key ingredient of reform is to add more time for instruction. I grew up in my mother's after-school program in Chicago, so I know firsthand the importance of after-school and summer programs. That is why we are asking districts to consider using Recovery Act funding, as well as title I funding, to extend the school day and the school year. In places like Cincinnati, we are already seeing such innovation taking place. Cincinnati is adding what they are calling a fifth quarter, where students must spend an extra month in school this summer.

This is also a key component of our school turnaround strategy, because we know that kids who are struggling absolutely need more time in order to catch up.

RACE TO THE TOP FUND

Through ARRA, we will be rewarding States, districts, and nonprofit leaders who are dedicating themselves to moving forward in each of these areas of reform. The $4.35 billion "Race To The Top" Fund will reward States that are making commitments to reforms, so they can push forward and provide an example for the rest of the country to follow.

WHAT WORKS AND INNOVATION FUND

The $650 million What Works and Innovation Fund will provide grants to districts and nonprofits to scale up successful programs and evaluate promising practices.

My department expects to issue invitations for applications this summer and start awarding grants in the late fall. With ARRA as a foundation, we have submitted a fiscal year 2010 budget that will build on the Recovery Act and advance all of the President's priorities.

FISCAL YEAR 2010 DISCRETIONARY FUNDING REQUEST

Overall, President Obama is asking for $46.7 billion in discretionary funding for the Department, an increase of $1.3 billion over the comparable 2009 level.

EDUCATION PRIORITIES

I want to highlight our request in several important areas: early childhood education, improving the pay and professional development of teachers, turning around low-performing schools, and ensuring that college students have financial aid and student loans. They need not just to enter college, but to complete. Again, the goal is not just access, it's attainment.

IMPROVING TEACHER QUALITY

In K–12 education, we are requesting two important investments in the key priorities identified under the stimulus: improving the quality of our teachers and turning around low-performing schools. In other countries, the top one-third of college graduates enter the teaching force. Unfortunately, too often here in the United States, our best college graduates choose other professions. We need to

change the way we promote and compensate teachers, so that we can attract the best and brightest into the profession by rewarding excellence and providing supports that enable success.

TURNING AROUND LOW-PERFORMING SCHOOLS

As for turning around low-performing schools, we all know that too many of our schools are actually letting our children down. In too many places, achievement is low and not improving. For example, in approximately 2,000 high schools, 60 percent of the entering freshmen class will drop out by the time they are supposed to be seniors. That collective loss of human potential and the long-term negative impact on our economy are both staggering.

Under ARRA, we have asked States to identify the bottom 5 percent of their schools. In our fiscal year 2010 budget request, we want to give them the resources to fix them, with a strong focus on dropout prevention in these so-called dropout factories.

ECONOMIC IMPACT OF HIGH SCHOOL DROPOUTS

And just to pause for a moment, our dropout rate for our country—for the Nation is approximately 30 percent. So it's a problem that plagues every community: urban, rural, and suburban. Recently the Alliance for Excellent Education came out with a study on the cost to the economy of the dropouts of the class of 2008; had they graduated and not dropped out, that would have added an additional $319 billion in income over their lifetimes. And if we don't do something about this dropout crisis, over the next decade the loss to our country will be $3 trillion. So the economic impact, beyond the lost human potential, is something we absolutely have to come to grips with.

SCHOOL IMPROVEMENT PROGRAM

Our budget includes $1.5 billion for the Title I School Improvement Program. That's almost a $1 billion increase over last year. When that amount is added to the $3 billion the program received in the ARRA, and the $545 million in fiscal year 2009, we will have more than $5 billion to help turn around low-performing schools.

I am talking about dramatic changes here. I will not be investing in the status quo or in changes around the margins. I want States and districts to take bold actions that will lead directly to improving student learning.

I want superintendents to be aggressive and take the difficult step of shutting down a failing school and replacing it with one that will work.

TEACHER INCENTIVE FUND

To improve both the quality of teachers and the critically important support they receive, we are requesting $517 million for the Teacher Incentive Fund, including $30 million for a national teacher recruitment campaign. This program is designed to improve the quality of the teaching workforce, using innovative professional development and compensation systems as a core strategy.

I want to be clear, I want the grants awarded under this program to be a cooperative effort between districts and teachers. The

President has often said that he believes changes to the teaching profession should be made by working with teachers and not by doing things to teachers. The chance for real collaboration here is remarkable.

Chicago was one of the first 34 projects to receive a grant from this program. Like many others, we worked closely with our teachers to create the program. In fact, a team of our best teachers actually gave the program shape, and designed the framework that became our foundation.

Together we created a program which emphasized improving professional practices of teachers, identifying what it takes to make teachers better, and rewarding those who improve.

One important change that we are requesting to the Teacher Incentive Fund would allow districts to reward all of the employees of a school for helping that school to improve student achievement. Students excel and thrive when all adults in the school work together. The janitors, the custodians, the cafeteria workers, the security guards also need to be rewarded when students in their school succeed.

I have seen throughout my life, that when every adult in the school building collaborates to create a culture of high expectations, magic happens for children.

READING PROGRAMS

In addition, we are seeking $370 million for the Striving Readers Program. The program now works to improve the literacy skills of adolescent students who are reading below grade level. We will dedicate $70.4 million for that purpose, almost double the amount in the fiscal year 2009 budget.

With the remaining $300 million, we will create a competitive grant program to support districts to create comprehensive and coherent programs that address the needs of our young readers. These programs would ensure that students learn all of the skills they need to become good readers, teaching them everything from awareness to reading comprehension.

We intend to build upon the successes and the lessons of the Reading First Program, while simultaneously fixing the problems.

RECOVERY FUNDS FOR TITLE I AND SPECIAL EDUCATION

I would like to say a word or two about the largest programs that have been entrusted to us: the title I program and the Special Education State Grants program under the Individuals With Disabilities Education Act, that Senator Harkin, you worked so hard on. Both programs received dramatic funding through ARRA.

Title I received $10 billion in funding for grants to districts, in addition to the $3 billion for school improvement program, while Special Education State Grants received $11.3 billion. That's almost as must as it received in fiscal year 2009. We are working closely with districts to ensure that they spend this money wisely, and not put it into programs that they won't be able to sustain when that money runs out.

I would also like to note that both of these programs didn't receive the increases they otherwise might have in the fiscal year

2010 request because of the amount of money provided in the Recovery Act and the period of availability.

We hope to resume our commitment to funding the increases for the programs, once the stimulus money has expired. In the short term, we need increased funding for school turnaround efforts. The students attending these schools cannot afford to wait. We are in crisis.

More of the same in our dropout factories will not help children succeed and beat the odds. That would only ensure that we, as educators, actually perpetuate poverty and social failure. We have too many examples of what does work and what is possible around the country to continue to allow devastating failure to exist.

EARLY CHILDHOOD EDUCATION

In fiscal year 2010, we will also be making important investments in early childhood programs. Under title I, we are requesting $500 million to encourage districts to use the program's money to expand preschool programs. This money will help build one piece of the comprehensive early childhood programs that President Obama has proposed. It is necessary to schools serving the title I population, which will benefit the most from early childhood education.

EARLY LEARNING CHALLENGE FUND

The budget also includes $300 million to start the Early Learning Challenge Fund. The program's initial goal is to help States build a network of services that will maximize the investment in early childhood education. Expanding access to high quality early childhood programs is one of the best investments we can make.

ARRA FUNDING FOR POSTSECONDARY EDUCATION

All of those changes will help push school reform in K–12 schools. We also have significant, important policy changes for higher education. The Recovery Act made an important down payment on our plans to expand student aid. And in addition to more aid, we want to make sure that more students are not just attending college, but also graduating.

BUDGET PROPOSAL TO MAKE PELL FUNDS MANDATORY

The stimulus bill provided $17.1 billion so we could raise the maximum Pell award from $4,850 to $5,350. In the fiscal year 2010 budget, we propose important and permanent changes to ensure students will have access to Federal grant aid and loans. The first thing we propose is to move the Pell Grant program from a discretionary to a mandatory appropriated entitlement. Second, we propose to link the increase in the maximum grant to the consumer price index (CPI), plus 1 percent, every year, which will allow the maximum grant to grow at a rate higher than inflation, so we can keep up with the rising cost of college.

I am grateful for all of the work that the appropriators have done to fund annual increases for Pell grants, particularly in the last 4 years. But even with that dedication, the maximum grant has not kept up with the rising cost of college tuition.

By making the Pell Grant program mandatory, and indexing annual increases to the CPI, we are ensuring that students will know that their Pell Grant will increase at the same rate as their tuition. This will give them the assurances that they will have the assistance they need to make it through college. This is, of course, a major financial commitment.

PROPOSAL FOR ALL NEW LOANS TO BE DIRECT LOANS

We are able to pay for this change, in part, by streamlining and improving the student loan program. We will move all loans over time from the Federal Family Education Loan Program to the Direct Loan Program, making loans more efficient for taxpayers, and freeing up money for Pell grants. In doing so, we can dramatically expand access to college without going back to taxpayers and asking them for one additional dollar.

PROPOSED BUDGET SAVINGS AND PROGRAM ELIMINATIONS

In closing, I would like to note that this budget makes tough decisions. President Obama asked all Cabinet agencies to examine their budgets, line by line, to identify programs that are ineffective and too small to have a significant impact.

Our student loan proposal saves more than $64 billion per year. In addition, we are proposing to eliminate 12 programs, creating an additional savings of $550 million. Even though we recommend cutting these programs, we remain committed to their goals. We are eliminating the $294 million State program under the Safe and Drug-Free Schools and Communities Program because several research studies have found that the program is ineffective. But we absolutely remain committed to fighting drug use and stopping violence in our schools, which is why we are recommending a $100 million increase in spending for the national activities under the Safe and Drug-Free Schools Program.

Also, we are proposing to eliminate the Even Start Program; we will continue to support the program's focus on comprehensive literacy programs through the expanded Striving Readers Program and Early Reading First.

These program eliminations show that our fiscal year 2010 budget is a responsible one. It is investing in our country's future economic security, and also making tough decisions to eliminate programs that are not working.

PREPARED STATEMENT

I appreciate the opportunity to discuss our fiscal year 2010 budget and look forward to your questions. Thank you so much.

[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 President Obama's fiscal year 2010 budget for the Department of Education, and to talk with you about how together we can lay the foundation for a generation of reform that can restore American leadership in education.

President Obama is asking for $46.7 billion in discretionary funding for the Department in fiscal year 2010, an increase of $1.3 billion over the comparable 2009 level, that would build on the historic increases provided for education in the American Recovery and Reinvestment Act (Recovery Act).

The combined resources of the Recovery Act and the 2010 request demonstrate the President's strong belief that improving education is the best way to ensure our long-term economic prosperity and security. Moreover, education is the civil rights issue of our generation, and the only truly effective weapon in our Nation's long war on poverty.

And it's not just more money that has created this unprecedented opportunity to dramatically improve the quality of our education system, but also broad, bipartisan agreement on what needs to be done to achieve this goal.

We need college-ready, career-ready, internationally benchmarked academic standards that reflect the fact that our kids today are not competing against children down the block or even across the country, but across the globe in countries like India and China. And to make sure all of our kids can meet those standards, especially those poor and minority children that currently suffer from the achievement gap, we need to invest more in quality early childhood education.

We also must do everything we can to get a great teacher in front of every classroom in the Nation. Everyone knows the difference that a good teacher can make, but we have far too few good teachers in our most challenging, lowest-performing schools. We need to change the incentives to encourage our best teachers and principals to work in the toughest schools.

And we need to be much more thoughtful about supporting reform and innovation that have been proven to increase student achievement. We need to identify and scale up best practices and promote effective strategies like expanding the number of charter schools and extending learning time to help turn around low-performing schools.

All of these priorities—higher standards, early childhood education, better teaching, and promoting effective innovation—will help more students enter and graduate from college. There is no question that one key to success in the global economy is a college education, and President Obama has set a national goal of ensuring that America is number one in graduating young people from college by 2020. Today roughly 40 percent of 25–34 year-old Americans hold college degrees, and we want to raise that to 60 percent.

The Recovery Act put significant resources—almost $100 billion—behind each of these strategies for ensuring that every child has the opportunity to obtain a quality education. Our 2010 request was developed in the context of Recovery Act funding, much of which will continue to be available to States and school districts in fiscal year 2010, and reflects our effort to build on and make the most of that historic investment in education.

EARLY CHILDHOOD EDUCATION

We know from decades of research that investment in high-quality early childhood education and services leads to better outcomes in both school and the working world. President Obama is drawing on this research for his comprehensive Zero-to-Five initiative to expand access to quality childcare and education. The 2010 request would jump-start this initiative by helping to improve readiness for school, particularly in the area of early literacy and reading skills. For example, the request includes $500 million for Title I Early Childhood Grants, which would provide incentives for school districts to use a larger share of Title I Grants to local educational agencies (LEAs) funding—including the $10 billion provided by the Recovery Act—to establish or expand title I preschool programs. We also are asking for $300 million to launch the Early Learning Challenge Fund, which would lay the groundwork for future investments in early childhood education by helping to build State capacity to measure and improve the quality of early childhood programs.

In addition, the 2010 request would strengthen early literacy through a $335 million increase that would expand the Striving Readers program to support comprehensive approaches to reading instruction for children in the elementary grades that are grounded in scientifically based reading research. A portion of the Striving Readers funds would continue to support interventions and whole-school efforts in secondary schools to help students who read significantly below grade level.

NEW INCENTIVES FOR EFFECTIVE TEACHING

President Obama believes strongly that "America's future depends on its teachers." We need more effective teachers, and we need them most in our lowest-performing schools. Our request supports both of these goals. For example, we are asking for a $420 million increase for the Teacher Incentive Fund to significantly expand programs developed with local stakeholders to reward effective teachers and principals and to expand incentives for teachers, principals, and other school staff to work in our most challenging schools. The request also includes $29.2 million for

the School Leadership program, an increase of $10 million, or 52 percent, to encourage effective principals to work in high-need schools and to train effective teachers to become principals or assistant principals in those schools.

PROMOTING INNOVATION IN STRUGGLING SCHOOLS

Creating new incentives for teachers and principals is part of a broader effort in our 2010 budget to promote innovation and reform in low-performing schools. If you look on our website, at www.ed.gov, you will see that as part of our Recovery Act guidance we have posted a list of almost 13,000 schools that are identified for improvement during the current school year. That number is up by more than 1,000 schools, or 9 percent, from the previous year. And more than one-third of these schools, or almost 5,000 schools, currently are in restructuring status—the final stage of improvement for chronically low-performing schools that demands fundamental changes in instruction and school governance to break the cycle of educational failure.

Congress recognized the challenges that these schools create for States and school districts and provided $3 billion for Title I School Improvement Grants in the Recovery Act. The Department is working to maximize the impact of these funds on efforts to build State and local capacity to support school improvement, and the 2010 request would build on those efforts by seeking $1.5 billion for School Improvement Grants, a $1 billion increase over the regular 2009 level. The request would help intensify efforts to identify and adopt effective turn-around strategies. The request also would begin to help take on the dropout crisis by requiring States to ensure that 40 percent of School Improvement Grant allocations are spent in low-performing middle and high schools.

In addition to school improvement funding, we are launching a major push to identify and scale-up best practices through our What Works and Innovation Fund, which received $650 million under the Recovery Act. We would add $100 million to this program in 2010, to support competitive grants to LEAs and partnerships between nonprofit organizations and LEAs that have made significant gains in improving student outcomes to expand or evaluate their work and serve as models of best practices. In many ways, this program is the linchpin of everything we are working on at the Department, because there is a huge need for effective, scalable strategies that can improve student achievement in high-poverty, high-need schools. Further, we request $72 million more for the Institute for Education Sciences, so we can identify what works based on rigorous research.

Our 2010 request also would begin to make good on President Obama's promise to increase support for one innovation that we know can improve student achievement—charter schools. We are seeking a $52 million increase as part of a commitment to double funding for Charter Schools Grants over 4 years. Other activities in our 2010 budget to promote innovation include $50 million for a High School Graduation Initiative to fund innovative and effective strategies designed to increase the high school graduation rate, and $10 million for a Promise Neighborhoods initiative that would promote comprehensive programs that provide the support children need to achieve success from birth through college and beyond.

HELPING MORE KIDS GO TO COLLEGE

We announced most of our 2010 proposals for postsecondary education in February as part of the 2010 President's budget overview, so I will just summarize them briefly here. I do think we have an extraordinary story to tell about the Federal student aid programs. Under the President's request, the Department of Education would administer over $129 billion in new grants, loans, and work-study assistance in 2010—a 32 percent increase over the amount available in 2008—to help more than 14 million students and their families pay for college. Our proposals to make Pell grants a mandatory, appropriated entitlement, raise the maximum Pell award from $5,350 to $5,550, and index the maximum award to inflation plus 1 percentage point, would result in a $10.4 billion or 57 percent increase in Pell Grant assistance from the 2008–09 school year to the 2010–2011 school year. And the number of Pell Grant recipients would rise by nearly 1.5 million, or 24 percent, over the same period.

We would be able to provide these dramatic increases in student aid in part because our proposal to use Federal capital to make all new loans through the Direct Loan program, along with our proposed restructuring of the Perkins Loans program, would save an estimated $24.3 billion over the next 5 years. This is an extraordinary opportunity to reform obsolete programs; increase aid available to students; and simplify the administration of student loans for students, families, schools, and the Department. In short, it is an opportunity that should not be missed.

Finally, our 2010 request would launch a 5-year $2.5 billion Access and Completion Incentive Fund that would support innovative State efforts to improve college completion rates for low-income students. This Federal-State partnership builds on ideas Congress included in the Higher Education Opportunity Act, such as the State Grants for Access and Persistence program designed to complement LEAP. A key goal of this program is to learn more about what works, and what doesn't work, in improving student persistence to degree. The administration also intends to reach out to the philanthropic community as potential partners, and expects to make use of the Experimental Sites authority that we already have, to issue regulatory waivers for the purpose of research on programs to improve persistence.

CONCLUSION

The Recovery Act provided unprecedented levels of Federal support for our schools in return for a commitment to meaningful reform strategies. President Obama and I believe that the Recovery Act has created a historic opportunity to improve the quality of our education system, and we are determined to make the most of that opportunity. Our 2010 budget request would build on the resources and reforms in the Recovery Act to help create a public school system that prepares more students for the opportunities provided by a college education and helps ensure that they can afford to take advantage of those opportunities. As I said at the beginning of my testimony, I believe these are goals we all can agree on, and I urge you to support the President's fiscal year 2010 request for education.

I will be happy to take any questions you may have.

PELL GRANTS AND COLLEGE ACCESSIBILITY

Senator HARKIN. Thank you very much, Mr. Secretary. That's a pretty awesome list of investments that you're making in education. I just, off the top, might say that on the issue of the Pell grants, well, I guess we are just going to have to discuss that further. I think there may be a little bit of concern here on this subcommittee and others about making that a mandatory program, but it's open for discussion. I don't have a closed mind on it, but I think there are reasons on both sides.

Secretary DUNCAN. I look forward to the discussion, and we are open to that. The thing, just, that I worry about a lot, Mr. Chairman, is that I worry about fifth and sixth and seventh graders who are really smart, and who because dad or mom is losing their job, or taking a huge pay cut, start to think college is not for them, and that they won't be able to afford it. And what I really want is for those young students to know that regardless of how tough things are at home, that they are going to have an opportunity down the road, if they work hard.

I worry about the psychological impact, where families are under tremendous financial stress, of children just thinking, "College is not for me." And those dreams start to die at an early age.

So whatever we can do to signal to young children that whatever stress your family is under, if you work hard and you are committed, you're going to have an opportunity to go to college—that's what is important to me.

Senator HARKIN. Well, I am glad to hear you say that. That's true. And you are saying that by making it mandatory that they have heard that. But there are a lot of other ways that we could be looking at, perhaps, making sure that students have access to college at any early age, as long as they study and get good grades. I am sure you have some ideas of your own about changing that system—about providing incentives to kids early on so that they can keep up their grades and keep up the work, that they get scholarships and they get access to college. But we will discuss

that. As I said, I don't have a closed mind on it, but there are arguments on both sides of that.

TITLE I FUNDING GAP

I want to cover my time a little bit on a couple issues you raised. One, on the Title I Program. Of course, we did put a lot in there, as you mentioned, in the Recovery Act, $10 billion. So for this year and next year, things are fine. But obviously we are looking at what happens when the Recovery funds are spent—now in your budget, you requested about a $1.5 billion cut.

Well, you can say that's okay since we have all this money in the Recovery Act. But the problem with that is you cut the base. And you said that we are going to resume a commitment to this funding after the Recovery Act money runs out.

But if we cut the base this year, then as we move into next year, you've got to make that up, plus an increase. And that's what I am concerned about is cutting the baseline.

TARGETING TITLE I FUNDS TO LOWER THE DROPOUT RATE

Secretary DUNCAN. Yes. I hear the concern. And what we are trying to do is really focus that title I money on title I children, particularly those schools that have historically struggled.

As I mentioned in the beginning, I worry tremendously about our national dropout rate. It's a 30 percent dropout rate. And there was a time in our country, you know, a couple decades ago, when that was an acceptable dropout rate. There were jobs out there for students who didn't have a high school diploma. But as all of you know so well, today there are no good jobs out there for people without a minimum of a high school diploma.

When we look at the high school dropout problem, it's fascinating. Again, a 30 percent rate. We have these 2,000 dropout factories, about half are in urban areas, 20 percent in rural, 30 percent in suburban. So this is a national issue. This isn't one or the other. And we can identify 2,000 high schools that are producing half of our Nation's dropouts. Half the total, and 75 percent are minority students who drop out from 2,000 high schools.

And the cost to our economy is just absolutely devastating, as is the loss of human potential. So what I want to do is target that title I money to really take this challenge on and not just keep perpetuating the status quo.

Senator HARKIN. And that's fine. I am concerned about making up the gap for next year. Now you've got to come back here again next year with the budget for fiscal year 2011, and I am concerned how you make up that $1.5 billion—I don't know that we are going to have any better allocation next year than we have had this year, and how do we make up that gap of $1.5 billion, because we cut the base. So we are in a bit of a quandary there, and I just—when you say resume, would you look next year at bringing it back up to the 2009 level or would it go higher than that? I mean, I am just trying to figure out where we are headed on this.

Secretary DUNCAN. Well, I think those commitments are really important to me, so how we do it is obviously not the question. I don't know yet, but I want to get those numbers back up and keep them up.

Senator HARKIN. Fair enough. We are concerned about that cut in the base.

Secretary DUNCAN. Yes.

IMPROVING EDUCATION FOR STUDENTS WITH DISABILITIES

Senator HARKIN. Students with disabilities, this is one that we pay special attention to. And we have done well, of course, in the Recovery Act with this money. It's an historic increase. But I am concerned about something that predates you. In 2004, reauthorization of IDEA, there was an allowance that a school district could reduce its special education expenditures by 50 percent of the increase—whatever the increase they got, they could reduce it by 50 percent over what they received in the prior year and spend those funds on any other purpose authorized in the Elementary and Secondary Education Act.

Now, if a school has fulfilled all of its responsibilities to kids with disabilities and is meeting their needs, then I could see that might be fine for them to do that. But in all of the information that we have received, and the things that we have looked at, obviously some schools have done that, but a lot of schools haven't. And if they haven't met the basic needs of kids with disabilities, then I am concerned that if they take that money out, the students won't get the services they need.

So I guess I would just say how—tell me again how your Department is supporting the effective use of the Recovery Act money to improve the education outcomes of students with disabilities and will you ensure the school districts are effectively meeting the needs of these kids before they are allowed to shift that IDEA money?

Secretary DUNCAN. Very simply, I am in absolute agreement with you. And so where States or districts are in compliance, we will give them flexibility. Where States are out of compliance, we will not give them that flexibility.

DROP OUT RATE OF STUDENTS WITH DISABILITIES

Senator HARKIN. Right on. Thank you very much. I appreciate that very much. Again, when we talk about dropout rates, kids with disabilities, right now, are dropping out at a much higher rate, and a lot of this for just lack of supporting services for these kids at school. Almost 34 percent leave school early, and 52 percent of kids with disabilities complete high school. So again, I appreciate your response on that.

I see that my time is out.

EARLY LEARNING PROGRAMS

Senator COCHRAN. Mr. Chairman, thank you very much. Mr. Secretary, the budget requests $300 million for the new early challenge program, providing grants for the development of statewide programs for children from birth through age 5. Some States don't have pre-school programs in place, like my State. Would States like Mississippi be eligible for funding under this program in some fashion?

Secretary DUNCAN. They would be and let me explain how, and obviously, we think this investment in early childhood is—you could make a pretty good case that it is the best investment any of us can make, so we are strongly encouraging it.

So what we are looking for from States like Mississippi, that haven't historically invested, is they can use the stimulus dollars, and they can use title I dollars to do that, and then we can match those resources. So with all the resources coming Mississippi's way, if they invest that in early childhood, that would count as a match.

So there is an absolute opportunity there, but we want the States to start to invest in early childhood. The State needs it, the country needs it.

INCREASING THE HIGH SCHOOL GRADUATION RATE

Senator COCHRAN. In some States, dropout rates are declining. I think in our State they are coming down. But most recent statistics seem to indicate that too many students still do not complete high school.

At what age was your program, again, under the new High School Graduation Initiative?

Secretary DUNCAN. That's a great question. I would argue that it's not one age. The folks in early childhood are helping to prevent that, but that's long term. So I don't think there is one magical age to stop. If you can start with 1 and 2 and 3 and 4-year-olds, that's the best. You know, prevention is a lot better than addressing the back end.

So I would argue that every investment that we are making helps, from early childhood to getting the best teachers to work in the toughest communities, to thinking about turning around schools, to making college more accessible and affordable, and we haven't talked about raising standards that we are pushing very hard on.

I would argue that everything that we are trying to do is with a single-minded goal of having more students graduate from high school, and having more of those graduates prepare to be successful, both in college and in the world of work.

So I wouldn't give you one age, because I think you have to have a comprehensive approach.

PROPOSED MOVE TO ALL DIRECT LENDING

Senator COCHRAN. The budget also proposes that all new postsecondary student loans originate and be serviced through the direct lending program. How do we pay for this entitlement program and ensure that students will not have their maximum grant reduced?

Secretary DUNCAN. This is one that I think, again, we can pay for without asking for any more money from taxpayers because we will basically—again, this is controversial and not everyone agrees—but we will get out of the business of subsidizing banks. We are going to put all of that money into students who are in high school and going on to higher education.

So this is a program that would generate savings, conservatively estimated at more than $4 billion annually, every single year.

And so this is one where we can dramatically increase access for students, and do it without going back to taxpayers, and do it more

efficiently. And this is not, sort of, a big Government idea. We want and we have to have dramatic private sector involvement on the servicing of those loans. We don't want to be in that business. We can't be in that business. So this is a real chance for the private sector to play, and we will reward those players who do a great job in servicing those loans.

Senator COCHRAN. Let me wish you well and assure you that on both sides of the aisle on this subcommittee, we are interested in improving opportunities in education for all students, whatever their financial situation is, or whatever State they come from. And like States like mine, where we have had to struggle over the years to meet the educational needs of elementary and secondary students, that still is an area that cries out for support and assistance from the Federal Government. And I can remember, we used to in my State, it was kind of you didn't want the Federal Government coming in and taking over our schools, and telling us how to teach and all the rest, but the fact of the matter is, a lot of these programs have been very valuable.

My mother spent a career in title I mathematics education, and was a supervisor for schools. My father was a county superintendent of education in the largest elementary and secondary school district in the State of Mississippi. I have observed at close range all of the challenges that face educators and students, alike, in States where there just doesn't seem to be enough money to go around and meet all of the needs that exist.

So we appreciate your efforts and your support for States like mine.

SAVINGS FROM ALL DIRECT LENDING

Secretary DUNCAN. I appreciate your comments. I look forward to working with you.

Senator HARKIN. Thank you, Senator. I might just add, CBO gave an estimate of $96 billion over 10 years, so you might want to talk to Mr. Orzag.

Secretary DUNCAN. I will try to—I was talking to Tom Skelly——

Senator HARKIN. There is Mr. Skelly here.

Secretary DUNCAN. Again, I talked about a minimum of $4 billion and maybe well north of that.

Senator HARKIN. I should have introduced for the record, Thomas Skelly, your Budget Director for the Department of Education. Welcome back to the subcommittee, again, Mr. Skelly.

Secretary DUNCAN. He is the brains of the organization.

Senator HARKIN. Yes. We have met him before. Senator Murray.

PARTNERING SCHOOL PROGRAMS WITH BUSINESS NEEDS

Senator MURRAY. Thank you, very much, Mr. Chairman. I mentioned in my opening remarks my focus on making sure that the skills that we are teaching in our schools actually match what our businesses need. And I often hear from employers in my State, whether it's our high-tech, clean-energy companies or whether it's our boat builders and our construction workers, that the skills don't match between what our students are learning and what they need in their jobs. And I think we have to bridge that gap and as I told you, I will be shortly introducing legislation, again, to bring

together all the players: the employers to the schools to the community; leaders to labor; and business workforce experts to design programs for their own communities, to focus on the employers and the skills that are needed in their own communities.

And I wanted to ask you if you see a place in your budget for promoting those kinds of partnerships for the local level?

COMMUNITY COLLEGE ROLE—ACADEMIC AND JOB SKILLS

Secretary DUNCAN. That's hugely important. I would also say, which we didn't talk enough about, I think the community colleges play a huge role in this, sort of, trajectory of education continuum and I think that's been a really underutilized, undervalued resource. And whether it's high tech jobs or green jobs or healthcare jobs or jobs specific to your area—such as boat building. I was in Miami, and there's a fashion industry there. There is a huge player that I am actually trying to bring in, my under secretary, she was a phenomenal junior college president. I understand there's never been a community college president at that level of our organization. We think that's strategic. I think it's so important that we begin preparing our students for real jobs and building those pipelines and working very closely with those multiple partnerships. In some places you see great, great progress and in some places you don't. But whatever we can do to make sure that those employers are actually helping to shape the curriculum and helping to shape the opportunities that our high school students, as well as our community college students, have. We can't do enough of that. We have to tie education to the real world.

PERKINS LOANS

Senator MURRAY. And we have to look at funding programs that are already there. Then you've got Carl Perkins loans that were level-funded in your budget. Is there any chance for improving funding in that?

SCALING UP WHAT WORKS

Secretary DUNCAN. Again, we have an opportunity not just to—this is a real chance for folks to be creative. In the $4.3 billion Race To The Top Fund, it's all about investing and scaling up what works. The $650 million What Works and Innovation Fund is a chance for nonprofits and local players that partner with districts. So there is a huge chance that where we have demonstrated partnerships that will lead to higher student achievement, for us to invest in them at unprecedented levels and do more of what's working, that's with those pools of money.

TEACHER INCENTIVE FUND

Senator MURRAY. I look forward to further conversations with you on that. You mentioned in your remarks to literacy and Striving Readers Act, which I introduced with Senator Sessions and I wanted to make sure that—I am not sure about my time. I want to ask you another question. But I would like to have an opportunity to talk to you in the future about that, and how you are going to include both adolescent and early literacy grants in the

proposal, but with the few minutes I have left, I did want to ask you about the proposal for the Teacher Incentive Fund.

It's a very large increase that you've asked for and it's going to grow the program five times the funding it currently receives to about $520 million. That program already received an additional $200 million this year in stimulus funds.

Now this administration often has stressed to us the importance to implementing reforms that we know and can prove are effective. So can you tell me what the research base is, where it shows the effectiveness for the incentives for teachers, that justify an expanse for growth in that program at such a high rate?

Secretary DUNCAN. It's a great question. There are two themes that I am going to keep coming back to. One I talked about is time. We need more time with our students. The school day, the school week, the school year is too short.

The second one I fundamentally believe is we have to invest more in our teachers. And there is a tremendous body of research that great teachers, great principals matter tremendously. And there are studies that I have seen that talk about where the average student has three great teachers in a row, that child is a 1 ½ to 2 years ahead of grade level. The average child that has three poor teachers in a row can be so far behind that it's hard for them to catch up.

FOCUS OF TEACHER INCENTIVE FUND

So I worry a lot about—we talk a lot about the achievement gap. I am more interested in what I call the opportunity gap, of how we get the best and brightest educators.

Senator MURRAY. Yes. I don't think anybody at all disagrees with the goal. I am just asking if you can provide us with some studies that show that the incentives actually are what makes those core teachers better.

Secretary DUNCAN. I would be happy to do that. It's not just making core teachers better. That's why I was trying to go to the next step. What it does is, we want to create incentives for the best teachers to go into the most underserved communities.

Senator MURRAY. So that's the focus of the program?

Secretary DUNCAN. That's a piece of it. It's both developing talent and creating incentives. And I can just say from personal experience, in Chicago, where we did this, we only put this program in hard-to-staff schools that had significant turnover, and we only put the program into schools where 75 percent or more of the teachers asked for it.

Senator MURRAY. Okay. Can you explain to me that you put a significant amount of money forward that has not been through authorization, can you tell me what safeguards are going to be in there against some subjective awards, or awards that are only based on test scores since you are putting this money out there?

Secretary DUNCAN. Absolutely. We can sit down and walk through it very, very carefully with you. And in any good program, test scores are never the only thing you evaluate.

TEACHER INCENTIVE FUND COMPETITIVE GRANTS

Senator MURRAY. My concern is that the program that goes out to the States, so it sounds good when you say it to us, I just want to know how it's going to be implemented?

Secretary DUNCAN. Let me be clear. The money is not going out to the States. This is going out on a competitive grant basis, so folks are going to have to apply to us. So we can walk through with you what our request for proposal is going to look like and what our criteria will be for evaluating those proposals.

So this is not money that is going to go out willy-nilly. We want to invest in those places that we think are doing this the right way. We would be happy to sort of walk through——

Senator MURRAY [continuing]. It's not just going to be test scores and——

Secretary DUNCAN [continuing]. Again, that never—let me be clear on two things. One, it can never just be about test scores. Second, it cannot pit teachers against each other.

Senator MURRAY. Okay. So I would like to, at some point, work through it with you so I understand how that is going to work.

Secretary DUNCAN. Absolutely.

Senator HARKIN. Senator Landrieu.

SCHOOL REFORM

Senator LANDRIEU. Thank you. Mr. Secretary, I just can't tell you how encouraged I am by what I have heard this morning. I just really believe you are the right person to lead this effort, and I am so encouraged with President Obama's continued focus, amidst all the other things that he's got to do, but he comes across to me and to many of us as just unrelenting, which is the way I think he should be, and obviously you are, on reforming a school system in crisis. And reforming a school system that is in such a state right now that is it unable to support the economic growth of this Nation. And the bold vision that you have outlined, I generally support, and I want to let you know that.

CHARTER SCHOOLS

I have a comment though, if you could take a minute to explain to me and to the subcommittee a little bit about why the President's and First Lady's first visit, they stopped at charter schools. What is it that they see that we need to know about? Because there are some questions, as you know, about this issue around the country. We have had very good experiences with what we call independent public schools. But tell us for a minute about why you and the President feel so strongly about this direction.

Secretary DUNCAN. It's a piece of the answer. It's not the answer. This budget, we didn't mention, includes an additional $52 million for charter schools. Let me tell you what we need. We don't need more charters, we need more good schools in this country. And for charters to be good, I think three things have to happen.

First, you have to have a very high barrier to entry. This is not let 1,000 flowers bloom. And if you do that, you just perpetuate the status quo. So, you only pick the best of the best to open schools. That's like a sacred obligation, a chance to educate children. That

should not go to everybody. That should go to the small percentage, the absolute best.

Second, after you set that high bar, you need to give these educators real autonomy. These are by definition entrepreneurs and innovators. And you need to give them room and freedom from bureaucracy.

Finally, you need to tie that real autonomy with real accountability. You have to have performance contracts. Obviously I am a big fan of charter schools, but I closed three for academic failure.

And so I think if you have just autonomy without accountability, you don't get there. If you just have the accountability without the autonomy, nobody would want to play. So you need to get those three conditions, and that doesn't happen that way all around the country. I think you guys are doing a great job of it in Louisiana and New Orleans. But when those three things happen, you generally have some very high-performing schools in some of the most underserved communities in our country—inner city, urban, and rural.

And so I think that it is not, by any means, the answer, but when done well and when done right, thoughtfully and strategically, it is a piece of the answer. And I think what is going on in your State, and New Orleans, specifically, is a fascinating example of what's possible when things are done the right way.

EARLY CHILDHOOD EDUCATION AND SPECIAL EDUCATION

Senator LANDRIEU. Thank you. My second question is about the disability issue and program, and Senator Harkin is such an extraordinary leader, and I try to be supportive where I can be, but I want to just share from my experience, Mr. Chairman, as the chairman of the D.C. subcommittee at some point. We looked into the disability, the cost of the disability program here in the District. And my staff is going to be getting me some specific numbers for the record, but I believe, if my memory serves me correctly, that the cost per student here is somewhere between $20,000 and $40,000 a year. Is that your understanding of the students in the District that are going to outside of the public system? And Mr. Skelly, do you know what the numbers are?

Mr. SKELLY. Senator, those numbers sound about right, but I am not aware of them specifically.

Senator LANDRIEU. I am going to ask the staff to get those numbers on the record, because the point that I am making here is that if we don't get on the front end of this situation, which is, I think, what your budget is attempting to do, which is investing in early childhood education, keeping children, Mr. Chairman, from getting an inappropriate and unnecessary label as dysfunctional just because they can't read. And then they get into a trap that is actually unsustainable for any budget to continue. It's a totally different issue than trying to provide basic services, which the Chairman on our committee will insist be given.

So I just want to lay the record down that we need to find those numbers out, because it's unsustainable at the $20,000 to $25,000 a year.

READING SKILLS AND SPECIAL EDUCATION

Secretary DUNCAN. I would argue that in many places, it's much higher than that. And as you know, so many children go into special education because they are labeled LD, learning disabled——

Senator LANDRIEU [continuing]. A lot of times they can't read——

Secretary DUNCAN [continuing]. And that means they can't read. So if we teach our children to read, they don't go into special education. And what's amazing to me is you almost never see anyone exit special education. Once you go in, in many cases, you are there forever. And so the right thing to do is to do a much better job on the front end, and it is right for multiple reasons, but if we could have—if we could reduce over time the numbers who are going into special education because they can't read, we will be doing those children a tremendous service.

Senator LANDRIEU. Thank you, Mr. Secretary.

Senator HARKIN. Thank you, Senator. Senator Kohl.

HIGH SCHOOL DROPOUTS

Senator KOHL. Thank you, Mr. Chairman. Mr. Secretary, as you sit here this morning, one of the most urgent crises that we face is the epidemic of high school dropouts and the fact that No Child Left Behind did not do very much to address this problem.

DUAL ENROLLMENT PROGRAMS AND DROPOUTS

Many ideas are proposed to increase high school graduation rates and better prepare our students for college. I have been talking about additional Federal support for what they call dual enrollment programs to help low-income students get on a fast track to get a high school as well as a college degree.

As you know, these programs help students. They save time and money on college courses while building the skills and confidence they need to succeed in the college environment. The President has expressed his efforts to help high school students begin earning college credits.

Do you anticipate increased support for early college and dual enrollment programs?

BENEFITS OF DUAL ENROLLMENT PROGRAMS

Secretary DUNCAN. Senator Kohl, I am very familiar with that work under your leadership, and I want you to know how much I appreciate it. It does a couple things for students, and I will tell you how we will support it, but let me tell you why I think it's so important.

First of all, in these tough economic times, having students get that college credit in their back pocket before they go on to college will save the high school student significant money.

The second thing it does, which I think is probably more important, particularly for children who might be first generation going to college, and English language learners, it helps them really understand in their heart, that they can be successful at the college level. They really can do it. Some of these children reach a psychological barrier, that they are academically prepared, but because they don't have family members who have taken that step, they

don't believe they can do it. And when they have that dual enrollment or dual credit system as a 10th, 11th, 12th grader, they know they can be successful at that collegiate level.

So there is a huge opportunity in both the $4.35 billion Race to the Top Fund for States, as well as the $650 million Innovation Fund for districts, community colleges, universities, cities, whatever it might be, to come together and expand upon those programs that are working. I think that's a very significant investment.

Senator KOHL. In terms of priority, the program seems to me should have a very high priority, if we talk about encouraging our high school students that aspire to going to college, and to more than talk about it, to give them a way in which they can start down that path.

What kind of a priority do you have on that?

Secretary DUNCAN. Dual enrollment is one of our FIPSE competitive priorities in fiscal year 2010.

INCENTIVE PAY FOR TEACHERS

Senator KOHL. Thank you. On the teacher incentive fund and merit pay, during your time in Chicago, how did you work with teachers and unions to get this kind of a system up and going and implemented? What did you learn?

Secretary DUNCAN. As I said, the only way—I know Senator Murray has some concerns, so I should have addressed this more clearly while she was here, the only way this works is when you do it in collaboration. And actually what we did in Chicago, is we had a set of the best teachers in the system who started an advisory council for me, they actually set the program up. So it was absolutely teacher led.

They figured it out. They went out and met with schools around the city and they applied for the grant through the Department of Education and did a phenomenal job. I think we were awarded the largest grant in the country.

And it's interesting. You do all this hard work, and you think you have a good idea, but at the end of the day, you don't know if anyone is going to be interested. We had 120 schools show interest and we would only go to schools where 75 percent of the teachers wanted the program. And at most of the schools we picked, 95, 98, 100 percent of the teachers asked for it.

So this is driven by great, great teachers. They want to be rewarded. They want that excellence, to shine a spotlight on that, and they want to get more great teachers into underserved communities. So this is a perfect opportunity for collaboration. And there can be tough conversations or differences of opinion, and that's part of the process. But the program we did in Chicago was created and established and led by a set of the best teachers in the city.

ADDRESSING IMMEDIATE FISCAL NEEDS AND SUSTAINABLE REFORM

Senator KOHL. Good. As you know, the Recovery Act passed by Congress contains billions of dollars for one-time funding for public schools. In many States, such as my own State, they are facing serious budget constraints and struggling just to preserve jobs and maintain existing education services. As you administer the funds provided in the Recovery package, how will you help States invest

in sustainable improvements while also addressing their immediate fiscal concerns?

Secretary DUNCAN. Right, and sometimes people can see that as a tension, and I think this is a real test of leadership and creativity. So it is, you know, times of crisis that provide us a huge opportunity. We have to be thinking about both. Let me give you an example, on the IDEA funding, unprecedented resources, how can you spend that money wisely? I would argue that one of the best things that we can do is invest a massive amount of money and train all teachers how to better work with special education teachers. I think we have had this divide between special education teachers and regular teachers, and the fact of the matter is so many of our regular education teachers have special education students in their classroom, and don't know how to do a good job with them. And so I think that's one area where the benefits for those teachers and school systems will far outlast the availability of those funds.

And so we want to work very, very hard. You see, again, I talk a lot about time. You know, thinking differently about time. You see lots of school districts trying to figure out how to do more over the summer, more on the weekends, more on Saturdays, and bring in nonprofit partners and build sustainable programs, where schools are open 12, 13, 14 hours a day. Where the money can be a catalyst by bringing in all these outside partners, you have a huge leverage on those resources.

So we are going to continue to provide guidance. We are going to highlight examples of success, like Cincinnati, that added what they call a fifth quarter, this summer, now, for their students, keeping them a month longer after the school year ends. We are going to continue to provide those kinds of best practices as examples for folks around the country.

PREPARED STATEMENT

And, you will see some real innovation. And you will see some folks that are paralyzed by the crisis, and this will be a real test of how leadership handles a tough situation and an opportunity, and I would argue that the nexus of crisis and opportunity gives a huge chance to push for the kind of dramatic change we need.

[The statement follows:]

PREPARED STATEMENT OF SENATOR HERB KOHL

Thank you, Mr. Chairman. Mr. Duncan, I join my colleagues in welcoming you here today. I appreciate the difficult task you face in improving our public education system, particularly in light of the fiscal constraints we face during this recession. As we seek to maintain America's competitiveness in the global economy and guarantee our children their chance at the American Dream, I believe your task is more important than ever.

As you know, one of the first orders of business must be to reform and reauthorize the Elementary and Secondary Education Act, currently known as No Child Left Behind. I initially supported this legislation because it guaranteed increased Federal funding and flexibility in exchange for real accountability from schools. However, over the years, funding levels have fallen billions short of what was authorized, and schools are struggling to meet the law's requirements without the necessary resources and evidence-based solutions to meet ongoing challenges. To make matters worse, Congress also has not provided the funding promised to States for special education under the Individuals with Disabilities Education Act. This chronic under-

funding of our public schools has caused serious hardships nationwide and makes it extremely difficult for teachers and students to meet their goals.

I am hopeful that President Obama and this Congress will make school funding one of our Nation's highest priorities. Although the current economic crisis requires fiscal prudence, I believe education is one of the best investments our Nation can make to ensure future economic growth and stability. I am also hopeful that, under your new leadership, the Department of Education will use Federal funding to foster innovative ideas and new policy solutions to ensure that all students have the opportunity to fulfill their potential—regardless of the State or neighborhood in which they live. I look forward to working with you and the President as we work toward these important goals.

Senator KOHL. Thank you so much. Thank you, Mr. Chairman.

Senator HARKIN. Thank you Senator Kohl. We call Senator Pryor.

STATEMENT OF SENATOR MARK PRYOR

Senator PRYOR. Thank you, Mr. Chairman. And Mr. Secretary, thank you for being here. I first want to start on the stimulus spending and say that the feedback from the Arkansas Department of Education and educators in our State are very positive on that and we appreciate your help and your Department's cooperation and assistance. And I am sure a lot of other States have had that same experience, and we want to thank you for that.

Secretary DUNCAN. We will try and keep it that way. Just one plug for our staff. They have done a phenomenal job. Folks are applying, and we are committed to turning around the applications in 14 days, and we have been doing it in 6. Our staff is working nights and weekends and I couldn't be more proud of their collective effort.

Senator PRYOR. That's very un-Federal and un-Government like, and that's good.

Let me also mention just one concern, and that is, our State Department of Education has put a lot of requirements and very stringent guidelines on the money to make sure it is going to the right places and doing the right things. And we understand that there is going to be an audit of that, and that's great. Everybody should welcome that. But the only thing is that I would ask, that your Department coordinate with our State departments around the country to make sure that we are auditing the same things, and that we are focused on the same things.

Secretary DUNCAN. I would be happy to go over that with you. With unprecedented resources you want to have unprecedented transparency and real clarity and visibility to see how every single dollar is being spent.

Senator PRYOR. Right.

Secretary DUNCAN. And as much as we coordinate and work together, and not waste and not overload and not duplicate resources, that makes a lot of sense.

ADDRESSING THE DROPOUT PROBLEM

Senator PRYOR. Exactly. Thank you very much for that. I also want to follow up on something that Senator Cochran mentioned earlier about dropouts and how that has been a real challenge for the Nation, and you mentioned about the drag on the economy and problems that that causes long term. I think you guys have set

aside, what, $50 million for a new high school graduation initiative, and how did you arrive at that figure and how do you envision that money being spent on that?

Secretary DUNCAN. That is a piece of the money, again, I would mention the $5 billion school improvement entitlement money that we really want to focus on this. And I think as a country, we have shied away from the complexity of this and the difficulties of this, and I think we do that at great detriment to those children, and at great harm to our Nation's economy long term. So I want to confront this front and center.

And again, when you look at the data, it's fascinating. The economic costs are staggering. When we think about 2,000 high schools producing half the Nation's dropouts, and 75 percent of the dropouts are minority children, that's a number you can get your hands around. You can't tackle every school tomorrow, but if we could systemically, year after year, come back and do something dramatically better, not just for those high schools, but those feeder elementaries as well, I think we could turn this around.

And what we have, why I am optimistic, is we have in every rural community that's poor, and any inner city urban community, while we have these "dropout factories" we also have schools where 95 percent of students are graduating, and 90 percent of those that graduated are going on to college. So we know what works. We know what is successful out there. There are more good examples out there today than ever before, and what we want to do is scale those up, invest in those best practices, and give more students those kinds of opportunities.

So this is a tough battle, but it's absolutely the battle I think we need to fight and I am committed to being in it for the long haul.

Senator PRYOR. And it's another example of where the public schools, the apparent demographics of the population that we are serving presents a lot of unique challenges and circumstances around the country.

THE GRADUATES ACT

Let me just let you know about something, if you don't already, and that is, last year, Senator Harry Reid and I had a bill, we called the Graduates Act, and basically what we were trying to do is come up with a way to incentivize and reward, innovative partnerships to try and keep people in school with the public and private sector. Are you familiar with that?

RAISING COLLEGE GRADUATION BY 2020

Secretary DUNCAN. Yeah, and we want to build upon all those—everything we can do to have students not just graduate from high school, but go to college; but not just go, but graduate from college. We have to. That's what this work is about at the end of the day, to try to dramatically drive up our college graduates by 2020. We have to take steps every single year, and I appreciate your leadership in that effort.

Senator PRYOR. Well, I just—that was a little bit before your time, before you got here, and I just wanted to make sure you were aware of it.

SAFE AND DRUG-FREE SCHOOLS STATE GRANTS

There are some grants that serve at-risk populations that the administration has eliminated or has proposed elimination of that deal with safe and drug-free schools. Could you talk a little bit about that?

Secretary DUNCAN. I did. I talked about it in my statement. That what we saw was that money we put out—obviously those are big issues for me, both trying to keep our schools drug-free, but also dramatically reduce violence. We found through research and doing evaluation of this money that we put through the States, there wasn't much effectiveness there. But money we put out directly to districts and schools, we saw more effectiveness. So we basically eliminated the State grants and put an additional $100 million into a national program.

So I was trying to be more strategic: same goals, same commitment. We are trying to be much more targeted in getting those resources where it needs to happen.

Money was dribbling out to States, and we just weren't seeing in objective research, in evaluative studies, we weren't seeing the impact we want.

Senator PRYOR. Do you feel like you have good ways to measure that? Are you confident in your ability to measure that?

Secretary DUNCAN. Yes, I am pretty confident we can measure that.

Senator PRYOR. Thank you, Mr. Chairman.

Senator HARKIN. Thank you, Senator Pryor. Senator Specter.

Senator SPECTER. Thank you, Mr. Chairman. I join my colleagues, Secretary Duncan, in welcoming you here. You have taken on a tough job. I have had the opportunity to work on this subcommittee for many years, and it's very, very difficult.

PROPOSAL TO MOVE FFEL TO ALL DIRECT LOANS

I would like to start by asking you about the Federal Family Education Loan Program, where the proposal has been made to have direct loans as of July 1, 2010 and questions have been raised in my State by the folks in the Pennsylvania Higher Education Assistance Agency as to whether that can be implemented in that length of time, and whether the allocation of funding set at $500 million per year would be adequate to take on the services which are currently provided, including early awareness, financial literacy training and counseling programs; and what will happen to the very substantial number of employees who are working for not-for-profit in public agencies in their State. So it is a sweeping change. No doubt this is a very important program, and necessary to keep young people in school, especially given the economic problems of today.

How do you propose to address those very serious considerations?

SAVINGS FROM MOVE TO DIRECT LOANS

Secretary DUNCAN. Yeah, so there are a couple pieces. First is by making that switch from FFEL to direct lending, we can dramatically increase the amount of money going out to students directly, you know, in Pell grants. So we are anticipating savings of over $4

billion a year, and at a time when going to college has never been more important, as you know, it's never been more expensive and families have never been under more financial duress.

So we can sustain indefinitely, dramatically higher levels of funding for students without going back to taxpayers for another dollar. The $2.5 billion over 5 years, to help work on not just access, but on completion, actually significantly increases the amount of resources that will go out to nonprofits. It will help keep those students in school and build a culture at universities where it's not just about access, but it's about attainment, making sure students know what the opportunities are and in making sure they graduate.

LOAN SERVICING UNDER DIRECT LOANS

So we think these are the right investments to make. On the servicing of loans, we don't want to get into that business. That is all going to be done by the private sector. We don't want to get into that. We have no expertise in it.

PROGRAMS PROVIDING TRANSITION TO COLLEGE SERVICES

Senator SPECTER. Mr. Secretary, how about programs that I stated and enumerated on: early awareness, financial literacy training, counseling programs, will they be maintained under the changed program?

Secretary DUNCAN. I think more than maintain, we want to actually enhance. We want to do more than that.

Senator SPECTER. Do you have more than the $500 million, which is currently allocated here?

Secretary DUNCAN. Well, that's a starting point. I think that's a very significant investment and to be able to do that every year over the next 5 years gives us a huge opportunity to better inform and better help students understand what their options are.

IMPACT ON EMPLOYMENT

Senator SPECTER. How about the large number of employees? Would there be some effort made to transition and accommodate the 2,200 employees who are in my State, and who are of great concern to me?

Secretary DUNCAN. Well, again, it depends what business they're in—on that side, we think there will be a growing market. We are going to need more folks doing this work and we think we are actually going to increase the market share for the folks working on the servicing of loans. And so we are hopeful that the job loss will be minimal and we're actually going to create jobs in those two areas.

GEAR UP PROGRAM

Senator SPECTER. Mr. Secretary, shifting to another program. There has been an operation called GEAR UP, which was originated by Congressman Fattah on the House side. And this subcommittee has provided very substantial funding of $300 million a year and the program has been in existence for 7 or 8 years now. So it has really taken off. And these are at-risk students, and they tie into efforts which this subcommittee has taken the lead on men-

toring. So many single parent families, working mothers, children at loose ends, not afterschool care, and efforts have been made to find adult mentors in the community, this ties into many facets of their lives: the learning program, the delinquency issue, the crime problems, and I would be interested to know what thought you might have of your Department supplementing efforts now being undertaken.

Secretary DUNCAN. I am a big fan of the GEAR UP program. We were a large beneficiary of that program in Chicago, and for all of the reasons you said, these are students who desperately need that help and need the chance to be supported in that transition from high school to college, and so we are going to support those efforts going forward.

IMPORTANCE OF MENTORING

Senator SPECTER. How about the mentoring aspect?

Secretary DUNCAN. That's hugely important. Our children need adults in their lives to help them to understand what their options are, and doing the hard work with them every single day to stay on track.

Senator SPECTER. Thank you, Mr. Secretary. I'd appreciate it if I could have your commitment to take a personal look at how the Direct Loan program is going to go, to accommodate as best you can the kinds of concerns I have raised.

Secretary DUNCAN. You have that, and I would be happy to sit down with you further and discuss exactly what's going on in your State.

Senator SPECTER. Thank you.

BASIS FOR AWARDING LOAN SERVICING CONTRACTS

Senator HARKIN. I just want to echo a little bit what Senator Specter just said here. The last thing I want to see happen is to see Mr. Lord get more money to buy—to build more private golf courses for himself. You know, this whole scandal that happened at Sallie Mae was awful. If someone can make that much money off the back of students, that just shouldn't be allowed. Now again, because Sallie Mae has gotten so big, because of the subsidies that we have given to Sallie Mae over the years, now they are able to undercut everybody else. So, it does require some more looking into.

If just the cost is the only basis on which we are going to award these service contracts, then Sallie Mae can undercut everybody. But, my gosh, we are the ones who gave them all these subsidies all these years so they could get that big.

Secretary DUNCAN. It just can't be cost. It is going to be cost and ability to help those students.

Senator HARKIN. Exactly. I appreciate it.

Secretary DUNCAN. You have to look at both.

Senator HARKIN. I appreciate that.

Secretary DUNCAN. You have to look at outcomes.

SUSTAINING RECOVERY FUND INITIATIVES

Senator HARKIN. And outcomes, exactly right. Exactly, Mr. Secretary. Mr. Secretary, you mentioned Cincinnati has increased the school year by a month?

Secretary DUNCAN. Yes.

Senator HARKIN. Well, that's pretty good. My question is where does the money come from?

Secretary DUNCAN. The stimulus.

Senator HARKIN. Stimulus money? So what are they going to do when the stimulus money runs out?

Secretary DUNCAN. Well, we will cross that bridge when we get there. But, this is the right thing to do for children now and it keeps students at-risk in school. It keeps teachers teaching. And what I would argue is that every dollar, historically, hasn't always been used really wisely, and you are going to see some innovation with stimulus dollars, and if these things work—I am very optimistic. Obviously we don't have any data yet, but what I would argue is if districts and States start to do some creative things with stimulus dollars, that might change their allocation and their strategic use of their dollars once that money is gone.

LONGER SCHOOL YEAR

Senator HARKIN. Don't misunderstand me. I happen to be one of those in favor of a longer school year. I think the school year ought to be 11 months.

Secretary DUNCAN. Twelve.

Senator HARKIN. Well, I am all for giving them the month of August, 3 or 4 weeks in August, that would be fine. But I do believe that it should be longer. And we have got to get to that point. It is just not right what we are doing with these kids today.

Secretary DUNCAN. And again, I think this is one bit where we have not had as much creativity as we need. And more and more, the data is showing this. And if we can use stimulus dollars as sort of the impetus to get this gain, I think folks will start to think about how they are using other resources and start to allocate more funding in this direction. But this opens that door, which I think is so important.

Senator HARKIN. Well, let's open the door further. I would, both on this subcommittee, as Chair of the subcommittee, but also on the authorizing committee, we ought to be saying what we can do over the next few years to expand that school year? We have got to do this. We just can't keep on like we are.

Secretary DUNCAN. I appreciate your leadership on this issue. I think it's a big, big deal.

Senator HARKIN. I don't know if I am much leadership, but I got a lot of support for you. I can put you out there on the point, Mr. Secretary. We'll be right there backing you up.

RECOVERY ACT DISCRETIONARY EDUCATION FUNDS

Let me ask you a little bit more about the Recovery Act. It provides that you get more money for discretion than any Secretary of Education has ever had. This is your money and you can just

sort of do with it as you wish, $4.35 billion for the Race To The Top Fund, $650 million for What Works and Innovation Fund.

RACE TO THE TOP FUND GOALS

Again, this can be powerful incentives. Again, we don't really have many details on what you plan to do with it. On the Race To The Top Fund, I mean, let's fast forward a few years. I mean, if we go ahead 5 years, what will you hope to have achieved, and how will we know if it has worked? What will be different in terms of what districts and States do in education?

Give me some idea about this Race To The Top.

Secretary DUNCAN. What we want to do—what I think, historically, what we have a bit is the race to the bottom. And that has really hurt our country and hurt our economy and hurt our children, and we want to fundamentally use these dollars to reverse that. And the Race To The Top means it's not by accident.

What we want to do, let me take the $4.35 billion first and I will come back to the $650 million. On the $4.35 billion, we want to work with a set of States that are willing to lead the country where we believe we need to go. There are four areas we are looking at.

SETTING HIGHER STANDARDS

One is we want to see higher standards. I have been arguing pretty vociferously that in too many States, due to political pressures, standards have been dummied down and watered down, and that in fact, we have been lying to children. Let me take 1 minute on why I say that.

When you tell a child that they are "meeting a State standard," the logical assumption by that child and that parent is that child is on track to be successful.

In far too many places, including the State I am from, from Illinois, those children who are "meeting the standards" are barely able to graduate from high school, and absolutely inadequately prepared to go to a competitive university, let alone graduate.

So we want to talk about common, college-ready, career-ready, internationally benchmarked standards. Really raising the bar there.

DEVELOPING COMPREHENSIVE DATA SYSTEMS

Second, we want to talk about comprehensive data systems, so that you can't lose children throughout the educational trajectory. You have to know how they are performing. You want to be able to track students to their teachers, to know which teachers are making the biggest difference in their students' lives, and you want to be able to track teachers back to their schools of education, so you can know which schools of education are producing the teachers, who are producing the students that are learning the most.

INVESTING IN TALENT

Third, we want to invest deeply in talent. Great teaching, great principals matter tremendously. And how do we think about getting the best and the brightest to work in the communities that have been historically underserved—rural, inner city, and urban?

We have had a shortage of math and science teachers for how long? A couple of decades? I would like to pay math and science teachers more. Some people disagree with me. I think we need to end that. And how can we create the next generation of engineers and mathematicians and people who are going to create the breakthrough technologies if they are not being taught by the teachers who know the content?

So really working with States that are willing to think differently about talent, getting the best and the brightest where we need them, awarding excellence, thinking about areas of critical need.

HELPING STRUGGLING SCHOOLS

And then finally, I keep coming back to this idea of struggling schools, and I want to take just 1 second on this. We have about 95,000 schools in our country. Let's call it 100,000. What if we took the bottom 1 percent, the bottom 1 percent of schools each year——

Senator HARKIN. You mean bottom in what way?

Secretary DUNCAN. One thousand schools, dropout factories, low gain, students not learning, basically just simply not working; and we can figure out State-by-State what that would look like. What if we took their bottom 1 percent every year and just fundamentally turned them around? Stop tweaking around the edges, stop looking at incremental change, but really trying to attack this dropout program full, square on, at both the high school, middle school, and at the elementary level.

What we want to do is look at those four reforms and work with a set of States and invest hundreds of millions of dollars in those States that are willing to lead the country where we need to go. This is really about having courage, and having the will to challenge the status quo in some areas.

RACE TO THE TOP—REQUEST FOR PROPOSALS

So in the next 2 months or so, we will issue a request for proposal to States. We will look at how they are making progress against these things, and we want to have a set of States, again, lead the country and set an example of what is possible.

On the $650 million, the Innovation Fund, investing in what works——

Senator HARKIN. Let me interrupt. So the request for proposals, when you put those out, and you are going to do that within the next month?

Secretary DUNCAN. Two to three months. We want to be very thoughtful about it, so we are spending lots of time thinking about it now.

Senator HARKIN. Okay. So they will include specific areas of focus in the requests?

Secretary DUNCAN. Yeah, and these echo and mirror the assurances we look for on the stimulus dollars, under the Recovery Act. These are the same areas. We are trying to be very, very consistent in our message. We ask States to make a series of assurances to receive stimulus dollars, and this RFP, this request for proposal, will mirror those same assurances. So we are trying, again, to be laser-like focused on those things that we think will make the biggest difference.

INVESTING IN INNOVATION

Senator HARKIN. Now the $650 million?

Secretary DUNCAN. The $650 million is not focused on States. It's focused on districts and nonprofits. So this is trying to—again, we have so many districts and we have so many schools and we have so many nonprofits that are making huge differences in students' lives.

For me, what's so helpful is that I don't think I have to come up with any great ideas. I think all of the great ideas are out there. We need to listen. We need to learn. We need to invest in what works and scale it up.

And what our challenge is and opportunity, I think, Mr. Chairman, is this. We have these huge pockets of excellence. We have these islands of excellence. I want to take those to scale. If something is working, I want to give more students, more teachers, more communities the opportunity to benefit from that.

We are seeing this flourishing of innovation in education over the past 10, 15 years. We have wonderful examples of what is happening, but they are all constrained by resources. If we can significantly invest in those and give more students, more teachers and more schools, more districts, more communities those kinds of opportunities, I just simply want to invest in what in those programs have demonstrated an ability to make a difference in students' lives. That's the purpose of this $650 million.

Senator HARKIN. Thank you very much. I will come back to that, but first I want to yield to Senator Reed.

ACCESS AND COMPLETION INCENTIVE FUND

Senator REED. Thank you, very much, Mr. Chairman, and welcome Mr. Secretary. And let me first raise a question that I suggested in my opening comments. That is that the Access and Completion Incentive Fund is something that we are all excited about. In your own statement, you suggest that it is going to be built on some form of the LEAP and GAP program that we passed last year. And I wonder if you might go into some of the details, Mr. Secretary?

Secretary DUNCAN. Yes. I think these are really complementary. What the LEAP—and this is your baby, so you well know that LEAP can help some States do more to create need-based aid, not just merit based, so really helping those students who are poor. And again, what I want to do is not just help give them access, I want to drive up completion rates. I want to work on attainment. So what these resources will do, it will go through States to universities, to really build a culture that helps those—probably help those very same students that your program is supporting—those students who come in, who may not have had family members who have gone to college, who might be English language learners, and so for me, the goal is not just about access. It's about completion. I think that these two, could actually be very, very complementary and mutually reinforcing.

Senator REED. Well, part of this whole process is making children aware, really, of their potential to go onto higher education, and also, to try and incentivize the State to put more money in

what are very difficult times. So anything you could do to coordinate those programs, make them work in tandem, not just to get them there, as you said, both financially and academically.

Secretary DUNCAN. It's really interesting, not to belabor the point, but as you well know, universities are actually, to me, a lot like high school. You have some high schools that do a great job on graduation rates, and some that don't. There are some colleges that do a great job in working with at-risk students and help them to graduate, and some don't. Again, we have to scale up those best practices. And I will tell you honestly, that we tracked this data very closely in Chicago, and we started to steer our graduates away from some universities, and towards others. Because as we looked at the data, we saw that some universities that would have—you know this type of population, this GPA, this class rank, this SAT score; 90 percent of those students were graduating, and at another university, 50 percent were. I mean, huge disparities from very similar populations.

And so the more we can share those best practices, and get more universities thinking about this—you know, we have done very little to incentivize universities to graduate students. We give them lots of money to get students in the door, but we haven't done enough on the completion side. And that's where I want to continue to focus every single year.

Senator REED. Thank you. Let me turn the page literally to another issue, and that is I commend you for the economic recovery package, getting money out. As you pointed out in your opening statement, preserving employment and preserving opportunity for students in thousands of communities, both large and small, across the country.

The first round was, essentially, to get the money out to plug gaps. And the second round, though, I think you are going to have to look closely at how that money has been spent, so that it is truly honed in on the objectives and the outcomes and the reform that you emphasized.

Can you give us an indication of how you are going to look at the second round of funding, and tell what judgments you will make?

Secretary DUNCAN. Sure. And it's a great question. We intentionally did not put out 100 percent of the money. We put out a lot because there was desperate need and we wanted to stave off this educational catastrophe. And again, coming from my previous job, you want to give States and districts the opportunity to plan for the upcoming school year and not have that uncertainty.

You are exactly right. As we go into the second round, let me be clear, where States are doing the right thing, and being creative and innovative, that's right. And we will continue to support them.

Where States have acted in bad faith, or are playing shell games or doing nothing, we have the ability to withhold that money.

And further beyond that—so that's the stick. And we are prepared—don't want to use it—but we are prepared to use it if need be.

And the second part of that—the carrot, as Mr. Chairman brought out, is that we have these unprecedented discretionary resources, you know, $4.35 billion Race To The Top, $650 million In-

vest in What Works Innovation Fund. And I will tell you, States that are trying to game the system or are playing shell games or act in bad faith, they will basically eliminate themselves from those further competitions, and deprive their States of unprecedented new resources coming in.

And so we are trying to work with both carrots and sticks to encourage States to do the right thing by their children.

Senator REED. Well, I think that's a very important message to get out today because States are under excruciating fiscal pressure. And the pressure to just get through the day is so excruciating that unless you lay down clear guidance and clear markers, from what you said today, I think that they will succumb to that.

Secretary DUNCAN. Yeah. We are trying to be absolutely, explicitly clear. We will continue to do that, and again, we are not looking for a fight. But we are prepared to have that, if need be.

This is too big of an opportunity for our Nation's school children to mess around.

IMPROVING LITERACY THROUGH SCHOOL LIBRARIES

Senator REED. Let me raise another issue, Mr. Secretary, and that is that with my colleagues, we work to improve school libraries, and not only just for the sake of the library, but for improving literacy. And we have had some very impressive results in terms of demonstrating increases in literacy. I know that the budget is rather slim, about $19 million, I think. The grants that have been put out, I think they were roughly 496 applicants and only 60 were filled because of the budget limitations.

And the other aspect to the legislation is that if we ever reach the $100 million mark, and it's a formula in every State, but a few States, the District of Columbia has never yet received a grant. So again, a difficult set of priorities. I would like to work with you to see if we can put some more resources on the program.

And also, to validate the effectiveness of this proposal.

Secretary DUNCAN. Yes. I appreciate that and we can look at that line item again, I would—I am happy to work with you in that, but with stimulus dollars, with Race To The Top dollars, it's a huge opportunity for States and districts to invest in creative ways. They have title I dollars, an unprecedented resource on the table, if folks can think about—not just line items, but how they can strategically use all of these resources to arrive at a common agenda. And that's a huge potential avenue for schools to improve.

Senator REED. I think just your sort of emphasis on school libraries and their role in literacy, together with those other resources might be a very important ingredient in this program.

Secretary DUNCAN. I appreciate that.

Senator REED. Thank you, Mr. Chairman.

RACE TO THE TOP FUND COMPETITION

Senator HARKIN. Back to the RFP, the request for proposals, how many do you expect to award; do you have any ball park idea at all?

Secretary DUNCAN. I really don't. Again, we are going to set a high bar, and so this is not—we are going to say "No" to some folks and that is going to create some pressure—but when we say a race

to the top, we literally mean that. So we will set a high bar, and States that hit it, that's great. And what we may do is we may come back with a second round, you know, down the road. So States that don't hit the bar now will come back and we will say you have another opportunity if you make these changes.

We will be very, very clear to States, this is where you hit it and this is where you didn't. And you know, I would love it if at the end of the day, when we are done with this, if we had all 50 States doing these things, that would be phenomenal. I mean, our children would be in great, great shape. But this is going to be—we are going to be very, very clear about our expectations and give folks a chance to hit it now, and give folks a chance to come back, and where they are a little short or not doing something that we think is important, they will have the opportunity to address that, to correct it and come back down the road.

We will also put all of this out for public comment. So before anything goes out, we are going to put out a draft and give folks feedback and go through that process before we finalize it.

OBLIGATION PERIOD OF RECOVERY ACT FUNDS

Senator HARKIN. Well, you are really going to have to move rapidly. That money is—you don't—that money expires, if I am not mistaken, September 30 of next year, right?

Secretary DUNCAN. No, it can be used beyond.

Senator HARKIN. It has to be obligated. No?

Secretary DUNCAN. We have to use it by 2010.

Senator HARKIN. That's what I mean. You have to get it out by 2010?

Secretary DUNCAN. They have time beyond that.

Senator HARKIN. But it has to be obligated by then? Yes.

Secretary DUNCAN. Yes. So we will get that out, I promise you.

RACE TO THE TOP FUND AND CHARTER SCHOOLS

Senator HARKIN. Okay. Let me ask you a question about the statement that said, "States will hurt their chances to compete for millions of Federal stimulus dollars if they fail to embrace innovations, like charter schools, Secretary of Education Duncan said Thursday."

Is that it? If States have a cap on the number of charter schools, that they would have a harder time of winning one of these awards? So are charter schools a litmus test?

Secretary DUNCAN. It's not a litmus test. It may be one factor—we are going to ask a series of questions around those four assurances, and so that may be a piece of that. And again, we haven't finalized the RFP, but it may be one of the questions that we ask in those topics.

And again, let me be clear, I am not just for more charters, I am for more good charters. And so it's not just about a cap. It's much more complex than that. It's about having accountability, autonomy, and a high barrier to entry.

Senator HARKIN. I'm glad to hear you say that——

Secretary DUNCAN [continuing]. We want to address all of those things.

Senator HARKIN. Yes. Because there seems to be some thought that you are focusing so much on charter schools, that every charter school is great, no matter what.

Secretary DUNCAN. I try to be explicitly clear. I have never said that, and again, if you look at my record, I closed three charter schools for failure, and so I am for good schools of every stripe and every ilk.

WHAT WORKS AND INNOVATION FUND

Senator HARKIN. I am glad to clear that up and make that clear, that it's not necessarily a litmus test.

There's one other thing I wanted to ask you about here, and that was in this What Works and Innovation Fund, I just don't know where this might fall. But it's been my view after all these years of looking at schools, and finding schools that work, that there are a lot of different reasons why a school might be successful and one year why it won't. You have to look at a lot of factors.

IMPORTANCE OF A GOOD PRINCIPAL

But the one element that always seems to be present is whether or not they have a good principal.

Secretary DUNCAN. Very true.

Senator HARKIN. A principal who is smart, who is dedicated, who knows how to organize, how to motivate teachers, it's just invaluable. But we haven't really had a good program for training principals. You are a teacher and then you become a principal. Well, sometimes the best teacher may not be the best principal. The skill set may be different.

SCHOOL LEADERSHIP PROGRAM

So we have this school leadership program, and quite frankly, you, in your request, in your budget, you bumped it up a lot, $19 million. We bumped it up quite a bit from 2008 to 2009, and then you asked for about $10 million increase, up to $29.2 million for 2010.

I guess my question has to do with these RFPs that go out. Are you going to be looking at things like that, too?

Secretary DUNCAN. Absolutely. That's exactly right—whether it's districts, whether it's States, whether it's universities, whether it's nonprofits, there are lots of folks that are training principals. Some are doing a great job of it and some aren't. We can look at the data at how those principals have been trained, that have done a lot in terms of driving up student achievement.

Senator HARKIN. Good.

Secretary DUNCAN. In those places, again, districts, universities, nonprofits, States, whatever players might be doing a great job of this, there is a huge chance to do more of that, and I absolutely concur with you. I don't think there is a good school in this country without a good principal.

I've seen quite the inverse. I have seen a school that struggled that had a great principal, that took 10 or 12 years to improve. And without the right succession plan, that good principal leaves,

and within 6 months the place is a disaster. It is much, much harder to build this thing up than it is to tear it down.

And just as in your business, and in any of the business, leadership matters tremendously. Good principals keep good teachers. They help good teachers improve. They work with the community. And so there is a huge opportunity here to invest in leadership, and that would cure many of the problems that ail us. When you see these high-performing schools in tough neighborhoods, every single one has a dynamic principal driving that change. It can't happen without it.

Senator HARKIN. I am really glad to hear you say that. So when I am looking at that request for the $29.2 million that you are requesting, but then there might be more than that in the——

Secretary DUNCAN [continuing]. The $650 million is absolutely eligible for that. That's the kind of thing we want to invest in.

STATE LONGITUDINAL DATA SYSTEMS

Senator HARKIN. I am really glad to hear that. Let's see what else? Let me be just a bit more general.

One of the four elements you mentioned on what you are looking at in these RFPs, comprehensive data systems on tracking students?

Secretary DUNCAN. The assurances? Yes.

Senator HARKIN. There are some systems that are out there that do this. I don't know which are good enough, but I am sure you are looking at those that are existing already?

Secretary DUNCAN. Yes. You bet.

Senator HARKIN. I don't know which ones are good enough, but I know there are some out there.

Secretary DUNCAN. Again, and this is where there is huge variation. Some States are doing a phenomenal job of this now, and other States are, you know, just sort of starting off. And what we are saying is, we're saying that this is important. You need to know where your students are, you need to know how your teachers are doing, and you need to know how the schools of education are producing the teachers that are helping.

And you have to have this fundamental basis of fact or otherwise we are just guessing. You can't guess at what is important. You need to know what is happening, and we have to track students throughout their educational career. You can't be losing students through the cracks. This is not right.

DATA QUALITY CAMPAIGN

Senator HARKIN. So you have already tasked someone in your organization to start gathering the information on this?

Secretary DUNCAN. Yes, it actually goes well beyond this. There is an outside group, called the Data Quality Campaign, DQC, that has done extensive work for years in this. They have ranked every State. They have 10 requirements. They have a set of States that make all 10. They have a set of States that make 9, 8, 7, 6, 5, and our goal would be to have every State to hit all 10 of those benchmarks.

So this goes far beyond our Department. This is really a national movement with some clear bars and clear, objective criteria, and

every State knows exactly where they stand. And we have money in the budget for data systems, and we just want to help every State get where they need to go.

I think there are 6 States now that hit all 10 of those criteria, so we have got some work to do.

Senator HARKIN. We have a system that started in Iowa just a few years ago. It's not complete in the State yet, but my information from the school board says that they really like this tracking system that they have. I will have to get more information on it. Objectively, I don't know, how well it's working, but from what I hear from people, they said they are doing a great job of tracking students and making sure they know what each student—where each student is and each teacher knows where the student is, and where they are weak, and where they are strong, what happened to them last year, that type of thing.

Secretary DUNCAN. That sounds like exactly what we are looking for.

TRANSITION AFTER RECOVERY ACT FUNDS ARE EXPENDED

Senator HARKIN. Yeah. Okay. Lastly, and I don't mean to keep you any longer, but on the Recovery Act funding, you mentioned some of the guiding principles that we would be doing. You said that they could spend money quickly and save and create jobs, implement school reform, minimize the funding cliff that we are going to be facing. And that is a big concern of all of us here. But what is going to happen when we get past next year? Some school districts are confused how to balance all of this. They say, "How do we create jobs without creating this funding cliff?" How do we implement school reform if we just focus on creating jobs?

I don't know that I have a real pointed question on that, it's just there is—and I am hearing back that there is some confusion from school districts out there. What am I supposed to do? Which is the priority: am I supposed to save some jobs, or am I supposed to hire some new employees, some new people? But then what is going to happen next year when the money runs out? What will happen to them?

I keep getting input on this all the time. I just want to explore that with you a little bit.

TARGETING RECOVERY RESOURCES—A TEST OF LEADERSHIP

Secretary DUNCAN. It's a really, really fair question, and what I would really urge is, first of all, I see these things not as contradictory, but you need to do both—let me be clear on saving jobs. With the stimulus, you know, we think we are going to save or create well north of 300,000 jobs.

Senator HARKIN. Saving? Otherwise, it would have been more?

Secretary DUNCAN. Yeah, if class size would have gone from 25 to 40, we would have laid off librarians and social workers and counselors. That would have been an absolute disaster. Obviously, I am pushing for us to get dramatically better. If we would have taken a step backwards, that would have been a catastrophe for the country.

So you have to do that. Simultaneously, I would push very hard, that if all we do is invest in the status quo, that's not going to get

us where we need to go either. And we have to attack this 30 percent national dropout rate. We have to attack these dropout factories. We have to think differently about time. We have to think differently about talent. And we can do these things at the same time. And you are seeing real innovation, real creativity happen in some places, and you are seeing other folks that are a little bit paralyzed. And this is hard. This is a lot of folks under huge financial pressure.

This is not just about principles. This is a real test of leadership and you are going to see some States and some districts and some schools do a phenomenal job of this, and also you are going to see some places get paralyzed, and they won't be able to handle the pressure.

And I would argue, you know, Rahm Emmanuel has this little— the President's Chief of Staff has this great line, "Never waste a good crisis." I really believe that. That sometimes it's in times of crisis, this intersection of crisis and opportunity, that you can sort of push this kind of fundamental reform. So I would argue, that if we could now, with existing resources, and the additional title I money that schools are requesting, that if we could fundamentally challenge some of these dropout factories and fix them, we would fix them forever, and we would stop this pouring out of kids onto the streets that have no ability to compete in today's economy and hold a good job, and support a family and own their own home.

You know, if we train a generation of teachers to work better with special education students and teach those students to read early, we would prevent a whole other generation of students being labeled special ed, a label they never escape.

So there are things that we can do now. The early childhood investment, if we do that well, these children are going to be better prepared for work and for life, you know, 20 years from now. So if we do the right thing now, on both fronts, we have this chance to fundamentally change education in our country. I really believe that.

And so these things aren't in conflict. I think they can be absolutely complementary. But it is going to take leadership and vision. And we want to share best practices. So there are no secrets in this. We are all in this together. Because as we see States and districts doing innovative things, we are going to try to continue to highlight those best practices, so that other folks can steal some ideas, and we are all in this together. We are all in this together.

PROPER USE OF RECOVERY ACT FUNDS

Senator HARKIN. Well, that's very encouraging. I read something from the States, that they might try to siphon some of this money off into other areas. I hope that we are being diligent in trying to check that.

Secretary DUNCAN. We are going to check it. And again, I am not looking for a fight, but we put out tens of billions of dollars, but we withheld tens of billions of dollars. We did that for a reason. That's exactly the reason. So that's, again, that's the stick side. The carrot side is unprecedented discretionary resources. And if States are gaming things, they are basically going to walk away and eliminate themselves from the hundreds of millions of dollars in

additional resources coming to their State. So we are trying to push very hard on both sides, carrots and sticks, to get States to do the right thing.

I know the pressure they are under. I know the difficulties and I don't imagine—and it varies. Some States are in disastrous situations, but everyone is under stress. But again, this is a test of leadership. When you are under stress, what do you do?

This is a real test of leadership right now.

RECOVERY ACT INVESTMENT IN EDUCATION

Senator HARKIN. Well, it is a real test and I think that the President was very bold in the Recovery Act, and I think that he met that by putting that money in there for education. I think the total was about $100 billion.

Secretary DUNCAN. North of that. It is a phenomenal investment and I appreciate your tremendous leadership in this.

Senator HARKIN. Now we just want to make sure that we use it well and wisely. I can't tell you how much I like everything I hear coming from you, and from the President on this, and that we are going to make some real changes and just get us really in a new direction on education. So whatever—we will look at these budgets and these numbers and we will obviously will be consulting with you and your people on this as we go through our appropriations cycle here.

NO CHILD LEFT BEHIND AND NARROWING OF CURRICULUM

The last thing I just wanted to mention. This is not very appropriate probably for this year, it would be probably more appropriate in my other hat on the authorizing committee, but what the heck, you are here and I am here.

I can't tell you how many times I met with your predecessor, Margaret Spellings, on the issue of No Child Left Behind. And that what we had seen is because of these AYPs, and the focus on schools to do more on math and science, that what we found is that schools under this pressure were trying to pour money into that, and the first people to go were their art teachers and music teachers and physical education teachers.

IMPORTANCE OF ARTS AND PHYSICAL EDUCATION COURSES

So there are two areas: one, the physical health of our kids in school. When you build an elementary school without a playground, I don't know what statement you are making about the health of our kids. I had this quote from this one principal that said that, "We are in the business of teaching kids, not letting them play around on monkey bars", when asked about the fact that they had built a school without a playground. And so the health of our kids is important in those early years.

But also Wynton Marsalis just gave a great 1 hour discourse on culture at the Kennedy Center, about a month or so ago. It was one of the most fantastic discourses on American culture, and the history of culture as it is interwoven with the arts and music. And it just seems that we do ourselves a disservice if we don't have, again, a school education for those kids where they learn about art

and music, and what music means. And not every kid is talented enough to be in math or science, but they may have other talents. They may have talents in artistic fields, and we have to engender that. And I just think we are falling way behind on that. We are just getting it short shrift, as though it's not important. I would submit it is vitally important, and so again, with all this pressure from No Child Left Behind, I hope we think about those other two things. And don't leave them behind in terms of their health, and don't leave them behind in terms of their culture, and their appreciation for culture and the arts, music, and that type of thing.

I just wanted to state that to you.

Secretary DUNCAN. I couldn't agree with you more. I worry a lot about the narrowing of the curriculum. I think our students desperately need arts and music and dance and drama. They need health. They need PE. I think we have to give students multiple opportunities to develop their unique skills and passions and talents and give them a reason to be excited about coming to school every single day.

For me, it was sports. For another kid, it might be debate or chess or dance, or drama. We have to provide those opportunities. Our students have to be healthy. They have to be physically active.

You and I went to a phenomenal school that I will never forget in your State that has an absolutely state-of-the-art PE program. But, guess what? I am convinced that students are going to do better academically because of what is going on there and the lessons that are being learned.

So, again, it's so funny when people always talk about these things being contradictory. Monkey bars, if they spent some time on the monkey bars, I think they will learn more. I was one of those young kids that couldn't sit still all day. This is a long time, frankly, for me to sit still here. It's still a challenge; I need some monkey bars. But kids need to get up, to get some fresh air and run around a little bit. I worry a lot about our young kids that don't have those kinds of opportunities.

IMPORTANCE OF DEVELOPING ALL SKILL SETS IN SCHOOL

So these things to me aren't contradictory. They absolutely need to—do you want to improve math scores? Do some music. There is actually a lot of data about that. And so I go back to the narrowing of the curriculum, that's a problem. The school day being too short, we can't pack all this stuff in. We have got to get some more time. So this could be before school, after school——

Senator HARKIN. A longer school year.

Secretary DUNCAN [continuing]. At lunch time, a longer school year, summer enrichment, so if a kid is great at the piano or violin or dancing, drama, it's not just more of the same, but for somebody to have the chance to build upon those skills.

And so I think we have a real chance to be creative and to stop those sort of false dichotomies and false battles, and say that every kid needs these kinds of opportunities and let them figure out what the right path is for them. So, this is one that we want to spend a lot of time and thought on and try and get it right.

Senator HARKIN. Well, how can we be helpful both on the authorizing end, but also on this end, the Appropriations Committee, if

there are things that we need to pilot or we need to look at in terms of boosting some funds some place, to enhance that, I would like to know your thoughts on that. We may have some of our own, but we would like to hear your thoughts.

Secretary DUNCAN. I look forward to that.

ADDITIONAL COMMITTEE QUESTIONS

Senator HARKIN. Mr. Secretary, thank you very much. You have been very generous with your time and input and I'm sure that we will be dealing with your people and others as we move ahead on this appropriations process.

Secretary DUNCAN. Thank you so much for your leadership. I really appreciate it.

[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

DATA ON LEA REDUCTION OF EXPENDITURES FOR SPECIAL EDUCATION UNDER THE INDIVIDUALS WITH DISABILITIES EDUCATION ACT (IDEA)

Question. The Recovery Act provided $11.3 billion under IDEA Part B (section 611) Special Education State grants program. These funds were intended to save jobs and improve student achievement through investments in evidence-based practices with the potential for long-term benefits. A provision in the IDEA allows States or school districts meeting requirements under IDEA to use funding increases received over the prior year to reduce levels of special education expenditures by up to 50 percent of the prior-year amount. What information has the Department collected on the number of districts and States using this provision up through the current academic year?

Answer. IDEA, section 613(a)(2)(C), permits (local education agencies (LEAs) that meet certain conditions to reduce their required level of local, or State and local, expenditures on special education by up to 50 percent of any increase in the LEA's allocation under IDEA, section 611. The Department does not have any data on the numbers of districts that have taken advantage of the flexibility available to LEAs under this provision in prior years. We do not currently have a data collection in place to collect this information; moreover, we have not learned of any districts that have taken advantage of this flexibility.

While we suspect that many more LEAs will be interested in taking advantage of this flexibility during the current fiscal year, it is worth noting that only certain LEAs will be eligible to do so. For example, pursuant to section 616(f), State educational agencies (SEAs) must prohibit any LEA that does not currently meet the requirements of the Act from taking advantage of this local maintenance of effort flexibility.

DATA COLLECTION ON LEA REDUCTION OF MAINTENANCE OF EFFORT

Question. Will the Department collect for the current academic year and future academic years the number of districts and States reducing maintenance of effort under current law; the amount of IDEA funds being used for purposes authorized under the Elementary and Secondary Education Act (ESEA); and the major categories of ESEA expenditures made using these IDEA resources?

Answer. The Department is currently developing a data collection instrument that will be used to obtain information on the extent to which LEAs reduce their special education expenditures under IDEA, section 613(a)(2)(C), or use funds for coordinated early intervening services under section 613(f). While this data collection package has not yet been formally approved, the agency is working to implement this collection in time to obtain data for the 2009 fiscal year.

DATA ON STATES INELIGIBLE TO USE MAINTENANCE OF EFFORT REDUCTION AUTHORITY

Question. What information does the Department have available on the number of States and districts ineligible to utilize the maintenance of effort (MOE) reduction

authority for reasons of: mandatory early intervening services, State not meeting requirements under IDEA or districts not meeting requirements under IDEA?

Answer. The Department does not currently have complete data on the number of LEAs that may be ineligible to utilize the MOE flexibility under section 613(a)(2)(C), either because those LEAs do not meet requirements or because they are required to spend the full mandatory 15 percent on coordinated early intervening services due a finding of significant disproportionality based on race and ethnicity. However, we do have information for particular States.

State	Number of LEAs	Number of LEAs not in meets requirements status (in 2007 or 2008)	Number of LEAs identified with significant disproportionality (in 2007 or 2008)
Arizona	590	296	([1])
Arkansas	244	([1])	23
California	980	85	([1])
Connecticut	180	66	([1])
Florida	67	16	([1])
Georgia	180	([1])	72
Hawaii	1	....	([1])
Idaho	129	([1])	6
Indiana	338	([1])	7
Kentucky	176	([1])	4
Louisiana	96	56	([1])
Maine	154	51	([1])
Massachusetts	391	([1])	....
New York	683	51	5
Ohio	941	542	([1])
Rhode Island	52	14	29
South Carolina	86	([1])	4
Tennessee	136	131	21
Texas	1,230	523	([1])
Virgin Islands	2	2	([1])
Wisconsin	471	137	([1])

[1] Not known.

LONG-TERM IMPACT OF RECOVERY ACT IDEA FUNDS

Question. Lastly, what is the Department's view of the long-term impact of Recovery Act IDEA dollars being used to reduce special education expenditures?

Answer. It is not yet clear what the long-term impact of Recovery Act IDEA dollars will be, but the Department's goal is to ensure that LEAs use these emergency one-time funds to avoid teacher layoffs and support essential services, in addition to making investments in improving student outcomes and advancing reforms that will have a positive long-term impact.

TECHNICAL ASSISTANCE FOR SPECIAL EDUCATION STATE DATA COLLECTION

Question. The budget request assumes that $15 million of part B Special Education State grants will be used for special education technical assistance related to data collection for State Performance Plans and Annual Performance Reports, as well as ensuring that LEAs are meeting the requirements of IDEA. How will requested funds be used to support these activities?

Answer. Under technical assistance for the State Data Collection program, established under section 616(i)(2) of IDEA, the Department makes competitive awards to provide technical assistance to improve the capacity of States to meet the section 616 data collection requirements. During fiscal year 2010, the Department expects to make approximately $13 million in new awards to States, but the focus of this upcoming competition has not yet been determined.

Technical Assistance Center on IDEA Accountability Data

The request would also support one $2 million continuation award to support a Technical Assistance Center on IDEA Accountability Data (called the Data Accountability Center). This project provides assistance and information to States to help them improve data collection infrastructures and to implement the requirements under section 616. This on-going project focuses on the following three areas: assessment of State needs; strategic planning and evaluation; and provision of technical assistance to States.

ADDITIONAL SUPPORT FOR STATES RELATED TO DATA COLLECTION

Question. What other Department of Education resources are being used currently and are requested in the fiscal year 2010 budget to assist States in carrying out their responsibilities in these areas?

Answer. The Department has not yet decided the focus areas for upcoming competitions during fiscal year 2010. The primary source of additional support to States on activities related to data collection comes from centers funded through the IDEA Technical Assistance and Dissemination program, including the Regional Resource Centers (for which $7.8 million was awarded in fiscal year 2009 to support approximately 4 new awards) and the Post-School Outcomes Center (which receives approximately $800,000 per year, over 5 years, beginning in fiscal year 2008).

SPECIAL EDUCATION GRANTS TO STATES PROGRAM IMPROVEMENT STRATEGIES

Question. The Congressional Budget Justification indicates that one of the Program Improvement Efforts under Special Education part B Grants to States is "identifying strategies in key topic areas that have the potential for improving results for children with disabilities." Specifically, what strategies has the Department identified and on what basis has it targeted these particular strategies?

Answer. The Department has identified strategies in a variety of areas, including: supporting on-going, formative, school-wide strategies such as multi-tiered interventions and Positive Behavioral Intervention Strategies (PBIS); enhancing general education and special education teacher effectiveness by supporting professional development and more effective pre-service training for teachers and school leaders; requiring all special educators to be highly qualified; improving the curricula of pre-service teacher training programs; supporting formal induction and mentoring programs, and incorporating assistive technology into classroom teaching practices; establishing coordinated data systems and using data to improve student outcomes; incorporating universal design for learning principles as widely as possible, and; encouraging States to adopt rigorous standards, curricula, and assessments and ensuring that students with disabilities have an opportunity to participate alongside their general education peers to the greatest extent possible.

The Department targets these areas by making them the topical focus of competitions under special education discretionary grant programs, and by encouraging States to use funds available through the grants to states, preschool grants, and grants for infants and families formula programs to support authorized activities related to these strategies.

FUNDING SOURCES FOR PROGRAM IMPROVEMENT STRATEGIES

Question. How much funding (and what funding sources) is dedicated to implementing these strategies in the current fiscal year and how much is included in the fiscal year 2010 budget request to continue and/or expand on these efforts?

Answer. The Department has not yet decided the focus areas for upcoming competitions during fiscal year 2010. However, special education discretionary grants programs are the primary source of funding used to support strategies in key topic areas that have the potential for improving results for children with disabilities.

Special Education Pre-service Training, Professional Development, and In-service Training

For example, the Personnel Preparation Program is the key source of funding used to support key strategies related to pre-service training, professional development, and in-service training for special educators and school leaders. In fiscal year 2009, in additional to several new competitions, the Department is supporting continuation awards that target a wide range of strategies that are likely to improve results for children with disabilities.

For example, Personnel Preparation Program investments in fiscal year 2009 include:

—A new award to a consortium of universities that will produce at least 30 new doctoral candidates in the area of low-incidence sensory disabilities, including visual and hearing impairments ($5 million over 5 years beginning in fiscal year 2009).

—Up to 15 new Paraprofessional Pre-Service Training Improvement grants. These grants will focus on improving pre-service training programs for paraprofessionals who serve children ages birth through 5, and children in grades kindergarten through grade 12, by enhancing or redesigning curricula to adequately train these paraprofessionals to address the needs of infants and toddlers with disabilities and their families.

—A single continuation award to support the Center to Improve the Recruitment and Retention of Special Educators ($2.5 million over 5 years).
—*Preparation of Leadership Personnel Grants*.—The Department will make approximately $5 million in new awards (to 23 grantees) and $12.3 million in continuations (to 68 grantees) in fiscal year 2009 to train personnel at the pre-service doctoral or postdoctoral level in early intervention, special education, or related services, and at the advanced graduate level (masters and specialists).
—*Pre-service Improvement Grants*.—The Department will make approximately $1.5 million in new awards (to 12 grantees) and $4.1 million (to support 48 continuation awards) in fiscal year 2009 to institutions of higher education to ensure that pre-service training programs and curricula are aligned with the highly qualified teacher requirements.

SPECIAL EDUCATION TECHNICAL ASSISTANCE AND DISSEMINATION PROGRAM

Question. The Congressional Budget Justification under the Technical Assistance and Dissemination Program narrative indicates that the Department will be collecting performance and other information to adjust issue coverage and reallocate resources for this program. Please provide the information being used in this process and identify specifically how funding would be reallocated under the budget request.

Answer. On an on-going basis the Office of Special Education Programs (OSEP) works to ensure that resources available under this program are invested in critical areas of need. In identifying new topics for funding priorities and allocating resources OSEP considers: Institute for Education Sciences (IES) research findings; information on the needs of SEAs and LEAs and other important customers and constituencies; results from formal program evaluations; and, other relevant materials. OSEP has also established an internal Technical Assistance and Dissemination (TA & D) workgroup. This group maps all current TA & D investments, identifies discrepancies and emerging trends, proposes modifications to the scope of work in current investments, recommends projects that should be phased-out, and recommends new priorities.

The Department has not yet decided the focus areas for upcoming fiscal year 2010 competitions.

RECRUITING AND RETAINING SPECIAL EDUCATION TEACHERS

Question. The Teacher Quality Under No Child Left Behind.—Final report documents the particular challenge that high-poverty schools face in recruiting and retaining special education teachers. What specific activities (and funding sources) will be undertaken to address this issue in fiscal year 2009 and under the fiscal year 2010 budget request?

Answer. Severe shortages in the supply of special education teachers have been documented for at least 15 years, and the problem is particularly acute in high-poverty districts. The Department has adopted a number of strategies to alleviate ongoing shortages of special education teachers, including:

—Supporting initiatives that are designed to improve the overall quality of special education training programs, to ensure that all special educators are highly qualified, and consequently to reduce the high turnover-rate of new and veteran special educators teachers. For example, since fiscal year 2007 the Department has made approximately 56 Special Education Pre-Service Training Improvement grants to institutions of higher education for the purpose of restructuring or redesigning preparation programs for special educators who teach grades K through 12 to ensure that training program curricula are aligned with evidence-based practices and that all graduates meet the highly qualified teacher requirements upon program completion. During fiscal year 2009, the Department is using $1.4 million in Personnel Preparation funds to make approximately 12 new awards in this activity area.
—Focusing limited Federal resources for scholarship support in areas where such investments are likely to have the greatest impact on supply (e.g., supporting scholarships in programs that prepare teachers of children with low-incidence disabilities and leadership personnel). During fiscal year 2009, the Department is using $4.5 million to support approximately 23 new awards in this area.
—Supporting novel strategies to attract and retain special education teachers, such as alternative teacher certification programs, high-quality professional development, partnerships between institutions of higher education and LEAs (particularly with high-poverty LEAs/schools), and mentoring programs for recent graduates from training programs. For example, the Department supports the National Center to Improve the Recruitment and Retention of Qualified Per-

sonnel for Children with Disabilities to help States develop and implement strategies to recruit and retain sufficient numbers of highly or fully qualified personnel.

Fiscal Year 2009 State Personnel Development Grant Focus on Promising Strategies

Section 14005(d)(2) of the Recovery Act requires each State, as a condition of receiving State Fiscal Stabilization Funds (SFSF), to commit to taking "actions to improve teacher effectiveness and comply with section 1111(b)(8)(C) of the ESEA . . . in order to address inequities in the distribution of highly qualified teachers between high- and low-poverty schools, and to ensure that low-income and minority children are not taught at higher rates than other children by inexperienced, unqualified, or out-of-field teachers." Consistent with the requirements of section 14005(d)(2), in fiscal year 2009 the Department is encouraging competitive applicants under the State Personnel Development Program to address these challenges by awarding additional points to applicants who propose promising strategies.

The Department has not yet decided on priorities for upcoming fiscal year 2010 competitions.

EDUCATIONAL MATERIALS IN ACCESSIBLE FORMATS

Question. Under the Technology and Media Services Program, funds are included for a competition for State System Improvement Grants which are intended to support the development or improvement of State systems for providing to students with disabilities educational materials in accessible formats. The Congressional Budget Justification describes initial awards made under this program as "very successful." What information enabled the Department to come to this conclusion about these awards?

Answer. In September 2007, the Department made awards under the "Educational Media Activities to Improve State Systems for Providing Educational Materials in Accessible Formats" priority to two consortia:

—The Accessible Instructional Materials (AIM) Consortium, which represents 15 States serving more than 1.3 million students under IDEA, of whom more than one-half million are estimated to have print disabilities; and

—The Pacific Consortium for Instructional Materials Accessibility Project (CIMAP). The Pacific CIMAP facilitates the collaborative efforts of the six Pacific Basin entities to build local and regional capacity for implementation of the National Instructional Materials Accessibility Standard (NIMAS) and National Instructional Materials Access Center (NIMAC) requirements, as well as all other accessibility requirements.

Educational Media Activities To Improve State Systems for Providing Educational Materials in Accessible Formats

The goals of the educational media activities to improve State systems in accessible formats are to:

—Facilitate the development of State systems for increasing the awareness and timely provision of accessible instructional materials via NIMAS/NIMAC for qualifying students and other means for nonqualifying students;

—Ensure that State systems for the identification, acquisition, and use of accessible instructional materials employ high-quality procedures and practices; and

—Produce related products and services that are scalable and can be made available to all States, Outlying Areas (OAs), and Freely Associated States (FAS), thus contributing to improving outcomes for all students with disabilities.

Making available appropriate accessible materials in a timely manner is key to improving outcomes for children and youth who are blind or have print disabilities. Every State and Pacific entity has indicated that it has made significant progress in implementing high- quality sustainable systems that ensure the provision of textbooks and related instructional materials in specialized formats in a timely manner to students with disabilities. The information that follows indicates that the participants in these projects are significantly ahead of where they were 18 months ago in leveraging local, State, and national resources so that students with print disabilities receive appropriate, accessible, and accurate core curriculum materials in a timely manner. State leaders involved in the consortia unanimously attribute much of their ability to move forward to the work of the consortia.

Educational materials obtained through source files provided by the NIMAC only may be provided to students who meet the eligibility requirements of the Act to Provide Books for the Adult Blind of March 3, 1931. However, the definition of eligibility promulgated to meet the requirements of this Act does not cover many students who are eligible under IDEA or students eligible under section 504 of the Re-

habilitation Act of 1973. The consortia have addressed the needs of both students who are eligible for materials created from NIMAS sources files and those who are not eligible for instructional materials produced from this source, but who have been determined to require accessible educational materials.

AIM Consortium

Regarding the AIM Consortium, data indicate that there are 1.3 million students with disabilities served under IDEA in the 15 States participating in the project. It is estimated that 500,000 of those students require accessible instructional materials of some sort. This number does not include students with learning disabilities who do not meet the eligibility requirements for materials produced from NIMAC source files or children with disabilities who receive services under section 504 of the Rehabilitation Act.

Throughout the grant period, the AIM Consortium and its independent evaluator have collected baseline data, periodic formative data, and summative data to determine progress and the potential impact of the work of the Consortium. To ensure that high- quality procedures and practices are used by the AIM Consortium, the Consortium's Steering Committee, made up of leaders from each of the 15 States, developed 7 Quality Indicators for the Provision of Accessible Instructional Materials to guide the development of high-quality, sustainable systems. Those quality indicators have been the basis of information-gathering on the status of State delivery systems, public awareness efforts, and targeted technical assistance. Data gathered in the fall of 2008 indicate that the current status of State systems on each of the indicators is markedly improved from the baseline obtained at the beginning of the grant period.

Progress of AIM Consortium States in Developing Systems To Provide Accessible Instructional Materials

The following table provides data on the progress the AIM Consortium States have made toward the development of individualized systems that align to the critical elements of high- quality systems for the provision of accessible instructional materials. The rating scale used to gather these data was: 1=Emerging; 2=Planning stages; 3=Under development; 4=Partly implemented; and 5=Fully implemented. The first number in the table is the mean rating that was reported by the AIM State Leaders at the beginning of the grant period. The second number represents the mean rating for the most recent data collection in February 2009, and the third number indicates the change between the baseline and the most recent data collection.

MEAN PROGRESS RATINGS IN DEVELOPING DELIVERY SYSTEMS FOR DELIVERY OF ACCESSIBLE INSTRUCTIONAL MATERIALS

Quality indicator	Mean rating—October	Mean rating—February	Change
The education agency supports the provision of appropriate, high-quality instructional materials in specialized formats to all students with print disabilities who require them	2.5	4.1	+1.6
The education agency supports the provision of appropriate specialized formats in a timely manner	2.5	4.0	+1.5
The education agency develops and implements written guidelines to define the responsibilities and actions needed for effective and efficient provision of specialized formats	1.9	3.7	+1.8
The education agency supports learning opportunities and technical assistance (e.g., professional development, training, and support) to facilitate the identification of students with print disabilities, as well as the selection, acquisition, and use of appropriate specialized formats	2.1	4.2	+2.1
The education agency develops and implements a systematic process to monitor and evaluate the equitable, timely provision of appropriate, high-quality materials in specialized formats	1.3	3.1	+1.8
The education agency uses data to guide changes that support continuous improvement in the selection, acquisition, and use of accessible instructional materials	1.3	2.7	+1.4
The education agency allocates resources sufficient to ensure the delivery and sustainability of quality services to students with print disabilities	1.9	3.8	+0.9

Educational Materials in Accessible Formats—Other Accomplishments

State leaders have also provided information on the following accomplishments:

—Formulation of definitions of "timely manner." (Each State has to develop its own definition.)

—Coordination with the NIMAC and designation of authorized users. (A recent NIMAC report indicates that AIM States were responsible for 34 percent of the files that have been drawn down or assigned to date.)

—Establishment of relationships with other federally funded NIMAS-related projects such as Bookshare for Education, Recording for the Blind and Dyslexic (RFB&D), and the American Printing House for the Blind (APH). (The Pacific entities did not have relationships with these programs prior to the grant.)

—Collaboration with State assistive technology service providers.

Web Links to Overview of Three State Systems for Educational Materials in Accessible Formats

Although every AIM State has developed a system specifically focused on the needs of that State and its students, three systems are included here as examples. URLs shown below provide access to overviews of those systems: Iowa at http://trueaim.iowa.gov/; Maine at http://aim.mainecite.org/; and Louisiana at http://www.atanswers.com/aim/downloads.html.

AIM Consortium Products

Based on input from the AIM Steering Committee, the AIM Consortium is also developing a suite of best practices products and Services that addresses critical areas of decisionmaking, which will be made readily available to all States, FASs, and OAs by the fall of 2009. Each of the products in the suite is designed to support high-quality collaborative decisionmaking by school personnel, families, and students about the selection, acquisition, and use of specialized formats of textbooks and related core materials. The primary means of distribution will be via the fully accessible AIM website.

AIM Consortium products include:

—The AIM DVD includes a variety of topics important to the selection, acquisition, and use of accessible instructional materials. The DVDs are expected to be accompanied by resource materials, possible sample lesson plans, and other training supports that would make the videos useful across multiple environments.

—The AIM Decision Making Guidelines provides a suite of tools (procedures/supports/materials) that increase awareness, knowledge, and skills related to AIM for IEP team members (the primary target group), policymakers, curriculum committee members, materials procurement personnel, publishers, and members of organizations with interest in and/or responsibilities related to the education of students with disabilities.

—The AIM Demonstration Software project provides training and support to educators and parents involved with the selection, conversion, and use of student-ready accessible instructional materials. The primary product in this project is a dual-platform laptop computer for each of the participating AIM Consortium States, on which will be loaded an extensive suite of assistive technology applications that support the use of AIM.

—The User's Guide to Federally-Funded Accessible Media Producers will provide an overview of federally funded Accessible Media Producers, the resources available from each, who can use them, and detailed step-by-step instructions on how to access the resources.

—The online graduate level course entitled, "AIM 102" is designed to provide practical, hands on experience in the acquisition and creation of student-ready specialized format versions of print instructional materials. This course is the second in the AIM online course series (prerequisite: AIM 101: Accessible Instructional Materials). The course will cover the creation/acquisition of digital materials (DAISY book, html, etc.), scan and read systems, supported reading software, large print, Braille, and tactile graphics.

—A toolkit for implementation entitled "Using AIM in the Classroom: A Model for Implementation and Efficacy" consists of a suite of materials that can be used by SEAs and LEAs interested in supporting the use of AIM with text-to-speech technology and to measure efficacy in achieving successful outcomes. Model materials for classroom implementation including a text-to-speech training module, overview DVD, pre- and postdata collection elements/forms, and a project planning implementation checklist.

Provision of professional development and training to key stakeholders is a major part of the work of the AIM Consortium. Data on professional development and

training reported by AIM State Leaders indicate that more than 6,250 participants received training in more than 215 sessions conducted across the 15 AIM States during the grant period to date. Responses to a recent informal query sent to the Aim State Contacts Listserv indicate that before the start of the AIM Consortium, training related to the provision of accessible instructional materials either did not occur or was limited to awareness of NIMAS and NIMAC, and the creation of accessible formats via assistive technology.

Pacific Consortium for Instructional Materials Accessibility Project (CIMAP) Project Accomplishments

Some specific accomplishments of the CIMAP include connecting consortium members with available resources, such as the American Printing House for the Blind and Bookshare for Education; helping them, after the determination was made that the areas are not covered by the exemptions to the U.S. copyright law, to find other sources they can use to obtain accessible versions of educational materials; and providing appropriate forms and materials for the entities to use in making direct requests to publishers for permission to make accessible copies of educational materials. In addition, the members made improvements in how they identify students with print disabilities, established a database for children with print disabilities, and provided training on how to identify and select materials and use them in instruction.

Accessible Educational Materials Competition

Question. How will the fiscal year 2010 competition be structured to build on what was learned through the initial competition?

Answer. We have learned a lot from these projects. They have acted as a laboratory for identifying barriers to the provision of accessible materials in a timely manner and creative solutions to these problems. In addition to working directly with the 15 States and pacific entities, the grantees have worked closely with the NIMAC, the NIMAS Technical Assistance Center, Recording for the Blind and Dyslexic, Bookshare for Education, the American Printing House for the Blind, publishers, and publishing association representatives to ensure that issues identified by the States and findings, creative solutions, and model practices developed by the projects are disseminated to all of the States.

Challenges to Timely Provision of Accessible Instructional Materials

Despite the progress made by the two consortia, there are a number of major areas where continued support of the initiative to provide accessible instructional materials to students who require them is critically needed. Some of the challenges to timely provision of accessible instructional materials that remain include, but are not limited to:

—Ambiguity related to the term "print disability";
—Differing interpretations of who can determine that a student meets eligibility criteria for accessible instructional materials produced from source files obtained through the NIMAC;
—The provision of materials to students who are ineligible for accessible instructional materials produced from source files obtained through the NIMAC;
—Systematic quality control across the distribution process: file creation, storage, retrieval and transformation; and
—Efficiency and the elimination of redundant effort.

In addition, while much progress has been made, many States are still struggling. Only 15 States and the 6 Pacific Basin entities have had opportunities for direct support and collaboration through these projects. However, a majority of the States wanted to participate in this program. We believe that many other States could benefit from the opportunity to participate in the program.

Fiscal Year 2010 Proposal for new Consortium

The current projects end in September 2009. In fiscal year 2010 we would propose to support a new consortium of States that have not participated in the AIM Consortium or Pacific CIMAP, but that would benefit from support and collaboration as they implement systems to address the needs of students with disabilities, regardless of where they are located or their eligibility for materials produced from NIMAC source files. These States also would be expected to work closely with the NIMAS technical assistance center and other entities involved with the production of accessible materials to ensure that effective systems that address the needs of all students are implemented in all of the States.

VIDEO DESCRIPTION GRANT COMPETITION

Question. The Congressional Budget Justification indicates that $2.5 million is included for new projects and $1.1 million for continuation projects for support of video description and closed-captioning of educational programming that would otherwise not be required to be described or captioned. How many projects and how much funding would be dedicated to a video description grant competition in 2010?

Answer. The entire $2.5 million would be dedicated to the video description grant competition in fiscal year 2010. We estimate that approximately five new projects would be funded through this competition.

VIDEO DESCRIPTION PERFORMANCE ASSESSMENT

Question. What has been the Department's evaluation/assessment of projects funded previously?

Answer. The Department has not conducted any formal evaluations or assessments of the video description projects. However, as part of the Department's annual Government Performance and Results Act process, we annually select a sample of Technology and Media Services projects to evaluate. For example, in fiscal year 2008, a panel of six special education experts reviewed a sample of projects that produced products in the previous fiscal year. This included four projects that produced described video or a combination of described video and captioning. The products were assessed, using a nine-point scale, along three dimensions: quality, relevance, and usefulness. Successful products are defined as those scoring 6.0 or above. These products scored an average of 6.5 on the quality dimension, 8.06 for relevance, and 7.81 for usefulness. The Department also attempts to assess the efficiency of the program by looking at the number of hours of captioning and video description obtained from its products in relation to its expenditures. For fiscal year 2008, the average cost for the captioning and descriptive video products that were reviewed was $89.41 per hour.

REHABILITATION SERVICES AND DISABILITY RESEARCH—VOCATIONAL REHABILITATION STATE GRANTS PROGRAM

Question. In May 2009, the percent of people with disabilities in the labor force was 22.9 compared with 71.1 for persons with no disability. The unemployment rate for those with disabilities was 13.7 percent, compared with 8.9 percent for persons with no disability. The fiscal year 2010 budget includes more than $3.5 billion under this account to support programs of vocational rehabilitation (VR) and independent living for individuals with disabilities.

What actions is the Department taking currently (or planning for fiscal year 2010) to assist State Vocational Rehabilitation agencies in increasing the number of individuals achieving and sustaining employment and how does the current budget and 2010 budget request support these actions; and lastly, what resources are available in the current year and included in the fiscal year 2010 budget request to support improved outcomes at State VR agencies?

Answer. The Department has undertaken three major initiatives in its effort to improve the performance of the VR State Grants program. These include implementing a new monitoring process that focuses on the performance of State VR agencies, enhancing the Rehabilitation Services Administration's (RSA) capacity to provide technical assistance, and developing a strategic performance plan for the VR program.

As you are aware, in fiscal year 2005, the Department redesigned its monitoring and technical assist activities to focus on performance and assist State VR agencies in increasing the number of individuals achieving and sustaining employment. Monitoring was centralized to ensure more uniform procedures, and a new organizational structure integrated RSA's data collection with monitoring activities so that the process of review and improvement is continuous and reduces the time period between assessing performance and conducting reviews. As performance and other issues are identified, RSA provides technical assistance directly to State VR agencies through the RSA monitoring team.

Monitoring and Technical Assistance Puts Performance Improvement at Forefront of RSA Activities

Investments in developing information from RSA databases for monitoring and technical assistance purposes has put performance improvement at the forefront of RSA activities. Current monitoring efforts are facilitated by several tools that provide information essential for the focus on performance. An enhanced RSA Management Information System (MIS) includes various data sets developed for performance monitoring purposes that allow RSA and State VR agency staff to perform ad

hoc queries on RSA databases and download data in MS Excel format from the RSA–2 Cost Report and the RSA–113 Quarterly Caseload Report data bases. Various sets of data tables are developed annually for use by RSA monitoring teams and State VR agencies for performance monitoring purposes. These data tables are a central beginning point for each State VR monitoring activity, and are used by RSA staff and State VR agency staff to discuss and identify program areas in need of improvement or in need of further discussion and investigation during on-site reviews. Performance information is presented and discussed in each on-site monitoring review. These data are also used to prepare annual review reports that include information about each State VR agency's program outcomes, use of resources, and performance on standards and indicators.

Technical Assistance and Continuing Education (TACE) Centers

A range of activities to assess and improve the performance of the VR program are also being conducted with support from other resources within RSA and the National Institute for Disability and Rehabilitation Research (NIDRR). The Department also recently established 10 new regional TACE Centers under the training program to provide technical assistance and continuing education to State VR agencies and other entities involved in the provision of vocational rehabilitation and independent living services. The TACE Centers assess the performance and compliance needs of agencies in their regions, including needs identified through RSA's review process, and work with RSA and State VR agencies to develop plans for addressing those needs. The TACE Centers are supported by a Technical Assistance (TA) Network consisting of other RSA- and NIDRR-funded projects focused on VR and employment.

Program Improvement Funds Projects Supporting Technical Assistance to State VR Agencies

Program Improvement funds provided under section 12 of the Rehabilitation Act are being used to support technical assistance activities, including a National Vocational Rehabilitation Technical Assistance Center (NTAC) that coordinates the activities of a TA Network that supports technical assistance and continuing education activities for State VR agencies. Nearly half (47 percent) of the funds would be used to continue support for the NTAC. Program improvement funds will also be used to increase service delivery capacity by providing forums for sharing promising practices, and by enhancing the capacity of grantees to fulfill their responsibilities more effectively and efficiently. Timely training and technical assistance will be delivered to RSA grantees and stakeholders using state-of-the-art communication methods as the primary means of dissemination, including web-based seminars (webinars), and RSA's new Dissemination and Technical Assistance Resource web-based resource. These strategies will allow RSA to reach a broader population of grantees and stakeholders without convening face-to-face meetings, greatly improving the cost effectiveness of providing ongoing training and technical assistance.

Evaluation Funds Support Studies To Improve Program Performance

Evaluation funds provided under section 14 of the act are also being used to conduct studies that will assist the Department to improve program performance. Additional information on these and other related projects and activities are provided on pages J–80 to 89 of Volume I of the Department of Education fiscal year 2010 Justification of Appropriation Estimates to Congress.

Improving Quality of Program Employment Outcomes

State VR agencies are serving more individuals with particularly challenging disabilities and personal histories, including, but not limited to, more individuals who are autistic, experience chronic mental illness, battle substance abuse, or have criminal records. New, innovative, and effective approaches are needed in order for VR agencies to improve the quality and quantity of the program's employment outcomes. Through NIDRR, the Department is supporting employment-related centers and projects that will identify and develop evidence-based practices that have been proven effective in improving employment outcomes for these and other challenging and emerging populations. The results of these investments will be disseminated to VR counselors and VR service providers to assist in their efforts to increase the number of individuals with disabilities that achieve and sustain employment.

Fiscal year 2010 Support for Projects on Employment and Vocational Rehabilitation of Individuals With Disabilities

The fiscal year 2010 budget request would support research centers and projects initiated in previous years and new projects that focus on employment and vocational rehabilitation of individuals with disabilities.

NIDRR will continue support for the following employment research centers and projects:

—Center on Demand-Side Employment Placement Models (fiscal year 2006).
—Center for Vocational Rehabilitation Research (fiscal year 2007).
—Vocational Rehabilitation Service Models for Serving Individuals with Autism Spectrum Disorders (fiscal year 2008).
—Center on Vocational Rehabilitation Program Management (fiscal year 2009).
—Center on Effective Delivery of Rehabilitation Technology by Vocational Rehabilitation Agencies (fiscal year 2009).
—Center on Improved Employment Outcomes for Individuals with Psychiatric Disabilities (fiscal year 2009).

Examples of new employment-related topics that are under consideration for NIDRR support in fiscal year 2010 include:

—Individual-level Characteristics Related to Employment Among People with Disabilities.
—Transition to Employment.
—Knowledge Translation of Employment Research Findings.
—Employer Practices Related to Employment Outcomes.
—Employment Measurement and Policy.
—Employment Outcomes for Individuals with Blindness and Low Vision.

Vocational Rehabilitation Strategic Performance Plan

Finally, RSA is developing a Vocational Rehabilitation Strategic Performance Plan, including goals, objectives, and outcome-oriented performance measures, to ensure a long-term strategic focus on program performance, performance improvement, and outcomes for individuals with significant disabilities. The plan will assist the Department in directing its resources (monitoring, technical assistance, training, demonstration, and evaluation) toward the implementation of policies and practices that are known to have a positive effect on increasing high-quality employment outcomes. RSA will use this plan to guide the administration of the VR program and address program challenges. The plan will assist RSA in monitoring progress of the VR program and to provide appropriate, targeted technical assistance to State agencies toward the achievement of desired outcomes.

FINDINGS FROM MONITORING REVIEWS OF STATE VR AGENCIES

Question. What are the major categories of findings from State VR reviews and the technical assistance provided to help State VR agencies implement corrective action plans?

Answer. Many of the findings from the reviews of State VR agencies often center on fiscal management, implementation of an order of selection for services (if a State agency does not have sufficient resources to serve all eligible individuals), and delays in service provision. When findings are identified, State VR agencies develop a corrective action plan (CAP) describing how they will address the findings. RSA then monitors the implementation of the plan until it is complete. If the compliance finding relates to a failure to meet one of the standards and indicators, the VR agency develops a program improvement plan (PIP) and RSA monitors the agency's progress toward improving its performance. In addition to compliance findings, RSA makes observations and recommendations to improve the performance of State VR agencies. Recommendations often focus on such issues as improving the VR agencies employment outcome rate, increasing the number of individuals applying for the program, improving the agency's case management system, strengthening the agency's management of data, implementing a comprehensive strategic planning process, improving internal and external communications, and developing and implementing a quality assurance system. RSA also provides technical assistance both during and after monitoring visits to assist State agencies in addressing compliance findings or to implement a recommendation. Furthermore, the TACE Centers provide additional technical assistance upon request.

DELIVERY OF TECHNICAL ASSISTANCE

Question. On average, how long does it take to complete delivery of technical assistance to address State needs?

Answer. The duration of technical assistance depends on the type and complexity of the need as well as when, how, and by whom the technical assistance is delivered. RSA offers on-site technical assistance during its reviews of State agencies, so that the delivery of some technical assistance is immediate or completed in a few days. RSA also has used annual fiscal and data management meetings to deliver technical assistance directly to agency personnel over the course of 2 days. If a State agency

has a PIP or CAP, the plan includes timelines for its completion and RSA may provide technical assistance at any point during that timeline.

The TACE Centers program provides longer-term and more systemic technical assistance. The TACE program was recently implemented and RSA does not yet have data on how long it takes the Centers to complete the delivery of technical assistance to States. The Centers submitted plans to RSA at the beginning of fiscal year 2009 describing the needs to be addressed and the activities the TACE will conduct to address them, including projected timelines for completion. The projected time for TACE Centers to complete technical assistance varies based on the complexity of the need or intervention. For example, assisting a State agency to create and launch a quality assurance system where none existed may take significantly longer than assisting a State agency to create a strategic plan for addressing personnel shortages. As such, according to TACE Center plans, the range of duration for technical assistance is anywhere from a few months to 2 years depending on the need.

IMPROVEMENT OF DEFICIENCIES IDENTIFIED IN STATE MONITORING REVIEWS

Question. Has the technical assistance, at least in part, led to improvement of the deficiencies identified in VR reviews?

Answer. Yes. Over the past 3 years, State VR agencies have made steady progress in completing corrective actions and taking steps to improve their performance as a result of RSA's technical assistance efforts. RSA provides technical assistance during and following its State monitoring reviews. RSA tracks State VR agency progress and completion of corrective actions outlined in either a CAP or a PIP. They also track a State agency's progress toward implementing recommendations aimed at improving performance. As of this time, RSA's technical assistance efforts have produced the following results:

—60 agencies have completed all of their required corrective actions that resulted from previous monitoring reviews, and 20 State VR agencies are implementing approved corrective actions plans resulting from fiscal year 2007 and fiscal year 2008 reviews;

—During the on-site portion of RSA's reviews, agencies have corrected a significant number of deficiencies relating to reporting and fiscal management requirements; and

—RSA received 84 requests for technical assistance from State VR agencies to address performance and compliance deficiencies identified during its fiscal year 2008 reviews of 19 State agencies. RSA is either providing that TA directly or is working with the TACE Centers to provide agencies with the technical assistance they requested.

RSA has also developed an informal evaluation survey that State VR agencies and other stakeholders are requested to complete after a monitoring review. The vast majority of comments received indicate that the reviews are helpful and that the technical assistance is timely and consistent.

RESOURCES FOR REVIEWS OF CENTERS FOR INDEPENDENT LIVING

Question. Are sufficient resources available in the current year and fiscal year 2010 budget request to conduct the 20 compliance reviews of Centers for Independent Living (CILs) required by the Rehabilitation Act?

Answer. The RSA has sufficient resources to conduct 20 on-site compliance reviews of the CILs in 2009 and in 2010. In addition, RSA uses performance information that is collected annually to monitor CIL performance and compliance with established standards and indicators.

TECHNICAL ASSISTANCE FOR CENTERS FOR INDEPENDENT LIVING

Question. What resources are available in the current year and under the fiscal year 2010 budget request to provide technical assistance to CILs?

Answer. In accordance with section 721(b) of the Rehabilitation Act, RSA is setting aside $2,965,788 of the funds appropriated for fiscal year 2009 under title VII, chapter 1, part C of the Rehabilitation Act, including $1,575,000 in Recovery Act funds, for training and technical assistance to CILs and statewide independent living councils (SILCs). Of this amount, $1,465,485 will be used to provide continuation funding for three grants, two of which provide training and technical assistance to CILs and one of which provides these services for SILCs. Funds remaining after funding the continuation awards will be used for new competitive awards, an estimated $1,325,000 of which would be used to support training and technical assistance to CILs. Under the budget request for fiscal year 2010, $1,444,788 would be set aside for training and technical assistance to CILs and SILCs. The CILs are

also eligible to receive technical assistance from the Technical Assistance and Continuing Education centers.

Question. Are these resources sufficient to meet the requirement under the Rehabilitation Act?

Answer. The allocations outlined above are sufficient to comply with the requirement in section 721(b) of the Rehabilitation Act that RSA reserve no less than 1.8 percent and no more than 2 percent of funds appropriated under title VII, chapter 1, part C of the Act for CIL and SILC training and technical assistance.

CAREER AND TECHNICAL EDUCATION

Question. A 2005 National Research Center for Career and Technical Education report found that a ratio of 1 CTE class for every 2 academic classes minimizes the risk of students dropping out of school. What role does the Department believe career and technical education courses funded under the Perkins Career and Technical Education Act have in working to support the administration's goal of decreasing the dropout rate, and contributing to the administration's high school reform efforts?

Answer. We know that many youth drop out of high school because they are not challenged and they do not feel their courses are relevant to their future careers and ambitions. Career and technical education (CTE) courses provide students with the information, training, and skills that are relevant to future careers, thus potentially making all of their classes more meaningful. As you have noted, we know that CTE courses can provide students, particularly those at risk of dropping out of school, with the motivation and justification for staying in school. According to the NCES report CTE in the United States: 1990 to 2005, students who take CTE courses in high school are likely to pursue postsecondary education. The 2006 reauthorization of the Perkins Act increased the Act's emphasis on the rigor of CTE courses and created the requirement that States create at least one "program of study," which, among other things, must include coherent and rigorous content aligned with challenging academic standards and must incorporate secondary and postsecondary elements. As such, the CTE program will continue to support the Administration's goal of decreasing the dropout rate by supporting high school reform efforts that make coursework more coherent, challenging, and relevant to postsecondary education, training, and the workforce.

INTERGOVERNMENTAL JOB TRAINING PROGRAMS REVIEW

Question. The Congressional Budget Justification indicates that the administration is conducting a comprehensive review of job training programs to assess their effectiveness. What is the Department's timeline for completing action on this review?

Answer. In preparation for the upcoming reauthorization of the Workforce Investment Act (WIA), the Department has been working with the Department of Labor, Domestic Policy Council, and Office of Management and Budget to review job training programs administered by both agencies. The goal is to ensure that education and labor programs work together effectively at the local level to provide seamless career advancement services for low-skilled adults, at-risk youth, and others needing employment and training. The review will inform the administration's policies on reauthorization of the WIA as well as budget policies in the President's 2011 budget request.

Question. What actions (and associated findings) have been completed to date?

Answer. The Office of Management and Budget has convened meetings with the Department of Education, Department of Labor, and the Domestic Policy Council to discuss the existing job training programs and the process for developing a reauthorization proposal.

NATIONAL INSTITUTE FOR LITERACY

Question. The fiscal year 2010 budget request proposes to eliminate funding for the National Institute for Literacy (NIFL). The Congressional Budget Justification indicates that the NIFL resources would be absorbed by the Department, which would continue NIFL activities that are of value to the field. How will the Department determine which activities to continue?

Answer. The Department has begun to organize meetings in order to learn more about the needs of the adult literacy and adult education communities. Once we have completed that process, we will review the existing NIFL activities and determine which of them still meet a current need and, of those, which could be subsumed within existing projects in the Department and which need to be continued regardless of the vehicle. NIFL's current system of delivery, LINCS, will be part of

this review. In addition, the Department has already heard from the adult literacy and adult education field that there is a desire to create a new center on adult literacy and education. The center could provide many of the services that are authorized for NIFL under the WIA.

Question. Which National Institute for Literacy activities are continued with resources available in the fiscal year 2010 budget request?

Answer. The Department will need to complete a review of NIFL's existing activities in order to determine which activities should be continued. The funds appropriated for NIFL are multi-year funds. NIFL has not yet begun to expend its fiscal year 2009 funds and will have access to its fiscal year 2009 appropriation through September 30, 2010. This provides the Department with ample time to review the fiscal year 2010 appropriations and make decisions about the activities to continue, initiate, or terminate.

RESEARCH ON ADULT EDUCATION AND LITERACY

Question. Roughly 30 million adults have educational issues that make difficult their pursuit of education, occupational training, and securing or retaining a job. Specifically, how much research, development, and dissemination funding has IES previously dedicated to specific funding opportunities to support rigorous research on programs and strategies designed to help adults develop the reading and writing skills they need to be successful in school and/or work?

Answer. The following chart includes grants and cooperative agreements, including award amounts, awarded by the IES for research projects that focus on the development of reading and writing skills in adult students. IES would have made additional awards on this topic if more applications had been judged to be of higher quality by peer reviewers. Approximately 30 percent of the funding of the National Center on Postsecondary Research is devoted to research related to helping adults develop reading and writing skills. Other grants shown are exclusively on this topic.

RESEARCH ON ADULT EDUCATION AND LITERACY

Title of research project	Grantee	Year	Amount
Improving Adults' Reading Outcomes with Strategic Tutoring and Content Enhancement Routines	Daryl Mellard/University of Kansas	2007	$1,991,961
Postsecondary Content-Area Reading-Writing Intervention: Development and Determination of Potential Efficacy	Dolores Perin/Teachers College, Columbia University.	2006	1,168,758
The Writing Pal: An Intelligent Tutoring System that Provides Interactive Writing Strategy Training	Danielle McNamara/University of Memphis.	2008	2,015,456
Assessing Reading Comprehension with Verbal Protocols and Latent Semantic Analysis	Joseph Magliano/Northern Illinois University.	2004	1,560,506
Developing Reading Comprehension Assessments Targeting Struggling Readers	John Sabatini/Educational Testing Service.	2004	1,572,635
Developing a Program of Postsecondary Academic Instruction Over the Corrections Learning Network	Stephen Steurer/Correctional Education Association.	2007	1,997,936
The Effects of College Remediation on Students' Academic and Labor Market Outcomes	Isaac McFarlin/University of Texas, Dallas.	2007	301,687
National Center for the Study of Adult Learning and Literacy (http://www.ncsall.net/?id=1)	John Comings	1996 (to 2007)	30,191,490
National Center for Postsecondary Research (http://www.postsecondaryresearch.org)	Thomas Bailey	2006	9,813,619

MAJOR FINDINGS OF RESEARCH ON ADULT READING AND WRITING

Question. What have been the major activities/findings supported by this funding?

Answer. Research on programs and practices to help adults develop their reading and writing skills has been funded through three mechanisms: (a) reading and writing research programs, (b) the postsecondary education research program, and (c) the national research and development center program.

Reading and Writing Research Programs for Adult Learners

IES has solicited applications for research on improving reading outcomes for adult learners through its research programs on reading and writing since 2002, but it has received relatively few applications for research on this topic despite the need for flexible and appropriate interventions for adult learners and for materials that enable adult education instructors to teach reading to underprepared adults. In

order to stimulate more interest in research on this topic, in 2007, IES created a separate research program called "Interventions for Struggling Adolescent and Adult Readers and Writers."

To date, five research projects on adult literacy have been awarded. IES-funded researchers at the University of Kansas are developing interventions for Job Corps participants that focus both on mastering literacy skills and on developing the knowledge and skills needed to pass the vocational certification tests. A team at Teachers College is working to improve interventions for community college students in remedial reading classes. University of Memphis researchers are developing a computer tutor that adults can use to support their mastery of writing. The remaining grant on this topic supports the development of assessments for use with adult readers and writers. The assessment of adults has provided ongoing challenges, both because the content of typical reading assessments is inappropriate for adults, and because current assessments do not provide sufficient discrimination at the low ability end. IES is supporting the development of two new sets of assessments to address these issues.

Improving Reading Outcomes for Adults Underprepared for Postsecondary Education

IES has funded research on improving reading outcomes for adults who are underprepared for postsecondary education through its postsecondary education research program. The researchers on one of the grants are evaluating the impact of a satellite-based distance learning program for prisoners aged 18–25 on the adults' academic achievement, progress toward a degree, recidivism, and subsequent workforce participation. The results of this evaluation are not yet available. A second project examines the effects of remediation courses on postsecondary students in Texas and Florida. Initial results have found existing remedial education programs to have no benefits for Texas students attending 2- or 4-year institutions in regards to academic credits attempted, likelihood of completing 1 year of college, degree completion, transferring to a 4-year college, or labor market earnings.

NATIONAL RESEARCH AND DEVELOPMENT CENTERS RESEARCH ON ADULT LITERACY

Through grants from IES, two national research and development centers, the National Center on Postsecondary Research and the National Center for the Study of Adult Learning and Literacy, have addressed adult literacy challenges. From 1996 to 2007, the Department of Education, through Office of Educational Research and Improvement and then IES, supported the National Center for the Study of Adult Learning and Literacy (NCSALL). NCSALL conducted primarily descriptive research highlighting the diversity of individuals being served by adult literacy instruction, characteristics of adult basic education teachers, and social and instructional processes that occur in adult education classes. In addition, NCSALL engaged in dissemination of information to practitioners.

The National Center for Postsecondary Research (NCPR) is measuring the effectiveness of programs designed to help students master the basic skills needed to advance to a degree. Their broad program of research includes two projects that specifically target reading skills for underprepared postsecondary students. The first study examines the impact of remedial English courses in community and 4-year colleges and has found that remediation improved persistence among Florida community college students but did not increase the likelihood of course completion, transfer to a 4-year school, or degree completion. The other project (no findings yet) focuses on the use of learning communities (some specifically target reading or English) in community colleges.

Although there is a great need for additional rigorous research in this area, the current capacity of the field to carry out this research is limited. In order to rectify this, IES continues to reach out to the adult education research community and to stimulate interest in adult education research on the part of researchers who have conducted rigorous research on K–12 students.

FUNDING FOR RESEARCH ON ADULT READING AND WRITING

Question. How much funding is allocated to adult reading and writing research in the current year, as well as under the budget request?

Answer. The number of grants IES awards in any year depends on the number of high-quality applications received under a specific program, such as the research program on Interventions for Struggling Adolescent and Adult Readers and Writers. No new applications for research on adult reading and writing were awarded in 2009 because IES did not receive any applications in 2009 that peer reviewers determined warranted support. Ongoing projects are receiving support. IES is unable to predict how much funding will be allocated to adult reading and writing research

in 2010, but the budget request for 2010 is sufficient to fund all applications on this topic that peer reviewers judge to be of high quality.

WHAT WORKS CLEARINGHOUSE

Question. Last year, in response to concerns raised about the operation of the What Works Clearinghouse (WWC), the National Board on Education Sciences convened an expert panel to perform a focused study addressing the fundamental question of whether the Clearinghouse's evidence review process and reports are scientifically valid. The panel report found that is generally the case, but made a number of recommendations, including that the Department of Education commission a comprehensive review of the full range of WWC activities and procedures, with a timeframe to allow a complete consideration of a number of issues that could not be fully evaluated in the Expert Panel report. What action is IES taking in and/or planning for the current fiscal year and fiscal year 2010 to address these recommendations?

Answer. The WWC and its statistical team are currently considering how the WWC standards should take into account study size and other issues noted by the expert panel. The WWC released a Procedures and Standards Handbook [Version 2.0] in December 2008 as a result of the panel's report. A comprehensive review of the full range of WWC activities and procedures and of its other dissemination activities will be a high priority for IES and its new leadership as it begins to consider reauthorization of the Education Sciences Reform Act and the development of a statement of work for the next competition for the WWC contract.

PROGRAM ADMINISTRATION STAFF INCREASES

Question. The fiscal year 2010 budget proposes a net increase of 58 full-time equivalent staff (FTEs) above the 2009 level for key positions not staffed in 2009 due to funding constraints and to implement the Recovery Act. The Congressional Budget Justification identifies 7 FTEs in the Office of Elementary and Secondary Education needed for Recovery Act implementation. Please identify the positions not staffed in 2009 due to funding constraints, as well as the impact of not staffing these positions in 2009 and in 2010.

Answer. The additional staff requested in fiscal year 2010 are necessary to perform several key functions not performed at optimal levels in 2009 due to funding constraints. These functions are grouped into the four areas listed below.

The first function requiring additional staff is monitoring grants awarded by the Department in a variety of areas including elementary education, postsecondary education, and in programs grants focusing on providing services to individuals with disabilities. Additional monitoring is needed to ensure that Department programs are both improving the quality of education and are fiscally sound.

Additional staff are also needed to work on increasing college access and student success by restructuring and dramatically expanding Federal financial aid, while making programs simpler, more reliable, and more efficient. A key component of this effort is to simplify the Federal application for student aid—Free Application for Federal Student Aid (FAFSA)—making it easier to complete and more effective for students.

Increased staff will also work on the administration's priorities related to reauthorization of the ESEA and the WIA.

Finally, staff are needed for the Department's staff offices to work on activities including budgeting, legislative affairs, public outreach, and policy formulation.

RECOVERY ACT ADMINISTRATIVE ACTIVITIES

Question. The Recovery Act required Department staff to take many actions this budget year, including developing and issuing guidance documents, allocating funds, and writing requests for proposals, without additional resources. What specific activities would be undertaken with these requested funds?

Answer. For several Recovery Act programs, such as the State Fiscal Stabilization Fund, Teacher Incentive Fund, and Impact Aid, the Department received appropriated funds for the purpose of administration and oversight. For Recovery Act programs without any administration and oversight funds, the Department has included funds necessary for this purpose in its fiscal year 2010 program administration budget request. ARRA-specific administration and oversight activities include policy development, grant award (either through allocation or grant competition), technical assistance—ensuring that grantees effectively and properly use their funds, grant reporting, and grant monitoring. In many cases, the Department assumed these activities would be covered with existing resources and staff time.

COMPLIANCE AND TECHNICAL ASSISTANCE ACTIVITIES IN THE OFFICE FOR CIVIL RIGHTS

Question. Over the last decade, more than half of the Office for Civil Rights' (OCR) complaint receipts have alleged disability discrimination. Please explain the compliance and technical assistance activities that OCR is taking currently or planning to undertake in the current budget year and fiscal year 2010.

Answer. Shown below is a list of the 29 fiscal year 2009 compliance reviews conducted by OCR. Also shown below is a list of the fiscal year 2009 planned technical assistance activities. More than 100 technical assistance presentations have already been done by OCR on the issues listed, some initiated by OCR and others requested by recipients or interested other parties such as parent groups or students. In addition, OCR does other technical assistance as requested.

Concerning the compliance reviews and technical assistance activities that OCR plans to conduct in fiscal year 2010, those plans are being developed now.

Fiscal year 2009 OCR Compliance Reviews

Fiscal year 2009 OCR Compliance Reviews:

—Providence Public Schools (RI)

Title VI: English Language Learners services, Limited English Proficient parent communication

—Sachem Central School District (NY)

Section 504/ADA: Coordinator, grievance procedures

—Hempstead Union Free School District (NY)

Section 504/ADA: Coordinator, grievance procedures

—New York City Department of Education, P.S. K396 (NY)

Section 504/ADA: Implementation of individual education programs

—New York City Department of Education, P.S. M094 (NY)

Section 504/ADA: Implementation of individual education programs

—College of Notre Dame (MD)

Title IX, Section 504/ADA: Coordinator, grievance procedures

—Hood College (MD)

Title IX, Section 504/ADA; Coordinator, grievance procedures

—Cleveland County (SC)

Title IX: Athletics

—Hillsborough County School District (FL)

Title IX: Sexual harassment policies and procedures

—St. Lucie County School District (FL)

Section 504/ADA: Disparate discipline

—Painesville City Local School District (OH)

Title VI: English Language Learners services

—Notre Dame College (OH)

Title IX: Sexual harassment policies and procedures

—Eastern Michigan University (MI)

Title IX: Sexual harassment policies and procedures

—Moline School District (IL)

Title VI: English Language Learners services, Limited English Proficient parent communication

—Ball State University (IN)

Title IX: Athletics

—Bayless School District (MO)

English Language Learners services

—Cape Girardeau #63 School District (MO)

Section 504/ADA: Physical accessibility

—South Brown County U.S.D. #430 (KS)

Title VI: National origin-based harassment, different treatment

—Jenks Public Schools (OK)

Section 504/ADA: Implementation of individual education programs

—Texas A & M University (TX)

Title IX, Section 504/ADA, Grievance procedures

—Campbell County School District (WY)

Section 504/ADA: Coordinator, grievance procedures

—Churchill County School District (WA)

Title IX: Athletics

—Idaho Falls School District 91 (ID)

Title IX: Athletics

—Seattle School District No. 1 (WA)

Title VI: School closings

—University of Montana (MT)

Section 504/ADA: Physical accessibility
—University of Montana-Western (MT)
Section 504/ADA: Physical accessibility
—Mt. Diablo Unified School District (CA)
Title VI: English language learners services
—Ontario-Montclair Elementary School District (CA)
Title VI, Section 504/ADA: Placement of English Language Learners in special education
—Vallejo Unified School District (CA)
Title VI: Race-based disparate discipline

Fiscal year 2009 Planned OCR Technical Assistance Activities

Fiscal year 2009 Planned OCR Technical Assistance Activities:
The list that follows is only the list of subjects that OCR planned to address in fiscal year 2009.
Section 504 /ADA:
—Identification and evaluation of students;
—TA to postsecondary institutions whose Web sites are inaccessible to individuals with disabilities;
—Transition of students with disabilities from high school to postsecondary institutions;
—Training to elementary and secondary special education directors and 504 coordinators;
—TA to postsecondary institutions and veterans concerning services for disabled veterans;
—Procedural safeguards and impartial hearing process;
—Academic adjustments and auxiliary aids; and
—Students with disabilities in college.
Title IX:
—Grievance procedures and responsibilities of Title IX coordinators; and
—Sexual harassment.
Title IX: Athletics (postsecondary)
Title VI:
—Limited English proficiency
Early Complaint Resolution:
—TA to promote the use of ECR by complainants and recipients.

PROPOSED ORGANIZATIONAL PLACEMENT OF OFFICE OF CIVIL RIGHTS STAFF INCREASES

Question. How will the additional 19 FTEs in the fiscal year 2010 budget request be deployed with respect to its organization and mission?

Answer. The 19 FTE will restore OCR's staff to a level necessary to fulfill its mission, and ensure successful management of OCR programs and priorities. Sixteen FTE will be assigned to OCR's regional offices for resolving complaints and compliance reviews, and three FTE will be used in headquarters for developing policy guidance and technical assistance materials.

QUESTIONS SUBMITTED BY SENATOR PATTY MURRAY

EARLY CHILDHOOD EDUCATION

Question. President Obama included $7.2 billion for Head Start in his budget, which is actually a decrease from the fiscal year 2009 regular appropriations level, not including stimulus funding. While I am pleased that the significant recovery funding for Head Start programs is starting to help our State and local communities who are struggling, I know that a strong, sustained investment in Head Start is the only way that this program can continue to be effective, particularly in light of the improvement and coordination tasks we have asked Head Start programs to take on as part of reauthorization. Do you plan to increase funding for Head Start programs in future years, when stimulus funding has ended?

Answer. Since the Head Start program is administered by the Department of Health and Human Services, Secretary Sebelius would be better suited to answer your question.

EARLY LEARNING CHALLENGE FUND

Question. How does your $300 million early learning challenge grant proposal connect to existing Federal and State funding streams such as Head Start, child care, pre-K, and their K–12 systems?

Answer. The new Early Learning Challenge Fund would serve to improve the quality of existing and proposed Federal investments in early childhood programs, including Head Start, by funding State efforts to develop a statewide infrastructure of integrated early learning supports and services for children. With this framework in place, States would be able to compare the quality of services for children from birth through age 5 without regard to funding source, which would also inform Federal and State decisionmaking regarding investments in early learning.

Question. How will the grants encourage recipient States to take high-quality pre-K to a larger scale and build an early childhood system around a strong and successful program?

Answer. The grants would support State efforts to improve the quality of existing early childhood services by holding all publicly funded programs to a common set of State-developed standards. The administration expects that this effort would build a pathway for increased Federal, State, and local investments in high-quality early childhood programs in the coming years.

LITERACY—EARLY READING PROGRAMS

Question. I was excited to see that the President included funding for early and adolescent literacy grants in the fiscal year 2010 budget proposal. In the last session of Congress, I introduced a literacy bill, called the Striving Readers Act, along with my colleague Senator Sessions. A companion bill passed on the House side last year. There is clearly bipartisan interest here in Congress for creating an improved adolescent literacy program, hopefully as part of a comprehensive literacy program for young children all the way through grade 12.

Can you tell us a little bit more about what this literacy program would look like and why the administration chose to include both adolescent and early literacy grants in the proposal?

Answer. The administration's request for the Striving Readers Act included an increase both to build on the success of the current Striving Readers program, which focuses on adolescent literacy, and to enable schools to implement innovative and effective strategies for improving the reading comprehension of students in low-income elementary schools. We structured the request to emphasize the importance of continued investment in high-quality literacy programs from elementary school through high school, and also to invoke an existing authority to request funds for early reading services that would draw lessons from and addresses the deficiencies of Reading First and other literacy efforts. Applicants would be required, at a minimum, to serve students in grades kindergarten to third grade and would be encouraged to extend services to children in pre-kindergarten and in the fourth or fifth grades. Applicants would also be required to demonstrate how they would coordinate their reading programs from preschool through fifth grade, including with activities supported with funds from other Federal, State, or local sources. The Department would require participating schools to incorporate proven practices into their programs, including by providing a significant amount of time focused exclusively on reading instruction as well as integrating reading instruction into other content areas across the curriculum.

FEDERAL SUPPORT FOR EARLY LEARNING LITERACY PROGRAMS

Question. Do you see a strong continued role for Federal support of kindergarten through grade three literacy programs in States?

Answer. Research shows that early reading skills are a major predictor of future success in school. We do believe that the Federal funds should be used support high-quality literacy programs. This is why the administration included $300 million for early reading in the budget request.

Question. Do I have your commitment to work together on this literacy proposal to ensure that we have the best continuum of literacy supports possible for our youth?

Answer. I look forward to having these discussions with you in the coming months.

ADULT LITERACY PROGRAMS AND REAUTHORIZATION OF THE WORKFORCE INVESTMENT ACT

Question. What is your vision for adult literacy, for those who may not yet have gained the skills they need to be successful in the workforce?

Answer. The reauthorization of the Workforce Investment Act (WIA) provides an opportunity for the administration to look carefully at the needs of low-literate adults. The Departments of Education and Labor envision a modernized service delivery system that provides seamless support for adults who seek employment, re-

gardless of their needs. This system would provide integrated solutions to meet the needs of both workers and employers. The Department of Education currently envisions a reauthorized WIA that leads to all States having adult education standards that are aligned with standards for college and career readiness. Finally, the Department of Education believes that the adult education and adult literacy communities must identify successful practices for meeting the needs of the diverse groups of adult learners, such as adults with limited English proficiency, youth at risk of dropping out of school, and adults who have not attained the requisite skills needed for jobs that will enable them to support themselves and their families.

DATA COLLECTION AND THE SDFSC PROGRAM

Question. Secretary Duncan, as you know the administration has proposed to move all of the SDFSC State Grant funding into national programs.

It is my understanding that the Department of Education under the last administration did very little to collect data under the SDFSC program, although these data collection efforts are specifically required by law. Why is the administration not taking the first step of fully honoring data collection and accountability requirements and examining the new data on whether this program works as a State grant before moving all of the funding to national efforts?

Answer. The Elementary and Secondary Education Act of 1965 requires that each State participating in the SDFSC State Grants program implement a Uniform Management Information and Reporting System (UMIRS) and make information about drug and violence prevention programs available to the public. Specifically, the UMIRS provisions require that States report information about truancy rates and drug- and violence-related offenses resulting in suspensions or expulsions. These data are required to be reported at the school-building level. Additionally, States must also report information about types of curricula, programs, and services provided with SDFSC State Grants program funds, and information about incidence and prevalence, age of onset, perception of health risk and perception of social disapproval of drug use and violence. We have monitored State implementation of the UMIRS requirements during the past several years and have not identified significant instances of noncompliance.

The SDFSC program also requires that States provide reports about their implementation and outcomes of programs supported with State Grants program funds, as well as information about their progress in attaining identified performance measures, and on the State's efforts to inform parents of and include parents in drug and violence prevention efforts.

We have collected some of this information from States as part of the Consolidated State Performance Report (CSPR). In an effort to minimize data collection and reporting burden for the States, we requested data from States only about truancy and suspensions and expulsions for drug- or violence-related offenses—information that States are required by the UMIRS provisions. States have also reported their progress toward meeting the performance measures they identified for the program.

The statute does not create a unified system of data collection and reporting; rather it requires that each State create its own, uniform system. Because we believe that it would be valuable for States to collect and report the required data in a manner that is more uniform across the States, we have worked with States to identify a uniform data set that includes common definitions and collection protocols for data required by the UMIRS requirements. We are beginning to use those definitions and protocols in CSPR collections, but the definitions and protocols are voluntary.

STATUTORY FUNDING REQUIREMENTS UNDER SDFSC STATE GRANTS PROGRAM

We believe that we have implemented the statutory requirements of the current authorization, but continuing concerns about the SDFSC State Grants program stem not just from the challenges involved in collecting and aggregating meaningful outcomes data for the program. The most significant concern is the current structure of the program, which requires that funding be distributed to any local school districts that wish to participate. Even when program funding levels were significantly greater than they are now, such as in fiscal year 2004 (2004–2005 school year), fully two-thirds of participating school districts (67 percent) received less than $10,000 under the program. Realistically, grants of this size are not sufficient to permit districts to adopt and implement high-quality programs for even a small proportion of their students.

FUNDING SUPPORT FOR DRUG AND ALCOHOL ABUSE PREVENTION AND VIOLENCE PREVENTION PROGRAMS

Question. With State and local budgets strained or massively cut back across the Nation, if a local educational agency (LEA) does not receive funding under the proposed new funding for the national program, how does the administration expect that this district will continue their efforts to prevent drug and alcohol abuse and prevent violence among students? I believe this question is particularly important in a time of economic crisis when we tend to see an increase in concerning activities among youth and families.

Answer. As your question suggests, many States and localities are experiencing the most significant economic challenges in memory, and the result is that policy makers at all levels of government are being forced to make very painful choices about where to spend a declining pool of revenues. Just as State and local officials are reviewing expenditures very closely and establishing priority uses for limited available funding, the administration engaged in a similar process in developing the President's fiscal year 2010 budget request. Ultimately, we had to identify program terminations or consolidations in order to reduce spending. Part of the process for formulating the fiscal year 2010 budget included reviewing available information about program effectiveness or other analyses that point to problems that may limit a program's capacity to produce desired outcomes. Findings from recent assessments of the program and from the Rand study suggested that the SDFSC program is not currently structured in a way that is likely to be able to demonstrate significant student outcomes.

I share your concern about the importance of preventing drug and alcohol use and violent behavior among students and know both of these behaviors not only imperil students, but also pose significant barriers to student academic achievement. We are anxious to make the best investments we can in order to address these problems, and believe that the new $100 million initiative to improve school culture and climate (included in the fiscal year 2010 budget request under SDFSC national programs) provides the best opportunity in the current economic climate to make a meaningful difference in a significant number of schools and communities.

Support provided under the State Fiscal Stabilization Fund (SFSF), part of funding appropriated under the American Recovery and Reinvestment Act of 2009, may also be a potential source of support for drug and violence prevention programs and activities. Monies available to States under either component of the SFSF program—the Education Stabilization Fund or the Government Services Fund—may be used to support a broad range of educational services and activities, including prevention programming, in elementary and secondary school settings.

TECHNICAL ASSISTANCE FOR LEAS FOR SDFSC PROGRAMS

Question. How will technical assistance and training be consistently provided to LEAs without the State assisting with that role, and does the Department of Education have the capacity to take on this role?

Answer. The Department will continue to provide some technical assistance to States relating to safe and drug-free schools, but lacks both the funding and staffing to become a primary provider of technical assistance directly to schools, school districts, and communities across the country. Several States have developed and maintain school safety centers or other technical assistance infrastructure. While some support for some of these centers has been provided by SDFSC State Grants funds, in other cases support for technical assistance has been provided with State monies. I encourage States to continue to make this kind of activity a priority.

QUESTIONS SUBMITTED BY SENATOR MARY L. LANDRIEU

EVEN START

Question. The President's budget request does not include funding for Even Start, the national early childhood and parenting program. I understand that some Even Start programs in the country have not been effective. However, in my State of Louisiana, we have some excellent Even Start programs that will be devastated by this loss. Could you explain the decision to eliminate Even Start and propose options for the 60,000 participants who will be left without services?

Answer. Based on the results of three national evaluations, the administration believes that the Even Start program has not yielded meaningful benefits for children and families. For example, the most recent evaluation concluded that, while Even Start participants demonstrated small improvements in some outcomes, they did not

perform better than the comparison group that did not receive Even Start services. As a result, the administration chose to direct the resources to other efforts that would better address the needs of children and families. Specifically, the administration has requested almost $1 billion for early childhood programs at the Department of Education, including $500 million for the new Title I Early Childhood Grants, $300 million for the new Early Learning Challenge Fund, and $162.5 million for Early Reading First, in addition to more than $6.5 billion in funding for Head Start at the Department of Health and Human Services (HHS). Further, the Department has requested more than $628 million for Adult Basic and Literacy Education State Grants, a program that supports activities similar to some of the components of Even Start, such as English literacy, adult basic education, and family literacy services. We believe that these programs will serve the same types of children and adults as are served by Even Start.

EARLY LEARNING CHALLENGE FUND

Question. Your budget request includes $300 million to launch the Early Learning Challenge Fund. How will this fund be administered and how does it fit into the administration's overall vision for early childhood education?

Answer. The Department will be working closely with HHS to administer the new Early Learning Challenge Fund program. This new program would support statewide systems of early learning and support that apply a standard set of expectations in both the educational and the social-emotional domains in order to provide children with the preparation they need to enter kindergarten ready for success while empowering parents to seek and select the care that best serves their children. The administration's overall vision is for children to come to school socially and cognitively prepared to learn, and we expect that the quality improvement efforts supported by the Early Learning Challenge Fund would build a pathway to improvements in early learning program quality and, in future years, increased investment in high-quality early childhood services.

TEACHER INCENTIVE FUND (TIF)

Question. The administration requests the TIF increase to $517 million. How does the administration plan to encourage these States and local educational agencies (LEAs) to develop and use innovative and effective teacher compensation systems?

Answer. With the requested fiscal year 2010 funds, the Department will hold a grant competition for up to 100 new awards to LEAs, including charter schools that are LEAs, or States (or partnerships of: an LEA, a State, or both; and at least one nonprofit organization) to develop and implement performance-based compensation systems for teachers, principals, and other personnel in high-need schools.

In an fiscal year 2010 competition, the Department will place a priority on the support of comprehensive, aligned approaches that: (1) support improved teacher and principal effectiveness and help ensure an equitable distribution of effective educators; (2) actively involve teachers (including special education teachers) and principals in the design of human capital and compensation systems; and (3) use data from emerging State and local longitudinal data systems to track outcomes and associate those outcomes with educator performance.

PRIORITIES IN USE OF FUNDS FROM AMERICAN RECOVERY AND REINVESTMENT ACT (ARRA) AND THE TEACHER INCENTIVE FUND

Question. How will the TIF work in conjunction with funds from the ARRA?

Answer. The Department expects to use approximately $140 million of the ARRA appropriation for about 60 new awards, $50 million for continuation awards, and up to $10 million for the mandated national evaluation. With ARRA funds, and in response to lessons learned from the first two rounds of TIF grants and from other efforts around the country to improve educator effectiveness, the Department will place a priority on the support of: comprehensive, aligned approaches that support improved teacher and principal effectiveness and help ensure an equitable distribution of effective educators; that actively involve teachers (including special education teachers) and principals in the design of human capital and compensation systems; and that use data from emerging State and local longitudinal data systems to track outcomes and associate those outcomes with educator performance.

With the funds requested for TIF in fiscal year 2010, the Department would launch a grant competition—for up to 100 new awards—encompassing the new strategies and emphases being implemented with the ARRA funding. This new competition will support the ARRA objectives of improving teacher effectiveness, reducing disparities in the access of students to effective teachers, and turning around

persistently low-performing schools. Funds requested for fiscal year 2010 would also support 94 continuation awards.

Priorities for an fiscal year 2010 competition would be similar to those for the ARRA competition; however, the Department has requested appropriations language that would also allow fiscal year 2010 grantees to use TIF funds to reward all staff in a school, as opposed to only teachers and principals.

FEDERAL FACILITIES FUNDING FOR CHARTER SCHOOLS

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 $52 million increase for Charter Schools Grants. How does the administration plan to address the challenges charter schools face in securing facilities funding?

Answer. The administration understands that access to public facilities or funding for facilities is one of the major challenges confronting charter school operators, and we are committed to helping charter schools secure facilities funding. This issue will certainly be one that we plan to address during reauthorization. In the meantime, there are a number of Federal programs that support facilities financing for charter schools, including the State Charter School Facilities Incentive Grants, Credit Enhancement for Charter School Facilities, Qualified Zone Academy Bonds (QZABs), Qualified School Construction Bonds (QSCBs), Build America Bonds (BABs), and one-time funding under the State Fiscal Stabilization Fund (SFSF).

The primary Federal funding sources for charter school facilities are the Department's State Charter School Facilities Incentive Grants and Credit Enhancement for Charter School Facilities programs. The State Charter School Facilities Incentive program provides 5-year grants to States with per-pupil facilities aid programs to assist charter schools in the purchase or acquisition of facilities. In the past 5 years, the Department has awarded more than $90 million to 4 States that, by combining Federal grant funds with State matching funds, have provided facilities funding to more than 600 charter schools. The administration is committed to maintaining the momentum of this program and plans to award more than $12.7 million this summer to a new cohort of State Facilities Incentive grantees. Similarly, the Department's Credit Enhancement for Charter School Facilities program provides grants to support charter schools in the acquisition or renovation of facilities. The Credit Enhancement grants are awarded on a competitive basis to public and nonprofit entities to assist charter schools in securing facilities financing, through loan guarantees, lease guarantees, and other credit enhancement methods. These grants operate until the Federal funds and earnings on those funds have been expended for the grant purposes or until financing facilitated by the grant has been retired. Since 2001, the Department has awarded more than $214 million in grants, with another $8.3 million requested in fiscal year 2010, to provide charter schools with access to financing to help them acquire, build, or renovate school facilities.

Charter schools may also benefit from other Federal subsidies for public school improvement and modernization activities, including QZABs, QSCBs, and BABs. The ARRA authorized tax-credit bonds for school construction by expanding QZABs from $400 million annually to $1.4 billion for each of calendar years 2009 and 2010, and authorizing $11.2 billion in the new QSCBs for each of those 2 years. QZABs provide funding for school repairs and renovation and certain other activities for eligible schools and may not be used for new construction, while QSCBs and BABs provide funding for new construction as well as renovation.

USE OF SFSF FOR CHARTER SCHOOL FACILITIES FUNDING

The SFSF, a one-time appropriation of $53.6 billion under ARRA, provides funds to States that also may be used to assist charter schools with their facilities challenges. By the end of 2009, the Department plans to award approximately $48.6 billion to governors under the SFSF program in exchange for a commitment to support essential education reforms, including reforms involving charter schools. Under the SFSF program, governors are required to use 81.8 percent of the SFSF State grant funds to support public elementary, secondary, and higher education programs and 18.2 percent for public safety and other government services, including the modernization, renovation, or repair of public schools and facilities. Therefore, a charter school LEA should receive stabilization funding on the same basis as other LEAs in the State. State educational agencies (SEAs) are also required to take necessary steps to ensure that a newly opened or expanded charter school LEA receives all of the Federal formula funds to which it is entitled. These additional funds should help address the challenges many charter schools face in securing facilities funding.

EXPANSION AND REPLICATION OF PROMISING CHARTER SCHOOL MODELS

Question. Currently, the Charter Schools Program funds can only go to new school creation and schools cannot receive more than one grant because of a statutory limitation. President Obama has called for replicating and expanding our most successful charter schools. What are ways in which the administration proposes to achieve this goal?

Answer. The replication and expansion of high-quality charter schools will play a central role in the administration's education reform agenda. Since 1995, the Charter School Program (CSP) has provided more than $2.2 billion in financial assistance to SEAs to support planning, development, and initial implementation activities for approximately 1,200 charter schools per year, as well as fund dissemination activities by schools with a demonstrated history of success. Under the program, SEAs also may reserve up to 10 percent of their grant for dissemination subgrants to share lessons learned about how to create, sustain, replicate, and expand high-quality, accountable charter schools.

In the President's fiscal year 2010 budget request, the administration has proposed new appropriations language and the use of available waiver authority to help expand or replicate successful charter school models or networks. The proposed appropriations language would allow the Department to make direct grants to Charter Management Organizations or other entities for replication and expansion of effective charter school models, which should significantly expand the reach of the program. The administration also plans to strengthen program capacity by waiving, in appropriate circumstances, the one-grant limitation and the 18-month planning limitation to allow grantees additional time within the 36-month grant period for planning and implementation.

The administration intends to use a portion of the $8 million available under the CSP national activities set-aside to support activities that promote the expansion and replication of promising charter school models. In fiscal year 2010, the Department plans to hold a new National Charter School Leadership grant competition to support projects of national significance that are designed to build State capacity and assist in the expansion of high-quality charter schools. The Department also will launch a new National Charter School Resource Center, which will provide technical assistance and resources to State and national charter stakeholders to expand the number of high-quality charter schools and increase the national understanding of the charter school model as a key reform strategy.

The administration is also calling on States to reform their charter laws and lift caps that limit growth among excellent high-quality charter schools. We plan to structure the Race to the Top competition in such a way as to create a financial incentive for States to lift their charter school caps and promote accountability and high academic standards in all charter schools. This, in turn, would allow for more rapid expansion and replication of successful charter school models nationwide.

ARRA INNOVATION FUND

Question. In the Innovation Fund section of ARRA, Congress included a special rule allowing nonprofits to apply for grants in partnership with LEAs. This rule says that the eligibility will be determined based on the track record of the nonprofit in improving student achievement. The intent of this language was to ensure that high-quality nonprofits like the ones leading reform efforts in Louisiana could compete for funding to grow their programs. What kind of guidance will the Department issue to facilitate the application process for nonprofits?

Answer. I can assure you that we are focused on providing funds to LEA and nonprofits that have demonstrated results to expand their work and serve as models for others. The Department is working on proposed requirements for the Innovation Fund, which we will release shortly for public comment.

Question. How will nonprofits have to show their impact on student achievement?

Answer. We are working on establishing the parameters of the competition now and will publish the Notice of Proposed Priorities later this summer. The notice will include more detail on how we intend to run the competition, including how nonprofits can demonstrate the impact they have had on student achievement. We encourage the public to review and comment on the Notice.

QUESTIONS SUBMITTED BY SENATOR MARK PRYOR

SAFE AND DRUG-FREE SCHOOLS AND COMMUNITIES

Question. Some concerns were raised during the hearing regarding the State grant and mentoring grant programs under the Safe and Drug-Free Schools and Communities (SDFSC) program. Can you direct me to the studies which determined that the State grant and mentoring grant programs under the SDFSC program are ineffective or not as effective as they were envisioned?

Answer. For the mentoring program, the study I referred to is the Institute of Education Sciences (IES) "Impact Evaluation of the U.S. Department of Education's Student Mentoring Program," which IES released in March 2009.

For the Safe and Drug-Free Schools and Communities State Grant program, there are two studies: (1) "Options for Restructuring the Safe and Drug-Free Schools and Communities Act," which was released by the RAND Corporation in 2001; and (2) "Prevalence and Implementation Fidelity of Research-Based Prevention Programs in Public Schools, which was conducted by Westat and covered the 2004–2005 schools year.

MEASURING THE EFFECTIVENESS OF THE SDFSC STATE GRANT PROGRAM AND MENTORING PROGRAM

Question. What standards did the Department of Education use when measuring the effectiveness of these grant programs?

Answer. The answer follows separately for each study.

Impact Evaluation of the U.S. Department of Education's Student Mentoring Program

The mentoring program evaluation used an experimental design where students were randomly assigned either to receive or not to receive school-based mentoring from one of the Department's grantees. The evaluation assessed the effectiveness of the program by estimating impacts at the end of one school year on the intended program outcomes, as stated in the authorizing legislation, for students who were offered program services versus those who were not.

Outcomes were collected through administration of a student survey and collection of student schools records, and included measures of "prosocial" behavior, absenteeism, school engagement, reading and math scores on State assessments, grades, future orientation, and delinquency (including gang membership). Promiscuous behavior was the only intended program outcome listed in the legislation that was not measured because in the initial phases of instrument development the study team found that questions regarding sexual behaviors or attitudes were not acceptable to principals or parents.

Outcomes were measured at the end of one school year because this provided the most policy-relevant information. Prior research has found that about half of the students in school-based mentoring programs do not receive mentoring after the first school year and that any benefits from a single year of school-based mentoring do not persist beyond the end of the school year.

The evaluation found that for the full sample of students, the program did not lead to statistically significant impacts on any of the measures. The full report and an executive summary are available online at: http://ies.ed.gov/ncee/pubs/20094047/

Options for Restructuring the SDFSC Act

To help inform deliberations on the SDFSC Act reauthorization in 2001, the Department awarded a grant to the RAND Corporation's Drug Policy Research Center to conduct an examination of the program and assess options for improving it. Under the scope of the resulting study, RAND commissioned three analyses of school drug and violence prevention and prepared a background paper describing the history and development of the SDFSC Act program. RAND also conducted two focus groups with teachers and practitioners on the drug and violence problems in their schools and on their experiences with the program in their districts. These activities were preparatory to a 2-day conference held in July 1999, which was attended by programmatic and policy leadership from the Department, classroom teachers, and local program operators, high-level representatives with drug and violence prevention responsibilities in the Departments of Justice and Health and Human Services, and prominent researchers and policy analysts.

The entire study is summarized in one report, and the commissioned papers, a summary of the focus groups, and the background paper are contained in a companion volume. Each can be found on-line at:

http://www.rand.org/pubs/monograph—reports/MR1328/

and

http://www.rand.org/pubs/monograph—reports/MR1328.1/

As the Department's fiscal year 2010 budget justification for the SDFSC State Grant program indicates, the study found that the program does not adequately target schools most needing help and generally spreads funding too thinly at the local level to support quality interventions.

Prevalence and Implementation Fidelity of Research-based Prevention Programs in Public Schools

This study examined, for the 2004–2005 school year: (1) the prevalence of research-based drug and violence prevention programs in schools; and (2) the extent to which research-based drug and violence prevention programs implemented in schools adhered to the program features on which they are based (i.e., were implemented with fidelity to the program design that was validated as effective by the research).

In conducting this study more than 300 programs were screened and reviewed by Westat to determine the level of research rigor behind the programs' literature base. The study identified 21 school-based prevention programs that demonstrated evidence of effectiveness through this systematic review of literature.

The study then used national probability sample surveys of districts and schools to estimate program prevalence, and national probability sample surveys of schools and research-based prevention programs to estimate fidelity of implementation. The surveys used both mail- and Web-based approaches to gather information on prevention programs and on the factors that may be associated with the adoption of research-based programs. Univariate analyses (e.g., percentage of schools with a research-based program) and bivariate analyses (e.g., percentage of schools with a research-based program by the number of students enrolled) were conducted. Tests of statistical significance were conducted. Because the surveys undertaken had a complex multistage sample design, a replication methodology was used to establish variance strata and primary sampling units, and create replicate weights for each specific subsample of the full sample.

The two main findings of the study were as follows: (1) only 7.8 percent of drug and violence prevention programs and practices supported with SDFSC State Grant funds in 2004–05 were research-based (i.e., the 21 research-based prevention programs comprised only 7.8 percent of all prevention programs implemented in schools); and (2) 44.3 percent of SDFSC-funded researched drug and violence prevention curriculum programs were implemented with fidelity (i.e., met minimum standards for overall fidelity of implementation). The report of the study is expected to be completed later this year.

SAFE AND DRUG-FREE SCHOOLS AND COMMUNITIES NATIONAL PROGRAMS

Question. How will you alter the SDFSC national program to meet the needs of the individual populations that are currently served through the State and mentoring grant programs?

Answer. No alteration of the national programs is needed. Generally, under the various national programs grant competitions, applicants have the opportunity to select target populations and design and implement projects based on locally identified needs, existing programming, or other unique local conditions.

Please also know that for the mentoring program, at our national conference in August we will be having a special grantee meeting focused on sustainability, to assist grantees in their transitions to no funding next year. We are also having discussions with organizations, such as Big Brothers, Big Sisters, which are active in mentoring, about possible assistance to grantees once the Federal funding ends.

MENTORING RESOURCE CENTER

Finally, SDFSC mentoring program funds will support the operation of the Mentoring Resource Center (MRC) through the end of this fiscal year. The MRC has served as the Department's training and technical assistance provider to grantees and provided them with training, publications, site visits, online learning, and other opportunities for program and staff development. When the MRC contract ends in October we are considering maintaining the significant body of resources it has developed on an archival site, or transferring the assets to another Federal agency where they can be a continued resource for mentoring grantees and for others involved in creating mentoring programs.

UPDATED GUIDANCE ON TITLE I WAIVERS

Question. With regard to stimulus funding, are there plans for additional or updated guidance pertaining to title I waivers, and if so, when do you anticipate this guidance to be available?

Answer. The Department expects to release guidance on title I waivers related to funding provided under the Recovery Act in July 2009.

STUDENTS AND THE LOAN PROCESS

Question. The fiscal year 2010 budget proposes to eliminate the Federal Family Education Loan Program (FFELP) and make certain that all Federal student loans are handled through the Direct Loan Program (DLP) by July 2010. One concern regarding this proposal is the potential loss of local services currently provided to students including loan default prevention, financial counseling and discounting interest rates for students that choose to enter high demand fields. Students can walk into their local bank or our State lending agency and receive personal guidance on making wise financial choices for their future.

How will students navigate the student loan process if they are calling the Department of Education (DOE) rather than their local bank or lending agency?

Answer. Students and families will see very little difference in the student loan process under the President's proposal. Consistent with current practice, initial interactions for most students will be with their school's financial aid office. Under either FFELP or direct loans, the loan process is highly automated, with applications, entrance and exit counseling, and other information available electronically through the school Website. Extensive guidance for students and parents is also available from the Department.

In addition, relatively few students interact with their local bank for a student loan. The FFELP is highly concentrated among large national lenders; the 25 largest lenders account for more than 80 percent of total volume. Local lenders that do participate in the program typically sell the loans before a borrower enters repayment. Loan servicing—which involves interactions with borrowers after they have left school—is even more concentrated among a small number of companies. Since the most efficient of these companies will be retained by the Department to service direct loans, with loan volume awarded based on performance, borrower service should be as good or better than that available in FFELP. The Department already provides loan default prevention and financial counseling services for DLP borrowers; these services will be expanded as the program grows.

ROLE OF LOCAL STUDENT LOAN INFRASTRUCTURE

Question. Do you intend for this proposal to utilize the existing local infrastructure and experienced workforce currently in place or will the proposal rely on the larger student lending institutions?

Answer. The President recognizes that local student loan agencies provide many valuable services to students and parents, and has specifically included those activities among those that could be funded under the proposed $2.5 billion College Access and Completion Fund. More broadly, the Department has not made a final decision regarding loan servicing arrangements; a procurement was just completed, however, that does include the requirement that the selected vendors be able to service all title IV federally held loans, including direct loans. Allocations of types and volume to any one vendor will be determined based upon servicer capabilities and performance. The current contractors have committed to sufficient capacity for the expansion of direct lending, and we expect they will consider subcontracting with other current participants in FFELP in order to more efficiently meet their commitments.

TECHNICAL ASSISTANCE FOR RURAL INSTITUTIONS

Question. How will the Department provide assistance and training to 2-year colleges and technical schools in remote areas such as Black River Technical College in Pocahontas, Arkansas, or Phillips County Community College in Helena, Arkansas?

Answer. Schools have recently transitioned to direct lending with little or no problem. To ensure that all schools are prepared, however, the Department has created a Direct Loan Transition Team to assist schools such as those you mention that may have unique requirements or need additional support. Department staff is working with those schools to answer questions and to offer assistance. Initial efforts have focused on HBCUs, HSIs, and Tribally Controlled institutions. Direct loan webinars have been held for community colleges and independent private colleges.

The transition to direct loans should be seamless for schools of all sizes. The Department system that originates direct loans is called the Common Origination and Disbursement (COD), the same system that schools use to originate title IV grants (Pell Grant, ACG, National SMART, and TEACH). Most schools (and their computer systems) already interact with the system they will use for direct loans.

ESTIMATED SAVINGS FROM SHIFT TO DIRECT LOANS

Question. The Department expects to save $4 billion a year by switching from FFELP to DLP. What factors were used to calculate the estimated savings?

Answer. Direct Loans produce savings primarily because, under current interest rate assumptions, borrower repayments exceed other program costs, including the cost of Government borrowing to finance loans. This results in net revenues to the Government.

INCREASED FEDERAL ADMINISTRATIVE COSTS

Question. Does the $4 billion include anticipated increases in administrative costs for the Federal Government to increase loan volume or for the costs associated with contracting out student lending services?

Answer. Consistent with the requirements of the Federal Credit Reform Act, the projected savings do not include Federal administrative costs. Even with the addition of these costs, however, the President's proposal to shift to 100 percent Direct Loans produces substantial savings.

STEPS TO INCREASE DIRECT LOAN CAPACITY

Question. Transitioning the student loan volume of DLP from around 30 percent of all Federal student lending to 100 percent is a considerable change, and the DOE has been preparing to increase DLP volume. Can you explain what steps the Department is taking to prepare for a potential increase in DLP loan volume?

Answer. The Department is expanding capacity for both loan origination and loan servicing. For loan origination, Direct Loans uses the COD system, which also disburses funds for the Pell Grant program, making the proposed expansion relatively simple for both the Department and participating schools. The Department has also increased its call center capacity to handle additional. On loan servicing, the Department has recently completed a procurement to substantially increase its loan servicing capacity. Loan volume will be allocated among the new vendors based on servicer capabilities and performance.

REPLACEMENT OF FFELP LOAN VOLUME

Question. Currently, the FFELP provides Federal funds to private lending institutions to keep interest rates on FFELP loans low and to reduce risks associated with providing loans to students with little or no credit history. Can you provide the amount of total loan volume that this Federal investment leverages through FFELP?

Answer. In fiscal year 2009, the Department estimates the FFELP would provide $64 billion in new student loans, as well as an additional $1 billion in consolidations of existing loans.

DIRECT LOAN CAPACITY

Question. Can the Department replicate this total loan volume in addition to the current volume of loans provided through the DLP solely through DLP?

Answer. Yes, the Department will have the capacity to originate and service 100 percent of new loan volume for the 2010–2011 award year.

STUDENT LOAN VOLUME

Question. If the President's proposal were adopted, what level of total loan volume do you expect to be able to fund through the DLP in fiscal year 2010?

Answer. Under current estimates, the Department would award $53.4 billion in new loans in fiscal year 2010. Because the FFELP would continue to originate loans until July 1, 2010, an additional $38.3 billion would be awarded through FFELP in fiscal year 2010, for total new loan volume of $91.7 billion. In fiscal year 2011, the first fiscal year in which direct loans would award 100 percent of new loan volume, total awards are estimated at $96.7 billion.

Questions Submitted by Senator Lamar Alexander

TEACHER INCENTIVE FUND

Question. I am very encouraged by the administration's proposal to increase the Teacher Incentive Fund to $487.3 million this year, and I strongly support your request. While Congress works on the reauthorization of the Elementary and Secondary Education Act, including the Teacher Incentive Fund, do you plan on making any changes to the program administratively?

Answer. The Department is requesting the inclusion of appropriations language permitting support for approaches that provide performance-based compensation to all staff in a school, because research indicates that this type of strategy can be effective in raising performance across a variety of organizations. This proposed language would replace language permitting the funding of performance-based compensation only for teachers and principals.

The Department would hold a new competition with the requested fiscal year 2010 funds, in addition to an upcoming Recovery Act competition. In both of these grant competitions, the Department will place a priority on the support of comprehensive, aligned approaches that: (1) support improved teacher and principal effectiveness and help ensure an equitable distribution of effective educators; (2) actively involve teachers (including special education teachers) and principals in the design of human capital and compensation systems; and (3) use data from emerging State and local longitudinal data systems to track outcomes and associate those outcomes with educator performance.

CHARTER SCHOOL PROGRAM

Question. I am very encouraged by the administration's proposal for a $52 million increase to the Charter School Program (CSP) for a total of $268 million this year, and I strongly support your request. I would have liked to see more funds reserved for charter school facilities, and hope that we can work to find resources for that purpose in the future.

While Congress works on the reauthorization of the Elementary and Secondary Education Act, including the CSP, do you plan on making any changes to the program administratively?

Answer. The administration is committed to supporting successful models of school reform, including high-quality charter schools. As you noted, the President's fiscal year 2010 budget has proposed an increase of $52 million for the CSP. We view this request as the first step in our effort to double support for charter schools over the next 4 years and to help drive reform strategies and innovation in our schools. The administration has proposed new appropriations language and the use of available waiver authority to help expand or replicate successful charter school models or networks. The proposed appropriations language would allow the Department to make direct grants to Charter Management Organizations or other entities for the replication and expansion of effective charter school models, which should significantly expand the reach of the program. The administration also plans to strengthen program capacity by waiving, in appropriate circumstances, the one-grant limitation and the 18-month planning limitation to allow grantees additional time within the 36-month grant period for planning and implementation.

PRESIDENTIAL AND CONGRESSIONAL ACADEMIES FOR HISTORY AND CIVICS

Question. I was very disappointed to see that the Presidential and Congressional Academies for History and Civics are proposed for elimination. I gave my maiden speech in the Senate about the importance of putting the teaching and learning of U.S. history back in our classrooms, which resulted in the creation of these academies, with the support of Senator Reid, Senator Byrd, and Senator Kennedy. While it is a small program, teachers and students each summer have benefited greatly which is why I recently introduced legislation to expand the program and why I hope that the Appropriations Committee will continue to fund these programs.

What can I do over the course of the next year to convince you of the merit of the Presidential and Congressional Academies?

Answer. The teaching of history in our classrooms is important to the administration and will continue to receive significant Federal funding. We proposed to eliminate the Presidential and Congressional Academies for History and Civics because we feel the program is too small to have a substantial national impact. Furthermore, the level of effort required to administer and monitor the program on behalf of the Department, in addition to the effort required of applicants to apply for support, provides compelling reasons to put resources into larger programs with a greater chance of having a national impact. Instead of the academies, we are pro-

posing the creation of a competitive grant program of more significant size called "History, Civics, and Government" that will "scale-up" effective practices and encourage wider adoption of successful programs in these subject areas. In addition to the new initiative, the administration continues to support the Teaching American History and Teacher Quality State Grants programs, which make substantial funding available for the professional development of history teachers nationwide.

The Department is looking closely at the effectiveness of all our programs, and in the coming years will make a greater and greater effort to request funding only for programs that can demonstrate evidence of effectiveness. If we are able to determine that the Presidential and Congressional Academies program had clear evidence of effectiveness (for instance, that the teachers who participate in the Presidential academies were raising the level of student achievement in their classrooms, or that the high school students attending the congressional academies were receiving a clear benefit that was somehow being extended to a wider population of students), we would likely look at the program differently. This evidence would need to be more than past survey results showing that the teachers and students enjoyed participating and liked the programs, which is frequently the type of "evaluations" that teacher in-service training and similar programs produce.

CHOICE IN STUDENT LOANS

Question. I have repeatedly expressed my concerns about the administration's proposal to convert the entire student loan program into the Government-run Direct Loan program. The Senate has agreed that parents, students, and schools should be able to make their own choices of student loan providers, as the current programs allow.

How does your proposal seek to retain the power of the competitive marketplace where parents, students, and schools can choose the best providers to help them afford their college tuition?

Answer. The competitive marketplace will play a key role in the Department's plans to ensure that students, parents, and schools continue to receive high-quality service. We have already contracted with a number of private-sector firms with extensive experience in the Federal Family Education Loan Program (FFEL) to expand our loan servicing capabilities. Work will be allocated among these vendors based on their performance; customer satisfaction will be among the key criteria used in determining these allocations. Private-sector vendors, chosen through competitive procurements, will also provide default aversion and collection services and borrower counseling.

ADMINISTRATIVE COST OF ORIGINATING ALL FEDERAL STUDENT LOANS THROUGH DIRECT LOAN PROGRAM

Question. I am also concerned about the estimated costs of administering this new program. The administration budget only asks for an increase of $117 million from $753 million to take over the FFEL Program. Could you provide the Appropriations Committee with estimates of what those total annual discretionary costs would be for the next 5 years to originate and administer all loans under the Direct Loan program?

Answer. Estimated costs for Student Aid Administration depend on many factors, most significantly origination and servicing volume. Recently, this volume has proven to be quite volatile, due in large part to loan purchase programs authorized by the Ensuring Continued Access to Student Loans Act of 2008. The recent introduction of multiple servicer contracts has also introduced a level of uncertainty. However, given current conditions, it is estimated that total Student Aid Administration costs will total approximately $5.5 billion to $6.5 billion over the next 5 years.

FUNDING FOR PELL GRANTS

Question. I agree that we should not charge students more for their student loans in order to generate profits for lenders. That's why I supported the College Cost Reduction Act which reduced the Special Allowance Payment for lenders and generated savings for students.

However, I am concerned about the administration's proposal to convert the entire student loan program into the Government-run Direct Loan program and use the profits made from charging students an artificially high interest rate on their loans to provide generous increases to the Pell Grant.

According to the Congressional Budget Office, the majority of savings generated by the administration's proposal comes from charging most students on most loans 6.8 percent in interest when it costs the Government much less to originate and service the loan.

Why shouldn't students be charged a lower interest rate to cover the actual costs of the loan instead of asking them to pay more in interest over the course of the life of their loan to generate revenue for the Federal Government to pay for the Pell Grant increases?

Answer. The administration strongly believes Federal student aid resources should be focused on broadening access to higher education for all Americans. Particularly in today's economically challenging times, the need-based Pell Grant program is the best vehicle for helping disadvantaged students and families attend colleges and other postsecondary institutions.

SUBCOMMITTEE RECESS

Senator HARKIN. Thank you for your leadership. Thank you, Mr. Secretary. Well, the subcommittee will stand adjourned.

[Whereupon, at 11:36 a.m., June 3, 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 2010

TUESDAY, JUNE 9, 2009

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

The subcommittee met at 2:30 p.m., in room SD–124, Dirksen Senate Office Building, Hon. Tom Harkin (chairman) presiding.

Present: Senators Harkin, Kohl, Pryor, Specter, Cochran, and Alexander.

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 and Human Services, Education, and related agencies will come to order.

Madam Secretary, I welcome you to your first hearing with this Appropriations subcommittee. You have a challenging job ahead of you, I believe the most challenging job, I think, in the Cabinet, but also I think the best job in the Cabinet.

Your responsibilities include not only comprehensive healthcare reform, preparing for a possible pandemic influenza, addressing costs of entitlements, but also biomedical research, substance abuse, drug safety, and quite a few others.

I certainly look forward to working with you in any way that I can. This hearing will focus of your discretionary budget, but I would just like to mention what we're doing on comprehensive healthcare reform.

I know that you feel very strongly that prevention in public health must be at the heart of any serious reform of the healthcare system and I commend you for your work in that area. I also believe that any reform of the healthcare system must address the injustice of people with severe disabilities, who are being forced to spend their lives in nursing homes because we do not provide the option of home-based services for the severely disabled. That's why I've introduced the Community Choice Act of 2009 (S. 683), which President Obama strongly supported during the campaign and

which he co-sponsored when he was here as a member of this subcommittee. So, I look forward to working with you on this issue.

Today, we want to talk about the fiscal year 2010 budget and also about the funding included in the Recovery Act of the stimulus that we passed. That bill included $10 billion for the National Institutes of Health (NIH), $1.1 billion for comparative effectiveness research, $700 million for prevention activities and $2 billion for discretionary health information technology activities, as well as funds for Head Start, child care, Community Services Block Grant, and health professions.

So, we will cover as much as we can. Again, we welcome you to the subcommittee. I will leave the record open for a statement by Senator Cochran and I would then recognize you, Madam Secretary, and your statement will be made a part of the record in its entirety.

HEALTHCARE WASTE AND HOSPITAL-ACQUIRED INFECTIONS

And, as a matter 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 as Governor of Kansas. And I thank you for coming up to Iowa many times. I always enjoyed seeing you in Iowa and working with you. She served in that capacity until her appointment as Secretary.

Prior to her election as Governor, she served as the Kansas State Insurance Commissioner and is a graduate of Trinity, Washington University, and the University of Kansas.

Madam Secretary, Mr. Cochran.

Senator COCHRAN. Mr. Chairman, I am happy to join you in welcoming the Secretary to the hearing. Thank you very much.

Senator HARKIN. Thank you, Senator. I left the record open for your statement.

Madam Secretary, welcome. And please proceed as you so desire.

SUMMARY STATEMENT OF HON. KATHLEEN SEBELIUS

Secretary SEBELIUS. Well, thank you Chairman Harkin, Senator Cochran, and members of the subcommittee. I want to thank you for the invitation to come and discuss the 2010 budget.

HEALTHCARE REFORM

I want to first start by thanking you for your hard work and leadership on a whole variety of health issues. We certainly face great challenges in the country today and I look forward to working with you to tackle those challenges together. Healthcare reform is one of the issues I know that is front and center in the Senate and the House right now and I think that there is great agreement that we can't continue with the status quo. The President is committed to healthcare reform. I think we're seeing businesses and Government and families and providers come together to acknowledge that the crushing costs are influencing family's bottom-line, the competitiveness of our businesses, and we have to find a way to deliver higher quality healthcare for all Americans.

I do agree with you, Senator, that prevention and wellness are an essential component of that transformational health policy. And

some of those building blocks, as you say, have already been provided. But I look forward to being part of that discussion as it moves forward, in terms of healthcare reform.

Now, I think the budget we're considering today puts us on the path to healthcare reform and adheres to the principles outlined by the President, building on the investments in a 21st century healthcare system. The American Recovery and Reinvestment Act funded some priority areas, including making a substantial down-payment on healthcare reform.

There's a focus on fraud, which is costing taxpayers billions of dollars each year. And we intend to do more to crack down on individuals who currently cheat the system. So, the Attorney General and I, first time ever at a Cabinet level, announced an interagency effort to fight Medicare and Medicaid fraud through improved data sharing, real-time information that would be available, and increase the number of strike forces that have been successful in a couple of areas and we would like to see them increase their operations. And the budget includes some recommended increase to help Health and Human Services achieve our part of the bargain.

We also have initiatives in the budget to move toward a central goal of healthcare reform, improving the quality of care. The patient-centered research that is funded in this budget helps give doctors and patients access to better information and better treatments, helps empower consumers and providers. So we hope that, not only would we be looking at some cost-saving strategies, but improving the quality of healthcare for everyone.

HEALTHCARE DISPARITIES

The budget invests $354 million in target activities to combat health disparities. Senators, I just came from a dialogue with close to 30 stakeholders representing various minority populations and communities who are very interested in working on closing the gap on quality of healthcare delivered across America. The gap that exists for higher income Americans versus lower income Americans and certainly the gap that we see persistent in ethnic minorities and low income and disadvantaged populations and that is a continued priority with the Department.

We have included more than $1 billion in the Health Resources and Services Administration (HRSA) to support a wide range of programs dealing with the workforce issues. Clearly a critical component of healthcare reform is having enough providers to deliver the care to all Americans. So, the funding will enhance the number of nurses and doctors, the number of dentists and mental health professionals, and particularly also targets minority and low-income students to encourage more access to the medical profession. And an increased emphasis to make sure seniors get the care and treatment they need.

PANDEMIC FLU

And finally, the budget will support our work at the Department to protect public health and the safety of our citizens. As the chairman has recognized, we are not only dealing with an ongoing presentation of the H1N1 flu virus, but also the ongoing preparedness

and operations to respond to whatever outbreaks may strike next and threaten the health of the American people.

There's no question that the investments made in pandemic planning and preparation by this subcommittee and Congress over the years has allowed our Department to respond efficiently, but we need to continue those efforts and make sure that we are well-prepared. We don't know what the next depths of this virus might be when it comes back in the fall in this country or what will happen exactly this summer, when it presents itself in the Southern Hemisphere in conjunction with their flu season. So, the President has submitted a supplemental request to support the Federal response to the recent outbreak. So the funds, in addition to those provided in the 2010 budget, will allow our Department to continue to be the primary health agency responding to this outbreak and remain prepared to protect the American people.

So Mr. Chairman, the President is committed to a safer, healthier, and more prosperous America and we feel this budget will help achieve those goals, investing in reform, improving on the quality of care, and continuing to provide essential services that so many families depend on.

PREPARED STATEMENT

So, I look forward to taking your questions and those from other subcommittee members and, more importantly, to work with you on these important goals.

Senator HARKIN. Madam Secretary, thank you very much for your summation and, as I said, your full statement will be made a part of the record in its entirety.

[The statement follows:]

PREPARED STATEMENT OF KATHLEEN SEBELIUS

Chairman Harkin, Senator Cochran, and members of the subcommittee, thank you for the invitation to discuss the President's fiscal year 2010 budget for the Department of Health and Human Services (HHS).

In these times of economic uncertainty, we at HHS are even more cognizant of the healthcare needs of American citizens. It is during times like these that we must be especially mindful to answer the call as public servants to protect the health of the American people as well as ensure the availability of healthcare resources. At HHS, we are dedicated to the continued improvement and accessibility of healthcare in the United States and committed to providing essential human services that families depend on, particularly in times of economic crisis.

The HHS fiscal year 2010 budget reflects a dedication to focus resources in the areas of health reform, improving the quality and accessibility of healthcare, delivering human services to vulnerable populations, securing and promoting public health, investing in scientific research and development, and ensuring the successful implementation of the American Recovery and Reinvestment Act.

The President's fiscal year 2010 budget for HHS totals $879 billion in outlays. The budget proposes $78 billion in discretionary budget authority for fiscal year 2010, of which $72 billion is within the jurisdiction of the Labor, Health and Human Services, Education, and related agencies Subcommittee.

Health Reform

I would like to begin my comments by addressing our efforts in the area of health reform.

One of the biggest drains on American family budgets and the performance of the economy is the high cost of healthcare. American families and small businesses are being crushed by sky-rocketing healthcare costs and they are losing the very choices they value most.

Health insurance premiums have doubled since 2000, rising four times faster than wage growth. This increase strains both families and the businesses that struggle

to sustain health benefits for their employees. At the same time, healthcare costs are consuming a rapidly growing share of Federal and State government budgets.

The United States spends more than $2.2 trillion on healthcare each year, a number that represents about 16 percent of the total economy. Experts predict that by 2018, 20 percent of the economy will be spent on healthcare.

Despite this record spending, about 46 million Americans lack healthcare coverage. The President is committed to reform that assures quality, affordable healthcare for all Americans. Covering all Americans is not only a moral imperative, but it is also essential to a more effective and efficient healthcare system.

HHS has already made major strides towards this goal.

We have supported efforts at the Centers for Medicare and Medicaid Services such as the Children's Health Insurance Program, which has provided healthcare for millions of previously uninsured children.

The administration is using Recovery Act dollars wisely to protect coverage for families and help strengthen our healthcare system. The funds this subcommittee provided are protecting Medicaid coverage and improving health services to low-income Americans. The Recovery Act temporarily lowers the cost of COBRA coverage by 65 percent for some workers and their families, helping workers who lost their jobs hold onto the coverage they need.

The Recovery Act advances the President's health IT initiative and accelerates the adoption of health information technology—an essential tool to modernize the healthcare system—and the utilization of electronic health records. We are striving to improve care and give patients and doctors more information by devoting $1.1 billion to comparative effectiveness research. In addition, we are working to improve the health of all Americans by investing $1 billion in prevention and wellness.

These are important first steps, but there is much more work to be done to ensure all Americans have the high-quality, affordable coverage they deserve.

Consistent with the President's vision for a reformed healthcare system that offers affordable, quality healthcare to all Americans, the HHS budget invests in key priority areas and puts us on the path to health reform.

The budget sends a clear message that we can't afford to wait any longer if we want to get healthcare costs under control and improve our fiscal outlook. Investing in health reform today will help bring down costs tomorrow and ensure all Americans have access to the quality care they need and deserve.

Consistent with these principles, the budget takes a significant step towards comprehensive reform and establishes a healthcare reserve fund of $635 billion over 10 years to finance health reform that brings down costs, improves quality, and assures coverage for all Americans. The reserve will be funded by new revenue and by savings from Medicare and Medicaid. While the reserve fund is a significant commitment, we are aware that this amount is not sufficient to fully fund comprehensive reform, and we look forward to working with the Congress to identify additional resources.

This saving proposal is supported by the following initiatives:

Aligning Incentives Toward Quality.—The budget includes proposals intended to improve incentives to provide high quality care in Medicare, including quality incentive payments to hospitals and voluntary physician groups and reduced payments to hospitals with high readmission rates.

Promoting Efficiency and Accountability.—The budget includes savings resulting from increased efficiency and accountability in Medicare and Medicaid, including reducing Medicare payments to private insurers by encouraging competition, implementing policies to decrease Medicaid costs for prescription drugs, improving Medicare and Medicaid payment accuracy, and bundling Medicare payments for inpatient hospital and certain post-acute care.

Encouraging Shared Responsibility.—The budget recognizes that successfully moving toward a reformed healthcare system will require all stakeholders to contribute a proportionate share. The budget includes a proposal to require certain higher-income Medicare beneficiaries enrolled in Part D to pay higher premiums, as is currently required for physician and outpatient services.

New Revenues.—Among other changes, the budget includes a proposal to limit the rate at which high-income taxpayers can take itemized deductions against revenues dedicated to health reform. This will help provide the savings needed to fund comprehensive health reform.

Improving Quality and Access to Health Care

At HHS, we continue to strive to find ways to better serve the American public, especially those citizens less 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 as well as the quality of health care

information and treatments through the advancement of health information technology (IT) and the modernization of the healthcare system.

The budget includes more than $1 billion within the Health Resources and Services Administration (HRSA) to support a wide range of programs to strengthen and support our Nation's healthcare workforce. This funding will enhance the capacity of nursing schools, increase access to oral healthcare through dental workforce development grants, target minority and low-income students, and place an increased emphasis on ensuring that America's senior population gets the care and treatment it needs.

The budget also supports HHS-wide comparative effectiveness research, including $50 million within the Agency for Healthcare Research and Quality. This research will improve healthcare quality by providing patients and physicians with state-of-the-science information about which medical treatments work best for a given clinical condition.

The budget advances the President's health IT initiative and accelerates the adoption of health information technology—an essential tool to modernize the healthcare system—and the utilization of electronic health records (EHR). The Office of the National Coordinator for Health Information Technology will continue its current efforts as the Federal health IT leader and coordinator. During fiscal year 2010, HHS will prepare to provide Recovery Act Medicare and Medicaid incentive payments to physicians and hospitals who demonstrate meaningful use of certified EHRs.

The Centers for Medicare and Medicaid Services (CMS) Program Management account increases by $235 million in fiscal year 2010 to cover statutory and policy workloads in claims processing and in healthcare facility survey frequencies to adequately protect beneficiary quality of care and safety. CMS Program Management funding increases will also go to important initiatives such as ICD–10 implementation and additional funding for Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) implementation as well as the necessary increase in staff to administer new workloads from MIPPA and other recent legislation. CMS will also expand its research efforts to lay the groundwork for long-term reforms of CMS' programs and the Nation's healthcare system.

Delivering Human Services to Vulnerable Populations

HHS shares the President's belief in increasing access to critical services and healthcare for citizens most in need of assistance. HHS takes seriously our responsibility to reach out to those Americans least able to provide for themselves such as children and senior citizens as well as those in rural areas where quality, affordable healthcare and services are less accessible.

Due chiefly to Recovery Act funding, the Head Start program run by the Administration for Children and Families (ACF), will serve 978,000 children in fiscal year 2009, an increase of approximately 70,000 over fiscal year 2008. Approximately 115,000 infants and toddlers, nearly twice as many as in fiscal year 2008, will have access to Early Head Start services in fiscal year 2009 and fiscal year 2010. The budget includes an additional $122 million to enable Head Start to sustain the historic increase in children served.

The budget includes $178 million in funds to support evidence-based teen pregnancy prevention programs. To improve outcomes for women and children, the President's budget also assumes $124 million for a new mandatory Home Visitation program to establish and expand home visitation programs for low-income families.

The budget includes $3.2 billion for the ACF Low Income Home Energy Assistance Program (LIHEAP), one of the largest LIHEAP funding requests ever. Energy prices are volatile, making it difficult to match funding to the needs of low income families. For this reason, the budget includes a legislative proposal to provide additional mandatory LIHEAP funding if energy prices increase significantly.

The budget includes $59 million, an increase of $35 million, within the Substance Abuse and Mental Health Services Administration to expand the treatment capacity of drug courts. Within this increased funding for drug courts, $5 million will support families affected by methamphetamine abuse. The budget also includes $986 million, an increase of $17 million, for the prevention and treatment of mental illnesses.

Securing and Promoting Public Health

Whether it's responding to the H1N1 flu virus or the recent recall of peanuts, HHS is responsible for keeping Americans healthy and safe, and we take that responsibility seriously.

The budget will help ensure we remain prepared to protect the American people. The investments we made in pandemic planning and preparation allowed us to re-

spond quickly and efficiently to the H1N1 virus in this country and helped get Americans the information and resources they needed early on during the outbreak.

The administration has requested supplemental funding to support the Federal response to the recent outbreak of 2009 H1N1 influenza. Resources will be vital to support the immediate response and to support potential longer term needs as determined by the severity of the virus in the Southern Hemisphere. It is important that we take steps now to ensure resources are available on a contingency basis in case they are needed. These funds, in addition to the fiscal year 2010 budget of $584 million, will allow HHS to develop and produce vaccines as well as distribute antivirals, personal protective equipment, and other medical countermeasures. This funding will also support public health surveillance and response efforts in the face of the current outbreak.

HHS has been working diligently to ensure that the public will be protected from this H1N1 virus and has created an H1N1 virus reference strain that has been distributed to the manufacturers to create a virus master seed. HHS recently committed $1.1 billion, through new orders on existing manufacturer contracts, to develop and test bulk supply of vaccine antigen and adjuvant for the production of pilot lots of an H1N1 vaccine. The Centers for Disease Control and Prevention (CDC), Office of the Assistant Secretary for Preparedness and Response, Food and Drug Administration, and NIH are working together to develop a commercial-scale vaccine production strategy, as well as working on the development of vaccine candidates.

HHS has also declared a nationwide Public Health Emergency; deployed teams to affected States according to the CDC Incident Action Plan; released 25 percent, or 11 million treatment courses of the antivirals in the Strategic National Stockpile for distribution to States; issued Emergency Use Authorization of diagnostic laboratory tests and to treat children under the age of 1 year with Tamiflu; issued regularly updated guidance for healthcare providers, public health officials, and the public on recommendations on antivirals, symptoms and reducing spread of the virus; and continued surveillance activities, particularly in the Southern Hemisphere to monitor the H1N1 virus.

People living with HIV disease are, on average, poorer than the general population, and Ryan White HIV/AIDS Program clients are poorer still. For them, the Ryan White HIV/AIDS Program is the payor of last resort because they are uninsured or have inadequate insurance and cannot cover the costs of care on their own, and because no other source of payment for services, public or private, is available. The budget includes more than $3 billion in CDC and HRSA to enhance HIV/AIDS prevention, care, and treatment. Within HRSA, an additional $54 million is included for the Ryan White HIV/AIDS Program to increase access to healthcare among uninsured and underinsured individuals living with HIV/AIDS and to help reduce HIV/AIDS-related health disparities. Within CDC, an additional $53 million is included to enhance testing and other HIV/AIDS prevention efforts.

The President's request also includes $354 million for combating health disparities and will help improve the health of racial and ethnic minorities and low-income and disadvantaged populations. This proposal includes $143 million for the Minority AIDS Initiative under the Ryan White Act, $116 million for Health Professions and Nursing Training Diversity Programs, $56 million for the Office of Minority Health, and $40 million for the REACH program administered by the CDC.

Rural Americans also often receive substandard care and the fiscal year 2010 budget includes $73 million for a new "Improve Rural Health Care" initiative, which increases access and improves the quality of care in rural areas.

Investing in Scientific Research and Development

HHS is dedicated to finding better ways to treat and prevent illnesses such as cancer through the support of programs dedicated to advancing medical research and development. The HHS budget includes nearly $31 billion for the National Institutes of Health (NIH) to continue support of biomedical research. These funds build on the unprecedented $10.4 billion in total provided to NIH in the Recovery Act. Within the budget total, more than $6 billion will support cancer research across NIH. This funding is central to the President's sustained plan to double NIH cancer research over 8 years. In fiscal year 2010, NIH estimates it will support a total of 38,042 research project grants, including 9,849 new and competing awards.

Recovery Act

The Department's portion of the American Recovery and Reinvestment Act of 2009 addresses and responds to critical challenges in our healthcare system and enhances human services through investments that immediately impact the lives of Americans.

The American Recovery and Reinvestment Act includes an estimated $167 billion over 10 years for programs at HHS. HHS mandatory budget authority is increased by an estimated $144 billion, which includes $113 billion for Medicaid, $23 billion for Medicare, $7 billion for the ACF entitlement programs, and $1 billion for administration. Most of the increase in this funding will take place in fiscal year 2009 and fiscal year 2010.

HHS also received $22 billion in discretionary budget authority. The majority of these funds will be obligated by September 2010 to achieve the most rapid impact for citizens and States affected by the current economic downturn.

HHS Recovery Act activities support efforts to increase access to healthcare, protect those in greatest need, expand educational opportunities, and modernize the Nation's infrastructure. HHS is committed to quickly and carefully distributing Recovery Act funds in an open and transparent manner that will achieve the objectives of the Recovery Act. HHS released over $16 billion in Recovery Act funds within the first 30 days of enactment, including crucial fiscal relief to States through increased Medicaid funding, funds for health centers, and funds for foster care and adoption assistance. Overall, HHS will distribute more than 90 percent of its increased discretionary funding, and approximately two-thirds of its increased mandatory spending, within 2 years of enactment.

Consistent with the President's call for accountability and responsible management in the Federal Government, HHS has established new policy and technical processes to review spending plans and to implement the Recovery Act requirements for transparency and accountability. To coordinate and manage the complexity of HHS' role and processes in the Recovery Act, HHS established an Office of Recovery Act Coordination run out of the Office of the Secretary. The Recovery Act also provides $48 million for the Office of Inspector General to enhance accountability and enforcement activities to prevent waste, fraud, and abuse.

In Closing

Consistent with the President's vision for a safer, healthier, and more prosperous America, HHS will continue to seek improvements and strive to exceed expectations in areas such as securing and promoting public health, delivering human services to vulnerable populations, and improving quality of and access to healthcare. HHS will continue to make investments that will improve the lives of children, families, and seniors by creating a healthy foundation for everyone to fully participate in the American community.

Again, I would like to thank the subcommittee for this opportunity to offer my comments and I look forward to working with you to advance the health, safety, and well-being of the American people.

HEALTHCARE WASTE AND HOSPITAL-ACQUIRED INFECTIONS

Senator HARKIN. Madam Secretary, thank you very much for your summation and, as I said, your full statement will be made a part of the record in its entirety. Madam Secretary, there is an article in The Washington Post this morning on healthcare. It pointed out two important things. It says here, "The pockets of medical excellence dot the landscape, but at least 100,000 people die each year from infections they acquired in the hospital. While 1.5 million are harmed by medication errors." And down here, "yet The Institute of Medicine estimates that one-third of all medical care is pure waste such as duplicate X-rays, repeat lab tests, and procedures to fix mistakes."

[The information follows:]

[From The Washington Post, June 9, 2009]

DECISION MAKERS DIFFER ON HOW TO MEND BROKEN HEALTH SYSTEM

(By Ceci Connolly)

Nowhere else in the world is so much money spent with such poor results.

On that point there is rare unanimity among Washington decision makers: The U.S. health system needs a major overhaul.

For more than a decade, researchers have documented the inequities, shortcomings, waste and even dangers in the hodgepodge of uncoordinated medical serv-

ices that consume nearly one-fifth of the nation's economy. Exorbitant medical bills thrust too many families into bankruptcy, hinder the global competitiveness of U.S. companies and threaten the government's long-term solvency.

But the consensus breaks down on the question of how best to create a coordinated, high-performing, evidence-based system that provides the right care at the right time to the right people.

During eight years in office, President George W. Bush took an incremental approach, adding prescription drug benefits to the Medicare program for seniors and the disabled and expanding the number of community clinics nationwide. President Obama, like the last Democrat to occupy the White House, contends that was insufficient and is pushing for an ambitious reworking of the entire $2.3 trillion system.

Framed by President Bill Clinton 16 years ago as a moral imperative to deliver health care to all, this summer's historic debate comes against a more urgent backdrop. As the national unemployment rate nears 10 percent and giants such as General Motors crumble, the expensive, inefficient health system has deepened the country's economic woes.

By virtually every measure, the situation has worsened.

Today, about 46 million Americans have no health insurance, so they go without or wait in emergency rooms for expensive, belated care. Everyone else helps pay for that Band-Aid fix in the form of higher taxes and an extra $1,000 a year in insurance premiums.

Pockets of medical excellence dot the landscape, but at least 100,000 people die each year from infections they acquired in the hospital, while 1.5 million are harmed by medication errors. Of 37 industrialized nations, the United States ranks 29th in infant mortality and among the world's worst on measures such as obesity, heart disease and preventable deaths.

Bright young physicians trained at prestigious and expensive universities enter a profession built on perverse financial rewards. They, like assembly-line workers of the past, are paid on a piecemeal basis, earning more money not by doing better but simply by doing more.

Yet more care rarely translates into better health. Extensive research by Dartmouth College has found the exact opposite: Health outcomes are often best in communities that spend less compared with cities such as Boston and Miami where the medical arms race of specialists and high-tech gadgets often leads to greater risks and injuries.

The Institute of Medicine estimates that one-third of all medical care is pure waste, such as duplicate X-rays, repeat lab tests and procedures to fix mistakes.

"Most Americans don't understand how bad health care in the United States is," said Michael F. Cannon, head of health policy at the libertarian Cato Institute. "We need big reforms."

Across the ideological spectrum, the diagnosis is remarkably consistent.

"Sure, some people here have the best health care in the world, but the average American is paying too much and not getting enough in return," said John D. Podesta, who led Obama's transition team and heads the Center for American Progress, a think tank.

Said Sen. Judd Gregg (R-N.H.): "What's tragic is that so much of this spending is on duplicative or unnecessary care that doesn't improve health outcomes."

Simply put, the goal of health reform is to finally get our money's worth, say industry leaders, policymakers, consumers and business executives.

They envision a health-care system that guarantees a basic level of care for everyone, shifts the emphasis to wellness and prevention, minimizes errors, and reduces unnecessary and unproved treatment. Such a system would coordinate care, track patients and doctor performance electronically, and reward good results. The high-value system of the future would be organized "so that people get the care they need and need the care they get," said Elizabeth A. McGlynn, associate director of the health research division of Rand Corp.

Nowadays, that is often not the case.

On average, Americans receive the recommended, proven care 55 percent of the time, according to Rand studies. Sometimes, doctors or nurses overlook a basic but critical step, such as prescribing a beta blocker medication to patients after a heart attack, a therapy shown to significantly reduce the risk of a fatal attack. At other times, patients undergo procedures when there is no evidence that they are any better than a simpler, cheaper alternative.

Ten years ago, in its landmark report "To Err is Human," the Institute of Medicine estimated that 44,000 to 98,000 people die each year from medical mistakes, highlighting the need for improvement. Since then, the tally has risen, said Janet Corrigan, president of the National Quality Forum, a nonprofit membership organization that promotes quality standards.

"We now know estimates of those who die from hospital-acquired infections is upwards of 100,000," she said. "Many of those, if not most, are avoidable and preventable."

Sen. Robert C. Byrd's recent hospital stay, for example, has been extended because the West Virginia Democrat developed a staph infection.

"Everyone agrees that hospitals are hazardous to your health," said Mitchell Seltzer, a consultant who advises large medical institutions. "For every day a patient is in a bed, they are subjected to a higher probability of medical errors, hospital-acquired infections, inappropriate tests that do not have a direct bearing on the medical condition being treated."

Part of the problem is cultural, said Rand's McGlynn.

"People tend to demand the new thing even if there's not much evidence it will make a difference in the length or quality of life," she said.

Few patients or physicians have any idea who delivers good, or bad, care, because few organizations track results. Consumers have more information to evaluate their cars than they do their surgeons. "It's like a doctor flying the plane without instruments," said James N. Weinstein, a spine surgeon who directs the Dartmouth Institute for Health Policy and Clinical Practice.

Obama set aside $19 billion in his economic stimulus package to promote the use of digital records, on the belief that they reduce duplication, produce more consistent care and cut down on errors.

Because the fee-for-service payment system rewards quantity over quality, there is little incentive—and there are even disincentives—for doctors, nurses and hospitals to improve, Corrigan said.

"Is it a surprise we have lots of extra imaging tests and lab tests?" she said. "Not at all."

The consequences are especially glaring in regions with larger numbers of specialists and pricey technology, the Dartmouth data show.

Take the case of Miami vs. La Crosse, Wis. In 2006, using inflation-adjusted figures, Medicare spent $5,812 on the average beneficiary in La Crosse, compared with $16,351 in Miami. Yet an examination of health status in both places, adjusted for age, finds no evidence that the extra spending resulted in better care, Weinstein said.

"That's the enigma here," he said. "Less is more, and more isn't better."

Physician behavior and spending patterns in Medicare have been good indicators of broader trends across the nation, Dartmouth has found.

Even the best physicians cannot stay current with all of the drugs, tests and treatments available today—another reason to digitize modern medicine, Corrigan said.

Many fear that the push to contain costs will result in rationing.

In today's system, "we don't ration care, we ration people," said Donald M. Berwick, president of the independent Massachusetts-based Institute for Healthcare Improvement. "We know that if you are black and poor or a woman, there are all sorts of effective interventions you are not going to get."

Though the transition would be painful and the politics treacherous, Berwick said it is possible to spend less on medical care and have a healthier nation.

"If we could just become La Crosse, think of how much better off we would be," he said.

Senator HARKIN. Madam Secretary, thank you very much for your summation and, as I said, your full statement will be made a part of the record in its entirety. So, as we look ahead for healthcare reform, people wonder how we are going to pay for all this. Well, if one-third, according to the Institute of Medicine, is pure waste, that comes out to be about $700 billion a year. I don't know if that's right or not, but even if it's half of that, it seems to me that's an area where we could work together and, with the IGs office and others, to begin a really concentrated, concerted effort to look at where it is that we might make changes.

You, in your capacity as the Secretary, and where we might be able to work with you, should find those areas where we can cut down on the waste, and also determine what we can do to cut down on the number of infections that people acquire in the hospitals. It

is becoming dangerous to go to the hospital. More and more people are getting sicker in hospitals.

And so I just throw that out as saying that I hope you will be looking at this. You've just come on board, I know you've been there, what, a month-and-a-half now? Two months?

Secretary SEBELIUS. Six weeks, but who's counting?

Senator HARKIN. Six weeks, okay. Something like that. But I would hope that you and your staff would get together and look at this and see what it is that you can do, or what we can do together, to go after both of those elements.

Secretary SEBELIUS. Well, Mr. Chairman, let me just say that I appreciate the concern and share it. We have already issued a challenge to the American hospitals to work in conjunction with our Department to reduce, by two-thirds, the number of hospital-related infections. It has been proven that using a fairly simple hospital checklist has a dramatic impact on hospital infections. So, we are using some of the funding provided by Congress in the Recovery Act to do just that. To challenge hospitals, and also to increase the State capacity to do inspections. That's one area.

I don't think there is any question that we know where there are, as you say, pockets of high-quality, lower-cost medical care being delivered day in and day out, but they haven't been scaled across the country and there's a lot of excessive and redundant care right now that is probably not only costly, but doesn't really add anything to the health outcome. So that's another area of concern.

The comparative effectiveness research will help promote the best practices and share that patient-centered research about what helps and what is most cost-effective. But I can guarantee you that, in the Department, we are very focused on trying to identify what does work in a cost-effective manner and what drives the best health outcomes and hopefully share that across the country.

Health information and technology, again, funded in the Recovery Act will have, I think, a dramatic impact on lowering medical errors and sharing best protocols and putting some transparency behind what is effective or not.

So, you've already started down the pathway with the funding provided in the Recovery Act and there are some more investments in this budget that we hope move forward.

PREVENTION AND WELLNESS

Senator HARKIN. Madam Secretary, thank you for that response. As long as we are talking about the Recovery bill, a top priority for me was the Prevention and Wellness Fund. You mentioned some of it. Actually, we got $5.8 billion in the Senate bill, the final amount was $1 billion, but that's okay. We got it. $650 million was dedicated to improve strategies to reduce chronic diseases. And we could have, obviously, specified exactly where we wanted all of this to go, but we left it sort of open, expecting that your Department, and the Appropriations Committee, would have an ongoing dialogue about what was the best strategy.

I've heard vague plans about a national media campaign. I don't know what diseases or conditions are being considered. I understand there might be community grants, but I don't know what's being targeted. I guess what I'm saying is that we need some more

specifics about how you're planning to allocate the Prevention and Wellness Fund. And I would like to have your assurance that you would consult with us, and have an opportunity for us to have meaningful input into this before it goes to OMB.

Secretary SEBELIUS. Well, Mr. Chairman, you have my assurance of that. As you know, Tom Frieden, who was named as the new Director of the Centers for Disease Control and Prevention, came on board on Monday, yesterday.

Senator HARKIN. Yes.

Secretary SEBELIUS. And I think that this is one of the significant investments in the Recovery bill and the most significant investment in prevention, granted significantly under where you hope it would end up, but still the most significant investment in prevention and wellness, I think in the history of the United States.

So, the leadership at the Department felt it was very important to collect a broad array of ideas and input and I can assure you that no final plans have been made. We wanted to get the leadership on board and we would be absolutely, not only willing, but delighted to consult with you as we move forward. Because sharing your expertise, I know this is an area that you are passionate about and have a lot of expertise to share, so we would very much look forward to coming back to you before a plan is finalized.

Senator HARKIN. Outstanding. Look forward to it. Thank you, Madam Secretary.

Senator Cochran.

Senator COCHRAN. Mr. Chairman, thank you. Madam Secretary, you know, one of the other responsibilities that I've had since being in the Senate is to chair the Agriculture Committee, in addition to this Appropriations Committee. And it occurs to me as we look at things that are done in the rural areas of the country, your Department, and the Department of Agriculture, share a lot or have some overlapping responsibilities. I wonder if you've thought about how maybe these can be coordinated and improved efficiencies or, in other ways, make available needed benefits like health screening, vaccinations, feeding programs. I just thought of those, the WIC program administration, for example.

In the case of a flu virus outbreak, it would be an important resource making available vaccinations. Do you have any thoughts about whether we need to improve the efficiencies of these programs by maybe combining that into one Department rather than having a division of responsibility between the two departments now?

Secretary SEBELIUS. Well, Senator, I can tell you that, in my short tenure here at the Department, I have already had a number of conversations with the Secretary of Agriculture, Tom Vilsack, who I served with as Governors in neighboring States. In Senator Harkin's home State, Tom Vilsack was the two-term Governor and he was actually Governor when I got elected, helped me get elected, and I have learned a lot from him.

So, there is a lot of collaborative discussion underway. Everything from food safety issues, as we redesign the food safety initiatives under the Food and Drug Administration, to looking at the obesity, food and nutrition in classrooms. A couple of the programs

that you mentioned we haven't had on our radar screen yet, but I think we definitely need to add those.

The President is very interested and committed to having Cabinet secretaries work in a very interagency fashion, leveraging the assets of the agencies and not replicating or duplicating programs that work well in one area, but borrowing good ideas and trying to work together in a collaborative fashion.

So, I think you've made some important suggestions and I will certainly circle back with those with the Secretary of Agriculture.

LIHEAP FUNDING DISPARITIES

Senator COCHRAN. The President's budget request creates a, or suggests that there should be created, a new mandatory LIHEAP program with a trigger mechanism for automatic increases in energy assistance. Under the current formula, these funds are distributed more to cold weather States than they are warm weather States, at least that's my observation.

When the new LIHEAP program is designed, how do you intend to address the funding disparity that endangers lower income residents in rural States in the South?

Secretary SEBELIUS. Well, Senator, I have to tell you that I wasn't aware of the disparity until I began some of the visits in preparation for my confirmation hearing. And it was raised by a number of warm weather Senators that the money runs out before it gets hot in the summertime.

And what I said at that point, and I intend to continue to do, is to take a look at the way that the funds are distributed. Because I agree with you, people are in jeopardy if they're sitting in 100 degree homes, the same way they are if they are in 30 degree homes. And the same kind of impact is had on vulnerable populations.

So, I can assure you that we would not only appreciate your input, but that I will certainly take into consideration, and ask the folks who are administering the program, if we are looking at the issues of warm weather States, because I think it is of concern.

Senator COCHRAN. Thank you. I have a couple more questions, but I am going to yield to other senators who are here.

Senator HARKIN. Senator Kohl.

Senator KOHL. Thank you so much. Secretary Sebelius, welcome.

Secretary SEBELIUS. Thank you.

Senator KOHL. As you know, the waiver for Wisconsin's Senior Care Program is scheduled to end on December 31 of this year. Currently, this program provides over 100,000 seniors in my State with high-quality, cost-effective prescription drug coverage, as I presume you are aware. According to the CBO, it does so while achieving ongoing savings for the Federal Government at the same time.

I understand that Governor Jim Doyle, who I know you are very familiar with has applied for a waiver to extend senior care through 2012, which should allow this very successful program to continue. Can you tell me the status of the waiver application and whether or not we can hope to achieve that waiver?

Secretary SEBELIUS. Well, Senator, as you know, that 1115 Program is the only one left in the country where the State-only drug program is being conducted. And I know it's wildly popular and I

know it's been enormously successful. You'll be pleased to hear that not only did my good friend, Jim Doyle, apply for the waiver of continuation before I got to the office, but he was in my office 3 days ago amplifying that request, to make sure that I did not forget. And, as you might be aware, the President is going to Green Bay, Wisconsin on Thursday to talk about healthcare reform and I don't doubt that he's going to hear a little bit of something about this popular program.

It is my understanding that we're in the final stages of review, that people in the Agency are aware of not only how popular it is, but how successful it's been. And I'm hopeful that we will be able to give you news in the very near future.

Senator KOHL. Well, I'll take that as a somewhat positive indication.

Secretary SEBELIUS. I just don't have the definitive answer today. I'd hoped I'd have it by today, but close.

Senator KOHL. Okay. I happen to have given a speech on Monday in Wisconsin to 400 people who are involved in issues that apply to seniors all across our State and I had something like a dozen applause lines written into my speech. The only one that got any applause——

Secretary SEBELIUS. Was this program.

Senator KOHL [continuing]. Was my reference to the senior care program and how effective it's been.

Secretary SEBELIUS. Well, I can tell you in the discussions that I've been involved in healthcare reform, I have asked our folks, just because before I came to this position, as a Governor and as someone who shared ideas with other governors, not only did I have our State looking at how successful Wisconsin had been and what kinds of things we could do to mirror it, but the healthcare reform team has the whole program and we want to look at it as a possibility to include as one of the options.

So, it definitely has caught the attention of lots of folks outside of Wisconsin.

QUALITY OF HEALTHCARE

Senator KOHL. Thank you.

Secretary Sebelius, lately, as I'm sure you're very much aware, there's been much media attention on how it costs two to three times as much to fund a Medicare recipient in some locales across our country than it does in others. We've seen articles in several publications come to the conclusion that healthcare quality does not increase with higher spending. In fact, The Washington Post reports that healthcare costs in a place in my State, Lacrosse, are much lower than the national average and yet quality is much better than the national average.

I'm sure this is one of the toughest, one of the toughest problems that you are going to be confronting in your time as Secretary. Do you have some initial thoughts on what we can do to take advantage of those areas that are doing a great job in controlling costs and extend it across the country to those areas that are not?

Secretary SEBELIUS. Well, Senator, I think you've just very adeptly defined the challenge as how to take what is happening in pockets, as Senator Harkin said earlier, across the country and sort

of scale up. So not only do we reduce overall costs, but we increase quality.

Someone said to me the other day that, you know, there's a lot of discussion about rationing healthcare. And this expert said that he thought what we were doing currently in America was rationing quality, which I thought was an interesting lens. I think the comparative effectiveness research that was funded, $1 billion worth in the Recovery Act, is a big step in that direction. To inform doctors and consumers, patients, what is happening and what the best practices are. I think there are certainly NIH studies which can lend to that and CDC is looking at areas that we can improve quality.

But part of it is learning from the folks who are running the health systems that have been identified as delivering high-quality care at a much lower cost. We have some improvements currently proposed in the budget and some Medicare demonstration projects. One of the areas we know is very erratic is what happens to a patient when you get released from a hospital. Right now, 20 percent are re-admitted. And a lot of evidence leads to the fact that that's because of a lack of follow-up care, which is very expensive and certainly not great for the patient. So, we're trying to expand best practices in that area.

Looking at bundled payments so providers are more concerned with ultimate outcome and not with contacts with patients. So we think that will be an effective strategy. And really driving, encouraging some voluntary collaboration, with single practice docs so that they can have a more coordinated care strategy.

So trying to take what we think is working and encourage others to follow that practice and use some of the Medicare, both incentives and payments, to enhance and accelerate quality care for all Americans.

Senator KOHL. Thank you very much. Thank you very much, Mr. Chair.

Senator HARKIN. Thank you, Senator. Senator Alexander.

Senator ALEXANDER. Thank you, Mr. Chairman. Madam Secretary, welcome. I'm glad you're here.

The President sent a letter to Senator Baucus and Senator Kennedy saying that, on June 2, saying that healthcare reform must not add to our deficit over the next 10 years and today he made a speech about pay-go, saying that we should only spend a dollar if you save, or I might add tax a dollar. Are we to assume then that so-called pay-go should apply to the healthcare reform bill that we are considering in Congress.

Secretary SEBELIUS. Well I think, Senator, certainly the estimates over a 10-year period of time are a bit difficult to reach. And I think one of the ongoing concerns, and it is something that I think the chairman shares, is that currently there is no scoring, for instance, for any prevention and wellness strategy. I'm not sure there's an expert who believes that it won't save money, and yet it is not scored.

So, whether or not the kind of transformational healthcare reform will actually have a dollar-for-dollar offset on day one, I can't tell you because I think that——

Senator ALEXANDER. So, pay-go does not apply to the healthcare reform bill we are considering?

Secretary SEBELIUS. Senator, I think it does. I haven't seen the outlines of exactly what the President is proposing to Congress. I know there was some discussion, about the 10-year timeline with the healthcare reform bill. Is it 10 years from the date it starts, is it 10 years from the date it passes? And there is a lively debate about prevention and wellness strategies and whether that can be scored at least in out-years.

Senator ALEXANDER. But would you agree that it might be a good idea to see the details of the proposal and to hear from the Congressional Budget Office what the scoring might be before making a decision about going forward, in light of the President's concern about pay-go?

Secretary SEBELIUS. Well, I think certainly it is a discussion to have. I'm not sure that the Congressional Budget Office is going to score prevention, although I think they're dead wrong in not assuming that there will be savings and cost effectiveness related to shifting a health system to a wellness prevention system.

Senator ALEXANDER. Well, without being overly redundant, if the President is going to write us a letter and say don't add to the deficit and give us a lecture about pay-go, shouldn't it apply to the healthcare reform bill, which is variously estimated between $1 to $2 trillion in new costs over the next year?

Let me ask you this, if it does cost between $1 to $2 trillion, depending upon whether it's the Kennedy bill or the bill being considered by the Finance Committee, what new taxes or what new savings would the administration recommend to make sure that we don't add to the deficit?

Secretary SEBELIUS. Well, Senator, as you probably know, in the 2010 budget, the President recommended about $630 billion worth of both savings and revenue enhancements. And we've also suggested, after reviewing the overall Medicare programs, that within the Medicare program, we think another $200 to $250 billion is possible in terms of savings. There's no question that the additional and enhanced efforts on fraud and abuse will generate some additional savings. And he has had lively discussions with members of the House and the Senate about their ideas for funding the remainder of the program.

But I think the good faith effort by the President, and it's demonstrated in his budget and moving forward, to come in with a substantial investment in reform moving forward, and then hopefully engaging Congress in that very discussion.

Senator ALEXANDER. But you would agree that the investment is only a beginning of the amount of money that we may need?

Secretary SEBELIUS. Well, $634 billion plus another $200 billion is $800 billion. And if it is in the $1 trillion to $1.2 trillion range, that's a pretty good investment moving forward.

Senator ALEXANDER. That's a pretty good investment, so it would be important to know the details of the proposal and the cost of the proposal before we vote on the proposal and act on the proposal, if we are to take, show respect to the President's desire for pay-go and not adding to the deficit.

Secretary SEBELIUS. Well, and hopefully as Members of Congress engage in this discussion, as the bill is written by the Finance Committee and the HELP Committee, the three committees dealing with it in the House will engage in those conversations about paying for healthcare reform, which will be a critical part of this dialogue moving forward.

A PUBLIC HEALTH INSURANCE OPTION

Senator ALEXANDER. Does the President or the administration support the Government-run insurance plan proposed by Senator Kennedy in his legislation? I note that the President, in his letter, said that he wanted to see a public or Government-run option as a part of a plan.

Secretary SEBELIUS. Well, I think that the President has maintained from the outset, during the course of the campaign and in the letter that you received, that in the Health Insurance Exchange, a marketplace where consumers would have choices and options for coverage if they want to choose new coverage, that a public option is very important. In many parts of the country, there is not a choice of private plans. There is a dominant carrier, a monopoly——

Senator ALEXANDER. Excuse me, but does he support or not support Senator Kennedy's——

Secretary SEBELIUS. I have not seen the specific language that you are referring to——

Senator ALEXANDER. So, he would want to read it and understand it and understand it and maybe see the cost of it before he made that decision.

Secretary SEBELIUS. You'd have to ask the President about that.

Senator ALEXANDER. Well, I'm asking—you represent him, would you want to read it and understand it?

Secretary SEBELIUS. And I will.

Senator ALEXANDER. And know the cost of it before you decided whether you supported it.

Secretary SEBELIUS. I'm sure we'll have that dialogue.

Senator ALEXANDER. Does that mean you would or you wouldn't?

Secretary SEBELIUS. I said I would read it, yes sir.

Senator ALEXANDER. So, you would want to read it and understand the cost before you decided whether to support it.

Secretary SEBELIUS. Yes, I will read it.

Senator ALEXANDER. Thank you, Mr. Chairman.

Senator HARKIN. I just want to make sure my colleague from Tennessee, who is also a member of the authorizing committee, I believe, right?

Senator ALEXANDER. Yes.

Senator HARKIN. That we're going to have a walk-through with our bill starting tomorrow, both Republicans and Democrats, that the Senator will have every opportunity to amend, offer, discuss these different things. I can tell you to right now that we're on this public option plan, that we're leaving it blank, because we want to have a discussion on it. And we want to have ideas that come forward, and see where the votes are. I think that's the fair and honest way to do that.

So, we're not coming out with anything and saying here is, take it or leave it. We are kind of leaving it open for discussion and then I we'll see where the votes are on it. I think that's the best way to proceed.

And then, after that, whatever we decide to do, then the administration can tell us what they think, but that's our deal and we have to do it.

Senator ALEXANDER. I thank the chairman. I just wanted to establish the principle that it is usually a good idea to read and understand know the cost of a proposal before we are asked to make a decision about it.

Senator HARKIN. Oh, I think that will happen in the next couple months. Senator Pryor.

Senator PRYOR. Thank you, Mr. Chairman, and thank you, Madam Secretary, for being here.

Let me start, if I may, with the issue of Comparative Effectiveness Research. And my understanding is that this research has great potential to empower patients and physicians to choose treatments that offer the most benefit; however, some have attacked this initiative, claiming that it could be used to ration care.

Do you mind talking to the subcommittee for a few minutes about Comparative Effectiveness Research and why you think that the Department is in a better position than the private sector to ensure this research is performed?

Secretary SEBELIUS. Well Senator, I think that, first of all, to the point you made citing detractors who are fearful that this will lead to rationing care, there is a provision in the funding of the research that prohibits Medicare from using Comparative Effectiveness Research to make cost decisions. I think that is clear in the law and certainly the folks at the Centers for Medicare and Medicaid Services (CMS) intend to follow the law.

We are very encouraged by the opportunity to learn from what's happening in this rapidly evolving area of medical care and certainly what is happening to produce high-quality, low-cost care in various parts of the country. And to help drive those best practices across the country, so all Americans have access to that care. And I think that the investment that Congress wisely made in Comparative Effectiveness Research gives us the opportunity to do that, to tie in what strategies lead to better health outcomes and lower cost which are, again, in places in pockets around the country, but not everywhere.

And I think the fear is that somehow this will drive rationing of care. I will suggest it will raise quality of care in a very effective manner.

HEALTHCARE ACCESS IN RURAL AMERICA

Senator PRYOR. Let me ask another question, something that I know is important to you, being from a rural State like I am. And that is that we have a real challenge in our State, as well as other senators do in their home States, where we just don't have enough doctors in rural America.

And my sense is that, you know, one reason is because a rural setting and the challenges for a rural practice just isn't that appealing for a lot of people coming out of medical school. But also,

I think that there is a practical part of this and that is that the Medicare reimbursement rates are often much lower in a State like Arkansas, and may be your home State, and elsewhere than they would be otherwise.

Secretary SEBELIUS. We like to call you "Our Kansas" but——

Senator PRYOR. I understand, I understand. We get that a lot by the way. But we do share that, so my question for you is, what is the best way to ensure that people in rural America have, not access to coverage, but actually access to care in their home communities?

Secretary SEBELIUS. Well, I think it's a great question and certainly one that I worked on as Governor in Kansas, and I share your concerns about the distribution of healthcare providers and the incentive to stay in practice in a rural community.

Certainly continuing to examine the pay differentials of Medicare is a piece of the puzzle and one that I take seriously and will make sure that we continue to look at. Whether or not that provides disincentives for all kinds of things. There are people who suggest that there are also disincentives for lower-cost care to be delivered in some areas because then they turn around and get penalized with lower reimbursement rates.

I think there's a lot that the investment that you made in health technology can also do to enhance rural practitioners by connecting with telemedicine to specialists and consultation experts who may be hundreds or even thousands of miles away, but can be very much part of their practice on an ongoing basis. And certainly the investment in the Expanded Commission Corps to look at underserved areas is a help, as well as the money—we just announced a couple of days ago, pushing out the door some of the Recovery Act money which will help pay student loans. And I know, at least in our State and I'm sure in Arkansas, the payment strategy for underserved areas has been particularly effective in having young providers locate. And once they are there, they don't leave, that has been our experience.

So, I think we've got to use a whole variety of incentives, loan repayment, telemedicine, to make sure that all Americans have high-quality care.

Senator PRYOR. Well, and I do appreciate the President and you putting into the budget the Improved Rural Health Care Initiatives. So, I think that's a step in the right direction. Thank you for your answer.

Mr. Chairman.

Senator HARKIN. Thank you, Senator. Senator Specter.

Senator SPECTER. Thank you, Mr. Chairman. Madam Secretary, thank you for taking on this difficult job and leaving the beautiful State of Kansas.

Secretary SEBELIUS. Our home State, I share with the Senator, yes.

Senator SPECTER. Today has been a Kansas Day in appropriations hearings. Secretary Gates testified this morning. He's from Wichita.

Secretary SEBELIUS. Yes, indeed.

Senator SPECTER. And went to a very distinguished grade school.

Secretary SEBELIUS. We're talking about Kansas, it's important.

Senator SPECTER. He went to a very distinguished grade school and it's called College Hill. It only went to the sixth grade. And I went there not quite at the same time, but the same school. And the Governor is from Kansas in a town not too far from Russett.

NIH FUNDING

So much for the pleasantries, Governor. Now on to your budget. To have an NIH budget of $442 million is a sharp retreat from what the chairman used to insist on, $3.5 billion a year increases. Senator Harkin wouldn't settle for any less than that for most of a decade. Well, I guess that's not entirely true, occasionally he settled for $3 billion. But if you take a look at the cost-of-living adjustments, the inflation rate, about 3.3 percent, that's $1 billion.

I know you don't construct the budget all by yourself, OMB, there are lots of constraints, but I would urge you to take another look at that figure. We can offer amendments, of course, to stay within the budget, but I appreciate it if you would take another look at it.

The $10 billion which was added in the stimulus package has created an enormous wave of excitement among young people. We are in jeopardy of losing a generation of young research scientists and I think we have to maintain the growth rate. We talk about cutting down the costs of healthcare, what better way to cut the cost factor than to prevent illness. And during the period of time when Senator Harkin had his way, increasing from $12 to $30 billion, the death rate from——

Senator HARKIN. Wait a minute, I was ranking member.

Senator SPECTER. What's that? Now, come to think of it, he didn't have all that much to do with it. But on a serious note, we used to trade gavels with some frequency. But on to the serious note, the death rate from strokes went down, from heart disease, improvements on cancer. And we just have to find some way to do better.

And I note that the budget calls for $268 million for cancer and $19 million for research into autism. That is a change from what we've always done. We'll have endeavored not to politicize the allocations by leaving it to the scientists. And one year the chairman of the Appropriations Committee who suffered from prostate cancer wanted to add $150 million to prostate cancer and he was unsuccessful in doing that.

So, I'd like you to take another look. And I know you can't focus on all of these matters and you don't have a long history like this subcommittee as to whether you really want to initiate a policy of picking and choosing.

UNIVERSITY OF PITTSBURGH BIODEFENSE INITIATIVE

My yellow light is on so I will make only one further comment. I want to express my thanks to you for meeting with a group by May 20 on the Biodefense Initiative from the University of Pittsburgh, UPMC. Do you have any initial thoughts on that subject? I know you haven't had time to go through it in detail, but any preliminary thinking? I don't get calls from UPMC more than twice a day, so when I have you here, I thought I'd ask.

Secretary SEBELIUS. Well Senator, I thought, first of all, the presentation was very impressive and certainly the notion that we should have a facility dedicated to production of a variety of vaccine lines is also incredibly timely and something that I think should be part of our preparedness arsenal.

I think that the issue that we're facing right now, as you well know, is whether we can adequately prepare for the uncertainties that still may be confronting us in the very near future with novel H1N1 strains, and the potential massive vaccination program, and production costs, and continue with the preparedness underway. And then add an additional factor to that. But I don't think there's any doubt about the importance about that being part of the strategy moving forward, but how quickly that could be implemented, I can't tell you right now.

Senator SPECTER. Well, we would appreciate your informing us at the earliest date you can.

Secretary SEBELIUS. I will, Senator. Thank you.

Senator SPECTER. Thank you, Madam Secretary and thank you, Mr. Chairman.

NIH STIMULUS FUNDING

Secretary SEBELIUS. And Senator, may I just respond briefly to the research questions, because I just want to tell you that I share both the concern that we continue to invest in science and research. And I have already heard enormously positive feedback about the investment from the Recovery Act and, as you say, the excitement of a new generation of researchers that we are recommitting to research funding.

I do think that, in putting together the 2010 budget, there was a recognition that the Recovery Act funds really will fund 2010 and some of the 2011 strategies. But working with you, Senator, not only Senator Specter, but the chairman, who I know has enormous interest in this research area, on future years I think will be very important to make sure that we don't reach a cliff and fall off the edge of the cliff, because we want to continue this multi-year research investment.

Senator SPECTER. Well, Madam Secretary, may I suggest that the stimulus package and that $10 billion ought not to be looked at for the regular funding. That is extra, designed to create 70,000 new jobs for the 2-year period, with the specific target that the President asked for and that Congress responded to in an affirmative way.

I perhaps, as much as any, under the circumstances casting the vote I did, that we were looking for that to stimulate the economy and for jobs. And I couldn't tell you, line by line, on all the other budget items, but I believe that it was not a generalization for the stimulus to be used in place of the future years' funding.

So we'd like to maintain NIH funding on its own, besides that.

Senator HARKIN. Madam Secretary, I just want to say that I fully concur with Senator Specter's views on this. We have worked in tandem on this for a long time and I can assure you that, when it comes to NIH funding, regardless of which side Senator Specter is on, he is going to be dogged on this and I am going to be joining with him on it.

Senator Specter is absolutely right. We put that money in there, in the stimulus, because it was stimulus for the 2 years. And I am concerned about the cliff and the baseline and what happens to that baseline funding.

Quite frankly, if you really look at it, Senator Specter, we finished that from about 2005 until now, basically our funding has been kind of flat. I think that in real dollars we are about at where we were in 2005, if I'm not mistaken. So, to only put in $442 million doesn't do much for getting our baseline up.

Senator SPECTER. Mr. Chairman.

Senator HARKIN. Yes.

Senator SPECTER. During the period of the last several years, you and I made the calculation we went down $5.2 billion in real dollars.

Senator HARKIN. Real dollars, yeah.

Senator SPECTER. As a result of not having a cost-of-living adjustment for several years and then these tiny across the board cuts, a percent here and half a percent there, and pretty soon a $30 billion allocation turns out to be less than $25 billion. So, were playing against that backdrop as well.

Senator HARKIN. So, this one thing we can probably concur on, I don't know about the second, but the $442 million is, I think, inadequate. We'll see what we can do about that. I don't know, within our allocation, what we can do. We don't have our allocation yet, we'll have to see about that. But we have a lot of demands for this and we'll just have to see what we can come up with.

But within that $442 million, I am somewhat concerned that $268 million was designated for cancer, for the National Cancer Institute, and I think, $19 million for autism. So, over half of that for two Institutes, for two diseases. And I mentioned this to the NIH Director, Acting Director, who was up here looking at their budget, that I don't know if this is a good way to do things. To put all that money just into those two programs, when there's a lot of other needs spread across the entire spectrum of research.

And I'm just thinking that, perhaps, we might look for a better distribution of the money than just in those two areas. Let the researchers at NIH decide where that money ought to go.

Secretary SEBELIUS. I appreciate that.

Senator HARKIN. I don't have anything else, Madam Secretary.

HEALTHCARE FRAUD AND ABUSE

Senator COCHRAN. Mr. Chairman, I have one other question, if I may.

Madam Secretary, I've been advised that fraud and abuse are draining about $60 billion a year from our healthcare system. This money could be going to patient care and to address other problems. I've co-sponsored, with other senators, The Seniors and Taxpayers Obligation Protection Act, as an acronym STOP, it's known as the STOP Act, which is designed to eliminate the use of Social Security numbers as the Medicare identifier to help curb fraudulent services.

I wonder if you agree that something like that is needed and, in view of the fact that your budget includes only $113 million for

Medicare safeguards, do we need to look elsewhere for ways and means of helping to curb Medicare waste, fraud, and abuse?

Secretary SEBELIUS. Well, I certainly share your concern about waste, fraud, and abuse, Senator. And any dime stolen from the program is stolen from not only the taxpayers, but from the delivery of healthcare services. And I think that's why the President was eager to have the Attorney General and I join together in a new initiative sharing real data, rather than following what were sometimes old audits, trying to get out ahead of some of this effort by monitoring billing.

And I am not familiar specifically with the legislation you mentioned, but I will certainly share those ideas with our folks and have them take a look at it. Because I think that anything we can do to discourage these practices before they occur and save those resources for the delivery of healthcare is incredibly important.

People are stealing from the system and we want to make it more difficult, if not impossible, not easier. So, this is one strategy that I would love to take back to our CMS folks.

Senator COCHRAN. Thank you very much. Thank you, Mr. Chair.

Senator HARKIN. Thank you, Senator Cochran.

ADDITIONAL COMMITTEE QUESTIONS

Well, Madam Secretary, thank you very much for your appearance here and your leadership at the Department. I will leave the record open for any written questions that the Senators who couldn't be here might want to propound. And, again, I look forward to working with you on the recovery money that we talked about before that's going out for prevention.

Secretary SEBELIUS. Absolutely. Thank you.

[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 DANIEL K. INOUYE

OCCUPATIONAL SAFETY AND HEALTH TRAINING PROGRAM

Question. Several years ago, at my request, the Centers for Disease Control and Prevention (CDC) established a National Institute for Occupational Safety and Health presence at the University of Hawaii at Hilo. Unfortunately, a now retired faculty member returned the funds. With new and energetic faculty now present, will you consider re-establishing a presence back on the island, given our truly unique rural and environmental needs?

Answer. CDC/NIOSH supported a Training Project Grant at the University of Hawaii—Hilo (T02–OH008627, entitled "Occupational Safety and Health Education—A Behavioral Approach," from August 2001 through June 30, 2006. The awarded application was competitively reviewed and was awarded based on its technical and scientific merit. The Principal Investigator, Dr. Stephen Worchel, Department of Psychology, indicated to CDC/NIOSH in August 2005 that the University did not plan to recompete for support of this project. The grant ended and was subsequently closed out.

On March 12, 2009, CDC/NIOSH provided a step-by-step process for submitting a new application to University of Hawaii at Hilo for a Training Project Grant. University officials indicated that the University of Hawaii—Hilo planned on submitting a highly competitive application for the upcoming August 24 deadline in response to NIOSH's Program Announcement PAR–06–484: http://grants.nih.gov/grants/guide/pa-files/PAR-06-484.html. The most meritorious applications are expected to be funded in June 2010.

NATIVE HAWAIIAN HEALTHCARE

Question. I am very pleased that your department continues to recognize the unique health needs of the Native Hawaiian population. I appreciate being kept informed of efforts to improve health outcomes, especially as they relate to diabetes and cancer in this population.

Answer. The Department of Health And Human Services (HHS) has a number of initiatives, grants, and partnerships to address the needs the Native Hawaiian population; attached is a list of some of the grants provided to organizations serving Native Hawaiians. In 2006, HHS established the HHS Workgroup on Asian, Native Hawaiian and other Pacific Islander Issues (WANHOPII). The mission of WANHOPII is to improve communication, coordination, and agency policies, programs, and evaluations that impact the health, healthcare, human services, and well being of Asian American, Native Hawaiian and other Pacific Islander (NHOPI) communities. In addition, the Office of Minority Health is supporting the development of the Native Hawaiian and Other Pacific Islander Health Agenda, including town hall meetings and summits that provide a forum for NHOPI community members, community-based organizations, and others to voice their issues, concerns, and recommendations, and to mobilize around a health and well-being agenda to address NHOPI health.

Several HHS offices and agencies have programs to improve health outcomes, including those related to diabetes and cancer, of the Native Hawaiian population. Summaries are provided below:

OFFICE OF MINORITY HEALTH

The Office of Minority Health (OMH) supported the development of the Native Hawaiian and Other Pacific Islander Health Agenda introduced by the Asian and Pacific Islander American Health Forum (APIAHF), and provided additional funding to APIAHF to explore health issues facing Native Hawaiians and Pacific Islanders.

In April 2007, OMH supported the California Native Hawaiian and Pacific Islander Town Hall Meeting to provide a forum for NHOPI community members, community-based organizations, and others working with NHOPI populations to voice their issues, concerns, and recommendations regarding NHOPI health to the HHS. The town hall and subsequent discussions resulted in the first ever Native Hawaiian and Pacific Islander Health and Well-Being Summit in October 2007 to articulate and mobilize around a health agenda. HHS recognizes that NHOPI communities have unique health needs, and has supported APIAHF in the formation of the Native Hawaiian and Pacific Islander Alliance. On January 30, 2008, APIAHF with the NHPI Alliance released the report "Guidance for the classification of Native Hawaiians and Pacific Islanders" that appropriately reflects the disaggregation of Asian Americans, Native Hawaiians, and Pacific Islanders.

In April 2009, OMH co-sponsored the Native Hawaiian and Pacific Islander Health Brain Trust, hosted by the APIAHF. The 2009 Brain Trust was the first of a two-series conference to learn about pressing health issues and discuss barriers to data collection and reporting on Native Hawaiians and Pacific Islanders, and to identify strategies for community and community-based organizations, researchers, funding agencies, policy makers, and advocates for improving the health and well-being of Native Hawaiians and Pacific Islanders.

OMH also works closely with our community partners, including Papa Ola Lokahi, to respond to the concerns and needs of the Native Hawaiian community. Through the Youth Empowerment Program, OMH supports the Lanakila Learning Center through the University of Hawaii at Hilo. The Lanakila Learning Center is an alternative learning center of Hilo High School servicing "at-risk" 10th–12th graders, and providing a variety of wellness workshops in substance abuse prevention/intervention, social skills training, anger management, health and nutrition, and fitness classes.

Through the Community Partnerships to Eliminate Health Disparities grant program, OMH supports the Life Foundation, a program that seeks to improve the health status of Native Hawaiians, Asians, and Pacific Islanders through targeted HIV prevention and care services. Life Foundation partners with Waikiki Health Center and Waianae Coast comprehensive Health Center.

HEALTH RESOURCES AND SERVICES ADMINISTRATION

The Health Resources and Services Administration (HRSA) provide funding for the Native Hawaiian Health Care Program, which is funded through the Health Center appropriation. The focus is to improve the health status of Native Hawaiians by making health education, health promotion, and disease prevention services

available through the support of the Native Hawaiian Healthcare Systems. The Native Hawaiian Healthcare Systems use a combination of outreach, referral, and linkage mechanisms to provide or arrange services. Services provided include nutrition programs, screening and control of hypertension and diabetes, immunizations, and basic primary care services. In fiscal year 2007, Native Hawaiian Healthcare Systems provided medical and enabling services to more than 6,500 people. The Native Hawaiian population is also served by the Health Centers operating more broadly across Hawaii.

NIDDK'S DIABETES EDUCATION IN TRIBAL SCHOOLS (DETS) PROJECT

The National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK) has provided funding to eight tribal colleges and Universities to develop supplemental curricula on diabetes education for K–12 schools that educate American Indian and Alaska Native children. The curricula are completed and the investigators are now recruiting and training teachers in the K–12 schools. Recently, the investigators were invited by some schools in Maui to provide professional education to their teachers so they can also use the DETS curricula to teach children in their K–12 schools about diabetes and prevention. You may find more information on the DETS at: http://www3.niddk.nih.gov/fund/other/dets/index.htm.

HHS NATIONAL DIABETES EDUCATION PROGRAM

The HHS National Diabetes Education Program (NDEP) is the leading Federal Government public education program that promotes diabetes prevention and control. Launched in 1997, NDEP's mission is to reduce the morbidity and mortality associated with diabetes. More than 200 organizations and many volunteers have joined with NDEP to help develop critical and effective initiatives. The NDEP Asian American and Pacific Islander Work Group has led development of tip sheets on comprehensive diabetes control and the primary prevention of diabetes in 15 Asian and Pacific Islander languages. Through the CDC, the NDEP supported Papa Ola Lokahi's Pacific Diabetes Education Program, serving Native Hawaiians and a diverse population across the Pacific Islands with culturally appropriate in-language diabetes materials.

The Hawaii Diabetes Prevention and Control Program (HI DPCP) has received funding from the CDC since 1987. Activities supported by the DPCP include surveillance, development of the Hawaii Diabetes Coalition, translation, development and distribution of resource materials, quality improvement initiatives, and review of the Hawaii State Practice Recommendations.

CENTERS FOR MEDICARE AND MEDICAID SERVICES

Many of the Centers for Medicare and Medicaid Services (CMS) activities have focused on the Native Hawaiian healthcare system (Papa Ola Lokahi is the lead agency) along with grants to various Federally Qualified Health Centers (FQHCs) and community health centers. CMS also funds a Cancer Prevention and Treatment Demonstration for Racial and Ethnic Minorities (ending in 2010) at Molokai General Hospital. The demonstration is using a randomized control design to study the impact of various evidence-based, culturally competent models of patient navigator programs designed to help minority beneficiaries navigate the healthcare system in a more timely and informative manner and facilitate cancer screening, diagnosis, and treatment to improve healthcare access and outcomes as well as potentially lower total costs to Medicare. Approximately 12,700 Medicare fee-for-service beneficiaries are eligible to be enrolled in the study during this 4-year project.

Through CMS-funded grants directed to States, State Health Insurance Assistance Programs, or SHIPs, provide free counseling and assistance to people with Medicare and their families. The Hawaii SHIP provides the following activities:

—Part D/LIS and general Medicare counseling, information and outreach to beneficiaries and information on how the plans will coordinate with the unqualified SPAP which will lead to improved access to medications by beneficiaries. While this is not specifically targeted to diabetes and cancer health outcomes, these activities will help improve access to needed medications for this population.

—Through the Executive Office on Aging of the Department of Health where the SHIP is housed, the Native Hawaiian programs participate in the Healthy Aging project.

ADMINISTRATION ON AGING

With funding from the U.S. Administration on Aging, Hawaii's Executive Office on Aging and Department of Health work together to offer Healthy Aging Partner-

ship—Empowering Elders (HAP–EE), which began in September 2006. HAP–EE carries out programs that have been proven effective in reducing the risk of disease, disability and injury among the elderly. These include the Chronic Disease Self-Management Program, Arthritis Self-Management Program, Diabetes Self-Management Program, and EnhanceFitness. These programs provide seniors with simple tools and techniques they can use to better manage their chronic conditions, reduce their risk of falling, and improve their nutrition and physical health. A pre-poststudy of the Hawaii Chronic Disease Self-Management Program reported improvements in physical activity; reductions in pain, fatigue and shortness of breath; and a reduction in medical care use. Results of pre-poststudy of Enhance Fitness participants in Hawaii showed improvements in gait and strength, increased levels of physical activity, and reduction in falls.

CENTERS FOR DISEASE CONTROL AND PREVENTION

The Division of Cancer Prevention and Control provides funding to the Hawaii Department of Health, through a cooperative agreement, to provide breast and cervical cancer screening and diagnostic services to underserved women, including Native Hawaiian women. The Division of Cancer Prevention and Control also provides funding to the Hawaii Department of Health for the Comprehensive Cancer Control Program. Hawaii has a comprehensive cancer control plan that was developed by a coalition that includes a diverse group of stakeholders. Coalition members include representatives of organizations, such as Papa Ola Lokahi, that focus on the needs of the Native Hawaiian population.

OFFICE ON WOMEN'S HEALTH (OWH)

Advancing System Improvements to Support Targets for Healthy People 2010 (ASIST2010) is a 3-year cooperative agreement program funded by the Office on Women's Health. ASIST2010 uses a public health systems approach to improve performance on objectives that target women and/or men in the following focus areas: cancer, diabetes, heart disease, stroke, access to quality health services, educational and community-based programs, nutrition and overweight physical activity, and fitness. Two of the 12 funded ASIST2010 programs targeting diabetes include as their target population Pacific Islanders:

—*National Kidney Foundation of Michigan (Ann Arbor, Michigan).*—The site utilizes PATH, Tomando Control de su Salud and Enhance Fitness programs to provide people with chronic diseases and those at-risk with the skills and tools needed to improve their health outcomes and manage their symptoms. To assure that the programs are culturally appropriate, leaders and programs are gender-specific as needed to reach certain racial and ethnic minority populations, including African Americans, Hispanic/Latinos, Asian Americans/Pacific Islanders, Native Americans, and Arab Americans.

—*Wise Woman Program of Saipan, Commonwealth of the Northern Mariana Islands.*—The Wise Woman Village Project (WWVP) of the Northern Marianas Islands Department of Public Health provides outreach, health screening, and education. WWVP addresses noncommunicable diseases (diabetes, mellitus, hypertension, cardiovascular disease, and cervical cancer) in addition to tobacco use assessment and cessation referral. It addresses physical activity promotion through a partnership with a faith-based organization and other community organizations.

—*BodyWorks.*—Another OWH program, BodyWorks, is designed to help parents and caregivers of adolescents improve family eating and activity habits. The program focuses on parents as role models and provides them with hands-on tools to make small, specific behavior changes to prevent obesity and help maintain a healthy weight. The program uses a train-the-trainer model to distribute the Toolkit through community-based organizations, State health agencies, nonprofit organizations, health clinics, hospitals and healthcare systems. There are approximately 20 trainers in Hawaii; a list can be found at: http://www.womenshealth.gov/BodyWorks/find.trainers.statedetail.cfm?state=HI.

ADMINISTRATION FOR CHILDREN AND FAMILIES: OFFICE OF HEAD START

The Office of Head Start provides grants to various entities including schools, tribes, and nonprofit and for-profit agencies to provide comprehensive child development services to economically disadvantaged children and family. A major focus of services to enrolled children and their families is towards improving health outcomes through the provision of educational, nutritional, and health services. These primary and secondary prevention services are making a major impact on improving health outcomes for those Native Hawaiian children and families that are currently

served under existing Head Start grants. Hawaii is served under region 9. The most recent statewide data (Source: 2008 OHS Program Report Information) shows that Head Start funds a total of 7 grantees, and 21 percent of the Hawaii State HS/EHS children served are Native Hawaiian or other Pacific Islander ethnicity. This includes 1,588 for Head Start and 377 for Early Head Start.

Head Start's goals include prevention and reduction of childhood overweight and obesity, to reduce the incidence of Type 2 Diabetes Mellitus. Obesity is a major risk factor for the development of Type 2 Diabetes Mellitus. The Office of Head Start is conducting a major initiative to prevent and reduce childhood obesity, through a program titled "I Am Moving, I Am Learning". I Am Moving, I Am Learning introduces multidisciplinary teams from local Head Start programs to the science of obesity prevention, and arms them with state-of-the-art resources and best practices for addressing the growing child obesity epidemic in an intentional and purposeful manner.

Head Start also works to prevent and reduce tobacco smoke exposure. The Family and Child Experiences Survey study shows that 45 percent of Head Start families smoke and 56 percent of Early Head Start families smoke. The Office of Head Start and the Indoor Environments Division of the U.S. Environmental Protection Agency are partnering to improve the overall health of Head Start children. The partnership aims to reduce young children's exposure to secondhand smoke and other asthma triggers. The goal of the partnership is not to get parents to stop smoking. Rather, the purpose of the toolkit is for Head Start staff to use the information as a means to educate parents of the many ways to enhance their children's health.

HHS GRANTS PROVIDED TO ORGANIZATIONS SERVING NATIVE HAWAIIANS

Administration for Children and Families/Administration for Native Americans (ACF/ANA)

Grantee.—Wai'anae Coast Comprehensive Health Center

Project Title.—Strengthening Families and Promoting Healthy Lifestyle

Project Funding.—$542,064 (includes anticipated continuation awards)

Total ANA Funding.—$2,014,024

The Wai'anae community is located on the western side of the island of Oahu. Its population grew from 3,000 people in 1950 to 45,000 people today, of which 40 percent are Native Hawaiian and 45 percent are under the age of 25. The Wai'anae coast is an economically distressed community ranked highest on the island for: households receiving financial aid and food stamps; households under the poverty line; and rates of unemployment, infant mortality and teen births. Health issues are a major concern in the community as Native Hawaiians have the highest prevalence of obesity and diabetes in the State. Additionally, an estimated 1,000 homeless residents, most of whom are Native Hawaiian, live on the Wai'anae coast.

The Wai'anae Coast Comprehensive Health Center is a Federal Public Health Service Community Health Center 330(e) grantee that has served the community for the past 32 years. During this time, the Center has developed a unique model of healthcare that addresses individual, family and community needs through a combination of traditional and modern practices.

The Strengthening Families and Promoting Healthy Lifestyle Project developed a healthy culinary training program to promote activities to retain and re-establish traditional foods in the family diet. There were 939 youth involved in this project. Many Native Hawaiian at-risk youth demonstrated improved self-esteem and began integrating the traditional culture into their daily lives. For the youth participants that were overweight, the project health activities provided a comforting and encouraging atmosphere to lose weight. The youth were involved in outreach activities like designing the "KidFit T-Shirt" and creating the Health Center's video public service announcements.

For the involved families, the project promoted bonding through exercise, healthy eating and the revitalization of Kumu Ohana, all of which contribute to healthy lifestyles that can prevent diabetes and cancer among Native Hawaiians. In addition, the project created 15 jobs and leveraged resources were more than $100,000.

Grantee.—Wai'anae Community Re-Development Corporation

Project Title.—The Center for Organic Agriculture and Sustainability

Project Funding.—$1,152,476 (includes anticipated continuation awards)

Total ANA Funding.—$1,790,037

According to the project leaders at Ma'o Organic Farms, Wai'anae youth struggle to achieve their socio-economic goals. The statistics suggest a bleak future for many Native Hawaiian youth with the State's highest rates of teen pregnancy, school suspensions, incidents of substance abuse, and juvenile arrests. In addition, Wai'anae is recognized as the most food insecure region of Hawaii with Native Hawaiians

having the highest rates of preventable disease including diabetes, heart disease and some cancers. Despite these statistics, Wai‘anae residents still maintain a rural vision, a willingness to perpetuate our community's "country" values and to offer hope and validation to our ‘opio of their personal and cultural identities.

The Center for Organic Agriculture and Sustainability, at Ma'o Organic Farms, will positively impact the well-being of Wai'anae youth by promoting healthy lifestyles and decreasing the incidence of diabetes. The project will engage Native Hawaiian youth in the development of organic agriculture and will provide a foundation for economic opportunities for youth participants.

The 3-year project will provide multi-purpose venue for food production that will increase commercial efforts of organic farms and develop a working base for social enterprise, organic agriculture and sustainability that can be replicated in other communities.

Grantee.—Waipa Foundation

Project Title.—Waipa Community Kitchen and Business Incubator Project

Project Funding.—$709,260

Total ANA Funding.—$867,010

This is a 3-year project to provide a fully-equipped and certified commercial kitchen facility that will allow farmers, families, and community members to process crops and grow small businesses. The Waipa Community Kitchen and Business Incubator will promote a healthy, diverse, and sustainable local food economy for the Halele'a-Kilauea communities.

Grantee.—University of Hawaii and Manoa Center (Collaborative Project)

Project Title.—The Hawaii Demonstration to Maintain Independence and Employment Project

Project Funding.—$1,539,002

The Hawaii Demonstration to Maintain Independence and Employment project is a joint endeavor between the Hawaii State Department of Human Services, the University of Hawaii at Manoa Center on Disability Studies, the Hawaii State Department of Health (DOH), and the Hawaii Business Health Council.

These agencies will engage in a collaborative effort with public and private employers, employee groups, and their healthcare providers in a comprehensive community-based effort to assist individuals who are at high risk of becoming disabled/ unemployed as a result of diabetes.

The partnership enlists promising and emerging practices to identify and support persons, ages 18 through 60 years old, with potentially disabling and medically determinable physical impairments as a result of diabetes.

Substance Abuse and Mental Health Services Administration (SAMHSA)

Grantee.—Hawaii Families as Allies—Aiea, HI

Program.—Statewide Family Networks SM057920

Congressional District.—HI–01

Fiscal Year 2008 Funding.—$70,000

Project Period.—9/30/2007–9/29/2010

The Hawaii Statewide Transformation and Empowerment Project (STEP) will conduct training, technical assistance, and networking activities aimed at substantially increasing the involvement of children and youth with emotional, behavioral or mental disorders and their families in all levels of Hawaii's system of care. Family members will be supported so that they will be able to develop and implement a legislative advocacy action plan. STEP will also involve key child-serving agencies, including those responsible for child welfare and juvenile justice, in an initiative to increase their awareness of and adherence to the CASSP values and principles. Another set of activities will focus on youth leadership development, focusing on developing and implementing a legislative advocacy initiative. HFAA Parent Partners will also provide peer supports and mentoring for youth and families in their home communities throughout Hawaii.

Grantee.—Hawaii State Department of Health—Honolulu, HI

Program.—Child Mental Health Initiative SM057063

Congressional District.—HI–01

Fiscal Year 2008 Funding.—$1,257,281

Project Period.—9/30/2005–9/29/2011

Project Ho'omohala (meaning in Hawaiian, "evolving toward maturity") will develop a system of care to meet transitional needs of youth with emotional and/or behavioral challenges, ages 15–21 in the Kalihi-Palama community. Culturally and linguistically appropriate services will utilize the transition to independence process. Families and youth will be active partners in the governing structure and evaluation process. The goal of this project is to implement a system of care encompassing the transition to independence process for youth with emotional or behavioral challenges between the ages of 15–21, living in the Kalihi-Palama Community. This goal

will be implemented through the following actions: (1) establish a Youth Community Center; (2) train and assign transition specialists to each youth; (3) develop a comprehensive life-skills program; (4) create a range of supportive services (e.g., vocational, healthcare); and (5) develop peer mentoring services. The applicant is the Hawai'i Department of Health on behalf of the governor. Daily management of the grant will be contracted through the Center on Disability Studies at the University of Hawai'i. The Youth Community Center will be operated by the Susannah Wesley Community Center. Wai Aka will provide the young adult support services; families and youth will guide the development, implementation, and evaluation of this project.

Grantee.—Hawaii State Department of Health—Honolulu, HI
Program.—State Data Infrastructure Grants SM058093
Congressional District.—HI–01
Fiscal Year 2008 Funding.—$156,000
Project Period.—9/30/2007–09/29/2010

During the project period, AMHD will focus on technical implementation of the URS measures, verification of data quality, and increased distribution of reports to its Purchase of Service Provider network. CAMHD will implement the remaining URS developmental measures, but emphasizes building capacity in the knowledge, skills, and abilities of personnel to define and distribute customized reports and to participate more fully in the DIG network. Upon completion AMHD and CAMHD should report on all URS measures, increase distribution of system information to stakeholders including State council, increase integration of the available information into planning and decision making.

Grantee.—Hawaii State Department of Health—Honolulu, HI
Program.—Mental Health Transformation State Incentive Grants SM057457
Congressional District.—HI–01
Fiscal Year 2008 Funding.—$2,190,500
Project Period.—9/30/2006–9/29/2011

The goal of this mental health systems transformation project is to create a sustainable, fully integrated, comprehensive statewide mental health plan and to implement a system-wide transformation process over the course of a 5-year period. Staffing for this grant can be conceptualized as a model of concentric circles whereby the transformation work group is at the center surrounded by mental health stakeholders coming together in different partnerships to breathe life into the transformation. The next ring supporting these activities is a technical assistance group and project evaluation team comprised of grant-funded staff and in-kind University of Hawaii staff who will assist the transformation work group and stakeholders in tasks such as planning, implementation, program evaluation and workforce development. Finally, the outer ring of the model is the community-at-large whose acceptance of mental health as an integral part of overall well being is required to bring about full transformation of the system. Hawaii, because of its diversity, is in a unique position to develop effective models of service delivery and care that address the needs of the growing multi-cultural population across the country. Hawaii is committed to seizing the opportunity created by national and State strengths and resources; directing and focusing the efforts of all sectors to address priority mental health needs; building on successes to move past an era of Federal court mandates; and realizing the vision of quality mental healthcare across all of Hawaii's communities for the entire population.

Grantee.—United Self-Help—Honolulu, HI
Program.—Statewide Consumer Network SM056346
Congressional District.—HI–01
Fiscal Year 2008 Funding.—$70,000
Project Period.—9/30/2004–9/29/2010

Bridging Islands will foster and sustain consumer networks within each neighbor island, collaborate with existing networks and strengthen pee mentors. Each goal will address county based needs within each area with specific outcomes. The process will increase State capacity to support effective mental health services while strengthening peer mentors and sustaining neighbor island consumer network development. Collectively, the county and consumers will evaluate lessons learned and incorporate recommendations into the next iteration of transformation activities.

Grantee.—Hawaii State Department of Health—Honolulu, HI
Program.—Youth Suicide Prevention and Early Intervention—Cooperative Agreement State-Sponsored SM058397
Congressional District.—HI–01
Fiscal Year 2008 Funding.—$500,000
Project Period.—9/30/2008–9/29/2011

The Injury Prevention and Control Section (IPCS) of the DOH is proposing to implement the Hawaii Gatekeeper Training Initiative (HGTI) to reduce completed and attempted suicides among youth ages 10–24. This will be accomplished through training adult gatekeepers in key agencies to recognize and respond to youth who are at risk for suicide. This will also increase youth access to trained gatekeepers in Hawaii. The HGTI will use three training curricula: Applied Suicide Intervention Skills Training (adults), SafeTALK (police officers), and Signs of Suicide (youth). IPCS will leverage the grant resources by incorporating gatekeeper training in three systems that already impact significant numbers of youth in both school and community settings. These agencies and their programs include: Department of Education (Peer Education Program), and School-Based Behavioral Health), the Department of Health Alcohol and Drug Abuse Division (agencies contracted to provide treatment services in their Adolescent Substance Outpatient School-Based Treatment Program), and prevention services in their Youth Substance Prevention Partnerships Initiative), and the Honolulu Police Department (Emergency Psychological Services/Jail Diversion Program). The HGTI will accomplish two goals: (1) enhance State level infrastructure for youth suicide prevention efforts, and (2) enhance youth suicide prevention efforts in three systems: Public School, Alcohol/Substance Abuse Treatment and Prevention, and Law Enforcement.

Center for Substance Abuse Prevention (CSAP)

Grantee.—Parents and Children Together—Honolulu, HI
Program.—Drug Free Communities SP012968
Congressional District.—HI–01
Fiscal Year 2008 Funding.—$100,000
Project Period.—9/30/2005–9/29/2010

The grantee will: (1) reduce substance abuse among youth and over time, among adults by addressing factors in the community that increase the risk of substance abuse and promote factors to minimize the risk of substance abuse; (2) establish and strengthen citizen participation and collaboration among communities, nonprofit agencies, and Federal, State, local, and tribal governments to support community efforts to deliver effective substance use prevention strategies for youth; (3) use the Strategic Prevention Framework of evidence based prevention strategies to assess needs, build capacity, plan, implement and evaluate community prevention initiatives; and (4) assess and report on the effectiveness of community prevention initiatives to reduce age of onset of any drug use, frequency of use in the past 30 days, increased perception of risk or harm, and increased perception of disapproval of use by peers and adults.

Grantee.—Waipahu Community Association—Waipahu, HI
Program.—Drug Free Communities SP011543
Congressional District.—HI–01
Fiscal Year 2008 Funding.—$100,000
Project Period.—9/30/2005–9/29/2009

The grantee will: (1) reduce substance abuse among youth and, over time, among adults by addressing the factors in a community that increase the risk of substance abuse and promoting the factors that minimize the risk of substance abuse; and (2) establish and strengthen community anti-drug coalitions.

Grantee.—Coalition For A Drug-Free Hawaii—Honolulu, HI
Program.—Drug Free Communities SP014887
Congressional District.—HI–01
Fiscal Year 2008 Funding.—$125,000
Project Period.—9/30/2008–9/29/2013

The grantee will: (1) reduce substance abuse among youth and over time, among adults by addressing factors in the community that increase the risk of substance abuse and promote factors to minimize the risk of substance abuse; (2) establish and strengthen citizen participation and collaboration among communities, nonprofit agencies, and Federal, State, local, and tribal governments to support community efforts to deliver effective substance use prevention strategies for youth; (3) use the Strategic Prevention Framework of evidence based prevention strategies to assess needs, build capacity, plan, implement and evaluate community prevention initiatives; and (4) assess and report on the effectiveness of community prevention initiatives to reduce age of onset of any drug use, frequency of use in the past 30 days, increased perception of risk or harm, and increased perception of disapproval of use by peers and adults.

Grantee.—Coalition For A Drug-Free Hawaii—Honolulu, HI
Program.—Sober Truth on Preventing Underage Drinking Act Grants SP015489
Congressional District.—HI–01
Fiscal Year 2008 Funding.—$50,000
Project Period.—9/30/2008–9/29/2012

The purpose of the Sober Truth on Preventing Underage Drinking (STOP) Act grant program is to prevent and reduce alcohol use among youth in communities throughout the United States. The STOP Act grant program will encourage existing local community coalitions to develop, assess, and implement effective strategies to prevent and reduce underage drinking. Strategies may include: changing local attitudes and norms, and re-evaluating existing laws and policies. (1) Grantee must participate in national evaluation activities of the STOP grant program. (2) STOP Grantees must use the Strategic Prevention Framework (SPF), a five-step evidence based process for community planning and decision-making. The five step process includes: needs assessment, capacity building, planning, implementation and evaluation. (3) STOP grantees must plan and implement a comprehensive approach inclusive of multiple strategies as emphasized in the 2007 Surgeon General's Call to Action to prevent and Reduce Underage Drinking located online at: http://www.surgeongeneral.gov/topics/underagedrinking/call—to— action.pdf Emphasis should be given to environmental strategies that incorporate prevention efforts aimed at changing or influencing community conditions, standards, institutions, structures, systems and policies. In addition, grantees must select strategies that lead to long term outcomes. (4) STOP grantees must enhance, not supplant, effective local community initiatives for preventing and reducing alcohol use among youth. For current Drug Free Community grantees, STOP ACT foods can not be used to supplant or replace activities that are presently being supported by Drug Free Community funds, and, separate DFC and STOP ACT accounting systems must be maintained for the purposes of reporting.

Grantee.—Kulia Na Mamo—Honolulu, HI

Program.—HIV/Strategic Prevention Framework SP013382

Congressional District.—HI–01

Fiscal Year 2008 Funding.—$254,320

Project Period.—9/30/2005–9/29/2010

The project targets Asian and Pacific Islander male-to-female transgender and men who have sex with men, age 27 and older. Many of the former are ex-incarcerated, and both groups, which make up the Mahu (two spirits) community in Hawaii, are minority populations at highest risk for HIV (i.e., of all API diagnosed with AIDS, over 65 percent are MSM, which includes transgender). From our own surveys of over 100 transgender clients, more than 60 percent are ex-inmates, 54 percent are sex industry workers and more than 30 percent are crystal meth users. 50 percent of the participants will be re-entry. Interventions will be provided to approximately 150 participants a year. The project is divided into two parts: (1) *Capacity Building*.—The application will spend the first 6 to 9 months of the first year establishing a workgroup or task force that will conduct a community needs assessment. The task force will be made up of the following agencies: Department of Health STD/AIDS Prevention Branch; Department of Health Disease Control and Outbreak Division; Life Foundation, an AIDS service organization; Drug Addiction Services of Hawaii, Inc.; Coalition for a Drug-Free Hawaii, a prevention agency; Hina Mauka, a treatment/prevention agency; Department of Public Safety; Hawaii Cares—the coalition of Ryan White providers; and other agencies. The needs assessment will be the basis for a strategic plan to be implemented after approval from SAMHSA. During this initial period Kulia Na Mamo will develop memoranda of agreement with treatment agencies, the Department of Public Safety, and others with which to establish linkages to care. Kulia will attend meetings of the HIV Community Planning Group, work with the Jade Ribbon Campaign for hepatitis B testing, and coordinate activities related to hepatitis C with the hepatitis C coordinator at the Department of Health STD/AIDS Prevention Branch. (2) *Implementation, Monitoring, and Evaluation*.—The proposal follows interventions endorsed by the CDC and/or SAMHSA: Prevention.

Grantee.—Hawaii State Office of the Governor—Kaplei, HI

Program.—Strategic Prevention Framework State Incentive Grants SP013944

Congressional District.—HI–01

Fiscal Year 2008 Funding.—$2,093,000

Project Period.—9/30/2006–9/29/2011

The purpose of Hawaii's SPF State Incentive Grant (SIG) is to improve the quality of life of our citizens by preventing and reducing the abuse and dependence on alcohol and other drugs among people of all ages. The SPF SIG will enable Hawaii to (a) support a coordinated and comprehensive approach to substance abuse prevention; (b) ensure that prevention is the first line of defense against illegal drug use and underage drinking; (c) establish effective alcohol and other substance abuse prevention efforts that are evidence-based, culturally appropriate, and long term; and (d) minimize duplicative efforts among partnering agencies, while promoting coordination and identifying gaps in data and services.

Grantee.—Five Mountains Hawaii—Kamuela, HI
Program.—Drug Free Communities SP012310
Congressional District.—HI–02
Fiscal Year 2008 Funding.—$125,000
Project Period.—9/30/2005–9/29/2013

The grantee will: (1) reduce substance abuse among youth and, over time, among adults by addressing the factors in a community that increase the risk of substance abuse and promoting the factors that minimize the risk of substance abuse; and (2) establish and strengthen community anti-drug coalitions.

Grantee.—Hamakua Health Center—Honokaa, HI
Program.—CSAP 2008 EARMARKS SP014596
Congressional District.—HI–02
Fiscal Year 2008 Funding.—$95,305
Project Period.—9/01/2008–8/31/2009

This project is designed to improve access for the low-income and uninsured population and improve the coordination of care between agencies in each of the Health Center service areas, resulting in greater accessibility to support services and increased referral follow-through for patients with risk for and active substance abuse.

Center for Substance Abuse Treatment

Grantee.—Hawaii State Department of Health—Honolulu, HI
Program.—Access to Recovery TI019437
Congressional District.—HI–01
Fiscal Year 2008 Funding.—$2,750,000
Project Period.—9/30/2007–9/29/2010

The Hawaii Access to Recovery (HI–ATR) program targets the adult population of child welfare families for the Hawaii Island of Oahu (City and County of Honolulu). "Ice" is the major factor behind Hawaii's explosion of child protection cases, in which Native Hawaiians represent more than 50 percent of Child Protective Services cases and other Asian-Pacific Islanders are also overrepresented. Hawaii is a unique State with (1) the greatest proportions of methamphetamine or "ice" abuse in the Nation, (2) inadequate and fragmented treatment resources and significantly limited recovery support services. HI–ATR Project will introduce a system of vouchers managed electronically through a 42 CFR, Part 2 and HIPAA-compliant web-based information technology (IT) system to improve access to treatment and, subsequent to adequate assessment and referral to an appropriate level of care, genuine independent client choice of service providers, including faith and community-based organizations (FCBOs), especially those that have not previously received public funding. This project will not only provide the critically needed additional capacity to address Hawaii's ice epidemic but will also contribute significantly to strengthening existing families and healing and reunifying shattered Asian/Pacific Island families, thus ensuring the preservation of the unique heritage and traditions of Hawaii's peoples.

PRACTITIONERS

Question. Given the need to create practice incentives for practitioners that are aligned with the health reform legislation being proposed (such as cost-effective practice, adoption of quality measures, and use of practice guidelines), what medical legal protections can be extended to practitioners on a Federal level such that the practice of defensive medicine is eliminated?

Answer. The President has stated that he understands that some doctors feel that they are looking over their shoulders out of fear of lawsuits and often order more tests and treatment to avoid being legally vulnerable. He does not advocate caps on malpractice awards, which could be unfair to people who've been wrongfully harmed, but he does think we should explore a range of ideas to put patients first while letting doctors focus on practicing medicine. There have been a number of proposals offered in recent years to reduce lawsuits and promote patient safety, from plans to expand the use of "Sorry Works" systems (early disclosure and apology-based mediation) as then-Senator Obama introduced in 2005, to proposals to encourage broader use of evidence-based guidelines as Senator Wyden and others have supported. There are many ideas out there and the President and I want to work with you.

Question. Given the shortage of rural practitioners across America and the limitations associated with recruitment and retention of practitioners to rural Hawaii, what incentives can be established to encourage rural training of practitioners, including needed specialists?

Answer. Effective health action requires an adequately staffed, highly skilled, diverse and interdisciplinary workforce prepared to address health challenges of the

21st century. In HRSA, the budget expands loan repayment and scholarship programs for physicians, nurses, and dentists who are committed to practicing in medically underserved areas. Additionally, funding will enhance the capacity of nursing schools, increase access to oral healthcare through dental workforce development grants, target minority and low-income students, and place an increased emphasis on ensuring that America's senior population gets the care and treatment it needs.

The administration also provided additional funds for the Indian Health Service (IHS) to cover the rising cost of tuition impacting scholarship and loan repayment programs. These programs help IHS compete with other public and private sector employers and bring needed healthcare professionals to remote, rural reservations. In addition, IHS provides grants to universities to train American Indians and Alaska Natives to return to their communities as healthcare professionals. We believe these programs will help ease the shortage of rural practitioners over time.

QUESTIONS SUBMITTED BY SENATOR PATTY MURRAY

HEALTHCARE WORKFORCE

Question. One area of concern that I believe must be addressed is the shortage of healthcare providers. And as the baby boomers retire, the problem is only going to get worse.

I have had a number of roundtables throughout my home State of Washington on this issue. And I know that what we're seeing in Washington State is similar to what is going on across the country. The shortage of doctors, nurses, and other healthcare providers is one of the most serious workforce challenges our country faces.

And as we are working on healthcare reform, I believe it is important to keep in mind that affordable care will not be possible without access to a healthcare provider. In addition, this workforce shortage is only going to get worse as we move to cover more people.

What do you see as our best tools to address this problem within the regular appropriations process?

Answer. The National Health Service Corps provides a venue to incentivize more primary care providers across the spectrum (including dentistry, nursing, and mental health) to serve in underserved areas. This program can be targeted towards people at the end of their education, to address short-term as well as long-term workforce needs. Expanding nurse faculty loan programs will address a critical bottleneck in the education of new nurses to address the current and looming nursing shortage. Providing additional funds for scholarships and loan repayment programs for students—including those targeted to improve diversity—can also have a dramatic impact on ensuring an effective workforce.

The fiscal year 2010 request includes over $1 billion supporting a wide range of programs to strengthen and support our Nation's healthcare workforce. These investments will expand loan repayment and scholarship programs for physicians, nurses, and dentists who are committed to practicing in medically underserved areas. Additionally, this funding will enhance the capacity of nursing schools and increase access to oral healthcare through dental workforce development grants.

Question. How do you think we can address this problem within healthcare reform?

Answer. We can and should build on existing workforce programs such as the National Health Service Corps and title VII and title VIII. These programs need to be modernized to better address a changing healthcare environment. We should also encourage innovation in telemedicine, health IT, and other avenues to improve practice environments which will enhance workforce productivity and retention.

HOME VISITING

Question. I am so pleased that President Obama and your agency are focusing on Home Visiting as an effective program to ensure that children and families receive the supports and information they need for healthy development, child abuse prevention, safety, and preparation for education. As you know, I introduced the Education Begins at Home Act with Senators Clinton and Bond earlier this year, which focuses on promoting high-quality, effective home visiting programs that improve the health, development, and school readiness of children ages 0 to 5.

I think it's necessary to highlight a few key components to any effective home visiting program to ensure the best outcomes for children across the country. It is critical that any program is evidence-based, which I know is important you and the President as well. Another important component is providing support not only for

health outcomes, but also well being and school readiness, in a continuum of home visiting care. When all of these outcomes are met, home visiting can reduce the need for special education services, help families raise their monthly earnings, reduce child abuse, prepare children to succeed in pre-K or kindergarten, and assist with stronger birth outcomes, among many other benefits.

Do I have your commitment to work towards a model that provides significant support for the continuum of home visiting programs and models, as long as they are evidence-based, in order to meet the varied needs of young children and their families across the country?

Answer. Yes, the Home Visitation initiative will give priority to models that have been rigorously evaluated and shown to have positive effects on critical outcomes for families and children. Additional funds will support promising programs, such as programs based on models with some research evidence of effectiveness and adaptations of previously evaluated programs.

TITLE X FAMILY PLANNING PROGRAM

Question. In a report released last week by the National Academy of Sciences Institute of Medicine, family planning was described as "one of the most significant public health achievements of the 20th century." The report goes on to say that family planning has resulted in improvements in health, economic and social well-being.

The Institute's study also cites that "funding for the title X (Ten) Program has not kept pace with a number of factors including: inflation; increased costs of contraceptives, great numbers of people seeking services; or rising insurance costs."

Do you agree with the assessment that family planning funding has not kept pace with these factors?

Answer. The title X program has been able to maintain access to services for millions of individuals who need family planning services each year through maximizing the resources provided in the appropriations each year. Through the program's training authority, training has been provided to title X administrators and clinical providers to encourage the most efficient utilization of resources while maintaining quality. In addition, title X providers have been encouraged to use the 340B Drug Pricing Program, cooperative purchasing programs, and other cost-savings mechanisms to cut costs where possible.

Question. Do you think that a significant increase in funding for the title X program will help serve the ever increasing number of American families who are unable to afford the most basic of healthcare services?

Answer. The fiscal year 2010 budget provides an increase that would enable the title X program to serve a greater number of low-income individuals who are currently not receiving services. Currently, 4 in 10 poor women of reproductive age have no insurance coverage, public or private. The Title X Family Planning Program requires that services be provided to all who want and need them, with a priority for services to individuals from low-income families. Title X-funded centers are an important source of preventive healthcare to nearly 5 million women each year, more than 90 percent of whom have family incomes at or below 200 percent of the Federal poverty level. At least 64 percent of those served by title X centers have no insurance coverage for primary healthcare, public or private. According to the most recent National Survey of Family Growth data, a majority of women who obtain care at a family planning center consider it their usual or primary source of healthcare. It is estimated that only 54 percent of women in need of publicly subsidized contraception received those services in 2006, with title X providing services to half (27 percent) of these women.

In addition to the contraceptive services provided under the title X program, title X-funded family planning centers provide a number of related preventive health services that millions of poor and uninsured individuals would likely not otherwise receive. For instance, in 2007, title X-funded health centers provided almost 2.5 million Pap tests; 2.4 million breast exams; 5.4 million tests for sexual transmitted diseases that if left untreated, may lead to infertility; and, 764,126 confidential HIV tests. In addition, it is estimated that nearly 970,000 unintended pregnancies were averted through the services provided by title X-funded centers in 2007.

U.S. DOMESTIC REFUGEE PROGRAM AND THE ECONOMIC CRISIS

Question. Historically, the United States has been the world leader in providing protection and assistance to refugees both internationally through humanitarian assistance and domestically by resettling refugees to the United States. Unfortunately, the resettlement program now finds itself on the brink of crisis.

The Office of Refugee Resettlement (ORR) within the Department of Health and Human Services was established in 1980 to assist refugees admitted by the United

States in obtaining economic self-sufficiency. Since then, ORR's mission has grown to include assisting numerous other vulnerable populations in the United States, among them trafficking victims, torture victims, Cuban/Haitian Entrants, Indochinese Parolees, Iraqi and Afghan Special Immigrants, and unaccompanied alien children. Unfortunately, ORR's budget has not kept up with its growing mission, the changing characteristics of the populations it now serves, and the costs and needs of resettling today's refugees. Coupled with chronic under funding, the challenges connected to the current economic crisis have placed the resettlement program in peril.

Even before the current economic recession, resettlement agencies have been struggling to meet the needs of refugees, and a number of agencies had to close down offices across United States. Now refugees are commonly experiencing great difficulty finding work and paying rent and other basic household needs. Agencies that have relied on private funding, donations and the help of our communities to overcome the insufficient funding are struggling to secure resources in the current environment. The situation is critical; the resettlement program needs immediate reform in key areas to maintain the success it has achieved in the past and to match our international commitment to provide protection to refugees.

How is ORR planning to respond to the consequences of the economic crisis on the resettlement program and ensure adequate assistance to refugees and other vulnerable populations while they work toward integration and self-sufficiency? What steps will ORR take in the future to better respond to emergency situations?

Answer. ORR provides a host of supports to refugees to assist them with achieving economic self-sufficiency and integration, including cash and medical assistance, case management, and employment services. The current economic conditions have made it more difficult for refugees to gain employment quickly, even for those in the Matching Grant program, which historically has been the most successful method for placing refugees into employment quickly. As a result, refugees and other eligible populations are accessing cash and medical assistance for longer periods of time, often for the full 8 months for which they are currently eligible. The number of refugees also is on the rise, and, for the first time since 2001, the number of arrivals appears to be approaching the refugee ceiling set by the State Department. For these reasons, the fiscal year 2010 budget request includes $337 million for refugee transitional and medical services, $55 million more than the amount appropriated in fiscal year 2009. ORR will closely monitor arrivals and benefit access, and provide updated cost estimates to Congress as necessary. The Administration is also keenly interested in examining ways to improve refugee resettlement programs, especially in light of the current economic crisis.

EMERGENCY HOUSING ASSISTANCE

Question. The economic crisis is negatively impacting refugees across the country, challenging their successful integration into our communities and making homelessness a real threat to many refugee families. Due to rising living costs and a shortage of jobs, newly arriving refugees are finding it increasingly difficult to secure and maintain employment and housing. As a result, some refugee families are not able to find jobs and meet the cost of rent, and are thus facing eviction and homelessness. Several recent news stories illustrate the challenges refugees are facing with housing and homelessness across the country.

A number of federally funded programs administered by local refugee resettlement agencies assist refugees in securing employment and housing. These programs have been highly effective in helping refugees achieve early self-sufficiency through employment. However, refugees are only eligible for benefits and services for a maximum of the first 8 months in the United States. In the current economic climate it can take refugees longer than 8 months to secure employment which would enable them to afford basic housing. Additionally, many of those refugees who have been able to secure employment have been recently laid off and have lost their source of income. In most of these cases refugees have not worked long enough to qualify for unemployment benefits.

What steps will you take to address the housing needs of resettled refugees and other vulnerable populations served by the ORR to prevent evictions and homelessness for these populations?

Answer. The President's budget request is intended to address many refugee needs. With respect to risk of homelessness, refugees can access a variety of homelessness prevention and assistance programs through the U.S. Department of Housing and Urban Development (HUD) or State or county housing programs. HHS Refugee Resettlement funds have not been targeted to homeless services, beyond the provision of cash assistance and some limited use of social services funds.

Question. How are you planning to address the housing needs of refugees that have been in the United States for more than 8 months, are not longer receiving cash assistance and have not achieve self-sufficiency?

Answer. The President's budget request is intended to address many refugee needs. With respect to risk of homelessness, refugees can access a variety of homelessness prevention and assistance programs through the U.S. Department of Housing and Urban Development or State or county housing programs. HHS Refugee Resettlement funds have not been targeted to homeless services, beyond the provision of cash assistance and some limited use of social services funds.

Question. The cash assistance refugees receive is determined by welfare rates in the States they reside in. In almost all cases (some stats would be nice), the level of assistance is below poverty line and does not even cover rent. How will you ensure that refugees are not resettled into an immediate crisis situation, critically dependent on securing a job in order to stay in their homes?

Answer. Refugee populations are exempted from any bars restricting legal permanent resident aliens from accessing public benefits such as TANF, Medicaid, and SSI, and may therefore access a number of services apart from cash assistance provided by ORR, if they are otherwise eligible. In addition, refugees may access services provided through ORR's Refugee Social Services and Targeted Assistance funds, including adjustment services, English language instruction, interpretation and translation services, day care for children, citizenship and naturalization services, etc. The goal of these services is to maximize refugees' prospects for self-sufficiency.

Question. Looking forward to the future, how ORR will ensure that refugees and other vulnerable people it serves have a safety net strong enough to prevent them from losing their homes while they look to secure employment?

Answer. Refugees can access a variety of homelessness prevention and assistance programs through HUD or State and county housing programs. They are also generally eligible for public benefits such as TANF, Medicaid, and SSI. ORR's mandate is to provide services such as cash assistance, medical assistance, case management, and employment services. The goal of these services is to maximize refugees' prospects for self-sufficiency, which will hopefully mitigate any risk of acute problems such as homelessness.

ASSISTING REFUGEES TO ACHIEVE SELF-SUFFICIENCY

Question. The resettlement program has as a main objective to assist refugees to obtain self sufficiency in a short period of time. The economic crisis has made it more difficult for refugees to achieve this goal. While most refugees have typically found employment quickly, the worsening economy has made this process lengthier and more difficult.

The current job market makes programs that provide employment services all the more critical. One of these programs is the Voluntary Agency Matching Grant program. This program enables refugees and other eligible persons to become self-sufficient within 4 to 6 months from the date of their arrival in the United States without resorting to Federal and State welfare programs. The program leverages public funds with private donations at a 2:1 ratio, requiring private voluntary agencies to provide one dollar of private, nongovernmental resources for every $2 that the Federal Government contributes. Nearly 80 percent of participants in fiscal year 2008 achieved self-sufficiency. Even though the outcomes have been impacted by the current economic crisis, Matching Grant continues to be the most successful program helping to place refugees in jobs in a 4- to 6-month period.

Currently the program serves approximately 27,000 individuals, the same number of individuals that were served by the program in fiscal year 2000. This equals roughly 30 percent of those who could benefit from the program. The program has also been expanded to serve not only refugees, asylees, Cuban/Haitian entrants, but also Iraqi and Afghan Special Immigrant Visas (SIVs) holders and victims of trafficking. The Iraqis arriving as refugees or SIVs are in most cases highly educated and experienced and would therefore be most appropriately served through the Matching Grant (MG) program. Without increased ORR resources, additional places in the MG program will not be available.

As the expression of the public-private partnership the Voluntary Match Grant Program is most successful program helping refugees find jobs. Are you planning to expand the program by providing more resources allowing access for more refugees and other vulnerable populations?

Answer. Under the fiscal year 2010 budget request, the Matching Grant program will be funded at the same level as fiscal year 2009.

Question. Many Iraqis who arrived as SIVs or refugees are highly educated and are facing challenges to achieve self-sufficiency and to find suitable jobs. In the past

the MG program provided better served populations with those characteristics. What role do you envision for the MG program for highly educates refugees, such as the case of Iraqis?

Answer. The Matching Grant program is indeed ideally suited for refugees with good employment prospects, and Iraqi SIVs and refugees are generally excellent candidates. To the extent that funded enrollment slots are available in the area of resettlement, highly educated refugees or SIVs may elect to enroll in the Matching Grant Program.

Question. Highly educated refugees often have to accept the first job available to be able to pay for their basic needs. Such a job may not be inappropriate for their skill level, which leads to frustration on their part and a waste of talent and potential for the American society. Do you plan to initiate and fund any programs that would help highly educated refugees with years of professional experience secure a job appropriate for their skills?

Answer. While there are no special programs that target skilled refugees and no plans to create any expanded assistance to refugee professionals, ORR does have an existing grant with a technical assistance provider looking at professional recertification issues. Most activities for skilled professionals are provided at the discretion of local refugee social services providers as part of their broader employment services assessment and activities related to each Individual Employment Plan. ORR has been working with the Department of Labor to identify resources available to refugee professionals through the Employment and Training Administration's One Stop Centers.

Question. The structure of the U.S. resettlement program and its emphasis on self-sufficiency is often too rigid to account for additional challenges faced by many more vulnerable resettled refugees. Many, for example, have been recently widowed or disabled and will be much less likely to find employment within the program's limited time frame. What changes can be made to account for the special circumstances of certain vulnerable refugees to ensure that they are able to achieve self-sufficiency in safety and dignity?

Answer. ORR has no special programs for individuals with disabilities or other needs, but ORR providers have broad flexibility to work with disabled refugees, and ORR funds may be used to pay for these individuals' medical and mental health costs if individuals are not eligible for Medicaid. ORR providers also make referrals to (SSI) and other benefits and services for refugees who meet disability definitions in title XVI of the Social Security Act. Disabled refugees who are awaiting adjudication of SSI applications may receive Refugee Cash Assistance for up to 8 months while their applications are processed. Finally, ORR is taking further steps to improve the self-sufficiency prospects of disabled refugees, including early discussions with the HHS Office on Disability regarding employment for disabled refugees.

QUESTIONS SUBMITTED BY SENATOR JACK REED

LOW INCOME HOME ENERGY ASSISTANCE PROGRAM

Question. As you know, the Low Income Home Energy Assistance Program (LIHEAP) was funded at $5.1 billion for the first time in fiscal year 2009, providing much needed assistance to millions of Americans at a time of economic uncertainty. Although some energy costs have temporarily stabilized, the economic standing of millions of Americans has worsened. Like funding for food stamps and unemployment insurance, LIHEAP provides a significant multiplier effect that is important in helping to bring us out of this recession.

While the President's budget request of $3.2 billion is greater than any request made to Congress in the past, it is still far below last year's appropriation. The National Energy Assistance Directors' Association found that a reduction in LIHEAP funding to $3.2 billion could result in more than 1.5 million households being dropped from the program, and the average grant for families left in the program being cut by $70. While I appreciate the fact that this Administration has proposed creating a mandatory contingency fund for LIHEAP when prices spike, that funding is dependent on price volatility and will produce on $450 million in funding on average per year. We need to have robust funding in the base program.

As you know, the congressional budget resolution matches the President's request of $3.2 billion for LIHEAP for fiscal year 2010, but would also accommodate an extra $1.9 billion through a discretionary cap adjustment that maintain funding at the $5.1 billion level. Would you support LIHEAP funding at the $5.1 billion allowed under the budget resolution? Will you also work to fully fund this program in future budgets?

Answer. Energy prices are volatile making it difficult to match funding to need. Fiscal year 2009 LIHEAP funding ($5.1 billion) was provided when energy prices were at their peak (oil at $124 per barrel in the second quarter of 2008). Oil prices subsequently declined significantly as did Energy Department estimates of average home heating costs. The administration proposed the mandatory trigger mechanism to address volatility in energy prices. Under this proposal, mandatory funding would be provided in response to quarterly energy price increases. If oil and gas prices in the fourth quarter of 2009 exceed peak 2008 prices by just 1.8 percent, total LIHEAP funding of $5.1 billion would be provided in fiscal year 2010 through a combination of the trigger ($1.9 billion) and the discretionary budget request ($3.2 billion).

IMMUNIZATIONS

Question. Immunizing our country's children—and adults—has been a priority for me throughout my tenure in Congress. I was particularly pleased that the Economic Recovery Act contained an additional $300 million over the next 2 years for immunizations for the uninsured and underinsured. But, once that funding runs out, the baseline funding that the President proposed would likely fall back to $500 million. As you may know, I have been joined by 17 of my colleagues in supporting more than $800 million in baseline funding to immunize this population. Have you given any thought to how you will fill the financial void after next year should funding fall back to $500 million?

Answer. Historically, vaccines are one of the most successful and cost effective public health tools for preventing serious disease and death. The Center for Disease Control and Prevention's (CDC) immunization investments save lives and dollars by providing individuals and communities with a strong level of protection from vaccine-preventable diseases. The Recovery Act 317 section funding provided a historic opportunity to leverage section 317 immunization investments by augmenting existing public health capacity and federally purchased vaccines.

In accordance with the Recovery Act, CDC is investing these funds in one-time efforts that will have the most health impact. The Recovery Act funding CDC received is being used to make vaccines available to more children, adolescents, and adults; help health departments learn how to improve their access to insurance reimbursement; increase awareness and provider education about immunization; and strengthen the evidence base for immunization policies and programs. These investments will have long-term benefits beyond the life of the funding by increasing the number of people vaccinated, providing immunization tools and resources for parents and healthcare providers, and assessing the impact of recently recommended vaccines to inform national vaccine policy.

PANDEMIC PREPAREDNESS

Question. According to testimony before this panel on April 30, I understand that States have purchased only 23 million of the 31 million courses of antiviral treatments called for under the National Strategy on Pandemic Influenza. Rhode Island is only equipped with 10.5 percent of its allocation. Given the potentially urgent need for these medications, how does the Department of Health and Human Services plan to address the shortfall in State stockpiling efforts and prevent illness?

Answer. Currently, State stockpiles have 24.5 million treatment courses. The Department is considering extending the Federal subsidy program for State antiviral stockpiling beyond the current end date of September 1, 2009, to allow States the ability to purchase up to an additional 4 million treatment courses during the fall and upcoming flu season necessitated by the current swine flu pandemic. States have already received 11 million treatment courses collectively from the Federal influenza antiviral drug stockpile in early May 2009 as a response measure for the H1N1 virus outbreaks in the United States These treatment courses pushed out to States from the Federal stockpile have now been added to each respective State stockpile total. For example, to use the case of Rhode Island, the Federal push of 25 percent of their pro rata Federal allotment now added to their State stockpile (representing about 40,000 treatment courses) brings the new total to about 52,000 treatment courses. Therefore, Rhode Island is now equipped with about 46 percent of its State stockpile program pro rata allocation. Furthermore, the 11 million treatment courses in total pushed out from the Federal stockpile will also be replenished in full and that process is now underway. In addition, the Federal stockpile, which will be replenished to the initial 44 million treatment course level, will again be available in full for distribution to States should the need arise.

HEALTHCARE WORKFORCE

Question. The Senate and the House are poised to have a meaningful debate on healthcare reform. With reform, we must also ensure that there is a workforce to adequately address the expected increase in patients. I am aware that the Economic Recovery Act contained an additional $200 million for title VII health professions programs. However, I am concerned that even with this increase, the funding level in the budget would not adequately address workforce shortages for years to come—especially in light of reform. In light of this, nearly half of my colleagues in the Senate have joined me in supporting $330 million for title VII health professions programs. How did the administration account for the potential effects of healthcare reform in budgeting for an adequate primary care workforce?

Answer. We are aware that with the expansion of coverage comes the need to provide primary care and other health services, particularly in areas that are currently underserved. Investments through the Recovery Act will assist in expanding and improving the efficiency of our provider workforce. We look forward to working with Congress to address the workforce needs that will arise from comprehensive health reform

CONQUER CHILDHOOD CANCER ACT

Question. Last year, Congress passed and President Bush signed the Caroline Pryce Walker Childhood Cancer Act. Among other provisions, this law requires CDC to collect information on the causes, treatments, and effects of childhood cancer within weeks of learning of this information in a comprehensive childhood cancer registry. Individualized and aggregate data would dramatically enhance research initiatives and open the door for new, successful treatment options for patients. The CDC Cancer Registry line has been flat funded for years. Given the administration's effort to spur health innovation and research, how will you capitalize on these tangential, but important, research, and treatment tools?

Answer. CDC collects and maintains individual level data on the diagnosis and treatment of childhood cancer cases in 45 States and the District of Columbia. The National Cancer Institute (NCI) collects similar data in the remaining 5 States and these data are combined to describe the incidence of cancer in the United States. Each year data are collected on approximately 12,000 to 13,000 cancer cases among children younger than 20 years of age. Data are collected on demographics, place of residence, type of cancer and stage at diagnosis, as well as first course of treatment. To fully understand the requirements for and feasibility of conducting national rapid case ascertainment for childhood cancers, CDC will host a meeting in the fall of 2009 which will include experts in childhood cancer research and cancer surveillance as well as critical partners such as the NCI and the American Cancer Society. One of the goals of this meeting will be to lay out all possible approaches that could be taken to address the data needs for childhood cancer research. In addition, optimal designs of a rapid-case ascertainment system will be described and explored for future planning.

CDC supports and encourages research utilizing cancer registry data. For example, CDC provides data annually to the Central Brain Tumor Registry of the United States which conducts research and provides detailed data on benign and malignant brain tumors among children. In addition, CDC utilizes cancer registry data to report incidence and geographic variation of childhood cancer. CDC encourages and provides leadership in the use of State and national data for research into treatment and survival among children diagnosed with cancer and will establish collaborative relationships with the pediatric cancer community that are needed to promote this research. Working with State central cancer registries, CDC promotes the use of registry data for research purposes within the States and the District of Columbia. CDC is active in developing electronic reporting systems for cancer surveillance data which holds great promise in improving the timeliness of data.

QUESTIONS SUBMITTED BY SENATOR THAD COCHRAN

Question. In your May 6 testimony on Health Reform in the 21st Century before the House Committee on Ways and Means, you noted the need for investments in prevention and wellness. In allocating those investments, will you devote any additional resources to the prevention of osteoporosis, a disease that 10 million Americans have and 34 million are at risk for, and that costs our healthcare system an estimated $19 billion per year?

Answer. The Recovery Act included $1 billion for prevention and wellness programs including $650 million for a prevention and wellness initiative. Details re-

garding this initiative will be announced this summer. Our health reform efforts will build on this initial investment in health reform by supporting proposals that improve access to appropriate clinical prevention services such as osteoporosis screening in postmenopausal women and community-based prevention interventions that target the main causes of chronic disease.

Question. In addition to a renewed focus on prevention, many of the health reform proposals under consideration include programs for chronic disease management. Given that 10 million Americans have osteoporosis and another 2 million Americans suffer from other rare diseases of the bone like Paget's disease of the bone and osteogenesis imperfecta, will you include these bone diseases as part of such disease management programs?

Answer. Yes. Osteoporosis is a classic example of a disease susceptible to chronic disease management. Models of chronic disease management apply to any disease that requires ongoing medical management and monitoring and will not be applied on a restrictive basis only to named diseases. This is why we feel it is important to avoid listing specific diseases for coverage—it implies that anything not listed is excluded. We take an entirely inclusive approach. The goal is to improve people's health.

QUESTIONS SUBMITTED BY SENATOR JUDD GREGG

REFUGEE RESETTLEMENT PROGRAM

Question. As you know, the main objective of the refugee resettlement program is to assist refugees so they become self-sufficient in the shortest period of time. Unfortunately, the economic crisis has made it more difficult for refugees to achieve this goal, making programs that provide employment services all the more critical, especially the Voluntary Agency Matching Grant program, which enables refugees and other eligible persons to become self-sufficient within 4 to 6 months from the date of arrival in the United States without resorting to Federal and State welfare programs. Leveraging public funds with private donations at a 2:1 ratio, the program currently serves approximately 27,000 individuals and is arguably the most successful job placement program for refugees with 80 percent of fiscal year 2008 participants achieving self-sufficiency. Given the overall objective of the refugee resettlement program, do you believe enough resources are being allocated to the Voluntary Agency Matching Grant program to maximize utility?

Answer. The current economic conditions have made it more difficult for refugees to gain employment quickly, even for those in the Matching Grant program, which historically has been the most successful method for placing refugees into employment quickly. As a result, refugees and other eligible populations are accessing cash and medical assistance for longer periods of time, often for the full 8 months for which they are currently eligible. The number of refugees also is on the rise, and, for the first time since 2001, the number of arrivals appears to be approaching the refugee ceiling set by the State Department. Office of Refugee Resettlement will closely monitor arrivals and benefit access, and provide updated cost estimates to Congress as necessary, including resources provided to the Matching Grant program.

Question. Recently, the administration requested additional funds to support efforts to combat H1N1 influenza, including the authority to use Project BioShield Special Reserve Funds (SRF) to fund the development and/or procurement of an H1N1 influenza vaccine. As you know, Congress created the Project Bioshield SRF to procure medical countermeasures against chemical, biological, radiological, and nuclear (CBRN) threats and appropriated $5.6 billion to remain available until 2013. A transfer of funds from the Project Bioshield SRF could have a devastating impact on efforts to develop countermeasures for CBRN threats and call into question the Government's commitment to procure such products, which could force companies to scale back, or abandon, efforts to produce biosecurity products. Recognizing the importance of pandemic influenza preparedness, how does the Department intend to balance these two critical priorities in the near-term? What do you believe is the appropriate funding level for the SRF to adequately support near-term CBRN acquisitions and provide confidence to the biodefense industry?

Answer. The Biomedical Advanced Research and Development Authority (BARDA) within the Department of Health and Human Services (HHS) Office of the Assistant Secretary for Preparedness and Response develops and procures medical countermeasures for CBRN threats, pandemic influenza, and emerging infectious diseases. BARDA programs are funded through the SRF (CBRN countermeasure procurement), pandemic influenza funding (including for advanced development and

procurement), and annual appropriations for advanced research and development (CBRN countermeasures). HHS' intent is to continue to utilize the SRF and annual advanced development appropriations for their intended uses (i.e., the procurement and development of CBRN countermeasures, respectively).

Project BioShield was funded through the Department of Homeland Security (DHS) Appropriations Act of 2004 (Public Law 108–90) which established the SRF by advance-appropriating $5.6 billion for the procurement of countermeasures against CBRN agents from fiscal year 2004 to fiscal year 2013. The act allows the HHS Secretary, with concurrence from the DHS Secretary and approval from the Director of OMB, to develop and procure products that are within 8 years of FDA approval. DHS has issued Material Threat Determinations and Population Threat Assessments for 13 CBRN agents, upon which the BARDA Implementation Plan is based. To date BARDA has obligated $2 billion of the Special Reserve Fund on 5 CBRN programs that have delivered anthrax vaccines and therapeutics, botulinum antitoxins, and radiological drugs to the Strategic National Stockpile. In fiscal year 2009, Congress transferred $412 million from the SRF to support CBRN advanced development and pandemic influenza. The fiscal year 2010 President's budget proposes transferring $305 million from the SRF for CBRN Advanced Development. The long-term success of Project BioShield is directly tied to the success of the Advanced Development program. Over the next 4 years, BARDA will obligate the remaining $2.9 billion in the SRF by expanding its portfolio of late-stage products in anthrax vaccines, smallpox antivirals, chemical agent antidotes, and other radiological drugs in order to develop next-generation products.

QUESTION SUBMITTED BY SENATOR KAY BAILEY HUTCHISON

MEDICAL COUNTERMEASURES

Question. In addition to the recently circulating H1N1 and H5N1 influenza strains, there is a host of emerging infectious diseases and biothreat agents for which we need to develop medical countermeasures in order to protect the health of the American people. In light of the broad range of possible biothreats, as well as the long lag time and high costs associated with developing drugs, how does HHS plan to transition R&D into these lifesaving countermeasures in quantities large enough to cover our population? And how does HHS plan to disseminate them rapidly enough to be able to make a difference in the event of an outbreak or attack?

Answer. HHS has implemented the Public Health Emergency Medical Countermeasures Enterprise (PHEMCE) to manage the development and deployment of CBRN countermeasures, from the basic research phase at NIH to procurement through Project BioShield. The PHEMCE is a coordinated, inter-agency effort led by the HHS Assistant Secretary for Preparedness and Response and includes the Centers for Disease Control and Prevention, Food and Drug Administration, and the National Institutes of Health (NIH). Ex officio members include the Department of Homeland Security, Department of Veterans Affairs, and the Department of Defense. The PHEMCE defines and prioritizes CBRN medical countermeasure (MCM) requirements, integrates and coordinates research, development, procurement, and deployment and use strategies for MCMs. The investment in biodefense research and development has led to fundamental discoveries and has laid the foundation for promising drugs and vaccines for biodefense purposes. To date, two programs started at NIH have reached the level of maturity required for consideration into a late-stage development program funded under Project BioShield (i.e., product is within 8 years of FDA approval). Once products are procured through Project BioShield, they are placed in the Strategic National Stockpile (SNS). The SNS works with State and local partners to ensure that medical countermeasures can be distributed as quickly as possible during a public health emergency.

CONCLUSION OF HEARINGS

Senator HARKIN. The subcommittee will stand recessed.

[Whereupon, at 3:32 p.m., Tuesday, June 9, the 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 2010

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 AIDS ACTION

I am pleased to submit this testimony to the members of this subcommittee on the importance of increased funding for the fiscal year 2010 HIV/AIDS portfolio. Since 1984, AIDS Action Council, through its member organizations and the greater HIV/AIDS and public health communities, has worked to enhance HIV prevention programs, research protocols, and care and treatment services at the community, State and Federal level. AIDS Action represents many AIDS service organizations located in the Nation's HIV epicenters, local health departments, smaller service providers, faith-based organizations, substance abuse treatment centers, and education and advocacy organizations from all over the country. AIDS Action's goals are to ensure effective, evidence-based HIV care, treatment, and prevention services; to encourage the continuing pursuit of a cure and a vaccine for HIV infection; and to support the development of a public health system which ensures that its services are available to all those in need. On behalf of AIDS Action Council's diverse membership I bring your attention to issues impacting funding for fiscal year 2010.

Nearly 30 years since it was first identified, the HIV/AIDS epidemic in the United States is characterized by needless mortality, inadequate access to care, persistent levels of new infection, and stark racial inequalities. Despite the good news of improved treatments, which have made it possible for people with HIV disease to lead longer and healthier lives, stark realities remain. Consider that in the United States:

—Every year, 56,300 people are newly infected with HIV—one new infection every 9½ minutes. According to the Centers for Disease Control and Prevention (CDC) the HIV infection rate has not fallen in 15 years and the new incidence figure represent a 40 percent increase from previous estimates

—CDC stated that the HIV incidence rate increased by 15 percent from 2006 to 2007.

—More than 1 million people are living with HIV or AIDS; an estimated half of people living with HIV/AIDS are not in care.

—Of those people living with HIV/AIDS 21 percent are unaware of their HIV status.

—CDC estimates in 2007, 14,561 people died from AIDS-related causes.

—African Americans represent 13 percent of the population but nearly half of all newly reported HIV infections.

—Hispanics/Latinos represent 13 percent of the population, but account for 18 percent of newly reported cases of HIV.

—The percentage of newly reported HIV/AIDS cases in the United States. among women tripled from 8 percent to 27 percent between 1985 and 2007.

—AIDS is the leading cause of death among Black women aged 25–34
—HIV is the No. 1 healthcare risk for gay men and men who have sex with men, especially in communities of color.
—More than half of all newly diagnosed individuals are identified with full-blown AIDS in less than 12 months of their initial diagnosis.
—There is neither a cure nor a vaccine for HIV and current treatments do not work for everyone.

The Federal Government's commitment to funding prevention, research, and care and treatment for those living with HIV is critical. We would be unable to respond to this epidemic without the Federal Government's increased commitment to funding HIV programs at home. However, we are not doing enough. The unsatisfactory outcomes from our country's response to AIDS have serious human and economic costs. A study published in 2003 found that failure to meet the Government's then goal of reducing HIV infections by half would lead to $18 billion in excess expenses through 2010. We need more prevention, more treatment and care and more research if we are ever to slow and eventually reverse the HIV epidemic.

It is AIDS Action's expectation that the Congress, through the good work of this subcommittee, will recognize and address the true funding needs of the programs in the HIV/AIDS portfolio. HIV is a 100 percent preventable disease that can be lessened with a focused, concentrated effort and increased funding. The community has come together under the umbrella of the AIDS Budget and Appropriations Coalition with the community funding request for the HIV/AIDS domestic portfolio for fiscal year 2010. The numbers requested represent that community work. These requests have been submitted to the subcommittee.

CDC estimate that approximately 13 percent of all HIV cases and approximately 60 percent of all hepatitis C cases in the United States are directly or indirectly related to intravenous drug use. One of the most important ways to reduce these epidemics is through the use of syringe exchange. More than eight Federal studies along with numerous scientific peer-reviewed papers published more than 15 years have conclusively established that syringe exchange programs reduce the incidence of HIV among people who inject drugs and their sexual partners. Such studies have all concluded that syringe exchange does not increase drug abuse. Instead, syringe exchange programs connect people who use drugs to healthcare services including addiction treatment, HIV and viral hepatitis prevention services and testing, counseling, education, and support.

The ban on Federal funding for syringe exchange is counterproductive and limits the ability of local and State jurisdictions to respond effectively to the twin HIV and hepatitis epidemics. AIDS Action and the HIV community recommends that the subcommittee remove any language prohibiting the use of Federal funds to establish or carry out a program of distributing sterile syringes to reduce the transmission of blood borne pathogens, including the human immunodeficiency virus (HIV) and viral hepatitis.

According to CDC estimates contained in the agency's March 2006 HIV/AIDS Surveillance Report, 1,014,797 cumulative cases of AIDS have been diagnosed in the United States, with a total of 565,927 deaths since the beginning of the epidemic. As noted above, the CDC estimates that between 1.1 and 1.2 million people are living with HIV/AIDS and that 250,000–350,000 people are unaware of their status and could unknowingly transmit the virus to another person. As funding has remained essentially flat for more than 8 years, money has shifted to new and needed HIV testing efforts and initiatives. As a result, grants to States and local communities have significantly decreased and new infections have increased to an estimated 56,300 per year, according to a CDC report released in August 2008. Therefore, AIDS Action Council, the HIV community, and the CDC in their budget justification before Congress September 2008, estimates that the CDC HIV Prevention and Surveillance programs will need $1.5 billion, an increase of $878 million, in fiscal year 2010 to address the true unmet needs of preventing HIV in the United States. In the United States, HIV is transmitted primarily through sex. In order to combat the rising rates of transmission, we must ensure that sexuality education programs are medically sound and effective in fostering healthy behavior over the long-term. Abstinence is an important component of comprehensive sexuality education and HIV prevention programs; however, when it is advocated as the only option for young people, research has shown that it is ineffective, unrealistic, and potentially harmful. We believe the Federal Government should only support those sexuality education and HIV-prevention programs that are evidence-based. For that reason we support the elimination of all funding for the Community-Based Abstinence Education (CBAE) programs. All such funds should be re-directed to evidence-based prevention and educational programs. This past World AIDS Day, President Obama affirmed that, "My administration will .work with Congress to enact an ex-

tensive program of prevention, including access to comprehensive age-appropriate sex education for all school age children." We request that at least $50 million be allocated to promote comprehensive sex education in our schools and communities nationwide.

Now in its 19th year, The Ryan White Comprehensive AIDS Resources Emergency (CARE) Act, administered by the Health Resources and Services Administration (HRSA) and funded by this subcommittee, provides services to more than 533,000 people living with and affected by HIV throughout the United States and its territories. It is the single largest source of Federal funding solely focused on the delivery of HIV services; it provides the framework for our national response to the HIV epidemic. CARE Act programs have been critical to reducing the impact of the domestic HIV epidemic. Yet in recent years, CARE Act funding has not kept pace with the epidemic and has decreased through across-the-board rescissions. It is important to remember that CARE Act programs are designed to compliment each other. It is necessary that all parts of the CARE Act receive substantial increased funding to ensure the success of the total program. AIDS Action and the HIV/AIDS community estimate that the entire Ryan White CARE Act portfolio needs $2.816 million in fiscal year 2010, an increase of $577.8 million to address the true needs of the hundreds of thousands of people living with HIV who are uninsured, underinsured, or who lack financial resource for healthcare.

Part A of The Ryan White CARE Act now includes five additional Transitional Grant Areas (TGAs). Some of the services provided under part A include physician visits, laboratory services, case management, home-based and hospice care, and substance abuse and mental health services. Under the most recent reauthorization these services are even more dedicated towards funding core medical services and to ensuring the ability of patients to adhere to treatment. These services are critical to ensuring patients have access to, and can effectively utilize, life-saving therapies. AIDS Action along with the HIV/AIDS community recommends funding part A at $766.1 million, an increase of $103 million.

Part B of the CARE Act ensures a foundation for HIV related healthcare services in each State and territory, including the critically important AIDS Drug Assistance Program (ADAP). Part B base grants (excluding ADAP) received a decrease of $28.5 million in fiscal year 2009. AIDS Action along with the HIV/AIDS community recommends funding for part B base grants at $514.2 million, an increase of $105.4 million.

The AIDS Drug Assistance Program (ADAP) provides medications for the treatment of individuals with HIV who do not have access to Medicaid or other health insurance. According to the 2009 National ADAP Monitoring Project, ADAP provided medications to approximately 183,299 clients in fiscal year 2007, including 36,354 new clients. AIDS Action along with the HIV/AIDS community recommends $1,083 million, an increase of $268.6 million, for ADAP for fiscal year 2010. This "community need" number is derived from a pharmacoeconomic model to estimate the amount of funding needed to treat ADAP eligible individuals in upcoming Federal and State fiscal years. The need number represents the amount of new funding required to allow State ADAPs to provide a minimum clinical standard formulary of HIV/AIDS medications to ADAP clients under the current eligibility rules for each State.

Part C of the Ryan White CARE Act awards grants to community-based clinics and medical centers, hospitals, public health departments, and universities in 22 States and the District of Columbia under the Early Intervention Services program. These grants are targeted toward new and emerging sub-populations impacted by the HIV epidemic. Part C funds are particularly needed in rural areas where the availability of HIV care and treatment is still relatively new. Urban areas continue to require part C funds as emerging populations as grantees struggle to meet the needs of previously identified HIV positive populations. AIDS Action, along with the HIV/AIDS community, requests $268.3 million, an increase of $66.4 million, for part C.

Part D of the Ryan White CARE Act awards grants under the Comprehensive Family Services Program to provide comprehensive care for HIV positive women, infants, children, and youth, as well as their affected families. These grants fund the planning of services that provide comprehensive HIV care and treatment and the strengthening of the safety net for HIV positive individuals and their families. AIDS Action and the HIV/AIDS community request $134.6 million, an increase of $57.7 million, for Part D.

Under Part F, the AIDS Education and Training Centers (AETCs) is the training arm of the Ryan White CARE Act; they train the healthcare providers, including the doctors, advanced practice nurses, physicians' assistants, nurses, oral health professionals, and pharmacists. The role of the AETCs is invaluable in ensuring

that such education is available to healthcare providers who are being asked to treat the increasing numbers of HIV positive patients who depend on them for care. Additionally, the AETCs have been tasked with providing training on Hepatitis B and C to CARE Act grantees and to ensure inclusion of culturally competent programs for and about HIV and Native Americans and Alaska natives. However no funding has been added for additional materials, training of staff, or programs. The AETCs received a modest increase of $0.3 million in fiscal year 2009. AIDS Action and the HIV/AIDS community request $50 million, a $15.6 million increase, for this program. Also under part F, Dental care is another crucial part of the spectrum of services needed by people living with HIV disease. Oral health problems are often one of the first manifestations of HIV disease. Unfortunately oral health is one of the first aspects of healthcare to be neglected by those who cannot afford, or do not have access to, proper medical care removing an opportunity to catch early infections of HIV. AIDS Action and the HIV/AIDS community request $19 million, a $5.6 million increase, for this program. Finally under part F, rising infections and strapped care systems necessitate the research and development of innovative models of care. The SPNS program is designed for this purpose and must continue to receive sufficient funding.

The Minority AIDS Initiative directly benefits racial and ethnic minority communities with grants to provide technical assistance and infrastructure support and strengthen the capacity of minority community based organizations to deliver high-quality HIV healthcare and supportive services to historically underserved groups. HIV/AIDS in the United States continues to disproportionately affect communities of color. According to the CDC in 2006, the overall rate of HIV diagnosis (the number of diagnoses per 100,000 population) in the 33 States (that currently report HIV data) was 18.5 per 100,000. The rate for blacks was roughly 8 times the rate for whites (67.7 per 100,000 vs 8.2 per 100,000). The Minority AIDS Initiative provides services across every service category in the CARE Act and was authorized for inclusion within the CARE Act for the first time in the 2006 CARE Act reauthorization. It additionally funds other programs throughout HHS agencies. AIDS Action and the HIV/AIDS community request a total of $610 million for the Minority AIDS Initiative.

Research on preventing, treating, and ultimately curing HIV is vital to the domestic and global control of the disease. It is essential that Office of AIDS Research continue its groundbreaking research in both basic and clinical science to develop a preventative vaccine, microbicides, and other scientific, behavioral, and structural HIV prevention interventions. The United States must continue to take the lead in the research and development of new medicines to treat current and future strains of HIV. NIH's Office of AIDS Research is critical in supporting all of these research arenas. Commitment in research will ultimately decrease the care and treatment dollars needed if HIV continues to spread at the current rate. AIDS Action requests that the NIH be funded at $34 billion in fiscal year 2010 and that the AIDS portfolio must be funded at $3.4 billion a $500 million increase.

HIV is a continuing health crisis in the United States. We must continue to work to fully fund our domestic prevention, treatment and care, and research efforts. On behalf of all HIV positive Americans, and those affected by the disease, AIDS Action Council urges you to increase funding in each of these areas of the domestic HIV/AIDS portfolio. Help us save lives by allocating increased funds to address the HIV epidemic in the United States.

PREPARED STATEMENT OF THE ALZHEIMER'S ASSOCIATION

Mr. Chairman and members of the subcommittee: As President and CEO of the Alzheimer's Association, I want to take this opportunity to thank you for the leadership role this subcommittee has played over the years in the fight to conquer Alzheimer's disease.

Indeed, it was this subcommittee that first drew attention to Alzheimer's disease in its fiscal year 1982 appropriations report. At the time, an estimated 2.5 million people were thought to be suffering with Alzheimer's disease, their families quietly bearing most of the financial, physical, and emotional burden of care giving. Even if they were personally affected, relatively few Americans had even heard of Alzheimer's disease because so many went undiagnosed or were inaccurately diagnosed; far fewer were aware of the crisis just beginning to unfold. All this is still too true today.

Alzheimer's disease now is now estimated to afflict more than 5 million Americans. It is in a virtual tie as the Nation's sixth leading cause of death, while significantly underreported and growing. It is already the third most expensive disease,

draining billions of dollars from our economy every year. But the story does not end with those grim statistics because this problem is not going to age itself away. On the contrary, as Baby Boomers shoulder their way into the age of highest risk, we will see 10 million members of this generation fall victim to Alzheimer's disease.

At times called the quiet epidemic, the great unlearning or the long dying, year by year Alzheimer's disease strips away memory, personality and independence, leaving its victims unable to handle the most basic functions of daily living. For those who do not succumb to pneumonia or other complications of Alzheimer's, there is the final act of forgetting—when the brain forgets to breathe.

But make no mistake the effects of Alzheimer's extend well beyond the human suffering and the physical and emotional strain it puts on families. Indeed, despite all that is challenging America today, Alzheimer's disease represents a grave threat to our Nation's social and economic well-being.

This year, Medicare and Medicaid will spend more than $100 billion to finance care for those struggling with Alzheimer's disease. Over the next 40 years, those two programs alone will spend almost $20 trillion on the care of Alzheimer patients.

Unless we find a way to prevent or slow its progression, by the year 2050 the annual cost of this disease to Medicare and Medicaid programs alone will be equal to one-tenth of our entire current domestic economy.

Alzheimer's disease is so expensive because, in addition to its direct costs, it greatly increases the use and costs of Medicare to treat other serious medical conditions. Ninety-five percent of Medicare beneficiaries with Alzheimer's disease have at least one co-morbid condition. Tasks such as medication management become extremely difficult and time-consuming. As a result, the health and long-term care costs of treating these individuals is more than three times that of a Medicare beneficiary without Alzheimer's disease.

BOLD ACTION IS NEEDED NOW

Over the years this body has exercised its prerogative to channel funds to the Nation's most pressing public health problems. Added funds provided by this subcommittee led to cancer patients living longer, with many beating the disease. Thanks to those investments, survival rates have steadily improved for breast, prostate, colorectal and some other types of cancer, so that today, the 5-year relative survival rate is 66 percent across all cancers. According to the most recent estimates, 10.8 million Americans with a history of cancer are alive today. As a result of this subcommittee's strong and sustained investment in cardiovascular disease research, death rates from heart disease and stroke fell by 40 percent and 51 percent, respectively, since 1975. And when challenged by the HIV/AIDS epidemic, this subcommittee responded quickly and decisively—providing a research investment that yielded vastly improved treatments and prevention strategies and a two-thirds reduction in annual deaths.

Mr. Chairman, unlike cancer, cardiovascular disease and so many other chronic conditions that have dramatically improved with significant investments in research, there are no Alzheimer's disease survivors. None. We cannot prevent, halt or reverse it. Every day some of the 5 million who have it die of this fatal disease, only to be replaced by even more who will progressively decline and die, as more replace them. Indeed, the only way to avert this rapidly developing social and economic catastrophe is if this subcommittee, once again, leads the way.

Past investments in Alzheimer's research have helped bring us to a point no one would have dreamed possible when this subcommittee first called attention to this disease. Scientists now have a much clearer, but still incomplete picture of the basic mechanisms of Alzheimer's; epidemiological research is shedding light on new targets for intervention that now must be tested in large-scale clinical trials. And work is underway to help identify potential uses of imaging and other surrogate markers to follow the progression of cognitive decline, and to assess the effectiveness of drug interventions. But we still have so much to accomplish.

Much of what we have learned came about because Congress invested in Alzheimer research throughout the 1980s and 1990s. But even those investments were not commensurate with the impact of the disease. The evidence from cancer and cardiovascular disease illustrates the returns that can be derived from additional investments in Alzheimer's research now. As the mortality rates for cancer and heart disease decline, Alzheimer's is still rising at a steady and rapid pace.

In fact, during the past 6 years we have seen a dramatic slowdown in overall research investments, signaling a slowdown in advances to come, but the effects on Alzheimer research are potentially greater as the funding stalled at such a comparatively low level. Today, the National Institutes of Health (NIH) devotes only $412 million a year for research on Alzheimer's disease—far short of the $1 billion that

leading scientific minds estimate as the minimum required investment to uncover ways to prevent, slow and more effectively treat this disease. That $412 million is also considerably less than what is spent for research on other major threats to society, such as cancer, cardiovascular disease, and AIDS. All of these problems merit significant investments, but Alzheimer's research is underfunded when measured against the suffering inflicted by the disease or by the potential cost savings in care that could be gained by investing in research today—before it's too late.

What can the subcommittee do to help stop this serious threat to America's future?

First and foremost, the Alzheimer's Association recommends that you appropriate an additional $250 million this year and next to raise the total NIH investment in Alzheimer's research up to $1 billion. These added funds will be put to use in three crucial areas:

—*Clinical Trials*.—The funding of clinical trials and epidemiological studies, particularly through the Alzheimer's Disease Cooperative Study (ADCS) national research consortium funded by the NIH, are identifying new targets for interventions, including compounds that are already widely available such as over-the-counter medications. Time is not on our side. If we hope to forestall this looming crisis, large-scale clinical trials must be undertaken soon and must be launched simultaneously, not sequentially.

—*Early Markers of Disease*.—Earlier diagnosis is critical if we hope to stop the disease before it ravages brain cells beyond repair. Additional resources are sorely needed to fully fund the next phase of a neuro-imaging initiative currently being supported at the National Institute on Aging.

—*Basic Science Research*.—Science must find new answers and ask better questions. While significant progress has been made, scientists are still searching for definitive answers to questions about the basic mechanisms of Alzheimer's disease. Congress must maintain the pipeline of basic scientific discovery to develop additional targets for treatment. At current funding levels, work on promising avenues of research is either delayed or never started. Young investigators—and their fresh new ideas—are discouraged from entering this field of study.

While research holds the answers, there are other steps we recommend you take to help forestall or lessen the impact of Alzheimer's.

EXPAND THE HEALTHY BRAIN INITIATIVE TO $5 MILLION

Four years ago, this subcommittee launched the first single-focused effort on brain health promotion at the Centers for Disease Control and Prevention (CDC). As a result of the investment that has been made in the Healthy Brain Initiative, the CDC, in partnership with the Alzheimer's Association, has developed a public health roadmap for maintaining cognitive health, implemented community education programs targeting African-American baby boomers, and developed modules for enhancing the surveillance system for cognitive decline.

The impetus for this program was the mounting scientific evidence suggesting that brain health may be maintained by preventing or controlling cardiovascular risk factors, such as high blood pressure, high cholesterol and diabetes, and by engaging in regular physical activity. In light of the dramatic aging of the population, scientific advancements in risk behaviors, and the growing awareness of the significant health, social and economic burdens associated with cognitive decline, the Federal investment in a public health response must be expanded. We recommend that this program be increased to $5 million to focus on the following activities:

—*Healthy Brain Engagement Initiative*.—The promising approaches that have been identified through the community education programs need to be expanded to additional locations and new target audiences to impact attitudes and behaviors related to cognitive health. Particularly, we must focus on other high-risk and underserved populations, specifically the Hispanic/Latino population.

—*Tracking Cognitive Impairment as America Ages*.—In order to accelerate the availability of data to clarify the burden of Alzheimer's, an enhanced surveillance system for cognitive health is required. This can be achieved through implementation of appropriate Behavioral Risk Factor Surveillance System (BRFSS) modules in as many States as possible. The development and testing of BRFSS modules is currently underway and will be available for use in 2010.

—*Tools for Care Coordination in the Face of Cognitive Impairment*.—Cognitive health challenges—from mild cognitive decline to dementia—can have profound implications on an individual's ability to self-manage other coexisting conditions. In order to effectively address this challenge, interventions that target the

coordination of care for those with cognitive impairment and coexisting chronic diseases will be adapted or developed.

—*Early Detection*.—Early recognition of Alzheimer's, an accurate diagnosis, and early intervention, including medication, can significantly improve the quality of life and mental function of people with the disease. Communications strategies that provide information on the signs and symptoms of the disease and options for maintaining brain health will be developed and disseminated, targeting consumers and providers.

CONTINUE ALZHEIMER'S DISEASE DEMONSTRATION GRANTS AND THE ALZHEIMER'S CONTACT CENTER

The Administration on Aging (AoA) operates two Alzheimer-related programs that warrant continuation. The first is a program of matching grants to States for the development of innovative, community-based services for Alzheimer patients and caregivers, especially hard-to-reach and underserved populations. For this program, we recommend an appropriation of $11.6 million.

In 2003, this subcommittee launched the Alzheimer's Contact Center, a nationwide call-in program that provides families in crisis with around-the-clock support and assistance. Services include access to professional clinicians who provide decision-making support, crisis assistance and referrals. In 2008, the center fielded more than 106,000 calls from families. The Alzheimer's Association recommends you appropriate $1 million to continue this valuable service.

Each of the recommendations I have outlined fall within the purview of this subcommittee. But I would also like to call your attention to a report issued recently, called A National Alzheimer's Strategic Plan: The Report of the Alzheimer's Study Group.

This landmark report was the culmination of nearly 2 years of work by an independent task force of prominent national leaders. It was co-chaired by former Speaker of the House Newt Gingrich and former U.S. Senator Bob Kerrey, and included other distinguished individuals such as former Supreme Court Justice Sandra Day O'Connor and Drs. Harold Varmus, David Satcher, and Mark McClellan. The Alzheimer's Study Group also drew on the knowledge and expertise of more than 100 experts in various facets of this disease.

Mr. Chairman, in a word, the Alzheimer's Study Group concluded that to achieve a world without Alzheimer's disease we do not need to re-invent the wheel; but we have to make it work more efficiently.

This report contains many important recommendations, including developing the capability to prevent Alzheimer's disease in 90 percent of individuals by 2020. But one that warrants special attention within the context of this subcommittee's deliberations is the creation of an outcomes-oriented, objective-driven Alzheimer's Solutions Project Office within the Federal Government. With support from the president and Congress, this effort would oversee a decade-long mission to undertake a coordinated and sustained attack on Alzheimer's disease.

Mr. Chairman, thank you for your time and attention. Should you have any questions or require additional information, please feel free to call on me.

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 as the Labor, Health and Human Services, and Education, and Related Agencies subcommittee plans the fiscal year 2010 appropriations for the National Institutes of Health (NIH) and the National Cancer Institute (NCI).

AACI applauds recent budgetary commitments—notably, increased funding for NIH and support from the Obama administration through the American Recovery and Reinvestment Act of 2009—that have created a more encouraging landscape for cancer research compared to the last 5 years. While AACI understands and appreciates the budgetary constraints currently facing our Nation, we also believe that advances in cancer and biomedical research must remain a very high national priority. Therefore, we hope that high levels of support will continue in the years ahead, to ensure that this recognition of the importance of biomedical research is sustained.

For fiscal year 2010, AACI joined its colleagues in the biomedical research community in supporting the request in the President's initial budget proposal for $6 billion in funding for cancer research in fiscal year 2010, and his commitment to double funding for cancer research over the next 5 years.

AACI also requests that total funding to NIH be increased by 10 percent, including a 20 percent increase for NCI and a 7 percent increase for the other Institutes and Centers within NIH. The Nation's investment in the NIH and NCI helps lead to scientific advances that can save lives and improve the health of Americans. Early funding increases helped speed the pace of cancer research, and this investment can be leveraged significantly with a renewed commitment to strong, sustained Federal funding of medical research and, in particular, cancer research. AACI will work to ensure that Congress approves the maximum possible appropriations for NIH and NCI.

THE GROWING CANCER BURDEN

In 2008, there were approximately 1.44 million new cases of cancer in the United States and approximately 565,650 deaths due to the disease.[1] About 150,090 new cancer cases were expected to be diagnosed among African Americans in 2009, with about 63,360 expected to die from the disease. In men, the death rate for all cancers combined continued to be substantially higher among African Americans than whites during 1975–2005. Similar trends were seen among women, although the gap is much smaller.[2]

Looking further into the future, the need for cancer care will expand dramatically. From 2010 to 2030, the total projected cancer incidence will increase by approximately 45 percent, from 1.6 million in 2010 to 2.3 million in 2030. This increase is driven by cancer diagnosed in older adults and minorities. A 67 percent increase in cancer incidence is anticipated for older adults, compared with an 11 percent increase for younger adults. A 99 percent increase is anticipated for minorities, compared with a 31 percent increase for whites. From 2010 to 2030, the percentage of all cancers diagnosed in older adults will increase from 61 percent to 70 percent, and the percentage of all cancers diagnosed in minorities will increase from 21 percent to 28 percent.[3]

The human toll of cancer is staggering, as is its financial toll; the NCI reports that in 2006, $206.3 billion was spent on healthcare costs for cancer alone. Additionally, NCI acknowledges that the burdens of cancer—physical, emotional, and financial—are "unfairly shouldered by the poor, the elderly, and minority populations." The number of cancer diagnoses will only continue to climb as our population ages, with an estimated 18.2 million cancer survivors (those undergoing treatment, as well as those who have completed treatment) alive in 2020.

CANCER RESEARCH: BENEFITING ALL AMERICANS

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.

Though more than a half-million Americans will die this year from the many diseases defined as cancer, progress is being made. Because of continued progress made by the Nation's researchers, cancer death rates have continued to decline; between 1991 and 2004, the death rates for cancer in men and women declined 18.4 percent and 10.5 percent, respectively.[4] Similarly, death rates among African Americans for all cancers combined have been decreasing since 1991 after increasing from 1975 to 1991. The decline was larger in men (2.5 percent per year since 1995) than in women (1.3 percent per year since 1997). Similar trends were observed among whites from 1991–2005, with a greater reduction in the rate among men than women.

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

[1] *Cancer Facts and Figures 2008*. American Cancer Society; 2008. (The publication of Cancer Facts & Figures 2009 has been delayed due to the late release of the US final mortality data by the National Center for Health Statistics.)

[2] American Cancer Society. *Cancer Facts & Figures for African Americans 2009–2010*. Atlanta: American Cancer Society, 2009.

[3] Smith et al., "Future of Cancer Incidence in the United States: Burdens Upon an Aging, Changing Nation", J Clin Oncol 2009; 27

[4] Cancer Statistics, 2008. CA: *Cancer Journal for Clinicians* 2008; 58(2): 71–96.

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. Another initiative, the Childhood Cancer Therapeutically Applicable Research to Generate Effective Treatments Initiative, is identifying targets that can lead to better treatments for young people with 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.

THE NATION'S CANCER CENTERS

The nexus of cancer research in the United States is the Nation's network of cancer centers that are 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 $3.17 billion[5] from NCI to conduct cancer research; this represents 66 percent of NCI's total budget. In fact, 85 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.

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 is dependent 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.

Beyond their healthcare and research roles, cancer centers are also reliable engines of economic activity for the Nation as a whole, and for the communities and regions that they serve. For every $1 spent on biomedical research, a national average of $2.21 in economic benefit results.[6]

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.[7]

Cancer physicians—while essential—are only one part of the oncology workforce that is in danger of being stretched to the breaking point. The Health Resources and Services Administration predicted that by 2020, more than 1 million nursing

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[5] *National Cancer Institute 2007 Fact Book*. U.S. Department of Health and Human Services, U.S. National Institutes of Health, 2007.

[6] In Your Own Backyard: How NIH Funding Helps Your State's Economy, Families USA, June 2008

[7] 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. American Society of Clinical Oncology, 2007.

positions will go unfilled, and a 2002 survey by the Southern Regional Board of Education projected a 12 percent shortage of nurse educators by last year.[8]

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. 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 within our healthcare system when demand for oncology services far outstrips the system's ability to provide adequate care for all.

AMERICANS SUPPORT FEDERAL FUNDING FOR RESEARCH

The research community has long understood the obstacles that are facing cancer research. Though the nuances of R01 grants and oncology workforce training may not be well understood by the average American, the people of the United States believe in supporting the disparate activities that make up America's biomedical research infrastructure.

In a 2007 Research!America poll, 91 percent of those surveyed believed it was somewhat or very important for policymakers to create more incentives to encourage individuals to pursue careers as nurses, while 89 percent believed the same for encouraging careers as physicians. Forty-seven percent of those surveyed agreed that he United States must increase investment in NIH to ensure our future health and economic security, and 54 percent favored annual 6.7 percent increases in funding for NIH in 2008, 2009, and 2010. An overwhelming majority—70 percent—agreed that the United States is losing its global competitive edge in science, technology, and innovation.

We encourage our Members of Congress to respond to the concerns of the American people by enhancing support for biomedical research that will lead to improved health for everyone in the United States and around the world.

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 place the highest priority on affording all Americans access to that 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 statement highlighting funding priorities for nursing education and research programs in fiscal year 2010. AACN represents more than 640 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 nurse faculty and researchers. Many of these nursing schools sponsor intensive research programs and training activities that are funded by the National Institute of Nursing Research (NINR).

THE NATIONWIDE NURSING SHORTAGE

The United States is in the midst of a nursing shortage that has expanded over the last decade. 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, and the shortage is projected to intensify as the baby-boomer population ages and the need for healthcare grows. The U.S. Bureau of Labor Statistics (BLS) recently reported that the healthcare sector of the economy is continuing to expand, despite significant job losses in nearly all other major industries. Hospitals, long-term care facilities, and other ambulatory care settings added 27,000 new jobs in February

[8] ONS: Ready to Collaborate with Other Policymakers to Ensure Future of Quality Cancer Care, Oncology Times, August 25, 2007; (29): 8–9.

2009, a month when 681,000 jobs were eliminated across the country. As the largest segment of the healthcare workforce, RNs likely will be recruited to fill many of these new positions. Moreover, according to the latest projections from the BLS, more than 1 million new and replacement nurses will be needed by 2016. 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 Advanced Practice Registered Nurses (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 an ongoing shortage of nurse faculty. The nurse faculty shortage continues to inhibit nursing schools from educating the number of nurses needed to meet the demand. According to AACN, 49,948 qualified applicants were turned away from baccalaureate and graduate nursing programs in 2008 primarily due to a lack of faculty. Of those potential students, nearly 7,000 were students pursuing a master's or doctoral degree in nursing, which is the education level required to teach.

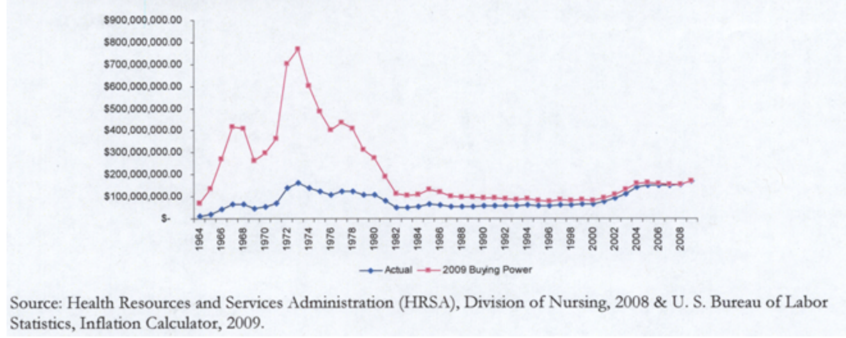
NURSING WORKFORCE DEVELOPMENT PROGRAMS: A PROVEN SOLUTION

For nearly five decades, the Nursing Workforce Development Programs 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. In a 2009 survey by AACN, 1,501 title VIII student recipients reported that these programs played a critical role in funding their nursing education. An overwhelming number of respondents (92.7 percent), reported that title VIII paid for a portion of their tuition and, of those students, approximately 11 percent reported their tuition was paid in full. 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 and needed. The nursing students responding to this study expressed overwhelming gratitude for the funding they receive through title VIII. Nursing remains an attractive and rewarding career with more than 135,000 current vacant positions, and according to the BLS, more than 587,000 new nursing positions will be needed by 2016. Providing support for title VIII is the key to filling these vacant positions and, in turn, improving healthcare quality.

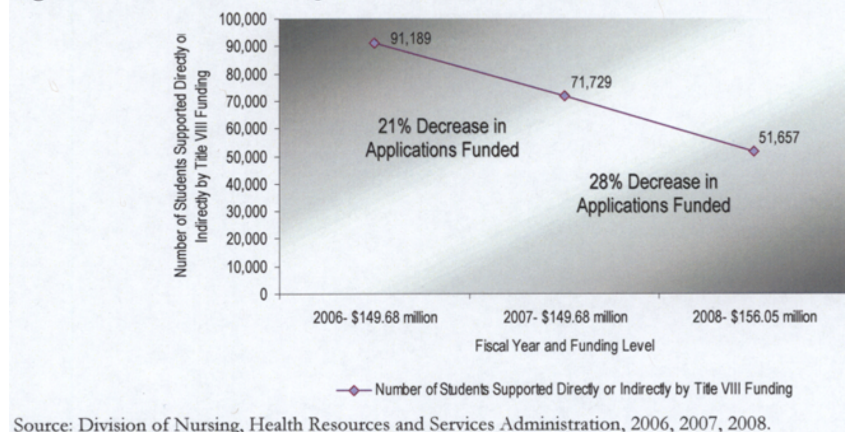
Over the last 45 years, Congress has used the title VIII authorities as a mechanism to address nursing shortages. When the need for nurses was great, higher funding levels were appropriated. During the nursing shortage of the 1970s, Congress provided $160.61 million to the title VIII programs in fiscal year 1973. Adjusting for inflation to address the 36-year difference, the fiscal year 2009 funding level of $171.03 million in 1973 dollars would be approximately $820 million today (see Figure 1). More recently, slow rising funding levels between fiscal year 2006 and fiscal year 2008 for title VIII, coupled with inflation and rising educational costs, have greatly decreased the purchasing power of these programs, resulting in a 43 percent decrease in the number of nurses supported by the programs (see Figure 2).

Figure 1: Historical Funding for Title VIII Nursing Workforce Development Programs (in millions) and Adjusted for Inflation



Source: Health Resources and Services Administration (HRSA), Division of Nursing, 2008 & U. S. Bureau of Labor Statistics, Inflation Calculator, 2009.

Figure 2: Nurses and Nursing Students Supported by Title VIII: FY 2006-2008



Source: Division of Nursing, Health Resources and Services Administration, 2006, 2007, 2008.

AACN is delighted that President Obama has noted the need for increased title VIII funding in his fiscal year 2010 budget proposal. Therefore, AACN respectfully requests the subcommittee's support for the President's proposal of $263.4 million for title VIII Nursing Workforce Development Programs in fiscal year 2010, an additional $92 million more than the fiscal year 2009 level. New monies would expand nursing education, recruitment, and retention efforts to help resolve all aspects contributing to the shortage.

NINR: SUPPORTING HEALTH PROMOTION AND DISEASE PREVENTION

As the scientific and research nucleus for nursing science, the NINR funds research that establishes the scientific basis for health promotion, disease prevention, and high-quality nursing care services to individuals, families, and populations. NINR is one of the 27 Institutes and Centers at the National Institutes of Health (NIH). 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;
—Improving quality of life;
—Eliminating health disparities; and
—Setting directions for end-of-life research.

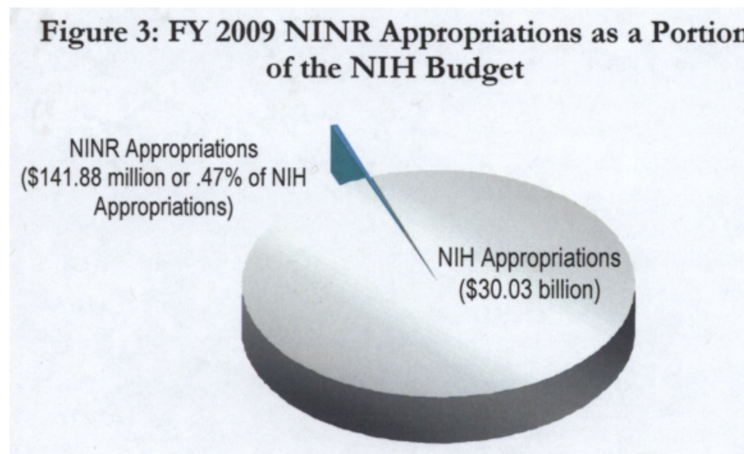
The science advanced at NINR is integral to the future of the Nation's healthcare system. With a renewed national priority on utilizing cost-effective treatment modal-

ities and preventive interventions, NINR has developed research programs in these areas:

Comparative Effectiveness Research.—Has been an NINR funding priority for many years. Comparative effectiveness research demonstrates how prevention strategies or interventions can impact system-wide savings. At a time when healthcare consumers and reformers are seeking quality care focused on prevention that is affordable and accessible by all, comparative effectiveness research is a critical area of inquiry.

Promoting Health and Preventing Disease.—Is vital considering that 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 which promotes prevention promises to be a major focus of health reform, and NINR is a leader in funding scientific research to discover optimal prevention methods.

NINR's fiscal year 2009 funding level of $141.88 million is approximately 0.47 percent of the overall $30.03 billion NIH budget (see Figure 3). 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, the Institute must receive additional funding. Cuts in funding have impeded the Institute from supporting larger comprehensive studies needed to advance nursing science and improve the quality of patient care.



Therefore, AACN respectfully requests $178 million for NINR, an additional $36.12 million more than the fiscal year 2009 level. 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.

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 (2009), 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 recently passed 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 2010.

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. NINR 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 $263.4 million for title VIII programs, $178 million for NINR, and $50 million for the Capacity for Nursing Students and Faculty Program in fiscal year 2010. 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 submitting this testimony in support of increased funding in fiscal year 2010 for the title VII health professions education programs, the National Health Service Corps (NHSC), 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 25 colleges of osteopathic medicine and three branch campuses that offer the doctor of osteopathic medicine degree. Today, more than 15,500 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 Health Resources and Services Administration (HRSA), support the training and education of health practitioners 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. 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, these needs strain an already fragile healthcare system. AACOM recommends $330 million in fiscal year 2010 for the title VII programs. Investment in these programs, including the Training in Primary Care Medicine and Dentistry Program, the Health Careers Opportunity Program, and the Centers of Excellence, is necessary to address the primary care workforce shortage. Such an investment will help sustain the health workforce expansion supported by the American Recovery and Reinvestment Act (ARRA) and restore funding to critical programs that suffered drastic funding reductions in fiscal year 2006 and remain well below fiscal year 2005 levels.

AACOM is pleased that President Obama requested considerable increases in the following title VII programs: Training in Primary Care Medicine and Dentistry ($56.4 million requested/16.5 percent increase); Centers of Excellence ($24.6 million requested/19.4 percent increase); and Health Careers Opportunity Program ($22.1 million requested/15.7 percent increase).

NHSC

Approximately 50 million Americans live in communities with a shortage of health professionals, lacking adequate access to primary care. Through scholarships and loan repayment, HRSA's NHSC supports the recruitment and retention of primary care clinicians to practice in underserved communities. The NHSC is comprised of more than 4,000 clinicians, with more than half working in community health centers. Growth in HRSA's Health Center Program must be complemented with increases in the recruitment and retention of primary care clinicians to ensure adequate staffing. ARRA funding for the NHSC is vital in this regard, and additional investment will be necessary to sustain the progress once the ARRA funding period ends. AACOM recommends $235 million in fiscal year 2010 for NHSC, the amount authorized under the Health Care Safety Net Amendments of 2002.

AACOM notes that President Obama requested significant increases for NHSC field placement ($46 million requested/6 percent increase) and recruitment ($123 million requested/29.5 percent increase).

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. The NIH funding under the ARRA will produce more high-quality research. To seize the momentum created by the ARRA and maintain a robust research agenda, further investment will be needed. AACOM recommends $33.35 billion in fiscal year 2010 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 (NCCAM) to continue fulfilling this essential research role.

AACOM appreciates President Obama requesting increases for NIH ($31 billion requested/1.45 percent increase) and NCCAM ($127 million requested/1.6 percent increase).

AHRQ

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 Effective Health Care Program in recent years, as well as the funding provided to AHRQ in the ARRA, will help AHRQ generate more comparative effectiveness 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. AACOM recommends $405 million in fiscal year 2010 for AHRQ. 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

The American Association of Colleges of Pharmacy (AACP) and its member colleges and schools of pharmacy appreciate the continued support of the Senate Appropriations Subcommittee on Labor, Health and Human Services, and Education, and Related Agencies. Our Nation's 111 accredited colleges and schools of pharmacy are engaged in a wide-range of programs supported by grants and funding administered through the agencies of the Department of Health and Human Services (HHS) and the Department of Education. 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.

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 $405 million for AHRQ programs in fiscal year 2010.

Pharmacy faculty are strong partners with 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.

—Last fall, AHRQ expanded its Centers for Education and Research on Therapeutics (CERTs) program by awarding $41.6 million over the next 4 years for a new coordinating center, 10 research centers and four new centers receiving first-time funding. The University of Illinois at Chicago College of Pharmacy

joins the 13 CERTs program centers in efforts to conduct research and provide education that advances the optimal use of therapeutics.
http://www.aacp.org/news/academicpharmnow/Documents/MarApr%202008%20APN.pdf

—Pharmacy faculty researchers, supported by AHRQ grant HS016097, determined that children who are prescribed medications related to their diagnosis of attention deficit/hyperactivity disorder were not at increased risk for hospitalization for cardiac events. The results of this research will be presented in a web conference sponsored by AHRQ and APhA on May 1, 2009.

Centers for Disease Control and Prevention (CDC)

AACP supports the CDC Coalition recommendation of $8.6 billion for CDC core programs in fiscal year 2010.

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.

—Grace Kuo, CDC-supported member of the faculty at the University of California, San Diego, is engaged in research aimed at improving the safety of medication use in primary care settings.

—Jeanine Mount, CDC-supported member of the faculty at the University of Wisconsin, is engaged in research to determine how pharmacists can be better utilized in increase the vaccination rates across our Nation.

Health Resources and Services Administration (HRSA)

AACP supports the Friends of HRSA recommendation of $8.5 billion.

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 (OPA)

AACP recommends a program funding of $5 million for fiscal year 2010 for OPA.

AACP member institutions are actively engaged in 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 federally 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. A recent USC study found that for every $1 spent on the Palmetto Poison Center, more than $7 was 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 $550 million for title VII and VIII programs in fiscal year 2010.

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 and the University of Montana) which 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 that align with the Institute of Medicine's recommendations for improving quality through team-based, patient-centered care.

OFFICE OF TELEHEALTH ADVANCEMENT

Technology is an important component for improving healthcare quality and maintaining or increasing access to care. Colleges and schools of pharmacy utilize technology to increase the reach of education to aspiring and current professionals.

—*Massachusetts College of Pharmacy and Health Sciences—Worcester Campus Distance Learning Initiative—Phase II.*—Grant support for this program will allow the expansion of health profession education programs throughout Massachusetts and New Hampshire. http://hrsa.gov/telehealth/granteedirectory/overview__ma.htm

—North Dakota State University College of Pharmacy, Nursing, and Allied Sciences uses grant funding to maintain access to pharmacy services in rural, underserved areas of North Dakota. This program helps more than 40,000 rural citizens maintain access to pharmacy services and also supports rural hospital pharmacies. http://hrsa.gov/telehealth/granteedirectory/overview__nd.htm

FOOD AND DRUG ADMINISTRATION (FDA)

AACP recommends a funding level of $3 billion for FDA programs in fiscal year 2010.

Academic pharmacy is working with the FDA to fulfill its strategic goals and the responsibilities assigned to the agency through the Food and Drug Administration Amendments Act. The FDA sees the colleges and schools of pharmacy as essential partners in assuring the public has access to a healthcare professional well versed in the science of safety.

—Carole L. Kimberlin, a professor, and Almut G. Winterstein, an assistant professor at the University of Florida College of Pharmacy Department of Pharmaceutical Outcomes and Policy, received a 1-year $184,229 award from the FDA to conduct an evaluation of Consumer Medication Information leaflets on selected prescription medications from community pharmacies throughout the United States.

—Thomas C. Dowling's research, "Evaluation of Biopharmaceutics Classification System Class 3 Drugs for Possible Biowaivers," is supported by an FDA grant.

—The FDA-supported National Institute of Pharmaceutical Technology and Education is funding research at the University of Connecticut focused on the development of freeze-dried products.

NATIONAL INSTITUTES OF HEALTH (NIH)

AACP supports the Ad Hoc Group for Medical Research recommendation of $32.4 billion for fiscal year 2010.

Pharmacy faculty are supported in their research by nearly every Institute at the NIH. The NIH-supported research at AACP member institutions spans theresearch spectrum from the creation of new knowledge through the translation of that new knowledge to providers and patients. In 2008, pharmacy faculty researchers received more than $260 million in grant support from the NIH.

—Researchers at the University of Illinois at Chicago College of pharmacy have received a $1.7 million 5-year Federal grant to develop a new approach to treat brain tumors. The novel approach stabilizes the drug and provides better control of the time and location of its activity, thereby reducing its side effects.

—University of Nebraska Medical Center (UNMC) received $10.6 million from the National Center for Research Resources (NCRR) to research nanomedicine, drug delivery, therapeutics, and diagnostics. UNMC researcher, Dr. Alexander V.

Kabanov, is the principal investigator on the $10.6 million COBRE (Centers for Biomedical Research Excellence) grant, which will be awarded by the NIH/NCRR over the next 5 years.

—Dr. Maria Croyle, associate professor of pharmaceutics at The University of Texas at Austin College of Pharmacy, has received $2.6 million from NIH to develop a vaccine against Ebola virus infection.

—As part of NIH funding for the new NIH Roadmap Epigenomics Program, Dr. Rihe Liu, associate professor at the University of North Carolina at Chapel Hill Eshelman School of Pharmacy, received a technology development grant to support the advancement of innovative technologies that have the potential to transform the way that epigenomics research can be performed in the future.

—A project funded by the National Institute of General Medical Sciences takes computer-aided drug design to the next level with the help of a University of Michigan College of Pharmacy professor.

—Fourteen additional universities were awarded the Clinical and Translational Science Award in May 2008. Five colleges of pharmacy are included in this group and will play significant collaborative roles with the new consortium members as the NIH provides $533 million over 5 years to help enable researchers to provide new treatments more efficiently and effectively to patients.

—Dr. Laurence H. Hurley, professor of pharmaceutical sciences at The University of Arizona College of Pharmacy, is 1 of 38 scientists to receive the 2009 NIH EUREKA grant.

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 $5,500.

—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 $77 million.

AACP recommends a funding level of $140 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.

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 recent large-scale investment in research through the American Recovery and Reinvestment Act (ARRA) and the fiscal year 2009 budget will support current projects and provide for new efforts in the fight against cancer. These new efforts 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 make the key investments that will leverage the ARRA funds so that they both create jobs today and save lives 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 occurred 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 support President Obama's vision for doubling cancer research funding over the next 5 years and strongly support other biomedical research funding at the National Institutes of Health (NIH). AACR supports the $6 billion for cancer research highlighted in the President's fiscal year 2010 budget outline, which would be best allocated to the National Cancer Institute (NCI). The AACR also supports the biomedical community's recommendation of a 7 percent increase for the NIH, which, when combined with President Obama's vision for cancer research, would fund NIH at a level of $33.3 billion in fiscal year 2010.

AACR: FOSTERING A CENTURY OF RESEARCH PROGRESS

The American Association for Cancer Research has been moving cancer research forward since its founding in 1907. Celebrating its 100th annual meeting, the AACR and its more than 28,000 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 past 100 years, 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 rarer 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 2009. 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 will be essential to avoid this cancer crisis.

BLUEPRINT FOR PROGRESS: NCI'S STRATEGIC OBJECTIVES

Basic, translational, and clinical cancer research in this country is conducted primarily through three venues—Government, academia and the nonprofit sector, and the pharmaceutical/biotechnology industry. The Congress provides the appropriations for the National Institutes of Health and 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 2010" 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 $2.1 billion as proposed for fiscal year 2010, the Director's proposed budget will enable the NCI to rebuild America's research infrastructure capacity and accelerate research progress in critical priority areas.

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 through-

out the country. More than 6,500 research grants are funded at more than 150 cancer centers and specialized research facilities located in 49 States. More than half the States receive more than $15 million in grants and contracts to institutions located within their borders. This Federal investment provides needed economic stimulus to local economies: on average, each dollar 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 2009 appropriations and the funds from the American Recovery and Reinvestment Act of 2009 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 the request in the President's budget proposal for $6 billion in funding for cancer research in fiscal year 2010 and his commitment to double funding for cancer research over the next 5 years and, thus, recommends a 20 percent increase in funding for the NCI to enable it to continue and expand its important work.

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.

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 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 has opened the door to the promise of personalized medicine.

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 multiple strategies to 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 its Chemistry in Cancer Research Working Group;
—convening an AACR–FDA–NCI Think Tank on Clinical Biomarkers;
—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;
—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 $219 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 one percent reduction in mortality from cancer would be worth nearly $500 billion in social value. Investments in cancer research stimulate the local economy today have 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, the AACR urges the United States House of Representatives to support a budget of $33.3 billion for the NIH, including $6 billion for the NCI.

LETTER FROM THE AMERICAN ASSOCIATION OF COLLEGES FOR TEACHER EDUCATION

APRIL 30, 2009.

Hon. TOM HARKIN,
Chairman, Subcommittee on Labor, Health and Human Services, and Education, and Related Agencies, Washington, DC.

DEAR CHAIRMAN HARKIN: I want to extend my appreciation to you and your colleagues in Congress for your support of Federal education programs. Your commitment makes a significant difference for the education of our millions of PK–12 and postsecondary students.

As you and your colleagues begin the fiscal year 2010 appropriations process, the American Association of Colleges for Teacher Education (AACTE) urges you to increase the Federal Government's investment in the preparation of professional educators. While there are significant funds behind title II of the No Child Left Behind Act in the Improving Teacher Quality State Grants, the vast majority of these funds, and other funds in title II, go towards class size reduction and the professional development of practicing teachers. Equally important, though, is the initial preparation of teachers and other school personnel. And, in this respect, the Federal Government's investment, until very recently, has declined over the years. As this Nation is in the midst of teacher retention and shortage crises, it is critical that the Government responds with a plan that provides for systemic change.

There are several programs within the Department of Education intended to strengthen and improve educator recruitment and preparation efforts. We are working with program authorizers in Congress and staff within the agencies to ensure that these programs work in concert with each other. However, one of the key factors that prevents these programs from becoming levers for systemic change is their consistent underfunding. The cost of preparing school personnel is significant.

The primary Federal program in this area is the Teacher Quality Partnership (TQP) Grants (title II, Higher Education Opportunity Act). During the reauthorization of the Higher Education Act we supported several changes to title II of the bill that have resulted in a much stronger TQP program. Under this program, these grants go to partnerships of institutions of higher education, high-need local educational agencies, and high-need K–12 schools to prepare teachers and other school personnel to effectively serve in the schools. The grants are particularly focused on strengthening the clinical component of preparation programs—research has shown that preservice clinical experiences are essential to preparing effective teachers and to teacher retention.

Grants can be used to strengthen prebaccalaureate preparation programs and/or to develop 1-year master's degree level teaching residency programs. In exchange for receiving a living stipend during the residency, teachers would commit to teaching for at least 3 years in a shortage field in a high-need school. The residency programs are targeted to recruiting career-changers and recent college graduates. In these

times of rising unemployment, these programs are ideal for those who have been laid off and are seeking a stable and rewarding new career. President Obama wrote the legislation for the teaching residency programs when he was a Senator on the HELP Committee. During his Presidential campaign and since his election he has stated that he wants to prepare 30,000 new educators through the residency programs.

In order to meet that goal, and to provide sufficient support to the partnerships that carry out TQP Grants, we ask that you fund the TQP program at the $150 million level in fiscal year 2010. The TQP program received $50 million in fiscal year 2009, and $100 million in the stimulus package. This is a significant boost to the program which was funded in fiscal year 2008 at $33 million. The $150 million in fiscal year 2010 appropriations will maintain the current level of funding when the stimulus funding concludes.

Below you will find AACTE's recommendations for funding additional programs in fiscal year 2010.

—*Fund Teachers for a Competitive Tomorrow at the $60 Million Level*.—This program was authorized in the America Competes Act, and it is currently funded at $2.18 million. This program and the TQP program are the only two Federal education program directed targeted to higher-education-based educator preparation programs. With the teacher shortage and retention crisis acutely felt in the math and science teaching fields, this program is a crucial piece of the response to ameliorate the teacher shortage challenges. This competitive grant program helps higher education institutions build baccalaureate and master's degree programs that allow students to major in STEM fields while working toward teacher certification.

—*Fund the Transition to Teaching program at the $60 Million Level*.—This program, authorized in title II of the No Child Left Behind Act at the $150 million level and currently funded at $43.7 million, supports the development of teacher preparation programs suited for career-changers and others who enter teaching through nontraditional routes. Higher education institutions and other entities have used funds from this program to develop innovative preparation programs that accommodate the needs of a diverse educator candidate pool while ensuring that candidates are prepared to teach in today's K–12 classrooms.

—*Fund the Troops-to-Teachers program at the $25 Million Level*.—Like Transition to Teaching, this program aims to attract teachers from another profession into the classroom. Troops-to-Teachers has been very successful at recruiting retired military into the teaching profession. By funding the program at $25 million, this would almost double the Government's investment in the program (currently at $14.4 million) during a time in which there is higher military interest in entering the K–12 teaching ranks.

—*Fund the IDEA Personnel Preparation Program at the $120 Million Level*.—Currently funded at $90.65 million, this program provides essential funds to prepare and develop special educators. Special education teachers, much like math and science teachers, are in high demand in the K–12 schools with the shortage being significant. With the wide breadth and increasing number of special need students there needs to be an adequate supply of teachers who can work with them to ensure student learning.

—*Fund the Centers for Excellence Program at the $20 Million Level*.—This new program was authorized in title II of the Higher Education Opportunity Act and is currently unfunded. Grants would support the strengthening of educator preparation programs at institutions that serve historically under-represented populations.

—*Fund the Teach to Reach Grant Program at the $15 Million Level*.—This new program was authorized in title II of the Higher Education Opportunity Act and is currently unfunded. Institutions of higher education would use grants to ensure that all of their teacher candidates were prepared to teach children with disabilities. Almost every K–12 classroom has students with learning, intellectual, and/or physical disabilities. It is critical that every teacher is prepared with instructional skills that will assure that every child has the opportunity to learn.

—*Fund the Graduate Fellowships To Prepare Faculty at Colleges of Education Program at the $15 Million Level*.—This new program was authorized in title II of the Higher Education Opportunity Act and is currently unfunded. The current shortage of K–12 teachers in the math, science, special education, and English language learners fields is directly correlated with the shortage of faculty at institutions of higher education who prepare teachers in these fields. This program would support doctoral students who intend to become faculty who prepare teachers in these shortage areas.

The AACTE is a national voluntary association of higher education institutions and other organizations and is dedicated to ensuring the highest-quality preparation and continuing professional development for teachers and school leaders. Our overarching mission is to enhance PK–12 student learning. Collectively, the AACTE membership prepares more than two-thirds of the new teachers entering schools each year in the United States.

Thank you for your consideration of the perspective of AACTE and its membership of close to 800 private, State, and municipal colleges and universities—large and small—located in every State, the District of Columbia, the Virgin Islands, Puerto Rico, and Guam.

Sincerely,

SHARON P. ROBINSON, ED.D.,
President and CEO.

PREPARED STATEMENT OF THE AMERICAN ASSOCIATION FOR DENTAL RESEARCH

The American Association for Dental Research (AADR) is a nonprofit organization with more than 4,000 individual members and 100 institutional members within the United States. The AADR's mission is to advance research and increase knowledge for the improvement of oral health for all Americans.

The AADR thanks the subcommittee for this opportunity to testify about the exciting advances in oral health science. Americans are living better and healthier lives into old age due to 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). NIDCR was formed in 1948 by the National Institutes of Health (NIH). Its staff has conducted research, trained researchers, and disseminated health information to improve the health of Americans and make it possible for them to live longer and healthier lives.

On February 17 of this year, President Barack Obama signed into law the $787 billion stimulus package known as the American Recovery and Reinvestment Act (ARRA). This legislation will provide NIH with $8.2 billion to conduct additional scientific research. AADR members, researchers across the country, would like to thank the committee for its past support and in particular for the funds contained in the stimulus package. The past investment in NIH has paid a dividend to taxpayers in the form of improved oral health.

HEALTH DISPARITIES

One very challenging issue we face in this country is health disparities. We must learn more about the causes of cultural inequality among individual members of society if we are to conduct more effective research.

The NIDCR's mission is to train and engage as many young investigators as possible in oral health disparities research to develop various methods of research to eliminate these disparities. They hope that this will improve the oral, dental, and craniofacial health of diverse populations.

Health disparities are the persistent gaps between the health status of minorities and nonminorities in the United States. Despite continued advances in healthcare and technology, racial and ethnic minorities continue to have higher rates of disease, disabilities, and premature death than nonminorities. African Americans, Hispanics/Latinos, American Indians and Alaska natives, Asian Americans, Native Hawaiians, and Pacific Islanders have higher rates of infant mortality, cardiovascular disease, diabetes, AIDS, and cancer, and lower rates of immunizations and cancer screening.

There is debate about what causes health disparities between ethnic and racial groups. However, it is generally accepted that disparities can result from three main areas:

—from the personal, socioeconomic, and environmental characteristics of different ethnic and racial groups;
—from the barriers certain racial and ethnic groups encounter when trying to enter into the healthcare delivery system; and
—from the quality of healthcare different ethnic and racial groups receive.

These are all considered possible causes for disparities between racial and ethnic groups. However, most attention on the issue has been given to the health outcomes that result from differences in access to medical care among groups and the quality of care that various groups receive. Since many scientific discoveries do not reach all people, there are disparities in the health and healthcare among various groups in the United States. Even though data on racial and ethnic disparities are rel-

atively widely available, data on socioeconomic healthcare disparities are collected less often.

The Health Disparities Research Program responds to the growing awareness that, despite improvements in some oral health status indicators, the burden of disease is not evenly distributed across all segments of our society. The program supports research that explores the multiple and complex factors that may determine oral and craniofacial health, diseases, and conditions in disadvantaged and underserved populations. Funds go to a wide variety of different scientific approaches designed to reduce and eventually eliminate oral and craniofacial diseases and conditions in disadvantaged and underserved populations. The program supports both qualitative and quantitative approaches.

The NIDCR will support interventional research that will have a meaningful impact on caries, oral and pharyngeal cancer, and periodontal disease, and that will influence clinical practice, health policy, community and individual action, ultimately eliminating disparities in vulnerable people. NIDCR will also fund health disparities interventional research beyond that conducted through the Centers for Research to Reduce Disparities in Oral Health program.

SALIVARY DIAGNOSTICS

For many oral and systemic diseases, early detection offers the best hope for successful treatment. 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 many years of research, saliva is poised to be used as a noninvasive diagnostic fluid for a number of oral and systemic conditions. Saliva, a protective fluid of the oral cavity, combats bacteria and viruses that enter the mouth and 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 affected by a disease—therefore, saliva is a mirror of the body. Since saliva is easy to collect, it is a good alternative to using blood or urine for diagnostic tests.

The year 2008 was exciting in the incremental development of salivary diagnostics. A consortium of NIDCR-supported scientists completed the first catalogue of the human salivary proteome, or the full set of 1,166 proteins present in saliva. This will help facilitate the future testing of saliva as a standard body fluid to detect early signs of disease. A team of NIDCR grantees also assembled the first panel of salivary protein biomarkers to detect oral squamous cell carcinoma (OSCC). This is the most common form of the oral cancers.

Salivary diagnostic techniques have already been developed for and are being used to detect HIV. Saliva could be used as a potential monitor of disease progression in systemic disorders, including Alzheimer's disease, cystic fibrosis, and diabetes. Specific protein markers in human saliva are being investigated that can be identified and quantified to provide an early, noninvasive diagnosis for even cancers distant from the oral cavity, such as pancreatic and breast cancer. Getting a diagnosis used to entail making a trip to the doctor's office. The doctor's examination often required the patient providing a blood and/or urine sample. Even though getting a diagnosis still requires a trip to the doctor's office, scientists are now identifying the genes and proteins that are expressed in the salivary glands that will help define the patterns and certain conditions under which these genes and proteins are expressed in the salivary glands. Building on this research, saliva will become a more commonly used diagnostic fluid.

ORAL CANCER

Oral cancer affects 38,000 Americans each year and 350,000 people worldwide. The death rate associated with this cancer is especially high, due to delayed diagnosis. Oral cancer is any cancerous tissue growth located in the mouth. About two-thirds of oral cancers occur in the mouth, and about one-third are found in the pharynx. On average, only 60 percent of people with the disease will survive more than 5 years. However, here again, disparities play a role, and only 35 percent of black men will survive 5 years. Oral cancer occurs most in people over the age of 40 and affects more than twice as many men as women. Researchers are developing a Point of Care diagnostic system (real-time) for rapid on-site detection of saliva-based tumor markers. Early detection of oral cancer will increase survival rates, improve the quality of life of cancer patients, and result in a significant reduction in healthcare costs.

Oral cancer forms in tissues of the lip or mouth. In 2008, approximately 22,900 new cases of oral cancer occurred in the United States. Oral cancer claimed roughly 5,390 deaths that year. It represents approximately 3 percent of all cancers. This,

however, translates to 30,000 new cases every year in the United States. More than 34,000 Americans will be diagnosed with oral or pharyngeal cancer this year. It will cause more than 8,000 deaths, killing roughly 1 person per hour, 24 hours per day. Of those 34,000 newly diagnosed individuals, only half will be alive in 5 years. The death rate for oral cancer is higher than that of cancers such as cervical cancer, laryngeal cancer, thyroid cancer, or skin cancer. Worldwide, the problem is much greater, with more than 400,000 new cases being found each year.

Survival rates can be calculated by different methods for different purposes. If oral cancer is caught when the disease has not spread beyond the original tumor site, the 5-year relative survival rate is 82 percent. However, half of oral cancers are not diagnosed until the cancer has spread to nearby tissues. At this stage, the 5-year relative survival rate drops to 53 percent. Those diagnosed when the cancer has spread further, to distant organs, have only a 28 percent 5-year relative survival rate. It's important to detect oral cancer early, when it can be treated more successfully. Typically, the earlier cancer is detected and diagnosed, the more successful the treatment, thus enhancing the survival rate.

CONCLUSION

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 for NIDCR in particular, is essential for continued improvement in the oral health of Americans. Oral cancer is one of the most expensive cancers to treat—the average cost for treating an advanced case is $200,000. Overcoming cancer health disparities is one of the best opportunities we have for lessening the burden of cancer. But the burden of cancer is too often greater for the poor, for ethnic minorities, and for the uninsured than for the general population.

A great amount of promising research is under way, and the potential to improve oral health specifically, and overall health in general, is significant. Therefore, we are requesting that NIDCR receive a fiscal year 2010 appropriation of $442 million, not including the ARRA funding, to help sustain and build upon the discoveries and employment opportunities that were created using stimulus funding. Thank you for the subcommittee's support of NIH programs in the past, and we are grateful for this opportunity to present our views.

Prepared Statement of the American Academy of Family Physicians

On behalf of the American Academy of Family Physicians (AAFP), I commend President Barack Obama for demonstrating a commitment to a strong primary care workforce by seeking to increase training under title VII, section 747 of the Public Health Services Act in his fiscal year 2010 budget. As one of the largest national medical organizations, representing 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 build on that commitment to title VII section 747 in fiscal year 2010 and increase funding for other key HHS programs to allow healthcare reform to succeed and support better healthcare all.

HEALTH RESOURCES AND SERVICES ADMINISTRATION (HRSA)

HRSA is charged with improving access to healthcare services for people who are uninsured, isolated, or medically vulnerable. One of the most critical aspects of this mission is ensuring a healthcare workforce which is sufficient to meet the needs of patients and communities.

HRSA—HEALTH PROFESSIONS

For 40 years, the training programs authorized by title VII of the Public Health Services Act evolved to meet our Nation's healthcare workforce needs. While it is increasingly clear that our Nation has a worsening shortage of primary care physicians, many "studies have found a strong, sometimes dose-dependent associations between title VII funding and increased production of primary care graduates, and physicians who eventually practice in rural areas and federally designated physician shortage areas." [1]

[1] Robert Graham Center. Specialty and Geographic Distribution of Physician Workforce: What Influences Medical Student & Resident Choices? 2009 Washington, DC.

The sixth report of the HRSA Advisory Committee on Training in Primary Care Medicine and Dentistry recommended an annual minimum level of $215 million for the title VII section 747 grant program. The subcommittee reasoned that:

Title VII funds are essential to support major primary care training programs that train the providers who work with vulnerable populations. It is critical that funds not only be restored to 2005 levels, but that funding be increased, as the need for healthcare of the public, including those high-risk groups identified in this report, increases. It is critical that funds offset the acknowledged rate of inflation. This additional funding is also necessary to prepare current and future primary care providers for their critical role in responding to healthcare challenges including demographic changes in the population, increased prevalence of chronic conditions, decreased access to care, and a need for effective first-response strategies in instances of acts of terrorism or natural disasters.

Healthcare reform demands that we must modernize workforce and education policies to ensure an adequate number of primary care physicians trained to serve in the new healthcare delivery model. The patient centered medical home will give patients access to preventive care and coordination of the care needed to manage chronic diseases as well as appropriate care for acute illness. The medical home practice model provides improved efficiency and better health because it serves as a principal source of access and care. As a result, duplication of tests and procedures and unnecessary emergency department visits and hospitalizations can be avoided

Section 747 of title VII, the Primary Care Medicine and Dentistry Cluster, is aimed at increasing the number of primary care physicians (family physicians, general internists and pediatricians). Section 747 offers competitive grants for family medicine training programs in medical schools and in residency programs. Section 747 is vital to stimulate medical education, residency programs, as well as academic and faculty development in primary care to prepare physicians to support the patient centered medical home.

The value of title VII grants extends far beyond the medical schools that receive them. The United States lags behind other countries in its focus on primary care. However, the evidence shows that countries with primary care-based health systems have population health outcomes that are better than those of the United States at lower costs.[2] Health Professions Grants are one important tool to help refocus the Nation's health system on primary care.

Although HRSA has not released the spending plan for the American Recovery and Reinvestment Act (ARRA) health professions training funds for fiscal year 2009–2010, the omnibus appropriation increased section 747 by less than 1 percent more than the final fiscal year 2008 amount to $48,425,000 for fiscal year 2009. It remains well below the $92 million provided for Primary Care Medicine and Dentistry Training in fiscal year 2003. The Nation needs significant additional support from section 747 because it is the only national federally funded program that provides resources for important innovations necessary to increase the number of physicians who will lead the primary care teams providing care in patient-centered medical homes.

AAFP recommends a substantial increase in the fiscal year 2010 appropriation bill for the Health Professions Training Programs authorized under title VII of the Public Health Services Act. We respectfully request that the subcommittee provide $215 million for the section 747, the Primary Care Medicine and Dentistry Cluster, which will signal the commitment of Congress to reform healthcare delivery in this Nation.

HRSA—NATIONAL HEALTH SERVICE CORPS (NHSC)

NHSC offers scholarship and loan repayment awards to primary care physicians, nurse practitioners, dentists, mental and behavioral health professionals, physician assistants, certified nurse-midwives, and dental hygienists serving in underserved communities. Research has shown that debt plays a complex yet important role in shaping career choices for medical students. The NHSC offers financial incentives for the recruitment and retention of family physicians to practice in underserved communities without adequate access to primary care. 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.

[2] Starfield B, et al. The effects of specialist supply on populations' health: assessing the evidence. *Health Affairs*. 15 March 2005

AAFP respectfully requests that the subcommittee fully fund these important scholarship and loan repayment programs by providing the authorized amount of $235 million for NHSC in fiscal year 2010.

HRSA—RURAL HEALTH

Americans in rural areas 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.

Family physicians provide the majority of care for America's underserved and rural populations.[3] 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. Rural Health Policy Development and Outreach Grants fund innovative programs to provide healthcare in rural areas. State rural health offices, funded through the NHSC budget, help States implement these programs so that rural residents benefit as much as urban patients.

AAFP encourages the subcommittee to provide adequate funding in the fiscal year 2010 appropriation bill for the important programs administered by HRSA's Office of Rural Health to address the many unique health service needs of rural communities.

AGENCY FOR HEALTHCARE RESEARCH AND QUALITY (AHRQ)

The mission of AHRQ—to improve the quality, safety, efficiency, and effectiveness of health care for all Americans—closely mirrors 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 promoting healthcare safety, quality, and efficiency initiatives.

AHRQ—COMPARATIVE EFFECTIVENSS RESEARCH

One of the hallmarks of the patient centered medical home is evidence-based medicine. Comparative effectiveness research, which compares the impact of different options for treating a given medical condition, is vital to quality care. Studies comparing various treatments (e.g., competing drugs) or differing approaches (e.g., surgery and drug therapy) can inform clinical decisions by analyzing not only costs but the relative medical benefits and risks for particular patient populations.

AAFP commends the Congress for including $1.1 billion in ARRA for comparative effectiveness research which holds out the promise of reducing healthcare costs while improving medical outcomes.

AAFP respectfully suggests that the subcommittee provide at least $405 million for AHRQ in the fiscal year 2010 appropriations bill, an increase of $32 million above the fiscal year 2009 level.

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 2010 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.

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[3] 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.

A NATIONAL HEALTH CRISIS: DEMOGRAPHIC PROJECTIONS AND THE MENTAL DISORDERS OF AGING

With the baby boom generation nearing retirement, the number of older Americans with mental disorders is certain to increase in the future. By the year 2010, there will be approximately 40 million people in the United States older than the age of 65. More than 20 percent of those people will experience mental health problems.

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, associated with Alzheimer's disease, can increase 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. 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. Unless changes are made now, older Americans will face long waits, decreased choice, and suboptimal care.

In order to implement the IOM report, AAGP believes that there are several critical issues that this subcommittee should address:

IOM Study on Geriatric Mental Health Workforce

AAGP believes that the broad scope of the 2008 IOM study, while meeting a crucial need for information on the many issues regarding the health workforce for older adults, precluded the in-depth consideration of the workforce needed for treating mental illness. The study should be followed by a complementary study focused on the specific challenges in the geriatric mental health field. This study should follow up the general IOM study in two specific ways: it should examine the access and workforce barriers unique to geriatric mental healthcare services; and, in discussing possible alternative models of geriatric service delivery (such as medical homes, PACE programs, collaborative care models like those demonstrated in the IMPACT and PROSPECT studies), it should articulate the importance of integrating geriatric mental health services as intrinsic components. "The Retooling the Health Care Workforce for an Aging America Act," S. 245/H.R. 46, contains a provision mandating this additional study.

In discussions with AAGP, the senior staff of IOM suggested the following language for inclusion in the Labor, Health and Human Services, and Education, and Related Agencies appropriations bill:

The subcommittee provides $1,000,000 for a study by the Institute of Medicine of the National Academy of Sciences to determine the multi-disciplinary mental health workforce needed to serve older adults. The initiation of this study should be not later than 60 days after the date of enactment of this act, whereby the Secretary of Health and Human Services shall enter into a contract with the IOM to conduct a thorough analysis of the forces that shape the mental healthcare workforce for older adults, including education, training, modes of practice, and reimbursement.

Title VII Geriatric Health Professions Education Programs

The Bureau of Health Professions in the HHS Health Resources and Services Administration (HRSA) administers programs aimed to help to assure adequate numbers of healthcare practitioners for the Nation's geriatric population, especially in underserved areas.

The geriatric health professions program supports three important initiatives. The Geriatric Education Center (GEC) Program, within defined geographic areas, provides interdisciplinary training for healthcare professionals in assessment, chronic disease syndromes, care planning, emergency preparedness, and cultural competence unique to older Americans. The Geriatric Training for Physicians, Dentists, and Behavioral and Mental Health Professionals (GTPD Program) 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 geriatricians in junior faculty positions who are committed to teaching geriatrics in medical schools across the country. GACA recipients are required to provide training in clinical geriatrics, including the training of interdisciplinary teams of healthcare professionals. AAGP supports increased funding for these programs as a means to increase geriatric specialist healthcare providers.

Specifically, AAGP supports expanding the number of GECs across the Nation; expanding GEC grants to offer mini-fellowships in geriatrics to faculty members of health professions schools in all disciplines; enhancing GACA awards to support and retain clinician educators from a variety of disciplines as they advance in their careers; and providing full funding for the National Center for Workforce Analysis to analyze current and projected needs for healthcare professionals and paraprofessionals in the long-term care sector.

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; and $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.

As the NIMH utilizes the new funding from "The American Recovery and Reinvestment Act of 2009," it is necessary that a portion of those funds be used to invest in the future evidence-based treatments for our Nation's elders. Beginning in fiscal year 2010, 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.

As little emphasis has been placed on the development of new treatments for geriatric mental disorders, AAGP would encourage the 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 Accountability Office (GAO) study on spending by NIH on conditions and illnesses related to the mental health of older individuals. The 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 (CMHS)

It is critical that there be adequate funding for the mental health initiatives under the jurisdiction of the CMHS within the Substance Abuse and Mental Health Services Administration (SAMHSA). While research is of critical importance to a better future, the patients of today must also receive appropriate treatment for their mental health problems. The final SAMHSA budgets for the last 8 years have included $5 million for evidence-based mental health outreach and treatment to the elderly. AAGP urges an increase in funding from $5 million to $20 million for this essential program to disseminate and implement evidence-based practices in routine clinical settings across the States. Of that $20 million appropriation, AAGP believes that $10 million should be allocated to a National Evidence-Based Practices Program, which will disseminate and implement evidence-based mental health practices for older persons in usual care settings in the community. This program will provide the foundation for a longer-term national effort that will have a direct effect on the well-being and mental health of older Americans.

CONCLUSION

AAGP recommends:

—An IOM study on the geriatric mental health workforce to examine the access and workforce barriers unique to geriatric mental healthcare services and, to articulate the importance of integrating geriatric mental health services as intrinsic components;

—Increased funding for the geriatric health professions education programs under title VII of the Public Health Service Act;

—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.

PREPARED STATEMENT OF THE AMERICAN ASSOCIATION OF IMMUNOLOGISTS

The American Association of Immunologists (AAI), a not-for-profit professional society representing more than 6,000 of the world's leading experts on the immune system, appreciates having this opportunity to submit testimony regarding fiscal year 2010 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 and the field of immunology.[1] With approximately 83 percent of NIH's approximately $29 billion budget awarded to scientists throughout the United States and around the

[1] The majority of AAI members receive grants from the National Institute of Allergy and Infectious Diseases or the National Cancer Institute; some receive grants from the National Institute on Aging, the National Institute of Arthritis and Musculoskeletal and Skin Diseases, or other Institutes or Centers.

world, NIH funding advances not only immunological and biomedical research, but also regional and national economies.[2]

THE SCOPE AND IMPORTANCE OF IMMUNOLOGY

From infectious diseases including influenza, HIV/AIDS, malaria, smallpox, and the common cold, to chronic diseases like cancer, diabetes, rheumatoid arthritis, asthma, and lupus, the immune system plays a central role in human and animal health.[3] Whether protecting the body from disease—or causing it (as in the case of autoimmune disease or the rejection of transplanted organs)[4]—the immune system is critical to maintaining individual human life and pivotal to community and global public health.[5] Prevention, treatments, and cures depend on our understanding of a scientific field that is relatively new: although the first vaccine was developed in 1798 (to protect against smallpox), most of our basic understanding of the immune system has developed in the past 30–40 years, making immunology ripe for the many new discoveries that are unfolding every day. Emerging areas in immunology involve understanding the immune response to environmental threats, to pathogens that threaten to become the next pandemic, and to manmade and natural infectious organisms that are potential agents of bioterrorism (including plague, smallpox, and anthrax). For all of these urgent needs, basic research on the immune system provides a crucial foundation for the development of diagnostics, vaccines, and therapeutics.

RECENT IMMUNOLOGICAL DISCOVERIES

Immunologists are making significant advances in the development of treatments and vaccines against pernicious viruses such as influenza strains and HIV. Recently, commonalities were identified among the viruses causing seasonal flu, avian flu, and the 1918 pandemic flu, indicating that some of the antibodies will react against all these strains. Such antibodies could be developed for therapeutic use in the case of a flu outbreak. In studies on HIV, immunologists have also identified a unique small antibody fragment that is able to stop a broad range of HIV strains from entering their target cells. This offers hope for a therapy against HIV, which mutates too quickly to be responsive to most traditional vaccine strategies.

An explosion of research has followed the major recent discovery of the central role of the inflammasome in immunity. Inflammasomes are broadly important molecular complexes within cells that sense infections, environmental pollutants, and other "danger" signals and control the activation of the pro-inflammatory, hormone-like molecules interleukin-1 and interleukin-18. Although it may help protect against infection, inflammasome-induced interleukin-1 has also been found to be a key "offender" in many inflammatory and autoimmune diseases. Inhibitors of these inflammatory molecules have already demonstrated significant clinical efficacy in autoimmune diseases, gout, and inherited periodic fever syndromes and are being investigated in other illnesses given the potential of the inflammasome to be relevant to almost any type of disease.

Immunologists have made important progress against the increasing prevalence of childhood peanut allergies by developing a mouse model that is being used to study the basis of this allergy. They have also identified a possible treatment course that might reverse the resulting potentially life-threatening anaphylaxis.

Immunologists are also focusing research efforts in the area of cancer vaccines. Novel delivery strategies, to effectively present tumor antigens or portions of the tumors themselves, have allowed the redirection of the immune system to attack cancerous cells within the body. Other strategies that manipulate molecules (including

[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." NIH Website: http://www.nih.gov/about/NIHoverview.html (April 28, 2009)

[3] Research on the immune system is also of enormous benefit to pets and livestock.

[4] The immune system works by recognizing and attacking "foreign invaders" (e.g., 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 attacking and destroying the virus, bacterium, or tumor cell—or partially, resulting in a less serious illness. It is also responsible for the rejection responses observed following transplantation of organs or bone marrow. The immune system can malfunction, causing the body to attack itself, resulting in an "autoimmune" disease, such as Type 1 diabetes, multiple sclerosis, or rheumatoid arthritis.

[5] NIH funds research "on 'neglected infectious diseases' such as malaria, tuberculosis, and a host of tropical diseases—diseases that are most prevalent in low-income countries, and that are insufficiently researched by the drug industry." Testimony of Ron Pollack, Executive Director, Families USA, before the House Energy and Commerce Subcommittee on Health, hearing on "Treatments for an Ailing Economy: Protecting Health Care Coverage and Investing in Biomedical Research," November 13, 2008, page 4.

the inhibitory receptor CTLA4) on immune cells have shown remarkable clinical promise for melanoma and prostate cancer. In addition, our understanding of how tumors evade and suppress immunity is evolving, providing new options for therapy, such as altering the function of T-regulatory cells, which normally suppress immunity and thereby promote tumor growth.

Immunologists have also made significant progress in understanding autoimmune disease by discovering that furin, a catalytic enzyme, prevents some forms of systemic autoimmunity. Scientists have found that mice lacking this enzyme had overactive effector T cells as well as suppressive T cells with impaired activity, a key finding which may lead to treatment of autoimmune disease without suppressing basic immunity.

THE NIH BUDGET: GREAT PROMISE—AND GRAVE DANGER

AAI is very grateful to this subcommittee and the Congress for doubling the NIH budget from fiscal year 1999 to fiscal year 2003 and for addressing the extremely serious problem caused by post-doubling subinflationary budget increases through passage of both The American Recovery and Reinvestment Act of 2009 (ARRA), which provided $10.4 billion to NIH, and the fiscal year 2009 Appropriations Act, which provided a 3.2 percent ($938 million) budget increase more than fiscal year 2008. NIH is now in the extraordinary position of being able to fund many worthy projects that had been denied funding, to invest in modernizing and enhancing the Nation's research infrastructure, and to support scientific and administrative jobs that are crucial to the scientific enterprise. This infusion of funds, together with the exceptional commitment to advancing scientific research articulated by President Obama, is also giving our brightest young students the confidence and desire to pursue careers in biomedical research, a crucial factor in helping research advances today become cures tomorrow.

Passage of ARRA acknowledged the multi-faceted impact of investing in biomedical research and the NIH: improving individual and global health, and stimulating local and national economic activity and job creation. NIH has estimated that each NIH grant supports on average, "6 to 7 in-part or full scientific jobs."[6] Families USA, a not-for-profit consumer advocacy organization, has reported that (1) on average, each $1 of NIH funding going into a State generates more than twice as much in State economic output, and (2) in fiscal year 2007, NIH funding created and supported more than 350,000 jobs that generated wages in excess of $18 billion, with an average wage of $52,000 (nearly 25 percent higher than the average U.S. wage).[7]

While AAI—and the entire biomedical research community—is deeply grateful for ARRA's tremendous influx of funds and support, some of the constraints accompanying the ARRA funding (i.e., that the funds must be obligated by the end of fiscal year 2010 and must be used for immediate economic impact, including creating jobs) are somewhat inconsistent with the longer view and nature of science and the strong need for reliable, sustained funding. Although significant advances can be made in 2 years, few projects can be completed in that time. As such, AAI looks ahead with concern to future years, when advances poised to be made may not come to fruition should ARRA funds end without adequate regular appropriations to cushion the reduction. AAI's appropriations recommendations for fiscal year 2010 (and ultimately for 2011, though not offered here), are premised on that concern and designed to address that future.

AAI RECOMMENDS A 7 PERCENT BUDGET INCREASE FOR FISCAL YEAR 2010

AAI urges the subcommittee to increase the NIH budget by 7 percent in fiscal year 2010. Such an increase would help ensure that research and jobs supported by ARRA funds are not lost, and that ongoing research would be on track to reach its full potential even after the ARRA funding is spent. A 7 percent budget increase would also put NIH on the path that most scientists have long sought and urgently

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[6] Testimony of Raynard S. Kington, M.D., Ph.D., Acting Director, National Institutes of Health, Witness appearing before the House Subcommittee on Labor, Health and Human Services, and Education, and Related Agencies Appropriations Subcommittee, March 26, 2009. Dr. Kington was citing the NIH report: "Estimating the Number of Senior/Key Personnel Engaged in NIH Supported Research," study issued October 2008.

[7] "In Your Own Backyard: How NIH Funding Helps Your State's Economy," Families USA, (June 2008). The report cited numerous economic benefits of NIH funding, including: (1) The amount of new business activity generated ranged from $8.39 billion in California to $13 million in Wyoming; (2) In 14 States, NIH funding generated more than $1 billion in new business activity; 3) In 10 States, each $1 of NIH funding generated at least $2.26 in economic activity; and (4) In 6 States, more than 20,000 new jobs were created.

need: a path of predictable, sustained funding that stabilizes ongoing research projects and the overall research enterprise.

AAI also supports President Obama's request for an additional $1.5 billion to specifically address recent developments regarding the emergent H1N1 (swine) influenza virus. This is an important investment in pandemic preparedness, whether that pandemic proves to be influenza or a pathogen not yet predicted.

OTHER KEY ISSUES

Seasonal Influenza and Pandemics.—Seasonal influenza leads to an average of more than 200,000 hospitalizations and about 36,000 deaths nationwide annually. An influenza pandemic could occur at any time; a pandemic as serious as the 1918 pandemic could result in the illness of almost 90 million Americans and the death of more than 2 million.[8] While researchers and public health professionals must respond to emergent threats (such as the current concern related to the H1/N1 flu virus), 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 (cell based), and seeking optimized flu vaccines and delivery methods.

Bioterrorism.—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.

The NIH "Common Fund".—The NIH Reform Act of 2006 established within NIH a "Common Fund" (CF) to support trans-NIH initiatives. Although AAI recognizes the value of interdisciplinary research, the existence of the CF should not permit the funding of lesser quality 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.

The NIH Public Access Policy ("Policy").—AAI continues to believe that the Policy will duplicate, at great cost to NIH and to taxpayers, publications and services which are already provided cost-effectively and well by the private sector. Therefore, AAI respectfully requests that the subcommittee require that NIH publicly report on the cost to date of implementing the Policy (both voluntary and mandatory), and projected future costs (including all personnel, administrative, infrastructure and enforcement costs) incurred by the various NIH Institutes, Centers, and Offices involved.

Preserving High-quality Peer Review.—NIH's recent completion of its "Peer Review Self-Study" has resulted in the adoption and implementation of numerous changes to its internationally respected and highly successful peer review system. While AAI applauds this effort to address some legitimate problems with the system, AAI urges that NIH be required to conduct timely and transparent evaluation of all pilot projects and permanent changes, and provide ample opportunity for public comment.

Ensuring NIH Operations and Oversight.—AAI urges the subcommittee to ensure adequate funding for the NIH Research, Management, and Services (RM&S) account, which supports the management, monitoring, and oversight of all research activities. Particularly with the infusion and rapid dissemination of ARRA funds, NIH must be able to properly supervise and oversee its increasingly large and complex portfolio.

CONCLUSION

AAI greatly appreciates this opportunity to submit testimony and thanks the Chairman and members of the subcommittee for their strong support for biomedical research, the NIH, and the scientists who devote their lives to preventing, treating, and curing disease.

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[8] A report issued by Trust for America's Health ("Pandemic Flu and the Potential for U.S. Economic Recession") predicted that a severe pandemic flu outbreak could result in the second worst recession in the United States since World War II, resulting in a projected cost of $683 billion. (March 2007)

PREPARED STATEMENT OF THE AMERICAN ASSOCIATION OF NURSE ANESTHETISTS

FISCAL YEAR 2010 APPROPRIATIONS REQUEST SUMMARY

[Dollars in thousands]

	Fiscal year 2009 actual	Fiscal year 2010 budget	AANA fiscal year 2010 request
HHS /HRSA /BHPr Title VIII Advanced Education Nursing, Nurse Anesthetist Education Reserve.	Awaiting grant allocations—in fiscal year 2008 awards amounted to approximately $3,500.	Grant allocations not specified.	$4,000 for nurse anesthesia education
Total for Advanced Education Nursing, from Title VIII.	$64.44 for Advanced Education Nursing.	$64.44 for Advanced Education Nursing.	$79.55 for Advanced Education Nursing
Title VIII HRSA BHPr Nursing Education Programs.	$171,031	$263,403	$263,403

The AANA is the professional association for more than 40,000 Certified Registered Nurse Anesthetists (CRNAs) and student nurse anesthetists, representing more than 90 percent of the nurse anesthetists in the United States. Today, CRNAs are directly involved in delivering 30 million anesthetics given to patients each year in the United States. 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 20 years previous. (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 Certified Registered Nurse Anesthetists (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, and it is important to note that through continual improvements in research, education, and practice, nurse anesthetists are vigilant in their 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. In May 2003 at the beginning of "Operation Iraqi Freedom," 364 CRNAs were deployed to the Middle East to ensure military medical readiness capabilities. For decades, CRNAs have staffed ships, remote U.S. military bases, and forward surgical teams without physician anesthesiologist support. In addition, CRNAs predominate in rural and medically underserved areas and areas where more Medicare patients live. A recent analysis of the nurse anesthesia workforce, indicates that in 2006, 38 percent of nurse anesthesia graduates went to work in a Medically Underserved Area or for a Medically Underserved Population.

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 $79.55 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 $79.55 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. In fact, this funding 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.

The CRNA workforce is seeing a shortage in the clinical and educational setting. 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 2000–2008, 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 2,158 graduates in 2008. This growth is expected to continue. However, it is important to note that 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 in 2003 to gauge the impact of the title VIII funding. Of the 11 schools that had reported receiving competitive 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, the title VIII authorization previously providing such a reserve expired in September 2002. Third, 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. Lastly, 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 a growing coalition of nursing organizations, including the Americans for Nursing Shortage Relief (ANSR) Alliance and representatives of the nursing community, and others in support of the subcommittee providing a total of $263 million in fiscal year 2010 for nursing shortage relief through title VIII. This amount is the same as the President's request for 2010. However, AANA asks that of the $263 million, $79.55 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 2009 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

Last, 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 2010:

—*Centers for Disease Control and Prevention.*—$9 million for provider education and patient awareness activities; $8 million to promote private-sector healthcare solutions to injection safety and infection control problems; $9 million for detection and tracking in order to enable States to investigate outbreaks of hepatitis and other potential pathogens related to injection safety.

—*Agency for Healthcare Research and Quality (AHRQ).*—$10 million in general patient safety funds for the AHRQ's Ambulatory Patient Safety Program.

—*Department of Health and Human Services.*—$1 million to expand its current focus for reducing HAIs from hospitals to all healthcare settings, including outpatient facilities.

PREPARED STATEMENT OF THE AMERICAN ACADEMY OF OPHTHALMOLOGY

EXECUTIVE SUMMARY

The American Academy of Ophthalmology (AAO) requests a fiscal year 2010 National Institutes of Health (NIH) funding increase of at least 7 percent, to a level of $32.4 billion, which represents a modest 3 percent increase plus the biomedical inflation rate, estimated at 3.8 percent in fiscal year 2009. This increase is necessary to keep pace with inflation and rebuild the base, since NIH has lost 14 percent of its purchasing power during the past six funding cycles. AAO commends the congressional leadership's actions in fiscal year 2008 and 2009 to increase NIH funding, including the $150 million in the fiscal year 2008 supplemental dedicated to investigator-initiated grants, the $10.4 billion in 2-year stimulus NIH funding within the American Recovery and Reinvestment Act (ARRA), and the final fiscal year 2009 appropriations inflationary increase of 3.2 percent. However, NIH needs sustained and predictable funding to rebuild its base and support multi-year, investigator-initiated research, which is the cornerstone of the biomedical enterprise. Annual increases of at least 7 percent put NIH on a pathway to budget-doubling within

the next 10 years. Secure and consistent funding for biomedical research is integral to the Nation's economic and global competitiveness. NIH is a world-leading institution that must be adequately funded so that its research can reduce healthcare costs, increase productivity, and save and improve the quality of lives.

AAO requests that Congress make vision health a top priority by increasing National Eye Institute (NEI) funding by at least 7 percent, to a level of $736 million, in this year that NEI celebrates its 40th anniversary. Over the past 6 funding cycles, NEI lost 18 percent of its purchasing power. Despite funding challenges, NEI has maintained its impressive record of breakthroughs in basic and clinical research that have resulted in treatments and therapies to save and restore vision and prevent eye disease. NEI will be challenged further, as 2010 begins the decade in which more than half of the 78 million Baby Boomers will turn 65 and be at greatest risk for aging eye disease. Adequately funding the NEI is a cost-effective investment in our Nation's health, as it can delay, save, and prevent expenditures, especially to the Medicare and Medicaid programs.

Fiscal year 2010 funding at $736 million enables NEI to expand its impressive record of basic and clinical collaborative research that has resulted in treatments and therapies to save and restore vision.

NEI continues to be a leader in basic research—especially that which elucidates the genetic basis of ocular disease—and in translational research, as those gene discoveries can lead to development of diagnostics and treatments. NEI Director Paul Sieving, M.D., Ph.D., has reported that one-quarter of all genes identified to date through NEI's collaboration with the National Human Genome Research Institute (NHGRI) are associated with eye disease/visual impairment. Recent examples include:

—In 2005, NEI reported that gene variants of Complement Factor H (CFH), the protein product of which is engaged in the control of the body's immune response, are associated with increased risk of developing age-related macular degeneration (AMD), the leading cause of vision loss. NEI-funded researchers are now working on potential therapies, including the manufacture and use of a protective version of the CFH protein in an augmentation strategy similar to that of treating diabetes with insulin. This therapy is under development and expected to enter Phase I clinical safety trials in summer 2009.

—In March 2008, NEI-funded researchers announced that damage from both AMD and diabetic retinopathy was prevented and even reversed when the protein Robo4 was activated in mouse models that simulate the two diseases. Robo4 treated and prevented the diseases by inhibiting abnormal blood vessel growth and by stabilizing blood vessels to prevent leakage. Since this research into the "Robo4 Pathway" used animal models associated with these diseases that are already used in drug development, the time required to test this approach in humans could be shortened, expediting approvals for new therapies

—In late April 2008, researchers funded by the NEI and private funding organization Foundation Fighting Blindness reported on their use of gene therapy to restore vision in young adults who were virtually blind from a severe form of the neurodegenerative disease Retinitis Pigmentosa, known as Leber Congenital Amaurosis (LCA). Seven years earlier, the researchers shared on Capitol Hill results of a preclinical study of the same gene therapy, which at the time was successfully giving vision to dogs born blind with LCA. The subsequent human gene therapy trial validated the process of putting genes in the body to restore vision. Although the primary goal of the Phase I study was to ensure patient safety, the researchers reported through both objective and subjective testing that the patients were able to read several additional lines on an eye chart, had better peripheral vision, and better eyesight in dimly lit settings. In further research, the investigators will treat LCA patients as young as 8 years old, since they believe the most dramatic results will be seen in young children.

—In late 2008, NEI initiated its new NEI Glaucoma Human genetics collaBORation, known as NEIGHBOR, through which seven U.S. research teams will lead genetic studies of the disease. Glaucoma is called the "stealth robber of vision" as it often has no symptoms until vision is lost, and anywhere from 50–75 percent of individuals with it are undiagnosed. It is also the leading cause of preventable vision loss in African American and Hispanic populations, which emphasizes the vital nature of determining the genetic basis of this disease.

Fiscal year 2010 funding at $736 million enables NEI to fully fund new initiatives that more fully characterize eye disease.

NEI has been a leader in collaborative research, the use of networks to study diagnostics and treatments and their use in clinical settings, and in ocular epidemiology to characterize the nature and frequency of eye disease in diverse populations to better manage public health. In fiscal year 2008, NEI reported on/launched the

initial phase of three important new programs to characterize eye disease requiring adequate future funding.

—In early 2009, the NEI and the National Aeronautics and Space Administration (NASA) reported on the use of a compact fiber optic probe developed for the space program that has proven valuable as the first non-invasive early detection device for cataracts, the leading cause of vision loss worldwide. Using a laser light technique called dynamic light scattering (DLS), which was developed to analyze the growth of protein crystals in a zero-gravity environment, the probe measures the amount of light scattering by an anti-cataract protein called alpha-crystallin. The probe senses protein damage due to oxidative stress, a key process involved in many medical conditions including age-related cataract and diabetes, as well as Alzheimer's and Parkinson's disease.

—In late 2008, NEI launched a new research network, the Neuro-Ophthalmology Research Disease Investigator Consortium, or NORDIC. It will initially lead multi-site observational and treatment trials, involving nearly 200 community and academic practitioners, to address the risks, diagnosis, and treatment of two "rare" diseases: idiopathic intracranial hypertension (visual dysfunction due to increased intracranial pressure) and thyroid eye disease (also called Graves' disease, in which muscles of the eye enlarge and cause bulging of the eyes, retraction of the lids, double vision, decreased vision, and irritation). The NEI and NORDIC's Principal Investigator have already begun coordinating with the Department of Defense's (DOD) newly established Vision Center of Excellence (VCE) about the applicability of NORDIC research to combat-related eye injuries, especially those associated with Traumatic Brain Injury (TBI).

—There is currently almost no information on the prevalence, risk factors, and genetic determinants in Asian Americans—one of the fastest growing racial groups in the United States. Studies from East Asia have suggested that Asians have a spectrum of eye diseases different from that of White Americans, African Americans, and Hispanics. In late 2008, NEI launched the Chinese American Eye Study to characterize the extent of eye disease in Chinese Americans, the largest Asian subgroup in the United States. Participants 50 years and older will be evaluated for blindness, visual impairment, and eye disease. These results will add to the expanding body of knowledge about vision health disparities already characterized by NEI in the African-American and Hispanic populations.

Vision impairment/eye disease is a major public health problem that increases healthcare costs, reduces productivity, and diminishes quality of life.

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.

—In public opinion polls over the past 40 years, Americans have consistently identified fear of vision loss as second only to fear of cancer. As recently as March 2008, the NEI's Survey of Public Knowledge, Attitudes, and Practices Related to Eye Health and Disease reported that 71 percent of respondents indicated that a loss of their eyesight would rate as a "10" on a scale of 1 to 10, meaning that it would have the greatest impact on their day-to-day life.

In 2009, the NEI will celebrate its 40th anniversary as the NIH Institute that leads the Nation's commitment to save and restore vision. During the next decade, more than half of the 78 million Baby Boomers will celebrate their 65th birthday and be at greatest risk for developing aging eye disease. As a result, sustained, adequate Federal funding for the NEI is an especially vital investment in the health, and vision health, of our Nation as the treatments and therapies emerging from research can preserve and restore vision. Adequately funding the NEI can also delay, save, and prevent health expenditures, especially those associated with the Medicare and Medicaid programs, and is, therefore, a cost-effective investment.

AAO urges fiscal year 2010 NIH and NEI funding at $32.4 billion and $736 million, respectively, reflecting an at-least 7 percent increase more than fiscal year 2009.

ABOUT AAO

The American Academy of Ophthalmology is a 501c(6) educational membership association. AAO is the largest national membership association of eye M.D.s with more than 27,000 members, more than 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 AAO members.

PREPARED STATEMENT OF THE AMERICAN ACADEMY OF PHYSICIAN ASSISTANTS

On behalf of the more than 75,000 clinically practicing physician assistants in the United States, the American Academy of Physician Assistants is pleased to submit comments on fiscal year 2010 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 $300 million for title VII programs in fiscal year 2010, 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 more than 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 1990–2006 demonstrates that PAs who have graduated from PA educational programs supported by title VII are 59 percent more likely to be from underrepresented minority populations and 46 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 49 percent between 2004 and 2014. 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 2010 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 (HRSA) 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 $300 million in funding for fiscal year 2010, 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 2010 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.

Many challenges will arise as Americans age in increasing numbers. There are approximately 36 million Americans aged 65 and older. That group is expected to double in size within the next 20 years, at which time at least 20 percent of the U.S. population will be older than 65. Of particular concern is the dramatic growth that is anticipated among those aged 85 and older. By 2050, 19.4 million Americans will be older than the age of 85.

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. The Alliance strongly believes that with a relatively modest investment, further advances in the area of longevity science could yield tremendous health and economic benefits by shortening the period during which humans suffer from costly, debilitating diseases.

Within the NIH, the NIA leads research efforts to better understand the nature of aging and to maintain the health and independence of Americans as they grow older. The NIA supports a range of genetic, biological, clinical, social, and economic research related to aging and the diseases of the elderly. Through the Division of Aging Biology, the NIA funds research focused on understanding and exploiting the mechanisms underlying the aging process. Research supported by the Division of Aging Biology 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. Other noteworthy NIA-supported projects focus on increasing healthspan. These include studies to assess the beneficial effects of reducing caloric intake in animals, as well as those 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 also participates in multi-Institute collaborations on disease-specific research aimed at preventing, diagnosing, and more effectively treating age-related illnesses. Action to Control Cardiovascular Disease, led by the National, Heart, Lung, and Blood Institute in partnership with the NIA and three other NIH Institutes, is a large clinical trial of adults with type 2 diabetes who are at high risk for cardiovascular disease. The trial involves the aggressive testing of interventions to reduce the burden of cardiovascular disease in high-risk patients, many of whom are elderly. Major cardiovascular disease events result in death for 65 percent of diabetic patients and no effective preventative strategies currently exist for this vulnerable population. 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 trials for Alzheimer's therapies. As many as 5.3 million people have Alzheimer's disease and it drains more than $148 billion from the Nation's economy each year. 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, which was an NIH-supported clinical trial involving the NIA, continues to reveal information about diabetes onset, prevention an outcomes. It was initially intended to examine the effects of multiple interventions for adults at risk of type 2 diabetes. While it succeeded in identifying lifestyle changes that were particularly effective in the 60 and older population, it is the analysis of the long-term effects of these interventions on diabetes onset that could have the most impact on the 57 million adults who are at risk for developing the disease.

In general, the NIH is the primary funder of biomedical research in this country. Eighty percent of all the nonprofit medical research in the United States is funded by the NIH. But the unfortunate reality is that shrinking budgets have impeded progress. In part the scarcity of resources has resulted in a decline of the overall success rate for NIH research grant applications. At its lowest point only 1 in 4 research proposals could be funded by the NIH. The effect of this has been reluctance on behalf of new investigators to submit truly ground-breaking research proposals for consideration. While we recognize that there is enormous competition for congressional appropriations each year, a lack of sustained funding for the NIH will have a devastating impact on the rate of basic discovery and the development of interventions that could have the significant public health benefits for our aging population.

Until recent actions taken by Congress and the President to provide a short-term resource infusion through passage of the American Reinvestment and Recovery Act, funding for the NIH had been on a downward trajectory. In the 6 years through 2008, a series of nominal increases and cuts has amounted to flat funding for the NIH, and as a result it has lost as much as 17 percent of its purchasing power. Aging in particular is a field of research that had been hampered by this stagnant funding. 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.

The Alliance for Aging Research applauds Congress and the Obama administration's renewed focus on the importance of medical research in improving the overall health of the country. In order to demonstrate a strong commitment to bolstering science, we would recommend an increase in funding for the NIH of at least 7 percent in fiscal year 2010. This increase would begin to restore the NIH's ability to pursue new basic, translational, and clinical research opportunities. A $32.4 billion budget for the NIH in fiscal year 2010 would allow the NIA specifically to increase support of new and existing investigator initiated research projects and better facilitate the acceleration of discoveries for a wide range debilitating age-related diseases and conditions among our growing population of older 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 2010 appropriations for the NIH and we would be happy to furnish additional information upon request.

Prepared Statement of the American College of Obstetricians and Gynecologists

The American College of Obstetricians and Gynecologists (ACOG), 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 National Institutes of Health (NIH). The Nation has made important strides to improve women's health over the past several years, and ACOG is grateful to this subcommittee for its commitment to ensure that vital research continues to eliminate disease and to ensure valuable new treatment discoveries are implemented.

The American Recovery and Reinvestment Act (ARRA) made a sizeable down payment on healthcare programs that have been underfunded in recent years. The

$10.4 billion for the National Institutes of Health (NIH) and the commitment to comparative effectiveness research will help to foster innovation and convey best practices to physicians. While ACOG is thankful for the generous funding from the stimulus package, funds for NIH must be used within 2 years, limiting the ability of programs to be carried out to their completion.

An increase in funds through the regular appropriations process will help supplement programs supported by the stimulus package beyond the 2-year mark. The President's budget provides a modest increase of 1.4 percent, not enough to sustain the 19,000 grant applications that have been submitted in the wake of the stimulus, which will result in lower pay lines. Therefore, we urge the subcommittee to support an appropriation of at least $32.4 billion for NIH, a $2.1 billion increase (7 percent) for fiscal year 2010.

WOMEN'S HEALTH RESEARCH AT THE NIH

NIH Institutes work collaboratively to conduct women's health research. The Eunice Kennedy Shriver National Institute of Child Health and Human Development (NICHD) conducts the majority of women's health research, and has made critical accomplishments in preterm birth, contraceptive research, and infertility. The National Cancer Institute (NCI) has made monumental discoveries on gynecologic cancers, and the National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK) works with the NICHD to discover treatments for urinary incontinence. The Office of Research on Women's Health (ORWH) in the NIH Office of the Director coordinates women's health research projects and manages mentoring programs for new investigators.

Despite the NIH's critical advancements, reduced funding levels have made it difficult for research to continue, largely due to the lack of new investigators. The NIH advanced women's health research during the congressional doubling between fiscal year 1998 and fiscal year 2003, but funding increases have been so low since fiscal year 2003, the NIH budget is almost the same as it was before the doubling.

OFFICE OF THE DIRECTOR—OFFICE OF RESEARCH ON WOMEN'S HEALTH (ORWH)

Coordinating and Promoting Women's Health Research Throughout NIH

Established in September 1990, the Office of Research on Women's Health (ORWH) is a focal point for women's health research at the NIH.

The Building Interdisciplinary Research Careers in Women's Health (BIRCWH) is operated by the ORWH, and the Women's Reproductive Health Research (WRHR) Career Development Program at the NICHD. BIRCWH programs are expanding women's health research through career development, increasing diversity in the field of women's health, promoting interdisciplinary research training and developing independent researchers with backgrounds in high-priority women's health research areas. These programs attract new researchers, but low pay lines make it difficult for the NIH to maintain them.

The ORWH recently launched the NIH Women's Health Fellowships in Intramural Women's Health Research. This intramural program is funded through the Foundation of the NIH, which was established by Congress to maximize the resources at the NIH and support medical research through public-private partnerships. The fellowships are supported by donations from Battelle and AstraZeneca.

An ob-gyn resident at Loyola University, Chicago, Illinois, is one of the first recipients of the fellowship. She is studying the difference in severity and prevalence of fibroids in African American and white women. The Women's Health Fellowship helps new investigators enhance their research skills, and mentor women to senior positions in science.

ACOG urges Congress to increase funding for the ORWH to help prepare the next generation of women's health researchers and to maintain a high level of research innovation and excellence, in turn reducing the incidence of maternal morbidity and mortality and discovering cures for other chronic conditions.

NICHD

ACOG supports a $90.6 million increase (7 percent) in funds more than fiscal year 2009 for NICHD at NIH. These funds will assist research into the following areas:

Expanding Maternal Health Research

The Maternal Fetal Medicine Units (MFMU) Network investigates clinical questions in maternal fetal medicine and obstetrics, with a focus on preterm birth, and has advanced women's health research by making several monumental discoveries including using progesterone treatments to reduce preterm birth. The MFMU is

working at 14 sites across the United States to reduce the risks of preterm birth, cerebral palsy, and pre-eclampsia (high blood pressure).

Reducing the Prevalence of Premature Births

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.

The 2008 Surgeon General's Conference on the prevention of preterm birth brought together experts from the public and private sectors to discuss key research findings and to develop an agenda to mitigate the problem of prematurity. The conference concluded by calling on the surgeon general to make the prevention of preterm birth a national public health priority. ACOG supports this effort and urges Congress to recognize the importance of new research to identify the causes and effective interventions for preterm births.

Improving Contraceptive Research

The United States has one of the highest unintended pregnancy rates of the industrialized nations. Of the approximately 6 million pregnancies each year, an estimated one-half is unintended. Contraceptive use saves as much as $19 billion in healthcare costs annually. Research has found that oral contraceptives are less effective in overweight and obese women, yet the causes are unknown. It is critical that Congress continue to invest in contraceptive research, ensuring that women have access to safe and effective contraceptives to help them time and space their pregnancies. The NICHD's research on male and female contraceptives can help reduce the number of unintended pregnancies and abortions, and improve women's health.

National Cancer Institute (NCI)

Developing Gynecologic Cancer Research, Prevention, and Education

—*Effects of Cervical Procedure on Pregnancy*.—At the Washington University School of Medicine, St. Louis, Missouri, researchers are studying the impact of the Loop Electrosurgical Excision Procedure (LEEP), which is a common treatment for abnormal cells on the cervix, on subsequent pregnancy. This study may determine whether LEEP increases the risk of preterm birth and other adverse pregnancy outcomes.

—*Stress and Ovarian Cancer*.—At the University of Texas, MD Anderson Cancer Center, Houston, Texas, researchers are examining the effects of chronic stress on growth and progression of ovarian cancer along with underlying mechanisms. Based on these results, researchers hope to gain a better understanding of the adverse effects of chronic stress and discover new strategies for blocking its harmful effects on cancer patients.

—*Pediatric Cancer Survivor Fertility*.—There are currently more than 250,000 childhood cancer survivors in the United States, and while cancer therapies improve long-term survival, such treatments may impair fertility potential and cause premature ovarian failure. Research at the University of Pennsylvania—Philadelphia, Philadelphia, will provide preliminary data for the establishment of a long-term study of pediatric cancer survivors and their pregnancy rates, pregnancy outcomes and the occurrence of premature menopause.

Expanding Ovarian Cancer Research

Despite the women's health research advancements at the NCI, much more needs to be done. According to the NCI, there will be 22,430 new cases of ovarian cancer and 15,280 deaths from ovarian cancer in the United States in 2007. With more ovarian cancer biomarker research, we may reduce ovarian cancer. ACOG urges Congress to pass the Ovarian Cancer Biomarker Act, S. 2569/H.R. 3689, which would increase funding for research and clinical centers at the NCI for risk stratification, early detection, and screening of ovarian cancer.

INCREASING GYNECOLOGIC CANCER EDUCATION

Public and provider education on gynecologic cancers is critical to early detection. When women and their doctors understand the symptoms and risk factors of gynecologic cancers they can find appropriate medical help quickly, increasing the potential for earlier detection. ACOG urges Congress to fully fund Johanna's Law,

Public Law 109–475, at $10 million in fiscal year 2009, which would increase provider and public education on gynecologic cancers, saving thousands of lives.

NIDDK

Exploring Treatments for Urinary Incontinence

The Urinary Incontinence Treatment Network (UITN) at the NIDDK and the NICHD, researches urinary incontinence treatments. The UITN clinical trials compare the outcomes of commonly used surgical procedures, drug therapies, and behavioral treatments for incontinence.

—*The Trial of Mid-urethral Slings*.—Researches the outcomes of surgical procedures to treat stress urinary incontinence. Although these surgical procedures are approved by the Food and Drug Administration, researchers are investigating which are more effective.

—*The Stress Incontinence Surgical Treatment Efficacy Trial*.—Studies the long-term outcomes of commonly performed stress urinary incontinence treatment surgeries. The Burch procedure and the sling produce have estimated cure rates of 60 percent –90 percent, and researchers are determining which produces the best long-term outcome.

—*The Behavior Enhances Drug Reduction of Incontinence*.—Studies whether adding behavioral treatment to drug therapy makes it possible to discontinue drug treatment, and still maintain a reduced number of incontinence accidents.

ACOG urges Congress to increase funding for critical women's health research at the NIDDK.

Again, we would like to thank the subcommittee for its continued support of programs to improve women's health, and urge Congress to increase funding for the NIH and its Institutes 7 percent more than fiscal year 2009 levels in fiscal year 2010.

PREPARED STATEMENT OF THE AMERICAN COLLEGE OF PHYSICIANS

Chairman Harkin and Ranking Member Cochran, thank you for allowing the American College of Physicians (ACP) to share our views on the Department of Health and Human Services budget for fiscal year 2010.

ACP represents 126,000 internal medicine physicians, residents, and medical students. ACP is also the Nation's largest medical specialty society and its second largest physician membership organization.

Today, ACP is urging the following funding levels:

—Title VII and title VIII programs, under the Public Health Service Act, $550 million;

—National Health Service Corps (NHSC), $235 million;

—Agency for Healthcare Research and Quality (AHRQ), $405 million; and

—National Institutes of Health (NIH), at minimum a 7 percent increase more than the fiscal year 2009 baseline.

PRIMARY CARE WORKFORCE

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 primary care specialties steadily declines. The reasons behind this decline in primary care physician supply are multi-faceted and complex. Key factors include the rapid rise in medical education debt, decreased income potential for primary care physicians, failed payment policies, and increased burdens associated with the practice of primary care.

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 the fact that primary care is known to improve health outcomes, increase quality, and reduce healthcare costs.

There are many regions of the country that 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. To help alleviate the shortage of primary care physicians, we believe sufficient funding should be provided for title VII and title VIII programs, as well as NHSC.

TITLE VII AND TITLE VIII PROGRAMS

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, 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. ACP was pleased that the American Recovery and Reinvestment Act (ARRA, Public Law 111–5) provided a down payment of $200 million for title VII and title VIII programs.

NHSC, along with the Health Professions and Nursing Education Coalition, is recommending that these programs require at least $550 million to adequately educate and train a healthcare workforce that meets the public's healthcare needs. This amount includes restoration of title VII to at least the fiscal year 2005 level (close to $300 million).

Lower funding or elimination of title VII programs will have an immediate impact on the training and recruitment of health professions students and the educational infrastructures developed and supported by title VII. It is important to note that these programs are unique in that they are the only federal investment in interdisciplinary training, which is vitally important as care is often provided in interdisciplinary settings. These programs are also designed to enhance minority representation in the healthcare workforce, which is essential when it comes to providing access to care as minority providers are more likely than others to care for underserved populations and help reduce the shortages in these specific areas. Moreover, not only does this funding support essential training programs, it also facilitates the delivery of care to the underserved areas of the country through the Area Health Education Centers and Health Education and Training Centers.

As the Nation's healthcare delivery system undergoes rapid and dramatic changes, an appropriate supply and distribution of health professionals has never been more essential to the public's health. The title VII and title VIII programs are critical to help institutions and programs respond to these current and emerging challenges and ensure that all Americans have access to appropriate and timely health services.

NHSC

In conjunction with other stakeholders, ACP is recommending a combined appropriation of $235 million for NHSC. We are pleased the ARRA provided an additional $300 million, which will enable 4,200 more clinicians to access the scholarship and loan repayment programs.

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. Over the years, the number of clinicians in those programs has grown from 180 to more than 4,000. 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. 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 NHSC estimates that nearly 50 million Americans currently live in health professions shortage areas (HPSAs)—underserved communities which lack adequate access to primary care services—and that 27,000 primary care professionals are needed to adequately serve the people living in HPSAs. Currently, more than 4,000 NHSC clinicians are caring for nearly 4 million people. The outstanding need remains unmet.

Limited funding has reduced new NHSC awards from 1,570 in fiscal year 2003 to an estimated 947 in fiscal year 2008, a nearly 40 percent decrease. The NHSC scholarship program already receives 7 to 15 applicants for every award available. 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.

AHRQ

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 supports a fiscal year 2010 budget allocation of $405 million for AHRQ. This amount will allow AHRQ to carry out its congressional mandate to improve healthcare quality and reduce costs by identifying which treatments work best and at what cost. ACP's request of an additional $32 million more than the fiscal year 2009 funding level would be designated for increased research in patient safety, health information technology, resources for research into the causes of and solutions to raising healthcare costs, chronic care management, and strategies to translate research into practice.

The additional $32 million will allow AHRQ to expand its investigator-initiated research program, a critically important element of our Nation's healthcare research effort. This funding stream provides for many clinical innovations—innovations that improve patient outcomes. It will also facilitate the translation of research into clinical practice and disease management strategies, and address 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.

ACP was pleased that the ARRA provided AHRQ with $300 million for comparative clinical effectiveness research. This funding, along with an additional $400 million for the Office of the Director of the NIH and $400 million to the Secretary of Health and Human Services, will stimulate the development of comparative effectiveness research and provide a good foundation for the establishment of the recommended, national comparative effectiveness entity. Furthermore, the act prohibits the Government from using the research for making any coverage or payment decisions or issuing clinical guidelines. The sole purpose is to develop this research and disseminate the results to all stakeholders.

NIH

Together, the fiscal year 2009 omnibus and the ARRA provided $38.5 billion to NIH, which will fund more than 16,000 new research grants for live-saving research into diseases such as cancer, diabetes, and Alzheimer's.

In his budget, the President envisions doubling our investment in basic research. Consistent with his proposal, we respectfully urge the subcommittee to increase funding for NIH by at least 7 percent more than the fiscal year 2009 baseline.

CONCLUSION

Mr. Chairman and Ranking Member Cochran, thank you for the opportunity to offer testimony on the importance of the Department of Health and Human Services budget for fiscal year 2010.

In conclusion, ACP would like to reiterate ACP's recommended funding levels:

—Title VII and title VIII programs, under the Public Health Service Act, $550 million;

—NHSC, $235 million;

—AHRQ, $405 million; and

—NIH, at minimum a 7 percent increase more than the fiscal year 2009 baseline.

The United States must invest in these programs in order to achieve a high-performance healthcare system. ACP greatly appreciates the support of the subcommittee on these issues and looks forward to working with Congress as you being to work on the fiscal year 2010 appropriations process.

PREPARED STATEMENT OF THE AMERICAN COLLEGE OF PREVENTIVE MEDICINE

Each year, 50,000 Americans die violent deaths. Homicide and suicide are, respectively, the third and fourth leading causes of death for people aged 1–39 years. An average of 80 people take their own lives every day.

Before the National Violent Death Reporting System (NVDRS) was created, Federal and State public health and law enforcement officials collected valuable information about violent deaths, but lacked the ability to combine it into one comprehensive reporting system. Instead, data was held in a variety of different systems, and policymakers lacked the clear picture necessary to develop effective violence prevention policies.

When it was created in 2002, NVDRS promised to capture data that is critical to identifying patterns and developing strategies to save lives. With a clearer picture of why violent deaths occurs, law enforcement and public health officials can work together more effectively to identify those at risk and provide effective preventive services.

Currently, NVDRS funding levels only allow the program to operate in the following 17 States: Alaska, California, Colorado, Georgia, Kentucky, Maryland, Massachusetts, New Jersey, New Mexico, North Carolina, Oklahoma, Oregon, Rhode Island, South Carolina, Utah, Virginia, and Wisconsin. Nine additional States, plus the District of Columbia were previously approved for participation in the NVDRS, but were unable to join due to funding shortfalls: Connecticut, Illinois, Maine, Michigan, Minnesota, New York, Ohio, and Texas. Several other States have expressed an interest in joining once new funding becomes available.

While NVDRS is beginning to strengthen violence and suicide prevention efforts in the 17 participating States, many other States have been forced to sit idle until additional funding is allocated. With the inclusion of $7.5 million for NVDRS in fiscal year 2010, NVDRS will be able to expand to additional States and continue its incremental growth toward national implementation.

NVDRS PROVIDES CRITICAL DATA FOR SUICIDE PREVENTION

Although it is preventable, more than 30,000 Americans die by suicide each year, and another 1.8 million Americans attempt it, costing more than $3.8 billion in hospital expenses and $13 billion in lost earnings.

In the United States today, there is no comprehensive national system to track suicides. However, because NVDRS includes information on all violent deaths—include deaths by suicide—information from the system can be used to develop effective suicide prevention plans at the community, State, and national level.

Among the ways NVDRS data is being used to inform suicide prevention programs: NVDRS data from 13 States uncovered significant racially and ethnically based differences in mental illness diagnoses and treatment among those who died by suicide. Specifically, whites were more likely to have been diagnosed with depression or bipolar disorder, while blacks were more likely than other groups to have been diagnosed with schizophrenia. Hispanics were less likely to have been diagnosed with a mental illness or to have received treatment at all, although the family reports of depression were comparable to other racial groups. Additionally, NVDRS data from all 17 States show that veterans accounted for 26 percent of males who died by suicide in 2004. While veterans also accounted for 26 percent of the male U.S. population, this finding points to the importance of veterans' services to potentially identify and treat at-risk individuals.

With such information available for the first time, officials in participating States are using NVDRS data in myriad ways. For example,

—With the sixth-highest rate of elder suicide in the Nation, Oregon tailored its NVDRS data to develop an epidemiological profile of victims and establish an elder suicide prevention plan. NVDRS data indicated that most victims of elder suicide in Oregon had been suffering from physical illness, and that 37 percent had visited a doctor in the 30 days prior to their death. As a result of this NVDRS data, the State developed an elder suicide prevention plan that calls for better integration of primary care and mental health services, so that potential suicide victims can be better identified and treated. The plan also calls for training primary healthcare providers, integrating mental healthcare into primary care, and educating family members about the risks of suicide and warning signs of depression.

—NVDRS data found that 1 in 4 of Virginia's suicide victims had served in the military. Among male victims older than 65, more than 60 percent were veterans. These findings indicate that the State's suicide prevention and education efforts must extend to veterans' hospitals and service providers.

—NVDRS data provides State health officials in South Carolina with vital information that indicates behavior patterns, enables health officials to identify individuals at risk, and to intervene early with appropriate preventive measures. After NVDRS data showed that more than 40 percent of suicide victims were currently or formerly receiving mental health treatment or tested positive for psychiatric medication, the State established its first ever suicide prevention plan, which also included the formation of a Suicide Prevention Task Force.

NVDRS PROVIDES CRITICAL DATA TO PROTECT CHILDREN AND ADOLESCENTS

Child abuse and other violence involving children and adolescents remains a problem in America, and it is only through a comprehensive understanding of its root

causes that many needless deaths can be prevented. Studies suggest that between 3.3 and 10 million children witness some form of domestic violence annually. Additionally, 1,387 children died as a result of abuse or neglect in 2004, according to the Federal Administration on Children, Youth, and Families, part of the Department of Health and Human Services.

Children are most vulnerable and most dependent on their caregivers during infancy and early childhood. Sadly, NVDRS data has shown that young children are at the greatest risk of homicide in their primary care environments. Combined NVDRS data from Alaska, Maryland, Massachusetts, New Jersey, Oregon, South Carolina, and Virginia determined that African American children 4 years old and younger are more than four times more likely to be victims of homicide than Caucasian children, and that homicides of children 4 and under are most often committed by a parent or caregiver in the home. The data also shows that household items, or "weapons of opportunity," were most commonly used, suggesting that poor stress responses may be factors in these deaths. Knowing the demographics and methods of abusers can lead to more effective, targeted prevention programs.

Other examples of how NVDRS data is informing programs to protect children and adolescents from violence, include the following:

—Data from NVDRS pilot sites in Connecticut, Maine, Utah, Wisconsin, Pennsylvania, and California found that almost 30 percent of suicide victims age 17 and under told someone they felt suicidal. Many teen suicides also appear to be linked to recent events in their lives, with nearly one-third of suicides taking place on the same day as a crisis and almost half within the same week. This data underscores the importance of developing community-based programs to rapidly respond to the warning signs of suicide.

—With data generated by NVDRS, State health officials in Massachusetts have been able to monitor suicides and homicides more accurately among specific populations, such as foster children and youths in custody. The NVDRS data has been used to secure grants for violence prevention programs for these special populations, about whom data had previously been impossible to obtain.

NVDRS PROVIDES CRITICAL DATA TO PREVENT INTIMATE PARTNER VIOLENCE

While intimate partner violence has declined along with other trends in crime over the past decade, thousands of Americans still fall victim to it every year. Women are much more likely than men to be killed by an intimate partner. Intimate partner homicides accounted for 33.5 percent of the murders of women and less than four percent of the murders of men in 2000, according to the Bureau of Justice Statistics.

Although the program is still in its early stages, NVDRS is providing critical information that is helping law enforcement and health and human service officials allocate resources and develop programs in ways that target those most at risk for intimate partner violence, thereby preventing needless deaths. For example, NVDRS data shows that while occurrences are rare, most murder-suicide victims are current or former intimate partners of the suspect, and a substantial number of victims were the suspect's children. In addition, NVDRS indicates that women are about seven times more likely than men to be killed by a spouse, ex-spouse, lover, or former lover, and the majority of these incidents occurred in the women's homes

Examples of how State officials are using NVDRS data to better understand and prevent intimate partner violence include:

—Based on an analysis of NVDRS data, the Kentucky Injury Prevention Research Center concluded that among women killed by an intimate partner, only 39 percent had had filed for a restraining order or been seen by or reported to Adult Protective Services. This finding underscored a perceived need in the community to improve outreach linking potential victims to local protective services.

—Working with the State's NVDRS program, the Alaska Department of Law and Public Safety found there is a high risk for intimate partner violence, both homicide and suicide, when one partner is attempting to leave the relationship. Findings such as this one are molding the State's strategy for domestic violence prevention.

STRENGTHENING AND EXPANDING NVDRS IN FISCAL YEAR 2010

At an estimated annual cost of $20 million for full implentation, NVDRS is a relatively low-cost program that yields high-quality results. While State-specific information provides enormous value to local public health and law enforcement officials, national data from all 50 States, the U.S. territories and the District of Columbia must be obtained to complete the picture and establish effective national violence prevention policies and programs.

That is why the National Violence Prevention Network, a coalition of national organizations who advocate for health and welfare, violence and suicide prevention, and law enforcement, is calling on Congress to provide no less than $7.5 million for NVDRS for fiscal year 2010. The cost of not implementing the program is much greater: without national participation in the program, thousands of American lives remain at risk.

PREPARED STATEMENT OF THE AMERICAN COLLEGE OF PREVENTIVE MEDICINE

RECOMMENDATION

The American College of Preventive Medicine (ACPM) urges the Labor, Health and Human Services, and Education, and Related Agencies Appropriations Subcommittee to reaffirm its support for training preventive medicine physicians and other public health professionals by providing $10.1 million in fiscal year 2010 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 $550 million be appropriated in fiscal year 2010 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".[15] 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.

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

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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.

[15] Training Physicians for Public Health Careers. Institute of Medicine. National Academies Press, June 2007.

[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.

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 pubic 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 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.

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.[9]

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.[10]

—Between 1999 and 2006, the number of residents enrolled in preventive medicine training programs declined nearly 20 percent.[11]

—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-

[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] Health Professions and Nursing Education Coalition. Recommendation for Fiscal Year 2007. March 2006.

[10] American Medical Association (AMA). Physician Characteristics and Distribution in the U.S. 2004, Table 5.2, p. 323.

[11] AMA. Graduate Medical Education Database. Copyright 1994–2005, Chicago, IL.

[12] 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.

existent.[12] 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 (such as the Armed Services) or who do not have specific interests in areas for which limited stipends are available (such as research in cancer prevention).

HRSA—as authorized in title VII of the Public Health Service Act—is a critical funding source for several preventive medicine residency programs. HRSA funding ($1.1 million in fiscal year 2008) currently supports only about 20 physicians in 5 preventive medicine training programs,[13] yet it represents the largest Federal funding source for public health and general preventive medicine (PH/GPM) programs. Funding is in steady decline; in fiscal year 2002 the level was $1.9 million.

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.[16]

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 guide 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

SUMMARY OF RECOMMENDATIONS FOR FISCAL YEAR 2010

Works towards fully funding the emerging Clinical and Translational Science Awards (CTSA) program by a providing $532 million of support. Continued support for the NIH K-awards for the training of research scientists. Continued emphasis on the importance of Comparative Effectiveness Research (CER).

Association for Clinical Research Training (ACRT) is committed to improving the Nation's health by increasing the amount and quality of clinical research through the expansion and improvement of clinical research training. This training is funded

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[12] 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.

[13] http://bhpr.hrsa.gov/publichealth/preventive/index.htm. Preventive Medicine Residency Training Grants.

[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.

[16] Percentage of ACGME Residents/Fellows Who are Black, Native American or Native Hawaiian by Speciality. AAMC/AMA National GME census, October 2008.

by both the National Institutes of Health (NIH) and the Agency for Healthcare Research and Quality (AHRQ).

The National Alliance of Socieities for Clinical Research Resources (NASCRR) is comprised of the national organizations that provide leadership in the field of clinical and translational medical research. NASCRR coalesces around areas of common concern for the entire community and works in support of the mission of the National Center for Research Resources (NCRR).

Let me begin by thanking the subcommittee for showing a strong commitment to improving public health through the recently passed fiscal year 2009 omnibus appropriations package. The legislation included $938 million for NIH; the first meaningful funding increase to the agency's baseline budget in many years. ACRT applauds the subcommittee for its role in securing this funding, and we hope that significant funding increases for NIH and other public health programs will continue in subsequent fiscal years.

Clinical research is an increasingly important component of medical research. A large, well-trained workforce is required to ensure that breakthroughs in bioscience are translated into improved treatment options for patients. Currently, the field of clinical research is facing the same work-force shortage and retention issues felt throughout the medical research community. Additionally, clinical investigators undertake comparative effectiveness research activities and as investment in this area is increased, it stands to reason that the present pressures on the clinical research community will be exacerbated. Commitments to increase funding for clinical research training activities and programs must be made to ensure that in the future, the workforce is robust and capable of improving the public health in an effective and expeditious manner.

THE IMPORTANCE OF FULLY FUNDING THE CTSA PROGRAM.

The CTSA program is a critical effort to modernize this Nation's clinical and translational research infrastructure, and bring the entire field of medical research into the 21st century. To accomplish this task, the program has identified four important goals; improving the way biomedical research is conducted across the country, reducing the time it takes for laboratory discoveries to become treatments for patients, engaging communities in clinical research efforts, and training the next generation of clinical and translational researchers.

The CTSA program is intended to assist institutions in creating a home for clinical and translational science. The program started with 12 academic health centers located throughout the Nation, and the NIH's plan for the CTSAs will ultimately link 60 institutions together to energize the discipline of clinical and translational science. Currently, there are 38 CTSA sites.

Recent years of near-level funding for NIH have hampered NCRR's budget and drained the pool of resources that could be committed to supporting the growing CTSA network.

NCRR has to reduce the size of awards by about half in some instances. NCRR does not have the funds necessary to support 60 sites.

When applying to be part of the CTSA network, institutions had to identify the types of programs and research they would be conducting. The proposals that were deemed meritorious were subsequently funded, but in most cases at a reduced level.

While we applaud the funding for NCRR that was provided through the economic stimulus package, this additional money has created a frustrating situation for CTSA-recipients. Presently, NCRR and other NIH Institutes, Centers, and Offices are holding competitions and accepting proposals to allocate the stimulus funds. Many of the research activities which are being proposed are very similar to activities the CTSA's already outlined in their initial peer-reviewed applications, but have been unable to undertake due to a lack of funding. In fact, many CTSA's are simply peeling off the programs which have been approved, but unfunded and redundantly competing for stimulus funds. Trying to fully fund CTSA activities in this manner is overly complicated and inefficient.

The CTSA program is currently funded at just under $475 million. You will note from the attached professional judgment provided by NCRR that to facilitate appropriate implementation, the program requires a funding level of $532 million in fiscal year 2010. Additionally, this document states that to fully implement the program and support a network of 60 centers by 2011, a funding level of $669 million is required.

It is our recommendation that the subcommittee work towards full implementation of the CTSA program by providing $532 million in support for fiscal year 2010.

THE IMPORTANCE OF CONTINUING TO SUPPORT THE K-AWARDS PROGRAM

As the CTSA program is rolled out, it is meant to subsume the activities of other NCRR programs, such as the K–30 Clinical Research Curriculum Awards (CRCA). However, while flat budgets slowed implementation of the CTSA network, the phasing out of K–30 awards continued on unimpeded. Last year the subcommittee showed strong leadership and urged NCRR to continue the CRCA program for those institutions that had not yet received a CTSA. I am pleased to inform you that the NCRR has complied with this request, and recently the Center issued the K–30 recompetition notice. Thank you for taking an interest in clinical research training and please continue to do so moving forward.

K–30 awards remain an exceedingly cost-effective approach to improving the quality of training in clinical research. This efficiency is seen throughout the larger K-award program which has many mechanisms that go beyond the scope of the K–30's to provide support for career development for individual researchers. Highly trained clinical researchers are needed in order to capitalize on the many profound developments and discoveries in basic science and to translate them to clinical settings at all research institutions.

While the K–30 awards are primarily funded by NCRR, these individualized K-awards, like the K–23 Mentored Patient-Oriented Research Career Development Awards and the K–24 Midcareer Investigator Awards in Patient-Oriented Research are administered by many NIH Institutes and Centers. K–23 awards support the career development of investigators who have made a commitment to focus their research endeavors on patient-oriented research. The purpose of K–24 awards is to provide support to mid-career health-professional doctorates that are typically at the Associate Professor level for protected time to devote to patient-oriented research and to act as research mentors primarily for clinical residents, clinical fellows and/or junior clinical faculty.

The universe of K-awards is vast and also includes K–01 Mentored Research Scientist Development Awards and K–08 Mentored Clinical Scientist Development Awards, amongst others. All of these awards mechanism fill a critical research training niche. As the role of the clinical investigator gains prominence, it is important to begin raising awareness of these mechanisms and to bolstering their support.

We ask the subcommittee to emphasize its interest in the K-award programs and to urge NIH to continue to provide adequate support for K-awards moving forward.

THE IMPORTANCE OF CONTINUING TO SUPPORT CER

The American Recovery and Reinvestment Act of 2009 contained $1.1 billion for CER activities at NIH and AHRQ. NIH has been conducting critical CER for some time and we are pleased that Congress is beginning to appreciate the importance of these activities.

Within the $1.1 billion allocation for CER, $400 million was provided to NIH. CTSA program recipients should compete well for a portion of these funds as many sites consider CER a crucial component of clinical and translational research. Additionally, the CTSA network is intended to be a collaborative endeavor capable of leveraging great resources to maximize productivity. As CER gains prominence, we hope the Subcommittee will recognize the CTSA network as an ideal home for comparative effectiveness research activities.

CER is just one example of how the role of the clinical investigator is becoming more critical in a modern healthcare system. However, without bolstering clinical research training opportunities we will not be able to properly prepare the next generation of clinical researchers. This will slow hinder our Nation's capability to stay on the cutting edge of medical research and slow the development of new treatment options for patients.

We ask the subcommittee to continue to appreciate and support CER activities at NIH and AHRQ. We also ask that concurrently the subcommittee express its interest in expanding clinical research training opportunities at both NIH and AHRQ.

Thank you for this opportunity to present the views and recommendations of the clinical research training community.

ADDENDUM

National Institutes of Health—National Center for Research Resources (NCRR)

CTSA/GCRC ESTIMATE PER CURRENT MODEL

[Dollars in millions]

Cohort	No.	Fiscal year 2009	Fiscal year 2010	Fiscal year 2011
Fiscal year 2006 Grants [1]	12	$140	$140	$116
Fiscal year 2007 Grants [1]	12	120	121	121
Fiscal year 2008 Grants [1]	14	107	107	107
Fiscal year 2009 Grants [1]	5	36	36	36
Fiscal year 2010 Grants [1]	2		14	14
Fiscal year 2011 Grants [1]	15			100
Total, CTSA Grants	60	403	418	494
CTSA Support Contract		3	3	3
K30 Recompetition			5	1
Total, CTSAs		406	426	497
GCRCs		69	41	3
Total, CTSAs/IGCRCs		475	467	500

[1] UL1, KL2, TL1 awards.

CTSAI/GCRC ESTIMATE IF REQUESTED AMOUNT AWARDED

[Dollars in millions]

Cohort	No.	Fiscal year 2009	Fiscal year 2010	Fiscal year 2011
Fiscal year 2006 Grants [1]	12	$140	$140	$140
Fiscal year 2007 Grants [1]	12	158	158	158
Fiscal year 2008 Grants [1]	14	155	155	155
Fiscal year 2009 Grants [1]	5	50	50	50
Fiscal year 2010 Grants [1]	2		21	21
Fiscal year 2011 Grants [1]	15			142
Total, CTSA Grants	60	503	524	[2] 666
CTSA Support Contract		3	3	3
K30 Recompetition			5	1
Total, CTSAs		506	532	669
GCRCs		69	41	3
Total, CTSAs/IGCRCs		575	573	672

[1] UL1, KL2, TL1 awards.
[2] It would cost $666 million to fund 60 CTSAs at the amounts requested by the institutions, which is $166 million more than the $500 million budget.

DIFFERENCE

[Dollars in millions]

Cohort	No.	Fiscal year 2009	Fiscal year 2010	Fiscal year 2011
Fiscal year 2006 Grants [1]	12			[2] $24
Fiscal year 2007 Grants [1]	12	38	$37	37
Fiscal year 2009 Grants [1]	14	$48	48	48
Fiscal year 2009 Grants [1]	5	14	14	14
Fiscal year 2010 Grants [1]	2		7	7
Fiscal year 2011 Grants [1]	15			42
Total, CTSA Grants	60	100	106	172
CTSA Support Contract				

DIFFERENCE—Continued

[Dollars in millions]

Cohort	No.	Fiscal year 2009	Fiscal year 2010	Fiscal year 2011
K30 Recompetition				
Total, CTSAs		100	106	172
GCRCs				
Total, CTSAs/IGCDCs		100	106	172

[1] UL1, KL2, TL1 awards.
[2] It would cost an additional $100 million in fiscal year 2009, $106 million in fiscal year 2010, and $172 million in fiscal year 2011 to fund the CTSAs at the amounts requested by the institutions.

PREPARED STATEMENT OF THE AMERICAN HEART ASSOCIATION

Despite considerable progress, heart disease, stroke, and other forms of cardiovascular disease remain major causes of permanent disability and our Nation's No. 1 and most costly killer, with a death every 37 seconds. Cardiovascular disease will cost our country a projected $475 billion in medical costs and lost productivity this year. Heart disease, alone, is our leading cause of death and stroke is our No. 3 killer.

In the face of these staggering statistics, heart disease and stroke research, treatment and prevention programs remain woefully underfunded. For example, National Institutes of Health (NIH) invests only 4 percent of its budget on heart research and a mere 1 percent on stroke research. This level of funding is not commensurate with scientific opportunities, the number afflicted and the economic toll exacted on our Nation.

Cardiovascular disease remains the No. 1 killer in every State and many preventable and treatable risk factors continue to escalate. Unfortunately, the Centers for Disease Control and Prevention (CDC) has been able to provide basic implementation awards to only 14 States through its Heart Disease and Stroke Prevention Program and only 20 States are funded for CDC's WISEWOMAN, a heart disease and stroke screening program for low-income uninsured and underinsured females. Moreover, where you live could affect whether you survive a particularly deadly form of heart disease, sudden cardiac arrest. At present, only 12 States receive funding for the 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 (AHA) appreciates Congress providing hope to the 1 in 3 adults in the United States who live with the consequences of cardiovascular disease, with the enactment of the American Recovery and Reinvestment Act (ARRA) and the fiscal year 2009 Omnibus Appropriations Act. The Association commends Congress for including $10 billion for the NIH and $1 billion for a Prevention and Wellness Fund in the ARRA. These are wise and prudent investments that will provide both a much needed boost to our Nation's economy and enhance health. Yet these funds represent a one-time infusion of resources. Stable and sustained funding is imperative to boost heart disease and stroke prevention and treatment.

FUNDING RECOMMENDATIONS: INVESTING IN THE HEALTH OF OUR NATION

With numerous new and promising research opportunities on the horizon and with cardiovascular disease risk factors on the rise, now is the time to make a wise enhanced investment to prevent and treat America's No. 1 and most costly killer. If Congress fails to capitalize on progress against cardiovascular disease now, Americans will pay more in the future in lost lives and higher healthcare costs. Our recommendations listed below address these issues in a comprehensive but fiscally responsible way follow.

FUNDING GAP FOR THE NIH

NIH research has revolutionized patient care and holds the key to finding new ways to prevent, treat, and cure cardiovascular disease, resulting in longer, healthier lives and reduced healthcare costs. NIH invests resources in every State and in 90 percent of congressional districts.

The AHA Recommends.—AHA supports the President's campaign pledge to double the NIH budget over the next decade. We advocate for a fiscal year 2010 appropriation of $32.4 billion for NIH, a 7 percent increase over the fiscal year 2009 appropriation, representing the first installment to double the NIH budget by fiscal year 2020. Stable and sustained funding is needed to help secure a solid return on Congress' investment that has saved millions of lives. NIH supported research prevents and cures disease and generates economic growth, creates jobs and preserves the U.S. role as the world leader in pharmaceuticals and biotechnology. Each NIH grant is associated with approximately seven jobs.

ENHANCE FUNDING FOR NIH HEART AND STROKE RESEARCH: A PROVEN AND WISE INVESTMENT

Death rates from coronary heart disease and stroke have each fallen by almost 30 percent since 1999. This decline is directly related to NIH heart and stroke research, with scientists on the verge of new and exciting discoveries that could lead to innovative treatments and even cures for heart disease and stroke. For instance, recent NIH research has shown that postmenopausal hormone therapy does not prevent heart disease and stroke, has defined the genetic basis of dangerous responses to vital blood-thinners, and funded early work of the 2007 Nobel Prize winners in Physiology or Medicine for development of gene targeting technology.

In addition to saving lives, NIH-supported 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 saving of $1.27 billion. But, despite such concrete returns on investments and other successes, NIH heart and stroke research continues to be disproportionately underfunded, with NIH spending only 4 percent of its budget on heart research, and a mere 1 percent on stroke research. NIH funding for these diseases are not commensurate with scientific opportunities, the number afflicted, the increasing prevalence, and the economic toll exacted on our Nation.

CARDIOVASCULAR DISEASE RESEARCH: NATIONAL HEART, LUNG, AND BLOOD INSTITUTE (NHLBI)

Cardiovascular disease research funding fails to keep pace with medical research inflation and cannot sufficiently support existing studies or permit investment in promising research opportunities. The sustained loss of purchasing power has reduced NHLBI's ability to support investigator-initiated research and has forced cuts in Institute programs. Cutbacks will limit the implementation of both the NHLBI general and cardiovascular-specific strategic plans. Studies that could be scaled back include, the translation of basic research on human behavior into real world ways to reduce obesity and promote cardiovascular health; research on genetic susceptibility to heart disease in the Framingham population followed for three generations, and additional research into the best methods for saving lives of sudden cardiac arrest sufferers.

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 6.5 million stroke survivors face physical and mental disabilities, emotional distress and huge costs—a projected $69 billion in medical expenses and lost productivity in 2009.

The NINDS-sponsored Stroke Progress Review Group has issued a long-term, stroke research strategic plan. A variety of research initiatives have since been undertaken, but more funding is needed to fully implement the plan. The fiscal year 2009 estimate for NINDS stroke research falls about 60 percent short of the plan's target and additional funding is needed for programs such as:

—*Stroke Translational Research*.—Translational studies are essential to providing cutting-edge stroke treatment, patient care and prevention. However, due to budget shortfalls, NINDS has been forced to scale back by 30 percent its Specialized Programs of Translational Research in Acute Stroke from a planned 10 centers to only 7.

—*Genetic Repository*.—NINDS could better understand genetic risk factors associated with stroke by helping more researchers contribute data and findings to an NIH-funded genetic repository and to study available samples.

—*Neurological Emergencies Treatment Trials Network*.—NINDS has established a clinical research network of emergency medicine physicians, neurologists and neurosurgeons to develop more and improved treatments for acute neurological

emergencies, such as strokes. However, the number of trials will be limited by available funding.

The AHA Recommends.—AHA supports an fiscal year 2010 appropriation of $3.227 billion for the NHLBI; and $1.705 billion for the NINDS. These represent a 7 percent increase more than fiscal year 2009—comparable to the Association's recommended percentage increase for the NIH.

INCREASE FUNDING FOR THE CDC

Prevention is the best way to protect the health of 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.

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 funds only 14 States to implement programs to reduce risk factors for heart disease and stroke, improve emergency response and quality care, and end treatment disparities. Another 27 States receive funds for capacity building (planning); but, 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.

This division also administers the WISEWOMAN program that screens uninsured and underinsured low-income women ages 40 to 64 in 20 States for heart disease and stroke risk. They receive counseling, education, referral, and followup as needed. Since January 2000, more than 84,000 women have been screened and more than 210,000 lifestyle interventions have been conducted. An estimated 94 percent of these women were found to have at least one risk factor or pre-condition for heart disease, stroke, or other forms of cardiovascular disease. This program should be expanded to the other 30 States and to screen more eligible women in currently funded States.

The AHA Recommends.—AHA joins with the CDC Coalition in support of an appropriation of $8.6 billion for CDC core programs, including increases for the Heart Disease and Stroke Prevention and WISEWOMAN programs. Within that total, we recommend $74 million for the Heart Disease and Stroke Prevention Program, allowing CDC to: (1) add the nine unfunded States; (2) elevate up to 18 States with capacity building awards 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 heart disease and stroke surveillance; and (6) provide additional support for prevention research and program evaluation. We advocates $37 million to expand WISEWOMAN to more States. During last year's national competition, 10 States received approved applications but were denied funding due to insufficient resources. And, we join with the Friends of the NCHS in recommending $137.5 million for NCHS and one-time funding of $15 million to modernize the vital statistics system.

RESTORE FUNDING FOR RURAL AND COMMUNITY ACCESS TO EMERGENCY DEVICES (AED) PROGRAM

About 92 percent of cardiac arrest victims die outside of a hospital. Receiving immediate CPR and the use of an AED can more than double your chance of survival. Communities with comprehensive AED programs have achieved survival rates of 40 percent or higher. The Rural and Community AED Program provides grants to States to buy and place AEDs and train lay rescuers and first responders to use them. During its first year, 6,400 AEDs were purchased, and placed and 38,800 individuals were trained. Due to budget cuts, only 12 States receive resources for this program.

The AHA Recommends.—For fiscal year 2010, AHA advocates restoring the 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 focused on outcomes, comparative effectiveness, and the appropriateness of pharmaceuticals, devices and healthcare services for conditions such as heart disease, stroke, and high blood pressure.

On another front, AHRQ's health information technology (HIT) plan will help bring healthcare into the 21st century through more than $260 million invested in more than 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 must continue as a key component to health reform.

The AHA Recommends.—AHA joins with Friends of AHRQ in advocating for a $405 million in base funding for AHRQ. It will preserve AHRQ's current initiatives and get the agency on track to a base budget of $500 million by 2013.

CONCLUSION

Cardiovascular disease continues to impose a deadly, disabling and costly burden on Americans. However, a robust funding increase for NIH, CDC and HRSA research, treatment, and prevention programs will continue to save lives and reduce rising healthcare costs. The AHA urges Congress to give serious consideration to our recommendations during the fiscal year 2010 congressional appropriations process. They are a wise investment for our Nation and the health and well-being of all Americans now and in future generations.

PREPARED STATEMENT OF ADVOCATE HEALTH CARE

INTRODUCTION AND OVERVIEW

Advocate Health Care (Advocate)—the largest integrated healthcare provider in Illinois—very much appreciates the opportunity to submit written testimony for the record regarding Federal funding for the title VII and title VIII programs of the Public Health Service Act. Advocate serves 3.1 million patients annually and has a presence in virtually every Illinois congressional district through the operation of more than 200 sites of care. Specifically, 9 acute care hospitals, 2 children's hospitals, 4 Level I trauma centers (the State's highest designation in trauma care), a home healthcare company, and the region's largest medical group—in Illinois' 1st, 2nd, 3rd, 4th, 5th, 6th, 7th, 8th, 9th, 10th, 13th and 14th Congressional Districts. Advocate also serves patients from—and employs people in the 11th and 16th Congressional Districts of Illinois. As the second largest employer in the Chicagoland area, Advocate employs 28,000 individuals, including 7,000 nurses. More than 5,000 physicians are also affiliated with Advocate.

Advocate maintains a long-standing commitment to supporting the nurses who work within the Advocate system and to increasing resources at the State and Federal level to bolster and expand Illinois' and the Nation's nursing workforce. High-quality, compassionate health professionals are critical to the delivery of care in the Advocate system. Without our 7,000 nurses—who work hard every day on behalf of patients and their families, our standard of care could not be achieved for the millions of people we serve throughout Illinois each year.

Advocate joins with Members of Congress, national nursing organizations, health professional societies and coalitions, and the general public in being deeply concerned about the current and anticipated national shortages of nurses and other health professionals and their potential adverse impact on patient access to quality care. To that end, Advocate respectfully urges the House Labor, Health and Human Services, and Education, and Related Agencies Appropriations Subcommittee to provide $550 million in fiscal year 2010 funding for the title VII and title VIII programs of the Public Health Service Act to support and expand diversity within the Nation's healthcare workforce, and ensure that the Nation has the nurses and other health professionals it needs to provide quality care to the patients of today and tomorrow.

THE NURSING SHORTAGE AND THE NEED FOR TITLE VIII FUNDING

According to an April 13, 2009 Wall Street Journal article, last summer, the nation was short approximately 125,000 nurses. The nurse faculty shortage is of serious concern, since it is widely recognized as a principal cause of the nursing shortage. The American Association of Colleges of Nursing reports that in 2008, nearly 50,000 qualified applicants were not able to matriculate in nursing school, "due primarily to a shortage of faculty shortage and resource constraints." Although the recent economic downturn has prompted some nurses, who were retired or otherwise not working, to return to the workforce, many communities across the nation still do not have enough nurses to work in their hospitals and nursing homes, or to provide care in home or ambulatory settings.

The Health Resources and Services Administration (HRSA) estimates that, due to a combination of increased demand and the anticipated insufficient supply of registered nurses, the Nation will face a growing shortage in the years ahead. Specifically, the Nation will be short an estimated 275,215 nurses in 2015—a deficit that will grow to approximately 808,416 by 2020. Within Illinois, HRSA predicts that the State will be short an estimated 9,300 nurses in 2010 and 31,900 in 2020. Since nearly 60 percent of all nurses are employed by hospitals, the national and State

level nursing shortages will have a significant and disproportionate impact on hospitals and hospital systems, including Advocate.

The Title VIII Nursing Workforce Development Programs, housed at HRSA, provide resources to support the education and training for entry-level and advanced practice nurses. Specifically, title VIII programs offer loans, scholarships, traineeships, and other support to tens of thousands of individuals each year. According to the Health Professions and Nursing Education Coalition (HPNEC), more than 50,000 nursing students and nurses received support from title VIII in fiscal year 2008. However, it is important to note that the demand for such financial support far exceeds current resources. In fiscal year 2008, HRSA received 6,078 applications for the Nurse Education Loan Repayment Program, but only had the funds to award 435 of those applications. Also, in fiscal year 2008, HRSA received 4,894 applications for the Nursing Scholarship Program, but only had funding to support 172 awards. As such, to ensure that the nation can educate, train, and deploy enough nurses to the communities most in need, Advocate urges the subcommittee to provide a significant increase to title VIII programs in fiscal year 2010.

PHYSICIAN SHORTAGES AND THE NEED FOR TITLE VII FUNDING

The title VII health professions programs, housed within HRSA, provide: loans, loan guarantees and repayments, and scholarships to students; and contracts and grants to nonprofit organizations and entities, as well as academic institutions. Program funding supports: (1) health professional training—with a focus on increasing minority representation in the healthcare workforce, and (2) myriad community-based programs, which seek to increase access to care for underserved individuals and communities in Illinois and across the nation. As the nation currently faces shortages of primary care and specialty physicians—shortfalls that are expected to worsen in the coming years—these programs play a critical role in bolstering the nation's health workforce and helping to ensure its diversity.

Advocate is proud that from fiscal year 2003 to fiscal year 2006, Advocate Illinois Masonic Medical Center (AIMMC)—an urban, Level I trauma center serving primarily high-risk populations in medically underserved and ethnically diverse Chicago northside communities—received a total of more than $600,000 in funding from HRSA for its two residency programs—in family practice and dentistry. HRSA funding helped support the training of 23 primary care/family practice residents, approximately 40 percent of whom were ethnic minorities. This Federal funding of the AIMMC residency program helped develop dozens of physicians who chose to practice in primary care, many of whom specifically work in underserved communities. For example, graduates of the AIMMC family residency program have gone on to practice in rural health clinics, Federally Qualified Health Centers, Federal and State Health Professional Shortage Areas, the Indian Health Service, and HIV/AIDS primary care clinics. In addition, past HRSA funding also supported the AIMMC dental residency program, allowing the staffing of a mobile dental van that provides care to approximately 600 individuals—primarily uninsured—who have limited access to dental providers and care.

As you know, funding for the title VII programs was reduced by more than 50 percent from fiscal year 2005 to fiscal year 2006, and funding for the title VIII program was decreased by nearly 34 percent during the same period. Due to these significant cuts—coupled with modest increases in the subsequent years—there have not been adequate resources to continue to fund Advocate's residency programs. The lack of title VII and title VIII funding has had a significant impact on our—and other hospitals'—ability to train the next generation of physicians and dentists. Moreover, we are concerned that the Nation is not investing adequately in health professionals who have an interest in—and commitment to—working in underserved communities. Increased fiscal year 2010 funding for title VII will help ensure that our nation is making the investment necessary to have the educated, well-trained, and diverse health professional workforce to care for a growing population in need.

FISCAL YEAR 2010 FUNDING REQUEST AND CONCLUSION

As the Congress works to increase access to healthcare for all Americans—a critical action we support—the number of individuals seeking care is anticipated to grow significantly. At the exact same time that demand for healthcare likely will rise, the Nation is facing a significant shortage of nurses, physicians, and other health professionals. Therefore, we urge the subcommittee to provide $550 million to the title VII and title VIII programs of the Public Health Service Act to bolster the Nation's health workforce and ensure access to care for all in need. We thank the subcommittee for its consideration of our views and stand ready to be a resource to you on health workforce and other matters.

PREPARED STATEMENT OF THE AD HOC GROUP FOR MEDICAL RESEARCH

The Ad Hoc Group for Medical Research, which is a coalition of more than 300 patient and voluntary health groups, medical and scientific societies, academic and research organizations, and industry, thanks and commends Congress for including the extraordinary investment in medical research through the National Institutes of Health (NIH) that was included as part of in the American Recovery and Reinvestment Act (ARRA, Public Law 111–5) as well as the $938 million increase in NIH funding in the Omnibus Appropriations Act for fiscal year 2009 (Public Law 111–8). In particular, we are deeply grateful to the subcommittee for its long-standing support of NIH. These are difficult times for our Nation and for people all around the globe, but the affirmation of science is the key to a better future is a strategic step forward.

The partnership between NIH and America's scientists, medical schools, teaching hospitals, universities, and research institutions continues to serve as the driving force in this Nation's search for ever-greater understanding of the mechanisms of human health and disease, from which arise new diagnostics and treatments, and cures, and better ways to improve the health and quality of life for all Americans. These advances also contribute to the Nation's economic strength by creating skilled, high-paying jobs; new products and industries; and improved technologies.

The recent history of the NIH budget has hindered scientific discovery and limited the capacity of a key engine for today's innovation-based economy. The additional funding in the ARRA and the fiscal year 2009 omnibus are critical first steps to returning the NIH to a course for even greater discovery. These investments give patients, their families and researchers renewed hope for the future, and will help ensure the success of America's medical research enterprise and leadership.

The funding increases in the ARRA and the fiscal year 2009 omnibus will provide an immediate infusion of funds into the Nation's proven and highly competitive medical research enterprise to sustain the pursuit of improved diagnostics, better prevention strategies, and new treatments for many devastating and costly diseases as well as support innovative research ideas, state-of-the-art scientific facilities and instrumentation, and the scientists, technicians, laboratory personnel, and administrators necessary to maintain the enterprise. More importantly, these funds will reinvigorate this Nation's ability to produce the human and intellectual capital that will continue to drive scientific discovery, transform health, and improve the quality of life for all Americans.

Moreover, we see this as the first step in renewing a national commitment to sustained, predictable growth in NIH funding, which we believe is an essential element in restoring and sustaining both national and local economic growth and vitality as well as maintaining this Nation's prominence as the world leader in medical research.

President Obama has committed to increase Federal support for research, technology, and innovation so that America can lead the world in creating new advanced jobs and products. A key element of his strategy is to double Federal funding for basic research to "foster home-grown innovation, help ensure the competitiveness of U.S. technology-based businesses, and ensure that 21st century jobs can and will grow in America." If America is to succeed in the information-based, innovation driven world-wide economy of the 21st century, we must recommit to long-term sustained and predictable growth in medical research funding.

As a result of this subcommittee's prior investment in NIH, we have made critical advances in several key areas including:

—*Stem Cells*.—Reprogramming skin cells from a patient with Parkinson's Disease into normal neurons that could be used to fight this degenerative disease.

—*Infectious Diseases*.—Developing more effective antibodies, and ultimately vaccines, to fight lethal flu viruses before they become pandemic.

—*Cancer*.—Launching the Cancer Genome Atlas as a partnership between the National Cancer Institute and the National Human Genome Research Institute to discover the genetic basis for various cancers.

In addition, as a consequence of the investment over the past two decades in the human genome project and other areas of genetics, we are now entering an era of personalized medicine, which has the potential to transform healthcare through earlier diagnosis, more effective prevention and treatment of disease, and avoidance of drug side effects. For example, the same medication can help one patient and be ineffective for, or toxic to, another. By applying our greater understanding of how an individual's genetic make-up affects a response to specific drugs, we will increasingly know which patients will likely benefit from treatment and which will not benefit, or worse, be harmed. Cancer chemotherapy and the use of the anticoagulant Coumadin are good examples of how this might be applied.

However, the discovery process—while it produces tremendous value—often takes a lengthy and unpredictable path. The talent base and infrastructure that we are creating needs to be maintained. Large fluctuations in funding will be disruptive to training, to careers, long range projects and ultimately to progress. The research engine needs a predictable, sustained investment in science to maximize our return.

We must ensure that after the stimulus money is spent we do not have to dismantle our newly built capacity and terminate valuable, on-going research. In 2011 and beyond we need to be able to continue to advance the new directions initiated with ARRA support.

The fiscal year 2009 omnibus and the ARRA provided $38.5 billion for NIH to provide more than 16,000 new research grants for live-saving research into diseases such as cancer, diabetes, and Alzheimer's. Keeping up with the rising cost of medical research in the 2010 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 achieve the President's goal of doubling our investment in basic research. Consistent with the President's vision, we respectfully urge this subcommittee to increase funding for NIH in fiscal year 2010 by at least 7 percent.

The ravages of disease are many, and the opportunities for progress across all fields of medical science to address these needs are profound. The community appreciates that this subcommittee has always recognized that science is unpredictable and that it is difficult to know exactly which discoveries gained through basic research will foster the next medical advancement. There are many examples of areas where important therapies for one disease have resulted from investments in unrelated areas of research. Investing broadly in biomedical research is the key to ensuring the future of America's medical research enterprise and the health of her citizens.

Thank you again for your leadership in improving the health and quality of life for all Americans.

PREPARED STATEMENT OF 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 2010 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 the Nation.

HIV/AIDS

HIV/AIDS remains one of the world's worst health pandemics in history. Worldwide, some 33 million people are infected with this incurable infectious disease, and 7,400 new infections occur each day. Tragically, AIDS has already claimed the lives of more than 25 million. In the United States 583,298 people have died of AIDS. Last year, 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.

Persons of minority races and ethnicities are disproportionately affected by HIV/AIDS. African Americans, who make up 12 percent of the U.S. population, account for half of the HIV/AIDS cases. HIV/AIDS also disproportionately affects the poor, and about 70 percent of those infected rely on public healthcare financing.

The U.S. Government has played a leading role in fighting HIV/AIDS, both here and abroad. The vast majority of the discretionary programs supporting HIV/AIDS efforts domestically are funded through your subcommittee. 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.

Below are the program requests and supporting explanation:

CENTERS FOR DISEASE CONTROL AND PREVENTION—HIV PREVENTION AND SURVEILLANCE

[In millions of dollars]

	Amount
Fiscal year 2009	692
Fiscal year 2010 President's budget request	745
Fiscal year 2010 community request	1,570

As stated above, the Centers for Disease Control and Prevention (CDC) has increased the estimate of people infected each year by 40 percent. New infections are particularly occurring in certain populations, such as the poor, African-Americans, men who have sex with men, Latinos, substance users, and the incarcerated. In order to address the specific needs of these populations and the increased number of people infected, CDC is going to need additional funding.

The CDC has developed a professional judgment budget outlining what funding is necessary to improve HIV prevention efforts and reduce HIV transmission in the United States. The professional judgment budget called for an additional $877 million in funding over the next 5 years. With the additional funding the CDC estimates that by 2020 it could decrease the HIV transmission rate by 50 percent, reduce the number of people who do not know their status by 50 percent, and halve the disparities in the Black and Hispanic communities.

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.

RYAN WHITE HIV/AIDS PROGRAMS

[In millions of dollars]

	Amount
Fiscal year 2009	2,238
President's budget request	2,292
Community request	2,816

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 and million low-income, uninsured, and underinsured people each year.

In fiscal year 2009, the Program received an increase of $72 million, or just 3.3 percent. This increase does not even cover the rate of inflation. In his fiscal year 2010 budget the President is proposing an increase of $54 million, or just 2.2 percent. This includes a $20 million increase, or only 2.5 percent, to the AIDS Drug Assistance Program. 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, according to the CDC, 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. All of this will necessitate the need for more Ryan White services and medications.

—The price of healthcare, including medications, is increasing and 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 50 percent of ADAP programs have experienced or will experience State funding decreases in fiscal year 2009.

—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 $103 million, for a total of $766.1 million.

—Part B base provides essential services including diagnostic, viral load testing, and viral resistance monitoring and HIV care to all 50 States, DC, Puerto Rico, and the territories. We are requesting a $105.4 million increase, for a total of $514.2 million.

The AIDS Drug Assistance Program (ADAP) provides life-saving HIV drug treatment to more than 140,000 people. Due to a lack of funding, States have not been able to include all necessary drugs on their formularies, have limited eligibility and capped enrollment. In order to address the 8,472 new ADAP clients and drug cost increases, we are requesting an increase of $268.6 million for a total of $1,083.6 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 $66.4 million increase, for a total of $268.3 million.

—Part D provides care to more than 84,000 women, children, youth, and families living with and affected by HIV/AIDS. This family-centered care promotes better health, prevents mother-to-child transmission, and brings hard-to-reach youth into care. We are requesting a $57.7 million increase, for a total of $134.6 million.

—Part F includes the AIDS Education and Training Centers (AETCs) program and the Dental Reimbursement program. We are requesting a $15.6 million increase for the AETC program, for a total of $50 million, and a $5.6 million increase for the Dental program, for a total of $19 million.

The AIDS Institute supports increased funding for the Minority AIDS Initiative (MAI). MAI funds services nationwide that address the disproportionate impact that HIV has on communities of color. We are requesting a $200.5 million increase across these programs, for a total of $610 million.

NATIONAL INSTITUTES OF HEALTH—AIDS RESEARCH

[In billions of dollars]

	Amount
Fiscal year 2009	3.01
President's budget request	3.06
Community request	3.5

Through the National Institutes of Health (NIH), research is conducted to 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. Much of this work at the NIH is done in cooperation with private funding. 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

The President's proposed budget eliminates appropriated funding for abstinence-only until marriage programs and instead creates a Teen Pregnancy Prevention Program primarily for interventions that have gone through a rigorous evaluation to delay sexual activity, reduce teen pregnancy, or increase contraceptive use. We fully support the zeroing-out of Community Based Abstinence Education programs. However, we hope these new programs will be used to fund efforts to protect teen sexual health beyond the prevention of teen pregnancy. Messages to prevent teen pregnancy may not speak to all youth, particularly gay youth, who are at a high risk of HIV infection. We request that the $110 million in discretionary funds in the President's budget for the Teen Pregnancy Prevention Initiative be maintained and that the language be broadened to include HIV and STD prevention.

SYRINGE EXCHANGE PROGRAMS

At least one-quarter of all reported AIDS cases in our country are attributed to injection drug use through the sharing of needles and syringes. Federal scientific studies have repeatedly demonstrated that syringe exchange programs reduce the transmission of HIV and other infectious diseases without increasing or encouraging the use of illicit drugs, and may even help reduce drug use by creating a point of entry for addiction treatment. Today, there are nearly 200 such programs operating in 38 States, DC, and Puerto Rico. Despite their proven effectiveness, there is a ban on the use of Federal funds for these programs. We urge you to lift the Federal funding ban on syringe exchange programs in fiscal year 2010.

VIRAL HEPATITIS

Viral Hepatitis, whether A, B, or C, is an infectious disease that also deserves increased attention by the Federal Government. According to the CDC, there are an estimated 800,000 to 1.4 million Americans chronically infected with Hepatitis B, and 46,000 new infections each year. An estimated 1.6 percent of Americans have been infected with Hepatitis C, of whom 3.2 million are chronically infected. It is believed that one quarter of those infected with HIV are co-infected with Hepatitis C.

Given these numbers, we are disappointed the program is currently funded at a level that is substantially less than what it was funded in fiscal year 2003 and falls far short of what is needed. In the President's budget, funding for Hepatitis Prevention at the CDC is slated to receive a negligible increase of $51,000. Funds are needed to establish a program to lower the incidence of Hepatitis through education, outreach, and surveillance. We are requesting an increase of $31.7 million for the program, for a total of $50 million.

The AIDS Institute asks that you give weight to our testimony as you consider the fiscal year 2010 appropriation bill.

PREPARED STATEMENT OF THE AMERICAN INDIAN HIGHER EDUCATION CONSORTIUM

Summary of Requests.—Summarized below are the fiscal year 2010 recommendations for the Nation's 36 Tribal Colleges and Universities (TCUs), covering three areas within the Department of Education and one in the Department of Health and Human Services (HHS), Administration for Children and Families' (ACF) Head Start Program.

DEPARTMENT OF EDUCATION PROGRAMS

Higher Education Act (HEA) Programs

Strengthening Developing Institutions.—Section 316 of 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 $32 million to support these two vital programs.

Pell Grants.—TCUs urge the subcommittee to fund the Pell Grant Program at the highest possible level.

Perkins Career and Technical Education Programs

The TCUs urge the Subcommittee to appropriate $8.5 million for section 117 of the Carl D. Perkins Career and Technical Education Improvement Act, which supports our two Tribally Controlled Postsecondary Vocational Institutions: United Tribes Technical College and Navajo Technical College. 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 funds 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 ad-

ministrators serving their reservation communities. The TCUs request that the subcommittee support these programs at $10 million and $5 million, respectively.

HHS PROGRAM

TCUs 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 $5 million be designated for the TCU-Head Start Partnership program, to ensure the continuation of current programs and the resources needed to support 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 provide access to higher education for American Indians and others living in some of the Nation's most rural and economically depressed areas. According to 2000 Decennial Census data, the annual per capita income of the U.S. population was $21,587. In contrast, the annual per capita income of Native Americans was $12,893 or about 40 percent less. In addition to serving their student populations, TCUs offer a variety of much needed community outreach programs.

These institutions, 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 effectively 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 just 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 2010 APPROPRIATIONS REQUESTS FOR TCUS

HEA

The Higher Education Act Amendments Act 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 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 $32 million in fiscal year 2010 for title III–A section 316, an increase of $8.8 million more than fiscal year 2009. 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.

The importance of Pell Grants to TCU students cannot be overstated. U.S. 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 ex-

actly 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. The 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 Vocational 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 $8.5 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 TCUs, State and local education agencies, Indian tribes, institutions, and agencies. 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 Adult Education State Grants appropriated funds 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.

HHS/ACF/HEAD START

TCUs 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 President's February 26, 2009 budget summary includes an additional $1 billion to improve and expand Head Start. The TCUs request that the subcommittee direct the Head Start Bureau to designate $5 million, of the more than $7.2 billion included in the President's budget, to fund the TCU-Head Start Partnership program, to ensure that this critical program can continue and expand so that all TCUs have the opportunity to participate in the TCU-Head Start Partnership program.

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 2010 appropriations needs and recommendations.

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, 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 2010 by providing the agency with at least a 7 percent increase more than fiscal year 2009.

AIRI is a national organization of 90 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 the Omnibus Appropriations Act for fiscal year 2009, the administration and Congress have taken critical steps to jump start the Nation's economy. 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.

NIH is responding to its charge of stimulating the economy through job creation by supporting new scientists, construction workers, and suppliers. NIH is also supporting the next generation of biomedical research through cross-cutting, interdisciplinary initiatives such as those supported in the NIH Roadmap, the NIH Neuroscience Blueprint, the Clinical and Translational Science Award program, and the Genes, Environment and Health Initiative. Independent research institutes are involved extensively in these initiatives and will be beneficiaries of ARRA funds, making them an important and vital component of the overall U.S. medical research enterprise. Therefore, independent research institutes are positioned to help Congress achieve its goal of improving the quality of life for all Americans.

However, the discovery process—while it produces tremendous value—often takes a lengthy and unpredictable path. The infrastructure that we are creating needs to be maintained. Large fluctuations in funding will be disruptive to training, to careers, long-range projects and ultimately to progress. The research engine needs a predictable, sustained investment in science to maximize our return.

We must ensure that after the stimulus money is spent we do not have to dismantle our newly built capacity and terminate valuable, on-going research. In 2011 and beyond we need to be able to continue to advance the new directions charted with the ARRA support.

Keeping up with the rising cost of medical research in the 2010 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 2010 by at least 7 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.

Providing Efficiency and Flexibility

AIRI member institutes' smaller size and greater 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 2010 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 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 & 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 full funding for the title V Maternal and Child Health Services Block Grant at its authorized level of $850 million for Federal fiscal year 2010.

To help illustrate the importance of title V MCH funding, I want to begin by sharing the story of a girl from Iowa who was helped by title V 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 also 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 thousand of children—children with special healthcare needs and pregnant women that are served by title V programs in Chairman Harkin's State alone. The MCH Block Grant supports a similar network in my home State of Florida, and none of this could happen without the Title V MCH Block Grant funding.

Title V of the Social Security Act was created during the Great Depression to "improve the health of all women and children." The MCH Block Grant is a celebrated example of an effective Federal and State partnership with a common goal of improving the health of all mothers and children, including those children with special healthcare needs. It is also at the forefront of promoting family-centered care in all of its work. But we are losing ground fast and we believe it is time to go back to the roots of title V and recommit ourselves to truly improving the health of our Nation's women and children by fully investing in the MCH Block Grant.

Despite major advances in medicine, technology, and our healthcare system, America still faces huge challenges to 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. As we sit here today, the United States ranks 29th in infant mortality rates 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, we are failing 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.

Sadly, there are gaps between what a family needs and actually receives for a child with a special need. Out of pocket healthcare costs are increasing and we are erasing gains we made in supporting effective services for children with special needs and their families. Currently, only 50 percent of these children 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.

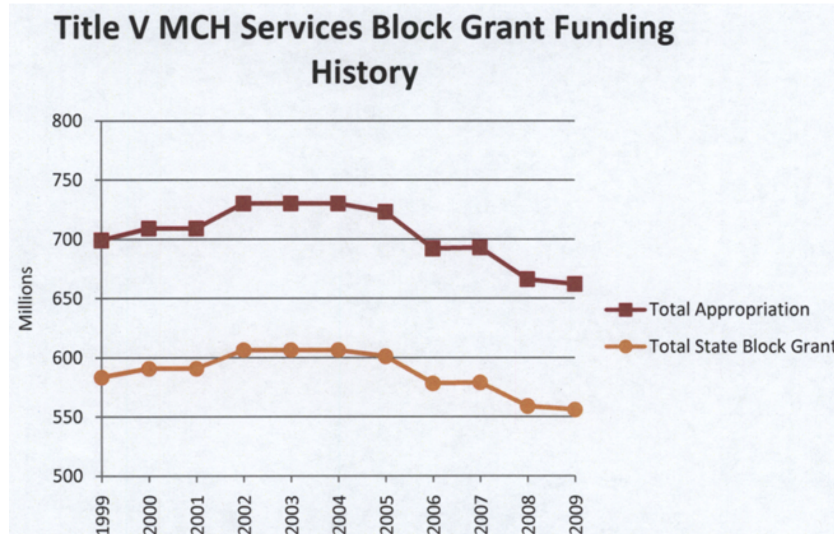
State programs, funded through MCH Block Grant dollars, are key to reversing this picture. Considering these and many other urgent health needs, AMCHP asks for your leadership in fully funding the MCH Block Grant at $850 million for fiscal year 2010.

AMCHP urges Congress to recognize the need to revitalize resources for States and their partners to reverse the trends and continue this critical work. We have a track record of demonstrating that we make a positive difference and are fully accountable for the funds that we receive. Fully funding the 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 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 Web site 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 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 MCH Block Grant funded programs. Due to years of reduced investment, the MCH Block Grant is at its lowest funding level since 1993, $662 million, meaning States again are being asked to serve additional people with less.



Now, as economic troubles increase demand for health services, State MCH programs desperately need additional resources to:

—increase outreach and screening services to identify and link women and children to available healthcare services;
—assure coordination of those services and assist new parents through efforts such as expanded home visitation programs; and
—deliver essential prevention and health promotion services to make sure that every mom has a healthy pregnancy; every child has the opportunity for a healthy birth and strong start in life; and every child with special healthcare needs receives ongoing comprehensive care within a medical home.

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 MCH Block Grant aims to do just that—using resources effectively to improve the health of all of America's women and children.

I want to close with one more story from a parent in my State that I think illustrates the personal impact of Title V MCH Block Grant funds.

My daughter Ashley continues to be at risk for a detached retina with myopia of the eye. Title V Children and Youth with Special Health Care Needs has been instrumental in providing medically necessary funding for the type of eyeglasses that she needs in order to be able to see and have some quality of life as an adolescent. There are medications that she needs to be able to control her executive functions, her impulses and her motor coordination in order to be able to function in school that I would not be able to afford as a parent. As a parent it would be devastating if she could not go to school which increases her chances of being able to transition into work and/or higher education.

PREPARED STATEMENT OF THE AMERICAN NURSES ASSOCIATION

The American Nurses Association (ANA) appreciates this opportunity to comment on fiscal year 2010 appropriations for nursing education, workforce development, and research programs. Founded in 1896, ANA is the only full-service national association representing registered nurses (RNs). Through our 51 constituent member associations, ANA represents RNs across the Nation in all practice settings.

The ANA gratefully acknowledges this subcommittee's history of support for nursing education and research. We appreciate your continued recognition of the important role nurses play in the delivery of quality healthcare services. This testimony will give you 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 American Hospital Association reported that hospitals needed 116,000 more RNs to fill immediate vacancies in July 2007. Hospitals report that this vacancy rate is hampering the ability to provide emergency care.

—The Bureau of Labor Statistics reports that registered nursing will have remarkable job growth in the time period spanning 2006–2016. During this time, 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.

A Joint Commission on the Accreditation of Healthcare Organizations study published in 2002 shows that the shortage of nurses contributes to nearly a quarter of all unexpected incidents that kill or injure hospitalized patients.

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. Prior to the release of President Obama's proposed budget for fiscal year 2010, ANA was strongly advocating Congress to increase funding for title VIII programs by at least $44 million to a total of $215 million. Now that President Obama is requesting $263 million for title VIII programs, we are urging the subcommittee to support this request and fund title VIII programs at $263 million.

Current funding levels are clearly failing to meet the need. In fiscal year 2008, the 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 four times the fiscal year 2009 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:

Nursing Education Loan Repayment Program and Scholarships (NELRP).—This line item is comprised of the NELRP and the NSP. In fiscal year 2009, the NELRP and the NSP received $37 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 percent 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 loan repayment program, the NSP has been stunted by a lack of funding. In fiscal year 2008, HRSA received 3,039 applications for the nursing scholarship. 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 2009, this program received $11.5 million.

This program is vital given the critical shortage of nursing faculty. America's schools of nursing can not 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. All together, the Nurse Education, Practice, and Retention Grants received $37.3 million in fiscal year 2009.

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.

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 2009, 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, 7,650 advanced education nurses were supported through these programs. In fiscal year 2009, these programs received $64.4 million.

These grants also provide traineeships for masters 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 2009, 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. In fiscal year 2006, HRSA continued 8 previously awarded grants and awarded 11 new ones.

NATIONAL INSTITUTE OF NURSING RESEARCH (NINR)

ANA also urges the subcommittee to increase funding for the NINR, one of the Institutes at the National Institutes of Health (NIH). The Institute's research focus transcends disciplines to address issues of health management, symptom management, and caregiving; health promotion and disease prevention; end-of-life care; technology integration; and research capacity development. This research is integral to improving the effectiveness of nursing care. Advances in nursing care arising from behavioral and biomedical research have shown excellent progress in reducing healthcare costs. Research programs supported by NINR address a number of critical public health and patient care questions. The cross-discipline research is driven by real and immediate problems currently facing patients and their families.

Recent NINR funded studies have shown that inadequate nurse staffing increases risks for patients; coping skills training improves teens' self-management of diabetes; a healthcare team helps reduce high blood pressure among inner-city black men; a community-based program improves self-management of arthritis among older Hispanics; home nursing visits benefit low-income mothers and their children; and transitional care improves outcomes for elders after leaving the hospital. NINR is leading the NIH research on end-of-life and palliative care. NINR is also the lowest-funded Institute at NIH. In fiscal year 2009, NINR received $141.88 million. ANA recommends $178 million, or a 25 percent increase more than fiscal year 2009, in fiscal year 2010 NINR funding.

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. The nursing shortage will continue to worsen if significant investments are not made. Recent efforts have shown that aggressive and innovative recruitment efforts can help avert the impending nursing shortage—if they are adequately funded.

ANA asks you to meet today's shortage with a relatively modest investment of $263 million in title VIII programs. Additionally, an investment of $178 million in the NINR will help assure that nurses are equipped with the latest information and research needed to provide the best patient care possible.

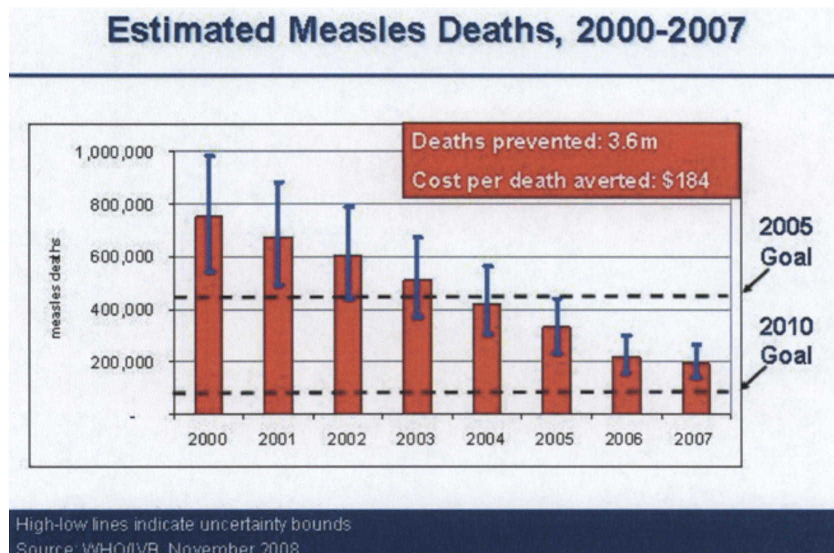
PREPARED STATEMENT OF THE AMERICAN NATIONAL RED CROSS

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 (WHO), and UNICEF—became one of the spearheading partners of 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 600 million children. Largely due to the Measles Initiative, global measles mortality dropped 74 percent, from an estimated 750,000 deaths in 2000 to 197,000 in 2007. During this same period, measles deaths in Africa fell by 89 percent, from 395,000 to 45,000.



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 $670 million and provided technical support in more than 60 developing countries on vaccination campaigns, surveillance, and improving routine immunization services. From 2000 to 2007, an estimated 3.6 million measles deaths were averted as a result of accelerated measles control activities (increased routine immunization coverage and mass immunization campaigns) at a 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 opportunities 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, 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 37 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.

[1] The Lancet, Volume 8, page 13 (January 2008).

Countries are well positioned to achieve the 2010 goal and to take a bold step toward achievement of the 2015 Millennium Development Goal #4 of reducing under 5 child mortality. However, achieving the 2010 goal will require:

—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 follow-up campaigns.

—Securing sufficient funding for measles-control activities both globally and nationally. The Measles Initiative faces a funding shortfall of an estimated $100 million for 2010. Implementation of timely follow-up campaigns is increasingly dependent upon countries funding these activities locally. The decrease in donor funds available at global level to support activities to reduce measles mortality 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 major 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, the number of reported measles cases in the United States more than doubled and outbreaks are currently on-going in Virginia, Maryland, Washington, District of Columbia, Pennsylvania, California, and Missouri. These outbreaks cause needless suffering and accrue public health costs which in the United States are upwards of $150,000 to respond to each case.

THE ROLE OF CDC IN GLOBAL MEASLES MORTALITY REDUCTION

Since fiscal year 2001, Congress has provided approximately $42 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 the 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 7 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 2009, Congress has appropriated approximately $41.8 million to fund CDC for global measles control activities. The American Red Cross and the United Nations Foundation thank Congress for the financial support that has been provided to CDC in the past and this year. We respectfully request a total of $51.8

million for fiscal year 2010 funding for CDC's measles control activities so that the gains made to date can continue and the 2010 goal of a 90 percent reduction in measles deaths can be achieved.

The additional funds we are seeking for CDC are critical for:

—Sustaining the great progress in measles mortality reduction in Africa by strengthening measles surveillance and strengthening the delivery of measles vaccine through routine immunization services to protect new birth cohorts;

—Conducting large-scale measles vaccination campaigns in South Asia, especially in India, thus protecting millions of children;

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 the Americans for Nursing Shortage Alliance

The undersigned organizations of the ANSR Alliance greatly appreciate the opportunity to submit written testimony on fiscal year 2010 appropriations for Title VIII—Nursing Workforce Development Programs. The Alliance represents a diverse cross-section of health care and other related organizations, healthcare providers, and supporters of nursing issues that have united to address the national nursing shortage. We stand ready to work with the 111th Congress to advance programs and policies 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 $263.4 million in funding in fiscal year 2010 for the Nursing Workforce Development Programs under title VIII of the Public Health Service Act at the Health Resources and Services Administration (HRSA).

—Fund the Advanced Education Nursing program (section 811) at an increased level on par with the other title VIII programs.

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 3.4 million licensed registered nurses (RNs) in 2006.[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. Approximately 59 percent of RN jobs are in hospitals.[2] A Federal report published in 2004 estimates that by 2020 the national nurse shortage will increase to more than 1 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, about 233,000 additional jobs for registered nurses will open each year through 2016, in addition to about 2.5 million existing positions. 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.

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[1] National Council of State Boards of Nursing. (2008). 2006 *Nurse Licensee Volume and NCLEX® Examination Statistics*. (Research Brief Vol. 31). On the Internet at: https://www.ncsbn.org/08__2006__LicExamRB__Vol31__21208__MW(1).pdf. (Accessed February 3, 2009).

[2] Bureau of Labor Statistics, U.S. Department of Labor. *Occupational Outlook Handbook, 2008–2009 Edition*, Registered Nurses. On the Internet at: http://www.bls.gov/oco/ocos083.htm (Accessed December 9, 2008).

[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 December 9, 2008).

[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.

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 today 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. In the 2006–2007 academic years, 99,000 qualified applications—or almost 40 percent of qualified applications submitted to prelicensure RN programs—were denied due to lack of capacity.[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.

ANSR 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 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

[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, (2009) *Nursing Data Review 2006–2007: Baccalaureate, Associate Degree, and Diploma Programs*. On the Internet at: http://www.nln.org/research/slides/index.htm. (Accessed March 20, 2009).

[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).

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 as a result 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 $263.4 million in funding for the Nursing Workforce Development Programs under title VIII of the Public Health Service Act at HRSA in fiscal year 2010. As part of this funding, the Advanced Education Nursing training program (section 811) should be funded at an increased level on par with the other title VIII programs.

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; 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; 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 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 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; Oncology Nursing Society; 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; Wound, Ostomy and Continence Nurses Society.

[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).

PREPARED STATEMENT OF THE AMERICANS FOR NURSING SHORTAGE RELIEF ALLIANCE

The Tri-Council for Nursing, a long-standing alliance focused on leadership and excellence in the nursing profession, is composed of the American Association of Colleges of Nursing, the American Nurses Association, the American Organization of Nurse Executives, and the National League for Nursing. The collaborative leadership of these four professional organizations impacts the breadth of nursing practice, including nurse executives, educators, researchers, and nurses providing direct patient care. The Tri-Council asks the subcommittee to provide $215 million in fiscal year 2010 for the Nursing Workforce Development Programs under title VIII of the Public Health Service Act, administered by the Health Resources and Services Administration (HRSA).

In light of the economic challenges facing our country today, the Tri-Council urges the subcommittee to focus on the larger context of building the capacity needed to meet the increasing health care demands of our Nation's population. Such public policy will require sustained investments aimed at refocusing the current health care system toward promoting health, while simultaneously improving value for our dollars. The title VIII Nursing Workforce Development Programs are proven policy instruments that help assure an adequately prepared nursing workforce. These programs—

—Increase access to healthcare in underserved areas through improved composition, diversity, and retention of the nursing workforce;

—Advance quality care by strengthening nursing education and practice; and

—Develop the identification and use of data, program performance measures, and outcomes to make informed decisions on nursing workforce matters.

The Tri-Council applauds the subcommittee for the emergency supplement provided across all the health professions programs via the American Recovery and Reinvestment Act (Public Law 111–5). We also value the enacted fiscal year 2009 omnibus appropriations bill (Public Law 111–8) providing $171.031 million specifically for the title VIII Nursing Workforce Development Programs. These investments are a critical component supporting our healthcare infrastructure.

Examining the broad context, the healthcare industry remains the largest industrial complex in the United States. Studies of the Nation's gross domestic product (GDP) show healthcare spending achieving a relatively high rate of real growth, with the portion of GDP devoted to healthcare growing from 8.8 percent in 1980 to 16.2 percent of GDP in 2007. While healthcare spending demands greater efficiencies, it also has helped to sustain our Nation's sagging economy.

Since 2001, healthcare is virtually the only sector that added jobs to the economy on a net basis. In March 2009, the U.S. Bureau of Labor Statistics (BLS) reported continued growth in the healthcare sector, despite our economy's freefall in a down cycle with unemployment reaching 8.1 percent in February 2009. With that month's job loss of 681,000 realized in nearly all major industries, BLS also reported the addition of 27,000 new jobs at hospitals, long-term care facilities, and other ambulatory care settings.

As the predominant occupation in the healthcare industry, the nurse workforce likely is filling most of the noted job openings. Nurses are the front line of healthcare delivery throughout the Nation, and the BLS numbers support that description showing the nurse workforce at well over four times the size of the medical workforce. Increased fiscal year 2010 investments in title VIII will help counterbalance the economic meltdown threatening nursing programs operating in congressional districts and serving communities by supporting nursing education—providing title VIII loans, scholarships, traineeships, and programmatic funding.

NURSING SHORTAGE OUTPACES CAPACITY-BUILDING

The Tri-Council contends that an episodic increased funding of title VIII will not fully fill the gap generated by an 11-year nursing shortage felt throughout the entire U.S. health system and projected to continue. The BLS projections estimate that RNs will have the greatest growth rate of all U.S. occupations in the period spanning 2006–2016, with more than 1 million new and replacement nurses needed by 2016. Despite this projected expansion in the profession, numerous other studies anticipate a growing national nurse workforce shortage to intensify as the baby boomer cohort ages, the current nurse workforce retires, and the demand for healthcare accrues.

Funding levels for the HRSA Title VIII Nursing Workforce Programs are failing to support the numerous qualified applicants seeking assistance from these programs. In the last 3 years, virtually flat title VIII funding, along with inflation and increased educational and administrative costs, has decreased purchasing power. According to HRSA statistics, in fiscal year 2006 the title VIII programs directly or

indirectly supported 91,189 nurses and nursing students. In fiscal year 2007, the number of grantees dropped by 21 percent and in 2008 the grantees dropped by 28 percent to support only 51,657 nurses and nursing students.

Additionally, schools of nursing continue to suffer from a growing shortage of faculty, a troubling infrastructure trend that exacerbates the nurse workforce demand-supply gap. According to a study conducted by the American Association of Colleges of Nursing (AACN) in 2008, schools of nursing turned away 49,948 qualified applicants to baccalaureate and graduate nursing programs. The top reasons cited for not accepting these potential students was a lack of qualified nurse faculty and resource constraints. Without faculty, nursing education programs are prevented from admitting many qualified students who are applying to their programs. (Data are Internet accessible at http://www.aacn.nche.edu/Media/NewsReleases/ 2009/ workforcedata.html.)

The AACN survey results are reinforced by the National League for Nursing's (NLN) study of all types of prelicensure RN programs, which prepare students to sit for the RN licensing exam (i.e., baccalaureate, associate, and diploma degree). The NLN statistics indicate more than 1,900 unfilled full-time faculty positions existed nationwide in 2007, affecting more than one-third (36 percent) of all schools of nursing. Significant recruitment challenges were found with 84 percent of nursing schools attempting to hire new faculty in 2007–2008, more than three-quarters (79 percent) reporting recruitment as "difficult" and almost 1 in 3 schools found it "very difficult." The two main difficulties cited were "not enough qualified candidates" (cited by 46 percent of schools), followed by inability to offer competitive salaries—cited by 38 percent. (Data are Internet accessible at www.nln.org/research/slides/ index.htm.)

THE FUNDING REALITY

If the United States is to reverse the eroding trends in the nurse and nurse faculty workforce, the Nation must make a significant investment in the title VIII programs, which are charged to favor institutions educating nurses for practice in rural and medically underserved communities. At adequate funding levels the title VIII programs supporting the education of registered nurses, advanced practice registered nurses, nurse faculty, and nurse researchers have demonstrated successful intervention strategies to solving past nursing shortages.

A brief examination of the HRSA title VIII illustrates the robust nature of these programs:

Section 811.—The Advanced Education Nursing (AEN) Program funds traineeships for individuals preparing to be nurse practitioners, nurse midwives, nurse administrators, public health nurses, and nurse educators, among other graduate-level education nursing roles. The AEN awards assisted nurse education programs to support 3,419 graduate nursing students in fiscal year 2008.

Section 821.—The Nursing Workforce Diversity Program funds grants and contracts to schools of nursing, nurse-managed health centers (NMCs), academic health centers, State and local governments, and nonprofit entities to increase nursing education opportunities for individuals from disadvantaged backgrounds and under-represented populations among RNs. This program—of proven intervention strategies—supported 18,741 students in fiscal year 2008, seeking to ensure a culturally diverse workforce to provide healthcare for a culturally diverse patient population.

Section 831.—The Nurse Education, Practice and Retention Program provides support for academic and continuing education projects designed to strengthen the nursing workforce. Several of this program's priorities apply to quality patient care including developing cultural competencies among nurses and providing direct support to establishing or expanding NMCs in noninstitutional settings to improve access to primary healthcare in medically underserved communities. The program also provides grants to improve retention of nurses and enhanced patient care. In fiscal year 2008, approximately 6,000 nurses and nursing students were supported.

Section 846.—The Nurse Loan Repayment and Scholarship Programs (NELRP) is divided into two primary elements. The NELRP assists individual RNs by repaying up to 85 percent of their qualified educational loans over 3 years in return for their commitment to work at health facilities with a critical shortage of nurses, such as departments of public health, community health centers, and disproportionate share hospitals. In fiscal year 2008, of the 5,875 applications reviewed by HRSA, only 435 students (7.4 percent) received NELRP awards. Similarly, the Nurse Scholarship Program (NSP) provides financial aid to individual nursing students in return for working a minimum of 2 years in a healthcare facility with a critical nursing shortage. In fiscal year 2008, NSP turned away most of the applicants owing to a lack of adequate funding, resulting in the distribution of only 169 student awards.

Section 846A.—The Nurse Faculty Loan Program (NFLP) supports the establishment and operation of a loan fund within participating schools of nursing to assist RNs to complete their education to become nursing faculty. The NFLP grants provide a cancellation provision in which 85 percent of the loan, plus interest, may be cancelled over 4 years in return for serving as full-time faculty in a school of nursing. NFLP granted 729 awards in fiscal year 2008.

Section 855.—The Comprehensive Geriatric Education Grant Program focuses on training, curriculum development, faculty development, and continuing education for nursing personnel caring for the elderly. In fiscal year 2008, 18 awards were made in this program.

While title VIII is the largest source of Federal funding for nursing, the current level of investment falls short of remedying a chronic underfunding of the Nursing Workforce Development Programs, compared to the existing and imminent shortages these programs address. The title VIII authorities are capable of providing flexible and effective support to assist students, schools of nursing, and health systems in their efforts to recruit, educate, and retain registered nurses. Recent efforts have shown that aggressive and innovative strategies can help avert the nurse and nurse faculty shortages. The Tri-Council for Nursing understands the competing priorities faced by this Congress, but we also maintain that title VIII Nursing Workforce Development Programs must be funded at an adequate level to begin to impact the shortage and to address the complex health needs of the Nation. The contributions of nurses in our healthcare system are multifaceted, and are impacted directly by the level of Federal funding that supports nursing programs.

Prepared Statement of America's Promise Alliance

THE DROPOUT CRISIS: AMERICA'S NEW SILENT EPIDEMIC

Chairman Inouye, Vice Chairman Cochran, members of the subcommittee, thank you for the opportunity to testify on the most pressing issue facing our Nation: the high school dropout crisis. America's low graduation rate is our most pressing issue as a Nation and the culmination of years of failure. Everyone with a stake in the future of our children and the Nation—schools, parents, businesses, community, and faith-based organizations—have a role to play in the resolution of this crisis. We all must work together in new and unprecedented ways in support of our children.

In addition to its significant social implications, the potential economic impact of the dropout crisis shows why this issue is our most critical national challenge. Today, America is the only industrialized nation in the world where children are less likely to graduate from high school than their parents. A student drops out of high school every 26 seconds, with 1.2 million kids falling through the cracks each year. The national dropout crisis has resulted in 3 in 10 students failing to graduate with their class, a percentage that doubles for minority, urban, and low-income students.

When President Obama and Secretary Duncan say that a long-term, sustainable economic recovery is only possible if we strengthen our education system, they are precisely correct. The dropout crisis may not be as visible or swift as other important issues problems facing this Congress and our new administration, but its implications are just as severe and lasting. The dropout crisis, persisting without acknowledgment or resolution, has emerged as America's "silent epidemic." Although we are working diligently to raise public awareness of this issue, it has yet to permeate the national agenda. This makes it easier for our actions to be slow, inadequate, or even worse, nonexistent.

Strengthening our graduation rate will take historic focus, unprecedented collaboration, and significant resources. The required investments in our young people are the most cost-effective investments we can make. We must understand that our future is at stake, and we must resolve that failure is not an option.

MAGNITUDE OF THE DROPOUT CRISIS

Between 25 to 30 percent of high school students do not graduate on time. For young people of color, on-time graduation is a 50–50 proposition, the flip of a coin. A new report commissioned by America's Promise Alliance and developed by the Editorial Projects in Education Research Center found that only 53 percent of all young people in the Nation's 50 largest cities graduate on time. Despite some progress made by several of these cities between 1995 and 2005, the average graduation rate of the 50 largest cities is well below the national average of 71 percent,

and an 18 percentage point urban-suburban gap remains.[1] While the Nation's 50 largest school districts educate 1 out of 8 high school students; they produce one-quarter of the Nation's students who do not graduate on time.[2]

A significant graduation rate gap exists between urban and suburban school districts: 18 percentage points separate the metropolitan areas of the 50 largest cities from their suburban counterparts.[3] Fifty-nine percent of high school students in urban school districts graduate on time from high school versus 77 percent of their suburban counterparts. The urban-suburban gap is most prominent in the Northeast and Midwest, with Baltimore, Cleveland, Columbus, and Milwaukee experiencing the largest differentials.[4]

Economic Impact

The economic significance of the Nation's low graduation rate cannot be overstated, as countries that out-educate us today will out-compete us tomorrow. A report from McKinsey & Company estimated the economic impact in 2008 if the United States had closed the achievement gap 15 years after A Nation at Risk's 1983 release. Their findings amount to nothing less than a multibillion dollar lost opportunity and what they term as a "permanent national recession." Closing the international achievement, racial, and income gaps would have produced up to a 30 percent gain in GDP, or $4.2 trillion.

On an individual level, high school graduation is a determining factor of a student's future income. High school dropouts are less likely to be steadily employed and earn less income when they are employed compared with those who graduate from high school. Only 37 percent of high school dropouts nationwide are steadily employed and are more than twice as likely to live in poverty.[5]

High school dropouts account for 13 percent of the adult population, but earn less than 6 percent of all dollars earned in the United States. In the 50 largest cities, the median income for high school dropouts is $14,000, lower than the median income of $24,000 for high school graduates and $48,000 for college graduates. The Editorial Projects in Education Research Center estimates that earning a high school diploma would increase one's annual income by an average of 71 percent, or $10,000.[6]

CONTRIBUTORS TO THE CRISIS

There are two major influences in students' lives that impact their scholastic achievement: what happens inside the school building and what happens outside of it. A number of factors contribute to the high school dropout crisis, ranging from the quality of standards and rigor in our high schools to the issues impacting students before they ever step foot into the classroom.

In 1983, A Nation at Risk recommended that schools, colleges, and universities adopt more rigorous, measurable standards for academic performance and higher expectations for student conduct. Today, few disagree with the need to raise expectations of student performance. We must offer our students challenging curricula that are aligned with the expectations of college and the needs of our future workforce. We need stronger, internationally benchmarked standards, so that students, educators, and parents understand the effectiveness of the educational system in which they are part.

Equally important, though not duly recognized, is the importance of a student's living and learning environment in affecting how he or she performs in the classroom. Schools cannot shoulder the responsibility of educating our children and youth on their own. Every year, our students spend about 1,150 waking hours in school, and nearly five times that number (4,700 waking hours) in their families and communities.[7] Today's teachers have to act as mothers, fathers, social workers, and

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[1] Christopher Swanson (2009). *Cities in Crisis 2009: Closing the Graduation Gap: Educational and Economic Conditions in America's Largest Cities*. Bethesda, Maryland: Editorial Projects in Education Research Center.

[2] The principal school districts of America's 50 largest cities collectively educate 1.7 million public high school students and produce 279,000 of the 1.2 million high school students who do not graduate on time (Ibid., p. 13).

[3] Ibid.

[4] Ibid.

[5] Ibid.

[6] Ibid.

[7] David Berliner (2009). *Poverty and Potential: Out-of-School Factors and School Success*. Boulder and Tempe: Education and the Public Interest Center and Education Policy Research Unit. Retrieved May 6, 2009 from http://epicpolicy.org/publication/poverty-and-potential.

sometimes even police officers, in addition to the central task of educating our students.

In its recent report, Parsing the Achievement Gap II, the Educational Testing Service (ETS) outlined 16 factors that correlate with student achievement; more than half of these factors are present in a child's life before or beyond the classroom, including forced mobility, hunger and nutrition, and summer achievement gain and loss.[8] Today's educators must address the confluence of many of these factors at the same time, which are disproportionately concentrated in the Nation's poorest schools. Less than 4 percent of white students attend schools where 70–100 percent of the students are poor. However, 40 percent of black and Latino students attend such high-poverty schools.

It is important that we have a thorough understanding of the prevalence and importance of the larger environmental factors in a student's life that influence their academic success. Unless we address these foundational issues, not even the best teachers with the highest quality curriculum will be able to ensure that every student graduates ready for college.

THE SOLUTION: A COMPREHENSIVE APPROACH

The dropout crisis calls for a holistic solution, driven by national leadership and local action. Research demonstrates that young people need five core resources to be successful in life. We refer to them as the "five promises:" caring adults, safe places, a healthy start, effective education, and opportunities to serve. These promises provide a simple but powerful framework for a robust national strategy to end the dropout crisis, and they are at the heart of the Dropout Prevention Campaign launched by America's Promise Alliance in April 2008.

America's Promise Alliance Dropout Prevention Campaign

The campaign begins with high-level summits in all 50 States and the 55 cities with the largest dropout rates in order to raise the visibility of America's "silent epidemic." Within 60 days of each summit, States, and communities are required to develop action plans that include a cross section of stakeholders: educators, the business community, nonprofit organizations, and students. To date, 36 high-level summits have been held in cities nationwide—bringing together more than 14,000 mayors and Governors, business owners, child advocates, school administrators, students, and parents to develop workable solutions and action plans.

Already, cities and States that held summits last year have started implementing changes based on the discussions and early results are promising. Detroit has set a 10-year goal to graduate 80 percent of its youth from the 35 high schools with significant dropout rates and created the Greater Detroit Venture Fund, a $10 million effort to assist these efforts. Louisville set a 10-year goal to cut dropout rates in half, and Tulsa's summit resulted in an innovative career exploration program.

Grad Nation

The Dropout Summits and the action plans they produce are a critical first step, but communities also need tools and guidelines for sustainably raising their graduation rates. Grad Nation is a first-of-its-kind research-based toolkit for communities seeking to reduce their dropout rate and better support young people through high school graduation and beyond. Commissioned by the Alliance and authored by Robert Balfanz, Ph.D. and Joanna Honig Fox from the Everyone Graduates Center at Johns Hopkins University and John M. Bridgeland and Mary McNaught of Civic Enterprises, Grad Nation brings together—in one place—the Nation's best evidence-based practices for keeping young people in school. Grad Nation gives communities a comprehensive set of tools to rally collective support, develop effective action strategies, prepare youth for advanced learning, and build strong, lasting partnerships around ending the dropout crisis.

The Gallup Student Poll

The youth voice is often overlooked and not included in the national dialogue on dropout prevention. In order to determine effective solutions to the crisis, their voices must be heard. America's Promise Alliance (APA), along with Gallup and the American Association of School Administrators, recently launched the Gallup Student Poll, the largest-ever survey of students in grades 5–12. The poll measures

[8] Paul Barton and Richard Coley (2009). *Parsing the Achievement Gap II*. Princeton, New Jersey: Educational Testing Service. Note: This report uses the term "frequent school changes." I use the term "forced mobility" because it more accurately describes the living circumstances of our most at-risk students that, in turn, causes reductions in school performance. For additional information, see Duffield and Lovell (endnote 20).

three key metrics—hope, engagement, and well-being—that research has shown have a meaningful impact on educational outcomes and more importantly, can be improved through deliberate action by educators, school administrators, community leaders.

The March 2009 polling brought in nearly 71,000 responses from students in 18 States, 58 districts, and more than 330 schools. Half of those surveyed (50 percent) reported that they are not hopeful, with one-third (33 percent) indicating that they are stuck, while 17 percent feel discouraged. Just half (52 percent) said they were treated with respect all day. The findings from this and future Gallup Student Polls will highlight causes of the dropout crisis from the perspective of students themselves. The youth voice is a critical part of the ongoing dialogue about dropout prevention, and they can help us develop initiatives that sustainably change outcomes for our young people.

SERVICE AND ENGAGEMENT

The recently passed Edward M. Kennedy Serve America Act will boost the efforts of our Alliance's service initiatives through the most sweeping expansion of our country's service programs in 16 years. APA believes service is a bedrock strategy for tackling issues such as the high school dropout and college-readiness crises. By affirming the power of service to address some of the biggest challenges now facing the United States, this landmark piece of legislation will help reverse current dropout rates in communities across the country.

The Serve America Act will update and strengthen national service programs, including service-learning, a teaching method that combines volunteer service and a rigorous curriculum to engage young people in solving community problems. Research has shown that service-learning helps students achieve academically, develop civic and career-related skills, increase their self-confidence, and heighten their respect for diversity. Service-learning is a key component of our objective to help communities in this time of need and to ensure brighter futures for our children and youth.

Many students who ultimately drop out of school say they become disengaged during the middle-school years. The choices young people make at this age could set them on a course for active citizenship and engaged learning, or down a path of risky behavior and potential failure. Not enough opportunities currently exist for these children to engage in active learning through real-world experiences, such as school or community-based learning and career-centric activities.

Our national action strategy, "Ready for the Real World," brings together partners from professional societies and businesses looking for ways to connect with and prepare their future workforce. By designing "real-world" experiences relevant to them, the initiative exposes youth to service learning and career exploration, increasing their motivation to achieve in school, college, and life.

Through America's Promise, partners provide a range of resources and real-life experiences, such as job shadowing and mentoring programs. Ready for the Real World established innovative after-school and summer programs for youth, which are integrated into school curriculums afterwards. This type experiential learning has inspired at-risk youth to achieve academically, pursue higher goals, and contribute positively to their communities.

PREPARED STATEMENT OF THE AMERICAN PSYCHOLOGICAL ASSOCIATION

The American Psychological Association (APA), the largest scientific and professional organization representing psychology in the United States and the world's largest association of psychologists, works to advance psychology as a science, as a profession and as a means of promoting human welfare. APA is grateful for the opportunity to submit written testimony on goals for the fiscal year 2010 appropriations bill. Below we enumerate recommendations for specific programs.

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 and Services Administration. This nationally competitive grant program provides integrated healthcare services to underserved communities—those individuals most in need of mental and behavioral health support with the least access to these services, including children, older adults, chronically ill persons, and victims of abuse or trauma.

Since 2002, GPE grants have provided interdisciplinary training for approximately 2,500 graduate students of psychology and other health professions to provide integrated healthcare services to underserved populations. There have been 70 grants in 30 States. Students benefiting from GPE grants have worked with more

than 30 different types of health professionals. GPE funding has allowed programs to double the number of students they are able to train: and more students trained means more impact on underserved populations. The GPE Program currently supports training grants at 18 academic institutions and training sites (e.g., children's and VA hospitals) throughout the Nation. All of the approximately 900 psychology graduate students who benefited from GPE funds are expected to work with underserved populations and 34–100 percent will be working in underserved areas immediately after completing the training.

Currently 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, this program has proven effective for meeting the growing health needs of our Nation's least served communities. This year, specific authorizing legislation has been introduced in the U.S. Senate (S. 811) as well as in the U.S. House of Representatives (H.R. 2066).

The GPE program specifically seeks to support our Nation's aging and veteran populations. Twenty percent of people older than 55 suffer from a mental disorder (2005); mental disorders affect physical health and the ability to function (2008); and approximately 70 percent of all primary care visits by older adults are driven by psychological factors. In addition, older adults with chronic illnesses such as heart disease have higher rates of depression than those medically well, and depression lowers immunity and may compromise a person's ability to fight infection (2008). One in five military personnel returning from Iraq and Afghanistan report symptoms consistent with major depression, generalized anxiety or post-traumatic stress disorder (PTSD) (2008). According to the Pentagon the number of U.S. troops diagnosed by the military with PTSD jumped nearly 50 percent from 2006 to 2007 as more troops served lengthy and repeated tours in Iraq and Afghanistan (2008). Furthermore, the U.S. Army reported in May (2008) that more U.S. soldiers committed suicide in 2007 than at any time since the first Gulf War.

Providing $7 million in fiscal year 2010 would allow for 30 additional GPE grants including those that focus solely on the needs of older adults and returning military personnel and their families. There are approximately 900 eligible universities, professional schools and hospitals in every State nationwide.

SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION (SAMHSA)

Garrett Lee Smith Memorial Act Programs—Campus Suicide Prevention Program

APA encourages the subcommittee to increase funding for the programs at SAMHSA authorized by the Garrett Lee Smith Memorial Act, especially the Campus Suicide Prevention program.

The Campus Suicide Prevention program is a small, but important program that seeks to assist college and universities raise awareness about mental and behavioral health to prevent suicides. By providing educational materials and outreach, the Campus Suicide Prevention program increases awareness about the signs of and risks of mental health problems and ensures greater success in college completion for those at risk of school failure because of concerns like stress, depression, eating disorders, risk behaviors, and suicidal thoughts.

There is a special need to increase funds for this program during the difficult economic times facing our Nation. A recent APA survey found that 18–29 year olds felt the economy added to their stress more than other concerns, like relationships or housing, a change from past years. The American College Counseling Association's 2008 Survey of College Counseling Center Directors found that "95 percent of directors report that the recent trend toward greater number of students with severe psychological problems continues to be true on their campuses." Addressing the mental and behavioral health needs of students in college and university settings can mean the difference between school failure or graduation on one hand, and life and death on the other.

Center for Mental Health Services, Minority Fellowship Program (MFP).—While minorities are projected to comprise 40 percent of the U.S. population by 2025, only 23 percent of recent doctorates in psychology, social work, and nursing were awarded to minorities. The MFP's mission is to address this need by increasing the number of minority mental health professionals and by training mental health professionals to become culturally competent. APA urges Congress to fund the Minority Fellowship Program at $7.5 million for fiscal year 2010.

Emergency Mental Health and Traumatic Stress Services Branch: Child Trauma.—SAMHSA has made tremendous efforts in this area through the outstanding National Child Traumatic Stress Network program. APA urges Congress to appropriate full funding for the National Child Traumatic Stress Initiative at the origi-

nally authorized level of $50 million for fiscal year 2010. To ensure continuity of leadership in this program, APA recommends the subcommittee encourage SAMHSA to expand the duration of NCTSI grant awards from 3 years to 6 years.

Center for Substance Abuse Prevention (CSAP): Substance Use and Mental Disorders of Persons with HIV.—According to recent reports, almost half of those with HIV/AIDS screened positive for illicit drug use or mental disorders. Unfortunately, healthcare providers fail to detect mental disorders and substance use problems in almost half of patients with HIV/AIDS. Several diagnostic screening tools are available for use by nonmental health staff. APA encourages SAMHSA and CDC to collaborate with HRSA to train healthcare providers to screen HIV/AIDS patients for mental health and substance use problems.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Lifespan Respite Program Family Caregivers.—Respite can provide family caregivers with relief necessary to maintain their own health, bolster family stability and well-being, and avoid or delay more costly nursing home or foster care placements. Under the Lifespan Respite Care Program, funds are available to improve access to respite for family caregivers. APA urges Congress to fund the Lifespan Respite Care Program at its authorized level of $71.1 million for fiscal year 2010.

CENTERS FOR DISEASE CONTROL AND PREVENTION (CDC)

National Center for Injury Prevention and Control: Child Maltreatment Prevention at Community Health Centers (CHCs).—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, including health and mental health outcomes.

National Center for Health Statistics (NCHS): Eating Disorders.—Eating disorders may have serious, chronic effects on one's quality of life and often co-occur with significant physical and mental health problems. However, the impact of these disorders has not yet been appropriately investigated. APA urges the subcommittee to encourage CDC to increase support for surveillance and research efforts regarding the incidence, morbidity, and mortality rates of eating disorders, including anorexia nervosa, bulimia nervosa, binge eating disorder, and eating disorders not otherwise specified across age, ethnicity and gender subgroups.

Sexual and Gender Identity Inclusion in Health Data Collection.—The National Health Interview Survey (NHIS) is the most comprehensive and widely referenced Federal health statistics survey, yet currently does not include any question concerning sexual orientation and gender identity. APA recommends the allocation of an additional $2 million in funding for NHIS in the NCHS budget, to enable Government agencies to better understand and plan for the unique health needs of lesbian, gay, bisexual, and transgender individuals.

Administration for Children and Families.—Sexualization of Girls. Throughout U.S. culture, female children, adolescents, and adults are frequently depicted and treated in a sexualized manner that objectifies them. 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.

National Institutes of Health (NIH).—APA supports the request of the Ad Hoc Group and Coalition for Health Funding, urging an increase of at least 7 percent for the NIH. Years of sub-inflation budgets have stressed the NIH research enterprise, and made sharing of resources among programs more difficult. The fiscal year 2009 increase provided by Congress begins to ameliorate the budget difficulties, but scientific research will benefit from a smooth, steady and predictable rise in spending.

APA likewise supports an increase of 7 percent (to $28.61 million) for the NIH Office of Behavioral and Social Sciences Research in the Office of the Director. This small but important office coordinates behavioral and social science research initiatives across Institutes and Centers, and helps form partnerships to leverage the intellectual and monetary resources that make good science possible.

The behavioral and social sciences are leading proponents of cooperation and cost-sharing in cross-cutting NIH initiatives. APA supports NIH's decision to authorize

a Basic Behavioral and Social Sciences Research "Blueprint," to which several Institutes would contribute, to strengthen NIH funding of basic research in the behavioral and social sciences. This innovation will build creative cooperation and cost-sharing, and help plug gaps in NIH-supported basic research.

A key area of cooperation is in research on obesity. Given the role of obesity as a risk factor for the development of cardiovascular disease, diabetes, cancer, and arthritis, many of NIH's Institutes are collaborating with investigators and other Institutes to develop new ways to prevent and treat obesity and overweight as well as fostering the adoption of positive health behaviors.

For example, the Eunice Kennedy Shriver National Institute of Child Health and Human Development supports research into physical activity and eating behaviors and that examines the impact of family and peer support, developmental and social context, school-based interventions, which include the use of media and literacy, motivation, and use of various behavioral approaches to influence motivation in physical activity, food choices, and media use.

Alcohol and tobacco use are among the leading causes of death and disability in the United States, but NIH research funding to prevent, understand the etiology of, and treat tobacco and alcohol addiction is not commensurate with the public health burden of those diseases. APA suggests that as the NIH Scientific Management Review Board (SMRB) undertakes its review of the NIH organizational structure to optimize the research of substance use, abuse and addiction, that it also quantify the amount of NIH research funding dedicated to studies of alcohol, tobacco use and illicit substance use. Further, APA recommends that the SMRB evaluate the proportion of all substance use research funding at NIH compared to CDC estimates of the public health burden of disease (and costs to the criminal justice system) and consider a reapportionment of NIH funding to Institutes based on those findings.

DEPARTMENT OF EDUCATION

Office of the Director (OD).—Culturally and Linguistically Appropriate Education. Ethnically diverse children and American Indian/Alaska native children are performing at far lower levels than other students. APA urges the subcommittee to increase support for educational systems and the strengthening of programs that meet the unique cultural, linguistic and educational needs of ethnic minority and AI/AN students from pre-school to graduate-level education.

Office of Safe and Drug-free Schools: Bullying Prevention.—Bullying directly affects about one-third of American school children in a given semester. APA urges appropriate Federal funding to support the implementation of effective, research-based, and comprehensive bullying prevention programs.

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, and sponsor studies on the impacts of socio-emotional, behavioral, and attitudinal aspects of disability.

ELEMENTARY AND SECONDARY SCHOOL COUNSELING PROGRAM

APA requests that the subcommittee increase funds for the Elementary and Secondary School Counseling program. Authorized by the Elementary and Secondary Education Act's Fund for the Improvement of Education, this program increases the range, availability, quantity, and quality of counseling services in the elementary and secondary schools across the country.

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 2010.

APPA has consistently supported an increase in the authorization level for LIHEAP. The administration's fiscal year 2010 budget requests $3.2 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 2010.

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 $32.4 billion for the National Institutes of Health (NIH) in fiscal year 2010.
- —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 carries out its plan to create a cross-NIH basic behavioral research funding initiative, 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 2010 appropriations for the 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 21,000 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 look at how children grow, learn, and develop; 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 $32.4 billion for NIH in fiscal year 2010, an increase of 7 percent more than the fiscal year 2009 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.

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.

BASIC BEHAVIORAL SCIENCE RESEARCH NEEDS A STABLE INFRASTRUCTURE

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. Basic behavioral research continues to fare poorly at NIH, a circumstance that jeopardizes the success of the entire behavioral research enterprise. Let me remind you of the current situation.

Traditionally, the National Institute of Mental Health (NIMH) was the home for far more basic behavioral science than any other Institute. Many basic behavioral and social questions were being supported by NIMH, even if their answers could also be applied to other Institutes. But NIMH has reduced its support for many areas of the most basic behavioral research, in favor of translational and clinical research. This means that previously funded areas now are not being supported.

NIMH's abrupt decision to narrow its portfolio came without adequate planning and happened at the expense of critical basic behavioral research. We favor a broader spectrum of support for basic behavioral science across NIH as appropriate and necessary for a vital research enterprise. But until other Institutes have the capacity to support more basic behavioral science connected to their missions, programs of research in fundamental behavioral phenomena such as cognition, emotion, psychopathology, perception, and development, will continue to languish.

Current NIH leadership recognizes this gap, and has asked the Directors of the National Institute of General Medical Sciences and the National Institute of Aging to co-lead a new initiative that supports and expands new basic behavioral research throughout NIH. In March 2009, NIH leadership confirmed its commitment to this Basic Behavioral Research Opportunity Network in testimony to this subcommittee, and APS asks you to ensure that NIH follows through with the planning and execution of this crucial step forward for basic behavioral science at NIH and ultimately the health of all Americans.

Despite the clear central role of behavior in health, behavioral research has not received the recognition or support needed to prevent, or reverse the effects of, behavior-based health problems in this Nation. APS asks that you continue to help make behavioral research more of a priority at NIH, both by providing maximum funding for those Institutes where behavioral science is a core activity, by encouraging NIH to advance a model of health that includes behavior in its scientific prior-

ities, and by encouraging stable support for basic behavioral science research at NIH.

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's Behavioral Research Program continues to make excellent progress, supporting basic behavioral research as well as translational research on the development and dissemination of interventions in areas such as tobacco use, dietary behavior, sun protection, and decisionmaking. Recently, NCI's behavioral research branch has made concerted efforts to incorporate innovative social psychological theories into cancer prevention research. Basic social psychology provides useful and practical approaches for understanding risky health behaviors and tailoring interventions to reduce the incidence of cancer. For example, NCI funded a research program to assess differential psychological and physiological responses to exercise and the possible genetic and biological mechanisms of those responses. As a result, we now understand the influence of responses to cardiovascular exercise on future exercise behavior, and the researchers are evaluating an intervention to increase exercise behavior in sedentary participants. It is this kind of basic behavioral research that helps us understand how people are persuaded to adopt and maintain healthy behaviors. APS asks Congress to support NCI's behavioral science research and training initiatives and to encourage other Institutes to use these programs 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, normal aging may be accompanied by declines not only in such cognitive functions, but also in the processes supporting social and emotional behavior. However, we currently know little about the changes that may occur as we age. NIA-supported research into the brain mechanisms and cognitive processes underlying social and emotional behaviors in healthy older adults promises to dramatically increase our knowledge in this area. Using a combination of behavioral and neuroimaging methods to study social and emotional processing in normal aging, this research will lead to much greater understanding of the nature of aging-related changes in these central human characteristics. NIA's commitment to cutting-edge behavioral science is further illustrated by the Institute's leadership role in NIH's new 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 older Americans.

National Institute on Drug Abuse (NIDA).—By supporting a comprehensive research portfolio that stretches across behavior, neuroscience, and genetics, NIDA is leading the Nation to a better understanding of drug abuse which is key to both prevention and treatment. One of the striking things about psychological science research is that it often dispels "common sense" intuition. For example, recent NIDA-supported research has shown that certain anti-drug media campaigns that include attention-grabbing features such as harsh content or strong graphics, have no positive effect, and that in fact the campaigns that use fewer such dramatic features actually lead to better processing of the public service announcement (PSA). This kind of message-framing research will be used to develop and tailor the most effective PSAs, such as those that focus on social risk rather than physical damage, to curtail use of a wide variety of illicit substances. NIDA is also encouraging brain imaging and prevention message investigators to work together, fostering increased validation of health communication models. APS asks the subcommittee to support this and other critical behavioral science research at NIDA, and to increase NIDA's budget in proportion to the overall increase at NIH in order to reduce the health, social, and economic burden resulting from drug abuse and addiction in this Nation.

Eunice Kennedy Shriver National Institute for Child Health and Human Development (NICHD).—Several Institutes recognize the value and relevance of basic behavioral research to their mission, and NICHD is to be particularly commended for its support of behavioral research on important topics such as mechanisms of cognition and learning, developmental trajectories of language, and linkages among brain, behavior, and genes. For example, studies have shown that caregiver behavior can modify genetic influences on social behavior. Children with a particular variation of the serotonin gene who live in families that provide low levels of social and emotional support were found to be at increased risk for extreme shyness and social withdrawal in middle school years. But those children whose families provide high

levels of support, and who have that same genetic variation, didn't show the same levels of shyness. Research supported by NICHD's behavioral science programs continues to yield fundamental new insights into understanding early cognitive and behavioral development that have the potential to change how and when medical and psychological specialists evaluate typical cognitive, social, and behavioral development during infancy. APS asks Congress 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.

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 Dental and Craniofacial Research, the National Institute of Mental Health, the National Institute on Alcohol Abuse and Alcoholism, the National Heart, Lung, and Blood Institute, the National Institute of Diabetes and Digestive and Kidney Diseases, and the National Institute on Neurological Diseases and Stroke. 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 2010 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 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). The funds you included in the American Recovery and Reinvestment Act of 2009 (ARRA) are providing the NIH with a substantial influx of resources at a crucial time. Several consecutive years of stagnant budget growth had been eroding the scientific capacity painstakingly built up during the doubling. The rapid distribution of ARRA funds will allow scientists to explore new avenues of promising research through the funding of additional grants, which is already building momentum and sparking excitement in the research community. The stimulus funds represent a first step toward enabling NIH to maintain and to increase employment for highly skilled workers, purchase critical equipment and supplies, and enhance research capacity at institutions across the country. However, consistent future budget growth for NIH will be necessary to sustain this momentum beyond the period of stimulus spending and prevent an abrupt halt in these new research initiatives after the ARRA. Furthermore, absent a continued increase in support for NIH, as many as 20,000 jobs created in the biomedical sciences by the stimulus money could be lost. Therefore, the APS urges you to make every effort to provide the NIH with a 7 percent increase in fiscal year 2010.

The 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. The APS offers these comments on the budget recognizing both the enormous financial challenges facing our Nation and the great opportunity before us to make progress against disease.

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 such as the swine flu 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 will result in new tools and knowledge that can be used to design novel treatments and prevention strategies.

The NIH selects and funds investigator-initiated research of only the highest scientific merit through the use of the peer review system. Among the breakthroughs in the last year:

—NIH-funded researchers discovered that people with certain genetic variants are at increased risk for a stroke. This genetic link provides molecular clues to how strokes develop and also moves the field closer to personalized medicine. This work was performed by researchers who collaborated to study large populations

of patients over a long period of time, and is an example of research that was supported by multiple institutes within the NIH.[1]

—Scientists recently discovered that adults retain brown fat, a metabolically active type of fat tissue that was previously thought to exist only in infants and children. Because brown fat burns calories and energy, there is hope that this discovery could lead to new treatments for obesity and diabetes.[2]

—Researchers studying obesity and diet in an animal model found that chronic consumption of high levels of fructose leads to excess weight gain and molecular changes when paired with a high-fat, high-calorie diet. Understanding the physiological changes associated with the development of obesity is a first step toward the design of interventions that could prevent the serious health consequences associated with being overweight.[3]

Over the past several years, the Office of the Director has supplemented existing research programs with new types of awards as part of the NIH Roadmap for Medical Research. These include the New Innovator, Pioneer and Transformative Research Award Programs. Such programs support bold and creative researchers as they engage in high-risk, high-reward research, thus allowing more flexibility to explore novel ideas and challenge existing paradigms. The NIH is also using these programs as a model for distributing funds under the ARRA. The Research and Research Infrastructure "Grand Opportunities" program will fund potentially high-impact areas of science that will benefit from short-term funding.

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.

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. Recent data from the NIH shows that the average age of NIH supported principal investigators is now 50.8 years.[4] This is up nearly 12 years from the average principal investigator's age of 39.1 years in 1980. In addition, the average age at which a researcher obtains their first major research award from NIH has increased to 42.4 years. As the scientific workforce continues to age, and more researchers retire, there may be an insufficient number of young scientists who are trained to replace them. Over the last year, the NIH has put in place policies to help new investigators succeed in competing for their first major research awards. 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 APS joins the Federation of American Societies for Experimental Biology (FASEB) and the Ad Hoc Group for Medical Research Funding in urging that NIH be provided with a 7 percent increase in fiscal year 2010 to permit the agency to maintain its current wide-ranging and important research efforts.

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 Subcommittee regarding funding for nursing and rehabilitation related programs in fiscal year 2010. ARN represents professional nurses 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 illness and physical disability 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 disability, achieve their greatest potential, and work toward

[1] M. A. Ikram et al, New England Journal of Medicine 360, 1718–28. (April 23, 2009).
[2] A. M. Cypress et al, New England Journal of Medicine 360, 1509–17. (April 9, 2009).
[3] A. Shapiro et al, American Journal of Physiology—Regulatory, Integrative and Comparative Physiology 295, R1370–75. (November, 2008).
[4] http://grants.nih.gov/grants/new__investigators/resources.htm#data (accessed April 29, 2009).

productive, independent lives. They take a holistic approach to meeting patients' 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 in the form of 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 maximal 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 practice, 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 on medical rehabilitation and nursing and 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 for individuals affected by chronic illness and/or physical disability.

According to the Department of Health and Human Services, the Federal Nursing Workforce Development program at the Health Resources and Services Administration (HRSA), an estimated 36,750 nurses need to be recruited, educated, and retained 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 2007, due to the nursing faculty shortage, more than 40,000 qualified applicants were not able to matriculate in nursing school. The number of full-time nursing faculty required to "fill the nursing gap" is approximately 40,000, and, currently, there are less than 20,000 full-time nursing faculty members. Further exacerbating this issue, HRSA predicts that the nursing shortage is expected to grow to 41 percent by 2020.

ARN strongly supports the national nursing community's request of $263 million in fiscal year 2010 funding for Federal Nursing Workforce Development programs at HRSA.

NIDRR

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 2010 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 health care 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 $178 million in fiscal year 2010 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 traumatic brain injury (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 the need 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 2010 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; $20 million for the HRSA Federal TBI State Grant Program; and $13.3 million for the HRSA Federal TBI Protection and Advocacy Systems Grant Program.

CONCLUSION

ARN appreciates the opportunity to share our priorities for fiscal year 2010 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 2010 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 AND OPHTHALMOLOGY

Association for Research in Vision and Ophthalmology (ARVO) has two major requests:

—For Congress to fund the National Institutes of Health (NIH) in fiscal year 2010 at $32.4 billion (a 7 percent increase more than fiscal year 2009); and
—For Congress to make vision health a priority in the total funding of NIH by increasing the National Eye Institute (NEI) funding to $736 million (also a 7 percent increase).

The requested 7 percent increase represents a 3 percent increase plus the 2009 biomedical inflation index.

ARVO commends Congress for actions taken in fiscal year 2008 and 2009 to fund NIH. This includes the $150 million fiscal year 2008 supplement for investigator-initiated grants, the $10.4 billion of NIH funding included in the American Recovery and Reinvestment Act, and the fiscal year 2009 inflationary increase of 3.2 percent. However, ARVO still has concerns about long-term, sustained, and predictable funding for vision research.

Vision disorders are the fourth most prevalent disability in the United States and the most frequent cause of disability in children.[1 2 3 4] Healthy vision contributes to injury prevention, independence, and economic security. Over the next 30 years the elderly population of the United States will double and if we fail to take action, age-related eye diseases (diabetic retinopathy, glaucoma, cataracts, and age-related macular degeneration) will quickly overburden our healthcare system. While age-related eye diseases are the most common visual impairments in the United States, childhood vision loss is also of great concern because of its lifelong economic burden.

ARVO requests $32.4 billion of NIH funding for fiscal year 2010. This represents a 7 percent increase more than fiscal year 2009.

This ensures that prior investments in training junior investigators and clinician scientists translate to future improvements in health and healthcare services.

If junior investigators are unable to obtain research grants from the NIH, then the prior Government investment in their training will not translate into future translational medical breakthroughs. These scientists will simply transfer acquired skills to other career options.[5]

With the doubling of the NIH budget (1993–2003) universities increased their infrastructure for training life science Ph.Ds and hired more full-time faculty.[6] NIH funding has since remained flat, resulting in decreased rates of grant funding. As a consequence many academic scientists have either lost their jobs or taken part-time positions.[7] The current economic crisis has further amplified the problem. In recent months, the private sector in the United States laid off more than 80,000 scientists.[8] We think the best solution is to maintain sustained and predictable funding for scientists at all stages. If the average age when scientists obtain their first source of independent NIH funding continues to rise (currently 43 years) and funding bodies continue to restrict many postdoctoral funding opportunities to 2–5 years, a generation of analytical thinkers will be forced to find more realistic career options.[9]

To maintain economic and global competitiveness, research and development is essential for the United States to remain competitive in a global market. Both corporate and Government support of research has been declining. Innovation is crucial for maintaining global competitiveness.[10] Since vision problems are a global economic concern, the prevention and treatment of ocular disease contributes to the economic well-being of the United States and international economy.

NIH and NEI have been leaders in basic research that translates to better vision therapies. The NEI Director (Paul Sieving, MD, Ph.D.) has reported that 25 percent of all genes identified to date are associated with eye disease. Research supported by the NEI is aimed at translating these genetic discoveries to improved diagnosis and therapy.[11 12 13 14 15] The NEI has worked in association with: (1) the National Institute on Aging to better diagnose, prevent, and treat age-related macular degeneration, diabetes, and cataract; (2) The National Institute of Neurological Disorders and Stroke to protect and regenerate cells that die from retinal degeneration and glaucoma; and (3) the National Institute of Diabetes and Digestive and Kidney Disorders on studies of diabetic retinopathy.

NEI-sponsored research has resulted in improved therapies for age-related macular degeneration and diabetic retinopathy, a promising gene therapy for retinitis pigmentosa, and genetic studies of glaucoma in minority populations that have a disproportional higher incidence of glaucoma.[16]

—To reduce the economic burden of eye disease on the United States healthcare system

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[1] 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 p.
[2] http://www.ncbi.nlm.nih.gov/pubmed/15078664
[3] http://www.healthypeople.gov/data/2010prog/focus28/2004fa28.htm
[4] http://www.preventblindness.org/vpus/
[5] http://www.the-scientist.com/article/display/16526/
[6] http://www.sauvonslarecherche.fr/IMG/pdf/the__postdoc__crisis.pdf
[7] http://sciencecareers.sciencemag.org/career__magazine/previous__issues/articles/2007__07__13/caredit.a0700099
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[9] http://www.brokenpipeline.org/brokenpipeline.pdf
[10] http://www.nsf.gov/statistics/nsb0803/start.htm#research
[11] http://www.v2020.org/page.asp?section=000100010002
[12] http://www.v2020eresource.org/newsitenews.aspx?tpath=news22007
[13] http://www.healthypeople.gov/HP2020/
[14] http://www.nei.nih.gov/resources/strategicplans/neiplan/frm__cross.asp
[15] http://www.nei.nih.gov/amd/
[16] http://www.eyeresearch.org/resources/NEI__factsheet.html ARVO

In 2008, 3,638,186 persons in the United States were blind. And 1 in 28 individuals older than age 40 has a visual disability . . . In 2010 more than half of baby boomers will be at high risk for developing age-related eye diseases. Adequate research funding of studies aimed at preventing these age related diseases will reduce future healthcare expenditures, particularly to the Medicare and Medicaid programs.[17] [18] [19]

Treatment of eye diseases in the United States costs $68 billion/year. Vision impaired adults are employed at 44 percent the rate of healthy individuals and earn an average of $10,000 less per year.[20] [21] [22] Vision science research leads to therapies that delay, prevent and treat blinding ocular disease, leading to increased productivity of our work force and savings in the cost of healthcare.

SUMMARY

ARVO urges fiscal year 2010 NIH and NEI funding at $32.4 billion and $736 million, respectively, reflecting an at least 7 percent increase more than fiscal year 2009.

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 2010 appropriation for the Centers for Disease Control and Prevention (CDC). The ASM supports the fiscal year 2010 funding level of $8.6 billion for CDC recommended by the CDC Coalition and the Campaign for Public Health. Funding levels in recent years have not adequately supported the CDC mission to protect public health through health promotion and disease prevention. The ASM appreciates that the administration and Congress have included science and public health programs in the American Recovery and Reinvestment Act of 2009. It is essential, however, to also provide increased funding through the fiscal year 2010 appropriation and future fiscal years, at levels that sustain CDC programs to protect public health.

There are persistent challenges for the Nation's public health agencies at the Federal, State, and local levels. Among these are the nationwide outbreaks of swine influenza, salmonella food poisoning, and upsurges in vaccine preventable diseases such as measles and meningitis.

CDC is instrumental in preventing death and illness caused by infectious diseases, contamination of food or water, or release of bioterror agents. The recent public health concern surrounding human cases of swine influenza A (H1N1) virus infection illustrates the importance of CDC's role in the investigation and response to outbreaks of infectious diseases. CDC is working closely with officials in States where human cases of swine influenza A (H1N1) have been identified, as well as with health officials in other countries experiencing outbreaks of H1N1. CDC staff are deployed in the United States and internationally to provide guidance and technical support in response to this emerging health threat. During a rapidly evolving situation, CDC is working to reduce transmission and severity of the disease and to provide information to healthcare providers, public health officials, and the public.

CDC COMBATS INFECTIOUS DISEASES

CDC mission specific components cover a wide spectrum of disease control and prevention activities. One of these, the Coordinating Center for Infectious Diseases (CCID), oversees national centers focused on immunization and respiratory diseases; zoonotic, vector-borne and enteric diseases; HIV/AIDS, viral hepatitis, sexually transmitted diseases and tuberculosis prevention; and healthcare associated infections, migration, and quarantine. CCID centers use the latest technological tools and scientific information to respond to emergent public health challenges as rapidly and effectively as possible.

Emerging Infectious Diseases.—Newly recognized infectious diseases attract considerable attention from the public and the research community, evidenced by swine influenza A (H1N1) virus infection, H5N1 avian influenza, severe acute respiratory

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[17] http://www.ncbi.nlm.nih.gov/sites/entrez?cmd=Retrieve&db=pubmed&dopt=AbstractPlus&list__uids=15078664

[18] http://www.researchamerica.org/uploads/factsheet16vision.pdf

[19] http://www.preventblindness.org/advocacy/Action__Plan.pdf

[20] http://www.nei.nih.gov/

[21] http://www.eyeresearch.org/pdf/RA__Vision__08__V5.pdf

[22] http://www.ncbi.nlm.nih.gov/sites/entrez

syndrome (SARS), HIV/AIDS, so-called "mad cow" disease, West Nile Virus, and methicillin-resistant Staphylococcus aureus (MRSA) among others. The CDC must respond to these and other emerging diseases with scientific proficiency and round-the-clock readiness. The National Center for Preparedness, Detection, and Control of Infectious Disease's Division of Emerging Infections and Surveillance Services recruits partnerships across the CDC and with both national and international organizations, to track outbreaks and train laboratory scientists from around the world in preventing and responding to such threats. The CDC has repeatedly taken part in identifying previously unrecognized pathogens like the SARS virus. It also participates in relevant field research around the world.

Influenza Preparedness.—The CDC effort against influenza includes programs that focus on both seasonal and potential pandemic forms of the disease, such as human cases of swine influenza A virus infection. Every year, between 5 and 20 percent of the U.S. population gets the flu, more than 200,000 are hospitalized, and about 36,000 die. The CDC works with U.S. partners in health departments, clinical laboratories, vital statistics offices and healthcare providers to assess the annual burden of flu. Comprehensive CDC incidence reports use data from nine different sources, like the Nationally Notifiable Disease Surveillance System and the Emerging Infections Program's Influenza Project. In October 2008, the CDC contracted with the American Type Culture Collection to implement the CDC Influenza Reagent Resource, which will serve as a source of diagnostic material for laboratories in the event of an emerging pandemic. The agency also awarded $24 million for 55 projects at 29 State and local health departments to develop better pandemic preparedness models. Last fall, the Food and Drug Administration approved a lab test co-developed by CDC that can reliably detect flu viruses with results within four hours.

CDC extensively monitors the avian influenza virus H5N1 that has spread throughout Asia, the Middle East, and parts of Europe. Recognition that the relatively new virus could cause a human pandemic has mobilized public health institutions worldwide. There have been only 413 confirmed human cases in 15 countries (by March 30), but the sustained 60-plus percent mortality is unprecedented for an influenza virus. The CDC developed a measurement tool to help at-risk countries assess their ability to respond to an avian influenza pandemic. Moreover, it continues its laboratory and field research on H5N1 and other flu viruses. CDC scientists reported last year that some avian influenza A H7 virus strains have acquired new features that might boost their potential to cause human disease.

HIV/AIDS.—In August 2008, the CDC released its first estimates of HIV infections in the United States based on a new CDC-developed laboratory assay called serologic testing algorithm for recent HIV seroconversion (STARHS). The results, unfortunately, indicate that approximately 56,300 new U.S. HIV infections occurred in 2006, about 40 percent higher than CDC's former estimate. The STARHS technology is the basis for the first national surveillance system relying on direct measurement of new HIV infections and provides more precise estimates of HIV incidence. CDC continually tracks the nation's progress against this recalcitrant disease. For example, the CDC and other health agencies updated guidelines in March for the prevention and treatment of opportunistic infections in HIV-infected people.

Global Infectious Diseases.—Infectious diseases are responsible for 15 million (26 percent) of the 57 million annual deaths worldwide and the CDC is a valuable contributor to public health campaigns against these diseases. Examples include its vigorous distribution in developing countries of Haemophilus influenzae type b (Hib) vaccine. One of the leading causes of severe childhood pneumonia and meningitis, Hib disease annually causes an estimated 3 million illnesses and 400,000 deaths worldwide in children 5 years and younger. Hib vaccines have been widely used in industrialized countries for nearly 20 years, but underused in the poorest countries. The CDC estimates that this year use of Hib vaccine in these countries will exceed 80 percent, compared to less than 20 percent in 2004.

CDC funding supports rigorous research on globally significant diseases like malaria and tuberculosis, and underwrites incidence data gathered from around the world. The CDC is developing a network of Global Disease Detection Centers, along with the participating nations' ministries of health, academic institutions, the World Health Organization, and U.S. Departments of State and Defense. Centers currently operational are located in China, Egypt, Guatemala, Kenya, Thailand, and, added in 2008, Kazakhstan. They extend the reach of three established CDC programs in emerging infections, epidemiology training, and influenza. The Coordinating Office for Global Health oversees more than 200 CDC staff in more than 50 countries, as first-responders to disease outbreaks. In 2008, CDC responded to more than 90 international disease outbreaks and public health events and found 22 new pathogens.

An estimated 1.8 million airline passengers cross international borders daily, opening multiple routes for disease transmission. The CDC maintains a specific branch to deal with global migration and quarantine issues, using its GeoSentinel Network Surveillance System to collect information from 41 sentinel sites and 200 medical clinics in 75 countries around the world. CDC personnel now staff U.S. quarantine stations at 20 ports of entry and land border crossings. The CDC also provides U.S. travelers with health threat alerts; educational efforts last year included recommendations to the U.S. Olympic teams traveling to China.

Vaccination Campaigns.—CDC collects vaccine-related information to assist Federal, State, and local health officials. The CDC also invests considerable resources in educating the public on the importance of vaccination as a preventive tool. At times, vaccines can also alleviate disease rather than prevent initial infection. Last year, the CDC recommended that people age 60 and older be vaccinated against shingles to reduce the number of painful episodes, even in those with previous cases. The most recent CDC survey of childhood immunization in this country found that rates remain at or near record levels, with at least 90 percent coverage for all but one of the recommended series for young children. Still, more measles cases were reported in 2008 than any year since 1996 largely due to failure to vaccinate. Another CDC report concluded that marked reductions in rotavirus-caused gastroenteritis in U.S. infants and young children may be due to a recently introduced rotavirus vaccine, recommended by CDC in 2006 for routine immunization of infants. Rotavirus is the leading cause of severe gastroenteritis in the young, typically causing 55,000–70,000 U.S. hospitalizations and about 410,000 physician office visits annually. Every day, rotavirus kills about 1,600 children under age 5 worldwide.

CDC CONFRONTS HEALTHCARE-ASSOCIATED INFECTIONS, ANTIMICROBIAL RESISTANCE

Each year, healthcare-associated infections (HAI) account for an estimated 1.7 million infections and 99,000 associated deaths in the United States. With more than 1 billion hospital and doctor visits made by Americans each year, there unfortunately is ample opportunity for HAI exposure. A CDC report released in March estimates that the annual direct hospital cost of treating HAI ranges from $28.4 billion to $45 billion, and that improving infection control could save roughly $6 billion to $32 billion, depending on the percentage of infections preventable in healthcare settings. With 2009 healthcare costs expected to reach $2.5 trillion, saving resources through CDC-facilitated prevention clearly offers a sensible public health strategy.

CDC works to optimize practices for HAI prevention. For example, CDC reports that 85 percent of all invasive infections caused by methicillin-resistant Staphylococcus aureus (MRSA) are associated with healthcare settings. CDC guidelines help assure best practices in healthcare settings. Hospitals in a CDC-supported study reduced bloodstream and MRSA infections as much as 70 percent by implementing CDC prevention guidelines. Last September, CDC launched a public MRSA education campaign.

Antimicrobial resistance has emerged as a daunting global challenge, increasing the lethality of pathogens from extensively drug-resistant tuberculosis (XDR TB) to this year's flu virus strain highly resistant to the most commonly used prescription drug. Last year, 16 CCID surveillance systems and programs gathered incidence data on antimicrobial resistance among bacterial, fungal, parasitic and viral agents. CDC scientists are developing laboratory protocols and diagnostics for a growing list of drug-resistant pathogens. One example is a new protocol for molecular typing of methicillin-resistant S. aureus. The CDC's Antimicrobial Resistance Team also recently validated tests that will amend 2009 clinical and lab standards in testing microbial resistance to mupirocin (used for staph infections) and the carbapenem drugs used to treat enteric pathogens resistant to most other drugs.

CDC STRENGTHENS NATIONAL DEFENSES AGAINST BIOTERRORISM, PUBLIC HEALTH CRISES

The CDC's Terrorism, Preparedness and Emergency Response (TPER) funds support the Coordinating Office for Terrorism Preparedness and Emergency Response objectives. CDC provides science-based strategies and tactical coordination during public health events and maintains emergency response operations like the Strategic National Stockpile (SNS) and the Emergency Operations Center (EOC). The SNS is an invaluable national repository of antibiotics, antitoxins and other medical supplies that can be mobilized rapidly to augment State and local resources during a large-scale health emergency. Opened in 2003, the DEOC is staffed with experts 24/7/365, an integral part of the country's National Incident Management System.

The CDC's inaugural annual report on its TPER-funded activities released in January enumerates its wide-ranging activities. Activities include assessing current administration routes and dosage for anthrax vaccine, inspecting 110 research entities registered to possess microbes on the Federal select agents list, and mapping the DNA of the vaccinia virus (similar to smallpox virus) and tularemia bacteria for greater scientific insight into potential bioagents. TPER-funded capabilities help CDC respond more aggressively to public health crises of all kinds, far beyond the threat of bioterrorism. In fiscal year 2008, the EOC was activated in response to 55 domestic and 16 international events, including the floods in the Midwest, multistate Salmonella and E.coli 0157 outbreaks, and outbreaks of cholera and hemorrhagic fever in Africa.

The ASM concurs with the recommended level of $8.6 billion, which will provide needed new funding for CDC's programs that are so critical to protecting people in the United States and worldwide.

PREPARED STATEMENT OF THE AMERICAN SOCIETY FOR MICROBIOLOGY

The American Society for Microbiology (ASM) appreciates the opportunity to submit a written statement on the fiscal year 2010 budget for the National Institutes of Health (NIH). The ASM is the largest single life science society with more than 42,000 members, many of whom receive funding from the NIH. We are grateful for the $10.4 billion increase in funding for the NIH in the American Recovery and Reinvestment Act (ARRA) and the 3.2 percent increase in funding for NIH in the fiscal year 2009 Labor, Health and Human Services, and Education, and Related Agencies Appropriations Act. The additional ARRA funding enables NIH to support the ARRA goals to create and save jobs and increase purchasing power, as well as advance scientific research. The Nation's biomedical research enterprise will be kept more robust at a time when it is experiencing the adverse effects of the economic downturn and years of flat funding.

As Congress considers the fiscal year 2010 appropriation for NIH, the ASM recommends a budget of $32.4 billion, a 7 percent increase. The recommended funding increase will help NIH keep pace with expanded research opportunities and higher costs. It is important for NIH to prepare for the poststimulus years, in 2011 and beyond. It is also important to resume sustainable NIH funding, avoiding fluctuations for research and training programs that can disrupt projects, training, careers, and research progress. To perpetuate the benefits of ARRA funding, it is vitally important to provide sustained growth for the NIH in fiscal year 2010 and beyond.

More than 83 percent of the NIH budget is awarded through 50,000 competitive grants awarded to more than 325,000 researchers at more than 3,000 universities, medical schools, and other institutions in all 50 States. About 10 percent of the NIH budget supports research in NIH laboratories conducted by nearly 6,000 scientists. Research project grants are highly productive in terms of medical advances to benefit public health. NIH funding contributes to the Nation's economic recovery by stimulating new opportunities and investments in biotechnology and related industries, as well as expanding the skilled workforce critical to U.S. competitiveness in science and technology. NIH funding also impacts allied health workers, technicians, students, trade workers, and others who receive the leveraged benefits from NIH funding.

The following describes some of the compelling reasons for increased and sustained support for the NIH research mission and its proven benefit to technological innovation and public health.

NIH RESEARCH IS CRITICAL TO SCIENTIFIC PROGRESS

NIH Institutes and Centers fund research programs that address the Nation's challenges of safeguarding public health, security, and the economy. The National Institute of Allergy and Infectious Diseases (NIAID), for example, focuses on research to understand, treat, and prevent infectious, immunologic, and allergic diseases, leading to the development of vaccines, therapies and diagnostic tools. The NIAID also funds research on medical countermeasures against potential bioterror agents. The National Institute of General Medical Sciences (NIGMS) supports basic research on life processes in fields such as computational biology, genetics, and bioinformatics. NIH resources invested in the agency-wide Roadmap initiatives make possible projects that hold great potential but might otherwise not be funded due to difficulty and scope. Recently funded Roadmap projects include a network of nine centers using high-tech screening methods for drug discovery.

The NIH funding to individual researchers and research groups, through competitive peer-reviewed grants, is of particular consequence to the U.S. research enter-

prise. More than 120 discoveries made by NIH and NIH-supported researchers have garnered Nobel Prizes, and NIGMS has funded the Nobel Prize-winning work of 64 scientists. More than three-fourths of the U.S. recipients of the Nobel Prize in Physiology or Medicine received NIH support prior to their award. In fiscal year 2009 NIH is striving to lower the average age of first-time grant recipients to refresh the Nation's scientific investigator pool and help revitalize research in the United States. Our national anxiety over waning global competitiveness and a shrinking technical workforce argues for sustained NIH funding for both new and established investigators.

NIH investigator-initiated grants create new opportunities for original biomedical inquiry and expand training environments for students in technical fields. Investigator-initiated research projects lead to inventive solutions for medical problems. Each year, NIH also identifies, in consultation with the extramural research community, targeted areas within an emerging need or opportunity, and then requests grant applications from U.S. researchers. Focused opportunities announced last year by NIAID include studies to advance vaccine safety and development of assays for high-throughput drug screening. NIGMS-featured areas currently include computational models to detect, control, and prevent emerging infectious diseases. NIGMS also awards grants for nontraditional research through its Exceptional, Unconventional Research Enabling Knowledge Acceleration (EUREKA) program. NIH has placed new emphasis on supporting high-impact transformative research that might create new disciplines, revolutionary technologies, or otherwise radically change biomedical research. In 2008, it initiated transformative grant funding to foster investigator-initiated work considered high-risk but exceptionally promising.

NIH RESEARCH YIELDS MEDICAL ADVANCES

NIH supported research consistently produces significant discoveries with both real-world relevance and potential future use against emerging health threats. The following are selected examples of recently reported research that illustrate the vitality and creativity supported by NIH funding.

Antimicrobial Resistance and Drug Discovery.—Drug resistance spreading among microbial pathogens is complicating control of infectious diseases and adding to rising healthcare costs. Response by U.S. research institutions has been aggressive, including creation of a Federal Interagency Task Force co-chaired by NIAID, the Centers for Disease Control and Prevention, and the Food and Drug Administration. Causes of drug resistance are many, from overuse of prescription drugs to natural microbial mutations, and NIAID's research portfolio is equally diverse. In fiscal year 2007, the Institute invested more than $800 million to support basic and translational research on antimicrobials and on drug resistance. Recent results include:

—Scientists from NIAID, California, and China studied the genetics of the major strain of methicillin-resistant Staphylococcus aureus (MRSA), concluding that a radical shift may be needed in how scientists design MRSA therapeutics. MRSA causes an estimated 94,000 cases of infection annually in the United States, with more than 19,000 deaths.

—NIGMS-funded researchers are developing a new generation of antibiotic compounds that do not elicit drug resistance. The enzyme-inhibitor compounds interfere with "quorum sensing"—a process by which bacteria communicate with each other. Those in the current study work against Vibrio cholerae, which causes cholera, and E. coli 0157:H7, the food contaminant that annually causes about 110,000 illnesses in the United States.

To circumvent antimicrobial resistance, NIH researchers and their extramural collaborators are intensifying research strategies better suited to rapidly changing pathogens and disease demographics. These include state-of-the-art technologies that fuel 21st century drug discovery. A recent example is NIGMS-funded research using mass spectrometry technology to determine the molecular structure of a class of natural compounds called nonribosomal peptides (NRPs), intensely studied for their drug potential (penicillin is an NRP). A significant advance over previous approaches, it may help reprogram nonpathogenic E. coli into NRP minifactories.

Infectious Diseases.—Infectious diseases remain among the most difficult global health challenges, accounting for about one-quarter of all deaths and nearly two-thirds in sub-Saharan Africa. At NIAID and NIGMS, multiple programs and interdisciplinary strategies target the major causes of global death and disability, with cutting-edge tools like genomics and nanotechnology.

Influenza.—Despite the availability of influenza drugs and vaccines, seasonal influenza still kills more than 250,000 people worldwide each year. Public health officials are now concerned about reports that 98 percent of a H1N1 influenza virus

strain (1 of 3 circulating in the 2008–2009 season) are resistant to oseltamivir (Tamiflu), the leading influenza drug, compared to 11 percent resistance among all viral strains during the 2007–2008 season. The possibility of an influenza pandemic caused by the more lethal H5N1 avian flu virus has mobilized an international response from health agencies and medical researchers. In January, the Department of Health and Human Services awarded a contract to build the first U.S. manufacturing facility for cell-based influenza vaccines, expected to increase the Nation's current capacity to make vaccine by at least 25 percent and much less time. NIH funding contributed to this major advance in vaccine production and to other recent advances, such as:

—NIAID-supported scientists used new monoclonal techniques to create human influenza-fighting antibodies in the laboratory in a matter of weeks, rather than the months previously required. The antibodies have potential for diagnosis and treatment regimens that can respond more quickly to newly emerging strains of influenza.

—NIGMS-funded researchers used super-computer capabilities to identify more than two dozen new candidate drugs to treat avian influenza ("bird flu"), in preparation for a possible pandemic of drug-resistant H5N1 virus strains.

—Three research teams and a computer informatics group—part of the NIGMS-funded Models of Infectious Disease Agent Study (MIDAS) Network—modeled pandemic influenza in the United States, concluding mitigation is possible with prompt, coordinated use of social-distancing measures and antiviral treatment until vaccine is available.

HIV/AIDS.—An estimated 33 million adults and children are living with HIV infection worldwide, and about 2 million die each year from related causes. In the United States, where nearly 546,000 people have died thus far from HIV/AIDS-related illnesses, there currently are an estimated 1.1 million infected, with 21 percent unaware of their infection. HIV/AIDS as both a domestic and global threat is a high priority at NIH. Difficulties in developing preventative vaccines prompted a 2008 NIH vaccine summit and subsequent re-examination of NIH's research agenda. NIH-supported basic research is steadily adding to our understanding of HIV/AIDS, evidenced by recent discoveries in mechanisms of HIV protease inhibition and the NIGMS-funded success in seeing microscopically for the first time molecules grouping in living cells to form single HIV particles. Other recent advances include:

—A vaginal gel to prevent HIV infection in women has shown encouraging signs of success in a clinical trial in Africa and the United States. This is the first human clinical study to suggest that a microbicide may prevent male-to-female sexual HIV transmission.

—An extended course of the antiretroviral drug nevirapine helps the breastfeeding babies of HIV-infected mothers remain HIV-negative and live longer, according to several new studies. About 150,000 infants worldwide acquire HIV annually through breastfeeding.

—The incidence of childhood illness and death due to HIV infection can be dramatically decreased by testing very young babies for HIV and giving antiretroviral therapy (ART) immediately to those found infected—giving ART to HIV-infected infants beginning at an average age of 7 weeks made them four times less likely to die in the next 48 weeks.

Tuberculosis.—One-third of the world's 6.7 billion people are thought to be infected by Mycobacterium tuberculosis (Mtb), the microbe that causes tuberculosis. An estimated 13.7 million have the active form. Each year, about 1.7 million die from this age-old disease that has adopted some disturbing modern-day features, striking as co-infections with the HIV virus and becoming resistant to drug therapies used to treat tuberculosis. In 2007, about 9.3 million people developed new cases of TB; 1.37 million were also HIV positive. The rapid spread of multidrug- and extensively drug-resistant forms (MDR TB/XDR TB) is alarming—MDR TB currently accounts for an estimated 5 percent of all TB cases and the frequently fatal XDR TB has been detected in 46 countries thus far. In April 2008, NIAID launched an aggressive research agenda against drug-resistant tuberculosis. NIH-supported research from the past year includes:

—NIAID scientists and industry collaborators found that, when the candidate TB drug PA–854 is metabolized inside Mtb bacteria, a lethal dose of nitric oxide gas is produced, killing the pathogen and suggesting new ways to develop drugs capable of killing latent TB bacteria. Currently there are no drugs available to target latent tuberculosis infections.

—Scientists reported that two FDA-approved drugs work in tandem to kill the tuberculosis pathogen and could help counter drug-resistant forms. The drugs are already used to treat other bacterial diseases, but their effectiveness against TB

bacteria had not been studied. NIAID is planning a clinical trial this year in patients with MDR TB and XDR TB.

Malaria.—Nearly half of the world's population is at risk of contracting malaria, a preventable and curable mosquito-borne disease in more than 100 countries. The World Health Organization (WHO) estimates that 300 to 500 million cases of clinical malaria worldwide occur each year, killing 1.3 million people. Unfortunately, its impact is intensifying with the emergence of drug-resistant parasites and insecticide-resistant mosquitoes. In April 2008, NIAID announced its new strategic plan to accelerate malaria control and eradication. NIH research often involves international partners and encompasses all aspects of malaria, including these recent examples:

—NIGMS funding supported the genetic decoding of the parasite responsible for 40 percent of infections, Plasmodium vivax, 1 of 4 malaria parasites that routinely affect humans. The most common species outside Africa (including the United States), P. vivax is increasingly resistant to some antimalarial drugs.

—The NIAID-funded Malaria Research and Training Center in Mali completed the first clinical trial of a vaccine to block the malaria parasite from entering human blood cells.

—NIGMS-supported research described how harmless E. coli bacteria can be harnessed to synthesize an antimalarial compound in bulk, far less expensive than the current process.

INFECTIOUS DISEASE RESEARCH USES INTERDISCIPLINARY STRATEGIES AND NEW TECHNOLOGIES

NIAID and NIGMS, like other NIH Institutes and Centers, support productive basic research on literally hundreds of diseases, from periodic foodborne E. coli or Salmonella outbreaks to isolated cases of Ebola fever or anthrax. This enormous responsibility forces constant adaptation to new challenges, often through greater reliance on interdisciplinary strategies or novel research tools and technologies—epitomized by the large-scale, genetics-based initiatives made possible with today's powerful computing capabilities. In 2008, NIH launched a multi-Institute epigenomics initiative to better understand the role of the environment in regulating mammalian genes, through genome mapping, data analysis, and technology development. NIH also agreed to share databases from its Human Microbiome Project in support of the newly formed International Human Microbiome Consortium. Characterizing the human microbiome, which is the collective DNA of all the microbes living in or on the human body, will elucidate the relationship between microbes and humans during health and disease. Shared sample repositories overseen by databases expedite information exchange among scientists. Computerized screening of pathogen genomes similarly accelerates the search for treatments, vaccines, and diagnostics.

CONCLUSION

ASM is thankful that Congress recognizes both the medical benefits and economic impacts of biomedical research and has provided an infusion of funding for the NIH to uncover new knowledge that will improve public health. Investing in NIH will impact the health of people for years to come and the biomedical community is working to ensure wise investment of the new resources in fiscal year 2009. We are confident that investments in the NIH will result in new discoveries and innovations that can address many of our health and economic challenges.

PREPARED STATEMENT OF THE AMERICAN SOCIETY FOR NUTRITION

The American Society for Nutrition (ASN) appreciates this opportunity to submit testimony regarding fiscal year 2010 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 $32.4 billion for NIH, and we request $137.5 million for NCHS in fiscal year 2010.

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—NIH and NCHS.

NIH

NIH is the Nation's premier sponsor of biomedical research and is the agency responsible for conducting and supporting 90 percent (nearly $1 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 2010 funding level of $32.4 billion for the agency, which is a 7 percent increase ($2.1 billion) more than fiscal year 2009.

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. We applaud Congress' inclusion of funds for NIH in H.R. 1, the American Recovery and Reinvestment Act, and also the boost provided in the fiscal year 2009 omnibus appropriations bill. 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 7 percent increase we recommend is an important step toward President Obama's campaign pledge to double funding for basic research over 10 years and is necessary to maintain both the existing and future scientific infrastructure. The discovery process—while it produces 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 is disruptive to training, to careers, long-range projects and ultimately to 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 NCHS

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.

Over the past few years, flat and decreased funding levels have threatened the collection of this important information, most notably vital statistics and the NHANES. ASN was pleased to see that Congress appropriated an additional $11 million to the agency—for nearly $125 million total—in fiscal year 2009. This 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.

To continue support for the agency and its important mission, ASN recommends an fiscal year 2010 funding level of $137.5 million for the agency, which is a $12.5 million increase over fiscal year 2009.

Current funding levels for NCHS remain precarious. Before the recent increase in funds, NCHS had lost $13 million in purchasing power since fiscal year 2005 due to years of flat funding, coupled with inflation and the increased costs of technology and information security. These shortfalls 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.

Moreover, nearly 30 percent of the funding for NHANES comes from other Federal agencies such as the NIH and the Environmental Protection Agency. When these agencies face flat budgets or cuts, they withdraw much-needed support for NHANES, placing this national treasure in even greater jeopardy.

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.

Providing an additional $12.5 million in fiscal year 2010 continues the progress on the path to boost funding for the NCHS to $175 million by 2013. Reaching this level over 5 years, through annual increases of approximately $11–12 million, would allow the agency to reach what its supporters call "blue sky." Such an increase would ensure uninterrupted collection of vital statistics and sustain over-sampling of vulnerable populations.

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.

Basic 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 drug discovery and therapies. Although the NIH does offer some funding support to plant biology research, with increased funding plant biologists can offer much more to advance the missions of

the NIH. In the next section, we highlight the particular relevance of plant biology research to human health.

PLANT BIOLOGY AND THE 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 healthy life and reduce the burdens of illness and disability" (http://www.nih.gov/about/index.html#mission). 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.

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. One World Health Organization (WHO) 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 illnesses such as respiratory infections and diarrhea. In other words, those illnesses would not have proved fatal had the children simply received proper nutrition. 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.

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 WHO 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 antimalarial 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 eventually isolated and named taxol after the tree's Latin name, Taxus brevifolia. Originally, taxol could only be obtained from the tree bark itself, but basic research led to identification 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 information 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 FOR PHARMACOLOGY AND EXPERIMENTAL THERAPEUTICS

The American Society for Pharmacology and Experimental Therapeutics (ASPET) is pleased to submit written testimony in support of the National Institutes of Health (NIH) fiscal year 2010 budget. ASPET is a 4,500-member scientific society whose members conduct basic and clinical pharmacological research within the academic, industrial, and government sectors. Our members discover and develop new medicines and therapeutic agents that fight existing and emerging diseases as well as increasing our knowledge regarding how therapeutics work in humans.

ASPET members recognize the trust and support that Congress displayed with the recent $10.4 billion provided to the NIH in the American Recovery and Reinvestment Act (ARRA). This was a visionary attempt by Congress to stimulate the economy by restoring their historic support of the NIH which has lagged over the last 6 years as appropriations have failed to adequately fund the NIH to meet scientific opportunities and challenges to our public health. Prior to ARRA funding, the NIH research portfolio could barely keep pace with the inflation rate and the country's leadership in biomedical research was in danger. Since the completion of a bipartisan plan to double the NIH budget that ended in 2003 and prior to ARRA funding, the NIH budget had been going backwards.

For fiscal year 2010, ASPET urges Congress to increase funding for the NIH by 7 percent. This would be the first step toward the President's pledge to double funding for basic research over 10 years and importantly, would help to maintain existing and future scientific infrastructure. Scientific discovery takes time and a 7 percent increase in fiscal year 2010 and beyond will help NIH manage its research portfolio effectively without necessitating disruptions in continuity of existing grants to researchers throughout the country. Only through sustainable and predictable funding can NIH continue to fund the highest-quality biomedical research to help improve the health of all Americans and continue to make significant economic impact in many communities across the country. Failing to capitalize upon the ARRA investments in fiscal year 2010 and beyond will mean that NIH will have to dismantle newly built research capacity and terminate important research projects after the ARRA funds have been spent. This would have serious consequences for future scientific discovery. Scientific discovery takes time and is unpredictable. As recent experience has shown from the postdoubling experience, boom and bust cycles of rapid funding followed by significant periods of stagnation or retraction in the NIH budget diminish scientific process. If NIH cannot sustain its recent investments from the ARRA, a rapid diminishment of funding will further disrupt scientific careers among promising young and early career scientists who see little hope of promising and rewarding careers in biomedical research. It is critical to avoid a boom and bust cycle for NIH funding. Thus, appropriating NIH a 7 percent increase beginning in fiscal year 2010 will help achieve the full promise of biomedical research.

NIH IMPROVES HUMAN HEALTH AND IS AN ECONOMIC ENGINE

A 7 percent increase in fiscal year 2010 will help to reverse what ASPET feels is a wrong signal that has been sent to the best and brightest of our students who will not be able to or have chosen not to pursue a career in biomedical research. Failing to address the NIH scientific and infrastructure needs post-ARRA in 2010 and beyond will mean a significant reduction in research grants, jobs lost and the resulting phasing-out of research programs. Additionally, there would be a loss of scientific opportunities to discover new therapeutic targets to develop, and fewer discoveries that produce spin-off companies that employ individuals in districts around

the country. A 7 percent increase would provide the Institutes with an opportunity to fund more high-quality and innovative research, and provide the resources and incentives that will drive more young scientists to commit to careers supporting continuing improvements in public health. This investment will also go directly into supporting jobs for U.S. citizens and residents and will continue to stimulate the economy.

Many important drugs have been developed as a direct result of the basic knowledge gained from federally funded research, such as new therapies for breast cancer, the prevention of kidney transplant rejection, improved treatments for glaucoma, new drugs for depression, and the cholesterol lowering drugs known as statins that prevent 125,000 deaths from heart attack each year. AIDS-related deaths have fallen by 73 percent since 1995 and the 5-year survival rate for childhood cancers rose to almost 80 percent in 2000 from under 60 percent in the 1970s. NIH studies have indicated that adopting intensive lifestyle changes delayed onset of type 2 diabetes by 58 percent and that progesterone therapy can reduce premature births by 30 percent in women at risk.

Historically, our past investment in basic biological research has led to innovative medicines that have virtually eliminated diphtheria, whooping cough, measles and polio in the United States. Eight out of ten children now survive leukemia. Death rates from heart disease and stroke have been reduced by half in the past 30 years. Molecularly targeted drugs such as Gleevec™ to treat adult leukemia do not harm normal tissue and dramatically improve survival rates. NIH research has developed a class of drugs that slow the progression of symptoms of Alzheimer's disease. The robust past investment in the NIH has provided major gains in our knowledge of the human genome, resulting in the promise of pharmacogenetics and a reduction in adverse drug reactions that currently represent a major worldwide health concern.

But unless NIH can maintain an adequate funding stream scientific opportunities will be delayed, lost, or forfeited to biomedical research opportunities in other countries and the human and economic cost will continue to impact all of us.

Scientific inquiry leads to better medicine and there remain many challenges and opportunities that need to be addressed. Two issues specific to ASPET highlight the need for appropriate NIH funding levels.

—The need to increase support for training and research in integrative/whole organ science. This will help to develop skilled scientists trained to understand how drugs act in whole animals, including human beings. Support for training and research in integrative whole organ sciences has been affirmed in the fiscal year 2002 Labor, Health and Human Services, and Education, and Related Agencies Appropriations Report (107–84). The Senate report supports ASPET recommendation that "Increased support for research and training in whole systems pharmacology, physiology, toxicology, and other integrative biological systems that help to define the effects of therapy on disease and the overall function of the human body." These principles and recommendations are also affirmed in the FASEB Annual Consensus Conference Report on Federal Funding for Biomedical and Related Life Sciences Research for fiscal year 2002.

—The need to meet public health concerns over growing consumer use of botanical therapies and dietary supplements. These products have unsubstantiated scientific efficacy and may adversely impact the treatment of chronic diseases, create dangerous interactions with prescription drugs, and may cause serious side effects including death among some users. Through the NIH, research into the safety and efficacy of botanical products can be conducted in a rigorous and high-quality manner. Sound pharmacological studies will help determine the value of botanical preparations and the potential for their interactions with prescription drugs as well as chronic disease processes. This research will allow the FDA to review the available pharmacology and review valid evidence-based reviews to form a valid scientific foundation for regulating these products.

CONCLUSION

NIH and the biomedical research enterprise face a critical moment. For the first time in 6 years, NIH has the potential to meet many of the more promising scientific opportunities that currently challenge medicine. Reversing the trends of the last half decade is only part of the solution. In order to help sustain scientific progress it is critical that NIH receive 7 percent to continue the progress made under the ARRA. A 7 percent increase for the NIH in fiscal year 2010 will permit the NIH to make greater strides to prevent, diagnose and treat disease, improving the health of our Nation and restoring the NIH to its role as a national treasure that attracts and retains the best and brightest to biomedical research.

PREPARED STATEMENT OF THE AMERICAN SOCIETY OF TROPICAL MEDICINE AND HYGIENE

OVERVIEW

The American Society of Tropical Medicine and Hygiene (ASTMH) appreciates the opportunity to submit written testimony to the Senate Labor, Health and Human, Services, and Education, and Related Agencies Appropriations Subcommittee. With more than 3,300 members, ASTMH is the world's largest professional membership organization dedicated to the prevention and control of tropical diseases.

We respectfully request that the subcommittee provide the following allocations in the fiscal year 2010 Labor, Health and Human, Services, and Education, and Related Agencies Appropriations bill to support a comprehensive effort to enhance malaria control programming globally:

—$18 million to the Centers for Disease and Control and Prevention (CDC) for malaria research, control, and program evaluation efforts with a $6 million set-aside for program monitoring and evaluation;
—$32.19 billion to National Institutes of Health (NIH);
—$5.07 billion to the National Institute of Allergy and Infectious Diseases (NIAID); and
—$73.5 million to the Fogarty International Center (FIC).

We very much appreciate the subcommittee's consideration of our views, and we stand ready to work with the subcommittee members and staff on these and other important global health matters.

ASTMH

ASTMH plays an integral and unique role in the advancement of the field of tropical medicine. Its mission is to promote global health by preventing and controlling tropical diseases through research and education. As such, ASTMH is the principal membership organization representing, educating, and supporting tropical medicine scientists, physicians, researchers, and other health professionals dedicated to the prevention and control of tropical diseases. Our members reside in 46 States and the District of Columbia and work in a myriad of public, private, and nonprofit environments, including academia, the U.S. military, public institutions, Federal agencies, private practice, and industry.

ASTMH's long and distinguished history goes back to the early 20th century. The current organization was formed in 1951 with the amalgamation of the National Malaria Society and the ASTMH. Over the years, the Society has counted many distinguished scientists among its members, including Nobel Laureates. ASTMH and its members continue to have a major impact on the tropical diseases and parasitology research carried out around the world.

ASTMH aims to advance policies and programs that prevent and control those tropical diseases which particularly impact the global poor. ASTMH supports and encourages Congress to expand funding for—and commitments to—national and international malaria control initiatives. As part of this effort, ASTMH recently conducted an analysis of federally funded tropical medicine and disease programs and developed fiscal year 2010 funding requests based on this assessment.

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 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.

The field of tropical medicine encompasses clinical work treating tropical diseases, work in public health and public policy to prevent and control tropical diseases, basic and applied research related to tropical diseases, and education of health professionals and the public regarding tropical diseases.

Tropical diseases are caused by pathogens that are prevalent in areas of the world with a tropical climate. These diseases are caused by viruses, bacteria, and parasites which are spread through various mechanisms, including airborne routes, sexual contact, contaminated water and food, or an intermediary or "vector"—frequently an insect (e.g. a mosquito)—that transmits a disease between humans in the process of feeding.

MALARIA

Malaria is a global emergency affecting mostly poor women and children; it is an acute and sometimes fatal disease caused by the single-celled Plasmodium parasite transmitted to humans by the female Anopheles mosquito.

Malaria is an acute, often fatal disease caused by a single-celled parasite transmitted to humans by the female Anopheles mosquito. 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. The World Health Organization (WHO) estimates there were 350 to 500 million malaria cases in 2000 and at least 1 million deaths from malaria, the vast majority of which were among young children in Africa. WHO estimates that one-half of the world's people are at risk for malaria, and that 109 countries are endemic for malaria. Malaria-related illness and mortality not only take a human toll, but also 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) indoor residual spraying of insecticide on the walls of homes; (2) long-lasting insecticide-treated nets; (3) Artemisinin-based combination therapies; and (4) intermittent preventive therapy for pregnant women. However, limited resources preclude the provision of these interventions and treatments to all individuals and communities in need.

REQUESTED MALARIA-RELATED ACTIVITIES AND FUNDING LEVELS

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.

CDC efforts on malaria fall into three broad areas—prevention, treatment, and vaccines. The agency performs a wide range of basic research within these categories, such as—

—investigation of the biology of host-parasite relationships;
—immune response to malaria;
—host genetic factors associated with malaria; parasite genetic diversity and drug resistance;
—HIV and malaria interaction; the efficacy of insecticide-treated nets in preventing illness and deaths;
—malaria and pregnancy;
—public health strategies for improving access to antimalarial treatment and delaying the appearance of antimalarial drug resistance;
—improved transmission reduction strategies; and
—vaccine development and evaluation.

Although endemic malaria has been eradicated in the United States, it remains one of world's leading causes of death and disease, and a significant proportion of CDC's malaria-focused work involves working in and with foreign countries to prevent the spread of malaria, and to assist in the treatment of those who have contracted the disease. CDC funding in fiscal year 2009 for global malarial activities is $9,396,000, which includes CDC's contribution to the $6.2 billion President's Malaria Initiative.

CDC participates in several global efforts, including:

—*The President's Malaria Initiative (PMI)*.—The PMI is a $6.2 billion, 9-year effort led by the U.S. Agency for International Development 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.
—*Amazon Malaria Initiative*.—This program works with countries in South America to combat the re-emergence of malaria in that part of the world.
—*West Africa Network Against Malaria During Pregnancy*.—CDC works with countries in Francophone West Africa to encourage the use of intermittent preventive treatment with sulfadoxine-pyrimethamine (IPTp/SP) to prevent anemia and death in pregnant women and malaria-related low-birthweight in their newborns.
—*Preventing and Controlling Malaria During Pregnancy in Sub-Saharan Africa*.—CDC works with many partners to prevent and control malaria among pregnant women and their newborns in sub-Saharan Africa.

—*International Red Cross and the Expanded Program for Immunizations*.—CDC works with these groups to implement and evaluate the effectiveness of distributing ITNs during immunization campaigns and during routine vaccine visits.

CDC collaborations support treatment and prevention policy change based on scientific findings; formulation of international recommendations through membership on WHO technical committees; and work with Ministries of Health and other local partners in malaria-endemic countries and regions to develop, implement, and evaluate malaria programs. In addition, CDC has provided direct staff support to the WHO; UNICEF; the Global Fund to Fight AIDS, Tuberculosis, and Malaria; and the World Bank—all stakeholders in the Roll Back Malaria Partnership.

NIH MALARIA PROGRAMS

As the premier biomedical research agency for the United States and the world, the NIH and its Institutes and Centers play an essential role in the development of new anti-malarial drugs, better diagnostics, and an effective malaria vaccine. NIH estimates that its fiscal year 2009 spending on malaria research will total $111 million while malaria vaccine efforts will receive $35 million. ASTMH urges that NIH malaria research portfolio and budget be increased by at least 6.6 percent in fiscal year 2010. To support a comprehensive effort to control malaria, ASTMH respectfully requests the following funding:

—$32.9 billion to NIH;
—$5.07 billion NIAID; and
—$73.5 million to the FIC for training that supports U.S. efforts targeting malaria and other neglected tropical diseases.

NIAID

Malaria continues to be among the most daunting global public health challenges we face. A long-term investment is needed to achieve the drugs, diagnostics and research capacity needed to control malaria. NIAID, the lead Institute for malaria research, plays an important role in developing the drugs and vaccines needed to fight malaria. ASTMH urges the subcommittee to increase NIAID funding so that present malaria research efforts be maintained and new areas explored such as:

—increasing fundamental understanding of the complex interactions among malaria parasites, the mosquito vectors responsible for their transmission and the human host;
—developing new diagnostics, drugs, vaccines, and vector management approaches; and
—enhancing both national and international research and research training infrastructure to meet malaria research needs.

FIC

Although biomedical research has provided major advances in the treatment and prevention of malaria, 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. By promoting applied health research in developing countries, the FIC can speed the implementation of new health interventions for malaria, TB, and neglected tropical diseases.

The 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 myriad 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, is 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 2010 to increase these efforts, particularly as they address the control and treatment of malaria.

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 2010 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

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. ATS, founded in 1905, is an independently incorporated, international education and scientific society that focuses on respiratory and critical care medicine. With approximately 18,000 members who help prevent and fight respiratory disease around the globe, through research, education, patient care and advocacy, ATS's long-range goal is to decrease morbidity and mortality from respiratory disorders and life-threatening acute illnesses.

RESPIRATORY DISEASE IN AMERICA

Respiratory disease is a serious problem in America. Respiratory disease is the third leading cause of death, responsible for 1 of every 7 deaths. Diseases effecting the lungs include chronic obstructive pulmonary disease, lung cancer, tuberculosis, influenza, sleep disordered breathing, pediatric lung disorders, occupational lung disease, sarcoidosis, asthma, and severe acute respiratory syndrome (SARS). The death rate due to chronic obstructive pulmonary disease (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. Cystic fibrosis and pulmonary hypertension, which jointly affect nearly 150,000 people in the United States, have no cure.

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 and the 3.2 percent increase provided through the omnibus fiscal year 2009 appropriations legislation. This funding will allow the NIH to continue to fund, rather than curtail, groundbreaking research into diseases that affect millions of Americans like COPD, asthma, and tuberculosis. It is critical that this urgently needed reinvestment in biomedical research is reinforced through annual budget increases that include inflationary adjustments. We ask that this subcommittee provide a 7 percent increase for NIH in fiscal year 2010 so that the institute can respond to biomedical research opportunities and public health needs.

Despite the rising lung disease burden, lung disease research is underfunded. In fiscal year 2008, 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 that is 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 to sustain the medical breakthroughs made in recent years.

CENTERS FOR DISEASE CONTROL AND PREVENTION

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 Centers for Disease Control and Prevention (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 also ask that the CDC budget be adjusted to reflect increased needs in chronic disease prevention, infectious disease control, in-

cluding 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 $8.6 billion for the CDC in fiscal year 2010. There are four lung diseases that illustrate the need for further investment in research and public health programs: COPD, pediatric lung disease, asthma and tuberculosis.

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 airflow obstruction associated mainly with emphysema and chronic bronchitis and is a growing health problem. CDC estimates that 12 million patients have COPD while an additional 12 million Americans are unaware that they have this life threatening disease.

Today, COPD is treatable but not curable. Medical treatments exist to relieve symptoms and slow the progression of the disease. Fortunately, promising research is on the horizon for COPD patients. Despite these leads, the ATS feels that research resources committed to COPD are not commensurate with the impact the disease has on the United States and that more needs to be done to make Americans aware of COPD, its causes and symptoms. 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 National COPD Education and Prevention Program. As this initiative continues, we encourage the NHLBI to maintain its partnership with the patient and physician community.

While additional resources are needed at NIH to conduct COPD research, CDC has a role to play as well. To address the increasing public health burden of COPD, the ATS encourages the CDC to create a COPD program at the Center for Chronic Disease Prevention and Health Promotion. We ask that the subcommittee provide an appropriation of $1 million in fiscal year 2010 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. The ATS also encourages the CDC to add COPD-based questions to future CDC health surveys, including the National Health and Nutrition Evaluation Survey (NHANES), the National Health Information Survey (NHIS) and the Behavioral Risk Factor Surveillance Survey (BRFSS).

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. However, of the seven leading causes of infant mortality, four are lung diseases or have a lung disease component. In 2005, lung diseases accounted for more than 19 percent of all infant deaths under 1 year of age. 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, of which 12.2 million had an asthma attack in 2005. 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.

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 illnesses and sleep disordered breathing affect an estimated 50–70 million Americans. A recent study conduced by CDC found that roughly 10 percent of Americans had not gotten enough rest at any point in the previous 30 days. The public health impact of sleep illnesses and sleep disordered breathing is still being determined, but is known to include 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 $2 million in fiscal year 2010 to support activities related to sleep and sleep disorders at the CDC, including for the National Sleep Awareness Roundtable (NSART), 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 (NCSDR) at the NHLBI.

TUBERCULOSIS

Tuberculosis (TB) is the second leading global infectious disease killer, claiming 1.7 million lives each year. It is estimated that 9–14 million Americans have latent tuberculosis. Drug-resistant TB poses a particular challenge to domestic TB control owing to the high costs of treatment and intensive health care resources required. Treatment costs for multidrug-resistant (MDR) TB range from $100,000 to $300,000, which can cause a significant strain on State public health budgets. The global TB pandemic and spread of drug resistant TB present a persistent public health threat to the United States.

Despite low 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/clusters occur, outstripping local capacity; (4) continued emergence of drug resistance threaten our ability to control TB; and (5) there are critical needs for new tools for rapid and reliable diagnosis, short, safe and effective treatments, and vaccines.

In recognition of the need to strengthen domestic TB control, the Congress passed the Comprehensive Tuberculosis Elimination Act (Public Law 110–392) in October, 2008. This historic legislation was based on the recommendations of the Institute of Medicine and 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 authorizes an urgently needed reinvestment into new TB diagnostic, treatment and prevention tools. The ATS, in collaboration with Stop TB USA, recommends a funding level of $210 million in fiscal year 2010 for CDC's Division of TB Elimination, as authorized under the Comprehensive TB Elimination Act.

The NIH has a prominent role to play in the elimination of tuberculosis through the development of new tools to fight the disease. We encourage the NIH to expand efforts, as requested under the Comprehensive TB Elimination Act, to develop new tools to reduce the rising global TB burden, including faster diagnostics that effectively identify TB in all populations, new drugs to shorten the treatment regimen for TB and combat drug resistance, and an effective vaccine.

FOGARTY INTERNATIONAL CENTER TB TRAINING PROGRAMS

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 care professionals in the area of TB treatment and research. These training grants should be expanded and offered to all institutions. The ATS recommends Congress provide $70 million for FIC in fiscal year 2010, which would allow the expansion 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 $340.1 million in fiscal year 2010 for NIOSH to expand or establish the following activities: the National Occupational Research Agenda (NORA); 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. It is this country's third leading cause of death. Lung disease and breathing problems are a leading killer of babies under the age of one year. Worldwide, tuberculosis is the second leading

infectious disease killer. 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 Association of Women's Health, Obstetric and Neonatal Nurses

The Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN) appreciates the opportunity to provide testimony on fiscal year 2010 appropriations for the Department of Health and Human Services (HHS).

AWHONN is a nonprofit membership organization made up of 23,000 nurses who care for mothers, their newborns, and women of all ages. AWHONN members are registered nurses, nurse practitioners, certified nurse-midwives, and clinical nurse specialists who work in hospitals, independent practices, universities and community clinics throughout the United States. Our mission is to promote the health of women and newborns.

Nurses are typically the first and most consistent point of contact in the healthcare setting. Evidence suggests that they spend more time with patients—up to four times on average—than any other healthcare provider. As such, nurses have a unique perspective on the healthcare system and the public health programs and agencies funded under HHS.

We thank the subcommittee for providing generous funding in past years and we are truly appreciative for the public health funding included in the American Recovery and Reinvestment Act of 2009. Recognizing the challenges the subcommittee will face in fiscal year 2010 in reconciling various expenditures in the face of overall budget deficits, please find our funding recommendations for fiscal year 2010 below.

HEALTH RESOURCES AND SERVICES ADMINISTRATION (HRSA)

As a member of the Friends of the Health Resources and Services Administration coalition, AWHONN recommends $8.5 billion for HRSA in fiscal year 2010.

HRSA programs support health professions education, healthcare services for underserved populations, programs to address the special needs of mothers and children, and more. For several years, HRSA has suffered from relatively level funding. In light of these difficult economic times, support for the Nation's safety net system is especially critical.

One of the most important aspects of HRSA's mission is to ensure a healthcare workforce that is sufficient to meet the needs of patients and communities.

Nursing Workforce Development Programs, title VIII of the Public Health Service Act

Along with the Nursing Community coalition, AWHONN recommends $215 million for title VIII programs in fiscal year 2010. An adequate supply of nurses is essential to ensuring that all Americans receive quality healthcare. Title VIII programs help to address the Nation's ongoing nursing and nurse faculty shortage by providing scholarships and loan repayment programs to nursing students, recent graduates and nursing school faculty. Title VIII also provides grants to schools of nursing and health centers to foster greater diversity and improved retention rates in the nursing workforce.

Maternal and Child Health (MCH) Block Grant, Title V of the Social Security Act

AWHONN recommends $850 million for the MCH Block Grant in fiscal year 2010. The MCH Block Grant, the only Federal program of its kind, is devoted to improving the health of women and children. For more than 70 years, the program has provided a source of flexible funding for States and territories to address their unique needs related to improving the health of mothers and children. Today, this program provides prenatal services to more than 2 million mothers—almost half of all mothers who give birth annually—and primary and preventive care to more than 17 million children, including almost 1 million children with special needs. Fully funding the MCH block grant will enable States to expand critical health services.

We recommend $30 million for newborn screening activities, which are currently funded under the MCH block grant Special Projects of Regional and National Significance. Newborn screening is a vital public health activity used to identify and treat genetic, metabolic, hormonal, and functional conditions in newborns. Screening detects disorders in newborns that, if left untreated, can cause disability, mental retardation, serious illnesses or even death. While nearly all babies born in the United States undergo newborn screening for genetic birth defects, the number and quality of these tests vary from State to State.

NATIONAL INSTITUTES OF HEALTH (NIH)

AWHONN, along with others in the science advocacy community, support increased funding for NIH in fiscal year 2010. Scientific research done at the NIH is leading to better patient care. In fact, federally funded research is responsible for nearly every major medical advancement in the last 50 years. While AWHONN supports the NIH in its entirety, several Institutes are especially important to the advancement of nursing and the health of women and newborns.

The Eunice Kennedy Shriver National Institute of Child Health and Human Development (NICHD)

The rate of preterm birth has increased 20 percent since 1990. The NICHD supports critical research into the causes and treatments for preterm birth.

AWHONN, along with the March of Dimes, recommends that Congress provide at least a 7 percent increase for NICHD in fiscal year 2010, a portion to be used to begin establishing transdisplinary research centers that focus on preterm birth. NICHD needs additional resources to expand research on the underlying causes of preterm birth taking into account the recommendations of the experts who participated in the Surgeon General's Conference on Preterm Birth in the summer of 2008.

National Institute of Nursing Research (NINR)

AWHONN, along with the American Nurses Association and the American Association of Colleges of Nursing, recommends $178 million for NINR in fiscal year 2010.

NINR supports nurse-led research that contributes to advancing high-quality, evidence-based care across the lifespan. Research at NINR has targeted, among other topics, health disparities, risk reduction, chronic illnesses, and care for rural and underserved populations. NINR promotes a uniquely important nursing perspective, as there is no caregiver that interacts with patients more or is more trusted by patients than nursing professionals. There is no other body that funds important nursing research similarly in this country, and NINR research has contributed measurably to more efficient and effective healthcare as our Nation struggles to fill continuing staffing shortages and gaps in healthcare services.

CENTERS FOR DISEASE CONTROL AND PREVENTION (CDC)

The CDC is dedicated to protecting health and promoting quality of life through the prevention and control of disease, injury, and disability. While AWHONN supports the CDC in its entirety, several agencies and programs are especially important to the advancing the health of women and newborns.

Safe Motherhood/Infant Health

The Safe Motherhood/Infant Health program works to promote infant and reproductive health. AWHONN is especially concerned with issues associated with prematurity. Preterm birth is the leading cause of neonatal death in the United States. In 2006, more than half a million babies—1 in 8 babies—were born prematurely in the United States.

In 2005, AWHONN launched its Late Preterm Initiative to address the special needs of infants born between 34 and 36 completed weeks of gestation. While many late preterm infants may appear healthy at birth, they are at risk for prematurity-related complications, increased morbidity and mortality and have an increased rate of rehospitalization in the first month of life.

Currently, the CDC is partnering with a number of universities and organizations to support research related to preterm birth and the reasons for disparities between racial and ethnic groups. AWHONN recommends a $6 million increase in the preterm birth line fiscal year 2010. This funding will allow the CDC to expand epidemiological work to evaluate the social, biological, and medical factors associated with preterm birth as authorized in the PREEMIE Act of 2006 (Public Law 109–450).

National Center on Health Statistics (NCHS)

NCHS is the Nation's principal health statistics agency, providing critical data on all aspects of the U.S. healthcare system. The agency provides data on healthcare trends, information that is essential for public health planning. However, current funding levels are threatening the collection of vital information, especially complete data on maternity and infant health status.

AWHONN, along with the Friends of NCHS, recommends at least $137.5 million for NCHS in fiscal year 2010. Additionally, we urge Congress to allocate $15 million bolus funding to support States and territories as they implement the 2003 birth certificates and electronic systems to collect these data.

PREPARED STATEMENT OF THE ANIMAL WELFARE INSTITUTE

The Animal Welfare Institute (AWI) respectfully requests that the subcommittee include the following report language regarding the funding of research involving the use of dogs and/or cats:

None of these funds shall be used 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 (i.e., individuals, dealers, breeders, and animal pounds) and resell them.

In response to the request included in last year's appropriation bill, the National Academy of Sciences (NAS) established a committee in the summer of 2008 to assess if there is a scientific rationale for relying on dogs and cats obtained from United States Department of Agriculture (USDA) licensed Class B dealers. Information on the Committee on Scientific and Humane Issues in the Use of Random-source Dogs and Cats for Research (ILAR–K–08–01–A) can be found at: http://www8.nationalacademies.org/cp/projectview.aspx?key=48974. The results of its deliberations are expected to be public later this month.

Based on our review of the data submitted to the NAS Committee, the presentations given during those portions of the meetings that were open to public, and our own extensive experience regarding Class B-licensed dealers, we anticipate findings in keeping with the proposed report language above.

According to USDA, of the nearly 95,000 total dogs and cats used in research, 2,863 dogs and 267 cats were supplied by random source dealers during fiscal year 2007. There are a mere 10 Class B dealers currently licensed by USDA and selling live random source dogs and cats for experimentation. One other dealer is presently under a 5-year license suspension. These dealers are notorious for selling to laboratories animals who have been acquired illegally and for their widespread failure to comply with other minimum requirements under the Animal Welfare Act. In fact, at this time, half of the remaining 10 dealers are under investigation by USDA for apparent violations of the Animal Welfare Act (AWA), and USDA is pursuing seven separate investigations regarding apparent supply violations identified during tracebacks conducted of dealer records.

Data from USDA inspection reports reveal myriad problems with licensed Class B dealers (we can supply copies of these inspection reports if they are of interest): Needed veterinary care is lacking for many random source animals. Hookworm and mange are a widespread problem as is heartworm, particularly in the South. An Ohio dealer had a dog with mange on his head, around the eyes, ears and neck. Another dog had enlarged pupils and bulging eyes, and a third had dried loose dark stool. An Indiana dealer was cited by USDA for dogs suffering from "loose stool with some blood," "loose stool with a drop of blood," "infected or irritated eye," "mange-like lesions," "ring-worm like lesions," "sore on left carpus which was red and warm to the touch," and an animal with "a bite wound to the right front foot." At another inspection, this dealer had two animals who were limping; one had a large tumor on his foot. A third animal had a bite laceration on his face. Another record notes a chronic cough in an underweight dog and a dog with a purulent discharge from his nose. In most cases there is no record of any veterinary care, and after being cited by USDA inspectors, given the poor status of the animals, they are typically killed. An Illinois dealer was cited by USDA for "euthanizing dogs with truck exhaust and tying sick dogs out at the corner of the property where they would die." Later he shifted to use of an electric current administered via clips.

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 in search of a taker. If not, the animal may be taken back and left to die or may simply be 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 by USDA inspectors 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 nonpotable water. Water was mixed with bread and dog food and sitting in the direct sun."

In addition, there are widespread problems with record-keeping and acquiring animals from illegal sources. Further, dealers commonly network with each other; that is, animals are sold from buncher (an unlicensed dealer) to dealer to another dealer before being sold for research. Also, typically, the buncher is immune from prosecution until he is caught by USDA and warned not to sell more than 25 animals in a year without a license again. Then he drops down to selling fewer animals so he is exempt from licensure, he sells some of the animals using the name of someone else he knows, or he steps forward and gets licensed for a while, makes a lot of money and then when USDA appears to be catching up with him, he turns in his license.

One example is the case of Clayton McDowell, a buncher with hunting dog kennels who didn't let the fact that he had no license stop him from selling 60 dogs to a USDA licensed Class B dealer in Illinois. According to USDA, he "knew about USDA licensing requirements. He stated he would quit selling dogs to B dealers. He stated there was too much hassle with identification, record keeping." McDowell received a Letter of Warning from USDA, and he addressed the matter by getting licensed. Ultimately, he decided to quit operating as a licensed Class B dealer, though he continued selling hunting dogs, claiming he would only sell the dogs retail for hunting purposes.

Then there's a Kentucky dealer cited by a USDA inspector who repeatedly failed to include essential details on the acquisition sheets, such as the seller's address, driver's license number, and vehicle tag number. He was found to have failed to collect this information on 3 different dates regarding 13 animals. And a Michigan dealer was cited for receiving stray cats from the city of Howard City. The city has no pound, but the licensed dealer was willing to step in and collect cats. An Illinois dealer was cited on at least three separate occasions for his failure to maintain complete records.

A veterinarian at a research facility expressed concern in an email to USDA that the animals it received from a dealer appeared to be "companion animals." A neutered male Airedale, an intact male Weimeriner and a male chocolate Labrador all were affectionate and obeyed commands. Similarly, the cats received by the facility were "some of the most obedient and affectionate cats that we ever met."

Another common pattern is for individuals to pass the business on to other members of the family after carefully 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. Though it's not a formal program, in essence some dealers offer an apprenticeship.

Brothers living in Missouri ran their licensed Class B dealer operation as a team, then one of them retired and the other's wife joined him in running the business. USDA finally caught up with the pair, 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. 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.

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." 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? In addition, with animals transported back and forth across the country, how on earth is USDA supposed to keep up with the movement of animals? USDA has spent years inspecting random source dealers four times a year instead of once a year as is done with all other licensees and registrants under the AWA. In the meantime, unlike any other licensees covered under the AWA, this one group of licensees—Class B dealers selling dogs and cats for research—have a long-standing problem maintaining complete and accurate records.

The Animal Welfare Act was passed in 1966 to address the illegal supply of dogs and cats to laboratories, and here we are 43 years later, and these problems are

still widespread. What has changed significantly over this lengthy period of time is the availability of animals from sources 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, and the health and vaccination status and the genetic background on each individual animal will be 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 licensed 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." In fact, in the rare circumstance that a researcher asserts the need for such animals, they can be obtained directly from pounds, as noted previously.

The distinction between nonpurpose-bred animals from pounds versus licensed Class B dealers must be made. By using licensed Class B dealers (middlemen) instead of pounds, researchers are contributing to the problem. In their search to fill researchers' demands for "genetically diverse, older or larger animals," random source dealers and their suppliers may be stealing pets from backyards and farms or they may be acquiring them from individuals who did not breed and raise them as required by the AWA.

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 is illegal acquisition of animals, fraudulent or incomplete records, and other illicit activities. Proper oversight of NIH's dispersal of extramural grants to those engaged in research using dogs and/or cats is urgently needed.

PREPARED STATEMENT OF BIG BROTHERS BIG SISTERS OF AMERICA

Big Brothers Big Sisters of America (BBBSA) supports $17 million in fiscal year 2010 for the Department of Education's Mentoring programs, $50 million for the Mentoring Children of Prisoners program and $50 million for the Volunteer Generation Fund.

Chairman Harkin and Ranking Member Cochran, thank you for the opportunity to submit this testimony for the subcommittee's record.

BBBSA is the Nation's oldest and largest mentoring organization. We have grown over the last 105 years to serve more than 250,000 at-risk youth in communities across the Nation. Our 392 agencies are located in all 50 States, Guam, and Puerto Rico. We match at-risk youth with a caring adult in a one-to-one mentoring relationship. These matches make a significant difference in the life of a child and are the foundation for developing the full potential of boys and girls as they grow to become competent, confident, and caring men and women. BBBSA offers an array of programs and services that focus on promoting positive youth development, helping each child discover his or her full potential.

With 17 million at-risk children growing up in America, the need for a proven strategy to reverse the statistics and to support their successful development has never been more critical. We believe that BBBS mentoring provides a significant return on investment, particularly compared to the consequences of social and educational failure. According to Independent Sector, the value of volunteer work was estimated at $20.25 per hour in 2008. Last year, our Bigs contributed more than 13 million volunteer hours at an estimated value of $676 million.

BBBSA original, core program model is its community-based match. Bigs are matched with Littles referred to the program by a parent, and typically a match will spend about 3 hours per week together. Professional case-management staff at each local agency guide Bigs and provide them with the support necessary to ensure a healthy and lasting relationship with their Littles. It is through the relationship with these committed adults that at-risk children can to begin to gain their own sense of self-confidence and develop healthy aspirations for the future.

Research has shown that BBBS mentoring works as a strategy to support at-risk youth. In 1995, Public/Private Ventures released its landmark impact study, which found that children matched with a Big Brother or Big Sister were:

—46 percent less likely to begin using illegal drugs;

—27 percent less likely to begin using alcohol;
—52 percent less likely to skip school;
—37 percent less likely to skip a class;
—more confident of their performance in schoolwork; and
—getting along better with their families.

SCHOOL-BASED MENTORING (MENTORING FOR SUCCESS GRANTS)

Our mentoring programs have grown exponentially over the last 10 years. A major source of this growth is the expansion of BBBSA school-based program model. Locating our service in schools has offered a strong complement to the traditional community-based approach and has resulted in a significant increase in volunteer recruitment. Further, because children are referred by teachers, it connects the positive impact of the BBBSA relationships directly with the educational enrichment for each matched child.

The President's fiscal year 2010 budget outline for the Department of Education has recommended that the Department's mentoring program be eliminated. This recommendation was made in follow-up to a Federal study examining outcomes for school-based mentoring. The findings of the study are generating important and welcome dialogue. BBBSA appreciates the focus on quality programs and has reached out to the administration to offer our input in finding the most effective way to achieve positive outcomes for children.

We believe that well-run school based mentoring programs can and do have real impact. We have both the local and national evidence to prove this, including a more recent evaluation by P/PV. In fact, findings from the P/PV study led us to adopt significant changes to the way we run our own school-based programs in order to ensure longer and stronger matches that lead to concrete and measurable outcomes for the young people we serve. As a learning organization, we take seriously our responsibility to respond to research and continually improve our service delivery.

In 2003, with support from Atlantic Philanthropies, BBBSA began a comprehensive study of our school-based mentoring program and evaluated impacts on randomly selected mentored youth compared to nonmentored youth in a control group. The scope of the study paralleled the BBBS Impact Study of Community-Based Mentoring conducted by P/PV in the 1990s and was the first nationwide, randomized study of school-based mentoring ever undertaken.

Among the findings:

—Three factors lead to better outcomes—
  —Socio-emotional match activities;
  —Matches that met more often and for longer periods; and
  —A strong school environment and involvement by teachers and principals;
—School-based mentoring has positive academic outcomes during the first year of the match, including higher grades, higher feelings of academic competence, greater number of assignments completed, fewer serious school infractions, and less skipping of school;
—But largely because so many matches did not continue into the second year, these outcomes were for the most part not sustained in the second year;
—Training, supervision, and school support are critical in fostering stronger and longer relationships; and
—The cost of school-based mentoring is only slightly less than community-based mentoring.

The challenge was clear: longer matches and closer relationships meant stronger impacts and so how were we going to create longer matches and their corresponding increased, longer-lasting outcomes? The recommendations, coming out of the Study, of our internal School-Based Mentoring Task Force were:

—Start matches as early in the school year as possible;
—Ensure that volunteers provide at least one school year of mentoring;
—Build programs in feeder schools to sustain matches and provide youth with consistency through school transitions;
—Select supportive schools for program involvement and continually foster these partnerships;
—Explore ways to bridge the summer gap such as taking school-based mentoring out of the school year and increasing match contacts and treating school-based mentoring as a year-round program with strong match support;
—Develop indices of match length that reflect the summer break and, in this way, are more sensitive predictors of impacts; and
—Explore more ways to provide volunteers (particularly young volunteers) with the support and ongoing training they need to create high-quality, effective mentoring relationships.

While BBBSA supports the administration's position of only funding effective programs going forward, we have proposed partnering with the Department of Education to ensure that existing grantees do not have to prematurely close any current mentoring relationships. We understand that the cost of honoring the last class of grants which were awarded in fiscal year 2008 would require Congress to provide $17 million for the program in fiscal year 2010.

AMACHI (MENTORING CHILDREN OF PRISONERS)

An estimated 2.4 million children have an incarcerated parent—and BBBS' Amachi program addresses this critical need. The goal of Amachi is to demonstrate that the best way to stop the vicious cycle of substance abuse, delinquency, and incarceration among children of incarcerated parents is to give the children what they need the most—a supportive and stable adult who will help them discover their own strengths, abilities, and resistance skills. Volunteers for the program are recruited through their congregations and matched with at-risk children and youth, spending time each week with the child to gradually build a supportive relationship. Research has shown that children and youth of incarcerated parents are at higher risk of child abuse, neglect, illiteracy, drug and alcohol abuse, crime, violence, and premature death than are their peers. A BBBS mentor in the life of an at-risk child can dramatically reduce a child's chance of falling prey to these risks. We respectfully request level funding for the "Mentoring Children of Prisoners" program in fiscal year 2010.

VOLUNTEER GENERATION FUND (CORPORATION FOR NATIONAL SERVICE)

In the wake of President-elect Obama's "call to service" in January, also known as National Mentoring Month, BBBSA saw a significant increase in volunteer applications. As the economic crisis deepens, these Big Brothers and Big Sisters will be helping to meet the critical demand our disadvantaged youth have for friendship, especially during these challenging times. There is an interest among Americans to serve the community and BBBSA is anxious to harness this hope. The bipartisan citizen service legislation signed in to law by President Obama on April 21 will expand opportunities for citizens to serve, will direct this service toward the Nation's most urgent challenges, and provides Congress the change to invest in new and innovative solutions to our most persistent social problems. In particular, BBBSA respectfully requests that $50 million for the Volunteer Generation Fund in fiscal year 2010 to spur innovation in volunteer recruitment and management.

As we all work to change how our children grow up in America, BBBSA is your proud partner.

LETTER FROM THE BRAIN INJURY ASSOCIATION OF AMERICA

MAY 6, 2009.

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 MR. CHAIRMAN HARKIN AND RANKING MEMBER COCHRAN: Thank you for the opportunity to submit this written testimony with regard to the fiscal year 2010 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.

And now we are seeing an increasing number of servicemembers 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 TBI during deployment. Many of these returning servicemembers 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 12 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 TBI. 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:

—$11 million for the Centers for Disease Control and Prevention (CDC) TBI Registries and Surveillance, Prevention and National Public Education/Awareness;
—$20 million for the HRSA Federal TBI State Grant Program; and
—$6 million for the HRSA Federal TBI Protection & Advocacy (P&A) Systems Grant Program.

The TBI Act Amendments of 2008, authorizes the Department of Health and Human Services, HRSA to award grants to (1) States, American Indian Consortia, and territories to improve access to service delivery and to (2) State P&A Systems to expand advocacy services to include individuals with TBI. For the past 12 years the HRSA Federal TBI State Grant Program has supported State efforts to address the needs of persons with TBI 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 TBI care.

Increasing the program to $20 million will provide funding necessary for each State including the District of Columbia, the American Indian Consortium 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.

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, I&R, 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 a TBI leads to reduced government expenditures and increased productivity, independence, and community integration. However, advocates must possess specialized skills, and their work is often time-intensive. A $6 million appropriation would trigger a formula that would ensure that each P&A can provide a significant PATBI program with appropriate staff time and expertise.

Funding for the TBI Model Systems 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 TBI. 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 $13.3 million in fiscal year 2010 funding for the National Institute on Disability and Rehabilitation Research's TBI Model Systems of Care Program, in order to add four new centers and two collaborative research projects. In addition, given the national importance of this research program, the TBI Model Systems of Care program should receive "line-item" status within the broader NIDRR budget.

We ask that you consider favorably these requests for the HRSA Federal TBI Program, NIDRR TBI Model Systems Program, and for CDC to gather needed data, shepherd public awareness, education, and prevention programs; as well as the sustain and bolster TBI Model Systems that conduct vital research.

Sincerely,

SUSAN H. CONNORS,
President/CEO.

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). 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 (IBD).

Let me say at the outset how appreciative we are for the leadership this subcommittee has provided in advancing funding for the National Institutes of Health (NIH). 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.

From the point of hearing the news, I refused to accept the fact that this disease could not be cured. As I studied all the relevant data I could find, I reached out to the organization that seemed to be repeatedly mentioned, The CCFA. This organization is leading the fight in research, education and support on behalf of the 1.4 million Americans that suffer from these illnesses.

I made a pest of myself at the national office seeking knowledge about how the fight was being staged. The more I learned the more I believed that we could do better. I was invited to join the national board and 6 years later, I have the privilege of leading an extraordinary staff of professionals and a network of volunteers across our entire country.

We are making dramatic progress that is the result of the scientific excellence of our funded researchers and our volunteer scientific leadership as well as the rapid advancement of available technology. It is now not "if" we will cure IBD, but "when."

Mr. Chairman, I will focus the remainder of my testimony on our appropriations recommendations for fiscal year 2010.

RECOMMENDATIONS FOR FISCAL YEAR 2010

NIH

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.

To further accelerate genetic research and advance understanding of IBD, NIDDK issued a research solicitation to establish an IBD Genetics Consortium approximately 8 years ago. This effort was informed by recommendations from external experts. Funding for the Consortium's six centers began in 2002, and intensive data and sample collection, genetic analysis, and recruitment of new patients and their families have been under way. In 2006, the Consortium published the major discovery of a new IBD gene. Some sequence variations in this gene, called IL23R, were found to increase susceptibility to IBD, while another variant actually confers protection. This gene was known previously to be involved in inflammation, and its newly discovered association with IBD may lead to the development of better therapies for IBD. In recognition of the success of the Consortium's large-scale collaborative effort, NIDDK decided to continue support for the program beyond its initial 5-year period which was slated to end in fiscal year 2007.

Renewed funding in fiscal year 2008 has enabled the Consortium to continue its genetic studies and recruit additional patients and relatives (as well as subjects without IBD for comparison). This expansion will facilitate the identification of additional predisposing genes and enable genetic analyses of certain patient subgroups, such as those from minority populations or those who experience an early onset form of IBD. These findings may then be used to pursue genetically based diagnostic tests that allow for earlier diagnosis and treatment intervention. In addition, the data can be used to identify new molecular targets for therapeutic development that are specifically targeted to a unique subset of patients.

Mr. Chairman, we are grateful for the leadership of Dr. Stephen James, Director of NIDDK's Division of Digestive Diseases and Nutrition, for pursuing this and other opportunities in IBD research aggressively. Fortunately, the field of IBD is widely viewed within the scientific community as one of tremendous potential. CCFA's scientific leaders, with significant involvement from NIDDK, have developed an ambitious research agenda entitled "Challenges in Inflammatory Bowel Diseases" that seeks to address many opportunities that currently exist. We look forward to working with NIDDK and the subcommittee to pursue these research goals in the coming years.

For fiscal year 2010, CCFA joins with other patient and medical organizations in recommending a 7 percent increase in funding for the NIH. We specifically encourage the subcommittee to support the invaluable work of the NIDDK and NIAID.

CENTERS FOR DISEASE CONTROL AND PREVENTION (CDC)

IBD Epidemiology Program

Mr. Chairman, 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.

We are extremely grateful for your leadership in providing funding over the past 5 years for an epidemiology program on IBD at CDC. This program is yielding valuable information about the prevalence of IBD and increasing our knowledge of the demographic characteristics of the IBD patient population. If we are able to generate an accurate analysis of the geographic makeup of the IBD patient population, it will provide us with invaluable clues about the potential causes of IBD.

I should note that the latest phase of this project focuses on Rhode Island. The "Ocean State Crohn's & Colitis Area Registry" is identifying each new case of inflammatory bowel disease diagnosed in the State. The result will be a unique, population-based cohort of newly diagnosed patients to be followed prospectively over time—the first of its kind in the United States, and one of very few such cohorts in the world. The goals of the study include: (1) describing the incidence rates of Crohn's disease and ulcerative colitis; (2) describing disease outcomes; and (3) identifying factors that predict disease outcomes. To date more than 85 newly diagnosed patients of all ages have been enrolled into the study.

Mr. Chairman, to continue this important epidemiological work in fiscal year 2010, CCFA recommends a funding level of $700,000, an increase of $16,000 more than fiscal year 2009.

PEDIATRIC IBD 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 pediatric population. We encourage the subcommittee to support our efforts to establish a Pediatric IBD Patient Registry with the CDC in fiscal year 2010.

Once again Mr. Chairman, thank you very much for the opportunity to be with you today. I look forward to any questions you may have.

PREPARED STATEMENT OF THE CHILDREN'S ENVIRONMENTAL HEALTH NETWORK

The Children's Environmental Health Network (the Network) appreciates this opportunity to comment on the fiscal year 2010 appropriations to the Departments of Health and Human Services and Education for activities that protect children from environmental hazards. The Network appreciates the wide range of priorities that you must consider for funding. We urge you to give priority to those programs that directly 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.

The Network is a national organization whose mission is to promote a healthy environment and to protect the fetus and the child from environmental health hazards. We recognize that children, in our society, have unique moral standing. The Children's Environmental Health Network was created to promote the incorporation of basic pediatric facts such as these in policy and practice:

—Children's bodies and behaviors differ from adults. In general, they are more vulnerable than adults to toxic chemicals.

—Children are growing. Pound for pound, children eat more food, drink more water and breathe more air than adults. Thus, they are likely to be more exposed to substances in their environment than are adults. Children are different from adults in how their bodies absorb, detoxify, and excrete toxicants.

—Children's systems, such as their nervous, reproductive, and immune systems, are developing. This process of development creates periods of vulnerability when toxic exposures may result in irreversible damage when the same exposure to a mature system may result in little or no damage.

—Children behave differently than adults, leading to a different pattern of exposures to the world around them. For example, because of their hand-to-mouth behavior, they ingest whatever may be on their hands, toys, household items, and floors. Children play and live in a different space than do adults. For example, very young children spend hours close to the ground where there may be more exposure to toxicants in dust and carpets as well as low-lying vapors such as radon or pesticides.

—Children have a longer life expectancy than adults; thus they have more time to develop diseases with long latency periods that may be triggered by early environmental exposures, such as cancer or Parkinson's disease.

Clear, sound science underlies these principles. A solid consensus in the scientific community supports these concepts. The world in which today's children live has changed tremendously from that of previous generations. There has been a phenomenal increase in the substances to which children are exposed. According to the Environmental Protection Agency (EPA), more than 83,000 industrial chemicals are currently produced or imported into the United States. Traces of hundreds of chemicals are found in all humans and animals. Every day, children are exposed to a mix of chemicals, most of them untested for their effects on developing systems.

We urge the subcommittee to provide the necessary resources for the Federal programs and activities that help to protect children from environmental hazards. The key programs in your jurisdiction are below.

CENTERS FOR DISEASE CONTROL AND PREVENTION (CDC) AND THE NATIONAL ENVIRONMENTAL HEALTH CENTER (NEHC)

The Network strongly supports the work of the CDC and the NEHC, especially NEHC's efforts to continue and expand its biomonitoring program and to continue its national report card on exposure information, using the highly respected National Health and Nutrition Examination Survey. A vital CDC responsibility in pediatric environmental health is to assist in filling the major information gaps that exist about children's exposures.

The Network supports a funding level of $8.6 billion for CDC's core programs in fiscal year 2010. The Network urges the subcommittee to provide an additional $19.6 million for CDC's Environmental Health Laboratory in fiscal year 2010. The Network believes it is especially critical for the NEHC to gather and publish expanded information in the report card on children's exposures.

PUBLIC HEALTH TRACKING

The CDC's National Environmental 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. We urge the subcommittee to provide $50 million for the tracking network in fiscal year 2010 to expand it to additional States and support the continued development of a sustainable, nationwide Network.

Additionally, 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.

GLOBAL CLIMATE CHANGE

We strongly urge the subcommittee to designate $50 million for the CDC to help the public prepare for and adapt to the potential health effects of global climate change in fiscal year 2010.

Global climate change presents major challenges to public health. Children, as a vulnerable subpopulation, are among those at greatest risk of harm. Children in communities that are already disadvantaged will be the most harmed. Recent studies have detailed how children's physical and social health may be harmed, ranging from respiratory diseases and melanoma (due to atmospheric changes), to gastrointestinal diseases (due to increased water contamination), to an increased range for some diseases (malaria, dengue, encephalitides, Lyme disease), to increased rates of malnutrition (due to severe drought and severe precipitation), to the harm caused by displacement, water and food insecurity, and forced migration (caused by drought, increased rain and severe storms, and rising sea levels) and the resulting international conflict and political unrest.

It is imperative that the Federal Government undertake efforts to mitigate and adapt to climate change. Providing funding to the CDC for preparing for the potential health effects of global climate change is an important step.

NATIONAL INSTITUTE OF ENVIRONMENTAL HEALTH SCIENCES (NIEHS) AND CHILDREN'S ENVIRONMENTAL HEALTH RESEARCH CENTERS OF EXCELLENCE

NIEHS 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 better understanding childhood exposures that may not affect health until decades later, or seeking answers to many other important questions.

The Children's Environmental Health Research Centers, funded by NIEHS and the EPA, play a key role in protecting children from environmental hazards. With budgets of $1 million per year per center (unchanged over more than 10 years), this program generates valuable research. A unique aspect of this program 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. Researchers have embraced this funding mechanism because of the ability it gives them to do interdisciplinary research and to be involved in the community—things that are not easy to do using other grant mechanisms. The scientific output of these centers has been outstanding. For example, four of the Centers had findings that clearly showed that prenatal exposure to a widely used pesticide affected developmental outcomes at birth and early childhood. Another recent example is the finding of a biomarker in newborns for childhood leukemia, firmly establishing the important role of prenatal environment factors in causation of this disease.

Unfortunately, almost all of the existing 12 centers are currently operating on no-cost extensions. We strongly support the center concept and the network of centers. We also support current efforts by NIEHS and the EPA to competitively renew and to expand this valuable program by adding four formative centers. However, only five of the existing centers are to be renewed. If centers are shuttered, we will lose access to valuable populations such as urban children with asthma or children in farm communities exposed to pesticides. We will lose the ability to learn about issues like early puberty concerns, exposures in school settings, and pre-adolescent and adolescent outcomes.

Thus, we urge the subcommittee to appropriate at least $15 million for the NIEHS share of funding so that, in concert with the EPA contribution, an adequate number of centers (old and new) will have funding in fiscal year 2010.

In addition, the Network urges the subcommittee to support NIEHS by increasing its overall budget, and that of the Superfund research program, by 5 percent more than last year's level and directing that included in this increase would be a $5 million increase specifically for research on children's environmental health issues. The Superfund research program has supported some vital children's research but funding has been level over the last 4 years.

NATIONAL CHILDREN'S STUDY (NCS)

The NCS is examining the effects of environmental influences on the health and development of more than 100,000 children in 105 communities across the United States, following them from before birth until age 21. The NCS will be one of the richest research efforts ever geared toward studying children's health and development and will form the basis of child health guidance, interventions, and policy for generations to come. The NCS will provide a better understanding of how children's genes and their environments interact to affect their health and development, thus improving the health and well-being of all children.

Enrollment in the NCS began this January, after 8 years of planning and development. The Network urges the subcommittee to continue its enthusiastic support for the NCS in this and future years, including full funding of $195 million in fiscal year 2010. The Network also asks the subcommittee to direct the National Institute of Child Health and Human Development to assure that protocols are in place for measuring exposures in the child care and school settings. The Network believes 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 (PEHSU)

A key, but dramatically underfunded, program is the PEHSU network. Funded by the Agency for Toxic Substances and Disease Registry and the EPA, the PEHSUs form a network with a center in each of the U.S. Federal regions, plus one center in Canada and one in Mexico. PEHSU professionals provide quality medical consultation for health professionals, parents, caregivers, and patients. Last year, the entire program, covering the 10 U.S. centers, received less than $2 million. These centers have done tremendous work on these small budgets. We urge the subcommittee to provide funding for this program in fiscal year 2010 at the level of $200,000 per center (compared to the $120,000 for each center last year).

SCHOOL ENVIRONMENTAL HEALTH

Each school day, about 54 million children and 7 million adults spend a full week inside schools. Unfortunately, many of the Nation's public and private school facilities are shoddy or even "sick" buildings whose environmental conditions harm chil-

dren's health and undermine attendance, achievement, and productivity. In 1996, GAO reported that more than 13 million children were compelled to be in schools that threatened their health and safety. Two Federal statutes that would create a foundation for healthy schools are already in place, authorizing the U.S. Department of Education and the EPA to address school environments. Unfortunately, to date neither of these programs have been funded.

We strongly urge the subcommittee to provide the $25 million authorized by the Healthy and High Performance Schools Act (Public Law 107–110) to the grant program for State agencies to develop and disseminate information and assistance on high performance school design standards. The subcommittee should also direct the Department of Education to conduct a National Priority Study, as required under HHPS, on the impacts of decayed facilities on children and to report to Congress. To date, Education has only produced a brief review of the scientific literature.

These programs and activities are especially vital in light of the "stimulus" funds for school modernization or renovation. The stimulus bill does not require consideration of environmental health or children's health and safety. Yet, without specific consideration of health, steps to "green" a school—such as increasing insulation at a school to improve energy efficiency—can have unintended harmful side effects, such as creating or exacerbating indoor air quality problems.

CHILD CARE ENVIRONMENTAL HEALTH

Thirteen million preschoolers—60 percent of young children—are in child care. Millions of preschoolers—our youngest and most vulnerable population—enter care as early as 6 weeks of age and can be in care for more than 40 hours per week. Yet little is known about the environmental health status of our child care centers nor how to assure that they are protecting this important group of children. The Network is working to correct these gaps.

We ask the subcommittee to direct the Department of Health and Human Services Assistant Secretary for Children and Families to report on the Administration for Children and Families activities that protect children from environmental hazards in childcare 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 the Network 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

NATIONAL INSTITUTES OF HEALTH (NIH)

On behalf of the Cystic Fibrosis Foundation (CFF), and the 30,000 people with cystic fibrosis (CF), we are pleased to submit the following testimony regarding fiscal year 2010 appropriations for CF-related research at NIH and other agencies.

ABOUT CF

CF is a life-threatening genetic disease for which there is no cure. People with CF have two copies of a defective gene, known as CFTR, which causes the body to produce abnormally thick, sticky mucus that clogs the lungs and results in fatal lung infections. The thick mucus in those with CF also obstructs the pancreas, making it difficult for patients to absorb nutrients from food.

Since its founding, CFF has maintained its focus on promoting research and improving treatments for CF. More than thirty drugs are now in development to treat CF, some which treat the basic defect of the disease, while others target its symptoms. Through the research leadership of CFF, the life expectancy of individuals with CF has been boosted from less than 6 years in 1955 to 37 years in 2007. This improvement in the life expectancy for those with CF can be attributed to research advances and to the teams of CF caregivers who offer specialized care. Although life expectancy has improved dramatically, we continue to lose young lives to this disease.

The promise for people with CF is in research. In the past 5 years, the CFF 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 more rapidly and efficiently discover and develop new CF treatments aimed at controlling or 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 the National Institutes of Health (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). 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 that the doubling and the infusion of funds from ARRA generated.

The flat-funding of the NIH since 2003 has decreased purchasing power, limiting the pursuit of critical research. CFF joins the Coalition for Health Funding to recommend increasing the budget for all health discretionary spending by 13 percent in fiscal year 2010, or $7.4 billion over the fiscal year 2009 Omnibus. This increased investment will help maintain the NIH's ability to fund essential biomedical research today that will provide tomorrow's care and cures. 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 peoples' lives.

STRENGTHEING OUR NATION'S RESEARCH INFRASTRUCTURE

Because CF is a disease that impacts several systems in the body, several Institutes at the NIH share responsibility for CF research. We urge the NIH to pay special attention to advances in treatment methods and mechanisms for translating basic research across Institutes into therapies that can benefit patients across Institutes. CFF has been recognized for its own research approach that encompasses 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 30 potential therapies that are being examined to treat people with CF.

THE CLINICAL AND TRANSLATIONAL SCIENCE AWARDS (CTSA)

CTSA program was a key component of the NIH's Roadmap initiative. The program is designed to transform how clinical and translational research is conducted, ultimately enabling researchers to provide new treatments more efficiently to patients. Tremendous effort brought institutions together to rally around this program, yet current funding levels make it difficult for the 39 programs (out of a planned 60) to succeed.

Key to the success of the CTSAs is the development of cost-sharing for use of infrastructure services. An example of this mechanism is the General Clinical Research Centers (GCRC), which allowed Institutes to reduce their research budgets by having investigators use the GCRC when clinical care such as inpatient stays, lab tests, nursing staff, was made available at no additional cost. Today, individual investigators must provide funds for clinical care cost-sharing from grants funded from other NIH Institutes. As research becomes more expensive and private capital dries up, it becomes even more critical to ensure support for translational research, that is, research that moves a potential therapy from development to the market. In order to maximize the potential of the CTSA, multiple Institutes within NIH must be able to provide financial resources for this critical program.

Supporting Clinical Research

A significant discrepancy persists between the funding awarded to clinical and basic laboratory investigators for first awards. 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.

FACILITATING CLINICAL RESEARCH AND DRUG DEVELOPMENT

CFF applauds the NIH's efforts to encourage greater efficiency in clinical research. CFF has been a leader in creating a clinical trials network to achieve greater efficiency in clinical investigation. Because the CF population is so small, a more significant portion of people with the disease must partake in clinical trials than in most other diseases. This unique challenge prompted CFF to streamline our clin-

ical trials processes. Research conducted by CFF is more efficient than ever before and we are a model for other disease groups.

The Model of the Cystic Fibrosis Therapeutics Development Network

CFF'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 its centralization of data management and analysis and data safety monitoring in the TDN will be useful in designing clinical trial networks in other diseases. We urge the subcommittee to direct the NIH and other agencies to allocate additional funds for innovative therapeutics development models like the TDN. CFF urges the subcommittee to allocate additional resources for clinical research in order meet the demand for testing the promising new therapies for CF and other diseases.

Alterative Models for Institutional Review Boards

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 (SSI)

An additional impediment in our effort to accelerate the development of new therapies is the Social Security Administration's (SSA) current 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. We urge the subcommittee to direct the SSA to disregard any compensation to an individual who is participating in a clinical trial testing rare disease treatments that has been reviewed and approved by an institutional review board and meets the ethical standards for clinical research for the purposes of determining that individual's eligibility for the SSI program.

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. CFF has enjoyed a productive relationship with the NCRR to support our vision for improving clinical trials capacity through its early financial support of the TDN. 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

CFF'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.

Exploring Protein Misfolding and Mistrafficking

We applaud the National Heart, Lung and Blood Institute (NHLBI), and the National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK) for their initiatives that target research on protein misfolding, and urge an aggressive commitment to facilitate continued exploration in this area to build upon promising discoveries. We urge the NIH to continue to devote special attention to research in protein misfolding and mistrafficking, an area which could yield significant benefits for patients with CF and other diseases where misfolding is an issue.

Opportunities In Animal Models

CFF 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 CFF, 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, cause an intense inflammatory response. CFF enthusiastically supports investments by the NIH to gain a greater understanding of inflammatory signaling and inflammatory cascades, 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 the NIH Roadmap suggestions. 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 must be integrated. To address this, CFF 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. CFF 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. Several companies developing CF treatments have used SBIR grants to fund their development process.

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. It is important to note, however that there are more than 25 million Americans with a rare disease. 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. CFF 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 CFF 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 CFF, we thank the subcommittee for its consideration.

PREPARED STATEMENT OF THE CENTER FOR GLOBAL HEALTH POLICY

The Center for Global Health Policy of the Infectious Diseases Society of America (IDSA) is pleased to submit testimony about the urgent need to increase funding for the Department of Health and Human Services' programs that address two deadly global pandemics—HIV/AIDS and tuberculosis.

IDSA represents more than 8,000 infectious diseases and HIV physicians and scientists devoted to patient care, education, research, prevention, and public health. Nested within the IDSA is the HIV Medicine Association (HIVMA), representing more than 3,500 physicians, scientists, nurse practitioners, and other health professionals working in HIV medicine. In 2008, IDSA and HIVMA launched the Infectious Diseases Center on Global Health Policy and Advocacy to address global HIV/AIDS, tuberculosis, and HIV/TB co-infection. Under the leadership of a scientific advisory committee of world-renowned scientific experts in these areas, IDSA works to educate policymakers, U.S. Government program implementers and the media about evidence-based policies and programs and the value of U.S. leadership in combating these deadly and synergistic epidemics.

GLOBAL HIV/AIDS PANDEMIC

There are 33 million people living with HIV/AIDS in the world, with 22 million of them or 67 percent living in sub-Saharan Africa. AIDS kills 2 million people annually. U.S. leadership has been the catalyzing force for preventing millions of infections, ensuring access to lifesaving HIV treatment for 3 million persons in developing countries, and providing care and support to millions of additional people, including orphans and vulnerable children. Despite tremendous progress, only about one-third of persons in developing countries who are clinically eligible for antiretroviral therapy are receiving it, and an ongoing and robust prevention campaign is essential to reduce the more than 7,000 new HIV infections that still occur on a daily basis.

The National Institutes of Health (NIH)-funded HIV research at the NIH research led to the development of lifesaving antiretroviral therapy, identified the efficacy of antiretroviral therapy during pregnancy to prevent mother-to-child transmission, demonstrated the HIV prevention benefits of male circumcision, and is paving the road to the availability of an effective microbicide. The Centers for Disease Control and Prevention (CDC) have been a critical implementing partner in the U.S. response to the global HIV epidemic, working with health ministries in developing countries to launch HIV prevention and treatment programs, conducting public health evaluation research, and supporting heavily impacted countries in their efforts to monitor and to employ evidence based strategies in response to their particular epidemics.

TUBERCULOSIS

Tuberculosis is the second leading global infectious disease killer, claiming more than 1.7 million lives annually. Worldwide, one-third of the world's population is infected with TB and nearly 9 million people develop active TB disease each year. In recent years, highly drug-resistant forms of TB have emerged. Drug-resistant tuberculosis is a direct result of human failure—failure to adequately detect and treat TB and to develop the necessary tools to effectively address this ancient and deadly scourge.

In 2006, the CDC and the World Health Organization (WHO) reported the findings from a survey of TB reference laboratories around the world indicating that 20 percent of M. tuberculosis isolates were multi-drug resistant (MDR)—that is, TB strains resistant to the two most potent drugs in the four-drug TB regimen. Four percent of these MDR–TB strains were resistant to multiple second-line drugs and were deemed extensively drug-resistant TB or XDR–TB. Mortality from XDR–TB can be as high as 85 percent, and close to 100 percent in individuals co-infected with HIV/AIDS. The increase in MDR–TB and the advent of XDR–TB have triggered grave alarm in the scientific community about the potential for an untreatable XDR–TB epidemic. In 2007, WHO estimated that there were 500,000 cases of MDR–TB and only 1 percent of these cases were treated according to WHO standards.

The global pandemic and alarming spread of drug-resistant TB present a persistent public health threat to the United States. Tuberculosis is an airborne infection.

Drug-resistant TB anywhere in the world easily translates into drug-resistant TB everywhere.

DEADLY SYNERGY OF HIV/TB CO-INFECTION

The costly MDR TB epidemic in the United States in the early 1990s emerged against a background of HIV infection in high HIV prevalence cities like New York City and Miami. Today, HIV–TB co-infection is ravaging sub-Saharan Africa. TB is the leading cause of death of persons with HIV worldwide. Tuberculosis facilitates HIV disease progression, and persons with HIV have poorer TB treatment outcomes than their non-HIV-infected counterparts. According to the WHO, in 2007, there

were at least 1.37 million cases of HIV positive TB—nearly 15 percent of the total incident cases. There were 456,000 deaths among this group.

CDC—TUBERCULOSIS

Last year, Congress passed landmark legislation—the Comprehensive Tuberculosis Elimination Act of 2008—Public Law 110–873. This bill authorizes a number of actions that will shore up State TB control programs, enhance United States 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. Realizing these goals will require additional resources; at a minimum, it is critical that the funding authorized for fiscal year 2010 in this important new law—$210 million—be appropriated for the CDC Division of TB Elimination. While this represents an increase more than current funding, the scientific community, including the National Coalition for the Elimination of Tuberculosis, has estimated that $528 million will be needed annually to implement strategies through the CDC that will advance the goal of TB elimination.

Funds are desperately needed to increase the clinical trial capacity of the Tuberculosis Trials Consortium (TBTC) to evaluate promising new drugs for MDR TB and to support clinical trials for vaccine candidates that hold the hope of eliminating the scourge of TB from the face of the earth. Additional financial support is also needed for the Tuberculosis Epidemiologic Studies Consortium (TBESC)—critical partnerships between TB control programs and academic institutions aimed at designing, conducting and evaluating programmatically relevant research.

Strengthening CDC's Division of TB Elimination to conduct research and support State TB control programs will protect our communities, and help ensure that another devastating outbreak of drug-resistant tuberculosis that plagued several American cities in the late 1980s does not recur. Ultimately, modest Federal investments will prevent the necessity to expend huge resources treating MDR–TB and XDR–TB, which can cost $468,000 per case to treat.

CDC—GLOBAL AIDS PROGRAM (GAP)

CDC's Global AIDS Program (GAP) helps resource-poor countries prevent HIV infection; improve treatment, care, and support for people living with HIV; and build healthcare capacity and infrastructure. To meet these objectives, CDC sends clinicians, epidemiologists and other health professionals to help foreign governments and health institutions with a range of prevention, care, and support activities. Working closely with health ministries in developing countries, CDC helps build sustainable public health capacity in laboratory services and systems, including country capacity to design and implement HIV surveillance systems and surveys.

The CDC GAP also plays an important role in helping governments monitor and evaluate the impact of HIV prevention, care and treatment programs. CDC GAP also works with the Office of the Global AIDS Coordinator as the lead on HIV prevention, and also works to evaluate the impact of US HIV prevention, treatment and care and support funding. For example, CDC GAP is currently conducting a public health evaluation (PHE) to assess the impact of PEPFAR funding on developing country health systems and access to other healthcare services. A funding level for CDC'GAP program of at least $218 million is essential.

NIH

NIH is the world's flagship biomedical research institution, supporting basic science research, behavioral research, drug and diagnostic development and research training. Unfortunately in recent years, NIH funding has eroded, and stagnant funding has resulted in decreasing support for original research and cuts in clinical trial networks. With only 1 in 4 approved research applications receiving funding, the pipeline for critical discoveries is dwindling and young scientists are being forced to turn their attention to different professional pursuits.

IDSA is extremely pleased that the recently enacted stimulus bill contained an infusion of billions of desperately needed dollars for the NIH research enterprise. Congress rightfully acknowledged the role of scientific research in stimulating the economy. It is vital, however, that the long overdue increases in funding enjoyed by the NIH in the economic stimulus bill are maintained and enhanced in this year's funding bill—funding that will ultimately translate into improvements in individual and public health, both domestically and globally.

HIV/AIDS RESEARCH

The successes of the HIV research investment is a testament to the value of research investment. A robust and comprehensive research portfolio was responsible for the rapid and dramatic gains in our HIV knowledge base, gains that resulted in reductions in mortality from AIDS of nearly 80 percent in the United States and in developing countries where treatment has been made available. Remarkable discoveries helped us to reduce mother-to-child HIV transmission to nearly 1 percent in the United States and this intervention has prevented HIV infection in hundreds of thousands of children worldwide. A continued robust HIV research effort is essential to accelerate our progress in developing more effective prevention strategies, and supporting the basic research necessary to continue our work developing a vaccine that may end the deadliest pandemic in human history. Research to improve treatment strategies to aid prevention and to maximize the benefits of antiretroviral therapy, especially in underserved populations in the United States and in resource-limited settings is a high priority.

The National Institute on Allergies and Infectious Diseases (NIAID) is the principal funding resource for basic and clinical HIV research, but critical HIV research is conducted through a range of NIH Institutes under the leadership of the Office for AIDS Research (OAR).

TUBERCULOSIS RESEARCH

NIAID is also a critical player in tuberculosis research. In 2007, NIAID developed a research strategy for drug-resistant tuberculosis, but limited resources have slowed implementation of this strategy. According to the NIH Research Portfolio Online Reporting Tool, RePORT, NIH funding for tuberculosis research, including vaccine research totaled $160 million in fiscal year 2008—a modest level for an infectious disease that kills millions through a pathogen that is showing increasing resistance to available medications. In fact, funding for TB research has gone in the wrong direction since NIH spent $211 million on TB research in fiscal year 2007. A doubling of funding for TB research would be a reasonable response to the world disease burden and the current scientific opportunities.

We must increase our investment in TB research as highlighted in the enacted Comprehensive TB Elimination Act of 2008. We must have the resources to conduct clinical trials on new therapeutics for both drug-susceptible and drug-resistant TB, to test new diagnostics in point-of-care settings, and to evaluate promising TB vaccine candidates. We urgently need treatment regimens that are shorter in duration and less toxic. Research related to pediatric tuberculosis, including drug development, must be stepped up.

It is also imperative that research activities focused on HIV/TB co-infection continue with enhanced funding. Tuberculosis is the leading cause of death among persons with HIV/AIDS worldwide. TB is more difficult to diagnose in persons with HIV and a number of important anti-TB drugs interact with HIV antivirals. Critical questions remain about how best to sequence HIV and TB treatment in co-infected individuals—questions with life and death ramifications for millions of individuals, especially those living in sub-Saharan Africa. Tuberculosis threatens to undermine the tremendous progress that has been made in saving the lives of persons in developing countries through the provision of antiretroviral therapy.

GLOBAL FUND TO FIGHT AIDS, TUBERCULOSIS AND MALARIA

Historically, one-third of U.S. funding for the Global Fund has been appropriated through the NIAID budget and IDSA strongly supports a significant U.S. contribution to the Global Fund. U.S. support for the Global Fund to Fight AIDS, Tuberculosis and Malaria is a crucial part of U.S. global health diplomacy. The Global Fund is a country-led, performance-based partnership that embraces transparency and accountability, and fosters multilateral cooperation. The Global Fund provides a quarter of all international financing for AIDS globally, two-thirds for tuberculosis, and three-quarters for malaria. Through these efforts, the Global Fund has helped save 3.5 million lives in 140 countries

In Pakistan, for example, an American-based international aid group called Mercy Corps has, using Global Fund resources, partnered with the private sector on a broad TB public education campaign, training thousands of health workers, and strengthening lab capacity to test for TB. This work has dramatically increased Pakistan's ability to detect TB cases, and now Pakistan is counting on the Fund's strong, continued support to ensure medication is available to people with TB. Continued progress on TB is essential to development in Pakistan, since 80 percent of

Pakistanis afflicted with tuberculosis are in the most economically productive years of their lives, and the disease sends many self-sustaining families into poverty.

The Global Fund projects an $8 billion need for new and continuing programs in 2010, but only $3 billion in pledges are in place. The Labor, Health and Human Services, and Education, and Related Agencies budget, through NIH, has been a crucial source of funding for the U.S. contribution to the Fund, providing $300 million in fiscal year 2009. The Global Fund has requested that the United States triple its total contribution for fiscal year 2010. The portion of the U.S. contribution provided by NIH should therefore be tripled to $900 million. The economic, strategic and moral case for this contribution to the Global Fund is clear, and the United States must do its part to help close this funding gap.

The IDSA and the HIVMA have many funding priorities to champion in the Labor, Health and Human Services, and Education, and Related Agencies appropriations bill including funds to address antimicrobial resistance, child and adult immunizations, pandemic influenza, the Ryan White CARE Act, and domestic HIV prevention. Thank you for the opportunity to highlight our funding priorities for research and programs related to global HIV and TB in the Labor, Health and Human Services, and Education, and Related Agencies account.

PREPARED STATEMENT OF CHILDREN AND ADULTS WITH ATTENTION-DEFICIT/HYPERACTIVITY DISORDER (CHADD)

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.

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 129,274 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 9,051 individual inquiries during the last year on 10,018 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 3,000 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

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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.

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 2010 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.[5]

Both the National Institutes of Health Consensus Conference on AD/HD (Nov. 1998) and the Centers for Disease Control and Prevention (CDC) Conference on Public Health and AD/HD (September 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.

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. "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 com-

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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 medication 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.

pared to 59 percent of individuals without AD/HD).[7] In addition, the study found that the household incomes of adults older than 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.

Therefore, we are asking that the National Center on Birth Defects and Developmental Disabilities (NCBDDD) AD/HD line item be increased from $1.777 million to $2.377 million and that the funding for the NRC be increased from $980,000 to $1.280 million. This is a $600,000 increase in the AD/HD line and $300,000 increase in the NRC line. Historically, half of the increase to the AD/HD line item has been used to fund research on AD/HD. This increase will allow the NRC to further develop its outreach to the African-American and Hispanic-Latino communities, restore education campaigns at nurse, educator, and related conferences, and most importantly during this current economic climate to initiate an employment information specialist service.

REQUESTED REPORT LANGUAGE FOR FISCAL YEAR 2010

The subcommittee continues to support the activities of the CDC's NCBDDD and the National Resource Center (NRC) on AD/HD and has provided $2.377 million to continue this support, including $1.28 million 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 educates health and education professionals on the impact of AD/HD on the ability 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 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 3,500 researchers, scientists, and policy experts, as well as 150 organizations that produce and use health services research.

Healthcare in the United States has the potential to improve people's health dramatically, but often falls short and costs too much. Health services research is used to understand how to better finance the costs of care, measure and improve the quality of care, and improve coverage and access to affordable services. Indeed, health services research is changing the face of American healthcare, uncovering critical challenges facing 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 uncovered that disparities and lack of access to care in rural and inner cities result in poorer health outcomes. And, it found 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.

Health services research does not just lift the veil on problems plaguing American healthcare; it also seeks ways to address them. Health services research framed the debate over healthcare reform in Massachusetts—forming the basis for that State's 2006 health reform legislation—and continues to frame the debate on the national stage today. It offers guidance on implementing and making the best use of health information technology, and getting the best care at the best value across a menu of treatment options. And there are increasing examples that demonstrate how comparative effectiveness research—an emerging science in the broader field of health services research—provides the scientific basis needed to determine what treatments work best, for whom, and in what circumstances.

Health services research can contribute greatly to better healthcare at better value. It is a true public good, providing a basis for improvements in our healthcare

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[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.

system that will benefit the general public. Americans overwhelmingly agree. A recent opinion survey commissioned by Research!America found that 95 percent of Americans say it is important to support research focused on how well our healthcare system is functioning. After all, the investment in basic research and the development of new medicines and equipment is wasted if the health system cannot safely and effectively deliver that care.

For the last 6 years, the Coalition has been collecting data to track the Federal Government's expenditures for health services research and health data. From information provided to us by these funders—including Agency for Healthcare Research and Quality (AHRQ), National Institutes of Health (NIH), and the Centers for Disease Control and Prevention (CDC)—funding for this field remained relatively constant from fiscal year 2003—2008 and did not kept pace with inflation. In stark contrast, spending on healthcare overall has risen faster than the rate of inflation—from $1.4 trillion in 2000 to nearly $2.2 trillion in 2007. The total Federal investment in health services research and data by our estimates approaches $1.7 billion in fiscal year 2008—representing just 0.074 percent of the $2.2 trillion we spend on healthcare annually.

The Coalition for Health Services Research greatly appreciates the subcommittee's recent efforts to increase the Federal investment in health services research and comparative effectiveness research through the fiscal year 2009 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 single funding increase health services research has experienced. With comprehensive health reform on the horizon, we ask that the subcommittee continue to strengthen 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. Steady, incremental increases for AHRQ's Effective Health Care Program in recent years, as well as the $300 million provided to AHRQ in the American Recovery and Reinvestment Act as a down payment on health reform will help 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 on health disparities, healthcare financing and organization, and access and coverage has languished as funding for AHRQ's base has remained relatively flat. Future investments should bolster these other important research topics to balance the recent investments in comparative effectiveness research. Comparative effectiveness research alone will not solve our health system challenges; the full spectrum of health services research on healthcare costs, quality, and access will be needed to support broader health reform efforts.

In fiscal year 2009, Congress provided AHRQ $13 million to reverse a decline in the number of, and funding for, grants that support researcher innovation and career development. AHRQ is using this funding for investigator initiated research grants to rejuvenate the free marketplace of ideas through the agency's new Innovations Research Portfolio. We request that Congress provide additional funding to sustain and expand investigator initiated grants in fiscal year 2010.

The Coalition remains concerned about AHRQ's limited investment in training grants for young researchers, which hit new lows in fiscal year 2009—just 40 awards totaling $5 million—down from nearly double that amount just 2 years ago. The Coalition requests that Congress will provide AHRQ more funding in fiscal year 2010 for training grants to ensure the field's capacity to respond to the growing public and private sector demand for health services research.

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. We join the Friends of AHRQ—a coalition of more than 250 health professional, research, consumer, and employer organizations that support the agency—in recommending a fiscal year 2009 base funding level of at least $405 million, an increase of $32 million more than the fiscal year 2009 level. This investment will allow AHRQ to restore its critical healthcare safety, quality, and efficiency initiatives; strengthen the infrastructure of the research field; and reignite innovation and discovery.

CDC

Housed within 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. Thanks to NCHS, we know that too many Americans are overweight and obese, cancer deaths have decreased, average life expectancy has increased, and emergency rooms are overcrowded. We also know how many people are uninsured, how many children are immunized, how many Americans are living with HIV/AIDS, and how many teens give birth.

Despite recent funding increases secured through your leadership, NCHS continues to feel the effects of long-term underinvestment, forcing the agency to eliminate or further postpone the collection of such vital information to the point where key data users now question whether NCHS itself is in good health. Years of flat funding and budget shortfalls forced the elimination of data collection and quality control efforts, threaten 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.

The Coalition joins the Friends of NCHS—a coalition of more than 250 health professional, research, consumer, industry, and employer organizations that support the agency—in recommending a base funding level of $137.5 million in fiscal year 2010 to ensure uninterrupted collection of vital statistics; restore other important data collection and analysis initiatives; to revise, pretest, and plan data collection activities for future calendar years, and modernize its systems to increase efficiency, interoperability, and security. In addition, we respectfully request that you provide NCHS $15 million in one-time funding to support the States and territories as they implement the 2003 birth certificates and electronic systems to collect birth data in real-time to facilitate public health monitoring and planning. Future supplemental funding will be required to implement the 2003 death certificates in all States and complete the automation of data collection. The Coalition greatly appreciates that through your leadership early versions of the American Recovery and Reinvestment Act in the House and Senate included $40 million for this infrastructure development; we were disappointed that it had to be eliminated from the final package.

While significant funding has been provided to improve the public health system's capacity to respond to a terrorist attack or a public health crisis such as pandemic flu, insufficient funding has been provided to support research that evaluates the effectiveness of our preparedness interventions and seeks to improve the delivery of public health services. For example, how cost effective are public health and prevention programs? How can the medical care and public health delivery systems be better linked? CDC's important Public Health Research program and Prevention Research Centers-a network of academic health centers that conduct public health research-have been flat funded since fiscal year 2006 at levels of $31 million and $29 million, respectively. The Coalition requests at least $35 million for Public Health Research and at least $33 million for Prevention Research Centers in fiscal year 2010. The programs seek ways to development, translate, and disseminate research to address obesity, diabetes, and heart disease, healthy aging and youth development, cancer risk, and health disparities.

CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS)

Steady funding decreases for the Office of Research, Development and Information, together with an increasingly earmarked budget, has hindered CMS' ability to meet its statutory requirements and conduct new research to strengthen our public insurance programs—including Medicare, Medicaid, and SCHIP—which together provide coverage to nearly 100 million Americans and comprise 45 percent of America's total health expenditures. At a time when these programs pose significant budget challenges for both the Federal and State governments, it is critical that we adequately fund research to evaluate these programs' efficiency and effectiveness, and seek ways to manage their projected spending growth.

The Coalition supports increasing CMS's discretionary research and development budget from $31 million in fiscal year 2009 to a base fiscal year 2010 funding level of $45 million—in addition to funding for programmatic earmarks—as a critical down payment to help CMS recover lost resources and restore research to evaluate their programs, analyze pay for performance and other tools to update payment methodologies, and to further refine service delivery methods.

NIH

The NIH reported that it spent $743 million on health services research in fiscal year 2008—roughly 2.9 percent of its entire budget—making it the largest Federal sponsor of health services research. For fiscal year 2010, the Coalition recommends a health services research base funding level of at least $940 million—2.9 percent of the $32 billion the broader health community is seeking for NIH in fiscal year 2010. We encourage NIH to increase the proportion of their overall funding that

goes to health services research from 2.9 to 5 percent to assure 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. At a time when you, your congressional colleagues, and members of the new administration are considering major health reform including ways to get more value for current expenditures, health services research and health data are needed more than ever to yield better information and lead to improved quality, accessibility, and affordability. We urge the subcommittee to accept our fiscal year 2010 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 2010 appropriations for the Low Income Home Energy Assistance Program (LIHEAP).

The governors appreciate the subcommittee's continued support for the LIHEAP program, and we thank you for providing the full authorized amount of $5.1 billion in fiscal year 2009 LIHEAP funding. The governors recognize the considerable fiscal challenges facing the subcommittee this year. However, we urge you to maintain the $5.1 billion level in regular fiscal year 2010 LIHEAP block grant funding as well as contingency funds to address unforeseen energy emergencies.

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 families with young children. The highest level of LIHEAP assistance is provided to households with the lowest incomes that pay a high proportion of their income (up to 17 percent) for home energy. A December 2007 study by the Oak Ridge National Laboratory found that, in recent years, the increase in the cost of home energy has far outpaced the rate of inflation and the increase in household income. Even with continued belt-tightening, there is just no room in the budget of these low-income households to pay for increasing energy bills.

The current economic crisis exerts additional pressures on these households, making energy assistance more important now than ever before. In 2007, even before the current recession took hold, 8.7 million residential consumers had their electricity or natural gas service terminated for failing to pay their bills, according to a survey by the National Association of Regulatory Utility Commissioners (December 2008). The same survey found at the end of the 2007–2008 winter heating season, the number of electricity and natural gas residential households with past due accounts had jumped to almost 40 million consumers, and represented nearly $8.7 billion in past due accounts.

According to the National Energy Assistance Directors' Association, the $5.1 billion in fiscal year 2009 LIHEAP funding makes it possible for States to serve approximately 7.3 million households this year. This record number represents a 25 percent increase more than last year and reflects the increased unemployment rate and rise in home energy costs. Yet this is only a small portion of the LIHEAP-eligible households in today's economy.

If the $5.1 billion level of LIHEAP funding is not sustained in fiscal year 2010, States nationwide will be forced to eliminate more than 1.5 million families from the program in order to maintain some of the purchasing power of the LIHEAP grant for the program's poorest families, or to reduce benefit levels overall. 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 $5.1 billion in regular block grant funding for LIHEAP in fis-

cal year 2010 as well as 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 with simply 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 COUNCIL ON SOCIAL WORK EDUCATION

On behalf of the Council on Social Work Education (CSWE), I am pleased to offer this written testimony to the Senate Appropriations Subcommittee on Labor, Health and Human Services, and Education, and Related Agencies for inclusion in the official subcommittee record. I will focus my testimony on the importance of fostering a skilled, sustainable and diverse social work workforce through training and financial support programs at the Department of Health and Human Services and the Department of Education.

CSWE is a nonprofit national association representing more than 3,000 individual members as well as 650 graduate and undergraduate programs of professional social work education. Founded in 1952, this partnership of educational and professional institutions, social welfare agencies, and private citizens is recognized by the Council for Higher Education Accreditation as the sole accrediting agency for social work education in the United States. Social work education focuses students on leadership and direct practice roles helping individuals, families, groups, and communities by creating new opportunities that empower people to be productive, contributing members of their communities.

Vulnerable populations from all walks of life—defined here as children and adults with physical or mental disabilities, those living in poverty, trauma victims, aging individuals, returning veterans, individuals under stress or facing coping challenges both temporary and permanent, and segments of society needing assistance to adjust to changing circumstances or overcome injustices—are faced with hurdles which for some cannot be overcome alone. Social workers help vulnerable populations in society be as healthy and productive as possible by working with them to navigate societal and personal challenges. Social workers are employed in schools, hospitals, VA facilities, rehabilitation centers, social service locations, child welfare organizations, assisted living centers, nursing homes, and faith-based organizations.

TRAINING OPPORTUNITIES AND DEBT LOAD RELIEF FOR SOCIAL WORKERS

Recruitment and retention pose the most significant challenge to the success of the social work profession. This is true across all sectors (public and private), at all levels (from BSW to the doctoral level), and in all fields of practice (child welfare, public health, mental health, geriatrics, veterans, etc.).

The Nation needs a workforce that is skilled, diverse, and able to keep pace with demand. In 2004, the Bureau of Labor Statistics (BLS) reported that by 2012 a total of 209,000 social workers will be needed in the fields of child, family, and school social work; medical and public health social work; and mental health and substance abuse social work. In 2006, the BLS estimated there would be a total of 258,000 job openings for social workers due to growth and net replacement between 2006 and 2016 in the same fields.

While recruitment and retention can be a significant challenge for many professions, especially those dealing with public health and the delivery of social services, the problem is exceptionally widespread for social work. Recruitment into the social work profession faces many obstacles, the most prevalent being low wages.

As we look toward reforming the American healthcare system, we must consider the needs of the workforce that will be responsible for ensuring the health of the population. The recommendations for fiscal year 2010 would help to ensure that we are fostering a sustainable, skilled, and diverse workforce that will be able to keep up with the increasing demand.

DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS)

The various agencies within the HHS provide training and fellowship opportunities for social workers, as well as loan forgiveness programs to help social workers stay in the field. CSWE urges the subcommittee's support of the following HHS programs; this is not an exhaustive list:

Minority Fellowship Program, Substance Abuse and Mental Health Services Administration (SAMHSA).—The goal of the SAMHSA Minority Fellowship Program (MFP), which is administered through the Center for Mental Health Services, is to

achieve greater numbers of minority doctoral students preparing for leadership roles in the mental health and substance abuse field. According to SAMHSA, "Minorities make up approximately one-fourth of the population, but only about 10 percent of mental health providers are ethnic minorities." CSWE has been a grantee of this critical program for years, administering funds to exceptional minority social work students. Together with a program at the National Institute of Mental Health (NIMH), CSWE has supported more than 500 minority fellows since the program's inception, with about two-thirds of those students having gone on to receive their doctoral degrees. For fiscal year 2010, CSWE urges the subcommittee to fund the SAMHSA Minority Fellowship Program at $7.5 million. This program has suffered from flat and declining budgets over the last several years. Thankfully, due to congressional support, it has been restored year after year, despite efforts by the Bush administration to cancel it. President Obama's fiscal year 2010 budget request includes level funding for the MFP at about $4 million. Funding the MFP at $7.5 million would directly encourage more social workers of minority background to pursue doctoral degrees in mental health and substance abuse and will turnout minority mental health professionals equipped to provide culturally competent, accessible mental health and substance abuse services to diverse populations.

Institutional Research Training Program in Social Work (T32), NIMH.—NIMH within the National Institutes of Health (NIH) initiated a training program in the 1970s that sought to increase the number of minority doctoral students focusing their research in mental health. Like the SAMHSA program mentioned above, CSWE has ably administered a grant from NIMH for many years, which provides mentored training opportunities to minority social work researchers. The social work profession depends on culturally competent and culturally relevant research to assess the circumstances facing vulnerable populations and the needs of those populations to succeed in their circumstances; evaluate the accessibility to and effectiveness of existing social services; and determine best practices for social work educators and practitioners for serving the community. While this program has been successful in enhancing diversity among social workers conducting mental health research and has allowed more underrepresented social work researchers to be brought into the fold as NIH investigators, NIMH recently announced its plan to cancel the program in 2010 and transition the funds to support the traditional, non-diversity-focused T32 training program at NIMH. CSWE is very concerned about the implications of this decision, both on the diversity of researchers at NIMH and what we feel could lead to an absence of social work research at NIMH. We hope the subcommittee will encourage NIMH to take the necessary steps to enhance diversity of the NIH/NIMH grant pool and express to NIMH the value and importance of social work research to the study of mental health.

Title VII Health Professions Programs, Health Resources and Services Administration (HRSA).—The title VII health professions programs at HRSA provide financial support for education and development of the healthcare workforce. The emphasis of these programs is on improving the quality, diversity, and geographic distribution of the health professions workforce, and is currently the only Federal program to do so. These programs provide loans, loan guarantees and scholarships to students and grants to institutions of higher education and nonprofit organizations to help build and maintain a robust healthcare workforce. Social work students and practioners are eligible for title VII funding. We thank you for recognizing the value of these programs by providing $200 million in stimulus funding to the title VII and title VIII (nursing) programs in the American Recovery and Reinvestment Act of 2009 (Public Law 111–5). CSWE urges the subcommittee to provide $330 million for the title VII health professions programs for fiscal year 2010.

Loan Repayment Program, Indian Health Service (IHS).—The Loan Repayment Program at IHS offers repayment of health professions educational loans in exchange for a commitment to work at an IHS or other Indian health program priority site for a minimum of 2 years. Social workers are eligible to participate in this program, as defined in section 4(n) of the Indian Health Care Improvement Act (Public Law 94–437). With appropriate funding, this program can serve as an effective recruitment tool. However, the program has been grossly underfunded for a number of years. For example, last year IHS denied funding to 231 healthcare professionals already working in IHS as well as 95 recruits, due to a lack of resources. CSWE, a member of the Friends of Indian Health Coalition, urges the subcommittee to provide an additional $18.5 million above fiscal year 2009 funding for the IHS Loan Repayment Program for fiscal year 2010 in order to address the critical recruitment needs of the agency.

DEPARTMENT OF EDUCATION

The last few years have seen the creation of a number of loan forgiveness and training programs for which social work would benefit, if adequately funded. CSWE urges the subcommittee to support the following programs at the Department of Education:

Graduate Assistance in Areas of National Need (GAANN) Program.—The GAANN program provides graduate traineeships in critical fields of study. Currently, social work is not defined as an area of national need for this program; however it was recognized by Congress as an area of national need in the Higher Education Opportunity Act of 2008 as discussed below. We are hopeful that the Department of Education will recognize the importance of including social work in the GAANN program in future years. Inclusion of social work would help to significantly enhance graduate education in social work, which is critically needed in the country's efforts to foster a sustainable health professions workforce. CSWE supports a budget of at least $41 million for GAANN in fiscal year 2010. However, if social work were to be added by the Department as a new area of national need, additional resources would need to be provided so as not to take funding away from the already determined areas of national need.

Loan Forgiveness for Service in Areas of National Need Program.—The Higher Education Opportunity Act of 2008 (Public Law 110–315) created the Loan Forgiveness for Service in Areas of National Need program. This program applies to full-time workers who are employed in areas of national need, such as social workers working in public or private child welfare agencies or mental health professionals with at least a master's degree in social work. CSWE urges full funding for this new program for fiscal year 2010.

In addition to these discretionary programs, a number of mandatory programs were created in the College Cost Reduction Act of 2007 (Public Law 110–84). We look forward to working with the Department of Education as these programs are implemented. Among the programs that include social work education are:

Income-based Repayment (IBR)Program.—IBR program will begin operation in July 2009. This new program caps Federal student loan payments at a reasonable percentage of income and cancels most remaining balances of student loans after 25 years. CSWE will be monitoring the implementation of this new program to assess the extent to which it is assisting social workers address their debt load reduction needs.

Income Contingent Payment for Public Sector Employment Program (Public Service Loan Forgiveness).—The College Cost Reduction Act of 2007 revised the Income Contingent Payment for Public Sector Employment program, which previously allowed a borrower who works in public service to pay their loans more than 25 years after which their debt would be forgiven. The law now states that public service workers working for an eligible nonprofit can cancel their loans after 10 years of service for loans taken out after October 1, 2007. Like the IBR program, CSWE plans to monitor the implementation of this program to assess its success in assisting social workers address high educational debt load.

We hope the subcommittee will take these points into consideration as you move forward in the fiscal year 2010 appropriations process.

PREPARED STATEMENT OF CENTRAL TECHNICAL SERVICES

SUMMARY OF RECOMMENDATIONS FOR FISCAL YEAR 2010

Continue the Commitment to Providing the National Institutes of Health (NIH) and the National Library of Medicine (NLM) with meaningful funding increases on an annual basis. Continue to support and defend the NIH's 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. Continue to support the medical library community's important role in NLM's outreach, telemedicine, disaster preparedness and health information technology (health IT) initiatives.

On behalf of the Medical Library Association (MLA) and the Association of Academic Health Sciences Libraries (AAHSL), thank you for the opportunity to present testimony regarding fiscal year 2010 appropriations for the NLM.

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 impor-

tance 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. 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 ANNUAL FUNDING INCREASES FOR NLM

I thank the subcommittee for its leadership and hard work on the American Recovery and Reinvestment Act of 2009 (Public Law 111–5), the economic stimulus package. As you know, the important mission of NIH and the important role that NLM plays in fulfilling that mission were hampered by past-years of near level funding. The investment in NIH and NLM provided by the stimulus package will not only create meaningful employment opportunities, it will also revitalize NLM's programs, which are focused on improving the public health.

We are pleased that the recently passed fiscal year 2009 omnibus appropriations package contains funding increases for NIH and NLM that will bolster their baseline budgets. We hope that this funding is an indication of the subcommittee's intention to provide annual, meaningful increases for NIH and NLM in the coming years.

I am confident that the recovery funding and the fiscal year 2009 budget increases will stimulate the economy, stimulate biomedical research, and in the case of NLM, improve the dissemination of health information to researchers, practitioners, and the general public. Moving forward, it will be critical to provide NIH's baseline budget with the funding increases necessary to allow the short-term growth generated by the stimulus to become a long-term investment towards improved public health through bolstered health information programs.

Building and Facility Needs

NLM has had tremendous growth in its basic functions related to the acquisition, organization, and preservation of an ever-expanding collection of biomedical literature. It also has been assigned a growing set of set of responsibilities related to the collection, management, and dissemination genomic information, clinical trials information, and disaster preparedness and response. As a result, NLM faces a serious shortage of space, for staff, library materials, and information systems. Digital archiving—once thought to be a solution to the problem of housing physical collections—has only added to the challenge, as materials must often be stored in multiple formats (physical and digital) and as new digital resources demand increasing amounts of storage space. As a result, the space needed for computing facilities has also grown. In order for NLM to continue its mission as the world's premier biomedical library, a new facility is urgently needed. 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.

The 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 integrated services such as GenBank and PubMed that are helping to revolutionize medicine and advance science to the next important era—individualized medicine based on an individual's unique genetic differences.

NLM's clinical trials database, ClinicalTrials.gov, which was launched in February 2000 and lists registration information on more than 70,000 U.S. and international trials for a wide range of diseases, also now serves as a repository for summary results information. The expanded system serves not only as a free, but invaluable resource for patients and families who are interested in participating in trials of new treatments for a wide range of diseases and conditions, but also as an important source of information for clinicians interested in understanding new treatments and for those involved in evidence-based medicine and comparative effectiveness research.

As the world's largest and most comprehensive medical library, services based on NLM's traditional and electronic collections continue to steadily increase each year.

These collections stand at more than 11.4 million items—books, journals, technical reports, manuscripts, microfilms, photographs, and images. By selecting, organizing and ensuring permanent access to health science information in all formats, NLM is ensuring the availability of this information for future generations, making it accessible to all Americans, irrespective of geography or ability to pay, and ensuring that each citizen can make the best, most-informed decisions about their healthcare. 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 all come to expect.

DEFEND PUBLIC ACCESS

The Appropriations Committee has shown unprecedented foresight and leadership by using the annual spending bills as the vehicle to establish a public access policy at the NIH. The current policy requires that all NIH-funded researchers deposit their final, peer-reviewed manuscripts in NLM's PubMed Central database within 12 months of publication. This policy will not only help NIH better manage its portfolio of research, but will contribute to the development of a biomedical informatics infrastructure that will stimulate further discovery by enabling a much greater and tighter interlinking of information from NLM's wide-ranging set of databases. It also contributes to outreach initiatives by providing much-needed access to health literature to those without direct access to medical libraries. While the fiscal year 2009 omnibus package made this policy permanent moving forward, challenges remain and we urge the subcommittee to continue to defend this policy.

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. NLM has taken a leadership role in promoting educational outreach aimed at public libraries, secondary schools, senior centers and other consumer-based settings. 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.

With help from Congress, NLM, NIH and the Friends of NLM, launched NIH MedlinePlus Magazine in September 2006. This quarterly publication is distributed in doctors' waiting rooms, and provides the public with access to high-quality, easily understood health information. Collaborating with the National Alliance for Hispanic Health, a Spanish version is now available, NIH MedlinePlus Salud. NLM also continues to work with medical librarians and health professionals to encourage doctors to provide MedlinePlus "information prescriptions" to their patients. This initiative also encourages genetics counselors to prescribe the use of NLM's Genetic Home Reference Web site.

"Go Local" is another exciting service that engages health sciences libraries and other local and State agencies in the creation of Web sites that link from MedlinePlus to relevant information on local pharmacies, hospitals, doctors, nursing homes, and other health and social services. In Iowa, for example, University of Iowa librarians developed an Iowa Go Local site that enables users to find local health resources by Iowa county or city. It allows Iowa citizens to link directly from a MedlinePlus health topic, for example asthma, to local services, such as clinics, pulmonary specialists, and support groups in the geographic area selected. By collecting such information in one place, Go Local also provides a platform for enhancing access to the information needed to prepare for and respond to disasters and emergencies.

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 2010.

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. We ask the subcommittee to show its support for this initiative, which has a major objective of ensuring continuous access to health information and effective use of libraries and librarians when disasters occur. Following Hurricane Katrina, for example, NLM worked 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 NNLM. Presently, libraries are a significant, but underutilized resource for community disaster planning and management efforts, which NLM can help to deploy. With assistance from its NNLM, NLM is working with health sciences libraries to develop continuity of operations and backup plans and is exploring the role that specially trained librarians—disaster information specialists—can play in providing information services to emergency personnel during a crisis. MLA and AAHSL see a clear role for NLM and the NNLM in the Nation's disaster preparedness and response activities.

HEALTH IT AND BIOINFORMATICS

NLM has played a pivotal role in creating and nurturing the field of biomedical informatics. Not only has NLM developed key biomedical databases, but for nearly 35 years, NLM has supported informatics research and training and the application of advanced computing and informatics to biomedical research and healthcare delivery including a variety of telemedicine projects. Many of today's informatics leaders are graduates of NLM-funded informatics research programs at universities across the country. Many of the country's exemplary electronic health record systems benefited from NLM grant support.

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 its 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 support health information technology initiatives in ONCHIT and the Agency for Healthcare Research and Quality that build upon initiatives housed at NLM.

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.

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. 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 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 authorized under section 1504 of the No Child Left Behind Act, has been continuously funded by a Congressional appropriation, through a U.S. Department of Education grant, for more than 35 years. 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 fellowships recipients are selected by their schools and must qualify according to the income eligibility guidelines.

As in most years, funding for the Close Up Fellowship Program was not included in the President's budget submitted to Congress. Close Up respectfully requests that Congress again include funding for this important program through the appropriations process. I also wish to address some of the arguments made by the administration for eliminating the Close Up Fellowship Program.

The administration's claim that peer organizations of Close Up provide scholarships to participants without Federal assistance is misleading. The average family income of a Close Up Fellowship recipient is approximately $24,000. To the extent that other nonprofit civic education organizations claim to provide scholarships, they usually are provided only to high academic achievers and certainly not on the scale and volume provided by Close Up. None of these organizations reach the numbers of economically disadvantaged students and teachers from under-resourced schools as Close Up does. Twenty-five percent of Close Up participants each year receive fellowship support provided through a mix of Federal funds and contributions raised from private sources by the Close Up Foundation.

Close Up is also concerned with the administration's statement that our private fundraising efforts would allow our civic education program to continue. The statement misses the point. The result of elimination of the Close Up Fellowship Program would immediately deny participation to deserving and diverse students who, but for the fellowship program, would be unable to attend. In turn, this would make Close Up's student composition dramatically less diverse. While Federal funding represents a small portion of Close Up's revenue, it is a critical portion of our funding that permits us to reach as many economically disadvantaged students as we do.

Finally, the administration wrongly asserted that it had minimal evidence that Close Up had a positive impact on the participating students and teachers. Close Up measures impact in four principle ways:

Qualitative Data (some of our findings include):

—97 percent of teachers said the program helped their students understand the role of a citizen in a democracy; 94 percent of students agreed.

—94 percent of teachers said the program helped their students understand current policy issues facing the United States; 94 percent of students agreed.

—91 percent of teachers said the program complements what they teach in school.

—95 percent of students said the program helped them understand that other students have views other than their own.

—78 percent of students said that the program inspired them to become more involved in activities in civic activities when they return home.

Qualitatively Data:

—Close Up conducts weekly focus groups with students and teachers about their program experience and its impact on their lives.

—Close Up assembles anecdotal information from teachers regarding the performance of their students and their community action projects.

College Credit:

—The University of Virginia and the University of Indiana, after a comprehensive evaluation of the academic value of the Close Up civic education programs, grant the opportunity for Close Up participants to receive undergraduate credit (students) and graduate credit (teachers), respectively.

Local Support:

—Thousands of schools organize and fundraise each year to send their young people on a Close Up program. Approximately 18,000 students and teachers participate annually.

—Local education officials have concluded that Close Up is of such value as to permit students and teachers to sacrifice a week of school and absence from all of their classes to participate.

—Many school systems contribute scarce budget dollars to help students attend while most others provide resources for substitute teachers.

Close Up 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 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 2010 request is based on 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 current economic climate, it will be 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'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 that Close Up Fellowship funding remained flat at just 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 supports the suffering transportation and hospitality economic sectors.

Senators have the opportunity to meet with Close Up groups from their States during Close Up "Capitol Hill Day". They see the excitement and pride as our students gain the confidence to express their views on the public policy issues that most directly affect their lives. Through workshops, seminars and the 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 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.

LETTER FROM THE DIGESTIVE DISEASE NATIONAL COALITION

Washington, DC, May 22, 2009.

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 SENATORS HARKIN AND COCHRAN: Thank you very much for your continued leadership in advancing healthcare policy.

The Digestive Disease National Coalition (DDNC) is an advocacy organization comprised of the major national voluntary and professional societies concerned with digestive diseases. The DDNC focuses on improving public policy related to digestive diseases and increasing public awareness with respect to the many diseases of the digestive system. The DDNC works cooperatively to improve access to and the quality of digestive disease healthcare in order to promote the best possible medical outcome and quality of life for current and future patients with digestive diseases.

In this capacity, the DDNC applauds the long-range research agenda as stated in the March 2009 publication Opportunities and Challenges in Digestive Diseases Research: Recommendations of the National Commission on Digestive Diseases by the National Institute of Diabetes, and Digestive, and Kidney Diseases (NIDDK). The DDNC requests that the subcommittee consider the following recommendations for the fiscal year 2010 Labor, Health and Human Services, and Education, and Related Agencies appropriations bill:

—A 6.5 percent funding increase for the National Institutes of Health, with a proportional increase for the NIDDK; and

—An increase of $75 million for the VA Medical and Prosthetic Research Program for a total of $555 million.

Thank you for the opportunity to present the views of the digestive disease community. Please do not hesitate to contact me if there is any more information you would like us to provide for your consideration.

Sincerely,

DR. PETER BANKS,
President.
LINDA K. AUKETT,
Chair.

PREPARED STATEMENT OF THE DYSTONIA MEDICAL RESEARCH FOUNDATION

SUMMARY OF RECOMMENDATIONS FOR FISCAL YEAR 2010

Provide a funding increase of at least 7 percent for the National Institutes of Health (NIH) and its Institutes and Centers.

Urge the National Institute on Neurological Disorders and Stroke (NINDS), the National Institute on Deafness and Other Communication Disorders (NIDCD), and the National Eye Institute (NEI) to expand their research portfolios on dystonia.

Urge the NIH Office of Rare Diseases (ORD) to explore opportunities to partner with the Dystonia Medical Research Foundation (DRMF) and advance dystonia research.

Dystonia is a neurological movement disorder characterized by powerful and painful involuntary muscle spasms that cause the body to twist, repetitively jerk, and sustain postural deformities. There are several different variations of dystonia, including; focal dystonias, which affect specific parts of the body, and generalized dystonia, which affect many parts of the body at the same time. Some forms of dystonia are genetic and others are caused by injury or illness. Dystonia does not affect a person's consciousness or intellect, but is chronic and progressive. In North America alone, conservative estimates indicate that between 300,000 and 500,000 individuals suffer with dystonia. Currently, there is no known cure and treatment options remain limited.

While the underlying mechanisms of dystonia remain a mystery and the onset of symptoms can occur for a number of reasons, two therapies have emerged with proven health benefits to the dystonia patient community. Botulinum toxin injections and deep brain stimulation have shown varying degrees of success, depending on the individual, in alleviating a dystonia patient's symptoms. More research is needed to fully understand how to combat and cure dystonia, and in the mean time, maintaining patient access to life-improving therapies remains critical.

DEEP BRAIN STIMULATIONS (DBS)

DBS is a surgical procedure that was 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 and delivers electrical stimulation to the areas of the brain that control movement. While the exact reasons for effectiveness are unknown, the electrical stimulation blocks abnormal nerve signals that cause abnormal muscle spasms and contractions.

Since DBS was approved for use by dystonia patients in 2003, it has drastically improved the lives of many individuals. Results have ranged from quickly regaining the ability to walk and speak, to regaining complete control over ones body and returning to an independent life as an able-bodied person. DBS is currently used to treat severe cases of generalized dystonia, but its promising role in treating focal dystonias is being explored and requires continuous support. Surgical interventions are a crucial and active area of dystonia research and may continue to lead to the development of promising 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 biological product, 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.

Injections of botulinum toxin should only be performed by a physician who is trained to administer this treatment. The physician needs to know the clinical features and study the involuntary movements of the person being treated. The physician doing the treatment may palpate (touch) 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 one to three 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.

DYSTONIA AND NIH

Currently, three Institutes at NIH conduct medical research into dystonia. They are NINDS, NIDCD, and NEI.

NINDS has released important Program Announcements in recent years to study the causes and mechanisms of dystonia. These awards cover a wide range of research areas, which 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 often works with NINDS to support as much critical research as possible and advance understating of dystonia.

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.

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. Presently, NEI is conducting a study entitled, Mexiletine for the Treatment of Focal Dystonia and a Doxilr Blepharospasm Treatment Trial, both of which have the potential to significantly improve treatment options for blepharospasm patients.

An emerging area of NIH that has the potential to stimulate important, new research into dystonia is ORD housed in the Office of the Director. ORD can facilitate research networks into certain rare conditions by pulling together resources housed at other NIH Institutes and Centers. Given the prevalence of dystonia, the DMRF would like to work more closely with ORD to stimulate and support new research opportunities.

DMRF also supports many extramural researchers studying dystonia. Research includes: exploring improved clinical rating scales for dystonia, elevations of sensory motor training, utilizing Botox as a possible treatment for focal hand dystonia, characterization of abnormalities in sensory regions of the brain, treatments for spasmodic dysphonia, DBS (the direct electrical stimulation of specific brain targets), noninvasive transcranial brain stimulation, anatomy imaging of the effect of dystonia on brain activity, and exploring the link between laryngitis and spasmodic dysphonia.

Recent years of near level-funding at NIH have negatively impacted the mission of its Institutes and Centers. For this reason, DMRF applauds initiatives like Senator Arlen Specter's (D-PA) successful effort to provide NIH with $10.4 billion in stimulus funds. IFFGD urges this subcommittee to show strong leadership in pursuing substantial funding increase through the regular appropriations process in fiscal year 2010.

For fiscal year 2010, DMRF recommends a funding increase of at least 7 percent for NIH and its Institutes and Centers.

For fiscal year 2010, DMRF recommends that NINDS, NIDCD, and NEI be urged to increase their research activities regarding dystonia and partner with voluntary health organizations to promote dystonia research and awareness.

For fiscal year 2010, DMRF asks the subcommittee to urge ORD to consider ways it can partner with DMRF and support dystonia research.

DMRF

DMRF was founded more than 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.

PREPARED STATEMENT OF THE FEDERATION OF AMERICAN SOCIETIES FOR EXPERIMENTAL BIOLOGY

The Federation of American Societies for Experimental Biology (FASEB), respectfully requests a funding increase of at least 7 percent above the fiscal year 2009 baseline level for the National Institutes of Health (NIH) in fiscal year 2010. This funding level is an important step toward President Obama's campaign pledge to double funding for basic research over 10 years and is necessary to maintain both the existing and future scientific infrastructure. We are in a crucial time for science in the United States. After years of stagnant funding for research, Congress has recently made significant new investments in NIH. The scientists and researchers represented by FASEB are sincerely grateful to Congress for your faith in the research community and your generosity in providing the resources that are essential for progress in science.

As a Federation of 22 professional scientific societies, FASEB represents nearly 90,000 life scientists, making us the largest coalition of biomedical research associations in the Nation. 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 biomedical and life scientists to improve—through their research—the health, well-being, and productivity of all people.

We especially thank and commend Congress for including the extraordinary investment in medical research at NIH that was included as part of in the American Recovery and Reinvestment Act (ARRA, Public Law 111–5) as well as the $938 million increase in NIH funding in the Omnibus Appropriations Act for fiscal year 2009 (Public Law 111–8). In particular, we are deeply grateful to the chairman and this subcommittee for your long-standing leadership in support of NIH. These are difficult times for our Nation and for people all around the globe, but the affirmation of science is the key to a better future is a strategic step forward.

The recent history of the NIH budget has hindered scientific discovery and limited the capacity of a key engine for today's innovation-based economy. The additional funding in the ARRA and the fiscal year 2009 omnibus are critical first steps to returning the NIH to a course for even greater discovery. These investments give patients, their families and researchers renewed hope for the future, and will help ensure the success of America's medical research enterprise and leadership.

The funding increases in the ARRA and the fiscal year 2009 omnibus will provide an immediate infusion of funds into the Nation's proven and highly competitive medical research enterprise to sustain the pursuit of improved diagnostics, better prevention strategies and new treatments for many devastating and costly diseases as well as support innovative research ideas, state-of-the-art scientific facilities and instrumentation, and the scientists, technicians, laboratory personnel, and administrators necessary to maintain the enterprise. These funds will are also reinvigorating this Nation's ability to produce the human and intellectual capital that will continue to drive scientific discovery, transform health, and improve the quality of life for all Americans. Moreover, we see this as the first step in renewing a national commitment to sustained, predictable growth in NIH funding, which we believe is an essential element in restoring and sustaining both national and local economic growth and vitality as well as maintaining this Nation's prominence as the world leader in medical research.

As a result of this subcommittee's prior investment in NIH, we have made critical advances in understanding basic science, saved and improved the lives of millions of Americans and provided doctors with tools to prevent and treat costly and devastating diseases including:

—*Cardiovascular Disease*.—New results from multiple studies provided the strongest evidence to date that a simple blood test for high-sensitivity C-reactive protein (hsCRP), whose characterization was funded by NIH, is a useful marker for cardiovascular disease. Furthermore, scientists have discovered that a daily dose of a commonly used statin, rosuvastatin (Crestor), reduced the risk of heart attack, stroke, and death by nearly half (44 percent) in individuals with high levels of hsCRP but with normal or low levels of low density lipoprotein (LDL), the so-called "bad cholesterol." These developments show great promise in helping clinicians better identify and treat individuals at risk for cardiovascular disease—potentially saving millions more lives.

—*Cancer*.—For the first time in a decade, incidence rates for all cancers combined are decreasing, driven largely by declines in some of the most common types of cancer, including breast cancer (2.2 percent decline among women) and prostate cancer (4.4 percent decline). Death rates declined for 10 of the top 15 causes of cancer death among both men and women.

—*Alzheimer's*.—Researchers isolated a toxic substance that appears to be a key to understanding Alzheimer's disease, suggesting a possible new target for developing drug therapies to combat the irreversible and progressive disorder. In addition, further insights into the early stages of Alzheimer's may answer questions not only about the disease, but also about age-related memory impairments.

—*Type 2 Diabetes*.—An international team that included NIH-funded scientists identified six new genetic variants associated with increased risk of type 2 diabetes. By pinpointing particular pathways involved in diabetes risk, this discovery can empower new approaches to understanding environmental influences and to the development of better, more precisely targeted drugs.

INVESTMENT IN NIH IS CRITICAL TO TAKING ADVANTAGE OF EMERGING SCIENTIFIC OPPORTUNITIES

Prior investment in NIH has begun to unlock the secrets of the human genome and allowed scientists to gain new insight into how disease works at the most basic levels within our bodies. Scientists are working tirelessly to translate research results into interventions for our most debilitating medical conditions. NIH also serves an invaluable role in communicating research findings to patients and their families, healthcare providers, and the general public in critical areas such as increasing knowledge about infectious diseases, improving cognitive health, and reducing health disparities.

THE CONSEQUENCES OF STAGNANT FUNDING FOR RESEARCH

The re-emergence of previously eradicated diseases such as mumps, the development of new health threats, a rapidly aging population, and significant increases in longevity lends a sense of urgency to the need to expedite scientific discovery. Yet even as our need to prevent disease becomes greater and the opportunities to succeed become more numerous, our national commitment to medical research has stagnated:

—"Success rates" dropped to an estimated 18 percent in fiscal year 2009. This means that more than 80 percent of the highly qualified, peer-reviewed research proposals go unfunded. With every unfunded idea, we risk missing or delaying critical discoveries leading to therapies for our most debilitating health conditions.

—The competition for funding is coming at a time when both the interest in careers in the science field and the number of newly trained researchers entering the workforce is increasing. Doctorates in the critical fields of engineering and biological sciences increased 10 percent and 11 percent respectively, in 1 year.[1]

—The medical schools, teaching hospitals, universities, and research institutes where NIH research takes place are among the largest employers in their respective communities. In fiscal year 2007, NIH grants and contracts created and supported more than 350,000 jobs that generated wages in excess of $18 billion in the 50 States.[2]

[1] Council of Graduate Schools. 2008. *Graduate Enrollment and Degrees: 1997–2007*. http://www.cgsnet.org/portals/0/pdf/N__pr__ED2007.pdf

[2] Families USA. 2008. *In your own backyard: How NIH funding helps your state's economy*. http://www.familiesusa.org/assets/pdfs/global-health/in-your-own-backyard.pdf

THE IMPORTANCE OF SUSTAINED, PREDICTABLE FUNDING FOR RESEARCH

The research engine needs a predictable, sustained investment in science to maximize our return on investment. The discovery process—while it produces 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 is disruptive to training, to careers, long-range projects, and ultimately to 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. We must ensure that after the stimulus money is spent we do not have to dismantle our newly built capacity and terminate valuable, on-going research.

The fiscal year 2009 omnibus and the ARRA provided $38.5 billion for NIH to provide more than 16,000 new research grants for live-saving research into diseases such as cancer, diabetes, and Alzheimer's. Keeping up with the rising cost of medical research in the 2010 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. Consistent with the President's proposal, we respectfully urge this subcommittee to increase funding for NIH in fiscal year 2010 by at least 7 percent more than the fiscal year 2009 level.

The Federal commitment to biomedical research is profoundly transforming medical practice, preventing disease, and creating better therapies but additional resources are needed to pursue the historic level of scientific opportunity that is available today. We recognize this subcommittee has the especially difficult task of providing funding for a wide range of critical human service programs and thank you for recognizing that prosperity and quality of life are increasingly shaped by investments in science and technology.

PREPARED STATEMENT OF THE FRIENDS OF THE HEALTH RESOURCES AND SERVICES ADMINISTRATION

The Friends of the Health Resources and Services Administration (HRSA) is a nonprofit and nonpartisan alliance of more than 140 national organizations, collectively representing millions of public health and healthcare professionals, academicians, and consumers. The coalition's principal goal is to ensure that HRSA's broad health programs have continued support in order to reach the populations presently underserved by the Nation's patchwork of health services.

Through its programs in every State and thousands of communities across the country, HRSA is a national leader in providing a health safety net for medically underserved individuals and families, including 86.7 million Americans who were uninsured for some or all of 2007–2008; 50 million Americans who live in neighborhoods where primary health services are scarce; more than 1 million people living with HIV/AIDS, and 34 million vulnerable mothers and children, including children with special health needs. In the best professional judgment of the members of the Friends of HRSA, to respond to this challenge, the agency will require an overall funding level of at least $8.5 billion for fiscal year 2010.

For several years, HRSA has suffered from relatively level funding, undermining the ability of its successful programs to grow. Our request reflects the minimum amount necessary for HRSA to adequately meet the needs of the populations they serve in fiscal year 2010, especially during these difficult economic times that are causing an increase in demand for HRSA programs and funding. Much more is needed for the agency to achieve its ultimate mission of ensuring access to culturally competent, quality health services for all; eliminating health disparities; and rebuilding the public health and healthcare infrastructure.

The coalition is very appreciative of the $2.5 billion HRSA received in the American Recovery and Reinvestment Act of 2009 for community health centers and health professions workforce development to prepare our health infrastructure for health system reform. This investment recognizes the critical role HRSA plays in building the foundation for health service delivery. However, we urge the subcommittee to support adequately funding all of HRSA's broad health programs and ensure that vulnerable populations transition smoothly into a new health system and receive continued, quality health services. By supporting, planning for and adapting to change, we can build on the successes of the past and address the new gaps that emerge as a result of health system reform.

Our $8.5 billion funding request is based on recommendations provided by coalition members for the various programs they focus on. It includes $2.602 billion for the Health Centers program, the fully authorized level under the Health Care Safe-

ty Net Act of 2008, as part of a long-term plan to provide care to 30 million Americans by 2015. Thanks to the leadership of the subcommittee, more than 7,000 health centers in every State and territory provide a healthcare home for more than 18 million medially underserved and low-income patients, and demand for their services continues to grow. The Health Centers program targets populations with special needs, including migrant and seasonal farm workers, homeless individuals and families, and those living in public housing. Health centers provide access to high-quality, family-oriented, culturally and linguistically competent primary care and preventive services, including mental and behavioral health, vision, and dental services. While recent growth in the health centers program has been substantial, a significant need remains in underserved communities across the country. We strongly encourage the subcommittee to continue its support of existing health centers and efforts to expand the reach and scope of the Health Centers program into new communities.

Coalition members recommend $235 million for the National Health Service Corps (NHSC), the amount authorized under the Health Care Safety Net Amendments of 2002. Approximately 50 million Americans live in communities with a shortage of health professionals, lacking adequate access to primary care. The Corps supports the recruitment and retention of primary care clinicians to practice in underserved communities in exchange for scholarships and loan repayment. The Corps supports more than 4,000 clinicians, with over half working in community health centers. Growth in the Health Centers program must be complemented with growth in the recruitment and retention of primary care clinicians to ensure adequate staffing.

Coalition members recommend $550 million for health professions programs under title VII and VIII of the Public Health Service Act. These programs are an essential component of America's health safety net and work in concert with the Health Centers Program and National Health Service Corps to enhance the supply, distribution and diversity of the health professions workforce. They are the only Federal programs that support the education and training of primary care providers in interdisciplinary settings to work in underserved communities and increase minority representation in the health professions workforce. Through loans, scholarships, and grants to academic institutions and nonprofit organizations, these programs provide support for the training of primary care physicians, nurses, dentists, optometrists, physician assistants, nurse practitioners, public health personnel, mental and behavioral health professionals, pharmacists, health educators, and other allied health providers. Adequate funding will reduce provider shortages in rural, medically underserved and federally designated health professions shortage areas and strengthen the pipeline of new providers that Health Centers and other safety-net health facilities need to meet the long-term needs of underserved communities. In addition, we recommend funds be appropriated to re-establish the National Center for Health Workforce Analysis to conduct and support statistical and epidemiological activities for assessing and improving decisionmaking to enhance the supply, distribution, diversity, and development of the current and future public health workforce. Finally, we urge the subcommittee to provide funding for the grant program under section 758 of the Public Health Service Act to develop interdisciplinary training and education programs on domestic violence and other types of violence and abuse as authorized by the Violence Against Women and Department of Justice Reauthorization Act of 2005.

We recommend $330 million for the Children's Hospital Graduate Medical Education (GME) Program, the amount authorized under the Children's Hospital GME Support Reauthorization Act of 2006. This program provides funds to freestanding children's hospitals to support the training of pediatric and other residents in GME programs. This program ensures that pediatric hospitals receive Federal funding comparable to other types of hospitals. We also request a significant investment in the Patient Navigator program that places navigators in underserved communities to help people with cancer and/or other chronic diseases make their way through the health systems and utilize community services that will help them beat chronic disease for longer, healthier lives.

We recommend $850 million for the Maternal and Child Health (MCH) block grant, the fully authorized level under title V of the Social Security Act. For more than 70 years, the MCH block grant has provided a source of flexible funding for States and territories to address their unique needs related to improving the health of mothers, infants, children, adolescent, and children with special healthcare needs. Today, this program provides prenatal services to more than 2 million mothers—almost half of all mothers who give birth annually—and primary and preventive care to more than 17 million children, including almost 1 million children with special needs. Fully funding the MCH block grant will enable States to expand critical health services and cope with ever increasing medical costs.

Newborn screening is a vital public health activity used to identify and treat genetic, metabolic, hormonal, and functional conditions in newborns. Screening detects heritable disorders in newborns that, if left untreated, can cause disability, mental retardation, serious illnesses, or even death. While nearly all babies born in the United States undergo newborn screening for genetic birth defects, the number of these tests varies from State to State. We recommend $30 million for the Heritable Disorders Program to support State efforts to improve programs, to acquire innovative testing technologies, and to increase capacity to reach and educate health professionals and parents on newborn screening programs and follow-up services. These activities and the funding level are authorized by the Newborn Screening Saves Lives Act.

We recommend $16 million for the Traumatic Brain Injury (TBI) program in order to better serve the 5.3 million Americans with a long-term or lifelong need for help to perform daily activities as a result of a TBI, including many of our returning war veterans. The TBI Program provides grants to States to coordinate, expand, and enhance service delivery systems in order to improve access to services and support for persons with TBI and their families. The TBI program also provides funds to State protection and advocacy programs that work to ensure that people with TBI get access to the supports and services they need.

We recommend $25 million for the Emergency Medical Services for Children (EMSC) program to address significant shortcomings in pediatric emergency care. The EMSC program is a national initiative designed to reduce child and youth disability and death due to severe illness and injury. EMSC grants provide funding for States and territories to improve existing emergency medical services systems and develop better procedures and protocols for treating children. Additional funding is needed to maintain and improve the program's activities, take advantage of important opportunities and address emerging threats such as terrorism.

We recommend $2.816 billion for the Ryan White HIV/AIDS programs, which is the estimated amount necessary to provide health services to all eligible individuals. The Ryan White programs provide the largest source of Federal discretionary funding to support health services for more than 500,000 low-income, uninsured, and underinsured people living with HIV/AIDS. Through grants to State and local governments and community-based organizations, the Ryan White HIV/AIDS programs support comprehensive care, drug assistance and support services for people living with HIV/AIDS; provide training for health professionals treating people with HIV/AIDS; provide assistance to metropolitan and other areas most severely affected by the HIV/AIDS epidemic; and address the disproportionate impact of HIV/AIDS on women and minorities. A significant funding increase is needed to meet growing medical costs and incidence of HIV, particularly among underserved populations.

The Office of Rural Health Policy promotes better health services for the 60 million Americans who live in rural communities. These communities suffer from inadequate access to quality health services and experience the higher rates of illness associated with lower socioeconomic status. Rural Health Outreach and Network Development Grants, and other programs are designed to support community-based disease prevention and health promotion projects, help rural hospitals and clinics implement new technologies and strategies, and build health system capacity in rural and frontier areas. In addition, Rural Health Research Centers help policymakers better understand the challenges that rural communities face in assuring access to health services and improving the health of their residents. Finally, the Rural and Community Access to Emergency Devices Program provides States with grants to train lay rescuers and first responders to use automated external defibrillators (AEDs) and purchase and place them in public areas where sudden cardiac arrests are likely to occur. We encourage the subcommittee to adequately fund these important programs that address the many unique health service needs of rural communities.

We recommend $700 million for the Family Planning programs under title X of the Public Health Service Act. Title X programs provide comprehensive, voluntary, and affordable family planning services to nearly 5 million low-income women at more than 4,500 clinics nationwide. Title X funded clinics help improve access to contraceptives, which help women plan the number and timing of their pregnancies, improve maternal and infant health, and help to prevent approximately 1.94 million unintended pregnancies each year, including nearly 400,000 teenage pregnancies. The Guttmacher Institute estimates that unintended pregnancies prevented each year would have resulted in 810,000 abortions and without publicly funded family planning programs, the U.S. abortion rate would be nearly two-thirds higher than the current level. Family planning is also cost-saving and for every public dollar invested in family planning, $3.80 is saved in costs associated with unintended births to women who are eligible for Medicaid. Today, almost 17 million women need pub-

licly supported contraceptive care—a number which continues to grow. Title X programs require a substantial increase in investment to meet the growing demand.

The Healthcare Systems Bureau provides national leadership on the transplantation of organs, bone marrow and cord blood. The recently passed Budget Resolution Conference Agreement calls for increased funding for "the organ transplant program." Coalition members recommend $35 million for the Division of Transplantation in order to meet the Office of Management and Budget's goal of doubling the number of transplants by 2013 and reduce the waiting list of 101,951 people in need of a life saving organ transplant. We recommend $38 million for the C.W. Bill Young Cell Transplantation Program, the amount authorized by the Stem Cell Therapeutic and Research Act of 2005. This program helps patients who need a potentially life-saving bone marrow or cord blood transplant, including patients with diseases like leukemia, lymphoma, sickle cell anemia, or other inherited metabolic or immune system disorders. We also recommend the fully authorized $15 million for the National Cord Blood Inventory, which collects and maintains high-quality cord blood units and makes them available for transplantation through the C.W. Bill Young Cell Transplantation Program.

Poison Control Centers, also administered by the Healthcare Systems Bureau, are a critical resource for people, health professionals, and organizations. Poisoning can happen to anyone, at anytime in any place and can lead to serious illness or even death. Each year, more than 2 million possible poisonings are reported to the nation's poison centers. On average, poison centers handle one possible poisoning every 13 seconds. These critical centers cannot afford to lose any resources and we encourage the subcommittee to fully fund this program.

Finally, we recommend a significant funding increase for HRSA's program management and staffing needs. Since 2001, HRSA has experienced a decline of almost 600 full-time equivalent employees. While HRSA has continued to administer its many programs effectively, the agency if facing ever growing demands as a result of the economic crisis and a changing health system. We strongly urge the subcommittee to increase program management funds to provide the agency with the necessary human and other resources to ensure the programs it administers are effective and improve the health of the American public.

We appreciate the subcommittee's hard work in advocating for HRSA's programs in a climate of competing priorities. The members of the Friends of HRSA thank you for considering our fiscal year 2010 request for $8.5 billion for HRSA and are grateful for this opportunity to present our views to the subcommittee.

We the undersigned organizations, thank you for your attention to this matter.

Academic Pediatric Association; Advocates for Youth; AIDS Action; AIDS Alliance for Children, Youth and Families; AIDS Foundation of Chicago; AIDS Project Los Angeles; The Alan Guttmacher Institute; Allergy and Asthma Network Mothers of Asthmatics; Alliance for Academic Internal Medicine; American Academy of Family Physicians.

American Academy of Nurse Practitioners; American Academy of Nursing; American Academy of Ophthalmology; American Academy of Pediatrics; American Academy of Physician Assistants; American Association of Colleges of Podiatric Medicine; American Association for Dental Research; American Association of Colleges of Nursing; American Association of Colleges of Osteopathic Medicine; American Association of Colleges of Pharmacy; American Association of Family and Consumer Services.

American Association of Nurse Anesthetists; American Association of Orthopedic Surgeons; American Association on Intellectual and Developmental Disabilities; American Cancer Society; American College of Nurse-Midwives; American College of Obstetricians and Gynecologists; American College of Physicians; American College of Preventative Medicine; American Counseling Association; American Dental Association.

American Dental Education Association; American Dental Hygienists' Association; American Dietetic Association; American Federation of State, County and Municipal Employees; American Foundation for AIDS Research; American Heart Association; American Hospital Association; American Medical Student Association; American Medical Women's Association; American Nephrology Nurses' Association.

American Nurses Association; American Occupational Therapy Association; American Optometric Association; American Pediatric Society; American Physical Therapy Association; American Podiatric Medicine Association; American Psychiatric Association; American Psycho-

logical Association; American Public Health Association; American Red Cross.

American School Health Association; American Society for Microbiology; American Society for Reproductive Medicine; Americans for Democratic Action; The Arc; Asian and Pacific Islander American Health Forum; Association for Prevention Teaching and Research; Association of Academic Health Centers; Association of American Medical Colleges; Association of American Veterinary Medical Colleges.

Association of Clinicians for the Underserved; Association of Departments of Family Medicine; Association of Family Medicine Residency Directors; Association of Maternal and Child Health Programs; Association of Medical School Pediatric Department Chairs; Association of Minority Health Professions Schools; Association of Organ Procurement Organizations; Association of Professors of Medicine; Association of Public Health Laboratories; Association of Reproductive Health Professionals.

Association of Schools of Allied Health Professionals; Association of Schools of Public Health; Association of State and Territorial Directors of Nursing; Association of State and Territorial Health Officials; Association of University Centers on Disabilities; Association of Women's Health, Obstetric and Neonatal Nurses; Avancer Health Policy; CAEAR Coalition; Catholic Health Association of the U.S.; Center for Health Policy Research and Ethics, GMU.

Center for the Advancement of Health; Center for Women Policy Studies; Center on Disability and Health; Charles Drew University; Children's Defense Fund; Coalition for American Trauma Care; Coalition for Health Funding; Coalition for Health Services Research; Consortium of Social Science Associations; Council of Accredited MPH Programs.

Easter Seals; Emergency Nurses Association; Epilepsy Foundation; Families USA; Family Violence Prevention Fund; Health and Medicine Counsel of Washington; HIV Medicine Association; Human Rights Campaign; Infectious Diseases Society of America; Institute for Children's Environmental Health.

Latino Council on Alcohol and Tobacco; Legal Action Center; March of Dimes; Meharry Medical College; Morehouse School of Medicine; NAADAC, the Association for Addiction Professionals; National AHEC Organization; National Alliance of State and Territorial AIDS Directors; National Assembly on School-Based Health Care; National Association of Addiction Treatment Providers; National Association of Community Health Centers.

National Association of Councils on Developmental Disabilities; National Association of County and City Health Officials; National Association of Local Boards of Health; National Association of People with AIDS; National Association of Public Health Statistics and Information Systems; National Association of Public Hospitals and Health Systems; National Association of Rural Health Clinics; National Association of Social Workers; National Associations of Children's Hospitals; National Black Nurses Association.

National Coalition for the Homeless; National Council for Diversity in the Health Professions; National Council of La Raza; National Disability Rights Network; National Episcopal AIDS Coalition; National Family Planning and Reproductive Health Association; National Health Care for the Homeless Council; National Hemophilia Foundation; National Hispanic Medical Association; National League for Nursing.

National Marrow Donor Program; National Medical Association; National Minority AIDS Council; National Network for Youth; National Rural Health Association; North American Primary Care Research Group; Oncology Nursing Society; Organizations of Academic Family Medicine; Partnership for Prevention; Planned Parenthood Federation of America.

Sexuality Information and Education Council of the United States; Society for Adolescent Medicine; Society for Pediatric Research; Society for Public Health Education; Society for the Psychological Study of Social Issues; Society of General Internal Medicine; Society of Teachers of Family Medicine; The AIDS Institute; Trust for America's Health; U.S. Conference of Mayors.

LETTER FROM THE FRIENDS OF THE NATIONAL INSTITUTE ON AGING

DEAR CHAIRMAN HARKIN AND MEMBERS OF THE SUBCOMMITTEE: I am writing to request the opportunity to testify at the fiscal year 2010 public witness hearing on behalf of The Friends of the National Institute on Aging regarding the important role that the National Institute on Aging (NIA) plays among the National Institutes of Health and the need for increased appropriations to ensure sustained, long-term growth in aging research in the fiscal year 2010 budget and beyond.

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. 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 the Institute. I serve as Chair of the Friends of the NIA and as such, am respectfully requesting permission to testify on behalf of the Friends of the NIA before the subcommittee.

Our testimony highlights 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 for NIH research and training activities in fiscal year 2010. I have attached a copy of our testimony for your review.

Mr. Chairman, The Friends of the NIA thanks you in advance for this opportunity to outline the challenges and opportunities that lie ahead as you consider the fiscal year 2010 appropriations for the NIH.

Regards,

KIMBERLY D. ACQUAVIVA,
Chair.

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 and CEO of the FSH Society, Inc. (facioscapulohumeral muscular dystrophy) and as an individual who has this common and most prevalent form of muscular dystrophy.

THE NEED FOR NATIONAL INSTITUTE OF HEALTH (NIH) FUNDING FOR FSHD

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 or FSHD, and the urgent need for increased NIH funding for research on this disorder.

According to our research, only a limited amount of work is going on across all the Institutes at the NIH. In fact, only 3 of the 27 Institutes at the NIH are funding FSHD research, e.g., the National Institute of Neurological Disorders and Stroke (NINDS), the National Institute of Arthritis, Musculoskeletal and Skin Disease (NIAMS), and the Eunice Kennedy Shriver National Institute of Child Health and Human Development (NICHD). Currently, the level of funding from NINDS, NICHD, and NIAMS for FSHD research is approximately $3,093,269.

Since 1994, I have submitted testimony before both House and Senate Appropriations Committees' Subcommittee on Labor, Health and Human Services, and Education and Related Agencies which stated that NIH and Congress with modest investments could help bring about a significant research and scientific opportunity which would benefit hundreds of thousands of people worldwide.

Today, I am asking Congress to communicate to the Public Health Service and National Institutes of Health the need for research funding on the FSHD disorder at a level of $10,000,000 annually in fiscal year 2010.

LIVING WITH FSHD

As a man with facioscapulohumeral muscular dystrophy, I will tell you that it is a hard way to live, and that FSHD is a strong fort—it will last a lifetime. Unless Congress mandates that the NIH ensure that it receives sufficient grant applications of highest quality on FSHD and to spend an equitable ratio of NIH muscular dystrophy dollars on FSHD, which is now conservatively $10 million.

At 47 years of age, I consider myself a lifelong survivor of the severe trauma and tension of FSHD, and I do not say this lightly. I have dealt with the continuing, unrelenting, and unending loss caused by FSHD from the first second, into the first minute, hour, day, week, over the months and through the years. Not for a moment

is there a reprieve from continual loss of my physical ability; not for a moment is there a time for me to mourn; not for a moment is there relief from the physical and mental pain that is a result of this disease. There is no known treatment and no known cause for this disease.

Look at what this disease does to people. Look at me. Look at what I see—a child with a profound hearing loss, the broken innocence of a child, alienation at an early age, a decision not to marry, a decision not to have biological children, disability in the prime of life, incapacitation in middle age, the guilt of a parent, a lifetime of physical challenge, a suicide, a premature death, anxiety caused by uncontrollable loss, decades spent somewhere between the able and the disabled, the loss of ambulating, the unstoppable atrophy and loss of muscle and the humiliation endured in the process.

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.

THE MOST PREVALENT FORM OF MUSCULAR DYSTROPHY IS NOW MARKEDLY UNDERFUNDED AT NIH

It is a fact that FSHD is now published in the scientific literature as the most prevalent muscular dystrophy in the world. The incidence of the disease is conservatively estimated to be 1 in 14,285. The prevalence of the disease, those living with the disease ranges to two or three 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 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". This update 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.

Estimated prevalence	Cases/100,000
Facioscapulohumeral muscular dystrophy (FSHD)	7/100,000
Duchenne (DMD) and Becker Muscular dystrophy (BMD) types	5/100,000
Steinert myotonic dystrophy (DM)	4.5/100,000

NIH MUSCULAR DYSTROPHY FUNDING HAS TRIPLED SINCE THE INCEPTION OF THE MD CARE ACT ($21 MILLION TO $56 MILLION)

Between fiscal year 2006 and 2007, NIH overall funding for muscular dystrophy increased from $39,913,000 to $47,179,000, an 18 percent increase.

Between fiscal year 2007 and 2008, NIH overall funding for muscular dystrophy decreased as shown in the "Estimates of Funding for Various Research, Condition, and Disease Categories (RCDC)" report on the new Research Portfolio Online Reporting Tool (RePORT) from $58 million to $56 million, a 3 percent decrease. These figures are from the new "2007/2008 NIH Revised Method" columns. The same RCDC RePORT system report shows $47 million as the 2007 figure under the "2007 NIH Historical Method" column, a 23 percent increase and restatement when converting to the new system.

Figures from the RCDC RePORT and the NIH Appropriations History for Muscular Dystrophy report historically provided by NIH/Office of the Director (OD) Budget Office and NIH OCPL show that from the inception of the MD CARE Act 2001, funding has nearly tripled from $21 million to $56 million for muscular dystrophy.

NIH FSHD FUNDING HAS REMAINED LEVEL SINCE THE INCEPTION OF THE MD CARE ACT ($3 MILLION/$56 MILLION)

Between fiscal year 2006 and 2007, NIH funding for FSHD increased from $1,732,655 to $4,108,555. In fiscal 2007, FSHD was 8.7 percent of the total muscular dystrophy funding ($4.109 million/$47.179 million).

Between fiscal year 2007 and 2008, NIH funding for FSHD decreased from $4,108,555 to $3 million under the "2007 and 2008 NIH Revised Method." The "2007 NIH Historical Method" was restated to $3 million. In fiscal 2008 under "NIH Revised Method," FSHD was 5.3 percent of the total muscular dystrophy funding ($3 million /$56 million). The previous years 2006/2007 figures are revised and restated under "2007 NIH Historical Method" as ($3 million/$58 million) which is 5.1 percent of the total muscular dystrophy funding. FSHD funding has merely kept its ratio in the NIH funding portfolio and has not grown in the last 7 years.

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.

NATIONAL INSTITUTES OF HEALTH (NIH) APPROPRIATIONS HISTORY

[Dollars in millions]

Fiscal year	FSHD research dollars	FSHD percentage of muscular dystrophy
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

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 7 years muscular dystrophy has tripled to $56 million and that FSHD has remained at 5 percent of the NIH muscular dystrophy portfolio or $3 million. Only three of the Institutes at the NIH are funding FSHD. OD, National Heart, Lung, and Blood Institute, National Institute of General Medical Sciences, National Institute of Biomedical Imaging and Bioengineering, National Institute on Deafness and Other Communication Disorders, National Human Genome Research Institute , NEI, National Institute on Aging, National Cancer Institute, and National Center for Research Resources are all aware of the high impact each could have on FSHD. FSHD is certainly still far behind when we look at the breadth of research coverage NIH-wide.

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 gravity that it still remains the most prevalent and one of the most underfunded dystrophies at the NIH and in the Federal research agency system (Centers for Disease Control and Prevention, Department of Defense, and Food and Drug Administration). In 2008, the third most prevalent dystrophy, Duchenne (DMD) and Becker Muscular dystrophy (BMD) type, received $22 million from NIH. In 2008, the second most prevalent dystrophy myotonic dystrophy (DM), received $9 million from NIH. In 2008, the most prevalent dystrophy, FSHD, received $3 million from NIH. It is now time to flip the stack and to make sure that FSHD with its equal burden of disease and highest prevalence gets more funding, stimulus and that NIH program staff initiates request for applications specifically in FSHD. It is crystal clear, if not completely black and white, that the open mechanism program announcement and investigator driven model are not achieving the goal mandated by the MD CARE Acts 2001/2008 and by the NIH Action Plan for the Muscular Dystrophies as submitted to the Congress by the NIH. Efforts of excellent program staff and leadership at NIH, excellent reviewers and study sections, excellent and outstanding researchers 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 NIH requests, contracts, and 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 over 20 years despite consistent pressure from appropriations language and Appropriations Committee questions, and an authorization and a reauthorization from Congress mandating research on FSHD.

OUR REQUEST TO THE NIH APPROPRIATIONS SUBCOMMITTEE

We request this year in fiscal year 2010, immediate help for those of us coping with and dying from FSHD. We ask NIH to fund research on FSHD at a level of $10 million in fiscal year 2010.

We implore the Appropriations Committee to request that the Director of NIH, the chairman/chairwoman, and executive secretary of the Federal advisory committee Muscular Dystrophy Coordinating Committee mandated by the MD CARE Act of 2008, to increase the amount of FSHD research and projects in its portfolios using all available passive and pro-active mechanisms and interagency committees. Given the knowledge base and current opportunity for breakthroughs in treating FSHD it is inequitable that only 3 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 FSHD. Our successes are continuing and your support must continue and increase.

We ask you to fund NIH research on FSHD at a level of $10 million in fiscal year 2010.

Mr. Chairman, thank you for this opportunity to testify before your subcommittee.

PREPARED STATEMENT OF THE FAMILY VIOLENCE PREVENTION FUND

The Family Violence Prevention Fund (FVPF) works to end violence against women and children around the world, because every person has the right to live free of violence. The FVPF's National Health Resource Center on Domestic Violence provides critical information to thousands of healthcare providers, institutions, domestic violence service providers, Government agencies, researchers, and policy makers each year. Its public education campaigns, conducted in partnership with The Advertising Council, have shaped public awareness and changed social norms for 15 years.

STRENGTHENING THE HEALTHCARE SYSTEM'S RESPONSE TO DOMESTIC VIOLENCE, DATING VIOLENCE, SEXUAL ASSAULT, AND STALKING

Through our work as the National Health Resource Center on Domestic Violence, I know the critical role healthcare providers can play in preventing and responding to violence against women and children, particularly during this difficult economic time when rates of abuse in families seem to be rising. But it is not simply a moral imperative that we try to reduce violence and abuse in this country; it is an economic necessity that Congress supports prevention and intervention efforts in the healthcare system. The Centers for Disease Control and Prevention (CDC) classifies violence and abuse as a "substantial public health problem in the United States," noting the long-term impact of violence and abuse has huge implications for health outcomes and costs.

Children who experience childhood trauma, including witnessing incidents of domestic violence, are at a greater risk of having serious adult health problems including tobacco use, substance abuse, cancer, heart disease, depression and a higher risk for unintended pregnancy. Twenty years of research links childhood exposure to violence with chronic health conditions including obesity, asthma, arthritis, and stroke. It is worth noting that victims, particularly of sexual violence, are linked with obesity. A meta-analysis of research on the impact of adult intimate partner violence finds that victims of domestic violence are at increased risk for conditions such as heart disease, stroke, hypertension, cervical cancer, chronic pain including arthritis, neck and pain, and asthma. In addition to injuries, adult intimate partner violence also contributes to a number of mental health problems including depression and PTSD, risky health behaviors such as smoking, alcohol and substance abuse, and poor reproductive health outcomes such as unintended pregnancy, pregnancy com-

plications, postpartum depression, poor infant health outcomes and sexually transmitted infections including HIV.

According to a CDC survey, women who have experienced domestic violence are 80 percent more likely to have a stroke, 70 percent more likely to have heart disease, 60 percent more likely to have asthma and 70 percent more likely to drink heavily than women who have not experienced intimate partner violence.

When Congress joined together to reauthorize the Violence Against Women Act (VAWA) of 2005 (Public Law 109–162), the law included new provisions to educate and train healthcare providers and public health professionals on how to safely screen and intervene in cases of domestic and sexual violence. These provisions were added after years of work by medical associations, health professionals, advocates and a National Health Care Standards Campaign on Domestic Violence funded by the U.S. Department of Health and Human Services. These collaborations successfully developed strategies, tools, and policies to identify and help victims in health settings.

We know that most women seek healthcare services regularly, either for routine, emergency, perinatal, or pediatric care. As a result, healthcare providers are in a unique position to identify and reach out to victims of violence, long before they may seek help from a domestic violence shelter, rape crisis center, law enforcement agency, or family member. However, fewer than 10 percent of primary care physicians routinely screen patients for domestic violence during regular office visits, according to a study published by the Journal of the American Medical Association.

Research on the most effective interventions in the healthcare setting and prevention messages would have significant public health benefits and cost savings to the healthcare system. While we do not know the full cost of violence and abuse to the healthcare system, previous studies have shown that those who experience abuse access healthcare 2 to 2.5 times more frequently than those without that history. Research shows that intimate partner violence alone costs a health plan $19.3 million each year for every 100,000 women between the ages of 18 and 64 enrolled.

Far more important is the cost of violence and abuse over time. Even 5 years after abuse has ended, healthcare costs for women with a history of intimate partner violence remain 20 percent higher than those for women with no history of violence. A study by the CDC in 2003 estimated the direct medical costs of only injuries and mental health services related to intimate partner violence at $4.1 billion alone, this does not include any evaluation of costs associated with chronic health issues or reproductive health issues discussed above and known to be highly prevalent among victims of abuse. A recent report by the Academy on Violence and Abuse estimated the actual cost to the healthcare system of violence and abuse may be nearly 17 percent of the total healthcare dollar or $333 billion in 2008.

But early identification and treatment of victims can financially benefit the healthcare system. Initial and unpublished findings from one study found that hospital-based domestic violence interventions may reduce healthcare costs by at least 20 percent. Preventing abuse or associated health risks and behaviors clearly could have long term implications for decreasing chronic disease and costs. Because of the long-term impact of abuse on a patient's health, I recommend integrating assessment for current and lifetime physical or sexual violence exposure and interventions into routine care. Regular, face-to-face screening of women by skilled healthcare providers markedly increases the identification of victims of intimate partner violence (IPV), as well as those who are at risk for verbal, physical, and sexual abuse. Routine inquiry of all patients, as opposed to indicator-based assessment, increases opportunities for both identification and effective interventions, validates IPV as a central and legitimate healthcare issue, and enables providers to assist both victims and their children.

When victims or children exposed to IPV are identified early, providers may be able to break the isolation and coordinate with domestic violence (DV) advocates to help patients understand their options, live more safely within the relationship, or safely leave the relationship. Expert opinion suggests that such interventions in adult health settings may lead to reduced morbidity and mortality. Assessment for exposure to lifetime abuse has major implications for primary prevention and early intervention to end the cycle of violence.

Just as the healthcare system has always played an important role in identifying and preventing other serious public health problems, I believe it can and must play a pivotal role in domestic and sexual violence prevention and intervention. It is clear that by funding these innovative and life-saving health provisions established by title V in VAWA 2005, we can help save the lives of victims of violence and greatly reduce healthcare expenses.

In order to advance necessary and needed health goals, I urge you to provide $13 million to the Department of Health and Human Services to fully fund the Violence

Against Women Act's Health Care Programs for fiscal year 2010, and specifically fund the following Labor, Health and Human Services, and Education, and Related Agencies programs accordingly:

—*Training and Education of Health Professionals Program*.—$3 million to train healthcare providers and students in health professional schools how to identify and screen victims of domestic and sexual violence; ensure immediate safety; document their injuries; and refer them to appropriate services;

—*Fostering Public Health Responses*.—$5 million to promote public health programs that integrate domestic and sexual violence assessment and intervention into basic care, as well as encourage collaborations between healthcare providers, public health programs, and domestic and sexual violence programs; and

—*Research on Effective Interventions*.—$5 million to support research and evaluation on effective interventions in the healthcare setting to improve abused women's health and safety and prevent initial victimization.

PROTECT NONABUSIVE PARENTS AND CHILDREN

Another area of concern is the intersection of domestic violence and child abuse, which often occur in the same family. Approximately 45 percent of female caregivers of children reported for child maltreatment have experienced intimate partner violence in their lifetime and 29 percent in the past year. In a study of families investigated for child maltreatment, 31 percent of female caregivers reported experiencing intimate partner violence in the past year; however child welfare workers only identified this abuse in 12 percent of the families.

When child welfare agencies work alone in responding to child maltreatment, they may not understand the complexity of the domestic violence situation and "preemptively" remove the child without offering services to the adult victim. This can have a devastating result for both the child and the nonabusive caretaker. In addition, the opposite approach may also be taken. Frequently, the child protective system fails to take seriously the threat posed by an abusive husband or partner and fails to take any action to support the mother's efforts to keep her and her children safe and hold him accountable for his actions.

By supporting agencies in cooperative efforts to provide services to victims—both children and their nonabusive caretakers—it is possible to keep families safe and united during the difficult process of ending abuse.

THE SOLUTION: IMPROVE COOPERATION BETWEEN CHILD WELFARE AND DOMESTIC VIOLENCE ADVOCATES

Building on what was commonly known as the "Greenbook Project," a federally funded demonstration grant program, VAWA 2005 authorized a program to create grants for training and collaboration on the intersection between domestic violence and child maltreatment. The intent is to ensure that nonabusive family members receive the services they need to keep their families safe, and community services can deal with both problems simultaneously, allowing for a better use of our limited resources. As the two problems often occur together, dealing with one problem and not the other is at the peril of our children.

I urge you to fully fund Training and Collaboration on the Intersection Between Domestic Violence and Child Maltreatment Program at $5 million to help serve families experiencing violence.

In addition, I ask that you continue to support full funding for the Family Violence Prevention and Services Act, the Nation's only designated Federal funding source for domestic violence shelters and services. As leaders committed to both the prevention of intimate partner violence and to the health and safety of victims, I urge you to fund these critical programs.

PREPARED STATEMENT OF THE HIV MEDICINE ASSOCIATION

The HIV Medicine Association (HIVMA) of the Infectious Diseases Society of America (IDSA) represents more than 3,600 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. As medical providers and researchers dedicated to the field of HIV medicine, we work in communities across the country and around the globe. We appreciate the fiscal challenges that you currently face, but the state of the economy makes it imperative that our Nation has

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 new HIV cases are increasing by at least 15 percent.

We face a critical juncture when we must either shore up our healthcare safety net, public health infrastructure, and research programs or risk serious regression in our fight against this deadly disease. The funding requests in our testimony largely reflect the consensus of the Federal AIDS Policy Partnership (FAPP) 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 $1.27 billion in funding for the CDC's NCHHSTP with an increase of $878 million for HIV prevention and surveillance, an increase of $31.7 million for viral hepatitis and $66.1 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. While new HIV cases have increased, the CDC's HIV prevention budget has declined 19 percent compared to inflation since 2002. 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.

We strongly support the CDC initiative to integrate HIV screening into medical care and remain seriously concerned about the lack of Federal resources available to State health departments, medical institutions, community health centers, and other community-based organizations for implementing these programs. 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 greatly reduces the risk of HIV transmission. Furthermore through education, counseling and treatment, individuals who are aware that they have HIV are less likely to transmit 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.

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. Identifying people with HIV earlier through routine HIV testing and linking them to HIV care saves lives and 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.

An infusion of HIV prevention funding is critical to restore and enhance HIV prevention cooperative agreements with State and local health departments; to optimize core surveillance cooperative agreements with health departments and to expand HIV testing in key healthcare venues by funding testing infrastructure, the purchase of approved testing devices, including rapid HIV tests and confirmatory testing.

Finally, we also must increase support for science-based, comprehensive sex education programs. We strongly urge Congress to discontinue funding for unproven abstinence-only sex education programs and shift these funds to support comprehensive, age-appropriate sex education programs.

CDC—TUBERCULOSIS

Tuberculosis is the major cause of AIDS-related mortality worldwide. Congress passed landmark legislation—the Comprehensive Tuberculosis Elimination Act of 2008—Public Law 110–873 last year 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 $210 million in funding authorized for fiscal year 2010 in this important new law is appropriated for the CDC Division of TB Elimination. This represents an increase of $66.1 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 $577 million in fiscal year 2010 with at least an increase of $68.4 million for part C for a total appropriation of $270,254,000. We also strongly support the $4 million included in the President's budget to support in-depth, long-term HIV training opportunities for primary care clinicians.

Ryan White part C funds comprehensive HIV care and treatment—the services that are directly responsible for the dramatic decreases in AIDS-related mortality and morbidity over the last decade. While the patient load in part C programs has been rising in number, funding for part C has effectively decreased. Part C programs expect a continued increase in patients due to higher diagnosis rates and declining insurance coverage. During this economic downturn people with HIV across the country will rely on part C comprehensive services more than ever. An increase in funding is critical to ensure that clinics are able to prevent staffing cuts, as well as, to ensure the public health of our communities. Part C of the Ryan White program has been under-funded for years, but new pressures are creating a crisis in communities across the country. The HIV medical clinics funded through part C have been in dire need of increased funding for years. Years of near flat funding, combined with large increases in the patient population, are negatively impacting the ability of part C providers to serve their patients.

With the rapid cost increases in all aspects of healthcare delivery, despite small funding increases, programs are still operating at a funding deficit because they are serving more patients than ever. In 2008, part C programs will treat an estimated 248,070—a dramatic 30 percent increase in less than 10 years. Part C clinics are laying off staff, discontinuing critical services such as laboratory monitoring, creating waitlists, and operating on a 4-day work week just to get by. 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 urgently critical to meet the needs of HIV patients served by part C around the country.

The $4 million proposed in the President's budget to support longer-term training opportunities in HIV medicine or clinical HIV fellowships for primary care practitioners is vital to drawing clinicians into the field of HIV medicine and ensuring new HIV clinicians have the skills and expertise to provide effective HIV care. More that a one-quarter of a century into the HIV epidemic, we are seeing the graying of our Nation's HIV clinical workforce, and we have serious concerns about ensuring a new generation of HIV medical providers to care for Americans with HIV. In a recent survey of Ryan White part C clinics—nearly 70 percent reported difficulty recruiting and retaining HIV clinicians. One of the top barriers identified to retention and to recruitment was lack of a qualified workforce. We must promptly and swiftly address this issue before its effects are felt in increases in morbidity and mortality from HIV and the proposed $4 million for more intensive training in HIV medicine would be an important first step.

We also respectfully urge you to include at least $1 million in this year's Labor, Health and Human Services, and Education, and Related Agencies appropriations bill for a study to evaluate the capacity of the HIV medical workforce as well as

potential strategies to increase the numbers of young physicians, nurse practitioners and physician assistants entering HIV medicine.

NATIONAL INSTITUTES OF HEALTH (NIH)—OFFICE OF AIDS RESEARCH

HIVMA strongly supports an increase of at least $3.7 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.

We also continue to support the NIH's Fogarty International Center (FIC) and recommend an expansion of its programs and funding. The FIC training programs play a critical role in developing self-sustaining healthcare infrastructures in resource-limited countries. These important programs offer invaluable training and mentoring to indigenous physicians from the countries hardest hit by the HIV pandemic and other deadly infectious diseases, such as malaria and tuberculosis. Physicians trained through the FIC are able to develop research programs that more effectively address the healthcare, cultural and resource needs of their country's residents while also fostering the development of ongoing, robust research and clinical programs.

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 sustain these programs now. We have 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.

LETTER FROM THE HIV LAW PROJECT

New York, NY, May 22, 2009.

Hon. TOM HARKIN,
Chairman, Subcommittee on Labor, Health, and Human Services, and Education, and Related Agencies, Washington, DC.

DEAR CHAIRMAN HARKIN: We respectfully request that you eliminate all funding for abstinence-only-until-marriage programs (in particular the Community-Based Abstinence Education Program as well as the Title V Abstinence Education Pro-

grams), and instead fund programs that provide medically accurate, age-appropriate comprehensive sex education.

President Obama has recently released a budget that zeroes out these funding streams for abstinence-only-until-marriage programs. We applaud his leadership in stopping the flow of dollars that has funded these ineffective and inaccurate programs for too long. Yet the President's budget proposes to replace these programs with a new Teen Pregnancy Prevention Initiative that falls short of the needed comprehensive sexuality education programming, and opens the door to again funding ineffectual abstinence-only programs with new dollars.

Moving forward, we ask that you follow President Obama's lead in advancing public health over ideology by embracing evidence- and science-based educational programs through the elimination of funding for abstinence-only programs. But we believe that new funds to protect the sexual and reproductive health of adolescents through educational programming must be comprehensive in nature, and not limited to the single issue of teen pregnancy prevention.

WHAT IS COMPREHENSIVE SEXUALITY EDUCATION?

Comprehensive sexuality education programs include age-appropriate, medically accurate information on a wide range of topics related to sexuality including relationships, decisionmaking, abstinence, contraception, and disease prevention. They provide students with opportunities for developing interpersonal and relationship skills as well as learning accurate information. Comprehensive sexuality education programs help young people exercise responsibility regarding sexual relationships by addressing abstinence, pressures to engage in sexual intercourse prematurely, and the use of contraception. Comprehensive sexuality education also addresses prevention against the triple threats of unwanted teen pregnancies, sexually transmitted infections, and HIV in order to preserve the sexual and reproductive health of our young people.

ABSTINENCE-ONLY PROGRAMS ARE INEFFECTIVE AND INACCURATE

Contrary to the claims of abstinence-only proponents, these programs have had no positive impact on teen sexuality. A study commissioned by the U.S. Department of Health and Human Services found that youth who participated in abstinence-only programs were no more likely than their peers to abstain from sex, and participants reported having similar numbers of sexual partners and having initiated sex at the same average age as their counterparts who did not participate in the programs.[1]

Teaching abstinence is appropriate if discussed as one among many possible approaches to staying healthy, and avoiding unintended pregnancy. The problem is teaching abstinence only. Abstinence-only-until-marriage programs are prohibited from teaching about contraceptives, except to emphasize their failure rates. Many of the most popular federally funded, abstinence-only curricula are rife with false and misleading information, including that condoms fail to prevent the spread of HIV approximately 31 percent of the time in heterosexual sex, and that HIV is spread through sweat and tears. By their very definition, abstinence-only programs perpetuate ignorance as well as homophobia by teaching that a mutually faithful monogamous relationship in the context of marriage is the expected standard of sexual activity, and that sexual activity outside of the context of marriage is likely to have harmful psychological and physical effects.

COMPREHENSIVE SEXUALITY EDUCATION PROGRAMS ARE EFFECTIVE

A rigorous review of 48 studies evaluating the efficacy of domestic comprehensive sexuality education programs found numerous positive outcomes, and debunked all the myths that serve to hamper governmental support of comprehensive sexuality education:[2]

—Comprehensive sexuality education program participants were found to delay sexual initiation in 40 percent of the programs reviewed, and no study found that comprehensive sexuality education programs hasten the initiation of sex.

[1] Trenholm, Christopher, Barbara Devaney, Ken Fortson, et al. for Mathematica Policy Research. "Impacts of Four Title V, Section 510 Abstinence Education Programs. Final Report." April 2007. Available at http://www.mathematica-mpr.com/publications/PDFs/impactabstinence.pdf

[2] Douglas Kirby, Ph.D. et al. "Emerging Answers 2007: Research Findings on Programs to Reduce Teen Pregnancy and Sexually Transmitted Diseases." November 2007. Available at http://www.thenationalcampaign.org/EA2007/EA2007__full.pdf

—Of the studies that measured the programs' impact on frequency of sexual activity among participants, 30 percent found that programs reduced the frequency of sexual activity, and none found an increase in frequency.
—A decrease in the number of sexual partners was documented by 41 percent of those studies measuring for this.
—An increase in condom use among program participants was found by 41 percent of the studies.
—56 percent of the programs found that sexuality and STD/HIV education programs significantly reduced sexual risk-taking. Reducing risk-taking reduces the transmission of STIs and HIV, and helps to prevent unwanted pregnancies. None of the programs increased sexual risk-taking.
—One of the studies estimated the cost-effectiveness of a sex education program, and found that for every $1 invested in the comprehensive sexuality program studied, $2.65 was saved in medical and social costs, attributable to pregnancy prevention and prevention of the transmission of sexually transmitted infections, including HIV.

THE PUBLIC SUPPORTS COMPREHENSIVE SEX EDUCATION

A 2004 poll by Harvard's Kennedy School of Government, the Kaiser Family Foundation, and National Public Radio found that 77 percent of Americans believe that giving teens information about how to obtain and use condoms makes it more likely that teens will practice safe sex now or in the future. Further, a mere 7 percent of Americans said sex education should not be taught in schools.[3]

YOUTH ARE SEXUALLY ACTIVE

One of the fundamental problems with abstinence-only programs is that they ignore the reality of teenage sexuality. According to the Centers for Disease Control and Prevention, in 2007, 47 percent of high school students had sex at some time. In addition, nearly 15 percent of students had sex with four or more sexual partners.[4] Further, that same year 38 percent of high school students who were then sexually active had not used a condom during last sexual intercourse. In other words, sexually active youth are engaging in risky sexual behaviors.

NEGATIVE HEALTH OUTCOMES ARE PREVALENT AMONG YOUTH

—Almost half of all new STD infections are among youth aged 15 to 24.
—Approximately 14 percent of the persons diagnosed with HIV/AIDS in 2006 were young people, between the ages of 13 and 24.
—In 2002, there were approximately 757,000 pregnancies among adolescents aged 15–19.[5]

Comprehensive sex education has great potential to influence safer sexual behavior among youth and reduce the risk of HIV and STI transmission, as well as prevent unwanted pregnancies. Yet many young people still lack both the knowledge and the skills to minimize their risk. Prevention is not possible without knowledge of risk and appropriate risk-reduction strategies.

SCHOOLS ARE FAILING TO EDUCATE STUDENTS ABOUT SEXUAL AND REPRODUCTIVE HEALTH

Unfortunately, recent history indicates that young people are becoming less able to protect themselves due to their schools' failure to provide comprehensive sexuality education. In 2006, only 38.5 percent of high schools provided students with information regarding proper condom use,[6] a decrease from 2000 when 55.1 percent of high schools provided this information.[7] Additionally, while 96 percent of States

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[3] National Public Radio, Kaiser Family Foundation, and Kennedy School of Government, "Sex Education in America: General Public/Parents Survey." January 2004. Available at http://www.kff.org/newsmedia/upload/Sex-Education-in-America-Summary.pdf

[4] Centers for Disease Control and Prevention. "Youth Risk Behavior Surveillance—United States, 2007". June 6, 2008. Available at: http://www.cdc.gov/mmwr/preview/mmwrhtml/ss5704a1.htm

[5] Centers for Disease Control and Prevention, "Sexual Risk Behaviors". Available at http://www.cdc.gov/healthyyouth/sexualbehaviors/index.htm

[6] SHPPS 2006. "HIV Prevention". Available at: http://www.cdc.gov/HealthyYouth/SHPPS/2006/factsheets/pdf/FS_HIVPrevention_SHPPS2006.pdf

[7] SHPPS 2000. "Fact Sheet: HIV Prevention". Available at: http://www.cdc.gov/HealthyYouth/SHPPS/2000/factsheets/pdf/hiv.pdf

provided funding for or offered staff development on HIV prevention to health educators in 2000, only 84 percent did so in 2006.[8]

In sum, young people need prevention information and skills in order to make healthy decisions. Funding for abstinence-only programming, which has been proven ineffective, must be eliminated and replaced with funds for comprehensive sexuality education. We cannot afford to continue to spend money on ineffective programs. Our young people deserve, and it is Government's obligation to provide, programs that give them the information they need to make responsible decisions to maintain their own sexual and reproductive health.

Sincerely yours,

ADAP Advocacy Association; African Services Committee; AIDS Alabama; AIDS Alliance for Children, Youth and Families; AIDS Law Project of Pennsylvania; Alliance of AIDS Services—Carolina; Cascade AIDS Project; Center for HIV Law & Policy; Center for Women & HIV Advocacy at HIV Law Project; CHAMP.

Christie's Place; Colorado AIDS Project; Community Access National Network; Global Life Works; HIVictorious, Inc.; Housing Works; Positive Women's Network; Latino Commission on AIDS; Lifelong AIDS Alliance; National Alliance of State and Territorial AIDS Directors.

New York City AIDS Housing Network (NYCAHN); Sisterlove; SMART (Sisterhood Mobilized for AIDS/HIV Research & Treatment); The Women's Collective; Women's HIV Collaborative of New York; Women's Initiative to Stop HIV—NY of the Legal Action Center; Women's Lighthouse Project; Women Organized to Respond to Life-Threatening Diseases (WORLD); Young Women of Color HIV/AIDS Coalition.

Prepared Statement of HONOReform

Mr. Chairman and members of the subcommittee: As president and cofounder 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 last year's Las Vegas, Nevada outbreak that potentially exposed more than 63,000 patients to hepatitis C. 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 notifica-

[8] SHPPS 2006. "HIV Prevention".

tions 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, can not 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 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.

In fiscal year 2009, the CDC received $2.5 million to establish a pilot campaign in Nevada for the launch of the One & Only Campaign, which we hope will be expanded to the national campaign with your support for continued and expanded funding in fiscal year 2010.

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, HHS, and the Agency for Healthcare Research and Quality (AHRQ) to help prevent future hepatitis and HIV outbreaks through the following fiscal year 2010 appropriations requests:

HONOReform requests $26 million for CDC's Division of Healthcare Quality and Promotion to build infrastructure for complete and consistent adherence to injection safety and infection control guidelines in the delivery of outpatient care.

As you know, the migration of healthcare delivery from primarily acute care hospitals to other nonhospital settings (e.g., home care, ambulatory care, free-standing specialty care sites, long-term care, etc.) requires that common principles of infection control practice be applied to the spectrum of healthcare delivery settings. 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. This request includes the following elements:

—*Provider Education and Awareness*.—Nine million dollars to be used to support CDC's efforts around provider education and patient awareness activities. Currently, the CDC along with patient advocacy organizations, foundations, provider associations and societies and industry partners have established the Safe Injection Practices Coalition. The requested funding would be used to roll out a national public health campaign focused on safe injection practices. Additionally, funds will be used to develop and disseminate safe practice materials and develop related tools designed for inpatient and outpatient settings. Innovative tools will be developed in conjunction with key partners and stakeholders for use by providers and healthcare personnel, including training tools to be used by professional organizations and accreditation and licensing groups to increase adherence to recommendations

—*Engineering and Innovation*.—Eight million dollars would be used to support CDC in promoting private-sector healthcare solutions to injection safety and infection control problems by engage and incentivizing the private sector to innovate and create fast track engineering solutions to injection safety and infection control problems through the development of innovative products to reduce infection transmission for inpatient and outpatient healthcare settings. With this funding, CDC will convene a roundtable with industry, conduct a study on available technology, assess opportunities for investment in research and devel-

opment, and examine incentives required for adoption of equipment designed with engineering controls (e.g., sharps disposal containers, self-sheathing needles, safer medical devices, such as sharps with engineered sharps injury protections and needless systems, etc.). CDC will also pursue mechanisms such as grants or CRADAs with industry to accelerate the development of products that have the potential for eliminating the opportunity for human error from process of administering injections.

—*Detection and Tracking*.—Nine million dollars would be used for detection and tracking in order to enable States to investigate outbreaks of hepatitis and other potential pathogens related to injection safety. In addition, this funding would provide support to CDC for emergency response to assist States in responding to hepatitis outbreaks (i.e., Nevada), including genetic sequencing tests. Funding would support efforts including training at health departments related to safe injection practices and recognition of errors, and to enable rapid investigation and intervention when errors are detected. The funding would also support the augmentation of survey capacity in outpatient settings to strengthen State capacity to detect infections that indicate systemic patient safety errors. The funding will enable CDC to provide support to 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 will also enable CDC to provide data analysis and feedback to States.

HONOReform requests $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 all healthcare settings, including outpatient facilities. We are deeply 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 the past year, more than 100,000 patients across the country have been exposed to hepatitis and HIV from healthcare providers failing to adhere to proper safe injection practices and infection control.

HONOReform requests $10 million in general patient safety funds for the AHRQ's Ambulatory Patient Safety Program. While much is known about risk and hazards in the hospital setting, the same cannot be said of ambulatory care setting. Few safety practices have been identified, and there is limited data on the nature of risk and hazards to patients and the threat to quality in the ambulatory care setting. As part of the overall AHRQ patient safety and quality improvement efforts, the identification, assessment, and modeling of risk and hazards prior to designing or implementing intervention strategy in ambulatory care is critical. In light of the growing number of incidents involving syringe reuse and hepatitis C transmission, this funding would enable AHRQ to expand its ambulatory safety and quality program "to identify the inherent risks in ambulatory settings and to develop potential solutions for protecting patients."

Mr. Chairman, on behalf of HONOReform, I would like to express my appreciation for this opportunity to present written testimony before the subcommittee. The growing number of incidents involving syringe reuse and hepatitis C transmission in non-hospital settings across the country highlights the need for enhancing education, awareness and public health activities related to proper infection control and safe injection practices.

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 $550 million in fiscal year 2010 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 organizations, 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 $200 million provided for the health professions programs in the American Recovery and Reinvestment Act (Public Law 111–5). We also greatly appreciate that the recently enacted fiscal year 2009 Omnibus Appropriations bill (Public Law 111–8) provides some increases for most title VII and VIII programs. These investments provide a crucial springboard to begin to wholly reverse chronic underfunding of these programs and address existing and looming shortages of health professionals.

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/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. Yet, despite some increases in recent years, many of the health professions programs remain well below their comparable fiscal year 2005 funding levels. HPNEC's $550 million recommendation will help sustain the health workforce expansion supported by funding in the recovery package. Further, this appropriation will restore funding to critical programs that sustained drastic funding reductions in fiscal year 2006 and remain well below fiscal year 2005 levels.

We are grateful to President Obama for highlighting the need to strengthen the health professions workforce as a national priority. This strategy is in line with numerous recent, highly regarded recommendations. In a December 2008 Institute of Medicine (IOM) report, HRSA's health professions programs were characterized as "an undervalued asset" and the Department of Health and Human Services was encouraged to support additional investments in the programs. Another IOM report on the future workforce for older Americans from April 2008 also called for increased funding for the health professions programs. The November 2008 issue of the peer-reviewed journal Academic Medicine chronicles the effectiveness of the programs, and the primary care programs in particular, while the December 2008 issue of the Mt. Sinai Journal of Medicine highlights the impact of the diversity programs. These most recent publications showcase the network of title VII and VIII initiatives across the country supporting the education and training of the full range of health providers. Together, the programs work in concert with other programs at the Department of Health and Human Services—including the National Health Service Corps and Community Health Centers (CHCs)—to strengthen the health safety net for rural and medically underserved communities.

The Health Professions Education Partnerships Act of 1998 (Public Law 105–392) consolidated the programs into 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 (SDS) make funds available to eligible students from disadvantaged backgrounds who are enrolled as full-time health professions students. Nurses received $15.1 million in fiscal year 2007 from SDS grants, 32 percent of funds appropriated for SDS.

—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 physi-

cians 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. 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. Additionally, these programs enhance the efforts of osteopathic medical schools to continue to emphasize 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 the elderly. The Quentin N. Burdick Program for Rural Health Interdisciplinary Training places an emphasis on long-term collaboration between academic institutions, rural healthcare agencies, and providers to improve the recruitment and retention of health professionals in rural areas. This program has received no funding since fiscal year 2006. 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 Eighth National Sample Survey of Registered Nurses, the Nation's most extensive and comprehensive source of statistics on registered nurses. However, the Workforce Information and Analysis program has received no appropriation since fiscal year 2006.

—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 pro-

grams are vital to the Nation's dental public health infrastructure. The Health Administration Traineeships and Special Projects grants are the only Federal funding provided to train the managers of our healthcare system, with a special emphasis on those who serve in underserved areas. However, the traineeships have received no appropriation since fiscal year 2006.

—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 51,657 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 between 50,000 and 88,000 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. Congress responded to this dire national need by passing the Nurse Reinvestment Act (Public Law 107–205) in 2002, which increases nursing education, retention, and recruitment. 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 administrators. 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 disadvantaged students 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 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 (LDS) 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. HPNEC members respectfully urge support for funding of at least $550 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 greatly appreciate the support of the subcommittee and look forward to working with Members of Congress and the new administration to reinvest in the health professions programs in fiscal year 2010 and into the future.

Prepared Statement of the Home Safety Council

INTRODUCTION

Chairman Harkin, Ranking Member Cochran, and members of the subcommittee, thank you for the opportunity to submit testimony on the fiscal year 2010 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 office and director of public policy for the Home Safety Council which is located in Washington, DC.

ABOUT THE HOME SAFETY COUNCIL (HSC)

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 $10 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 HEALTHCARE 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.

—In a single year, more than 50 million injuries required medical attention, with an estimated total lifetime cost of $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 interventions 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 S. Res. 674 and the introduction of H. Res. 1478 for the first National Falls Prevention Awareness Day in September 2008. For the good intentions of Congress to bear fruit, an appropriation of $10 million is needed for fiscal year 2010 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 $10 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 and our supporting organizations, thank you for the opportunity to share our fiscal year 2010 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 LEGISLATIVE FUND

The Humane Society Legislative Fund (HSLF) supports a strong commitment by the Federal Government to research, development, standardization, validation, and acceptance of nonanimal and other alternative test methods. We are also submitting our testimony on behalf of The Humane Society of the United States and Doris Day Animal League, representing more than 11 million members and supporters. Thank you for the opportunity to present testimony relevant to the fiscal year 2010 budget request for the National Institute of Environmental Health Sciences (NIEHS) for activities of the National Toxicology Program Center for the Evaluation of Alternative

Toxicological Test Methods (NICEATM), the support center for the Interagency Coordinating Committee for the Validation of Alternative Test Methods (ICCVAM).

Function of the ICCVAM

The ICCVAM performs a valuable function for regulatory agencies, industry, public health and animal protection organizations by assessing the validation of new, revised, and alternative toxicological test methods that have interagency application. After appropriate independent peer review of the test method, the ICCVAM recommends the test to the Federal regulatory agencies that regulate the particular endpoint the test measures. In turn, the Federal agencies maintain their authority to incorporate the validated test methods as appropriate for the agencies' regulatory mandates. This streamlined approach to assessment of validation of new, revised, and alternative test methods has reduced the regulator burden of individual agencies, provided a "one-stop shop" for industry, animal protection, public health, and environmental advocates for consideration of methods and set uniform criteria for what constitutes a validated test methods. In addition, from the perspective of animal protection advocates, ICCVAM can serve to appropriately assess test methods that can refine, reduce and replace the use of animals in toxicological testing. This function will provide credibility to the argument that scientifically validated alternative test methods, which refine, reduce or replace animals, should be expeditiously integrated into Federal toxicological regulations, requirements, and recommendations.

History of the ICCVAM

The ICCVAM is currently composed of representatives from the relevant Federal regulatory and research agencies. It was created from an initial mandate in the NIH Revitalization Act of 1993 for NIEHS to "(a) establish criteria for the validation and regulatory acceptance of alternative testing methods, and (b) recommend a process through which scientifically validated alternative methods can be accepted for regulatory use." In 1994, NIEHS established the ad hoc ICCVAM to write a report that would recommend criteria and processes for validation and regulatory acceptance of toxicological testing methods that would be useful to Federal agencies and the scientific community. Through a series of public meetings, interested stakeholders, and agency representatives from all 14 regulatory and research agencies, developed the National Institutes of Health (NIH) Publication No. 97–3981, "Validation and Regulatory Acceptance of Toxicological Test Methods." This report, and subsequent revisions, has become the sound science guide for consideration of new, revised, and alternative test methods by the Federal agencies and interested stakeholders.

After publication of the report, the ad hoc ICCVAM moved to standing status under the NIEHS' NICEATM. Representatives from Federal regulatory and research agencies and their programs have continued to meet, with advice from the NICEATM's Advisory Committee and independent peer review committees, to assess the validation of new, revised and alternative toxicological methods. Since then, several methods have undergone rigorous assessment and are deemed scientifically valid and acceptable.

Request for Committee Report Language

In 2006, the NICEATM/ICCVAM at the request of the U.S. Congress began a process of developing a 5-year roadmap for assertively setting goals to prioritize ending the use of antiquated animal tests for specific endpoints. The HSLF and other national animal protection organizations provided extensive comments on the process and priorities for the roadmap.

While the stream of methods forwarded to the ICCVAM for assessment has remained relatively steady, it is imperative that the ICCVAM take a more proactive role in isolating areas where new methods development is on the verge of replacing animal tests. These areas should form a collective call by the Federal agencies that compose

ICCVAM to fund any necessary additional research, development, validation, and validation assessment that is required to eliminate the animal methods. We also strongly urge the NICEATM/ICCVAM to closely coordinate research, development, and validation efforts with its European counterpart, the European Centre for the Validation of Alternative Methods (ECVAM) to ensure the best use of available funds and sound science. This coordination should also reflect a willingness by the Federal agencies comprising ICCVAM to more readily accept validated test methods proposed by the ECVAM to ensure industry has a uniform approach to worldwide chemical safety evaluation.

We respectfully request the subcommittee consider the following report language for the fiscal year 2010 Senate Labor, Health and Human Services, and Education, and Related Agencies appropriations bill:

"The Committee acknowledges the publication of the NICEATM/ICCVAM Five-Year Plan but remains concerned by the slow pace at which federal agencies have moved to adopt regulations that would replace, reduce or refine the use of animals in testing. The Committee therefore requests that NICEATM/ICCVAM hold an initial workshop, based upon input received from a workshop steering committee with representation of scientists from academia, federal government, animal welfare organizations and industry, on "Challenges to Incorporating Alternative Methods into US Federal Agency Programs." The Committee also requests that NICEATM/ICCVAM convene a workshop in fiscal year 2010 to assess the difficulty of obtaining high-quality relevant data for validating alternative methods, which is a significant barrier to validation and acceptance. NICEATM/ICCVAM are also urged to establish timetables for completion of all validation reviews that are currently under way."

National Institutes of Health Support for—"Toxicity Testing in the 21st Century: A Vision and a Strategy"

NIH has launched an ambitious collaboration with the Environmental Protection Agency (EPA) to dramatically transform the way drugs, consumer products, pesticides, and other chemicals are assessed for safety. The new approach will use isolated cells, molecular targets, and lower organisms such as roundworms, instead of laboratory animals. According to the NIH, the research collaboration is expected "to generate data more relevant to humans; expand the number of chemicals that are tested; and reduce the time, money and number of animals involved in testing."

The tripartite arrangement is designed to capitalize on the NIH Chemical Genomics Center's high-speed, automated screening robots to test compounds for toxicity; the experimental toxicology expertise of the National Toxicology Program, which is headquartered at the NIH's NIEHS; and the computational toxicology capabilities at the EPA's National Center for Computational Toxicology.

The Government collaboration seeks to implement a June 2007 report by the National Research Council (NRC) entitled Toxicity Testing in the 21st Century: A Vision and a Strategy, which calls for a sustained, well-funded effort across the toxicology community to shift the traditional toxicity-testing paradigm away from its heavy reliance on animal testing and towards high-throughput systems that monitor perturbations in toxicity pathways.

The Government project could be seen as a successor, with equally visionary possibilities for biology, to Dr. Collins and NHGRI's highly successful Human Genome Project. In order for the new vision to be fully realized within a decade, what is needed is a well-funded Government effort that would attract additional partners and resources from interested industries and overseas governments. We urge the subcommittee to support the efforts of the NIH to implement the NRC report.

PREPARED STATEMENT OF THE HUMANE SOCIETY OF THE UNITED STATES

On behalf of The Humane Society of the United States (HSUS) and our 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 2010. We are also submitting our testimony on behalf of The Humane Society Legislative Fund (HSLF) and the Doris Day Animal League. Thank you for the opportunity to present testimony relevant for the fiscal year 2010 budget request.

The HSUS requests that no Federal funding be appropriated for (1) the breeding of chimpanzees for research, or (2) the transfer of Government-owned chimpanzees to private hands (including endowments for their maintenance) unless for retirement to appropriate sanctuary. The basis of our request can be found below.

BREEDING OF CHIMPANZEES FOR RESEARCH

The National Center for Research Resources (NCRR) of the National Institutes of Health (NIH), responsible for the oversight and maintenance of federally owned chimpanzees, has announced a permanent end to funding the breeding of federally owned and supported chimpanzees primarily due to the excessive costs of lifetime care of chimpanzees in laboratory settings. We recently discovered 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.

The cost of maintaining chimpanzees in laboratories is exorbitant, totaling up to $8.5 million each year for the current population of approximately 500 federally

owned or supported chimpanzees (approximately $54 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.

TRANSFER OF OWNERSHIP OF GOVERNMENT-OWNED CHIMPANZEES

If the Government-owned and supported chimpanzees leave the Federal system and are transferred into private hands with an accompanying federally funded endowment, their lifetime support will not be guaranteed as required now by the CHIMP Act and their transfer to a suitable sanctuary will be highly unlikely. These chimpanzees will instead of warehoused and/or used for research for their entire lifetime—with the backing of the Government through an endowment. This will surely lead to a public outcry.

—If private industry breeds and uses chimpanzees in invasive research with Federal endowment money, the private sector would be unfairly, and perhaps illegally, benefiting from federally owned "resources" meant for the betterment of the American public, not for the profit of private industry.

—To date, the private sector has been less than fiscally responsible for the lifetime care of chimpanzees who they have used for private profit. Even in the situations where they eventually retire their chimpanzees, private users rarely offer financial compensation for their chimpanzees' lifetime care and on the few occasions that they have offered some financial compensation, it falls far short of what is actually needed.

We instead urge the Government to transfer all 500 Government-owned chimpanzees to the national sanctuary system and appropriate a portion of the funding currently being given to chimpanzee laboratories to the sanctuary system. A transfer of the chimpanzees to sanctuary would: (1) consolidate and lessen chimpanzee maintenance costs, (2) provide the chimpanzees with better care, and (3) offer the public the humane solution they are asking for.

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 500 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 as well as NIH-funded research. 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 90 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 2010.

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 (OLAW) 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.

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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.

Aside from the HSUS investigation, inspections conducted by the USDA demonstrate that basic chimpanzee housing requirements are often not being met. Inspection reports for two other federally funded chimpanzee facilities reported 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.

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 subcommittee report language:

"The Committee directs that no funds provided in this Act be used to support the breeding of chimpanzees for research, research that requires breeding of chimpanzees, or the transfer of ownership of federally owned chimpanzees to private entities, including endowments for their maintenance, with the exception of a transfer to an appropriate sanctuary that meets the national chimpanzee sanctuary system standards."

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 2010. 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.

PREPARED STATEMENT OF THE HARLEM UNITED COMMUNITY AIDS CENTER, INC.

FUNDING REQUEST OVERVIEW

Harlem United Community AIDS Center, Inc. (Harlem United) appreciates the opportunity to submit written comments for the record regarding fiscal year 2010 funding for HIV/AIDS related programs. Harlem United was founded in 1988 as a community-based, nonprofit organization providing comprehensive, integrated care in a healthy and healing environment. We serve individuals and families living with HIV and AIDS in the greater Harlem and South Bronx neighborhoods of New York City. Touching the lives of more than 6,000 people each year through our programs, Harlem United offers its clients an array of evidence-based, outcomes-driven, culturally sensitive medical and support services, including: primary healthcare and dental care; mental health and substance use counseling; individual psychotherapy and case management; and supportive housing.

For far too long, Federal funding for domestic HIV/AIDS programs has been inadequate, leaving communities struggling to meet the prevention, care, and treatment needs of people at risk for and living with HIV/AIDS. Harlem United values working with policymakers at the local, State, and Federal levels to advance policies and programs that support HIV prevention, care, and treatment. We respectfully request

[3] The Chimpanzee Sequencing and Analysis Consortium/Mikes, TS, et al.,(1 September 2005) Initial sequence of the chimpanzee genome and comparison with the human genome, Nature 437, 69–87.

[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.

the subcommittee provide the following allocations in fiscal year 2010 to promote HIV prevention and HIV related research and treatment innovations:

—$1.57 billion for HIV prevention and surveillance at the Centers for Disease Control and Prevention (CDC) to help stem the tide of the Nation's HIV/AIDS epidemic, particularly among individuals and communities of color.

—At least $2.81 billion in overall funding for the Ryan White Program, including the AIDS Drug Assistance Program, to provide essential services for more than 530,000 uninsured and underinsured low-income individuals and families impacted by HIV/AIDS.

—A minimum of $610 million for the Minority AIDS Initiative, which funds programs across 8 Federal agencies to address HIV infection-related disparities among racial and ethnic groups.

—At least $34 billion for the National Institutes of Health (NIH), with $3.35 billion allocated to HIV/AIDS research to help identify and deliver new therapies.

INTRODUCTION AND OVERVIEW

Despite ongoing prevention efforts, approximately 56,300 new HIV infections occur each year, and an estimated 21 percent of infected individuals are unaware of their HIV status. Moreover, CDC estimates that there are 430,000 people with HIV in the United States, who are not currently receiving HIV-related medical care. In 2004, the Institute of Medicine estimated that more than 50 percent of Americans living with HIV had no reliable access to the care they needed to stay alive. Evidence has shown that new infections have been driven in large part by (1) people who were unaware of their status and unwittingly transmitted the virus, and (2) individuals who were diagnosed, but who were not treatment eligible and who were engaging in risk behaviors.[1] Prevention programs, routine HIV testing and universal access to care are essential to stemming the tide of the HIV/AIDS epidemic nationwide.

To prevent the incidence of HIV and ensure that all people living with HIV/AIDS have access to comprehensive and quality care that they need and deserve, Harlem United advocates ongoing and significant Federal funding for domestic HIV/AIDS programs.

BOLSTER CDC HIV PREVENTION AND SURVEILLANCE EFFORTS

The CDC estimates that there are more than 1.1 million people living with HIV/AIDS in the United States and an estimated 56,300 new infections occur each year. With these staggering statistics, it becomes clear that a sustained Federal investment in and commitment to HIV/AIDS initiatives are essential to advancing efforts to prevent and treat HIV infections. However, over the past 6 years, as the number of people living with HIV/AIDS has increased, Federal funding for HIV prevention programs at CDC has decreased by 19.3 percent. In fiscal year 2009, CDC HIV related prevention and surveillance programs were flat-funded after facing a $3.5 million cut in fiscal year 2008. Harlem United calls upon the subcommittee to provide a specific allocation of $1.57 billion, an increase of $877 million, for HIV prevention efforts at CDC.

The current body of knowledge and research surrounding HIV prevention provides evidence for effective interventions, yet CDC and State and local public health departments do not always have the resources to implement them. With increased Federal funding, gaps in resources and fiscal needs will be alleviated and prevention efforts can be scaled up. Specifically, additional funding will allow CDC to expand HIV testing efforts and prevention outreach, particularly among high-risk populations and communities of color, where the epidemic is disproportionately concentrated. CDC also would be able to assist State and local health departments fund prevention programs that go beyond just testing for HIV. Furthermore, additional funding would allow CDC to continue to build the capacity of community-based organizations to implement evidenced-based interventions and provide technical assistance, Lastly, CDC would also be able to improve HIV monitoring and surveillance activities to ensure that accurate data on the disease is captured.

PRESERVE ACCESS TO HIV TREATMENT FOR LOW-INCOME INDIVIDUALS THROUGH THE RYAN WHITE PROGRAM

Each year, the Ryan White Program provides care and treatment to more than half a million low-income individuals living with HIV/AIDS. This program is vital

[1] Federal guidelines do not allow for treatment until an individual's viral load reaches 350 or lower.

to those who have no medical coverage or face coverage limits, as it steps in as the "payer of last resort." While the Ryan White Program was initially implemented as an emergency measure, it has become an integral part of the Nation's response to HIV, providing treatment for individuals who would otherwise not have access to care.

The AIDS Drug Assistance Program (ADAP), a critical component of the Ryan White Program that exists under part B, provides HIV medications to program participants and funds for purchasing health insurance for eligible participants and services that enhance drug treatment therapies.

Unfortunately, growing caseloads and costs of treatment have left current funding levels inadequate. As such, Harlem United calls upon the subcommittee to allocate at least $2.81 billion in overall funding for the Ryan White Program, including the AIDS Drug Assistance Program.

STRENGTHEN THE MINORITY AIDS INITIATIVE

The HIV/AIDS epidemic in the United States has hit racial and ethnic minority communities hard. While only 12 percent of the U.S. population is African American, this racial group accounts for 49 percent of all new AIDS cases. Hispanics account for 19 percent of new AIDS diagnoses, yet comprise only 12 percent of the total U.S. population. Combined, minorities represent 71 percent of new AIDS cases, 67 percent of all people living with HIV/AIDS, and 70 percent of deaths caused by AIDS. These grim statistics demonstrate the critical need for the Minority AIDS Initiative (MAI).

MAI provides funding to community-based organizations and healthcare providers to implement prevention and treatment programs specifically tailored to racial and ethnic minority populations. The Initiative, designed to complement other HIV efforts, strengthens the capacity of organizations serving communities of color to implement culturally appropriate HIV prevention programs and treatment services, in order to reduce the incidence of HIV and improve HIV related health outcomes among these communities.

Given the urgent need to reduce HIV/AIDS disparities among racial and ethnic communities in the United States, Harlem United urges the subcommittee to allocate a minimum of $610 million for the Minority AIDS Initiative.

ENHANCE HIV TREATMENT AND THERAPEUTICS RESEARCH

Despite breakthroughs in HIV treatment and prevention research, currently, no vaccine or cure exists for HIV/AIDS. With approximately 56,300 new HIV cases each year, it is crucial that the United States increase its commitment to research aimed at the prevention and treatment of this disease.

The NIH is the global leader in AIDS research. It conducts research on drug therapies, vaccines, and evidenced-based behavior and biomedical prevention interventions. Previous breakthroughs in NIH AIDS research include advances in antiretroviral therapy and drug regimens that have decreased HIV-related morbidity and mortality and reduced the risk of mother-to-child transmission of HIV. While NIH research has significantly contributed to HIV prevention and treatment programs that have improved the quality-of-life for many, additional and on-going research is needed to advance existing HIV/AIDS treatments. Therefore, Harlem United calls upon the subcommittee to allocate at least $34 billion for NIH, with $3.35 billion allocated to HIV/AIDS research.

CONCLUSION

Harlem United maintains a strong commitment to working with Members of Congress, other community-based organizations, and stakeholders to curtail the HIV epidemic and ensure that individuals living with HIV/AIDS have access to quality care and treatment. By providing the fiscal year 2010 funding levels detailed above, we believe the subcommittee will be taking the necessary steps towards accomplishing the goals of HIV prevention and universal access to care, ensuring that this disease will no longer threaten our Nation.

LETTER FROM THE INTERSTITIAL CYSTITIS ASSOCIATION

MAY 22, 2009.

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 SENATOR HARKIN AND COCHRAN: Thank you very much for your continued leadership in advancing healthcare policy.

Interstitial cystitis (IC) is pelvic pain, pressure, or discomfort related to the bladder typically associated with high urinary frequency and urgency, in the absence of infection or other pathology. IC is also called chronic pelvic pain syndrome, painful bladder syndrome (PBS), and bladder pain syndrome (BPS).

The Interstitial Cystitis Association (ICA) is a nonprofit organization committed to finding more effective treatments and a cure for interstitial cystitis. ICA promotes IC research; educates the medical community and public; advocates for IC patients, healthcare providers and researchers; and offers support for IC patients and their families. In this capacity the ICA requests the following funding considerations for the fiscal year 2010 Labor, Health and Human Services, and Education, and Related Agencies bill:

—A 7 percent increase for the National Institutes of Health (NIH) for fiscal year 2010. A 7 percent increase will allow NIH to continue to expand basic biomedical research on all diseases, and take advantage of the explosion of opportunities that exist in reducing suffering from debilitating medical disorders.

—A 7 percent increase for the National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK). NIDDK is the key NIH agency funding research on interstitial cystitis (IC). ICA urges that NIDDK continue to expand the research portfolio on IC, so millions of American women and men can benefit from advances and breakthroughs in medical care and treatments. NIDDK supports the Multidisciplinary Approach to Chronic Pelvic Pain clinical trial-a critical priority of ICA.

—A 7 percent increase for the NIH Office of Research on Women's Health. Located in the NIH Office of the Director, the NIH Office of Women's Health supports research and program activities that contribute to the understanding of interstitial cystitis which primarily affects women.

—$1 million for the Centers for Disease Control and Prevention (CDC) interstitial cystitis program. A funding level of $1 million will allow the modest expansion of IC program activities at CDC and continue the critical CDC/ICA cooperative agreement on public and professional awareness on interstitial cystitis.

Thank you for the opportunity to present the views of the IC community. Please do not hesitate to contact me if there is any more information you would like us to provide for your consideration.

Sincerely,

BARBARA GORDON,
Executive Director.

PREPARED STATEMENT OF THE INFECTIOUS DISEASES SOCIETY OF AMERICA

The Infectious Diseases Society of America (IDSA) appreciates this opportunity to speak in support of Federal efforts to prevent, detect, and respond to infectious diseases in the United States and abroad as part of the fiscal year 2010 funding cycle. IDSA represents more than 8,500 infectious diseases physicians and scientists devoted to patient care, prevention, public health, education, and research. Our members care for patients of all ages with serious infections, including meningitis, pneumonia, tuberculosis (TB), antibiotic-resistant bacterial infections such as methicillin-resistant Staphylococcus aureus (MRSA), and those with cancer or transplants who have life-threatening infections caused by unusual microorganisms, food poisoning, and HIV/AIDS, as well as emerging infections like the 2009 H1N1 virus (swine influenza) and severe acute respiratory syndrome (SARS).

2009 H1N1 Virus (Swine Influenza)

IDSA's leadership strongly commends the administration's efforts to date in managing and responding to the 2009 H1N1 outbreak. Of critical importance, experts and scientists are driving key decisions. The leadership of the Centers for Disease Control and Prevention (CDC) and the Department of Health and Human Services

(HHS) has been strong, and their coordination with other Federal, State, and local governments is clear. Undeniably, the investments and subsequent preparations the country has made since the National Strategy for Pandemic Influenza was issued in November 2005 are paying off. As the 2009 H1N1 virus outbreak unfolds, we are witnessing firsthand the important role a robust public health infrastructure plays in rapidly detecting and containing disease outbreaks. Yet, additional resources are needed to adequately respond to the 2009 H1N1 outbreak as well as to continue to prepare our Nation for other bioemergencies.

We thank the subcommittee for providing funding for pandemic influenza preparedness and response activities in the recent fiscal year 2009 supplemental bill. IDSA supports a funding level of $2.05 billion to complete the funding to implement the National Strategy for Pandemic Influenza, as well as to develop a 2009 H1N1 virus vaccine and replenish the Strategic National Stockpile, support grants to State and local health departments so they may adequately prepare for and respond to the 2009 H1N1 virus and other infectious diseases outbreaks, and provide additional funding for global pandemic preparedness activities. IDSA further believes that funding is needed annually to adequately maintain State and local pandemic preparedness activities. IDSA also strongly supports strengthening funding for ongoing pandemic influenza preparedness activities at CDC, the Food and Drug Administration (FDA), National Institutes of Health (NIH), and HHS' Office of the Secretary.

Congress also must fully fund the Biomedical Advanced Research and Development Authority (BARDA) within HHS so that the United States can begin to realize goals envisioned under the Pandemic and All-Hazards Act enacted in 2006 to address a broad spectrum of biological threats in addition to pandemic influenza. IDSA recommends that $1.7 billion of multi-year appropriations be allocated to BARDA in fiscal year 2010 to fund biological therapeutics, diagnostics, vaccines, and other technologies. Such funding would help ensure the availability of resources throughout the stages of development and the flexibility for BARDA to partner effectively with industry.

CDC

A strong CDC is essential to the United States' efforts to rapidly detect and control infectious diseases as witnessed by the current H1N1 outbreak. CDC is the primary Federal agency responsible for conducting and supporting public health protection through health promotion, prevention, preparedness, and research. IDSA recommends increasing funding for CDC's core programs to $8.6 billion, to enable it to maintain a strong public health infrastructure and protect Americans from public health threats and emergencies.

IDSA is especially concerned about CDC's Infectious Diseases program budget, which supports critical management and coordination functions for infectious diseases science, program, and policy, including related specific epidemiology and laboratory activities. IDSA recommends an fiscal year 2010 funding level of $2.7 billion for CDC's Infectious Diseases programs.

Within the Infectious Disease programs' proposed budget, the agency's already severely strapped Antimicrobial Resistance budget stands at $16.9 million. This vital program is necessary to help combat the rising tide of drug resistance, a critical medical problem marked most publicly by the upsurge in methicillin-resistant Staphylococcus aureus (MRSA) and other drug-resistant bacterial infections. Antimicrobial resistance also has serious implications for our collective response to the 2009 H1N1 virus. Viruses are unpredictable, and should the 2009 H1N1 virus develop resistance to oseltamivir and zamamir, our ability to respond effectively to the influenza outbreak will significantly diminish. For these reasons, IDSA recommends increasing fiscal year 2010 funding for resistance programs at CDC by $48 million, to a total of $65 million. Such funding increases will enable CDC to more effectively gather morbidity and mortality data related to resistance, track the development of dangerous resistant bugs as they develop, educate physicians, patients and the public about the need to protect the long-term effectiveness of antimicrobial drugs, and strengthen infection control activities across the United States. This recommended level coincides well with an internal CDC professional judgment prepared last year which, unfortunately, was not provided to Congress.

The Emerging Infectious Diseases (EI) budget line boosts the agency's capacity to nimbly identify and respond to emerging infections, such as the 2009 H1N1 virus. Much of CDC's infectious diseases funding is highly disease-targeted, making it difficult to fund cross-cutting or emergent needs. Unique in its flexibility, the EI line supports dozens of research and surveillance programs that address new and unpredictable threats. Such threats have included rabies, rotavirus, food-borne diseases, Ebola and SARS. Inadequate funding would severely affect CDC's laboratory capac-

ity, research grants to academic partners, and support for State public health departments and public health laboratories and would reduce CDC's flexibility in setting priorities and taking action against new infections that may emerge throughout the year. IDSA recommends, at a minimum, that the Other Emerging Infectious Diseases line item be increased to $160 million for fiscal year 2010.

Immunizing our population against vaccine—preventable diseases is one of our country's greatest public health achievements. Through CDC's Section 317 Program, which funds State and local immunizations efforts, the United States has made significant progress toward eliminating vaccine-preventable diseases among children. IDSA applauds the actions by the Congress over the past year to increase funding for this program in the American Recovery and Reinvestment Act and in the fiscal year 2009 omnibus appropriations bill. At a time when new CDC-recommended vaccines are available and a greater commitment to immunizations for both children and adults is necessary, we need to continue to increase access to this critical intervention that saves lives and millions of dollars in unnecessary medical spending. To build on this important effort, IDSA recommends a funding level for the Section 317 Program of $802 million in fiscal year 2010.

IDSA also supports changes which will significantly strengthen the Section 317 Program's support for adult and adolescent immunization. Each year, more than 46,000 adults die of vaccine-preventable diseases. Costs related to illnesses from adult vaccine-preventable diseases are approximately $10 billion. IDSA recommends the establishment of distinct funding floors for adult vaccine purchase and infrastructure in amounts sufficient to cover immunization of the majority of under-insured and uninsured adults with all CDC-recommended vaccines.

Last year, 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. At a minimum, it is critical that the funding authorized for fiscal year 2010 in this important law—$210 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 IDSA also supports for inclusion in fiscal year 2010 appropriations.

HIV prevention and surveillance activities at CDC are critical to reducing the number of new cases occurring annually in the United States. Sufficient resources must be devoted to HIV prevention to support CDC's portfolio of prevention programs, including the initiative to identify people with HIV/AIDS earlier through routine HIV screening. This program will lead to lifesaving care sooner and will help to prevent further transmissions. IDSA supports funding in the amount of $1.57 billion for these programs in fiscal year 2010. We also support funding of $2.81 billion for the Ryan White CARE Act programs within the Health Resources and Services Administration and urge you to increase funding for critical part C medical care by $68.4 million, to a total of $270.3 million for part C programs. Ryan White programs provide a vital link in our healthcare safety net and are currently struggling to meet the need for HIV services in communities across the country.

NIH

NIH is the single-largest funding source for infectious diseases research in the United States and the life-source for many academic research centers. The NIH-funded work conducted at these centers lays the groundwork for advancements in treatments, cures, and other medical technologies. Between 2003 and 2009, NIH lost 13 percent of its purchasing power due to the rate of biomedical research inflation and stagnating annual budgets. Because of the flat budget, 3 out of 4 research proposals submitted to NIH were not funded. Peer reviewers were forced to become more risk averse, leading to a narrowing of scientific vision and a diminishing rate of medical advancement. Without medical advancements, thousands of Americans will have to wait longer for the cures they need.

IDSA is extremely pleased that the recently enacted American Recovery and Reinvestment Act provided $10 billion in additional funding to support NIH's research efforts in 2009 and 2010. Congress rightfully acknowledged the role of scientific research in stimulating the economy. It is vital, however, that this long overdue increase in funding be sustained and become part of NIH's baseline. Making this increase permanent ultimately will translate into long-term improvements in human health, both domestically and globally.

NIH's Fogarty International Center is at the forefront of global health and is a leader in extending the U.S. Federal biomedical enterprise abroad. It taps innovative thinking from all parts of the world and fosters important scientific partner-

ships. Through Fogarty, the United States has supported research and research training programs conducted by both U.S. and foreign investigators across a wide range of infectious diseases and needs, including HIV/AIDS, malaria, and tuberculosis. The Center's efforts have led to improved local health outcomes—but so much more can be done. For this reason, IDSA strongly supports increasing Fogarty's funding level in fiscal year 2010 to $100 million—an increase of $31.3 million. These additional resources will enable Fogarty to increase research training initiatives, forge new partnerships between U.S. and foreign research institutions, and conduct much-needed implementation research to increase the effectiveness of international programs.

IDSA also urges the National Institute of Allergies and Infectious Diseases (NIAID) at NIH to increase its antimicrobial resistance research funding by $100 million in fiscal year 2010, bringing overall funding in this area to $271 million. This will allow NIAID to strengthen clinical research and establish a clinical trials network to study resistant infections as well as antibacterial use and development. Well-designed, multi-center, randomized, controlled trials would create an excellent basis of evidence from which coherent and defensible recommendations could be developed.

FDA

Additionally, in the Agriculture Appropriations bill, IDSA supports a strengthening of antimicrobial resistance efforts at FDA. Specifically we support a $20 million increase in antimicrobial resistance funding for FDA in fiscal year 2010, bringing the agency's resistance funding to $44 million. This will allow FDA to establish and periodically update antibiotic susceptibility breakpoints based on testing and data collection, including through the purchase of vendor data; fund Critical Path initiatives for antibiotics; more aggressively review the safety of antibiotic use in food animals; and quicken its pace in developing critical guidance for industry on antibiotic clinical trial designs.

Today's investment in infectious diseases research, prevention, and treatments will pay significant dividends in the future by dramatically reducing healthcare costs and improving the quality of life of millions of Americans and others. It also will continue to enable Federal agencies to respond effectively and efficiently to the 2009 H1N1 virus and other potentially devastating outbreaks.

Prepared Statement of the International Foundation for Functional Gastrointestinal Disorders

SUMMARY OF RECOMMENDATIONS FOR FISCAL YEAR 2010

Provide a funding increase of at least 7 percent for the National Institutes of Health (NIH) and its Institutes and Centers.

Urge the National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK) to prioritize and implement the recently released research recommendations of the National Commission on Digestive Diseases.

Urge NIH And NIDDK to expand the research portfolio on functional gastrointestinal and motility disorders, such as Irritable Bowel Syndrome (IBS).

Thank you for the opportunity to present this written statement regarding the importance of functional gastrointestinal and motility disorders research.

Since our establishment in 1991, the International Foundation for Functional Gastrointestinal Disorders (IFFGD) has been dedicated to increasing awareness of functional gastrointestinal and motility disorders among the public, health professionals, and researchers. We also work to bolster digestive disease research and generate new treatment option for patients. For example, IFFGD worked with the NIDDK, the National Institute of Child Health and Human Development (NICHD), and the Office of Medical Applications of Research (OMAR) to facilitate an NIH State-of-the-Science Conference on the Prevention of Fecal and Urinary Incontinence in Adults, which was held in December of 2007. Furthermore, I served on the National Commission on Digestive Diseases (NCDD) which recently released a long-range road map for digestive disease research, entitled Opportunities and Challenges in Digestive Diseases Research: Recommendations of the National Commission on Digestive Diseases

The majority of diseases and disorders we address have no cure and treatment options are often limited. We have yet to completely understand the mechanisms of the underlying conditions. Patients face a life of learning to manage a chronic illness that is accompanied by pain and an unrelenting myriad of gastrointestinal symptoms. The medical and indirect costs associated with these diseases are enormous; estimates range from $25 billion–$30 billion annually. Economic costs spill over into

the workplace, and are reflected in work absenteeism and lost productivity. Furthermore, the human toll is not only on the individual but also on the family. In essence, these diseases account for lost opportunities for the individual and society.

IBS

IBS strikes people from all walks of life. It affects 30 million to 45 million Americans and results in significant human suffering and disability. This chronic disease is characterized by a group of symptoms, which include abdominal pain or discomfort associated with a change in bowel pattern, such as diarrhea and/or constipation. Although the cause of IBS is unknown, we do know that this disease needs a multidisciplinary approach in 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.

Numerous research recommendations regarding IBS were included as components of the NCDD's Long-Range Research Plan for Digestive Diseases. For fiscal year 2010, IFFGD urges Congress to review the NCDD's Report, and provide NIH and NIDDK with the resources necessary to adequately implement the plan's recommendations.

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 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 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 provide the necessary funding for the expansion of the research activities at NIDDK and the Office of Research on Women's Health (ORWH) regarding functional gastrointestinal disorders and motility disorders. Additional funding will allow necessary growth of the research portfolios on functional gastrointestinal disorders and motility disorders at NIDDK and ORWH, and also facilitate implementation of the NCDD's research recommendations.

Recent years of near level-funding at NIH have negatively impacted the mission of its Institutes and Centers. For this reason, IFFGD applauds initiatives like Senator Arlen Specter's (R-PA) successful effort to provide NIH with $10.4 billion in stimulus funds. IFFGD urges this subcommittee to show strong leadership in pursuing substantial funding increase through the regular appropriations process in fiscal year 2010.

For fiscal year 2010, IFFGD recommends a funding increase of at least 7 percent for NIH and its Institutes and Centers.

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 2010 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, affecting an estimated 750,000 people worldwide and its prevalence appears to be is increasing significantly.

No one knows the exact causes of myeloma. Doctors can seldom explain why one person develops this disease and another does not. Research has shown that people with certain risk factors such as age and race are more likely than others to develop myeloma. Growing older increases the chance of developing multiple myeloma as most people with myeloma are diagnosed after age 65. However, in recent years the diagnosis of myeloma in people 40 years of age and younger appears to have become more common as our ability to detect and diagnose this disease has improved. The risk of myeloma is highest among African Americans and lowest among Asian Americans.

Scientists are studying other possible risk factors for myeloma. Toxic chemicals (for example, agricultural chemicals and Agent Orange used in Vietnam), radiation (including atomic radiation), and several viruses (including HIV, hepatitis, herpes virus 8, and others) are associated with an increased risk of myeloma and related diseases.

According to the American Cancer Society, 19,920 Americans were expected to be diagnosed with myeloma and 10,690 would lose their battle with this disease in 2008. Even while they live with the disease, myeloma patients can suffer debilitating fractures and other bone disorders, severe side effects of their treatment, and other problems that profoundly affect their quality of life, and significantly impact the cost of their healthcare. Despite these grim statistics, significant gains in the battle against myeloma have been made through our Nation's investment in cancer research and its application. Research holds the key to improved myeloma prevention, early detection, diagnosis, and treatment, but such breakthroughs are meaningless unless we can deliver them to all Americans in need.

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). The IMF advocates $33.3 billion for NIH in fiscal year 2010. This will allow NIH to sustain and build on its research progress resulting from the recent doubling of its budget while avoiding the severe disruption to that progress that would result from a minimal increase. Myeloma research is producing extraordinary breakthroughs—leading to new therapies that translate into longer survival and improved quality of life for myeloma patients. Although myeloma was once considered a death sentence with limited options for treatment, 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. But these achievements are not a substitute for a cure and therefore the IMF calls upon Congress to allocate $6 billion to the National Cancer Institute in fiscal year 2010 to continue our battle against myeloma and its sequelae.

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 joins with our partners in the cancer community—including One Voice Against Cancer—in calling on Congress to provide additional resources for the CDC to support and expand much-needed and proven efforts in such areas as cancer prevention, early detection, and risk reduction. Specifically, the IMF advocates the appropriation of $471 million in fiscal year 2010 for CDC's cancer prevention and control initiatives.

Within that allocation, the IMF specifically advocates $6 million for the Geraldine Ferraro Blood Cancer Program. Authorized under the Hematological Cancer Re-

search 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 2010 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 2010 funding levels necessary to ensure that our Nation continues to make gains in the fight against myeloma.

PREPARED STATEMENT OF THE JEFFREY MODELL FOUNDATION

Thank you for the opportunity to present to you our testimony concerning the activities of the Jeffrey Modell Foundation (JMF) dedicated to Primary Immunodeficiency (PI). As you know, most of our programs are conducted in partnership with various governmental agencies under the jurisdiction of this subcommittee. We very much appreciate the support, generosity, and kindness of spirit that we have received from the members and staff of this subcommittee and look forward to continuing to work together closely in the future.

As a baseline, Mr. Chairman, please let me make clear the following four fundamental points:

—JMF programs always include our own investment of funds and resources, thereby assuring accountability.
—JMF programs improve patients' quality of life issues through prevention and earliest possible diagnosis.
—JMF programs, therefore, lower healthcare costs.
—JMF programs save lives as demonstrated in the 2008 Wisconsin newborn screening program.

All of the data concerning the impact of the education and awareness program that this subcommittee has long supported has been published in a leading scientific journal, "Immunologic Research", Humana Press, January 13, 2009 and is entitled, "From Genotype to Phenotype. Further Studies Measuring the Impact of a Physician Education and Public Awareness Campaign on Early Diagnosis and Management of Primary Immunodeficiencies".

PHYSICIAN EDUCATION AND PUBLIC AWARENESS CAMPAIGN ON PRIMARY IMMUNODEFICIENCIES

Five years ago, Mr. Chairman, this subcommittee set us on a path to work with the Centers for Disease Control and Prevention (CDC) to create a physician education and public awareness program. Today, that program has far exceeded even our most optimistic dreams.

JMF has now generated more than $100 million in donated media from television, radio, print, Web site, airport, and mall dioramas. This translates to more than $18 million annually and represents $7 donated to support this campaign for every $1 of Government support appropriated by this subcommittee. But all that visibility would be meaningless if there were not real impact on the health of these patients. And, there are.

The number of patients referred, tested, diagnosed, and treated has more than doubled every year for the past 5 years in which the campaign has been conducted.

The Jeffrey Modell Centers Network of Research, Diagnostic and Referral Centers now include 304 physicians, from 138 academic teaching hospitals and medical schools. Twenty-three of the 30 "Best Pediatric Hospitals" in the United States are designated Jeffrey Modell Centers. The physician-experts at these centers have provided JMF with data on more then 30,000 patients. And we can now pinpoint the specific disease, where the patient is treated, who is treating the patient, and how the patient is treated. This data can make an enormous contribution to registries not only in the United States, but on a global platform.

After diagnosis and treatment, physicians reported annual decreases of more than 70 percent in the number of severe infections, physician, hospital, and emergency room visits, pneumonias, school/work days missed, days in hospital, acute infections, and days with chronic infections.

The consequences of these changes in patient outcomes were assigned economic values. JMF's published study drew from the hospital accounting reports at the Centers for Medicare and Medicaid services. The specific hospital charges and length of stay data was obtained from the Hospital Cost and Utilization Project, Nationwide In-patient Sample, under the auspices of the Agency for Healthcare Research and Quality.

The study showed that each undiagnosed patient costs the healthcare system $102,736 annually in emergency room visits, hospitalizations, and medical treatment for severe complications. It costs $22,696 annually to treat patients after they have been diagnosed-a savings of more than $80,000 per patient per year.

The National Institutes of Helath (NIH) states that "while individual primary immunodeficiency diseases are somewhat rare, affecting 500,000 Americans, this group of diseases may affect 1–2 percent of the U.S. population or 3 million–6 million Americans." Using the most conservative estimate, the minimum cost to the U.S. healthcare system for undiagnosed PI patients is more than $40 billion annually. Ensuring that these patients are properly diagnosed makes enormous economic sense, not to mention their improved quality of life.

RESEARCH COLLABORATION WITH NIH

JMF established a $12 million research partnership with four of the U.S. National Institutes of Health. The RO1 research grants solicit investigations on Primary Immunodeficiency (PI) diseases. JMF also established the Robert A. Good/Jeffrey Modell International Fellowship Program, funding the brightest young investigators from around the world, focused on PI and stem cell transplantation. JMF awarded 4 Fellowships in 2008 under this program.

Finally, in 2008, JMF established Endowed Chairs in Pediatric Immunology Research at Children's Hospital Boston, Children's Hospital Seattle, as well as the Jeffrey Modell Endowed Fellowship in Immunology Research at the University of Washington.

NEWBORN SCREENING FOR PRIMARY IMMUNODEFICIENCIES

JMF and the State of Wisconsin launched the first newborn screening program for Severe Combined Immune Deficiency. Since January 2008, every baby born in the State of Wisconsin has been screened. The T Cell Receptor Excision Circles assay was utilized and the screening test identified a patient with a combined immunodeficiency disease. The baby received a life-saving bone marrow transplant. The screening protocol has picked up several other newborns with life threatening disorders including Complete Di George Syndrome, T-Cell lymphopenia, and a disorder where white blood cells are unable to migrate to sites of infection. We anticipate that Massachusetts, Illinois, Connecticut, Texas, and New York will move forward with pilot programs in 2009.

At this date, the cost to screen for these life threatening diseases is $5 per child. It is anticipated that this cost will decrease. There are approximately 4 million newborns per year in the United States. Thus, the outside cost to screen every newborn in the United States is estimated to be less than $20 million.

SPIRIT—SOFTWARE FOR PRIMARY IMMUNODEFICIENCY RECOGNITION INTERVENTION AND TRACKING

JMF brought its 2008 data to the annual meeting of the Managed Care Network (MCN). Senior executives and medical directors of private and Medicare/Medicaid health plans nationwide, as well as the leadership of pharmacy groups representing more than 150 million covered lives, attended the 2-day meeting. JMF was asked to develop an early warning system software program matching the ICD–9 codes to

the 10 Warning Signs and Physician Algorithm. This software, known as SPIRIT, is now in development and will be piloted with National managed care carriers during 2009. The software protocol is being developed by JMF and its Medical Advisory Board, and the technology will be produced by Xcenda, a division of AmeriSource Bergen Corporation. Besides the listing of the ICD–9 codes, the program assigns relative weights for each code, identifies each code as a chronic or acute condition, and provides specific exclusion criteria.

SUMMARY

Mr. Chairman, I hope you will agree that the many programs run by the Jeffrey Modell Foundation are a "perfect fit" with the announced approach to reforming healthcare articulated by the President and currently being addressed by this Congress. Specifically we have focused our attention on:

—Prevention through physician education and public awareness;
—Quality of care through the JMF Network of specialized centers;
—Control of healthcare costs through early diagnosis and Newborn Screening; and
—Use of technology to streamline records and generate electronic data though new software developed by JMF for third-party payers.

For fiscal year 2010, we bring you what we consider to be a very modest agenda:

—We ask for no new appropriations or programs from the subcommittee.
—We ask for continuation of the successful programs that we are now operating.
—We ask for Government encouragement and support for these programs.

In exchange, we can assure you that we will continue to contribute our own funds to every program with which we are involved. We will continue to operate these programs by fully exercising good management and ever-cognizant of our responsibilities to this subcommittee and to the taxpayers who have supplied the funds that you pass on to us.

Mr. Chairman, we are at a critical time in our Nation's healthcare history. JMF is proud of the contributions we have made to the healthcare system and look forward to continuing to work with you and with all members of Congress to continue to serve the American people.

PREPARED STATEMENT OF THE MENTOR CONSULTING GROUP

> "It must not for a moment be forgotten that the core of any social plan must be the child."
>
> President Franklin Roosevelt
> U.S. Committee on Economic Security, Report to the President, 1935

Senator Harkin and distinguished members of the subcommittee: Mentor Consulting Group (MCG) is pleased to submit testimony for the outside witness record to ask the subcommittee to direct its attention to the President's fiscal year 2010 proposed budget recommendation calling for the elimination of the U.S. Department of Education's (ED) mentoring program. MCG is seeking your help in restoring the funding for this important and much needed program to enable agencies from Storm Lake, Iowa, to McAllen, Texas, from Rhinelander, Wisconsin to Starkville, Mississippi, to continue supporting match relationships for a third year.

It is our understanding that the cost of restoring the third year of funding for 2008 mentoring program grantees is estimated at $17 million.

Mentoring is fundamentally predicated on creating healthy and meaningful relationships for youngsters who are in jeopardized circumstances with respect to their potential for achieving long-term educational and socio-emotional success. Research demonstrates that youth who successfully transition from risk-filled backgrounds to responsible adulthood are consistently distinguished by the presence of a caring adult in their lives. Prematurely ending matches, such as those that have been recently established through the mentoring program grants, can be potentially harmful to mentees. MCG strongly urges the subcommittee to prevent this possibility from turning into a tragic reality for thousands of vulnerable children.

The ED mentoring program, authorized under the No Child Left Behind Act (NCLB) of 2002, section 4130, is a competitive Federal grant program managed by the Office of Safe and Drug Free Schools (OSDFS). It addresses the lack of supportive adults at critical turning points in the lives of youngsters in grades 4–8. The funding supports mentoring programs operating in local education agencies (LEAs); nonprofit community- and faith-based organizations; and partnerships between LEAs and local nonprofits. Funded programs are designed to:

—improve interpersonal relationships with peers, teachers, family members, and other adults;
—increase personal responsibility and community involvement;
—discourage the use of drugs and alcohol;
—discourage the use of weapons;
—reduce delinquency;
—improve academic achievement; and,
—reduce school dropout.

Since 2004, MCG has worked on-site with 57 ED mentoring program grantees serving in the capacity of overall technical assistance provider, e.g., mentor/mentee training, mentor recruitment, marketing, sustainability planning, and/or as the external evaluator. Our client sample is rich with diversity both with respect to the size and scope of their grants, e.g., we work with the agency receiving the smallest of the 2008 awards, as well as their experience in operating a formal mentoring program. Another of our clients, also a 2008 grantee, is among the 30 largest school districts in Texas and is working with 17 partnering school campuses. This grantee exceeded their 1 to 1 match goal of 150 matches before the end of the first year of the grant. The potential impact on 150 youngsters, in this one community alone, should this program be eliminated, is unimaginable.

A key "lesson learned" based on our experience with all of these clients is that the complexities of operating a mentoring program cannot be overstated. Building safe and secure relationships between youngsters and caring adults requires the attention and involvement of trained, committed, and competent staff who understand the quality assurance standards of the mentoring field.

Beyond the potential benefits for the youth, the ED mentoring program has enabled grantees to forge strategic community partnerships between concerned citizens and multiple youth serving organizations to maximize the use of community resources. Also negatively affected by this proposed termination of funds is those staff hired to work with the ED mentoring program who have worked diligently over the past 13 months to introduce and promote these programs in their community and to build these vital new mentor/mentee relationships. Premature termination of this grant program would, of course, force layoffs in 110 communities across the country. By contrast, the economic stimulus package is working hard to counter just such layoffs.

Research over the past decade has demonstrated that mentoring is a viable intervention strategy that holds considerable promise. Studies of structured mentoring programs, including those that have received Federal funding, suggest that the programs are likely to be more successful when they include a strong infrastructure and facilitate caring relationships. Infrastructure refers to a number of activities including identifying the youth population to be served and the activities to be undertaken, screening and training mentors, supporting and supervising mentoring relationships, collecting data on youth outcomes, and creating strategies for long-term sustainability. (Ref. Jean Balwin Grossman, ed., Contemporary Issues in Mentoring, Public/Private Ventures, p.6). The ED mentoring program is providing much needed funding to ensure the integrity of the requisite infrastructure and facilitation of caring relationships in programs that would otherwise be severely marginalized.

Another signal research finding is that mentoring relationships are likely to promote positive outcomes for youth and avoid harm when they are close, consistent, and enduring. (Ref. Rhodes and DuBois, "Understanding and Facilitating the Youth Mentoring Movement," p. 9). Closeness is the bond that is created between the youth and mentor. The characteristics of the volunteer mentors (no mentors in ED mentoring program matches are able to be remunerated) have also proven to be important in shaping the relationships and strengthening the bond. For example, individuals with prior experience in helping roles or occupations, an ability to understand and respect cultural differences, and an overall sense of commitment to mentoring all appear to contribute positively to the relationship and overall match quality. Further, it appears that relationships may be especially beneficial when they remain part of the youth's life for multiple years (Klaw, Fitzgerald & Rhodes, 2003: McLearn et al., 1998) and have the opportunity to facilitate adaptation throughout significant portions of their development (DuBois & Silverthorn, 2005b; Werner, 1995). These findings are of particular importance to the 4th through 8th grade population served by the ED mentoring program.

The ED mentoring program garnered national attention recently following publication of the Impact Evaluation of the U.S. Department of Education's Student Mentoring Program report prepared by Abt Associates for the Institute of Education Sciences (March 2009). ED contracted with Abt in 2005 to conduct the study which used an experimental design in which students were randomly assigned to a treatment or control group. The study involved 32 ED Mentoring Program grantee sites

that were funded beginning in 2004 or 2005. Grantees selected for participation in the Impact Study were required to meet three criteria:

—Be operational so that it could recruit and match students to mentors in the fall of 2005 for the first group of grantees and fall 2006 for the second group;
—Able to oversubscribe or identify excess demand supporting experimental study needs for an unserved control group (i.e., able to provide tangible evidence of a pool of 4th through 8th grade students referred to the mentoring program) of adequate size to support study requirements; and
—Willing and able to cooperate with the data collection and logistical needs of the national evaluation, including random assignment.

While the findings of the impact evaluation study are indeed mixed, MCG is encouraged that this study has captured several of the inherent challenges that often confront early cohorts of federally funded mentoring initiatives. This study contributes to the growing body of research evidence, however, the field warrants additional comparative evaluation studies that look at different program models. Each and every cohort of a federally funded initiative should be evaluated and this study helps to make that very point. More recently funded ED mentoring program grantees, including those in 2008, have had the benefit of an expanded comprehensive technical assistance package that includes conference trainings, webinars, resource materials (available online), and site visits designed to help program coordinators with all aspects of program implementation, data tracking, and operation. In addition, grantees are now trained on specific aspects of program sustainability.

In closing, we would like to share with you a comment from a mentee who met with us during a recent site visit. When asked what having a mentor meant to him, Isaiah, a fourth grade student replied, "Having a mentor has been the best thing that has happened to me in my whole life."

MCG fully acknowledges and appreciates the widespread economic and social challenges facing our country at this time. However, reinstatement of the ED mentoring program funding in the 2010 budget is a clarion call for moral policymaking.

That call is befitting of your role as members of this august body and will ensure that youngsters like Isaiah will one day achieve their full potential and enjoy their opportunity to sit as a distinguished member of Congress.

Thank you for the opportunity to submit this testimony.

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 3 years ago. It was a shock to me and my family, friends, and clients.

One morning 3 years ago, when doing a load of laundry, I had no idea how to set the dials, despite the fact that I had used them weekly for the last 10 years. I stood there for what seemed an eternity before I figured out how to set the dials.

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 emergency room, 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 poststroke depression was harder than the recovery of my arms and legs and even speech.

Being a psychotherapist, 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 3 years poststroke, I am back to my practice full time. I lead support groups for stroke survivors and caregivers through the Montgomery County Stroke Association and served on its Board. I now lecture on stroke, stroke prevention and stroke recovery. I founded "hope for stroke"—individual and family counseling for stroke survivors and caregivers. And I have developed, together with a colleague, a seminar for professionals in the stroke field on the role of mental health providers in stroke recovery. In addition, I have participated in a National Institutes of Health (NIH) study about stroke recovery.

Once again, I am in excellent health and have resumed my active lifestyle. 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

Chairman Harkin and Ranking Member Cochran, we thank you for the opportunity on behalf of MENTOR to submit written testimony in support of resources for youth mentoring.

Primarily, this includes $100 million in Federal funding for youth mentoring—$50 million for the Department of Health and Human Services' Mentoring for Children of Prisoners program and $50 million for the Department of Education's Mentoring Programs grants. MENTOR has appreciated the support of the subcommittee in previous years, in funding these programs at these levels since fiscal year 2004.

Mentoring has been recognized as an important form of service by the Obama administration and the 111th Congress, given its inclusion in several portions of the recently signed Edward M. Kennedy Serve America Act. The act, in its wide-ranging call to significantly increase service opportunities, will also augment the pool of volunteers who can become mentors to young people.

We would like to appeal that the Serve America Act be fully funded in fiscal year 2010 to ensure that this historical boost in national and community service is allowed to occur. We also are recommending that Congress continue to provide $50 million each for the U.S. Department of Education Mentoring Programs grants and the U.S. Department of Health and Human Services' Mentoring for Children of Prisoners program.

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.

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 4,100 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 4,100 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 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, 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 Big Brothers Big Sisters of America's newer, school-based mentoring 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.

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. 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.

Since fiscal year 2004, Congress has devoted approximately $100 million annually for youth mentoring, split evenly between two critical grant programs:

—*Department of Education, Mentoring Programs Grants*.—These grants go to local mentoring organizations to establish or expand their mentoring program. It can support recruiting, screening, and training of mentors, as well as hiring

and professional development of mentoring coordinators and support staff. Community-based organizations, faith-based organizations, and schools are eligible to apply for funding.

—*Department of Health and Human Services, Mentoring for Children of Prisoners*.—This program provides funding to organizations that match mentors with young people whose parents are incarcerated. It also is open to community-based and faith-based organizations.

Both of these programs provide much-needed Federal dollars to help mentoring programs get established or to expand to serve more children. Both programs are competitive grant programs, with all funding being awarded to local organizations. The request for proposals for both programs require applicants to detail how they will be able to carry out key mentoring best practices. Since 2004, coinciding with this significant increase in Federal support, we have seen the number of young people in mentoring relationships grow from 2.5 million to the current level of 3 million. Clearly, this funding is having an impact on the mentoring gap.

President Obama stated in remarks about his fiscal year 2010 budget February 26, 2009, "Education Secretary Duncan is set to save tens of millions of dollars more by cutting an ineffective mentoring program for students, a program whose mission is being carried out by 100 other programs in 13 other agencies." Once again, we are not certain that this means the total elimination of school-based mentoring programs in the Department of Education, but even in the absence of a detailed budget justification, we feel that comment is warranted.

We understand that this decision may rest in large part on a recent evaluation that showed that school-based mentoring, as practiced by many programs around the country, failed to increase grades or test scores. However, just 2 years ago, another rigorous evaluation of school-based mentoring found that teachers reported the quality of the mentored students' school work improved.

To understand these apparently contradictory findings, it is important to note that the earlier evaluation answered the question, "What effect does a well-run, school-based mentoring program have?" The more recent evaluation answered the question, "What effect does the average school-based mentoring program have?" Findings from both studies reveal that strong programs can improve academic performance, while programs that do not incorporate best practices cannot. Interestingly, both types of programs have increased attendance.

School-based mentoring was never designed to be a program that primarily improved academic achievement. Mentoring aims more broadly to keep children on a constructive, responsible path (such as encouraging behaviors like coming to school and following the rules). Mentors are not supposed to be teachers, but friends and role models. Even so, the earlier evaluation did show that well-run programs improved academic performance and behavior by the end of the school year.

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.

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, which is linked to higher levels of classroom engagement and higher grades.

—School-based mentoring enhances connectedness to schools, peers and society, and mentored youth have more positive attitudes toward school and teachers;

—Evaluations of mentoring programs indicated that both one-to-one mentoring and group mentoring result in better school attendance for mentored youth;

—Mentored youth experience improvements in parental relationships and their own sense of self-worth; and

—Mentored youth are significantly less likely to participate in high-risk behaviors, including substance abuse, carrying a weapon, unsafe sex, and violent behaviors.

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.

These are tough economic times that warrant tough decisions. However, rather than eliminating or cutting funding for school-based mentoring, Congress and the administration could restrict the funding to programs that truly incorporate best practices—the kind of programs that have been shown to produce results. MENTOR recommends that the request for proposals issued for the program be revisited to ensure that it focuses on the key functions mentoring programs must perform and their adherence to The Elements of Effective Mentoring Practice—research-based industry standards now in their third edition. These standards work to ensure that programs do their utmost to ensure that mentoring does, in fact, work for America's young people by providing the best mentoring experience possible. Within the Elements, Program Design and Planning includes comprehensive guidelines to launch an effective new mentoring initiative. Program Management and Program Operations contain guidelines for managing and implementing the many elements of a new program or fine-tuning certain elements for an established program. Program Evaluation provides guidance for analyzing a program to ensure it is safe, effective and able to meet its goals. It is important to ensure that funding is going to high-quality programs with real potential to make a difference, rather than dismantle a strong infrastructure for service that is now in place in thousands of American schools.

Thus, MENTOR recommends that $50 million once again be provided to the Department of Education's Mentoring Programs grants in fiscal year 2010. Some of this funding is needed to simply support commitments already made to existing grantees. All grants awarded under this program are 3-year projects and require continued appropriations. We also expect new grants to be made out of fiscal year 2009 funding, approved at $48.5 million. Those organizations that see their funding terminate early would likely have to downsize or even close. This would likely result in the premature end to hundreds—if not thousands—of mentoring relationships. Research shows that when mentoring relationships terminate unexpectedly, it can have a detrimental impact on the child.

Besides the immediate 1-year impact, the elimination of this program will mean the end of the only authorized Federal program specifically focused on providing mentors for young people at risk of failing academically—this is not a function that is duplicated in many programs more than 13 different agencies as the President mentioned in February. In the 7 years the program has been in existence, more than 600 grants have been awarded to local mentoring programs in every State, including rural, suburban, and urban settings. These grants have totaled nearly $300 million. At the average per-child mentoring cost of $1,500 per year, this means that approximately 200,000 young people are benefiting from a mentoring relationship that otherwise likely would not have been possible.

To conclude this portion of my testimony, we respectfully request that Congress provide $50 million each for the Department of Education Mentoring Programs grants and the Department of Health and Human Services Mentoring Children of Prisoners program.

The Call to Fund Service.—MENTOR joined the strong ranks of community organizations delighted when the Edward M. Kennedy Serve America Act became law last week. With significant, bi-partisan support, this legislation provides for the largest expansion of national and community service since the 1930s and expands major initiatives, such as AmeriCorps and the Retired Senior Volunteer Program, which emerged during the course of the past 20 years. The legislation also includes key new provisions that recognize mentoring as an important form of national and community service and support its growth.

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, 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 2010 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. 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.

CONCLUSION

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.

LETTER FROM MAUI FAMILY SUPPORT SERVICES

Wailuku, HI, May 12, 2009.

Hon. TOM HARKIN,
Chairman, Subcommittee on Labor, Health and Human Services, and Education, and Related Agencies, Washington, DC.

I write to express support for increased funding for the Child Abuse Prevention and Treatment Act (CAPTA) programs. We propose to increase CAPTA basic State grant funding to $84 million, community-based prevention grants funding to $80 million, and research and demonstration grants funding to $37 million in fiscal year 2010.

CAPTA's title II authorizes grants to States to help develop community-based prevention services to support families, including parenting education classes, home visiting services, respite care, as well as family resource centers to connect families and children to the services they need. While we spend billions of dollars every year on foster care to protect the children who have been the most seriously injured, we can do a much better job at protecting children before the damage is so bad that we have no other choice than to remove them from their homes. Community prevention services to at-risk families are far less costly than the damage inflicted on children from abuse and neglect. Increasing for CAPTA prevention grants to $80 million would help communities support proven, cost-effective approaches to preventing child abuse and neglect.

It is extremely important that we give the highest priority to the children of this Nation for they are the most vulnerable population that needs protection and support to grow into a well-balanced, healthy, and productive citizenry.

Thank you for your time and consideration.

AVE DIAZ,
Healthy Start Home Visiting Supervisor.

PREPARED STATEMENT OF THE NATIONAL ASSOCIATION OF ANOREXIA NERVOSA AND ASSOCIATED DISORDERS

Founded in 1976, the National Association of Anorexia Nervosa and Associated Disorders (ANAD) is our Nation's first nonprofit organization dedicated to education, early detection, and prevention of anorexia nervosa, bulimia nervosa, binge eating disorder, obesity, and related eating disorders.

Eating disorders are severe mental illnesses which often have significant physical health consequences for their victims, including malnutrition, obesity, and diabetes, as well as death due to cardiac arrest, organ failure, blood imbalances, and suicide. Anorexia nervosa has the highest mortality rate of any mental illness. An estimated 6 percent of those who have the disease die as a result. These disorders also frequently lead to or co-occur with other serious illnesses such as severe depression, alcoholism, and drug abuse.

Eating disorders are at epidemic levels in America. An estimated 7 million women and 1 million men have eating disorders. These illnesses affect all segments of society—the young and old, the rich and poor, and all races and ethnicities, including African Americans, Asian Americans, Latino Americans, and Native Americans. But this is an epidemic that can be averted with education and prevention programs, and cured with early diagnosis and appropriate treatment.

Data from an ANAD survey of 18 middle and high schools in 15 States indicates that eating disorders are almost as prevalent as alcohol or drug problems among female middle school and high school students. The survey also indicates that our schools are spending far less time on eating disorder prevention than on alcohol or drug prevention programs. Seventeen percent of the schools surveyed spent 1 hour

per year on eating disorder education. Eleven percent of the schools surveyed had no eating disorder prevention program of any kind.

The failure to fund eating disorder education and prevention in schools is especially troubling in light of the fact that eating disorders are often accompanied by or lead to alcoholism or drug addiction, as well as diabetes, severe depression, and suicide.

Tens of millions of dollars are spent each year at the local, State, and Federal levels to ensure that our children are properly educated to the dangers of alcohol and drugs. The value of such programs has been proven and accepted in schools throughout the country. With eating disorders almost as prevalent as alcohol and drug abuse in our schools, it is imperative that we provide more support for eating disorder prevention efforts in our middle schools and high schools. Millions of our youth can benefit from proven, low-cost educational and preventive measures that help faculty and students to understand and avoid the dangers of eating disorders.

Eating disorder research into the underlying causes and risk factors associated with eating disorders is just as important as education and prevention. As we continue to learn more about underlying causes, risk factors and predictors through medical research, it will undoubtedly improve the efficacy of our education and prevention efforts.

Based on the foregoing, ANAD respectfully makes this request of the subcommittee with regard to funding priorities for fiscal year 2010. Millions of our youth can benefit from proven, low-cost services that assist students to understand and avoid the dangers of eating disorders. Programs, such as those provided by ANAD's Eating Disorders and Obesity Education/Prevention Program for Middle and High Schools, promote the elements of a healthy lifestyle: self-acceptance, a good diet, adequate exercise and sufficient sleep.

Given the troubling lack of education and prevention in our schools, ANAD respectfully requests $4 million or $75.00 per school be allocated to place these life-enhancing programs in every middle and high school in the United States. This $4 million in funds is above and beyond the current request in the administration's proposed budget, for the Department of Education's Safe and Drug-Free Schools programs to provide grants for eating disorder prevention and education programs in our Nation's middle schools and high schools.

Eating disorders cause serious physical problems that can last a lifetime. They rob people of their ability to function as productive members of society because, if not properly treated, victims of these illnesses find themselves requiring more and more costly medical services throughout their lives. With early education and detection, eating disorders are treatable and at a much lower economic and personal cost to society.

SUMMARY OF ANAD EATING DISORDERS STUDY

Data from a 2005 ANAD study shows that eating disorders are almost as prevalent as alcohol or drug problems in middle and high school female students. The study also shows that far less time is spent on eating disorder prevention than on alcohol or drug prevention programs.

This is especially significant since eating disorders are often accompanied by or lead to severe depression, suicidal tendencies, self-mutilation, or diabetes. Many victims become alcohol or drug addicted.

Eating disorders cause great suffering for victims and families and are expensive to treat. Anorexia nervosa has the highest mortality rate of any mental illness. An estimated 6 percent of all anorexics die from an eating disorder or from complications from their disorder. However, these very dangerous illnesses can be cured and prevented.

Eight middle schools and 10 high schools from 15 States were surveyed for this study.

Incidence of Alcoholism, Drugs, and Eating Disorders in Schools

Nine point eight percent of girls have problems with alcohol; 8 percent of girls have problems with drugs; and 7.8 percent of girls have problems with eating disorders.

Time Devoted to Education/Prevention

Time devoted to Alcohol Education/prevention—12.3 percent; time devoted to Drugs Education/Prevention—13.8 percent; and time devoted to Eating Disorders Education/prevention—6.2 percent.

Three schools reported 1 hour per year was spent on eating disorders education and two schools reported that they did not have any program.

PREPARED STATEMENT OF THE NATIONAL ASSOCIATION OF COUNTY AND CITY HEALTH OFFICIALS

The National Association of County and City Health Officials (NACCHO) represents the Nation's approximately 2,860 local health departments (LHDs). These governmental agencies work every day in their communities to prevent disease, promote wellness, and protect health. They organize community partnerships and facilitate community conversations to create the conditions in which people can be healthy. The work of local health departments and NACCHO improves economic well-being, educational success, and nationwide competitiveness community by community.

The current H1N1 influenza cases in the United States could signal the onset of the next pandemic. State and local public health agencies are actively engaged in outbreak investigation, control and response activities to control the virus' spread and minimize illness and death. NACCHO appreciates the past support of the subcommittee for public health emergency preparedness and urges the subcommittee to provide the necessary resources so that State and local health departments are able to respond to all hazards, including a possible resurgence of pandemic influenza in the fall.

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 local health departments to play this role well. A LHD is the only local governmental entity that works from a population-wide perspective. LHDs have statutory powers which enable their role and enshrine a duty to serve every person and household in their jurisdiction.

Funding to local health departments continues to be inadequate and many people in the United States suffer from conditions whose causes are preventable, whose costs for treatment are unsustainable into the future, and whose treatment is of erratic quality, effectiveness and efficiency. One clear, measured result is that the United States is not the healthiest Nation in the world despite higher per capita expenditures than any other Nation.

The Nation's current recession further diminishes the ability of local health departments to measure population-wide illness and death, organize efforts to prevent disease and prolong quality of life, and to serve the public through organized programs not offered elsewhere. Repeated rounds of budget cuts and layoffs in LHDs continue to erode capacity. Reductions in local and State tax bases further undermine these sources of support. A NACCHO survey found that in 2008, at least 7,000 LHD jobs were lost in 46 States across the country. Far more are expected this year and many LHDs are currently reporting budget cuts in the 20 to 40 percent range.

Protections people take for granted—from enforcement of rules requiring safe food in restaurants and schools to early identification of disease outbreaks to the expectation that their LHD will examine, discover, and take action—are disappearing. In economic hard times, people are more dependent than ever on their local health departments. Programs offered by LHDs serve as a safety net for people in communities where the numbers of unemployed, uninsured, and underinsured are growing daily, compounding the numbers of formerly working adults who need care.

NACCHO's recommendations focus on the Centers for Disease Control and Prevention (CDC) and the Health Services and Resources Administration (HRSA). Consistent funding with growth over time is needed. NACCHO recommends an overall funding level for CDC of $8.6 billion not including funding for Vaccines for Children.

CHRONIC DISEASE PREVENTION AND HEALTH PROMOTION

Preventive Health and Health Services Block Grant

NACCHO recommends: Not less than fiscal year 2005 funding of $131 million. Local public health departments receive approximately 40 percent of the Preventive Health and Health Services block grant (PHHS) nationally. The proportion received by local health departments varies among states from less than five percent to almost 100 percent. Increasing the availability of flexible funds is particularly important as the gaps in public health protections grow.

PHHS funds enable States to address critical unmet public health needs. Improving chronic disease prevention through screening programs and programs that promote healthy nutrition and physical activity are prime examples of activities to which many jurisdictions devote PHHS funds. Population-based strategies which create the conditions in which people are more likely to be healthy are also supported with these funds. Flexible PHHS funds allow local priorities and unexpected problems to be addressed. West Nile virus, a fully preventable disease spread to humans by mosquitoes, is one good example. Finally, PHHS funds provide leverage for additional support from non-Federal sources.

NACCHO also recommends that the subcommittee include language with the appropriations bill which would require concurrence of LHDs with State public health officials in the uses for and distribution of these funds. Such language has been instrumental in the effective use of preparedness funds, assuring that a reasonable proportion of funds help local communities.

EMERGENCY PREPAREDNESS

Public Health Emergency Preparedness Cooperative Agreement

NACCHO recommends not less than fiscal year 2005 funding of $919 million. Federal funding for improving State and local public health emergency preparedness has stalled for the past several years and is substantially down from $919 million in fiscal year 2005 to $746 million in the fiscal year 2009 omnibus appropriations bill. Local health departments successfully responded to the outbreak of H1N1 influenza this spring, but a sustained epidemic would further tax resources and stretch the capacity of local health professionals to respond adequately to the influenza outbreak as well as other responsibilities in the areas of infectious and chronic disease.

Last year more than 25 percent of LHDs reduced their preparedness activities, delayed completion of plans, and/or delayed acquisition of equipment and supplies as a result. Constant readiness for both new and emerging threats requires staff, plans, training and practice, all of which require financial support. The benefits to safety and well-being of local communities are clear when LHDs are prepared and work effectively with their communities to be prepared for all hazards. Reduction in Federal financial support has reduced readiness and the capacity to respond to emergencies.

ADVANCED PRACTICE CENTERS

NACCHO recommends level funding of $5.3 million plus inflation adjustment. NACCHO appreciates the past support of the subcommittee for the Advanced Practice Centers program. The Advanced Practice Center (APC) program funded through CDC provides funds to seven local health departments to develop innovative field-tested tools and models to help other LHDs meet emergency preparedness goals. The APCs are located in Santa Clara County, California; Cambridge, Massachusetts; Montgomery County, Maryland; Twin Cities Metro, Minnesota; Western New York Public Health Alliance; Tarrant County, Texas and Public Health—Seattle and King County, Washington. The 70 unique preparedness tools produced to date by the APCs have become essential instruments that LHDs nationwide routinely employ to assess their vulnerability, strengthen their response capacity, and enhance the resilience of their communities and workforce. The APC network provides a national learning laboratory that creates tools, resources, and technical guidance that can be used for all LHDs and that align with public health preparedness priority areas.

PUBLIC HEALTH WORKFORCE

NACCHO recommends $10 million new funding. The shortages in the public health workforce have been well-documented, particularly in public health nursing, epidemiology, laboratory science, and environmental health. The Nation's wellness depends on a continuing supply of people for this workforce. Additional funding and leadership is required to support a program of training, continuing education, and education for the full range of public health professions and community workers. Section 765 of the Public Health Service Act authorizes grants that would allow State and local health departments to provide training and trainee support. Funds have never been appropriated for this purpose.

EMERGENCY PREPAREDNESS WORKFORCE

NACCHO recommends $10 million new funding. Workforce shortages also exist in the area of public health preparedness. In 2006, the Pandemic and All-Hazards Preparedness Act created two new programs within the National Health Service Corps (NHSC) in the Health Resources and Services Administration, yet no funding was appropriated for these programs. Funding would allow expansion of the NHSC on a trial basis to include loan repayment for individuals who complete their service in a State, local, or tribal health department that serves health professional shortage areas or areas at risk of a public health emergency. The second program establishes grants to States to create loan repayment programs. These programs are essential to ensure a workforce trained to carry out specialized tasks in preparedness.

PREPARED STATEMENT OF THE NATIONAL ALLIANCE TO END HOMELESSNESS

The National Alliance to End Homelessness (the Alliance) is a nonpartisan, nonprofit organization that has several thousand partner agencies and organizations across the country. These partners include local faith-based and community-based nonprofit organizations and public sector agencies that provide homeless people with housing and services such as substance abuse treatment, job training, and physical health and mental healthcare. The Alliance represents a united effort to address the root causes of homelessness and challenge society's acceptance of homelessness as an inevitable byproduct of American life.

SUMMARY OF APPROPRIATIONS GOALS

Moving Forward To End Homelessness.—Communities are using Federal, State, and local funds to help homeless persons maintain housing. Especially during the current economic recession, it is important that this progress not be undermined. To this end, the Alliance recommends the following:

—Allocate $120 million for services for people experiencing homelessness within the Programs of Regional and National Significance accounts of both Substance Abuse and Mental Health Services Administration's (SAMHSA) Center for Mental Health Services and Center for Substance Abuse Treatment.

—Increase funding for the Projects for Assistance in Transition from Homelessness (PATH) program to $75 million.

—Increase funding for the Runaway and Homeless Youth Act (RHYA) Programs to $165 million.

—Provide $2.602 billion in the Community Health Center program within the Health Resource Services Administration (HRSA). This would result in $226.3 million for the Health Care for the Homeless (HCH) program, a $36 million increase from fiscal year 2009.

—Fund Education for Homeless Children and Youth (EHCY) services at $210 million.

—Increase funding for the Homeless Veterans Reintegration Program to $50 million, its authorized level.

Connecting Homeless Families, Individuals, and Youth to Mainstream Services

People experiencing homelessness also depend on mainstream programs. The Alliance recommends the following to meet this goal:

—Fund the Social Services Block Grant (SSBG) program at $2.3 billion.

—Fund the Community Services Block Grant (CSBG) program at $725 million.

—Appropriate $60 million in education and training vouchers for youth exiting foster care under the Safe and Stable Families Program.

—Fund the Community Mental Health Services Performance Partnership Block Grant at $486.9, a $66.1 million increase.

—Fund the Substance Abuse Prevention and Treatment Block Grant at $1.929 billion, a $150 million increase more than fiscal year 2009.

BACKGROUND

Our 2009 report, Homelessness Counts: Changes in Homelessness from 2005 to 2007, estimates that 671,859 people are homeless on any given night. This includes 248,511 persons in families and 423,348 individuals. Eighteen percent of all homeless people are defined as chronically homeless; these are people who have a disability and who have been homeless repeatedly or continuously for 12 months. These numbers are based on homeless counts performed in 2007, prior to the current economic recession. Compared to 2005, there were decreases across the country resulting in a 10 percent overall decline in homelessness. Anecdotal evidence suggests there could be increases in homelessness as communities report the results of their 2009 counts. To help stave off drastic increases in homelessness, we need Congress to invest in what we know works. Successful interventions for all homeless populations couple housing with an appropriate level of services for the family or individual. We call on Congress to adequately fund programs that assist States and local entities in developing permanent housing and the necessary social services to end homelessness for all Americans.

DETAILED PROGRAM DESCRIPTIONS

Goal No. 1—Moving Forward To End Homelessness

Support Services for Permanent Supportive Housing Projects

The Alliance 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.

PATH

The Alliance 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, Medicaid, and welfare programs. 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.

RHYA PROGRAMS

The Alliance recommends funding the RHYA programs at $165 million. RHYA programs support cost effective, community- and faith-based organizations that protect youth from the harms of life on the streets. The RHYA programs can either reunify youth safely with family or find alternative living arrangements. RHYA programs end homelessness by engaging youth living on the street with Street Outreach Programs, quickly providing emergency shelter and family crisis counseling through the Basic Centers, or providing supportive housing that helps young people develop lifelong independent living skills through Transitional Living Programs. Recently, the Congressional Research Service issued a report complimenting the good work of RHYA programs but detailing the gaps in services due to limited funding. For example, only one-tenth of the youth who connect with a RHYA program are able to receive services. It is essential that Congress increase this program.

COMMUNITY HEALTH CENTERS AND HCH PROGRAMS

The Alliance recommends $2.602 billion in the Community Health Center program within HRSA. This would result in $226.4 million for the HCH program, a $36 million increase more than fiscal year 2009. 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. Healthcare for 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.

EDUCATION FOR HOMELESS CHILDREN AND YOUTH (EHCY)

The Alliance recommends funding EHCY at $210 million. The most important potential source of stability for homeless children is school. The mission of the EHCY program is to ensure that these children can continue to attend school and thrive. EHCY, within the Department of Education's Office of Elementary and Secondary Education, removes obstacles to enrollment and retention by establishing liaisons between schools and shelters and providing funding for transportation, tutoring, school supplies, and the coordination of statewide efforts to remove barriers.

HOMELESS VETERANS REINTEGRATION PROGRAM (HVRP)

The Alliance recommends that Congress increase HVRP funding to $50 million. HVRP, which is within the Department of Labor's Veterans Employment and Training Service (VETS), provides competitive grants to community-based, faith-based, and public organizations to offer outreach, job placement, and supportive services to homeless veterans. HVRP is the primary employment services program accessible by homeless veterans and is the only targeted employment program for any homeless subpopulation. It is estimated that this program only reaches about two percent of the overall homeless veteran population. An appropriation at the authorized level of $50 million would enable HVRP grantees to reach approximately 19,866 homeless veterans.

Goal No. 2—Connecting Homeless Families, Individuals and Youth to Mainstream Services

SOCIAL SERVICES BLOCK GRANT (SSBG)

The Alliance recommends that Congress increase SSBG funding to $2.3 billion. SSBG funds are essential for programs dedicated to ending homelessness. In particular, youth housing programs and permanent supportive housing providers often receive State, county, and local funds which originate from the SSBG. As the Department of Housing and Urban Development has focused its funding on housing, programs that provide both housing and social services have struggled to fund the service component of their programs. This gap is often closed using Federal programs such as SSBG.

COMMUNITY SERVICES BLOCK GRANT (CSBG)

The Alliance recommends that Congress rejects cuts and fund CSBG at $725 million. Funding cuts for CSBG will destabilize the progress communities have made toward ending homelessness by not only ending services directly provided by CSBG funds but limiting a community's ability to access other Federal dollars, such as those provided by the Department of Housing and Urban Development. Community Action Agencies (CAAs), which are the primary local recipients of CSBG funding, are directly involved in housing and homelessness services. In several communities, CAAs lead the Continuum of Care (CoC). CoCs coordinate local homeless service providers and the community's McKinney-Vento Homeless Assistance Grant application process with the Department of Housing and Urban Development.

In the fiscal year 2006 Community Services Block Grant Information Systems report published by the U.S. Department of Health and Human Services, CAAs reported expending approximately $42 million on housing-related services. In addition, approximately $50 million was spent nationwide on youth services, some of which related to housing. States reported that 180,000 clients served with CSBG funds were homeless.

FOSTER YOUTH EDUCATION AND TRAINING VOUCHERS

The Alliance recommends that Congress appropriate $60 million in education and training vouchers for youth exiting foster care under the Safe and Stable Families Program. The Education and Training Voucher Program offers funds to foster youth and former foster youth to enable them to attend colleges, universities, and vocational training institutions. Students may receive up to $5,000 a year for college or vocational training education. The funds may be used for tuition, books, housing, or other qualified living expenses. Given the large number of people experiencing homelessness who have a foster care history, it is important to provide assistance such as these education and training vouchers to stabilize youth, prevent economic crisis, and prevent future homelessness.

COMMUNITY MENTAL HEALTH PERFORMANCE PARTNERSHIP BLOCK GRANT

The Alliance 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

The Alliance recommends 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 NATIONAL ALLIANCE FOR EYE AND VISION RESEARCH

National Alliance for Eye and Vision Research (NAEVR) requests a fiscal year 2010 National Institute of Health (NIH) funding increase of at least 7 percent, to a level of $32.4 billion, which represents a modest 3 percent increase plus the biomedical inflation rate, estimated at 3.8 percent in fiscal year 2009. This increase is necessary to keep pace with inflation and rebuild the base, since NIH has lost 14 percent of its purchasing power during the past 6 funding cycles.

NAEVR commends the congressional leadership's actions in fiscal year 2008 and 2009 to increase NIH funding, including the $150 million in the fiscal year 2008 supplemental dedicated to investigator-initiated grants, the $10.4 billion in 2-year stimulative NIH funding within the American Recovery and Reinvestment Act (ARRA), and the final fiscal year 2009 appropriations inflationary increase of 3.2 percent. However, NIH needs sustained and predictable funding to rebuild its base and support multi-year, investigator-initiated research, which is the cornerstone of the biomedical enterprise. Annual increases of at least 7 percent put NIH on a pathway to budget-doubling within the next 10 years. Secure and consistent funding for biomedical research is integral to the Nation's economic and global competitiveness. NIH is a world-leading institution that must be adequately funded so that its research can reduce healthcare costs, increase productivity, and save and improve the quality of lives.

NAEVR requests that Congress make vision health a top priority by increasing National Eye Institute (NEI) funding by at least 7 percent, to a level of $736 million, in this year that NEI celebrates its 40th anniversary. Over the past 6 funding cycles, NEI lost 18 percent of its purchasing power. Despite funding challenges, NEI has maintained its impressive record of breakthroughs in basic and clinical research that have resulted in treatments and therapies to save and restore vision and prevent eye disease. NEI will be challenged further, as 2010 begins the decade in which more than half of the 78 million baby boomers will turn 65 and be at greatest risk for developing aging eye disease. Adequately funding the NEI is a cost-effective investment in our Nation's health, as it can delay, save, and prevent expenditures, especially to the Medicare and Medicaid programs.

Fiscal year 2010 funding at $736 million enables NEI to expand its impressive record of basic and clinical collaborative research that has resulted in treatments and therapies to save and restore vision.

NEI continues to be a leader in basic research—especially that which elucidates the genetic basis of ocular disease—and in translational research, as those gene discoveries can lead to development of diagnostics and treatments. NEI Director Paul Sieving, M.D., Ph.D., has reported that one-quarter of all genes identified to date through NEI's collaboration with the National Human Genome Research Institute (NHGRI) are associated with eye disease/visual impairment. Recent examples include:

—In 2005, NEI reported that gene variants of Complement Factor H (CFH), the protein product of which is engaged in the control of the body's immune response, are associated with increased risk of developing age-related macular degeneration (AMD), the leading cause of vision loss. NEI-funded researchers are now working on potential therapies, including the manufacture and use of a protective version of the CFH protein in an augmentation strategy similar to that of treating diabetes with insulin. This therapy is under development and expected to enter phase I clinical safety trials in summer 2009.

—In March 2008, NEI-funded researchers announced that damage from both AMD and diabetic retinopathy was prevented and even reversed when the protein Robo4 was activated in mouse models that simulate the two diseases. Robo4 treated and prevented the diseases by inhibiting abnormal blood vessel growth and by stabilizing blood vessels to prevent leakage. Since this research into the "Robo4 Pathway" used animal models associated with these diseases that are already used in drug development, the time required to test this approach in humans could be shortened, expediting approvals for new therapies

—In late April 2008, researchers funded by the NEI and private funding organization Foundation Fighting Blindness reported on their use of gene therapy to restore vision in young adults who were virtually blind from a severe form of the neurodegenerative disease Retinitis Pigmentosa, known as Leber Congenital Amaurosis (LCA). Seven years earlier, the researchers shared on Capitol Hill results of a preclinical study of the same gene therapy, which at the time was successfully giving vision to dogs born blind with LCA. The subsequent human gene therapy trial validated the process of putting genes in the body to restore vision. Although the primary goal of the phase I study was to ensure patient safety, the researchers reported through both objective and subjective testing that the patients were able to read several lines on an eye chart, had better peripheral vision, and better eyesight in dimly lit settings. In further research, the investigators will treat LCA patients as young as 8 years old, since they believe the most dramatic results will be seen in young children.

—In late 2008, NEI initiated its new NEI Glaucoma Human genetics collaBORation, known as NEIGHBOR, through which seven U.S. research teams will lead genetic studies of the disease. Glaucoma is called the "stealth robber of vision" as it often has no symptoms until vision is lost, and anywhere from 50–75 percent of individuals with it are undiagnosed. It is also the leading cause of preventable vision loss in African-American and Hispanic populations, which emphasizes the vital nature of determining the genetic basis of this disease.

FISCAL YEAR 2010 FUNDING AT $736 MILLION ENABLES NEI TO FULLY FUND NEW INITIATIVES THAT MORE FULLY CHARACTERIZE EYE DISEASE

NEI has been a leader in collaborative research, the use of networks to study diagnostics and treatments and their use in clinical settings, and in ocular epidemiology to characterize the nature and frequency of eye disease in diverse populations to better manage pubic health. In fiscal year 2008, NEI reported on/launched the initial phase of three important new programs to characterize eye disease requiring adequate future funding.

—In early 2009, the NEI and the National Aeronautics and Space Administration (NASA) reported on the use of a compact fiber optic probe developed for the space program that has proven valuable as the first noninvasive early detection device for cataracts, the leading cause of vision loss worldwide. Using a laser light technique called dynamic light scattering (DLS), which was developed to analyze the growth of protein crystals in a zero-gravity environment, the probe measures the amount of light scattering by an anti-cataract protein called alpha-crystallin. The probe senses protein damage due to oxidative stress, a key process involved in many medical conditions including age-related cataract and diabetes, as well as Alzheimer's and Parkinson's disease.

—In late 2008, NEI launched a new research network, the Neuro-Ophthalmology Research Disease Investigator Consortium, or NORDIC. It will initially lead multi-site observational and treatment trials, involving nearly 200 community and academic practitioners, to address the risks, diagnosis, and treatment of two "rare" diseases: idiopathic intracranial hypertension (visual dysfunction due to increased intracranial pressure) and thyroid eye disease (also called Graves' disease, in which muscles of the eye enlarge and cause bulging of the eyes, retraction of the lids, double vision, decreased vision, and irritation). The NEI and NORDIC's principal investigator have already begun coordinating with the Department of Defense's (DOD) newly established Vision Center of Excellence (VCE) about the applicability of NORDIC research to combat-related eye injuries, especially those associated with Traumatic Brain Injury (TBI).

—There is currently almost no information on the prevalence, risk factors, and genetic determinants in Asian Americans—one of the fastest growing racial groups in the United States. Studies from East Asia have suggested that Asians have a spectrum of eye diseases different from that of White Americans, African Americans, and Hispanics. In late 2008, NEI launched the Chinese American Eye Study to characterize the extent of eye disease in Chinese Americans, the largest Asian sub-group in the United States. Participants 50 years and older will be evaluated for blindness, visual impairment, and eye disease. These results will add to the expanding body of knowledge about vision health disparities already characterized by NEI in the African-American and Hispanic populations.

VISION IMPAIRMENT/EYE DISEASE IS A MAJOR PUBLIC HEALTH PROBLEM THAT INCREASES HEALTHCARE COSTS, REDUCES PRODUCTIVITY, AND DIMINISHES QUALITY OF LIFE

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.

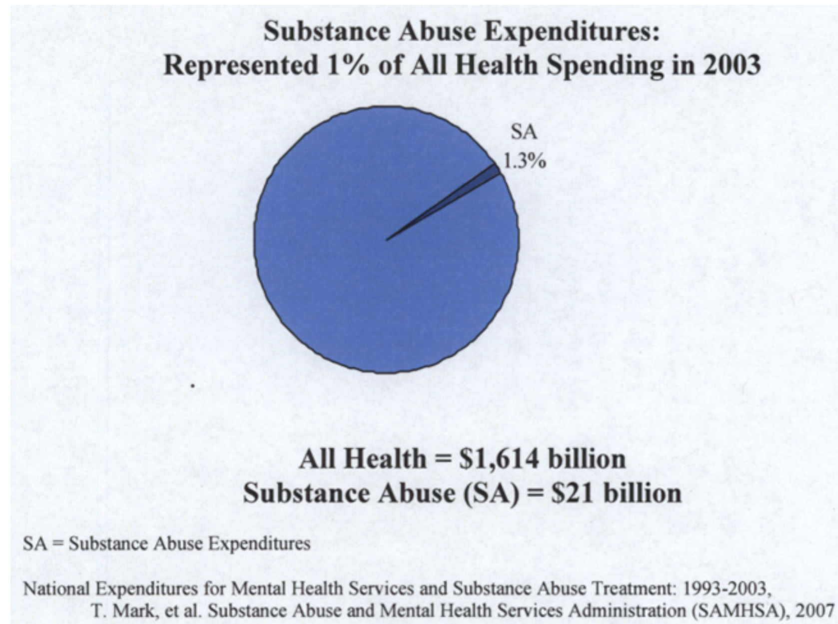
Although the NEI estimates that the current annual cost of vision impairment and eye disease to the United States is $68 billion, this number does not fully quantify the impact of direct healthcare costs, lost productivity, reduced independence, diminished quality of life, increased depression, and accelerated mortality. The continuum of vision loss presents a major public health problem and financial challenge to the public and private sectors.

In public opinion polls over the past 40 years, Americans have consistently identified fear of vision loss as second only to fear of cancer. As recently as March 2008, the NEI's Survey of Public Knowledge, Attitudes, and Practices Related to Eye Health and Disease reported that 71 percent of respondents indicated that a loss of their eyesight would rate as a "10" on a scale of 1 to 10, meaning that it would have the greatest impact on their day-to-day life.

In 2009, the NEI will celebrate its 40th anniversary as the NIH Institute that leads the Nation's commitment to save and restore vision. During the next decade, more than half of the 78 million baby boomers will celebrate their 65th birthday and be at greatest risk for developing aging eye disease. As a result, sustained, adequate Federal funding for the NEI is an especially vital investment in the health, and vision health, of our Nation as the treatments and therapies emerging from research can preserve and restore vision. Adequately funding the NEI can also delay, save, and prevent health expenditures, especially those associated with the Medicare and Medicaid programs, and is, therefore, a cost-effective investment.

NAEVR urges fiscal year 2010 NIH and NEI funding at $32.4 billion and $736 million, respectively, reflecting an at least 7 percent increase more than fiscal year 2009.

PREPARED STATEMENT OF THE NATIONAL ASSOCIATION OF STATE ALCOHOL AND DRUG ABUSE DIRECTORS



Chairman Harkin, Ranking Member Cochran, members of the subcommittee, on behalf of the National Association of State Alcohol and Drug Abuse Directors (NASADAD), and our component organizations, the National Prevention Network, and the National Treatment Network, thank you for your leadership on issues related to addiction. I am Flo Stein, NASADAD President and member from North Carolina. I am pleased to present testimony regarding fiscal year 2010 funding priorities.

Scope of the Problem.—According to the Substance Abuse and Mental Health Services Administration's (SAMHSA) National Survey on Drug Use and Health (NSDUH), approximately 23.2 million Americans aged 12 or older needed services for an alcohol or illicit drug problem in 2007. During the same year, approximately 2.4 million received treatment for such a problem at a specialty facility. As a result, approximately 20.8 million people needed but did not receive services in 2007 in a specialty facility.

Substance Abuse Spending Represents a Tiny Fraction of all Health Expenditures.—Substance abuse expenditures represented 1.3 percent of all healthcare expenditures in 2003 ($21 billion for substance abuse compared to $1,614 billion for all health expenditures). Using inflation adjusted terms, the growth rate for all health spending from 1993 to 2003 was 4.6 percent, while the growth rate for substance abuse spending during this same time period was 1.4 percent.

Yet Addiction is Associated With Many Other Diseases.—In a 2004 study appearing in the Journal of the American Medical Association (JAMA), researchers examined "actual causes of death" defined by the Centers for Disease Control and Prevention (CDC) as factors that contribute to leading killers such as heart disease, cancer and stroke. The study identified nine leading "actual causes of death." Tobacco, alcohol and illicit drugs—killing 530,000 Americans in 2000—were 3 of the top 9. The others were diet/weight; microbial agents; toxic agents; motor vehicles; firearms and sexual behaviors.

Unaddressed Substance Abuse Problems are Costly.—As noted in SAMHSA's National Expenditures for Mental Health Services and Substance Abuse Treatment, 1993–2003 (2007), when substance abuse spending was $15.5 billion in 1998, the total economic costs of alcohol abuse were approximately $184.6 billion and the total economic costs for drug abuse were $143.4 billion (Harwood, 2000). These costs were

linked not only to medical consequences of alcohol/drug use, but also crime, lost earnings, motor vehicle crashes, and more.

Financial Investments in Addiction Services Save Taxpayer Dollars.—The National Institute on Drug Abuse (NIDA) notes that for every $1 spent on addiction treatment programs, there is an estimated $4 to $7 reduction in the cost of drug-related crimes. With some outpatient programs, total savings can exceed costs by a ratio of 12:1 (NIDA InfoFacts, 2006).

Maintain SAMHSA as Strong Agency.—NASADAD supports action to ensure that SAMHSA remains a unique, strong and vibrant agency. SAMHSA has demonstrated excellent leadership and collaboration—promoting innovative strategies to improve our service delivery system. NASADAD thanks Dr. Eric Broderick, Acting Administrator of SAMHSA, for his work. SAMHSA is to be commended and should be considered a vital voice in discussions related to health reform.

Top Priority for Fiscal Year 2010—Increase Funding for Substance Abuse Prevention and Treatment (SAPT) Block Grant.—NASADAD recommends $1,928.6 million for the SAPT Block Grant in fiscal year 2010—an increase of $150 million more than fiscal year 2009 and more than the President's request. Since 2007, as the economy and State budgets struggled, unemployment grew by 5.5 million. This is critical news for the SAPT Block Grant given that the NSDUH found unemployed persons need services at almost twice the rate as those with jobs. An increase in SAPT Block Grant funds would help our public treatment system to better serve this increased need on the part of the low-income and uninsured population.

Background.—The SAPT Block Grant, a program distributed by formula to all States and territories, serves our Nation's most vulnerable, low-income populations: those with HIV/AIDS, pregnant and parenting women, youth, and others. This vital program helps States and communities address their own unique needs—whether the problem is alcohol, methamphetamine, and prescription drug abuse or persons using multiples substances. The SAPT Block Grant represents approximately 40 percent of treatment expenditures by State substance abuse agencies across the country.

SAPT Block Grant Funded Services Achieve Results.—The SAPT Block Grant is an effective and efficient program that emphasizes accountability through the reporting of outcomes data. In particular, States have worked diligently with SAMHSA to implement the National Outcome Measures (NOMs) initiative. The SAMHSA/State partnership on NOMs promotes continuous quality improvement through a more systematic approach to data management and reporting. States now measure the impact of services on the use of alcohol and other drug use; employment; having stable housing; involvement with criminal activity; and efforts to live productively in the community. As noted by SAMHSA in 2008, SAPT Block Grant funded programs had positive results, where ". . . at discharge, clients have demonstrated high abstinence rates from both illegal drug (68.3 percent) and alcohol (73.7 percent) use."

In my own State of North Carolina, our Division of Mental Health, Developmental Disabilities and Substance Abuse Services reported 21,102 to treatment admissions in State fiscal year 2006/2007. In State fiscal year 2006/2007, North Carolina showed the following client outcomes at discharge: 82 percent were abstinent from alcohol use; 74 percent were abstinent from drug use; and 77 percent were involved in social support groups.

Important Prevention Funding Within SAPT Block Grant.—Twenty percent of the SAPT Block Grant is dedicated to funding much needed substance abuse prevention programming. In many States set-aside funding represents a large source of prevention funds for the agency. Overall, SAPT Block Grant funding represents 64 percent of State substance abuse agency prevention funding. In 21 States, the set-aside represents 75 percent or more of the agency's prevention budget.

The prevention set-aside has also helped produce demonstrable results. The Monitoring the Future (MTF) Survey found a 25 percent decline in any illicit drug use in the past month by 8th, 10th, and 12th graders combined between 2001 and 2008. As a result, there were 840,000 fewer teens using drugs in 2008 compared to 2001. A strong commitment to the SAPT Block Grant will ensure a strong commitment to much needed prevention services for our youth.

Recent History of SAPT Block Grant Funding.—NASADAD is thankful for the increase of $19.9 million for the SAPT Block Grant in fiscal year 2009. However, the program has suffered over the past few years: from fiscal year 2004 to fiscal year 2008, funding was cut by more than $20 million. In fact, it is estimated that the 2010 SAPT Block Grant appropriation would have to be increased by $403.7 million above the 2009 appropriation to maintain services at 2004 levels using the CPI–U as the proxy (Data courtesy of the New York State Office of Alcoholism and Sub-

stance Abuse Services (OASAS)]). As a result, NASADAD and others view an increase of $150 million as a down payment to make up for lost ground.

Center for Substance Abuse Treatment (CSAT).—NASADAD recommends $489.3 million in fiscal year 2010—an increase of $75 million compared to fiscal year 2009 and an increase of $29.3 million compared to the President's request. NASADAD acknowledges Dr. H. Westley Clark, Director of CSAT, for his excellent leadership.

NASADAD is thankful for the President's proposed $45.7 million increase for CSAT in fiscal year 2010. NASADAD is also thankful for an increase of $14.5 million for CSAT in fiscal year 2009. This increase reversed the previous administration's proposal to cut CSAT by $63 million. The fiscal year 2009 omnibus bill restored all or a portion of a number of NASADAD priority programs that were set to be eliminated.

Center for Substance Abuse Prevention (CSAP).—NASADAD recommends $276.3 million—an increase of $75 million compared to fiscal year 2009 and an increase of $77.7 million compared to the President's fiscal year 2010 request. NASADAD applauds the work of Fran Harding, Director of CSAP, for her work and dedication.

NASADAD appreciates the $6.8 million increase for CSAP in fiscal year 2009. Approving the fiscal year 2009 omnibus package restored funding for CSAP programs which were slated to be eliminated or reduced by the previous administration.

Safe and Drug Free Schools and Communities—State Grants.—NASADAD is extremely concerned with the President's proposal to eliminate or zero out the Safe and Drug Free Schools and Communities (SDFSC)—State Grants portion in fiscal year 2010.

NASADAD believes that the SDFSC State Grants program is an effective initiative that represents a core component of each State's substance abuse prevention system. The efficiency of the program can in part be attributed to principles of effectiveness that each grantee follows. These principles include (1) an assessment of the problem; (2) development of measurable goals and objectives; (3) implementation of effective programs and (4) assessment of program outcomes.

We believe the program also benefits from close collaboration with NASADAD members. In particular, certain Governors choose NASADAD members as the designee to manage these important funds. This designation allows for a more comprehensive and coordinated approach to planning and implementing an effective State-wide system of care.

NASADAD recommends $346.5 million, representing a $51.8 million increase more than fiscal year 2009 and representing a $346.5 million increase more than the President's fiscal year 2010 request for the program.

National Institute on Drug Abuse (NIDA).—NASADAD recommends $1,105.1 million for NIDA, representing a $59.3 million increase compared to the President's fiscal year 2010 request and a $72.3 million increase compared to fiscal year 2009. NASADAD wishes to thank Dr. Nora Volkow, Director of NIDA, for her collaboration with State substance abuse agencies through its "Blending Initiative." This work improves the translation of research into everyday practice.

National Institute on Alcohol Abuse and Alcoholism (NIAAA).—NASADAD recommends $481.7 million for NIAAA, which represents a $26.6 million increase compared to the President's fiscal year 2010 request and a $31.5 million increase compared to fiscal year 2009.

Prepared Statement of the National Association for State Community Services Programs

The National Association for State Community Services Programs (NASCSP), the national association representing State administrators of the Department of Health and Human Services' Community Services Block Grant (CSBG) and State directors of the Department of Energy's Low-Income Weatherization Assistance Program, would like to thank Congress for its continued support of the CSBG and requests an appropriation of $800 million for fiscal year 2010. We are requesting $800 million in CSBG funding for fiscal year 2010 to ensure the CSBG Network has adequate resources to sustain its expanded efforts to address the long-term needs of those families affected by the current economic recession and those transitioning from welfare to work. In addition, increased funding would enable the network to continue and strengthen its efforts to assist low-income workers in remaining at work through supportive services such as transportation and child care. The across the board cuts to the CSBG funding in past years have severely decreased the ability of the CSBG Network to provide and enhance essential services to low-income Americans. It is essential that the CSBG funding be increased for fiscal year 2010.

BACKGROUND

The States believe the CSBG is a unique block grant that has successfully transferred decisionmaking to the local level. Federally funded with oversight at the State level, the CSBG has maintained a local network of nearly 1,100 agencies which operate in 99 percent of counties in the Nation. This network serves nearly 16.2 million low-income individuals, members of more than 6.4 million low-income families, CSBG eligible entities, largely local Community Action Agencies (CAAs), provide States with a stable and guaranteed network of designated entities which are mandated to change the conditions that perpetuate poverty for individuals, families, and communities. There is no other program in the United States mandated by Federal statute to respond to poverty. To fulfill that mandate, CAAs provide services based on the characteristics of poverty in their communities. For one community, this might mean providing job placement and retention services; for another, developing affordable housing. In rural areas, it might mean providing access to health services or developing a rural transportation system.

Since its inception, the CSBG has shown how partnerships between States and local agencies benefit citizens in each State. We believe it should be viewed as a model of how the Federal Government can best promote self-sufficiency for low-income persons in a flexible, decentralized, nonbureaucratic, and accountable way.

Long before the creation of the Temporary Assistance for Needy Families (TANF) block grant, the CSBG set the standard for private-public partnerships that work to revitalize local communities and address the needs of low-income residents. Family oriented, while promoting economic development and individual self-sufficiency, the CSBG relies on an existing and experienced community-based service delivery system of CAAs and other nonprofit organizations to produce results for its clients.

WHAT DO LOCAL CSBG AGENCIES DO?

One thing that is common to all CAAs is the goal of self-sufficiency for all of their clients. But, since CAAs operate in rural areas as well as in urban areas, it is difficult to describe a typical CAA. Most CAAs will provide some, if not all, of the services listed below:

—a variety of crisis and emergency safety net services;
—employment and training programs;
—transportation and child care for low-income workers;
—individual development accounts;
—micro business development help for low-income entrepreneurs;
—local community and economic development projects;
—housing, transitional housing, and weatherization services;
—Head Start;
—energy assistance programs;
—nutrition programs;
—family development programs; and
—senior services.

CSBG is the core funding which holds together a local delivery system able to respond effectively and efficiently, without a lot of red tape, to the needs of individual low-income households as well as to broader community needs. In addition, CSBG funds many of these services directly. Without the CSBG, local agencies would not have the capacity to work in their communities developing local funding, private donations and volunteer services and running programs of far greater size and value than the actual CSBG dollars they receive.

CAAs manage a host of other Federal, State, and local programs which makes it possible to provide a one-stop location for persons whose problems are usually multifaceted. More than half (52 percent) of the CAAs manage the Head Start program in their community. Using their unique position in the community, CAAs recruit additional volunteers, bring in local school district personnel, tap into faith-based organizations for additional help, coordinate child care and bring needed healthcare services to Head Start centers. In many States they also manage the Low Income Home Energy Assistance Program (LIHEAP), raising additional funds from utilities for this vital program. CAAs may also administer the Weatherization Assistance Program and are able to mobilize funds for additional work on residences not directly related to energy savings that, for example, may keep a low-income elderly couple in their home. CAAs also coordinate their programs with the Community Development Block Grant program to stretch Federal dollars and provide a greater return for tax dollars invested. They also administer the Women, Infants and Children nutrition program, as well as job training programs, substance abuse programs, transportation programs, domestic violence and homeless shelters, and food pantries.

For every CSBG dollar they receive, CAAs leverage $5.59 in non-Federal resources (State, local, and private) to coordinate efforts that improve the self-sufficiency of low-income persons and lead to the development of thriving communities.

WHO DOES THE CSBG SERVE?

National data compiled by NASCSP show that the CSBG serves a broad spectrum of low-income persons, particularly those who are not being reached by other programs and are not being served by welfare programs. Based on the most recently reported data, from fiscal year 2007 CSBG serves:

—More than 3 million families with incomes at or below the poverty level; of these customer families, 1.4 million are severely poor as they have incomes at or below 50 percent of the poverty guideline.
—More than 1.3 million families headed by single mothers.
—More than 1.7 million "working poor" families relying on wages or unemployment benefits as income.
—More than 384,000 TANF participant families, 23 percent of all TANF families nationwide.
—About 4 million children.
—Almost 2.7 million people without health insurance.
—More than 1.7 million adults who had not completed high school.

MAJOR CHARACTERISTICS OF THE CSBG NETWORK

Due to the unique structure of the CSBG, the CSBG Network has earned a reputation for its:

Emergency Response.—CAAs are utilized by Federal and State emergency personnel as a frontline resource to deal with emergency situations such as floods, hurricanes, and economic downturns. They are also relied on by citizens in their community to deal with individual family hardships, such as house fires or other emergencies. In fact, during and after Hurricanes Katrina and Rita, the State CSBG offices and local CAAs quickly mobilized to provide immediate and long-term assistance to evacuees.

Leveraging Capacity.—In fiscal year 2007, every CSBG dollar leveraged $18.40 from all other sources. Of those leveraged funds, $5.59 came from non-Federal resources (State, local, and private) to coordinate efforts that improve the self-sufficiency of low-income persons and lead to the development of thriving communities.

Volunteer Mobilization.—CAAs mobilize volunteers in large numbers. In fiscal year 2006, the most recent year for which data are available, the CAAs elicited more than 46 million hours of volunteer efforts, the equivalent of almost 21,857 full-time employees. Using just the minimum wage, these volunteer hours are valued at nearly $266 million.

Adaptability.—CAAs provide a flexible local presence that governors have mobilized to deal with emerging poverty issues.

Moreover, the CSBG Network has also earned a reputation for its:

Accountability.—The Federal Office of Community Services, State CSBG offices, and CAAs have worked closely to develop a results-oriented management and accountability (ROMA) system. Through this system, individual agencies determine local priorities within six common national goals for CSBG and report on the outcomes that they achieved in their communities.

Local Direction and Oversight.—Tri-partite boards of directors guide CAAs. These boards consist of one-third elected officials, one-third representatives from the private sector, and not less than one-third of the members are representative of the low-income persons in the neighborhoods served by the CAA. The boards are responsible for establishing policy and approving business plans of the local agencies. Since these boards represent a cross-section of the local community, they guarantee that CAAs will be responsive to the needs of their community.

The statutory goal of the CSBG is to ameliorate the effects of poverty. The primary goal of every CAA is self-sufficiency for its clients. Helping families become self-sufficient is a long-term process that requires multiple resources. This is why the partnership of Federal, State, local, and private enterprise has been so vital to the successes of the CAAs.

EXAMPLES OF CSBG AT WORK

Since 1994, CSBG has implemented a Results-Oriented Management and Accountability (ROMA) system. Through ROMA, the effectiveness of programs is captured through the use of goals and outcomes measures. Below you will find several of the network's nationally aggregated outcomes achieved by individuals, families

and communities as a result of their participation in innovative CSBG programs during fiscal year 2007:

—*Increased Economic Asset Enhancement and Utilization*.—694,000 low-income households achieved an increase in financial assets or financial skills as a result of Community Action assistance.

—*Procured Supports To Reduce or Eliminate Barriers to Employment*.—1.3 million low-income participants obtained supports which reduced or eliminated barriers to initial or continuous employment through assistance from Community Action.

—*Gained Employment*.—193,000 low-income participants in Community Action employment initiatives got a job, obtained an increase in employment income, or achieved "living wage" employment and benefits.

—*Improved Child and Family Development*.—2.9 million Infants, children, youth, parents, and other adults participated in developmental or enrichment programs facilitated by Community Action and achieved program goals.

—*Secured Independent Living for Low-Income Vulnerable Populations*.—2 million low-income vulnerable individuals received services from Community Action and maintained an independent living situation as a result.

At the end of the day, the CSBG Network represents our abiding national commitment to care for the less fortunate and in recognition that we are stronger when we do so. The CSBG and CSBG Network, in addition to other nonprofit faith-based and community-based organizations, are a critical complement to the public sector's efforts towards helping to lift low-income Americans and their communities out of poverty and into self-sufficiency.

In fiscal year 2007, the CSBG Network assisted approximately 20 percent of the persons in poverty that year and almost 15 million low-income individuals who are members of more than 6.4 million low-income families. Renewed funding for the CSBG Network is one of the best ways to ensure that America has an experienced, guaranteed and trusted network to assist its working and vulnerable families in achieving and maintaining self-sufficiency. As such, NASCSP requests $800 million in CSBG funding for fiscal year 2010.

Prepared Statement of the National Association of State Directors of Career Technical Education Consortium

Department of Education Budget

In his budget submission to Congress, President Obama has requested flat funding for programs funded under the Carl D. Perkins Career Technical Education (CTE) Act. If this level of funding holds, this will be the third year in a row these programs will have received flat funding. These programs are worthy of stronger support because of the valuable contributions they make to serving adults and high school students in their journey for education and training and eventual entry into the workforce. Perkins CTE programs:

—Provide education that is relevant to students;

—Are actively reforming high school curriculum;

—Provide coordination between high schools and community colleges; and

—Prepare workers for jobs that are in demand.

We respectfully request that the subcommittee include $1.4 billion in support of Perkins programs. The last substantial funding increase for Perkins occurred in fiscal year 2002. Since that time funding has decreased by $42 million. When factoring in inflation this is the equivalent of a reduction of $254 million.

Perkins includes a "hold harmless" provision that protects small States from significant losses when there are reductions in Tech Prep (title II of Perkins) funding. However, this provision only applies as long as the total funding for Tech Prep does not fall below 1998 levels. Unfortunately, during the fiscal year 2008 appropriations cycle, Tech Prep funding fell below this level and in turn, the hold harmless provision put in place to protect small States was de-activated. While most States have taken a loss of Tech Prep funds, the small States have felt this cut in funding disproportionately. These States have seen their Tech Prep funds reduced between 7 and 56 percent below their fiscal year 2007 levels, costing some States hundreds of thousands of dollars over the last 2 years. Below is a chart that details the States and the approximate amount of funds they have lost over the last 2 years. The funding figures are approximated because only tentative fiscal year 2009 allocation numbers are available.

State	Amount
Alaska	$221,390

State	Amount
Delaware	426,666
District of Columbia	349,264
Hawaii	224,508
Montana	144,226
Nevada	279,600
New Hampshire	295,212
North Dakota	50,758
Rhode Island	370,442
South Dakota	92,616
Vermont	209,334
Wyoming	86,416

Tech Prep funding for the last 2 years was less than $100,000 below the fiscal year 1998 hold harmless level of $103 million. If funding for Tech Prep is raised ever so slightly to $103 million these States will not be so negatively impacted.

Why Career Technical Education?

Career technical education (CTE) provides students and adults with the academic and technical skills, knowledge and training necessary to succeed in future careers and develop skills they will use throughout their careers. CTE programs have been organized into 16 career clusters, or similar occupational groupings, that identify the knowledge and skills students need as they follow a pathway to their goals. These clusters are: Agriculture, Food, and Natural Resources; Architecture and Construction; Arts, A/V Technology and Communications; Business Management and Administration; Education and Training; Finance; Government and Public Administration; Health Science; Hospitality and Tourism; Human Services; Information Technology; Law, Public Safety, Corrections, and Security; Manufacturing; Marketing; Science, Technology, Engineering and Mathematics; and Transportation, Distribution and Logistics.

CTE prepares students for the world of work by introducing them to workplace competencies, and makes academic content accessible to students by providing it in a hands-on context.

CTE programs can be found in comprehensive high schools with career technical education programs, as well as high schools solely devoted to career technical education. Community colleges, technical institutes, and skill centers also offer career technical education at the postsecondary level. Nationally, about 60 percent of Perkins funds are allocated for secondary school purposes and 40 percent for postsecondary programs.

Programs of Study

The Carl D. Perkins Career and Technical Education Act of 2006 (Public Law 109–270), which funds CTE programs, requires States to develop programs of study to guide students when choosing courses. These programs of study include career and technical areas that:

—Incorporate both secondary and postsecondary education elements;

—Include rigorous content, challenging academic standards, and relevant career and technical content in a coordinated, nonduplicative series of courses that align secondary and postsecondary education;

—May allow high school students to participate in dual or concurrent enrollment programs or otherwise acquire postsecondary credit; and

—Result in an industry-recognized credential or certificate, or associate or baccalaureate degree.

Tech Prep

Tech Prep is a program in the Perkins Act that links a minimum of 2 years of secondary school and 2 years of post-secondary school or an apprenticeship program, resulting in an associate degree or certificate. Tech Prep allows students to begin a sequence of classes in a career pathway while still in high school. Students enroll in both academic and career and technical classes in the career field of their choosing in order to develop the technical skills necessary for future employment.

The Benefits of CTE

Academic

—Students enrolled in CTE programs are held to the same rigorous academic standards as all students;

—CTE provides a strong foundation for those pursuing a traditional 4-year degree; and
—CTE students are more interested and motivated in their coursework because of its connection to the real world, and have lower dropout rates than traditional students.

Economic

—Many sectors of the economy that require skilled workers report a shortage of qualified applicants to fill these positions. CTE programs prepare individuals for skilled professions that are essential to our Nation's economic recovery.
—CTE programs prepare students, adults, and displaced workers for entry into high-skill, high-wage, and high-demand careers in every industry sector.

The Federal role in "vocational" education began as a way to prepare students for the newly industrialized economy. Over the years, the program has evolved to match the needs of the changing economy, focusing on postsecondary as well as secondary education while giving students skills they can use throughout their careers.

In 2006, the language "vocational and technical" was updated to "career and technical" education. This transition was more than just a name change. It represented a fundamental shift in philosophy from CTE being for those who were not going to college to a system that prepares students for both employment and postsecondary education. The integration of academic and technical education programs was strengthened, further emphasizing the goal of ensuring that students who participate in CTE are taught the same rigorous content aligned with challenging academic standards as all other students. With all school programs now adhering to the same academic standards, the separate "track" system that has stigmatized CTE is disappearing. The chart that follows summarizes these changes.

Traditional vocational education	New career and technical education
For specific students	For all students
Limited program areas offered Separate "track" with a focus on technical education	16 Career Clusters and 79 pathways offered Integrated with academics in a rigorous and relevant curriculum
High school focused	High school and postsecondary partnerships providing pathways to employment and/or associate, bachelor's, and advanced degrees
Students trained with focus on specific occupational skill set	Progression of foundational, pathway, occupational, and 21st century skills

Career technical education programs have changed with the times and are a fundamental piece of the education and training available to Americans so that they can get the skills they need in today's economy. Today, there are more than 15 million students and displaced workers enrolled in CTE programs all across America. An increase in funding would enable CTE programs to produce more skilled workers to fill the jobs that are crucial to America's economy. Funds for these programs will help high schools that are reeling from State and local budget reductions and help community colleges accommodate their increasing enrollments. We hope that you can provide $1.4 billion for Perkins CTE supported programs in the fiscal year 2010 budget.

PREPARED STATEMENT OF THE NATIONAL ALLIANCE OF STATE AND 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.

As you craft the fiscal year 2010 Labor, Health and Human Services, and Education, an Related Agencies appropriations legislation, we urge you to consider the following critical funding needs of HIV/AIDS, viral hepatitis, and sexually transmitted diseases (STD) programs:

—$1.6 billion for the Ryan White Part B Program, including $514 million for the Part B Base and $1.1 billion for the AIDS Drug Assistance Program (ADAP);
—$1.6 billion for the Centers for Disease Control and Prevention's (CDC) HIV/AIDS Prevention Program, including an additional $249 million for State and

local health department prevention cooperative agreements to include an additional $49 million for State and local HIV/AIDS surveillance systems, and the expansion of the domestic HIV/AIDS Testing Initiative to additional populations and jurisdictions;

—$50 million for CDC's Viral Hepatitis Prevention Program, including a doubling of resources for the Adult Viral Hepatitis Prevention Coordinator Program to $10 million.

—$16 million for hepatitis B vaccination for high-risk adults through the Section 317 Vaccine Program;

—$451 million for CDC's STD Prevention Program for prevention, treatment and surveillance cooperative agreements with State and local health departments; and

—$610 million for the Minority AIDS Initiative to enhance capacity in communities of color.

HIV/AIDS Care and Treatment Programs

The Health Resources and Services Administration administers the $2.2 billion Ryan White Program that providing health and support services to more than 500,000 HIV-positive individuals. NASTAD respectfully requests a minimum increase of $362 million in fiscal year 2010 for State Ryan White Part B grants, including an increase of at least $113 million for the Part B Base and at least $269 million for ADAPs. With these funds all 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—for some States it's a doubling of new clients per month from the previous year. This is due to a number of factors including, increased testing efforts and unemployment.

Ryan White Part B Base programs include ambulatory medical services, case management, laboratory services, and an array of support services. As of October 10, 2008, four States report that 266 individuals are on either a medical or support service waiting list for services that include housing, mental health counseling, specialty medical care, and transportation. Five States report that funding is insufficient to ensure that all eligible patients attend medical appointments every 3 months, which is the standard of care. Eight part B programs are also considering cost containment measures for their part B services in light of high demand and reduced funding.

State ADAPs provide medications to low-income individuals with HIV disease who have limited or no coverage from private insurance or Medicaid. While only three States currently have a waiting list with 53 individuals, the present fiscal condition of State ADAPs remain fragile. In fiscal year 2008, State ADAPs were relatively stable due to increased State contributions, increased rebates from drug companies, $39.7 million in ADAP Supplemental grants, transfers of Part B Base funding into ADAP, and program savings from the Medicare Part D Prescription Drug Benefit. The continuing increase in clients and the cuts in State contributions to ADAP (one State has cut their ADAP contribution by $70 million) render the fiscal future of ADAPs uncertain. On average, State spending accounts for 21 percent of the total ADAP budget. Additionally, CDC estimates that their on-going Domestic HIV/AIDS Testing Initiative will find 20,000 new infections over the next year.

While we are very supportive of the funding increases in recent years for the community health center (CHC) program, we want to be clear that this hasn't necessarily translated into more care for person living with HIV/AIDS. CHCs focus on primary care with most of the HIV/AIDS care being provided in centers with Ryan White Part C grants.

HIV/AIDS Prevention and Surveillance Programs

At the request of Congress, the CDC developed a Professional Judgment Budget detailing the needed resources to significantly reduce the number of Americans becoming infected with HIV each year. CDC identified the need for a funding increase of $878 million for total funding of $1.6 billion for CDC's HIV prevention program in fiscal year 2010. As Congress strives to reach the $1.6 billion overall investment in HIV prevention, NASTAD respectfully requests an initial increase of $249 million in State and local health department HIV prevention and surveillance cooperative agreements. This would include an additional $49 million for State and local HIV/AIDS surveillance systems and the expansion of the Domestic HIV/AIDS Testing Initiative to additional populations and jurisdictions.

An estimated 56,300 new infections occur every year while State and local HIV prevention cooperative agreements have been cut by $21 million between fiscal year 2003 and fiscal year 2008. CDC's 2007 surveillance reports showed a 15 percent increase in HIV diagnoses in the 34 States included in the national database while CDC's HIV prevention funding was cut in fiscal year 2008 and flat-funded in fiscal year 2009. Additionally, core HIV/AIDS surveillance funding has eroded over the last decade, while the importance of this data has become paramount for targeting prevention efforts and directing Ryan White resources.

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. 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, ensure fiscal responsibility and refer partners of HIV-positive individuals to counseling and testing services.

The Domestic HIV/AIDS Testing Initiative is an important step to increasing knowledge of serostatus, particularly among African Americans. Currently 25 jurisdictions (20 States and five cities) receive $36 million for the Expanded Testing Initiative (ETI), including rapid testing, in clinical settings such as emergency rooms, community health centers, correctional health facilities, and STD and tuberculosis clinics. Both CDC and NASTAD conducted assessments of year 1 including progress and challenges faced. Following significant scale-up efforts in all jurisdictions, 21 of the funded jurisdictions conducted 446,503 tests in year 1 of the ETI. Nearly 4,000 new HIV infections were identified, 80 percent of which were in clinical settings. During the first year, 86 percent of testing occurred in clinical settings. Of the total number of tests conducted in the first year, 64 percent were administered to African Americans. Seventy percent of the newly identified infections were among African Americans.

We are requesting that CDC receive sufficient resources to expand the number of jurisdictions participating in the initiative—all jurisdictions have a need for increased resources for testing if we are to truly commit to providing access to testing for all individuals who do not yet know their HIV status. Additional funding would also allow the targeting of additional populations such as gay and bisexual men of all races and Latinos. Another key component of the initiative to expand is identification, notification and counseling of partners of persons living with HIV/AIDS. Partner services are time and resource intensive but maximize prevention efforts.

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.

We urge the subcommittee to not include language banning use of Federal funds for syringe exchange programs in the fiscal year 2010 Labor, Health and Human Services, and Education, an Related Agencies appropriations bill. Abundant research, endorsed by the findings of eight federally commissioned reviews, has conclusively demonstrated that syringe exchange is effective in reducing the transmission of HIV without increasing drug use. In communities that fund and support access to sterile injection equipment using State and local funds, transmission of HIV and hepatitis in persons who inject drugs has declined as a proportion of all cases by mode of transmission. Unfortunately, State and locally funded syringe exchange are only reaching a small portion of persons who inject drugs. It's time for the Federal Government to use every tool at its disposal to arrest the further spread of HIV and hepatitis C.

We also urge you to eliminate funds for the three separate Federal abstinence-only-until-marriage programs. Instead, we request that you create a dedicated Federal funding stream of at least $50 million in your 2010 budget to fund medically accurate, comprehensive sex education programs that teach young people about both abstinence and contraception.

Lastly, we thank you and ask that you continue to limit the funding for the duplicative Early Diagnosis Grant Program in Section 209 of the Ryan White Treatment Modernization Act of 2006. This program is a carve out of limited HIV testing resources when there is already $10 million dedicated to perinatal prevention.

Viral Hepatitis Prevention Programs

NASTAD respectfully requests an increase of $36.4 million for a total of $50 million in fiscal year 2010 for the CDC's Division of Viral Hepatitis (DVH) to enable State and local health departments to provide basic core public health services. DVH currently receives $18.3 million to address chronic viral hepatitis B and C impacting 6.2 million Americans. This is $7 million less than its peak funding of $25 million in fiscal year 2001. Currently CDC addresses viral hepatitis on outbreak at a time, which is neither cost-effective nor real prevention.

Of the DVH funding, $5.2 million is used to fund the Adult Viral Hepatitis Coordinator Program with an average award to States of $90,000. Doubling this program to $10 million would allow States to implement a hepatitis prevention strategy. The coordinator position receives precious little above personnel costs, leaving little to no money for the provision of public health services including public education, hepatitis counseling, testing, and hepatitis A and B vaccine. In addition, there are no funds for surveillance of chronic viral hepatitis, which would allow States to better target their limited resources. Given the recent hepatitis public health crises in Nevada and New York, the Government has a choice—invest in prevention now or wait until public systems are overwhelmed by a lack of infrastructure to address future outbreaks.

The greatest remaining challenge for hepatitis A and B prevention is the vaccination of high-risk adults. High-risk adults account for more than 75 percent of all new cases of hepatitis B infection each year and annually result in an estimated $658 million in medical costs and lost wages. In fiscal year 2007, CDC allowed States to use $20 million of 317 Vaccine funds to vaccinate high-risk adults for hepatitis B and $16 million in fiscal year 2008. By targeting high-risk adults, including those with hepatitis C, for vaccination, the gap between children and adults who have not benefited from routine childhood immunization programs can be bridged. NASTAD requests a continuation of the $16 million in section 317 Vaccine funds in fiscal year 2010 for hepatitis B vaccination for high-risk adults with the request that in the future DVH receives dedicated funding for hepatitis A and B vaccine for high-risk adults and funding to support the infrastructure necessary for vaccine delivery.

STD Prevention Programs

NASTAD supports an increase of $299 million for a total of $451 million in fiscal year 2010 for STD prevention, treatment and surveillance activities undertaken by State and local health departments. STD prevention programs at CDC have been cut by $6 million since fiscal year 2004 while the number of persons infected continues to climb. The United States has the unwanted distinction of having the highest rates of STDs of all industrial nations with 1 in 4 adolescent girls in the United States, or more than 3 million, having an STD. The rates of syphilis infection have increased for the seventh year in a row. In 1 year, our Nation spends more than $8 billion to treat the symptoms and consequences of STDS. Additional Federal resources are needed to reverse these alarming trends and reduce the Nation's health spending.

Minority AIDS Initiative

NASTAD also supports a $200 million increase for a total of $610 million for the Minority AIDS Initiative (MAI) in fiscal year 2010. The MAI provides targeted resources to four agencies and the Office of the Secretary to address the HIV/AIDS epidemic in hard-hit communities of color. The data from CDC on the disproportionate impact on African Americans and Latinos continues to be alarming. Support for the MAI along with the traditional funding streams that serve these populations is essential.

As you craft the fiscal year 2010 Labor, Health and Human Services, and Education, an Related Agencies 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 CONGRESS OF AMERICAN INDIANS

On behalf of the tribal nations of the National Congress of American Indians (NCAI), we are pleased to present our recommendations for fiscal year 2010 funding

of Indian programs in the Departments of Labor, Health and Human Services, and Education, and Related Agencies. President Obama released a broad budget plan for fiscal year 2010 and from what NCAI has reviewed of the blueprint so far, the new administration plans to ensure America's promise extends to the entire Nation, including throughout Indian country.

After tribes witnessed years of declining resources for critical Indian programs in the Federal budget, the attention the administration's fiscal year 2010 proposed budget has given to tribal priorities is a welcome change. The chairman of this subcommittee has heard often of the social and economic challenges facing Indian country. This subcommittee has also heard that the recent resurgence of tribal self-determination has resulted in measurable improvements in the poverty, income, and unemployment among Indian people.

Indian tribes are rebuilding our Nations in ways that honor our ancestors and cultures as well as meeting the demands and opportunities of living in the modern world. An analysis of socioeconomic change between 1990 and 2000 showed that Indian country economies grew at a faster pace than the economy as a whole. Although Indian tribes have made great strides in addressing the long-accumulated economic deficits in our communities, much work remains to be done. Tribes also have a critical role to play in the recovery as the Nation pulls out of the current destructive recession. As the President and Congress aim to invest in people to strengthen the middle class and the drivers of economic growth, NCAI looks forward to tribal self-determination playing a part in the solution. To ensure tribes continue to make progress, sustained investment in tribal governments and programs that support self-determination will be critical in fiscal year 2010. With the new administration and the fiscal year 2010 budget request, there is renewed hope in Indian country.

The President's fiscal year 2010 budget priorities appear to align with many of Indian country's priorities: education, healthcare, infrastructure, and clean energy. Below are some budget recommendations for the Labor, Health and Human Services, and Education, and Related Agencies appropriations bill.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Tragically, over the last year, nearly 3,000 American Indians and Alaska natives died of cardiovascular disease, more than 16,500 were diagnosed with a sexually transmitted disease, 5,000 were diagnosed with diabetes for the first time, more than 22,000 are now living with cancer (45 percent of which were diagnosed in the late-stages), and 400 took their own life.

These people are our tribal leaders; our daughters and sons; our mothers and fathers; and, our brothers and sisters. For more than 100 years, Native people have experienced inferior health outcomes. Our life expectancy is still 5 years less than that of other Americans. Adequate funding is needed to end this lasting injustice and uphold the Federal trust responsibility of the United States and the Federal Government.

Provide $1 billion overall for Head Start funding. Provide $10 million for Esther Martinez language programs under the Administration for Native Americans. Fifteen million dollars to fund SAMHSA Behavioral Health Services Grants for American Indian and Alaska Natives. Increase Circles of Care, SAMHSA by $5 million

ADMINISTRATION FOR CHILDREN AND FAMILIES

Head Start.—Over the past 40 years, Head Start has played a major role in the education of Indian children and in the well-being of many tribal communities. However, because of inadequate funding, only about 16 percent of the age-eligible Indian child population is enrolled in Indian Head Start. The comprehensive nature of this program integrates education, health, and family services. Since it closely mirrors a traditional Indian educational model, it is one of the most successful Federal programs operating in Indian country. Despite these successes, Head Start funding has declined by 14 percent over the last 6 years, after factoring in inflation. Head Start should be funded at a rate substantially greater than inflation to make up for prior year cuts and also to trigger special Indian expansion funds that Congress provided when the Head Start Act was reauthorized in 2007.

—$1 billion—Head Start funding (overall)

ADMINISTRATION FOR NATIVE AMERICANS

Native Languages.—Throughout Indian country, tribes are combating the loss of traditional languages by advocating for and instituting language programs within their communities. These language programs serve Native communities by preventing the loss of tribal traditions and cultures. The tribal students in these lan-

guage immersion programs perform substantially better academically, including on national tests, than Native students who have been enrolled in such programs.

—$10 million—Esther Martinez language programs under the Administration for Native Americans

SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION (SAMHSA)

American Indian and Alaska Native Grant Program.—This grant program within SAMHSA has been authorized to award grants to Indian health programs to provide the following services: prevention or treatment of drug use or alcohol abuse, mental health promotion, or treatment services for mental illness. To date, these funds have never been appropriated.

—$15 million to fund SAMHSA Behavioral Health Services Grants for American Indian and Alaska natives.

Circles of Care.—Increase funding to $10 million a year for the Circles of Care children's mental health grant program under Programs of National and Regional Significance under SAMHSA. This grant program has historically been funded at about $5 million a year, which provides for approximately seven tribal grants during each 3-year grant cycle. The program has been very successful and has spawned several new tribal children's mental health programs in Indian country that as a result have been self-sustaining.

—Increase of $5 million

DEPARTMENT OF EDUCATION

The administration intends to make investments in education so all Americans can have the chance to receive a world-class education from cradle to career. The 2007 National Indian Education Study indicated that in reading and math, American Indian and Alaska native students scored significantly lower than their peers in both fourth and eighth grades. To ensure that Native students—from pre-school to college—meet the same challenging academic standards as other populations and experience the benefits of a quality and supportive education, it is imperative that the Federal Government uphold its responsibility for the education of Indian people.

Provide $195.5 million for title VII funding under the No Child Left Behind Act. Increase Impact Aid funding 10 percent to adjust for inflation and population growth ($1,365 million). Provide $32 million for title III, Higher Education Act (HEA). Provide $62 million (one-time) forward funding for Tribal Colleges and Universities (TCUs). Provide $10 million for tribal education departments.

Title VII Funding.—This funding provides critical support for culturally based education approaches for American Indian and Alaska native students and addresses the unique educational and cultural needs of Native students. It is well-documented that Native students are more likely to thrive in environments that support their cultural identities while introducing different ideas. Title VII has produced many success stories within our communities, but increased funding is critical in this area to bridge the achievement gap for Native students.

—$195.5 million

Impact Aid Funding.—Impact Aid provides resources to public schools whose tax bases are reduced because of Federal activities, including the presence of an Indian Reservation. Impact Aid affects Native children living on or near tribal lands and children of military families living on or near bases. Approximately 95 percent of American Indian and Alaska Native youth are educated in public schools. Impact Aid funding must be adjusted based on population increases and inflation.

—Increase impact aid funding 10 percent to adjust for inflation and population growth ($1,365 million)

TCUs.—Titles III and V of the HEA, known as Aid for Institutional Development programs, support institutions with a large proportion of financially disadvantaged students and low cost-per-student expenditures. TCUs fit this definition. The Nation's 36 TCUs serve some of the most impoverished areas in the Nation, yet they are the country's most poorly funded postsecondary institutions. Congress recognized the TCUs as young and struggling institutions and authorized a separate section of title III (part A, section 316) specifically to address their needs. Additionally, a separate section (section 317) was created to address similar needs of Alaska native and Native Hawaiian institutions. Section 316 is divided into two competitive grants programs: Formula funded basic development grants and competitive single-year facilities construction grants. Under the Tribal College Act, securing the one-time payment to transition institutional operating grants to a forward funded program would finally end the cycle of delayed payments, short-term loans, and layoffs that currently plague TCUs each year; and, further for the first time, it would provide these institutions the resources they need at the start of each academic year.

—$32 million—Title III, HEA
—$62 million (one-time) forward funding for TCUs

Tribal Education Departments.—More than 100 Indian tribes have started Tribal Education Departments (TED). TEDs develop and administer policies, gather and report data and perform critical research to help tribal students from early childhood through higher and adult education. TEDs serve thousands of tribal students nationwide in BIA, tribal, and public schools. They also cultivate leadership skills and train a potential workforce. Funding for TEDs has been authorized by Congress but never appropriated in either the BIA budget or that of the Department of Education. Both of these authorizations are retained in the No Child Left Behind Act of 2001. Tribes must have access to funding in order to close the achievement gaps so that tribal students will be better equipped to perform well in school. We recommend that $5 million of the funding be directed from the Department of the Interior and $5 million of the funding be directed from the Department of Education.
—$10 million—Tribal education departments

CONCLUSION

NCAI realizes Congress must make difficult budget choices this year. As elected officials, tribal leaders certainly understand the competing priorities that you must weigh over the coming months. However, the Federal Government's constitutional and treaty responsibility to address the serious needs facing Indian country are unique. These responsibilities remain unchanged, whatever the economic climate and competing priorities may be. We at NCAI urge you to make a strong, across-the-board commitment to meeting the Federal trust obligation by fully funding those programs that are vital to the creation of vibrant Indian nations. Such a commitment, coupled with continued efforts to strengthen tribal governments and to clarify the Government-to-government relationship, truly will make a difference in helping us to create stable, diversified, and healthy economies in Indian country.

PREPARED STATEMENT OF THE NATIONAL CONSUMER LAW CENTER [1]

The Federal Low Income Home Energy Assistance Program (LIHEAP) [2] 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. In fiscal year 2009, the program is expected to assist 7.3 million low-income households afford their energy bills. Residential consumers continue to pay much higher heating bills than in the past, and depending on the region of the country and the heating fuel, the increase in expenditures for heating fuel have been substantial over time. 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 2010 and that advance funding of $5.1 billion be provided for the program in fiscal year 2011.

HOME ENERGY BILLS REMAIN HIGH AT A TIME WHEN UNEMPLOYMENT AND UNDEREMPLOYMENT IS GROWING

Residential heating expenditures remain at high levels. Average residential heating expenditures this winter are expected to be about 38 percent higher for heating oil, 16 percent higher for natural gas, 42 percent higher for propane, and 24 percent higher for electricity when compared to the 5-year average for 2002–2007.[3] The steady, high energy bills are hitting low-income households struggling in this economic downturn. According to the Bureau of Labor Statistics, in March 2009, the number of unemployed workers was 13.2 million, with half the increase in the number of unemployed occurring within the past 4 months.[4] According the Economic Policy Institute, the number of involuntary part-time workers nearly doubled to more than 8 million in the past year, largely due to full-time workers accepting re-

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[1] Prepared by Olivia Wein, Staff Attorney, National Consumer Law Center (202–452–6252, owein@nclcdc.org).
[2] 42 U.S.C. §§ 8621 et seq.
[3] Derived from data in the Energy Information Agency, Short-Term Energy Outlook (Feb. 2009), Table WF01.
[4] US, DOL, Bureau of Labor Statistics, *The Employment Situation: March 2009* (rel. April 3, 2009).

duced hours.[5] 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

The steady and dramatic rise in residential energy costs has resulted in increases in electric and natural gas arrearages and disconnections. For example, in Rhode Island in 2008 there were 8 percent more service disconnections for nonpayment than in any other year on record, and 21 percent of those accounts were not restored.[6] A recent national survey by the National Association of Regulatory Utility Commissioners 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 this past May 2008.[7]

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 number of disconnections 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.

Iowa.—Iowa has experienced a steady increase in enrollment for the regular LIHEAP program from fiscal year 2007 to fiscal year 2009 with 86,000 households in 2007; 87,000 in 2008 and projects 95,700 in fiscal year 2009.[8] As a testament to the difference LIHEAP can make for low-income households, in February 2009, the number of Iowa low-income households with past-due energy accounts and the total amount of the low-income arrears were lower than for the past 3 years at this point in time (e.g., February 2006, February 2007, and February 2008). Comparatively, when looking at the arrearage data for February over time for the total residential gas and electric accounts in arrears and the amount of those arrears, those numbers are at historic highs.[9]

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 9 percent from January 2008 to January 2009. The increase is an even more dramatic 86 percent between January 2003 and January 2009. The total dollar amount owed (arrearage) by low-income PIPP customers increased 11 percent from January 2008 to January 2009 and 52 percent when comparing PIPP customer arrears from January 2003 to January 2009.[10] Ohio has experienced a steady increase in enrollment for the regular LIHEAP program (HEAP) from fiscal year 2007 to fiscal year 2009 with 360,000 households in 2007; 370,000 in 2008 and projects 400,000 in fiscal year 2009.[11]

Pennsylvania.—Pennsylvania has also experienced a steady increase in enrollment for the regular LIHEAP program from fiscal year 2007 to fiscal year 2009 with 367,000 households in 2007; 398,000 in 2008 and projects 490,000 in fiscal year 2009.[12] 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 17,745 households entered the current heating season without heat-related utility service—this number includes about 3,373 households who are heating with potentially unsafe heating sources such as kerosene or electric space heaters and kitchen ovens. In

[5] See Ross Eisenbrey and Kathryn Edwards, *Downtime: Workers forced to settle for fewer hours*, Economic Policy Institute (Jan. 14, 2009).
[6] Analysis of John Howat, senior policy analyst at National Consumer Law Center (April 2009).
[7] 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).
[8] NEADA press releases from April 25, 2008 and January 12, 2009.
[9] Based on data provided by the Iowa Bureau of Energy Assistance.
[10] Public Utilities Commission of Ohio.
[11] NEADA press releases from April 25, 2008 and January 12, 2009.
[12] NEADA press releases from April 25, 2008 and January 12, 2009.

mid-December 2008, an additional 13,595 residences where electric service was previously terminated were vacant and more than 6,442 residences where natural gas service was terminated were vacant. In 2008, the number of terminations increased 73 percent compared with terminations in 2004. As of December 2008, 18.3 percent of residential electric customers and 16.9 percent of natural gas customers were overdue on their energy bills. These 2008 overdue utility bills have increased 9.57 percent more than 2007. In addition, in recognition of the increases in media reports of deaths of terminated customers the PA PUC implemented a new reporting requirement. Utilities in Pennsylvania are now required to file reports regarding any incidents involving death at locations where residential utility service has been terminated.[13] The economic downturn is putting additional pressures on local human service agencies as well. A report on the effect of economy on Pittsburgh, Pennsylvania shows a 73.3 percent increase in “first time” applicants for a range of basic needs assistance, including energy assistance.[14]

States are Predicting Record LIHEAP Participation.—NEADA reports that for fiscal year 2009, 15 States have projected increases in participation of at least 21 percent, with Texas estimating a 201 percent increase; Florida 200 percent; California 162 percent; Tennessee 60 percent; Arkansas 50 percent; Arizona 35 percent; Alaska 34 percent; New Mexico 26 percent; Oregon 26 percent; Alabama 25 percent; Massachusetts 25 percent; New Hampshire 25 percent; Pennsylvania 23 percent; Connecticut 23 percent; and Delaware 21 percent.[15] In Arkansas, many of the community action agencies are estimating that about 40 percent of the people contacting them for services over the past 8 to 10 months are new applicants; overwhelmingly, these new applicants are seeking utility assistance.[16] Thus there is great need for a fully funded LIHEAP program in the States.

LIHEAP IS A CRITICAL SAFETY NET PROGRAM FOR THE ELDERLY, THE DISABLED AND HOUSEHOLDS WITH YOUNG CHILDREN

LIHEAP is Vital to Poor Seniors.—Poor seniors are cutting back on energy usage because it is not affordable. In general, elder households use less total household energy than nonelderly households, which is attributable primarily to the smaller dwelling units. However, poor elderly households use markedly less energy than nonpoor elderly households. Even worse, poor elderly households, on average, consume 12 percent more energy per square foot of living space (this measurement is also referred to as energy intensity) than non-poor elderly households. This disparity is attributable to the poorly weatherized living spaces and the use of old, inefficient heating equipment and appliances.[17] LIHEAP is critical for helping low-income seniors maintain safe temperatures in their homes.

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.[18] 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.[19] 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.[20]

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[13] Pennsylvania Public Utility Commission Bureau of Consumer Services.

[14] Vivien Luk and Stacy Kehoe, *Understanding the Impact of the Economic Downturn on Pittsburgh Residents and Human Service Agencies*, the Forbes Funds (November 2008).

[15] NEADA press release, *Applications for Low Income Energy Assistance Reach Record Levels: States Call on Congress to Increase Funding for LIHEAP* (January 12, 2009).

[16] Estimates provided by Arkansas Community Action Agencies Association, Inc.

[17] NCLC analysis of U.S. Energy Information Administration, 2001 Residential Energy Consumption Survey data on elderly energy consumption and expenditures.

[18] *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.

[19] 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.

[20] 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 Pediat-

Continued

Clearly, families are going without food during the winter to pay their heating bills, and their children fail to thrive and grow. The loss of essential utility services can be devastating, especially for poor families that can find themselves facing eviction. A 2007 Colorado study found that the second leading cause of homelessness for families with children is the inability to pay for home energy.[21]

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,[22] ovens and burners, all of which are fire hazards. In 2006, 73 percent of home heating fire deaths, 43 percent of home heating fire injuries and 51 percent of property damage from home heating fires involved stationary or portable space heaters. 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 person 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.[23] The CDC also notes that air-conditioning is the number one protective factor against heat-related illness and death.[24] 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 2010 in light of the steady increase in 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 2011 advance funding would facilitate the efficient administration of the State LIHEAP programs. Advanced funding provided 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 of STD Directors

The National Coalition of STD Directors (NSCD) is a nonprofit, nonpartisan association of public health sexually transmitted (STD) program directors in the 65 Centers for Disease Control and Prevention (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 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, infer-

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rics 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 the *Testimony of Dr. Frank Before the Senate Committee on Health, Education, Labor and Pensions Subcommittee on Children and Families* (March 5, 2008).

[21] 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).

[22] John R. Hall, Jr., *Home Fires Involving Heating Equipment: Space Heaters* (In 2006 there were an estimated 64,100 home fires involving space heaters resulting in 540 deaths, 1,400 injuries and $943 million in property damage) National Fire Protection Association (Jan. 2009).

[23] CDC, "Heat-Related Deaths—United States, 1999–2003" MMWR Weekly, July 28, 2006.

[24] CDC, "Extreme Heat: A Prevention Guide to Promote Your Personal Health and Safety" *available at* http://emergency.cdc.gov/disasters/extremeheat/heat__guide.asp.

tility, 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 three- to fivefold 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. MSM have historically experienced high rates of all STDs, including HIV/AIDS. In 2007, 65 percent of all primary and secondary syphilis cases were among MSM. The syphilis rate among males is now six 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/Alaska natives, and Hispanics are also at higher risk of contracting STDs. In 2007, the rate of chlamydia among African Americans was eight times that of whites, for American Indian/Alaska natives it was five times higher than whites, and for Hispanics it was three times higher than whites. African American women experience syphilis rates 14 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 steadily declined since fiscal year 2003. 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.

NSCD requests an fiscal year 2010 funding level of $451.3 million, an increase of $299 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 (+$40 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, drastic 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 (+$24 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 programs. 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 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 current swine flu epidemic. The versatile expertise of DIS make them indispensable during a public health crisis, and also highlights 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.

Expand Chlamydia Screening and Infertility Prevention (+$100 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 the Department of Health and Human Services, 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, 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 (+$78 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 19 times greater than that of whites in 2007. African-American men aged 15 to 19 years old experience gonorrhea rates 39 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 2006, 13.8 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 only 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 (+$50 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 76 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 been 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 MSM and minority populations, and expanded screening in correctional facilities.

Build a Response to Viral STDs (Herpes, HPV, Hepatitis B)

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.

PREPARED STATEMENT OF THE NATIONAL DOWN SYNDROME SOCIETY

Mr. Chairman and members of the subcommittee: As Chairperson 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 2010.

There are more than 400,000 people living with Down syndrome in the United States, 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 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. On behalf of the National Down Syndrome Society, we recommend that you appropriate $5 million in the fiscal year 2010 to implement the requirements of the Prenatally and Postnatally Diagnosed Conditions Awareness Act of 2007.

As you know, last year, Congress passed the Prenatally and Postnatally Diagnosed Conditions Awareness Act of 2007. 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, Web sites, 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. By including $5 million in the fiscal year 2010 Labor, Health and Human Services, and 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 NEPHCURE FOUNDATION

ONE FAMILY'S STORY

Chairman Cochran 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 1 of 2 filter diseases called Minimal Change Disease 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 NephCure Foundation (NCF) has been very helpful to my family. They have provided us with educational information about NS, Minimal Change Disease, 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 National Institutes of Health. 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–07–367).

Mr. Chairman, on behalf of the thousands of people suffering from NS and FSGS and NCF, thank you for this opportunity to submit this testimony to the subcommittee and for your consideration of my request; Thank you.

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 to support the establishment of the Nephrotic Syndrome Rare Disease Clinical Research Network. This network is a new collaboration between research institutions and NCF 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. 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 of 2006, is glomerular-disease specific. The announcement will utilize the R01 mechanism to award researchers funding.

We ask the subcommittee to encourage the ORD to support the Nephrotic Syndrome Rare Disease Clinical Research Network to expand FSGS research. We also ask the 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.

We also applaud the work of the NIDDK in establishing the National Kidney Disease Education Program (NKDEP), and we seek your support in urging the NIDDK to make sure that glomerular disease remains a focus of the NKDEP.

We ask the subcommittee to encourage the NIDDK to have glomerular disease receive high visibility in its education and outreach efforts, and to continue these efforts in conjunction with NCF's work. These efforts should be targeted towards both physicians and patients.

GLOMERULAR DISEASE STRIKES MINORITY POPULATIONS

Nephrologists tell us that glomerular disease strikes a disproportionate number of African Americans. No one knows why this is, but some studies have suggested that a genetic sensitivity to sodium may be partly responsible. DNA studies of African Americans who suffer from FSGS may lead to insights that would benefit the thousands of African Americans who suffer from kidney disease.

I ask that the NIH pay special attention to why this disease affects African Americans to such a large degree. 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 Panamanian 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.

We ask the subcommittee to join with us in urging the NIDDK and NCMHD to collaborate on research that studies the incidence and cause of this disease among minority populations. We also ask that the NIDDK and the NCMHD undertake cul-

turally appropriate efforts aimed at educating minority populations about glomerular disease.

PATIENT REGISTRY AND BIOBANK

Experts currently believe glomerular disease is increasing in frequency and it is often misdiagnosed or undetected and, as a result, is often unreported. Since many cases of glomerular disease are unreported, it is difficult to ascertain different aspects of the disease and to form more comprehensive data sets on the patient population. While databases and registries have helped defeat other diseases, one does not exist for FSGS.

The development of a biobank would be beneficial in understanding the genetic components of glomerular disease and their corresponding interactions with environmental factors.

We ask the subcommittee to support the funding of the first-ever national database/registry for FSGS within NIDDK. Experts say that the incidence of FSGS is increasing and that the disease is often misdiagnosed, undetected, or unrecorded. We also ask the subcommittee support the development of a biobank as a further means of understanding the causes of FSGS, both genetic and environmental.

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, the points we wish to make to this subcommittee are that NFCB:
—Requests $542 million in funding for CPB for fiscal year 2012;
—Supports a $307 million supplemental appropriation in fiscal year 2010 to ensure that public broadcasting is not lost to any parts of the country because of the economic crisis;
—Requests $40 million in fiscal year 2010 for conversion of public radio and television to digital broadcasting;
—Requests $27 million in fiscal year 2010 for replacement of the radio interconnection system;
—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 Native American, African-American, and Latino radio stations;
—Supports CPB's efforts to help public radio stations utilize new distribution technologies and requests that the subcommittee ensure that these technologies are available to all public radio services and not just the ones with the greatest resources.

Community Radio fully supports the appropriation of $542 million in Federal funding for the Corporation for Public Broadcasting in fiscal year 2012. Federal support distributed through CPB is an essential resource for rural stations and for those serving communities of color. These 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. Federal 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, inde-

pendent, 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 non-governmental support to augment the Federal funds. Most important, the insulation that advance funding provides "go[es] a long way toward eliminating both the risk of and the appearance of undue interference with and control of public broadcasting." (House Report 94–245.)

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 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.

NFCB commends CPB for the leadership it has shown in supporting and fostering programming services to Latino stations and Native American stations. For example, Satélite Radio Bilingüe 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. At the same time, Native Voice One (NV1) is distributing politically and culturally relevant programming to Native American stations. There are now more than 33 stations in the United States controlled by and serving Native Americans.

Five years ago, CPB funded the establishment of the Center for Native American Public Radio (CNAPR). After 4 years in operation, CNAPR has assisted with the renewal of licenses and expansion of the interconnection system to all Native stations and has advanced the opportunity for native nations to own their own, locally controlled station. In the process of this work, it was recognized that radio would not be available to all native nations and broadband and other new technologies would be necessary. CNAPR has been repositioned as Native Public Media (NPM) and is working hard to double the number of native stations within the next 3 years. These stations are critical in serving local, isolated communities (all but one are on Indian Reservations) and in preserving cultures that are in danger of being lost. CPB's 2003 assessment recognized that ". . . Native Radio faces enormous challenges and operates in very difficult environments." CPB funding is critical to these rural, minority stations. The funding of the Intertribal Native Radio Summit by CPB in 2001 helped to gather these isolated stations together into a system of stations that can support one another. The CPB assessment goes on to say "Nevertheless, the Native Radio system is relatively new, fragile and still needs help building its capacity at this time in its development." NPM promises to leverage additional new funding to ensure that these stations continue providing essential services to their communities.

CPB also funded a Summit for Latino Public Radio which took place in September 2002 in Rohnert Park, California, home of the first Latino public radio station. This year, CPB has provided funding to the Latino Public Radio Consortium to develop a strategic plan and business model to expand the service of public radio to the Latino population. The Latino population is growing in this country and requires news services geared toward them in order to fully participate in civic life. Hispanics were 12.5 percent of the population in 2000, by 2007 they were 15 percent, and the number is only growing.[1]

CPB plays an extremely important role in the public and Community radio system: They convene 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.

Community radio supports a $307 million supplemental appropriation in fiscal year 2010 to ensure that public broadcasting is not lost to any parts of the country because of the economic crisis. Public Broadcasting is requesting a one-time investment of Federal resources to help stations maintain local service and assist their communities cope with the economic crisis and to assure continuity of public broadcasting service to the American people. Financial contributions from corporations, foundations, institutions are down dramatically and listeners contributions, the main source of funding for Community radio are beginning to be impacted by the

[1] Pew Hispanic Center, Statistical Portrait of Hispanics in the United States, 2007.

growing unemployment. Community stations are critical sources of local information and it is essential that they be able to continue to provide their unique local service.

Community radio supports $40 million in fiscal year 2010 for the conversion to digital broadcasting by public radio and television. While public television's digital conversion needs are 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. CPB has provided funding for more than 650 radio transmitters to convert to digital. Of those, 160 are multicasting two or more streams of programming. The development of second and third audio channels will potentially double or triple the service that public radio can provide listeners, particularly in un-served and underserved communities. However, this initial funding still leaves nearly 200 radio transmitters that must ultimately convert to digital or become obsolete.

Community radio strongly supports $27 million in fiscal year 2009 for the public radio interconnection system. Public radio pioneered the use of satellite technology to distribute programming. The Public Radio Satellite System's recently launched ContentDepot continues this tradition of cutting edge technology. Satellite capacity supporting it must be renewed and upgrades are necessary at the station and network operations levels. Interconnection is vital to the delivery of the high-quality programming that public broadcasting provides to the American people. This is the last year of a 3-year request for $80 million to the complete the project.

We are in a period of tremendous change. "Radio is well on its way to becoming something altogether new—a medium called audio."[2] The digital movement is transforming the way we do things; new distribution avenues like digital satellite broadcasting and the Internet are changing how we define our business; and, the concentration of ownership in commercial radio makes public radio in general, and Community radio in particular, more important as a local voice than we have ever been. New Low Power FM stations are providing local voices in their communities an avenue of expression, and many new community stations will be going on the air within the next few years. Community radio is providing essential local emergency information, programming about the local impact of major global events taking place, and culturally relevant information and entertainment in native languages, as well as helping to preserve cultures that are in danger of dying out. During the natural disasters of recent years, radio proved once again that it is the most dependable and available medium for getting emergency information to the public.

During these challenging times, the role of CPB as a convener of the system becomes even more important. The funding that it provides will allow smaller stations to participate alongside larger stations that have more resources as we move into a new era of communications.

PREPARED STATEMENT OF THE NATIONAL FRAGILE X FOUNDATION

Mr. Chairman and members of the subcommittee: As President of the Board of Directors for the National Fragile X Foundation, I want to take this opportunity to thank you for the leadership role this subcommittee has played over the years in the fight for Fragile X-associated Disorders. I am pleased to offer the following written testimony regarding appropriation requests in fiscal year 2010.

Fragile X-associated Disorders are genetic disorders that cause behavioral, developmental, and language disabilities across a person's lifespan. It is linked to a mutation on the X chromosome, and is the most commonly inherited form of intellectual disabilities. Fragile X is also linked to reproductive problems in women including early menopause Fragile X-associated primary ovarian insufficiency (FXPOI) and, a Parkinson's-like condition in older male carriers Fragile X-associated tremor/ataxia syndrome (FXTAS). More than 100,000 Americans have Fragile X Syndrome and more than 1 million Americans carry a Fragile X mutation and either have, or are at risk for developing a Fragile X-associated disorder.

These appropriations requests are significant in order to continue to build the infrastructure needed and assure continued progress toward targeted treatments for Fragile X-associated Disorders. The National Fragile X Foundation has invested significantly in the creation of the Fragile X Clinical & Research Consortium, a network of 20 clinics across the country who collaborate to align data collection efforts, participate in clinical trials of new pharmacological agents, share research findings and develop consistent best practices and standards of care for the treatment of Fragile X-associated Disorders.

[2] The State of the News Media, Pew Project for Excellence in Journalism, 2008.

In addition, these appropriations requests would assist in building upon important work already initiated by the Federal Government. We have been successful at building programs at the Centers for Disease Control and Prevention (CDC), National Institutes of Health (NIH), and Health Resources and Services Administration (HRSA). The CDC has recognized the value of this important collaboration, and has provided resources to ensure the continued growth and evolution of the Fragile X Clinical & Research Consortium. Previously, the CDC had secured nearly $4.5 million in funding since fiscal year 2005 for the CDC Fragile X National Public Health Initiative. The program is currently funded at just more than $1.8 million annually. Furthermore, the CDC has worked with Congress to define the highest impact public health priorities for the Fragile X community. These efforts led to:

—Development of a newborn screening test for fragile X syndrome;
—Single gene resource network for fragile X syndrome;
—Fragile X syndrome cascade testing and genetic counseling protocols;
—Fragile X Family Needs Assessment; and
—Support for the Fragile X Clinical & Research Consortium.

Moreover, public efforts, including three National Institute of Child Health and Human Development (NICHD)-funded Fragile X Research Centers, has proven critically important in the development of effective treatments. The development of key therapeutics for Fragile X will likely be effective for a much larger population living with related autism spectrum disorders. We recognize that in order to translate basic science findings into viable treatments for Fragile X, additional coordination and resources are required at the NIH.

The Fragile X community has been working to promote the work of NIH to ensure improved coordination among the various Institutes to ensure the most effective use of Federal research dollars devoted to Fragile X-associated Disorders (i.e., Fragile X Syndrome, Fragile X-associated Tremor/Ataxia Syndrome, and Fragile X-associated Primary Ovarian Insufficiency). Congress has advocated for greater resources at NIH leading to an increase in NIH Fragile X-associated Disorders efforts from approximately $12 million annually in 2001 to approximately $27 million in fiscal year 2009. With this increase, NIH recently awarded the largest Fragile X Federal research grant in history, a 5-year, $21.8 million grant to a team of researchers at the UC Davis School of Medicine and M.I.N.D. Institute.

As you know, the fiscal year 2008 Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriations Act included language directing the NIH, under the leadership of the NICHD (Senate Report 110–107) to coordinate, intensify, and expedite research efforts related to Fragile X-associated Disorders. The law specifically directed the NIH to convene a scientific session in 2008 to develop pathways to new opportunities for collaborative, directed research across Institutes, and to produce a blueprint of coordinated research strategies and public-private partnership opportunities for Fragile X. The NICHD was directed to lead this initiative and was urged to collaborate with the three existing federally funded Centers of Excellence as well as the Fragile X Clinical & Research Consortium.

In response to this directive, NICHD leadership convened a 2-day scientific session and created a rigorous working group infrastructure consisting of the world's leading researchers and NIH staff to ensure timely development of the NIH Research Blueprint on Fragile-X associated disorders. The leadership team at NICHD and three working groups prepared a comprehensive blueprint that will provide a clear direction for future research activities for Fragile-X associated disorders. The final draft of this report was completed in late 2008, and will be published by NIH this week.

Mr. Chairman, we respectfully request Congress to continue its support of these ongoing initiatives, and to support increased prioritization of Fragile X-associated Disorders at the CDC and NIH in order to accelerate the critical work being accomplished through the Fragile X Clinical & Research Consortium.

The National Fragile X Foundation recommends that you appropriate the following fiscal year 2010 requests:

—A $2 million increase in funding from fiscal year 2009 levels, for the National Fragile X Public Health Initiative and other CDC initiatives to:
  —Focus efforts on identifying ongoing needs, effective treatments, and positive outcomes for families by increasing epidemiological research, surveillance, screening efforts, and the introduction of early interventions and supports for individuals living with Fragile X-associated Disorders.
  —Focus on the continued growth and development of initiatives that support health promotion activities and foster rapid, high-impact translational research practice for the successful treatment Fragile X-associated Disorders,

including ongoing collaborative activities with the Fragile X Clinical & Research Consortium.
- —Report language and increased resources for Fragile X at the NIH to:
  - —Support continued implementation of the recommendations outlined in the NIH Fragile X-associated Disorders Research Blueprint as well as increased NIH support for the Fragile X Clinical & Research Consortium.
  - —Enhance its efforts across its Institutes to translate basic science findings into viable treatments for Fragile X, and encourage clinical drug trials for this orphan indication.
  - —Maximize Fragile X resources by ensuring that appropriate resources and direction is provided to implement the objectives outlined in the Fragile X Research Blueprint.
  - —Strengthen and broaden research on Fragile X- associated disorders (i.e., FXTAS and FXPOI).

Furthermore, as part of our overall to increase support and prioritization of Fragile X-associated Disorders at the Federal level, the Fragile X community is also working with the Defense Subcommittee on Appropriations to include Fragile X-associated Disorders among the list of eligible healthcare conditions for targeted biomedical research funding through the U.S. Department of Defense. The success from all of these intense public and private research efforts, including the NIH and CDC, has brought discoveries to bear for Fragile X-associated Disorders. However, we feel continued expansion of Federal efforts and resources at each of these agencies will be instrumental to conduct promising research on Fragile X-associated Disorders.

Mr. Chairman, thank you for your time and attention. We, at the National Fragile X Foundation, believe that continued awareness and support for enhancing Fragile X research and translational activities is imperative. Given the significant impact this condition has on families and communities across the country, the promise of a breakthrough for the treatment and cure of this disease is urgent. Should you have any questions or require additional information, please feel free to call on me.

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 $2.9 billion for the Consolidated Health Centers Program in fiscal year 2010.

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 Health Care for the Homeless Program—administered by the Health Resources and Services Administration (HRSA)—currently supports 205 HCH projects in all 50 States, the District of Columbia, and Puerto Rico. Congress established HCH 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 742,588 in 2007—a sizable number, but far below the 3.5 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. 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.

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, unemployment jumped to 8.5 percent in March 2009, the highest in 14 years. With continued increases in unemployment, more Americans are expected to lose health coverage, thus placing additional burden upon community health centers.

Fiscal Year 2010 Appropriations.—In recognition of the growing need for primary healthcare services, the Senate Committee on Appropriations along with other Members of Congress has been supportive of strengthening and expanding community health centers. In the current year, Congress appropriated $2.2 billion—$125 million above the fiscal year 2008 appropriation. This included $56 million in base grant adjustments and provided a total of $191 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 $2.9 billion for the Community Health Center program (including $252 million for the HCH program) in fiscal year 2010. The National Council's request is consistent with planned increases outlined in the Access for All America Act (S. 486). This important legislation, introduced by Senator Bernie Sanders, would quadruple the amount of funding for community health centers over the next 5 years.

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 MARFAN FOUNDATION

Mr. Chairman, thank you for the opportunity to submit testimony regarding the fiscal year 2010 budget for the National Heart, Lung and Blood Institute (NHLBI), the National Institute of Arthritis, Musculoskeletal and Skin Diseases (NIAMS), and the Centers for Disease Control and Prevention (CDC). The National Marfan Foundation is grateful to you and the subcommittee for your strong support of the National Institutes of Health and CDC, 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, skeleton, 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.

NHLBI

Pediatric Heart Network Clinical Trial

NMF applauds NHLBI 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.

NHLBI Director Dr. Elizabeth Nabel describes this promising research well:

"After the discovery that Marfan syndrome is associated with the mutation in the gene encoding a protein called fibrillin-1, researchers tried for many years, without success, to develop treatment strategies that involved repair of replacement of fibrillin-1. Then a major breakthrough occurred with the discovery that one of the functions of fibrillin-1 is to bind to another protein, TGF-beta, and regulate its effects. After careful analysis revealed aberrant TGF-beta activity in patients with Marfan syndrome, researchers began to concentrate on treating Marfan syndrome by normalizing the activity of TGF-beta. Losartan, which is known to affect TGF-beta activity, was tested in a mouse model of Marfan syndrome and the results showed that drug was remarkably effective in blocking the development of aortic aneurysms, as well as lung defects associated with the syndrome.

Based on this promising finding, the NHLBI Pediatric Heart Network, has undertaken a clinical trial of losartan in patients with Marfan syndrome. About 600 patients aged 6 months to 25 years will be enrolled and followed for 3 years. This development illustrates the outstanding value of basic science discoveries, and identifying new directions for clinical applications. Moreover, the ability to organize and initiate a clinical trial within months of such a discovery is testimony to effectiveness of the NHLBI Network in providing the infrastructure and expertise to capitalize on new findings as they emerge."

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 fibrillin-1 and TGF-beta play 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.

NMF is also proud to actively support the losartan clinical trial in partnership with the Pediatric Heart Network. Throughout the life of the trial we will provide 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.

NHLBI "Working Group on Research in Marfan Syndrome and Related Conditions"

In April 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.

—The developmental underpinnings of apparently acquired phenotypes should be explored. This effort will be facilitated by the dedicated analysis of both prenatal and early postnatal tissues in genetically defined animal models and through the expanded availability to researchers of surgical specimens from affected children and young adults."

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. Mr. Chairman, for fiscal year 2010 NMF joins with other professional and patient organizations in recommending a 7 percent for NHLBI.

NIAMS

NMF is proud of its longstanding partnership with NIAMS. 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 clinical trail moves 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 in support of this research moving forward.

For fiscal year 2010, NMF recommends a 7 percent increase for NIAMS.

CDC

Mr. Chairman, we are grateful for the subcommittee's encouragement in recent years of collaboration between CDC and the Marfan syndrome community. 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.

Despite our ongoing efforts to raise awareness among the general public and healthcare providers, we know of too many families who have lost a loved one because of a missed diagnosis.

We are very appreciative of CDC's support of our 25th annual patient conference taking place in Rochester, Minnesota August 6–9, 2009. We have also discussed other potential collaborations with the National Center on Birth Defects and Development Disabilities focused on education and early diagnosis. We ask the subcommittee to continue to encourage CDC to work with us to initiate these activities in fiscal year 2010.

For fiscal year 2010, NMF joins with the CDC Coalition in recommending an appropriation of $8.6 billion for core CDC programs.

PREPARED STATEMENT OF THE NATIONAL NETWORK TO END DOMESTIC VIOLENCE

Chairman Harkin, Ranking Member Cochran, and members of the subcommittee, thank you for the opportunity to submit written testimony to the Labor, Health and Human Services, and Education, an Related Agencies (LHHS) Appropriations Subcommittee. We are grateful to the subcommittee for your continued leadership and your investment in lifesaving programs that prevent and end domestic violence.

The National Network to End Domestic Violence (NNEDV) is a membership and advocacy organization representing the 56 State and U.S. territory domestic violence coalitions. NNEDV provides a national voice for the coalitions, their more than 2,000 local domestic violence member programs, and the millions of domestic violence survivors who turn to them for services. In their work with victims and their families, our members see the impact that abuse and violence have on the lives of children who are vulnerable both as witnesses to violence and as victims themselves.

Over the last 25 years, millions of victims have found refuge and safety through domestic violence programs funded by the Family Violence Prevention and Services Act (FVPSA). The success of this LHHS-funded program, however, is threatened by budget stagnation and an increasing demand for services. Small budget increases, while appreciated, simply cannot meet the desperate needs of victims. Now, more than ever, we need to increase our country's investment in this vital, cost-effective program. Increases to FVPSA funding will help bridge the unconscionable gap created by an increased demand and inadequate funding. On behalf of the millions of victims and families that our member programs serve each year, we urge you to fully fund the FVPSA/Battered Women's Shelter Services program (FVPSA) at $175 million, the National Domestic Violence Hotline at $3.5 million, and the Community Initiatives to Prevent Abuse (DELTA) program at $6 million in the fiscal year 2010 congressional budget.

DOMESTIC VIOLENCE

Domestic violence is pervasive and life-threatening. According to the 2005 Bureau of Justice Statistics' Family Violence Statistics, of the total victims of violence between 1998 and 2002, 11 percent were victims of family violence.[1] One in four women has been beaten or raped by a husband, boyfriend, or partner in her lifetime.[2] In 2005 alone, 1,181 women were murdered by an intimate partner in the United States[3] and approximately one-third of all female murder victims are killed by an intimate partner.[4]

The cycle of intergenerational violence is perpetuated as children witness violence. It is estimated that a staggering 15.5 million children are exposed to domestic violence every year.[5] Children who are exposed to domestic violence are more likely to exhibit behavioral and physical health problems including depression, anxiety, and violence towards peers.[6] They are also more likely to attempt suicide, abuse drugs and alcohol, run away from home, engage in teenage prostitution, and perpetrate sexual assault.[7] One study found that men exposed to physical abuse, sexual abuse, and adult domestic violence as children were almost four times more likely than other men to have perpetrated domestic violence as adults.[8]

Domestic violence is not just a crime; it is a public health crisis that leads to chronic health conditions, disabilities, lost work time, frequent trips to the emergency room and, all too often, serious injury or death.

In addition to the terrible cost domestic and sexual violence have on the lives of individual victims and their families, these crimes cost taxpayers and communities. In fact, the cost of intimate partner violence exceeds $5.8 billion each year, $4.1 billion of which is for direct medical and mental healthcare services.[9] Research shows that for every 100,000 women between 18 and 64 enrolled, intimate partner violence

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[1] U.S. Department of Justice, Bureau of Justice Statistics, Family Violence Statistics: Including Statistics on Strangers and Acquaintances, June 2005.

[2] Tjaden, Patricia & Thoennes, Nancy. National Institute of Justice and the Centers of Disease Control and Prevention, "Extent, Nature and Consequences of Intimate Partner Violence: Findings from the National Violence Against Women Survey," 2000. The Centers for Disease Control (CDC) (2008). *Adverse Health Conditions and Health Risk Behaviors Associated with Intimate Partner Violence, United States*, 2005.

[3] Bureau of Justice Statistics, Homicide Trends in the U.S. from 1976–2005. US Department of Justice. (2008).

[4] Bureau of Justice Statistics, Homicide Trends from 1976–1999. U.S. Department of Justice. (2001)

[5] McDonald, R., et al. (2006). "Estimating the Number of American Children Living in Partner-Violence Families." *Journal of Family Psychology, 30(1)*, 137–142.

[6] Jaffe, P. and Sudermann, M., "Child Witness of Women Abuse: Research and Community Responses," in Stith, S. and Straus, M., *Understanding Partner Violence: Prevalence, Causes, Consequences, and Solutions*. Families in Focus Services, Vol. II. Minneapolis, MN: National Council on Family Relations, 1995.

[7] Wolfe, D.A., Wekerle, C., Reitzel, D. and Gough, R., "Strategies to Address Violence in the Lives of High Risk Youth." In Peled, E., Jaffe, P.G. and Edleson, J.L. (eds.), *Ending the Cycle of Violence: Community Responses to Children of Battered Women*. New York: Sage Publications. 1995.

[8] Greendfeld, L. A. (1997). Sex Offences and Offenders: An Analysis of Date on Rape and Sexual Assault. Washington, DC. Bureau of Justice Statistics, U.S. Department of Justice.

[9] National Center for Injury Prevention and Control. *Costs of Intimate Partner Violence Against Women in the United States*. Atlanta (GA): Centers for Disease Control and Prevention; 2003.

costs a health insurance plan $19.3 million each year.[10] Domestic violence costs U.S. employers an estimated $3 to $13 billion annually.[11]

THE FAMILY VIOLENCE PREVENTION AND SERVICES ACT (FVPSA)

Despite this grim reality, we know that when immediate, essential services are available victims can escape from life-threatening violence and begin to rebuild their shattered lives.

FVPSA has significantly enhanced community-based domestic violence intervention and prevention efforts since it was first authorized by Congress in 1984. Administered by the Department of Health and Human Services Administration on Children and Families through a State formula grant, FVPSA provides funding to States, territories and tribes to support domestic violence services in their communities using a population-based formula. These essential services that are at the core of ending domestic violence: emergency shelters, hotlines, counseling and advocacy, primary and secondary prevention—immediate crisis response and the comprehensive support to help victims put their lives back together. FVPSA also authorizes the Community Initiatives to Prevent Abuse program (frequently referred to as Domestic Violence Prevention Enhancement and Leadership Through Alliances (DELTA) Grants) and the National Domestic Violence Hotline. Working together, these FVPSA programs have made significant progress toward ending domestic violence and keeping families and communities safe. Since its passage in 1984, FVPSA remains the only Federal funding directly for shelter programs.

There are approximately 2,000 FVPSA-funded community-based domestic violence programs for victims and their children, providing emergency shelter to approximately 300,000 victims and offering services such as counseling, crisis lines, safety planning, legal assistance, and preventative education to millions of adults and children annually.[12] In just 1 day in 2008, 60,799 victims were served by 1,553 domestic violence programs. Of the 20,307 victims in emergency shelter that day, nearly 50 percent were children.[13] Programs answered 21,683 hotline calls and trained 30,210 community members.

These effective programs save and help rebuild lives. A recently released multi-State study shows conclusively that the Nation's domestic violence shelters are addressing both urgent and long-term needs of victims of violence, and are helping victims protect themselves and their children.[14] Research shows that shelter programs are among the most effective resources for victims with abusive partners [15] and that staying at a shelter or working with a domestic violence advocate significantly reduced the likelihood that a victim would be abused again and improved the victim's quality of life.[16] The impact of being and feeling safe cannot be underestimated—

[10] *Ibid*.

[11] Bureau of National Affairs Special Rep. No. 32, Violence and Stress: The Work/Family Connection 2 (1990); Joan Zorza, *Women Battering: High Costs and the State of the Law*, Clearinghouse Rev., Vol. 28, No. 4,383,385; *Supra note* 10.

[12] National Coalition Against Domestic Violence, *Detailed Shelter Surveys* (2001).

[13] Domestic Violence Counts 08: A 24-hour census of domestic violence shelters and services across the United States. The National Network to End Domestic Violence. (Jan. 2009).

[14] Lyon, E., Lane S. (2009). *Meeting Survivors' Needs: A Multi-State Study of Domestic Violence Shelter Experiences*. National Resource Center on Domestic Violence and UConn School of Social Work. Found at http://www.vawnet.org.

[15] See: Bennett, L., Riger, S., Schewe, P., Howard, A., & Wasco, S. (2004). Effectiveness of hotline, advocacy, counseling and shelter services for victims of domestic violence: A statewide evaluation. Journal of Interpersonal Violence, 19(7), 815–829; Bowker, L. H., & Maurer, L. (1985). The importance of sheltering in the lives of battered women. Response to the Victimization of Women and Children, 8, 2–8; Gordon, J. S. (1996). "Community services for abused women: A review of perceived usefulness and efficacy." Journal of Family Violence 11(4): 315–329; Sedlak, A. J. (1988). Prevention of wife abuse. In V. B. Van Hasselt, R. L. Morrison, A. S. Bellack, & M. Hersen (Eds.), Handbook of Family Violence (pp. 319–358). NY: Plenum Press; Straus, M. A., Gelles, R. J., & Steinmetz, S. K. (1980). Behind closed doors: Violence in the American family. NY: Anchor Press; Tutty, L. M., Weaver, G., & Rothery, M. (1999). Residents' views of the efficacy of shelter services for assaulted women. Violence Against Women, 5(8), 898–925.

[16] See: Berk, R. A., Newton, P. J., & Berk, S. F. (1986). What a difference a day makes: An empirical study of the impact of shelters for battered women. Journal of Marriage and the Family, 48, 481–490; Bybee, D.I., & Sullivan, C.M. (2002). The process through which a strengths-based intervention resulted in positive change for battered women over time. American Journal of Community Psychology, 30(1), 103–132; Constantino, R., Kim, Y., & Crane, P.A. (2005). Effects of a social support intervention on health outcomes in residents of a domestic violence shelter: A pilot study. Issues in Mental Health Nursing, 26, 575–590; Goodkind, J., Sullivan, C.M., & Bybee, D.I. (2004). A contextual analysis of battered women's safety planning. Violence Against Women, 10(5), 514–533; Sullivan, C.M. (2000). A model for effectively advocating for women with abusive partners. In J.P. Vincent & E.N. Jouriles (Eds.), Domestic violence: Guide-

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when asked what he liked best about staying in the shelter, a 10-year-old boy in Maryland replied, “I can sleep at night.”

Once FVPSA appropriations reach $130 million, a portion will be set aside solely for children’s services. Battered women’s shelters and domestic violence programs provide safety and support for children, but struggle to meet the demand for children’s services. They see the needs of children who are recovering from the trauma of witnessing or experiencing abuse and they are eager to implement new and expanded children’s programming.

The Community Initiatives to Prevent Abuse/DELTA Grants program supports community-based primary prevention that address the underlying causes of domestic violence in order to stop abuse before it starts. DELTA is administered by the Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, and it is one of the few funding sources for primary prevention work. DELTA programs use innovative strategies including peer education programs for men about family and relationships, community change initiatives focused on engaging men in prevention efforts, school-based education to prevent youth bullying that often carries into adulthood, and youth-led initiatives to prevent dating violence and promote healthy relationships.

FVPSA also includes the National Domestic Violence Hotline, a 24-hour, confidential, toll-free hotline, located in Texas. Since opening in 1996, the National Domestic Violence Hotline has received more than 2 million calls from individuals in need of support and assistance. Highly trained hotline advocates provide support, information, referrals, safety planning, and crisis intervention to hundreds of thousands of domestic violence victims and perpetrators. More than 60 percent of callers report that their call to the hotline is the first time they open up about the abusive relationship.

THE FUNDING GAP

Due to the overwhelming success of Violence Against Women Act (VAWA) and FVPSA funded programs, more and more victims are coming forward for help each year. This rising demand for services, without a concurrent increase in funding, means that many desperate victims are turned away from life-saving services. In just 1 day last year, nearly 9,000 requests for services went unmet across the country due to a lack of resources, including 3,286 requests for emergency shelter.[17] Additionally, the National Domestic Violence Hotline was unable to answer 42,500 calls (17 percent of the total) because they lacked the resources to answer the calls.

The economic crisis further exacerbates the gap created by the increasing demand for services and the lack of adequate resources. While economic hard times do not cause violence, the economic stresses can increase the frequency and level of violence in a home. With fewer personal, family, and community resources upon which to rely, more victims turn to domestic violence programs for help. A survey of domestic violence shelters across the country revealed that 3 out of 4 domestic violence shelters have seen an increase in women seeking assistance from abuse since September 2008, a major turning point in the U.S. economy. Just as more victims are seeking services, programs are facing cutbacks from State and country funding sources, as well as philanthropic dollars. Many programs have been forced to lay off staff and cuts services—a number of programs have even been forced to close their doors permanently.

Laurie Schipper, Executive Director of the Iowa Coalition Against Domestic Violence explains the stark consequences of this reality, “If women have nowhere to go, especially in rural areas, women and kids are going to die. It’s difficult to overstate the gravity of this.”[18]

FVPSA REAUTHORIZATION

Due to a busy congressional calendar, FVPSA expired in 2008 and has yet to be reauthorized. The Senate HELP Committee is currently working to reauthorize FVPSA, along with the Child Abuse Prevention and Treatment Act. Advocates remain concerned, however, that while FVPSA remains expired programs will be further jeopardized. We call on the Senate LHHS Appropriations Subcommittee to in-

lines for research-informed practice (pp. 126–143). London: Jessica Kingsley Publishers; Sullivan, C.M., & Bybee, D.I. (1999). Reducing violence using community-based advocacy for women with abusive partners. Journal of Consulting and Clinical Psychology, 67(1), 43–53.

[17] Domestic Violence Counts 08: A 24-Hour census of domestic violence shelters and services across the United States. The National Network to End Domestic Violence. (Jan. 2009).

[18] Alex, Tom. Wife flees, alleging decades of abuse. DesMoinesRegister.com, April 18, 2009. Available at: http://www.desmoinesregister.com/apps/pbcs.dll/article?AID=/20090418/NEWS01/904180322.

clude report language in the final appropriations bill that acknowledges the vital work of FVPSA and directs the funding to be spent in a way consistent with its authorization.

NNEDV chairs a national coalition of FVPSA stakeholders who have delineated clear priorities for the FVPSA reauthorization. Collectively, we want to see FVPSA continue its success while expanding to reach the needs of victims who have historically been underserved. These needed improvements will require commitment and investment from the Appropriations Committee.

INVESTING IN SERVICES SAVES LIVES

In the fiscal year 2008 congressional budget, FVPSA funding was cut by $2.1 million, bringing FVPSA funding to $122.6, which is $52.5 million below the authorized level of $175 million. We applaud the subcommittee's commitment to these programs, evidenced in the modest funding increases allocated in fiscal year 2009. FVPSA was funded at $127.7 million (a $5 million increase from fiscal year 2008), the National Domestic Violence Hotline was funded at $3.2 million (a $0.2 million increase from fiscal year 2008), and DELTA was funded at $5.5 million (a $0.5 million increase from fiscal year 2008). While these increases will pay dividends over time by preventing other costly social ills, in order to meet the ever-growing demand for services, it is essential that Congress continue to provide steady increases.

The President's fiscal year 2010 budget proposal requests level funding for all three programs. Yet we know that level funding simply will not bridge the gap in funding. Congress should invest in FVPSA not only to meet the needs of victims in life-threatening situations but also to prevent future social ills.

Fully funding FVPSA at $175 million, the hotline at $3.5 million and DELTA at $5.5 million will allow communities across the country to continue to provide critically needed direct services to victims of domestic violence and their children, which will help to prevent homicides and break the cycle of violence.

Without effective intervention, domestic violence will repeat itself and continue to impact successive generations. FVPSA is a critical component in breaking the cycle of violence affecting our children, families and communities. FVPSA funding, has begun to make our country a safer place for families, victims and communities. Now, however, this phenomenal progress is in jeopardy. We have seen a reduction in homicides and the incidence of these heinous crimes. Yet these tough economic times, combined with funding cuts forcing shelters to close, real victims face life-threatening situations with no support. Every day shelters and service providers must turn away families in danger due to lack of resources. While a tough economy may tempt lawmakers to cut or maintain existing funding levels, we cannot allow this unmet need to continue.

By prioritizing these vital, cost-effective funding streams, Congress will help to break the cycle of domestic violence in our country.

PREPARED STATEMENT OF THE NATIONAL PSORIASIS FOUNDATION

The National Psoriasis Foundation (NPF) appreciates the opportunity to submit written testimony for the record regarding Federal funding for psoriasis and psoriatic arthritis research for fiscal year 2010. NPF serves as the Nation's largest patient-driven, nonprofit, voluntary association committed to finding a cure for psoriasis and psoriatic arthritis, which affects as many as 7.5 million Americans, and eliminating their devastating effects. Psoriasis is among the most prevalent autoimmune diseases.

As part of our mission, we educate health professionals, the public and policymakers to increase public awareness and understanding of the challenges faced by people with psoriasis and psoriatic arthritis. Moreover, NPF maintains a strong commitment to securing public policies and programs that support its focus of education, advocacy, and research toward better treatments and a cure. NPF specifically seeks to advance public and private efforts to improve treatment of these diseases, 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 the highest quality of life possible.

NPF stands ready to partner 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. Specifically, NPF advocates that in fiscal year 2010 the National Institutes of Health (NIH) receive an additional $2.1 billion for a total allocation of $32.5 billion to 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 ex-

plore the nascent understanding of co-morbidities, such as obesity, depression and heart disease that may be associated with inflammation in the skin and joints. In addition, we urge that Congress provide $1.5 million in fiscal year 2010 to the Centers for Disease Control and Prevention (CDC) to support such data collection to increase understanding of the comorbidities associated with psoriasis, examine the relationship of psoriasis to other public health concerns, such as the high rate of smoking and obesity among those with the disease, and gain insight into the long-term impact and treatment of these two conditions.

THE IMPACT OF PSORIASIS AND PSORIATIC ARTHRITIS

According to the NIH, as many as 7.5 million Americans have psoriasis—an immune-mediated, genetic, chronic, inflammatory, painful, disfiguring, and life-altering disease that requires life-long sophisticated medical intervention and care, and imposes serious adverse effects on the individuals and families affected. On average, 17,000 people with psoriasis live in each Congressional District.

Psoriasis typically first strikes between the ages of 15 and 25, but can occur at any time. It lasts a lifetime. Unfortunately, psoriasis often is overlooked or dismissed, because it typically does not cause death. It is commonly and incorrectly considered by insurers, employers, policymakers, and the public as a mere annoyance—a superficial problem, mistakenly thought to be contagious and/or due to poor hygiene. Yet, together psoriasis and psoriatic arthritis impose significant economic costs on individuals and society. Total direct and indirect healthcare costs of psoriasis are calculated at more than $11,250,000,000 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-threatening conditions. Although data are still 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 comorbidities, such as Crohn's disease, diabetes, metabolic syndrome, obesity, hypertension, heart attack, cardiovascular disease, liver disease, and psoriatic arthritis—which occurs in up to 30 percent of people with psoriasis. Other recent studies have found that people with severe psoriasis have a 50 percent higher mortality risk and that these patients die 3 to 6 years younger than those who do not have psoriasis. Of serious concern is that studies have shown 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 improved quality of life and effective, safe, and affordable therapies, which could be delivered through an increased Federal commitment to genetic, clinical, and basic research. Research holds the key to improved treatment of these diseases, better diagnosis of psoriatic arthritis and eventually a cure for both conditions.

FEDERAL PSORIASIS AND PSORIATIC ARTHRITIS RESEARCH

Although overall NIH funding levels improved for psoriasis research in fiscal year 2007, 3 out of 5 NIH agencies decreased psoriasis funding that same year. NPF is concerned that at the historical and current rate of psoriasis funding, NIH funding is not keeping pace with research needs, nor is the investment commensurate with the impact of the disease. Within the NIH, the National Institute of Arthritis and Musculoskeletal and Skin Diseases (NIAMS), 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 psoriasis research. Additionally, research activities that relate to psoriasis or psoriatic arthritis also have been undertaken at the National Cancer Institute. An analysis of longitudinal Federal funding data shows that, on average over the past decade, NIAMS has spent less than $1 per person with psoriasis per year.

Adequate investment in psoriasis and psoriatic arthritis in fiscal year 2010 and beyond is imperative, because a rare opportunity for breakthroughs in both conditions is presenting itself at this time. A convergence of findings reached through various types of studies has stimulated new ideas about the mechanisms involved in psoriasis.

It has taken nearly 30 years to understand that psoriasis is not solely a disease of the skin, but also of the immune system. Finally, scientists are identifying the genes immune cells involved in psoriasis—findings that will help improve understanding of which cells or molecular processes should be targeted in psoriasis drug

development. With these important advances, we are poised and positioned, as never before, to identify and develop a permanent method of control for psoriasis and, eventually, a cure. 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;
—Studying a number of important epidemiologic issues, such as the risk of heart attack, diabetes, increased mortality, and lymphoma in psoriasis patients;
—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.

THE ROLE OF CDC IN PSORIASIS AND PSORIATIC ARTHRITIS RESEARCH

NPF is concerned that there have been very few efforts to collect epidemiological and other related data on individuals with psoriasis and psoriatic arthritis. Researchers and clinicians continue to be limited in their longitudinal understanding of these conditions and their effects on individual patients. There are many mysteries related to psoriasis and psoriatic arthritis. For example, we know of people who never had any evidence of disease who, after falling ill with the flu or spiking a fear, wake the next day to be covered in psoriasis plaques. Why? A treatment could work well for an individual for years and then suddenly become ineffective. Why?

Researchers agree that collecting data through a patient registry would help increase the understanding of: the other chronic conditions that co-occur with psoriasis; how factors like age or gender impact the course and burden of psoriasis; and how certain environmental exposures might contribute to the occurrence and severity of psoriasis and psoriatic arthritis. In turn, this information would help improve treatments and advance efforts toward a cure. CDC psoriasis and psoriatic arthritis data collection efforts would help answer myriad questions about these autoimmune conditions, contribute to improved disease treatment and management, and further the Nation's efforts to find a cure.

For 3 years, your subcommittee has encouraged CDC to undertake data collection, and we very much appreciate your recognition of this much-needed effort. We have met with CDC staff to offer our assistance and expertise, however, it is clear the agency must receive specific, dedicated funding so it has the resources necessary to develop a registry. To that end, NPF respectfully requests that the subcommittee allocate $1.5 million in fiscal year 2010 for the National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP) within the CDC to examine and develop options and recommendations for the creation of a National Psoriasis and Psoriatic Arthritis Patient Registry. A national patient registry that collects longitudinal patient data will help researchers to learn about key attributes, such as response to treatment, substantiating the waxing and waning of psoriasis, understanding associated manifestations like nail disease and arthritis, and the relationship of psoriasis to other public health concerns.

FUNDING REQUEST SUMMARY

NPF recognizes that Congress and the Nation face unprecedented fiscal challenges. However, we also believe that greater fiscal year 2010 investment in biomedical and epidemiologic research at NIH and CDC will prove simulative to the economy and 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 allocations:

—$32.4 billion to NIH and its Institutes and Centers that play an integral role in psoriasis and psoriatic arthritis research and urge them to initiate and/or expand psoriasis and psoriatic arthritis research and;
—$1.5 million to the NCCDPHP within the CDC to collect data on psoriasis and psoriatic arthritis and begin to establish a patient registry to improve the knowledge base of the longitudinal impact of these diseases on the individuals they affect.

CONCLUSION

On behalf of NPF's Board of Trustees and the as many as 7.5 million individual with psoriasis and psoriatic arthritis who we represent, thank you for this oppor-

tunity to submit written testimony regarding the fiscal year 2010 funding levels necessary to ensure that our Nation adequately addresses psoriasis and psoriatic arthritis and to make gains in improving therapies and eventually attaining a cure. We believe that additional research undertaken at the NIH coupled with epidemiologic efforts at the CDC together will help advance the Nation's efforts to improve treatments and identify a cure for psoriasis and psoriatic arthritis. 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 NATIONAL PUBLIC RADIO

Thank you Chairman Inouye and Senator Cochran for the opportunity to offer testimony on behalf of National Public Radio (NPR), our more than 850 public radio station partners, and for other producers and distributors of public radio programming including American Public Media, Public Radio International, the Public Radio Exchange, and many, many stations, both large and small, that create and distribute content through the Public Radio Satellite System (PRSS).

The state of public radio today is both sobering and heartening. While the economic crisis has undermined the financial stability of the public radio system, the audience is tuning at record levels. But without your help, we will not be able to continue to achieve our public service mission, and your expectations.

AN ADDITIONAL INVESTMENT IN STATIONS

Public broadcasting is requesting $307 million—$96 million for public radio stations and $211 million for public television stations—in additional emergency investment funding for the fiscal year 2010 budget of the Corporation for Public Broadcasting (CPB). This action is necessary to offset the tide of losses at public broadcasting stations. This one-time investment of Federal resources will help protect thousands of station jobs now at risk, and assure continuity in services used daily by tens of millions of Americans. These funds are in addition to the $420 million that Congress approved 2 years ago as part of the advance funding process.

The funds we are requesting only partially close the expected 2-year revenue shortfall of almost $170 million at the public radio station level, plus an additional $55 million in loses at NPR. The remainder will come about as a result of significant cost cutting at the local and national levels. Every week brings another announcement of a service reduction or employment layoff at public broadcasting stations. In fact, a survey last month of locally licensed and operated public radio stations projected more than a 46 percent reduction in financial support from local and State government agencies, a 23 percent decline in foundation and philanthropic contributions and a 23 percent drop in underwriting from local businesses.

Public broadcasting's contribution to America's democracy is more important today than at anytime during our four decades of public service. More than 33 million people each week are tuning into public radio programming and listening to member stations. Our audience has grown 66 percent in the past 10 years, bucking a precipitous decline in other media and stands in sharp contrast with the general overall decline in radio listening. Consider that public radio programming today reaches more people than the circulation of USA Today, the Wall Street Journal, the New York Times, Los Angeles Times, the Washington Post and the next top 45 newspapers combined.

Stations in every State have become living embodiments of journalistic excellence, providing news, information and cultural programming that have become increasingly rare in other media. Public radio programming is rooted in the fundamentals of accuracy, transparency, independence, balance, and fairness and serves as cornerstone of understanding for millions of Americans seeking information, context and insight.

PUBLIC FUNDS FOR PUBLIC MEDIA

CPB is the primary public funding mechanism for public radio, accounting for roughly 12 percent of an average public radio station's annual budget. These funds help public broadcasting stations produce, purchase and distribute programming that sparks imagination and kindles thought about our world. Several stations specifically serve rural and minority communities including numerous African-American, Native American, Latino, and multicultural licensees. In many cases, they are the sole local broadcasting service available. These critical Federal funds allow all

stations to continue serving the needs of public radio's 33 million weekly listeners, irrespective of their communities' location or financial status.

CPB's general appropriation is allocated according to a congressionally set formula that ensures the funds go directly to the people and organizations that create and deliver highly valued programs and services. The public broadcasting community is urging Congress to appropriate $542 million in 2-year advanced funding for fiscal year 2012 for CPB.

THE PUBLIC RADIO SATELLITE SYSTEM

As the public broadcasting community grapples with the financial crisis, we also remain committed to ensuring that the Nation's public radio infrastructure continues to be robust and viable. This commitment requires a periodic investment by Congress in PRSS. This year, CPB is requesting $27 million as the third and final installment of a 3-year request to renew and replenish the PRSS.

This system, originally built in 1979 with funds provided by this Committee, distributes 400,000 hours of programming, or 7½ billion listener hours each year. Every minute of every hour of public radio programming—from NPR's Morning Edition, and All Things Considered, to American Public Media's Marketplace and A Prairie Home Companion, to Public Radio International's This American Life and Capitol News Connection—is distributed by the PRSS. Quite simply, without the PRSS, there would be no public radio in the United States.

An important mission of the PRSS is to facilitate the cost-effective and efficient distribution of news, information, cultural, and educational programming to this country's increasingly diverse population. As part of that mission, the PRSS provides satellite transmission services to distribute programming that targets unserved or underserved audiences from sources who meet certain criteria established by the NPR Board, including demonstrated financial need. PRSS is the indispensable distribution backbone for everything heard on public radio. On behalf of all in public radio, I ask for your support of this critically important funding request.

DIGITAL TRANSITION FUNDING

Change is rapidly occurring in over the air radio broadcasting, the last enclave of the old analogue world. As of today, more than 650 public radio stations had either completed or have nearly completed conversion to a digital signal, which improves the overall listener experience by enhancing audio quality; eliminating reception interference; and utilizing multiple audio programming channels, or multicasting. To continue supporting this necessary change in our basic broadcast technology, CPB is requesting $40 million as part of its fiscal year 2010 budget.

Digital broadcasting technology has enabled public radio stations to increase local services to their communities. More than 160 stations are multicasting—doubling and tripling their programming to broaden and expand the base of listeners. Many stations have created Spanish language channels to provide news, including through BBC Mundo. Stations serving Native American communities are providing tribal programming over the air and online. Local community events such as concerts, town hall meetings, committee hearings, legislative floor sessions, and other government programming are broadcast live using HD radio technology. Listeners with HD radio receivers may view a variety of useful messages that scroll across radio display screens, including artist name and song title, emergency alerts, live weather and real-time traffic updates, local news, school closings, and movie listings.

Digital technology using the Internet and mobile platforms expands public radio programming and community services. Expansion and improvement of public radio Web sites and our digital connections with audiences remain a major priority. Public radio stations and public radio program producers are all expanding to new platforms, and in so doing bring broader, deeper and more varied content to our audiences. The impact is already being felt. News coverage of the U.S. Presidential election resulted in record level traffic to public radio station Web sites and NPR.org in terms of both visitors and page views. Ten million visitors went each month to NPR.org during October and November 2008 to view 115 million pages during the same time period. And just this past week, public radios web sites became an essential platform for updated information on Swine flu.

Other Internet and mobile platform program distribution efforts using iPhone applications, for example, have gained wide acceptance among public radio listeners and brought a new generation of consumers to our coverage. Local public radio station and NPR podcasts have become very popular, with some 14 million downloads occurring each month. Podcasts offered by stations are expanding programming in areas such as science, poetry, music, arts, history, politics, international affairs, and

health. The audience may also now download interactive media such as photo slide shows, video, Web streams and audio of local news, music, and programming on their local station Web site.

Audiences are visiting station Web sites with greater frequency for local news and community events. Online community calendars posted on station Web sites allow local organizations of all sizes and areas to list public events and reach a wide audience. Listeners viewing station Web sites are connecting with local nonprofit organizations to obtain information about special cultural activities, festivals, public health fairs, musical events, educational seminars, lectures, classes, and workshops. Station Web sites also increasingly have online music play lists allowing the audience to find information on music played at their local station. Web-based social-networking features are used to foster online communities to give listeners the opportunity to connect over common interests and passions by engaging in dialogue and sharing viewpoints about their lives.

We are confident in our ability to meet the needs of our audience and our ability to emerge from the current economic crisis more prepared and better structured. But we cannot do either without your help. We ask for your approval of CPB's funding requests, including the additional, emergency, one-time investment to stations of $307 million in fiscal year 2010.

PREPARED STATEMENT OF 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, and 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 recommends that you maintain this support for NIH in fiscal year 2010 by providing the agency with at least a 7 percent increase more than fiscal year 2009. The NPRCs also respectfully request that the subcommittee encourage the National Center for Research Resources (NCRR), the sponsoring institute of the NPRCs within NIH, to carry out the NPRCs 5-year Federal advancement initiative, which as explained in this testimony, would help to ensure that the NPRCs continue to serve effectively in their role as a vital national resource.

Through passage of the American Recovery and Reinvestment Act (ARRA) and the Omnibus Appropriations Act for Fiscal Year 2009, the administration and Congress have taken critical steps to jump start the Nation's economy. Simultaneously, Congress is advancing and accelerating the biomedical research agenda in this country by focusing on scientific opportunities to address public health challenges. The success of the U.S. Government's efforts, however, is contingent upon the quality of research resources that enable and enhance scientific research ranging from the most basic and fundamental to the most highly applied.

Biomedical researchers have relied on one such resource—NPRCs—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. NCRR provides the NPRCs with an annual base grant (funded through NCRR's P51 program) which supports the operational costs of the NPRCs. In fiscal year 2009, the 8 NPRCs received $79.235 million from NCRR's P51 program.

The NPRCs also serve an essential role in translating basic research toward a clinical outcome. Specifically, the nonhuman primate models that are housed at the NPRCs often provide the critical link between research with small laboratory animals and studies involving humans. As a result, 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.

The NPRCs face several serious barriers to successfully supporting and advancing nonhuman primate research; specifically, the lack of adequate infrastructure to breed and house animals for research, the limited number of primates available, and the shortage of properly trained staff to handle nonhuman primates and provide sophisticated care. The need to address these problems has become even more critical due to the additional nonhuman-primate-related grants that will be funded as a result of ARRA, the new demands to increase research in nonhuman primate chal-

lenge models for AIDS, and the need for nonhuman primates to enhance our emerging infectious disease and biodefense response capabilities.

NCRR has published on the need for increased primate resources in its 2009–2013 Strategic Plan. The plan specifically States that nonhuman animal models are indispensable for finding ways to treat and prevent cancer, HIV/AIDS, Alzheimer's disease, and Parkinson's disease, as well as to develop effective biodefense strategies. The NPRCs have been leading the development of new IT approaches, including the Biomedical Informatics Research Network (BIRN) for linking brain imaging, behavior, and molecular informatics in nonhuman primate preclinical and translational models research.

In an effort to address many of the concerns within the scientific community, ranging from the lack of infrastructure improvements to the shortage of relevant nonhuman primates to the need for quality, trained personnel, the NPRCs have developed a 5-year Federal advancement initiative which addresses the necessary program capacity expansions and required upgrades. This initiative will help to ensure that the NPRCs will continue to serve effectively in their role as a vital national resource. As part of the 5-year plan development process, the NPRCs calculated the increases in NIH funding dedicated specifically to the National Primate Research Centers Program (NCRR's P51 program) necessary to achieve their goals. Below is an outline of the plan:

—*Primate Infrastructure Investment*.—Request for an additional $90 million over 5 years to improve the quality and capacity of primate housing and breeding facilities and ensure availability of related state-of-the-art diagnostic and clinical support equipment at the NPRCs.

While NIH has been responsive in their actions during the past few years to provide funding to the NPRCs for infrastructure improvements, the difficulty the National Primate Research Centers Program has in meeting even current demands, let alone future increases is inexorably linked to the ability to house these animals in the unique living environments that they require and to provide specialized facilities equipped with state-of-the-art diagnostic and clinical support equipment to conduct research. The NPRCs plan to focus on the following goals in their effort to comprehensively improve primate infrastructure:

—Bring older primate housing facilities and related equipment up to present-day standards.

—Construct additional primate housing facilities and acquire related equipment to accommodate the projected increase in breeding colonies.

—*Primate Model Investment*.—Request for an additional $75 million over 5 years to enhance the availability of primates for research.

NCRR's Expert Panels have repeatedly stated that the NPRCs do not have the capacity to satisfy the needs of outside investigators, and have recommended that the NPRCs program must be responsive to national needs for nonhuman primates. Currently, outside investigators who are already funded for their studies must sometimes wait a year or more to begin their research because of the high demand for the limited number of primates. In addition, there are ongoing difficulties associated with acquiring certain types of primates from their natural places of origin. Accordingly, increasing domestic breeding capabilities and developing bridging programs to effectively use other types of primates are critical to the success of the NPRCs program.

—*Primate Care and Research Personnel Investment*.—Request for an additional $35 million over 5 years to train NPRC personnel in primate care and management.

Numerous scientific reports have highlighted the vital need for experts who are well-trained in laboratory animal medicine and in research methodology. Since nonhuman primates represent the most sophisticated and relevant animal models, there is a heightened responsibility to properly care for and manage these animals. Each NPRC requires a primate management team comprised of behaviorists, veterinarians, and primate research specialists. As the number of primates at the NPRCs grows, the primate management teams must expand proportionally.

Total anticipated cost of the National Primate Research Centers Program 5-year Federal Advancement Initiative—$200 million more than the current funding that is dedicated specifically to the National Primate Research Centers Program during the 5-year period of fiscal years 2010–2015.

Thank you for the opportunity to submit this written testimony and for your attention to the critical need for primate research and enhancement of the NPRCs P51 base grant, as well as our recommendations concerning funding for NIH in the fiscal year 2010 Labor, Health and Human Services, and Education, and Related Agencies Appropriations bill.

PREPARED STATEMENT OF THE NATIONAL SLEEP FOUNDATION

SUMMARY OF FISCAL YEAR 2010 RECOMMENDATIONS

- —Provide $5 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 to create targeted public educational initiatives for schools and workplaces; training materials for current and future health professionals; build and test public health interventions; expand surveillance and epidemiological activities; and create fellowship and research opportunities.
- —Encourage the National Institutes of Health (NIH) to conduct multi-center clinical trials to evaluate whether healthcare costs and the incidence of stroke, cardiovascular disease and diabetes can be reduced by treating sleep disorders such as obstructive sleep apnea as part of usual care practices.

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 health care 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 report that they have driven drowsy at least once in the past year, with 28 percent reporting 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.

First, one of the most devastating sleep disorders is obstructive sleep apnea (OSA), a sleep-related breathing disorder which affects at least 5 percent of adult Americans and is closely related to some of America's most pressing health problems, such as obesity, hypertension, heart failure, and diabetes. NSF and its partners, including the National Center on Sleep Disorders Research at the National Institutes of Health, have been working diligently to create better patient and primary care physician awareness of sleep apnea. However, despite considerable progress, sleep apnea remains woefully underdiagnosed and undertreated primarily due to a lack of understanding in the primary care community, good epidemiological data, and randomized evidence regarding long-term treatment. Therefore, we recommend that the NIH be encouraged to conduct multi-center clinical trials to evaluate whether treatment of OSA can reduce healthcare costs and the incidence of stroke, cardiovascular disease and diabetes.

Second, 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 5 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 20 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 2 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 eight States to include an optional sleep module in their data collection efforts through the Behavioral Risk Factor Surveillance System (BRFSS), which will occur in the summer of 2009. 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 participated in NSF's national public awareness initiatives including National Sleep Awareness Week and Drowsy Driving Prevention Week. CDC also launched its own Sleep and Sleep Disorders Web site, created a fellowship position to analyze sleep and chronic disease data, held a Sleep and Public Health Workshop at the CDC campus, and released a number of multi-media health marketing materials to promote better sleep.

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.

NSF and NSART have actively been involved in conducting outreach to public health officials and are currently working to develop a national action plan. This document will address ways to organize and implement effective public and professional awareness and education initiatives primarily aimed at the diagnosis and treatment of obstructive sleep apnea and the promotion of sleep as a healthy behavior. NSART is seeking to expand its membership by reaching out to new organizations and State and Federal agencies that are interested in raising awareness of sleep issues and implementing NSART initiatives.

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 as well as the goals and activities of the National Sleep Awareness Roundtable.

—$5 million—All activities detailed in the $2 million scenario, plus:

—*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.

—*Training Materials*.—Tools and programs could be developed for current and future health professionals, including school nurses, to promote sleep as a healthy behavior and increase the diagnosis and treatment of sleep disorders. Today, most health care professionals receive no such training, which increases the Nation's health burden.

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 Committee will provide funding of $5,000,000 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

Mr. Chairman and members of the subcommittee: I am pleased to present the fiscal year 2010 budget request for NTID, 1 of 8 colleges of Rochester Institute of Technology (RIT), in Rochester, New York. Created by Congress, we provide university technical education, serving a total of 1,450 students, including 1,284 deaf and hard-of-hearing students from across the Nation and 166 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 41 years.

BUDGET REQUEST

This request details the importance of obtaining our full fiscal year 2010 request of $71,352,000. We ask for $65,952,000 for continuing operations and $5,400,000 for construction to replace aging mechanical systems as detailed below. The NTID and President's requests are:

[In millions of dollars]

	Operations	Construction	Total
NTID request	65,952	5,400	71,352
President's request [1]	63,037	5,400	68,437
Difference	2,915	....	2,915

[1] These numbers are our understanding of what the President will submit to Congress.

We respectfully request your support of our full appropriation request. We do not request new operations funding for additional academic programs or headcount; instead, we commit to fund increases, if any, through reallocating resources. This commitment continues our history of funding changes through internal reallocation. From fiscal year 2003 through fiscal year 2007 we documented $6,200,000 in budget reductions, including the elimination of 49 headcounts, and increasing our revenues. These difficult savings allowed us to improve our programs and services while limiting our request for Federal support. As one example, we dramatically increased

the number of captionists employed to deliver in-classroom speech-to-text real-time access services to students, without additional funding.

We are proud of those cost savings and reallocations accomplishments.

Our fiscal year 2010 operations request represents costs driven by personnel and health benefits, as well as payment for services provided by RIT that are subject to the same inflationary pressures. The significant enrollment increases detailed below add proportionally to anticipated costs. We do not ask for funds to address program modifications; we will reallocate to meet those needs.

ENROLLMENT

As we prepare to enter fiscal year 2010, we do so having attracted, in fiscal year 2009, the largest enrollment in our 41-year history. Truly a national program, NTID enrolls students from all 50 States. Current enrollment of 1,450; in the last 2 years our enrollment has increased by 200 students, an increase of 16 percent. For fiscal year 2010, NTID anticipates maintaining or slightly increasing enrollment. Our 5-year enrollment history follows.

NTID ENROLLMENTS: FIVE-YEAR HISTORY

Fiscal year	Deaf/Hard-of-Hearing students			Subtotal	Hearing students			Grand total
	Undergrad	Grad RIT	MSSE		Interpreting program	MSSE	Subtotal	
2005	1,055	42	49	1,146	100	35	135	1,281
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

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/non-profits, and 8 percent in Government.

Graduation from NTID has a significant, positive effect on earnings over a lifetime, and results in a noteworthy reduction in dependence on welfare 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 NTID graduation 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 withdraw. Students who withdraw 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 Supplemental Security Income (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 rejected for admission continued to participate in the SSI program. Graduates also accessed Social Security Disability Insurance (SSDI), an unemployment benefit, at far lesser rates than students who withdrew; by age 50, 34 percent of nongraduates were receiving SSDI, while only 22 percent of baccalaureate graduates were receiving them and only 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.

NEW "MILITARY VETERANS WITH HEARING LOSS" PROGRAM

In fiscal year 2010, NTID will establish the "Military Veterans with Hearing Loss" program to enroll veterans who have suffered significant hearing loss as a result of their military service. Recently returned veterans with hearing loss can earn bachelor or graduate-level degrees at RIT with access services—such as real-time captioning and notetaking in the classroom—from NTID. Our faculty and staff are experienced in helping those with sudden hearing loss, and we provide comprehensive services for those with hearing aids or cochlear implants.

The access services provided at NTID are unparalleled. More than 50 classroom captionists provide real-time captioning to students. More than 120 sign language interpreters support students who benefit from interpreting.

As many as 10 veterans could be admitted each year, growing to 50 veterans over time. (RIT also recently announced it will become a "Yellow Ribbon" institution.)

CONSTRUCTION

For the past 3 years, NTID has informed Congress of on-going planning to replace the deteriorating 25 boilers and 23 chillers in individual buildings throughout the RIT campus. Existing heating, ventilation and air conditioning systems remain from the original campus construction more than 40 years ago. Although prudent in providing on-going maintenance, RIT/NTID reached a point where normal maintenance was no longer feasible and the decision was reached to replace the existing system with five new boilers and seven new chillers.

All of the buildings and spaces devoted to NTID programs across the RIT campus are connected to this system. An analysis determined the square footage used by NTID in each building serviced by the new system, and the resulting proportion of the total expenses was allocated to NTID. That analysis showed that NTID buildings and other spaces utilized 15 percent of the total square footage. With a total project cost of $36,000,000, NTID is responsible for $5,400,000 (15 percent) of the total cost, which we request for fiscal year 2010.

In addition to discussions with Congress, this request has been discussed repeatedly over several years with the U.S. Department of Education (ED); presentations and facilities tours were provided during oversight visits to NTID. We understand that the President supports this request, and we ask that Congress also support this construction cost.

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. Expanding transfer associate degree programs better serve the higher achieving segment of our student population who seek bachelors and masters degrees in an increasingly demanding marketplace. These transfer programs provide seamless transition to baccalaureate studies in other colleges of NTID where we support students in baccalaureate programs with access services and tutoring. One of NTID's greatest strengths is our outstanding track record of assisting high-potential students gain admission to and graduate from the other colleges of RIT at rates that are better than their hearing peers.

Research

Our research program is guided and organized according to these general research areas: language and literacy, teaching and learning, sociocultural influences, career development, technology integration, and institutional research. All benefit the deaf and hard-of-hearing population.

Outreach

Extended outreach activities to junior/senior high school students, expand their horizons regarding a college education. We also serve other universities and postcollege adults.

Student Life

Our activities foster student leadership and community service, and provide opportunities to explore other educational interests.

SUMMARY

It is extremely important that our funding be provided at the full level requested as we continue our mission to prepare deaf and hard-of-hearing people to enter the workplace and society.

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 Federal welfare 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 deaf and hard-of-hearing people, remains deserving of your support and confidence.

LETTER FROM THE NATIONAL UNION OF LABOR INVESTIGATORS

DEAR SIR OR MADAM: Before the budget for the Department of Labor, Office of Labor-Management Standards (OLMS) is approved, please consider the 43 employees who were recently deemed "unaffordable" because of budget shortfalls, and please consider the OLMS's re-organization in 2008, a reorganization that now seems morally reprehensible. "Fiscal Year 2010 Budget Shortfalls and Solutions" was presented to OLMS employees on May 8, 2009, and during that presentation Deputy Assistant Secretary Andrew Auerbach said that OLMS hired just about as many investigators as it could afford because OLMS had been criticized for leaving itself understaffed.

The presentation went on to point out that approximately $4.5 million cut from the OLMS budget would return OLMS to its 2003 staffing level, and that OLMS's mission would not be compromised because workload and productivity have remained (relatively) constant since 2003. The presentation reported 260 full-time employees in fiscal year 2003, and 303 full-time employees in fiscal year 2009. The result, we were told, is that 43 OLMS employees are no longer affordable.

The tone taken during the presentation was that the result was unavoidable. However, OLMS's reorganization in 2008 moved all managers to a higher pay grade, and given the current budget shortfalls, and the speed with which the reorganization took place, it seems less like a move intended to improve OLMS's effectiveness, and more like a case of traders with inside information dumping stocks just before the company that issued them goes bankrupt. Managers at every level, and in every

office, warned their investigators of potential budget cuts and of the affect they might have on OLMS, and yet management went forward with a reorganization that exacerbated OLMS's budget crisis.

It seems that if an unaltered work load and unaffected productivity has been used to defend OLMS's $4.5 million budget cut, the same logic should be applied to the reorganization. If their job responsibilities have not changed since 2003, why were OLMS managers given a raise in pay and grade, and why haven't managers been returned to their 2003 GS levels in order to address the budget shortfall? If all OLMS management positions were returned to their 2003 pay grade, would (all) 43 employees have become unaffordable?

I appreciate your consideration of this matter.

Sincerely,

BENNETT ALLEN.

LETTER FROM THE NATIONAL UNION OF LABOR INVESTIGATORS

May 11, 2009.

Hon. TOM HARKIN,
Chairman, Subcommittee on Labor, Health and Human Services, and Education, and Related Agencies,
Washington, DC.

DEAR SUBCOMMITTEE ON LABOR, HEALTH AND HUMAN SERVICES, AND EDUCATION, AND RELATED AGENCIES MEMBERS: The new budget is out and our agency, Office of Labor Management Standards (OLMS), within the Department of Labor suffered a severe reduction in our budget. On May 8, 2009, all employees of OLMS were notified that 43 positions were deemed unaffordable by the Employment Standards Administration (ESA), which OLMS falls under. As of the same date, 20 employees were involuntarily transferred to other agencies. They have 5 days to agree to this or lose their job. Though it was repeated this was not a Reduction in Force (RIF), this is essentially what has occurred.

Additionally, the remaining 23 employees/positions have not been identified. OLMS is represented by an independent union, created in 1971, the National Union of Labor Investigators (NULI). Despite an official union request seeking documents regarding the reorganization, nothing has been provided to NULI that represents all bargaining unit employees. Anxiety runs high as OLMS employees cannot know whether they are one of the designated 23 employees, and whether they should immediately look for work.

NULI cannot possibly negotiate the impact of a plan that they do not have and cannot obtain. OLMS has essentially ignored the collective bargaining agreement negotiated by OLMS and NULI; and the right of NULI as the sole and exclusive bargaining representative for all unit employees. Regardless of the political powers, reasonable notice is still warranted. Rights of working people should be respected.

In 1959, the Labor Management Reporting and Disclosure Act was enacted to correct the abuses which had crept into labor and management which was revealed during the investigations of the McClellan Committee. The Secretary of Labor administers and enforces the act.

Shortly after the election of President Obama, the AFL–CIO wrote a proposal entitled AFL–CIO 2008 Transition Project Recommendations for the Obama Administration: Regulations of Union Finances and Elections Under the Labor Management and Disclosure Act that was provided to the Obama-Biden Transition team. Their recommendations asked for immediate revocation of revisions made to union financial disclosures. This was essentially enacted. They recommended a scaling back of OLMS' enforcement efforts. This, too, was enacted.

Additionally, the transition team evaluating the OLMS was headed by Deborah Greenfield, former AFL–CIO Associate General Counsel. Her first stop in that position was to OLMS. Ms. Greenfield was one of the attorney's suing OLMS on behalf of the AFL–CIO. According to a recent Washington Times article, Ms. Greenfield currently is in charge of the Department's Executive Secretariat's office, which handles much of the correspondence for Secretary Solis. This appears to be in violation of President Obama's pledge to the American public when he said:

> "No political appointees in an Obama-Biden administration will be permitted to work on regulations or contracts directly and substantially related to their prior employer for two years."

OLMS is not a partisan issue; it is about protecting the money and the democratic rights of American workers who engage in legitimate union activity. We are the only

agency, created by Congress, to oversee and protect the rights of union workers. Allowing the budget to pass as is, allows for the rights of American workers to be trampled on.

The rationale and the statistics provided to justify the decrease in funding and reduction in staff are gravely misconstrued and misleading. The Secretary of Labor has now directed OLMS to reduce the number of staff back to the levels when union officers and employees rest assured that the Government could not closely monitor or oversee their actions. As a society we are aware that when the Government cannot monitor, oversee, or enforce Federal law, those affected by those laws are left susceptible to violations of the law. What does this mean? It simply means that hard-working Americans who are union members may be subjected to an increase of theft: theft of their hard-working union dues and theft of their right to democracy in their union.

I understand that our economy is currently struggling and we all need to make sacrifices. Every other agency within the Department of Labor has seen an increase in funding, except ours. While I greatly applaud the Secretary's efforts to bring back enforcement in areas that have been sorely underfunded in recent years, it seems somewhat antithetical that the one area that protects a large portion of the America's workers are scaled back. Let's not hurt the American workers more by allowing their hard earned money to be misused or having their democratic rights within the union reduced.

I write to you not only as an employee but as a union member as well. I urge the Subcommittee on Labor, Health and Human Services, and Education, and Related Agencies to ask for a full inquiry and accounting into the reasoning behind the reductions of the OLMS budget and who will truly benefit from the lack of enforcement. I also ask that prior to approving the budget to please educate yourself on the true role and purpose of OLMS.

Union rights are human rights. Whether you are for or against labor unions, they are an essential component for any true democracy. Cutting funding will only make unions weaker by reducing the rank and file's faith in their union leadership.

Thank you for you time and consideration.

Sincerely,

ELIZABETH MESSENGER.

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 education 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, green jobs education and training, and national service programs that we believe are vital to NWF's mission to inspire Americans to protect wildlife for our children's future. NWF 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 Space and Atmospheric Administration, National Oceanic and Atmospheric Administration, and U.S. Department of the Interior.

SUMMARY OF RECOMMENDATIONS

Agency	Program	Fiscal year 2010 recommendation	Fiscal year 2009 level
Education	University Sustainability Program.	$50 million	Not authorized in fiscal year 2009
Education	Healthy High Performance Schools.	$25 million	None
Labor	Green Jobs Act	$125 million	Funded at $500 million total in ARRA
Labor	Community Based Jobs Training Grants.	$250 million—green priority.	$125 million

SUMMARY OF RECOMMENDATIONS—Continued

Agency	Program	Fiscal year 2010 recommendation	Fiscal year 2009 level
CNCS	Clean Energy Service Corps	$100 million	Not authorized in fiscal year 2009

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 cap global warming pollution this year, a priority that NWF strongly supports. To be successful as a Nation under a new cap and trade system, we must have an environmentally literate 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. Consider the following examples:

—Survey research shows that most Americans do not know what the carbon cycle is or understand what actually causes global warming. They do not know how most electricity is generated or the importance of healthy forests and oceans in generating oxygen and absorbing carbon dioxide.

—Less than half of the population recognizes that the cars and appliances they use contribute to global warming, and 8 out of 10 parents admit that they know "little" to "nothing" about the specific causes of climate change.

—The average high school student fails a quiz on the causes and consequences of climate change (nearly 82 percent of participants affirmed, incorrectly, that "scientists believe radiation from nuclear power plants cause global temperatures to rise").

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 by a cap and trade system. 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, through conservation corps programs that educate and train at-risk youth for careers in clean energy, and through green workforce education and training programs through the Department of Labor.

DEPARTMENT OF EDUCATION

University Sustainability Program (USP)

The National Wildlife Federation supports funding the newly authorized USP at $50 million in fiscal year 2010. 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 NWF 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 USP at the Department of Education as part U of the recently enacted 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.

HEALTHY HIGH PERFORMANCE SCHOOLS PROGRAM

The National Wildlife Federation supports funding the Healthy High Performance Schools Program at $25 million in fiscal year 2010. 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. States may use the funds to provide information, technical assistance, monitor, evaluate, and provide funding to local education agencies for healthy, high-performance school buildings. In turn, local agencies may use the funding to obtain technical assistance, develop plans that address reducing energy and meet health and safety codes, and conduct energy audits. Funds may not be used for construction, maintenance, repair or renovation of buildings. Research clearly shows that improving specific factors such as school indoor environmental quality improves attendance, academic performance, and productivity. This program has yet to be funded by Congress.

NWF also supports a priority for funding green Career and Technical Education programs and initiatives at the Department of Education.

While not yet authorized, NWF strongly supports authorization of and full funding at $100 million per year for the No Child Left Inside (NCLI) Act of 2009, which has the support of more than 1,300 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 K–12 education system. These State plans support teacher training and professional development and support capacity building for environmental education. The House passed a modified version of the bill in the 110th Congress by a bipartisan vote of 293–109.

DEPARTMENT OF LABOR

NWF supports a priority for green jobs education and training at the Department of Labor though the Workforce Investment Act Adult and Youth funding streams, the Energy Efficiency and Renewable Energy Worker Training Program, and the Community-Based Job Training program.

Energy Efficiency and Renewable Energy Worker Training Program

NWF supports funding the Energy Efficiency and Renewable Energy Worker Training Program at $125 million in fiscal year 2010. NWF greatly appreciates this subcommittee's first-time investment in Green Jobs Education and Training in the recent American Recovery and Reinvestment Act (ARRA). This unprecedented investment will help jumpstart the education and training needed to prepare Americans for the clean energy economy. We hope that the subcommittee will fund The Green Jobs Act (GJA), title X of the Energy Independence and Security Act, which authorizes $125 million per year in grants for an Energy Efficiency and Renewable Energy Worker Training Program. NWF is seeking $125 million in this fiscal year 2010 bill, recognizing that the subcommittee will assess how the investment through ARRA is spent before making new funding available. 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." The program is administered by the Department of Labor in consultation with the Department of Energy. ARRA responds to already existing skill shortages. The National Renewable Energy Lab has identified a shortage of skills and training as a leading barrier to renewable energy and energy efficiency growth. This labor shortage is only likely to get more severe as baby-boomers skilled in current energy technologies retire; in the power sector, for example, nearly one-quarter of the current workforce will be eligible for retirement in the next 5 to 7 years.

Community-Based Job Training Grants Program

NWF supports funding the Community-Based Job Training Grants Program at $250 million in fiscal year 2010. NWF believes that community colleges are critical partners in training and educating the next generation of Americans for green jobs. NWF supports a priority within this program for green jobs education and training grants. The Community-Based Job Training Grants program supports partnerships of community colleges, business, and workforce investment boards seeking to train workers for high-demand occupations. These competitive grants help ensure that efforts funded through the program are well coordinated with other local and regional workforce development efforts. Community-Based Job Training Grants support workforce training for high-growth industries through the Nation's community and technical colleges. Their primary purpose is to build community colleges' capacity to equip workers with the skills required to succeed in local industries.

CORPORATION FOR NATIONAL AND COMMUNITY SERVICE

Clean Energy Service Corps

NWF supports funding the Clean Energy Service Corps at $100 million in fiscal year 2010. 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. In a manner similar to the Civilian Conservation Corps of the 1930s, disconnected young people may be mobilized through this program to retrofit, weatherize, and otherwise improve the energy efficiency of residential and public facilities that account for more than 40 percent of carbon emissions. Specific projects that are authorized include weatherizing and retrofitting housing units for low-income households, cleaning and improving rivers, and working with schools and youth programs to educate students and youth about ways to reduce home energy use and improve the environment.

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.

PREPARED STATEMENT OF THE OVARIAN CANCER NATIONAL ALLIANCE

On behalf of the Ovarian Cancer National Alliance (the Alliance), thank you for this opportunity to submit comments for the record regarding the Alliance's fiscal year 2010 funding recommendations. We believe these recommendations are critical to ensure advances to help reduce and prevent suffering from ovarian cancer. For 12 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 45 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 2008, 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 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 problems, 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 Ini-

tiative. The Alliance respectfully requests that Congress provide $10 million for the program in fiscal year 2010.

The Alliance also fully supports Congress in taking action on ovarian cancer through its recent passage of 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 2010.

Further, the Alliance urges Congress to continue funding the Specialized Programs of Research Excellence (SPOREs), including the four 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 $6 billion to NCI for fiscal year 2010.

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.

Through the OCCI, the National Comprehensive Cancer Control Program is helping States address issues related to ovarian cancer. The program currently funds efforts in California, Florida, Michigan, New York, Pennsylvania, Texas, and West Virginia. These projects are working to develop ovarian cancer health messages for the general public and for healthcare providers.

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. Together, Johanna's Law and the Ovarian Cancer Control Initiative will help increase awareness and understanding of ovarian cancer and work to reduce ovarian cancer morbidity and mortality.

Already, with only a small amount of seed money, the CDC has launched the Inside Knowledge: Get the Facts About Gynecologic Cancer campaign to raise awareness of the five main types of gynecologic cancer: ovarian, cervical, uterine, vaginal, and vulvar. Many fact sheets, including the ovarian cancer fact sheet, are already available on the CDC's Web site for download. The CDC plans to develop broadcast advertisements, posters—such as dioramas for bus stops—and other print materials, a comprehensive brochure on gynecologic cancers, and materials aimed at healthcare providers.

NCI

SPOREs at NIH

The Specialized Programs of Research Excellence were created by the NCI in 1992 to support translational, organ site-focused cancer research. The ovarian cancer SPOREs began in 1999. There are four currently funded Ovarian Cancer SPOREs located at the MD Anderson Cancer Center, the Fred Hutchinson Cancer Research Center, the Fox Chase Cancer Center and the Dana Farber/Harvard 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

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 (GOG), 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 2010 funding for the CDC's Ovarian Cancer Control Initiative and $10 million in fiscal year 2010 funding for Johanna's Law as well as your continued support of the SPORES program, an appropriation of $6 billion to NCI.

PREPARED STATEMENT OF THE ONCOLOGY NURSING SOCIETY

OVERVIEW

The Oncology Nursing Society (ONS) appreciates the opportunity to submit written comments for the record regarding fiscal year 2010 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 1.44 million Americans will be diagnosed with cancer, and more than 565,650 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 adverse 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

[1] American Cancer Society. *Cancer Facts and Figures 2008*. http://www.cancer.org/downloads/STT/2008CAFFfinalsecured.pdf.

and sustain and strengthen the Nation's nursing workforce. We thank the subcommittee for its consideration of our fiscal year 2010 funding request detailed below.

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 drop precipitously 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 has joins with President Obama and others in the nursing community in advocating $263 million as the fiscal year 2010 funding level necessary to support implementation of the Nurse Reinvestment Act and the range of nursing workforce development programs housed at the U.S. Health Resources and Services Administration (HRSA). Enacted in 2002, the Nurse Reinvestment Act (Public Law 107–205) included new and expanded initiatives, including loan forgiveness, scholarships, career ladder opportunities, and public service announcements to advance nursing as a career. Despite the enactment of this critical measure, HRSA fails to have the resources necessary to meet the current and growing demands for our Nation's nursing workforce. For example, in fiscal year 2008 HRSA received 6,078 applications for the Nurse Education Loan Repayment Program, but only had the funds to award 435 of those applications.[3] Also, in fiscal year 2008 HRSA received 4,894 applications for the Nursing Scholarship Program, but only had funding to support 172 awards.[4]

A number of years ago, one of the biggest factors associated with the shortage was a lack of interested and qualified applicants. Due to the efforts of ONS, our nursing community partners, and other interested stakeholders, the number of applicants is growing. As such, now one of the greatest factors contributing to the shortage is that nursing programs are turning away qualified applicants to entry-level baccalaureate programs, due to a shortage of nursing faculty. According to the American Association of Colleges of Nursing (AACN), U.S. nursing schools turned away 50,000 qualified applicants from baccalaureate and graduate nursing programs in 2008,

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[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.

[3] U.S. Health Resources and Services Administration: Nurse Education Loan Repayment Program: http://bhpr.hrsa.gov/nursing/loanrepay.htm. Accessed April 22, 2009.

[4] U.S. Health Resources and Services Administration: Nursing Scholarship Program Statistics: http://bhpr.hrsa.gov/nursing/scholarship/. Accessed April 22, 2009.

due to insufficient number of faculty and inadequate resources.[5] Of those potential students, nearly 7,000 were students pursuing a master's or doctoral degree in nursing, which is the education level required to teach. Within the next decade, it is expected that half of all nurse faculty will reach retirement age.[6] Given the expected wave of retirement among faculty, the nurse faculty shortage is only expected to worsen as there are insufficient numbers of candidates in the pipeline to take their places. The number of full-time nursing faculty required to "fill the nursing gap" is approximately 40,000, and, currently, there are less than 20,000 full-time nursing faculty in the system.

With additional funding in fiscal year 2010, the HRSA Workforce Development Programs will have much-needed resources to address the multiple factors contributing to the nationwide nursing shortage, including the shortage of faculty. 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 $263 million in fiscal year 2010 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. ONS and its allies have serious concerns that without full funding, the Nurse Reinvestment Act will prove an empty 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 10 percent increase ($33.349 billion) for NIH in fiscal year 2010. 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 $5.957 billion to the National Cancer Institute, as well as $227 million to the National Center for Minority Health and Health Disparities in fiscal year 2010 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 2010 allocation of $178 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

[5] American Association of Colleges of Nursing ,"2006–2007 Enrollment and Graduations in Baccalaureate and Graduate Programs in Nursing." http://www.aacn.nche.edu/IDS/datarep.htm, March 2007.

[6] Preliminary Results: "National Survey of Nurse Educators: Compensation, Workload, and Teaching Practices." *National League of Nursing/Carnegie Foundation*. (February 7, 2007) http://www.nln.org/newsreleases/pres__budget2007.htm.

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 2010 funding levels for the following CDC programs:

—$250 million for the National Breast and Cervical Cancer Early Detection Program;
—$65 million for the National Cancer Registries Program;
—$25 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 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 societies, 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 2010 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, Mr. Chairman Harkin, Mr. 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 (BLS).

Background on the Population Association of America (PAA)/Association of Population Centers (APC) and Demographic Research

The Population Association of America (PAA) is a scientific organization comprised of more than 3,000 population research professionals, including demographers, sociologists, statisticians, and economists. The Association of Population Centers (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, including, for example, the University of Wisconsin—Madison, RAND Corporation, State University New York Albany, Brown University, Ohio State University, University of North Carolina—Chapel Hill, and Pennsylvania State University.

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 of 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 2009 and 2010, HRS is seeking to increase its minority sample size and collect unique, enhanced data on the effects of the current economic downturn on older people.

With additional support in fiscal year 2010, the NIA BSR program could fully fund its existing centers programs and support its ongoing surveys without resorting to cost cutting measures, such as cutting sample size. Currently, the Demography of Aging and Roybal Centers programs are recompeting their 5-year awards. Additional funding may give the Institute resources it needs to award more center grants. NIA could also use additional resources to improve its funding payline and sustain training and research opportunities for new investigators.

NICHD

Since its establishment in 1968, the 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 2010, NICHD could restore full funding to its large-scale surveys, which serve as a resource for researchers nationwide. Furthermore, the Institute 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), 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 a funding increase last year, 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 have been cut, while other surveys, most notably the National Hospital Discharge Survey, are not being fielded. In addition, in 2009, NCHS has 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.

The administration recommends NCHS receive $138 million in fiscal year 2010. PAA and APC, as members of The Friends of NCHS, support the administration's request, but also hope Congress will give the agency an additional $15 million in fiscal year 2010. The additional $15 million should be designated specifically for supporting the States so they can modernize their vital statistics systems and make all collections electronic according to the 2003 birth and death certificates. If NCHS receives this funding, they can abandon their proposal to collect core vs. enhanced vital statistics data as well and focus on improving the current system. The underlying fiscal year 2010 budget request should be targeted at precluding further cuts in key surveys and collecting the full panel of vital statistics data.

If Congress fails to, at a minimum, provide the administration's fiscal year 2010 request, NCHS will be forced to eliminate over-sampling of minority populations in NHANES, which will compromise our understanding of health disparities at a time when our society is becoming increasingly diverse. Further, we will lose insurance coverage information on who's covered and who's not (particularly within minority populations), how people are covered and why they're not—at a time when Congress and the administration are debating healthcare reform. Finally, we will lose vital statistics, adversely affecting the amount of data researchers and health practitioners alike need to be effective in identifying trends and developing interventions.

BLS

During these turbulent economic times, data produced by 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 $611,623,000 in fiscal year 2010, an increase of $14,441,000 more than the 2009 enacted level. According to the agency, this funding level would enable BLS to meet its highest-priority goals and objectives in 2010. Ideally, the agency will receive enough funding not only in 2010, but also in future years to invest in research and assure continuous improvement of its measures, including the Consumer Price Index. We also hope BLS receives sufficient funds to maintain, or increase, the sample sizes of key surveys, such as the Current Population Survey. It is imperative sample sizes be increased to ensure surveys are accurate and providing adequate detail. We also hope fiscal year 2010 marks the beginning of a steady, predicable growth trend in the BLS budget.

Summary of Fiscal Year 2010 Recommendations

Despite the generous, short-term funding the NIH received from the American Recovery and Reinvestment Act (ARRA), the agency faces "falling off the cliff" in 2011

when ARRA funds expire. Thus, PAA and APC, as members of the Ad Hoc Group for Medical Research Funding, are asking Congress to provide NIH with and appropriation of $32.4 billion in fiscal year 2010, an increase of 7 percent more than the fiscal year 2009 appropriation. This funding level would put NIH on a stable course, ensuring the agency receives an inflationary increase plus enough money to support the best research projects, including new and innovative projects, and stabilize research training programs in fiscal year 2010.

As part of the NIH request, we also urge the subcommittee to appropriate $194.4 million for the National Children's Study (NCS) in fiscal year 2010 through the NIH Office of the Director, as proposed by the President's budget. This funding will allow for the completion of the pilot phase of the NCS.

PAA and APC, as members of the Friends of NCHS, ask that NCHS receive $138 million in fiscal year 2010, with an additional $15 million set aside for vital statistics infrastructure development. 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, $611.6 million, for the BLS, in fiscal year 2010.

Thank you for considering our requests and for supporting Federal programs that benefit the field of demographic research.

Prepared Statement of the Program for Appropriate Technology in Health

OVERVIEW

Program for Appropriate Technology in Health (PATH) appreciates the opportunity to submit written testimony to the Senate Labor, Health and Human Services, Education, and Related Agencies Appropriations Subcommittee. PATH is a U.S.-based, international nonprofit organization that creates sustainable, culturally relevant solutions that enable 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. Our work improves global health and well-being.

The broad, ongoing, and successful 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 the developing world, 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.

Several programs funded in the Labor, Health and Human Services, and Education 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 a 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, serving widely dispersed populations. Specialized equipment, personnel, and safe waste disposal systems are often not available. Without diagnostic testing, healthcare professionals have to rely on just evaluating symptoms to diagnose and treat illness—an imperfect method given the similarity of symptoms between 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.

Fortunately, there is an array of promising new tests in the pipeline—inexpensive, portable, easy-to-use diagnostics that are practical at even small, local health centers, and which can deliver results the same day. Some are new takes on established technologies like the home pregnancy test. Others are exciting scientific advances. 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.

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 these 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.

Point-of-care diagnostics are one of the most critical global health technologies whose development of testing is supported by NIH and CDC. One example of this support is the ongoing and successful partnership between the NIH's National Institute of Biomedical Imaging and Bioengineering (NIBIB) and PATH. Working together with an investment from NIH/NIBIB, PATH formed the Center for Point-of-Care Diagnostics for Global Health (GHDx Center), a diagnostics research, development, testing, needs assessment and training program that works to improve the availability, accessibility, and affordability of essential point-of-care diagnostic tests for use in low-resource settings around the world. The GHDx Center, managed by PATH in collaboration with its partners at the University of Washington, is on the cutting edge of developing new diagnostic tools that can be used in developing countries to quickly and accurately diagnose diseases that disproportionately impact the developing world, but which until now have been difficult to accurately diagnose without laboratory facilities or extensively trained medical workers.

The GHDx Center focuses its work on four main areas that encompass the breadth of the health technology product development cycle. The GHDx Center performs and supports clinical needs assessments that help diagnostics developers target the most pressing global health challenges and increase the likelihood of product success. It supports exploratory technology projects that could have a significant positive impact on public health outcomes. It conducts laboratory and field-based clinical testing of prototype point-of-care diagnostics. Finally, the GHDx Center—in a program led by the University of Washington Department of Global Health and Department of Medicine (Division of Infectious Diseases)—trains individuals with varied experience and backgrounds from the fields of assay and device development, clinical laboratories, and disease specialties, with the objective of creating a networked group of researchers trained in state-of-the-art technology that address the challenges for global health in low-resource settings.

This extraordinarily promising new program would not have been possible without NIH support, and PATH thanks the subcommittee for its wise investments in NIH. Without robust funding for NIH and CDC, much of the cutting-edge research and development 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, hepatitis b, and other conditions whose heaviest burden falls on the developing world, or which can be used in resource—poor conditions where laboratory equipment are scarce, do not have a significant commercial market that incentivizes research and development. Without investment by the U.S. Government, efforts to develop these diagnostic technologies—and by doing so improve care and reduce 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.

Another area where agencies funded by this subcommittee are making a significant contribution to global health is in 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 which 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, includ-

ing 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 the research and development of malaria interventions such as vaccines, as is the PATH Malaria Vaccine Initiative (MVI). 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. Unfortunately, funding for this critical research at NIH and CDC has been relatively flat for several years. By increasing investments in NIH and CDC, Congress can help advance the day when a highly effective malaria vaccine is available, thereby saving many lives.

Continued progress in our Nation's effort to improve global health requires the development of new tools and technologies. Point-of-care diagnostics and, eventually, malaria vaccines, are important components of the portfolio of needed tools and technologies, and the development of those tools and technologies is heavily reliant on Federal support. For this reason, we respectfully request that the subcommittee expand funding for research and development at NIH and CDC. We very much appreciate the subcommittee's consideration of our views, and we stand ready to work with subcommittee members and staff on these and other important tropical disease matters.

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 2010 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 2010 to help promote eye health and prevent eye disease and vision loss:

—$4.5 million for the Vision Health Initiative at the Centers for Disease Control and Prevention (CDC);

—$32.4 billion for the National Institutes of Health (NIH) to support biomedical research; and

—$736 million 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] Refractive errors are the most frequent vision problem in the United States—an estimated 150 million Americans use corrective eyewear to compensate for their refractive

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[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.*

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 significant Federal funding for vision research and application, as well as resources for programs that help promote eye health and prevent eye disease, vision loss, and blindness. We thank the subcommittee for its consideration of our specific fiscal year 2010 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 10 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 program 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:

—Support for the eye evaluation component of the National Health and Nutrition Examination Survey (NHANES) that provides current, nationally representative data and help assess progress for vision objectives contained within Healthy People 2010 and the future efforts for Healthy People 2020.

—Development of 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.

—Utilization of 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.

—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.

—Developing best practices for the integration of vision care services with community health centers, as well as methods for linking clients to appropriate and needed care.

—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.

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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.

In fiscal year 2009, PBA requested $4.5 million to sustain and expand the Vision Health Initiative. In the final fiscal year 2009 Omnibus Appropriations Act, Congress allocated $3.222 million. 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 again respectfully requests the subcommittee provide a $4.5 million allocation for the Vision Health Initiative. Increased fiscal year 2010 funding for this important program will support additional vision screenings, increased public awareness efforts regarding risk of vision loss, develop best practices for linkage to care, and the expansion of eye disease surveillance and evaluation systems, which will help ensure our Nation has much-needed epidemiological data regarding overall burden and high-risk populations, so we can best formulate and assess strategies to prevent and reduce the economic and social costs associated with vision loss and eye diseases.

ADVANCE AND EXPAND VISION RESEARCH OPPORTUNITIES

Our Nation has benefited from past Federal investment in biomedical research at the NIH. Unfortunately, due to flat funding over the past six appropriations cycles, NIH has lost 14 percent of its purchasing power. While we commend Congress for the $10.4 billion in funding provided in the American Recovery and Reinvestment Act, PBA joins the broader vision community in advocating a 7 percent increase ($32.4 billion) for NIH in fiscal year 2010. This level of investment will allow NIH to sustain and expand its research progress and avoid the potential disruption of vital research that could result from a minimal increase.

PBA also calls upon the subcommittee to provide a specific allocation of $736 million 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. Celebrating 40 years of service this year, NEI is a leading Institute in translating basic research into clinical practice. Just as NIH has seen a decline in purchasing power, so too has the NEI, an overall decrease of 18 percent in the last 6 appropriations cycles. In fiscal year 2009, NEI's funding level of $688 million reflected just 1 percent of the estimated $68 billion annual costs of eye disease and vision impairment. Despite significant funding challenges, NEI has maintained its impressive record of breakthroughs in basic and clinical research that have resulted in treatments and therapies to save and restore vision and prevent eye disease. However, NEI will be challenged further, as 2010 begins the decade in which more than half of the 78 million Baby Boomers will turn 65 and be at greatest risk for developing aging eye disease. Adequate funding to NEI is a cost-effective investment in our Nation's health, as it can delay, save, and prevent eye disease-related expenditures, especially to the Medicare and Medicaid programs.

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.

Vision screening is an appropriate and essential element of a strong public health approach to children's vision care; the sooner vision problems are identified, the faster they can be addressed. As you know, the Maternal and Child Health Bureau (MCHB) oversees the Maternal and Child Health Services State title V (Title V) Block Grant program. As a condition of funding under title V, States are required to report on certain measures to the MCHB. PBA urges the subcommittee to sup-

[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.

port the development and implementation of a nationwide title V core performance measure related to vision screening. A core performance measure regarding vision screening will help ensure that more children receive comprehensive eye examinations at a young age and provide specific information to MCHB and other public health officials regarding the progress of the programs and identify areas where improvement can be made to provide better vision care to children served by the title V program. Specifically, we hope the subcommittee will include language in the report accompanying the fiscal year 2010 Labor, Health and Human Services, and Education, an Related Agencies appropriations measure that expresses support for MCHB's work in this area.

We are pleased that the Head Start program currently requires children to be screened for vision problems. Unfortunately, there are no procedures for training, tracking, or even conducting the screening. As such, without a national uniform standard, many Head Start enrollees are falling through the cracks and vision problems are not being identified in this already often underserved and at-risk population. PBA stands ready to work with Head Start, the Congress, and other stakeholders to ensure that all Head Start enrollees receive vision screening services and other related resources available to them in their community. PBA respectfully requests that the subcommittee include language in the report accompanying the fiscal year 2010 Labor, Health and Human Services, and Education, an Related Agencies appropriations measure that encourages collaborations and initiatives within the Head Start program to ensure that such screenings are delivered and provided in a manner that promotes consistency and quality in protocol and administration.

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 2010 funding for the CDC's Vision Health Initiative, NIH, and 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.

PREPARED STATEMENT OF THE PANCREATIC CANCER ACTION NETWORK

Mr. Chairman and members of the subcommittee: You may recall that last year you received testimony from Dr. Randy Pausch, a computer science professor at Carnegie Mellon University, author of the widely acclaimed "Last Lecture", which was released on YouTube and later as a book, and at that time, a pancreatic cancer survivor.

Last year, Randy in his frank and humorous manner, told you that it was unlikely that he would survive until Father's Day and that his widow, Jai, and three beautiful children, Dillon, Logan, and Chloe would have to mark that holiday without him.

Approximately 76 percent of pancreatic cancer patients die within the first year of diagnosis. Randy used to call himself a "Pancreatic Cancer Rock Star" given that he had already survived 18 months when he provided his testimony to you. While I am very happy to report that Randy did indeed survive long enough to spend Father's Day with his family, he unfortunately passed soon after on July 25, 2008. With his passing, we lost a dear friend to the pancreatic cancer community, and as I'm sure you would all attest to, a phenomenal pancreatic cancer advocate.

Much has changed in the last year, including some of the statistics. According to the American Cancer Society's recently released Cancer Facts & Figures 2009, the projected incidence for pancreatic cancer rose 12 percent in the last year. Pancreatic cancer is now the 10th most commonly diagnosed cancer in both men and women.

Unfortunately, the survival rate has not changed. Pancreatic cancer is still one of the most deadly cancers and is still the fourth-leading cause of cancer-related death. It is still true that 95 percent of all pancreatic cancer patients die within 5 years of diagnosis, a fact that has changed little in the last 30 years. The new statistics show that 75 percent of these patients die within the first year of diagnosis. There are still no early detection or treatment tools for this disease. And while pancreatic cancer funding did increase last year, it is also still true that pancreatic cancer research is not funded at a level that will likely change this picture any time soon.

The news gets worse as we look to the future. According to an article recently released in the Journal of Clinical Oncology,[1] a 55 percent increase in pancreatic cancer incidence is expected by 2030. This would be among the top five most significant increases across all forms of cancer. According to the authors, "Alarmingly, certain cancer sites with particularly high mortality rates, such as liver, stomach, pancreas, and lung, will be among those with the greatest relative increase in incidence. Therefore, unless substantial improvements in cancer therapy and/or prevention strategies emerge, the number of cancer deaths may also grow dramatically over the next 20 years." We simply cannot afford to keep the status quo in terms of funding levels or scientific approaches for pancreatic cancer in the face of these statistics. We must make finding early detection tools and effective treatments for pancreatic cancer and the other highest mortality cancers an immediate priority.

Admittedly, part of the problem has been the recent flat or declining biomedical research budgets. Adjusting for inflation, the National Cancer Institute's (NCI) budget has decreased by nearly $639 million (13.9 percent) since fiscal year 2003. However, it is also clear that NCI is not making pancreatic cancer a research priority. In fact, the NCI currently allocates just $87 million for pancreatic cancer research, a mere 2 percent of its total budget. A percentage that is also unchanged from last year.

We, like many in the cancer and biomedical research communities, worked hard to secure funding increases for the National Institute of Health (NIH) in the fiscal year 2009 Omnibus Appropriations bill and in the American Recovery and Reinvestment Act and we are grateful to you for granting the community's requests and providing increases through these bills. The Pancreatic Cancer Action Network took part in these efforts because we believed that increasing funding through these bills would lead to increased funding for pancreatic cancer research. Unfortunately, it does not appear that this hope is turning into a reality.

As the National Institute of Health (NIH) was preparing the Challenge Grants, we were excited about the potential that these grants might bring to the most deadly diseases such as pancreatic cancer. Unfortunately, once we had an opportunity to review the Requests for Applications (RFAs), we realized that few if any of the grants were actually applicable to pancreatic cancer.

We have also been looking forward to learning more about how NCI plans to use their remaining portion of the stimulus funds. Our hope is that Dr. Niederhuber will dedicate some portion of the funds for the cancers with the highest mortality, defined as those cancers with 5-year survival rates of 50 percent or less. Currently, just 8 cancers (ovarian, brain, myeloma, stomach, esophageal, lung, liver, and pancreatic) account for 50 percent of all cancer deaths. For some of these, such as pancreatic and lung cancer, there has been little movement in survival rates in the last 30 years.

As you may know, NIH Director, Dr. Raynard Kington recently asked Dr. Niederhuber and Dr. Steve Katz, Director of National Institute of Arthritis and Musculoskeletal and Skin Diseases to co-chair a task force to develop an NIH-wide cancer research plan in response to the President's call to double cancer research funding in 8 years. Ideally, this plan would include some defined focus on steps that should be taken to reduce mortality for the deadliest cancers. Unfortunately, while we have not yet seen the actual plan, based on the NCI's statement about it on April 20, 2009[2] and based on conversations we have had with Dr. Niederhuber earlier this week, we are concerned that again, our hopes may not turn into a reality.

The mission of the Pancreatic Cancer Action Network is based on hope and on action, so it is in the spirit of both that I am today submitting testimony. I am not only asking that you significantly increase funding for the NCI, but that you also take steps to ensure that NCI places special emphasis on the most deadly cancers, including pancreatic cancer.

While I realize that Congress is reluctant to direct how NCI allocates research dollars, I would argue that something is wrong when one of the deadliest types of cancer receives so little attention. In fact, pancreatic cancer research receives the least amount of NCI funding of any of the top cancer killers.

One of our most significant issues in addition to the overall funding level, is that there are relatively few researchers studying pancreatic cancer—including both young investigators and more experienced investigators. While the NCI's commitment to young investigators has increased from 2007 when it awarded zero Career

[1] Benjamin D. Smith, Grace L. Smith, Arti Hurria, Gabriel N. Hortobagyi, and Thomas A. Buchholz, "Future of Cancer Incidence in the United States: Burdens Upon an Aging, Changing Nation," *Journal of Clinical Oncology* 27 (April 2009), 4.

[2] National Cancer Institute, *National Cancer Institute's Plan to Accelerate Cancer Research Announced*, http://www.cancer.gov/newscenter/pressreleases/AccelerateResearch (April 22, 2009).

Development Awards (K awards) or Research Training Awards (F and T awards), it still has a long way to go. For example, last year, NCI made nearly 180 awards to young breast cancer researchers and more than 70 K, T, or F awards to young researchers in fields of each of the other top 5 cancer killers (lung, colon, and prostate); only 32 were awarded to young pancreatic cancer researchers. We can and must do better.

The story is much the same for experienced investigators. In 2008, only 32 pancreatic cancer projects were funded at $500,000 or above, and only 11 projects received at least $1 million. In contrast, the number of projects funded at $500,000 or above was 109 for lung, 114 for colon, 237 for breast, and 105 for prostate.

Further, though the pool of researchers that the NCI has funded to conduct pancreatic cancer has expanded, it is still a very small pool, especially when compared to the numbers of researchers funded in the other leading cancer fields. In fact, by way of comparison, in 2008 the NCI funded close to 1,600 different investigators in breast cancer research, of whom 231 received multiple awards. As many as 91 of these researchers received an aggregate of $1 million in funding for their research. By comparison, NCI funded 327 different investigators in pancreatic cancer research last year, of whom 41 received multiple awards and just 13 received an aggregate of $1 million for their research.

Given that the current 5-year survival rate for breast cancer is nearly 90 percent, it is clear that a similar pipeline of committed and federally funded scientists is needed in pancreatic cancer to help speed advances and medical breakthroughs if we are to hope to finally increase survival beyond 5 percent.

The fact is that the number of new pancreatic cancer cases and deaths are increasing—not decreasing. The projected number of new pancreatic cancer cases is expected to reach 70,000 by 2040. As stated above, while overall cancer death rates have significantly declined, the 5-year survival rates for pancreatic cancer have remained largely unchanged in the last 30 years. If we do not take steps to address this issue now, 95 percent of these patients will continue to hear their diagnosis expressed as a death sentence.

Sadly, it is also a fact that for too long, the broader scientific research community has faced the challenge of doing more with less. While they have achieved some important successes, the funding crisis has fostered an environment of focusing on "safe bets." Compared to most other cancers, we know relatively little about pancreatic cancer. More research is needed in the basic biology of the disease to understand how it starts and why it spreads so rapidly. Therefore, pancreatic cancer research does not fall into a "safe bet" category. It falls into the category of high risk/ high reward.

The time has come to not only fund new progress and give our researchers the opportunity to do more with more, but to also find new ways to encourage the research community to tackle the hardest and most complex problems. As Randy mentioned in his testimony last year, it is by solving the hardest problems that we will likely see the greatest rewards for the entire field. On behalf of the tens of thousands of pancreatic cancer patients who die without a chance, including Dr. Randy Pausch, I am asking that you not only inject significant new funding into the cancer research community, but that you also issue a challenge to the NCI to focus on the hardest problems by placing special emphasis on finding answers for the most deadly cancers, including pancreatic. Doing so will not only fuel progress, but will also generate jobs and stem the current trend of losing American-trained researchers to other countries more willing to invest in scientific research.

We therefore join with our partners in the One Voice Against Cancer coalition to ask that you provide $5.96 billion in funding for the NCI in fiscal year 2010—an increase of $993 million (20 percent) more than fiscal year 2009. We recognize that this is a significant request. However, the reality is that this is the minimum amount needed to make true progress on all forms of cancer, including pancreatic and the other cancers for which we have yet to see significant improvement in survival.

We also respectfully request that you work with us to ensure that NCI creates a strategic plan for the highest mortality cancers, defined as those with 5 survival rates below 50 percent, and that the NIH-wide cancer research plan that is currently under development also includes these cancers as a specific area of focus.

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 (CDC), and Health Resources and Services Administration (HRSA). 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 PH community.

In addition, I want to commend the subcommittee for actively addressing the current backlog in Social Security Disability applications at the Social Security Administration. Many PH patients end up applying for disability coverage, and streamlining the benefits process would go a long way toward improving the quality of life for our most in-need families.

I am honored today to represent the hundreds of thousands of Americans who are fighting a courageous battle against a devastating disease. PH 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 does not discriminate based on race, gender, or age. 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 PHA, 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.

Today, PHA includes:

—More than 10,000 patients, family members, and medical professionals as members and an additional 34,000 supporters and friends.
—A network of more than 200 patient support groups.
—An active and growing patient-to-patient telephone helpline.
—Three research programs that, through partnerships with the National Heart, Lung and Blood Institute (NHLBI) and the American Thoracic Society, have committed more than $7.5 million toward PH research as of December 2008.
—Numerous electronic and print publications, including the first medical journal devoted to PH—published quarterly and distributed to all cardiologists, pulmonologists, and rheumatologists in the United States.

A Web site dedicated to providing educational and support resources to patients, medical professionals, and the public. Thanks to support from CDC, PHA's online resources now include the PHA Online University which provides PH-specific continuing education opportunities to medical professionals.

THE PH COMMUNITY

Mr. Chairman, I am privileged to serve as the president of the PHA 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 lead 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 30th, 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 7 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 PH 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 PH 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 2010 APPROPRIATIONS RECOMMENDATIONS

NHLBI

Recently, the 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 six 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.

One crucial step in continuing the progress we have made in the treatment of PH is the creation of 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.

In order to maintain the important momentum in pulmonary hypertension research that has developed over the past few years, and to create a much needed pulmonary hypertension research network, the Pulmonary Hypertension Association encourages the subcommittee to provide the NIH, particularly the NHLBI, with a 7 percent increase in funding in fiscal year 2010.

CDC

PHA applauds the subcommittee for its leadership over the years in encouraging CDC to initiate a Pulmonary Hypertension Education and Awareness Program. 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.

Mr. Chairman, we are grateful to the Congress for providing $238,000 in support of a pulmonary hypertension awareness program in fiscal year 2009. By educating physicians and patients about pulmonary hypertension, this funding will save lives. We encourage the subcommittee to continue its support for PH awareness activities through the CDC in fiscal year 2010.

"Gift of Life" Donation Initiative at HRSA

Mr. Chairman, PHA applauds the success of HRSA'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 2010, PHA recommends an appropriation of $30 million for this important program.

PREPARED STATEMENT OF THE RELIGIOUS COALITION FOR REPRODUCTIVE CHOICE

Mr. Chairman and members of the subcommittee: The Religious Coalition for Reproductive Choice (RCRC) appreciates this opportunity to submit testimony. We strongly support President Obama's proposal to eliminate the dedicated funding streams for abstinence-only programs and to support proven teen pregnancy prevention programs.

RCRC is an interfaith alliance of national mainstream religious organizations dedicated to ensuring access to reproductive healthcare and achieving reproductive justice. For more than 35 years, RCRC has brought together 40 national religious and religiously affiliated organizations from 15 denominations and traditions. Our membership includes the Episcopal Church, the Presbyterian Church (USA), the United Church of Christ, the United Methodist Church (General Board of Church and Society and Women's Division, General Board of Global Ministries), the Unitarian Universalist Association of Congregations; and Reform, Reconstructionist and Conservative Judaism.

As faith communities, we are committed to sex education in our public schools that empowers and protects young people, honors diverse values, and promotes the highest ethical standards. Religious Americans overwhelmingly favor responsible sex education that is complete, age appropriate and includes accurate information about abstinence and contraception.

Abstinence-only-until-marriage programs cannot offer this and moreover they are ineffective. These programs often are dishonest and scientifically inaccurate. There is no justification for endangering the health and well-being of the young people of our Nation for the sake of a very parochial moral vision.

In fact, while there certainly is great value in adolescents postponing sex until they are mature, Federal policies that withhold important life saving information about STDs or HIV/AIDS or other aspects of reproductive health raise serious moral and ethical questions. Young people have a basic human right to complete and accurate HIV/AIDS and sexual health information. Without it they will be unable to realize the highest attainable standard of health and for some, their futures will be compromised with disease or unintended pregnancy.

SUPPORT OF RELIGIOUS COMMUNITIES FOR COMPREHENSIVE SEXUALITY EDUCATION

Major faith traditions representing millions of Americans support comprehensive sex education. In keeping with our Nation's constitutional guarantee of freedom of religion, they oppose civil laws that would impose specific religious views about sexuality education on all Americans.

These faith communities take seriously their duty to instill a set of religious and moral values that will help guide young people to responsible life choices. They believe that it is the role of Government to ensure that the Nation's youth receive the facts—unblemished by ideology—that will protect them from disease and unintended pregnancy.

RCRC has compiled excerpts of official statements of religious denominations and traditions on the importance of sexuality education. We have attached a copy of the complete document, Religious Communities and Sexuality Education: In the Home, In the Congregation, In the Schools, for your review. But to give you a brief taste of these statements, please consider the following:

United Methodist Church
—"Children, youth and adults need opportunities to discuss sexuality and learn from quality sex education materials in families, churches and schools."
United Synagogue of Conservative Judaism
—". . . supports comprehensive sex education . . . calls upon the U.S. Congress to cease funding of abstinence only education."
Presbyterian Church (U.S.A.)
—". . . supports . . . comprehensive school health education that includes age and developmentally appropriate sexuality education in all grades . . ."
Muslim Women's League
—"Sex education can be taught in a way that informs young people about sexuality in scientific and moral terms."
Episcopal Church
—". . . we encourage the members of this Church to give strong support to responsible local public and private school programs of education in human sexuality."

NEED FOR ATTENTION TO DISEASE PREVENTION

Although the President's budget does not link the issues of teen pregnancy prevention and disease prevention, we know that the most effective programs are comprehensive and do connect the two. According to the American Social Health Association, each year 9 million new cases of STDs occur among young people aged 15–24. Sexually active youth have the highest STD rates of any age group in the country. Young people are at greatest risk for STDs because, as a group, they are more likely to have unprotected sex.

The health consequences of STDs include chronic pain, infertility, cervical cancer and increased vulnerability to HIV, the virus that causes AIDS. The transmission of STDs to babies—prenatally, during birth or after—can cause serious life-long complications and even death.

We urge the Appropriations Committee to include language that expands the requirement for funded programs to include disease prevention.

How did you learn about sex?

This past year, RCRC put out a request to "tell us your story: how did you learn about sex?" We received well more than 400 responses from individuals around the country age 17 through 94. These replies offer thoughtful reflections and often intimate, sometimes painful, glimpses into personal lives.

Among other things, we found that what you learn—or don't learn—as a young person can have life-long repercussions. And abstinence-only programs, by their design, leave out important health information.

"If I had known what sex was, I would have understood what was happening to me when I was molested by a male relative beginning at age 8."——Deborah, 45

"I wish I'd learned what intercourse was and how easy it is to get pregnant."——Anonymous, 79

"I wish I'd learned about STDs and the way in which they can be transmitted. I was under the impression that oral sex was safe, since you couldn't get pregnant from it."——Miranda, 26

"The good girl/bad girl images prevalent when I was young only served to instill a great deal of fear in me, which negatively impacted on my marriage for years."——Anonymous, 57

COMMUNITIES OF COLOR

According to former Surgeon General Joycelyn Elders, the black community's "problem with sexuality has contributed more to the poverty in the black community than anything else in our society. A pregnant teenager who does not finish high school or marry has an 80 percent likelihood of being poor." She challenged Congress to "stop legislating morals and start teaching responsibility." Abstinence-only education has been proved through studies and in harsh reality to be a horrible failure. A low-income woman is four times as likely to have an unintended pregnancy, five times as likely to have an unintended birth and more than four times as likely to have an abortion as her higher-income counterpart. It is the poor and communities of color who suffer from illogical and ineffective public policy. The denominations and people of faith that comprise RCRC agree with Dr. Elders that "If I could make any changes at all to the current health care system, you know I would start with education, education, education. You can't educate people that are not healthy. But you certainly can't keep them healthy if they're not educated."

RCRC addresses these issues through our National Black Church Initiative, a program begun in 1997 to "break the silence" about sex and sexuality in the African

American community. The initiative assists Black clergy and laity in addressing teenage pregnancy, sexuality education and reproductive health within the context of African American religion and culture. We have worked in more than 700 churches providing our "Keeping It Real!" faith based sexuality education curriculum to more than 7,000 young men and women. We have a similar faith based initiative, La Iniciativa Latina (LIL), which provides model programs on sexuality and reproductive health for Latino youth, adults and clergy in the context of Latino values, religion and culture.

But the answer to the Nation's high rate of unintended pregnancy and pandemic of sexually transmitted diseases does not rest with churches and nonprofit organizations alone. Public schools must be part of the solution. We are morally compelled to empower our young people with the knowledge to make responsible decisions. As Dr. Elders so succinctly stated, "Vows of abstinence break more easily than latex condoms." According to the CDC's National Center for Health Statistics, in 2002, the pregnancy rates for black and Hispanic teenagers were each more than two and one-half times the rate for white teenagers. This is the reality.

One of the most compelling arguments for comprehensive sexuality education was made by a member of our youth program, a proud Pentecostal Christian from rural Mississippi. In a meeting with her Member of Congress, she explained that there was no sex education in her high school and a lot of girls in her class got "knocked up." They did not graduate from high school. They did not marry. Their futures were compromised. But the impact of these unintended pregnancies goes well beyond the lives of these young women and their children. They contribute to the economic depression of their communities.

CONCLUSION

Let's be real and make a real difference. We know that 95 percent of Americans will have sex before they marry; therefore programs need to teach about abstinence and also about contraception, relationships and disease prevention. We must empower youth with the knowledge to make responsible decisions.

We believe that being of faith means being engaged in the world. And like it or not, the facts are clear: more than 80 percent of the 750,000 teen pregnancies each year are unintended and 25 percent of American teens contract an STD. We want our young people to be safe. For that to happen, they must be informed by comprehensive sex education. Offering them anything less is irresponsible and dangerous.

PREPARED STATEMENT OF THE RAILROAD RETIREMENT BOARD

Mr. Chairman and members of the committee: We are pleased to present the following information to support the Railroad Retirement Board's (RRB) fiscal year 2010 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 fiscal year 2008, the RRB paid $10.1 billion in retirement/survivor benefits and vested dual benefits to about 598,000 beneficiaries. We also paid $80 million in net unemployment/sickness insurance benefits to about 30,000 claimants.

PROPOSED FUNDING FOR AGENCY ADMINISTRATION

The President's proposed budget would provide $109,073,000 for agency operations, which would enable us to maintain a staffing level of 920 full-time equivalent staff years in 2010. The proposed budget would also provide about $1,651,000 for information technology (IT) investments. This includes $615,000 for costs related to information security and privacy, and for continuity of operations in the event of an emergency. The remaining IT funds will be used for E-Government initiatives, systems modernization, infrastructure needs and system support.

AGENCY STAFFING

The RRB's dedicated, experienced employees have been the foundation for our tradition of excellence in customer service and satisfaction. And, we have an ongoing need and responsibility to effectively manage our human capital resources. This is particularly important given the number of RRB employees who are eligible for retirement and those who soon will be. We are developing a long-range approach to

workforce planning that will position the agency for continued success in administering our programs. This includes a detailed analysis of the demographic features of the RRB workforce and the skills needed to fulfill our mission. It will also establish a procedural framework for recruiting, training, and developing talented employees.

Like many agencies, the RRB has an aging workforce. About 30 percent of our workforce is currently eligible to retire, and more than 50 percent will be eligible by fiscal year 2012. In response to this trend, we have placed added emphasis on filling entry-level positions, focusing on front-line service employees and claims examiners to the extent possible. In anticipation of an increase in the agency attrition rate as more employees become eligible to retire, these new employees will be key to effectively administering the RRB's programs and continuing to provide excellent service over the long term.

SERVICE IMPROVEMENTS

In fiscal year 2009, we have implemented nationwide, toll-free telephone service, which enables us to dynamically route phone calls among our offices based on logical business rules and customer needs. In addition to providing our customers with faster response times, the toll-free service allows agency management to more effectively balance and share workloads among offices. We plan to continue expanding the functionality and services offered through the toll-free number (1–877–772–5772 or 1–877–RRB–5RRB). Enhancements will focus on new self-service options available through the toll-free system.

The RRB's long-term information technology strategy also calls for expanded use of the Internet to provide services to our customers. We plan to use contractor services to augment agency staff to expand the electronic services available to the railroad public via the RRB's website. As part of this strategy, we are continuing to work on the Employer Reporting System to increase the amount of information related to railroad compensation, employment and service that employers can transmit to the RRB through the Internet. In fiscal year 2010, we plan to expand services to provide additional notifications to rail employers and enable employers to correct data through the system.

SYSTEMS MODERNIZATION

Over the last few 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. Our next steps involve modernizing the agency's computer processes.

Many of the RRB's existing systems are old, complex, and require a large investment in maintenance. As projected staff attrition occurs, we will be losing both experienced technical staff and some of the business subject-matter experts who now support our legacy systems. The modernization process will enable us to maintain the capability of our business function in the face of expected staff turnover, and to upgrade our systems based on the improvements that we have already completed. Through these initiatives, we will eliminate or reduce unnecessary or redundant activities, improve the accuracy and security of our systems and their transactions, make the systems more user-friendly for agency employees and our customers, improve the interoperability and flexibility of systems, and improve the RRB's ability to collaborate with agency partners. These improvements will ultimately decrease the time and cost to develop and operate RRB systems and allow an increased focus on new initiatives.

We plan to begin this process in fiscal year 2009, with selection of the agency's first system to modernize and development of a project plan. The selected system will serve as a pilot for further modernization. In fiscal year 2010, we will use contractor services to evaluate the pilot project's business requirements, identify possible solutions, analyze them, and recommend one for implementation.

The President's proposed budget includes $64 million to fund the continuing phase-out of vested dual benefits, plus a 2 percent contingency reserve, $1,280,000, 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 website. The market value of Trust-managed assets on September 30, 2008, was approximately $25.3 billion. Trust-managed assets have declined as a result of the general economic downturn in 2008 and the early part of 2009. The Trust reported that Trust-managed assets amounted to $19.1 billion as of March 31, 2009. The Trust has transferred to the RRB for payment of railroad retirement benefits approximately $7.3 billion since the inception of the Trust.

In June 2008, we released 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 report, which reflects changes in benefit and financing provisions under the RRSIA, addressed the 25-year period 2008–2032 and contained generally favorable information concerning railroad retirement financing. The report included projections of the status of the retirement trust funds under three employment assumptions. These indicated that, barring a sudden, unanticipated, large decrease in railroad employment or substantial investment losses, the railroad retirement system would experience no cash flow problems throughout the projection period. Our next report, which will be released in June 2009, will include updated projections reflecting the economic events of the past year.

Railroad Unemployment Insurance Account.—The equity balance of the Railroad Unemployment Insurance Account at the end of fiscal year 2008 was $99.9 million, a decrease of $0.8 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 2008. The report indicated that even as maximum daily benefit rates rise 47 percent (from $59 to $87) from 2007 to 2018, experience-based contribution rates maintain solvency. The report did not recommend any financing changes. We will update this analysis in our next annual report on the system, which will be released in June 2009.

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 (RRB). I would like to thank you, Mr. Chairman, and the members of the subcommittee for your continued support of the Office of Inspector General (OIG).

BUDGET REQUEST AND BACKGROUND INFORMATION

I wish to describe our fiscal year 2010 appropriations request and our planned activities. The OIG respectfully requests funding in the amount of $8,186,000 to ensure the continuation of its independent oversight of the RRB.

The RRB's central mission is to pay accurate and timely benefits. During fiscal year 2008, the RRB paid approximately $10.1 billion in retirement and survivor benefits to 598,000 beneficiaries. The RRB also paid $80 million in net unemployment and sickness insurance benefits to almost 30,000 claimants during the benefit year ending June 30, 2008.

The RRB contracts with a separate Medicare Part B carrier, Palmetto GBA, to process Railroad Medicare Part B claims. As of September 30, 2008, there were 469,442 Railroad Medicare Part B beneficiaries and during fiscal year 2008 Palmetto GBA paid more than $844 million in medical insurance benefits on their behalf.

During fiscal year 2010, the OIG will focus on areas affecting program performance; the efficiency and effectiveness of agency operations; and areas of potential fraud, waste, and abuse.

OFFICE OF AUDIT (OA)

The mission of the OA is to (1) promote economy, efficiency, and effectiveness in the administration of RRB programs, and (2) 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 2010, 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; and
—Security, privacy, and information management.

During fiscal year 2010, 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 2010, OA will complete the audit of the RRB's fiscal year 2009 financial statements and begin its audit of the agency's fiscal year 2010 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 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)

The 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 initiates cases based on information from a variety of sources. The agency conducts computer matching of employment and earnings information reported to State governments with RRB benefits paid. 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 OA.

OI's investigative results from October 1, 2008 through March 31, 2009 are:

Civil judgments	Indictments/information	Convictions	Recoveries/collections
12	16	29	$5,125,573

OI anticipates an ongoing caseload of approximately 450 investigations in fiscal year 2010. At present, OI has cases open in 47 States, the District of Columbia, and Canada with estimated fraud losses totaling almost $16 million.

OI will continue to concentrate its resources on cases with the highest fraud losses. Typically, these cases are related to the RRB's disability program. Disability fraud cases currently constitute approximately 50 percent of OI's total caseload. These cases involve more complicated schemes and result in the recovery of substan-

tial funds for the agency's trust funds. They also require considerable time and resources such as travel by special agents to conduct sophisticated investigative techniques such as surveillance and witness interviews. These fraud investigations are extremely document-intensive and involve complicated financial analysis.

Since March 2008, OI has added Railroad Medicare fraud investigations to its caseload and has identified 35 cases which involve losses to the Railroad Medicare program. Similar to the disability fraud matters, Medicare fraud cases are extremely complex in nature and often involve extensive document/data reviews that demand significant resources.

OI will continue to investigate fraud violations of railroad employees collecting unemployment or sickness insurance benefits while working and receiving wages from an employer. OI will also investigate retirement fraud and will continue to use the Department of Justice's Affirmative Civil Enforcement Program to recover trust fund monies from cases that do not meet U.S. Attorney's guidelines for criminal prosecution.

OI will also investigate complaints involving administrative irregularities and any alleged misconduct by agency employees.

In fiscal year 2010, 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.

REQUESTED CHANGE IN OPERATIONAL AUTHORITY

Oversight of the National Railroad Retirement Investment Trust

The National Railroad Retirement Investment Trust (NRRIT) was established by the Railroad Retirement and Survivors' Improvement Act of 2001 (RRSIA) to manage and invest Railroad Retirement assets. As of February 28, 2009, the RRB's investments in the NRRIT were valued at approximately $18.3 billion. Although the Trust is a tax-exempt entity independent of the Federal Government, RRSIA requires the Trust to report to the RRB. This office has previously reported its concerns about the RRB's passive relationship with the NRRIT and has identified the RRB's oversight in this area as a critical issue. However, the RRSIA does not provide the OIG with oversight authority to conduct audits and investigations of the NRRIT. This office believes that independent oversight of the Trust's operations is necessary to ensure that sufficient reporting mechanisms are in place and to ensure that the Trustees are fulfilling their fiduciary responsibilities. The OIG respectfully requests oversight and enforcement authority to conduct audits and investigations of the NRRIT.

SUMMARY

In fiscal year 2010, 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 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 it 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

Dear Chairman and Ranking Member: I am Dr. Kathleen Clanon, an HIV physician and director of the Tri-City Health Center's HIVACCESS program in Oakland, California. I am submitting public testimony on behalf of the Ryan White Medical Providers Coalition (RWMPC). I appreciate the opportunity to discuss the important HIV/AIDS care conducted at Ryan White Part C funded programs around the country and to request a dramatic increase in funds. Specifically, we recommend a $68.4 million increase for part C for fiscal year 2010 resulting in a total appropriation of $270,254,000.

Our 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. Our membership has rapidly increased as word

spread that an advocacy group was forming to speak on behalf of the needs of part C programs.

Ryan White Part C funds comprehensive HIV care and treatment—the services that are directly responsible for the dramatic decreases in AIDS-related mortality and morbidity over the last decade. We speak for those who often cannot speak for themselves and we advocate for a full range of primary care services for this unique population. Sufficient funding for part C is essential for the work that we do in service of those living with HIV/AIDS.

While the patient load in our programs is rising in number, funding for part C has effectively decreased. At the same time, we expect a continued increase in patients due to higher diagnosis rates and declining insurance coverage. The Centers for Disease Control and Prevention (CDC) reports that the number of HIV/AIDS cases increased by 15 percent from 2004 to 2007 in 34 States.[1] Our patients struggle in times of plenty; during this economic downturn they will rely on our comprehensive services more than ever. An increase in funding is critical to ensure that we are able to sustain and improve our current staffing levels, which is important to ensure access to healthcare for our patients, as well as, to provide security to our community. Part C of the Ryan White program has been under-funded for years, but new pressures are creating a crisis in our community. The HIV medical clinics funded through part C have been in dire of increased funding for years. An infusion of new funding would offer much needed assistance. Years of near flat funding, combined with large increases in the patient population, are negatively impacting the ability of part C providers to serve their patients.

With the rapid cost increases in all aspects of healthcare delivery, despite small funding increases programs are still operating at a funding deficit because we are serving more patients than ever. In 2008, part C programs will treat an estimated 248,070—a dramatic 30 percent increase in less than 10 years. Our clinics are laying off staff, discontinuing critical services such as laboratory monitoring, creating waitlists, and operating on a 4-day work week just to get by. All of this at a time when the new data reporting requirements resulting from the 2006 reauthorization of Ryan White are requiring even more staff and administrative time than the 10 percent allocation permitted.

Frankly, we can do better than this and the HIV/AIDS population served through part C deserves more support. I have included the following graph in my testimony to demonstrate the growing disparity between funding for part C and our patient population. I call the gap between funding and patients the “Triangle of Misery” because it represents the thousands of patients who deserve more than we can offer them and the part C programs around the Nation who are struggling to serve them with rapidly shrinking resources.

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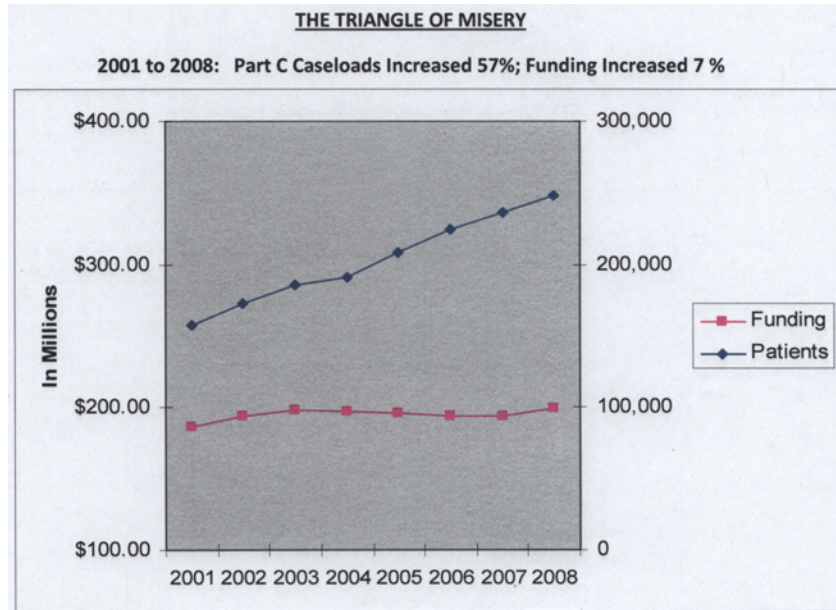
[1] Centers for Disease Control and Prevention. HIV/AIDS Surveillance Report, 2007. Vol. 19. U.S. Department of Health and Human Services, Centers for Disease Control and Prevention; 2009:5 www.cdc.gov/hiv/topics/surveillance/resources/reports.



The purpose of my testimony is to urge you to respond to this crisis and ask that you commit to doubling funding for Ryan White Part C programs by fiscal year 2012. Through a careful process that determined the actual cost of our care for our patients, the Ryan White Medical Providers Coalition worked collaboratively with the CAEAR Coalition and the American Academy of HIV Medicine to calculate the funding demands for Ryan White Part C. We unanimously agreed that a Federal appropriation of $407,300,078 is needed for part C.

These are challenging fiscal times, and we recognize the multiple fiscal constraints you face as you determine how to allocate limited Federal dollars. That is why we are not asking for $407.3 million for Ryan White Part C for fiscal year 2010. Rather, we join with our partners in asking you to commit to doubling our funding by fiscal year 2012. Such an agreement would result in an increase of $68.4 million for part C for each year: fiscal years 2010, 2011, and 2012. We believe this is a reasonable approach to meeting the needs of HIV/AIDS patients served by part C around the country.

It is important for you to understand how we developed our request number. It is based on the following calculations:

—We assumed that 1,381,418 will be the number of people living with HIV/AIDS in 2012 based on the Centers for Disease Control and Prevention, New Estimates of HIV Prevalence, 2006. The estimate equals the CDC's 2006 estimated cases multiplied by their annual estimated prevalence increases for the years 2007–2012.

—Using data from the HRSA HIV/AIDS Bureau we estimated that 248,070 uninsured people living with HIV/AIDS were served by part C programs in 2008.

—Using data from a report by Julie Gerberding, MD, MPH and Elizabeth Duke, Ph.D. to the Honorable Henry Waxman (http://oversight.house.gov/story.asp?ID1675) we estimated that 168,688 PLWHA who were underinsured were served by part C programs in 2008.

—We estimate the cost of care per patient at $3,501 per year. (Gilman, BH, Green, JC. Understanding the variation in costs among HIV primary care providers. AIDS Care. 2008:20;1050–6.)

—We calculated the cost of providing care to uninsured part C patients to be $277,916,382 per year (79,382 patients × $3,501 cost of care).

—We calculated the costs of providing care to underinsured part C patients to be $129,383,696 per year (168,688 patients × $767 cost of care). The cost of care for underinsured patients is a conservative estimate based on Institute of Medicine figures.

—The total cost of care for all part C patients will be $407,300,078 in fiscal year 2012.

Our data demonstrate the undeniable. Our patient load is increasing as is the cost of their care. A substantial Federal investment is necessary to support part C sites around the country in their efforts to provide the comprehensive care that we know HIV/AIDS patients deserve and from which both they and our communities benefit.

I thank you for your attention to our request and urge you to commit to doubling the funding for Ryan White Part C in 3 years. We request a $68.4 million increase for part C for fiscal year 2010 resulting in a total appropriation of $270,254,000. By working together, we are hopeful that in fiscal year 2012 the full appropriation for Ryan White Part C will be $407,300,078.

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 2010 to help improve quality-of-life for people with Spina Bifida:

—$7 million for the National Spina Bifida Program at 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.

—$4.818 million for the CDC's national folic acid education and promotion efforts to support the prevention of Spina Bifida and other neural tube defects.

—$25.623 million to strengthen the CDC's National Birth Defects Prevention Network.

—$77.059 million for the CDC's National Center on Birth Defects and Developmental Disabilities.

—$405 million for the Agency for Healthcare Research and Quality (AHRQ).

—$33.349 billion for the National Institutes of Health (NIH) to support biomedical research.

BACKGROUND ON SPINA BIFIDA

On behalf of the more than 185,000[1] individuals and their families who are affected by 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 2010 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 Spina Bifida Foundation 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 re-

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[1] At the First World Congress on Spina Bifida Research and Care in March 2009 representatives from the CDC reported on new data indicating that there are an estimated 185,000 individuals living with Spina Bifida in the United States.

search, 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—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, 1,500 babies are still born each year with Spina Bifida, 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. The emotional, financial, and physical toll and costs of Spina Bifida on the individuals and families affected are extraordinary. 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

SBA has worked with Members of Congress 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 expectancy. 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 program seeks to ensure that what is known by scientists is practiced and experienced by the individuals affected by Spina Bifida. Moreover, the National Spina Bifida Program works to improve the outlook for a life challenged by this complicated birth defect—principally, identifying valuable therapies from in-utero throughout the lifespan and making them available and accessible to those in need.

The National Spina Bifida Program serves as a national center for 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 taught what they need to know 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 185,000 individuals living with Spina Bifida with the goal being living well with Spina Bifida.

One way to enhance the knowledge base of Spina Bifida, improve quality of care, and save precious resources is to establish a patient registry for Spina Bifida. Plans are underway to create the National Spina Bifida Patient Registry. This registry is intended to determine the best clinical practices and the most cost-effective treatment for Spina Bifida, as well as, support the creation of quality measures to improve overall care. It is only through clinical research towards improved care that we can truly save lives, while also realizing a significant cost savings.

In fiscal year 2009, SBA requested $7 million be allocated to support and expand the National Spina Bifida Program. In the final fiscal year 2009 Omnibus Appropriations Act, Congress provided $5.468 million for this program, 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 million in fiscal year 2010 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, and each year approximately 3,000 pregnancies in this country are affected by Spina Bifida, resulting in an estimated 1,500 births. 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.

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. 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. 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 2010, 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 million fiscal year 2010 allocation for the National Spina Bifida Program, SBA urges the subcommittee to provide $4.818 million for the CDC's national folic acid education and promotion efforts to support the prevention of Spina Bifida and other neural tube defects; $25.623 million to strengthen the CDC's National Birth Defects Prevention Network; and a total of $77.059 million for 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 $405 million fiscal year 2010 allocation for AHRQ, so it can continue to provide guidance and support to the National Spina Bifida Patient Registry.

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 $33.349 billion in fiscal year 2010. 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 language in the report accompanying the fiscal year 2010 Labor, Health and Human Services, and Education, and related Agencies appropriations measure:

—Urging the National Institute of Child Health and Human Development to continue to support—and expand—a more comprehensive Spina Bifida research portfolio that focuses on addressing the myriad secondary effects and conditions associated with Spina Bifida;
—Commending the National Institute of Diabetes and Digestive and Kidney Diseases for its interest in exploring issues related to the neurogenic bladder and to encourage the Institute to forge ahead with its work in this important topic area; and
—Encouraging the National Institute of Neurological Diseases and Stroke to continue and expand its research related to the treatment and management of hydrocephalus.

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 2010 funding for programs that will improve the quality-of-life for the 185,000 Americans and their families living with Spina Bifida.

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 (NIH) 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.

OVERVIEW OF THE SCLERODERMA FOUNDATION AND 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.

Scleroderma Overview

Scleroderma is an autoimmune disease which means that it is a condition in which the body's immune system attacks its own tissues. In autoimmune disorders, this ability to distinguish foreign from self is compromised. As immune cells attack the body's own tissue, inflammation and damage result. Scleroderma (the name means "hard skin") can vary a great deal in terms of severity. For some, it is a mild condition; for others it can be life threatening. Although there are medications to slow down disease progression and help with symptoms, there is as yet no cure for scleroderma.

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.

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

There are two major types of systemic sclerosis (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 one-half 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.

FISCAL YEAR 2010 APPROPRIATIONS RECOMMENDATIONS

A 7 percent overall increase for NIH.

A 7 percent increase for the National Institute of Arthritis and Musculoskeletal and Skin Diseases (NIAMS) at the NIH.

A subcommittee recommendation encouraging NIAMS to support a State of the Science Conference on Scleroderma in fiscal year 2010.

Subcommittee 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 SOCIETY FOR HEALTHCARE EPIDEMIOLOGY OF AMERICA

Society for Healthcare Epidemiology of America (SHEA) was founded in 1980 to advance the application of the science of healthcare epidemiology. SHEA works to achieve the highest quality of patient care and healthcare personnel safety in all health care 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 disease 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 (DHQP) and the Federal Healthcare Infection Practices Advisory Committee (HICPAC), and the Council of State and Territorial Epidemiologists 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. More recently, SHEA has 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 organization also contributes expert scientific advice to quality improvement organizations such as the Institute for Healthcare Improvement (IHI), the National Quality Forum, and State-based task forces focused on infection prevention and public reporting issues.

The current swine flu emergency and the Obama administration's request for an additional $1.5 billion to address the situation highlights the need for ongoing congressional support of a national prevention strategy and dedicated funding stream for core public health programs. It is our hope that health reform can serve as an opportunity to strengthen our public health infrastructure and reorient our health system towards prevention and preparedness.

SHEA applauds the Congress for its support of HAI prevention and reduction activities through the American Recovery and Reinvestment Act (ARRA) and the fiscal year 2009 Omnibus Appropriations bill. The Society is collaborating with the Department of Health and Human Services (HHS) and the CDC to translate agency goals and objectives for these funds into actions at the bedside that can achieve meaningful reductions in preventable HAIs. However, SHEA believes that this level of funding is substantially insufficient to address a problem estimated by CDC to be one of the top 10 causes of death in the Nation and one that poses a significant economic burden on the Nation's healthcare system.

SHEA supports the conclusions of last year's GAO report on coordination among HHS agencies related to HAI prevention. We believe that coordinated action among CDC, the Centers for Medicare and Medicaid Services (CMS) and AHRQ is critical. CDC and its DHQP should function as the lead agency in surveillance and prevention activities related to HAIs at the Federal level because of its historic and successful role in this area. CDC has had an enviable track record of prevention and its development and management of the foremost surveillance system of its kind,

the National Healthcare Safety Network (NHSN) has created a national resource that many States have now mandated as their public reporting tool. Furthermore, guidelines developed by the HICPAC are widely regarded as the standards for the field. Coordinated activity among the agencies can lead to better informed public policy and payment reform.

Clearly, the CDC plays a critical role in public health protection through its health promotion, prevention, preparedness, and research activities. As you consider fiscal year 2010 funding levels for the CDC, SHEA urges your support of at least $8.6 billion for CDC's "core programs" (not including the mandatory funding provided for the Vaccines for Children Program) 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. 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 and improving the public's health.

Within this total, SHEA recommends a fiscal year 2010 funding level of $2.4 billion for CDC's Infectious Diseases program budget which supports vital management and coordination functions for infectious disease science, program, and policy, including infectious disease specific epidemiology and laboratory activities. In particular, 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. NHSN has now been adopted by 19 States and more than 2,100 U.S. hospitals for the surveillance and reporting of HAIs. It is an enormously important national resource and effective funding and support is essential to expand its implementation. Further, recognizing that multiple States mandate the use of NHSN for State public reporting, immediate efforts should be made to enable interfaces between electronic health records and NHSN. In this way, additional burdens are not placed upon healthcare entities from either an infection prevention and control or information technology perspective as the desirability for national database integration proceeds.

As already noted, SHEA believes that additional Federal dollars should be appropriated for HAI prevention and reduction to build upon the investment already made through the ARRA and fiscal year 2009 omnibus appropriations bill. It is SHEA's perspective that additional funding in this area will have the greatest impact when prioritized in the following ways:

—SHEA strongly encourages an emphasis on implementation of evidence-based practices, as supported by guidelines (CDC–HICPAC) and evidence-based recommendations (Compendium of Strategies to Prevent Healthcare-Associated Infections in Acute Care Hospitals). Protecting the health of our patients and preventing HAIs in the settings where healthcare is delivered in the United States will require a multi-faceted approach that includes identification and widespread adoption of evidence-based best practices. Where evidence does not exist, uniformity in practice should be adopted and studied to determine effectiveness. Failed practices should be discarded and successes widely disseminated. Prevention and control of HAIs also will require better tools in the form of new and novel antimicrobial agents, better knowledge of strategies to effect implementation and adherence to proven prevention methods, and accountability for performance.

—SHEA supports investment in training and education programs for both hospital-wide personnel, local public health personnel and patients/families in evidence-based prevention practices and development of educational materials /tools for patients and families with respect to HAI and multiple drug resistant organisms (MDRO).

—SHEA supports a broad context for use of dollars for HAIs rather than pathogen-specific targets or mandates (e.g., on MRSA or C. difficile). Ideally, funding should be tied to locally identified priorities emphasizing that implementation of best practice bundles for catheter-associated bloodstream infections (CLA–BSI), ventilator-associated pneumonia and catheter-associated urinary tract infection (CA–UTI) will have a greater impact on prevention of HAIs, including those due to MDRO, than pathogen-specific practices. This approach recognizes the influence of local conditions on the control of healthcare-associated infections, and allows rapid modification of strategies as new knowledge is gained. As an example, SHEA and CMS emphasize that a risk assessment must be the first step in any epidemiologic study or infection prevention and control pro-

gram in order to target preventive efforts effectively. We are pleased that the Joint Commission supports this critical step by developing it into a basic infection prevention standard. SHEA believes that this strategy allows healthcare facilities to use local information to develop and implement optimal and individualized prevention plans designed to reduce healthcare-associated infections that are identified as local problems. Goals should be written in such a way to allow hospitals the flexibility to identify and target their own safety threats within the domains that are considered critical, and healthcare facilities should be expected to be able to justify their infection prevention program based on local risk assessments.

—SHEA supports investment in hospital infrastructure and qualified personnel for infection prevention and control including epidemiologists, infection prevention and control professionals, NHSN implementation, and adequate microbiology/lab diagnostic capability as dictated by locally derived needs assessment and priority.

—SHEA believes that funds made available through CDC and AHRQ 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 HRET projects (for example PHRI 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 strongly favors local decision-making about priorities for use of funds; however, State efforts should be aligned with CDC priorities and should be carried out through collaboration with key stakeholders such as State hospital associations and local experts. CDC should lead the effort to measure and report on the success of State prevention efforts to HHS.

With respect to the National Institutes of Health (NIH), SHEA is very pleased that the ARRA infused the Institutes 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 life-source 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.

SHEA believes that any national effort designed to address the problem of HAIs should begin with the following principles: scrutiny of the science base; development of an aggressive, prioritized research agenda; the conduct of studies that address the identified questions; creation and deployment of guidelines based on the outcomes of these studies, followed by studies that assess the efficacy of the intervention.

In order to determine the preventability of infections, we first need to understand how and why these infections occur. A comprehensive national research agenda on HAIs must include at least three major categories of research: pathogenesis, epidemiology, and infection prevention strategies. A fourth area of, perhaps, even greater importance is the development and use of improved approaches to the design of healthcare epidemiology studies. Carefully designed multicenter prospective clinical trials are needed to establish the effectiveness of prevention and control strategies.

Unfortunately, support for basic, translational, and epidemiological research on HAIs has not been a priority of major funding bodies. 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 dollars on funding for HIV/AIDS research, about $2 billion on cardiovascular disease research, about $664 million on obesity research and, by comparison, National Institute of Allergy and Infectious Diseases provided $18 million for MRSA research. SHEA believes that as the magnitude of the HAI problem becomes part of the dia-

logue 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 2010 to ensure adequate support for the research foundation that holds the key to addressing the multifaceted challenges presented by HAIs.

SHEA thanks for the subcommittee for this opportunity to share our priorities with respect to fiscal year 2010 funding for HHS, CDC, and the NIH. SHEA is pleased to serve as a resource to the subcommittee going forward on issues related to healthcare epidemiology.

Prepared Statement of the Society for Maternal-Fetal Medicine

Mr. Chairman and members of the subcommittee: The Society for Maternal-Fetal Medicine (SMFM) is pleased to have the opportunity to submit testimony in support of the fiscal year 2010 budget for the National Institute of Child Health and Human Development (NICHD).

Established in 1977, SMFM is dedicated to improving maternal and child outcomes; and raising the standards of prevention, diagnosis, and treatment of maternal and fetal disease.

ISSUE

Preterm birth is a major public health priority and a major research priority for NICHD.

- —Nearly 500,000 babies born in the United States (1 of every 8 births) are preterm and the number continues to rise.
- —The annual cost due to preterm birth in the United States is estimated to be $26 billion.
- —These infants are at high risk for a variety of disorders including mental retardation, cerebral palsy and vision impairment.
- —They are also at high risk for long-term health issues including heart attack, stroke, and diabetes.

NICHD has been given the mandate of supporting almost all research into maternal, child, and fetal health problems. In 1986, the NICHD established the Maternal Fetal Medicine Units Network to achieve a greater understanding and pursue development of effective treatments for the prevention of preterm births, intrauterine fetal growth disorders, and medical complications during pregnancy. The Network currently funds 14 university-based clinical centers and one data coordinating center, located around the country. Each site is funded for 5 years and is renewed by open competition. The advantages of doing clinical trials within the Network include: having large populations with which to conduct studies (there are approximately 120,000 births per year within the Network); provides diverse populations across an array of ethnic and socioeconomic backgrounds—as a result, the study outcomes are more likely to prove effective in real-world clinical practice.

The Network has made a number of landmark contributions to obstetric practice. In particular, NICHD-supported research identified progesterone as a medication that can reduce premature deliveries significantly, and now patients are benefiting from this treatment. Another major advance is the use of magnesium sulfate—a common treatment to delay labor—to reduce the risk of cerebral palsy in preterm infants.

Building on information gathered in previous Network studies, the Network is currently addressing whether progesterone will also prevent preterm birth in first pregnancies found to have a short cervix. We have learned that:

- —one of the largest segments of women at risk for preterm births are those having their first child.

—when an ultrasound exam shows a short cervix (the opening of a woman's uterus), the risk of preterm birth is much higher.
—progesterone injections reduce the risk for those women with a prior preterm birth.

If benefit can be shown, progesterone will then be an intervention for prematurity prevention to apply to the largest segment of pregnant women at risk for preterm birth.

While we are making progress, there are still many areas about maternal health, pregnancy, fetal well-being, labor, and delivery and the developing child that NICHD investigators must understand better. For example:

—Steroids for the prevention of respiratory distress syndrome (RDS) and neonatal complications in the late preterm infant (34–37 weeks).
—Evaluation of the STAN monitor as an adjunct to intrapartum fetal monitoring to improve outcome of labor.

However these areas are not being pursued due to a projected limited budget.

We urge the subcommittee, as you move forward with your deliberations on the fiscal year 2010 budget, to provide greater resources to National Institutes of Health and in particular to the NICHD. Without a substantial increase and sustained investment in the critical medical research being conducted by the NICHD, therapies and preventive strategies that have a significant impact on the health of mothers and their babies will be delayed.

RECOMMENDATION

SMFM recommends that Congress provide at least a 7 percent increase more than the fiscal year 2009 budget for NICHD in fiscal year 2010.

Within the funds appropriated to the NICHD, SMFM urges Congress to instruct NICHD to adequately fund the Maternal Fetal Medicine Units Network.

Thank you for the opportunity to submit our concerns to the subcommittee.

PREPARED STATEMENT OF THE SOCIETY OF TEACHERS OF FAMILY MEDICINE

Mr. Chairman, the Society of Teachers of Family Medicine, the Association of Departments of Family Medicine, the Association of Family Medicine Residency Directors, and the North American Primary Care Research Group thank you for the opportunity to provide this testimony in support of funding for family medicine training in health professions training, the Agency for Healthcare Research and Quality (AHRQ) and the National Institutes of Health (NIH).

HEALTHCARE REFORM REQUIRES A ROBUST PRIMARY CARE WORKFORCE

Healthcare reform without measures to address the need for more primary care physicians will never be comprehensive or effective; it will not be able to help the most vulnerable populations, and it will not address the significant cost and quality issues currently so problematic in the United States. 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.

Solving the problem of the primary care crisis requires a multi-faceted solution. One key element is to increase the value of primary care, both in terms of payment rates and loan forgiveness, and through other avenues to make primary care an attractive specialty choice for medical students. A second is to change the incentives and rules surrounding training under the Medicare graduate medical education system. A third is to increase funding of programs that are effective in producing more primary care physicians, such as the primary care medicine and dentistry cluster of the health professions training programs. And the fourth is to support research regarding the clinical needs of most people seeking care, relating to the most common acute, chronic, and comorbid conditions routinely cared for by primary care physicians.

It is the latter two building blocks: funding for primary care physician training programs and funding for primary care research that come under this subcommittee's jurisdiction and that this testimony addresses

Health Professions: Primary Care Medicine and Dentistry (title VII, section 747)

We recommend that Congress build on the investment in primary care medicine training made in the American Recovery and Reinvestment Act (ARRA) by providing an appropriation of $215 million for primary care medicine and dentistry health professions training grants. The fiscal year 2009 omnibus appropriations bill only provided $500,000 more for these programs than in fiscal year 2008. This fund-

ing level ($48.4 million) is less than half of the funding these programs received in fiscal year 2003. We appreciate your efforts in that the House had proposed to double that account in the ARRA. We applaud the $300 million included for the National Health Service Corps, but we do not know how the remaining $200 million in workforce funds will be distributed between the many other workforce programs included in the ARRA.

KEY ADVISORY COMMITTEES KNOW THESE PROGRAMS ARE EFFECTIVE

The Institute of Medicine (IOM) calls the title VII program an "undervalued asset." Title VII, section 747, administered by HRSA, is the only program aimed directly at training primary care physicians. On December 12, 2008, the Institute of Medicine released "HHS in the 21st Century: Charting a New Course for a Healthier America," which points to the drastic decline in title VII funding. Within that report, the IOM terms title VII an "undervalued asset.

The HRSA Advisory Committee on Training in Primary Care Medicine and Dentistry [1] recommends an annual minimum level of $215 million for the title VII, section 747 grant program. The Committee reasoned that:

> Title VII funds are essential to support major primary care training programs that train the providers who work with vulnerable populations . . . additional funding is also necessary to prepare current and future primary care providers for their critical role in responding to healthcare challenges including demographic changes in the population, increased prevalence of chronic conditions, decreased access to care, and a need for effective first-response strategies in instances of acts of terrorism or natural disasters.

The Congressional Research Service also found that reduced funding for the primary care medicine and dentistry cluster had a deleterious impact on the effectiveness of these programs—at a time when more, rather than less primary care is needed. For example, "In fiscal year 2006, the program supported a total of 17,870 individuals in clinical training in underserved areas, a decrease from the support of 31,153 individuals in fiscal year 2005." [2] This is a decrease of almost 43 percent, in only 1 year.

A study in the Annals of Family Medicine (September/October 2008) shows that medical schools that receive primary care training dollars produce more physicians who work in Community Health Centers (CHCs) and serve in the National Health Service Corps compared to schools without title VII primary care funding. In spite of an effort to double the capacity of CHCs between 2002 and 2006, CHCs have found it difficult to recruit a sufficient number of primary care physicians and have hundreds of vacant positions.

PROGRAMS ARE ECONOMIC DRIVERS OF COST-SAVINGS AND HIGHER QUALITY

A Health Affairs (April 2004) article found a lower quality of care in States with higher levels of Medicare spending. The authors from the Dartmouth Center for the Evaluative Clinical Sciences found that States with more specialists and fewer primary care physicians had significantly higher costs and lower quality. A small increase in the number of primary care physicians in a State was associated with a large boost in that State's quality ranking. Indeed, States at the 75th percentile in number of primary care physicians per capita recorded Medicare costs $1,600 less per Medicare beneficiary per year and higher-quality indicators than States at the 25th percentile. If all States were to move to this level of primary care services, higher-quality care could be delivered at a savings of $60 billion or more per year for Medicare patients alone. Increased funding for title VII, section 747 could train more family doctors to be available to provide this much needed high-quality, lower-cost care.

The Government Accountability Office (GAO) and the Medicare Payment Advisory Commission have noted research indicating that access to primary care is associated with better health outcomes and lower healthcare costs. The GAO states "Ample research in recent years concludes that the nation's over reliance on specialty care services at the expense of primary care leads to a healthcare system that is less efficient. At the same time, research shows that preventive care, care coordination for

[1] *The Role of Title VII, Section 747 in Preparing Primary Care Practitioners to Care for the Underserved and Other High-Risk Groups and Vulnerable Populations*. Sixth Annual Report to the Secretary of the U.S. Department of Health and Human Services and to Congress.

[2] CRS Report to Congress. February 7, 2008 Title VII Health Professions Education and Training: Issues in Reauthorization (Order Code RL32546).

the chronically ill, and continuity of care—all hallmarks of primary care medicine—can achieve improved outcomes and cost savings." [3]

According to a report prepared by the National Association of Community Health Centers, The Robert Graham Center, and Capitol Link,[4] "There is a growing consensus among the Nation's political and industry leaders that the U.S. health care crisis has shifted from the realm of the poor and disenfranchised, to the doorstep of middle-class America." Additionally, they cite the following:

"If every American made use of primary care, the healthcare system would see $67 billion in savings annually. This reflects not only those who do not have access to primary care, but also those who rely extensively on costly specialists for most of their care, leading to inefficiencies in the system. More specifically, the expansion of Medical homes can even more dramatically facilitate effective use of health care, improve health outcomes, minimize health disparities, and lower overall costs of care."

Another study by the Robert Graham Center,[5] found that the economic impact of one family physician to his or her community was just more than $900,000 annually. Family physicians are the specialty most widely distributed throughout the United States. Using the data from their study on the economic impact of family physicians in their communities, they estimate that family physicians generate a nationwide economic impact of more than $46 billion per year. This is a conservative estimate, and does not include a number of intangible and other tangible economic benefits of family physicians, such as their contribution to the generation of income for other local healthcare organizations such as hospitals and nursing homes. In addition, while most medical specialties tend to cluster in urban areas and near academic health centers, family physicians are the specialists that are most likely to work in the poorest rural and urban areas. These underdeveloped geographies are also the ones most likely to be medically underserved.

Multiple studies from the Johns Hopkins Bloomberg School of Public Health have demonstrated that disparities in healthcare outcomes due to income inequality and socioeconomic status are reduced when there is an adequate supply of primary care.

AHRQ and NIH—Health Care Reform Requires New Areas of Endeavor 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. Funding should be increased both for the training of primary care researchers and for this type of clinical research. Such training is necessary to impart critical research skills to the primary care workforce and to contribute to the body of knowledge necessary to put primary care on similar footing with other specialties that have established research infrastructures. We are pleased with the infusion of funding through the ARRA for comparative effectiveness research, but there is a need to provide new funding directly toward specific clinical and translational endeavors.

AHRQ

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. We support the request of the Friends of AHRQ which recommends an fiscal year 2010 base funding level of $405 million, an increase of $32 million over the fiscal year 2009 level. This increase will preserve AHRQ's current initiatives and get the agency on track to a base budget of $500 million by 2013.

IOM'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.

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[3] Testimony before the Committee on Health, Education, Labor, and Pensions, U.S. Senate. Primary Care Professionals: Recent Supply Trends, Projections and Valuation of Services. Statement of A. Bruce Steinwald, Director Health Care, United States Accountability Office. February 12, 2008 GAO–08–472T.

[4] Access Granted: The Primary Care Payoff, August 2007, National Association of Community Health Centers, The Robert Graham Center, Capitol Link (pgs 1–2).

[5] The Family Physician as Economic Stimulus, http://www.graham-center.org/online/graham/home/tools-resources/directors-corner/dc-economic-stimulus.html.

One of the hallmarks of the Patient-Centered Medical Home is evidence-based medicine. Comparative effectiveness clinical research, compares the impact of different options for treating a given medical condition, and is vital to improving the quality of healthcare. Studies comparing various treatments (e.g., competing drugs) or differing approaches (e.g., surgery vs. drug therapy) can inform clinical decisions by analyzing not only costs, but the relative medical benefits and risks for particular patient populations.

NIH

Historically, the NIH has placed little emphasis on the research questions asked by primary care physicians and in primary care settings. We have been encouraged by the development of the NIH Roadmap and the Clinical and Translational Science Awards (CTSA), along with the establishment, in statute, of a funding stream that would make NIH more relevant to where most people receive care. We support an increase in NIH funding. In addition, we would like to see some report language that would help NIH ensure that the promise of "bench to bedside" research truly becomes "bench to bedside to community"—and community to bedside to bench.

We support the inclusion of the following language in the report to accompany the Labor, Health and Human Services, and Education, and Related Agencies appropriations bills for fiscal year 2010:

"Translational Research has been identified by the former Director of the National Institutes of Health (NIH) as a road map initiative. The committee supports this effort and encourages NIH to integrate such research as a permanent component of the research portfolio of each institute and center. The committee urges NIH to work with the primary care community to determine how best to facilitate progress in translating existing research findings and to disseminate and integrate research findings into community practice. Translational research should also include the discovery and application of knowledge within the practice setting using such laboratories as practice-based research networks. This research spans biological systems, patients, and communities, and arises from questions of importance to patients and their physicians, particularly those practicing primary care. The committee requests that the Director of NIH include a progress update in next year's Budget Justification."

CONCLUSION

As the United States moves toward major healthcare reform, we urge the subcommittee to support programs needed to ensure the proper supply of primary care physicians and the type of research that will work together to improve healthcare outcomes, enhance equity in care, and lower healthcare costs. We support increases in these three important programs: health professions primary care medicine and dentistry training, AHRQ, and NIH.

PREPARED STATEMENT OF THE STATE AND TERRITORIAL INJURY PREVENTION DIRECTORS ASSOCIATION

Thank you for the opportunity to offer written testimony to the Senate Appropriations Subcommittee on Labor, Health and Human Services, and Education and Related Agencies regarding the critical need for investments in State and territorial injury and violence prevention programs. It is well-recognized that injury and violence are a significant public health problem in terms of risk and costs to society. Injuries are the leading cause of death among persons 1–44 years of age, and a major cause of death, disability, and hospitalization for all age group. There are more than 170,000 injury-related deaths each year in the United States and approximately 30 million people seek emergency treatment as a result of injuries and violence annually.[1] Injury is the most common cause of premature deaths before age 65, accounting for 30 percent of years of potential life lost. In 2004, 1 in 14 deaths was caused by an injury, including 3 out of 4 deaths for adolescents and young adults.[2]

[1] National Center for Health Statistics. (2005). Deaths, Leading Causes. Center for Disease Control and Prevention. Retrieved December 2, 2008 from http://www.cdc.gov/nchs/FASTATS/lcod.htm.

[2] Injury in the United States: 2007 Chartbook.. U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Health Statistics. March 2008.

In 2000 alone, Americans suffered injuries resulting in more than $117 billion in medical costs and an estimated $289 billion in productivity losses, approximately 10 percent of total U.S. medical expenditures.[3] Long-term disabilities from brain, spinal cord, and burn injuries, and fall-related hip fractures, frequently result in high costs for continued, long-term care. Additionally injuries, especially fractures, for persons age 65 and older make up a substantial proportion of Medicare expenditures. As the U.S. population continues to age, this problem will be an even more significant burden on the Medicare system.

Despite the enormous toll of injury and violence, dedicated and ongoing Federal or State funding to respond to these problems does not exist as it does for other major public health priorities. State governments have a responsibility to protect the public's health and safety. A comprehensive injury and violence prevention program at the State health department provides focus and direction, coordinates and finds common ground among the many prevention partners, and makes the best use of limited injury and violence prevention resources. State public health injury and violence prevention programs apply the public health approach to help understand, predict and prevent injuries and use a population-based approach to extend the benefits of prevention beyond individuals.

State and Territorial Injury Prevention Directors Association (STIPDA) believes that all State and territorial health departments in the United States must have a comprehensive injury surveillance and prevention programs. These programs must be adequately staffed and funded commensurate with the magnitude of the burden of injury and violence in each State. They must have programs and expertise to address the leading causes of unintentional and violent injuries; and have disaster and terrorism epidemiology and injury mitigation programs. State public health departments bring significant leadership to reduce injuries and injury-related healthcare costs by:

—Informing the development of public policies through data and evaluation.

—Designing, implementing, and evaluating injury and violence prevention programs in cooperation with other agencies and organizations.

—Collaborating with partners in healthcare and the community.

—Collecting and analyzing injury and violence data from a variety of sources to identify high-risk groups and geographic locations.

—Providing technical support and training to injury prevention partners.

State injury and violence prevention programs use surveillance data to determine how injuries occur, who is most at risk, and what other factors contribute to whether or not an individual will be injured and to what degree. State programs have come a long way in understanding of how to prevent injuries and look beyond just the personal behaviors that lead to an injury. They also investigate the products that people use, the physical and social environment, and how organizational and governmental policies affect the safety of our environments.

State programs have also contributed to the dissemination of effective practices through partnerships with injury control research centers, local health departments, local coalitions and other organizations. To ensure the widespread adoption of these interventions, State programs provide training and technical assistance to local injury prevention efforts every day and often financial and in-kind support, as well as implement interventions.

The following are some examples of how State public health departments have contributed to the declines we have seen in deaths due to injuries in this country:

—Washington State's Injury and Violence Prevention Program has seen a decline in youth suicide while the U.S. rates have remained static. Washington found that on average 2 young people were dying of suicide per week with another 16 attempts that required hospitalization. The program estimated that a 50 percent reduction in youth suicidal behavior would result in $12 million in healthcare savings alone. The program implemented a comprehensive prevention program including gatekeeper training, public awareness and strengthening community safety nets for youth.

—The Georgia State Injury and Violence Prevention Program have been able to document at least 56 lives potentially saved through a unique partnership with Emergency Medical Services since 2006 through a child safety seat education and distribution program for low-income families in 109 of 169 counties throughout the State.

—The New York Injury and Violence Prevention Program was able to document reductions in bicycle-related injuries and traumatic brain injuries following the

[3] Zaloshnja, E., Miller, T. R., Lawrence, B. A., & Romano, E. (2005). The costs of unintentional home injuries. *Am J Prev Med*, 28: 88–94.

implementation of a statewide comprehensive bicycle helmet program that culminated in a bicycle helmet law passing easily through the State legislature.
—The Oklahoma Injury Prevention Service was able to identify a high-risk area in Oklahoma City for house-related fire injuries. In response, they conducted a smoke alarm distribution program. After the program, Oklahoma saw an 81 percent decline in residential fire injury-related deaths in the target population while rates declined only 7 percent in the rest of Oklahoma during the same time period.
—After finding that its drowning rate was ten times the national average, Alaska's Department of Health and Human Services formed a unique partnership with the U.S. Coast Guard, State Office of Boating Safety, Alaska Safe Kids to develop the "Kids Don't Float" program. Following extensive analysis of the problem, the coalition found that 90 percent of fatality victims were not wearing a life jacket (personal flotation device), more than half occurred in lakes and rivers, and that children younger than 18 make up a significant proportion of the victims. The program consists of adult and youth education (including peer-to-peer education for teens) and a life jacket loaner program. At least 5 documented lives have been saved through this program that is now implemented in 200 locations throughout the State.
—California's Epidemiology and Prevention for Injury Control Branch-funded and -evaluated a statewide social marketing campaign designed to engage high school age males as allies in preventing sexual violence through a message "My Strength is Not for Hurting." Through media efforts and "Men of Strength (MOST)" clubs in six pilot sites, California found that campaign appear promising, particularly when it involves MOST clubs, for favorably influencing high-school age males towards more respectful attitudes and affecting a healthier social climate in high schools.

When evidence-based injury prevention strategies are implemented, the estimated return on investment is substantial. For instance, home visitation programs have been demonstrated to be particularly effective in reducing child abuse and injury, and provide a cost savings of nearly $2.88 to $5.70 per $1 spent. Other proven cost-effective injury prevention strategies include:

Intervention	Cost per unit	Total benefits to society [1]
Booster seat	$31/seat	$2,200
Child bicycle helmet	$11/helmet	$570
Motorcycle helmets	$240/helmet	$4,300
Sobriety checkpoints	$9,600/checkpoint	$73,000
Midnight curfew and provisional licensing for teen drivers	$74/driver	$600
Smoke alarm purchases	$33/smoke alarm	$940
Fall prevention for high-risk elderly	$1,250/person	$10,800
Youth suicide prevention, native american	$175/youth	$6,700

[1] The total benefit to society is defined as the amount injury prevention interventions saved by preventing injuries, including medical costs, other resource costs (police, fire services, property damages, etc.), work loss, and quality of life costs. These benefits are calculated in 2004 dollars.

Currently, the National Center for Injury Prevention and Control (NCIPC)provides very minimal funding to 30 States through the Public Health Injury Surveillance and Prevention Program (PHISPP). According to STIPDA's 2007 State of the States survey, States with PHISPP funding were more likely to have a centralized program, a full-time director, and greater access to key injury data sets. They were also more likely to provide support to local injury efforts and provide surveillance data and technical assistance to inform public policy related to injury and violence. States with PHISPP funding are well-positioned to leverage additional resources, implement interventions for major injury issues, evaluate interventions, gain political support for specific injury topics, and raise awareness of injury trends.

We are asking the Senate to provide an additional $10 million to the NCIPC at the Centers for Disease Control and Prevention to supplement current investments for State injury and violence prevention programs. This funding would allow for:
—Expansion and stabilization of resources for State injury and violence prevention programs;
—Strengthening the ability of States to improve the collection and analysis of injury data, build coalitions and establish partnerships to promote programs and policies; and
—Disseminating proven injury and violence prevention strategies, with a focus on persons at highest risk.

Preventable injuries exact a heavy burden on Americans through premature deaths and disabilities, pain and suffering, healthcare costs, rehabilitation costs, disruption of quality of life for families and disruption of productive for employers. Strengthening the investments made to public health injury and violence prevention programs is a critical step to keep Americans safe and productive for the 21st century.

ABOUT STIPDA

Formed in 1992, STIPDA, is the only organization that represents public health injury prevention professionals in the United States. STIPDA has a membership of more than 300 professionals committed to strengthening the ability of State, territorial, and local health departments to reduce death and disability associated with injuries and violence. STIPDA engages in activities to increase awareness of injury, including violence, as a public health problem and works to enhance the capacity of public health agencies to conduct injuries and violence prevention.

PREPARED STATEMENT OF THE SOCIETY FOR WOMEN'S HEALTH RESEARCH AND THE WOMEN'S HEALTH RESEARCH COALITION

On the behalf of the Society for Women's Health Research and the Women's Health Research Coalition, we are pleased to submit the following testimony in support of Federal funding of biomedical research, and in particular women's health research.

The Society for Women's Health Research is the Nation's only nonprofit organization whose mission is to improve the health of all women through advocacy, research, and education. Founded in 1990, the Society brought to national attention the need for the appropriate inclusion of women in major medical research studies and the need for more information about conditions affecting women exclusively, disproportionately, or differently than men. The Society advocates increased funding for research on women's health; encourages the study of sex differences that may affect the prevention, diagnosis and treatment of disease; promotes the inclusion of women in medical research studies; and informs women, providers, policy makers and media about contemporary women's health issues. In 1999, the Women's Health Research Coalition was created by the Society as a grassroots advocacy effort consisting of scientists, researchers, and clinicians from across the country that are concerned and committed to improving women's health research.

The Society and Coalition are committed to advancing the health of women through the discovery of new and useful scientific knowledge. We believe that sustained funding for biomedical and women's health research programs conducted and supported across the Federal agencies are absolutely essential if we are to meet the health needs of the population and advance the Nation's research capability.

NATIONAL INSTITUTES OF HEALTH (NIH)

Congressional investment and support for NIH continues to make the United States 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. Great strides and advancements were made through the doubling of the NIH budget from $13.7 billion in 1998 to $27 billion in 2003, though the momentum driving new research in recent years was eroded under budgetary constraints. The 111th Congress saw the importance of increasing funds to NIH in the fiscal year 2009 omnibus bill providing the NIH with $30.317 billion, $937.5 million over fiscal year 2008, (a 3.2 percent increase.) Thankfully, Congress also sought fit to include the NIH in the American Recovery and Reinvestment Act of 2009 (Public Law 111–5) (ARRA) providing it with an infusion of short-term funding of $10.4 billion. This funding will have and is having an enormous impact on research and research facilities throughout the United States, creating new jobs, new innovations and improved technologies.

Without a robust budget, NIH has shown that it is forced to reduce the number of grants it is able to fund. The number of new grants funded by NIH has dropped steadily since fiscal year 2003 and this trend must stop. This shrinking pool of available grants has a significant impact on scientists who depend upon NIH support to cover their salaries and laboratory expenses to conduct high-quality biomedical research. Failure to obtain a grant results in reduced likelihood of achieving tenure. This means that new and less established researchers are forced to consider other careers, the end result being the loss of the critical workforce so desperately needed to sustain America's cutting edge in biomedical research.

In order to continue the momentum of scientific advancement and expedite the translation of research findings from the laboratory to the patients who depend on these advances for improved health and welfare, the Society proposes a 10 percent increase more than fiscal year 2009, and establishing a goal of reaching an annual appropriation of $40 billion in the next 3 years. In addition, we request that Congress strongly encourage the NIH to utilize ARRA funding as well as appropriated dollars to assure that women's health research receives resources sufficient to meet the health needs of all women. Further, the Society recommends that NIH support the advances being discovered in sex-based biology research.

Scientists have long known of the anatomical differences between men and women, but only within the past decade have they begun to uncover significant biological and physiological differences. Sex-based biology, the study of biological and physiological differences between men and women, 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. It is imperative that research addressing these important differences between males and females be supported and encouraged. Congress clearly recognizes these important sex differences and NIH should as well.

OFFICE OF RESEARCH ON WOMEN'S HEALTH (ORWH)

The NIH 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 women biomedical scientists and engineers in both the NIH and extramural 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). 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.

The BIRCWH program 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. It is expected that each scholar's BIRCWH experience will culminate in the development of an established independent researcher in women's health. The BIRCWH program has released four RFAs (1999, 2001, 2004, and 2006). Since 2000, 335 scholars have been trained (76 percent women) in the 24 centers resulting in more than 1,300 publications, 750 abstracts, 200 NIH grants and 85 awards from industry and institutional sources. 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.

The SCOR program was developed by ORWH in 2002. SCORs are designed to increase the transfer of basic research findings into clinical practice by housing laboratory and clinical studies under one roof. The eleven SCOR programs are conducting interdisciplinary research focused on major medical problems affecting women and comparing gender differences to health and disease. Each SCOR works hard to transfer their basic research findings into the clinical practice setting. In 2007, seven SCORS competed successfully for renewal and four new SCORS were added. In 2008, the 11 SCORs report publishing 113 journal articles, 144 abstracts, and 30 other publications. Each program costs approximately $1 million per year and results in research that would not have taken place without this program.

Advancing Novel Science in Women's Health Research (ANSWHR) was created by ORWH in 2007 and funding starting in July 2008 to promote innovative new concepts and interdisciplinary research in women's health research and sex/gender differences. This program has had broad appeal and is evolving into an important scientific tool for both early-stage investigators and veteran researchers to test nascent scientific concepts relevant to women's health research and the study of sex and gender differences. Researchers can apply for support to promote innovative, interdisciplinary research to answer unresolved questions and expand the knowledge

base in a host of areas relevant to women's health research. In fiscal year 2009, 13 ICs have one or more applications that have been scientifically reviewed and are considered competitive for funding. These applications, and the fiscal year 2008 awards, represent a wide range of scientific areas as well as junior investigators and experienced researchers. ANSWHR serves as a way for interested researchers to compete for funding that is expanding the scientific basis for women's health research and the study of sex and 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 pharmacogenomics, 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.

Despite all of ORWH's advancements of women's health research and its innovative programs to advance women scientists, the office has seen its budget flat lined at $40.9 million for fiscal year 2008 and 2009 after having also received a cut of $249,000 in fiscal year 2006 and no additional funding in fiscal year 2007. Flat funding is the same as receiving a decrease in budget and must not continue to happen. In order for ORWH's programs and research grants to thrive Congress must direct that NIH to continue its support of ORWH and provide it with $2 million budget increase.

DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS)

Under the HHS several agencies have Federal offices on women's health, in addition to ORWH described above. Agencies with offices, advisors, or coordinators for women's health or women's health research are HHS, the Food and Drug Administration, the Centers for Disease Control and Prevention, the Agency for Healthcare Quality and Research (AHQR), the Indian Health Service, the Substance Abuse and Mental Health Services Administration, the Health Resources and Services Administration, and the Centers for Medicare and Medicaid Services. It is imperative that these offices are funded at levels adequate for them to perform their assigned missions. We ask that the Committee Report clarify that Congress supports the permanent existence of these various Federal women's health offices and recommends that they are appropriately funded to ensure that their programs can continue and be strengthened in the coming fiscal year.

HHS OFFICE OF WOMEN'S HEALTH

The HHS Office of Women's Health (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. The OWH coordinates women's health efforts in HHS to eliminate disparities in health status and supports culturally sensitive educational programs that encourage women to take personal responsibility for their own health and wellness. OWH has a central role in communicating the appropriate messages to patients and healthcare providers, helping to move forward recent research discoveries. Without OWH's actions the task of translating research into practice would and will be only more difficult and delayed.

Over the years OWH has been active in various efforts such as: joining with NIH to launch the "The Heart Truth" campaign, a prevention and awareness campaign concerning heart disease and women; leading a series of Women's Heart Health Fairs nationwide; partnering with the Lupus Foundation of America and the Advertising Council to launch a new lupus public awareness campaign targeted toward young minority women of childbearing age who are at most risk for developing the disease to identify early warning signs.

OWH created a new training program "Body Works" for parents and caregivers designed to improve family eating and activity habits and is available in both English and Spanish. They collaborated with other organizations to lead a conference on "Charting New Frontiers in Rural Women's Health," as well as hosting the third Minority Women's Health Summit to address the unique health issues many women of color experience. In addition, OWH has continued its efforts to improve the health of young women by providing information on their Web site to address eating disorders and HIV/AIDS prevention for adolescent girls, in conjunction with conducting their HIV/AIDS National Awareness Day. Further, OWH is leading

efforts to improve breastfeeding information available to women of all cultures by offering multilingual Web sites and help-lines.

This year marks the 10th anniversary of the launch of the womenshealth.gov Web site and care center and National Women's Health Week. As part of the annual celebration, OWH is sponsoring many events with communities, businesses and other governmental and health organizations to educate women on how they can improve their physical and mental health. Further, this year OWH is celebrating the publication of "The Healthy Women" a book with wonderful health information and tips for women of all ages.

It is only through continued and increased funding that the OWH will be able to achieve its goals. While the budget for fiscal year 2008 increased the OWH budget by $2 million to a total of $30 million, its budget was flat lined for fiscal year 2009. This is, 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 for fiscal year 2010.

AHQR

AHQR is the lead public health service agency focused on healthcare quality, including coordination of all Federal quality improvement efforts and health services research. AHRQ'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. This important information provided by AHRQ is brought to the attention of policymakers, healthcare providers, and consumers all of whom make a difference in the quality of healthcare women receive. Through AHRQ's research projects and findings, lives have been saved and underserved populations have been treated. For example, 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 are moving AHRQ in the right direction. However, more core funding is needed to help AHRQ fulfill its mission. AHRQ's budget for fiscal year 2009 was $372 million. This must change for fiscal year 2010. The Society recognizes that AHRQ received a dramatic boost under ARRA of $400 million of dedicated stimulus funding for the comparative effectiveness project this amount does not add to AHRQ's base numbers. 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 $405 million for fiscal year 2010, an increase of $32 million more than the fiscal year 2009 level. This will ensure that adequate resources are available for high-priority research, including women's healthcare, sex and gender-based analyses, Medicare, and health disparities.

In conclusion, Mr. Chairman, we thank you 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. I am grateful for the opportunity to submit testimony to the subcommittee about public health appropriations.

Americans deserve a well-financed, modern, and accountable public health system. Funding for public health and disease prevention is a down payment toward reducing healthcare costs over the long term. As you craft the fiscal year 2010 Labor, Health and Human Services, and 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.

CASE FOR SUPPORT

There is increasing evidence that community level interventions, the kind of programs that CDC funding supports, make a difference in health outcomes and costs. In 2008, TFAH released a report, Prevention for a Healthier America: Investments in Disease Prevention Yield Significant Savings, Stronger Communities, which examines how much the country could save by strategically investing in community-based disease prevention programs. The report concludes that 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 could save the country more than $16 billion annually within 5 years. This is a return of $5.60 for every $1 spent. The findings are based on a model developed by researchers at the Urban Institute and a review of evidence-based studies conducted by the New York Academy of Medicine. The evidence shows that implementing these programs in communities reduces rates of type 2 diabetes and high blood pressure by 5 percent within 2 years; reduces heart disease, kidney disease, and stroke by 5 percent within 5 years; and reduces some forms of cancer, arthritis, and chronic obstructive pulmonary disease by 2.5 percent within 10 to 20 years, which, can save money through reduced health care costs to Medicare, Medicaid and private payers.

CHRONIC DISEASES

Chronic diseases, most of which are preventable, account for 70 percent of deaths in the United States and approximately 75 percent of healthcare spending. CDC's Division of Nutrition, Physical Activity, and Obesity (DNPAO) provides funding to States to create, implement, and monitor a nutrition, physical activity, and obesity State plan. In the previous grant cycle, 28 grantees were supported, but CDC is only able to award funds to 25 States in fiscal year 2009. The Division of Adolescent and School Health's (DASH) Coordinated School Health Program assists States in improving the health of children through a program that engages families and communities and develops healthy school environments. The President's fiscal year 2010 budget proposes to increase funding for DASH by $5 million to fund 10 additional State educational agencies to assist them in meeting the needs of their K–12 children. TFAH strongly supports this request. In the coming years, we will ultimately need chronic disease prevention and promotion programs in all 50 States. That will require $90 million for DNPAO to fund all approved States at the level at which they applied for funds and at least an additional $20 million for DASH's School Health program to fund all States that have been approved.

Another important anti-obesity program is the Healthy Communities Program. Healthy Communities grants support communities, cities, States, and tribal entities to implement health promotion programs and community initiatives. TFAH supports at least $30 million for the Healthy Communities Program. Yet, funding for this program has decreased dramatically over recent years, from $43 million in fiscal year 2007 to $22.7 million in the fiscal year 2009 omnibus appropriations bill. We support restoration of Healthy Communities funding because action at the local level is essential if we are to begin to mitigate the obesity epidemic.

PREPARING FOR PUBLIC HEALTH EMERGENCIES

In December of last year, TFAH released its annual “Ready or Not” report on the Nation's preparedness for a catastrophic event. Unfortunately, there are many areas where the United States remains underprepared. Funding for the Public Health Emergency Preparedness Cooperative Agreements to States and localities—where public health actually happens—has been cut in recent years. With these funds, local health departments have enhanced their disease surveillance systems and trained their staff in emergency response, including the recent H1N1 outbreak. More than 90 percent of local health departments have developed mass vaccination and prophylaxis planning, conducted all-hazards preparedness training, and implemented new or improved communication systems. All States have established the infrastructure necessary to evaluate urgent disease reports and to activate emergency response operations 24 hours a day. Yet despite this progress, challenges remain. In its 2008 progress report, CDC noted that 31 State public laboratories reported difficulty recruiting qualified laboratory scientists, and no State public health laboratory can rapidly identify priority radioactive materials in clinical samples. To continue our commitment to emergency preparedness, sustainable funding is necessary. TFAH recommends $1 billion for upgrading State and local capacity, an increase of $253 million more than the fiscal year 2009 level. We also recommend $596 million for ASPR's Hospital Preparedness Program, an increase of $208 million over the fiscal year 2009 level, to improve the capacity of our hospitals and other

supporting healthcare entities to respond to bioterrorist attacks, infectious disease epidemics, and other large-scale emergencies by enabling hospitals, EMS, and health centers to plan a coordinated response. To begin to build toward these funding levels, TFAH is very supportive and appreciative of the $14.5 million increase included in the President's budget proposal for upgrading state and local capacity, as well as for the $32 million increase for the Hospital Preparedness Program.

Another important program for our Nation's preparedness is the Biomedical Advanced Research and Development Authority (BARDA). BARDA was established in 2006 to help jumpstart innovation in vaccines, diagnostics, and therapeutics to combat health threats; yet limited funds have prevented BARDA from fulfilling its mission. BARDA provides incentives and guidance for research and development of products to counter bioterrorism and pandemic flu and manages Project BioShield, which includes the procurement and advanced development of medical countermeasures for chemical, biological, radiological, and nuclear agents. The fiscal year 2009 omnibus appropriations bill provided $275 million for BARDA, an increase of approximately $173 million more than fiscal year 2008 levels. TFAH applauds Congress' commitment to BARDA, as well as the President's proposed $30 million increase, but notes that a significant increase in funding would be necessary to support the successful development of medical countermeasures. TFAH requests $500 million for BARDA in fiscal year 2010, with 2 years of fiscal availability, noting that over the next few years, higher funding levels must be allocated and sustained.

BOLSTERING THE NATION'S ABILITY TO DETECT AND CONTROL INFECTIOUS DISEASES SUCH AS PANDEMIC INFLUENZA

In fiscal year 2006, Congress appropriated $5.6 billion to the Department of Health and Human Services (HHS) for emergency and agency funding for pandemic preparedness. The funding has been used for stockpiling enough antiviral drugs for the treatment of more than 50 million Americans, licensing a prepandemic influenza vaccine, developing rapid diagnostics and completing the sequencing of the entire genetic blueprints of 2,250 human and avian influenza viruses. The recent H1N1 influenza outbreak clearly demonstrates the importance of this investment.

TFAH was pleased that the fiscal year 2009 omnibus provided $507 million in no-year funding to be used to build vaccine production capacity, maintain a ready supply of eggs for the production of vaccine, and enable HHS to purchase medical countermeasures for its critical employees and contractors, as well as the Indian Health Service population. We are also appreciative that the House and Senate versions of the supplemental appropriations legislation include significant funding to address the H1N1 outbreak. In light of the challenges that could be posed if H1N1 resurfaces this fall, TFAH urges you to include $350 million for State and local preparedness activities, as proposed by the House, in the final version of the supplemental and to continue support for State and local preparedness through the annual appropriations process. Additionally, TFAH is hopeful that Congress will create a contingency fund to cover the production costs for a potential H1N1 vaccine, should health officials determine that mass production is necessary.

In fiscal year 2010, we urge Congress to fully fund the President's request for pandemic preparedness activities, including $354 million to the Public Health and Social Services Emergency Fund for vaccine, antivirals, ventilators, and countermeasures and personal protective equipment for HHS clinical and patient populations, and $230 million for agency budgets.

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. In fiscal year 2009, the Environmental Health Laboratory was funded at $42.7 million. Additional funds are needed to upgrade facilities and equipment and to bolster the workforce. Of the suggested $19.6 million increase, $10 million would be used extramurally to support State public health laboratory biomonitoring capabilities. An additional $7.6 million would be used for intramural activities, including increasing the number of chemicals CDC measures, providing training and quality assurance for State laboratories; and increasing the number of studies used to assess health effects associated with exposure to environmental chemicals. Additionally, $2 million would support the

National Report on Biochemical Indicators of Diet and Nutrition in the U.S. Population.

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 the omnibus for a Climate Change Program at CDC. To expand this program, for fiscal year 2010, TFAH recommends $17,500,000 to enable CDC to bolster its climate change staff, conduct climate change research and begin to work with State and local health departments on capacity building for climate change and health preparedness. Ultimately, $50 million is needed to develop a credible and effective Climate Change Program.

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. Health tracking, through the integration of environmental and health outcome data, enables public health officials to better target preventive services so that health care providers can offer better care, and the public will be able to develop a clear understanding of what is occurring in their communities and how overall health can be improved. Since 2002, Congress has provided funding for pilot programs in some States and cities. The National Network is launching in 2009. With that in mind, TFAH recommends providing $50 million for CDC's Environmental and Health Outcome Tracking Network, an increase of $19 million more than the fiscal year 2009 level, to expand it to additional States and support the continued development of a sustainable Network.

Finally, TFAH supports the expansion of CDC's Global Disease Detection (GDD) Program. Despite remarkable breakthroughs in medical research and advancements in immunization and treatments, infectious diseases are undergoing a global resurgence that threatens health. Worldwide, infectious diseases are the leading killer of children and adolescents and are one of the leading causes of death for adults. 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. To address the magnitude and urgency of emerging and resurging diseases, TFAH recommends $56 million for the GDD Program, an increase of $22 million over the fiscal year 2009 level. Funding will increase the number of GDD centers across the globe and bring some existing centers to full capacity.

Mr. Chairman, thank you again for the opportunity to submit testimony on the urgent need to enhance Federal funding for public health programs which can save countless lives and protect our communities and our Nation.

PREPARED STATEMENT OF THE TB COALITION

TUBERCULOSIS

The TB Coalition is a network of public health, research, professional, and advocacy organizations working to support policies to eliminate tuberculosis (TB) in the United States and around the world. The TB Coalition is pleased to submit our recommendations for programs in the Labor, Health and Human Services, and Education, and Related Agencies Subcommittee purview. The TB Coalition, in collaboration with Stop TB USA, recommends a funding level of $210 million in fiscal year 2010 for CDC's Division of TB Elimination, as authorized under the Comprehensive TB Elimination Act.

TUBERCULOSIS

Tuberculosis (TB) is an airborne infection caused by a bacterium, Mycobacterium tuberculosis. TB primarily affects the lungs but can also affect other parts of the body, such as the brain, kidneys or spine. TB is the second leading global infectious disease killer, claiming 1.8 million lives each year. Currently, about a one-third of the world's population is infected with the TB bacterium. It is estimated that 9–14 million Americans have latent TB. Tuberculosis is the leading cause of death for people with HIV/AIDS in the developing world. According to a 2009 World Health Organization (WHO) report on global TB control, about 5 percent of all new TB cases are drug resistant. The global TB pandemic and spread of drug resistant TB present a persistent public health threat to the United States.

The major factors that have caused the spread of drug resistant TB—including multi-drug resistant TB (MDR) and extensively drug resistant (XDR) TB—are inadequate attention to and funding for basic TB control measures in high TB burden; resource-limited settings, which also have high HIV prevalence; as well as the lack of investment in new drugs, diagnostics and vaccines for TB. While most TB prevalent today is a preventable and curable disease when international prevention and treatment guidelines are used, many parts of the world—such as Africa and Eastern Europe—are struggling to implement them, giving rise to more drug resistant TB and increasingly, XDR–TB.

XDR–TB AS A GLOBAL HEALTH CRISIS

XDR–TB has been identified in all regions of the world, including the United States. The strain is resistant to two main first-line drugs and to at least 2 of the 6 classes of second-line drugs. Because it is resistant to many of the drugs used to treat TB, XDR–TB treatment is severely limited and the strain has an extremely high-fatality rate. In an outbreak in the Kwazulu-Natal province of South Africa from late 2005 through early 2006, XDR TB killed 52 out of 53 infected HIV-infected patients within just 3 weeks of diagnosis. According to the CDC, there have been 83 cases of XDR–TB in the United States between 1998 and 2008. While the treatment success rate for XDR–TB in the United States is about 64 percent, the extremely high costs of treating XDR–TB, coupled with high fatality rates associated with the strain make XDR–TB a significant public health concern for the United States.

NEW TB TOOLS NEEDED

Although drugs, diagnostics, and vaccines for TB exist, these technologies are antiquated and are increasingly inadequate for controlling the global epidemic. The most commonly used TB diagnostic in the world, sputum microscopy, is more than 100 years old and lacks sensitivity to detect TB in most HIV/AIDS patients and in children. Skin tests used in the United States are more effective at detecting TB, but take up to 3 days to complete. Current diagnostic tests to detect drug resistance take at least 1 month to complete. Faster drug susceptibility tests must be developed to stop the spread of drug resistant TB. The TB vaccine, BCG, provides some protection to children, but it has little or no efficacy in preventing pulmonary TB in adults.

There is an urgent need for new anti-TB treatments, and particularly for a shorter drug regimen. Currently, the drug regime for TB treatment is 6–9 months. A shorter drug regimen with new classes of drugs active against susceptible and drug-resistant strains would increase compliance, prevent development of more extensive drug resistance, and save program costs by reducing the time required to directly observe therapy for patients. There is also a critical need for drugs that can safely be taken concurrently with antiretroviral therapy for HIV. The good news is that new drugs in development hold the promise of shortening treatment from 6–9 months to 2–4 months.

TB IN THE UNITED STATES

Although the numbers of TB cases in the United States continue to decline, with 12,898 new cases reported in 2008, progress towards TB elimination has slowed. The average annual percentage decline in the TB rate slowed from 7.3 percent per year during 1993–2000 to 3.8 percent during 2000–2008. Foreign-born and ethnic minorities bear a disproportionate burden of U.S. TB cases. The proportion of TB cases in foreign-born people has increased steadily in the last decade, from 27 percent of all cases in 1992 to 58 percent of all cases in 2008. Border States and States with high immigration levels such as California, Texas, and New York are among the highest-burdened TB States. U.S.-born blacks make up almost half (45percent) of all TB cases among U.S.-born persons.

In the 1970s and early 1980s, the United States began significantly reducing the TB control infrastructure. Consequently, the trend towards TB elimination was reversed and the Nation experienced an unprecedented resurgence of TB, including many MDR–TB cases. There was a 20 percent increase in cases reported between 1985 and 1992. In just one city, New York City, the cost to regain control of TB was more than $1 billion. The 2000 Institute of Medicine (IOM) report, Ending Neglect: the Elimination of Tuberculosis in the United States, found that the resurgence of TB in the United States between 1985 and 1992 was due in large part to funding reductions and concluded that with proper funding, organization of prevention and control activities, and research and development of new tools, TB could be eliminated as a public health problem in the United States.

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 (MDR) TB range from $100,000 to $300,000, which can cause a significant strain on State public health budgets. Inpatient care has been estimated for California XDR TB patients from 1993–2006 at an average of approximately $600,000 per patient.

STRONG STATE AND LOCAL TB CONTROL PROGRAMS

The best defense against the development of drug-resistant tuberculosis is a strong network of State and local public health programs and laboratories. State, local, and territorial health departments provide important TB control services such as directly observed therapy (DOT, a proven method to improve adherence and thus prevent drug resistance), laboratory support, surveillance, contact tracing, and patient counseling. CDC provides about $100 million annually in support to State, local and territorial health departments to prevent and control TB.

According to the National Tuberculosis Controller's Association, for every confirmed case of TB, State and local health department must identify and test an estimated 14 persons who may have been exposed. Yet after almost a decade of stagnant funding, many State TB programs have been left seriously under-resourced at a time when TB cases are growing more complex to diagnose and treat. The higher percentage of foreign-born TB patients adds to the need for specially trained TB professionals. According to a recent assessment by CDC's Division of TB Elimination, more than 1,077 jobs have been lost in State TB control programs over the last 3 years—ranging from doctors and nurses to lab personnel and outreach workers.

Despite low 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/clusters occur, outstripping local capacity; (4) continued emergence of drug resistance threaten our ability to control TB; and (5) there are critical needs for new tools for rapid and reliable diagnosis, short, safe, and effective treatments, and vaccines.

CONGRESSIONAL RESPONSE TO TB

In recognition of the need to strengthen domestic TB control, the Congress passed the Comprehensive Tuberculosis Elimination Act (CTEA) (Public Law 110–392) in October 2008. This historic legislation was based on the recommendations of the Institute of Medicine and 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 authorizes an urgently needed reinvestment into new TB diagnostic treatment and prevention tools. The TB Coalition, in collaboration with Stop TB USA, recommends a funding level of $210 million in fiscal year 2010 for CDC's Division of TB Elimination, as authorized under the CTEA. The CTEA, as introduced, included a separate authorization of $100 million through CDC's TB elimination program for the development of urgently needed new TB diagnostic, treatment and prevention tools to ease the global TB pandemic. We hope that this unique area of need will also be considered in the final fiscal year 2010 funding levels.

NATIONAL INSTITUTES OF HEALTH (NIH)

The NIH has a prominent role to play in the elimination of tuberculosis through the development of new tools to fight the disease. However, the Coalition is concerned that the NIH has reduced funding for TB research from $211 million in 2007 to $160 million in 2008. We encourage the NIH to expand efforts, as requested under the Comprehensive TB Elimination Act, to develop new tools to reduce the rising global TB burden, including faster diagnostics that effectively identify TB in all populations, new drugs to shorten the treatment regimen for TB and combat drug resistance, and an effective vaccine.

CONCLUSION

The global TB epidemic endangers TB control efforts in the U.S. TB case rates in the United States reflect the global situation. The best way to prevent the future development of drug-resistant strains of tuberculosis is through establishing and supporting effective global and domestic tuberculosis control programs and research programs through the CDC, NIH, and U.S. Agency for International Development (USAID). The TB Coalition appreciates this opportunity to provide testimony.

PREPARED STATEMENT OF THE TRI-COUNCIL FOR NURSING

The Tri-Council for Nursing, a long-standing alliance focused on leadership and excellence in the nursing profession, is composed of the American Association of Colleges of Nursing (AACN), the American Nurses Association, the American Organization of Nurse Executives, and the National League for Nursing (NLN). The collaborative leadership of these four professional organizations impacts the breadth of nursing practice, including nurse executives, educators, researchers, and nurses providing direct patient care. The Tri-Council asks the subcommittee to provide $263.4 million in fiscal year 2010 for the Nursing Workforce Development Programs under title VIII of the Public Health Service Act, administered by the Health Resources and Services Administration (HRSA).

In light of the economic challenges facing our country today, the Tri-Council urges the subcommittee to focus on the larger context of building the capacity needed to meet the increasing healthcare demands of our Nation's population. Such public policy will require sustained investments aimed at refocusing the current healthcare system toward promoting health, while simultaneously improving value for our dollars. The title VIII Nursing Workforce Development Programs are proven policy instruments that help assure an adequately prepared nursing workforce. These programs—

—Increase access to healthcare in underserved areas through improved composition, diversity, and retention of the nursing workforce;
—Advance quality care by strengthening nursing education and practice; and
—Develop the identification and use of data, program performance measures, and outcomes to make informed decisions on nursing workforce matters.

The Tri-Council applauds the subcommittee for the emergency supplement provided across all the health professions programs via the American Recovery and Reinvestment Act (Public Law 111–5). We also value the enacted fiscal year 2009 Omnibus Appropriations bill (Public Law 111–8) providing $171.031 million specifically for the title VIII Nursing Workforce Development Programs. These investments are a critical component supporting our healthcare infrastructure.

Examining the broad context, the healthcare industry remains the largest industrial complex in the United States. Studies of the Nation's gross domestic product (GDP) show healthcare spending achieving a relatively high rate of real growth, with the portion of GDP devoted to healthcare growing from 8.8 percent in 1980 to 16.2 percent of GDP in 2007. While healthcare spending demands greater efficiencies, it also has helped to sustain our Nation's sagging economy.

Since 2001, healthcare is virtually the only sector that added jobs to the economy on a net basis. In March 2009, the U.S. Bureau of Labor Statistics (BLS) reported continued growth in the healthcare sector, despite our economy's freefall in a down cycle with unemployment reaching 8.1 percent in February 2009. With that month's job loss of 681,000 realized in nearly all major industries, BLS also reported the addition of 27,000 new jobs at hospitals, long-term care facilities, and other ambulatory care settings.

As the predominant occupation in the healthcare industry, the nurse workforce likely is filling most of the noted job openings. Nurses are the front line of healthcare delivery throughout the Nation, and the BLS numbers support that description showing the nurse workforce at well more than four times the size of the medical workforce. Increased fiscal year 2010 investments in title VIII will help counterbalance the economic meltdown threatening nursing programs operating in congressional districts and serving communities by supporting nursing education—providing title VIII loans, scholarships, traineeships, and programmatic funding.

NURSING SHORTAGE OUTPACES CAPACITY BUILDING

The Tri-Council contends that an episodic increased funding of title VIII will not fully fill the gap generated by an 11-year nursing shortage felt throughout the entire U.S. health system and projected to continue. The BLS projections estimate that RNs will have the greatest growth rate of all U.S. occupations in the period spanning 2006–2016, with more than 1 million new and replacement nurses needed by 2016. Despite this projected expansion in the profession, numerous other studies anticipate a growing national nurse workforce shortage to intensify as the baby boomer cohort ages, the current nurse workforce retires, and the demand for healthcare accrues.

Funding levels for the HRSA title VIII Nursing Workforce Programs are failing to support the numerous qualified applicants seeking assistance from these programs. In the last 3 years, virtually flat title VIII funding, along with inflation and increased educational and administrative costs, has decreased purchasing power. According to HRSA statistics, in fiscal year 2006 the title VIII programs directly or

indirectly supported 91,189 nurses and nursing students. In fiscal year 2007, the number of grantees dropped by 21 percent and in 2008 the grantees dropped by 28 percent to support only 51,657 nurses and nursing students.

Additionally, schools of nursing continue to suffer from a growing shortage of faculty, a troubling infrastructure trend that exacerbates the nurse workforce demand-supply gap. According to a study conducted by the AACN in 2008, schools of nursing turned away 49,948 qualified applicants to baccalaureate and graduate nursing programs. The top reasons cited for not accepting these potential students was a lack of qualified nurse faculty and resource constraints. Without faculty, nursing education programs are prevented from admitting many qualified students who are applying to their programs. (Data are Internet accessible at http://www.aacn.nche.edu/Media/NewsReleases/2009/ workforcedata.html.)

The AACN survey results are reinforced by the NLN study of all types of prelicensure RN programs, which prepare students to sit for the RN licensing exam (i.e., baccalaureate, associate, and diploma degree). The NLN statistics indicate more than 1,900 unfilled full-time faculty positions existed nationwide in 2007, affecting more than one-third (36 percent) of all schools of nursing. Significant recruitment challenges were found with 84 percent of nursing schools at-tempting to hire new faculty in 2007–2008, more than three-quarters (79 percent) reporting recruitment as "difficult" and almost 1 in 3 schools found it "very difficult." The two main difficulties cited were "not enough qualified candidates" (cited by 46 percent of schools), followed by inability to offer competitive salaries—cited by 38 percent. (Data are Internet accessible at www.nln.org/research/slides/index.htm.)

THE FUNDING REALITY

If the United States is to reverse the eroding trends in the nurse and nurse faculty workforce, the Nation must make a significant investment in the title VIII programs, which are charged to favor institutions educating nurses for practice in rural and medically underserved communities. At adequate funding levels the title VIII programs supporting the education of registered nurses, advanced practice registered nurses, nurse faculty, and nurse researchers have demonstrated successful intervention strategies to solving past nursing shortages.

A brief examination of the HRSA title VIII illustrates the robust nature of these programs:

Section 811.—The Advanced Education Nursing (AEN) Program funds traineeships for individuals preparing to be nurse practitioners, nurse midwives, nurse administrators, public health nurses, and nurse educators, among other graduate-level education nursing roles. The AEN awards assisted nurse education programs to support 3,419 graduate nursing students in fiscal year 2008.

Section 821.—The Nursing Workforce Diversity Program funds grants and contracts to schools of nursing, nurse-managed health centers (NMCs), academic health centers, State and local governments, and nonprofit entities to increase nursing education opportunities for individuals from disadvantaged backgrounds and under-represented populations among RNs. This program—of proven intervention strategies—supported 18,741 students in fiscal year 2008, seeking to ensure a culturally diverse workforce to provide healthcare for a culturally diverse patient population.

Section 831.—The Nurse Education, Practice and Retention Program provides support for academic and continuing education projects designed to strengthen the nursing workforce. Several of this program's priorities apply to quality patient care including developing cultural competencies among nurses and providing direct support to establishing or expanding NMCs in noninstitutional settings to improve access to primary healthcare in medically underserved communities. The program also provides grants to improve retention of nurses and enhanced patient care. In fiscal year 2008, approximately 6,000 nurses and nursing students were supported.

Section 846.—The Nurse Loan Repayment and Scholarship Programs is divided into two primary elements. The Nursing Education Loan Repayment Program (NELRP) assists individual RNs by re-paying up to 85 percent of their qualified educational loans over 3 years in return for their commitment to work at health facilities with a critical shortage of nurses, such as departments of public health, community health centers, and disproportionate share hospitals. In fiscal year 2008, of the 5,875 applications reviewed by HRSA, only 435 students (7.4 percent) received NELRP awards. Similarly, the Nurse Scholarship Program (NSP) provides financial aid to individual nursing students in return for working a minimum of 2 years in a healthcare facility with a critical nursing shortage. In fiscal year 2008, NSP turned away most of the applicants owing to a lack of adequate funding, resulting in the distribution of only 169 student awards.

Section 846A.—The Nurse Faculty Loan Program (NFLP) supports the establishment and operation of a loan fund within participating schools of nursing to assist RNs to complete their education to become nursing faculty. The NFLP grants provide a cancellation provision in which 85 percent of the loan, plus interest, may be cancelled over 4 years in return for serving as full-time faculty in a school of nursing. NFLP granted 729 awards in fiscal year 2008.

Section 855.—The Comprehensive Geriatric Education Grant Program focuses on training, curriculum development, faculty development, and continuing education for nursing personnel caring for the elderly. In fiscal year 2008, 18 awards were made in this program.

While title VIII is the largest source of Federal funding for nursing, the current level of investment falls short of remedying a chronic underfunding of the Nursing Workforce Development Programs, compared to the existing and imminent shortages these programs address. The title VIII authorities are capable of providing flexible and effective support to assist students, schools of nursing, and health systems in their efforts to recruit, educate, and retain registered nurses. Recent efforts have shown that aggressive and innovative strategies can help avert the nurse and nurse faculty shortages. The Tri-Council for Nursing understands the competing priorities faced by this Congress, but we also maintain that title VIII Nursing Workforce Development Programs must be funded at an adequate level to begin to impact the shortage and to address the complex health needs of the Nation. The contributions of nurses in our healthcare system are multifaceted, and are impacted directly by the level of Federal funding that supports nursing programs.

Prepared Statement of The Endocrine Society

The Endocrine Society is pleased to submit the following testimony regarding fiscal year 2010 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.

Since the doubling of its budget, the NIH has received annual funding increases below the rate of biomedical inflation. Fiscal year 2009 appropriations resulted in the first real-dollar increase in NIH funding since fiscal year 2003. This decline in useable dollars has resulted in a significant decrease in the number of R01 grants funded. In 2003, the number of new and continuing R01s was 7,211; the number of grants awarded in 2008 dropped to 5,886. As a result of the decreasing number of grants awarded, the success rate for new R01 grants dropped from 25.5 percent in 1999 to a low of 16.3 percent in 2006 (the 2008 success rate was 19 percent). Not only does the decline in grants affect the number of scientists who are able to continue their research and discover new treatments and cures, it also has a significant impact on the U.S. economy.

In fiscal year 2007, every $1 million that the public invested in NIH research generated $2.21 million in new business activity across the Nation. At a recent House Energy and Commerce Committee hearing, Dr. Raynard Kington, Acting Director of the NIH, stated that each NIH grant supports seven jobs on average. Since grants are dispersed to all 50 States and 90 percent of Congressional Districts, increasing funding for science will have a significant positive impact on job growth. And unlike many other proposals to stimulate the economy, funding NIH grants can have an immediate impact on the economy because these grants can be funded in a matter of weeks, stimulating local economies through salaries and purchase of equipment, laboratory supplies, and vendor services.

Members of Congress and President Obama recognized the positive impact that funding NIH research can have on the economy and allocated more than $10 billion to the NIH in the American Recovery and Reinvestment Act of 2009. These funds will go a long way towards increasing the success rate of new R01 applications, keeping scientists employed, and creating new jobs. The Endocrine Society thanks Congress for the support of biomedical research funding in the ARRA.

However, the Federal Government needs to make a long-term, sustainable commitment to biomedical research funding. The money allocated to the NIH in the ARRA is a one-time infusion of money, and it is unclear how much NIH's budget will be when the stimulus funds run out at the end of fiscal year 2010. These funds will create thousands of new jobs, most of which will end when fiscal year 2011 begins if Congress does not bring NIH's budget closer to $40 billion than to $30 billion.

The loss of these jobs could have a drastic effect on our economy and counteract the benefits realized during fiscal year 2009 and 2010 as a result of the stimulus funding.

While the Nation is struggling with a failing economy, health reform is also on the top of the minds of Members of Congress and the American people. With the aging of the Baby Boomer generation, the incidence of costly, chronic conditions will significantly increase, and a large portion of the projected increase in healthcare costs will be as a result of escalating costs associated with diabetes, obesity, hypertension, Alzheimer's disease, muscular dystrophy, cystic fibrosis, and stroke. In order to prevent and treat these diseases, and save the country billions in healthcare costs, significant investment in biomedical research will be needed. For instance, treatments that delay or prevent diabetic retinopathy save the country $1.6 billion a year, and new treatments that delay the onset and progression of Alzheimer's disease by 5 years can save $50 billion a year in healthcare costs.

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 supports President Obama's campaign pledge to double the NIH budget over 10 years. We therefore recommend that NIH receive an increase of at least 7 percent in fiscal year 2010 to prepare for the poststimulus era and ensure the steady, sustainable growth necessary to complete the President's vision of doubling the investment in basic and clinical research.

PREPARED STATEMENT OF THE MENDED HEARTS, INCORPORATED

I am Robert A. Scott, National Advocacy Chairman for The Mended Hearts, Incorporated, a heart disease support group with more than 300 chapters across the United States and Canada. In 2008, accredited Mended Hearts volunteers visited about 3,000 heart patients in more than 400 hospitals throughout the United States.

As a walking testimony of the benefits of the National Institutes of Health (NIH)-supported heart research, I would like to share my story. 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 experience this type of episode—a heart attack with no warning.

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 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 survive the heart bypass surgery. 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 an implantable defibrillator was inserted to control the problem in 2002. However, this device had to be replaced 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 Hospital. 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. They explained that it could open up the original blockage

from my silent heart attack. My doctor explained that if these state-of-the art stents had been available in 1998, I would not have had to have heart bypass surgery.

Today, heart attack, stroke, and other cardiovascular diseases remain our Nation's most costly and No. 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 I am. 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 UNITED TRIBES TECHNICAL COLLEGE

For 40 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. We are governed by the five tribes located wholly or in part in North Dakota. We have consistently had excellent results, placing Indian people in good jobs and reducing welfare rolls. The Perkins funds constitute about half of our operating budget and provide for our core instructional programs for many of our Associate of Applied Science degrees. We do not have a tax base or State-appropriated funds on which to rely.

The request of the UTTC Board is for the following authorized programs:

—$8.5 million or $727,000 above the fiscal year 2009 enacted level for section 117 of the Carl Perkins Act. These funds are shared via a formula by UTTC and Navajo Technical College.

—Provision of additional funding for title III and title III–A of the Higher Education Act (HEA) that provide construction funds for facilities at institutions of higher education (title III) and at tribally controlled colleges (title III–A). For example, UTTC needs an additional $10.9 million to complete the construction of a new science and technology building towards which UTTC already has obtained $3 million.

The students who attend UTTC are from Indian reservations from throughout the Nation, with a significant portion of them being from the Great Plains area. Our students 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 funds from section 117 of the Carl Perkins Act, 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. The Carl Perkins funds we receive are essential to our students' success.

Perkins Authorization.—Section 117 of the Carl D. Perkins Career and Technical Education Act (20 U.S.C. section 2327) is the source of authorization of Perkins funding for UTTC. Section 117 is entitled "Tribally Controlled Postsecondary Career and Technical Institutions." First authorized in 1991, Congress has continued this authorization in the subsequent reauthorizations of the Perkins Act. Funding under this act has in recent years been distributed on a formula basis to UTTC and to Navajo Technical College.

Despite the explicit congressional authorization for Carl Perkins funding for section 117, and despite the administration's requests for funding for section 117 in all previous years, the Bush administration requested nothing for this program for fiscal year 2009. We are pleased that Congress recognized the value of UTTC's programs, and instead gave a priority to UTTC and Navajo Technical College by appropriating a $227,000 increase for section 117 Perkins in the recently enacted Omnibus appropriations bill for fiscal year 2009. However, in the process our section 117 program was listed as an earmark, despite the authorization for the appropriated amount. As a continuing, authorized Native American serving program, we should not be considered an earmark.

UTTC Performance Indicators.—UTTC has:

—An 80 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 1 of only 2 tribal colleges accredited to offer accredited on-line (Internet-based) associate degrees.
—More than 20 percent of our graduates go on to 4-year or advanced degree institutions.

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.

The demand for our services is growing and we are serving more students. For the 2008–2009 year we enrolled 1,023 students (an unduplicated count), nearly four times the number served just 6 years ago. Most of our students are from the Great Plains, where the Indian reservations have a jobless rate of 76 percent (Source: 2003 BIA Labor Force Report), along with increasing populations. These statistics dramatically demonstrate the need for our services at increased levels for at least the next 10 years.

In addition, we are serving 141 students during school year 2008–2009 in our Theodore Jamerson Elementary school and 202 children, birth to 5, are being served in our child development centers.

UTTC course offerings and partnerships with other educational institutions. We offer 17 accredited vocational/technical programs that lead to 17, 2-year degrees (Associate of Applied Science (AAS)) and 11, 1-year certificates, as well as a 4-year degree in elementary education in cooperation with Sinte Gleska University in South Dakota.

Licensed Practical Nursing.—This program has one of the highest enrollments at UTTC and results in the greatest demand for our graduates. Our students have the ability 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.—Our Tribal Environmental Science 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, the leading cause of death among Native Americans ages 1–44, and the third leading cause of death overall. This program has in the past been supported by the Indian Health Service, and is the only degree-granting Injury Prevention program in the Nation. Given the overwhelming health needs of Native Americans, we continue to seek new resources to increase training opportunities for 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. However, we also note the lack of on-line opportunities for Native Americans in both urban and rural settings, and encourage the Congress to devote more resources in this area.

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. More than 80 courses are currently offered online, including those in the Medical Transcription and Coding program. We presently have 50 online students in various courses and 137 online students in the Medical Transcription program.

We also provide an online Indian Country Environmental Hazard Assessment program, offered through the Environmental Protection Agency. This is a training course designed to help tribes understand how to mitigate environmental hazards in reservation communities.

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.—UTTC helps meet the challenge of fighting diabetes and other health problems in Indian Country, such as cancer, through education and research. Indians and Alaska natives have a disproportionately high rate of type 2 diabetes, and have a diabetes mortality rate that is three times higher than the general U.S. population. The increase in diabetes among Indians and Alaska natives is most prevalent among young adults aged 25–34, with a 160 percent increase from 1990–2004. (Source: Fiscal Year 2009 Indian Health Service Budget Justification). Our research about native foods is helping us learn how to reduce the high levels of diseases in our communities.

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. Currently, there are very few Indian professionals in the country with training in these areas. Our degree places a strong emphasis on diabetes education, traditional food preparation, and food safety. We have also established the United Tribes Diabetes Education Center that assists local tribal communities, our students and staff to decrease the prevalence of diabetes by providing educational programs, training and materials. We publish and make available tribal food guides to our on-campus community and to tribes.

Business Management/Tribal Management.—Another critical program for Indian country is business and tribal management. This program is designed to help tribal leaders be more effective administrators and entrepreneurs. As with all our programs, curriculum is constantly being updated.

Job Training and Economic Development.—UTTC continues to provide economic development opportunities for many tribes. We are a designated Minority Business Development Center serving South and North Dakota. We administer a Workforce Investment Act program and an internship program with private employers in the region.

South Campus Development.—The bulk of our current educational training and student housing is provided in 100-year-old buildings, part of a former military base used by UTTC since its founding in 1969 and donated to us by the United States in 1973. They are expensive to maintain, do not meet modern construction and electrical code requirements, are mostly not ADA compliant, and cannot be retrofitted to be energy efficient.

As a result, UTTC has developed plans for serving more students in new facilities that will provide training and services to meet future needs. We are now developing land purchased with a donation that will become our south campus. Infrastructure for one-fourth of the new campus has been completed, and we have now obtained partial funds for a new, and badly needed, science, math, and technology building. We need an additional $10.9 million to help complete this building. Our vision for the south campus is to serve up to 5,000 students. We expect that funding for the project will come from Federal, State, tribal, and private sources. Without additional funding for titles III and III–A of the HEA, that provide construction funds for campuses such as ours, many students will be denied the opportunity for higher education.

Our Department of Education funds are essential to the operation of our campus. Our programs at UTTC continue to be critical and relevant to the welfare of Indian people throughout the Great Plains region and beyond. Thank you for your consideration of our request.

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